HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD

TUESDAY 13 MARCH 2018, THE BOARDROOM, HULL ROYAL INFIRMARY AT 9.00AM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC
OPENING MATTERS

1.	Apologies	verbal	Chair – Terry Moran
2.	Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this Agenda	verbal	Chair – Terry Moran
3.	Minutes of the Meeting of 30 January 2018 • To review, amend and approve the minutes of the last meeting	attached	Chair – Terry Moran
4.	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker	attached	Director of Corporate Affairs – Carla Ramsay
	4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
	4.3 Board Reporting 4.3.1 Board Reporting Framework 2017-19 4.3.2 Board Development Framework 2017-19 • To review the current Board Reporting Framework and Board Development Framework and determine if any updates are required	attached attached	Director of Corporate Affairs – Carla Ramsay
5.	Chair's Opening Remarks	verbal	Chair – Terry Moran
6.	Chief Executive's Briefing • To receive the Chief Executive's briefing to the Board	attached	Chief Executive Officer – Chris Long
	QUALITY		
7.	Patient Story • To focus the Trust Board on quality of patient care	verbal	Chief Medical Officer – Kevin Phillips
8.	Quality Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and /or actions are required	attached	Chief Nurse – Mike Wright
9.	Nursing and Midwifery Staffing Report The Trust Board is requested to receive this report and: • Decide if any further information and /or actions are required	attached	Chief Nurse – Mike Wright
10.	Fundamental Standards Report • The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits	attached	Chief Nurse – Mike Wright

	Item		Lead
11.	Quality Committee Minutes 11.1 29 January 2018/26 February 2018 Minutes • Receive the final minutes from the 29 January 2018 and the draft minutes from 26 February 2018 meeting • Committee Chair to highlight any areas of escalation to the Trust Board from the minutes	attached	Chair of Committee – Trevor Sheldon
	PERFORMANCE		
12.	Performance and Finance Report • To highlight the Trust's performance against the required standards	attached	Chief Operating Officer – Ellen Ryabov Chief Financial Officer – Lee Bond
13.	Tracking Access Update • The Board to receive an update	verbal	Chief Operating Officer – Ellen Ryabov
14.	Performance and Finance Committee Minutes 14.1 29 January 2018/26 February 2018 Minutes • Receive the final minutes from the 29 January 2018 and the draft minutes from 26 February 2018 meeting	attached	Chair of Committee – Stuart Hall
	STRATEGY AND PLANNING		
15.	Financial Planning 2018/19 • The Trust Board is asked to note the progress being made with regard to finalising the financial plan for 2018-19 and confirm the approach to take for signing off the final submission to NHSI by 30th April, including the decision with regard to the agreement or not of the revised control total for 2018/19	attached	Chief Financial Officer – Lee Bond
	15.1 Capital Planning 2018/19 • The Trust Board is asked to approve the Capital Programme for 2018/19	attached	Chief Financial Officer – Lee Bond
	15.2 Draft Operating Plan 2018/19 • The Trust Board is asked to review the Draft Operating Plan 2018/19	attached	Director of Strategy and Planning – Jacqueline Myers
16.	Equality Diversity and Inclusion Strategy • The Board is asked to approve the Trust's Equality, Diversity and Inclusion Strategy 2018-21	attached	Director of Workforce and OD – Simon Nearney
	ASSURANCE AND GOVERNANCE		
17.	Organ Donation Team Update • The Board is asked to receive an update from the Organ Donation Team	presentation	Organ Donation Team – Alexandra Wray
18.	Gender Pay Gap Report • The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2017, prior to publication of the data in line with statutory requirements.	attached	Director of Workforce and OD – Simon Nearney
19.	National Staff Survey 2017 results • The Trust Board is asked to note the contents of this report and commit to supporting continuing work to improve the working environment for staff and the culture of the organisation.	attached	Director of Workforce and OD – Simon Nearney

20.	Guardian of Safe Working Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required	attached	Chief Medical Officer – Kevin Phillips
21.	Standing Orders • To approve the use of the Trust seal	attached	Director of Corporate Affairs – Carla Ramsay
22.	Draft Audit Minutes 27 February 2018 • Receive the draft minutes from the February 2018 meeting	attached	Chair of Committee – Tracey Christmas
23.	Draft Charitable Funds Minutes 15 February 2018 • Receive the draft minutes from the February 2018 meeting	attached	Chair of Committee – Andy Snowden
24.	Any Other Business	verbal	Chair – Terry Moran
25.	Questions from members of the public	verbal	Chair – Terry Moran
26.	**Date and time of the next meeting:** Tuesday 15 May 2018, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary		

Attendance

	2018						2019		
Name	**30/1**	**13/3**	**15/5**	**10/7**	**11/9**	**13/11**	**29/1**	**12/3**	**Total**
T Moran	✓								1/1
A Snowden	✓								1/1
S Hall	✓								1/1
V Walker	✓								1/1
T Christmas	x								0/1
M Gore	✓								1/1
T Sheldon	x								0/1
C Long	✓								1/1
L Bond	✓								1/1
M Wright	✓								1/1
E Ryabov	✓								1/1
K Phillips	✓								1/1
In Attendance									
M Veysey	x								0/1
J Myers	✓								1/1
S Nearney	✓								1/1
C Ramsay	x								0/1
R Thompson	✓								1/1

	2017										
Name	**4/4**	**2/5**	**25/5 Extra**	**6/6**	**4/7**	**1/8**	**5/9**	**3/10**	**7/11**	**5/12**	**Total**
T Moran	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	9/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
S Hall	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	9/10
V Walker	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	9/10
M Gore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
T Sheldon	x	✓	✓	x	✓	✓	✓	x	✓	✓	7/10
C Long	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
L Bond	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
M Wright	✓	✓	✓	✓	✓	✓	JL	✓	✓	✓	9/10
E Ryabov	✓	✓	✓	✓	x	✓	MK	✓	✓	✓	8/10
K Phillips	✓	✓	✓	✓	✓	MP	✓	✓	✓	CH	8/10
In Attendance											
M Veysey	-	-	-	-	-	-	✓	✓	✓	✓	4/4
J Myers	✓	✓	✓	✓	✓	x	✓	x	✓	✓	8/10
S Nearney	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	9/10
C Ramsay	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
R Thompson	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10

JL – Jo Ledger
MK – Michelle Kemp
MP – Makani Purva
CH – Caroline Hibbert

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
MINUTES OF THE TRUST BOARD
HELD ON 30 JANUARY 2018
THE BOARDROOM, HULL ROYAL INFIRMARY

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

NO.	ITEM	ACTION
1	**APOLOGIES** Apologies were received from Prof. T Sheldon, Non Executive Director, Mrs T Christmas, Non Executive Director, Prof. M Veysey, Associate Non Executive Director and Ms C Ramsay, Director of Corporate Affairs	
2	**DECLARATIONS OF INTEREST** **2.1 CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING** • Mrs Ryabov declared that her sister is now working on the Trust Bank. • Mrs Walker declared that she was now a Governor of East Riding College. • Mr Gore declared that he had been appointed as Specialist Finance Adviser to the Audit Committee of the UK Anti Doping Agency. **2.2 TO CONSIDER ANY CONFLICTS OF INTEREST ARISING FROM THIS AGENDA** There were no conflicts of interest raised in relation to the agenda.	
3	**MINUTES OF THE MEETING HELD 5 DECEMBER 2017** Mrs Walker and Mr Snowden were incorrectly included in apologies for the last meeting. Following the above change the minutes were approved as an accurate record of the meeting.	
4	**MATTERS ARISING** Mr Wright advised that he would add the Serious Incident and Never Event trend analysis to his next Quality Report in March 2018.	**MW**

4.1 ACTION TRACKER

VTE Assessments – Mr Phillips updated the Board and advised that the current performance was 89.4% against a target of 95%. This was due to assessments not being recorded on the Lorenzo system and not about the assessments not being carried out. Dr Smithson was liaising with the Lorenzo team to work with any poor performing clinical areas.

The Quality Committee were reviewing VTE performance and would escalate any issues back to the Board if necessary.

The Fundamental Standards improvement work to be presented at the Quality Committee in February 2018.

4.2 ANY OTHER MATTERS ARISING

There were no other matters arising.

4.3 BOARD REPORTING

4.3.1 BOARD REPORTING FRAMEWORK

The Board received the reporting framework.

4.3.2 BOARD DEVELOPMENT FRAMEWORK

The Board received the development framework.

5 CHAIR OPENING REMARKS

Mr Moran spoke about the Chief Operating Officer job share interviews and that the successful candidate had been selected and would be made public in the next few days.

He also thanked all members of staff at the Trust for the commitment and extraordinary efforts made despite challenging pressures and added that their work does not go unnoticed.

6 CHIEF EXECUTIVE'S BRIEFING

Mr Long reported that the hospital was under pressure with the challenges of winter and the level of illness being seen. The volume of patients and acuity of medically ill patients was increasing the average length of stay and putting yet more pressure on the system and also the staff.

Mr Long advised that the trust would be running operation Wintergreen, (a 'perfect week') and an update would be presented at the next Board meeting.

The Trust's finances had been discussed with NHS Improvement and a revised control total had been agreed. A review of agency staffing and stock levels were being carried out to help with reducing expenditure approaching the financial year end.

In relation to the written report from Mr Long, Mr Snowden was particularly interested about the work being carried out to treat respiratory patients at home and asked if this would be widened to other forms of treatment. Mr Long advised that the STP agenda was reviewing home care, in particular end of life care which had specific benefits. Mr Long also mentioned the Integrated Care Centre in East Hull that would hopefully ease some pressure on the system.

Mr Hall reported that he had attended the excellent City of Culture event at the Guildhall which celebrated the new babies born in 2017 by creating artwork using their footprint. Mr Hall commended Jan Cairns and Sally Ward for all their hard work.

Mr Gore asked if the Trust was receiving support from its local partners and Mr Long assured him that there were strong levels of commitment.

Mr Moran also added that the Sepsis work undertaken was fantastic and thanked the staff involved.

7 PATIENT STORY

The first story was regarding a patient who had miscarried her baby but was not offered the scan picture of her baby. This process was under review as it was felt the scan pictures should be offered as is the case for all expectant mothers. Not providing it in the circumstances of losing her baby meant that they had no physical memento to store in a memory box. This had further negatively impacted the grieving process. The patient had now received the scan picture and the Board assured future processes had changed.

Mr Phillips' second story was a thank you letter from a patient who recognised the pressure that the NHS was under but despite this had received excellent care and compassion. One of the nurses had cancelled a holiday due to the workload of the department. The patient thanked all staff in wards 6 and 60 and also for the aftercare that they had received.

Mr Gore thanked the ED staff as his wife had been seen in the department over the Christmas period and had received excellent care in a busy environment.

8 QUALITY REPORT

Mr Wright presented the report and updated the Board regarding the Trust's 3rd Never Event in year, and the lack of national guidance relating to rib marking. The Cardiothoracic Team were reviewing the procedures and had already added real imaging at the point of commencing surgery. Mr Wright advised that the wrong site spinal surgery had been removed from the new list of Never Events recently published.

The 4th Never Event had not yet concluded and Mr Wright would report back to the Board once the investigation had been completed.

The Safety Thermometer audits were showing 98.73% of harm free care. VTE assessments were at 94% which was a higher rate than the Lorenzo system suggesting that VTEs were not being recorded rather than the assessments not being carried out.

Mr Wright informed the Board that the organisation had dealt with an MRSA infection attributed to the Trust. He reported that it had been a complicated case but that the screening had not been carried out in line with Trust Policy. Work was underway with the ward to review processes.

He highlighted that a patient who had been severely injured whilst away on holiday and arrived at the hospital carrying rare infections both Candida Auris and highly resistant *Acinetobacter baumannii* (which was highly infectious). The Trust managed the case well but the nature of the infection had to result in the closure of theatres for deep cleaning.

The Australian version of the flu was also being managed appropriately. Mr Wright reported that existing vaccines would not always protect people from this particular strain.

Mr Wright spoke about the 40 working day turnaround of complaints responses. He advised that there had been an error in the previous report but that this had been corrected. Mr Wright was discussing with Health Groups to ensure timely turnaround of complaints investigations. Mr Hall asked for assurance around the process for checking the numbers and ensuring they were now correct. Mr Wright assured the Board that the numbers had been checked but would request independent assurance from the internal auditors.

Resolved:
The Board received and accepted the report.

9 NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that the fill rates were tight but stable and the winter ward had been opened. There were 6 safety briefings per day to ensure the correct nursing levels were on each ward with patient safety as the priority.

Mr Wright also reported that another 161 students had been secured for the October 2018 intake.

Mr Gore spoke about the Philippine recruits and the delays in immigration clearance. Mr Wright assured the Board that, whilst the process was a slow one, the Trust continued to chase the clearance and was a national issue.

Mr Snowden asked what the Trust was doing to escalate the lack of funding for training more nurses on a national basis. Mr Wright reported that he had escalated his frustrations to the regional and national Chief Nurses and had recently been appointed Chair of the North of England Chief Nurse Steering Group to review this issue. Work was also being done via the Medical Directors Conferences and through the STP work, looking at locally driven solutions. Mr Long added that due to the nurse staffing shortages each Trust was competing for every new member of staff.

Mr Hall asked about retention once the overseas staff joined the Trust and Mr Nearney reported that there was a good level of support for the new recruits with a HR lead induction not only into work life but social aspects as well.

Resolved:
The Board received and accepted the report.

10 QUALITY COMMITTEE MINUTES

Mr Snowden presented the minutes to the Board and highlighted the discussion around the whole Trust approach to the Tracking Access issues and the Clinical Harm Group set up to address any patients suffering harm from the incident. He commended Mrs Ryabov for her leadership in the process and the robust processes in place. He added that NHS Improvement had asked the Trust to share their processes with other Trusts.

Mr Gore asked about the Safeguarding section of the QIP and Mr Wright assured the Board that this was now completed and showing green on the QIP.

Resolved:
The Board received and accepted the minutes and verbal update from Mr Snowden.

11 INTEGRATED PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted that the diagnostic performance was experiencing significant challenges and the Trust was expecting the cardiac breaches to increase whilst the new scanner was being installed. Endoscopy breaches had improved.

RTT performance was 81.2% in December 2017. This was due to reduced medical capacity and capacity issues in ICU. Infection in the hospital was problematic and the Tracking Access issues had also impacted performance. The 52 week wait performance was also largely due to the Tracking Access issues. Mr Moran commended the Trust on its transparency about the issues and Mrs Ryabov assured the Board that the regulators were being kept up to date.

ED performance continued to be challenging with performance at 82.4% although the Trust was performing above the national average. Ambulance waits had increased although this was mainly due to the increased numbers being received.

Cancer performance standards were improving.

Resolved:
The Board received and accepted the report.

11.1 FINANCIAL POSITION 2017/18

Mr Bond presented the report and advised that the Trust was reporting a year to date adjusted deficit of £9.4m. The positon included £3.6m due to the non-receipt of STF funding in quarter 3

The Health Group run rate positions had deteriorated in month by £2.1m. Mr Bond advised that discussion were ongoing with the Health Groups to address the issues.

After adjusting for the allocation of income to Health Groups to reflect pass-through drugs and devices costs, there was a net shortfall of £2.5m. Areas of overtrading were offset by difficult to release costs such as outpatients and excess bed days.

Agency expenditure was below plan but this was being offset by overtime and medical staffing. Mrs Ryabov added that variable pay was driving the Health Group's overspend, so a variable pay group had been established to address the issues on a weekly basis. Mrs Walker was keen to have the assurance checks in place to ensure patient safety at all times. Mr Wright assured the Board that management of the rotas was key and that at no point would patient safety be compromised. Mr Phillips added that great work had been done around the nursing rotas and work was ongoing with the medical staff to review their rotas and new ways of working.

The Capital plan was on plan and £300k had been received to enhance the Trust's cyber security developments.

The revised control total was being reviewed and risks managed with weekly briefings to the Chairman.

Mr Bond added that the cash position was extremely challenging as a result of the deficit position.

Mr Bond was keen to learn lessons from 2017/18 and build into the 2018/19 plan sound productivity and planning assumptions, allowing for winter pressures and the lack of medical staff available and to exercise caution.

Resolved:
The Board received and accepted the report.

11.2 BORROWING REQUIREMENTS 2017/18
Mr Bond presented the paper which highlighted loan applications to a maximum of £15m for quarter 4, 2017/18. It also asked that authority be given to the Chief Financial Officer, Chief Executive and the Chairman to execute loan documentation and sign Board resolutions.

Mr Gore asked if the loan repayments would affect the capital budget and Mr Bond advised that these cash loans would not impact on the capital budget.

Resolved:
The Board approved:

- Loan applications up to a maximum of £15m in quarter 4
- Authority for the CFO, CEO and Chairman to execute loan documentation and sign Board resolutions.

11.3 FINANCIAL PLANNING 2018/19
Mr Bond reported that he was awaiting guidance from the regulators and was attending a Financial Directors meeting in London on 31 January 2018 which would review 2018/19 planning.

The Trust was reviewing the underlying position with the Commissioners as well as the RTT issues. Capacity planning was underway with assumptions around vacancies being revisited and the financial gaps reviewed. There would be more discussions around transforming services.

Mr Bond advised that a full report would be received at the March 2018 Board meeting to outline the 2018/19 plan.

Resolved:
The Board received the update.

12 TRACKING ACCESS REPORT

Mrs Ryabov presented the Tracking Access Report which had been prepared by MBI who had carried out an external, independent review.

She explained the issue had come to light in March 2017 following a patient complaint relating to a follow up appointment that had not been booked. This meant that the tracking access process had not been systematically followed and resulted in a wider investigation being carried out.

By mid July 2017 it was found that 30,000 patients needed further review either clinically or from an admin point of view. Around 85,000 records were reviewed and from the 30,000 patients it was found that 9,000 patients needed some form of clinical review. 2100 of the 9000 had been reviewed so far.

The clinical reviews began in August 2017 with each consultant picking up their own patients. This meant an extra 40 patients per week to complete the validation in a timely way. Validation rooms had been running at Hull Royal Infirmary and Castle Hill 7 days per week with the objective of completing all the clinical reviews by the end of March 2018.

Mrs Ryabov reported that although health partners had reduced referrals the increase in activity was not helping as the Trust does not have the resources to deliver the current levels of activity. A system wide reset of RTT would take place and delivery of the 92 day standard discussed with the regulators.

There had been 3 patients identified with harm relating to the Tracking Access issues and all 3 have now been seen and the Duty of Candour process implemented. A new Clinical Harm Group had been established which would be chaired by Mr Shaw (Medical Director of Surgery Health Group) to address any issues with patients suffering harm as an outcome of tracking issues.

Clear discussions around demand planning and increased outpatient referrals in challenged areas would be had with the Commissioners as a retrospective piece of work. Mrs Ryabov also reported that patient education was required as very few patients had contacted the Trust to let them know that they had not been contacted for a follow up appointment.

A number of strategic challenges had been highlighted: workforce, demand and capacity strategy, job planning and addressing new follow ups. A review would be carried out with patient engagement to support the process.

Mr Hall added that he would be attending a number of the Tracking Access meetings as Performance and Finance Committee Chair to reassure the Board.

Mr Gore asked if the Trust was confident that new patients were being followed up appropriately and Mrs Ryabov advised that forward validation was being carried out which meant any issues were being picked up.

Mr Wright advised that the Tracking Access issue had been declared as an overarching Serious Incident, but any incident relating to individual patients would be declared also. He added that the Trust had independent assurance from NHS Improvement and the Commissioners that the process was robust and working well.

Mr Bond commented that there had been some confusion about how the issue had arisen. Mrs Ryabov stated that this was not an issue created by Lorenzo and had it not been for Lorenzo the problem might not have been identified. Mrs Ryabov wanted to report that the problem was not about secretaries not tracking patients correctly but about a paperless system with elements of paper added. The whole system had not been managed efficiently.

Mrs Walker asked if the Trust was confident that the involvement of the Quality Committee regarding the Tracking Access issue was robust and Mr Wright assured her that the outcomes of the Clinical Harm Group and any other quality issues or Serious Incidents following the validation work would be presented at the Quality Committee. In fact there had been a full discussion at QC only the day before. The Performance and Finance Committee and the Board would also have regular progress updates.

Mr Moran added that he felt assured that at all levels the issues were being dealt with appropriately and the right transparency with the regulators and commissioners was in place. He asked that the Board receive updates at meetings for the foreseeable future.

Resolved:
The Board received and accepted the report and requested update reports at future meetings. **ER**

13 PERFORMANCE AND FINANCE COMMITTEE MINUTES

Mr Hall presented the minutes of the meetings but advised that the main areas had been discussed as part of this Board agenda. In addition he highlighted that the Committee had discussed ED performance and the number of patients held in the hospital that were fit for discharge, how the teams were reviewing the front end of the pathway and that the 62 day cancer standard had been achieved for the first time in 2 years.

He spoke about the financial recovery plan 2017/18 and the key actions being around land revaluation and possible capital transfer for demolition works, clinical stock levels and non pay projects to help achieve the control total.

More work identifying CRES and the Health Group run rates were being reviewed on a weekly basis as well as variable pay.

Resolved:
The Board received and accepted the minutes and verbal update from Mr Hall.

14 MORTALITY REVIEWS

Mr Phillips presented the report and advised that the process and finding of the Structured Case Note Reviews had been presented to the Quality Committee and formed part of a Board development session.

Mr Phillips highlighted a number of key themes that were being identified following the reviews: poor quality documentation, delays in senior reviews and delay in escalation of high NEWS scores. He advised that e-Observations would address the escalation issues but this would mean accessing capital funding for well performing networks and wifi.

The Serious Incident process was being aligned with the Structured Judgement Case Note Reviews.

Mr Moran asked how the Board gained assurance that this specialist area of work was being carried out correctly and robustly. Mr Phillips assured him that the process was independently reviewed by trained staff. He also advised that the process would also be subjected to external review in the future.

Resolved:
The Board received and accepted the report and agreed to receive updates on a quarterly basis. **KP**

15 STANDING ORDERS

Mrs Thompson presented the report which highlighted the use of the Trust's seal, a new section in Standing Financial Instructions for the approval of bids in new areas of work and the changes made to the Audit Committee Terms of Reference.

Resolved:
The received the report and approved:

- The use of the Trust seal
- The new section relating to the approval of bids
- The Audit Committee Terms of Reference

16 BOARD ASSURANCE FRAMEWORK

Mrs Thompson presented the updated report to the Board. The Board was asked to identify any gaps in assurance, highlight any positive assurance and approved the proposed Q3 risk ratings.

Mr Snowden added that the BAF had been presented to the Quality and Performance and Finance Committees the day before.

Resolved:
The Board received the report and approved the proposed Q3 risk

ratings.

17 DRAFT AUDIT COMMITTEE MINUTES
Mr Gore presented the minutes and highlighted the unsuccessful STF funding bid relating to diagnostics as being regrettable.

18 ANY OTHER BUSINESS
There was no other business discussed.

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

20 DATE AND TIME OF THE NEXT MEETING:
Tuesday 13 March 2018, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
January 2018						
01.01	Mortality Reviews	Report to be received quarterly	KP	May 2018		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB	Mar 2018 to PAF	May 2018	To be included in the IM&T Strategy
COMPLETED						
November 2017						
	Performance Report	VTE Assessments – Update to be received	KP			Update received at the Jan 2018 meeting

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
Quality Committee						
Aug 2017	Fundamental Standards	Improvement approach and how nurses are supported in the areas were more work is needed to be discussed at the committee	MW	Feb 2018		Completed

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

Overarching aims:

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

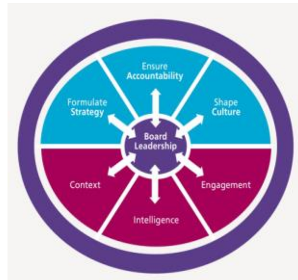
Board Development Dates 2017-19	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion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

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

Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve What could prevent the Trust from achieving this goal? Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence	BAF 2: There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There are recurring risks of under-recruitment and under-availability of staff to key staffing groups There is a risk that the Trust continues to have shortfalls in medical staffing What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence	BAF 3: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years What could prevent the Trust from achieving this goal? Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like	BAF 4: There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements What could prevent the Trust from achieving this goal? For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a	BAF 5: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships What could prevent the Trust from achieving this goal? Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP	BAF 6: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2017-18 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services BAF 7.2: Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment BAF 7.3: Principal risk: There is a reputational risk as a result of the Trust's ability to service creditors on time, with the onward risk that businesses refuse to supply What could prevent the Trust from achieving this goal? Lack of sufficient cashflow

Principles for the Board Development Framework 2017 onwards

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

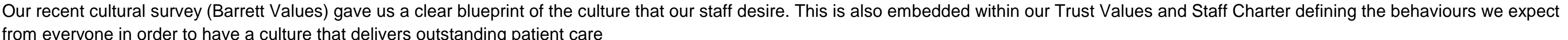


<u>Overarching aim:</u>

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

<u>Area 1 – High Performing Board</u>

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



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

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

<u>Area 2 – Strategy Development</u>

Strategy refresh commenced

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

<u>Area 3 – Looking Outward/Board education</u>

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

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

<u>Area 4 – Deep Dive and exceptions</u>

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

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

February 2018

1. KEY MESSAGES AND MEDIA STORIES

Thank you to all staff
This winter has been hugely challenging for our staff. We continue to see increasing numbers of patients presenting in the Emergency Department and the recent cold weather has only served to increase the pressure on our hospitals. Despite this our staff maintain a professional and cheerful approach in their delivery of great care.

While parts of the country were brought to a standstill by the recent wintry weather many of our staff braved the wintry conditions to come to work.

Ophthalmology staff kept our busiest clinic running after the heating broke down during the Arctic conditions. Maintenance workers at the Eye Hospital were called in after the heating system in the main reception area broke down on Wednesday 28th February. With the temperature outside several degrees below freezing staff remained at work and wore gloves and coats so they could still type in patients' details and send out appointment letters.

Radiotherapy staff at the Queen's Centre also battled through heavy snow and blizzard conditions from Sheffield, Brigg, Bridlington and Rotherham to ensure they were at their posts so patients' cancer treatment could begin on time.

Team members covered for co-workers who had been unable to get into Hull Royal Infirmary and Castle Hill Hospital, working well beyond the end of their shifts so patients continued to receive the best possible care.

Estates staff also worked round the clock to clear pathways and car parks, ensuring patients, staff and visitors were able to get into the hospitals.

Once again our staff in all areas continue to demonstrate their dedication to our patients and on behalf of the Trust Board I would like to formalise our thanks to them in this meeting of the Trust Board.

Care Quality Commission inspection
The latest stage of our Care Quality Commission inspection has now concluded. The Chief Nurse delivered a presentation to the inspection team last week covering the 'Well Led' domain Key Lines of Enquiry (KLOEs) such as governance, risk management and patient engagement, before the team continued the three-day inspection across wards and departments. As always the initial feedback is not sufficiently detailed for us to make any predictions regarding the outcome of the inspection however we received no urgent improvement notices and the inspectors noted that improvements had certainly been made in many areas. Thank you to everyone who contributed and who took the time to talk to inspectors while they were on site.

We anticipate the outcome of the inspection to be publicised from 1st June.

Inpatient Survey 2017
The Trust conducted its 2017 Inpatient Survey with the assistance of the Picker Institute last year. Recent data provided by Picker has shown an outstanding improvement for our organisation within the last year, with the Trust being the 6th most improved overall out of

the 81 organisations Picker worked with. The Trust's 'problem score' based on feedback from patients and service users was 45 out of 81 in 2016, but this has since improved to 24 in the most recent survey results. Thank you to everyone who has contributed to this clear improvement in patient experience across our hospitals.

Operation Wintergreen achieves benefits for patients and staff
Despite the ongoing pressures in our hospitals fewer patients experienced delays in the Emergency Department during our eight-day Wintergreen initiative which freed up beds and diverted staff to the frontline to cope with winter pressures.

The programme was launched on Monday, January 29, to reduce ED delays and the number of patients with medical conditions who were being sent to surgical wards because of bed pressures.

As the initiative ended on 5th February, figures show almost 87 per cent of patients were seen within four hours during Operation Wintergreen compared to 83 per cent the previous week, with 85 fewer patients waiting longer than four hours.

Fewer medical patients were sent to surgical wards, during the week, an improvement of more than 31 per cent on the previous week's figures.

While there was not a dramatic transformation, Operation Wintergreen has been of benefit to both our patients and our staff.

Extended career opportunities for student nurses
During February we offered new careers to around 165 students, set to qualify as adult nurses in September. Now, following this latest success of our "Remarkable People, Extraordinary Place" recruitment campaign, we are increasing the number of career pathways open to students to attract more applications as well as making the application process easier, with students able to select their own interview days and times.

As part of this approach we have opened up most of our specialties to student nurses to allow them to experience career paths they may not have considered during their training. We are also offering 18-month rotations as an option, where students will spend six months in three diverse areas across the range of hospital services to enable our new recruits to experience the full spectrum of nursing.

From theatre and frontline emergency work to ward-based nursing in specialities including medical elderly, neurology and women's health, we can offer students complete grounding in the profession and allow them to determine where they would like to work.

While the majority of our applications have come from the University of Hull, applications have also been received from students at universities in Lincoln, Leeds, Sheffield, York, Manchester and Tees-side.

New hospital service to help families find care homes for loved ones
Families are benefiting from a new hospital service supporting families to find the right care home or respite care.

Our Trust has commissioned a new service from CHS Healthcare to help families through the difficult decision of placing a loved one in residential or nursing care. Under the new scheme, people who have been assessed by local authority social care teams as requiring residential or nursing care are 'matched' with homes best suited to their needs.

They and their families are then taken to visit the selection and are supported by fully trained staff as they make their decision, with the team able to place patients in care homes within an average of three days.

The new service has received 32 referrals since it was introduced on January 29 for patients living in the East Riding. Patients requiring residential or nursing care and who have Hull GPs will benefit from the service from this week.

With research showing patients over 80 suffer 10 years of muscle ageing for every 10 days spent in a hospital bed, the new service is allowing people to be discharged to a facility more suited to their health needs more quickly.

Working with the British Red Cross to get patients home sooner
Patients well enough to be discharged from hospital are returning home sooner after the launch of a new seven-day service. Our Trust has teamed up with the British Red Cross to offer the assisted discharge scheme to patients ready to be discharged from Hull Royal Infirmary and Castle Hill Hospital.

For the first time, the service is operating seven days a week between 10am and 6pm and patients with East Riding GPs are now benefiting from the extended service as well as those living in Hull.

Many of our patients require some form of support in the immediate aftermath of hospital stays. Offering this service means our patients are being supported in those first few days at home while they are getting back on their feet. It also means we are able to free up beds to cope with increasing admissions of patients with complex health conditions seen at hospitals all over the country this winter.

In the six weeks since the scheme was extended in January, 215 patients have been helped by hospital staff and the Red Cross to return home sooner from Hull Royal Infirmary. The service from Castle Hill is due to begin shortly.

Once home, Red Cross staff and volunteers will check on the person in their own environment, ensuring they have provisions, family or friends have been contacted and alert systems such as Lifeline are working.

New parents brave ‘Beast from the East’ to attend Carousel event
Also braving the bad weather last month were 64 prospective parents who attended a special event at Hull Women and Children’s Hospital on 28th February..

The HEY Baby Carousel saw midwives on hand to answer questions, give advice and practical information to people preparing for the arrival of their new babies.

As well as midwives who could talk to mums about the delivery ward, staff from the Fatima Allam Birth Centre were also giving out information about the midwifery-led unit, an option for those women considered at low risk of complications.

The next Carousel will be held on Wednesday, March 28, between 6pm and 8pm at Hull Women and Children’s Hospital. There’s no need for an appointment, just drop in and get a warm welcome from our team.

World Kidney Day - Mum thanks doctors for saving her life
A mother-of-two has told how she has battled kidney disease after undergoing four kidney transplants including two from her parents.

To mark World Kidney Day on March 8, Michelle Barber has thanked the team of renal experts at Hull Royal Infirmary who have spent 24 years saving her life.

Michelle, 37, underwent her first of four kidney transplant at 16, became one of the few women to become pregnant during kidney dialysis and then did it again. She even survived at one stage thanks to an infusion of antibodies from a rabbit.

Chronic kidney disease affects 195 million women worldwide and events, including at Hull Royal Infirmary were held around the world to raise awareness of kidney disease and women's health to mark both World Kidney Day and International Women's Day on March 8.

Women offered ultrasound images by hospital staff after early miscarriages
Women who suffer miscarriages in the early stages of pregnancy are to be offered ultrasound images of their babies.

Our Trust recently introduced special "Forget-Me-Not" memory boxes to help women cope with the loss of their child in the first few weeks of pregnancy. Now, a new policy ensures parents enduring the loss of their babies will be offered scan photographs.

The trust introduced the memory boxes last year to help parents who lose a child to miscarriage, ectopic or molar pregnancy.

While memory boxes were already provided for women losing babies in later stages of pregnancy or shortly after birth, staff nurse Hayley Ellenton came up with the idea of providing the boxes for women on Cedar Ward at the Woman and Children's Hospital and in the Early Pregnancy Assessment Unit.

She set up a fund to buy and fill the box with items including a packet of forget-me-not flower seeds to plant in remembrance, a journal and candle, a bespoke pendant and a memorial certificate to mark the day the pregnancy was lost.

Children's surgeon highlights concerns over 'body piercing' magnet craze
A children's surgeon is raising awareness of the dangers of magnets after saving the lives of children falling victim to a new 'body piercing' craze.

Hull Royal Infirmary's paediatric surgery department has treated three children who have swallowed high powered ball-bearing magnets in the past three months. A four-year-old child was lucky to escape injury as the magnets stuck to each other and passed through their digestive system without complications.

Sanja Besarovic, a consultant paediatric surgeon at Hull and East Yorkshire Hospitals NHS Trust, has written to the Royal Society for the Prevention of Accidents as the latest craze where young people attempt to mimic body piercings sweeps schools.

Grieving family donate incubator described as 'next best thing to the womb'
The family of a young man killed in a motorbike accident are donating an incubator described as "the next best thing to the womb" to care for the area's sickest babies. Kirsty and Rob Gill decided to raise £18,000 to pay for the incubator in memory of their son Christopher, who was just 20 when he lost his life in an accident in Ottringham in June 2009.

Specialist staff at the neonatal intensive care unit (NICU) based in Hull Women and Children's Hospital will began a trial of the Drager Babyleo incubator during February. To support the baby's development, the Babyleo incubator has a low operating noise level and low level lighting, reducing the baby's exposure to potential harmful stimuli.

The mother's voice or heartbeat can be recorded as part of an integrated audio function to soothe her baby and the height can be adjusted so the parents can sit as close to their baby as possible. The incubator features a mattress and heaters synchronised to avoid both heat loss and overheating for babies being cared for on the unit.

Information on the baby's condition is displayed as part of a "family view", enabling parents to understand progress at a glance and help them feel involved in the infant's care.

Golden Hearts Awards 2018
Thank you to everyone who nominated a team or individual for a Golden Hearts award this year. A record number of 241 entries was received. The judging panel will meet on Thursday 8th March to agree their finalists in each of the award categories, and details of the top three individuals and teams in each category will be released shortly afterwards. Staff will also be invited to vote for their winners in each of the four Outstanding Individual categories (Nursing/Clinical/Non Clinical/Scientific, Therapeutic and Technical) via Pattie from Friday 9th March. The awards ceremony will take place on Friday 15th June at the Hilton DoubleTree on Ferensway.

2. MEDIA COVERAGE

The Communications team targets 80% positive coverage during any given month and during January we achieved 85% from 71 articles generated.

During February 2018 53 articles out of 88 generated were positive (60%). Performance this month was negatively impacted upon by coverage of the trial and conviction of a Trust nurse for paedophile offences, committed outside of work, and a patient diary publicised as part of an inquest into the death of a 30-year-old patient.

13 news releases were issued from the Communications office this month (click on links to read full story):

1 February - Operation Wintergreen ensuring patients are seen more quickly
5 February - 'It's great to work as a team': Staff volunteer for Operation Wintergreen
6 February - Operation Wintergreen achieves benefits for patients and staff
6 February - Grieving family donate incubator described as 'next best thing to the womb'
7 February - What you need to know about giving birth in water
14 February - Patient tracking issues – Trust statement
20 February – Trust offers nursing careers to record numbers of university students
20 February - Deadline reminder for 'Baby Footprints' artwork
21 February - False nails and blackheads: The 'medical emergencies' at Hull Royal's A&E
22 February - Children's surgeon highlights concerns over 'body piercing' magnet craze
22 February - Support for prospective parents at HEY Baby Carousel event
23 February - Hospitals work with British Red Cross to get patients home sooner
26 February - Hospital trust extends career opportunities for student nurses
27 February - Women offered ultrasound images by hospital staff after early miscarriages

Social media

The total "reach" for Facebook posts on all Trust pages in February was 246,084 (January 464,499; December 405,200; November 189,600.

- Hull Women and Children's Hospital – 104,712 (January 238,446, Dec 202,300)

- Hull Royal Infirmary – 50,945 (January 108, 313; Dec 98,700)
- Hull and East Yorkshire Hospitals Trust – 35,514 (January 59, 444, Dec 65,400)
- Castle Hill Hospital – 28,158 (January 58, 296, Dec 38,800)
- HEY Jobs page 26,755

Twitter
@HEYNHS

- 78,500 impressions in February (144,700 in January, 177,000 in December; 64,000 in November)
- Followers 5,216 (5,154 in January)

@AllisonCoggan (only for fly on the wall tweets with staff)

- Carousel event at Hull Women and Children's Hospital - 12,036 impressions (figures submitted 12 hours after event, therefore this figure should rise).

3. 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 February we received 76 Moments of Magic nominations, which is the highest number we have ever received in one month since we launched the scheme in 2011:

The Neurology Secretarial Team	In the face of challenging times, the Neurology secretarial team has recently pulled together to present a real team spirit!! The change in approach from all members of the team has not gone unnoticed; whilst there is still lots of work to be done, it is refreshing to see this positive "can-do" approach from the team - well done, all!!	**27/02/2018**
Tina Hair	Being a great colleague , always helping out , positive attitude , great with patients . Being that colleague that you know you will have a good shift if she is in your team. Reliable and hard working person , always putting a smile on people faces.	**24/02/2018**
Andy Tozer	for being a very good team player. positive attitude towards staff and patients. very supportive in crisis situations.	**24/02/2018**
Ruth Doggitt	Both myself and my Colleague were trying to locate	**23/02/2018**

	some casenotes for the Senior Sisters, but were having great difficulty finding them. We'd tried every avenue and were beginning to wonder if we would ever find them. Ruth was one of members of Staff we asked and we knew if anybody could find them, it would be her. Sure enough, Ruth came to our rescue at the 11th hour and found them for us! Always pleasant, willing to help anybody, I think she deserves a Golden Heart any day.	
Peter Hudson	Peter became a volunteer in the patient lounge, he shows great compassion to all he meets, his pleasant manner towards the patients and staff make a friendly atmosphere while waiting for discharge. He helps the staff in many ways and I believe this needs to be rewarded.	**22/02/2018**
Natalie Clark	I would like to nominate Natalie Clark she is the management assistant in AMU/ED/ACU The dept is such a positive environment to work in and her door is always open for any problems any of us may have, well done Natalie your a breath of fresh air in this dept keep up the great work your doing fab	**20/02/2018**

Suzanne Thompson	Suzanne I find is really helpful in the department,she goes over and beyond and lovely to all of the customers that arrive, always smiling. keep up the good work Suzanne well done	**20/02/2018**
Ashleigh Jaffray	Ashleigh has made a massive impact on the ward since she joined us just over a year ago as our discharge assistant that we don't know what we'd do without her now! She always ensures the patient's discharge is as fluent as possible, and chases the doctors round ensuring the IDLs are done before she goes home that day! As an animal lover, she always make sure if a patient has a pet at home that the animal is being looked after or if she can help in any way to ensure they are safe. She once rescued a patient's budgie from their home and brought into hospital for him! This comforted	**20/02/2018**

	the patient greatly and he was forever thankful for Ashleigh's kindness and goodwill. Thank you Ashleigh for your positive working attitude and for keeping spirits high with your warm smile and kind nature. Ward 5 are forever grateful, never leave us!	
Sallie Ward	Following a reduction in staff supporting Sallie, she has continued to support the community staff over and beyond what is expected of her. She ensures all staff have a sensible rota, she is never too busy to speak with anyone and always listens to their concerns. Despite this, she manages the junior sisters, the community services, and completes tasks given to her by the senior matrons and head of Midwifery. A truly amazing person and a credit to the profession. Her work and commitments rarely being acknowledged by those she works with	**19/02/2018**
Amy, Melissa, Sue	For being an amazing help throughout previous challenging weekends! We couldn't have been without you! Thank you, keep up the good work!	**18/02/2018**
Pam Barnes and if you can find the name of my lovely anaesthetist	I went for day surgery in unit 3 CHH (CDS3) on friday 16th Feb 2018 for a hip injection under GA and Pam was the nurse who looked after me throughout my visit...from arriving into the department she acted in a friendly, kind, professional manner to not just me but all the other patients waiting for surgery. Even when I was in having my paperwork checked she was informative of what I was to expect before and after.I then witnessed that our original anaesthetist had phoned in sick so our replacement arrived at our door (Sadly I cant remember his name but also another value member of the NHS team who kindly stepped in to allow our list to continue and not be cancelled...thankyou) who she greeted and as there were no available rooms for him to complete his checks on us all she	**17/02/2018**

	apologised to me and we vacated the room to another area to allow him to continue with his value part of the care team to allow this list to run. Once changed Pam kept popping in with updates and I went to surgery. From the kind operating team with impecable care, the surgeon Mr Shaw , the recovery team and everyone behind the scenes not forgetting the lovely house keeper who bought me a a very welcomed cup of coffee and toast. Pam was there to do the finale with Post-op instructions and contact numbers......... yes I work for the trust, yes it was only a trivial procedure compared to all the other stuff that goes on and yes I'm proud of you all.	
Pam Burke	During a particularly busy shift recently with some exceptionally sick patients, the nurse in charge took a ventilated patient due to the high acuity on the unit. This resulted in her being unable to take a break. Pam is always very supportive to all staff, and often misses breaks.	**17/02/2018**
Angela Robinson	A very kind and caring person, helping me to comes to terms with the sudden deteration of my husband. She was always around to give and cuddles if I needed them I cannot thank her enough a very valuable member of ward 9.	**16/02/2018**
Hannah Hatherley	Helping my in my new role as a auxiliary nurse on ward 10! she has given me confidence and supported me throughout all of my shifts! always a pleasure to work with, and nothing is ever too much bother.	**16/02/2018**
Dave	Dave really helped me on a night shift whilst I was struggling with an unstable diabetic, he took time out of his own work load to come over to my ward and help both myself and the doctor in getting the patient more controlled. He was so helpful and didn't complain once but was happy to help!	**16/02/2018**

	Thank you so much :D	
Lisa Gallagher Kenningham	I would like to put forward lisa for a magic moment, Lisa has gone through a lot of personal family losses last year, she is always thinking of others, Lisa has raised over £500 pounds for the daisy appeal and has done many raffles to help out e.n.t o.p.d , this is not the first time she has gone that extra mile to help us all, What a great asset to ent department.	**16/02/2018**
Lisa Gallagher/Kennington	Lisa has helped raise £525.43 towards the Daisy Appeal she has also donated quite a lot of prizes herself .The fund raising is an on going thing which Lisa play a big part in. This must make a great impact to this course Lisa is always on the lookout and ways to make money for this great course.	**16/02/2018**
Denise Tate	would like Denise to be recognised for her hard work especially the night of 14.02.18, she came in on over time at the last minute set straight to work catching up on the out standing jobs which had been left because the area had no HCA until she arrived, jobs added up with the arrival of new admission but she kept going, as soon as she was up to date she set to work cleaning the kitchen having to wash pots by hand. a patient could not get comfortable on the mattress, Denise noticed it was sunk in the middle so changed this for her. also this week she has stayed after her shift because the unit was short,	**15/02/2018**
Vivian, Carol, Jenny	I would like to nominate the SAL at castle hill hospital .from arriving for surgery to leaving for theatre the staff could not have been more attentive or kinder . Thoroughly professional and a credit to the NHS . Vivian who admitted me had come in for an extra shift and had a bit of a strange start to her journey ,was lovely , it was a pleasure to meet her . Special thanks also to Carol	**15/02/2018**

	and Jenny for the speedy preparation . They all made me feel like royalty !	
Nicky Hebblethwaite	Nicky is a fantastic pharmacy technician and a true team player, whether its working on the wards or down in pharmacy, she's efficient, proactive and dedicated to her patients and colleagues. Her quick whit and positive attitude makes working with Nicky a real pleasure. Taking an active interest in the training and support of newer members of staff, whilst keeping up with all her own responsibilities, makes a real difference and it's very much appreciated.	**15/02/2018**
Rosemarie Naan	Rosemarie was sat at the cinema enjoying an evening out with her friends when she received a text message from a friend a fellow staff nurse. Unfortunately an agency nurse had not arrived for duty and her friend was left manning a ward on her own. Rosemarie came straight to work - stopping on the way for her uniform. Thank you Rosemarie for your support for ward H12 and your friend, you were amazing.	**15/02/2018**
Vicky Lancaster	Vicky was working on her own ward on a night shift. Unfortunately the agency nurse who was expected did not arrive. Vicky continued to work on her own - keeping all the patients safe and well cared for until further help arrived. When it became apparent that it was going to be difficult to find a second staff nurse (all other wards were at a minimum). Vicky phoned a friend (a staff nurse from a different ward) - who came straight from the Cinema - stopping to collect her uniform on the way and worked a the rest of the shift from 12 midnight until the morning. Thank you Vicky.	**15/02/2018**
Leanne Hardy	Leanne volunteered to come in and work overtime on her own ward H7. Unfortunately on another ward the expected agency nurse did not arrive leaving 1 staff nurse trying to	**15/02/2018**

	manage a busy surgical ward on her own. Leanne went and assisted that nurse and ensured that the ward was safe until a further staff nurse could be sourced. Leanne stayed the whole of her shift helping out but what was really great was that she did it with enthusiasm and kindness and did not make anyone feel guilty or awful because she had been moved. Thank you Leanne	
Nimi Soundararajan	Goes out of her way constantly to ensure trainees are supported and getting the best possible training. Always using her own time to help anaesthetic trainees. Really does have a golden heart.	**14/02/2018**
Simon Spaven	Simon is an amazing physiotherapist and also staff member. He is always there to help if needed whether patient or visitor. He doesn't work by his allocated hours, he comes in early and will stay until the work is done. Nothing is too much trouble and he always goes above and beyond for his patients and his colleges. He is always a pleasure to work with.	**14/02/2018**
Myra Williams	I want to put forward Myra Williams for the golden hearts award, on the 18th of January, I had an epileptic fit in theatre 3, there was nobody else about, and she laid me on the floor talking to me all the time, making sure there was nothing to injure me nearby. Rushed to get Yvonne and Sharon out of theatres to help, all the staff in general theatre looked after me, and apparently I bite poor Chris Davies as he was trying to help me, Myra then followed the ambulance to hull royal infirmary to make sure I was ok. Then Myra went back to work to finish her shift, after work she then came back to hospital and saw id been put in the discharge lounge, waiting for my husband whos a hgv driver and was on his way back from Newcastle and it was going to be hours before he got to HRI . Myra could see I was still disorianated and tired	**14/02/2018**

	and took me home which was completely the opposite way to where she lived. SO in my opinion she is definitely a star and the only person to win the golden hearts award. Kind regards a thankful Hayley Boulton	

Dr Kelvin Mizen	Over and above duty of care taking time to listen and explain	**14/02/2018**
Mr Kelvin Mizen	Talking to a consultant who genuinely cares and treats all his patients with compassion	**14/02/2018**
Mr Kelvin Mizen	This surgeon noticed that something wasn't quite right with my partner, just short of a year after previous surgery to the same location. He arranged surgery with in a week and a half. He treated all areas concerned, my partner is now recovering on the ward with a shorter recovery time	**14/02/2018**
Harry Allon and all nursing staff	Whilst waiting for my wife to undergo surgery at CHH day surgery 3, I was impressed by the care and information given to all patients and partners by the nurse who explained the expected timescales of the day and answered any concerns held by anyone. it was also a delight to meet Harry Allon an octogenarian volunteer who spent time delivering tea and sandwiches to all patients but also made time to sit and chat with waiting partners relieving the apprehension whilst waiting.	**14/02/2018**
Claire Richardson	Claire goes above and beyond every shift she always comes to work with a smile on her face and aalways there with a helping hand. thank you for been you	**14/02/2018**
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Lesley Gath	Lesley is always there for every member of the team, she is trustworthy and honest and is always helping out different members of the team. She has helped me out on several occasions and always makes me feel better when I am upset and/or stressed. She deserves a golden heart for being such an amazing and vital member of the team.	**13/02/2018**
Ward Catering Assistants	The ward catering team at CHH works extremely hard together and works as a team and pulls together whilst there is staff shortages to ensure the patients receive their food and beverage whilst their stay within the hospital. The catering assistants go out of their way to make sure the patients have a pleasant stay by listening and communicating with the patient about experiences and understanding the patients dietary needs by providing the correct menu and go the extra mile to offer an alternative meal.	**13/02/2018**
Daphne Alexander	Soon after surgery Daphne from the Outreach team contacted me by telephone. She asked how I had been feeling, how I was coping and managing at home. If I needed any extra support or involvement. At present I haven't needed any extra support. However Daphne has telephoned me each month. Although I have not met her in person, I feel encouraged by Daphne's friendliness, professionalism and look forward to our monthly calls. Thank you Daphne.	**13/02/2018**

Pauline Thornton	Pauline Thornton is our Sister in ENT/Breast & Plastic Theatres. We feel the need to tell her publicly just how appreciated she is and she is without doubt one of the most supportive, approachable people, despite constant pressures.Sara,	**13/02/2018**
Theatre Staff	Thank you to all of the theatre staff, who helped numerous departments during winter green. Your help made a difference to patient care in lots of areas and was gratefully received. You were all a credit to your departments and turned up every morning with smiles on your faces, ready to face the challenges of the day. Once again, thank you.	**12/02/2018**
Paula Butcher	Paula always goes above and beyond, She's always there if needed and is a valued member of the ward 9 team.	**12/02/2018**
Karen and Paula	After a very long winded treatment pathway for a shoulder injury I had to have an injection into my shoulder (one of many!). It was my first day back to work and I was feeling quite low, however Paula and Karen were wonderful. They were utterly professional and calming, helping me feel at ease and cheering me up no end. They made the injection process pain free, in fact I laughed more than in a long time! Their care really made a difference to me that day, they are true assets to the Ultrasound department.	**12/02/2018**
Jeanette Hughes	Jeanette is our hygienist on the eye clinic, and she is an absolute diamond. She has constantly got a smile of her face and a spring in her step. We really could not ask for a better hygienist. She not only keeps the clinic looking sparkling clean, she also has a great way with our patients, and she will always go out of her way to help anybody in anyway she can. She is not only a great colleague but she is such a loving, caring friend too. Her job is her passion and we all just simply love her!! Thanks Jeanette :-) x	**12/02/2018**
Gavin Hitchings	Gavin was sent to ED to help with transferring patients to the ward as the ED department was under immense pressure. Unfortunately our team	**11/02/2018**

	was short staffed and therefore Gavin was asked to help in a team with 2 nurses. Gavin worked extremely hard and helped the team so much! we would have really struggled if Gavin didn't help as much as he did. He was willing to help us with all our patients, offering them refreshments due to being in the department nearly 8 hours, assisting with turns and ensuring that patients needs were met at all times. Gavin was a credit to the team! Well done x	
Teresa Gill	Tess always comes to work with a smile on her face, always willing to help patients in any way that she can. She walks into a room and brightens it up. She is the most friendly and supportive member of staff and is amazing with patients. She really is a fantastic nurse and doesn't get enough recognition for her hard work day in, day out. Nothing is ever too much for her.	**11/02/2018**
Tricia Kay	Tricia is always there to help with education and training and to improve the skills of other nurses on her speciality in Respiratory Medicine. No question is to small or big, she is always there to answer and help when needed.	**11/02/2018**
Leanne Ellis	Leanne Ellis is a member of the Ward Catering Team at CHH, So always goes above and beyond in her role as a Ward Caterer, Always helping other members of staff when required, Leanne will go on any Ward and do any task asked of her, comes into early, very helpful member of staff	**11/02/2018**
All on ward 27	I am currently a trainee associate nurse on ward 27 chh, very sadly in November my grandma past away suddenly in my working surroundings. This was a very unexpected and sad time. With all my academic work and working I felt this was a very stressful event. Without my team/ friends on the ward I would not of been able to focus and carry on. I just wanted to say a special thank you to them all. Also a very special thank you to my mentor Kerry Bulliment for been amazing and supportive. Thank you for everything.	**11/02/2018**

Louise Rhind	Louise is a valued member of the Team on Rowan ward, she uplifts the spirits of team members around her on a demanding and busy ward. She offers a hand when needed and is empathetic towards the women she cares for. When the workload is demanding she plays a vital role in coordinating care on the ward and being fair to the team working, enabling them share workload. She provides a extensive knowledge base for junior staff and students like myself to learn from in the postnatal setting enhancing the care delivered to women and families.	**10/02/2018**

Nicola Blake	Coming to work with a smile and a positive attitude, always professional and dedicated, during extremely stressful and difficult times.	**10/02/2018**
The whole team, Main Reception, HRI	The team that work on the main reception desk of Hull Royal Infirmary, seem to always go above and beyond the expected duties of admin staff. From what I have witnessed, this is a team of extremely kind and helpful ladies, who are ready to assist in whatever way they can. I truly believe this team is an absolute credit to the hospital!	**09/02/2018**
Eleanor Needham	when I gave birth to my baby girl in May my midwife Eleanor was amazing. There was a student nurse who was looking after me on the ward who then followed me and helped deliver my baby, I think her name was Katie. Eleanor allowed Katie to help her with the delivery and with my consent I didn't mind either. Eleanor and Katie worked well together and made me feel at ease and that I was able to deliver my baby which I did. After the birth I had a few problems/unexpected complications and I needed to go to theatre. The theatre team didn't seem to understand the seriousness of the situation and said that I was the next patient to go into theatre. whilst I was waiting for my slot to go I became more and more unwell. The sister on duty that day (Vicky) and Eleanor told them I needed to be in theatre ASAP and explained my situation. The next minute a theatre was opened for me at around 7pm and I went to theatre. I was there over an hour. Eleanor was late home due to still doing her paperwork and	**09/02/2018**

	she stayed close by the whole time. Katie the student nurse stayed right next to me and relayed messages to my partner for me who was looking after our brand new baby. This meant a lot as we were both in shock with what was happening and she made us feel so much better. She told me that the baby was fine and that my partner was quietly awaiting my arrival back to the ward. I stayed in hospital for a few days and 2 days after this Eleanor came to see me before the start of her shift. This made my day! she cared about us and took the time to check how we both were. I was a little nervous about giving birth but all the midwives I saw during my stay were all wonderful.	
Esam Akoud	Esam is a very caring compassionate doctor he makes every shift easier in any way he can, tonight his bed side manner with a deceased patient's family was admirable he is a credit to our department.	**09/02/2018**
Fay Turner	This individual is a strong person, a good team leader and have been very supportive with my phased return to work. This person always has a smile on her face, I had approached this person with a problem with another staff member knowing that what the other person had said was rather upsetting for myself, as I have been anxious about my return to work. This person was there for myself and extremely supportive and tackled the issue professionally, I have never felt so much support from one individual who made myself feel more comfortable and accepted returning to work. I am extremely grateful to this person.	**09/02/2018**
Louise Robinson	I believe this person deserves this award as she has always gone above and beyond her duty. She is so helpful with patients and we are constantly getting good feedback from patients that she has helped. She is reassuring and kind towards people. She is also helpful towards other staff members and will always help even if its not her duty to do so and if she doesn't know the answer she will make sure she gets one for you. This person has a massive heart and deserves to be nominated.	**08/02/2018**

Sue Smith	since I stared as clerical officer in a&e, aau & acu sue has made me feel a part of the team and shown me how to do things in a professional manor I don't think I could have made it thought the past 11 months without her friendship guidance and continued support. you are appreciated more then you know xxx	**08/02/2018**
Emma Rugg	Emma works in Biochemistry, part of her role involves processing genetic tests for patient's affected by early heart disease. Emma is the ultimate professional, she never fails in her efforts to deliver this support. The patient's have a huge amount invested in this process and as the nurses providing the screening we have complete trust in her. Its difficult to describe her in terms of "moments of magic" as her impressive levels of competency are displayed daily, she never fails to follow-up, improve, learn and aim for the highest standards we can achieve as a team. Unfortunately patients won't witness first hand the "great care" that she provides behind the scenes; when we talk about "great staff" Emma is one of our best.	**08/02/2018**
Kaylee Porter	I was in hospital and kaylee was very helpful. I had trouble logging in and kaylee spent time to help me log in properly. I was very upset as I was in lost of pain but kaylee got me some water and made me sit near her desk to look after me until I was seen to. She keep checking I was ok and asking if I needed anything. I told the nurse about kaylee and she said I could come on this site and tell kaylee I am grateful. She said her full name was kaylee Porter	**08/02/2018**
Gill	Gill is the morning domestic on the acorn ward, she always has a smile on her face the children, parents and staff love her! Since she started working on the ward she always got 100% on her cleaning audit, whenever she is on shift the ward is spotless she takes great pride in her job.	**08/02/2018**
Millie (Young Health Volunteer)	Millie has been volunteering on the acorn ward for the last few weeks, she is a fantastic asset to the young volunteers that is ran by Rachael Pearce. Millie was very shy when she started but has easily	**08/02/2018**

	come out of her shell, she is doing a fantastic job with all of the children undertaking the role of a play specialist. She interacts well with the children, the parents and other members of staff. She has already created an activity board in the paediatric outpatients department and at the same time ensures the children on the ward all have activities to do throughout the day and have a nice clean & tidy playroom to enjoy!	
Wendy Perry	Wendy was working in the breast screening unit and xrayed a patient who needed transport home. The transport she planned didn't come and she was worried, vulnerable and on her own. Wendy stayed behind 2.5 hours after her shift ended to resolve the issues with transport and make sure the patient could get home safely.	**08/02/2018**
Amy Barnett	It is clear from the perspective of a colleague in a different speciality, that Amy's knowledge and skills are excellent. She is always willing to take time to discuss cases and look at ways we can work together to give patients gold standard care. She is incredibly well respected by the whole MDT and will always contribute her clinical opinion to ensure the patient gets what he/she needs. She is a pleasure to work with and this moment of magic is on the behalf of the whole SLT team on the Stroke Unit.	**08/02/2018**
Tammy Coyle	Tammy Coyle is a valued member of Orthotics team. She always goes above and beyond her duties to support colleagues and patients. Tammy is a very valued member of the team and motivates us all to give the best service we could offer. She has been there to support us all individually at times and helps us come together as a team. She is extremely caring within her nature, and very well respected. It has transpired in months past she has had to deal with a lot of personal stress, this never came across in her dedication to the team or her work. She is always 100 per cent committed and is valued and respected by every member of the orthotics team.	**07/02/2018**
Ward Catering	I am a ward catering supervisor at hri I have a fantastic team that we all work together when	**07/02/2018**

Team HRI	pressure is put on the department , we have to make sure every patient receives a meal and the care that is required from our team . the last few months it has been hard on us all and we always pull together and keep the team smiling I think it would be good for them all to receive a golden heart as they a fantastic team . if I could thank every single one of them and let them know we know they are doing a fantastic job . well done	
Christina, Dave, Kate and Karen	I would like to nominate the Boots pharmacy team in the Queens centre. They are always happy and greet you with a smile, they are friendly, polite and very helpful, nothing is too much trouble for Christina, Dave, Kate and Karen and they always go that extra mile to make to help and advise you on your visit. A great team, well done and keep up the good work.	**07/02/2018**
Dr Howard Moore	In a week where the elderly medicine department was understaffed and struggling to get through the volume of admissions on the elderly assessment unit, Dr Moore stayed behind past his hours and even came in on a day off after a long week and weekend on call to provide a service and most importantly, to ensure that patients received optimum care given the limitations of the environment. He never once resented this and only cared that patients received the care they so rightly deserve. If Dr Moore had not done this, patients would have been waiting to be clerked and waiting to receive vital antibiotics, analgesia and investigations, thus their hospital stay would have been prolonged. Dr Moore's actions ensured that the smooth patient journey continued in spite of low staffing and hospital pressures.	**07/02/2018**
Tammi Visser	Always helping patient's with there telephone queries and going above and beyond to help them and make them feel at ease, it is not easy working for a call centre under so much pressure but she always goes in and gives it 100% and gets on with the work and gives great enthusiasm to work colleagues and patients. They never get thanked for what they have done and I think this would mean a lot.	**07/02/2018**

Gemma Constantine	A patient asked me to say thanks on their behalf to a Fracture clinic staff member making her day in the fracture clinic Gemma kept me informed of what was happening and who I was waiting to see at all times and with a lovely smile that got me through what was to begin with a pretty daunting visit, I was put at ease by her friendly caring attitude and felt much calmer throughout my stay Thank you and keep up the good work Gemma your a credit to your department	**06/02/2018**
Linda	My Dad unfortunately died on ward 500 over the weekend. One member of staff who was on duty during the last two days stood out for me and not only cared for my Dad but my family also. Nothing was too much for her, her kindness and helpfulness stood out for me. I can never repay the staff for all they did for us. Linda kept cheerful which was appropriate to our needs at this time. This care made such a big difference to being able to cope with the situation during such a sad and emotional time. Working for the Trust myself I know how much pressure the Trust and staff are under at the moment, this never came across once, I was never rushed and felt my Dad was safe and able to ask for the care he deserved. Thank you is not enough.	**05/02/2018**

Stephanie Flanagan and Leonie Cholerton	Steph & Becky are both supportive to the whole of the H@N team. They go above and beyond putting more hours into each day attending meetings and carrying out extra activities even on their days off to improve the service as a whole. A lot of the time they are not thanked for the things they do for the H@N service so this is a huge thank you from myself and the full team.	**04/02/2018**
Jeanette Kirby	Jeanette is a hard working and cheerful team member and she brightens up the ward every shift. Patients give positive feedback when being looked after by her.	**02/02/2018**
Ann Shields	We had to cancel the majority of the Day Surgery lists for this week due to winter pressures and I was unable to contact a patient to inform her that her	**02/02/2018**

	surgery was cancelled for the Monday. The only thing I could do was to send her a letter but wasn't sure if she would receive it in time. Ann offered to take the letter personally to the patient. Not only did she go to the address she actually knocked at the door to ensure it was the correct one. This meant that the patient did not have a wasted journey on the Monday.	
Michael Hookem	For his amazing job at managing the relocation the Max Fax outpatient department from HRI to CHH. Where do I begin...The long hours and late nights; The stressful situations he has taken in stride; The countless problems that have occurred, that he has found a solutions for. There are too many other things, that I can't think of right now, but he has been awesome through it all, and the model of what a great manager should be. All of the department staff have played their own part, but Michael has really shone. You deserve a long holiday in the sun after all of the hard work but it has really paid off and the new department is beautiful.	**02/02/2018**
Michael Hookem	Michael Hookem has been instrumental in the recent relocation of his service (Oral Maxillofacial Surgery) from HRI on to the CHH site. He has gone above and beyond his duties to ensure that the move has taken place as smoothly as possible. Michael has attended every project group meeting and has always been available to sort queries and offer assistance when required. He has been so helpful and always cheerful, despite being faced with a number of challenges. I am not sure how we would have managed if we hadn't had Michael 'on board' with the project. We just wanted to thank him for all his efforts over the last few years which have been greatly appreciated by us. I am sure his staff would also agree! Thank you Michael.	**02/02/2018**
Shelly	Shelly spotting something with a patient that others may well have missed. She escalated the problem and the patient got the care they needed in a prompt manner	**02/02/2018**
Melanie	Mel is covering our Ward Manager who is on	**01/02/2018**

Jopling	maternity leave and she is doing a fantastic job. We have had a few changes and seen an increase in the Medical Elderly ladies we have as patients on the ward. Mel has remained level headed dealing with the pressures not just of patients but also the staff. If Mel can do it, then Mel WILL do it....if Mel will do it you can bet Mel will sing about it! There is a song for every word and Mel will know it and sing it with a smile on her face! It makes all the difference on the ward, lightening the atmosphere and it is noticeable. Mel is always caring and compassionate with patients and her staff, if she can do it no matter how busy she is, if she says she will help she will. We all on Cedar Ward want Mel to know she is appreciated more than words can describe and to carry on being such a good Ward Manager!!	
George Aynsley	George Aynsley was an absolute star on Saturday 27th January. We had a very confused, agitated and aggressive patient on ward 11. Despite this patient not being under George's speciality group, when asked, he went outside in the cold to do a capacity assessment for us and the patient's safety. The doctors of the speciality group she was under had gone to HRI and were not available to help. Being in charge of the ward that day I was so very grateful he put aside his jobs to help in this situation, as he didn't have to. He was also very comforting and supportive to the staff on the ward in a very stressful situation. His help enabled us to get the patient back to a safe environment and then home a few days later. Thank you George (I won't forget your help and support).	**01/02/2018**
Hannah (CSW), Sally (Auxiliary) and Cheryl (Domestic)	Friday 26th Jan: Due to service pressures I was covering 2 area's, I had to cater on ward 30 and ward 34, there was 17 to feed on 34 and no dishwasher and 10 to feed on 30, I had to work between 2 area's and to get timings right can be quite a challenge. I had finished on 30 and was dreading having 17 lots of place settings to hand wash and not much time. The amazing ladies had collected my pots, emptied bins and washed floors and hand washed all the pots for me. I want them to know how grateful I was for all their help, they went above and beyond #greatteamwork	**01/02/2018**

Richard Horner, Carly McIntyre, Andrew McGill, Georgia Newington, Gabi Taft, Megan Taylor	I would like to say a huge thank you to Richard Horner, Andrew McGill, Carly McIntyre and the Employee Service Centre Helpdesk (Georgia Newington, Gabi Taft and Megan Taylor). Just before Christmas I met with the team to discuss some issues I was having with new starters getting access to Pattie on time, and all the queries I was getting about it. They offered to be a central point of contact for all queries to do with access to Pattie. The team took this over on 8th January and in the first three weeks, they took 124 calls and emails, most of which were from new starters or from people who had forgotten their password. For the six months prior to this, all of these calls were coming through to one person (me). As the only person in Web Services, I found the number of user access queries I received after Pattie launched to be completely overwhelming and unprecedented. This significantly impacted on the amount of time I was able to dedicate to developing and maintaining our public-facing and staff-facing websites, in addition to supporting content authors, responding to user feedback, and supporting my colleagues in Communications. Being able to direct Pattie users to a central helpdesk which is covered every day (by more than one person!) is a huge weight off my mind and I am extremely grateful to the Employee Service Centre Helpdesk for offering to do this, and taking it on so quickly after our initial discussions. A definite Moment of Magic and a wonderful solution to a problem that was causing me a lot of concern... thank you!	**01/02/2018**

HEY LONG TERM GOALS - December 2017 data

Great Staff	Great Care	Great Future

Quality

RAG	Indicator	Target	Performance January	Trend v Previous Month
G	Never Events	0	0	⇨
R	Complaints (QIP - closed within 40 working days)	90%	72.00%	⇧
G	Healthcare Associated Infections - MRSA	0	0	⇨
G	Healthcare Associated Infections - C.Diff (YTD target)	53	35	⇧
G	Safety Thermometer - Harm Free Care	95%	95.38%	⇧
R	Venous Thromboembolism (VTE) Risk Assessment (Q3 v Q2 1718)	95%	89.22%	⇩
R	Mortality - HSMR (November 17)	<100	101.6	⇧
G	Friends & Family Test - Inpatients (December 17 - Trust v National %)	95.40%	97.50%	⇩
R	Friends & Family Test - Emergency Department (December 17 - Trust v National %)	85.50%	85.40%	⇨

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

Workforce

RAG	Indicator	Target	Performance January	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.90%	⇩
G	Staff Sickness	<3.9%	3.70%	⇩
R	Staff Vacancies	<5.0%	4.88%	⇧
R	Staff WTE in post (<0.5% from Plan)	7327	7246	⇧
G	Staff Appraisals - AFC Staff	85%	85.30%	⇧
G	Staff Appraisals - Consultant and SAS Doctors	90%	91.70%	⇧
G	Statutory/Mandatory Training	85%	91.60%	⇧
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£4.0m	£6.5m	⇧
R	Staff: Friends & Family Test - Place of Work (Q1 1718 v Q2 1718)	64%	63%	⇨
R	Staff: Friends & Family Test - Place of Care (Q1 1718 v Q2 1718)	81%	80%	⇨

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance January	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	88.40%	80.70%	⇩
R	52 Week Referral To Treatment Breaches	0	0	24	⇩
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	1.90%	10.41%	⇧
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	77.68%	⇩
R	Cancer: ADJUSTED 62 Days Referral To Treatment (November Data)	85%	85.30%	83.10%	⇧
G	Length of Stay (<5.2) (October data)	<5.2	-	4.8	⇩
R	Clearance Times	12 weeks	-	12.6	⇩
R	Waiting List Size	50,915	-	52,689	⇩
R	Clinic Slot Utilisation (January provisional)	80%	-	65.70%	⇧
R	Theatre Utilisation	90%	-	72.70%	⇩
G	E-Referrals (Q2 target v current performance)	80%	-	90.5%	⇩
R	Appointment Slot Issues	35% (TBC)	-	46.40%	⇧

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

Finance

RAG	Indicator	Target	Performance January	Trend v Previous Month
R	Capital Expenditure	11.1	12.9	⇧
R	Statement of Comprehensive Income Plan - Year to Date	-1.4	-9.8	⇩
R	CRES Achievement Against Plan	10.5	10.1	⇧
R	Invoices paid within target - Non NHS	95%	45%	⇩
R	Invoices paid within target - NHS	95%	40%	⇨
R	Risk Rating	3	4	⇨

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT MARCH 2018

Trust Board date	13 March 2018			**Reference Number**	2018 – 3 - 8		
Director	Mike Wright, Chief Nurse			**Authors**	Mike Wright, Chief Nurse Kevin Phillips, Chief Medical Officer Sarah Bates, Deputy Director Quality Governance 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		Review		

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

QUALITY REPORT
MARCH 2018

EXECUTIVE SUMMARY

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

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

The Trust Board is requested to receive this report and:

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

QUALITY REPORT
MARCH 2018

1. PURPOSE OF THIS REPORT

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

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

The Trust Board is requested to receive this report and:

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

This report covers the reporting period for the months of January and February 2018. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE)

In February 2018, the Trust declared a Never Event relating to a patient receiving a root nerve block to the wrong side of their spine. This is a 'Wrong Site Surgery' Never Event and is the fifth Never Event reported in 2017/18. The incident is now subject to an investigation in line with national guidance and its findings will report in due course. The patient had the correct side block on the same day and Duty of Candour obligations were met at that time.

Prior to February 2018, this incident would not have met the criteria for a Never Event. However, a revised Never Event Framework was introduced from NHS Improvement in February 2018 and one of the changes included within the 'Wrong Site Surgery' category was nerve root blocks for pain relief. A bulletin and email have been sent out to all Trust staff informing them of this incident, the requirement for all staff, where appropriate, to comply with all safety checking requirements and of the changes to the Never Event Framework.

The other changes to the Never Event framework from February 2018 are:

<u>Wrong Site Surgery now:</u>

- includes when it is a pain relief block *(previously an exclusion)*
- excludes extraction of milk teeth (unless carried out under general anaesthetic)
- excludes spinal surgery *(previously included this type of surgery. This is excluded currently but is still subject to national review so may yet be included again at a future point in time)*
- excludes contraceptive hormone in the wrong arm

<u>Wrong Implant/prosthesis now:</u>

- includes implantation of intrauterine contraceptive device that differs from the one in the procedural plan
- excludes where the implant/prosthesis differs from the one intended due to incorrect pre-procedural measurements or incorrect interpretation of the pre-procedural data

Overdose of insulin due to abbreviations or incorrect device now:

- includes when a healthcare professional withdraws insulin from an insulin pen/refill and administers it using a syringe and needle.

Two new categories of Never Events have been added, also. These are:

- Unintentional connection of a patient requiring oxygen to an air flowmeter

- Undetected oesophageal intubation **–** *please note this is under temporary suspension as a Never Event while a query is being resolved at NHS Improvement but is still included in the latest guidance.*

In addition to this new Never Event investigation, the other remaining Never Event (no. 4) relating to the 'Wrong Route Administration of Medication' is nearing completion and will meet its reporting deadline. The findings from this will be included in the next version of this report.

2.2 Serious Incidents declared in January and February 2018

The Trust declared 3 Serious Incidents in January 2018 and 5 in February 2018, all of these are in the process of being investigated fully. So far this financial year, the Trust has declared 64 Serious Incidents, which is a similar figure to 2016/17, when 68 were declared.

The outcomes of all Serious Incident reports are reported to the Trust Board Quality Committee; any findings of note will also be reported to the Trust Board in due course. A summary of the incidents is contained in the following tables:

Declared in January 2018

Ref Number	Type of SI	Health Group
2018/108	Sub-optimal care of the deteriorating patient – patient suffered cardiac arrest following surgery	Surgery
2018/109	Pressure Ulcer – patient developed two unstageable pressure ulcers	Medicine
2018/1899	Pressure Ulcer – patient developed an unstageable pressure ulcer	Clinical Support

Declared in February 2018

Ref Number	**Type of SI**	**Health Group**
2018/2877	Obstetric Incident – Unexpected admission to Neonatal Intensive Care Unit	Family and Women's
2018/2910	Treatment Delay – failure to refer the patient on for lung cancer follow up	Surgery
2018/3202	Obstetric Incident – Unexpected admission to Neonatal Intensive Care Unit and subsequent neonatal death	Family and Women's
2018/3330	Diagnostic Incident – Potential delayed diagnosis of cancer	Family and Women's
2018/5157	Never Event – Wrong Site Surgery See Section 2.1 Never Events	Clinical Support

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 February 2018 are attached as **Appendix One**.

From the 885 in-patients surveyed on Friday 9th February 2018, the results are as follows:

- **94.1%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.36% [n=12]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98.64%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 885 patients, 68 did not require a VTE risk assessment. Of the remainder, 771/817 had a VTE risk assessment undertaken. This is **94.3%** compliance on the day. VTE incidence on the day of audit was **3** patients; **2** of which were with a pulmonary embolism and **1** was a deep vein thrombosis.
- There were **5** new pressure ulcers on the census day. However, 34 patients had pre-hospital admission pressure ulcers (26 at Grade 2, 5 at Grade 3 and 3 at Grade 4). These are now being fed back to commissioners to manage. In addition, a health-economy wide group has now been established to look at the significant number of patients that come into hospital with pre-existing pressure damage. The Trust is a member of this group.
- There were **16** patient falls recorded within three days of the audit day. Of these, 12 resulted in no harm to the patient and 4 with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection were low in n umber at **10/165** patients with a catheter **(6%)**. Of the **10** patients with infections, **none** of these were infections that occurred whilst the patient was in hospital.

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

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

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2017/18 as at 31st January 2018

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

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**35** **(66% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1** **(over threshold)**
MSSA bacteraemia	**44**	**32** **(72% of threshold)**
Gram Negative Bacteraemia		
E.coli bacteraemia	**73**	**94** **(over threshold)**
Klebsiella (new this year)	**14**	**Baseline monitoring period**
Pseudomonas aeruginosa (new this year)	**10**	**Baseline monitoring period**

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

4.1.1. *Clostridium difficile*

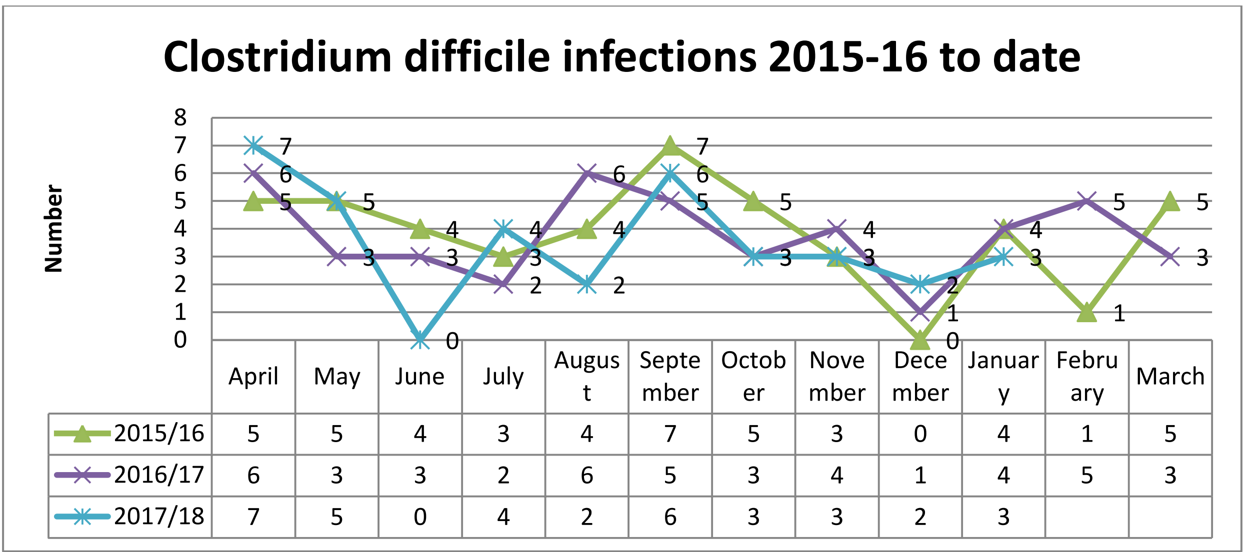
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and 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 revised reporting requirements for 2017/18.

To date this financial year, at Month 10 (January), the Trust is reporting 35 infections against an upper threshold of 53 (66% of threshold). This is really positive performance, particularly when many other trusts are struggling to stay under threshold, currently. Three Trust apportioned *C. difficile* cases were reported during January 2018, all in the Medical Health Group.

Organism	*2017/18 Threshold*	*2017/18 Performance (Trust apportioned)*	*Lapses in practice / suboptimal practice cases*
Post 72-hour *Clostridium difficile* infections	**53**	**35** (66% of threshold)	All three cases reported during January 2018 are still subject to RCA investigation

There are no lapses in practice to report.

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



4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of PIR Investigation / Final assignment
MRSA bacteraemia	**Zero**	**1 case** **(over threshold)**	Ward C33 apportioned case. Post Infection Review (PIR) completed with involvement from Northern Lincolnshire & Goole NHS Foundation Trust & North Lincolnshire Clinical Commissioning Group Case deemed Trust apportioned to Hull & East Yorkshire Hospitals NHS Trust

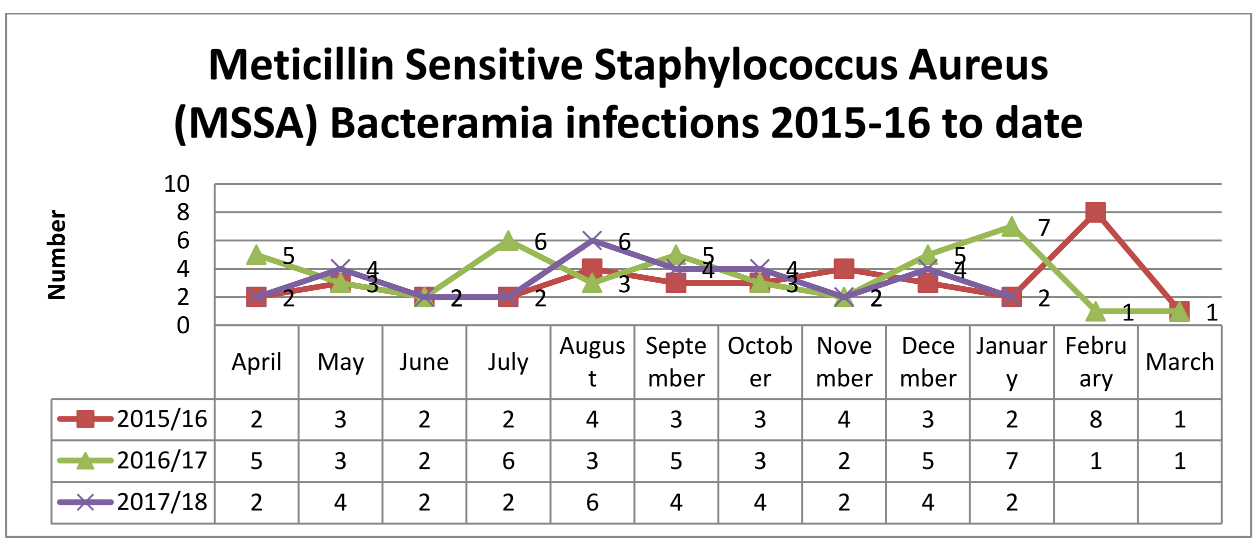
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

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 causes them no problems usually, 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 or 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**	**32** (73% of threshold)	15 unavoidable 10 possibly avoidable 5 avoidable 2 cases awaiting completion of RCA process

There are no lapses in practice to report. MSSA bacteraemia performance is provided in the following table. Again, this is positive performance overall. There are no national thresholds for this infection. The need for continued and sustained improvements regarding this infection remains a priority. Actions on vascular access devices/line management continue and are considered key in reducing rates of this infection both locally and nationally. The following graph highlights the Trust's performance from 2015-16 to date:

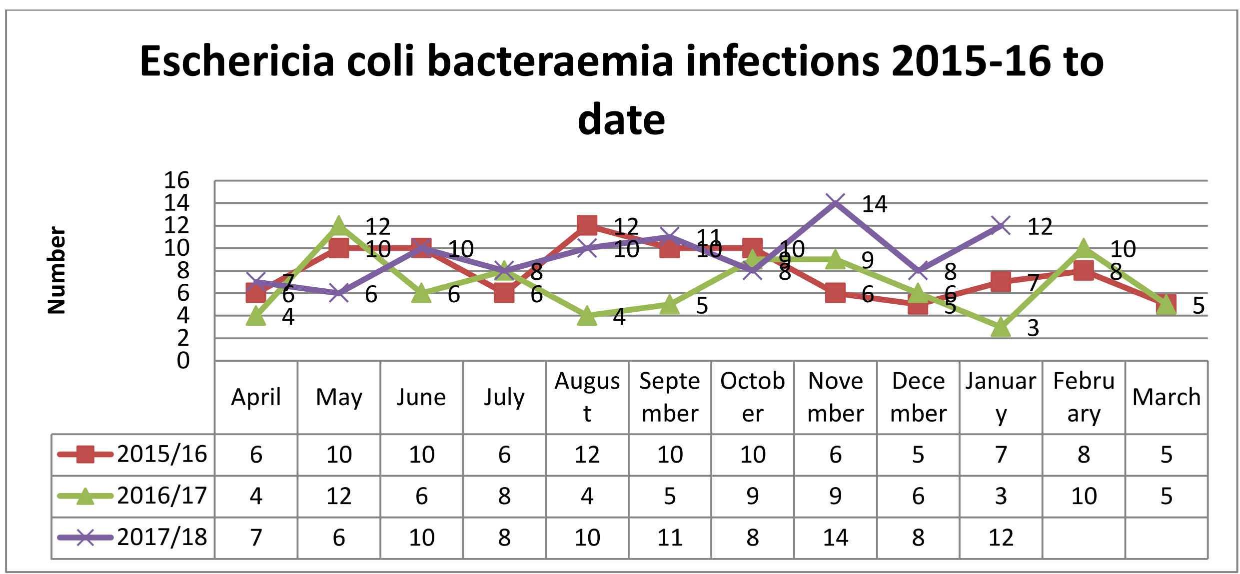


4.1.4 *Escherichia-coli* Bacteraemia
There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of humans and most animals. However, when strains of *E. coli* are outside their normal habitat of the gut, they can cause serious infections, several of which can be fatal. Potentially dangerous *E. coli* can exist temporarily and harmlessly on the skin, predominantly between the waist and knees (mainly around the groin and genitalia), but also on other parts of the body, i.e. a person's hands after using the toilet.

E. coli is now the commonest cause of bacteraemia reported to Public Health England.
E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example. During 2017/18, Trusts are required by NHS Improvement to achieve a 10% reduction in E. *coli* bacteraemia cases. Achievement of reductions is expected to be through a collaborative approach with commissioners working to a single action plan, as required by NHS Improvement. A joint action plan is now in place to try and achieve the required reductions in both the hospital and community settings.

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)**	**94 (over threshold)**	94	7 x avoidable 9 x possibly avoidable 78 x unavoidable (the majority related to biliary sepsis)

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



A significant number of apportioned cases in both the Trust and Community settings that account for the increase in cases are detected because of improved compliance with sepsis screening, both in the Emergency Department and for inpatients. Although increases are noted and the Trust has already breached the threshold by Month 8 for this infection, patients are receiving improved quality of care because of more targeted identification, treatment and appropriate management, largely because of the sepsis work.

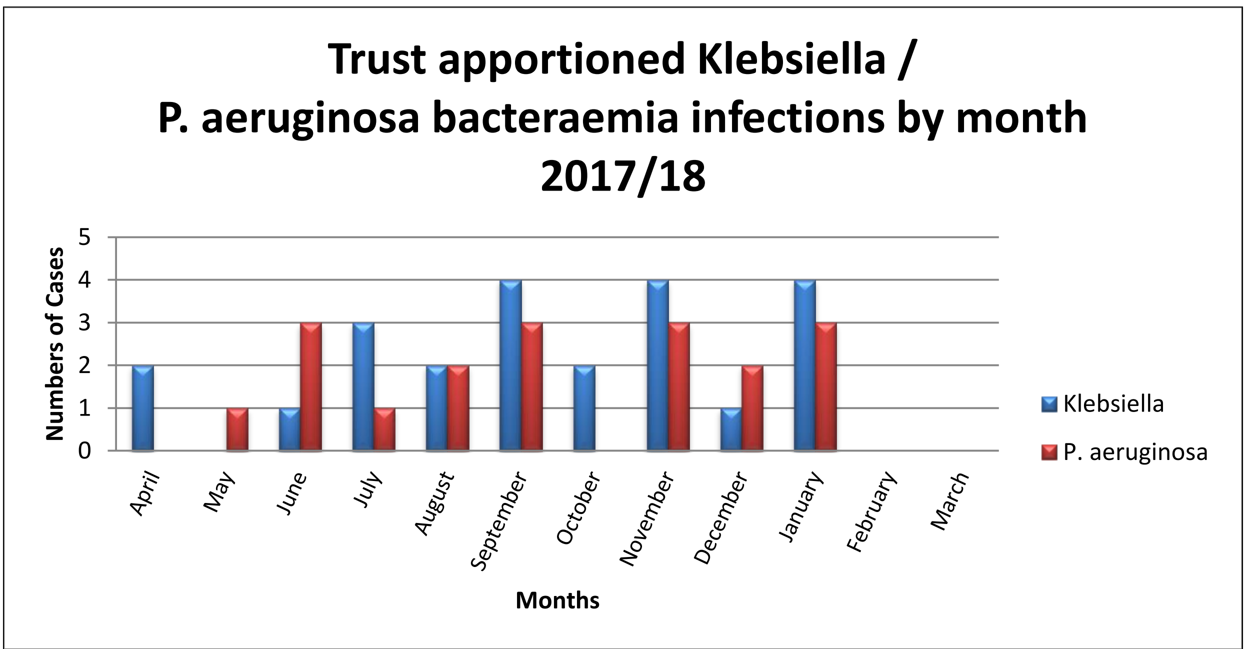
Trust and Community apportioned *E. coli* bacteraemia cases from November 2017 have also benefitted from an additional Infectious Diseases (ID) Consultant review. The review involves the collation of patient demographics, admission method, and speciality on admission. It also includes co-morbidities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

By reviewing cases since April 2017 and following a deeper dive into cases from November 2017, those deemed 'avoidable' relate to patients with hospital acquired pneumonia, management of vascular access devices and the management of urinary catheters e.g. not removing them at the earliest opportunity when no longer needed and/or when a line infection is suspected. Ongoing surveillance will continue until the end of March 2018 and will provide valuable information from which lessons can be learned.

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

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

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



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

During January 2018, there were no outbreaks associated with diarrhoea and vomiting/ Norovirus to report across the Trust, although more have occurred in February and March. This has resulted is some ward/bay closures during this time.

4.2.3 Influenza trends
The Trust's 'flu' vaccination programme continued during January 2018. Up to the end of December 2017, 78% of Trust staff had received a flu vaccination, which is very positive. A renewed call for staff to be vaccinated was disseminated on the 5th January 2018 in the light of increased cases of flu. Staff were able to have access to the flu vaccination up to the end of February 2018.

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

During January 2018, a shift occurred with a significant number of Influenza B cases reported, occurring mainly in younger patients (under 65's), and some 'at risk' patients that had not been vaccinated previously. Seventy cases of Influenza were reported during January 2018 with 73% of cases detected as Influenza B. During January 2018, no hospital apportioned cases were reported with the majority of cases detected on and/or shortly after admission to hospital. In addition, 2 deaths associated with Influenza occurred in patients with multiple comorbidities in ICU. From January 2018, the Trust was required to report Influenza data to NHS Improvement on a daily basis, including number of inpatients with Influenza cared for in ICU settings, inpatients in other clinical areas with Influenza and the number of reported cases in the previous 24-hour period.

Yorkshire & the Humber has been particularly affected and although the Trust has managed to isolate and/or cohort affected patients successfully, there has been no evidence of onward patient to patient transmission resulting in bay/ ward closures, which have been seen in other trusts in the region.

Chart 1 represents influenza activity at the Trust since October 2017

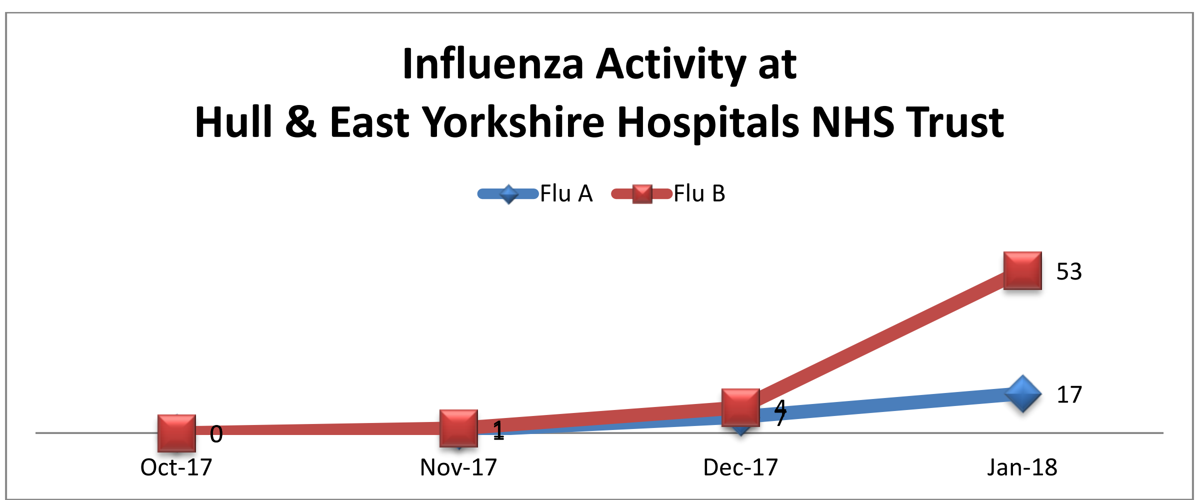
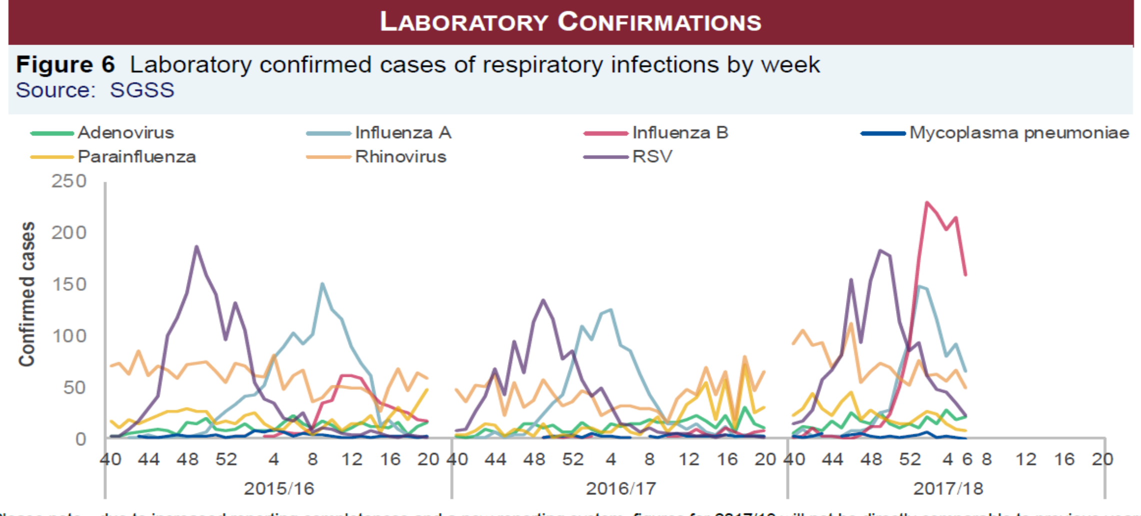


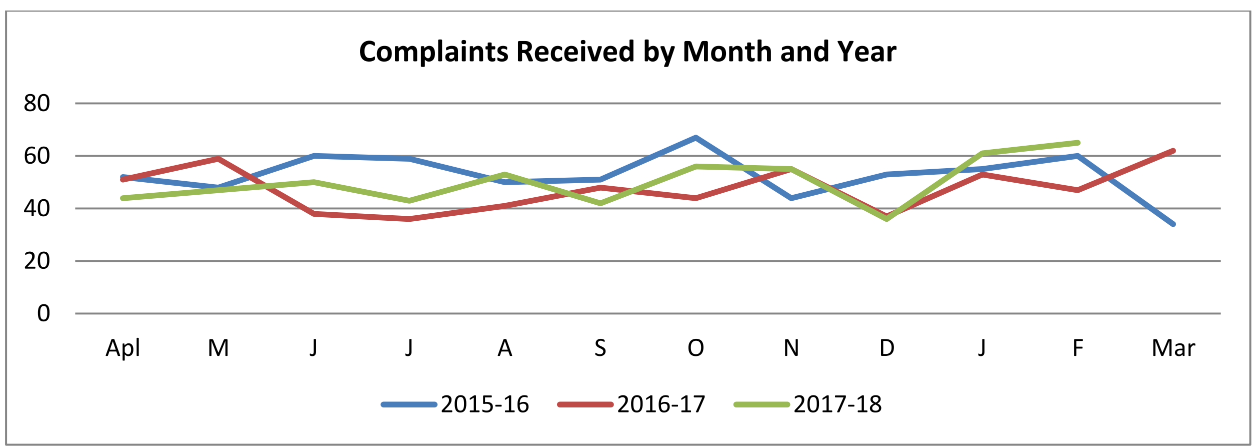
Chart 2 represents activity of respiratory infections including Influenza A & B across the Yorkshire & Humber region (PHE Field Epidemiology Service) [calendar years]



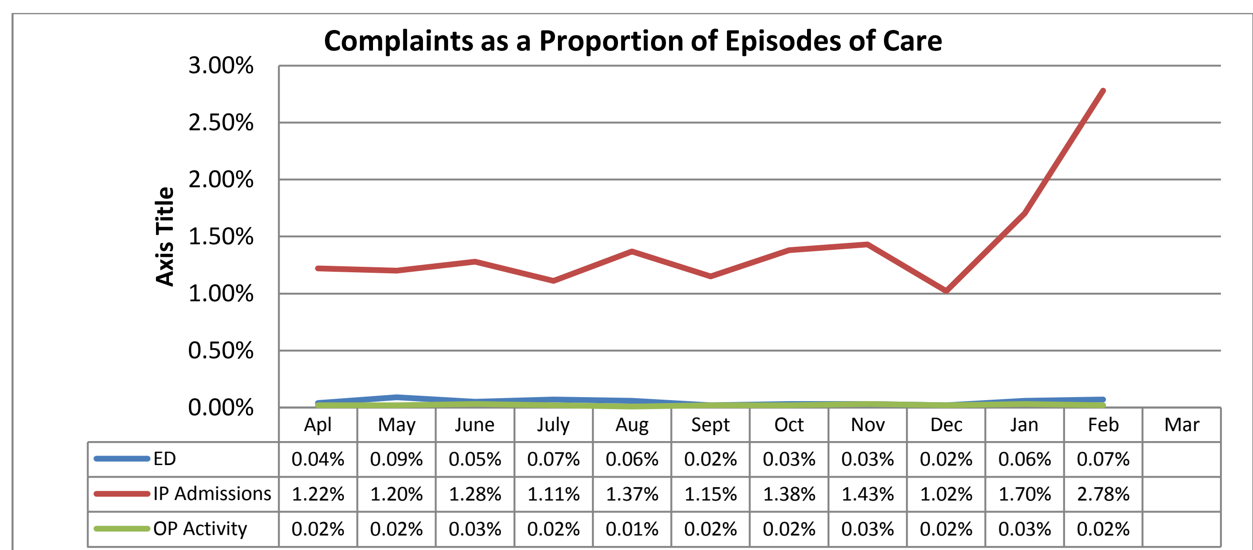
5. PATIENT EXPERIENCE – January and February 2018

5.1 Complaints

The following graph sets out comparative complaints data from 2015 to date. There were 60 new complaints recorded in January 2018 and 65 complaints in February 2018. These figures show an increase on the previous two years, with February being the highest number of complaints received since October 2015, which is of concern. The Patient Experience team has reviewed the complaints received to identify any themes and trends and have raised awareness with senior staff when several complaints have been received within a specific area. The average so far this financial year is 50 per month compared to an average of 47 in 2016/17 and 53 in 2015/16.



The following table indicates the number of complaints compared with activity. There has been a sharp increase in complaints regarding inpatient admissions, which is of concern. Complaints usually reflect activity in the previous three months and this increase could be related to higher inpatient activity in October and November. These are now being analysed more closely to determine the reasons for them along with the time they occurred as opposed to when the complaint was received. Work will be undertaken to look at the same period last year to see if a similar trend has occurred.



	Apl	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.04%	0.09%	0.05%	0.07%	0.06%	0.02%	0.03%	0.03%	0.02%	0.06%	0.07%	
IP Admissions	1.22%	1.20%	1.28%	1.11%	1.37%	1.15%	1.38%	1.43%	1.02%	1.70%	2.78%	
OP Activity	0.02%	0.02%	0.03%	0.02%	0.01%	0.02%	0.02%	0.03%	0.02%	0.03%	0.02%	

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

Complaints Received by Health Group and Subject – January 2018

Complaints by Health Group and Subject (primary)	Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancellations	Discharge	Safeguarding	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0	0	0
Clinical Support	1	0	0	0	1	2	0	0	4
Family and Women's	0	4	0	1	3	1	0	10	19
Medicine	1	1	3	1	1	0	1	13	21
Surgery	0	1	1	1	3	1	0	9	16
Totals:	2	6	4	3	8	4	1	32	60

Complaints Received by Health Group and Subject – February 2018

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancellations	Discharge	Treatment	Total
Corporate Functions	0	0	1	0	0	0	1
Clinical Support	0	0	1	0	0	4	5
Family and Women's	0	0	0	0	0	16	16
Medicine	1	2	2	1	4	15	25
Surgery	1	3	0	1	1	12	18
Totals:	2	5	4	2	5	47	65

As can be seen from the tables, complaints regarding 'treatment' remain the highest recorded category. However, there have been a very high number of complaints received in January and February, which follows a very low receipt of complaints during December 2017. In February 2018, the Family and Women's Health Group received 16 complaints, all of which related to 'treatment' as the primary subject. More work is being undertaken to understand the reasons for these more fully and the findings will be provided in the next version of this report.

The complaints team is now attending ward staff meetings to provide training on dealing with concerns raised effectively. The aim is to inform staff, improve the patient experience and to learn from complaints that have been raised. The training is specific to the area and reflects on theme and trends and actions resulting from complaints for the ward. It also reviews compliments and shares positive experiences. The feedback from staff has been very encouraging. Since the beginning of 2018, five wards have received the 30 minute sessions and more are booked for the coming months.

5.1.1 Examples of outcomes from complaints closed during January/February 2018:

- A child was transferred from another hospital and there were difficulties in obtaining specialist medication and milk.

Outcome: The Paediatric team has developed a checklist to be completed for all patients that transfer in to Hull Royal Infirmary from another hospital to ensure that all relevant supplies are available/ordered prior to transfer of the patient.

- A relative was very unhappy at the delay in obtaining a death certificate following the death on a Saturday afternoon.

  Outcome: The patient had not been seen by the doctor on call on the day she died and was therefore legally unable to sign the death certificate. The doctor and consultant completed the paperwork the following Monday morning and sincere apologies were provided to the family with an explanation for the delay. The medical team would not have wanted to cause any distress but only to ensure the paperwork was accurate and complete when it was delivered to Bereavement services.

- A patient had experienced rudeness and unprofessional comments from an auxiliary nurse on several occasions when attending appointments.

  Outcome: The Business Manager and Outpatient Sister have met with the member of staff concerned to raise awareness of the issues raised and ensure lessons are learned. The performance of this staff member will be monitored closely.

- The family of an elderly patient who had fallen whilst on the ward were concerned at the differing information they had received from staff.

  Outcome: The Senior Matron has discussed the concern with staff on the ward and arranged for auxiliary nurses to attend refresher training.

- The Patient was given a diagnosis of cancer without a family member or other support being available. The delivery of this information was carried out in a very casual way and without any empathy or compassion.

  Outcome: Sincere apologies were offered to the patient and his family that this news was not given to them with appropriate support or in a suitable environment. The ward now has an area where this can be undertaken in a confidential and sensitive manner. The concerns raised have been discussed in detail with the staff member involved.

5.1.2 Performance against the 40-day complaint response standard

In view of the recent concerns over the way in which this performance indicator has been reported, a review of the methodology used for calculating how many complaints have been closed within 40 days has been undertaken. The 40-day period relates to 40 working days, not 40 calendar days and there has been a lack of clarity as to whether bank holidays are included in the 40 days or not; they are to be excluded. Therefore, this indicator will now be calculated manually rather than rely on automated systems.

The methodology used is, "of the complaints closed within that month, how many of these were within the 40-working day target?"

The figures for January and February 2018 have been reviewed thus far and this will now be calculated back to April 2017. The Trust's target is for 90% of complaints to be closed within this timeframe. The following table indicates the percentage of complaints closed within 40 working days of receipt. Meanwhile, the figures for January and February 2018 are in the following tables:

Health Group	Total Number Closed	Closed Within 40 days	%	Total Number Closed	Closed Within 40 days	%
	January 2018			February 2018		
Corporate	0	0	100	1	1	100
Clinical Support	1	1	100	3	3	100
Family and Women's	19	8	42.1	18	12	66.7
Medicine	26	22	84.61	15	14	93.4
Surgery	23	19	82.6	11	11	100
Monthly Total	**69**	**50**	**72%**	**48**	**41**	**87.50%**

As can be seen, performance is variable across the Health Groups, with the Family and Women's Health Group having the poorest performance against this indicator. However, this Health Group is working hard to improve this performance. The Clinical Support Health Group is the better performer. Nonetheless, this Health Group has only small numbers of complaints to manage by comparison. The Chief Nurse continues to review each Health Group's performance weekly and improvement trajectories will now be set for those that need to improve. This will continue be managed through the monthly performance and accountability meetings with Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

PALS received 202 concerns, 31 compliments, 6 comments or suggestions and 72 general advice issues in the month of January. These figures show a very slight decrease in the number of concerns received in December, although the themes and trends remain the same in that they relate to delays, waiting times, cancellation of procedures and cancellation of clinics, including a number of elective waiting lists. This is not surprising bearing in mind the pressure that the Trust has been and continues to be under. This information has been shared with the Health Groups in order that they can review and consider any actions that are necessary. PALS has also highlighted with the Performance team concerns regarding patients waiting longer than expected for surgery. Again, this is perhaps to be expected, currently.

February 2018 figures show that PALS received 187 concerns, 20 compliments, 109 general advice requests and 1 comment/suggestion. The levels of concern have decreased slightly. However, the number of general advice requests has increased, mainly due to patients seeking information regarding appointment/waiting list matters. Media coverage has, in some instances, prompted patients to contact PALS just 'to check' that everything is in order where their appointment is concerned. PALS continues to monitor contact from patients that have waited longer than expected.

PALS Received by Health Group and Subject – January 2018

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times and Cancellations	Discharge	Environment	Hotel	Safeguarding	Treatment	Total
Corporate Functions	6	0	0	2	1	0	1	1	0	0	11
Clinical Support	1	0	0	1	4	0	0	0	0	2	8
Family and Women's	4	2	0	5	25	1	1	0	1	10	49
Medicine	8	3	2	8	21	4	0	1	0	17	64
Surgery	2	6	1	6	40	5	1	0	0	9	70
Totals:	21	11	3	22	91	10	3	2	1	38	202

PALS Received by Health Group and Subject – February 2018

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times and Cancellations	Discharge	Hotel	Treatment	Total
Corporate Functions	4	2	0	4	2	1	3	0	16
Clinical Support	0	2	0	1	3	0	0	3	9
Family and Women's	2	3	0	5	22	0	0	14	46
Medicine	4	3	4	8	23	3	0	13	58
Surgery	0	1	2	2	35	0	0	18	58
Totals:	10	11	6	20	85	4	3	48	187

5.2.1 Examples of outcomes from PALS contacts:

- A woman, who at the time of contacting PALS was 35-weeks pregnant, explained that she had a phobia of childbirth. Although she had seen a doctor on the 11 January 2018 to make arrangements for an elective C-Section, she had left the consultation unsure if she would have a C-Section, as she did not fit the criteria and this was causing her distress.

  Outcome: PALS arranged for the woman to be seen by a consultant in the next available clinic. Following PALS liaison with the woman, the consultant and external agencies, a report was sent subsequently to the clinical team, prepared by Humber NHSFT, to support the patient's request. A healthy baby girl was delivered by C-Section on the 13 February 2018.

- On the 19 February 2018, a patient arrived at Castle Hill Hospital for his appointment only to be told it had been cancelled. He had waited a long time for this appointment and was extremely unhappy that he had not been contacted.

  Outcome: Apologies were provided by PALS on behalf of the service and an appointment was obtained for the patient to be seen on the 27 February 2018. The patient was extremely grateful and called into the PALS office following his appointment to convey his appreciation for the support provided.

- An elderly patient contacted PALS to complain of the difficulties he had experienced in locating the Urology Ambulatory department at Castle Hill Hospital. He said he got lost and was late for his appointment.

  Outcome: PALS contacted the Estates Department and a sign was erected to indicate the location of Ward 12.

5.3 Compliments

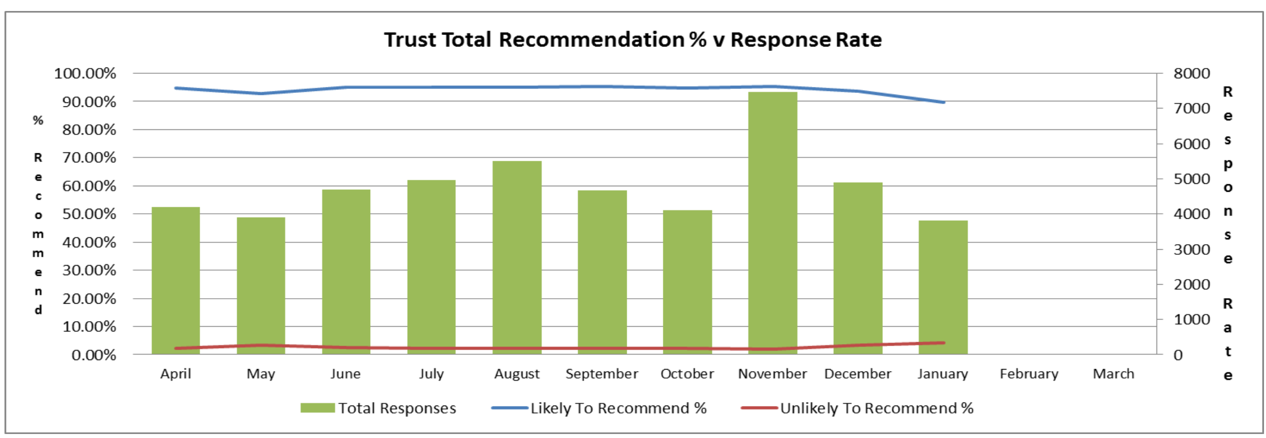
- An elderly lady had a fall resulting in attendance at the Emergency Care department. The lady wrote to convey her grateful thanks for the care and attention given to her. She said "I felt everyone gave 100%. I did thank those concerned at the time but I just wanted to put my feelings in writing. Everyone was so caring".

- A gentleman wrote to advise that he received 'exceptional service' whilst undergoing surgery to replace his right hip. He said "from the very first appointment with Miss Moulder, Consultant Orthopaedic Surgeon, to the aftercare since I have had my operation, has been outstanding". He went on to say "I cannot praise Miss Moulder highly enough. She is an extremely gifted surgeon and I would like her to receive the praise she so greatly deserves. She is a caring, understanding and very supportive person. And her whole team have been wonderful".

- The daughter of a patient who died in Hull Royal Infirmary wanted to put on record how impressed she was with all those who had looked after and cared for her mum. She said “the care and attention shown to my mum was outstanding and I would like to pass on my thanks to all concerned”. She said “clearly it is the patient who must be attended to first and rightly so, though sometime the relatives feel that they are not included, often at a time when they feel very emotional, vulnerable and outside of the whole process. This was not the case with me, as I was looked after with care and compassion by the nurses on both Ward 7 and HICU2. This helped me to get through the difficult time leading up to my mum’s death. Thank you again”.

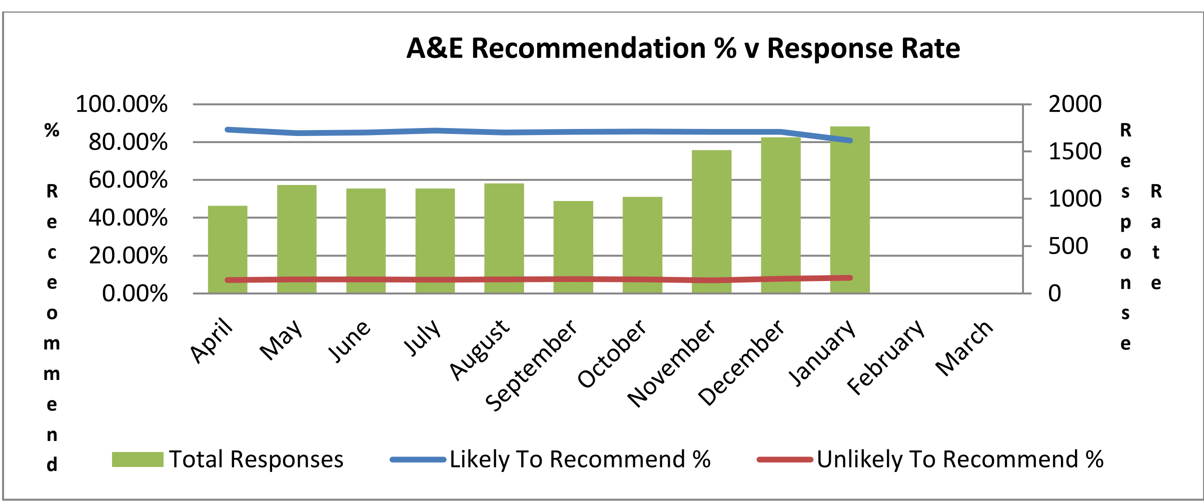
- PALS received an email from a patient who said “I have just spent 8 days on Ward 4 at Hull Royal Infirmary. I cannot praise the staff enough, they were amazing”.

5.3 Friends and Family Test (FFT)
The Trust’s Friends and Family results for all areas, including the Emergency Department, recorded a lower number of responses for January 2018 with 3,817 responses, compared to December 2017 when 4,890 responses were received. The January 2018 results indicate that **89.81%** were extremely likely/likely to recommend the Trust to friends and family, which is below the nationally set-target of **95%** and would correlate with the increase in complaints received during the same period. The Trust has seen a decline in response rates for January, which correlates with the winter pressures. This dip in performance and responses is unusual for the Trust and this will need to be monitored closely for any emerging trends. The following chart shows the trends over time.



With regards to the Emergency Department, 1,651 patients that attended in December 2017 responded to the Friends and Family Test with **85.40%** of patients giving positive feedback and **7.81%** negative feedback. Again, the positive comments have seen slight decline in number. The remainder were neither positive nor negative. 1,722 patients that attended the Emergency Department in January 2018 responded to the Friends and Family Test with **82.75%** of patients giving positive feedback and **10.39%** negative feedback. These trends will continue to be reviewed to determine if this is concomitant with winter pressures or whether there are other factors driving these changes in results.

This SMS text messaging methodology is now the predominant way of obtaining this information from patients that use ED services now.



The Trust figures for the month of February will not be available nationally until the 13th of March.

There are early indications that the Trust has seen an increase in responses for February already.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
No new cases were received from the PHSO for investigation during January and February. One case was closed, which was partly upheld.

5.5 Adult Volunteers
Adult voluntary services and young voluntary services worked together recently on a Trust induction for volunteers. This was very successful and positive feedback was received from volunteers. Induction is to be held bi-monthly and will include existing volunteers and new volunteers. The induction will include information from the Infection Control team and a request has been sent to the Fire Safety Officers to attend future sessions to provide instruction, also.

The Patient Experience Officer for adult voluntary services has assisted recently a number of volunteers to apply for jobs within the Trust. One volunteer has successfully been appointed as a Physiotherapy Helper and another has an interview for a Ward Hygienist role in the near future.

Applications for volunteering continue to be on the rise. Interviews will be taking place again on 12 March 2018. Work has been undertaken to identify areas that would benefit from a volunteer and prospective applicants will be notified of these areas at interview.

6. OTHER QUALITY UPDATES
6.1 Care Quality Commission (CQC) - Well-Led and Core Services Inspections
The Trust received an ‘unannounced’ Core Services inspection from the CQC from the 7th February to the 9th February 2018 and an ‘announced’ Well-Led inspection from the 27th February to the 1st March 2018.

During the Core Services inspection, the CQC inspected wards and departments across the Hull Royal Infirmary and Castle Hill Hospital sites. This element of the inspection focused on Medical Care, Surgery, Maternity and Outpatients core services. However, the inspectors also reviewed some practices within Children & Young Peoples’ services. Inspectors spoke with staff, patients and carers during this element of the inspection as well as observing the care and treatment being provided to patients.

During the Well-Led inspection, the CQC interviewed senior members of the Trust, including the Chairman, Chief Executive, Chief Nurse, Chief Financial Officer and a sample of Non-Executive Directors. In addition, they interviewed leads for Infection, Prevention and Control, Sepsis, ‘Freedom to Speak Up’ Guardian, Guardian of Safe Working, Mortality and Falls. Due to

availability, the CQC will interview the Chief Medical Officer and the Chief Operating Officer on the 14th March 2018 to conclude the interviews required for the well-led element of the inspection.

The Trust received 'high level' feedback at the end of both elements of the inspections. Whilst the feedback was general in nature, the CQC noted the welcoming, honest and open culture they found whilst in the Trust and that they had seen a positive difference in this respect. They acknowledged that improvements had been made across the Trust but in some cases further work was still required. The CQC continues to request information from the Trust, in order to triangulate its findings. With regards to the publication of its findings, the following draft timetable has been issued by the CQC:

- Ratings Meeting between the Chief Executive and the CQC – 19th April 2018
- Report received by the Trust for Factual Accuracy – 26th April 2018
- Publication of the report on the CQC website – 1st June 2018

There will no longer be a quality summit to support the CQC's publication of its report. This will now be down to the Trust and how it wishes to publicise and manage the CQC's findings.

6.2 Learning from Deaths

There have been a total of 350 structured judgement reviews of patient deaths undertaken to date, which indicate that the care delivered to patients in each phase of case is rated as very good overall but with some areas for improvement and learning. This is broken down as follows (average scores):

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

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

On January 30th, 2018, the Trust undertook a multi-agency review with the two main Clinical Commissioning Groups (Hull and ERY) and Humber NHS Foundation Trust. This was the first of its kind, and was to look at a patient's whole health journey through primary and secondary care. The patient was discharged from the Trust but died subsequently in a residential home within 48 hours of discharge.

The multi-agency review panel consisted of General Practitioners from the Hull CCG, along with Consultants from Hull and East Yorkshire Hospitals NHS Trust. A summary of the findings of the review is being compiled and will be submitted to the Trust's Mortality Committee in March 2018.

This is all part of the Trust's commitment to cross-organisational learning.

7. RECOMMENDATION

The Trust Board is requested to receive this report and:

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

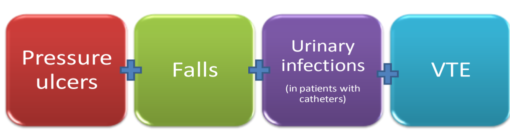
Mike Wright
Chief Nurse

Kevin Phillips
Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

Appendix One – Safety Thermometer February 2018

Hull and East Yorkshire Hospitals NHS Trust



SAFETY THERMOMETER NEWSLETTER February 2018

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 9th February both hospital sites. 885 patients were surveyed

94.1% of our patients received HARM FREE CARE

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

1.36% (12) of our patients suffered a New Harm

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

98.64% 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 July 17 – February 18

	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Harm Free Care %	95.3%	93.6%	95%	93.9%	94.6%	94.9%	95.3%	94.1%
Sample: Number of patients	875	859	873	886	903	854	888	885
Total Number of New Harm	12	17	16	15	14	6	15	12
NEW HARM FREE CARE %	98.6%	98.02%	98.1%	98.3%	98.4%	99.3%	98.3%	98.6%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	3	0.34%	2	1	0

	Number	%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	68	7.68%	
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	771	87.12%	94.3%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	46	5.2%	5.7%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	39	4.41%	31	5	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.	34	3.84%	26	5	3
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	5	0.56%	5	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)	16	1.81%
Severity **No Harm**: fall occurred but with no harm to the patient	12	1.36%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	4	0.45%
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	165	18.64%	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	10	1.13%	6%
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	10	1.13%	6%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	0	0%	0%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 9th March 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	13 March 2018		**Reference Number**	2018 – 3 - 9	
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse	
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission				
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

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

The last report on this topic was presented to the Trust Board in January 2018 (December 2017 position). This report presents the 'safer staffing' position as at 31st January 2018 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

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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 fill rate trends are now provided on the following pages:

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%
Oct-16	88.51%	100.79%	90.58%	106.38%
Nov-16	91.30%	97.10%	95.70%	107.30%
Dec-16	91.23%	100.10%	97.00%	100.76%
Jan-17	93.00%	103.50%	99.10%	101.10%
Feb-17	90.10%	98.10%	94.80%	100.30%
Mar-17	86.80%	95.90%	89.60%	102.10%
Apr-17	85.20%	97.61%	89.15%	102.19%
May-17	83.70%	94.20%	89.20%	102.60%
Jun-17	90.40%	94.20%	93.90%	102.90%
Jul-17	84.00%	89.60%	91.30%	100.90%
Aug-17	78.40%	93.20%	88.00%	100.80%
Sep-17	77.50%	96.70%	87.60%	101.80%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	82.20%	95.90%	92.60%	103.20%
Dec-17	82.50%	93.50%	92.30%	100.30%
Jan-18	84.30%	93.00%	93.80%	101.00%

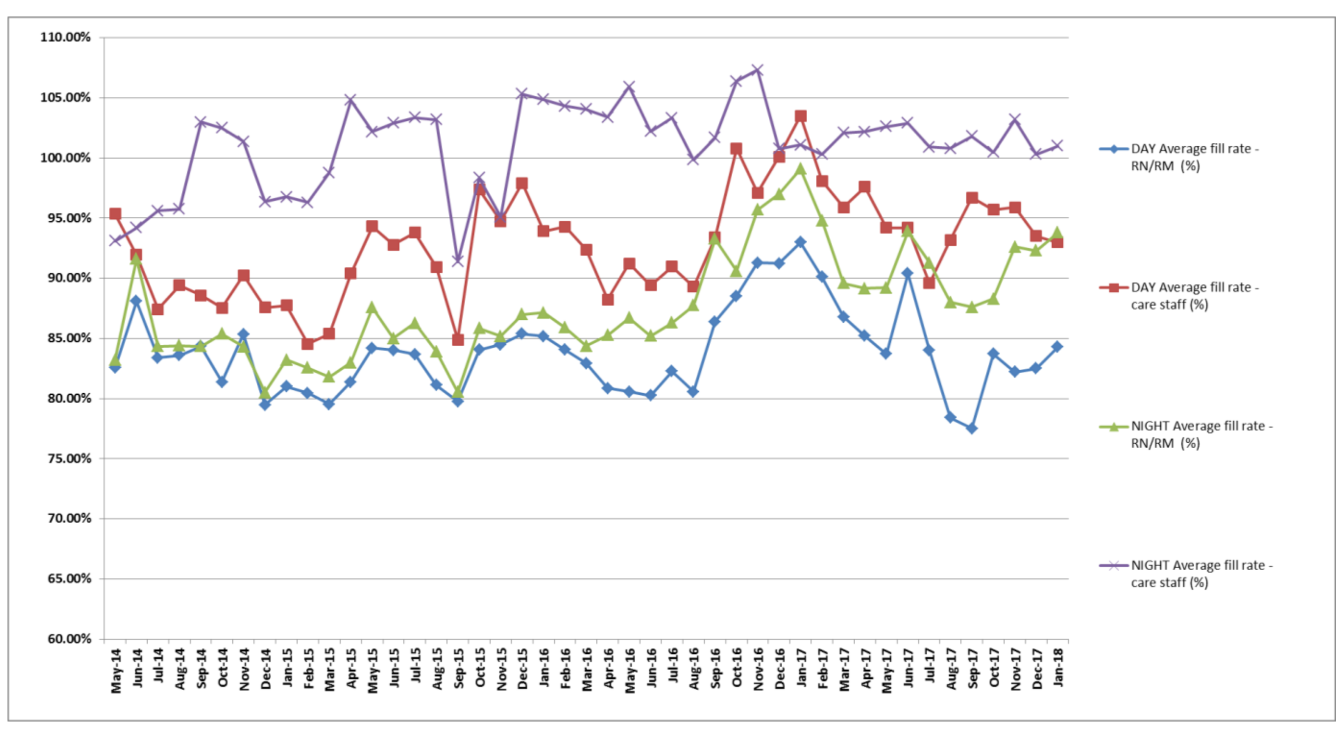
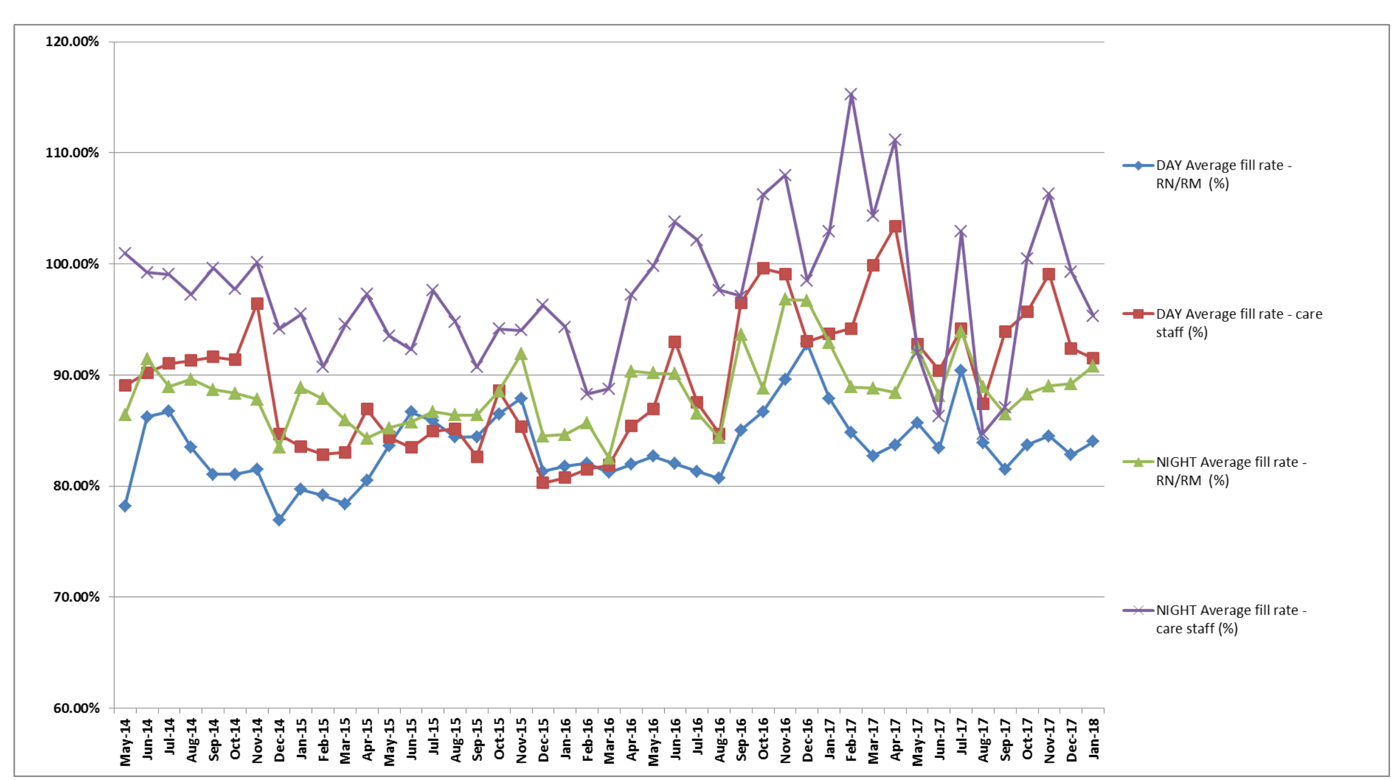


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%
Oct-16	86.70%	99.59%	88.79%	106.24%
Nov-16	89.60%	99.10%	96.80%	108.00%
Dec-16	92.79%	93.03%	96.70%	98.50%
Jan-17	87.90%	93.70%	92.90%	102.90%
Feb-17	84.80%	94.20%	88.90%	115.30%
Mar-17	82.70%	99.90%	88.80%	104.30%
Apr-17	83.71%	103.40%	88.41%	111.16%
May-17	85.70%	92.80%	92.50%	92.00%
Jun-17	83.40%	90.40%	88.10%	86.30%
Jul-17	90.40%	94.20%	93.90%	102.90%
Aug-17	83.90%	87.40%	88.90%	84.70%
Sep-17	81.50%	93.90%	86.50%	87.10%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	84.50%	99.10%	89.00%	106.30%
Dec-17	82.80%	92.40%	89.20%	99.30%
Jan-18	84.00%	91.50%	90.80%	95.30%



As indicated in the aformentioned tables, the fill rates for both HRI and CHH have remained at reasonable levels overall.

From an international recruitment perspective, the Trust has 17 international recruits that are working as healthcare assistants and preparing for the Objective Structured Clinical Examination [OSCE]. The OSCE is the exam that the recruits must pass in order to become fully registered with the Nursing and Midwifery Council (NMC). To support the international recruits, the clinical education team is supporting the nurses with an intensive training programme for 2.5 days per week, focussing on specific clinical skills. For the remaining time, the nurses will be working within a clinical area under the supervision of a Registered Nurse in order to consolidate these skills.

The Trust has also had approval for 5 further certificates of sponsorship, it is therefore anticipated subject to visas being issued, this group of candidates should arrive in the UK by early March 2018. However, it is understood that there are challenges with some of these nurses not getting through OSCE process. This is not just at this Trust but also across the country. This is of concern and is being looked into. A fuller description will be provided in the next version of this report.

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

- The closure of identified beds within Family & Women's Health Group (9 beds) and Clinical Support Health Group (6 beds).
- The redeployment of staff from CHH to support HRI.
- Reduction in the number of Ward Sister/Charge Nurse supervisory shifts within all of the Health Groups on a temporary basis to support the areas where there are significant vacancies. (Additional managerial support is being provided by the Senior Matron for the clinical areas).
- The placement of Senior Matrons into clinical shifts across all Health Groups to help boost direct care-giving hours
- Support being given to wards by specialist nurses
- Utilisation of some agency shifts, albeit on a controlled basis. This has required the Trust to pay over the NHSI 'capped rate' on a small number of occasions in order to ensure patient safety.

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns. Following successful interviews, the Trust is currently pursuing 78 student nurses who are due to complete their training in September 2018. A further interview date is scheduled for March 2018, and it is anticipated an additional 60 student nurses will be interviewed then offered posts if successful.

The Chief Nurse has introduced a Nursing Workforce Committee focused on the delivery of the following:

- Improving retention by understanding why staff leave and what can be done to address that beforehand.
- Focused work with those approaching 55-year age/early retirement to see if anything can be done to persuade such staff to stay on, including part-time and flexible hours
- Considering more flexible working opportunities in general
- Looking at skill mix; as one key reason for leaving is due to the apparent lack of career progression opportunities

- Undertaking time/motion work to understand the roles and tasks that RN's are doing compared to that of the non-registered workforce and other healthcare professionals with a planned pilot to commence early May 2018.
- Review of nursing shift patterns (underway currently)
- Undertake staff surveys about what would make the difference to help keep nurses working here.
- The possibility of pursuing an alternative entry point to nurse training using the apprenticeship route. However, this would require funding from the Trust to support in terms of paying the apprenticeship salary and backfill costs. Options to look at this more closely are being developed and a proposal to support this will be going to the Executive Management Committee for consideration in March 2018. Although this will not produce a short-term solution to the registered nurse supply chain, the options for training more nurses into the future through nationally-available and nationally-funded routes are not available. Unless other national monies and entry routes are to be made available to support this in the future, trusts are going to need to supplement the development of registered nurses from their own budgets. This will only add further financial pressures to already-challenged trust budgets.

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

The Chief Nurse for the North of England held a Nursing workforce summit/think tank on 13th December 2017 to consider the solutions to the registered nursing shortfalls. The Trust's Chief Nurse has been requested to chair the North of England Nursing and Midwifery Workforce Group. This group met for the first time on Friday 23rd February in Leeds. The early work of this group is focusing on retention of nurses and a fuller analysis of the impact of the ageing nursing workforce.

4. ENSURING SAFE STAFFING

The safety brief reviews, which are now completed six times each day, are led by a Senior Matron with input from a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved but is extremely challenging on some occasions. The Trust has a minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. Staffing levels are assessed directly from the live e-roster and SafeCare software and this system is working well.

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

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

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

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

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

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

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

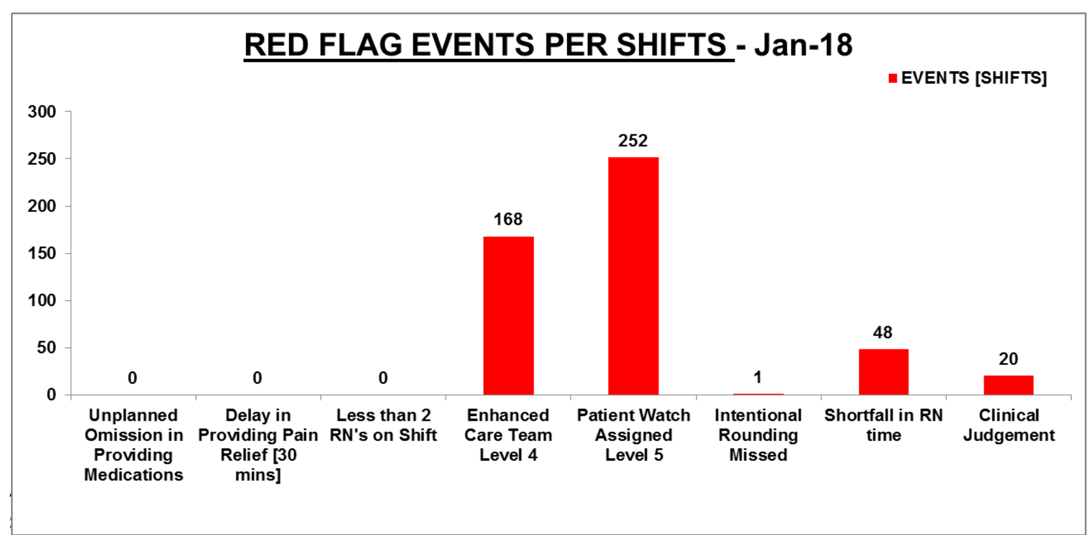
The 'red flags' suggested by NICE, are:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
- Pain: asking patients to describe their level of pain level using the local pain assessment tool.
- 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 January 2018. 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.

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

Jan-18	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	0	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	0	0%
	Enhanced Care Team Level 4	168	34%
	Patient Watch Assigned Level 5	252	52%
	Intentional Rounding Missed	1	0%
	Shortfall in RN time	48	10%
	Clinical Judgement	20	4%
	TOTAL:	489	100%



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

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

5. AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

There are a number of key areas that remain particularly tight in terms of meeting their full establishments. These are:

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

- **Elderly Medicine [x5 wards]** have 16.74 wte RN vacancies. The specialty has over recruited by 10.04wte auxiliary nurses to support the RNs in the ward areas to deliver nursing care with supervision. These are all within budget. The Senior Matrons are supporting the ward in the interim by moving staff in the Medical Health Group.

- **H5, RSU and H500 (Respiratory Services)** have 6.85 wte RN vacancies between them. Support continues to be provided from the Nurse Bank to ensure staffing levels are maintained at a safe level. Critical Care have released 2.0 wte RN's to work in the RSU. In addition there are 2.00 wte RNs on rotation from critical care working within the respiratory support unit. This has been favourably received by both clinical areas as it is offering a learning opportunity for the staff involved as well as improving the staffing numbers.

- **H11 and H110** have 12.47 wte RN vacancies. The impact of this shortfall is supported by part-time staff working extra hours, bank shifts and over filling of auxiliary shifts. Additional support is also being provided by Critical Care, who have released 2.0 wte. registered nurses to support the HASU.

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

- **Ward H7 -** Vascular Surgery has 5.52 wte RN vacancies. Support is being provided from within the Health Group until substantive posts are filled.

- **Ward H12 & H120 –** Trauma Orthopaedics have 6.83 wte RN vacancies across the floor.

- **Ward C10 & C11 -** Elective Colorectal Surgery has 5.70 wte RN vacancies across both wards.

- **Wards 30-33** – Oncology and Haematology have 8.55 wte RN vacancies. Staff are moved between the wards following assessment daily by the Senior Matron. An RN from the Oncology Health Centre is working on the wards, C33 have over recruited non registered nurses to support and the Sisters and Matrons are all undertaking clinical shifts.

- **Winter Ward H10 -** continues to be supported through the temporary redeployment of staff from all of the Health Groups. As part of the winter plan, work will commence to support the closure of the Ward early April 2018.

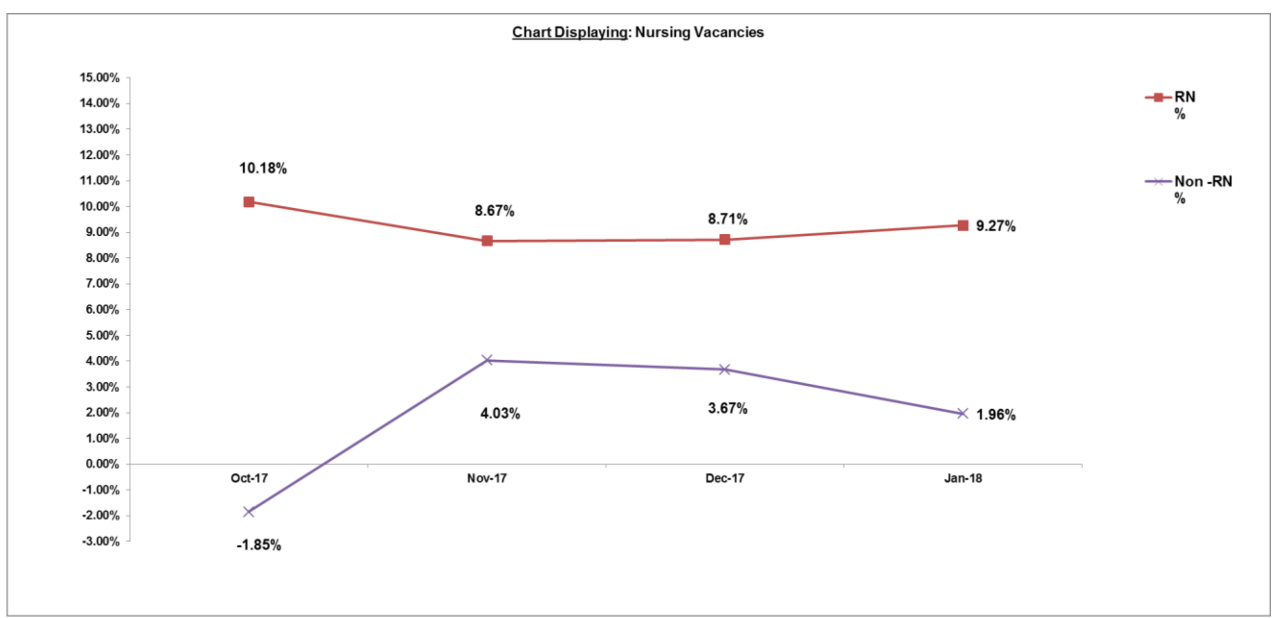
In addition to the above areas, as highlighted in appendix 1, there are a number of areas whose fill rate is less than the desired 80%. The justification for this is essentially two-fold; firstly, providing support to the winter ward and intentional roster changes to support additional capacity over a 7 day period. Secondly, increased absence levels, which is being monitored closely by the Nurse Directors.

As indicated in the narrative, support is being provided to wards that have staffing shortfalls through the redeployment of registered nurses from elsewhere within the Trust. This has been completed in a planned and coordinated manner, in order to try and minimise the continual movement of staff on a daily basis, although staff are still moved daily in response to further short notice shortfalls and assessments of the workload and patient acuity in clinical areas. Despite the work undertaken, there

remain some significant shortfalls in some wards and these are risk assessed and managed each day.

The following table illustrates a summary of the Vacancy position for both Registered and Non-Registered nurses (wards and ED) since October 2017. There has been a decrease of 7.08 wte Registered Nurse in the last month.

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.5917807	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.2866765	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.0371387	1276.47	509.93	1786.4	7.28%
Jan-18	118.31	9.27%	10.00	1.96%	128.4026853	1276.47	509.93	1786.4	7.19%



In summary, as illustrated above, the RN vacancy rate on the Trust's wards, ED and ICU is 118.31 wte against an establishment of 1276.47 wte (9.27%).The non-registered workforce vacancies are 10.00 wte (1.96%) although a number of wards have over recruited to support the RN vacancies, as mentioned earlier in this report.

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

6. SUMMARY

Nursing and midwifery establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. This is all managed very carefully and in a way that balances the risk across the organisation and will continue to be so. The challenges remain around recruitment and with regard to the supply of registered nurses.

In summary there are many nurse staffing challenges and difficulties; however, it is recognised that significant effort is being made by many registered and non-registered nursing staff, which includes many working outside their normal area of speciality, to help care for patients in these challenging circumstances.

7. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
March 2018

Appendix 1: HEY Safer Staffing Report – January 2018

APPENDIX 1

HEY SAFER STAFFING REPORT JANUARY-18

NURSE STAFFING / HIGH LEVEL QUALITY INDICATORS [which may or may not be linked to nurse staffing]

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES DAY: Average fill rate - RN/RM (%)	FILL RATES DAY: Average fill rate - care staff (%)	FILL RATES NIGHT: Average fill rate - RN/RM (%)	FILL RATES NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CHPPD: RN / RM	CHPPD: CARE STAFF	CHPPD: OVERALL	ROTA EFFICIENCY [25-12-17 to 21-01-18]: ANNUAL LEAVE [11-17%]	ROTA: SICK RN & AN [3.9%]	ROTA: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M10]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN Est. [WTE]
MEDICINE	ED	ACUTE MEDICINE	NA	0									13.6%	2.1%	2.2%	4.09	4.4%	-0.13	-0.6%	3.96	115.34
	AMU	ACUTE MEDICINE	45	3	105%	71%	109%	101%	1180	4.8	2.3	7.2	9.6%	4.3%	2.6%	8.94	20.2%	0.24	1.0%	9.18	67.57
	H1	ACUTE MEDICINE	22	8	79%	103%	99%	97%	618	2.7	1.8	4.5	9.1%	9.3%	0.0%	1.76	12.1%	0.33	4.2%	2.09	22.51
	EAU	ELDERLY MEDICINE	21	11	94%	97%	68%	85%	604	3.8	3.1	6.9	12.1%	2.1%	5.2%	1.78	9.3%	-4.15	-31.5%	-2.37	32.27
	H5 / RHOB	RESPIRATORY	26	1	73%	92%	100%	103%	580	2.8	1.9	4.7	7.7%	7.9%	6.9%	4.29	17.4%	1.40	10.6%	5.69	37.84
	H50	RENAL MEDICINE	19	7	71%	106%	101%	110%	533	3.2	2.3	5.6	11.8%	8.6%	0.0%	0.31	2.1%	0.43	5.1%	0.74	23.54
	H500	RESPIRATORY	24	0	81%	101%	98%	101%	703	2.4	2.5	4.9	9.0%	8.6%	0.0%	2.56	15.1%	0.25	2.1%	2.81	29.10
	H70	ENDOCRINOLOGY	30	33	68%	126%	74%	108%	888	2.2	2.4	4.6	7.1%	5.7%	0.0%	8.90	44.4%	0.92	7.6%	9.82	32.22
	H8	ELDERLY MEDICINE	27	0	75%	102%	104%	103%	798	2.5	2.3	4.8	8.7%	2.5%	3.3%	0.86	5.2%	-1.34	-10.2%	-0.48	29.78
	H80	ELDERLY MEDICINE	27	5	68%	105%	100%	100%	785	2.4	2.4	4.9	9.5%	8.6%	6.2%	2.63	15.8%	-1.16	-8.8%	1.47	29.78
	H9	ELDERLY MEDICINE	31	21	71%	127%	99%	108%	910	2.1	2.4	4.4	7.4%	1.3%	4.6%	4.82	29.0%	-1.04	-7.9%	3.78	29.78
	H90	ELDERLY MEDICINE	29	7	65%	124%	100%	115%	824	2.2	2.7	4.9	10.3%	6.6%	3.7%	6.65	40.0%	-2.35	-17.9%	4.30	29.78
	H11	STROKE / NEUROLOGY	28	99	57%	165%	77%	113%	824	2.2	2.6	4.8	9.0%	7.4%	0.1%	6.89	30.6%	1.25	11.8%	8.14	33.16
	H110	STROKE / NEUROLOGY	24	3	70%	129%	88%	92%	544	3.9	2.9	6.8	13.6%	11.5%	0.0%	5.58	24.8%	0.64	5.8%	6.22	33.64
	CDU	CARDIOLOGY	9	0	60%	24%	100%		80	13.2	2.0	15.2	22.9%	21.9%	0.0%	0.01	0.1%	0.63	21.6%	0.64	15.74
	C26	CARDIOLOGY	26	11	70%	89%	81%	92%	633	4.1	1.7	5.8	9.4%	9.2%	14.7%	3.07	11.9%	-0.39	-4.9%	2.68	33.73
	C28 /CMU	CARDIOLOGY	27	11	79%	89%	83%	61%	675	6.3	1.6	7.9	11.8%	3.2%	0.0%	5.10	13.4%	0.69	7.2%	5.79	47.78
SURGERY	H4	NEURO SURGERY	30	18	76%	114%	85%	112%	785	2.9	2.0	5.0	9.3%	7.6%	3.6%	5.08	23.3%	0.44	4.2%	5.52	32.28
	H40	NEURO HOB / TRAUMA	15	16	88%	92%	104%	102%	361	6.7	3.8	10.5	13.6%	9.2%	0.0%	1.19	5.7%	1.12	10.1%	2.31	31.95
	H6	ACUTE SURGERY	28	1	92%	76%	88%	147%	696	3.2	2.2	5.5	11.5%	8.6%	0.0%	2.91	15.2%	0.47	4.4%	3.38	29.74
	H60	ACUTE SURGERY	28	7	95%	91%	87%	144%	718	3.2	2.2	5.4	9.4%	4.9%	2.1%	0.56	2.9%	0.38	3.6%	0.94	29.74
	H7	VASCULAR SURGERY	30	20	79%	74%	94%	98%	861	2.9	2.1	5.1	9.6%	5.0%	0.0%	5.52	25.4%	1.09	8.3%	6.61	34.89
	H100	GASTROENTEROLOGY	24	7	80%	105%	83%	108%	793	2.5	2.2	4.6	7.5%	4.9%	8.8%	2.67	14.0%	-0.66	-5.5%	2.01	31.23
	H12	ORTHOPAEDIC	28	14	76%	94%	84%	134%	735	3.1	2.8	5.9	11.4%	10.6%	4.5%	5.35	24.5%	-1.03	-7.8%	4.32	35.00
	H120	ORTHO / MAXFAX	22	13	87%	109%	79%	112%	582	3.4	2.9	6.4	10.2%	7.5%	0.0%	1.48	8.9%	0.35	3.0%	1.83	28.42
	HICU	CRITICAL CARE	22	0	93%	210%	91%	77%	474	27.9	2.2	30.2	7.8%	7.0%	2.8%	0.46	0.4%	-7.04	-96.2%	-6.58	112.20
	C9	ORTHOPAEDIC	35	1	75%	80%	98%	97%	723	3.6	1.9	5.5	14.8%	14.6%	2.0%	1.91	8.8%	0.22	1.9%	2.13	33.39
	C10	COLORECTAL	21	0	76%	61%	73%	113%	376	5.0	2.3	7.3	15.6%	7.5%	2.6%	3.54	19.4%	-0.09	-1.2%	3.45	26.08
	C11	COLORECTAL	22	4	87%	91%	89%	113%	531	4.2	2.1	6.3	14.6%	5.4%	4.3%	2.16	11.8%	1.79	22.9%	3.95	26.08
	C14	UPPER GI	27	0	79%	76%	83%	133%	629	3.8	1.9	5.6	15.7%	8.4%	9.0%	-0.08	-0.4%	0.04	0.4%	-0.04	29.38
	C15	UROLOGY	26	1	83%	76%	85%	85%	589	4.2	2.3	6.5	17.6%	6.2%	3.1%	0.50	2.4%	0.44	3.6%	0.94	32.71
	C27	CARDIOTHORACIC	26	1	87%	91%	93%	103%	691	4.1	1.6	5.7	13.9%	7.1%	7.8%	1.77	7.5%	-0.66	-7.7%	1.11	32.22
	CICU	CRITICAL CARE	22	0	89%	122%	91%	76%	441	24.0	2.5	26.6	9.8%	8.9%	1.3%	6.51	7.0%	0.66	8.7%	7.17	100.50
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	71%	90%	107%	67%	210	9.3	5.2	14.5	18.1%	5.9%	9.0%	1.72	9.3%	1.47	13.2%	3.19	29.65
	H130	PAEDS	20	0	102%	37%	98%	65%	474	6.3	0.8	7.1	14.0%	3.7%	2.8%	-0.79	-3.7%	2.02	38.7%	1.23	26.59
	H30 CEDAR	GYNAECOLOGY	9	2	75%	58%	110%		339	4.6	1.8	6.4	19.0%	22.0%	0.0%	0.27	3.6%	0.12	3.1%	0.39	11.33
	H31 MAPLE	MATERNITY	20	0	86%	90%	116%	99%	382	6.1	3.6	9.7	8.1%	7.9%	0.0%	-0.42	-0.9%	2.38	10.5%	1.96	73.34
	H33 ROWAN	MATERNITY	38	0	93%	81%	89%	99%	1147	2.9	1.5	4.3	12.5%	2.1%	0.3%						
	H34 ACORN	PAEDS SURGERY	20	0	93%	85%	98%	59%	234	11.0	2.7	13.7	16.0%	4.3%	0.0%	-0.82	-4.0%	-0.46	-8.8%	-1.28	26.00
	H35	OPHTHALMOLOGY	12	0	87%	19%	109%		311	4.8	0.5	5.3	7.9%	4.4%	20.1%	1.38	12.4%	3.76	138.8%	5.14	13.84
	LABOUR	MATERNITY	16	0	113%	86%	103%	88%	249	24.3	6.9	31.2	10.6%	2.8%	1.7%	-0.58	-1.2%	0.79	5.8%	0.21	63.84
	NEONATES	CRITICAL CARE	26	0	77%	62%	90%	87%	620	12.6	0.9	13.5	10.6%	5.7%	8.8%	1.22	1.8%	-0.24	-3.2%	0.98	74.51
	PAU	PAEDS	10	0	103%		99%		106	14.2	0.0	14.2	11.0%	9.1%	6.8%	-1.24	-11.9%	0.00	0.0%	-1.24	10.44
	PHDU	CRITICAL CARE	4	0	108%	54%	100%		47	32.8	2.6	35.4	8.7%	3.5%	0.0%	-1.80	-15.4%	0.00	0.0%	-1.80	11.66
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	23	104%	75%	105%	117%	400	3.8	2.4	6.2	10.2%	13.6%	0.0%	1.58	13.1%	2.48	30.2%	4.06	20.22
	C29	REHABILITATION	15	134	97%	94%	100%	69%	449	3.5	4.0	7.5	13.2%	8.4%	0.0%	-0.53	-4.0%	2.11	13.4%	1.58	28.89
	C30	ONCOLOGY	22	4	95%	105%	99%	100%	606	3.0	1.9	5.0	8.7%	13.6%	5.2%	1.11	7.9%	1.35	16.9%	2.46	21.97
	C31	ONCOLOGY	27	0	97%	94%	102%	102%	708	2.6	2.2	4.9	9.6%	4.2%	8.6%	1.26	9.0%	1.33	11.3%	2.59	25.74
	C32	ONCOLOGY	22	0	90%	100%	98%	101%	608	2.9	1.8	4.7	9.9%	2.3%	0.0%	2.17	15.5%	2.68	28.0%	4.85	23.57
	C33	HAEMATOLOGY	28	3	83%	133%	93%	129%	666	4.5	2.2	6.7	9.7%	4.2%	4.6%	4.01	14.6%	-3.98	-49.8%	0.03	35.44
		TOTAL:		489	AVERAGE or TOTAL:				586	6.4	2.3	8.8	11.5%	7.2%	3.4%	118.31	8.7%	9.55	3.7%	127.86	1786.40

WARD	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
ED				6	1			1						0	7
AMU	93%			2				0		1		2		3	5
H1	100%							0		1				1	1
EAU	100%				3	1		4				1		1	5
H5 / RHOB	100%		1					0		1				1	2
H50	100%	1			2			2						0	3
H500	95%		1			1		1		1				1	3
H70	100%	1	1	1	3	1		4	1	3			1	5	12
H8	100%			1				0						0	1
H80	96%		2		3	1		4						0	6
H9	100%		2	1	1	2		3		1		1		2	8
H90	100%		1		3			3						0	4
H11	100%	3			3			3						0	6
H110	100%	4	1		1			1				1		1	7
CDU	100%							0						0	0
C26	100%							0						0	0
C28 /CMU	100%		1					0				1		1	2
H4	100%		2					0						0	2
H40	100%			2				0	1	1		1		3	5
H6	100%	1		1				0						0	2
H60	100%	4	1					0						0	5
H7	89%	4			1			1		1		1		2	7
H100	96%				2	1		3	1	2				3	6
H12	92%	2						0						0	2
H120	100%		1		1			1		1				1	3
HICU	83%		1	5				0		3		4		7	13
C9	100%				2			2		1		1		2	4
C10	100%							0						0	0
C11	100%	1	1	1				0				1		1	4
C14	100%		1					0						0	1
C15	90%			1				0						0	1
C27	100%				1			1						0	1
CICU	100%			1				0						0	1
C16	100%							0						0	0
H130	100%			1				0						0	1
H30 CEDAR	100%	2	2		1			1						0	5
H31 MAPLE	100%	1						0						0	1
H33 ROWAN	100%		1					0						0	1
H34 ACORN	100%		1					0						0	1
H35	100%			1				0						0	1
LABOUR	100%	2	2					0						0	4
NEONATES	100%		1	2				0						0	3
PAU	100%							0						0	0
PHDU	100%							0						0	0
C20	100%							0				1		1	1
C29	93%	2	2	1	2			2						0	7
C30	100%				3			3						0	3
C31	96%				1	1		2		1			1	2	4
C32	100%				1		1	2						0	2
C33	100%				1			1						0	1
(average)	98.4%														
TOTALS:	48	28	26	27	36	8	1	45	3	18	0	15	2	38	164

TOTALS:

Jan-18	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	84.3%	93.0%	93.8%	101.0%	19900	4.8	2.3	7.1
CHH SITE	84.0%	91.5%	90.8%	95.3%	9017	4.9	2.1	7.1

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.5917807	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.2866765	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.0371387	1276.47	509.93	1786.4	7.28%
Jan-18	118.31	9.27%	10.00	1.96%	128.4026853	1276.47	509.93	1786.4	7.19%

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

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

Trust Board date	13.3.18			**Reference Number**	2018 – 3 - 10	
Director	Mike Wright - Chief Nurse			**Author**	Mike Wright, Chief Nurse Jo Ledger, Deputy Chief Nurse Caroline Grantham, Practice Development Matron	
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits					
Type of report	Concept paper		Strategic options		Business case	
	Performance	✓	Information		Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Determine if this report provides sufficient information and assurance • Determine if any further actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): All Safe domains; E1 (evidence-based); E2 (outcomes); E3 (staff skills); E4 (team working); C1 (care, respect and dignity)					
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N		**Legal advice taken?** N	**Raises sustainability issues?** N	
5	**BOARD/BOARD COMMITTEE REVIEW** The Board receives this report on a quarterly basis, to provide an overview of fundamental standards of care, positive assurance on progress and any risk issues arising.					

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

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in October 2017. Good progress is being made and this report presents the position as of February 2018.

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

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

The methodology of the Fundamental Standards audits was presented to the Trust Board's Quality Committee on the 26th February 2018 in order to provide further assurance about this programme.

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

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our nursing and midwifery teams. The last report on this topic was presented to the Trust Board in October 2017. This provides a progress report up to the end of February 2018.

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

Table to illustrate the Nine Fundamental Standards
1. STAFF EXPERIENCE
2. PATIENT ENVIRONMENT
3. INFECTION CONTROL
4. SAFEGUARDING
5. MEDICINES MANAGEMENT
6. TISSUE VIABILITY
7. PATIENT CENTRED CARE
8. NUTRITION & HYDRATION
9. PATIENT EXPERIENCE

Table 1

2. ASSESSMENT PROCESS

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

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

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

Score	Less than 80%	80% to 88%	89 to 94.9%	Above 95%
Frequency of Review	3 month review	6 month review	9 month review	12 month review

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

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

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

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

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in the **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard then the Ward Sister/Charge Nurse will have an appraisal completed by the Senior Matron, with clear objectives set. If the ward gets a second consecutive Red then the Senior Sister/Charge Nurse will have an appraisal completed by the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse in order to determine what additional help/support and/or performance action may be required. An example of this practice is Ward's 4 and 40, who obtained two consecutive Red-rated scores for Nutrition. A meeting was convened with both Charge Nurses, Nurse Director for Surgery, Deputy Chief Nurse and the Head of Dietetics. A robust plan was formulated and implemented with support from the dietetic team, resulting in an improved rating for both clinical teams.

In an endeavour to strengthen further the `Ward to Board` concept, the Chief Nurse has introduced an additional panel, chaired by the Deputy Chief Nurse that reviews the performance of each ward against all of the Fundamental Standards in conjunction with the ward/department Charge Nurse/Sister every six months. This purpose of this is essentially threefold:

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

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

Ward 60's "How are we doing?" board

Figure 1

3. CURRENT POSITION

The results are shown for fifty two clinical areas. Table 2 below illustrates the overall Trust position in relation to all of the fundamental standards as at the 28th February 2018.

Appendix One provides an overview of individual ratings by clinical area, where applicable. Please note that a number of the fundamental standards are not applicable within all clinical areas, for example the nutritional fundamental standard is not completed on the Labour ward, this relates to the duration of time the patients spend within this clinical setting.

Current Trust Position for all Fundamental Standards: February 2018								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
20 wards	23 wards	4 wards	50 wards	15 wards	10 wards	12 wards	10 wards	27 wards
25 wards	24 wards	12 wards	2 wards	23 wards	8 wards	28 wards	21 wards	17 wards
7 wards	4 wards	36 wards	0 wards	14 wards	31 wards	11 wards	11 wards	8 wards
0 wards	0 wards	0 wards	0 wards	0 wards	0 wards	0 wards	4 wards	0 wards

Table 2

The following tables illustrate progress made in relation to each fundamental standard from September 2017 to February 2018, across the four Health Groups. In some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of the fundamental standard assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken currently and as a priority to address those fundamental standards rated Red**.**

4. STAFF EXPERIENCE

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	April 17	**Jun 17**	Sep 17	**Feb 18**
4	**4**	4	**2 wards**	6	**6**	5	**4 wards**	10	**9**	9	**9 wards**	7	**5**	5	**5 wards**
2	**2**	2	**2 wards**	3	**3**	5	**6 wards**	9	**10**	7	**5 wards**	7	**8**	12	**12 wards**
0	**0**	0	**2 wards**	1	**1**	0	**0 wards**	0	**0**	1	**3 wards**	5	**6**	2	**2 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**

Progress since September: 30 reviews have been completed during this period. There are no outstanding reviews or Red-rated areas for this standard. The number of clinical areas rated as Blue has decreased within Family & Women's and Clinical Support, which relates to the changes made to the questions for this standard.

The standard now incorporates staffs views on whether there is sufficient staff working in that area and, also, whether staff are able to demonstrate knowledge of the escalation processes if they are concerned. The resulting impact has seen a shift from Blue to Green and Green to Amber rated scores in some areas. However, this standard still scores relatively highly overall. In order to address a number of concerns raised by staff out of hours, particularly on a weekend, the site team has been enhanced by the addition of a band 7 sister/charge nurse. The purpose of which, is as follows:

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

In addition, the Chief Nurse has commissioned the development of a quarterly staff briefing, (as illustrated in appendix 2), identifying all of the initiatives that are currently being implemented by the Trust in order to improve both the skills and number of the current nursing workforce.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**
0	**0**	0	**0 wards**	3	**4**	4	**7 wards**	5	**6**	6	**8 wards**	7	**8**	8	**8 wards**
6	**6**	5	**5 wards**	5	**5**	5	**2 wards**	11	**10**	9	**8 wards**	7	**9**	9	**9 wards**
0	**0**	1	**1 wards**	1	**0**	0	**0 wards**	2	**2**	2	**1 wards**	5	**2**	2	**2 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**

Progress since September: 20 reviews have been completed during this period. There are no areas rated Red. These improvements are related predominantly to enhancements made to patient areas such as ward day rooms and storage areas, where staff have implemented the core elements of "Productive Ward" (NHS Innovation) to eliminate unnecessary stock levels and ensure effective stock rotation.

There has been an increase in Blue rated areas across Surgery and Family & Women's Health Groups. Clinical Support is predominantly rated as Green with no areas rated as Blue; this relates to equipment cleaning. Clinical Support is considering increasing the number of ward hygienist roles to pick up this workload.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	April 17	**Jun 17**	Sep 17	**Feb 18**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	1	**1**	2	**2 wards**	1	**2**	2	**2 wards**
2	**3**	3	**2 wards**	1	**1**	8	**2 wards**	3	**3**	4	**4 wards**	2	**2**	4	**4 wards**
4	**3**	3	**4 wards**	9	**9**	2	**8 wards**	15	**15**	11	**11 wards**	16	**15**	12	**13 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	1	**0 wards**

Progress since September: There are 18 outstanding reviews for this standard this quarter. 9 reviews were completed during this period. There are no areas rated Red. Across all the Health groups the predominant rating remains Amber. This relates to the failure to clean equipment consistently at weekends, although some areas have addressed this issue by pooling their hygienists so that wards have some cover over a weekend. The Practice Development Matrons are working closely with the facilities department to ascertain if the domestic staff can take on any cleaning of equipment, which should support improved compliance in this area. The high number of outstanding reviews relate to staffing issues within the Infection Control Team. The team has seen a number of staff retire or leave the Trust due to promotion. The Lead Infection Control Nurse is actively recruiting to the team therefore by the end of quarter one the reviews for this standard should be back on track.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**
5	**5**	6	**6 wards**	7	**7**	8	**10 wards**	16	**16**	18	**17 wards**	12	**12**	13	**17 wards**
1	**1**	0	**0 wards**	2	**2**	2	**0 wards**	2	**2**	1	**0 wards**	6	**6**	5	**2 wards**
0	**0**	0	**0 wards**	1	**1**	0	**0 wards**	1	**1**	0	**0 wards**	1	**1**	1	**0 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**

Progress since September: 22 reviews have been completed during this review. There are 6 outstanding reviews for this standard, which will be completed throughout March 2018. Across of all the Health Groups there has been an increase in Blue rated clinical areas. There are no Red rated areas for this standard.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**
0	**0**	0	**0 wards**	7	**7**	7	**7 wards**	6	**7**	6	**3 wards**	5	**5**	5	**5 wards**
3	**2**	4	**5 wards**	2	**2**	2	**3 wards**	9	**11**	6	**10 wards**	7	**8**	8	**5 wards**
3	**4**	2	**1 wards**	1	**1**	1	**0 wards**	4	**1**	5	**4 wards**	7	**6**	6	**9 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**

Progress since September: 25 have been completed during this period. There are eight outstanding reviews for this standard but there is a plan in place to complete all by the end of March. There has been an increase in the number of Green-rated clinical areas within Clinical Support, Family & Women's and Surgery. Medicine has seen a slight decreased in Green-rated areas. There are no clinical areas rated Red for this standard. The improvements are related to a step-changed sustained compliance in 24 hour monitoring of medication fridges and controlled drugs checks.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**
0	**0**	0	**0 wards**	5	**6**	5	**5 wards**	1	**1**	1	**1 wards**	3	**3**	3	**4 wards**
2	**2**	0	**1 wards**	0	**2**	2	**2 wards**	1	**4**	5	**4 wards**	1	**1**	0	**1 wards**
4	**5**	6	**5 wards**	5	**3**	3	**3 wards**	12	**11**	10	**12 wards**	8	**10**	12	**11 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	5	**3**	1	**0 wards**	4	**2**	1	**0 wards**

Progress since September: 15 reviews have been completed during this period, with 10 outstanding reviews for this standard. There has been an increase in the number of Blue and Green-rated clinical areas within Clinical Support and Medicine. There are no Red-rated for this standard. As a result of the areas of concern highlighted through the completion of the Tissue Viability Fundamental Standard, relating specifically to documentation, a task and finish group had been set up to review the current Nursing Record. The reformatted Nursing Care Bundle has been successfully piloted and will be rolled out Trust Wide during May 2018.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	April 17	**Jun 17**	Sep 17	**Feb 18**
0	**0**	0	**0 wards**	5	**5**	5	**4 wards**	5	**5**	4	**5 wards**	2	**2**	2	**3 wards**
2	**2**	4	**4 wards**	1	**3**	4	**5 wards**	4	**6**	7	**8 wards**	5	**5**	9	**11 wards**
4	**4**	2	**2 wards**	2	**1**	0	**0 wards**	7	**8**	6	**4 wards**	8	**9**	8	**5 wards**
0	**0**	0	**0 wards**	1	**0**	0	**0 wards**	3	**0**	0	**0 wards**	4	**3**	0	**0 wards**

Progress since September: 24 reviews have been completed during this period. There has been an increase in Green and Amber-rated scores within Medicine & Surgery. There are no Red rated areas for this standard. There are no major concerns with this standard. Please note that this standard does not assess the documentation associated with, Nutrition, Infection Control and Tissue Viability this is completed as part of the individual standard reviews.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	April 17	**Jun 17**	Sep 17	**Feb 18**
0	**1**	1	**1 wards**	2	**2**	2	**3 wards**	4	**5**	5	**3 wards**	2	**1**	1	**3 wards**
1	**2**	2	**4 wards**	2	**2**	2	**2 wards**	4	**7**	7	**8 wards**	5	**5**	8	**7 wards**
4	**3**	3	**1 wards**	2	**1**	2	**2 wards**	7	**5**	5	**5 wards**	8	**6**	4	**3 wards**
1	**0**	0	**0 wards**	1	**2**	1	**0 wards**	4	**2**	0	**1 wards**	2	**3**	4	**3 wards**

Progress since September: 22 reviews completed during this period. There has been an increase in Green and Blue-rated scores within Clinical Support, Medicine and Family & Women's. Only 4 clinical areas are still rated as Red for this fundamental standard. There are two predominant reasons for the Red-rated scores within this standard. Firstly, poor compliance in relation to the completion of the Food and Hydration charts. Although staff members are entering what the patients are eating on a daily basis the current food chart requires the staff to calculate a score which is not always completed consistently. Secondly, although the nursing staff are activating an appropriate plan of care based on a comprehensive risk assessment, they are not documenting specific patient needs consistently. There is no evidence to suggest that this is resulting in patient harm or that patients are not receiving appropriate nutrition and hydration.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**	Apr 17	**Jun 17**	Sep 17	**Feb 18**
2	**3**	3	**2 wards**	5	**5**	5	**7 wards**	10	**8**	7	**11 wards**	8	**6**	6	**7 wards**
4	**3**	3	**3 wards**	4	**4**	5	**3 wards**	9	**11**	10	**5 wards**	5	**8**	9	**6 wards**
0	**0**	0	**1 wards**	1	**1**	0	**0 wards**	0	**0**	0	**1 wards**	6	**5**	3	**6 wards**
0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	0	**0 wards**	0	**0**	1	**0 wards**

Progress since September: 38 reviews completed during this period. There are no Red-rated areas for this standard. There has been a decrease in Blue-rated clinical areas for this standard within Clinical Support and an increase in Family & Women's, Medicine and Surgery. The reasons for this are multifactorial but include being unable to secure sufficient numbers of patients that are able to respond. There are no major concerns with this standard.

12. OVERALL POSITION:

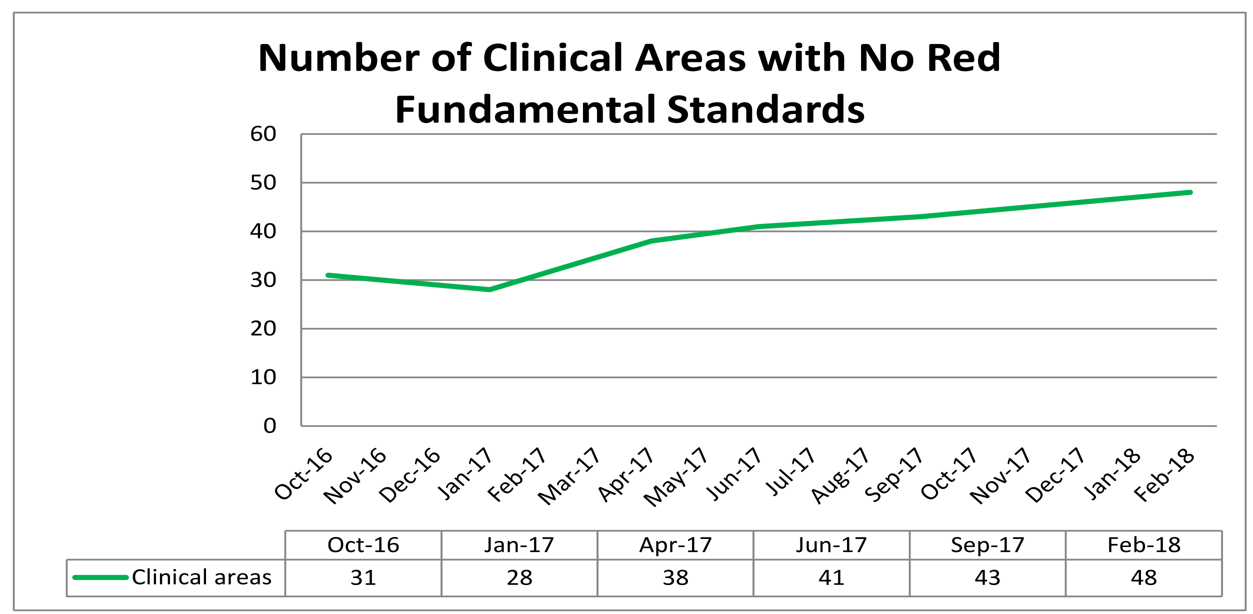
Good progress is being made against all of the fundamental standards; 48 of the 52 clinical areas reviewed now have no Red Standards. Figures 2 and 3 illustrate the progress that has been made from a Trust perspective over the last quarter in relation to the number of Fundamental Standards rated Red. Figure 4 illustrates progress since July 2016 in the reduction of red fundamentals.

4 clinical areas have one fundamental standard rated as Red. These Red ratings are all within the core fundamental standard of Nutrition. These areas are:

- H100, H70, H80 & H110

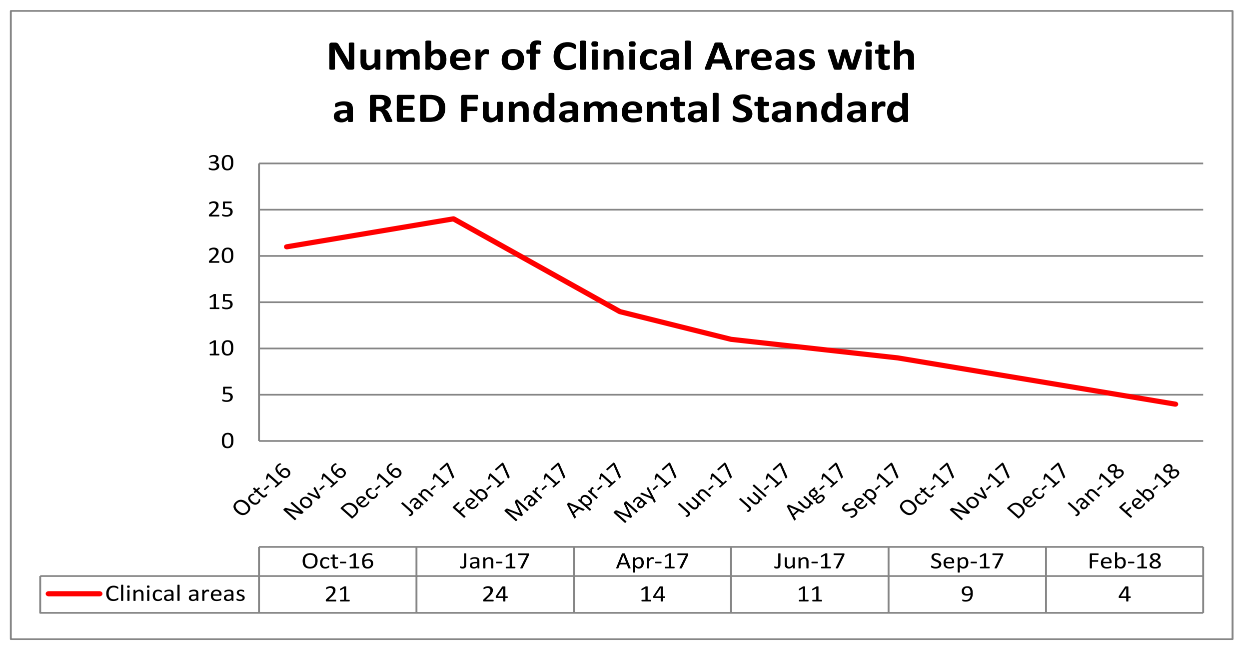
These areas need to improve their compliance in relation to the completion of the Food and Hydration charts. Although staff members are entering what the patients are eating on a daily basis the current food chart requires the staff to calculate a score which is not always completed consistently. Secondly, although the nursing staff are activating an appropriate plan of care based on a comprehensive risk assessment, they are not documenting specific patient needs consistently and thirdly, the patients are not being weighed every 72 hours.

Therefore specific attention will be focused on these areas over the next two months.



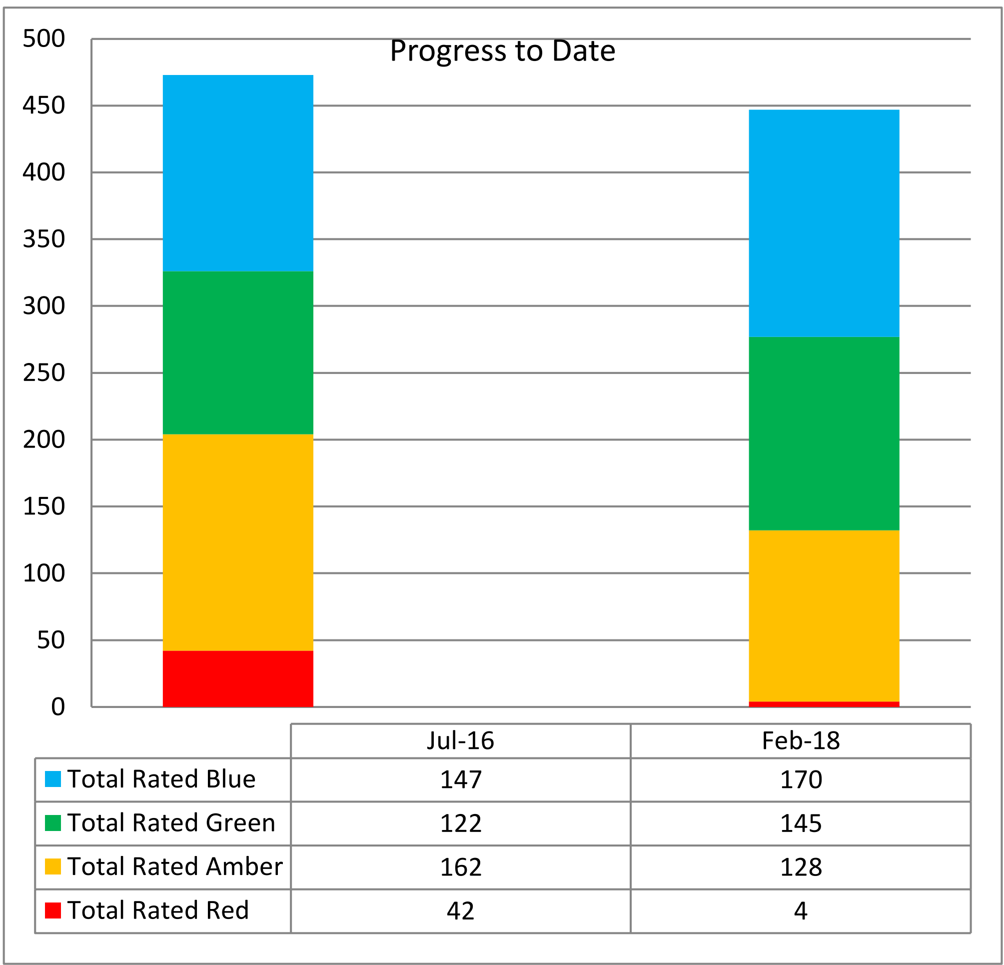
	Oct-16	Jan-17	Apr-17	Jun-17	Sep-17	Feb-18
Clinical areas	31	28	38	41	43	48

Figure 2



	Oct-16	Jan-17	Apr-17	Jun-17	Sep-17	Feb-18
Clinical areas	21	24	14	11	9	4

Figure 3



	Jul-16	Feb-18
Total Rated Blue	147	170
Total Rated Green	122	145
Total Rated Amber	162	128
Total Rated Red	42	4

Figure 4

The reduction in the total number of standards audited between 2016 and 2018, relate to the reconfiguration of a number of services, elective Orthopaedics and Critical Care.

13. AREAS FOR IMPROVEMENT

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

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

Although elimination of all Red rated fundamental standards has not been achieved fully, significant improvement has been made, as demonstrated in the charts above. The number of fundamental standards rated as Blue and Green have both increased to approximately 70% of the total. A concentrated effort will now be focused on eliminating the remaining Red rated fundamental standards, all of which are due for re-audit May 2018, where it is the expectation of the Chief Nurse that this position will be significantly improved.

14. SUMMARY

Currently there is only one core fundamental standard with any Red ratings, that is nutrition with four areas still rated as Red. A concentrated effort on improving this position remains a key priority of the Senior Nursing Teams.

15. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
March 2018

Appendix One – Overview Fundamental Standards February 2018
Appendix Two – Staff Briefing relating to Workforce Initiatives

FUNDAMENTAL STANDARDS February 2018 – APPENDIX ONE

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C20	99%	April 18	86%	Jan 18	87%	April 18	100%	Mar 18	89%	July 18	93%	Sept 18	86%	April 18	90%	Mar 18	89%	Nov 18
C29	88%	July 18	90%	Sept 18	80%*	Mar 18	100%	Feb 19	85%	June 18	80%*	Mar 18	93%	April 18	100%	June 18	93%	Oct 18
C30	96%	April 18	93%	Oct 18	80%*	Oct 17	100%	Feb 19	90%	April 18	83%	April 18	81%	Mar 18	94%	Mar 18	93%	Aug 18
C31	90%	Nov 18	89%	Oct 18	80%*	Dec 17	100%	Mar 18	94%	Nov 18	84%	Feb 18	91%	July 18	94%	Sept 18	82%	Aug 18
C32	92%	Nov 18	92%	Sept18	91%	Dec 17	100%	Mar 18	89%	April 18	85%	Feb 18	89%	Oct 18	80%	June 18	99%	Jan 19
C33	87%	July 18	90%	Sept 18	94%	July 18	97%	Sept 18	91%	Nov 18	84%	April 18	89%	Mar 18	94.5%	Nov 18	100%	Jan 19

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	93%	Nov 18	95%	April 18	86%	April 18	97%	Nov 18	94%	April 18	83%	Mar 18	90%	Oct 18	92%	June 18	96%	Jan 19
Cedar H30	89%	May 18	91%	April 18	86%	Aug 18	97%	Oct 18	95%	Feb 18	93%	Oct 18	91%	Mar 18	93%	Nov 18	96%	June 18
H31	96%	April 18	96%	Jan 19	85%	April 18	100%	Oct 18	93%	Nov 18	89%	Jan 18	100%	Jan 19	NA		96%	Jan 19
H33	94%	Oct 18	89%	April 18	84%	April 18	100%	Nov 18	96%	Feb 19	100%	April 18	100%	Jan 19	NA		100%	Jan 19
ACORN	95%	April 18	100%	Jan 19	90%	May 18	100%	Feb 18	100%	Mar 18	100%	June 18	92%	Nov 18	88%	June 18	96%	Mar 18
H35	99%	Nov 18	97%	June 18	93%	June 18	96%	Feb 19	94%	Mar 18	88%	April 18	96%	Feb 18	86%	April 18	92%	Dec 18
H130	94%	Nov 18	95%	Mar 18	81%	April 18	100%	Feb 18	97%	Mar 18	100%	April 18	89%	Oct 18	98%	Dec 18	94%	June 18
Labour	93%	Oct 18	NA		80%*	Jan 18	100%	Jan 19	96%	Nov 18	80%*	Mar 18	100%	Jan 19	NA		98%	Jan 19
NICU	91%	Oct 18	95%	June 18	88%	Dec 17	97%	Mar 18	100%	Mar 18	100%	Mar 18			100%	June 18	98%	Mar 18
PHDU	97%	Mar 18	100%	Jan 19	86%	Jan 18	100%	Dec 18	100%	Jan 19	100%	June 18	92%	June 18	96%	Mar 18	97%	Dec 18

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C9	94%	Oct 18	90%	Sept 18	91%	April 18	96%	Jan 18	94%	April 18	89%	April 18	92%	Feb 18	80%	June 18	98%	Jan 19
C10	93%	Oct 18	95%	June 18	94%	June 18	100%	Nov 18	89%	July 18	80%	Mar 18	80%	Mar 18	92%	Mar 18	94%	Nov 18
C11	95%	Oct 18	95%	Nov 18	83%	April 18	100%	Feb 19	97%	June 18	87%	Mar 18	83%	Feb 18	93%	Mar 18	96%	Oct 18
C14	89%	Oct 18	95%	Nov 18	80%*	Jan 18	96%	July 18	94%	Nov 18	80%*	Mar 18	82%	Feb 18	87%	June 18	86%	Aug 18
C15	95%	July 18	93%	Mar 18	80%*	May 18	97%	July 18	94%	April 18	80%*	Aug 18	92%	April 18	93%	Mar 18	97%	Jan 19
C27	97%	Feb 19	92%	Aug 18	88%	April 18	100%	Mar 18	96%	July 18	89%	Jan 18	93%	Oct 18	88%	June 18	93%	Oct 18
CICU1	98%	April 18	100%	April 18	97%	April 18	100%	May 18	89%	July 18	93%	Mar 18	96%	June 18	96%	May 18	100%	Feb 19
CICU2	90%	April 18	100%	May 18	91%	July 18	100%	May 18	89%	July 18	96%	April 18	95%	April 18	100%	May 18	98%	Jan 19

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	95%	Mar 18	95%	Mar 18	81%	Oct 17	97%	Dec 18	87%	Feb 18	80%*	Feb 18	88%	Aug 18	90%	Nov 18	91%	Oct 18
H40	94%	June 18	92%	June 18	85%	April 18	95%	Dec 18	89%	May 18	84%	Jun 18	93%	Apr 18	83%	Aug 18	91%	July 18
H6	95%	Mar 18	90%	July 18	80%*	Aug 18	97%	June 18	89%	Oct 18	80%*	Jan 18	96%	Dec 18	86%	Aug 18	96%	Jan 19

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
H60	95%	Mar 18	97%	June 18	**89%**	April 18	97%	Jan 18	89%	July 18	**80%***	Jan 18	96%	Mar 18	**91%**	Mar 18	95%	Mar 18
H7	88%	Jun 18	97%	Mar 18	**82%**	April 18	97%	Mar 18	87%	Jan 18	**80%***	Mar 18	**96%**	Mar 18	**95%**	June 18	90%	July 18
H12	87%	Mar 18	93%	Mar 18	80%*	April 18	97%	Dec 17	83%	Jan 18	83%	Jan 18	89%	Oct 18	**89%**	Mar 18	96%	Mar 18
H120	95%	Mar 18	93%	Mar 18	**87%**	May 18	96%	Dec 17	93%	April 18	**80%***	Mar 18	90%	Nov 18	**90%**	Mar 18	95%	Mar 18
H100	84%	July 18	84%	June 18	**80%***	Dec 17	100%	Jan 19	84%	July 18	**83%**	June 18	94%	Nov 18	78%	May 18	96%	Jan 19
HICU1 & 2	89%	Oct 18	94%	June 18	100%	Oct 18	100%	April 18	98%	Feb 19	94%	April 18	94%	Nov 18	**92%**	Mar 18	100%	Dec 18

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	92%	Oct 18	**95%**	April 18	97%	May 18	97%	June 18	92%	April 18	88%	May 18	**88%**	Aug 18	92%	Mar 18	95%	Oct 18
C26	91%	Nov 18	97%	Feb 19	89%	June 18	100%	Mar 18	91%	April 18	86%	May 18	84%	Aug 18	83%	June 18	82%	Aug 18
C5DU	94%	Aug 18	97%	Feb 19	97%	Oct 17	96%	June 18	96%	Feb 19	100%	April 18	98%	Mar 18	100%	Mar 18	95%	Feb 19

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
MAU	94%	June 18	89%	April 18	86%	April 18	97%	Feb 19	89%	Mar 18	**80%***	July 18	**85%**	April 18	**100%**	April 18	94%	Mar 18
H1	93%	July 18	91%	April 18	**83%**	April 18	97%	Oct 18	83%	Feb 18	96%	Nov 18	**92%**	April 18	**96%**	Feb 19	93%	Mar 18
H200/EAU	96%	Mar 18	95%	Mar 18	**83%**	Jan 18	100%	Jan 19	95%	Jan 19	**94%**	Sept 18	90%	Sept 18	**93%**	Mar 18	88%	July 18
H5	92%	Oct 18	89%	April 18	**80%***	Nov 17	96%	Feb 19	89%	April 18	84%	Jan 18	**91%**	Oct 18	**93%**	Mar 18	95%	Dec 18
H50	86%	July 18	89%	July 18	**80%***	Jan 18	100%	Mar 18	96%	Mar 18	**96%**	Jan 18	**94%**	Oct 18	**93%**	Jun 18	82%	July 18
H500	97%	Jan 19	95%	June 18	**80%***	Dec 17	100%	Dec 18	90%	Mar 18	**80%***	Jan 18	92%	Oct 18	**93%**	Mar 18	91%	Oct 18
H70	95%	Mar 18	95%	June 18	**84%**	Aug 18	100%	Nov 18	87%	Jan 18	**85%**	Aug 18	**92%**	Oct 18	**59%**	May 18	**91%**	Aug 18
H8	92%	Sept 18	97%	Mar 18	80%*	Oct 17	**100%**	Feb 19	87%	July 18	95%	Oct 18	95%	Mar 18	87%	May 18	81%	Mar 18
H80	95%	Mar 18	94%	July 18	80%*	Jan 18	95%	May 18	80%	May 18	80%	Jan 18	94%	June 18	**56%**	May 18	85%	Mar 18
H9	91%	June 18	90%	Aug 18	87%	Aug 18	100%	Mar 18	85%	Feb 18	80%	Mar 18	87%	Aug 18	83%	April 18	89%	June 18
H90	92%	June 18	90%	Aug 18	82%	April 18	90%	Nov 18	80%	May 18	**80%**	Mar 18	92%	Sept 18	89%	Aug 18	83%	Mar 18
H11	85%	July 18	**86%**	Jan 18	80%*	Dec 17	97%	Mar 18	83%	July 18	**80%***	Mar 18	**91%**	July 18	93%	Mar 18	90%	Oct 18
H110	90%	Sept 18	**88%**	Jan 18	80%*	Oct 17	100%	Jan 19	80%	May 18	**80%***	Mar 18	94%	Mar 18	68%	May 18	97%	Dec 18

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management				Patient Centred Care (inc TV)				Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due			Rating	Next due			Rating	Next due
Majors ED	94%	Nov 18	**94%**	July 18	91%	April 18	100%	Dec 18	96%	Oct 18			86%	Mar 18			97%	Jan 19
Paeds ED	95%	April 18	**94%**	July 18	94%	April 18	96%	Aug 18	95%	Feb 18			93%	Sept 18			97%	Jan 19
Emergency Care	92%	July 18	**96%**	Oct 18	93%	April 18	89%	July 18	84%	May 18			100%	Nov 18			100%	Jan 19

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

Practice Devement

How you feel...

Under pressure in your day-to-day roles
Concerned about the trust's ability to recruit and retain staff
In need of support when moving to different wards and departments

NHS
Hull and East Yorkshire Hospitals
NHS Trust

What you want...

Flexible hours and shifts to suit your life and home commitments
More time and help to complete your NMC revalidation
Support when moving from student nurse to staff nurse

We're listening...

More than 135 new nurses joined the trust last year and 162 students from the University of Hull have been lined up for interviews in 2018.

The Induction Essentials checklist, providing vital information and a welcome introduction to staff when they are moved to new areas, either as a one-off or in the longer-term.

We're working hard to improve clinical supervision, helping our nurses improve and enhance their skills and knowledge through regular meetings with senior staff.

The vital role played by non-registered staff is being recognised by our commitment to encourage them to complete the nationally recognised Care Certification, demonstrating their ability to provide high quality, compassionate care.

In response to the Shape of Caring review just two years ago, 20 Band 3 staff are already taking part in the nursing associate pilot to support registered nurses on the wards. Another 50 trainees are being lined up for the rollout of the scheme this year.

We've seen a phenomenal increase of opportunities for our unregistered workforce. Before rolling out nursing associates and nursing apprenticeships, only nine staff applied for functional skills enabling them to be considered for further study in 2016/17. This year, 54 have applied, a six-fold increase. Contact Anne Burdis at HEY Education and Development if you'd like to find out more.

Key nursing performance objectives are being introduced to support staff appraisals and NMC revalidation.

Our Nursing Associate Programme, Apprenticeship Nursing and STaR research project to support transition and retention in newly qualified nurses are strengthening our links with the University of Hull and its world-class facilities at the new Allam Medical School.

The Nurse Bank is trialling new shifts, making it easier for existing staff to join and book shifts in familiar work environments and for students to take part earlier in their careers.

Almost 100 new starters completed our "Let's Get Started" induction programme, with 85 per cent rating it either very good or excellent.

We're following up our new starters by introducing Let's Get Started catch-up sessions to reduce some of the training responsibilities from ward staff and to ensure we're gauging the views of new recruits as they work through our training programme.

Flexible retirement options, with rotas drawn up to encapsulate a good work/life balance, are being drawn up.

Rosters are being monitored every day to ensure optimum staffing levels to protect patient care and better working conditions on the wards.

Your Comments...

Remarkable people.
Extraordinary place.

MINUTES OF THE QUALITY COMMITTEE
HELD ON
MONDAY 29 JANUARY 2018

PRESENT:	Prof. T Sheldon	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mr K Phillips	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Dr M Purva	Deputy Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Green	Lead Clinical Research Therapist
IN ATTENDANCE:	Mrs K Southgate	Head of Compliance
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

NO.	**ITEM**	**ACTION**
1	**APOLOGIES FOR ABSENCE** Prof. M Veysey – Associate Non Executive Director	
2	**DECLARATIONS OF INTEREST** There were no declaration of interest received.	
3	**MINUTES OF THE MEETING HELD 18 DECEMBER 2018** **Item 4.5 – Robotics update –** Mr Simms name spelt incorrectly at the top of page 2.	
3.1	**MATTERS ARISING** The new programme of 'Getting it right first time' would be monitored through the QIP process.	
	Mrs Southgate agreed to bring more information relating to the NRLS incident categorisation to the February 2018 meeting.	**KS**
	Mr Wright advised that the Safeguarding section of the QIP was now green and that there were no issues with any of the processes.	
	Mrs Southgate to include details around the increase in Serious Incidents in the February report.	**KS**
	Prof. Sheldon asked about quoracy at the Wound management committee and Mr Wright advised that attendance was improving but that clinical leads were under pressure in the hospital which sometimes meant that apologies were given.	
	Mrs Walker to attend the anaesthetic clinical lead meeting. Dr Purva to invite Mrs Walker. Mrs Walker also asked Mrs Thompson to enquire whether there were other clinical lead meetings that she could attend.	**MP**
3.2	**ACTION TRACKER** Ms Ramsay to present how governance is assured with other external providers at the February 2018 meeting.	**CR**

Prof. Sheldon to be invited to a Mortality Committee where structured case note reviews would be discussed. **RT**

Mr Wright advised that the Fresenius report had been received and all issues addressed. Ongoing monitoring had been put into place.

3.3 ANY OTHER MATTERS ARISING

No other matters were discussed.

3.4 WORKPLAN 2017/18

The workplan was reviewed by the Committee. No changes were made.

3.5 WORKPLAN 2018/19

The draft workplan was reviewed by the Committee. No changes were made.

4.1 SERIOUS INCIDENTS

Mrs Southgate presented the report to the Committee. Prof. Sheldon queried the steady increase in serious incidents and Mrs Southgate assured the Committee that the variance was usual and no concerns had been raised. Mr Wright added that the Tracking Access serious incidents were also included in the numbers. Prof. Sheldon suggested that the Tracking Access incidents be recorded separately.

Ms Ramsay suggested a review of whether the themes had grown or shrunk to show any failure to learn from the incidents.

Prof. Sheldon spoke about e-Observations and how important this was for the deteriorating patient performance. Site comparisons would show the improvements being made once e-Obs was established.

There was a detailed discussion around Never Events and how unusual and individual the report findings had been. The de-escalation process was also discussed and Ms Ramsay advised that only the Commissioners could authorise de-escalation after presentations were made to their panel. Mr Wright added that the new, revised list of Never Events had been published and the spinal marking Never Event had been removed from the list. The Committee agreed to receive the National Guidance at the February 2018 Committee. **MW**

Mrs Walker was finding it difficult to analyse the Serious Incident report findings and Mr Wright suggested that the summary reports were made clearer with the specific actions highlighted.

Mr Wright stated that the Patient Safety Committee would be re-introduced at some point and it was agreed that a Non Executive Director would sit on the group.

4.2 QUALITY IMPROVEMENT PLAN

Mrs Southgate presented the Quality Improvement Plan and reported that a number of projects had been closed in the last few months, but that winter pressures could cause slight slippage.

Mrs Southgate also reported that a review of the QIP had been undertaken and any projects that had been deemed 'business as usual' had been removed.

Safeguarding was reviewed and Mr Wright assured the Committee that all outstanding issues had been dealt with and the indicator would be green in the next report.

Mrs Walker asked about the Service Level Agreement between the Trust and Humber Foundation Trust. Mr Wright assured Mrs Walker that this issue had been escalated to senior management level and there was an improved documented plan of care in place.

Medicines management was discussed and Prof. Sheldon suggested linking this QIP to the Medicines Management Framework.

Falls had improved and Mrs Southgate reported that targeted training was being carried out starting with the DME wards and staff groups. Mr Phillips added that the falls training was being reviewed to ensure the right training was being given and that it was current and fit for purpose.

VTE was discussed at length and Mr Phillips reported that Health Group performance differed not only in specialities but down to members of staff. He advised that the Safety Thermometer spot checks were showing 93% of assessments were being carried out but they were not being recorded on the Lorenzo system.

Prof. Sheldon asked for a forensic report which would highlight the exact areas of poor performance and what was being done to rectify the issues and what needed to change to ensure all members of staff recorded the assessments electronically.

Resolved:
The Committee received the report and requested a detailed report relating to VTE. **KP**

4.3 MEDICINES MANGEMENT FRAMEWORK

Mr Corral presented the framework and highlighted the 4 guiding principles for medicines optimisation and spoke around the patient centred approach. The framework aimed to improve health outcomes, ensure patients took their medicines, avoided taking unnecessary medicines, reduce medicine wastage and improve medicine safety.

The framework also included information around achieving good patient outcomes, workforce planning and development and use of resources.

Resolved:
The Committee received and endorsed the framework.

4.4 NICE COMPLIANCE REPORT

Mrs Southgate presented the report and outlined the mandatory

areas of NICE (Technology Appraisals Guidance TAG) and the Interventional Procedures which were not mandatory but still required monitoring.

She advised that they were monitored operationally and reported to the Clinical Effectiveness Committee.

Mrs Southgate reported that the Trust was compliant in all areas were appropriate and that there were no risks relating to NICE Guidance on the Risk Registers.

The Committee also discussed the Quality Standards, which were aspirational standards and related to service frameworks.

The reporting route was from the Health Groups to the Operational Quality Committee and any high risk areas would be escalated to the Quality Committee.

Resolved:
The Committee received the report and a were assured that there were no areas of risk to escalate.

4.5 MORTALITY
Mr Phillips presented the Mortality Structured Judgement Reviews report which highlighted the findings from the 302 case note reviews carried out so far.

The report drew out some themes and trends but there was still work to do around sharing the learning from the reviews and identifying changes in practice coming out of the investigations. Key areas were around poor escalation, poor quality of documentation and delay in senior review.

Mr Phillips also reported that the Trust would still be reporting if any of the deaths were avoidable. There would be regular reporting to the Quality Committee and the Trust Board.

Resolved:
The Committee received and accepted the report.

4.6 CLINICAL HARM GROUP
Mr Wright presented the Terms of Reference of the new Clinical Harm Group that had been set up as a result of the Tracking Access issues highlighted in May 2017.

This was in relation to patients that had not received an expected follow up appointment or treatment at the Trust. This matter came about following a review of three urology patients; whereupon it became apparent that the due follow-ups of three patients had not been arranged as intended.

An administration exercise to review 85,000 patient records is now nearing completion and 8,200 patients have been identified as needing a primary clinical review of their situation. This is being undertaken by the patient’s consultant. If harm is thought or

suspected to have occurred, then each of these patients will have a secondary clinical review, which will be undertaken by someone trained in the structured judgement review process. The Clinical Harm Group has been established to oversee and sign off the process for reviewing any patients identified as having possible or actual harm. An overarching serious incident has been reported for the tracking access issue as a whole. It has been agreed that any individual patient harm that has occurred as a consequence of this issue will be reported as a separate serious incident in its own right.

Mr Wright reported that the Terms of Reference showed the definitions of harm there were being applied to these reviews.

Mr Wright advised that any deaths that had occurred during this time were being reviewed, but might not be attributable to the Tracking Access issue. This was being investigated thoroughly. To date, 24 patients had been identified as having died whilst awaiting their review. However, each of these has now been reviewed independently of the respective service. From the 24 patient deaths that have occurred thus far, none of them has been related to their wait for treatment/appointment. In order to obtain assurance on this, the Clinical Harm Review Group had asked the person that undertook the reviews to attend the meeting to describe the process they followed and their findings. It was clear from the reviews that there was no causal link between the access delay and each patient's death.

Mr Wright gave two examples whereby the patient was awaiting an out-patients follow-up appointment for one condition but where they had died of an entirely different and un-associated event. After reviewing this process, the Clinical Harm Review Group was content with the process that was followed and its findings. Mr Wright reported that NHS Improvement and the Commissioners were members of the CHG, in order to provide independent scrutiny and challenge. The CQC is also being kept informed of this issue. To date, regulators and commissioners appear satisfied with how the Trust is addressing this matter. In addition, the Trust had been asked by NHSI to share its methodology with others.

The Trust had also commissioned an external review of the whole tracking access issues and the company leading this (MBI) were attending the Harm Group.

The Harm Group reports to the Operational Quality Committee and any issues would be escalated up to the Quality Committee in due course. Mr Wright also advised that there would be regular updates directly to the Quality Committee and the Trust Board on progress with this matter.

Resolved:
The Committee received and accepted the report.

5.1 INTEGRATED PERFORMANCE REPORT

The Committee reviewed the Integrated Performance Report and Prof. Sheldon highlighted the Trust's diagnostic performance which was

showing a downturn. Ms Ramsay advised that the new CT Scanner was being installed at Castle Hill and Mrs Ryabov had predicted that performance would get worse whilst the bedding in period took place.

The Committee discussed the worsening RTT position and the challenges in ED but noted that the cancer performance and improved significantly. Mrs Walker stated that high performance could not be expected whilst the winter pressures were so evident.

The Committee discussed Mortality (HSMR and SHMI) and stated that the trends were showing a reduction on week days and an increase on weekends. Mr Phillips agreed to review the data and give an update at the February 2018 meeting. **KP**

Resolved:
The Committee received and accepted the report.

5.2 OPERATIONAL QUALITY COMMITTEE
The summary of the meeting was presented. Mrs Walker asked how well attended the meeting was and Mr Wright assured the Committee that there was good representation from the Health Groups and senior managers and that all relevant areas were covered.

Resolved:
The Committee received and accepted the report.

5.3 QUALITY REPORT
Mr Wright presented the report and advised that there had been no Never Events reported in month.

The hospital had been particularly challenged with different infections but these had been managed efficiently and effectively. He spoke about the Influenza B strain of flu that had occurred and how this was due to patients who had not received the flu vaccination (under 65s) and the changing nature of the virus.

Resolved:
The Committee received and accepted the report.

6. BOARD ASSURANCE FRAMEWORK
The Committee received the report and:
- Supported the proposed Q3 ratings
- Accepted the report with no additional information to be added

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

8. DATE AND TIME OF THE NEXT MEETING:
Monday 26th February 2018, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

MINUTES OF THE QUALITY COMMITTEE
HELD ON
MONDAY 26 FEBRUARY 2018

PRESENT:	Prof. T Sheldon	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Prof. M Veysey	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mr M Wright	Chief Nurse
	Mrs G Gough	Deputy Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Green	Lead Clinical Research Therapist
IN ATTENDANCE:	Mrs R Thompson	Corporate Affairs Manager (Minutes)
	Mrs C Grantham	Practice Development Matron
	Mr J Illingworth	Research and Development Manager

NO.	ITEM	ACTION
1	**Apologies** Mr K Phillips – Chief Medical Officer, Mr D Corral – Chief Pharmacist	
2	**Declarations of Interest** There were no declarations of interest.	
3	**Minutes of the meeting 29 January 2018** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Mrs Walker advised that she had not yet had any dates confirmed for the Clinical Lead meeting.	**MP**
	Mrs Bates advised that the Getting It Right First Time projects would be monitored by Michelle Kemp and information would be triangulated.	
	Mr Wright confirmed that the Patient Safety Committee would be reviewed after the CQC visit in February 2018.	
	The Committee requested an in-depth VTE report to give the committee assurance that the assessments were on track.	**KP**
	The Committee requested more outcome information in the next mortality case note review report.	**SB**
	Mrs Walker asked about the engagement between the Trust and Humber Foundation Trust and Mr Wright informed the committee that this was in hand and would be reviewed through the Quality Improvement Plan.	
	3.2 Action Tracking List Mrs Bates advised that NRLS categorisation report was not yet available but would present it to the Committee when available.	**SB**
	Ms Ramsay advised that she would review the governance processes with external providers and report to the next meeting.	**CR**

DRAFT

3.3 Any Other Matters Arising
There were no other matters arising.

3.4 Workplan 2017/18
The Committee received and accepted the workplan 2017/18.

3.5 Draft Workplan 2018/19
The Committee received and accepted the workplan 2018/19.

The agenda was taken out of order at this point

4.5 Fundamental Standards
Mrs Grantham gave a presentation around the methodology relating to fundamental standards. Nine fundamental standards were measured including privacy and dignity and tissue viability. The aim of the audits was to drive up safe high quality care in line with the Trust objective.

Mrs Grantham advised that the process had been developed by the Chief Nurse and the senior nursing teams and the audits carried out by the corporate teams, patient representatives and the compliance team.

A set of key questions were asked, documentation reviewed and even discussions with patients around their care take place. There are 3/6/9 month reviews depending of the score achieved by the ward. The Deputy Chief Nurse and Mrs Grantham met with charge nurses to discuss their scores, give feedback and offer support where necessary.

All results are published on boards outside of the wards which shows patients and other staff how well each ward is performing. The results of the audits were presented every quarter to the Corporate Patient Experience Effectiveness and Safety Committee. What was working well and areas for improvement would be discussed in this forum. Any areas of escalation would be forwarded to the Executive Nursing Committee for further review.

A number of initiatives were being reviewed to embed sustained performance such as catering helping with snacks and teas to improve nutrition scores, training packages for staff relating to care plans and document re-formatting where this was appropriate. Mrs Grantham also mentioned the Senior Matrons Handbook which gave guidance to nursing teams and that the CQC were interested in the development of this.

The Committee was impressed with the work that had been undertaken by the teams and asked how the standards triangulated with complaints/PALs etc. Mrs Bates reported that triangulation was taking place in the Quality Improvement Programme and the Corporate Patient Experience Effectiveness and Safety Committee. Mrs Grantham added that as processes became electronic there would be more objectivity.

Prof Veysey asked about how the medical teams were engaged in the process and Mr Wright reported that there was more work to do around this area. Prof Sheldon suggested that the Quality Committee could receive quarterly updates and Ms Ramsay agreed to add this into the committee workplan.

DRAFT

Prof Veysey asked if the process could be put into a flowchart and Mrs Grantham agreed to review this.

Resolved:
The Committee received the report and agreed to receive further updates on a quarterly basis. Mrs Grantham to develop a flowchart of the Fundamental Standard process. **CR/CG**

Mrs Grantham left the meeting

4.8 Research and Innovation Strategy
Mr Illingworth presented the strategy which through research hoped to contribute to the core principles of the Trust to deliver high quality care.

The strategy set out to support services and enhance the reputation of the Trust by building relationships with the Univeristy of Hull and the Hull and York Medical School.

Mr Illingworth also spoke about the barriers to innovations, mainly the costs and how this could be used to the Trust advantage and increase income and grow capacity. He stated that the strategy was ambitious but not yet embedded, although 25 clinical specialties were currently carrying out clinical research. He also reported that development of the Hull Health Trials unit, both for the Trust and other organisations was ongoing.

Prof. Veysey stated that Board buy in of the strategy was key to its success and Ms Ramsay reported that there would be a session on the strategy at the March development meeting. Mrs Walker offered herself as a Non Executive champion as she had experience working as a research nurse in the past.

There was a detailed discussion around tying all the different work streams together and Mrs Green added that there was a number of Allied Healthcare Professionals wanting to work with the research teams to further develop projects. Mr Illingworth advised that the Director of Strategy and Planning would be involved in the process of implementing and monitoring the strategy.

Resolved:
The Committee received the strategy and agreed to discuss further at the Board Development session in March 2018.

Mr Illingworth left the meeting
The agenda returned to order at this point

4.1 Serious Incidents
Mrs Bates presented the report to the Committee and highlighted the number of serious incidents. She advised that the Trust was seeing a reduction in the number of Serious Incidents and that the themes and trends were typical.

Mrs Bates highlighted 3 incidents in urology that had been handled under 1 Serious Incident linked to FGM as well as the tracking access issues experienced by the Trust.

DRAFT

Prof. Veysey praised the work carried out by the Trust relating to falls, but expressed concerns around the deteriorating patient performance. Mrs Bates advised that Dr Purva was reviewing the deteriorating patient and how this is escalated.

There was a discussion around communication and how this was a recurring theme and how this could be dealt with. Mrs Bates reported that the Organisational Development Team were looking at communication strategies to raise awareness.

Mr Snowden praised the systematic approach being taken with the report and asked if the commissioners had commented on the Trust's RCA process. Mrs Bates reported that the commissioners worked closely with the Trust to close down Serious Incidents and that the relationship was good and robust. Also the Trust had received significant assurance from the Auditors.

Prof Sheldon reported that the Health Foundation were reviewing communication and the Trust could be a research site. Prof Sheldon offered to pass on contact details if required.

Resolved:
The Committee received and accepted the report.

4.2 NRLS Report
Mrs Bates presented the report and highlighted that the Trust was reporting too many incidents in the 'other' category. These incidents were being reviewed and this piece of work would be completed by the end March 2018 and reported to the Committee. The Trust was reporting pressure ulcer incident cases that were not attributable to the Trust and the Risk Team were reviewing these to cleanse the data.

Mrs Bates added that the majority of the Trust's incidents were in the low harm category.

Resolved:
The Committee received and accepted the report.

4.3 Mortality
Mrs Bates presented the report which highlighted the themes and trends from a sample of Structured Judgement Reviews carried out.

An improved thematic analysis database had been designed to better capture themes and trends on a weekly basis and this would be presented to the Quality Committee on a quarterly basis.

There was a discussion around negative and positive results and Mrs Bates advised that the negative score was poor practice and the positive score was good practice.

Resolved:
The Committee received and accepted the report.

DRAFT

4.4 Quality Improvement Programme
Mrs Bates presented the report and advised that one project was rated amber/red and that was consent. The issues were around implementation of the standardised forms and not development. Work was ongoing around engaging medical leadership.

VTE was discussed and the Committee expressed concerns regarding the process. Mr Wright advised that the Chief Medical Officer had tasked the 4 Medical Directors with addressing the issues.

Prof Sheldon expressed his concern regarding the deteriorating patient performance. Mrs Bates advised that Dr Purva was reviewing action specific to the deteriorating patient in the Emergency Department.

Resolved:
The Committee received and accepted the report.

4.6 Never Events List 2018
Mr Wright presented the list to the Committee. He advised that the wrong site surgery and undetected oesophageal intubation Never Events had been temporarily suspended.

Resolved:
The Committee received the updated Never Events List 2018 and noted the temporary suspensions.

4.7 CQC Unannounced Visit Update
Mr Wright updated the Committee. A number of the Executive Team had travelled to Leeds to present the Trust's Governance presentation in preparation for the Well Led inspection commencing 27 February 2018. Mr Wright would update the Committee in March 2018. **MW**

5.1 Integrated Performance Report
Prof Sheldon presented the report and highlighted that diagnostic performance was getting worse, as was breast symptomatic 2 week waits.

Prof Sheldon highlighted two areas where more information was required, emergency C-Section and 28 day readmissions. Mr Phillips to provide further information at the meeting in March 2018.

There was a discussion around outcomes of patient care due to delays and any evidence of harm being presented.

Resolved:
The Committee received and accepted the report. Mr Phillips to provide further information relating to emergency C-Sections and 28 day readmissions to the March 2018 committee. **KP**

5.2 Operational Quality Committee Report
Mr Wright presented the report and highlighted the good news relating to the sepsis work carried out by the Trust, work was ongoing around avoidable mortality and the good progress around the still birth care bundle.

DRAFT

5.3 Clinical Harm Group Update
Mr Wright reported that good progress was being made regarding the Tracking Access clinical reviews and there were 30 patients requiring a second clinical review to determine the levels of harm (if any).
The Clinical Harm Group had met three times so far and work was ongoing to review the processes around the Tracking Access clinical reviews.

Resolved:
The Committee received the verbal update.

5.4 Workforce Update Report
The Committee received the Workforce Update Report for information. Prof. Veysey was concerned that the Junior Doctor allocation discussion with Health Education England had not featured in the report and asked that it be on a future agenda.

6. Board Assurance Framework
Ms Ramsay presented the Board Assurance Framework which reflected the discussions at the January 2018 Board meeting.

Ms Ramsay also spoke about the Board's risk appetite and what level of risk it was prepared to live with. She asked the Committee if it was comfortable with the levels of risk outlined in the quality based risks. Prof. Sheldon stated that standards of quality and safety were improving and learning and cultural behaviours were being addressed. Mr Veysey added that finance and performance issues can also affect the quality of care, he added that electronic systems would be key to improvements being made.

Resolved:
The Committee received and accepted the report. No changes were made to any of the risk ratings.

7. Any Other Business
Prof. Sheldon asked about the Paediatric Review and whether any conclusions had been arrived at. Mr Wright advised that 3 options were being considered but no conclusion reached.

8. Chairman's Summary to the Board
Prof. Sheldon agreed to summarise the meeting at the Board meeting in March 2018.

9. Date and time of the next meeting:
Monday 26th March 2018, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

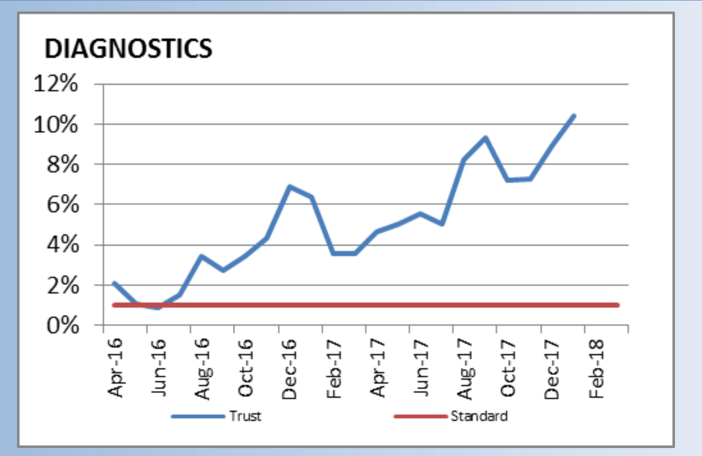
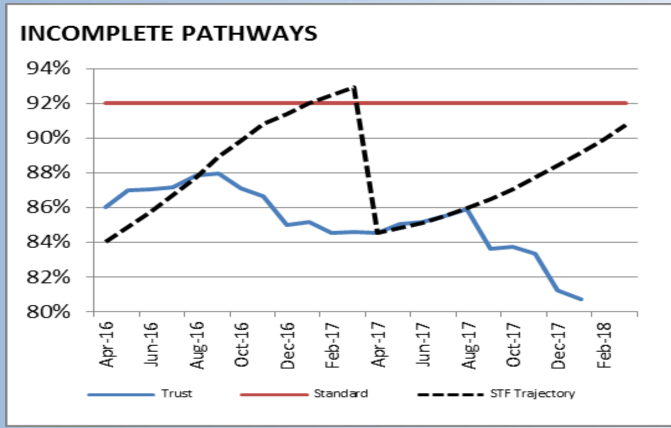
Integrated Performance Report
2017/18

March 2018

January data

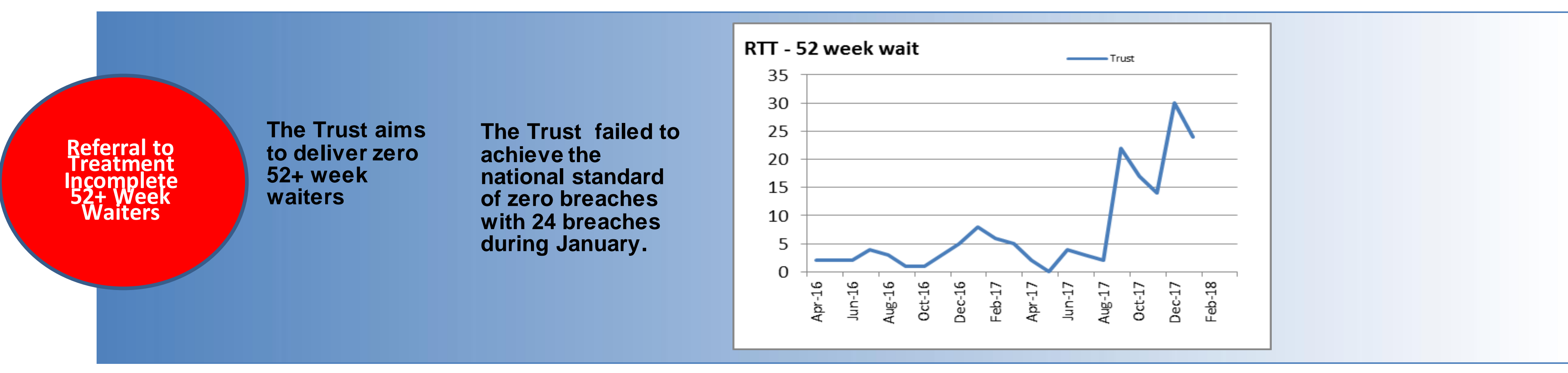
The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined in the NHS Improvement – Single Oversight Framework. This has been updated in August 2017. The draft proposal location is https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/

RESPONSIVE

Description		Aggregate Position	Trend	Variation
Diagnostic Waiting Times: 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made The target is less than 1% over 6 weeks	Diagnostic waiting times has failed to achieve target with performance of 10.01% in January		
Referral to Treatment Incomplete pathway	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%	The Trust failed to achieve the January Improvement trajectory of 89.1% January performance was 80.69%. This failed to meet the national standard of 92%.		The RTT return is grouped in to 19 main specialties. During the month there were 17 specialties that failed to meet the STF trajectory

RESPONSIVE

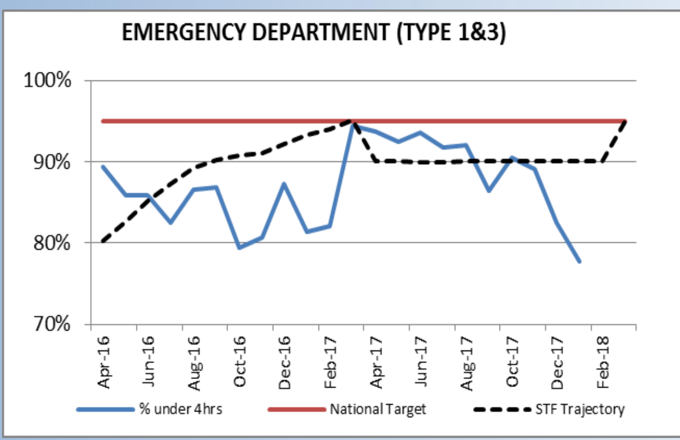
Description	Aggregate Position	Trend	Variation



A&E Waiting Times

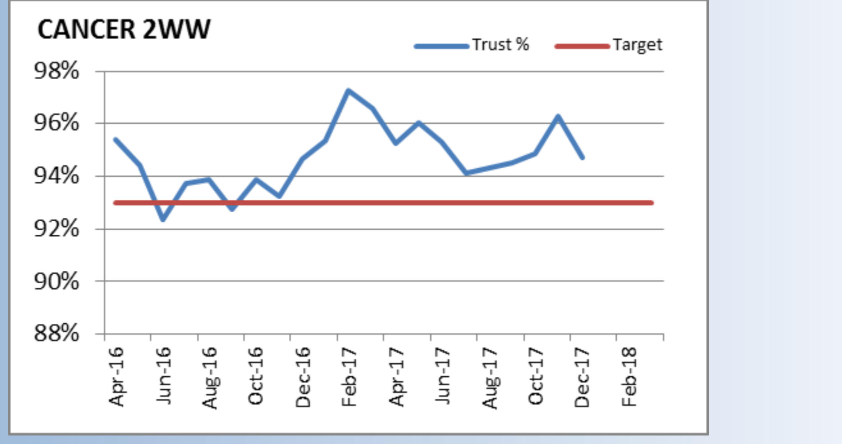
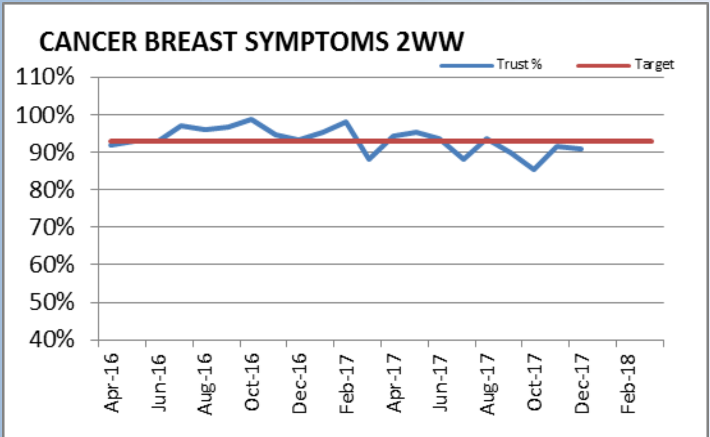
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance failed to achieve the Improvement trajectory of 90.0% with performance of 77.7% for January. This has failed to achieve the national 95% threshold.



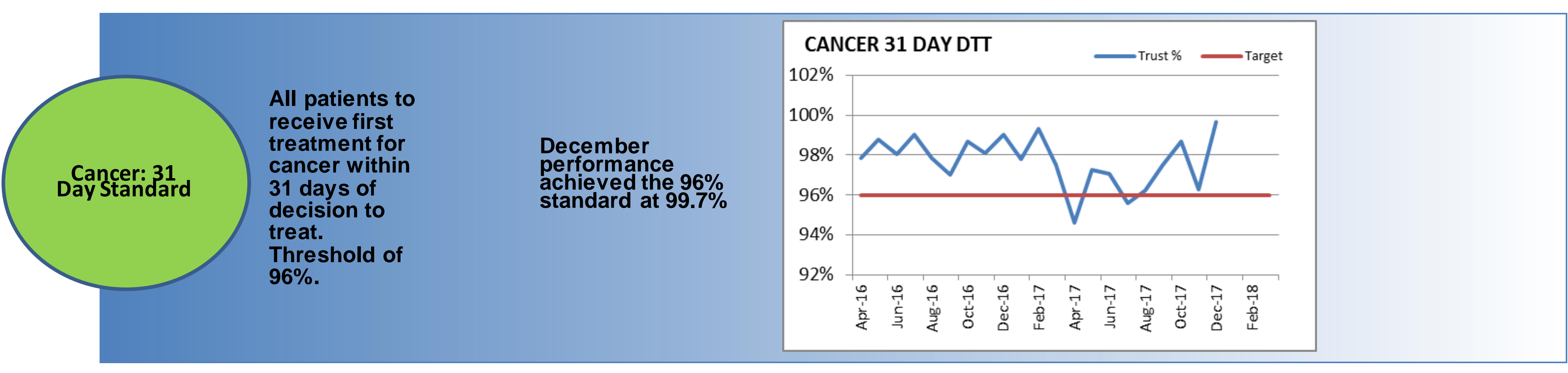
Performance has decreased by 4.7% during January compared to December performance of 82.4%.

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%.	December performance achieved the 93% standard at 94.7%		
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.	December performance failed to achieve the 93% standard at 90.8%		

RESPONSIVE

Description	Aggregate Position	Trend	Variation



Cancer: 31 Day Standard

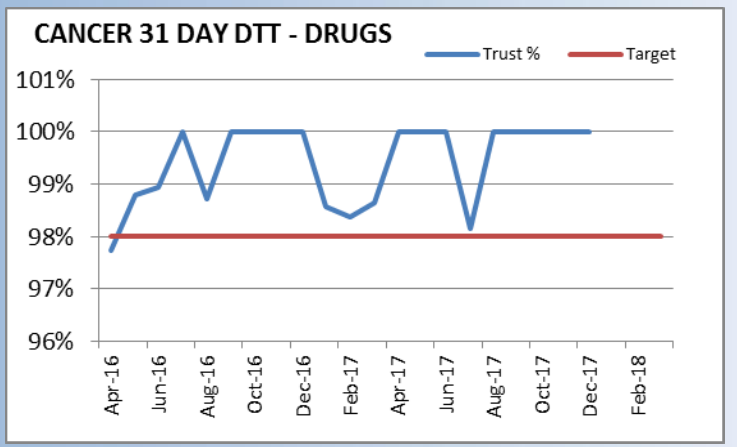
All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.

December performance achieved the 96% standard at 99.7%

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%.

December performance achieved the 98% standard at 100%



Integrated Performance Report - March 2018

RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy

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

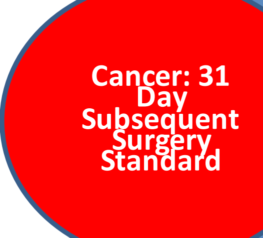
December performance achieved the 94% standard at 97.7%

CANCER 31 DAY DTT - RADIOTHERAPY

Trust % — Target

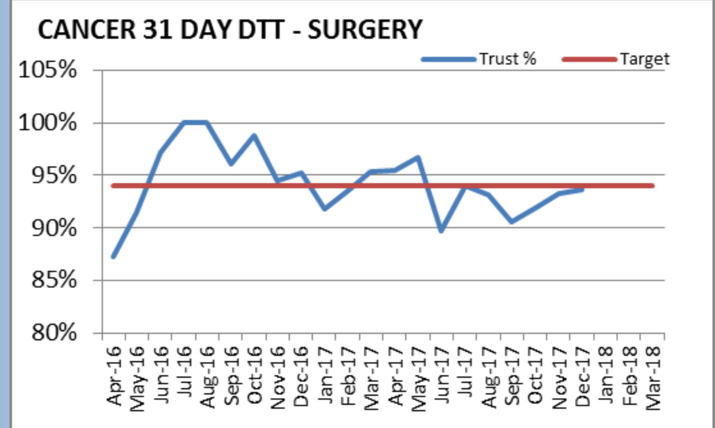
102%, 100%, 98%, 96%, 94%, 92%, 90%

Apr-16, Jun-16, Aug-16, Oct-16, Dec-16, Feb-17, Apr-17, Jun-17, Aug-17, Oct-17, Dec-17, Feb-18



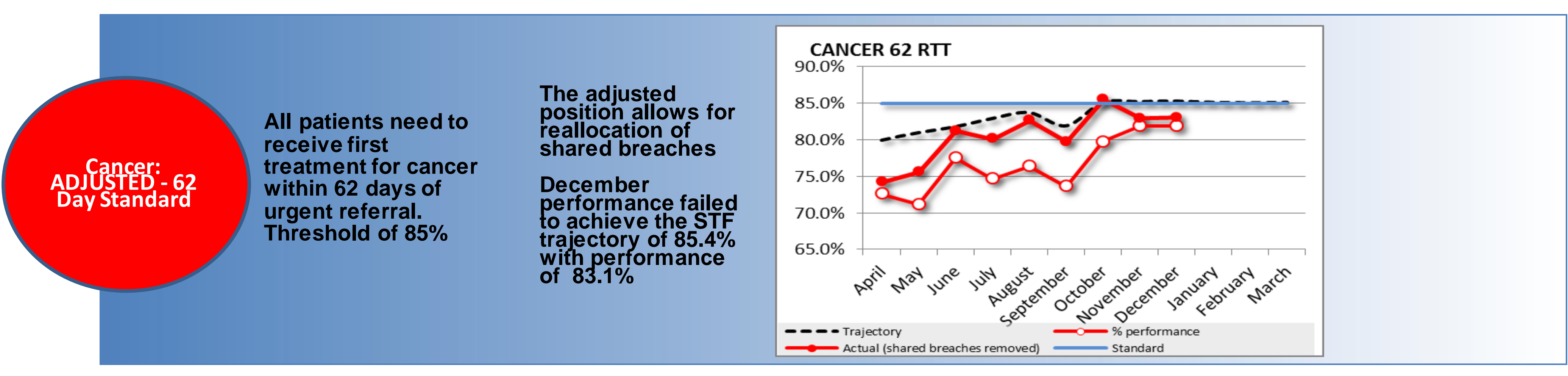
All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.

December performance failed to achieve the 94% standard at 93.7%



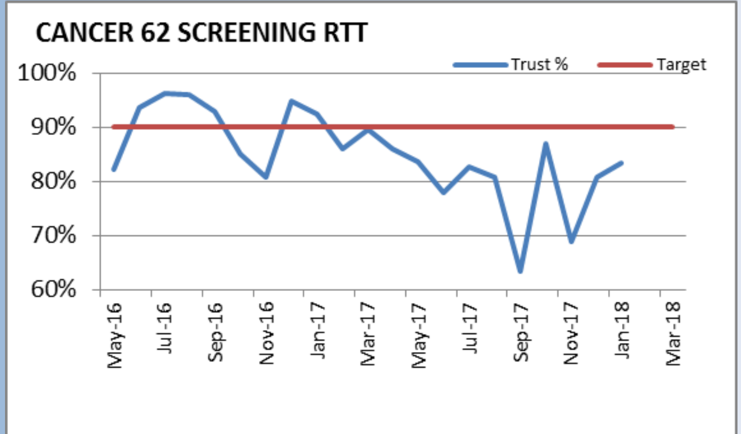
RESPONSIVE

Description	Aggregate Position	Trend	Variation



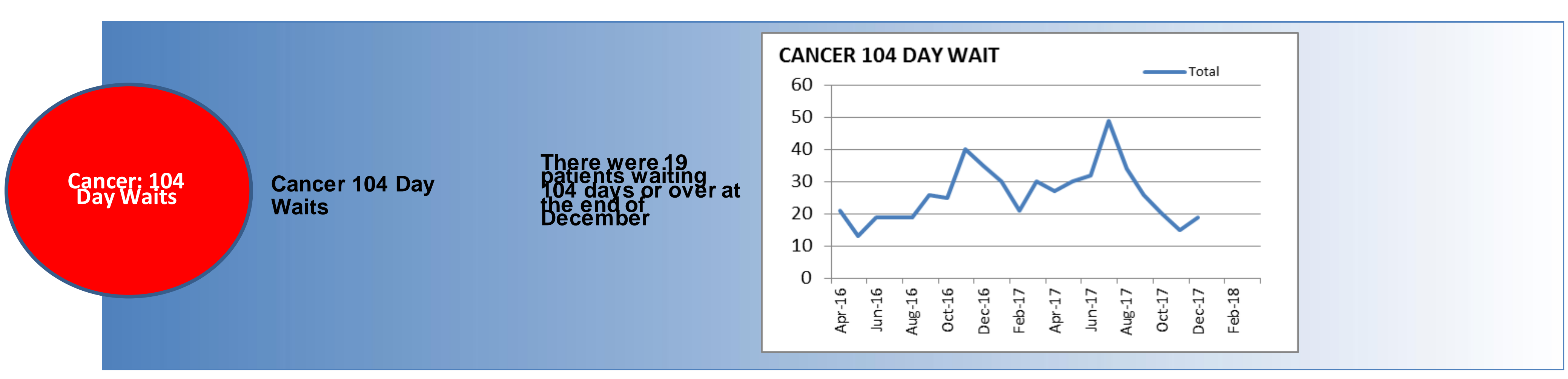
All patients need to receive first treatment for cancer within 62 days of urgent screening referral. Threshold of 90%

December performance failed to achieve the 90% standard at 83.3%



RESPONSIVE

Description	Aggregate Position	Trend	Variation



Cancer 104 Day Waits

There were 19 patients waiting 104 days or over at the end of December

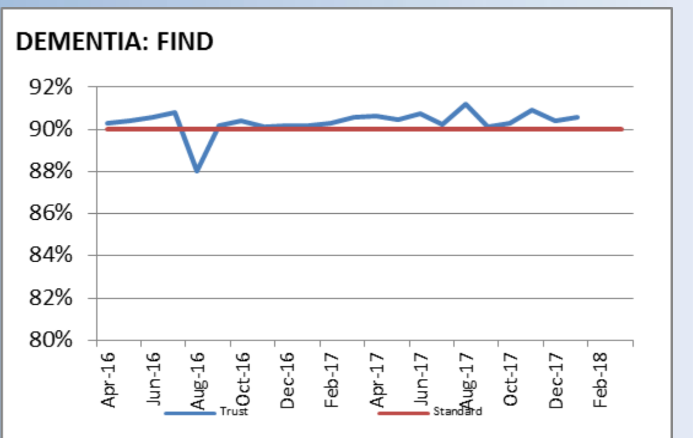
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is January 2018.

The standard for this indicator is to achieve 90%.

Performance for January achieved this standard at 90.60%



RESPONSIVE

Description	Aggregate Position	Trend	Variation

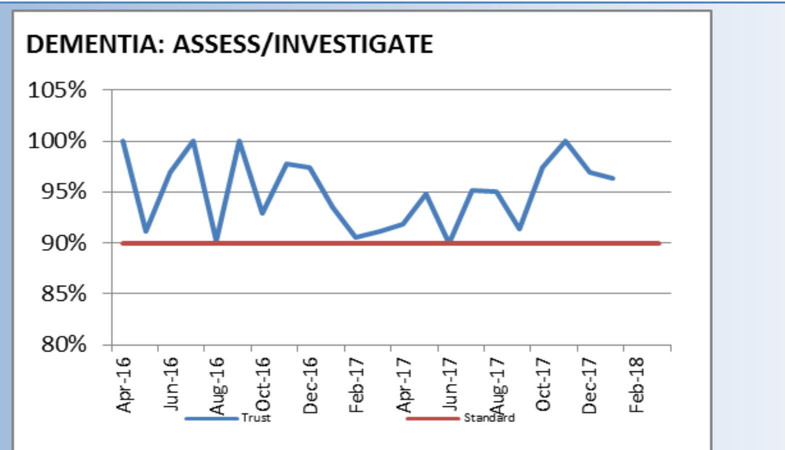
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is January 2018.

The standard for this indicator is to achieve 90%.

Performance for January achieved this standard at 96.4%



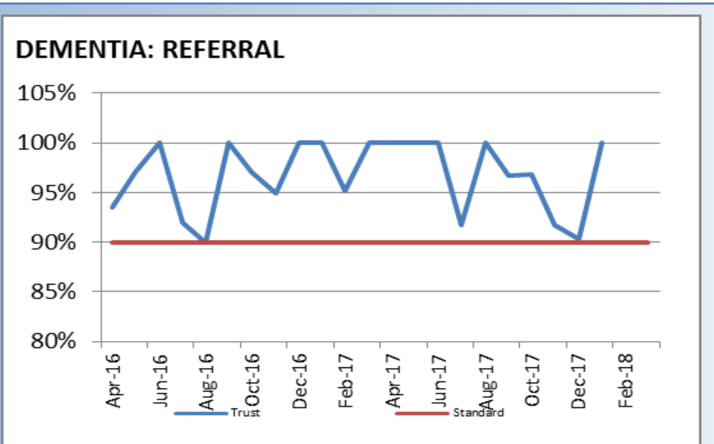
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is January 2018.

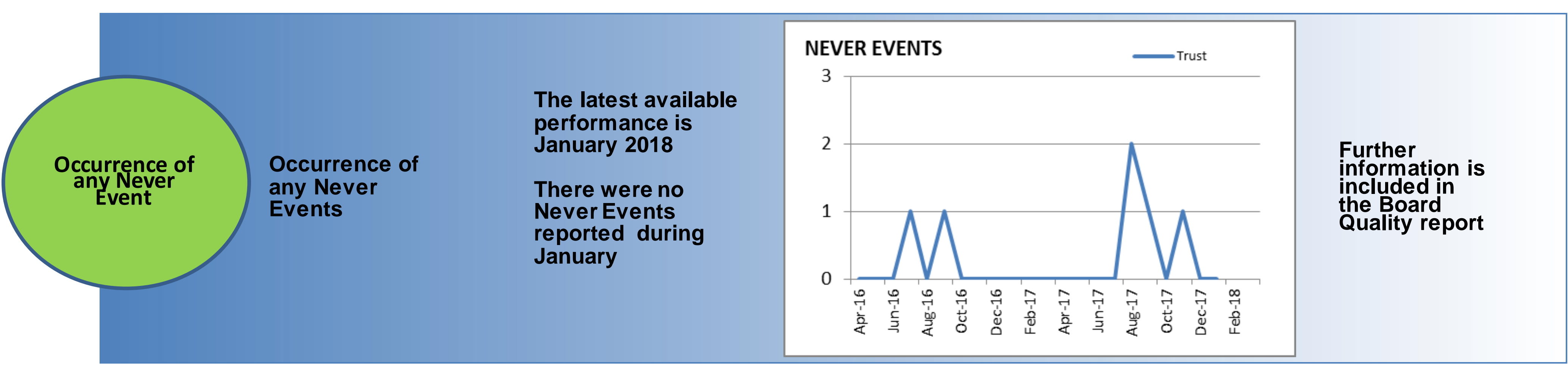
The standard for this indicator is to achieve 90%.

Performance for January achieved this standard at 100%



SAFE

Description	Aggregate Position	Trend	Variation



Occurrence of any Never Events

The latest available performance is January 2018

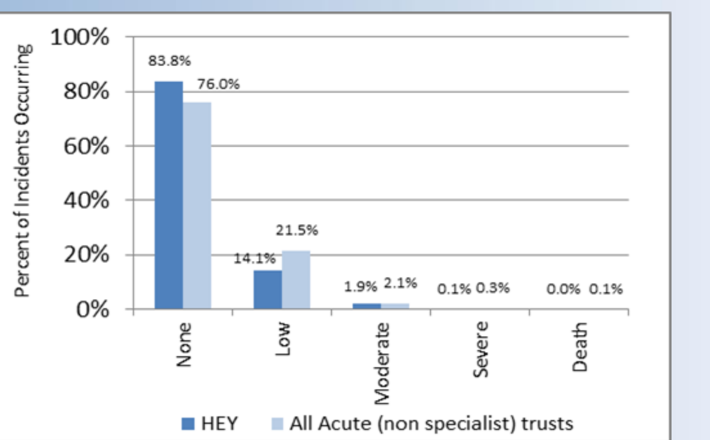
There were no Never Events reported during January

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 October 2016 to March 2017 as reported by the National Reporting and Learning System (NRLS).

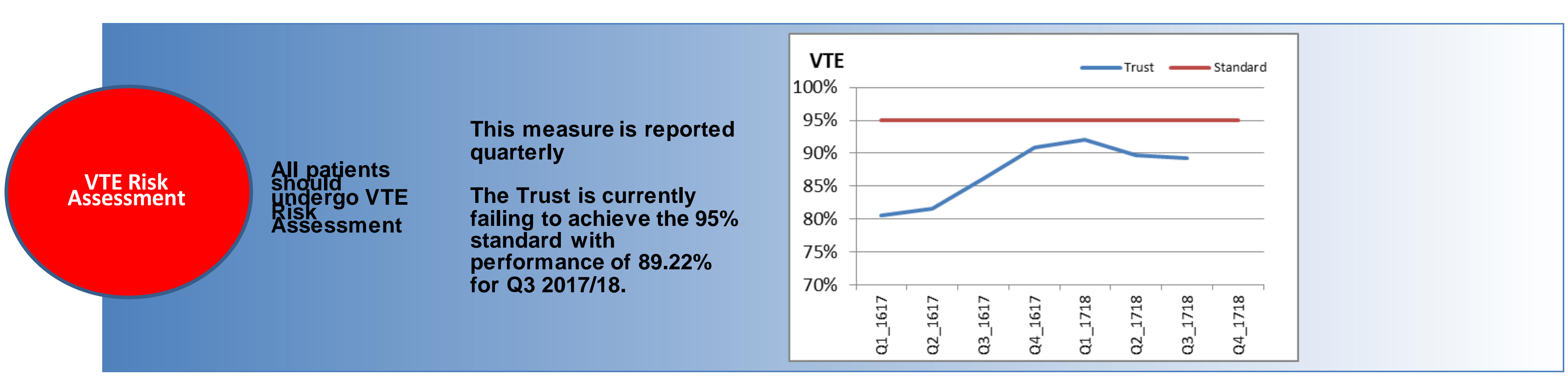
The Trust reported 9,468 incidents (rate of 55.67) during this period.



Integrated Performance Report - March 2018

SAFE

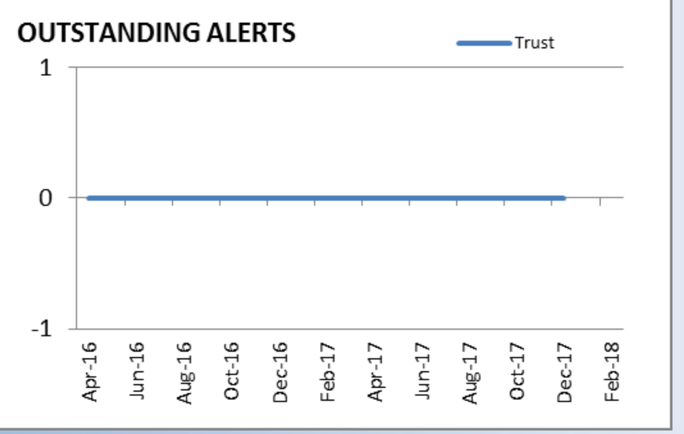
Description	Aggregate Position	Trend	Variation



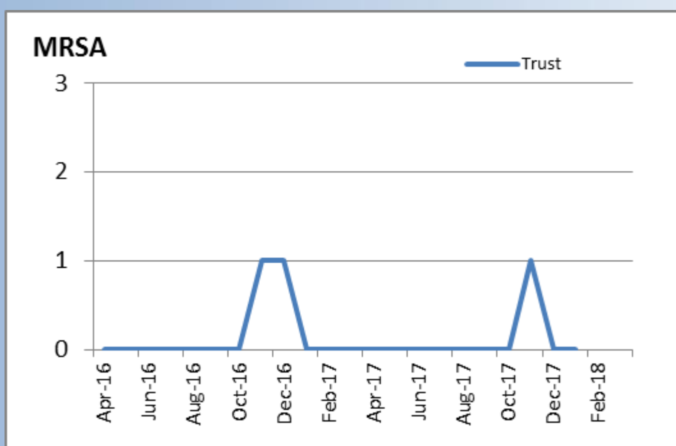
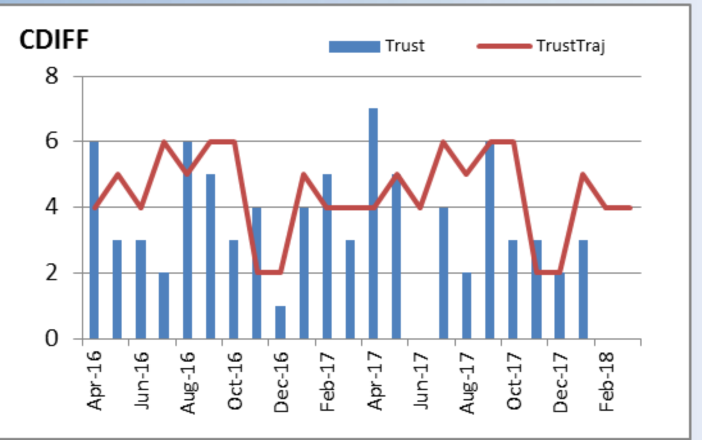
Number of alerts that are outstanding at the end of the month

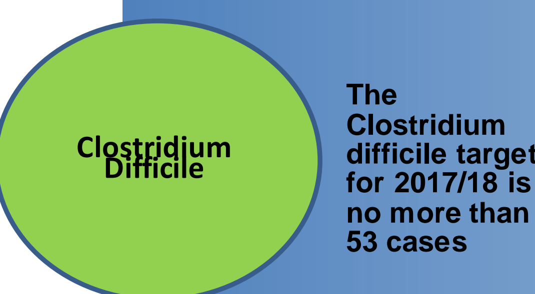
There have been zero outstanding alerts reported at month end for January 2018.

There have been no outstanding alerts year to date.

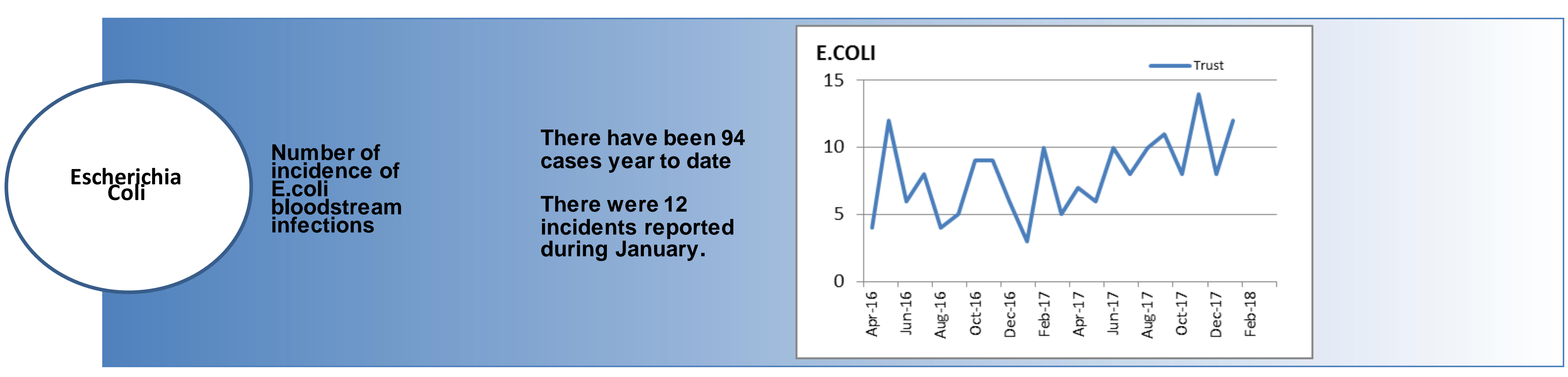
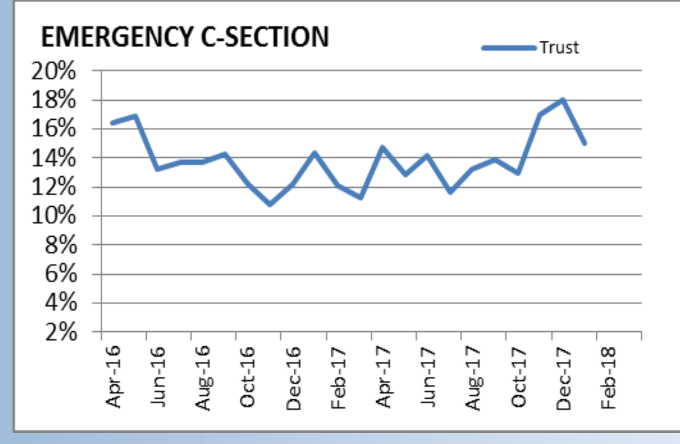


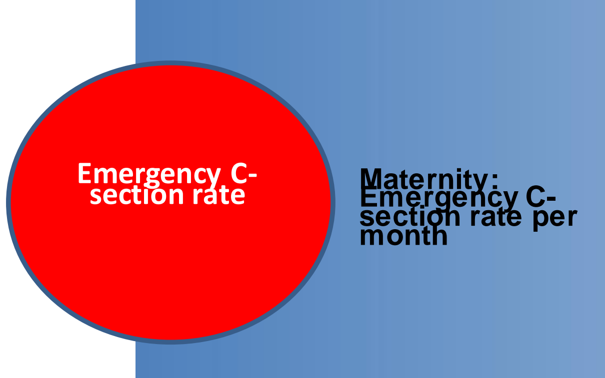
SAFE

Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 1 case of acute acquired MRSA bacteraemia during 2017/18. There have been no cases reported during January 2018.		Further information is included in the Board Quality report
Clostridium Difficile The Clostridium difficile target for 2017/18 is no more than 53 cases	There have been 32 cases year to date There were 3 incidents reported during January which achieved the monthly trajectory of no more than 5 cases		

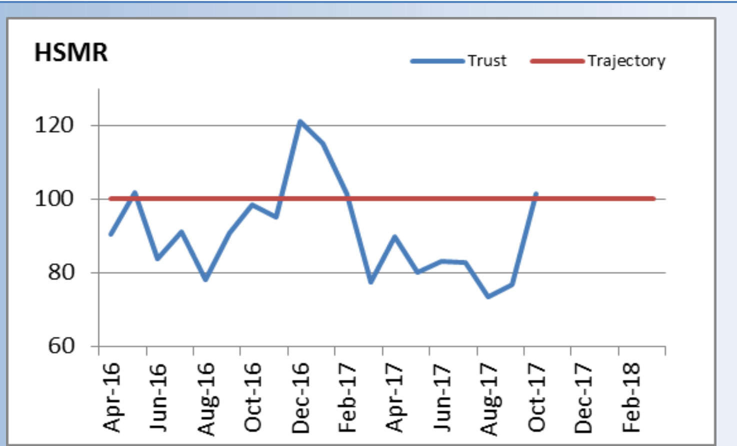
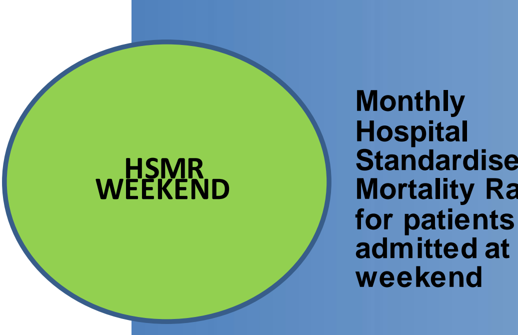
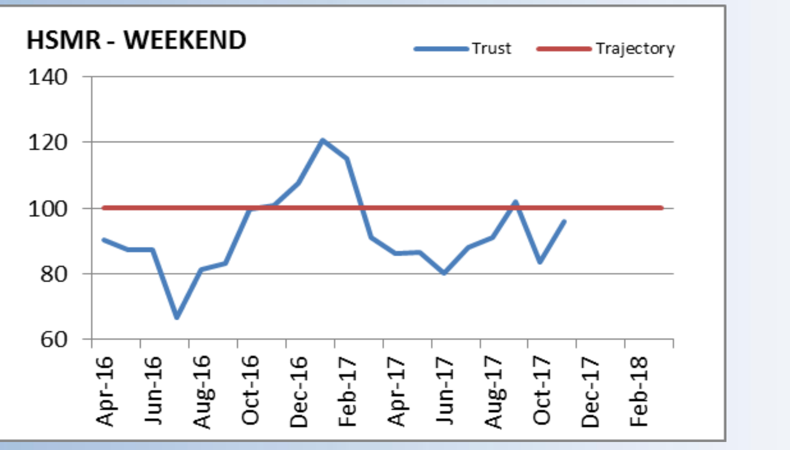


SAFE

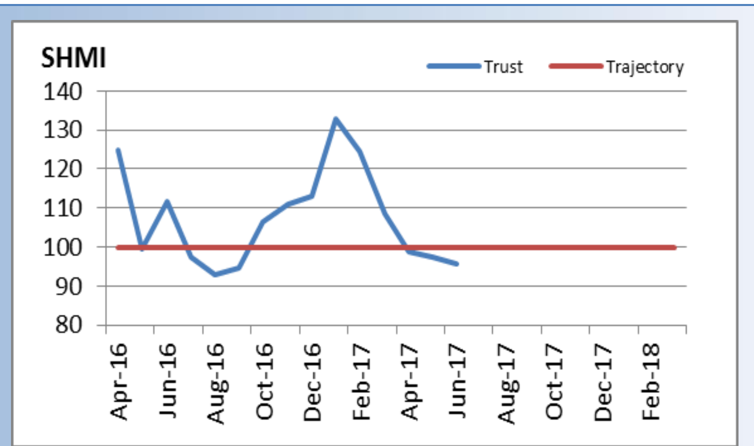
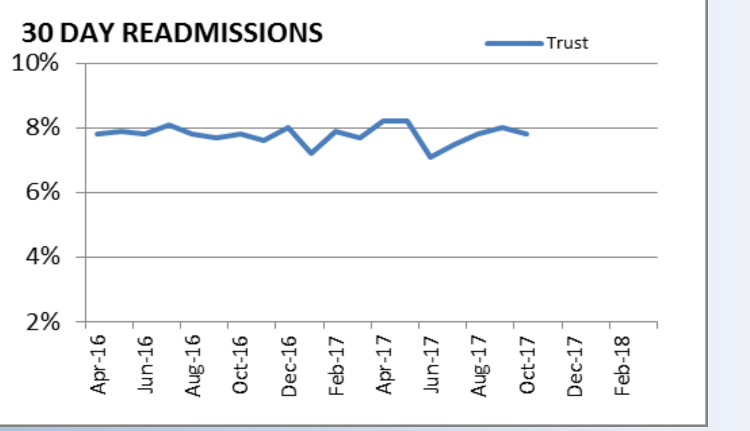
	Description	Aggregate Position	Trend	Variation
Escherichia Coli	Number of incidence of E.coli bloodstream infections	There have been 94 cases year to date There were 12 incidents reported during January.		
Emergency C-section rate	Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for January failed to achieve this standard at 15%		Further information is included in the Board Quality report



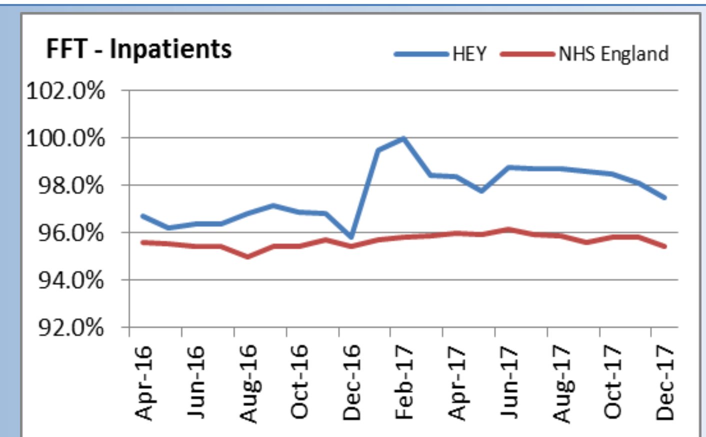
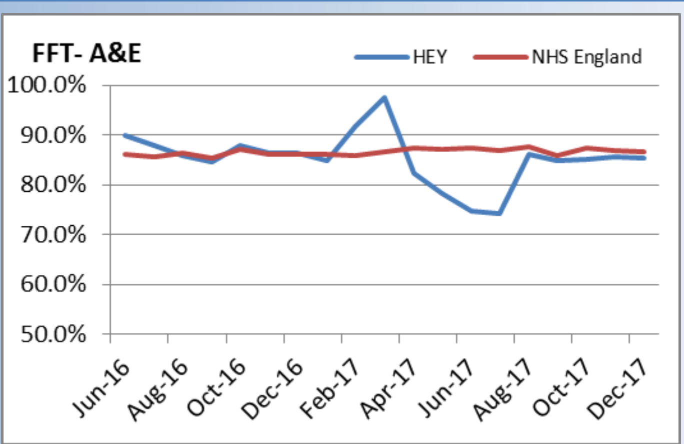
EFFECTIVE

	Description	Aggregate Position	Trend	Variation
HSMR	HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS)	November 2017 is the latest available performance The standard for HSMR is to achieve less than 100 and November 2017 failed to achieve this at 101.6		
 HSMR WEEKEND	Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend	November 2017 is the latest available performance The standard for HSMR at weekends is to achieve less than 100 and November 2017 achieved this at 96.0		

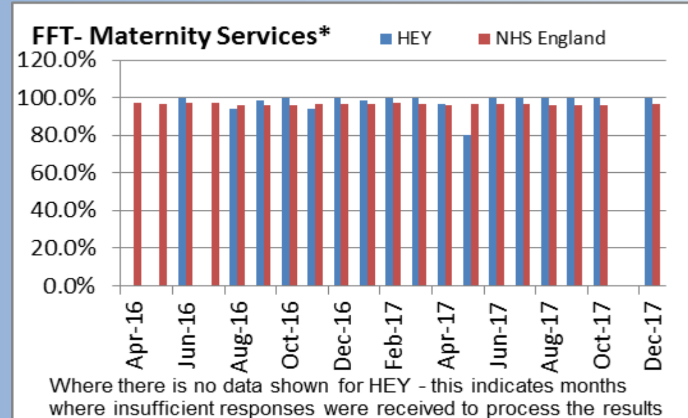
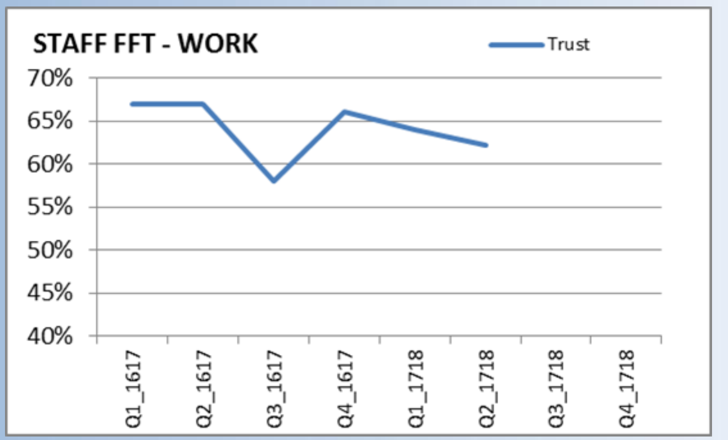
EFFECTIVE

	Description	Aggregate Position	Trend	Variation
SHMI	SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	June 2017 is the latest published performance The standard for SHMI is to achieve less than 100 and June 2017 achieved this at 95.8		
30 DAY READMISSIONS	Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month	Following changes to NHS Digital data guidance. The latest available performance is October 2017, November performance will be provided once we have processed the new methodology. The readmissions performance is measured against the peer benchmark position for 2016/17 to achieve less than or equal to 7.4%. The Trust failed to achieve this measure with performance of 7.8%.		

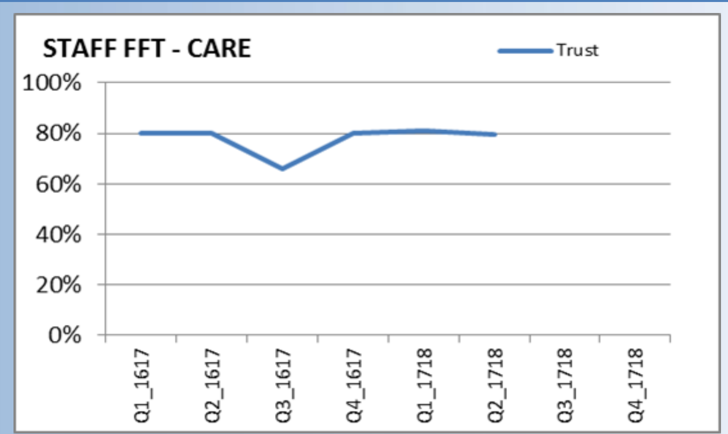
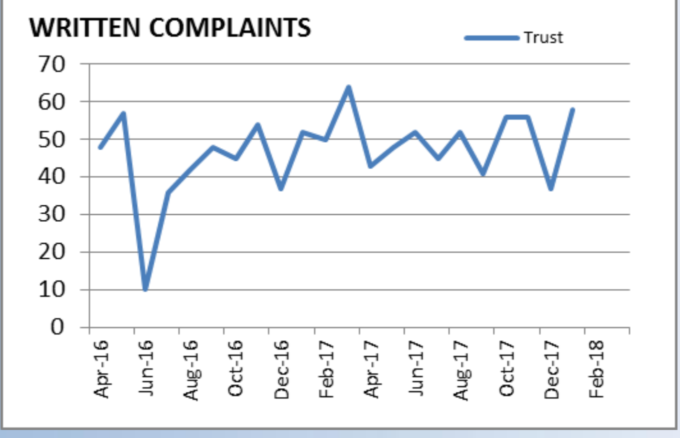
CARING

	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 December was 97.50% The latest published data for NHS England is December 2017. January performance will be published on 8th March 2018.		
A&E Scores from Friends and Family Test - %	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for December was 85.40% The latest published data for NHS England is December 2017. January performance will be published on 8th March 2018.		

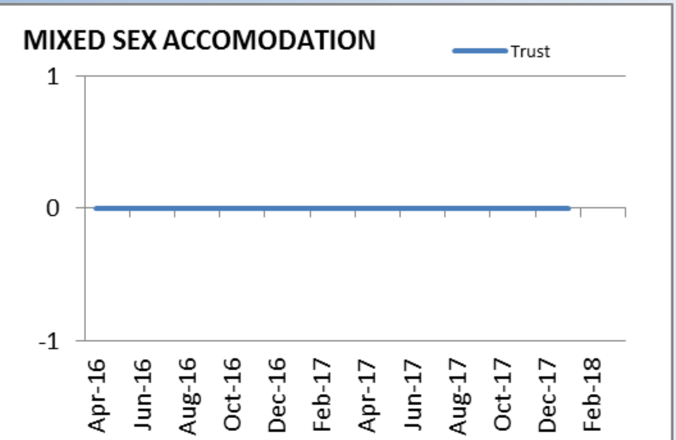
CARING

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 December was 100% The latest published data for NHS England is December 2017. Months with no data for HEY is due to insufficient responses		* Question relates to Birth Settings Unfortunately, it has not been possible to validate the Maternity returns for the November publication
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?	The latest Friends and Family Test position is quarter 2 2017/2018 shows that 62% of surveyed staff would recommend the Trust as a place to work, this has decreased from the quarter 1 position of 64%. Q3 will be published in March 2018.		

CARING

	Description	Aggregate Position	Trend	Variation
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?	The latest Friends and Family Test position is quarter 2 2017/2018 shows that 79% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has decreased from the quarter 1 position of 81%. Q3 will be published in March 2018.		
Written Complaints Rate	The number of complaints received by the Trust	The latest available performance is January 2018 The Trust received 58 complaints during January, this has increased from the December position of 37 complaints		There have been 488 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 January 2018.		

ORGANISATIONAL HEALTH

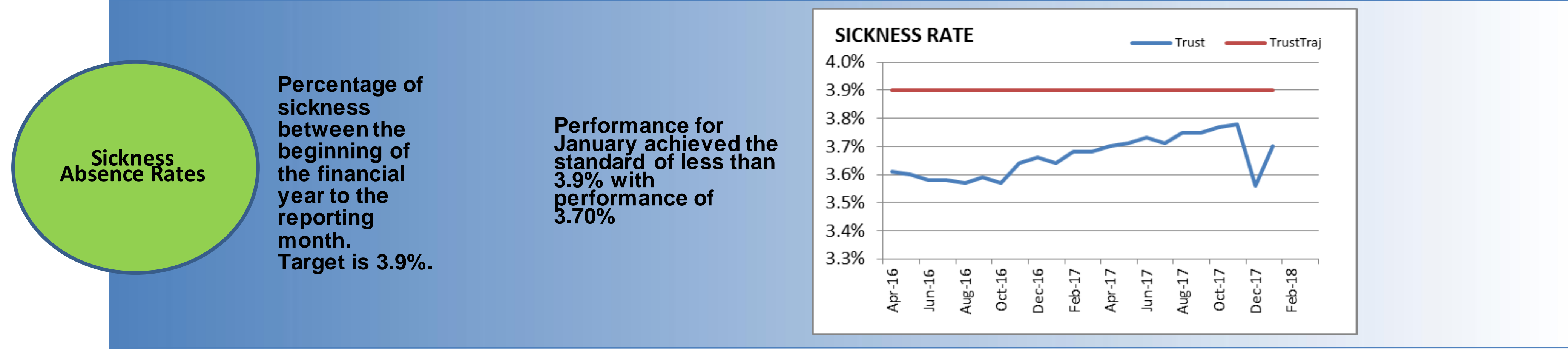
Description	Aggregate Position	Trend	Variation
WTEs in post — Contracted WTE directly employed staff as at the last day of the month	Trust level WTE position as at the end of January was 7246	WTE in post (chart)	

WTE in post

Trust

7300
7250
7200
7150
7100
7050
7000
6950
6900
6850
6800

Apr-16 Jun-16 Aug-16 Oct-16 Dec-16 Feb-17 Apr-17 Jun-17 Aug-17 Oct-17 Dec-17 Feb-18



Integrated Performance Report - March 2018

ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

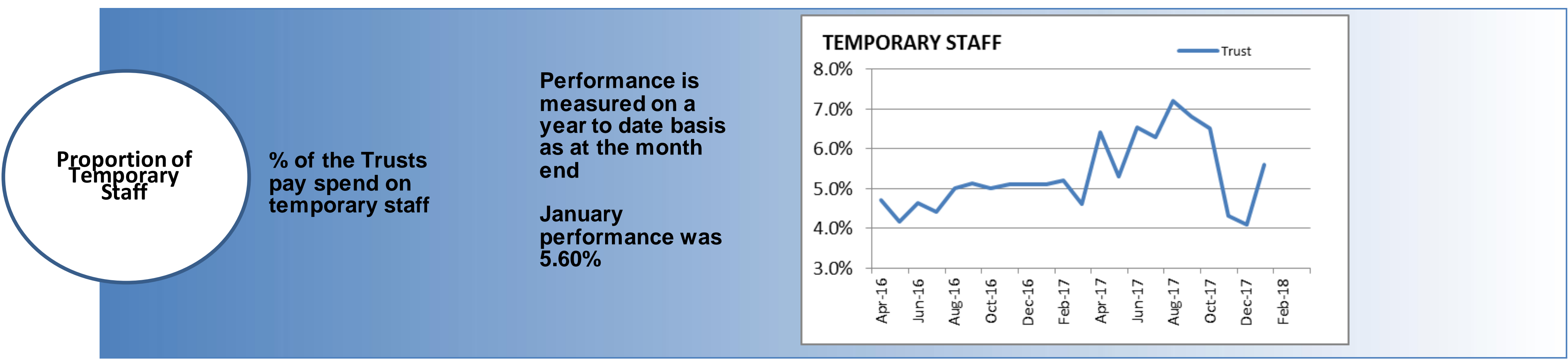
Turnover has been 0% for the Executive team within the last 12 month period.

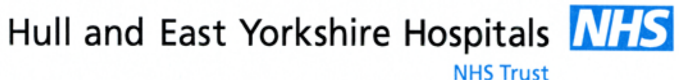
EXEC TEAM TURNOVER

Trust

10%
5%
0%
-5%
-10%

Apr-16 Jun-16 Aug-16 Oct-16 Dec-16 Feb-17 Apr-17 Jun-17 Aug-17 Oct-17 Dec-17 Feb-18

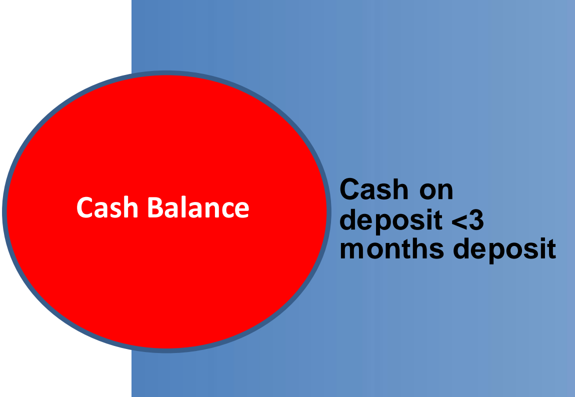




FINANCIAL SUMMARY: 10 MONTHS TO 31st JANUARY 2018

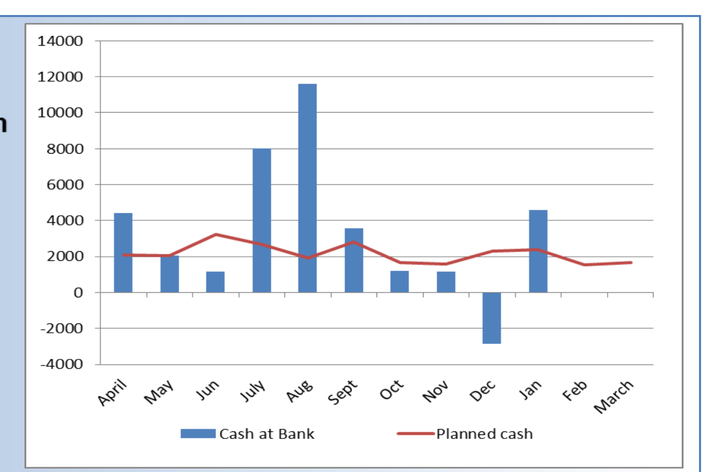
1. As at the end of January, the Trust is reporting a year to date adjusted deficit of £9.8m which is £9.8m away from the plan.
2. This position includes £5.0m deficit due to non-receipt of STF funding since the quarter 2 award. Excluding STF the Trust is £4.8m away from plan. This is a deterioration of £0.4m in month which is a lower rate than earlier months and demonstrates some progress against the agreed recovery action plan.
3. The Trust has a gross contract income gain of £7.4m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs, there is a net shortfall of £2.7m which is a £0.2m adverse movement in the month. Although the AIC contract is broadly in balance there is an impact on expenditure due to being above in areas of high variable costs eg Wet AMD, Drugs, ED but are below plan on areas where it is difficult to release costs. This is estimated to be costing around £2.5m at this point.
4. The Trust has a CRES shortfall at month 10 of £3.1m. The in month shortfall on CRES delivery is £0.2m. The year end forecast has improved by £0.4m to £12.0m (80%). This is the minimum delivery that was targeted but individual Health Groups are still being pushed to achieve 80%. If each health group achieved that level the improvement would be £0.8m.
5. HG run rate positions have deteriorated in month by £0.7m which were all in line or slightly better than forecast. CSS HG position deteriorated by £0.5m and continues to be driven by increased non pay expenditure, medical staffing & CRES shortfalls. SHG position deteriorated by £0.2m with additional pressures on medical staffing pay, agency nursing and non pay overspends. MHG & FWH's run rates were slightly better than expected.
6. Agency spend to the end of January is £8.6m which is below planned levels (£8.9m). The overall variable pay position, however, is similar to the same period last year.
7. Overall HG & Corporate forecasts have improved by £0.16m indicating some impact of the recovery action plan. Most health groups had small gains from release of accruals but these were partially offset by the increased agency usage in Surgery.
8. As reported last month the Trust has formally revised its forecast outturn for month 10 and is reporting an outturn deficit of £15m, excluding STF (£3.5m worse than plan). Including STF for the first two quarters reduces the reported Trust deficit forecast to £11.3m.
9. Achievement of the forecast outturn is dependent on continued delivery of recovery actions in the final 2 months of the year. The Trust's scheme of delegation has been revised to limit the number of budget holders signing off expenditure and to enhance the message across the Trust regarding the deteriorating financial position. The forecast position also assumes additional income from Commissioners and to date there has been an agreement reached with NHSE that sees the Trust benefit to the value of £750k. Negotiations are continuing with local CCGs and our specialised commissioner . Weekly updates on the actions being taken have been introduced in order to provide greater assurance to the Chairman and the Non-Executive Directors.
10. The reported capital position at month 10 shows gross capital expenditure of £12.9m. The forecast position for capital expenditure is £19,580 which is £700k lower than that reported last month due to slippage in schemes funded from charitable donations. This forecast continues to include the £3m in relation to the proceeds from a land sale which has capital cover agreed with the central capital team.
11. The cash position is extremely challenging and the cash shortfall is expected to be between £15-20m by the end of the financial year. Deficit support loan funding of £11m during February and March has been requested. In addition, we have the option to apply for an "exceptional working capital" loan of around £4m. The amount we will apply for will depend on the timing of payments from our Commissioners and whether our financial position improves in line with our revised plans.

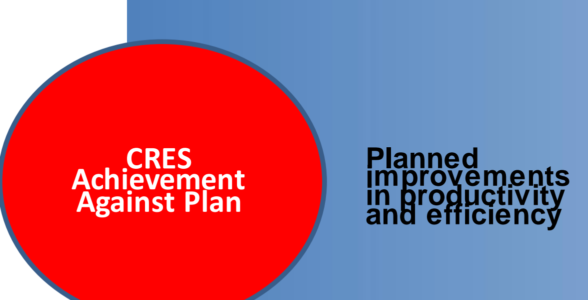
Description	Aggregate Position	Trend	Variation



Cash on deposit <3 months deposit

End of January cash was £4.586m, which represents 3 days of operating expenditure. There was £4.574m held in bank accounts and £0.012m in petty cash. During January we managed to keep on top of payments to most suppliers with minimal impact on operations. The cash shortfall is expected to be £15-20m by the end of the financial year. NHSI will allow the Trust to draw deficit support loans of £10.899m to fund the shortfall in cash. We drew £4m in February and will receive the balance of £6.899m in mid-March. Also, the Trust has the option to apply for an "exceptional working capital" loan. The amount we apply for will depend on the timing of payments from our Commissioners and whether our financial position improves in line with our revised plans. The exceptional working capital loan is not guaranteed. Latest forecasts show we would be likely to need such a loan in May 2018.





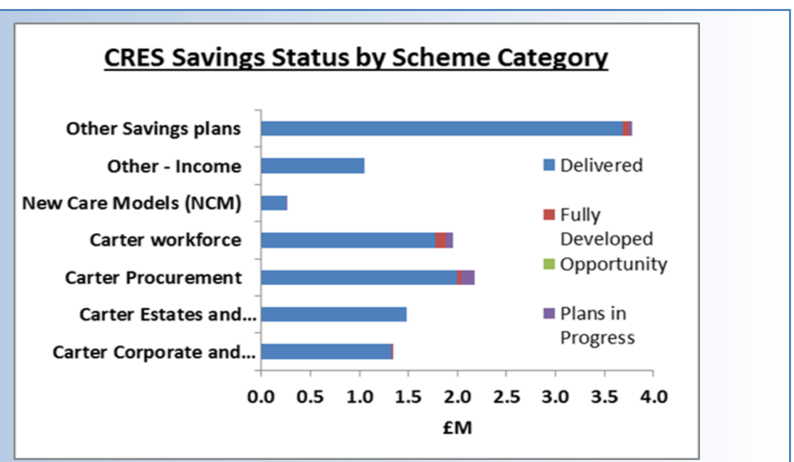
Planned improvements in productivity and efficiency

As at month 10 the Trust has delivered £8.9m of CRES savings against a CRES ytd plan of £12.0m (£3.1m adverse variance)

The target for the year is to save £15m.

The chart shows an analysis of year to date CRES schemes that are being delivered in terms of fairly broad categories.

The Trust is currently forecasting delivery of £12.0m of savings against the plan but is still working to identify new schemes.



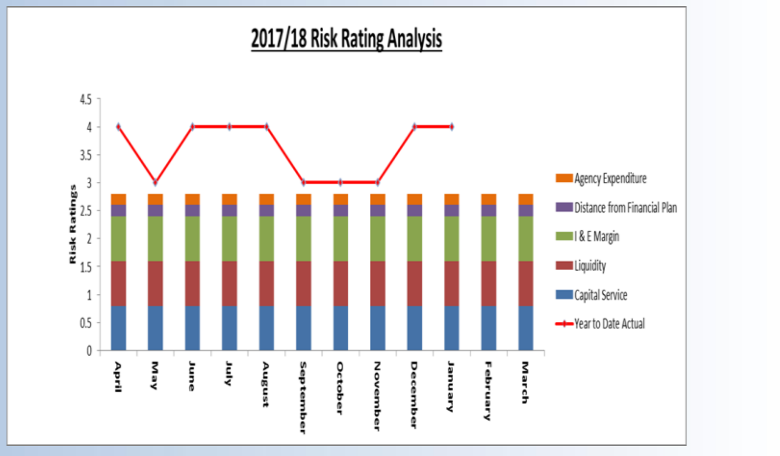
Description	Aggregate Position	Trend	Variation

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

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

As at month 10 the Trust is reporting a deficit of £9.8m against a planned position of £42k surplus. This has resulted in liquidity , Capital servicing , I&E margin and distance from plan being rated as a 4, with the agency metric being a rating of 2, this culminates in an overall risk rating of 4.

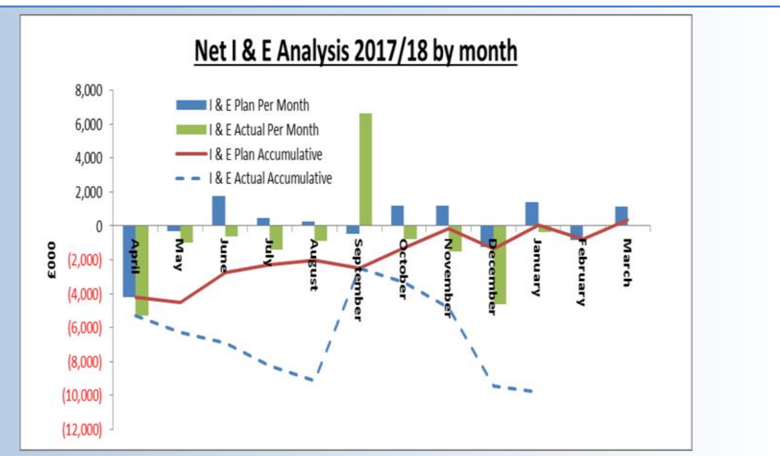


Net income and Expenditure

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 10 the Trust has delivered a deficit of £9.75m against a planned surplus of £42K (£9.7m adverse)

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



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE MINUTES
29 JANUARY 2018, 2.00 PM – 5.00 PM

PRESENT:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer (4pm onwards)
IN ATTENDANCE:	Mrs R Thompson	Corporate Affairs Manager (Minutes)
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance

NO.	ITEM	ACTION
1	**APOLOGIES** Apologies were received from Mr S Nearney – Director of Workforce & OD	
2	**DECLARATIONS OF INTEREST** There were no declarations of interest.	
3	**MINUTES OF THE MEETING HELD ON 18 DECEMBER 2017** The minutes were accepted as an accurate record of the meeting.	
4	**MATTERS ARISING FROM THE MINUTES** There were no matters arising from the minutes.	
5	**ACTION TRACKER**	
	GIRFT – Mr Gore to meet with Mrs Kemp regarding outcomes	**MG**
	Patient Level Costing – Revised profit and loss table to be included in the next Finance Report – February 2018	**LB**
	E Roster Business Case update – February 2018	**SN**
6	**WORKPLAN 2017/18** The Committee reviewed the workplan and no changes were made.	
	6.1 – DRAFT WORKPLAN 2018/19 Ms Ramsay presented the draft Workplan 2018/19 and advised that the timings were based on this year's timings and welcomed any comments. The Committee agreed with the workplan timings.	

The agenda was taken out of order at this point

9.1 DEMAND REPORT

Mrs Drury presented the report and stated that at week 42 overall, referrals had reduced by 3.8% compared to last year. GP referrals were also reducing overall at 5.9%.

Elective activity at the end of December 2017 is 4.6% below plan overall (3086 cases) and for the AIC partners this is 2.5% below planned levels. The specialties with significant variances are

highlighted below:
Plastic surgery is 15% below (647) although this has started to increase since the nursing to support for the daycase procedures has improved.

Oral surgery is 11% below plan (309) which is commissioned by NHSE and this variance is due to consultant vacancies. Interviews are scheduled for February.

The grouping of Gastroenterology, Upper GI and Colorectal Surgery is overall below planned levels by 8.5% (1415). This variance is mainly due to medical staffing gaps and a slower start to the additional capacity required for bowel screening. The bowel screening daycases will increase from January as additional lists have been agreed.
The main areas of overtrade in elective activity are Neurosurgery 13.8% (+145) and Urology at 7.6% (+264).

Outpatient activity is 2% below plan for follow-ups (including procedures) and 7.5% below plan on new outpatients. Compared with the first 9 months of last year, this represents activity which is 4.1% lower than last year for new outpatients and 2% higher compared with last year for follow-ups (it was expected that more would be undertaken this year to address the follow-up backlogs).

Mr Hall asked if the follow up appointments were quick hits and Mr Bond advised that they were but they were paid at a reduced rate. Ms Ramsay added that follow ups were prioritised with the longest waiting patient's first and clinical need.

Cumulatively to the end of December 2017 ED attendances are in excess of planned levels by 1.8% however November and December ED attendances have been broadly in line with planned levels

At month 9 the estimated overall contract trading position if all commisioners were on a PbR contract basis would be an overtrade of £7.5m. He added that the vast majority of the overtrade was related to pass thrugh drugs and devices. In response to a question Mr Bond stated tha the cost to the Trust at month 9 of adopting the AIC contract was estimated at £0.5m and as such was not having a material impact on the Trust's overall financial position.

Resolved:
The Committee received and accepted the report.

8.1 AGENCY REPORT
Mr Bond presented the report and highlighted that agency spend had reduced but bank and overtime costs had increased. Admin and clerical had reduced the most but the Trust was spending more on medical staff.

Mr Bond added that although agency pay was reducing and close to the 25% reduction, this was not contributing to a reduction from the pay budget. The calculation was not straight forward but he assured the Committee that any staff covering gaps in rotas was to keep services safe and any extra session incurred had to be justified.

Resolved:
The Committee received and accepted the report.

10.5 APPROVAL FOR FIRE SAFETY RELATED CAPITAL FUNDING
Mr Bond presented the paper which outlined an application to the centre for PDC funding to meet fire safety standards.

The PDC would be used predominantly to prevent fires spreading in roof voids and the application had been discussed with NHS Improvement.

Mr Bond asked the Committee to support the request and recommend the application to the Trust Board.

Resolved:
The Committee received the paper and supported the application.

11.1 CAPITAL RESOURCE ALLOCATION COMMITTEE
Mr Bond presented the report and advised that the demolition work was now going to be capital expenditure rather than revenue expenditure and that projects need to be completed before end of March 2018.

There was a discussion around the Trust being a Lorenzo digital exemplar and what this meant financially for the organisation. Mr Bond agreed to provide more details when they were available.

Mr Smith to attend the March 2018 committee to discuss the IM&T Strategy.

Resolved:
The Committee received and accepted the report.

- Mr Bond to provide more information relating to Lorenzo digital exemplar Trust **LB**
- Mr Smith to be invited to the March 2018 meeting to discuss the IM&T Strategy **MS**

11.2 BOARD ASSURANCE FRAMEWORK
Ms Ramsay presented the report and asked the Committee for any comments regarding gaps in assurances, any new assurance that could be added and to review risk 7.1 in relation to achieving the financial plan.

The other risks had been reviewed but there were no proposed changes to ratings in Q3.

The Committee discussed the capital risks and staffing levels. The Committee agreed to the proposed changes in Q3 and agreed to review them again at the end of Q4 in preparation for the new BAF 2018/19.

Resolved:
The Committee received and supported the recommendations made.

10.1 CORPORATE FINANCE REPORT
Mr Bond presented the report and at the end of December the Trust was reporting a year to date adjusted deficit of £9.4m which was £8.0m away from the plan.

The position included £3.6m due to non-receipt of STF funding for quarter 3.

The Trust had a gross contract income gain of £6.3m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs, there was a net shortfall of £2.5m

Although the contract is broadly in balance there is a disproportionate impact on expenditure as the Trust is above plan on areas with high variable costs eg Wet AMD, Drugs, ED but below plan on areas where it is difficult to release costs eg outpatients, excess bed days. This is estimated to be costing around £2.25m.

The Health Group run rate positions had deteriorated in month by £2.1m. CSS HG position deteriorated by £1.1m which was £0.7m more than forecast. The in month position was driven by increased non pay expenditure. The Surgery position deteriorated by £0.7m with additional pressures on medical staffing pay and non pay (Mr Bond added that there could be a matching issue with Goods Received Not Invoiced (this was being reviewed) overspends. Medicine's reported in month position shows a small deterioration (-£0.1m) which was in line with forecast. The Family and Women's run rate deteriorated by £0.1m mainly related to non pay issues.

Mr Bond had included a financial position breakdown of months 8 and 9 to show how the positions had changed.

There was a discussion around CRES shortfalls and how this would be rectified and Mr Bond advised that the underlying run rates were more of an issue.

Mrs Christmas expressed her concern around the Health Group run rate and CRES positions and ask what extra was being done to address the issues. Mr Bond advised that the Health Groups had much better information streams, were more transparent and were in some cases re-designing their processes. He added that culture and good management was key going forward.

Mr Gore asked that productivity be measured on the balanced scorecard which was presented at the Trust Board meetings.
Resolved:
The Committee received and accepted the report.

10.2 CRES REPORT
Mr Bond reported that at month 9 the Trust had reported actual delivery of £7.3m of savings against the plan of £10.2m, which was a shortfall of £2.9m (72% delivery).

The forecast of £11.6m is 77% delivery. This was an improvement of

£0.3m in month. Forecast delivery needed to increase by £0.4m over last 3 months to achieve the 80% Trust target. However, Mr Bond stated that Clinical Support and Family and Women's were likely to remain well short of this target with Family and Women's struggling to reach 70%.

Resolved:
The Committee received and accepted the report.

10.4 FINANCIAL RECOVERY PLAN 2017/18
Mr Bond reported that the Trust Chairman, Chair of the Performance and Finance Committee and himself had recently attended a meeting with NHS Improvement where the Trust had presented a formal financial recovery plan for 2017/18.

It was noted that the current forecast outturn was not considered acceptable by the regulators and discussions had taken place over the actions being pursued by the Trust in the final quarter of the year.

Agreement had been reached with NHS Improvement on a revised outturn position totalling £15m, (£13.5m away from the Trust's control total). Mr Bond explained the measures being taken to improve the monthly financial run-rate and also highlighted the discussion which would be required with commissioning bodies in the final quarter. He also explained the revised weekly reporting arrangements requested by the Chairman as part of the overall assurance process.

Resolved:
The Committee received and accepted the report and agreed to monitor the financial position and the financial recovery actions in particular going forward.

10.3 FINANCIAL PLAN 2018/19
Mr Bond presented the report which gave the updated position around the planning process and assumptions for 2018/19.

The underlying financial position at the end of 2017/18 is assessed at £25.7m. He reported that the CCGs would be reviewing their contract levels for 2018/19 and would probably be in line with the contact income received in 2017/18. Mr Bond expected that the Specialist Commissioner's contract would be uplifted to reflect the outturn activity plus some growth.

Mr Bond expressed his concern around the Capital position and the risks involved. He agreed to prepare a paper for the February 2018 meeting to address this.

As a minimum the Trust would need to deliver an £11m efficiency requirement in 2018/19 to maintain the recurrent underlying £25.7m deficit.

The Committee discussed winter 2018/19 and that the plan needed to flex and be realistic to absorb the pressures faced. Length of stay was also discussed and this was being addressed were possible.

There was a detailed discussion around the next steps, the role of the Committee and Mrs Christmas stated that next year's plan should be realistic and achievable.

Mrs Ryabov added that in such a large organisation with complex issues, this can lead to spending more money than budgeted for and this is compounded by less activity being achieved. She added that all staff act with the best intentions and sometimes there are no alternatives in the busy winter months.

Resolved:
The Committee received the report and agreed to discuss it further at the Board Development session arranged for 30 January 2018. The Committee agreed that the Board should be unified in its approach to the 2018/19 financial plan.

7.1 PERFORMANCE REPORT
Mrs Ryabov reported that the Emergency Department was still a big challenge, performance was currently 82.4%. She advised that the Trust was still performing at above the national standard. The main issues were around higher levels of acuity, meaning patients were staying longer in the hospital. Patients were not being discharged quickly enough due to complex issues and infections in the hospital had also hindered discharges.

Mr Gore asked how the Trust's partners were helping and Mrs Ryabov advised that the CCG's had added 30 beds as part of the winter plan.

Mrs Ryabov reported that RTT performance was at 81.2%, but that the overall number had dropped by 347 since the beginning of the year. Each of the Health Groups had been asked to review where they were and where they would be at the end of the year relating to RTT.

The 52 week breaches were mainly due tracking access issues and the others were complex pathways.

Cancer performance was improving in all areas except 62 day which had dropped to 83% in November 2017. This was still above the national average of 82.3%.

Diagnostic performance had deteriorated, but this had been anticipated due to the new CT scanner at Castle Hill Hospital which had just been installed. Endoscopy breaches had reduced.

Mr Hall asked if there would be fewer scan requests during operation Wintergreen due to more senior staff being in the ED. Mrs Ryabov thought that this could be the case as there had been a reduction in diagnostic activity during the Junior Doctor strike but she also commented that this would not impact on cardiac CT.

Resolved:
The Committee received and accepted the report.

7.2 IMPACT OF WINTER PRESSURES
Mrs Ryabov reported that the impact of the winter pressures had been unpleasant and challenging and that she had met with the Medical Directors to look at reducing gynaecology, ENT and plastic activity.

The winter ward had been opened and some patients had been transferred to Castle Hill Hospital to create more capacity on 12th floor. Mrs Ryabov had concerns that this was reducing patient flow and was not sustainable.

The Trust was to implement operation Wintergreen by cancelling a number of procedures and deploying admin staff into the hospital to help and having senior decision makers in the Emergency Department. This initiative would be similar to the Perfect 10 week carried out previously by the Trust. Mrs Ryabov hoped that this would increase flow and improve staff morale.

Mr Bond added that the winter pressures would be reviewed as part of the financial plan for 2018/19, to ensure realistic plans were in place and manage expectations.

Resolved:
The Committee received the verbal update.

7.3 TRACKING ACCESS FULL MBI REPORT
Mrs Ryabov presented the MBI report to the Committee and advised that the clinical reviews identified due to the Tracking Access issue would be completed by the end of March 2018.

Mrs Ryabov added that the Patient Tracking List was being robustly managed but expressed her concern at the size of the list and the challenge to reduce it. She reported that the team was reviewing the front end of the pathway as a priority.

Resolved:
The Committee received and accepted the MBI Tracking Access report.

13 ANY OTHER BUSINESS
There was no other business discussed.

14 DATE AND TIME OF THE NEXT MEETING:
Monday 26th February 2018, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE MEETING
26 FEBRUARY 2018

PRESENT:	Mr Stuart Hall	Non-Executive Director (Chair)
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce and OD
IN ATTENDANCE:	Mr T Moran	Chairman
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No.	Item	Action
1	**Apologies** Apologies were received from Mrs Ryabov – Chief Operating Officer	
2	**Declarations of interest** There were no declarations made.	
3	**Minutes of the meeting held 29 January 2018** The minutes of the meeting were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** Mr Bond updated the Committee regarding the PDC funding to meet fire safety standards. The Trust had not yet submitted the application but would report back to the Committee in due course.	**LB**
	Mr Gore asked for more information around the preparation works for the helipad and Mr Bond agreed to brief Mr Gore outside of the meeting.	
	Mr Bond to provide a capital position paper for the March 2018 meeting.	**LB**
5	**Action Tracking List** Mr Bond reported that the Trust was working with NHS Improvement to develop an exemplar digital Trust. NHS Digital were also involved and what the consequences would be to capital and revenue expenditure. Mr Bond to update the Committee with more information when it was available.	**LB**
	The IM&T strategy to be presented to the March 2018 Committee and the May 2018 Board meeting. Mr Moran stated that it was appropriate for the Committee to review it first.	**LB**
	Mr Evans to circulate the patient level costing profit and loss table to the committee prior to the next meeting in March 2018.	**SE**
	Due to Mrs Ryabov's apologies the Discharge Task and Finish group update would be carried forward to March 2018.	**ER**

DRAFT

There was a discussion around the cost of activity and staffing and Mr Bond agreed to prepare a paper which compared staffing and non pay costs against activity.

Simon Nearney updated the Committee regarding e-Rostering. He reported that 60% of staff groups were using the e-Rostering system and there were plans in place to extend this to other areas including theatres. He reported that there was a cost to this and the investment was being discussed and evaluated.

6 Workplan 2017/18

The Committee received the workplan and no changes were changed.

6.1 Workplan 2018/19

Ms Ramsay presented the workplan 2018/19 and advised that no statutory changes had been made. Mr Hall asked committee members to review the draft workplan and forward any comments to Ms Ramsay before the next meeting in March 2018.

7.1 Performance Report

Mr Bond presented the report and highlighted the 62 day cancer, RTT and Emergency Department performance.

There was a discussion around consultant annual leave and annual conference attendances and the dips in performance around holiday seasons. Mr Bond advised that sickness levels had not helped the figures but Mr Nearney added that all managers knew their service minimum staffing levels. Mr Bond reported that the Variable Pay meeting would be reviewing the rota gaps on a weekly basis and control mechanisms would be put into place.

Mr Moran suggested that this issue be escalated to the Board and Mr Nearney added that he would raise it at the Executive meeting also.

There was a discuss around RTT and achieving the 92% standard. Mr Bond advised that the planning guidance for 2018/19 was different and the only stipulation would be that the list at the end of the year should be no bigger than it was at the start.

Due to the waiting list increases and decrease in follow up appointments Mr Hall asked that this issue be added to the March 2018 agenda to be discussed in more detail.

52 week waits were discussed and it was noted that 13 of the 24 patients was related to tracking access issues. Mr Bond advised that all patients were reviewed by the operational teams.

Breast symptomatic performance was expected to recover in month and the 62 day referral to treatment standard breaches were mainly due to diagnostics and pathology waits.

There was a discussion around the diagnostic 6 week wait standard and Mr Bond reported that CT should start to improve following the implementation of the new scanner but that discussions were ongoing with

DRAFT

NHS Improvement about the MRI scanners and emergency funding. Mr Moran suggested that this issue be escalated to the Board.

Resolved:
The Board received and accepted the report and agreed to escalate the issue around MRI scanner funding to the Board. **SH**

7.2 Tracking Access Update
Mr Bond updated the Committee regarding the Tracking Access issue and advised that completion of the validation would be the end March 2018. He reported that the Harm Group had met 3 times so far to review the outcomes of the clinical reviews and 3 urology cases had been identified so far but that there might be more in the remaining reviews being undertaken.

Mr Hall suggested that the item should remain on the agenda until the process had been cleared and fully understood what happened, why it happened and to ensure it did not happen again.

Mr Bond advised that the Executive Team would be carrying out a RCA investigation regarding the Tracking Access issue. Mr Hall asked if he could be involved as Chair of the Performance and Finance Committee. Mr Bond would report further details when available.

Resolved:
The Committee received and accepted the update.

8.1 Agency Report
Mr Nearney presented the report and advised that overall the Agency Report spend was £8.5m which was against a budget of £8.9m, although variable pay costs had increased.

Mr Nearney updated the Committee regarding the Health Groups and reported that Surgery, Medicine and Clinical support had all over spent but that Family and Women's was on plan. Challenges in the Health Groups were around theatres, Junior Doctors, elderly and ED vacancies. Another advert would be sent out nationally to help recruit nurses, doctors and key consultants.

There was a discussion relating to Clinical Support £1.2m adverse spend and what was being done to rectify the issues. Mr Nearney advised that 9 Physician Associates had commenced training and that this was helping.

Resolved:
The Committee received and accepted the report.

8.2 Workforce Report
Mr Nearney presented the report and highlighted successful recruitment interviews for nurse students, flu vaccination uptake and the Golden Hearts awards.

Mr Gore asked about exit data and Mr Nearney agreed to forward the information to the Committee members.

Mr Moran asked about the Values Based Recruitment interview training

and Mr Nearney advised that the medics would be introducing it from 1st April 2018.

Mr Hall asked how the Trust was measuring the effectiveness of the leadership programme and what benefits would be seen. Mr Nearney advised that regular meetings were being carried out with managers as well as information being captured through the appraisal process. Mr Moran asked to discuss leadership and capability with Mr Nearney outside of the meeting.

Resolved:
The Committee received and accepted the report.

8.3 Job Vacancies
Mr Nearney presented the report which set out the consultant vacancies (37), the Junior Doctor fill rates (84.6%) and other staff vacancy rates (5.71%).

Mr Gore thanked Mr Nearney for the comprehensive report and asked if he could sign off workforce plans to ensure accurate financial planning and Mr Bond advised that Mr Nearney was sighted on workforce plans.

Resolved:
The Committee received and accepted the report.

9.1 Demand Report
The updated position on all referrals at week 46, compared with last year indicates that there is a cumulative reduction of 8,682 referrals (3.8%)

GP referrals had also seen reductions with Hull CCG 7% reduction and East Riding CCG there was a 2.7% reduction compared with last year, with the South Bank seeing a 4% reduction.

The information from CCGs on referrals to other providers as at the end of December shows that in Hull, Spire referrals are lower than last year by 775 (17%) whereas in East Riding there is an increase of 295 (7.7%). For East Riding, referrals are 6.6% lower than last year at York FT and10% lower at NLAG.

Elective IP & DC – as at end of January, activity is 4.6% below plan overall (3364 cases). The specialties with significant variances are highlighted below:

Plastic surgery is 13.5% below (618) which is an increase in the rate of activity since last month (when a 15% variance was reported)
Oral surgery is 12% below plan (355) which is commissioned by NHSE and this variance is due to consultant vacancies. Interviews are scheduled for February.

The grouping of Gastroenterology, Upper GI and Colorectal Surgery is overall below planned levels by 9% (1552). This variance is mainly due to medical staffing gaps and a slower start to the additional capacity required for bowel screening. As exepcted, the bowel screening daycases increased in January (activity to December 350, and 95 cases reported for January)

DRAFT

The main areas of overtrade in elective activity are Neurosurgery 8.8% (+98) and Urology at 8% (+296) although Neurosurgery saw a reduction in January as the variance previously was (13.8% and +145 cases)

Overall activity is 2% below plan for follow-ups (including procedures) and 7.6% below plan on new outpatients. Compared with the first 9 months of last year, this represents activity which is 4.1% lower than last year for new outpatients and 2% higher compared with last year for follow-ups (it was expected that more would be undertaken this year to address the follow-up backlogs).

Cumulatively to the end of January, the trust is currently noting A&E attendances in excess of planned levels by 1.4%. January attendances were actually below trajectory.

Mr Hall asked about endoscopy referral and Mrs Drury advised that there had been a slight increase in the activity levels. Mrs Drury agreed to check the referral figures for this speciality.

Mr Gore asked for more information relating to follow up appointments and who decides to have them. Mr Bond agreed to review the CHKS information to provide further details to the Committee.

There was a discussion around ED referrals and how the average age of the patients had increased. Mrs Drury agreed to provide further information comparing age profiles and conditions to the next meeting in March 2018.

Resolved:
The Committee received the report and:

- Requested further information relating to follow up appointments
- Mrs Drury to check the figures for endoscopy referrals
- Mrs Drury to provide further information comparing age profiles and conditions of patients referred to ED

10.1 Corporate Finance Report
Mr Bond presented the report and advised that at Month 10 the Trust was reporting a £9.8m deficit which included non receipt of STF funding.

Mr Bond reported that excluding pass through drugs and devices the Trust was under-trading by £2.7m.

Mr Bond advised that the Health Group positions had deteriorated in month, but highlighted that Surgery Health Group had a number of backdated accruals. The overall forecasts remained the same.

As previously reported the Trust had revised its forecast outturn for month 10 was reporting a deficit of £15m excluding STF which was £3.5m worse than plan.

Mr Bond reported that a further £1.5m additional investment from Hull CCG had been secured.

DRAFT

There was an amount of capital monies still left to spend in the remaining 6 weeks of the year and a lot of work was going on to ensure this money was spent.

Cash position difficult – finance systems – paying suppliers on time – Leeds submitted actions financial recovery

Resolved:
The Committee received and accepted the report.

10.2 CRES Report
Mr Bond presented the report which reported actual delivery of £8.9m of savings against the plan of £12m (74%). The Trust was forecasting 80% delivery at year end.

Resolved:
The Committee received and accepted the report.

10.3 Financial Plan 2018/19
Mr Bond presented information relating to the financial plan 2018/19 which highlighted the Trust's underlying position, the revised control total and the amount of money needed to reach it.

There was a discussion around potential SPV, land revaluation at Castle Hill Hospital and CRES targets.

Resolved:
The Committee received the Financial Plan 2018/19 update.

11.1 Board Assurance Framework
Ms Ramsay presented the report which incorporated the discussions at the January 2018 Board meeting and no changes to risk ratings. Ms Ramsay also stated that the Committee could consider risk appetite going into the next financial year, the deliverability of the financial plan, the gaps in controls and the risks to closing the gaps and the impact on patients, contracts and costs.

Resolved:
The Committee received the report and agreed to feedback any comments before the next meeting in March 2018.

11.2 - Domestic Contract Extension
Mr Bond presented the contract extension highlighting Mitie extending their contract until the new supplier took over.

Resolved:
The contract extension was approved by the Committee.

11.3 Orthopaedic Prostheses Contract Extension
The Orthopaedic Prostheses contract extension was presented to the Committee for approval.

Resolved:
The contract extension was approved by the Committee.

DRAFT

11.4 Carter Minutes
The Carter minutes were presented to the Committee for information. Mr Gore advised that he would be attending the next meeting.

12 Items delegated by the board
There were no items delegated by the board.

13 Any Other Business
There was no other business discussed.

14 Date and time of the next meeting:
Monday 26th March 2018, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

Trust Board

Meeting date	13th March 2018	**Reference Number**	2018 – 3 - 15
Director	Lee Bond– Chief Financial Officer	**Author**	Lee Bond– Chief Financial Officer
Reason for the report	The purpose of the report is to update the Board on the latest financial planning position for 2018/19.		

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

1	**RECOMMENDATIONS** The Board is asked to consider whether the Trust can agree its control total for 2018/19 in the final submission of the plan to NHSI, due for submission at the end of April.					
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, Quality, Performance and Risk;					
	Assurance Framework	**Raises Equalities Issues? N**	**Legal advice taken? N**	**Raises sustainability issues? N**		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FINANCIAL PLANNING 2018/19

1. INTRODUCTION

This paper sets out an updated position with regard to the Trust's financial planning for 2018/19.

NHSI have indicated that they see 2018/19 as the second year of a two year plan that commenced in 2017/18. This planning round is therefore a "refresh" of the original plan. A draft plan is to be submitted on 8th March, with the final submission due on 30th April. For the final submission the Board will need to confirm its position with regard to acceptance or not of the control total for 2018/19.

2. CONTROL TOTAL 2018-19

As part of the planning refresh there is updated NHS England and NHS Improvement joint planning guidance and the Trust has received notification of its revised control total for 2018-19, which is summarised below:-

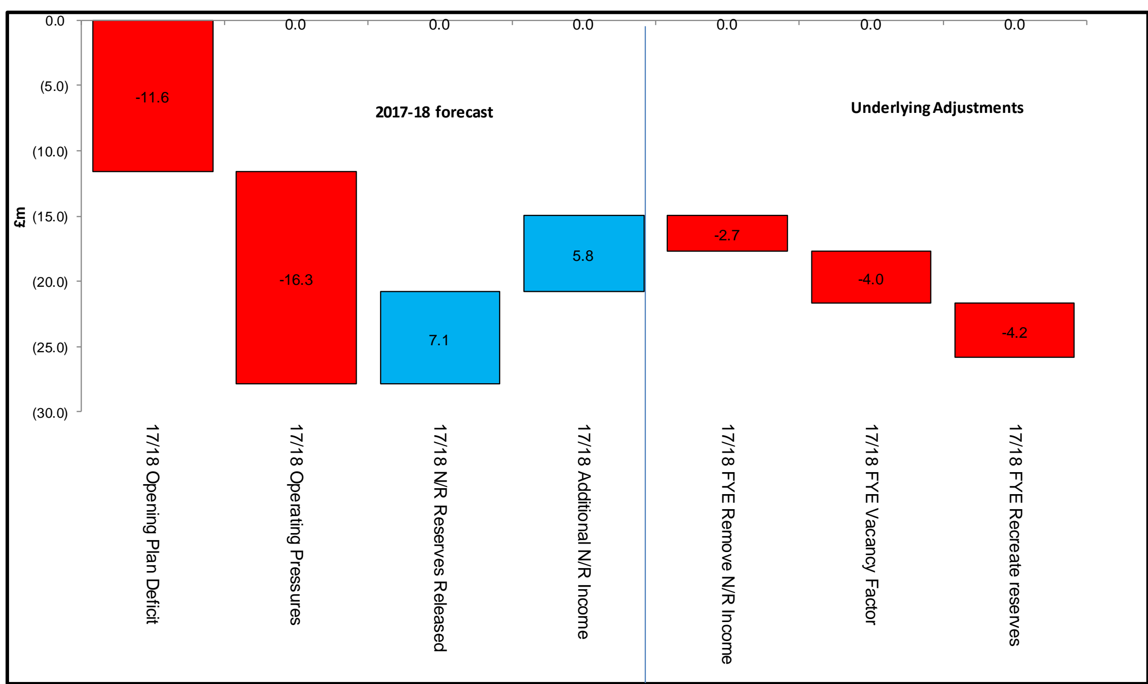
	£'000s				
Original Control Total 2018-19	5,595	*surplus*			
CNST Gain	4,425	*from income & reduced charges*			
National Risk Reserve	-1,309				
Increase in STF Funding	4,848				
Revised Control Total	**13,559**	***surplus***			
STF Funding	*16,781*				
Control total excl STF	**-3,222**	***deficit***			

This control total seeks to accelerate the process of financial recovery. Compared with the 17/18 control total of £11.5m deficit (excluding STF) this revised total will, if delivered, require an improvement of £8.3m. Given that the Trust is not currently delivering its 17/18 control total the scale of the improvement required is that much larger.

3. REPORTED 2017/18 FINANCIAL PERFORMANCE

At month 10, the Trust is forecasting a revised deficit position of £15m which is a £3.5m variance from the original planned deficit of £11.5m excluding STF.

This forecast financial position requires the use of all the Trust's reserves as well as a number of non-recurrent actions. The overall underlying deficit position is currently assessed as £25.9m before any inflationary adjustments relating to 2018/19.



The underlying position of £25.9m accounts for the fact that there is a non-recurrent element of income (£5.8m) and a non-recurrent benefit from reserves (£7.1m) within the 17/18 forecast outturn position of £15m deficit.

4. 2018/19 PLANNING

Inflation

The tariff has already been set for 2018/19 as part of the two year planning framework and includes an assessment of inflation at 2.1% and an efficiency target of 2%, which is a net uplift of 0.1%.

In line with planning guidance, the Trust's inflationary expenditure assumptions include an increase of 1.5% uplift for pay (1% pay award plus incremental pay drift), 2.7% uplift for non-pay excluding drugs and devices and 1% for non-pass through drugs. There may be some upside, particularly on the non-pay, to contribute to the level of CRES required, although there are known pressures above this rate (eg electricity) which are currently being assessed.

CQUINs

The Trust will seek to achieve compliance with the national CQUINs in 2018/19, having successfully achieved all of the National CQUIN schemes in 2017-18. In 2018/19 there are minimal changes – with one scheme to be dropped 'proactive discharge' and one new scheme relating to preventing ill health by risky behaviour (smoking and alcohol), the rest remain the same as in 2017-18, as below:

- NHS Staff Health and Wellbeing
- Reducing the impact of serious infections
- Improving services to people with mental health needs who present to the Emergency Department
- Advice and guidance

- E-Referrals.

The rates for CQUIN will remain the same as previous years with CCG contracts receiving uplifts of 2.5% and NHS England specialist contracts receiving 2.8% where the Trust is a network lead for Hepatitis services. The overall value of CQUINS is expected to be £12.6m for 2018-19 and for Hull and East Riding CCGs, this is built into the AIC.

Cost Pressures

A number of cost pressures have emerged through the planning process which are provided for in the Trust reserves at this point. These cost pressures, totalling over £3m include: Scan for Safety, Nurse Apprenticeships, Drugs & Devices risk, Radiology on-call as well as provision for the exploration and development of a case for an alternate delivery model for a number of the Trusts non clinical services and professional fees associated with the preparation and development of a case to market surplus land held by the Trust. Whilst there has been no decision made yet regarding the cost pressures to be funded, an estimated provision has been included within the draft financial plan.

5. UPDATE ON COMMISSIONER AGREEMENTS FOR 2018/19

Negotiations are being finalised with NHS Hull and NHS East Riding CCGs which would see the AIC continuing into year 2 and an uplift on the current forecast outturn (which is in line with the current contract value, albeit with a different mix of points of delivery) by 1% for inflationary pressures. In addition, the negotiations being finalised should allow for further income of circa £5-6m supporting the cost of sustaining the level of non-elective investment (including the additional winter expenditure) incurred this year as well as, within this sum, a specific allocation for increased Ophthalmology activity (Wet AMD injections). The other notable change that will be reflected in the contract for 2018-19 is the introduction of a new Dermatology provider for East Riding CCG which is expected to result in a 65% reduction in Dermatology outpatient activity provided by HEYHT, for East Riding CCG in 2018/19. At this point it is understood that the funding withdrawal for this service will be at 35% of tariff recognising the fixed costs that the trust is unable to release.

Hull and East Riding commissioners are planning on buying outturn with the intention being that any growth in year will be suppressed and managed outside of the hospital with the introduction of the Integrated Care Centre in Hull and various measures in East Riding including the extended opening hours and reconfiguration of the Urgent care centres expected to commence from October 2018. Clearly this poses a risk and we will need to work closely with all partners to ensure that the flow into the Trust is limited. This approach worked well this year although in the latter months of the year the non-elective medical admissions increased. In terms of the negotiations, we are approximately £2m away from agreeing values and expect to conclude favourably before 23rd March deadline.

The smaller CCG contracts are also being refreshed, based on forecast outturn activity levels in the main, plus 1% for inflationary pressures and 1% growth in non-elective

activity. Some activity growth is incorporated in the North Lincolnshire & North East Lincolnshire contracts to reflect a transfer of Clinical Haematology day case activity from NLAG of circa 320 cases at £220k

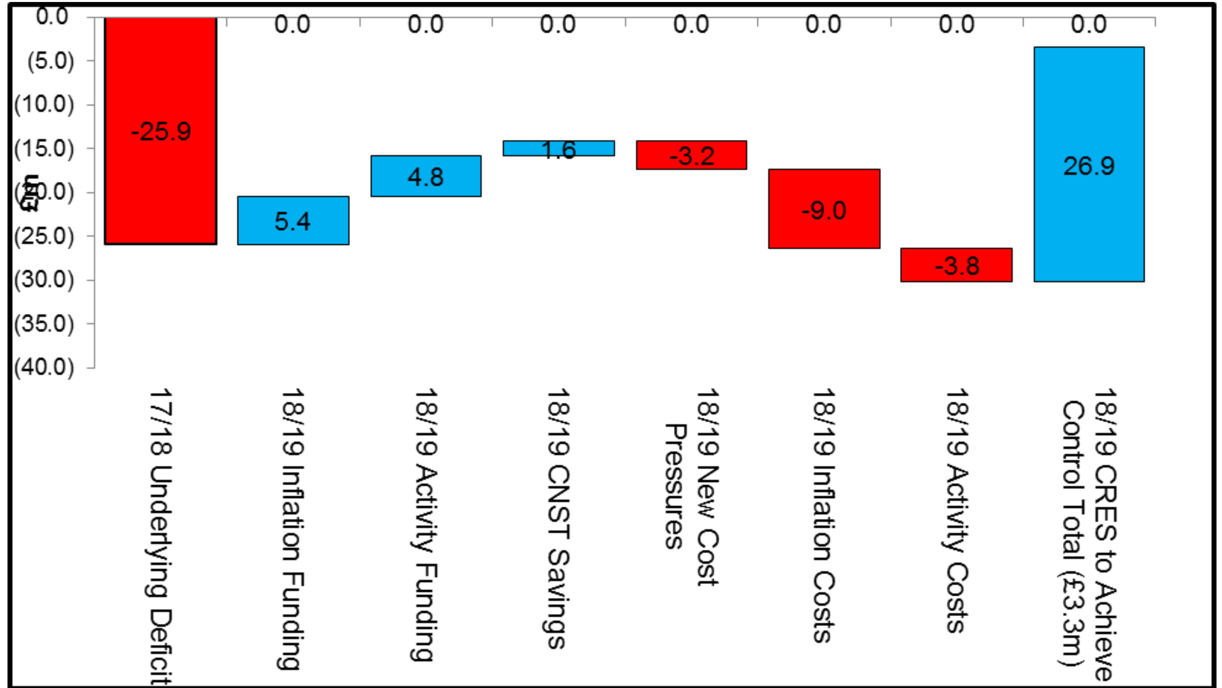
The Trust would expect the Specialist Commissioning contract to be uplifted to reflect outturn activity plus growth in pass through drugs to reflect new NICE guidance and growth in elective activity for Cardiothoracic Surgery & Neurosurgery, however at a recent meeting it is clear that this is not affordable and NHSE have indicated that a higher level of QIPP would be required to negate this growth. The QIPP schemes shared to date total £3m and relate mainly to expected savings from generic drugs.

In the main, pressures on this contract relate to pass through costs and as seen this year, the in-year overtrades are directly related to a corresponding growth in expenditure. Work is underway to model the growth in drugs required based on new NICE guidance and the impact of expected price changes and respective pharmacy representatives are meeting to review the assumptions. There is a potential to explore a move to an AIC approach for this contract however it would need to guard against the risks of overtrade by incorporating a significant growth assumption within any block arrangement.

The deadline for concluding the contract settlements for 2018/19, which will be via contract variations to the existing contracts given the 2 year agreements, is 23rd March and there is currently no indication to suggest any risks in meeting this deadline.

6. EFFICIENCY REQUIREMENT

The Trust has modelled the impact of the above issues and assessed the scale of the financial challenge, commencing with the 2017/18 underlying position of £25.9m, as indicated earlier. This is summarised below



Compared with the latest notified control total deficit of £3.2m for 2018/19 excl STF, there would be an overall efficiency requirement of £26.9m (4.8%). The activity cost provision allows for the extra costs in Ophthalmology and a reserve for additional activity costs pending the final RTT modelling with flexed capacity for winter.

The Trust needs to consider what is felt to be a maximum level of efficiency that can be safely and realistically delivered going forward. The latest financial modelling has assumed a target of 3% of turnover (which is at the lower end of NHSI expectations and the national position on CRES delivery in 2017/18). This equates to a 3.6% target for Health Groups compared with their underlying position. This would deliver £17m of savings. In calculating the size of the "efficiency" gap this year the historic vacancy factors applied by Health Groups have been removed. The impact of this is to effectively increase the efficiency requirement for 2018/19. Work is now underway to revisit, by staff group, the impact that forecast vacancy rates will have on the financial and operational position of the organisation. It is likely that some form of vacancy factor will be included within the 2018/19 efficiency plan subject to satisfactorily completing the quality impact assessment test. Preliminary assessments suggest that this could be in the region of £2m.

It should also be noted that a CRES risk reserve has been included within the plan totalling £2.5m to mitigate against slippage.

At this point the Trust does not have a fully worked up cost improvement program of £17m in place. Work is urgently underway within the organisation to develop deliverable schemes that will meet this target.

Notwithstanding the fact that the £17m target remains aspirational at this point, the overall shortfall against the Trust's control total at this time is circa £10m (£26.9m less £17m). In trying to close this gap the Trust is exploring a number of avenues to identify non recurrent solutions with which to bridge this gap. The development of an alternate delivery model for non-clinical services and the ability of the Trust to convert surplus land into assets held for sale are perhaps the two most ambitious of these plans. Discussions are ongoing with NHSI over the likelihood and ability of the Trust to pursue either of these options. Whilst by no means certain, these opportunities could provide the Trust with an option of submitting a plan to NHSI that delivers the control total. This would require the Trust to make some high level assumptions concerning these technical gains whilst further work is undertaken to assess the feasibility and financial opportunity.

Draft income and Expenditure Position – 2 scenarios

	Not accepting	Accepting
	Annual Budget £000	**Annual Budget £000**
Nhs Contract Income	523,786	523,786
Stf Income	0	16,781
Nhs Other Clinical Income	1,078	1,078
Education + Training Income	18,329	18,329
Other Income	5,900	5,900
Total Income	**549,093**	**565,874**
Surgery	(123,058)	(123,058)
Medicine	(94,427)	(94,427)
Clinical Support Services	(127,585)	(127,585)
Family + Womens Health	(71,789)	(71,789)
Corporate Directorates	(93,378)	(93,378)
Reserves	(15,870)	(5,984)
Other Operating Expenditure	(7,535)	(7,535)
Total Operating Expenditure	**(533,642)**	**(523,756)**
Donated Asset Income	(3,600)	(3,600)
EBITDA	**11,851**	**38,518**
Depreciation	(12,800)	(12,800)
Interest Payable	(6,892)	(6,892)
Interest Receivable	40	40
Pdc Dividends	(5,766)	(5,766)
Profit / Loss On Disposal	0	0
Total Non Operating Expendit	**(25,418)**	**(25,418)**
Net Surplus/Deficit	**(9,967)**	**16,700**
Impairment		
Donated Asset Adjustment	(3,141)	(3,141)
Adjusted Financial Performan	**(13,108)**	**13,559**
Excl STF	***(13,108)***	***(3,222)***
	CRES of £17m assumed	CRES of £26.9m assumed

Clearly, the expected benefit from accepting the Control Total is that the Trust would protect its eligibility for access to discretionary capital or other bidding processes in year, should these become available in 2018-19. In addition, the Trust would also benefit from being protected against all national and local contractual financial sanctions (recognising that the AIC with Hull and East Riding currently provides some protection).

7. CAPITAL

The Trust has developed a Capital Programme to cover the 3 year period 2018/19 to 2020/21 and details are included as a separate Board Paper. The capital programme is

based on assessments received and reviewed at the Capital Resource Allocation Committee (CRAC).

The assessments were based on a "do minimum" basis and include the replacement of existing medical equipment but does not make any provision for expansion. Similarly, the IM&T programme focusses heavily on the replacement of the existing network and on essential system replacements to meet nationally mandated timescales for system architecture and capability. The assessments also included a backlog maintenance investment programme, based on a 10 year programme, which would bring the condition of the Trusts estate to condition B.

There is £13.7m included in the programme to finance significant investment in energy efficient heating and lighting infrastructure which will generate significant revenue benefit for the Trust. This will be funded by a specific loan from the Department of Health.

More recently, the Trust has also received an enforcement notice from Humberside Fire and Rescue on the back of the Grenfell review, with estimated costs of £4.5m. This is included within the capital programme based on the assumption the Trust will receive PDC funding to cover this.

The capital plan contains a significant level of risk and it is clear that the programme does not provide for any developments or expansions in capacity. With regards to imaging service capacity in particular, this poses a significant risk to service delivery. In addition, the amount of capital funding available to the Trust in 2018/19 is significantly short of what is assessed as being required to secure sustainable clinical service provision, principally from the Hull Royal site. Backlog maintenance, IM&T replacement and equipment replacement budgets are all severely restricted and additional funding is urgently required to manage the risk to the services operating from Hull Royal Infirmary. At this time no provision has been include within the plan for loan funding to manage this risk. It is therefore likely that the Trust may need to consider additional loan funding to support the essential capital requirements going forward.

8. CASH IMPACT

The challenging financial position is significantly impacting on the Trust's cash position and in 2017/18 additional revenue support funding of circa £15m was received. Given the planning assumptions highlighted above and the shortfall against the control total, the cash planning position will also be affected by the decision on whether the control total is accepted or not. Accepting the control total will allow the Trust to claim STF funding, up to £16.8m, should the targets be delivered at the quarter stages.

Ignoring the control total, the forecast SOCI deficit, assuming delivery of a £17m CRES plan, equates to a £13.1m deficit. Given the Trusts underlying liquidity issues, and the fact that the full depreciation budget will be expended in pursuit of the Trusts capital programme then the Trust will have to look to secure working capital loans of a minimum £13m at this point.

A further challenge for 2018/19 is that in February 19, the Trust is due to repay a £15.7m loan which was taken in 2015/16 before the introduction of STF.

9. LONGER TERM FINANCIAL STRATEGY

Given the scale of the financial challenge and level of savings required for the Trust to return to recurrent financial balance, a longer term model is being developed, with draft planning assumptions regarding activity levels, income, expenditure and efficiency savings incorporated for the three year period 2018/2021. This model is being developed to show how the Trust would get back to an underlying break-even position.

The challenge for the organisation is then to develop operational plans and strategies that will meet the requirements of the model. Clearly these detailed plans will need to be developed as part of the emerging STP processes working equally with both internal and external stakeholders.

10. NEXT STEPS

The Trust will continue to work on the following issues to refine the plan for the final submission to NHSI at the end of April:

1) Agree the Contract Variations for year 2 of the contracts with commissioners
2) Development of the CRES program and finalisation of reserves
3) Review income and expenditure profiles alongside activity profiles
4) Update the cash flow forecast
5) Develop the concept paper for establishing an alternate delivery model
6) Consider the requirement for additional capital loan funding.
7) Assess the expected waiting list position at March 19
8) Confirm the assumptions for the winter plan for 2018/19
9) Agree a Board date in April for signing of the final submission.

11. RECOMMENDATION

The Trust Board is asked to note the progress being made with regard to finalising the financial plan for 2018-19 and confirm the approach to take for signing off the final submission to NHSI by 30th April, including the decision with regard to the agreement or not of the revised control total for 2018/19.

Lee Bond
Chief Financial Officer
5.3.18

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CAPITAL PLANNING 2018/19

Meeting date	13 March 2018		**Reference Number**	2018 – 3 – 15.1	
Director	Lee Bond – Chief Financial Officer		**Author**	Lee Bond – Chief Financial Officer	
Reason for the report	This paper sets out an updated position with regard to the Trust's Capital Programme for 2018/19 and builds upon the position reported at PAF in October 2017.				
Type of report	Concept paper		Strategic options	Business case	
	Performance		Briefing	Review	✓

1	**RECOMMENDATION** The Trust Board is asked to approve the Capital Programme for 2018/19 and to note the funding shortfall and the risk to the sustainable provision of service that failure to service the Trust building and equipment infrastructure represents. The Board is asked to endorse the approach being taken with NHSI and to recommend any alternative sources of funding that may be pursued					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Briefing		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework		**Raises Equalities Issues? No**	**Legal advice taken? No**	**Raises sustainability issues? No**	
5	**BOARD/BOARD COMMITTEE REVIEW** The Capital Programme is reviewed and monitored at the Performance and Finance Committee and the Capital Resource Allocation Committee.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CAPITAL PLANNING 2018/19

1. INTRODUCTION

As part of its Financial Planning for 2018/19 the Trust needs to include a capital plan based upon the anticipated capital resources available.

This paper sets out an updated position with regard to the Trust's Capital Programme for 2018/19 and builds upon the position reported at PAF in October 2017.

2. CAPITAL PROGRAMME OVERVIEW

The Trust has developed a Capital Programme for 2018/19. This is based on assessments received and reviewed at the Capital Resource Allocation Committee (CRAC).

In Quarter 3, CRAC undertook an exercise to quantify the funding requirements for the next three years (to 20/21). The CRAC Committee reviewed prioritised lists for Medical Equipment which had been scrutinised by the Medical Equipment Group; Backlog, Maintenance and Compliance which had been assessed by the Director of Estates, Facilities & Development; and IM& T capital which had been assessed by the Director of IT & Innovation.

These assessments were based on a "do minimum" basis and were presented to PAF in October 2017. Investment totalling £30m was assessed as being required for equipment replacement. This did not make any provision for expansion. Similarly, the IM&T programme focusing on the replacement of the existing network and on essential system replacements to meet nationally mandated timescales for system architecture and capability required £13m over the next three years. A backlog maintenance investment programme, which would bring the condition of the Trusts estate to condition B over 10 years, would cost a further £7m per year. Over the 3 year period capital investment totalling £64 was identified.

A further £13.7m has been identified for investment in energy efficient heating and lighting infrastructure which will generate a significant revenue benefit for the Trust. It is hoped that this will be funded by a specific loan from the Department of Health. This is profiled for £11.2m in 2018/19 and £2.5m in 2019/20.

More recently, the Trust has also received an enforcement notice from Humberside Fire and Rescue on the back of the Grenfell review, with estimated costs of £4.5m. An application for emergency Public Dividend Capital is currently being progressed so that this work can be urgently addressed.

3. CAPITAL PROGRAMME 2018/19

The capital programme will be predominantly funded through depreciation with some additional schemes funded from charitable donations; PDC funding and new capital loans. In addition to depreciation funding, the Trust has the ability to generate capital receipts from the sale of surplus land, particularly at CHH. Phase 1 of this is currently being finalised and it is hoped that Phase II will become a reality over the course of this period.

The Trust has a pre commitment on its depreciation funding as it must first service the Trusts existing long term debt commitments (a combination of long term loans and PFI contracts). This is expected to cost £5.1m in 2018/19. This financing is the first call on the Trust's available cash resources from depreciation.

The following table sets out at a summary level the anticipated source and applications of capital for 2018/19. This also shows whether the source of funding is the Trusts internally generated funds or items expected to be funded externally. A detailed breakdown of the capital programme can be found at Appendix 1.

	£m	£m	£m
Resources:	**Internal**	**External**	**Total**
Depreciation	12.8		12.8
Donated Assets		3.6	3.6
Loan Funding		11.2	11.2
PDC Allocation (Linear Accelerators & Digital Slide Scanners)		2.0	2.0
PDC Allocation Fire Safety		4.5	4.5
	12.8	**21.3**	**34.1**
Less Required Financing Commitments:			
Loan Repayments	-1.8		-1.8
PFI & Finance Lease Liabilities	-3.3		-3.3
Subtotal Capital Resources Available	**7.7**	**21.3**	**29.0**
Capital Programme			
Energy Scheme		11.2	11.2
Fire Safety		4.5	4.5
Backlog Maintenance & Compliance	2.1		2.1
IM& T	2.2		2.2
Medical & Scientific Equipment	2.3	0.3	2.6
Linear Accelerator		1.7	1.7
Donated Assets - Brocklehurst Reprovision		3.0	3
Donated Assets - Other		0.6	0.6
Other	1.1		1.1
			0
Total Capital Programme	**7.7**	**21.3**	**29.0**

The above table shows the Trust has internal sources of funding totalling approximately £7.7m to use for capital expenditure in 2018/2019. Over a 3 year period this equates to circa £23.1m of funding versus a requirement for £64m, a funding shortfall of £40.9m over the period.

A further £20m is forecast to be available through land sales at Castle Hill. Included within this is £9m of sale proceeds which may not be realised until year 4 (ie 21/22) and therefore outside this 3 year planning period. It may be possible, assuming that Phase I is successful, to secure additional borrowing or bridging finance against these future cash receipts in order to bolster the capital budget over the 3 year period.

If the Trust is able to secure capital receipts or bridging finance using the land as security the funding shortfall would reduce to circa £21m.

In 2018/19 the risk assessed minimum capital investment required from internal funding is £23m in 2018/19, a shortfall of £15m against current resources. There is insufficient capital available to meet the requirements needed. The programme does not provide for any developments or expansions in capacity and with regards to imaging service capacity in particular, this poses a significant risk to service delivery and transformation.

The table below summarises the high risk areas that make up the additional £15m capital investment required. These are NOT included in the main capital programme for 2018/2019. A detailed breakdown of these schemes and the risks involved can be seen at Appendix 2. It is essential that the Trust starts to make some inroads into its backlog maintenance issues, the schemes identified for 2018/19 all provide essential support to the provision of clinical services at the Hull Royal infirmary with Theatre replacement, Ward upgrade programme and urgent replacement of the Trusts IT network all starting to be addressed in this plan. Failure of any part of this infrastructure would be critical for the Trust and is reflected as a high risk on the Trusts Risk Register and Board Assurance Framework.

In order to fund this capital investment the Trust is looking to apply for capital loan funding. This is not currently included within the financial plans for 2018/19. NHSI are aware of the issues faced by the Trust and discussions are taking place with them with regards the ability of the Trust to realise the land sale receipts and the ability of the Trust to secure loan funding required to underwrite the three year program.

High Risk Areas needing Capital Investment	£m
Buildings Maintenance & Compliance:	
Theatre Upgrade Phase 1	3.0
Ward Upgrade x2	1.2
Lift B	0.3
Essential road repairs	0.4
Other	0.6
IM&T:	
Network Servers/System replacements	0.9
Lorenzo ePMA/Theatres	0.5
Data Centre, servers, Eobs	0.4
Medical & Scientific Equipment:	
Gamma Camera	1.4
CT Replacements	1.3
Ultrasounds	0.5
Haemodynamic equipment	0.4
Aria Upgrade	0.3
Endoscope replacements	0.3
Other planned replacements	2.3
Theatre Stack 7	0.4
General X Ray	1.0
Total High Risk Capital Investment requirements	**15.2**

4. RECOMMENDATION

The Trust Board is asked to approve the Capital Programme for 2018/19 and to note the funding shortfall and the risk to the sustainable provision of service that failure to service the Trust building and equipment infrastructure represents. The Board is asked to endorse the approach being taken with NHSI and to recommend any alternative sources of funding that may be pursued.

Lee Bond

Chief Financial Officer

05 March 2018

Hull and East Yorkshire Hospitals

DEVELOPMENT OF THE CAPITAL PROGRAMME - 2018/19

CATEGORY	2018/19 Internal £000	2018/19 External £000	2018/19 Total £000	Comments
Sources of Funding				
Depreciation	12,800	0	12,800	Allocation may change subject to estate revaluation
Loan Funding - Energy Scheme	0	11,200	11,200	timing of loan needs confirming over split years
Land Sale receipts	2,478	0	2,478	
CRL Cover back to NHSI	-2,478	0	-2,478	
Charitable Funds Brocklehurst Reprovision	0	3,000	3,000	final figure needs confirming
Charitable Funds (General) & helipad	0	600	600	
PDC Funding - Digital Slide Scanners	0	243	243	Subject to PDC funding confirmation
PDC Funding - Linac	0	1,737	1,737	Subject to PDC funding confirmation
PDC Fire	0	4,500	4,500	Subject to PDC funding confirmation
Less Capital Loan Repayments Existing Loans	-1,772	0	-1,772	
Less Capital Element of IFRIC/PFI/Finance Lease	-3,286	0	-3,286	
TOTAL	**7,742**	**21,280**	**29,022**	
Corporate Developments:				
Fire Safety Notice PDC	0	4,500	4,500	
Energy Scheme Loan	0	11,200	11,200	timing of loan needs confirming over split years
	0	***15,700***	***15,700***	
Buildings Maintenance and Compliance:				
Engineering Schemes				
Fire Safety (fire notice)	400	0	400	
Lift Car Tower block	290	0	290	
Electrical Infrastructure (high risk)	70	0	70	
Mechanical Infrastructure (high risk)	70	0	70	
Water Main Repairs/Replacement	50	0	50	
Electric Charging Points	45	0	45	
Theatre Upgrade Enabling Works	50	0	50	
Security system/Alarms	75	0	75	
Theatre Lights x 2	50	0	50	
Environmental Schemes				
External Repair works	120	0	120	
CQC essential Clinical repairs	300	0	300	
Flooring Repairs	100	0	100	
Update External Signage	60	0	60	
Ward 7 Sanitary Accommodation	45	0	45	
Outpatients Part upgrade	50	0	50	
Ground floor remaining circulation	75	0	75	
Car Park repairs	100	0	100	
DDA essential works	75	0	75	
Harrow Street Roof	75	0	75	
	2,100	***0***	***2,100***	
IM&T:				
IT Network Servers/System Replacement	600	0	600	
Data Centre, Servers, Systems	200	0	200	
Desktop/Device replacement programme	50	0	50	
RA/Smartcard upgrade	50	0	50	
Enhanced Business Intelligence	60	0	60	
Lorenzo Optimisation development	310	0	310	
Lorenzo ePMA	300	0	300	
Nervecentre E-Obs	100	0	100	
Patient Knows Best	50	0	50	
Cardiology - CARDDAS replacement	450	0	450	
	2,170	***0***	***2,170***	
Medical and Scientific Equipment:				
Planned Equipment Replacements	90	0	90	
Theatre 11 Stack	425	0	425	
MRI & Enabling Works	1,450	0	1,450	
Linear Accelerator - Enabling Works	50	0	50	Subject to PDC funding confirmation
Linear Accelerator Replacements (PDC)		1,737	1,737	Subject to PDC funding confirmation
Digital Slide Scanners - (PDC)		243	243	Subject to PDC funding confirmation
Bladder Scanners	85	0	85	pre commitment from 17/18
Retinal Van	50	0	50	pre commitment from 17/18
Radiopharmacy - Replacement of Isolators	170	0	170	pre commitment from 17/18
	2,320	***1,980***	***4,300***	
Other Allocations:				
Feasibility Work	50	0	50	
17/18 slipped schemes due to land receipt	522	0	522	pre commitment from 17/18, CRL/Land receipt reduction
Other (17/18 overcommitments)	280	0	280	
Non Medical Equipment	300	0	300	
Charitable Funds (General)	0	600	600	Helipad £500k & General £100k
Charitable Funds Brocklehurst Reprovision	0	3,000	3,000	final figure needs confirming
	1,152	***3,600***	***4,752***	
TOTAL	7,742	21,280	29,022	
UNDER (-) OR OVER (+) COMMITMENT	0	0	0	

Hull and East Yorkshire Hospitals

Appendix 2

High Risk Areas - Capital Investment required in 2018/19 not currently funded

CATEGORY	2018/19 Total £000	Comments
Buildings Maintenance and Compliance		
Theatre Upgrade Phase 1	3,000	Ventilation plant is 60 years old serving 7 main trauma theatres (total scheme is £13m)
Ward Upgrade x 2	1,200	Ward engineering services are 60 years old, urgently need upgrading
Lift B	290	Failing weekly, need full replacement
Essential Roofing repairs	150	Ageing flat roofs to be re-covered with liquid plastic
Leaking Water Main	40	
Autoclaves	140	Replacement programme required to maintain instrument sterilisation
Steam Generators	120	Replacement programme required to maintain instrument sterilisation
Gladstone Street Essential Road Repairs	100	Newly adopted road; collapsing due to traffic and lack of investment by HCC
Gate 2 (CHH) Essential Road Repairs	140	Road collapsing due to traffic
Gate 1 (CHH) Essential Road Repairs	250	Planning requirement
Nurse Call System	100	50 year old systems in urgent need of replacement
	5,530	
IM&T		
IT Network Servers/System Replacement	900	There is a significant clinical risk from loss of service (due to end of life kit) and from the delayed roll-out of e-Prescribing & eOBS.
Data Centre, Servers, Systems	300	Significant operational risk that end of life hardware replacement cannot take place. No capacity to implement small systems.
Lorenzo ePMA	400	Clinical risk increases as small pockets of wards go digital in isolation. Also, opportunities for wide scale efficiency gains and clinical benefits are deferred.
Lorenzo - Theatres	50	Not moving to Lorenzo Theatres maintains the risk of disconnection between theatres and core EPR. Opportunities for wide scale efficiency gains and clinical benefits are deferred. Annual savings of £65k (from reduced cost of Lorenzo v ORMIS are deferred).
Nervecentre E-Obs	150	Significant clinical risk re deteriorating patients and clinical alerting is not addressed. Significant operational risk that the project withers away.
	1,800	
Medical and Scientific Equipment		
Cardiology Servers & Central Stations	190	These are end of support in December 2018 and the risk would be significant if the central servers failed. Further discussions required with Philips.
Ultrasounds	490	Risk of misdiagnosis increases due to image quality degradation as machine ages
Endoscope Replacements	300	Risk of cancelled patients as repairs increase. The 2012 procurement programme had an anticipated life span of 7 years for return-on-investment, benefit realisation and life of scopes. Four years in, the scopes have been heavily used and a number of scopes are out of service and with the supplier for servicing or repair at any one time. The cost of a MES is prohibitive and therefore a rolling programme of replacement and increasing stock to meet demand is required.
Gamma Camera & Enabling	1,320	The cameras at CHH are between 14 and 15 years. They are becoming more unreliable and breaking down regularly, with image quality issues. Work is ongoing to assess future requirements of the service including the closure the room at HRI in the future.
CT - RT Planning & Enabling	500	There are image quality issues with this CT scanner and reconstruction problems. The aim was to obtain an upgrade from the manufacturer (which may happen in 18/19) which would resolve some issues and delay replacement for approximately 2 years.
CT Toshiba Aquilion 64 & Covidien contrast injector & Enabling	800	If this equipment failed beyond repair, the impact would mainly be on inpatient capacity and lack of flexibility for the ED scanner . Inpatient length of stay at HRI would likely increase. Van hire would be sought at high revenue cost although no guarantee one could be sought.
Aria 15.5 Upgrade	300	This is the Aria system underpinning chemotherapy and Radiotherapy which requires an upgrade. This also impacts NLAG under an SLA. The upgrade requires hardware elements to be replaced which are no longer current. The consequence of not doing this could be an increase in the value of the support contract, degradation of performance of system, and not make full use of new linacs. If the system fails the whole Oncology service will not have access to Aria therefore cannot be provided.
Papillon (Rectal Cancer)	250	This is used for internal Colorectal brachytherapy for theYorkshire and Humber network. Equipment is increasinly unreliable with frequent unplanned breakdown. The Supplier struggling to repair, parts are an issue. Without this machine this treatment cannot be delivered. No back up in the region. Liverpool or Nottingham next centres
Haemodynamic Equipment	380	This equipment is leased to January 2019 but is end of support as there are no parts available. (There are 4 of them - 1 each per cath lab) If the equipment fails and a replacement part is not available, the whole cath lab is closed until the equipment is replaced. There is currently funding in the corporate lease budget for this equipment but a top up for replacement equipment may be required. Discuss with the UK Manager of GE Healthcare. Meeting to be arranged with lessor, manufacturer, Leaseguard to explore funding options.
Philips Optimus HRI 2nd Floor Rm 1 & enabling	360	The equipment is currently working with parts available. Currently 16/17 yrs old (lifespan 10 yrs) If the rooms failed beyond repair the plain film capacity would decrease.
Philips Optimus HRI 2nd Floor Rm 2 & Enabling	360	The equipment is currently working with parts available. Currently 16/17 yrs old (lifespan 10 yrs) If the rooms failed beyond repair the plain film capacity would decrease.
MII Philips Endura	100	Utilised in theatres - image quality issues as machine ages. Failure would result in delays in theatre/ potential for cancelled cases
MII Philips Libra	100	Utilised in theatres - image quality issues as machine ages. Failure would result in delays in theatre/ potential for cancelled cases
Theatre Stack 7	400	Image quality a signficant issue for the surgeons.
CR processor 25	50	The CR processor is obsolete with no parts available. This CR processor is in ED X-ray and used for the mobile X-ray machines and the OPT machine in X-ray. Without this machine the mobile X-rays / OPT images could not be processed. The long term aim is for all X-ray equipment to be DR negating the need for the CR processor.
General MSE Allocation	2,000	Obsolete, old equipment within Health Groups, not included above
	7,900	
TOTAL	**15,230**	

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

REFRESH OF THE TRUST'S OPERATIONAL PLAN FOR 2018/19

Meeting date	13TH March 2018			**Reference Number**		
Director	Lee Bond, Chief Financial Officer Jacqueline Myers, Director of Strategy and Planning			**Author**	Jackie Railton Head of Strategic Planning	
Reason for the report	To provide the Board with an overview of the recently published national guidance for refreshing the NHS Operational Plans for 2018/19 and to seek comment on the Trust's Draft Operational Plan 2018/19.					
Type of report	Concept paper		Strategic options	✓	Business case	
	Performance	✓	Information	✓	Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to review the Draft Operational Plan 2018/19 and: i. Provide feedback on its contents ii. Confirm the approach for signing off the final version of the Operational Plan.					
2	**KEY PURPOSE:**					
	Decision	✓	Approval		Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): **All**					
	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

REFRESH OF THE TRUST'S OPERATIONAL PLAN FOR 2018/19

1. PURPOSE OF PAPER

To provide the Board with an overview of the recently published national guidance for refreshing the NHS Operational Plans for 2018/19 and to seek comment on the Trust's Draft Operational Plan 2018/19.

2. BACKGROUND

The *NHS Operational Planning and Contracting Guidance 2017-2019*[1] was published in September 2016 and outlined a planning process which was built around the shared tasks of implementing *The Five Year Forward View* to drive improvements in health and care, restore and maintain financial balance, and deliver core access and quality standards.

In December 2016, in line with the national planning guidance, the Trust produced a two year operational plan for 2017/18 and 2018/19 which included a narrative summary, as well as financial, activity and workforce plans.

Further refinements were made to the financial, activity and workforce plans following agreement of two year contracts with local commissioners and NHS England.

3. REFRESHING NHS PLANS FOR 2018/19

In February 2018, NHS England and NHS Improvement published guidance setting out the expectations for commissioners and providers in updating their operational plans - *Refreshing NHS Plans for 2018/19* [2]. The main areas as they relate to NHS Trusts are:

- £1.4billion increase in CCG allocations to fund realistic levels of emergency activity, additional elective activity necessary to tackle waiting lists, universal adherence to the Mental Health Investment Standard and transformation commitments for cancer services and primary care.

- An additional £650million added to the £1.8billion Sustainability and Transformation Fund to create an enhanced £2.45billion Provider Sustainability Fund, targeted at the same objectives as the existing Sustainability and Transformation Fund. As in 2017/18, 30% of the total Fund will be linked to A&E performance. To access the performance element, the Trust will need to achieve A&E performance in 2018/19 that is the better of either 90% or the equivalent quarter for 2017/18.

- There is an expectation that the majority of providers will be achieving the 95% A&E standard by March 2019, with the NHS returning to 95% overall performance within the course of 2019.

- No assumption to be made of any capital resource above the level in the current 2018/19 operational plan unless NHS England and NHS Improvement have given written confirmation of additional resource.

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[1] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

- Approval of additional STP capital will be contingent on the STP having a compelling estates and capital plan.

- Local systems are expected to continue to implement efficiency programmes, eg: reducing avoidable demand, reducing unwarranted variation in clinical quality and efficiency (*Getting It Right First Time)*, participation in networked arrangements for procurement, corporate services and diagnostic services, achieving best practice in clinical and other workforce productivity standards, improving the safety and efficiency of the estate and facilities, and making best use of new digital and technological systems and innovations.

- RTT waiting lists (incomplete pathways) will be no higher in March 2019 than in March 2018 and, where possible, waiting lists should be reduced.

- Numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible.

Refreshed operational plans must:

- Be stretching and realistic, and show a bottom line position consistent with the control totals set by NHSE and NHSI.

- Be the product of partnership working across the ST, with clear triangulation between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions.

- Include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter, and ensuring efficiency savings are not back-loaded into the later part of the financial year.

The timetable for submission of key documents is as follows:

Item	Date
Draft 2018/19 Operational Plan submitted to NHSI	8 March 2018
National deadline for signing 2018/19 contract variations and contracts	23 March 2018
Final Board-approved Operational Plan submitted to NHSI/NHSE	30 April 2018
2018/19 Winter Demand and Capacity Plans submitted to NHSI/NHSE	30 April 2018

4. TRUST OPERATIONAL PLAN 2018/19

As indicated in the timetable above, the Trust is required to submit a draft and a final plan submission for 2018/19. This will include finance, activity, workforce and triangulation returns alongside an update to the existing two year plan narrative.

The refreshed Draft Trust Operational Plan narrative is attached as an appendix.

The Trust's Operational Plan takes into account the strategic context set out in the national planning guidance and the Humber, Coast and Vale Sustainability and Transformation Plan. It is also informed by the operational plans developed at Divisional and Health Group level.

The internal planning process commenced in July 2017 and assumptions in relation to activity, finance and workforce are based on 2017/18 forecast out-turn, known factors in relation to growth, pathway redesign and future commissioning intentions.

Negotiations with commissioners are ongoing in relation to levels of activity for 2018/19 and therefore the Operational Plan will be subject to change based on the final contract agreement.

4.1 NARRATIVE SUMMARY
The content of the narrative summary is set out in Annex F of the technical guidance: *'NHS Improvement Guidance for Operational and Activity Plans'*. Whilst no template for the narrative is provided, the document is expected to include details on the Trust's approach to:

- activity planning
- quality planning
- quality improvement
- quality impact assessment
- the triangulation of quality, workforce and financial indicators
- workforce planning
- financial planning, and
- alignment with the local Sustainability and Transformation Plan.

4.2 ACTIVITY
In 2017/18 the Trust agreed an Aligned Incentive Contract (AIC) with Hull and East Riding Clinical Commissioning Groups for a two year period. This marked a fundamental change from an organisational-based contract to a system contract with shared risk, shared opportunity and shared vision. It provides all parties with a common goal: the effective management of patient pathways irrespective of organisational boundaries.

Negotiations are being finalised with the Hull and East Riding CCGs regarding Year 2 of the AIC contract to take account of activity changes, including:

- increased Ophthalmology activity (Wet AMD injections)
- introduction of a new Dermatology provider for East Riding CCG which is expected to result in a 65% reduction in outpatient activity provided by the Trust in 2018/19.

The smaller CCG contracts are also being refreshed based on forecast outturn activity levels in the main, plus 1% for inflationary pressures and 1% growth in non-elective activity. Some activity growth is incorporated in the North Lincolnshire and North East Lincolnshire contracts to reflect a transfer of Clinical Haematology day case activity of circa 320 cases to this Trust from North Lincolnshire and Goole NHS Foundation Trust (NLAG).

The Trust would expect the Specialist Commissioning contract to be uplifted to reflect outturn activity plus growth in pass through drugs to reflect new NICE guidance and growth in elective activity for Cardiothoracic Surgery and Neurosurgery. However, at a recent meeting, it was clear that this is not affordable and NHS England has indicated that a higher level of Quality, Innovation, Productivity and Prevention (QIPP) initiatives would be required to negate this growth. The QIPP schemes shared to date are £3million and mainly relate to expected savings from generic drugs.

The deadline for concluding contract settlements for 2018/19 is 23 March 2018 and there is currently no indication to suggest any risks in meeting this deadline.

4.3 FINANCE

The financial section in the Draft Operational Plan is informed by the financial plan and capital programme papers which have been submitted separately to the Board for consideration.

The section will be updated following finalisation of the financial plan and capital programme for 2018/19.

4.4 WORKFORCE

The following table shows the original forecast establishment for 2017/18 and 2018/19 which was based on a 3% reduction in our establishment. In refreshing the plan for 2018/19, the actual establishment wte to March 2018 has been included. The variance between the original and refreshed plan to March 2019 is 201 wte and can be explained by an increase in establishment to support the ongoing development of the Lorenzo electronic patient record, expansion of services to improve patient pathways, increase the provision of services at weekends, and the introduction of new roles.

	Establishment WTE						
Staff Group	**2016/17**	**Planned 2017/18**	**Actual 2017/18**	**Variance 2017/18**	**Original Plan 2018/19**	**Refreshed Plan 2018/19**	**Variance 2018/19**
Nursing	**3130**	**3130**	**3052**	**-78**	**3130**	**3052**	**-78**
Of which are Registered Nursing	2140	2140	2111	-29	2140	2111	-29
Of which are Registered Midwife	175	175	184	9	175	184	9
Of which are Non Registered Nursing	815	815	757	-58	815	757	-58
Medical Staff Group	**1067**	**1037**	**1024**	**-13**	**1037**	**1028**	**-9**
Allied Health Professionals & Technical	**918**	**885**	**967**	**82**	**885**	**967**	**82**
Healthcare Scientists	**500**	**460**	**521**	**61**	**460**	**521**	**61**
Admin, Estates & Senior Managers	**1525**	**1419**	**1540**	**121**	**1419**	**1540**	**121**
Healthcare Assistants and Support Staff	**510**	**490**	**514**	**24**	**490**	**514**	**24**
Total	**7650**	**7421**	**7618**	**197**	**7421**	**7622**	**201**

The Staff in Post (wte) table overleaf shows the original plan for 2017/18 and 2018/19 compared to the actual position for 2017/18 and the refreshed 2018/19 plan. The variance between the original plan and refreshed plan is 107 wte.

The Trust is making significant investment in its ‘Remarkable People, Extraordinary Place’ campaign to recruit to vacant posts, particularly in the hard-to-recruit-to staff groups. Our recruitment campaigns will undoubtedly enable the Trust to reduce its vacancy position, but given the national shortage for qualified staff, this will remain a significant challenge.

	Staff in Post WTE						
Staff Group	**2016/17**	**Planned 2017/18**	**Actual 2017/18**	**Variance 2017/18**	**Original Plan 2018/19**	**Refreshed Plan 2018/19**	**Variance 2018/19**
Nursing	**2970**	**3040**	**2984**	**-56**	**3040**	**3019**	**-21**
Of which are Registered Nursing	1982	2050	1992	**-58**	2050	2023	-27
Of which are Registered Midwife	173	175	160	**-15**	175	160	-15
Of which are Non Registered Nursing	815	815	832	**17**	815	836	21
Medical Staff Group	**973**	**1000**	**965**	**-35**	**1000**	**968**	**-32**
Allied Health Professionals & Technical	**842**	**860**	**876**	**16**	**860**	**890**	**30**
Healthcare Scientists	**419**	**440**	**436**	**-4**	**440**	**451**	**11**
Admin, Estates & Senior Managers	**1413**	**1419**	**1464**	**45**	**1419**	**1476**	**57**
Healthcare Assistants and Support Staff	**507**	**510**	**522**	**12**	**510**	**572**	**62**
Trust Total	**7124**	**7269**	**7247**	**-22**	**7269**	**7376**	**107**

4.5 KEY RISKS

The Trust has undertaken an assessment of the risks to delivery of its operational plan and identified, where possible, mitigating actions. A standard risk matrix was used to assess likelihood of occurrence and severity of impact. Risk scores can range from 1 (very low risk) to 25 (high risk).

Risk	Score	Mitigating Action	New Score
Failure of the proposed local QIPP schemes to reduce activity as intended	12 (moderate)	Work closely with commissioners on implementation plans and monitor closely Continue to work together to develop further schemes to manage elective and non-elective demand	8 (moderate)
Inability to identify and deliver sufficient efficiency savings	20 (high)	Ongoing work with Health Groups and Corporate teams to identify schemes	12 (moderate)
Insufficient capital availability to deliver safe levels of investment in estate and IT infrastructure and equipment replacement	12 (moderate)	Agreement of safest balance of spend within tight budget and exploration of alternative sources of investment	8 (moderate)
Insufficient cash liquidity	15 (high)	Access working capital loans	8 (moderate)
Failure to appoint to essential posts and breaching of the Trust's agency spend cap	12 (moderate)	Recruitment campaigns utilising successful Trust brand Development of alternative staffing models Tight control of authorisation	8 (moderate)
Failure to deliver the Emergency Care Standard	16 (high)	Agreement of a trajectory for 18/19 Further work with partners on system resilience	12 (moderate)
Failure to deliver the cancer or elective RTT standards	12 (moderate)	Agreement of trajectories for 18/19 Agreement of an activity plan which supports delivery	8 (moderate)
Late or only partial impact of the STP leading to pressure on Trust services	16 (high)	Provision of system leadership and support to developing schemes	12 (moderate)

5. OPERATIONAL PLAN SIGN OFF

Further refinement of the Operational Plan 2018/19 will be undertaken during March/early April 2018. Members of the Board are asked to review the draft and provide feedback on the content.

The planning guidance indicates that final Board-approved Operational Plans must be submitted to NHSE/NHSI by 30 April 2018. The Board is asked to consider the approach to be taken for signing off the final version of the Operational Plan.

6. RECOMMENDATIONS

The Trust Board is asked to review the Draft Operational Plan 2018/19 and:

i. Provide feedback on its contents
ii. Confirm the approach for signing off the final version of the Operational Plan.

Lee Bond	**Jacqueline Myers**
Chief Financial Officer	**Director of Strategy and Planning**

05 March 2018

NHS
Hull and East
Yorkshire Hospitals
NHS Trust
OPERATIONAL
PLAN
2018/19
Remarkable people.
Extraordinary place.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

OPERATIONAL PLAN 2018/19

1. INTRODUCTION

Hull and East Yorkshire Hospitals NHS Trust (HEY Trust) is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. The Trust employs 7,618 WTE staff (March 2018), has an annual turnover of £573m (2017/18) and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

2. VISION, VALUES AND GOALS

Our vision is *'Great Staff, Great Care, Great Future'*, as we believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community.

We have developed a set of organisational values - *'Care, Honesty, Accountability'* - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2016-2021.

3. LOCAL HEALTH AND CARE SYSTEM

The local health system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

3.1 Humber Coast and Vale Sustainability and Transformation Partnership (STP)

The Humber Coast and Vale vision for 2021 is for a system that supports everyone to manage their own care better, reduces dependence on hospitals, and uses resources more efficiently. In order to realise this vision, the STP's key area of focus is the development of enhanced, integrated primary, community and social care at neighbourhood and 'place' level in communities of circa 50,000 people and within Local Authority, Clinical Commissioning Group (CCG) geographies such as Kingston Upon Hull and The East Riding of Yorkshire.

The Trust's role in delivering this plan is to work openly and collaboratively with partners to support the development of new models of care and the closer integration of health and social care services.

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The Trust is also supporting two reviews of acute or secondary care, one across the Humber region and one across the York and Scarborough areas. The Trust is working closely with local partners on the Humber Acute Services Review to identify opportunities for collaboration and joint working, in particular with colleagues from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG).

3.2 Commissioning Intentions of Hull and East Riding CCGs

The commissioning intentions of both Hull and East Riding of Yorkshire CCGs have been developed in response to the challenges arising from an ageing population, an increase in the number of people living with multiple long-term conditions and the need to address local health inequalities. They also incorporate the priorities for improvement within the Humber Coast and Vale STP.

During 2018/19, Hull and East Riding CCGs will continue to build on the Commissioning Intentions for 2017/18 and to work collaboratively within the STP to commission and work with all partner agencies across health and social care.

The CCGs acknowledge the success and opportunities achieved from the Aligned Incentive Contract agreed in 2017/18 and wish to continue to commission and support new models of service delivery. The focus in 2018/19 will include:

- Reduction in healthcare acquired infections
- Reduction in community-based pressure ulcers
- Right care developments in Dermatology, Respiratory Medicine, Musculoskeletal Services and Cardiology
- Promotion of self-management
- Development of the Frailty pathway
- Mental Health
- Sustainable finances.

4. ACTIVITY PLANNING AND SERVICE DEVELOPMENTS

4.1 Capacity and Demand

The Trust has developed its workload forecasts and service delivery plans for 2018/19 using recognised capacity and demand models. The Trust's plans for the current financial year anticipated additional capacity being deployed in a number of service areas. In some of these areas the deployment of the additional capacity has been delayed, primarily due to problems in recruiting new members of staff. This has affected the achievement of elective workload targets. As a consequence waiting list backlogs in some specialties are still significantly above NHS Intensive Support Team recommended levels.

There is a significant gap between current capacity and the activity levels needed to clear backlogs and sustain delivery of waiting time thresholds. The Trust's commissioners are unable to commission the level of additional activity required due to income constraints. The Trust will therefore continue to work to increase productivity and to redesign pathways to drive improvement against the waiting time thresholds and within these constraints.

4.2 Activity Plan

As outlined in 3.2 above, in 2017/18 the Trust agreed an Aligned Incentive Contract (AIC) with Hull and East Riding Clinical Commissioning Groups for a two year period. This marked a fundamental change from an organisational-based contract to a system contract with shared risk, shared opportunity and shared vision. It provides all parties with a common goal: the effective management of patient pathways irrespective of organisational boundaries.

The Aligned Incentive Contract provides:

- a move away from the standard Payment By Results (PbR) contract
- a fixed value contract
- commitment to system-wide improvement

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- incentives to reducing activity
- joint responsibility – ensuring patients receive the right care in the right setting as efficiently as possible
- a single monitoring system
- a revised governance structure.

The benefits of the AIC are:

- place-based, system working
- equitable contracting arrangements and allocation of resource
- a focus on value-cost, efficiency and effectiveness
- a refocus of transactional to transformational
- contracts that enable transformation – to provide clinical and financial sustainability
- transparent working
- collaboration – risk sharing, joint planning, joint Quality, Innovation, Productivity and Prevention (QIPP) programmes.

Negotiations are being finalised with the Hull and East Riding CCGs regarding Year 2 of the AIC contract to take account of activity changes, including:

- increased Ophthalmology activity (Wet AMD injections)
- introduction of a new Dermatology provider for East Riding CCG which is expected to result in a 65% reduction in outpatient activity provided by the Trust in 2018/19.

The smaller CCG contracts are also being refreshed based on forecast outturn activity levels in the main, plus 1% for inflationary pressures and 1% growth in non-elective activity. Some activity growth is incorporated in the North Lincolnshire and North East Lincolnshire contracts to reflect a transfer of Clinical Haematology day case activity of circa 320 cases to this Trust from North Lincolnshire and Goole NHS Foundation Trust (NLAG).

The Trust would expect the Specialist Commissioning contract to be uplifted to reflect outturn activity plus growth in pass through drugs to reflect new NICE guidance and growth in elective activity for Cardiothoracic Surgery and Neurosurgery. However, at a recent meeting, it was clear that this is not affordable and NHS England has indicated that a higher level of QIPP would be required to negate this growth. The QIPP schemes shared to date are £3million and mainly relate to expected savings from generic drugs.

The deadline for concluding contract settlements for 2018/19 is 23 March 2018 and there is currently no indication to suggest any risks in meeting this deadline.

4.3 Service Developments and Transformational Change

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced. Across all departments operational arrangements are being systematically reviewed and revised in order to maximise productivity and contribute to the achievement of cash releasing efficiency savings. Each Health Group has drawn up an integrated programme of service developments that will deliver significant safety, quality and financial benefits, aligned to the delivery of the Humber Coast and Vale STP. These service developments include:

Surgical Services

- Development of a regional centre in conjunction with Sheffield Teaching Hospitals FT for the management of pancreatic cancer patients
- Continuing development of Endoscopy Services across the Trust to ensure sufficient capacity and facilities to retain JAG accreditation and provide Bowel Scope Screening for the extended population.
- Partnership working with NLAG and York FTs on the further development of Urology Services across the STP
- Development and upgrading of the Central Decontamination Unit.

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- Continued review and improvements to the productivity of Trust theatres.
- Implementation of Scan4 Safety within theatres.

➢ **Medical Services**
- Further development of Frailty Intervention model to deliver an extended service 7 days a week
- Working collaboratively with partners on the development of the Integrated Care Centre in Hull
- STP network development in Cardiology and Neurology
- Further development of the hyper acute stroke service to ensure compliance with best practice standards
- Decommissioning of the Brocklehurst Building at Hull Royal Infirmary and the relocation of the Diabetes, Endocrinology and Metabolic Bone Disease services to a new facility on the HRI site.

➢ **Family and Women's Services**
- Development of plans for the relocation and centralisation of paediatric services within the Women's and Children's Hospital
- Development of a Plastic Surgery Trauma Clinic at Hull Royal Infirmary with improved links to the Emergency Department
- Development of Head and Neck Services in partnership with NLAG
- Review of Paediatric and Neonatal Surgery.

➢ **Clinical Support Services**
- Development of rotational therapy posts between local providers to ensure best use of resources, greater understanding across organisational boundaries and to reduce competition for staff recruitment between providers
- Work with partners to identify opportunities to consolidate specialist pathology services within the Trust, in particular virology, molecular diagnostics and immunology.
- Participate in the procurement of a regional digital pathology system incorporating the acquisition, management, sharing and interpretation of pathology information.
- Consolidation of HEY and NLAG Haematology Service, and collaboration with NHS England on the development of a longer term model for Haematology services across the STP
- Development of an ambulatory chemotherapy service and walk in assessment area at Castle Hill Hospital
- Effective procurement and commissioning of replacement Radiology and Radiotherapy equipment.
- Development of a service model for Mechanical Thrombectomy for hyper acute stroke.

The Trust has an established Improvement Programme, with Director level leadership and dedicated project management resource, to drive service changes forward at scale and pace. The Improvement Programme is currently focussing on theatre efficiency, outpatient services and improving hospital discharge.

4.4 Winter Plan

As in previous years, the Trust will seek to continually strengthen both its internal arrangements for the management of Winter Pressures and to work with local providers and commissioners across health and social care to ensure a robust and comprehensive system response. Provision for a range of enhanced resources in winter, including increased acute medical bed capacity, is built into our operational plans.

The Trust's escalation and response arrangements are in line with the national Operational Pressures Escalation Levels (OPEL) Framework.

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For Winter 2017/18 the Trust created additional medical capacity of 27 beds (winter ward) through reduction in elective surgical capacity and redeployment of nursing resource. Additional physiotherapy, occupational therapy, radiology, pharmacy and pathology support was put in place to support timely patient flow and discharge. These initiatives have been built into our plan on a recurrent basis and will therefore be reinstated for Winter 2018/19.

The enhanced patient flow management model is led by a Director of the Day, supported by a General Manager of the Day. In addition the Trust has a site Management Team.

A lesson learnt event is undertaken each Spring and adjustments made to the Winter Plan as appropriate.

4.5 Urgent Care Developments in the Local Health Economy

The Trust is working with local commissioners, health and social care providers to achieve greater integration and redesign of urgent care in the local health economy. Locally, all parties have responded to the national initiatives under the Integrated Urgent Care Strategy.

Urgent Care teams continue to work together in:

- Development of the Integrated Care Centre in Hull which will deliver specialist care, better management of long term conditions and services for frail, elderly patients.
- Supporting Hull and East Riding CCGs in their plans to reconfigure and enhance urgent care treatment centres.
- Supporting City Health Care Partnership CIC in the delivery of community health services in Hull and the East Riding of Yorkshire.
- Continuing to develop an integrated Emergency Department minor illness/injuries service provided through a multi-disciplinary team, including acute, primary and community care specialists.

5. QUALITY

The provision of high quality care is the top priority for the Trust. Over the next five years we will deliver ambitious and significant improvements in the quality of our care in the areas of concern highlighted by our patients, staff and partners.

5.1 The Trust's Approach to Quality

The Chief Medical Officer has the Executive Lead responsibility for Quality within the Trust.

The Trust's Strategy has a stated aim of achieving a CQC rating of 'Good' or better. It sets out the organisation's long term goals and is supported by an implementation plan and three further underpinning strategies - the Trust's People Strategy 2016-18, Estates Strategy 2017-2022 and Digital Strategy 2018-2023. Delivery of the whole of this agenda will support collectively the achievement of improved CQC ratings.

5.2 Quality Improvement Method and Governance Arrangements

The Trust has developed its improvement approach based on the NHS Change Model and with support from the NHS Advancing Change Team and the Yorkshire and Humber Academic Health Sciences Network (AHSN).

The Trust has also created a comprehensive Improvement Programme which aims to facilitate the delivery of large scale programmes of improvement and to develop the Trust's capability and capacity for continuous improvement.

The Trust promotes a multi-disciplinary approach to improvement and has created a single quality and service improvement training package. Our approach involves front line staff leading change through engagement, small scale testing, measurement of impact and sharing successes for wider adoption. They are supported by the Trust's HEY Improvement Team who are accredited AHSN 'Gold' Improvement trainers.

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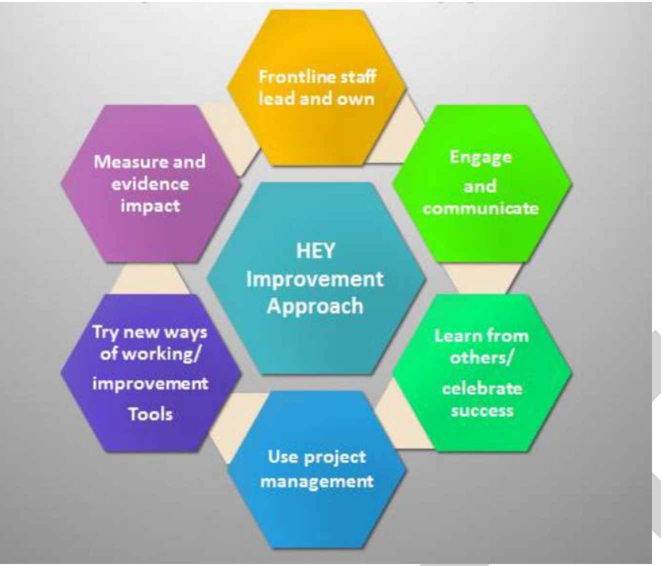

The Trust has developed a suite of improvement techniques, tools and project management documentation to ensure a consistent approach to improvement across the organisation.

Trust Improvement Programmes are supported by the Trust Programme Management Office and are governed by the HEY Improvement Programme Board, which is the Executive Management Committee in session, with the addition of the Improvement Programme Director, Lead Clinician and the Sponsor of each live programme. The purpose of the Programme Board is to approve programme charters, which cover the aims, stakeholders and measures of success, allocate PMO resource and then oversee the delivery of programmes, helping to unblock difficulties and challenge the project teams to achieve. Each programme or project has a steering group and provides a regular progress report to the Programme Board.

Each Health Group has its own monthly Health Group Board and sub-Divisional Boards, which consider quality performance and quality priorities within their specific services/groupings.

At corporate level, there are a number of mechanisms that provide governance and assurance with regard to the Trust's quality performance. The Chief Nurse chairs the monthly Operational Quality Committee, which includes the membership of the Chief Medical Officer, Deputy CMO, Chief Pharmacist, Deputy Director of Quality Governance and Assurance, Assistant Chief Nurses, the risk team, and senior clinical members of each Health Group. This meeting considers all of the key quality priorities for the organisation and seeks assurance and evidence in relation to their delivery.

The Operational Quality Committee provides matters for escalation and communication to the Trust's Executive Management Committee (EMC), which is chaired by the Chief Executive and comprises membership of the corporate executive directors and health group medical, nursing and operations directors. The chair of the Trust's Patients' Council is a member of this committee also, and presents an independent challenge from a patient's/service user perspective.

The Operational Quality Committee also reports to the Trust's Quality Committee, which is a committee of the Trust Board. This is chaired by a non-executive director (NED) and comprises membership of two additional NEDs, the Chief Nurse, Chief Medical Officer, Chief Pharmacist and Deputy Director of Quality Governance and Assurance. This committee seeks assurance on behalf of the Trust Board on key areas of quality performance and concerns.

5.3 Strengthening the Trust's Ability to Manage Quality and Safety

In order to enhance the organisation's ability to manage quality and safety, the Trust has:

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- A corporate quality governance and assurance team;
- A dedicated Improvement Team that supports the delivery of improvement projects, utilising quality improvement and project management expertise;
- appointed a Deputy Chief Medical Officer (Quality) to work directly with the clinical teams;
- reviewed the nursing structure and established four Quality Matron posts, one for each Health Group;
- Created a Deputy Director post for Quality Assurance and Governance. The clinical governance structure, including the role of the Quality Safety Managers, has been reviewed to ensure that their work is aligned to the Trust's quality priorities.
- Appointed to a new post of Clinical Outcomes Manager with the remit to develop a structured case note review process for implementation across the organisation.

The Trust will assess the impact of the additional investment in quality improvement through the Trust's Integrated Performance Report and associated Board reports which include data in the quality KPIs (safety thermometer results, hospital acquired infection rates, etc), waiting time and access thresholds, serious incidents, nurse staffing levels, Friends and Family survey results.

5.4 Quality Priorities 2017/18

The Trust consulted widely on its quality and safety improvement priorities for 2017/18. These are:

- Reduce and eliminate avoidable infections
- Prevent all patients developing pressure ulcers
- Assess all patient nutrition and hydration requirements
- Assess all patients for venous thromboembolism
- Reduce the number of patient falls
- Ensure our patients receive the right medicines, at the right dose, at the right time
- Identify and treat patients with sepsis
- Complete equipment and safety checklists
- Act quickly on patient complaints
- Improve the safeguarding arrangements for Adults and Children
- Reduce all avoidable deaths
- Ensure we have a culture of learning lessons
- Improve facilities and pathways for children and young people
- Improve the care of dementia patients
- Ensure Critical Care is fully staffed with correct skill mix
- Provide better care for patients who are unable to make or express choices
- Standardise consent forms and have robust governance in place
- Deliver more consistent and better outpatient services

The Trust's Quality Accounts 2016/17 set out in detail the actions that the Trust will take to achieve its quality priorities, the measures for success and the arrangements for monitoring and reporting on progress.

5.5 Quality Improvement Plan

The Trust received a comprehensive inspection by the Care Quality Commission (CQC) in February 2014. A follow up inspection was undertaken in May 2015 in response to concerns that had been identified in 2014 and subsequently. The 2015 inspection report was published in October 2015, with the Trust receiving an overall rating of 'Requires improvement'.

A further comprehensive inspection was undertaken by the CQC in June 2016. Whilst it was acknowledged that the Trust had made improvements since the last inspection, these were not significant enough to change the rating for the Trust as a whole. The Trust therefore retained its 'Requires improvement' rating.

The CQC undertook a Well-Led Inspection of the Trust on 27 February – 1 March 2018. Feedback on the inspection is awaited.

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In response to previous CQC inspections, the Trust developed an overarching and integrated Quality Improvement Plan which brought together all of the Trust's key quality priorities and required actions. This is a dynamic document that is reviewed and updated monthly. A copy of the Quality Improvement Plan 2017/18 is attached as an appendix which contains the details of the priorities.

In addition to the actions outlined within the Quality Improvement Plan, the Trust is taking steps to address a number of other local and national quality initiatives:

- National Clinical Audits – During 2016/17, the Trust participated in 42 clinical audits and 5 national confidential enquiries. The data submission rates and outcomes of the audits are reported in the Quality Accounts.
- Compliance with the four priority Clinical Standards for Seven Day Hospital Services – The Trust has undertaken a stocktake of progress against compliance with the four priority standards and is working to achieve full compliance by March 2018.

Standard	Compliance	Actions to address
Standard 2 Time to First Consultant Review	Partial compliance	Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system.
Standard 5 Diagnostic Services	Partial compliance (critical and urgent care times met, only partially compliant for non-urgent patients)	Recruitment to vacant posts and review of staffing rotas to enable extension of diagnostic services.
Standard 6 Consultant-directed interventions	Fully compliant	
Standard 8 Ongoing review	Partial compliance	Review of medical staffing resource in key areas, including recruitment to vacant posts and review of job plans.

- Safe Staffing – The Trust continues to meet the requirements of the National Quality Board, including the reporting to the Trust Board (each time it meets in public) on:
    - Planned versus actual fill rates
    - Average nurse/carer to patient ratios
    - High level quality indicators on each ward
    - Number of occasions when staffing levels deemed to be inadequate (red alerts)
    - Any areas of concern and the actions that are being taken to address these.

  The Trust undertakes twice-daily safety briefings, seven days a week. These are led by either a Nurse Director or Site Matron and review the nursing and midwifery staffing levels in all inpatient areas across the Trust including patient acuity and workload assessments. These ensure at least minimum safe staffing levels at all times.
- The Trust uses accredited tools to help determine the appropriate staffing level for each area. These include the Safer Nursing Care Tool (Shelford Tool) for adults', children's and critical care areas; Birth-Rate Plus for maternity, NICE for the Emergency Department and the College of Emergency Medicine's Guidance for Acute Assessment Units.
- Care Hours Per Patient Day (CHPPD) – The Trust is developing the use and reporting of the new CHPPD metric. This is now part of the functionality of the Trust's e-rostering software.
- Better Births Review – The Trust has agreed an action plan with commissioners and is working towards compliance with the recommendations of Better Births by 2020. Actions include enhancing continuity of care, better postnatal and perinatal mental health care, strengthening multi-professional working and ensuring systems are in place to enable effective working across organisational boundaries.
- End of Life Care – The Trust has implemented a series of measures to improve the provision of care and support for patients and their relatives. This includes:

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- Provision of ‘Sage and Thyme’ Communication Skills training. This is designed to train all grades of staff on how to listen and respond to patients or carers who are distressed or concerned.
    - Chief Nurse membership of the End of Life Steering Group.
    - Closer working between the Palliative Care Team and wider healthcare teams to improve patient care and achieve enhanced supportive care for advanced cancer patients.
- National CQUINs – Through achievement of the Trust’s quality priorities, Quality Improvement Plan, service developments, People Strategy and the initiatives outlined above, the Trust will seek to achieve compliance with the national CQUINs 2018/19, having successfully achieved all of the national CQUIN schemes in 2017/18. In 2018/19 CQUINs will include:
    - NHS Staff Health and Wellbeing
    - Preventing ill health by risky behaviour (smoking and alcohol)
    - Reducing the impact of serious infections
    - Improving services to people with mental health needs who present to the Emergency Department
    - Advice and guidance
    - E-Referrals.

5.6 Quality Impact Assessment

The Trust has identified a series of cost improvement schemes during 2018/19 based on external benchmarking information, operational productivity opportunities identified in the Lord Carter Review (2015) and our own identification of efficiency opportunities.

The Trust’s approach to Quality Impact Assessment (QIA) is based on guidance issued by the National Quality Board and CQC requirements. Our QIA policy and procedure was approved by the Executive Management Committee in July 2016 and refreshed in February 2018. It includes the requirement for completion of a standard QIA template. The Trust’s QIA process ensures that all cost improvement schemes are assessed in the context of patient safety, service effectiveness and patient experience. All associated risks are identified. Each cost improvement scheme has identified milestones and checkpoints where the quality impact is reassessed during implementation, with post-implementation reviews to ensure that no unintended quality impacts have materialised. The senior officer responsible for each cost improvement scheme is accountable for ensuring that a QIA is undertaken.

Any scheme at a value of £100k or less requires approval by the respective Health Group Medical Director, Nurse Director, Operations Director and Head of Finance. All schemes over £100k in value require final approval and authorisation by the Executive Directors: Chief Nurse, Chief Medical Officer, Chief Operating Officer and Chief Finance Officer (or Deputy).

Schemes greater than £100k are monitored via the Operational Quality Committee, Quality Committee and Trust Board.

5.7 Triangulation of Quality Indicators

The Trust works with neighbouring Trusts to improve the triangulation of intelligence in order to provide meaningful data and assurance or early warning of potential risk. The Trust has used three processes, these are:

- Production of CQC core service reports which triangulate information from the 5 domains in order to provide an overview of key issues and potential risks. This covers workforce and quality.
- Utilisation of the Health Foundation Framework for safety measurement and monitoring.
- Monitoring and sharing of intelligence at the monthly ‘CIRCLE’ Group (Clinical Incident Review Creating a Learning Environment) which is made up of senior staff from a wide variety of disciplines to review concerns and issues or potential issues identified through data analysis.

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The Trust also utilises an integrated performance dashboard approach to performance management which enables it to easily triangulate performance, quality, workforce and financial information to identify any areas of concern at an early stage.

Both the Quality Committee and the Performance and Finance Committee review the Integrated Performance Report (IPR) prior to its submission to the Trust Board. In addition to the IPR, the Trust Board also receives a Quality Report at each meeting in public, which provides them with further analysis on topics, such as:

- Patient safety matters, including an update on Never Events
- Healthcare Associated Infections
- Patient experience matters
- Other quality updates, such as progress against the Quality Improvement Plan
- Ward fundamental standards performance
- Mortality.

Through its programme of internal audits, the Trust seeks to ensure that key aspects of the quality agenda are operating at a local level within the organisation. Reviews include the HEY Safer Care Audit and the Fundamental Standards Audit. The outcomes of these audits are reported to the Audit Committee.

The Trust, represented by the Chief Nurse and Chief Medical Officer, meets monthly with its main commissioners to review quality and clinical governance performance and agree priorities for improvement.

6. WORKFORCE

The following table shows the original forecast establishment for 2017/18 and 2018/19 which was based on a 3% reduction in our establishment. In refreshing the plan for 2018/19, the actual establishment wte to March 2018 has been included. The variance between the original and refreshed plan to March 2019 is 201 wte and can be explained by an increase in establishment to support the ongoing development of the Lorenzo electronic patient record, expansion of services to improve patient pathways, increase the provision of services at weekends, and the introduction of new roles.

	Establishment WTE						
Staff Group	**2016/17**	**Planned 2017/18**	**Actual 2017/18**	**Variance 2017/18**	**Original Plan 2018/19**	**Refreshed Plan 2018/19**	**Variance 2018/19**
Nursing	**3130**	**3130**	**3052**	**-78**	**3130**	**3052**	**-78**
Of which are Registered Nursing	2140	2140	2111	-29	2140	2111	-29
Of which are Registered Midwife	175	175	184	9	175	184	9
Of which are Non Registered Nursing	815	815	757	-58	815	757	-58
Medical Staff Group	**1067**	**1037**	**1024**	**-13**	**1037**	**1028**	**-9**
Allied Health Professionals & Technical	**918**	**885**	**967**	**82**	**885**	**967**	**82**
Healthcare Scientists	**500**	**460**	**521**	**61**	**460**	**521**	**61**
Admin, Estates & Senior Managers	**1525**	**1419**	**1540**	**121**	**1419**	**1540**	**121**
Healthcare Assistants and Support Staff	**510**	**490**	**514**	**24**	**490**	**514**	**24**
Total	**7650**	**7421**	**7618**	**197**	**7421**	**7622**	**201**

The Staff in Post (wte) table overleaf shows the original plan for 2017/18 and 2018/19 compared to the actual position for 2017/18 and the refreshed 2018/19 plan. The variance between the original plan and refreshed plan is 107 wte.

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The Trust is making significant investment in its 'Remarkable People, Extraordinary Place' campaign to recruit to vacant posts, particularly in the hard-to-recruit-to staff groups. Our recruitment campaigns will undoubtedly enable the Trust to reduce its vacancy position, but given the national shortage for qualified staff, this will remain a significant challenge.

	Staff in Post WTE						
Staff Group	**2016/17**	**Planned 2017/18**	**Actual 2017/18**	**Variance 2017/18**	**Original Plan 2018/19**	**Refreshed Plan 2018/19**	**Variance 2018/19**
Nursing	**2970**	**3040**	**2984**	**-56**	**3040**	**3019**	**-21**
Of which are Registered Nursing	1982	2050	1992	**-58**	2050	2023	-27
Of which are Registered Midwife	173	175	160	**-15**	175	160	-15
Of which are Non Registered Nursing	815	815	832	**17**	815	836	21
Medical Staff Group	**973**	**1000**	**965**	**-35**	**1000**	**968**	**-32**
Allied Health Professionals & Technical	**842**	**860**	**876**	**16**	**860**	**890**	**30**
Healthcare Scientists	**419**	**440**	**436**	**-4**	**440**	**451**	**11**
Admin, Estates & Senior Managers	**1413**	**1419**	**1464**	**45**	**1419**	**1476**	**57**
Healthcare Assistants and Support Staff	**507**	**510**	**522**	**12**	**510**	**572**	**62**
Trust Total	**7124**	**7269**	**7247**	**-22**	**7269**	**7376**	**107**

6.1 Workforce Planning

The workforce planning framework and methodology used by the Trust is the Calderdale Framework which provides a systematic, objective method of reviewing skill, role and service design and is used to examine past trends, understand current and future challenges, and forecast future workforce needs. The Framework incorporates a clinical risk assessment.

The Trust's workforce planning is also informed by the ongoing review of clinical services, local population demographic change, commissioner intentions, capacity and demand modelling, strategic partnerships, the intelligence received from the Yorkshire and Humber workforce planning network, national policy and education and training establishments. Through the production of workforce plans and use of the intelligence data, opportunities for new roles will continue to be identified, including Apprenticeships, Nurse Associates, Advanced Clinical Practitioners and Physicians' Associates.

Activity, finance and workforce plans are developed at a service, divisional and Health Group level and are formally signed off by their respective management teams. The plans are validated by the corporate finance, planning and workforce teams to ensure that they are robust, aligned to the Trust's clinical and organisational strategies and comply with operational planning guidance. They are subject to a 'Confirm and Challenge' process with Executive Directors and support service leads before being signed off by the Executive Management Committee, Workforce Transformation Committee, Performance and Finance Committee and Trust Board. Performance monitoring is undertaken at each level of the organisation via the monthly performance management report.

6.2 People Strategy 2016-18

It is acknowledged that the shape of the organisation will change as we, with our STP partners, seek to deliver integrated, high quality care designed around patients' needs, in both the acute and community care settings. The Trust will require a workforce with the right knowledge and skills and which is able to adapt to new roles and ways of working, some of which will be across organisational boundaries.

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The Trust's focus will be on creating the right organisational culture where we operate as one team, with a clear set of values and objectives and where we can clearly hold one another to account in a positive and supportive way. A number of workstreams have been identified as part of the People Strategy 2016-18:

- Recruitment and retention
- Education and development
- Health and wellbeing
- Modernising the way we work.
- Leadership capacity and capability
- Equality and diversity
- Employee engagement and recognition

Progress against each of these workstreams is monitored by the Workforce Transformation Committee on a monthly basis. Reports are provided to the Executive Management Committee and Performance and Finance Committee on a quarterly basis.

6.3 Workforce Development – Humber Coast and Vale STP

The STP has a well-established Local Workforce Action Board (LWAB) to address the shortage and development of clinical and non-clinical staff within the Humber, Coast and Vale footprint. The two key initiatives being progressed at scale are:

- Support staff and development of an Excellence Centre to enable the system to attract and recruit more people to the health and social care sector and provide career and training information for partner organisations, staff and prospective staff.
- Advanced Practice – Develop advanced practitioners across the STP in acute, community, mental health and primary care.

6.4 Workforce Transformation

The Trust has in place a programme for the modernisation of back office functions. The principle drivers are consistent with the Lord Carter of Coles' recommendations, but there is recognition that we need to make better use of technology, seek to standardise wherever possible, and improve our business processes in order to move to a paperless environment. A number of projects are underway:

- Deployment of patient e-observations.
- Maximise the full benefits and complete the roll out of e-rostering across the Trust.
- Complete the roll out of e-job planning for Consultant staff.
- Improvement the management of our temporary workforce and expand internal bank arrangements
- Implement manager self-service so that end-to-end employment processes are fully automated.
- Continue to reduce time to recruit figures via the use of electronic recruitment systems across all staffing groups.
- Working with partner organisations to reduce duplication of corporate functions.

6.5 Management of Agency Staff

As identified above, the Trust has implemented e-rostering across the majority of wards and utilises the information provided by the system to monitor staffing levels, understand un-used hours and inform the allocation of permanent or bank staff to vacant shifts. Where shifts cannot be filled from the Nurse Bank, the Trust will look to appoint Agency staff via the approved framework agencies. All agency spend is authorised at Director level.

The Trust has a number of medical staff vacancies. Where it has not been possible to fill these with permanent staff, the Trust has sought to appointment suitably qualified staff on fixed term contracts or to provide cover from the Bank or internal locums. The Trust has a Temporary Worker (Agency) Policy which is adhered to and the Trust in on track, at Month 10, to reduce agency spend for 2017/18 by 20%.

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The Trust has developed and implemented several new roles to support clinical staff. These include the utilisation of non-registered staff to better support ward nursing teams, ie Recreational Assistants, Discharge Assistants and Nutritionists. Advanced Clinical Practitioners and Physician Associate roles are being implemented to supplement junior doctor staffing levels.

6.6 Impact of Workforce on Quality and Safety

The Trust has a series of workforce indicators which include sickness absence, turnover, appraisal, statutory/mandatory training, staff engagement and nursing/midwifery fill rates. Performance against these indicators are reported on a monthly basis to the Trust Board via the Integrated Performance Report which also provides the Board with updates on progress against KPIs for patient safety, clinical effectiveness, access and responsiveness and patient experience. The information on workforce within the Integrated Performance Report is supplemented by the monthly Nursing and Midwifery staffing report from the Chief Nurse.

Workforce issues and the potential impact on quality and safety are also monitored at a monthly meeting of the Chief Nurse and Director of Workforce. Action plans are developed to address any issues or risks identified. Health Groups and clinical leads monitor workforce issues on an ongoing basis. In addition, they review and re-submit their workforce risk registers every six months. This data informs the workforce returns for Health Education England and NHS Improvement.

Where service developments or transformational change programmes are likely to impact on the workforce, Health Group management teams are required to complete quality impact assessments which must be approved by the Health Group Board.

7. FINANCIAL PLAN

7.1 Reported 2017/18 Financial Performance

As at Month 10 2017/18 the Trust is forecasting a revised deficit position of £15m which is a £3.5m variance from the original planned deficit of £11.5m excluding receipt of Sustainability and Transformation Funding (STF).

This forecast financial position requires the use of all of the Trust's reserves, as well as a number of non-recurrent actions. The overall underlying deficit position is currently assessed as £25.9m before any inflationary adjustments relating to 2018/19. This underlying deficit has had a significant impact on the plans for 2018/19 in terms of both the revenue and capital positions.

7.2 Control Total 2018/19

The Trust has received notification of its revised control total for 2018/19 which is summarised below:

	£000s	
Original Control Total 2018-19	5,595	Surplus
CNST Gain	4,425	From income and reduced charges
National Risk Reserve	-1,309	
Increase in STF Funding	4,848	
Revised Control Total	**13,559**	**Surplus**
STF Funding	16,781	
Control Total excluding STF	**-3,222**	**Deficit**

This control total seeks to deliver some progress with financial recovery and compared with the 2017/18 control total of £11.5m deficit (excluding STF), this would deliver an improvement of £8.3m, for which £4.4m is from CNS, leaving £3.9m additional improvement required. However, as the Trust is not currently delivering its 2017/18 control total, this should be considered against the Trust's underlying financial position and scale of efficiency savings required if this was to be achieved.

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7.3 Efficiency Requirement

To achieve the control total for 2018/19 the Trust would be required to deliver a £26.9m CRES programme in 2018/19.

The latest financial modelling has assumed a target of 3% of turnover (which is at the lower end of NHSI expectations and the national position on CRES delivery in 2017/18). This equates to a 3.6% target for Health Groups compared to their underlying position. This would deliver £17m of savings and would allow vacancy factors to contribute to this target, where appropriate, which could be at least £2m. In addition, the CRES risk reserve has been reinstated to £2.5m to mitigate against any slippage.

The overall shortfall against the Trust's control total is therefore circa £10m (£26.9m less £17m) which is a £13.1m deficit overall. At this stage, there are no definitive plans to address the scale of the gap.

7.4 Income and Expenditure

The Trust has made some initial assumptions with regard to the levels of income and expenditure in 2018/19.

	Indicative Annual Budget £000
Total Income	**565,874**
Total Operating Expenditure	**(523,756)**
Donated asset income	(3,600)
EBITDA	**38,518**
Total non-operating expenditure	**(25,418)**
Net surplus/Deficit	**16,700**
Donated Asset Adjustment	(3,141)
Adjusted Financial performance	**13,559**
Excl STF	**(3,222)**

These assumptions will be refined further as the contract negotiations with commissioners are progressed.

The Trust has identified some potential opportunities that could provide some financial benefit in 2018/19, including the potential establishment of a Special Purpose Vehicle (SPV) to trade the estates service provision, and the revaluation of Trust land. Together these two opportunities could yield technical accounting gains of between £5m and £10m. Further work is to be undertaken to assess the feasibility and financial opportunity of these options.

7.5 Cash Releasing Efficiency Savings

As identified in Section 7.3 above, the Trust has identified a CRES target of £26.9m for 2018/19.

7.5.1 Delivery, Monitoring and Reporting

The Trust has a performance management process which includes monthly meetings between the Health Group Triumvirates and Trust Executives. These ensure that delivery of objectives remains on track as far as possible and risks to the Trust's objectives are identified and managed effectively. These meetings also help to identify resource gaps within the Health Groups, working with them to source additional capacity to facilitate successful delivery of the various work streams as required. Health Groups who are failing to achieve in a key area of their plan are moved into a more intensive performance regime, with additional meetings with the relevant Director (in the case of CRES with the Chief Finance and Operating Officers).

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To specifically support the development and delivery of financial sustainability, a Productivity and Efficiency Committee has been formed. This works with the Health Groups to draw on new ideas and evidence, to challenge each other to create new schemes and monitors delivery.

A Patient Safety and Quality Report is produced by the Business Intelligence Team for all Health Groups on a monthly basis. The report contains a comprehensive suite of indicators on clinical quality and patient safety matters within their service areas.

7.5.2 CRES Plans 2018/19

Key delivery areas are:

- Transforming clinical pathways to drive improved clinical quality, outcomes and patient experience, enabling effective rationalisation of the Trust estate and its supporting services;
- Pathway transformation, length of stay improvement, increasing ambulatory care services and re-alignment of services across sites and across the health community to improve bed usage;
- Maximise the efficiency and effectiveness of theatres, outpatient services and clinical support services;
- Reducing total workforce costs through workforce transformation, role design, improved productivity, minimising variable pay spend;
- Reducing the cost of goods and services and delivering better value for money;
- Improving back office processes, thereby reducing the cost of these services;
- Use of technology as an enabler to increasing clinical productivity, enhancing clinical quality, improving operational effectiveness, reducing administrative overheads and supporting workforce transformation.
- Reduction in levels of agency usage to stay within cap levels.

Further work is being undertaken to develop the programme. At this stage there is a significant level of unidentified CRES which contributes to the risk with regard to the deliverability of the control total.

7.6 Capital Programme

The development of the Trust's Capital Programme is based on assessments received and reviewed at the Capital Resource Allocation Committee (CRAC). These assessments were developed on the basis of "do minimum" and were presented to the Trust's Performance and Finance Committee in October 2017. They included:

- Equipment replacement but with no provision for expansion (estimated cost of £30m over the next 3 years)
- Replacement of the existing IT network and essential system replacements to meet nationally mandated timescales for system architecture and capability (estimated cost of £13m over the next three years)
- A backlog maintenance investment programme which would bring the condition of the Trust's estate to Condition B over 10 years (estimated cost of £7m per year)

Over the 3 year period capital investment totalling £64m was identified.

A further £13.7m has been identified for investment in energy efficient heating and lighting infrastructure which will generate significant revenue benefit for the Trust. It is hoped that this will be funded by a specific loan from the Department of Health. This is profiled for £11.2m in 2018/19 and £2.5m in 2019/20.

More recently, the Trust has also received an enforcement notice from Humberside Fire and Rescue on the back of the Grenfell review, with estimated costs of £4.5m. An application for emergency Public Dividend Capital (PDC) is currently being progressed so that this work can be addressed urgently.

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The Capital Programme 2018/19 totals £29m and will be funded predominantly through depreciation with some additional schemes funded from charitable donations, PDC funding and new capital loans. In addition to depreciation funding the Trust has the ability to generate capital receipts from the sale of surplus land, particularly at Castle Hill Hospital. Phase 1 of this is currently being finalised and it is hoped that Phase 2 will become a reality over the course of this period.

The Trust has a pre-commitment on its depreciation funding as it must first service the Trust's existing long term debt commitments (a combination of long term loans and Private Finance Initiative (PFI) contracts). This is expected to cost £5.1m in 2018/19.

The following table sets out at a summary level the anticipated source and applications of Capital for 2018/19. This also shows whether the source of funding is the Trust's internally generated funds or items expected to be funded externally.

	£m	£m	£m
Resources:	**Internal**	**External**	**Total**
Depreciation	12.8		12.8
Donated Assets		3.6	3.6
Loan Funding		11.2	11.2
PDC Allocation (Linear Accelerators & Digital Slide Scanners)		2.0	2.0
PDC Allocation Fire Safety		4.5	4.5
	12.8	**21.3**	**34.1**
Less Required Financing Commitments:			
Loan Repayments	-1.8		-1.8
PFI & Finance Lease Liabilities	-3.3		-3.3
Subtotal Capital Resources Available	**7.7**	**21.3**	**29.0**
Capital Programme			
Energy Scheme		11.2	11.2
Fire Safety		4.5	4.5
Backlog Maintenance & Compliance	2.1		2.1
IM& T	2.2		2.2
Medical & Scientific Equipment	2.3	0.2	2.6
Linear Accelerator		1.7	1.7
Donated Assets - Brocklehurst Reprovision		3.0	3
Donated Assets - Other		0.6	0.6
Other	1.1		1.1
			0
Total Capital Programme	**7.7**	**21.3**	**29.0**

The table shows the Trust has internal sources of funding totalling approximately £7.7m to use for capital expenditure in 2018/19. Over a 3 year period this equates to circa £23.1m of funding versus a requirement for £64m, a funding shortfall of £40.9m over the period.

In 2018/19 the risk assessed minimum capital investment required from internal sources of funding is £23m in 2018/19, a shortfall of £15m against current resources. There is insufficient capital available to meet the requirements needed. The programme does not provide for any developments or expansions in capacity and with regards to imaging service capacity in particular, this poses a significant risk to service delivery and transformation.

The table below summarises the high risk areas that make up the additional £15.2m capital investment required. These are NOT included in the main capital programme for 2018/2019. It is essential that the Trust starts to make some inroads into its backlog maintenance issues. The schemes for 2018/19 all provide essential support to the provision of clinical services at the Hull Royal Infirmary with Theatre replacement, ward upgrade programme and urgent replacement of the Trust's IT network all starting to be addressed in this plan. Failure of any

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part of this infrastructure would be critical for the Trust and is reflected as a high risk on the Trust's Risk Register and Board Assurance Framework.

High Risk Areas needing Capital Investment	**£m**
Buildings Maintenance & Compliance:	
Theatre Upgrade Phase 1	3.0
Ward Upgrade x2	1.2
Lift B	0.3
Essential road repairs	0.4
Other	0.6
IM&T:	
Network Servers/System replacements	0.9
Lorenzo ePMA/Theatres	0.5
Data Centre, servers, Eobs	0.4
Medical & Scientific Equipment:	
Gamma Camera	1.4
CT Replacements	1.3
Ultrasounds	0.5
Haemodynamic equipment	0.4
Aria Upgrade	0.3
Endoscope replacements	0.3
Other planned replacements	2.3
Theatre Stack 7	0.4
General X Ray	1.0
Total High Risk Capital Investment requirements	**15.2**

In order to fund this capital investment the Trust would need to apply for capital loan funding. This is not currently included within the financial plans for 2018/19. NHS Improvement are aware of the issues faced by the Trust and discussions are taking place with them with regard to the Trust's ability to realise the land sale receipts and to secure loan funding to underwrite the Trust's 3 year capital programme.

8. RISKS TO DELIVERY

The Trust has undertaken an assessment of the risks to delivery of its operating plan and identified, where possible, mitigating actions. A standard risk matrix was used to assess likelihood of occurrence and severity of impact. Risk scores can range from 1 (very low risk) to 25 (high risk).

Risk	Score	Mitigating Action	New Score
Failure of the proposed local QIPP schemes to reduce activity as intended	12 (moderate)	Work closely with commissioners on implementation plans and monitor closely Continue to work together to develop further schemes to manage elective and non-elective demand	8 (moderate)
Inability to identify and deliver sufficient efficiency savings	20 (high)	Ongoing work with Health Groups and Corporate teams to identify schemes	12 (moderate)
Insufficient capital availability to deliver safe levels of investment in estate and IT infrastructure and equipment replacement	12 (moderate)	Agreement of safest balance of spend within tight budget and exploration of alternative sources of investment	8 (moderate)

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Risk	Score	Mitigating Action	New Score
Insufficient cash liquidity	15 (high)	Access working capital loans	8 (moderate)
Failure to appoint to essential posts and breaching of the Trust's agency spend cap	12 (moderate)	Recruitment campaigns utilising successful Trust brand Development of alternative staffing models Tight control of authorisation	8 (moderate)
Failure to deliver the Emergency Care Standard	16 (high)	Agreement of a trajectory for 18/19 Further work with partners on system resilience	12 (moderate)
Failure to deliver the cancer or elective RTT standards	12 (moderate)	Agreement of trajectories for 18/19 Agreement of an activity plan which supports delivery	8 (moderate)
Late or only partial impact of the STP leading to pressure on Trust services	16 (high)	Provision of system leadership and support to developing schemes	12 (moderate)

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Quality Improvement Overview Plan 2017-18

Introduction

The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey HEY is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts and our Sign Up to Safety Pledges.

The plan outlines the trust's overall ambition to meets its vision of Great Staff, Great Care, Great Future. It is therefore not the intention that the improvement goals will all be achieved by March 18 but rather significant progress can be demonstrated against all of them. The plan includes a number of key milestones and these will be reported on at the monthly Operational Quality Committee. The milestone dates are all the end of the month unless a specific date is recorded. The Plan will be reviewed and refreshed at the end of the financial year.

A separate monthly progress report will be produced to demonstrate progress against milestones and improvement goals.

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
Safety	QIP02	**Learning Lessons** *The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry.* *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.*	Change in cultural of learning organisation as defined by improvements in cultural surveys	Baseline for cultural surveys defined Improvement by year end against baseline culture survey	No baseline	All 2017-18 QIPs linked to QIP02 Learning Lessons Support to be received from Improvement Academy via Measuring & Monitoring Safety Framework (MMSF)	Chief Medical Officer (Kevin Philips)	Risk Manager (April Daniel)	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **April 2017** 1st Improvement Academy workshop completed – **April 2017** Project areas (wards) determined for MMSF – **April 2017** Project areas (wards) behaviour and cultural survey completed – **April 2017** Behaviour and cultural surveys analysed and next steps determined – **May 2017** 2nd Improvement Academy Workshop Completed – **May 2017** CIRCLE group re-launch – **May 2017** Datix amended to include contributory factors which will be sued for themes and trends analysis – **May**	In-house investigation training package developed (RCA) – **August 2017** Quality dashboard revised and launched – **August 2017** Regional learning event with Improvement Academy held – **September 2017** Re-launch of Sign Up to Safety – **September 2017** Sharing the Learning Events held – **September 2017**	Quality Improvement Framework for 2017-18 completed – **March 2018** Project areas (wards) behaviour and cultural survey completed – **March 2018**

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									2017 Quality improvement training programme defined – **June 2017** Quality Improvement Framework / Strategy developed – **June 2017** Kitchen Table Event held (including Quality Accounts and Sign Up to Safety) – **June 2017** 3rd Improvement Academy Workshop Completed – **June 2017**		
Safety	QIP04	**Safeguarding, MCA and DoLs** *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.* *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.*	Robust, safe and effective safeguarding arrangements for adults and children.	Full implementation of improvement plan	Partially delivered	CQC Actions	Chief Nurse (Mike Wright)	Assistant Chief Nurse (Kate Rudston)	Allegations against Staff for adult and children and young people policy developed and approved – **April 2017** Chaperone Policy reviewed, revised and updated – **April 2017** Adults at risk of suicide policy developed and approved – **April 2017** Absconding Children and Young People and Adults with lack of mental capacity policy developed and approved – **April 2017** End of Life Policy reviewed with a view to add a section on patients with Dementia and Learning Disabilities – **May 2017** Allegations against Staff for adult and children	Implementation of the improved recording and reporting of all patients detained under the Mental Health Act monitored and further action taken where appropriate – **August 2017** ED staff to use safeguarding sheets (purple edge) for all children who have suspected NAI and safeguarding concerns – **September 2017** 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 – **September 2017**	Action plan from the CQC looked after children review delivered – **March 2018**

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									and young people implemented - **May 2017** Revised Chaperone Policy implemented - **May 2017** Adults at risk of suicide policy implemented – **May 2017** Absconding Children and Young People and Adults with lack of mental capacity policy implemented - **May 2017** Revised End of Life Policy implemented – **June 2017** Safe room in the Medical Assessment Unit created – **June 2017** 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 – **June 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **July 2017** A protocol for transfer of care and clear process for staff to		

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									follow for delays in children receiving full medical examination following admission to Childrens wards implemented – **July 2017**		
Safety	QIP05	**Medicines Management** *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.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment (12.2.G – the proper and safe management of medicines).*	Provide a multi-disciplinary, person centred approach to ensuring that patients receive the right medicines, the right dose at the right time.	Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hours Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time 10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy – reduce to >1hour 33 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	46% 81% 1 hour 43 minutes No baseline	Quality Accounts, Sign Up to Safety and CQC Actions	Chief Medical Officer (Kevin Phillips)	Chief Pharmacist (David Corral)	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 – **April 2017** Medicine management clinical audit plan delivered – **June 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **June 2017** Content and monitoring systems for nurses medicines management training approved – **July 2017** Trust Discharge policy reviewed and updated – **July 2017**	Medication processes at discharge reviewed – **September 2017** Electronic prescribing on ward 29 at Queens Centre introduced – **September 2017** 'safety net' system introduced to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled – **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 – **October 2017** Reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time – **October 2017** Trial to identify patients who have been admitted for <20 hours so pharmacy teams can target for medicines reconciliation completed – **October 2017** Discharge bundle approved	Reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs achieved - **March 2018** Project to increase the use of patient's own drugs be undertaken on selected wards – **March 2018** Dispensing errors reduced – improved environment – **March 2018** Trial of Pharmacists prescribing discharge medication completed – **March 2018**

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	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
										and implemented – **December 2017** Ratification of Trust Discharge Policy – **December 2017**	
Safety	QIP06	**Deteriorating Patient Adult** *NICE Guidance (CG50) requires that physiological observations are carried out in all hospital settings and that the deteriorating patient is recognised and escalated in a timely and appropriate manner. A Trust audit highlighted significant shortfalls in clinical observation competencies and knowledge around undertaking clinical observations and some weakness around fluid balance recording. Furthermore, a number of Serious Incidents during 2015-16 and 2016-17 identified the deteriorating patient as an issue.* *The aim of this QIP is to ensure that all Registered Nurses have undertaken both the NEW's on-line training and have been assessed as competent to complete Clinical observations on patients and can demonstrate an awareness of the importance of accurate fluid balance recording.*	Ensure that patients are not harmed from failure to escalate incidents	95% compliance for all relevant and available staff with combined NEWS training (on-line) and Observation Competency Completion Reduction in failure to escalate Incidents – 12 or below	No baseline 13	CQC Actions	Chief Nurse (Mike Wright)	Outreach Lead (Vicky Kirkby)		Review of all deteriorating patient incidents within the last 12 months completed including cleansing of information – **September 2017** System developed for deteriorating leads to review all failure to escalate categorised incidents – **September 2017** Ratification of Deteriorating Patient Policy (CP326) – **September 2017** Baseline figures gathered and validated for levels of training compliance with observations – **October 2017**	Outreach link established for each ward – **January 2018** NEWS eLearning and completion of observation competencies launched – **March 2018** Monthly spot check audits of the NEWS charts completed by the Outreach Team – **March 2018** Any lessons to learn from audit fed back to the ward for action and support from Outreach if indicated – **March 2018** Outreach Lead Nurse to be involved with serious incidents review panel to identify lessons learned and improvement area for focus work – **March 2018**
Safety	QIP08	**Infection Control** *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.*	Ensure the Organisations compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) and reduce the number of	To have 0 Hospital acquired MRSA bacteraemia To reduce the number of Hospital acquired Clostridium Difficile to <=53 (CQUIN) To reduce the number of Hospital acquired MSSA to <=46	2 45 44	Quality Accounts, Sign Up to Safety and Trust Strategy	Chief Medical Officer (Kevin Phillips)	Director of Infection Prevention & Control (Dr Peter Moss), Infection Control Consultant (Dr Rolf Meigh) and Lead Nurse	Individual 5 moments of hand hygiene posters in place on all wards - **April 2017** Infection Prevention Control intranet content reviewed - **May 2017** Health Economy Nursing Conference on E.coli bacteraemia	Theatre Discipline Policy developed - **August 2017** Infection Prevention Control intranet content updated - **August 2017** Catheter passport relaunched - **August 2017** Infection Prevention and Control strategy updated for	Fundamental Standard Audits completed in line with the Trust programme by IPC Team – frequency determined by audit result - **March 2018** Annual PLACE inspections HRI/ CHH complete - **March 2018**

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			avoidable hospital acquired infections	(CQUIN) To reduce the number of Hospital acquired E. Coli to <=73 (CQUIN) *NB NHSI requirement to achieve 10% reduction on last year's return*	 81			Infection Prevention & Control (Greta Johnson)	attended and presented by Infection Prevention Control Lead Nurse - **May 2017** Continence management, catheter training and knowledge across Health Groups scoped to support reduction in catheter acquired infections - **May 2017** Surveillance data for July-and August 2016 and Jan- March 2017 analysed and trends/ differences in trends of Trust apportioned cases identified - **May 2017** Infection Prevention Control risk matrix VIP chart rolled out - **June 2017** Barriers regarding compliance with sharps bin management identified e.g. physical / design / culture - **June 2017** Infection Prevention Control risk matrix VIP chart updated - **June 2017** Infection Prevention Control risk matrix VIP chart piloted in oncology - **June 2017** Action plan, based on surveillance data for July-and August 2016 and Jan- March 2017	2017/19 - **August 2017** Review of recommendations from recent NICU Serious Incident complete and further milestones added in response to the recommendations - **September 2017** The Infection Prevention & Control Practice in the Operating Department Policy ratified - **October 2017** Options for amendment to existing sharps management with waste manager scoped - **October 2017** Theatre Discipline Policy ratified - **November 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded - **December 2017**	Infection Prevention Control ownership tool completed on a monthly basis by all wards - **March 2018** Observational hand hygiene '5 moments' audit completed monthly - **March 2018** Existing Infection Prevention Control education reviewed and recommendations for amendments developed - **March 2018** Twice yearly Daniels audit completed and recommendations / actions developed - **March 2018**

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									findings, developed – e.g. CAUTI/ gram negative bacteraemia/ management of patients with biliary associated conditions - **June 2017** Senior Matron / Site Coordinator resource folder published - **July 2017** The Infection Prevention & Control Practice in the Operating Department Policy developed - **July 2017**		
Safety	QIP09	**Falls** *The aim of this project will be to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention through the completion of e-learning.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment (12.2.A and B) – assessing the risks of the health and safety of servicer users of receiving the care or treatment and doing all that is practicable to mitigate any such risks.*	Ensure that falls assessments, e-learning programmes and lessons learned are embedded across the Trust to help eliminate all avoidable patient falls.	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above 50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018	6.39% No baseline	Sign up to Safety and Quality Accounts	Chief Nurse (Mike Wright)	Assistant Chief Nurse (Jo Ledger) Chair of Falls Committee (Rosie Hoyle) Falls QSM (Bridget Wainman)		Completed review of all improvement work undertaken in 2016/17 to ensure embedded – **August 2017** Content of the quality and safety bulletin for falls prevention agreed – **August 2017** Actions from the RCP Fall and Fragility Fracture Audit reviewed and next steps identified – **October 2017** Development of a non-clinical e-learning module for the prevention of falls – **November 2017** Development of ‘fall prevention’ poster campaign – **November 2017** Auditing processes for the monitoring of the checks for injury and medical examination after a fall	Re-audit undertaken using the census tool to identify compliance with the accurate completion of falls risk assessment, clinical appropriateness use of the bedrails and individualised care plans – **March 2018** Full roll-out of weekend mobility plan completed including risk assessments and kit availability achieved – **March 2018** Review undertaken of patients medical records who have fallen with a harm moderate or above to provide assurance of rationale behind decision making process for the declaration of the SI – **March 2018** Quarterly audit of compliance against

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										established – **December 2017**	RIDDOR guidance completed. Trust bedside vision tool for falls prevention (using RCP as guidance) agreed – **March 2018**
Safety	QIP10	**Pressure Ulcers** *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.*	Zero incidence of avoidable Hospital Acquired pressure ulcers	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 9 avoidable hospital acquired unstageable pressure ulcers To have no more than 26 avoidable hospital acquired SDTI To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers (no more than 37) 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	1 0 13 35 52 81% 83.3% 93.3%	Quality Accounts and Sign Up to Safety Support to be received from Improvement Academy via Measuring & Monitoring Safety Framework	Chief Nurse (Mike Wright)	Tissue Viability Leads (Angie Oswald and Karen Harrison)	NHS England – Learning from Experience. Learning Candour and Accountability workshop – **April 2017** 1st Improvement Academy workshop completed **– April 2017** 2nd Improvement Academy Workshop Completed – **May 2017** HEY Safer Care Bulletin – Device Related Pressure Ulcers published – **May 2017** Tissue Viability Service quarterly HEY! Skin matters bulletin / newsletter developed to improve learning **– June 2017** 3rd Improvement Academy Workshop Completed – **June 2017** Lessons Learned reviews shared at each wound management committee – **June 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **June 2017**	Tissue Viability service eLearning modules on pressure prevention equipment, PU / Wound healing and nutritional requirements developed **– August 2017** Cultural survey conducted on the pilot wards – **August 2017** Pilot commenced on new care plans – **August 2017** Each clinical area to have a TVLN who attends the mandatory TVLN twice yearly study day (qualified & unqualified) – **September 2017** Tissue Viability Service embedded pressure ulcer prevention cares with Hull University student nurses and midwives - intensive training provided – **September 2017** Link nurse event regarding Stop The Pressure held – **November 2017** Further actions determined to address duty of candour through CIRCLE – **November 2017** Pilot of new care plan concluded including any	100% completion of eLearning module by all available nursing staff providing direct patient care **– March 2018** Each clinical area to demonstrate 100% of available staff having completed the bedside assessment – **March 2018**

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									Assurance provided by Medicine Health Group through the Wound Management Committee of actions being taken to address avoidable hospital acquired pressure ulceration - **June 2017** Assurance provide by Clinical Support Health Group through the Wound Management Committee of actions being taken to address avoidable hospital acquired pressure ulceration – **June 2017** Assurance provided by Family & Women's Health Group through the Wound Management Committee of actions being taken to address avoidable hospital acquired pressure ulceration – **June 2017** Assurance provided by Surgery Health Group through the Wound Management Committee of actions being taken to address avoidable hospital acquired pressure ulceration – **June 2017** Identified wards to pilot new care plan – **July 2017** Random audit of pressure ulcer investigation outcome	required changes identified within the pilot – **November 2017**	

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									and Duty of Candour communication completed – **July 2017**		
Safety	QIP11	**Maternity & Gynaecology** *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.* *Linked to a regulation breach. Regulation 11 Need for Consent. Regulation 12 Safe Care and Treatment 12(2)(b) – doing all that is reasonably practicable to mitigate such risks. Regulation 17 Good Governance (2)(a) – assess, monitor and improve the quality and safety of services provided. Regulation 18 Staffing (18)(1) – sufficient numbers of suitably qualified, competent, skilled and experienced persons.*	Embedded learning from Never Events	100% compliance with the daily swab count audit	94%	CQC Actions	Chief Nurse (Mike Wright)	Nurse Director Family and Women's Health (Mel Carr) and Lead Midwife/Supervisor of Midwives (Lorraine Cooper)	All midwives and obstetric staff attended learning lessons event in relation to the retained vaginal swab Never Event and learning lessons DVD – **July 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded **July 2017** Continued auditing of the swab counts to ensure 100% is achieved – **July 2017**		
Safety	QIP12	**Children and Young People with Mental Health needs and CAMHS** *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.* *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. (12.2.C) – ensuring that persons providing care and treatment to service users have the qualification, competence, skills and experience to do safely. (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*	Accessible, responsive and safe service for Children and Young People with mental health needs	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	25%	CQC Actions	Chief Medical Officer (Kevin Phillips)	Senior Matron Children and Young People Services (Vanessa Brown)	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **May 2017**	Service level agreement developed and signed off to formalise the external support from CAMHS to HEYHT – **December 2017**	Quarterly audits of the individual self-harm risk assessments completed, compliance assessed and any learning identified – **March 2018**

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		ensure that timely care planning takes place.									
Safety	QIP14	**VTE** *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.*	Achieve the 95% of patients assessed for VTE within 24 hours of admission	Achieve 95% compliance with the VTE Risk Assessment Achieve 0 VTE Serious Incidents To increase the number of doctors completing the VTE e-learning module	92.5% (Q4) 2 986	Quality Accounts and Sign up to Safety	Chief Medical Officer (Kevin Phillips)	Deputy Medical Director, Surgery (Dr Ahmed Saleh)	Lorenzo VTE 'live' database activated and implemented – **May 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **June 2017**	24 hour VTE risk assessment form developed with the associated clinical assessment attached – **September 2017** 24 hour VTE risk assessment and clinical assessments implemented – **October 2017**	Compliance with NICE CG92 achieved – **March 2018**
Safety	QIP15	**Sepsis** *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.*	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.	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% Q1, 50% Q2, 75% Q3 and 90% 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% reduction on baseline	92% Inpatient 96% Emergency Department 90% Inpatient 90% Emergency Department No baseline 54926.73 per 1,000 admissions	Quality Accounts and Sign Up to Safety Support to be received from Improvement Academy via Measuring & Monitoring Safety Framework	Chief Medical Officer (Kevin Phillips)	Sepsis leads – Dr Kate Adams (Consultant Lead), Donna Gotts (Nurse Lead)	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **April 2017** 1st Improvement Academy workshop completed – **April 2017** Second Sepsis Nurse recruited – **May 2017** 2nd Improvement Academy Workshop Completed – **May 2017** Second Sepsis Nurse in post – **June 2017** 3rd Improvement Academy Workshop Completed – **June 2017**	Sepsis Intranet site developed – **September 2017** Trust taken part in national Sepsis Day – **September 2017** Review of NEWS in the community completed – **September 2017** Review completed of effectiveness of link nurse meetings – **October 2017** Paediatric sepsis pathway developed – **October 2017** Review completed of standardisation of sepsis emergency boxes / trollies – **October 2017** Paediatric sepsis pathway training developed – **November 2017** Sepsis training delivered as part of the faculty of 5th year medical students. – **November 2017**	Sepsis pathway embedded in all areas of the organisation - **March 2018** Sepsis training programme completed – **March 2018** Awareness raised within the community with GPs, Midwives and Nurses – **March 2018** Awareness raised with HEY midwives – **March 2018** Awareness raised with HEY medical staff – **March 2018**

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				2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions – 1% reduction on baseline 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions – 1% reduction on baseline	643.53 per 1,000 admissions 728.89 per 1,000 admissions						
Safety	QIP16	**Resuscitation Equipment Checklist Compliance** *The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards.* *Linked to a regulation breach. Regulation 12 Safe Care and Treatment 12.2.G– 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.*	Ensure completion of the daily and monthly resuscitation equipment checks	Achieve 95% compliance with the completion of the daily resuscitation equipment checks Achieve 95% compliance with the completion of the weekly resuscitation equipment checks Achieve 95% compliance with the completion of the monthly resuscitation equipment checks Achieve 0 incidents reported relating to missing equipment	93% No baseline 95% 0	CQC Actions	Chief Medical Officer (Kevin Phillips)	Neil Jennison (Resuscitation Manager)	New template for recording the completion of the daily and monthly resuscitation equipment checks rolled out - **April 2017** Data collection period amended - **July 2017** Audit results included in the Health Group Briefing Reports - **July 2017**	Audit arrangements agreed at Resuscitation Committee for area specific i.e. CMU / ICU trolley checklists - **September 2017** Incident review of all incidents reported regarding missing or out of date equipment on a resuscitation trolley - **October 2017** Additional performance target monitored for monthly checks - **October 2017** All laryngoscopes replaced with sealed packs following concerns raised via Datix and CQC - **October 2017** Resuscitation Policy remit and content agreed with Exec Team - **November 2017** Resuscitation policy updated to include changes to monthly check frequency (weekly) and clarified trust staff members incident reporting requirements - **December 2017**	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 - **March 2018**

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Effectiveness	QIP22	**Nutrition** *The aim of this project is to ensure that all wards are rated amber and above using the Trust's Fundamental Standards Ward audits which will ensure that all patients have an appropriate personal nutritional needs assessment completed and receive an appropriate care plan or referral to a dietician where required.* *Linked to a regulation breach. Regulation 14 Meeting Nutritional and Hydration needs*	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	90% of wards rated amber or above using the Trust's Fundamental Standards audits	79.6%	Quality Account , Sign up to Safety and CQC Inspection Actions	Chief Nurse (Mike Wright)	Chair of Nutrition Steering Group (Steve Jessop), Senior Matron Surgery Health Group (Rosie Hoyle), Head of Dietetics (Tina McDougal)	Baseline data from monthly ward census audits established - **May 2017** QIP leads attended Trust Board's Quality Committee to detail QIP progress and update on Nutrition and Hydration - **May 2017** Additional milestones which are required based on the baseline data from the monthly ward census audits identified - **June 2017** Trustwide communication produced detailing plan for NG training for registered nurses on wards - **June 2017** Nutrition and Hydration Policy reviewed - **June 2017** One outpatient area identified for Nutrition Screening trial - **July 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 - **July 2017**	Fluid balance training package delivered on all relevant wards by Trust Teacher Trainers - **August 2017** Nutrition and Hydration Policy ratified - **August 2017** Commissioning Excellent Nutrition and Hydration Guidance reviewed - **August 2017** Appraisal of the role of the Nutritional Apprentice impact completed and placement of apprentices' agreed - **September 2017** To develop a Task and Finish group to look at implementation of outpatient nutritional screening - **October 2017** NG training delivered to senior nursing teams which enables cascade training - **October 2017** Review completed on all housekeeping / ward hostess roles and standardisation of job description - **October 2017** Nutrition Steering Group receive monthly updates NG feeding training programme - **October 2017** Review of Fundamental Standards audit results to highlight specific areas of non-compliance completed - **October 2017**	All wards assessed in CQC language, based on Fundamental Standards and census audit results (good, requires improvement etc.) and disseminated - **January 2018** Monthly ward nutrition and hydration census audits completed - **March 2018** Nutrition and Hydration Fundamental Standards audit programme completed in line with methodology - **March 2018**

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										Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded - **November 2017** Trust Collaborative Group and agenda established - **November 2017** Nutrition Census re-audit completed - **November 2017**	

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Effectiveness	QIP23	**Dementia** *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.	Achieve 90% for identification of dementia/delirium assessments on Cayder. Achieve 75% compliance with the use of blue butterfly symbol over the bed and reach out to me. Work towards 60% compliance/ awareness of the John's campaign.	65% 50% No baseline	Trust Actions	Chief Medical Officer (Kevin Phillips)	Lead Consultant (Dr Dan Harman) and Lead Dementia Nurse (Suzy Bunton)	Dementia awareness within Hull and East Yorkshire promoted through the media – **April 2017** Attended Dementia Carer's event at Hull City Hall to promote awareness of living with Dementia – **April 2017** Dementia Awareness Week completed – (involvement to drive forward organisational engagement to focus on the senses and nutritional challenges in a person living with Dementia) – **May 2017** Attended Nurses Day conference – (to show collaborative working in relation to staff education in Dementia) – **May 2017** Participated in the Dementia Awareness Event at Princes Quay, Shopping Centre, Hull – **May 2017** The Dementia Garden at Castle Hill Hospital and Burnby Hall Gardens completed – **June 2017** EoL policy reviewed with regards to Dementia and best practice – **July 2017**	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **August 2017** Cinema area on Ward 80 created – **September 2017** Established links made with Dietetic team and Dementia Lead Nurse with regards to reviewing Nutritional overview of patients with Dementia and improvements **– November 2017** Audit completed to review transfers of care and quality of information (admissions, transfers and discharges) – **November 2017**	Audit completed of the use or adherence to the Dementia and Delirium Screening Pathway, including the Butterfly Scheme and the John's Campaign principles – **March 2018**
Effectiveness	QIP24	**Children and Young People Services** *The aim of this project is to continue*	Improved facilities on the 13th floor	Delivery of the Children and Young	Partially delivered	CQC Actions	Chief Nurse (Mike	Matron Senior Matron	Procedural document for undertaking a	Completed review of all improvement work	Children Strategy implemented – **January**

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		to improve the overall children and young people services and facilities on the 13th floor. *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.*		People Services improvement project by March 2017			Wright) and Chief Medical Officer (Kevin Phillips)	Children and Young People Services (Vanessa Brown)	pregnancy test prior to surgery for young people audited and next steps agreed – **July 2017**	undertaken in 2016/17 to ensure they are embedded – **August 2017** Children Strategy developed and approved – **December 2017**	**2018**
Experience	QIP28	**Patient Experience and Complaints** *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*	Seek and act upon feedback from patients, relatives and carers.	Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate	61.60%	Quality Account and Sign up to Safety	Chief Nurse (Mike Wright)	Deputy Director of Quality Governance and Assurance/ Assistant Chief Nurse (Sarah Bates)	Patient experience dashboard used within the Health Groups to inform service changes/improvements – **June 2017** Interpreters Policy and supporting tools implemented – **June 2017** Patient Experience Strategy presented to the Trust board approved – **July 2017** Patient Experience work plan developed (based on the Patient Experience Strategy objectives) – **July 2017**	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **August 2017** Development of Interpreters using telephone interpreting service and 'Browse Aloud' service for the visually impaired completed – **September 2017**	Patient Experience work plan delivered – **March 2018** Quarterly monitoring and updating against the Patient Experience Strategy work plan completed – **March 2018** Undertake review of surveys regarding complaint handling **– March 2018**
Effectiveness	QIP30	**Avoidable Mortality** *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.*	Reduction in avoidable mortality	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 identified to have a severe mental health illness To review all deaths of patients subject to care interventions	No baseline No baseline No baseline	Quality Account and Sign Up to Safety Support to be received from Improvement Academy via Measuring & Monitoring Safety Framework	Chief Medical Officer (Kevin Philips)	Clinical Outcome Manager (Chris Johnson)	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **April 2017** Executive Director Appointed to lead on Mortality – **April 2017** 1st Improvement Academy workshop completed – **April 2017** Quality check process in	Mortality Policy developed – **October 2017** Good practice shared – **November 2017** Ideas explored to make current review process leaner and more efficient. – **November 2017** Monthly Mortality Review Team Formed – **December 2017**	Full map of Trust Morbidity and Mortality meetings created. Including timetable/location/MM lead – **January 2018** Robust process in place to allow the capturing and sharing of learning, and the recording of action plans, that can be monitored for delivery. – **January 2018**

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
				from which a patient's death would be wholly unexpected, for example in relevant elective procedures. Sample of 10% of all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis. To review all deaths of patients that underwent elective procedures during their last episode.	 No baseline No baseline				place – **May 2017** Reporting structure including Board Reports reviewed – **May 2017** Review of mortality work included in Quality Accounts completed – **May 2017** Quality check audit completed – **May 2017** 2nd Improvement Academy Workshop Completed – **May 2017** Trust Policy written for mortality review – **May 2017** Patients with Learning Difficulties identified – **May 2017** Non-Executive Director Appointed to lead on Mortality – **June 2017** Criteria for prescribed deaths via death certificates, reviews and investigations defined – **June 2017** Process for learning from reviews and investigations developed – **June 2017** Criteria for selecting patients to undergo case record review defined – **June 2017** First quarterly dashboard report		Initial "Quick Screen" form developed for Specialties with more than 10 deaths per month. Implemented within Specialties with an average of more than 10 deaths per month. - **January 2018** Quality check audit completed – **January 2018** Multi Agency Review undertaken on patients that died within 48 hours of admission from a care home. – **March 2018**

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									published – **June 2017** 3rd Improvement Academy Workshop Completed – **June 2017** Quality Improvement Work – NOF fracture documentation – Baseline audit – **June 2017** Process for informing and involving next of kin confirmed – **July 2017** Engaged with Royal College of Physicians to increase training provision – **July 2017**		
Safety	QIP34	**Critical Care** *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.* *Linked to a regulation breach. 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).*	A fully staffed and trained Critical Care Unit which will support the provision of optimum care.	16 Critical Care Consultants in post To be monitored from November 2017 once audit complete: 100% of patients reviewed within 12 hours by a consultant following admission 100% of days when two ward rounds are completed	10 No baseline No baseline *(Baseline could not be identified in 2016/17 due to significant staffing shortfalls within the unit)*	CQC Actions	Chief Medical Officer (Kevin Philips)	Critical Care lead Consultant and Nurse (Dr Andrew Gratrix and Becky Smith)	Consultant recruitment campaign commenced - **April 2017** Audit of documentation for ward rounds and review of new patients within 12 hours commenced - **April 2017** Business case completed for 4 advanced practitioner posts - **May 2017** 4 advanced practitioner posts recruited to and applications to the University made - **June 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 - **August 2017** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded - **August 2017** Audit of documentation for ward rounds and review of new patients within 12 hours completed - **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 - **November 2017**	Review of current critical care qualifications to ascertain how nursing staff can achieve a critical care qualification - **January 2018** Review of National Guidelines to complete gap analysis. Gap analysis to provide the focus for 2018/19 QIP - **February 2018** Implement the training of 5 advanced practitioner posts - **March 2018**

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
Safety	QIP35	**Five Steps for Safer Surgery (WHO Checklist)** The aim of the project is to reduce *mortality and morbidity, including wrong site surgery, haemorrhage and infection, through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) in all specialities across the Trust.* *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 for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.*	To reduce mortality and morbidity, including wrong site surgery, haemorrhage and infection	To be agreed	To be agreed	CQC Inspection Actions	Chief Medical Officer (Mr Kevin Philips)	Deputy Chief Medical Officer (Dr Purva), HEY Improvement Project Lead (Vicky Marshall)	Performance targets agreed - **July 2017** Project finalised - **July 2017** Governance process for ratification of NatSSIPs and LocSSIPs agreed - **July 2017** Steering group commenced - **July 2017**	Core NatSSIPs checklist ratified - **August 2017** Pre-theatre checklist ratified - **August 2017** Recovery handover form ratified - **August 2017** NatSSIPs and LocSSIPs policy ratified - **September 2017** Audit process in place for all LocSSIPs checklists developed - **September 2017** Training needs assessment completed - **December 2017** Scoping for any additional external training required complete - **December 2017**	Training rolled out as per needs assessment - **January 2018** LocSSIPs checklist ratified for all specialities - **March 2018** Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded - **March 2018**
Effectiveness	QIP36	**Transition from Children's 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.* *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).*	To provide a service that ensures an effective transition from Paediatric services to adult services.	Procedural document ensuring the effective transition for young people to adult services implemented	Not implemented	CQC Actions	Chief Nurse (Mike Wright) and Chief Medical Officer (Kevin Phillips)	Family and Women's Operations Director (Michelle Kemp) and Head of Outpatient Services (Eileen Henderson)	Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded – **April 2017** 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 – **April 2017** Baseline assessment of all transitional arrangements from children to adults within the Trust and from specialist centres completed – **April 2017**	Procedural document ensuring there is effective transition for young people to adult services approved - **August 2017** Communication campaign promoting the procedural document ensuring there is effective transition for young people to adult services launched – **September 2017** Procedural document ensuring there is effective transition for young people to adult services implemented **– September 2017** Ready, Steady, Go toolkit implemented in Diabetes, Epilepsy and Cystic Fibrosis and audited in order to learn any lessons prior to	

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									Ready, Steady, Go toolkit approved - **April 2017** Virtual network of all adult and paediatric clinicians both nursing medical and AHP's working in the transition from children to adults developed – **May 2017** Baseline assessment completed to demonstrate Trust compliance against the Transition NICE quality standards and areas of improvement – **May 2017** Procedural document ensuring there is effective transition for young people to adult services developed – **July 2017**	implementing across the other speciality services – **September 2017**	
Safety	QIP37	**ReSPECT** *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*	ReSPECT process is fully embedded across the organisation.	Delivery of the ReSPECT quality improvement project (implementation plan)	No baseline	Trust Actions	Chief Medical Officer (Kevin Phillips)	Resuscitation Manager (Neil Jennison) and Consultant Anaesthesia and Intensive Care (James Pettit)	Formal adoption agreed by the Trust and sign up to ReSPECT terms of use completed – **April 2017** ReSPECT implementation task and finish group established – **April 2017** Formal links established with key health and social care providers in the Humber Region – **June 2017** Training needs identified – **June 2017**	Staff and patient awareness and communications plan developed – **September 2017** ReSPECT process staff and patient awareness and communication disseminated – **September 2017** Training package and plan developed – **September 2017** Review completed of the electronic development opportunities for an IT solution – **September 2017**	Implementation progress audited and baseline compliance identified – **March 2018** Future monitoring arrangements agreed - **March 2018**

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		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.								Training package rolled out – **October 2017** Local launch date agreed – **October 2017** Review of current Trust policy completed and revised to embed ReSPECT processes into Trust policy – **November 2017**	
Effectiveness	QIP38	**Consent** *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.*	To have centrally governed electronic consent forms	To have all consent forms managed and monitored through a central process by March 2018	No baseline	Trust Actions	Chief Medical Officer (Kevin Phillips)	Deputy Director of Quality Governance and Assurance / Assistant Chief Nurse (Sarah Bates)	Consent task and finish group task terms of reference and work plan agreed – **April 2017** Ward rounds undertaken and all old consent forms removed from circulation – **June 2017** Consent Policy reviewed and revised to incorporate the new CJD wording – **July 2017**	Pilot areas identified for the Lorenzo consent forms - **September 2017** Pilot of the Lorenzo consent forms completed – **December 2017**	Pilot of the Lorenzo consent forms analysed and next steps agreed – **January 2018** New CJD wording added to all consent forms – **March 2018** Lorenzo consent forms fully developed – **March 2018** To have new printed consent forms available for patients – **March 2018** Consent forms linked to up to date patient information leaflets and leaflets available at the time of consent – **March 2018** Development, approval and monitoring process for the Trust consent forms developed and implemented – **March 2018**
Effectiveness	QIP39	**Outpatients** *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.*	Robust leadership and governance structure in place for outpatients Outpatient areas are of the required safe standard for	Outpatients governance committee held	No baseline	CQC Actions	Chief Operations Officer (Ellen Ryabov)	Head of Outpatient Services (Eileen Henderson)	Head of Outpatient Services appointed - **April 2017** Board level lead for Outpatient Services identified - **April 2017**	Risk register developed specific to Outpatient Services - **August 2017** Existing asset management process for outpatient areas assessed for efficiency and assurance - **September 2017**	

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		Relates to Regulation 17 HSCA (RA) Regulations 2014 Good governance: Systems and processes were not always operated effectively to ensure improvement and good governance of services	patients						Audiology Outpatients clinical area deep cleaned - **April 2017** Audiology Outpatients clinical area unsuitable furnishings replaced - **April 2017** Programme of development in place to address all outpatient areas where the environment is not fit for purpose - **April 2017** Surgical Outpatients preparation room assessed and made fit for purpose - **April 2017** Plastics outpatients consultants rooms desks replaced - **April 2017** Terms of reference developed for a trustwide governance committee - **May 2017** Targeted information developed for outpatient staff on all outpatient SIs to provide learning - **June 2017** A trustwide governance committee for Outpatient Services established with required regular health group attendance - **June 2017** Clear governance map for outpatients	Skill mix review for nursing staff completed for all outpatient areas - **September 2017** Create Learning Space for outpatient staff members on the intranet to include resource on risks, incidents and learning lessons - **November 2017** Communications strategy for internal and external Outpatient Services with a focus on public and patient engagement - **December 2017** Fundamental Standards Audit developed for Outpatient Services - **December 2017**	

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
									produced which demonstrates a ward to board process - **June 2017** Targeted information developed for outpatient staff on all outpatient incidents to provide learning - **July 2017** Terms of reference approved for a trustwide governance committee - **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 - **July 2017** Targeted information developed for outpatient staff on all outpatient complaints/PALs to provide learning - **July 2017**		
Effectiveness	QIP41	**Getting it Right First Time (GIRFT) – Paediatric Surgery** *The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Paediatric Surgery.*	Improved Paediatric Surgical services	Full implementation of the project	No baseline	Trust Actions	Chief Nurse (Mike Wright)	Family and Women's Divisional General Manager (Lisa Pearce)		Coding of anti-reflux procedures reviewed and next steps agreed – **September 2017** Board Level Review of Paediatric Surgical Services possibly tied to local STPs completed – **October 2017** Policy for repairs of umbilical hernias in children under the age of 3 developed, approved and implemented – **November 2017**	Audit arrangements agreed for the Policy for repairs of umbilical hernias in children under the age of 3 – **March 2018** Audit arrangements agreed for the circumcisions and review/decision making process and the use of high dose topical steroid – **March 2018**

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
										Policy for the no circumcision of children under the age 5 years unless recurrent symptomatic balanitis developed, approved and implemented – **November 2017** Visit to obtain support and advice from high volume centres in how to introduce a day case hypospadias surgery undertaken – **December 2017** Introduction of a day case hypospadias surgery – **December 2017** Torsion of the Testis Policy developed, approved and implemented **– December 2017** Coding of the torsion of the testis process agreed to ensure they are coded together with orchidopexy or orchidectomy – **December 2017** Audit of reoperations completed to determine if incidence is correct and to if the appropriate remedial action was taken Review completed of the coding issues regarding the discrepancy between diagnosis of appendicitis and operative code of appendicectomy and the coding issues solved Audit of the emergency list delivery times against category of emergency	

Quality Improvement Overview Plan 2017-18

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
										completed Achieve a negative appendicectomy rate of 10% Participated in GIRFT paediatric appendicectomy surgical site infection audit Audit of the coding of acute scrotal exploration to ensure consistent coding practices completed	
Effectiveness	QIP42	**Getting it Right First Time (GIRFT) – Ophthalmology** *The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Ophthalmology.*	Improved Ophthalmology services	Full implementation of the project	No baseline	Trust Actions	Chief Nurse (Mike Wright)	Family and Women's Divisional General Manager (Damian Haire)		Summary report and findings circulated to service leads and consultants with actions – **December 2017** Review of coding for intravitreal injection service completed – **December 2017**	Review of the code across the specialty to ensure accuracy in recording completed – **January 2018** Patients referred for cataract review prior to their appointment contacted by telephone with the aim of reducing the attrition rate for cataract appointments – **January 2018** Continued development of multidisciplinary team in Ophthalmology – **March 2018** Improved engagement with community optometry colleagues to reduce number of false positive referrals – **March 2018** Review options for increased presence of HEY ophthalmology service in the community completed – **March 2018**
Effectiveness	QIP43	**Getting it Right First Time (GIRFT) – ENT** *The aim of this project is to ensure there is an effective and well led*	Improved ENT services	Full implementation of the project	No baseline	Trust Actions	Chief Nurse (Mike Wright)	Family and Women's Divisional General		Review completed of number of overnight stays for patients requiring procedures in the ENT	Review completed of claims history for ENT/Head and Neck patients in the last two

	No	Quality Improvement Project	Long-Term Improvement Goal/Outcome	KPI/Measure (2017-18)	Baseline (2016-17)	Dependency / Resources / Support	Exec Lead	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
		response to the recommendations and actions arising from the GIRFT review of ENT.						Manager (Damian Haire)		service – **December 2017**	years – **January 2018** Review coding across the specialty completed – **March 2018** Review completed of Septoplasty numbers – **March 2018**

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

EQUALITY, DIVERSITY AND INCLUSION STRATEGY 2018-21

Board date	13 March 2018			**Reference Number**			
Director	Jacqueline Myers Director of Strategy and Planning Simon Nearney Director of Workforce and OD			**Author**	Jackie Railton Head of Strategic Planning and Chair of the Diversity and Inclusion Steering Group		
Reason for the report	The purpose of this paper is to seek the Board's approval of the Trust's Equality, Diversity and Inclusion Strategy 2018-2021.						
Type of report	Concept paper		Strategic options	✓	Business case		
	Performance		Information		Review		

1	**RECOMMENDATIONS** The Board is asked to approve the Trust's Equality, Diversity and Inclusion Strategy 2018-21.					
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): HSCA Regulations - 5,9,10,13,15,17,18,19					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y		**Legal advice taken?** Y/N	**Raises sustainability issues?** Y/N	
5	**BOARD/BOARD COMMITTEE REVIEW** Executive Management Committee – January 2018					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

EQUALITY, DIVERSITY AND INCLUSION STRATEGY 2018-21

1. PURPOSE OF PAPER

The purpose of this paper is to seek the Trust Board's approval of the Trust's Equality, Diversity and Inclusion Strategy 2018-2021.

2. BACKGROUND

The Equality Act 2010 imposes general and specific duties on all public bodies. When exercising its functions, the Trust must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard means that we must take account of these three aims as part of our decision-making processes, both as a provider of healthcare and an employer.

The Equality, Diversity and Inclusion Strategy 2018-21 demonstrates the Trust's commitment to meeting the duties placed upon it by the Equality Act 2010 and to meeting the needs and wishes of the local population and the workforce.

3. EQUALITY, DIVERSITY AND INCLUSION STRATEGY 2018-21

The Equality, Diversity and Inclusion Strategy 2018-21 is attached. It describes the legal and regulatory context under which the Trust operates in respect of equality, diversity and inclusion and provides an overview of the local population, patient/service user and workforce profiles.

The Strategy sets out the Trust's aim to promote equality and diversity for patients and staff, tackling all forms of discrimination and removing inequality in the provision of both health services and employment. Actions to ensure that the Trust's aims are realised include:

- Improving the way in which we collect and use patient data to monitor equity of access to services;
- Involving more patients, service users, parents and carers in the planning and delivery of services;
- Looking at ways of improving the facilities and environment within our hospitals for patients and services users;
- Ensuring that the equality impact of policy and service change is taken into account before decisions are taken;
- Using new technology to support people's information and communication support needs;
- Increasing the level of community engagement;

- Working to ensure that all staff have equality of opportunity for career progression, including access to education and training opportunities, appraisals and performance development reviews;
- Looking to increase the opportunities for staff networking and increased consultation and engagement on issues affecting them;
- Celebrating the diversity of our workforce by participating in national and local community events;
- Reviewing our equality, diversity and inclusion training programmes to raise the awareness of staff to the needs of their colleagues and patients/service users;
- Reviewing our employment policies and procedures to ensure they reflect current legislation and best practice.

The Equality, Diversity and Inclusion Strategy is aligned to the Trust Strategy (2016-21) and People Strategy (2016-18).

Delivery of the Strategy and associated actions will be monitored through the Trust's Diversity and Inclusion Steering Group which will submit reports to the Executive Management Committee and Workforce Transformation Committee, with an annual report on progress being presented to the Trust Board.

4. RECOMMENDATION

The Trust Board is asked to approve the Trust's Equality, Diversity and Inclusion Strategy 2018-21.

Jacqueline Myers
Director of Strategy and Planning

Simon Nearney
Director of Workforce and OD

February 2018

EQUALITY, DIVERSITY AND INCLUSION STRATEGY

2018-21

Remarkable people. Extraordinary place.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

EQUALITY, DIVERSITY AND INCLUSION STRATEGY 2018-21

1. INTRODUCTION

Hull and East Yorkshire Hospitals NHS Trust believes in fairness, equity and above all values diversity in all dealings, both as a provider of health services and employer of people.

This Equality, Diversity and Inclusion Strategy demonstrates our commitment to meeting the needs and wishes of local people and our staff, and the duties placed upon us by the Equality Act 2010. It sets out our progress towards achieving the goals and outcomes of the NHS Equality Delivery System and identifies the actions we will take to achieve our Equality Objectives.

2. LEGAL DUTIES AND REGULATORY REQUIREMENTS

2.1 EQUALITY ACT 2010

The Equality Act 2010 imposes general and specific duties on all public bodies.

2.1.1 The General Equality Duty

When exercising its functions (for example, developing and implementing policies and services), the Trust must give due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard means that we must take account of these three aims as part of our decision-making processes, both as a provider of healthcare and an employer. The Act requires us to:

- Remove or minimise disadvantages suffered by people due to their protected characteristic.
- Take steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encourage people from protected groups to participate in public life or in other activities where participation is particularly low.

The term ‘protected characteristics’ refers to groups who are protected under the Equality Act. The protected characteristics are as follows:

- **Age** – The Act protects people of all ages.

- **Disability** – Applies to a range of people that have a condition (physical or mental) which has a significant and long-term adverse effect on their ability to carry out ‘normal’ day-to-day activities. This protection also applies to people that have been diagnosed with a progressive illness such as HIV or cancer.

- **Gender Reassignment** – The definition of gender reassignment has been expanded to include people who chose to live in the opposite gender assigned to them at birth by removing the previously legal requirement for them to undergo medical supervision.

- **Pregnancy and Maternity** (including breastfeeding mothers) – A woman is protected against discrimination on the grounds of pregnancy and maternity. With regard to employment, the woman is protected during the period of her pregnancy and any statutory maternity leave to which she is entitled. Also, it is unlawful to discriminate against women breastfeeding in a public place.

- **Marriage and Civil Partnership** – The Act protects employees who are married or in a civil partnership against discrimination. Single people are not protected.

- **Race** – This includes colour, ethnic/national origin or nationality.

- **Religion or belief** – The Act covers any religion, religious or non-religious beliefs. It also includes philosophical belief or non-belief. To be protected, a belief must satisfy various criteria, including that it is a weighty and substantial aspect of human life and behaviour. Denominations or sects within a religion can be considered a protected religion or religious belief.

- **Gender** – Applies to male and female.

- **Sexual Orientation** – The Act protects lesbian, gay, bi-sexual and heterosexual people.

Complying with the general duty may involve treating some people more favourably than others as far as is allowed in discrimination law. It also explicitly recognises that disabled people's needs are different from those of non-disabled people and this may mean making reasonable adjustments for them or treating them differently.

2.1.2 The Specific Public Sector Equality Duty

As well as complying with the General Duty, the Trust must also comply with the following specific duties:

- Publish information to demonstrate compliance with the Public Sector Equality Duty at least annually.
- Prepare and publish equality objectives at least every four years. All such objectives must be specific and measureable.
- Analyse the effect of our policies and practices on equality.

The information must be published in a manner that is accessible to the public, either in a separate document or within another published document.

2.2 HUMAN RIGHTS ACT 1998

The Human Rights Act 1998 is underpinned by the core values of fairness, respect, equality, dignity and autonomy and goes beyond the nine protected characteristics to outlaw discrimination on all grounds. Specific rights include:

- Right to life
- Right to liberty and security
- Freedom of thought, conscience and religion
- Freedom of expression
- Right to marry
- Prohibition of discrimination.

2.3 NHS CONSTITUTION

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled and pledges which the NHS is

committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

2.4 CARE QUALITY COMMISSION STANDARDS

In addition to meeting our legal duties, we are required to meet the fundamental standards set out by the Care Quality Commission (CQC). There are a range of standards determined by the CQC that are linked both directly and indirectly to equality, diversity and human rights. http://www.cqc.org.uk/content/fundamental-standards. The delivery of our Equality, Diversity and Inclusion Strategy will support us in ensuring that we continually meet these standards.

3. WHAT IS EQUALITY, DIVERSITY AND INCLUSION?

- **Equality** – is treating everyone with fairness and respect and recognising the needs of individuals. It is about addressing existing disadvantages affecting how people participate in society.
- **Diversity** – is recognising, valuing and taking account of people's different backgrounds, knowledge, skills, needs and experience. It is also about encouraging and using those differences to create a cohesive community and a productive and effective workforce.
- **Inclusion** – is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included.

4. VISION

We aim to promote equality and diversity for our staff and our patients, tackling all forms of discrimination and removing inequality in the provision of both health services and employment. By doing this, we will achieve better services and have a positive impact on patient outcomes.

We want to create an environment that encourages every member of staff, whatever their role or background, to succeed. We want to be known as an organisation where our people work hard to make a difference for patients, where staff access opportunities to learn, develop and grow and work in a positive, inclusive environment free from discrimination.

To deliver this we will:

- Embed equality, diversity and human rights into all decision-making processes in a meaningful way and adapt tools (including Equality Impact Assessments) to ensure they are more effective and user friendly.
- Develop and deliver the Trust's annual work plan for equality, diversity and inclusion.
- Promote equal opportunity and a balanced workforce that understands and reflects the communities of Hull and the East Riding of Yorkshire.
- Continue to develop a sustainable and effective apprenticeship programme across the Trust.
- Promote careers in the NHS in non-typical groups where traditionally the opportunities do not exist.
- Create and enhance strategic partnerships in health and external organisations in promoting diversity and inclusion.
- Review equality and diversity training provision and build equality and diversity into all Trust training programmes.
- Raise awareness and sensitivities with colleagues and service users in respect of equality, diversity and human rights.
- Learn from what we do – both when we do well and when we can improve.

To realise this vision, we are committed to consulting, engaging and involving those who wish to be involved in the development and delivery of our services.

5. INFORMATION

5.1 Our Local Population

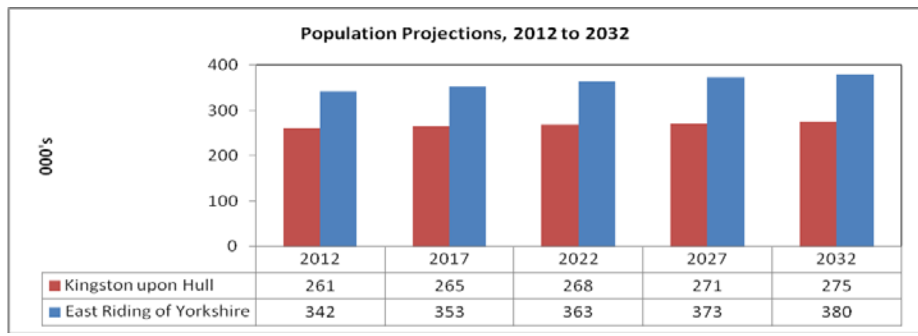
The local health system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull has a population of approximately 260,000 living within an area of 71km^2 and was identified as the 3rd most deprived local authority in England (out of 326 local authorities) in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The proportion of children living in poverty (31.5%) is substantially higher than average and the city has a higher than average proportion of Local Authority housing which does not meet the Decent Homes Standard. The health of people in Hull is generally worse than the England average and life expectancy for both men and women is lower than the England average.

The East Riding of Yorkshire has a population of approximately 342,000 dispersed across a predominantly rural area covering 2,479km^2. A higher than average proportion of Local Authority housing in the East Riding of Yorkshire satisfies the Decent Homes standard and deprivation and child poverty overall are below average (12.6%), although some wards in Bridlington, Withernsea and Goole, are relatively deprived. A larger proportion of the East Riding population is over 65 years of age compared to Hull. The health of the people in the East Riding is varied compared with the England average, with life expectancy higher for men than the England average.

Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are either South Asian, Black, mixed race, Chinese or other origin.

The population of Hull and the East Riding of Yorkshire is expected to increase by 52,600 (8.7%) between 2012 and 2032. For Hull the projected increase is 5.6%, whilst the percentage increase for the East Riding is expected to be greater at 11%.



	2012	2017	2022	2027	2032
Kingston upon Hull	261	265	268	271	275
East Riding of Yorkshire	342	353	363	373	380

Figure 1: Population Projections, 2012 to 2032, (Source: ONS, 2012)

Hull has seen a net inward migration of European Union (EU) nationals in recent years and this is predicted to continue.

In terms of the demand for the Trust's services from the local health economy, it is expected that, as the population grows and ages, there will be an increased need, particularly in the provision of services for older people, and in the management of cancer, coronary heart disease, stroke, dementia and long term conditions.

5.2 Our Patient/Service User Profiles

During 2016/17, 415,588 patients/service users made a first contact with the Trust either as an outpatient, inpatient, day case or attendance at the Emergency Department. (If a patient had multiple attendances and/or admissions within the period, only the first attendance and/or admission was taken into account for the purposes of this document). Of the 415,588 first attendances/admissions during the period, 47% of the patients were male and 53% were female.

The age range of patients is provided in Figure 2 below.

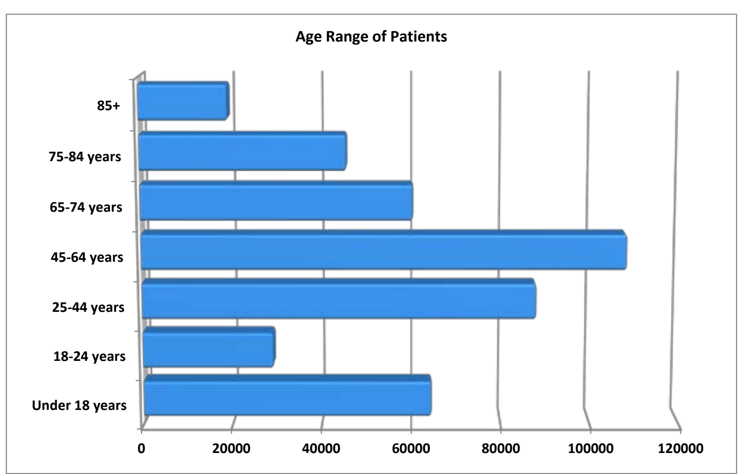


Figure 2: Age range of patients, April 2016 – March 2017
(Source of data: CHH-BI Views – Reporting Services Report)

Figure 3 provides an overview of the partnership status of patients/service users. Some 32.9% of patients identified as being single, with 31.5% being married or in a civil partnership. However, data was incomplete for 26.3% of patients with their partnership status being either unknown, not disclosed or not recorded.

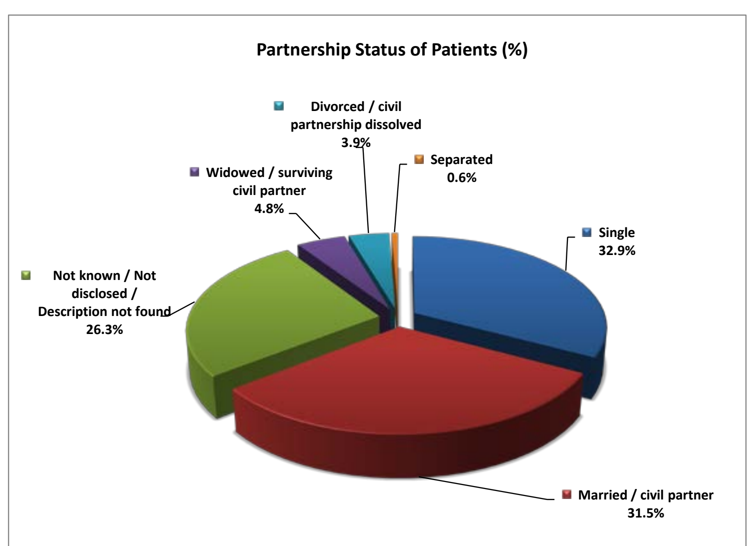


Figure 3: Partnership Status of patients, April 2016 – March 2017
(Source of data: CHH-BI Views – Reporting Services Report)

The ethnicity of patients/service users who had a first contact with the Trust over the period is provided at Figure 4. Some 77.0% (320,186) were listed as White/British with a further

2.9% (11,932) identifying themselves as ‘White – Other’. 16.9% of patients had not stated their ethnicity.

The highest representations of other ethnic groups were: Other Ethnic Group (1.3%), Other Asian (0.3%), Other Mixed Background (0.3%), Black African (0.2%), Asian/Asian British – Indian (0.1%) and White and Asian (0.1%).

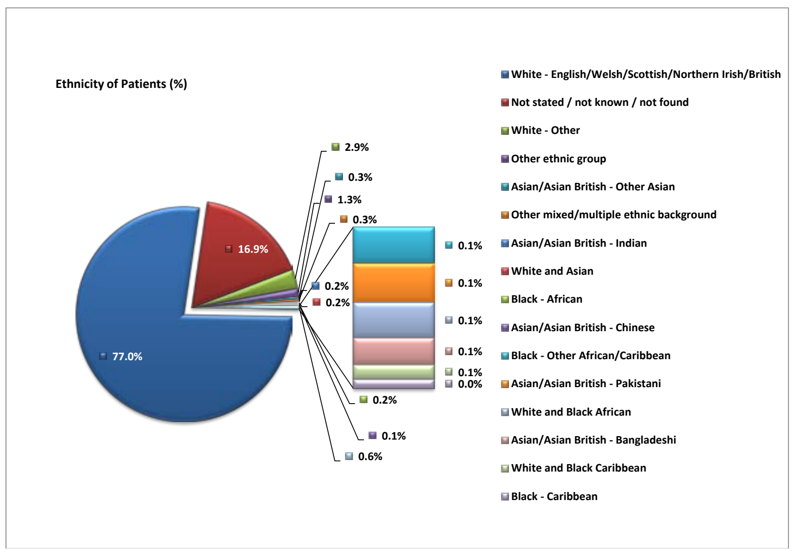


Figure 4: Ethnicity of patients, April 2016 – March 2017
(Source of data: CHH-BI Views – Reporting Services Report)

The data held by the Trust in relation to a patient/service user’s religion or belief is incomplete. The Trust does not have a record of the religion or belief for 35% of patients and, of the remaining 65%, the religion is predominantly Christian.

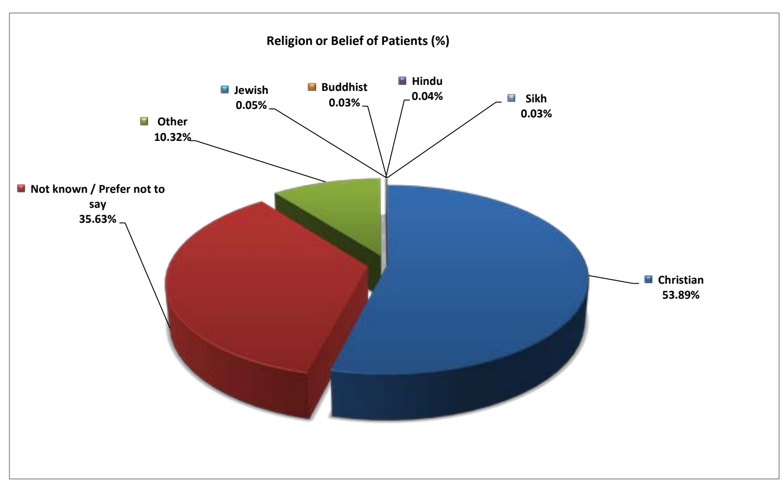


Figure 5: Religion or Belief of patients, April 2016 – March 2017
(Source of data: CHH-BI Views – Reporting Services Report)

If English is not a patient’s first language and they have difficulty in talking with members of staff, the Trust offers an interpreter service. A member of staff will arrange for an interpreter to assist the patient. The Trust uses Global Accent, a leading translation and interpreting company based in Hull which offers face to face and telephone interpreting services that are

available to the Trust's patients 24 hours a day. The company aims to provide an interpreter to the Trust within 30 minutes of the request.

Figure 6 below provides an overview of the number of requests made by Trust staff to Global Accent for Interpreter Services during 2016/17. Some 13,010 requests for interpreter services were responded to at a cost of £421,800, the largest user of foreign language interpretation services being the Obstetric Service.

LANGUAGE	Total	LANGUAGE	Total	LANGUAGE	Total
Polish	5,490	Punjabi	66	Tamil	4
Arabic	1,021	Bulgarian	66	Pashto	3
Russian	950	Kurdish-Sorani	65	Dutch	2
Kurdish	658	Urdu	61	Indonesian	2
Romanian	644	Oromo	40	Ukranian	2
Lithuanian	601	Spanish	37	Bosnian	2
Mandarin	482	Albanian	35	Swedish	1
Latvian	441	Amharic	31	Macedonian	1
Swahili	422	Kurdish-Badini	25	Burmese	1
Persian (Farsi)	274	French	21	Nepali	1
Bengali	232	Dari	19	Sinhalese	1
Portugese	220	Hindi	17	Lingala	1
Turkish	220	Italian	13	Susu	1
Cantonese	187	Tigrinya	12	Belorussian	1
Kinyarwanda	158	Vietnamese	7	Greek	1
Slovak	157	German	6		
Hungarian	106	Thai	6	Overall total	13,010
Czech	99	Hakka	4		
Somali	89	Armenian	4		

Figure 6: Interpreter Service Requests, April 2016 – March 2017
(Source of data: Global Accent)

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 Trust is able to provide translations of key documents on request. Key documents can also be made available in alternative formats, including Braille, Audio or large print.

3.3 Our Workforce

The Trust has reviewed the standard entries within its Electronic Staff Record (ESR) system to determine whether information against each of the protected characteristics can be collected and reported on. At the present time information on gender reassignment and pregnancy is not collected, although maternity leave is recorded.

All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on the ESR. However, the Trust had noted that the level of data completeness for existing staff was variable. In order to improve the quality of workforce data by protected characteristic, staff were encouraged to update their personal details early in 2016 when the new electronic Employee Self Service system was introduced. This enabled staff to check their ESR record and update personal information, including their religious beliefs, sexual orientation and disability status. Staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

The following workforce profile data is based on the ESR data.

As at 31 March 2017, the Trust employed 8,823 staff (headcount), 23% of whom were male (2,034) and 77% female (6,789). 1.78% of the workforce is known to be disabled.

The gender of the workforce by pay band is demonstrated in Figure 7 below. (Bands 1-9 relate to the Agenda for Change pay banding, M&D refers to Medical and Dental staff)

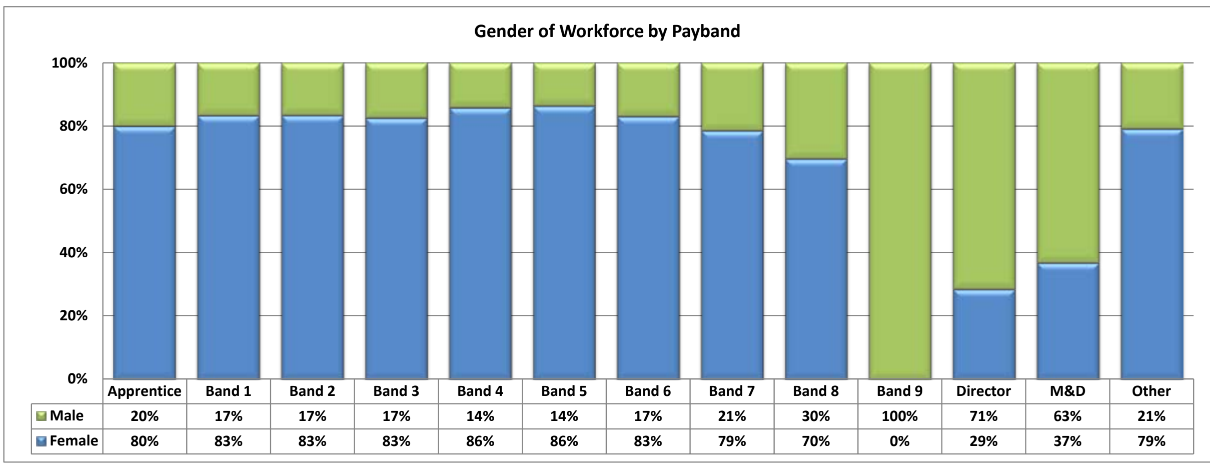


Figure 7: Gender of Workforce by Pay Band, as at 31 March 2017
(Source of data: ESR)

The Trust supports the principle of equal pay for work of equal value and recognises that we should operate a pay system that is based on objective criteria. The Equal Pay Audit in 2015 demonstrated the fact that the Trust's average pay gaps reflect the greater incidence of men at the higher ends of the Trust's pay scales and of women at the lower. This mirrors existing patterns in the NHS and in the wider UK workforce.

In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, employers with 250 or more employees are required to publish statutory calculations no later than March each year. The information will demonstrate the pay gap between male and female employees as at 31 March of the previous year.

The legislation requires an employer to publish information on their website and via a national website on:

- Gender pay gap (mean and median averages)
- Gender bonus gap (mean and median averages)
- Proportion of men and women receiving bonuses
- Proportion of men and women in each quartile of the organisation's pay structure.

Work is currently being undertaken to prepare the Trust's Gender Pay Gap report for publication by March 2018.

Figure 8 provides information on the ethnicity of the Trust's workforce. It shows that 87.33% of the workforce is White, with the next largest ethnic groups being Asian (7.02%), Black (1.75%) and Chinese (1.31%).

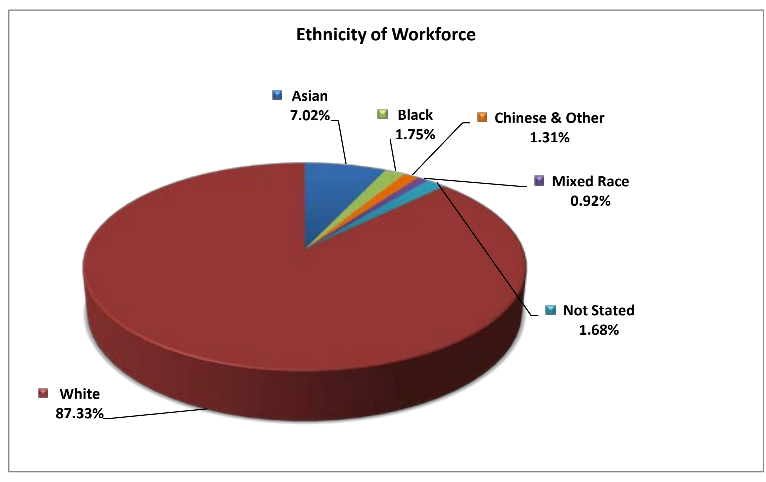
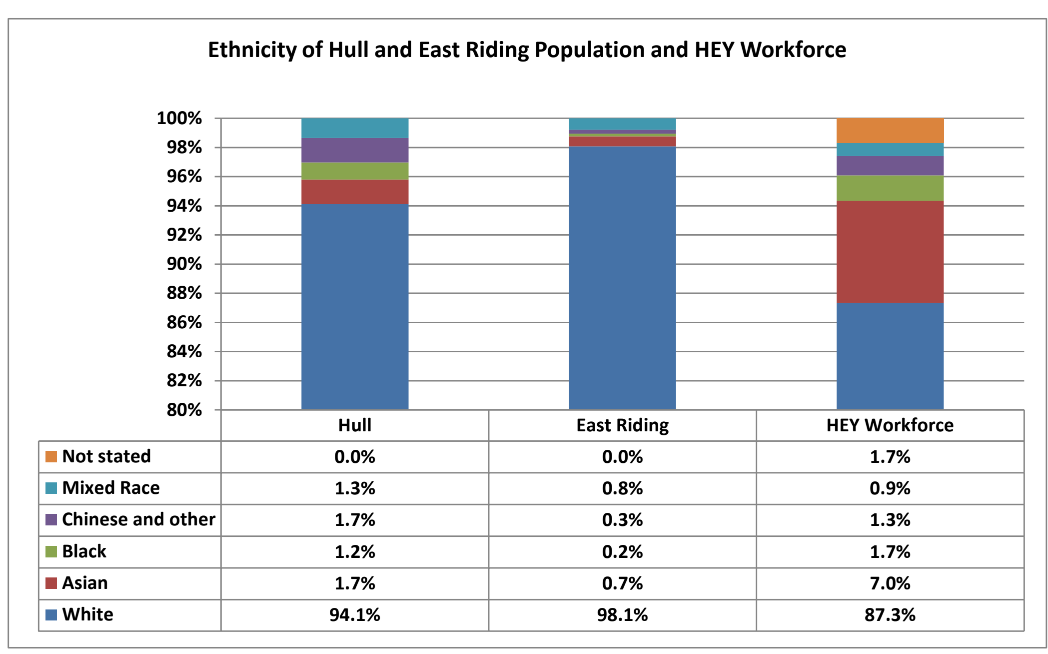


Figure 8: Ethnicity of Workforce as at 31 March 2017
(Source of data: ESR)

Figure 9 provides a comparison of the ethnicity of the Trust's workforce with the ethnicity of the Hull and East Riding populations.



	Hull	East Riding	HEY Workforce
Not stated	0.0%	0.0%	1.7%
Mixed Race	1.3%	0.8%	0.9%
Chinese and other	1.7%	0.3%	1.3%
Black	1.2%	0.2%	1.7%
Asian	1.7%	0.7%	7.0%
White	94.1%	98.1%	87.3%

Figure 9: Ethnicity Hull and East Riding Population and HEY Workforce as at 31 March 2017
(Source of data: ONS 2011 Census and HEY ESR)

The age range of the workforce at 31 March 2017 is given in Figure 10 and is compared to the local population for Hull and the East Riding of Yorkshire. It is noted that the Trust has a significantly higher level of staff in the 25-44 and 45-64 years categories than the local population.

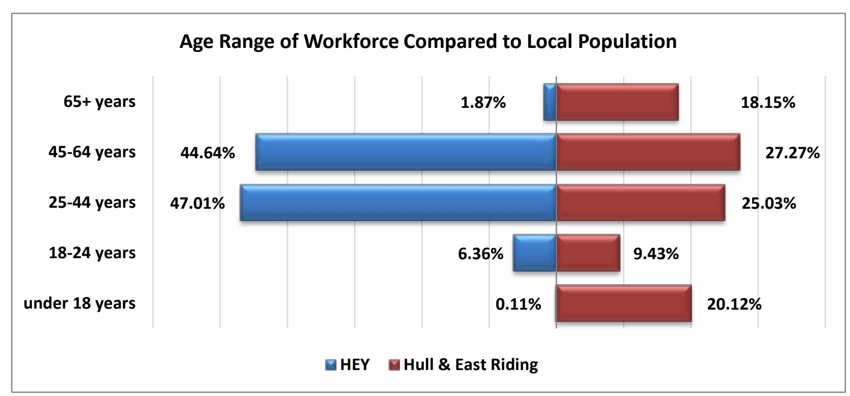
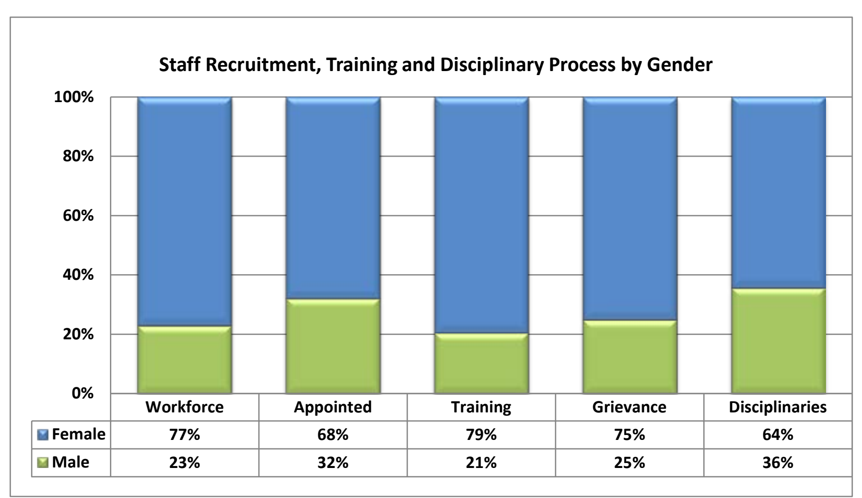


Figure 10: Age Range of Workforce as at 31 March 2017

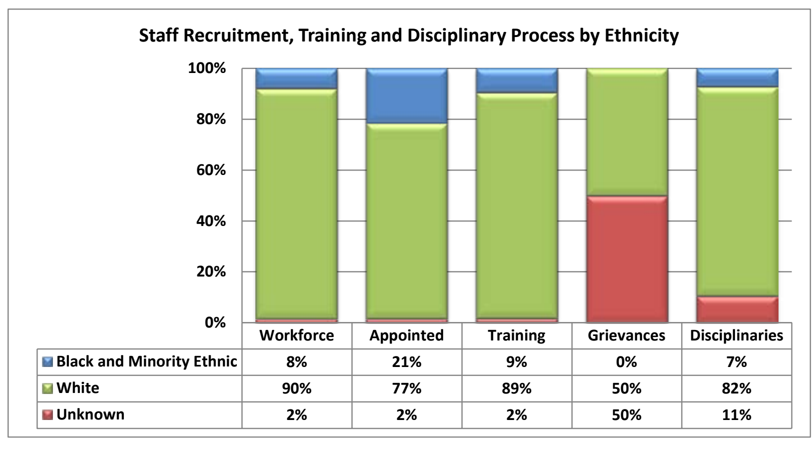
Figure 11 provides an overview of the staff recruitment, training and disciplinary processes undertaken by gender as at 31 March 2017. The number of staff appointed covers the 12 month period from April 2016 to March 2017. Training is compliant records as at 31 March 2017 and the information on grievances and disciplinaries reflects the number of open cases at 31 March 2017.



	Workforce	Appointed	Training	Grievance	Disciplinaries
Female	77%	68%	79%	75%	64%
Male	23%	32%	21%	25%	36%

Figure 11: Staff Recruitment, Training and Disciplinary Process by Gender, as at 31 March 2017 (Source of data: ESR)

Figure 12 shows staff recruitment, training and disciplinary processes by ethnicity for the same period.



	Workforce	Appointed	Training	Grievances	Disciplinaries
Black and Minority Ethnic	8%	21%	9%	0%	7%
White	90%	77%	89%	50%	82%
Unknown	2%	2%	2%	50%	11%

Figure 12: Staff Recruitment, Training and Disciplinary Process by Ethnicity as at 31 March 2017

5.3.1 National Staff Survey Results 2016

3,509 staff at Hull and East Yorkshire Hospitals NHS Trust took part in the National Staff Survey 2016. This was a response rate of 44% which is above average for acute trusts in England, and compares with a response rate of 36% in this Trust in the 2015 survey.

The demographic characteristics of respondents by age, gender, ethnic background, religion or belief and disability are detailed overleaf.

Demographic Characteristic	Grouping	Staff Survey Respondents 2016	Average (median) for acute Trusts 2016
Gender	Male	24%	21%
	Female	76%	79%
Age Group	Between 16 and 30 years	16%	16%
	Between 31 and 40 years	22%	20%
	Between 41 and 50 years	28%	27%
	51 years and over	34%	37%
Ethnic Background	White	91%	89%
	Mixed	1%	1%
	Asian/Asian British	6%	7%
	Black/Black British	1%	2%
	Chinese	0%	0%
	Other	1%	1%
Sexual Orientation	Heterosexual (straight)	90%	92%
	Gay man	1%	1%
	Gay woman (lesbian)	1%	1%
	Bisexual	1%	1%
	Other	0%	0%
	Preferred not to say	7%	6%
Religion	No religion	40%	33%
	Christian	49%	55%
	Buddhist	1%	1%
	Hindu	1%	1%
	Jewish	0%	0%
	Muslim	2%	2%
	Sikh	0%	0%
	Other	1%	1%
	Preferred not to say	6%	5%
Disability	Longstanding illness, health problem or disability	21%	16%
	If longstanding disability and if adjustments felt necessary, % saying adequate adjustments were made	77%	74%

Figure 13: Demographic Characteristics of Respondents to NHS Staff Survey, 2016

The Trust's overall score for staff engagement was 3.77 in 2016. Despite being an improvement on the 2015 overall score of 3.75, the Trust remained below (worse than) average when compared to Trusts of a similar type (national average for Trusts was 3.81).

Two key findings are attributed to the theme of equality and diversity within the national staff survey:

Key Finding	Trust Score 2015	Trust Score 2016	Change compared to 2015	National average 2016
KF20: % of staff experiencing discrimination at work in the last 12 months **(2016 – Lowest (best) 20% of Trusts)**	12%	9%	**-3%**	11%
KF 21: % of staff believing that the organisation provides equal opportunities for career progression or promotion **(2016 – Above (better than) average)**	85%	88%	**3%**	87%

Figure 14: Equality and Diversity Key Findings, National Staff Survey 2016

Six key findings are listed under the Violence, Harassment and Bullying section of the survey results report.

Key Finding	Trust Score 2015	Trust Score 2016	Change compared to 2015	National average 2016
KF22: % of staff experiencing physical violence from patients, relatives or the public in the last 12 months **(2016 – Below (better than) average)**	12%	14%	**2%**	15%
KF23: % of staff experiencing physical violence from staff in the last 12 months	2%	2%	0%	2%
KF24: % of staff/colleagues reporting most recent experience of violence **(2016 – Below (worse than) average)**	67%	65%	**-2%**	67%
KF25: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months **(2016 – Below (better than) average)**	26%	25%	**-1%**	27%
KF26: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months **(2016 - Worst 20% of acute Trusts)**	38%	31%	**-7%**	25%
KF27: % of staff/colleagues reporting most recent experience of harassment, bullying or abuse **(2016 – Below (worse than) average)**	37%	43%	**7%**	45%

Figure 15: Violence, Harassment and Bullying Key Findings, National Staff Survey 2016

The Staff Survey included a specific question in relation to staff experiencing discrimination on the grounds of their ethnic background, gender, religion, sexual orientation, disability and age. The outcomes are detailed overleaf:

Discrimination - % saying they had experienced discrimination on the grounds of:	Trust Score 2016	Average (median) for acute trusts	Trust Score 2015
Ethnic background	2	4	4
Gender	1	2	1
Religion	0	0	1
Sexual orientation	1	0	0
Disability	1	1	0
Age	1	2	1
Other reason	4	3	6

The key findings by gender, disability and ethnicity are summarised below:

Key findings by demographic group	Better than average	Worse than average	Best Trust score	Worst Trust score
Men	10	22	1	3
Women	23	9	4	1
Disabled	2	30	0	25
Not disabled	28	4	9	0
White	22	10	1	0
BME	25	6	19	2

In summary, the Staff Survey results for 2016 show an improving position for the Trust in relation to equality and diversity, when compared to its performance in 2015, however overall the Trust remains worse than average across a number of indicators when compared to other acute Trusts.

Significant improvements have been made in staff experiences overall, particularly in relation to BME staff, however the experiences of those with disabilities and within particular occupational groups or Health Groups indicate that there is still work to be done in relation to changing attitudes and behaviours and in developing a diverse and inclusive organisation.

The Trust has established a Staff Survey Working Group aimed at addressing the issues raised in the staff survey, in particular in relation to disabled staff or those with a long standing condition, and within particular staff groups such as Medical and Dental, Admin and Clerical, Estates, Facilities and Development. An action plan has been developed for the Trust and this was approved by the Board in April 2017.

5.3.2 Workforce Race Equality Standard (WRES)

The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce race equality. By using the WRES, NHS England expects that all NHS organisations will, year on year, improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

The Trust's Workforce Race Equality Standard (WRES) submission for 2017 was approved by the Board in September 2017 and is published on the Trust's website - https://www.hey.nhs.uk/wp/wp-content/uploads/2016/07/equalityWRESReturn2016.pdf - together with the Trust's action plan which details how the Trust will address the issues

identified in the WRES - https://www.hey.nhs.uk/wp/wp-content/uploads/2016/07/equalityWRESActionPlan2016.pdf.

The Trust is working with the Black and Minority Ethnic Staff Network to identify potential barriers to career progression and to encourage the participation in personal and leadership development opportunities.

5.3.3 Workforce Disability Equality Standard (WDES)
The Workforce Disability Equality Standard has been mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18. The Trust is currently reviewing the draft metrics for the WDES. These follow a similar format to the Workforce Race Equality Standard looking at numbers of disabled staff across different pay bandings, as well as drawing on results from the NHS Staff Survey.

5.3.4 Equality Delivery System (EDS2)
The Trust has utilised feedback from staff, patients, service users and community groups to assess progress against the goals and outcomes of the EDS2. In each case the Trust has rated itself as 'developing' as it recognises that there is further work to be done in terms of:

- demographic data collection,
- improving Trust performance in relation to access targets,
- communication with patients, service users and carers, and
- promoting equality, diversity and inclusion across the organisation.

Each of the outcomes links to the Trust's equality objectives.

6. EQUALITY OBJECTIVES
The purpose of setting equality objectives is to strengthen the Trust's performance of the general Equality Duty and to ensure that we are making year on year progress in advancing equality and human rights for all groups and beyond, with our patients, carers and those who work in the organisation.

The Trust's equality objectives to 2020 have been informed by:

- A review of progress against our previous equality objectives
- The NHS Equality Delivery System (EDS2) methodology to identify areas for further improvement
- Consultation with stakeholder groups, including staff and patients/service users.
- The findings and recommendations of key reports, including:
  - The Care Quality Commission's Quality Inspections of the Trust in 2014 and 2015
  - The Advisory, Conciliation and Arbitration Service (ACAS) Review of Hull and East Yorkshire Hospitals NHS Trust (2014)
  - NHS Patient and Staff Survey results
  - 'Making the Difference: Diversity and Inclusion in the NHS' (The King's Fund, 2015).
  - Reviewing progress in achieving compliance with the Accessible Information Standard and NHS Workforce Race Equality Standard
  - Analysis of patient and workforce equality data.

The equality objectives have been linked to the achievement of the goals and outcomes within the NHS Equality Delivery System, ie:

Goal 1 - Better health outcomes
Goal 2 - Improved patient access and experience
Goal 3 - A representative and supported workforce
Goal 4 - Inclusive leadership.

Our equality objectives are:

- To improve our evidence base for patient equality of access to services.
- To make information more accessible, to better meet the needs of people who have a disability, impairment or sensory loss.
- To build an inclusive environment for all staff.
- To demonstrate progress against the indicators within the NHS Workforce Race Equality Standard (WRES).

Detailed information on each of the objectives, the context, actions and key performance measures is attached as an appendix.

7. DELIVERING EQUALITY, DIVERSITY AND INCLUSION

The actions we will take to deliver equality, diversity and inclusion for patients/service users and staff are detailed below.

Action	How we will do this
Improve the way in which we collect and use patient data to monitor equity of access to services and act on information where inequalities are identified.	o Work with patients/service users to ensure we have up-to-date demographic and contact details. o Target specific groups which may appear to be under-represented in terms of access to Trust services (eg: through promotion of health screening programmes) o Work with commissioners and public health colleagues to identify and address any inequalities in access to services
Involve more patients, service users, parents and carers in the planning and delivery of services	o Promotion of membership and participation in the Patient Council. o Promotion and recruitment to the Young Health Champions Programme in association with The Prince's Trust and local schools o Inclusion of patient/user representatives on service development project groups o Feedback from Membership Events o Feedback from patient surveys, FFT surveys, complaints and PALs issues o Expansion of the Volunteer Programme o Trust participation in local Equality Networks and Disability Advisory Group
Look at ways of improving the facilities and environment within our hospitals for patients and services users	o Further enhancement of facilities for Dementia patients o Participation in John's Campaign, including provision of overnight accommodation for carers of people with dementia to enable them to support their relative during their hospital stay o Increased user participation in PLACE (Patient-led Assessments of the Care Environment) assessments which include facilities for the disabled, people living with dementia, privacy and dignity issues, etc. o Reviewing access and signage across the hospital sites

Action	How we will do this
	o Ensuring that our buildings and equipment are fit for purpose
Ensure that the equality impact of policy and service changes is taken into account before decisions are taken.	o Undertake equality impact assessments to inform decision-making and allocation of resources
Use new technology to support people's information and communication support needs	o Review the support and resources available for people for whom English is not their first language. This includes foreign language and British Sign language interpretation services. o Utilisation of SMS messaging and email for those with a disability, impairment or sensory loss who require communication or information support. o Utilisation of QR reader and code software to enable users to receive Trust information leaflets direct to their mobile phone or tablet. Enabling them to view the information in a different language or large font, where required. o Continue to review compliance with the Accessible Information Standard within the Trust and implement remedial action as appropriate.
Increase the level of community engagement	o Develop and strengthen links with schools, colleges and Universities o Develop and strengthen links with community groups and networks o Participation in City of Culture events o Showcase careers and innovation in the NHS through participation in Health Expo events, recruitment fairs
Work to ensure that all staff have equality of opportunity for career progression, including access to education and training opportunities, appraisals and performance development reviews	o Ensure effective monitoring of workforce data to highlight areas for further action, including related responses to questions within the NHS Staff Survey o Promote education and learning opportunities to all staff, including annual development programme and NHS Leadership Academy courses o Promotion of Trust Coaching and Mentoring Programme
Look to increase the opportunities for staff networking and increased consultation and engagement on issues affecting them	o Continued development of the BME and LGBT staff networks. o Explore opportunities and interest in establishing other networks eg disabled/long standing conditions o Utilisation of new intranet capability to encourage staff networking
Seek to celebrate the diversity of our workforce by participating in national and local community events	o Promotion of cultural/religious festivals using Trust media eg intranet, newsletter, Team Brief o Trust participation in national/local events eg Pride o Sponsoring of staff attendance at local/national conferences eg WRES Conference, Disability Summit o Promotion of NHS Equality, Diversity and Human Rights Week
Review our equality, diversity and inclusion training programmes to	o Refresh the Trust's EDI training programme to reflect requirements:

Action	How we will do this
raise the awareness of staff to the needs of their colleagues and patients/service users	o At induction o On becoming a supervisor/manager o On an ongoing basis o Of senior managers (eg understanding of PSED, WRES, WDES, business case for ED&I) o Ensure content of EDI programme is up to date and offers a blend of training to meet the needs of the individual eg e-learning, face to face, case studies, videos
Review our employment policies and procedures to ensure they reflect current legislation and best practice	o Ongoing programme of policy/procedure refresh and development o Consultation and engagement with staff, staff side representatives and staff networks on content of policies and procedures

8. MONITORING AND REVIEWING THE STRATEGY

Delivery of the Strategy and achievement of the Trust's Equality Objectives will be monitored through the Trust's Diversity and Inclusion Steering Group, which will submit reports to the Executive Management Committee and Workforce Transformation Committee, with an annual report on progress being presented to the Trust Board.

The Strategy itself will be reviewed and updated on an annual basis by the Diversity and Inclusion Steering Group and recommendations made to the Executive Management Committee and Trust Board.

Jackie Railton
Chair – Diversity and Inclusion Steering Group

January 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
GENDER PAY GAP REPORTING

Trust Board date	13 March 2018		**Reference Number**	2018 – 03 - 18		
Director	Simon Nearney – Director of Workforce and OD		**Authors**	Louise Whiting, Employment Policy and Resourcing Manager & Andy Barker, Workforce Planning & Information Manager		
Reason for the report	The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2017, prior to publication of the data in line with statutory requirements.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is asked to receive and accept this report.					
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 18 - Staffing					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** Y		**Legal advice taken?** N	**Raises sustainability issues?** N	
5	**BOARD/BOARD COMMITTEE REVIEW** Remuneration Committee 30 November 2017 – interim report pending ESR release Trust Board (Part 2) 30 January 2018 – detailed report following ESR release					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
GENDER PAY GAP REPORTING

1 PURPOSE OF THIS REPORT

The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2017, prior to publication of the data in line with statutory requirements.

2 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage.

The Regulations have been brought in to highlight any imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. Additionally, nationally there is demand, by regulators and the public, for a move to greater pay transparency.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

Closing the gender pay gap is not just about achieving gender equality but also about boosting the economy given the cost of the under-utilisation of women's skills to the UK economy, and the impact on productivity. The Government anticipates that reducing the gap at workforce level will help to narrow the gap at a national level.

Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

3 REPORTING REQUIREMENTS

The Trust is required to publish six gender pay gap measures;

- **Mean pay gap** – the difference between the mean hourly rate of pay (excluding overtime) of male and female employees
- **Median pay gap** – the difference between the median hourly rate of pay (excluding overtime) of male and female employees
- **Mean bonus gap** – the difference between the mean bonus paid to male and female employees who received a bonus in the relevant pay period

- **Median bonus gap** – the difference in the median bonus pay for male and female employees who received a bonus
- **Bonus distribution by gender** – the proportions of male and female employees who received bonus pay
- **Pay distribution by gender** – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands

The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2017. The figures must be calculated using the mechanisms set out in the gender pay gap reporting legislation.

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2018) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

4 THE PROPOSED GENDER PAY GAP REPORT FOR 2017

The Trust's overarching Gender Pay Gap Report (see Appendix 1) is for the Board's approval. This includes supporting narrative with key findings following a more in-depth analysis of the data, to help understand the Gender Pay Gap Reporting outcomes.

5 RECOMMENDATION

The Board is requested to note and approve content of this report.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites.

Simon Nearney
Director of Workforce & OD
March 2018

APPENDIX 1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

GENDER PAY GAP REPORT 2017

1 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

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The Regulations have been brought in to highlight any imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. Additionally, nationally there is demand, by regulators and the public, for a move to greater pay transparency.

Closing the gender pay gap is not just about achieving gender equality but also about boosting the economy given the cost of the under-utilisation of women's skills to the UK economy, and the impact on productivity. The Government anticipates that reducing the gap at workforce level will help to narrow the gap at a national level.

Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

2 NHS PAY STRUCTURE

The majority of staff at the Trust are paid on the national Agenda for Change Terms and Conditions of Service. The basic pay structure for these staff is across 9 pay bands and staff are assigned to one of these on the basis of job weight as measured by the NHS Job Evaluation System. Within each band there are a number of incremental pay progression points.

Medical and Dental staff have different sets of Terms and Conditions of Service, depending on seniority. However, these too are set across a number of pay scales, for basic pay, which have varying numbers of thresholds within them.

There are separate arrangements for Very Senior Managers, such as Chief Executives, Directors and Casual Worker staff.

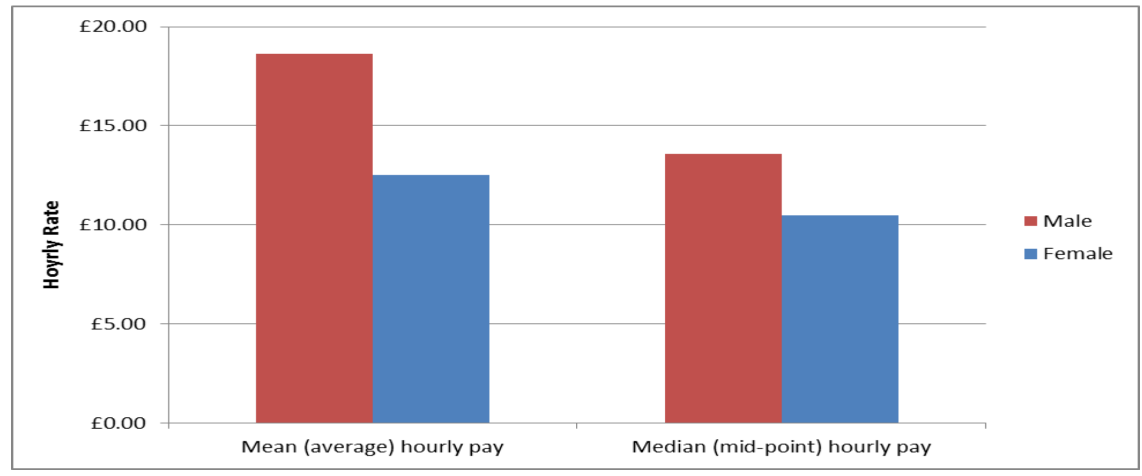
3 GENDER PAY GAP DATA 2017

The figures set out below have been calculated using the standard methodologies used in the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, utilising the national NHS Electronic Staff Record Business Intelligence report functionality.

Hull and East Yorkshire Hospitals NHS Trust's Gender Pay Gap Data for the snapshot date of 31 March 2017 is as follows;

Mean and Median Gender Pay Gap

Gender	Mean (average) hourly pay	Median (mid-point) hourly pay
Male	£18.63	£13.60
Female	£12.51	£10.48
£s difference	£6.12	£3.12
% difference	**32.85%**	**22.89%**



- The mean gender pay gap is **32.85%** (i.e. this means that women's average earnings are 32.85% less than men's).
- The median gender pay gap is **22.89%** (i.e. this means that women's average median earnings are 22.89% less than men's).

Note; Gender pay gap calculations are based on ordinary pay which includes; basic pay, allowances (including shift premiums), extra amounts for on-call, pay for leave but excludes; overtime, expenses, payments into salary sacrifice schemes (even though employees opted into the schemes voluntarily, as they provide a benefit in kind), and Pensions.

Key Findings

- The Trust has an overall gender split of 77.30% female and 22.70% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 22.70% of the workforce, there are a disproportionate number of males, 38.87% in the highest paid quartile, predominantly medical staff.
- The Trust's median gender pay gap is 22.89% in favour of males compared to the national average of 18.1 per cent in favour of males (ONS data from the Annual Survey of Earnings and Hours).
- Medical staff pay has a strong impact on the mean and median data. If Medical staff were excluded from the data above the mean (average) hourly pay gap is 7.45% or £0.95, and the median (mid-point) hourly pay is 3.27% or £0.34.

Nationally the Consultant workforce is predominately male. In recent years women have made up the majority of medical graduates, and this should impact on data in the years ahead.

Pay Quartiles by Gender

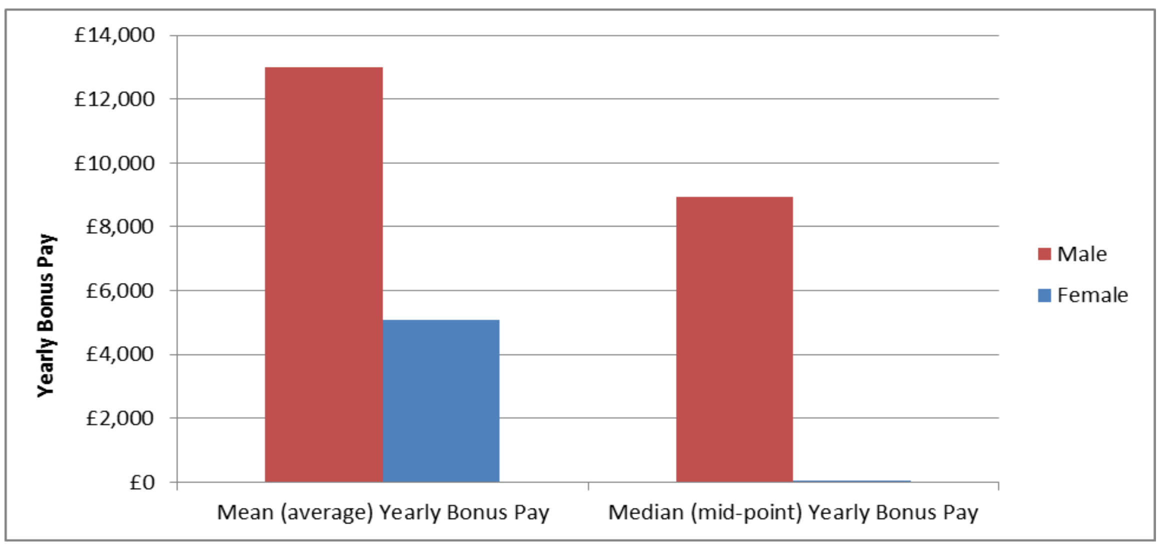
Quartile Pay	Males	Females
Lower	18.87%	81.13%
Lower Middle	14.20%	85.80%
Upper Middle	18.87%	81.13%
Upper	38.87%	61.13%

Key Findings

- Based on the Trust's overall gender split (77.30% female and 22.70% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. There are a disproportionate number of males, 38.87%, in the upper quartile with 61.13% being female. There is a mean gender pay gap of 26.50% and £7.91 in the upper quartile.
- Within the Medical staff group there is a disproportionate gender split (35.99% females and 64.01% male). In the Upper Quartile for Medical staff the split is 30.82% female and 69.18% male. This group accounts for the majority of the Trust's highest earners.
- The Trust has a split of 58.35% full time and 41.65% part time staff. 93.24% of part time staff are female. The majority of part time staff (69.97%) are in the lower quartiles.
- Only 25.41% of staff in the upper quartile are part time. This is disproportionate when compared with the Trust wide figure of 41.65% of staff being part time.
- The gender pay gap calculations are based on pay excluding payments made into salary sacrifice schemes (even though employees opt into the schemes voluntarily, as they provide a benefit in kind). As payment into these schemes reduces the salary and hourly rate of pay this has impacted on the Trust's data, including the mean female average and where females fall in pay quartiles. The Trust operates a number of salary sacrifice schemes. 80% of female staff pay into salary sacrifice schemes compared to 20% of male staff, particularly the high values schemes i.e. Family Car Lease and Childcare Vouchers. This is especially so in the Upper Middle quartile.

Mean and Median Gender Bonus Gap

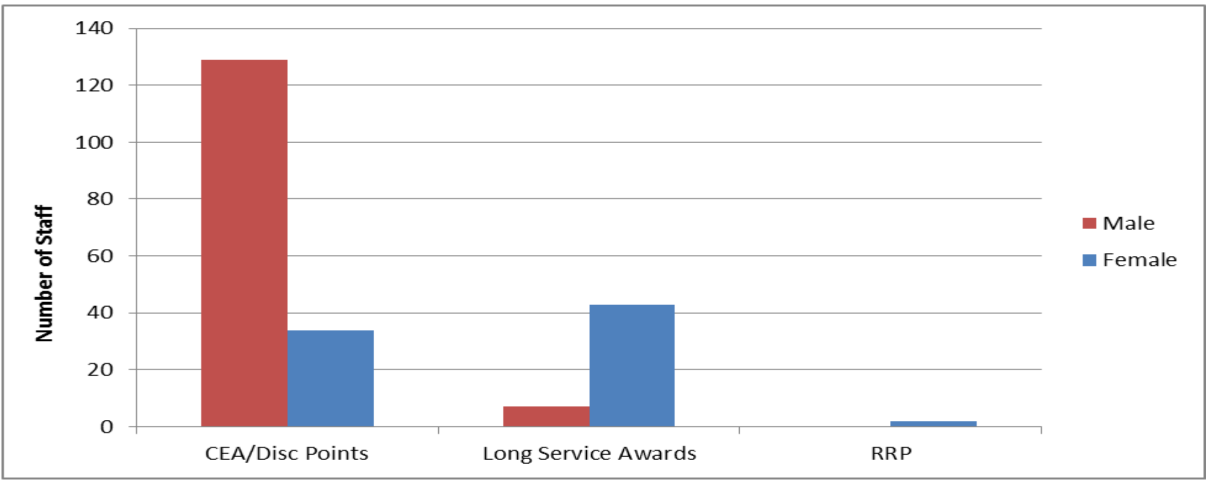
Gender	Mean (average) Yearly Bonus Pay	Median (mid-point) Yearly Bonus Pay
Male	£13,002.27	£8,950.75
Female	£5,068.31	£50.00
£s difference	£7,933.96	£8,900.75
% difference	**61.02%**	**99.44%**



- The mean gender bonus gap is 18.03% when long service awards* are excluded from the data, rising to **61.02%** when they are included in line with national guidance.
- The median gender bonus gap is 36.99% when long service awards* are excluded from the data, rising to **99.44%** when they are included.
- The proportion of male employees receiving a bonus is 6.43% excluding long service awards* (**6.78%** when included) and the proportion of female employees receiving a bonus is 0.53% excluding long service awards (**1.17%** when included).

Bonus Type by Gender

Bonus Type	Female	Male	Total
CEA/Disc Points	34	129	163
Long Service Awards	43	7	50
RRP	2	0	2
Total	79	136	215



Key Findings

- The Trust has three types of bonus that meet reporting requirements – Clinical Excellence Awards (which are awarded based on the performance of Consultant

Medical Staff subject to national and local eligibility criteria), Long Service Awards and Recruitment and Retention Premia.

- *The Trust's gender bonus data is significantly distorted by the Trust's Long Service award scheme as given the gender makeup of our workforce more females receive this. Calculations have therefore been made both including and excluding this data. Including long service awards, the median bonus pay for females is £50. Excluding long service awards, the median bonus pay for females is £5,718.59. This compares to £8,950.75 and £9,075.17 for males.
- The Long Service Award scheme is applicable to any employee, whether male or female, who has achieved 25 years substantive service within the NHS. Staff are invited to attend an awards ceremony to be presented with a certificate and a token gift to the value of £50, or a donation of the same value to a registered charity of their choice, in recognition of their contribution and commitment.
- If long services awards are excluded, the mean bonus pay gap reduces from 61.02% (£7,933.96) to 18.03% (£2,471.44) and the median bonus pay gap reduces from 99.44% (£8,900.75) to 36.99% (£3,356.58).
- The difference in bonus pay is also driven by the availability of higher bonuses for Consultant Medical staff where there is a greater proportion of men. CEA and Discretionary points account for 76% of all bonuses awarded. Those eligible for CEA/Discretionary points are consistent with the Consultant gender split (35.99% female and 64.01% male), however when it comes to applying, 7.71% fewer females applied than were eligible, with 20.86% of females and 79.14% males receiving CEA and discretionary payments.

Note; In order to tackle the distinct issues underpinning the gender pay gap in medicine and to help monitor progress in July 2016 the Secretary of State for Health announced an independent review of how the gender pay gap can be eliminated in medicine.

4 SUMMARY OF RESULTS AND ACTIONS

The Trust is committed to ensuring all staff are treated and rewarded fairly irrespective of gender.

The Trust is using the workforce gender pay gap figures, which highlight that there are aspects to address, to help understand the underlying causes for its gender pay gap and to identify suitable steps to minimise it.

The Trust gender pay gap data, which shows the difference in average pay between men and women in the workforce, reflects that it has a majority of men in higher-paid roles, predominantly medical staff. The Trust's mean and median gender pay gap figures are higher than the average national figures, but comparable with other large Acute NHS Trusts. The Trust's bonus data, excluding long service awards, is also comparable to other large Acute Trusts with a high proportion of Medical staff.

The Trust is committed to addressing the gender pay gap and is undertaking a range of actions and initiatives to reduce this including;

- Further developing its evidence base of data to ensure effective gender monitoring is in place.
- Reviewing output of exit and retention data to better understand any blocks to gender pay progression and to identify and implement actions to improve this.
- Reviewing and updating appropriate policies and practises, for example recruitment and selection, in partnership with staff side representatives and managers.

- Reviewing training, including the introduction of mandatory Equality and Diversity training for all staff, and greater emphasis on unconscious bias in Recruitment and Selection training.
- Taking steps to make the most of flexible working, including a review of flexible working arrangements across the Trust, removing barriers to this, and ensuring that the Trust's culture supports staff to do so at all levels, including senior staff and Medics.
- Encouraging female participation in leadership development programmes and reviewing career and talent development opportunities so that capable employees of both genders can progress, including the launch of a Coaching and Mentoring Network.
- Reviewing reward processes to ensure fairness and consistency in their approach and application.
- Undertake a separate detailed analysis of medical and dental pay arrangements and take steps to encourage a greater proportion of eligible female Consultants to apply for clinical Excellence Awards.

Solutions to the gender pay gap lie in culture changes both in society and organisations. None of the initiatives will, in themselves, remove the gender pay gap, and it may be several years before some have any impact at all. In the interim the Trust is committed to reporting on an annual basis on what it is doing to reduce the gender pay gap, and the progress it is making.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
NATIONAL STAFF SURVEY 2017 RESULTS

Trust Board date	13 March 2018			**Reference Number**	2018 – 3 – 19	
Director	Simon Nearney, Director of Workforce and OD			**Authors**	Simon Nearney, Director of Workforce and OD	
Reason for the report	The purpose of the report is to inform the Trust Board of the National Staff Survey 2017 results					
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 and commit to supporting the continuing work to improve the working environment for staff and the culture of the organisation.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	✓	Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework BAF 2	**Raises Equalities Issues?**		**Legal advice taken?**		**Raises sustainability issues?**
5	**BOARD/BOARD COMMITTEE REVIEW** The report is scheduled to be presented at the Executive meeting and Workforce Transformation Committee on 22nd March, 2018 to discuss and agree on action plan.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NATIONAL STAFF SURVEY 2017 RESULTS

1. PURPOSE OF THE REPORT

The purpose of the report is to inform the Trust Board of the National Staff Survey 2017 results. While the National Staff Survey shows that the Trust continues to improve in many areas, with many areas of strength, the report also details where further improvements are required.

2. KEY ISSUES

The Trust has seen performance in national staff surveys improve significantly since 2014. The challenge now is to move into the top 20% of organisations nationally.

There are many good areas of performance in the National Staff Survey 2017. Improvements have once again been made to issues of bullying and harassment, reporting concerns, and visibility of very senior managers, to state a few.

Medical Engagement remains a key area for improvement, together with addressing issues affecting staff with a disability or health condition.

There will need to be a strong focus on enabling managers and leaders to shift from good performance to outstanding performance and a culture of excellence. Staff continue to report feeling undervalued by the organisation, they describe being short-staffed and unable to deliver the care they aspire to, while communication from managers, despite improving, remains poor.

The survey results continue to correlate with the Barrett cultural survey with some staff still feeling that the organisation remains overly bureaucratic and hierarchical with a focus on the short-term.

3. BACKGROUND

At the March 2015 Trust Board meeting an approach to Transforming the Culture of the Trust was agreed. Since that time the CQC which had previously identified cultural issues, including bullying, has specifically noted improvements to the working culture within the organisation. The most recent report described the organisation as being on the cusp of good.

Furthermore, a cultural assessment tool, the Barrett Values Indicator ran in 2017 described the cultural improvement at the Trust as twice that which they would have expected to see in the 30 months since the survey was last completed.

From 1st April 2014 all organisations providing acute, community, ambulance and mental health services were required to implement the Staff Friends and Family Test (Staff FFT); giving all staff the opportunity at least once a quarter to answer two standard questions. The third quarter test is not undertaken because it coincides with the NHS National Staff Survey. Since November 2014 the Trust has measured cultural performance using the four quarterly surveys, with the overall score for engagement being the key measure. Since 2014 the Trust's staff engagement score has improved from the worst in the country to rank among the middle 60% of organisations.

For the third quarter, National Staff Survey, 2017 Capita Surveys and Research processed 3,451 completed survey questionnaires from Trust employees; this gives a response rate of 42% against a national average response rate of 43%. The survey ran from 9th October to 1st December, 2017.

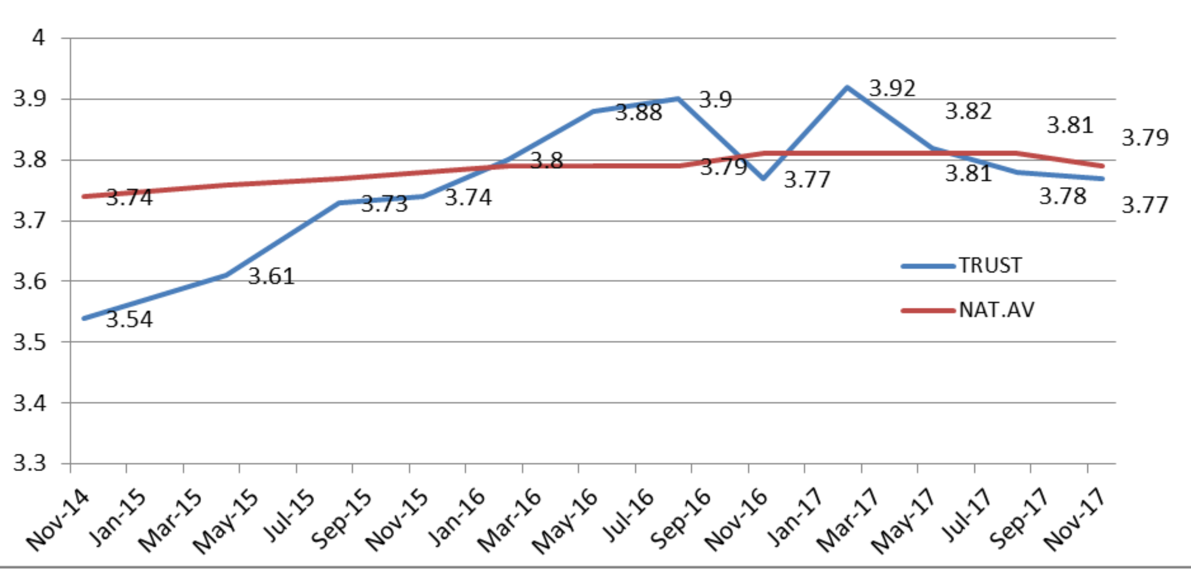
4. OVERALL SCORE FOR ENGAGEMENT

The Trust's overall score for engagement in 2017 (3.77) has remained the same as in 2016 and is just below the national average for Trusts, 3.79. It is worth noting that whilst the Trust has held its position the national score has deteriorated from 3.81, as many organisations have struggled to maintain their position.

The overall score for engagement comprises nine questions with the maximum score possible being 5. The Trust has improved against the three questions relating to pride in the organisation, remained the same against those relating to staff ability to improve their services and deteriorated against motivation and enthusiasm at work.

Question	%	2017	2016	Diff
21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation		67	66	1
21c I would recommend my organisation as a place to work		59	58	1
21a Care of patients / service users is my organisation's top priority		72	70	2
4d I am able to make improvements happen in my area of work		56	56	0
4b I am able to make suggestions to improve the work of my team/department		74	74	0
4a There are frequent opportunities for me to show initiative in my role		73	73	0
2c Time passes quickly when I am working		76	77	-1
2b I am enthusiastic about my job		74	76	-2
2a I look forward to going to work		58	60	-2

The trend scores for overall engagement since 2014 are as follows, where this graph shows the Trust average compared with the national average.

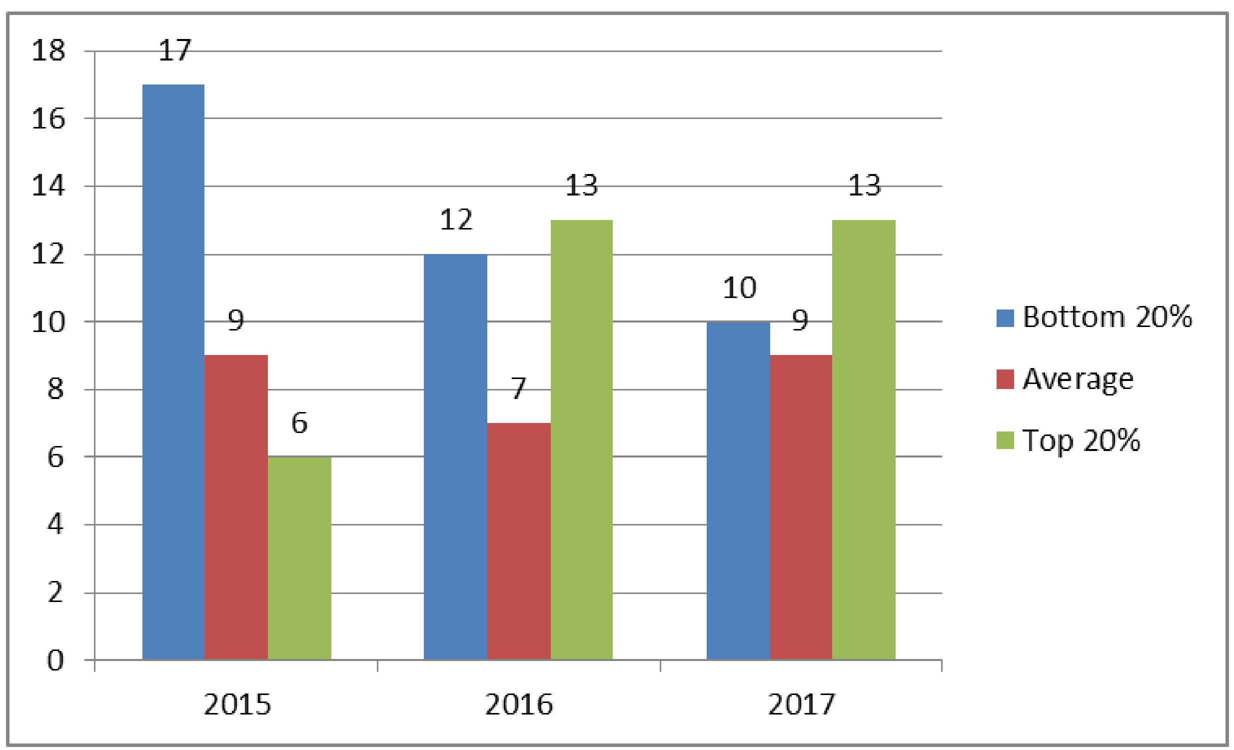


5. KEY FINDINGS

The National Staff Survey comprises 32 key findings. Performance against these key findings has improved significantly over the past three years. Trusts can see how they benchmark against other organisations and whether their scores are in the worst 20% of organisations, average or in the top 20% of organisations.

Our performance in 2017 shows that fewer of our key findings feature in the bottom 20% of organisations while those in the top 20% have remained the same.

Performance against the 32 key findings over the past three years is as follows:

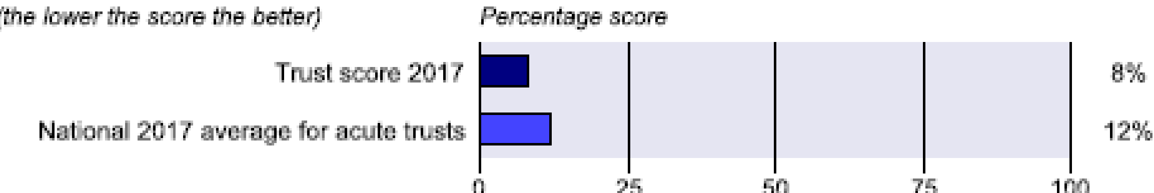


The Trust is in the bottom 20% of Trusts for the following key findings:

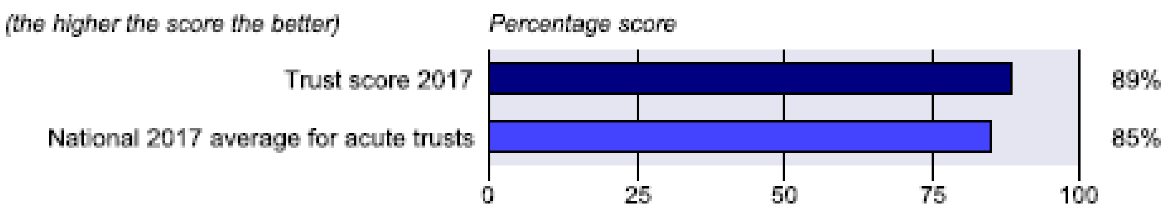
- Quality of appraisals
- Management interest in health and wellbeing
- Staff recommendation of the Trust as a place to work or receive treatment
- Staff able to contribute towards improvements at work
- Effective team working
- Agreeing that their role makes a difference to patients
- Effective use of patient feedback
- Staff reporting the most recent experience of violence
- Experiencing bullying or harassment from a colleague in the last 12 months
- Reporting the most recent incident of bullying or harassment

6. TOP FIVE RANKING SCORES

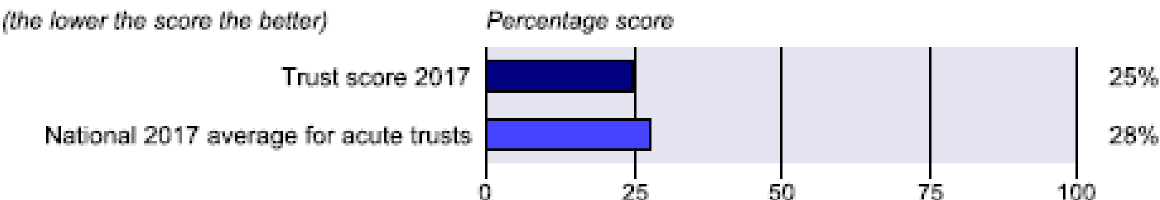
✓KF20. Percentage of staff experiencing discrimination at work in the last 12 months



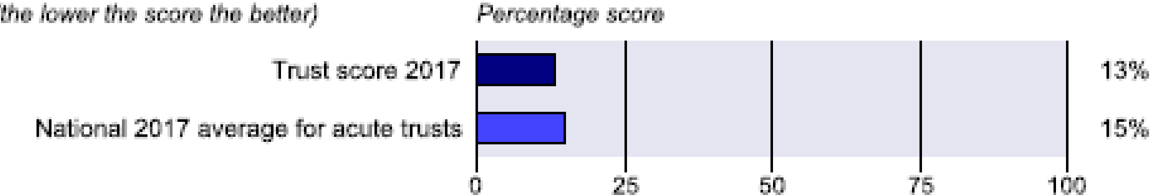
✓KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



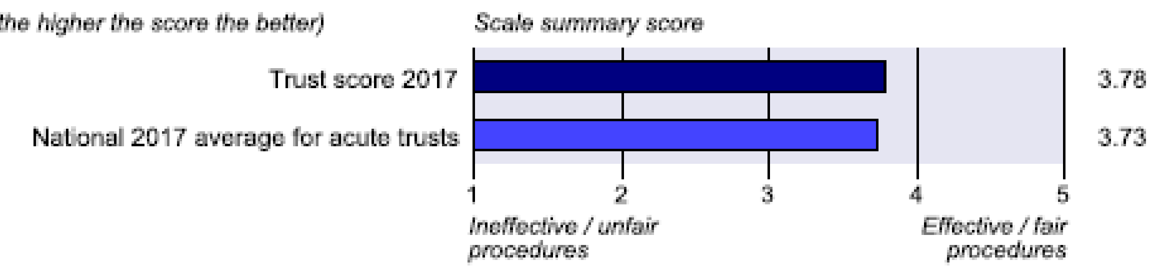
✓KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

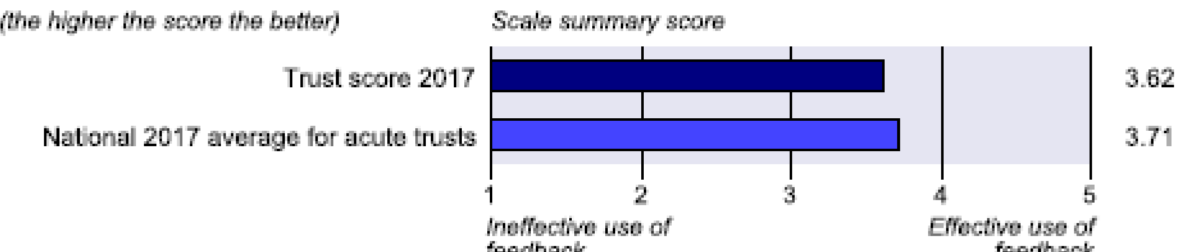


✓KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

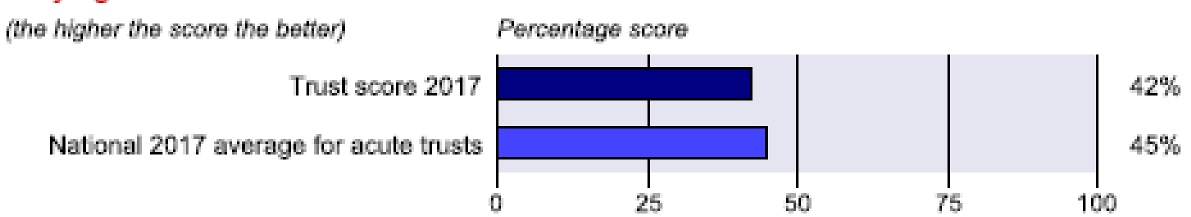


7. BOTTOM FIVE RANKING SCORES

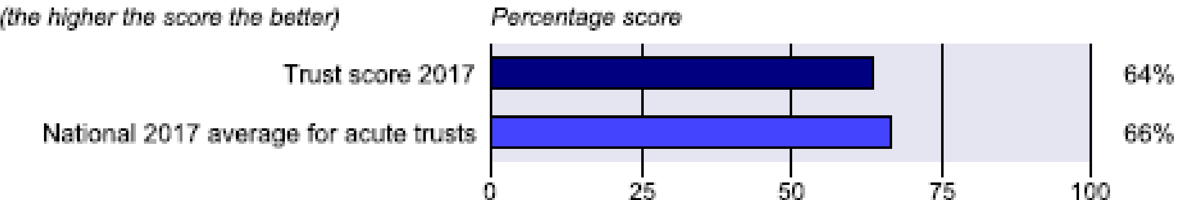
! KF32. Effective use of patient / service user feedback



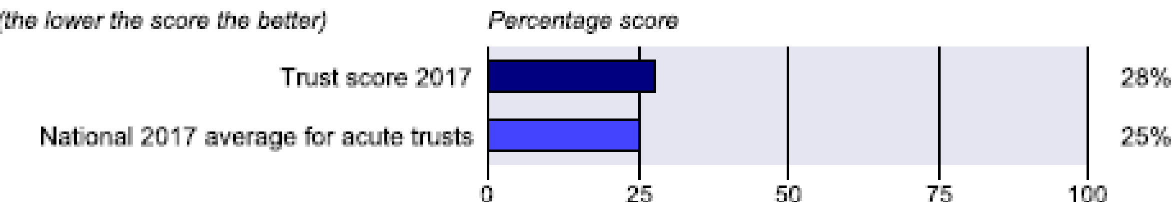
! KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse



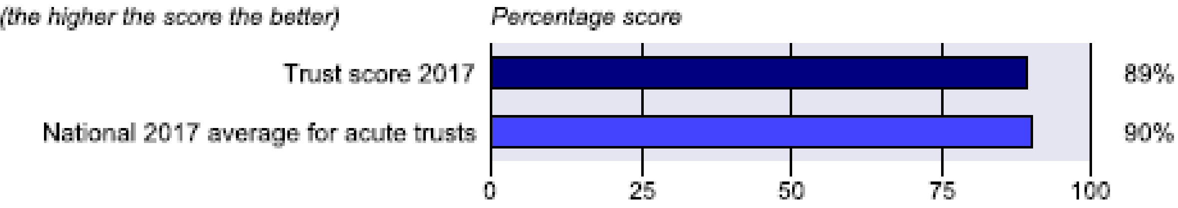
! KF24. Percentage of staff / colleagues reporting most recent experience of violence



! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users



8. HEALTH, WELLBEING AND SAFETY AT WORK

A key improvement area for the Trust since 2014 has been staff reporting issues of bullying and harassment. This work has also been enhanced with the development of the Equality, Diversity and Inclusion Strategy and the adoption of the Workforce Race Equality Standard (WRES), which seek to ensure no member of the workforce is disadvantaged based on the ethnic background, gender, sexual orientation, disability or age.

Over time the Trust has seen its performance improve against these indicators. In 2015 38% of staff reported that they had experienced some form of bullying and harassment from colleagues. In 2016 this dropped to 31% and in 2017 it is it was 28%. This is one of the most improved scores for the Trust in the 2017 survey. Despite this it remains worse than the national average, which is 25%. In an organisation where we have a zero tolerance policy on bullying and harassment this is an area that continues to require focus as we strive to provide a positive working environment for staff.

In terms of reporting of bullying and harassment issues, in 2016 43% of staff said they had reported issues and in 2017 this has fallen to 42%, but again it remains below the national average of 45%, which suggests more work is required to encourage staff to come forward.

Where discrimination is concerned only 8% of staff survey respondents (282 people in total) say they have experienced some form of discrimination from colleagues in the last 12 months, ahead of the national average of 12%. The numbers based on grounds for discrimination are as follows:

Ethnic background	29%
Age	20%
Gender	16%
Disability	9%
Sexual orientation	4%
Religion	4%
Other	41%

(NB - numbers do not add up to 100% as some staff reported two or more forms of discrimination)

89% of staff reported that they believe the Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, sexual orientation, disability or age.This is better than the national average, 85%.

9. JOB SATISFACTION

The 2017 National Staff Survey contains six questions relating to job satisfaction. The Trust performs as follows, where those in red are deteriorating measures and those in green are improving measures.

1. 43% said they are satisfied with the extent which the organisation values their work
2. 72% said they are satisfied with the opportunities they have to use their skills
3. 75% said they are satisfied with the amount of responsibility they are given
4. 81% said that they are satisfied with the support they get from their colleagues
5. 68% said they are satisfied with the support they get from their immediate manager
6. 52% said they are satisfied with the recognition they get for good work

Given that the higher scoring measures are all deteriorating scores while the remaining measures are relatively low scoring, this is an area of the survey which the Trust might consider focusing on during 2018.

10. KEY ACTIONS

This report will be presented at the Executive meeting and Workforce Transformation Committee on 22nd March, 2018 for discussion and to agree the action plan, above and beyond the following key developments already planned, which connect to the People Strategy 2016-2018:

- Chief Executive-led summer briefings for senior leaders – reinforce people management responsibilities and expectations to foster a great working environment
- Leadership programme – continue with Great leaders programme, launch new programme for new leaders and People Management programme
- Continue with medical engagement programme during 2018/19
- Deliver Health and Wellbeing strategy and programme of actions during 2018/19
- Continue to embed Equality, Diversity and Inclusion actions for 2018/19
- Implement the recruitment strategy for 2018/19 including apprenticeship programme
- Health Groups to continue to review exit interview data and implement retention plans

The approved action plan will connect with and include other departments such as the HEY Imporvement team, IT, Estates facilities and Development and Patient Experience.

11. RECOMMENDATIONS

The Trust Board is requested to note the contents of the report and commit to supporting the continuing work to improve the working environment for staff and the culture of the organisation. A progress report will be presented to the Board in 3 months time.

Simon Nearney
Director of Workforce and OD
March, 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
GUARDIAN OF SAFE WORKING HOURS

Meeting date	13 March 2018	**Reference Number**	2018 – 3 - 20
Director	Kevin Phillips – Chief Medical Officer	**Author**	Helen Cattermole - Director of Medical Education and Acting Guardian of Safe Working
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to: • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate		

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

1	**RECOMMENDATION** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing	✓	Assurance	✓	Delegation	

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

4	**LINKED TO:**			
	CQC Regulation(s):			
	Assurance Framework	**Raises Equalities Issues? No**	**Legal advice taken? No**	**Raises sustainability issues? No**
5	**BOARD/BOARD COMMITTEE REVIEW** The report is received by the Trust Board on a quarterly basis.			

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING OCT-DEC 2017

EXECUTIVE SUMMARY

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

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

The Trust Board is requested to receive this report and:

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

1. PURPOSE OF THIS REPORT

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

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

The Trust Board is requested to receive this report and:

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

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

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

2. HIGH LEVEL DATA

Number of doctors / dentists in training (total):	526 (establishment)
	484 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	484
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors: varies between HGs)	0.25 PAs per trainee (max;

This quarter has seen the final large group of trainees start on the 2016 terms and conditions of service (TCS). Since the beginning of October 2017, all trainees in the Trust are now on the 2016 TCS.

All doctors currently on the 2016 terms and conditions of service (TCS) have received their work schedules and all bar a handful of the October 2017 intake received them in accordance with the timings set out in the HEE Code of Practice. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hours adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.

The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

3. JUNIOR DOCTOR WORKING HOURS

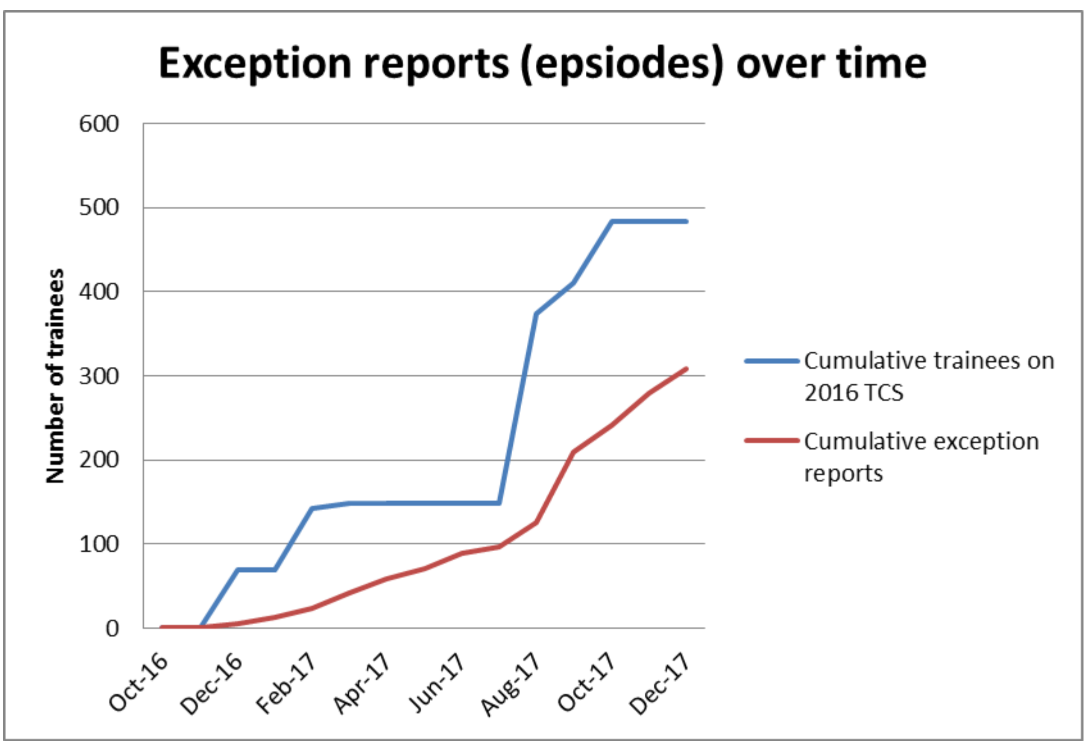
The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.

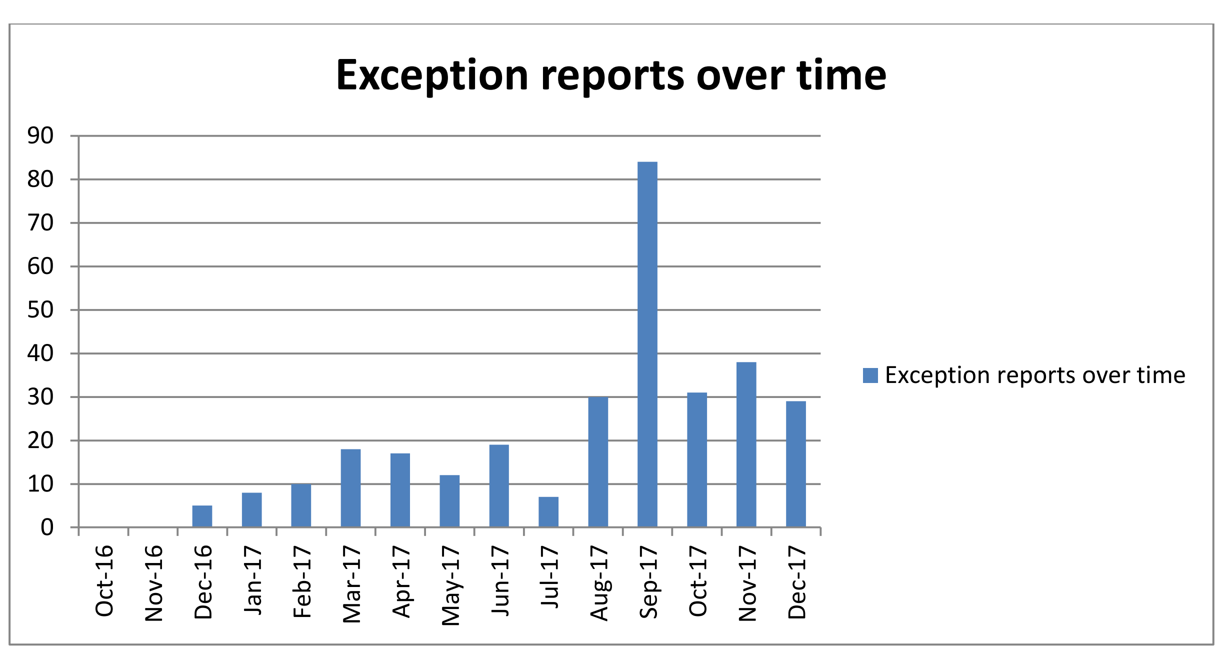
In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern.

There were 103 exception report episodes submitted between 1 October and 31 December 2017 and 36 carried forwards from the previous quarter. The number of reports has shown a steady rise in tandem with the number of doctors on the contract.

a) Exception reports (with regard to working hours)

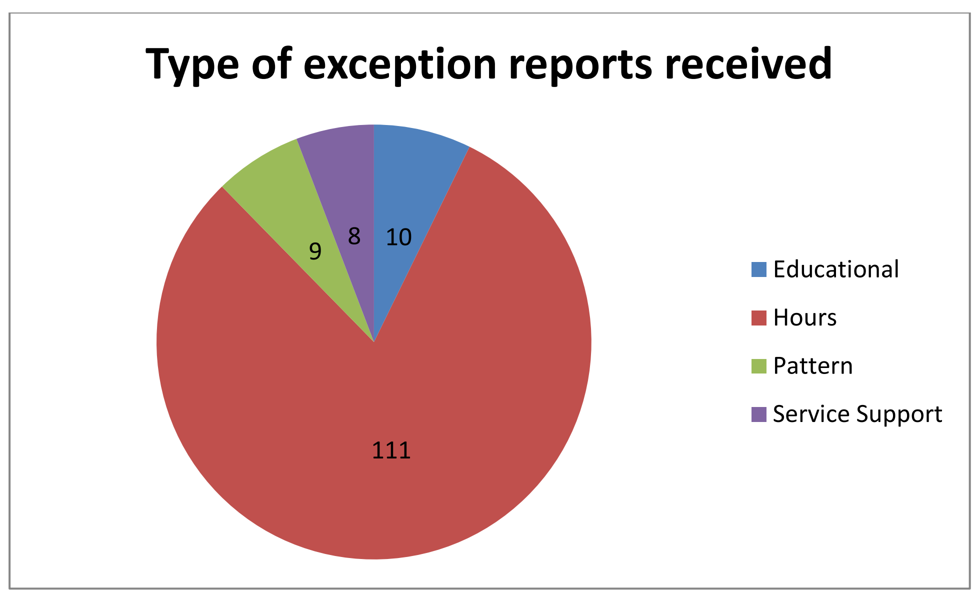
Exception report episodes over time





Types of exception reports received 1 Oct 2017 – 31 Dec 2017

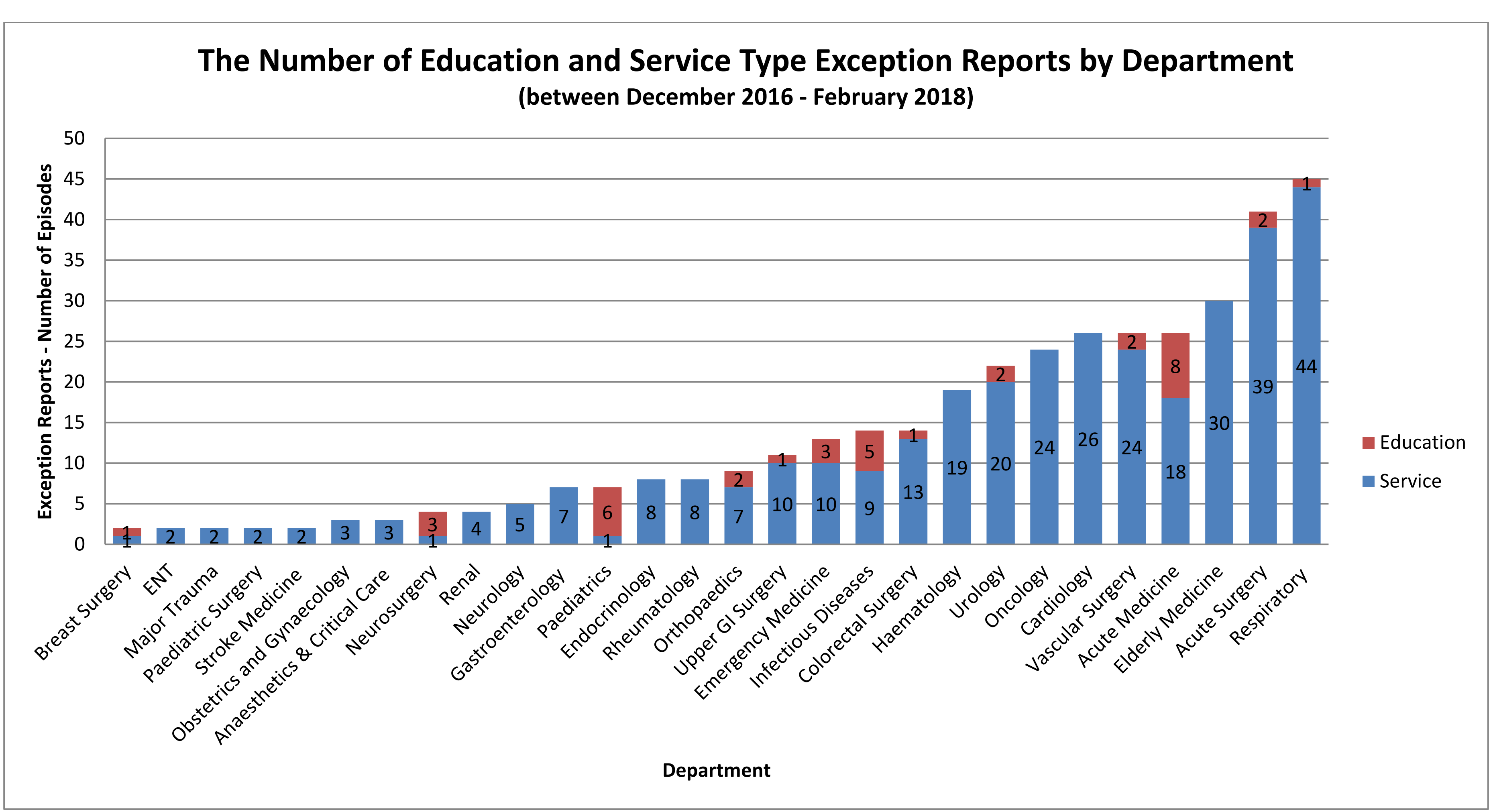
The types and proportions of exception report received has stayed remarkably constant in each quarter to date, however there is an expected trend towards more educational exception reports being submitted as trainees become familiar with the system.



Exception reports (episodes) by specialty 1 Oct 2017 – 31 Dec 2017

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by the trust but trainee feels issue unresolved
AAU	1	0	1		
Acute Surgery HRI	3	3	6		
Anaesthetics		1	1		
Cardiology		7	7		
Colorectal Surgery	1		1		
DME		11	9	2	
Emergency Medicine	4	6	5	5	
Endocrinology		1	1		
General Medicine	1	1	2		
Haematology		10	10		
Infectious Diseases		1	1		
Neurosurgery		3	3		
Obstetrics & Gynaecology	1	2	2		1
Oncology		15	15		
Orthopaedic Surgery	2	2	4		
Paediatric Surgery		1		1	
Paediatrics		1	1		
Respiratory	1	12	12	1	
Stroke Medicine		3	1	2	
Upper GI Surgery		3	3		
Urology	18	2	20		
Vascular Surgery	5	16	20	1	
TOTAL	**37**	**101**	**125**	**12**	**1**

To put these into context, now that we are beginning to have some longitudinal data, we have looked at the data from Dec 2016 to Feb 2018:



Exception reports (episodes) by grade 1 Oct 2017- 31 Dec 2017

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by the trust but trainee feels issue unresolved
ACCS 3		1	1		
CT2		3	3		
F1	26	78	98	6	
F2	5	9	13	1	
GPSTR		1	1		
ST1		2	1		1
ST2	1		1		
ST3	1		1		
ST4		1	1		
StR	4	6	5	5	
TOTAL	**37**	**101**	**125**	**12**	**1**

**** Above numbers based on exception report episodes.**

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades, as time goes on and as they get used to the contract and the exception reporting mechanism. Numbers are small, however, and it is not possible to draw conclusions from these reports yet.

Exception reports (episodes) by rota 1 Oct 2017 – 31 Dec 2017

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by the trust but trainee feels issue unresolved
Rota 124b General Surgery (Uro/ENT) SHO	3	2	5		
Rota 133 - Neurosurgery (ENT) F2 & CT		3	3		
Rota 134 - Orthopaedic F2	1	2	3		
Rota 135 - Orthopaedic & Plastic Surgery CT	1		1		
Rota 18 - Medicine F1	1	27	28		
Rota 2 - A&E SpR	4	6	5	5	
Rota 23 - Vascular Surgery F1	5	16	20	1	
Rota 25 - Acute-Elective Surgery F1	4	6	10		
Rota 4 - Medicine F1		16	12	4	
Rota 4B - Medicine F1	15	14	29		
Rota 51 - O&G ST1-2	1	2	2		1
Rota 58 - Paediatrics SHO		1	1		
RMO 6 -RMO	1		1		
Rota 60 - Paediatric F1		1		1	
Rota 73 - Anaesthetics SHO (Acute)		1	1		
Rota 8 - Oncology/Haematology SHO		2	2		
Rota 9 - Medicine SHO blp 575	1	2	2	1	
TOTAL	**37**	**101**	**125**	**12**	**1**

**** Above numbers based on exception report episodes.**

Exception reports (episodes) - response time 1 Oct 2017 – 31 Dec 2017

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
F1	16	36	47		6	* Difficulty completing report, extra training given. * Further info required, ES on leave * ES put down by trainee instead of CS - now corrected.
F2	4		9		1	
GPSTR			1			
ST1			6		5	* ES away, second overdue copied to clinical lead
ST2 / CT2		2	2			
ST3		1	1			
ST4			1			

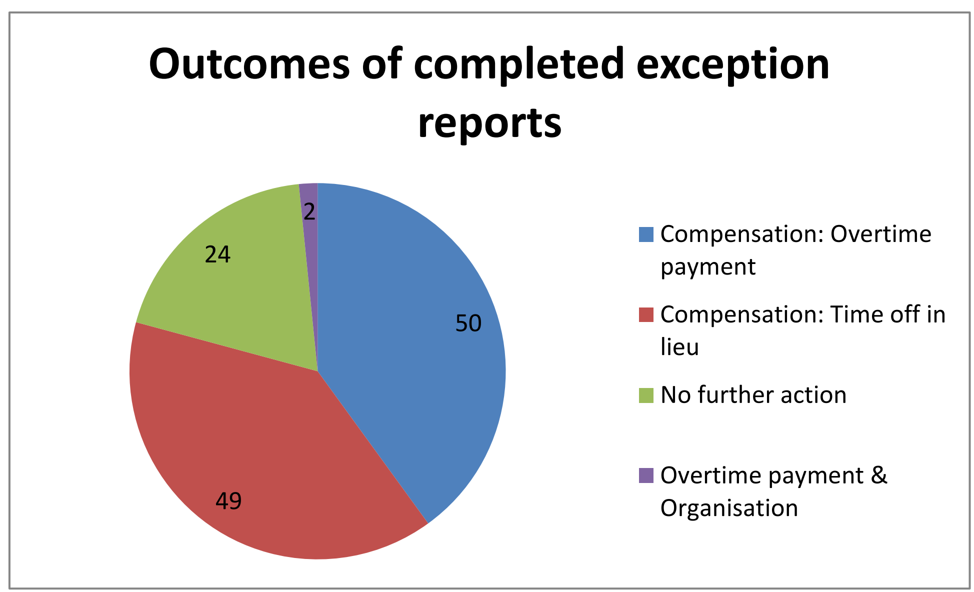
The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.

This is shown in the table below:

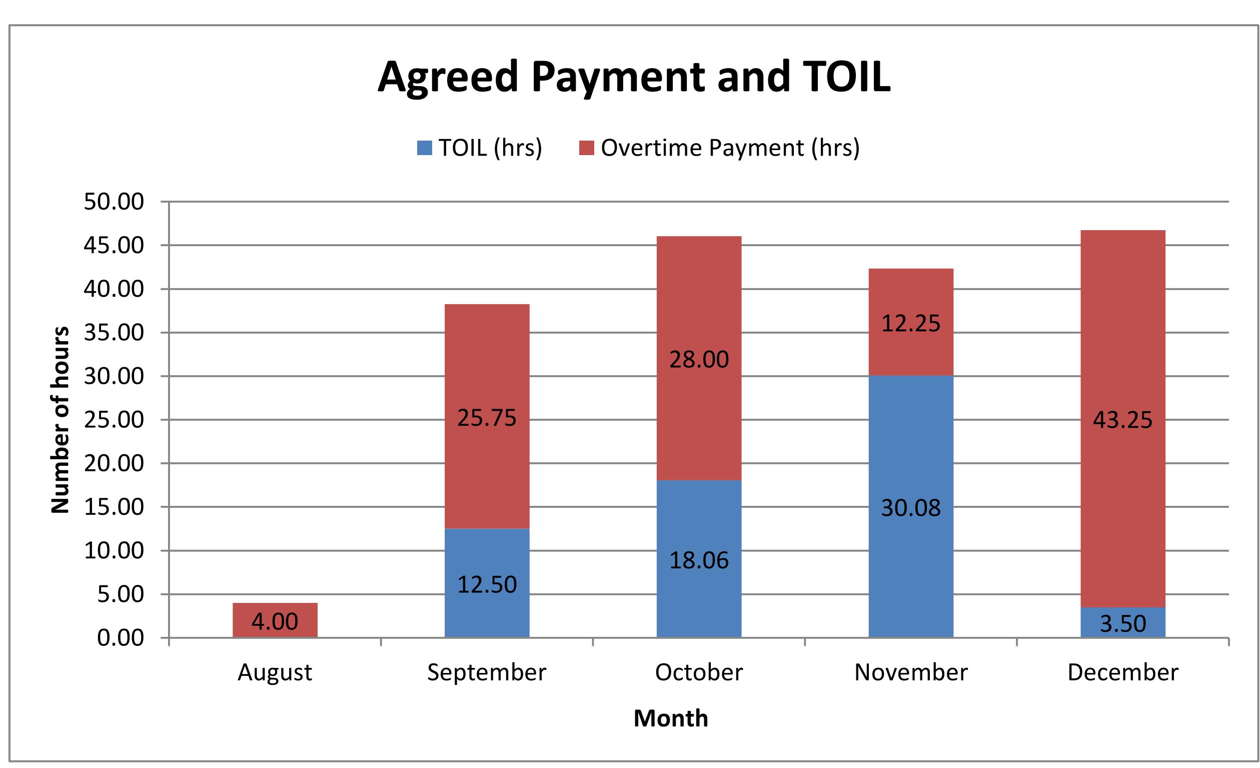
Department (base dept.)	No of reports	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open on 31 Dec	Notes for outstanding reports
Anaesthetics	1		1			
Breast Surgery	5			5		
Cardiology	7	1	4	2		
Colorectal Surgery	1			1		
DME	7	1	2	4		
Emergency Medicine	10			5	5	Very delayed ES report
Endocrinology	1			1		
Gastroenterology	2			2		
Haematology	10		10			
Infectious Diseases	2	1		1		
Neurology	4				4	Wrong supervisor selected
Neurosurgery	3		1	2		
Obstetrics & Gynaecology	3		1	2		
Oncology	16	5	7	4		
Orthopaedic Surgery	4	2		2		
Paediatrics	2	1			1	Error in writing report - needs software support to change
Respiratory	14	6	6	1	1	Meeting notes not saved
Rheumatology	1		1			
Upper GI Surgery	3	2	1			
Urology	20			20		
Vascular Surgery	22	1	4	16	1	Very delayed ES report
TOTAL	**138**	**20**	**38**	**68**	**12**	

Outcomes of completed exception reports 1 Oct 2017 – 31 Dec 2017



This shows broadly similar proportions of time versus payment compared to the last quarter. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Extra hours paid resulting from exception reporting 1 Oct 2017– 31 Dec 2017:

Specialty	Grade	Overtime worked at standard rates	Overtime worked at night rates	Overtime worked at punitive rates	Cost
DME	F1	£92.51			£92.51
Orthopaedics	F2	£29.54			£29.54
Urology	F1	£114.84			£114.84
Vascular Surgery	F1	£407.36			£407.36
Psychiatry (repaid by Humber FT)	F2	£435.55			£435.55

Extra paid hours agreed by exception reporting 1 Oct 2017-31 Dec 2017 but not paid in that period:

Specialty	Grade	Overtime worked at standard rates	Overtime worked at night rates	Overtime worked at punitive rates	Cost
Acute Surgery	F1	6 hr 30	2 hr 45		
Cardiology	F1	32 hr			
DME	F1	1 hr			
Emergency Medicine	StR		1 hr 30		
Endocrinology	F1	45 mins			
Haematology	F1	4 hr 15			
Oncology	F1	5 hr 45			
Oncology	F2	2 hr 15	2 hr		
Urology	F1	3 hr 30			
Vascular Surgery	F1	5 hr 30	3 hr 30		

Agreed time off in lieu resulting from exception reporting 1 Oct 2017 – 31 Dec 2017:

Specialty (base dept)	Grade	TOIL
Anaesthetics	ACCS 3	5 hr
Cardiology	F1	1 hr 45
Haematology	F1	5 hr 45
Infectious Diseases	F1	3hr 30
Medical Oncology	F1	4 hr 15
Obstetrics and Gynaecology	ST1	2 hr 30
Oncology	F1	8hr 15
Paediatrics	F2	1 hr
Respiratory	F1	17 hr
Upper GI Surgery	F1	2hr 45
Urology	F1	11 hr
Urology	F2	1 hr
Vascular Surgery	F1	1 hr

It should be recognised that TOIL and overtime payments can only be given after the supervisor has agreed this with the trainee. Delayed responses from either party mean that the trainee cannot receive their overtime payment or take time back. The total owed to trainees from this quarter is higher than the tables would suggest due to the delayed responses.

Patterns and responses

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

Vascular Surgery
Two F1 trainees on this rota failed to start their F1 placement. This left a situation with severe rota gaps between August and December 2017. Locums have been sought and appointed; additionally trainees on the rota have been extremely flexible in moving shifts around to maintain patient safety. The number of exception reports received is probably a significant underestimate of the problems trainees experienced.
Exceptions from this department reduced after the changeover of doctors in December 2017; however in recognition of the severe workload pressures and tight rotas, F1 schedules across surgery are in the process of being reconfigured, with the hope that a new rota pattern can be agreed from the beginning of April. The main beneficiaries of this rota change will be vascular surgery and acute general surgery.

Acute General Surgery
F1 trainees rotate to acute general surgery from Upper GI surgery, colorectal surgery, and vascular surgery so these reports often have to be considered together and are hard to separate out.

Urology
The work on this unit is heavy and continuous seven days a week. There have been rota gaps and less than full time trainees. Trainees also report lack of phlebotomy services which impact on their workload. The daytime work of an absent doctor is not routinely covered by locums in the surgery HG.

Respiratory
Routine heavy ward work continues to be reported by trainees. No common factors have been identified and the Medicine HG is aware of the reports.

Medical Elderly
Trainees report rota gaps and a heavy workload. Again, the Medicine HG is aware of the workload issues being reported, locum cover is sought when needed, but no other common factors have yet been identified.

Haematology and Oncology
The majority of these reports came from foundation doctors, who cover both departments, so they are considered together in this report. Trainees report heavy workload, including lack of phlebotomy support, and difficulty leaving complex tasks to the on-call teams as reasons for working overtime.

Paediatrics
These reports relate mainly to induction days being scheduled during rest time for some trainees, which required full days to be given back in lieu.

Gastroenterology
In the last quarter, exception reports suggested there were a number of issues arising over a long period of time. The department were made aware of these concerns, and have made adjustments. No further exception reports have been received from this department in this quarter.

Trainees in psychiatry placements

The Trust has a number of Foundation trainees in psychiatry placements. These trainees are employed by this Trust, but have their placements in Humber Foundation Trust, who are responsible for the working hours, work patterns and training opportunities during the length of the placement. We have had to work collaboratively with colleagues in Humber FT to produce work schedules for these trainees.

Humber FT has now identified an issue with their rotas which was causing some of our Foundation trainees to work beyond their contracted hours. The rota pattern has been altered so this is no longer a regular problem. Trainees working on these rotas before the adjustments were made have submitted exception reports; these have been managed by Humber FT and copied to HEY Guardian. Payment for any extra hours has been made through our payroll and repaid by Humber FT.

Hours Monitoring Exercises

Routine bi-annual hours monitoring ceased in July 2017 as trainees migrated on to the new 2016 TCS where hours monitoring is replaced by exception reporting.

Monitoring of trainees in GP placements

Historically, and nationwide, hours monitoring of Junior Doctors working out of the Trust on placement at local GP practices has never taken place. The posts were unbanded, as there was an expectation that trainees worked 40 hours Mon-Fri. Foundation trainees in GP placements are now on the 2016 TCS and are able to exception report. This change has required a significant amount of negotiation to confirm individual GP practice timetables so that work schedules can be issued. The Trust has now also worked with the training practices to agree a Memorandum of Understanding to ensure that any extra payments as a result of trainees working outside of their core hours is able to be repaid by the practice concerned.

There have been no exception reports from general practice this quarter.

b) Work schedule reviews

There have been no formal work schedule reviews this quarter. For service reasons a number of rota reviews have taken place; these have followed the new rota approval process to ensure that the appropriate permissions, agreement and notice periods have been followed in line with the 2016 TCS.

c) Locum bookings October to December 2017

i) Bank October to December 2017

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

Since the previous report, the Medical Staffing team has updated the way that they log Locum shifts to ensure greater accuracy. The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade				
Grade	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
F1*	29	0	191.75	0
F2	13	13	128.25	128.25
F2/CT/ST-2/GPSTR	821	112	8378.50	1098.25
ST3+	92	9	1236.25	112.50
TOTAL	**955**	**134**	**9934.75**	**1339**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

All unfilled internal locum shifts are sent to agency for patient safety reasons while efforts continue to fill these internally up until the last minute, since this is a cheaper option.

Locum Bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts Worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	114	16	1239	183.25
Anaesthetics	12	0	87.25	0
Cardiology	4	0	49	0
Cardiothoracic Surgery	8	0	91.5	0
Chest Medicine	38	0	440.50	0
Colorectal Surgery	143	23	1626	226
Elderly Medicine	156	19	1140	102.5
ENT	15	3	183.5	39
Neonates	6	0	78	0
Neurology	39	0	412.75	0
Neurosurgery	85	2	962.5	26
Obstetrics & Gynaecology	2	0	25	0
Oncology	34	0	188	0
Oral & Maxillofacial Surgery	15	11	362.75	137.5
Orthopaedics	142	46	1590.75	452.25
Paediatric Surgery	1	0	4	0
Plastic Surgery	5	0	65	0
Rheumatology	77	2	795.75	24.5
Upper GI	23	11	232.5	137.5
Urology	19	1	216	10.5
Vascular Surgery	17	0	145	0
TOTAL	**955**	**134**	**9934.75**	**1339**

Since the last report, Medical Staffing has removed a misleading column regarding the number of shifts that were not covered by bank doctors and were sent to agency. This column was misleading as the agency stats below include those doctors that are booked on a long term basis to provide stable cover for rota gaps that cannot be recruited into. These shifts are not sent to Bank Doctors.

The Emergency Department books its own bank doctors directly; these figures are currently reported slightly differently.

Locum Bookings (bank) by 1st October 2017 to 31st December 2017 INTERNAL					
Emergency Medicine	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Total	1118	516	1118	8821.7	4125

Locum Bookings (bank) by reason					
Reason	**Number of shifts requested**	**Number of shifts Worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	2382	251	2131	20468.95	2017.95
Additional Staff	145	70	75	990.41	473.92
Sick	51	0	51	545.75	0
Other Leave	127	0	127	1124	0
TOTAL	**2705**	**321**	**2384**	**23129.11**	**2491.87**

As indicated above, because of the specialised nature of the work, the Emergency Department books internal locums directly, and this information is collected by ED and passed on to Medical Staffing. In a similar fashion, and for specialised clinical reasons, the anaesthetic department also books its own internal locums. The anaesthetic department uses a specialised rota management software system, designed specifically for anaesthetic departments. Now that anaesthetic trainees are on the 2016 TCS, reports from this software system about internal locum bookings is being passed on to Medical Staffing for Trust-wide collation, but at present this data is not able to be presented in the same fashion as the rest of the doctors. Work is ongoing in this area to collect and present this anaesthetic data in a consistent fashion.

Data in these tables is still work in progress and should be interpreted with caution until the internal bank is fully operational and all shifts are logged routinely on e-roster using consistent processes. There has been a continued improvement in logging the reasons for bank requirement. Medical Staffing are continuing their ongoing exercise to capture ‘the life of a vacant shift’ which will improve qualitative and quantitative information.

ii) Agency Oct – Dec 2017

The data in these tables is collected and presented in the standard fashion requested by NHS Employers, and this provides more information about locum requirements for junior doctor vacant posts.

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	165	47	1856.83	524.33
Cardiology	72	0	571.5	0
Care of the Elderly	100	68	1026.5	677.25
Chest Medicine	97	53	923.75	428
Colorectal Surgery	2	0	24	0
Emergency Medicine*	662	291	5314.29	2544.04
Endocrinology	1	1	12	12
ENT	78	59	695	551.50
Gastroenterology	2	1	20.5	8.75
General Medicine	187	65	1768.25	737.25
General Surgery	127	74	1162.66	700.16
Haematology	70	0	525	0
Infectious Diseases	10	5	115.5	56.75
Neonatal Medicine	72	62	587	490
Neurology	32	6	373.25	70.25
Neurorehabilitation	5	5	37.5	37.5
Neurosurgery	141	83	1550.16	916.66
Obstetrics & Gynaecology	11	0	129	0
Oncology	34	10	353.75	98.25
Oral & Maxillofacial Surgery	1	0	12	0
Orthopaedic and Trauma Surgery	393	283	3675.25	2714.25
Paediatric Surgery	8	8	137.51	137.51

Paediatrics	26	4	259	37
Plastic Surgery	5	0	67.5	0
Renal Medicine	8	0	90	0
Rheumatology	30	13	336	136.25
Upper GI Surgery	43	40	501.5	465.50
Urology	11	1	123	12
Vascular Surgery	77	60	725	550
TOTAL	**2470**	**1239**	**22973.2**	**11905.2**

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

Locum bookings (agency) by grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	145	75	1509.75	727.50
F2/CT/ST-2/GPSTR	1833	912	17189.86	8946.11
ST3+	492	252	4273.59	2231.59
Total	**2470**	**1239**	**22973.2**	**11905.2**

Locum bookings (agency) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	11	11	138	138
Compassionate/ Special Leave	9	6	96.25	58.25
Extra Cover	71	64	555.48	470.48
None given	65	0	487.5	0
Other	2	0	24	0

Pregnancy/ Maternity Leave	11	8	111	96
Sick	89	35	971	347
Study Leave	3	2	36.75	25
Vacancy	2209	1113	20553.22	10770.47
Total	**2470**	**1239**	**22973.2**	**11905.2**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered safely and consistently while recruitment is underway.

It is clear from the data that there is, however, often a shortfall between the number of shifts required, and the number of shifts covered.

All vacant shifts are offered to internal staff first. If these shifts are not filled internally, then a decision is taken by the service whether to go to agency or not. In some cases, the service decides not to request agency cover. This may be, for example, to cover a short gap in cover (e.g. three hours) where experience has shown that there will be no uptake from agency staff. In this case, the service is short-staffed, but only for a brief period, which can be managed, usually by senior doctors acting down in combination with increased nursing input.

For a longer period without internal or external cover, a number of strategies may be employed to maintain patient safety. One option is to redeploy existing doctors, for example by sending home a daytime doctor to get rest before asking them to come back and cover a vacant night shift. Other options include moving doctors from one ward or site to another, where the gap is more critical. Where the wider, non-medical, workforce can be deployed to help cover the gap, this is done. Sometimes it is possible to obtain cover at a higher level , in which case one of the senior doctors will act down to cover the gap. In the worst case scenario, senior doctors will act down but at the expense of the service; the emergency situation is covered but at the expense of the routine work.

d) Locum work carried out by trainees Oct-Dec 2017

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available for all trainees. Further information is required about the trainee's rostered hours and the actual hours worked. In an ideal situation this would be entered 'live' on to e-roster. This is the next stage in the roll-out of the e-roster system, but can only be commenced once e-roster is being fully utilised as a live system. In some parts of the Trust this live usage is happening, and it is hoped that actual hours worked, overtime and TOIL will be entered as the next stage in the roll-out process.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Speciality/Rota	**Grade**	**Number of hours worked**	**Number of hours rostered per week**	**Opted out of EWTD**
ENT	CT	98	46:45	Yes
Urology	ST3+	97	46:45	Yes
Upper GI Surgery	ST3+	70.5	46:45	No
Oncology	CT	58	46:30	Yes
Upper GI Surgery	CT	50	47:30	No
Vascular Surgery	F1	43.5	28:15	Yes
Anaesthetics	ST3+	39	46:30	Yes
Plastic Surgery	CT	39	46:45	Yes
Emergency Medicine	F2	36	44:00	Yes
Trauma & Orthopaedics	ST3+	25.5	47:15	Yes

This information shows that two trainees, who had not opted out of the EWTD, were able to book extra shifts that put them at risk of breaching the working time directive. This is despite new processes in Medical Staffing that should have prevented this breach. Procedures have now been tightened in Medical Staffing so that potential breaches of the WTD, as well as the contract, are actively considered before allowing trainees to book extra, planned, locum shifts.

e) Vacancies – table showing vacancies among medical training grades on 19 October 2017

This section shows significantly improved data from the previous quarterly report.
The table shows Trainee Establishment (blue) next to the Rota Establishment (pink) which includes Trust doctors that sit on rotas with Trainees. The right column (purple) shows the number of doctors in post at each level (Trust and Trainee) and the fill rate of the rotas in the department. The overall current rota fill rate incorporating both Trainee and Trust Doctors is 84.6%.

	Trainee Establishment						Rota Establishment						In Post						
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	0	5	0	0	0	5	100.0
Acute Medicine	3	6	9	0	6	24	3	6	9	0	6	24	3	6	9	0	2.5	20.5	85.4
Anaesthetics	4	4	19	0	29	56	4	7	16	0	32	59	4	4	14	0	25	47	79.7
Breast Surgery	2	0	1	0	2	5	2	0	1	0	2	5	2	0	1	0	2	5	100.0
Cardiology	2	1	4	1	9	17	2	1	4	1	9	17	2	0.5	5	0	9	16.5	97.1
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	3	0	0	9	12	100.0
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	1	1	50.0
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	0	0	0	1	50.0
Elderly Medicine	5	3	6	7	6	27	5	3	6	7	6	27	4	4	5	5	4.5	22.5	83.3
Emergency Medicine	0	12	8	5	13	38	0	12	7	5	6	30	0	11	6.5	5	6	28.5	95.0
Endocrinology	3	0	2	0	4	9	3	0	2	0	4	9	2	0	2	0	3	7	77.8
ENT	1	1	2	1	5	10	1	1	3	1	6	12	1	1	2	1	6	11	91.7
Gastroenterology	3	0	2	0	5	10	3	0	2	0	5	10	3	0	1	0	4	8	80.0
General Practice	0	19	0	0	0	19	0	19	0	0	0	19	0	17	0	0	0	17	89.5
General Surgery	0	1	0	0	0	1	0	1	2	0	0	3	0	1	0	0	0	1	33.3
Haematology	1	0	2	0	3	6	1	0	2	0	6	9	1	0	2	0	4	7	77.8
Histopathology	0	0	0	0	4	4	0	0	0	0	4	4	0	0	0	0	2	2	50.0
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.0
Infectious Diseases	2	0	2	0	4	8	2	0	2	0	5	9	2	0	2	0	1	5	55.6
Lower GI Surgery	7	0	2	0	3	12	7	0	2	0	3	12	7	0	2	0	2.5	11.5	95.8
Neurology	2	2	4	0	5	13	2	2	4	0	6	14	2	1	4	0	6	13	92.9
Neurosurgery	1	1	2	0	4	8	1	1	6	0	11	19	1	1	3	0	8	13	68.4
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	5	4	11	22	0	1	6	2.5	10	19.5	88.6
Oncology	3	1	3	4	6	17	3	1	6	4	12	26	3	1	4	3	11	22	84.6
Ophthalmology	1	1	3	0	4	9	1	1	3	0	4	9	1	1	3	0	3	8	88.9
Oral & Maxillofacial Surgery	0	0	10	0	3	13	0	0	10	0	6	16	0	0	8	0	2	10	62.5
Paediatric Emergency Medicine	0	0	7	0	0	7	0	0	7	0	0	7	0	0	7	0	0	7	100.0
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	7	0	0	7	14	0	0	4	0	8	12	85.7
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	?	2	0	0	2	0		2	100.0
Paediatrics	3	4	3	2	8	20	4	4	3	2	8	21	3	4	2	1.5	8	18.5	88.1
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	0	1.5	0	1.5	75.0
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	7	10	0	0	3	0	7	10	100.0
Psychiatry	5	5	0	4	0	14	5	5	0	4	0	14	3	4	0	4	0	11	78.6
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0	0.0
Radiology	0	0	0	0	25	25	0	0	10	0	14	24	0	0	9	0	13	22	91.7
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	2	1	2	0	5	10	100.0
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	4	2	1.5	2	8	17.5	87.5
Rheumatology	0	0	1	3	3	7	0	0	1	2	3	6	0	0	1	1	2.5	4.5	75.0
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Trauma & Orthopaedics	0	5	3	1	9	18	0	12	4	1	15	32	0	6	4	1	13	24	75.0
Upper GI Surgery	7	0	2	0	3	12	7	0	2	0	3	12	7	0	1.5	0	3	11.5	95.8
Urology	1	3	2	0	3	9	1	3	2	0	5	11	1	2	2	0	5.5	10.5	95.5
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	3	9	4	0	1	0	2	7	77.8
TOTAL	70	84	123	37	212	526	71	101	131	36	233	572	63	77.5	119.5	27.5	196.5	484	84.6

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

Gaps in Trust doctor numbers have an adverse effect on training. Usually, patient safety is maintained by moving doctors from shift to shift, or ward to ward, but this comes at the expense of training.

This information can be used to explain heavy locum usage in some specialties; these are usually the specialties with the biggest problem of rota gaps in one particular tier. For example, Trauma & Orthopaedic rotas are only 50% filled at F2 level, therefore the locum spend in this department is one of the largest.

f) **Fines**

There have been no Guardian fines levied during the last quarter. However, a number of potential breaches of safe working over the Christmas and New Year period are being investigated and some of these may result in fines in the next quarter. This compares very favourably with Trusts across the region.

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at the end of this quarter
£221.26	£00.00	£00.00	£221.26

Qualitative information

E-roster roll out

E-roster continues to be rolled out across the organization. All new starters in August 2017 had their rotas added to e-roster and this is proving very popular among the trainees, particularly the ability to see their rotas and those of their colleagues on their phones. There are still some issues regarding live updating and locking down of the roster in some areas, and the trainees are keen to see the development of a module which will allow them to swap duties without waiting for third party approval. Although some areas still face challenged in implementation, the majority of duties are now available for viewing and reporting which will improve the quality of data about junior doctor working available to the Trust.

Implementation of the new contract

For the October changeover, all trainees apart from one department where there was a local delay, received their work schedules on time. Maintaining this high standard for each changeover will be a challenge, particularly for Medical Staffing and Medical Education.

There have been a few rota queries where the change to the new contract has resulted in some anomalies becoming evident; these are being worked through on a rota by rota basis.

Junior Doctor Forum

The Junior Doctor Forum is well-established. Since August, however, there has been a fall in the number of trainees attending the Forum and it has not been quorate on a couple of occasions. The reasons for this are not clear. An open Junior Doctor Forum is planned for February 2018 to stimulate interest in the work of the Forum and to promote discussion of the contract among trainees who have not previously been involved.

The minutes of the Forum are available on the junior doctor pages of Pattie, along with other items of interest to trainees.

Rota administrative support

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

We are encouraging departments to move away from producing multiple different copies of the department rota in different formats, and to use the e-roster only, but this is challenging for the more complicated rotas and remains an area where considerable work is required.

Issues arising

The amount of data available to provide information about the working conditions of trainees continues to improve, however streamlining of processes and information remains a challenge. Much of this information was not collected in any systematic fashion over the past decade, and therefore it would be unrealistic to expect instant answers. There is still a lot of background work required, particularly at the business level, to make the required changes.

It is clear that rota gaps, for whatever reason, are putting a significant strain on the system, particularly when shifts are put out for cover and this cannot be found. There has been a significant improvement in the availability of data on rota gaps but more work is still required, particularly at the health group and individual business level, to understand the effects of a gap on training and patient safety.

Trainees are still under-reporting problems with the exception reporting system. Some have concerns that raising issues will have a negative effect on how they are perceived at work, others have remain to be convinced of the utility of making a report and the effect this will have on improving working conditions.

The management of outlying patients remains a concern for trainees, both in the impact on working hours and on training. This issue was extensively discussed in the run-up to winter; trainees were encouraged to exception report any adverse effects so these could be monitored while the Trust refined its action plan for managing excessive admissions.

The response of the Health Groups to the issues arising from exception reporting was added by the CEO to the HG performance and accountability review in December 2017; this produced a flurry of activity as the Health Groups tried to understand more about the systems and the information available. I hope that this response continues to be monitored through the performance system and that the outcomes are visible on the performance tracker.

Actions taken to resolve issues

All trainees are now on the 2016 TCS and all are now using e-rostering. This system is very popular among trainees, as it provides real-time rota information available on their smartphones. Further work is required among businesses and departments to make the most of this technology, so that they can realise the benefits.

There is a significant investment across all Health Groups into administrative support for e-rostering. However the next steps in making the most of this system will involve real-time input of the hours that trainees actually work, rather than just their rostered hours. Additionally, businesses and departments will need training to ensure that they can make the most of the information available, to help them plan their services and reduce the effect of rota shortages.

Humber FT has put a considerable amount of work into ensuring that trainees employed by HEY but working in Humber are safe. They have undertaken a comprehensive rota review and have altered

their rotas to improve the working lives of trainees working in psychiatry. The exception reporting system is working well there, and the Guardian at that Trust is in regular and systematic communication with HEY Guardian to ensure that trainees working hours are monitored and reviewed.

Within this Trust, a robust rota change process has been instigated, which ensures that any planned rota changes are agreed by the department, the trainees, the College Tutor (for protection of education and training) and the Guardian. Inbuilt into the process are adequate notice periods for any trainees affected by rota changes.

Summary

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

Questions for consideration

The Trust Board is requested to receive this report and:

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	13 March 2018	**Reference Number**	2018 – 3 - 21
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson Director of Corporate Affairs – Carla Ramsay
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to authorise the use of the Trust's seal.

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

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

4	**LINKED TO:**			
	CQC Regulation(s): W2 - Governance			
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N

5	**BOARD/BOARD COMMITTEE REVIEW** Approval of the Trust's seal and amendments to standing orders are reserved to the Trust Board.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

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

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2018/02	Hull and East Yorkshire Hospitals NHS Trust and Cityfibre Metro Networks Ltd – Wayleave agreement relating to the property at HYMS Medical Education Centre, Hull Royal Infirmary, Anlaby Road, Hull, HU3 2JZ	25.01.18	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/03	Hull and East Yorkshire Hospitals NHS Trust and WH Smith Hospitals Ltd – Lease relating to WH Smith premises at Hull Royal Infirmary, Anlaby Road, Hull, HU3 2JZ	25.01.18	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/04	Hull and East Yorkshire Hospitals NHS Trust and Truby Stevenson Limited – Forms of Agreement and amendments to the original order for Theatre Plan Tower Block, Hull Royal Infirmary	23.02.18	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/05	Hull and East Yorkshire Hospitals NHS Trust and Mr Abolfazl Ramzani – Sale of Greenwich Avenue. 1 TR1 form transfer of property, 1 contract for the sale of freehold land with vacant possession at former Bilton Grange Surgery, Greenwich Avenue, Hull, HU9 4UX	23.02.18	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/06	Hull and East Yorkshire Hospitals NHS Trust and Secretary of State for Health – Deed of release of restrictive covenant relating to land and buildings lying to the north of Greenwich Avenue, Hull	23.02.18	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs

3. RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Corporate Affairs Manager
March 2018

Hull and East Yorkshire Hospitals NHS Trust

Audit Committee held Tuesday 27 February 2018

Present:	Mrs T Christmas	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mr P Sethi	Grant Thornton
	Mr G Kelly	Grant Thornton
	Mr G Baines	MIAA
	Mr D Davies	MIAA
In Attendance:	Mrs A Newlove	Claims Manager
	Mr M Smith	Director of IT
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

DRAFT

No.	Item	Action
1	**Apologies** Apologies were received by Mrs D Roberts – Deputy Director of Finance	
2	**Declarations of Interest** There were no declarations of interest made.	
3	**Minutes of the meeting held 18 December 2017** The minutes were approved as an accurate record of the meeting.	
4	**Matters Arising** The wifi installation at Castle Hill Hospital was discussed and Mr Bond advised that work was ongoing with the Network Project Board regarding any restrictions required. The Safeguarding policies had been discussed and the action closed. Mr Long and Mr Nearney had met with Health Education England regarding the Trust's allocation of Junior Doctors and there was proactive work ongoing before the next medic rotation to make their experience as pleasant as possible.	
	4.1 Tracking Access discussion with Auditors Mr Bond reported that he and Mrs Ryabov had met with the Auditors to discuss the Tracking Access issues and informed them of the action plan for recovery. Mr Baines advised that it was a good, open meeting and that the Auditors were comfortable with the approach being taken.	
	4.2 Action Tracker Mr Kelley reported that he was the national lead for benchmarking Trust annual reports and work had begun as he was collecting information from 170 Trusts. He advised that an early version of the findings would be shared with Ms Ramsay and circulated to the Committee once agreed.	**GK/CR**

The Committee requested an update from Mr Phillips relating to consultant electronic job plans. This would be circulated to the Committee. Mr Baines advised that there was an audit on consultant job planning in their plan 2018/19 **KP**

4.3 Workplan 2017/18
Ms Ramsay advised that the changes to accounting policies, standing orders and standing financial instructions had been moved to the April 2018 meeting, but only minor changes had been made.

Workplan 2018/19
There was a discussion around SLR/PLCs assurance and it was agreed that this would be received at the Performance and Finance Committee meeting. Mr Bond would provide the certification of reference costs annually to the Audit Committee. **LB**

Mr Davies requested that the Counter Fraud Plan be received in February and progress reports in July 2018 and January 2019.

Mr Baines added that the MIAA Audit Plan would be submitted to the Committee in April 2018 for approval.

5.1 Performance and Finance Minutes 20.01.18
The minutes were received and accepted by the Committee.

5.2 Quality Minutes 29.01.18
Ms Ramsay to circulate the governance assurance process used for external providers to the Committee members. **CR**

Safeguarding issues had been reviewed and resolved.

5.3 Charitable Funds Minutes 30.11.17
There was a discussion around the homeless provision that the Trust had supplied in the past and how this had been funded. Mr Bond advised that the funding had not been taken from charitable contributions.

The agenda was taken out of order at this point

7.1.1 IT Service Continuity Review Report
Mr Smith attended the meeting to discuss IT Service Continuity.

There was a detailed discussion relating to system back up processes and restoration times and Mr Smith advised that systems were fully backed up but may take time to restore. He added that the Trust did not mirror everything and did not have a fully replicated data server for either site.

Mr Moran expressed his concern and asked how the Trust had assessed continuity of services. Mr Bond advised that the risks had been reviewed and the likelihood was minimal of full hardware and software loss. He also stated that business continuity plans were in place to address server or hardware damages.

DRAFT

Mr Smith reported that critical systems had been reviewed for restoration but that most of the Trust's systems had returned with a critical status.   Mr Bond suggested carrying out a case study relating to a catastrophic event and how the Trust would respond to this. Mr Smith's successor would be given this objective on commencing with the Trust.

Following the Care Certificate Audit Mr Smith also reported that 3rd party clinical systems had been reviewed as there were a number of vulnerabilities across a number of machines such as CT/MRI. Pathology, radiology and oncology systems were also vulnerable. Mr Bond advised that work was ongoing with 3rd party providers to manage the processes and give assurance that security patching and anti-virus regimes were in place.

Mr Baines added that MIAA were working with another Trust to survey information asset owners to understand the issues.

Mr Smith reported that due to the lack of security oversight for all devices, due diligence was being consistently applied and the overall control framework was effective. He recommended that responsibility for all systems should be pulled back into the Corporate IT Services.

IT Service Continuity had been given limited assurance by the internal audit process.

Resolved:
The Committee received and accept the report and the work ongoing to ensure safe service provision, but expressed concern regarding both IT Service Continuity and 3rd Party systems.

7.1 Internal Audit Report
Mr Baines presented the report and highlighted 3 areas of significant assurance, IG Toolkit, conflicts of interest and communications and engagement. The level of engagement with clinical staff however, was highlighted as an improvement area.

Mr Baines reported that internal assurance work would be carried out on the tracking access issue and was included in next year's plan. Mrs Christmas stated that the audit plan had a lot of activity in quarter 4, but Mr Baines assured her that he was confident the work would be completed.

Resolved:
The Committee received and accepted the report.

7.2 Outstanding Audit Actions
Mr Baines presented the report which updated the Committee regarding old outstanding audit actions and the significant progress made to sign off old actions. There were a number of actions still to be completed but evidence was required before these could be cleared.

Mr Baines thanked Ms Ramsay for her help and stated that it had been advantageous to have a central point of contact.

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The Committee discussed table B2 which related to medical staffing planned absence and the minimum requirement of staff when booking annual leave/training/conferences etc. Mrs Christmas and Mr Hall both expressed their concern that the issue around holiday cover and Mr Bond agreed to raise it with the Chief Executive.

Mrs Christmas thanked Ms Ramsay for her hard work in reducing the number of outstanding actions.

Resolved:
The Committee received and accepted the report.

7.3 Internal Audit 2018/19 Plan
Mr Baines presented the report and advised that the draft plan had been reviewed by the Executive Team who had fed back their comments and suggested changes. Mr Baines stated that it was a robust plan with a lead identified for each area. The final plan would be presented to the Committee in April 2018 with the fees attached. Mr Bond added that the Executive Team were fully engaged with the process.

Mr Hall asked if core audits could tie in with non-pay cost issues and Mr Baines advised that budget control and financial system reviews were part of the audits.

Mr Gore asked if there would be a further review of job planning and Mr Baines advised that this was currently being reviewed.

Ms Ramsay asked if absence management could feed into the job planning audits.

Resolved:
The Committee received and accepted the draft audit 2018/19 plan.

7.4 Effectiveness Review
Mr Baines gave an update regarding the effectiveness review of internal audit and advised that MIAA would be completing a KPI Report which would measure retrospectively the work carried out for the Trust. This would ensure a more bespoke review of effectiveness.

He advised that the report would be available for the June 2018 meeting.

Resolved:
The Committee received and accepted the verbal update.

7.5 Anti-Fraud Progress Report
Mr Davies presented the report and advised that the NHS Counter Fraud Authority had introduced a 3 year strategy which had a similar approach to NHS Protect. Mr Davies agreed to highlight any impact to the Trust and report back to the Committee.

Mr Davies advised that 2 investigations had been closed and that there were no current investigations being undertaken. There were no issues around delivery of the workplan.

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Resolved:
The Committee received and accepted the report.

7.6 Anti-Fraud Plan 2018/19
Mr Davies presented the plan to the Committee and reported that it was aligned with the internal audit plan and he had met with Mr Bond to ensure plans met the needs of the Trust as well as NHS Counter Fraud standards.

He advised that the fees would remain the same as last year.

Resolved:
The Committee approved the Anti Fraud Plan 2018/19.

Mrs Newlove joined the meeting

10 Claims Report
Mrs Newlove presented the 3rd quarter report which highlighted the clinical negligence figures, coroners information and the general national overview of claims.

Mrs Newlove reported that the Trust had seen a decrease in letters before action, claims and formal allegations.

She also advised that the Team were being proactive in closing dormant cases where possible and were trying to keep investigations in house to keep the costs to a minimum and resolve issues in a more timely manner.

There was a discussion around the valuation of claims and Mrs Newlove assured the Committee that values were challenged regularly and that high value claims would always be reviewed by and expert in the particular field of litigation.

Mr Gore highlighted Appendix 1 of the report which identified issues to be address by the Trust following receipt of Letter of Claim in the 3rd quarter 2017/18. Mr Gore asked if a management response should be prepared in light of the letter and Mr Bond assured him that the Executive Team would be aware of the issues raised and would be responding to each one.

Mrs Newlove reported that the NHS had set aside £1.66bn to cope with the amount of claims. She also reported that NHS Resolution wanted to progress mediation within Trusts.

Resolved:
The Committee received and accepted the report.

Mrs Newlove left the meeting

6.1 External Audit Plan 2017/18
Mr Sethi presented the report and highlighted the areas of review which included value for money, management controls, PFI schemes and going concern.

He also highlighted the key risks as employee remunerations and operating expenses with additional work around the Trust's cost improvement programme and delivery against key quality targets.

Mr Bond thanked Mr Sethi for working closely with the Trust's finance teams and building good relationships through the planning processes.

Resolved:
The Committee received and accepted the report.

6.2 External Audit Update Report
Mr Kelly presented the report which set out the initial work undertaken by Grant Thornton.

He reported that work was ongoing to prepare the financial statements audit and value for money audit.

The report also included a sector update which included information relating to the Apprentice Levy in England.

There was a discussion around Brexit and how this would impact the NHS in 5 key areas: medicines and medical devices, regulation of science, staff and health care, customs and trade, health programmes and agencies and reciprocal and cross-border health care. Ms Ramsay stated that a strategic review of Brexit would need to take place.

Resolved:
The Committee received and accepted the report.

8 Review of Debts >£50k and over 3 months old
Mr Bond presented the report and highlight the debtors (mainly NHS organisations) that had been nominated a finance lead to work through issues around payments.

There was a discussion around a firm that had gone into liquidation before settling their debt, but Ms Ramsay advised that discussions were ongoing with the finance teams and there was positive assurance that some costs would be recovered.

Resolved:
The Committee received and accepted the report.

9 Single Source Waivers
Mr Bond presented the report to the Committee to provide assurance around the single source waiver process. He also attached a list of contract that had single source suppliers.

The report was received on a regular basis by the Committee and had specific rules which were included in the Trust's Standing Financial Instructions. In the majority of cases the supplier was a sole provider of goods.

The Committee questioned the taxi firm on the list of suppliers and Mr Bond agreed to review this item.

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Resolved:
The Committee received and accepted the report.

11 Gifts and Hospitality Report

Ms Ramsay presented the report which highlighted declarations made in 2017/18 to date. Ms Ramsay added that the process had not identified anything of concern to raise at the Committee.

The level of declarations had increase which demonstrated that the policy was being adhered to. The Corporate Affairs team were proactive with communications for staff awareness.

Mrs Christmas thanked the team for their hard work but asked for further emphasis regarding declarations stating 'no value'.

Resolved:
The Committee received and accepted the report.

12 Register of Interests Report

Ms Ramsay presented the report which detailed the declarations to date. She advised that declarations were more timely and more staff were declaring interests. The Corporate Affairs Team prompt declarations where necessary. Ms Ramsay had no issues to raise at the Committee.

Resolved:
The Committee received and accepted the report.

13 Board Assurance Framework

Ms Ramsay presented the report which had been reviewed at the Performance and Finance and Quality Committees previously. She also stated that the Board and Committees were reviewing risk appetite and the level of risk that could be tolerated, bearing in mind the nature of the long term risks detailed on the report.

There was a discussion around 7.2 and the infrastructure risk, which included IT risks and business continuity. Ms Ramsay advised that the Digital/Estates strategy and Capital Plan would be reviewed at a Board development to allow robust scrutiny. Mr Bond added that the risk rating should remain the same at present but could change in 2018/19.

Resolved:
The Committee received and accepted the report.

14 General Data Protection Regulations Update

Ms Ramsay assured the Committee that work was ongoing with the IG Team to ensure the Trust was compliant with what was known of the new regulation.

NHS guidance was now beginning to be shared and the information was being analysed by the Business Intelligence and IG Team to check the Trust's compliance in each area.

Ms Ramsay mentioned subject access requests and a portal for

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patients to access their records in a secure way. Mr Hall was concerned that patients might access their data before the clinician but Mr Kelly advised that the rules around accessing data would be made clear in the first instance.

Ms Ramsay was confident that the Trust was compliant in most areas but advised that an action plan was in place to review this.

Resolved:
The Committee received and accepted the report.

15 Any Other Business
There was no other business discussed.

16 Date and time of the next meeting:
Thursday 26 April 2018, 9am – 12pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	15 February 2018	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- Financial report was presented for Quarter 3, 2017/18
- Fund balances and spending plans
- The Strategic direction of the WISHH Charity

Decisions made by the Committee:

- Agreed funding requests for general charitable funds
- Agreed the Charitable Funds budget for 2018/19
- Agreed the Administration Charge for 2018/19

Key Information Points to the Board:

Matters escalated to the Board for action:
Nothing to escalate, key issues discussed captured above

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHARITABLE FUNDS COMMITTEE
HELD ON THURSDAY 15 FEBRUARY 2018
THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr A Snowden (Chair), Vice Chair, Non Executive Director Mrs V Walker, Non Executive Director Mr D Haire, Project Director, Fundraising Mr L Bond, Chief Financial Officer
IN ATTENDANCE:	Mrs D Roberts, Deputy Director of Finance Ms C Ramsay, Director of Corporate Affairs Mrs L Roberts, Corporate Affairs Administrator (Minutes)

1 APOLOGIES FOR ABSENCE

No apologies were received.

2 DECLARATIONS OF INTEREST

Mr Bond declared an interest in agenda item 12, WISHH Charity – Going forward. Mr Bond is a Trustee of the WISHH charity.

3 MINUTES OF THE MEETING 30 NOVEMBER 2017

The minutes of the meeting held on 30 November 2017 were approved as an accurate record.

4 ACTION TRACKER

February 2016 – Terms of Reference

It was agreed that this action could be removed from the action tracker and a review of the Terms of Reference would be added to the 2018/19 Committee workplan.

5 MATTERS ARISING

Mr Haire advised that work was ongoing on the post implementation review for phase 2 of the Da Vinci Robotic Surgical System, which was expected to be completed by March 2018.

Benchmarking information surrounding the performance of the Da Vinci Robotic Surgical System was also ongoing. Mr Haire would liaise with other Trusts surrounding data and report back to the Committee in due course.

Mr Bond advised that he had spoken with Mr D Taylor regarding the Trust creating a provision to assist the homeless in the city during the winter months. It was noted that the property previously used was no longer available. Following discussion it was agreed that Mr Bond would liaise with Mr D Taylor to discuss provisions for next winter. Mr Snowden would speak with Miss Johnson from the Communications Team regarding the promotion of this project.

Resolved

The Committee agreed to:

- Receive a post implementation review of the Da Vinci Robotic Surgical System **DH**
- Receive a Da Vinci Robotic Surgical System benchmarking report **DH**
- Mr Bond and Mr Taylor to discuss next year's winter provisions for homelessness **LB**
- Mr Snowden to speak with the Communications Team regarding the promotion of the homeless project **AS**

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6 WORKPLAN 2017/18

The Committee noted the workplan.

6.1 – Draft workplan 2018/19

The draft Charitable Funds workplan for 2018/19 was agreed by the Committee.

7 PROJECT DIRECTOR'S REPORT

The paper was presented to the Committee by Mr Haire who gave an overview of the fundraising activities.

Replacement of the Brocklehurst Building to enhance research capacity

A Project Board for the replacement of the Brocklehurst Building project had been established. It was envisaged that work would be completed and the facility fully functional by June 2019.

A business case would be produced and presented at the Performance & Finance Committee and Charitable Funds Committee meetings. Mr Haire continued to meet with the benefactor to discuss the finer details of the project.

Creating a Dementia Friendly Environment – Wards 8 and 80

Mr Haire advised that he had met with Dr Harman to discuss the proposed review and updating of the creating a Dementia Friendly Environment project. Dr Harman would attend the next committee meeting to discuss general matters and the strategic direction of the project.

Integrated Cyclotron and Radiopharmacy Development

It was advised that ground works on the Integrated Cyclotron and Radiopharmacy Development were now on-going and would be followed by construction of the sub-structure. This was following the delays due to increased cost issues and various technical aspects reported at the previous Committee meeting. A plaque was due to be unveiled at the end of February 2018.

Mr Haire informed the Committee that he would meet with Mr D Taylor to discuss some issues associated with the development that had been identified.

It was noted that this development was a significant step in enhancing the overall research programme undertaken by the University of Hull, the Daisy charity and the Trust, the latter primarily relating to clinical trials activities.

Paediatrics Fundraising Group

It was advised that support had been sought for a fundraising project to improve the environment of an area where assessments of children with complex disabilities are carried out. After initial consideration the Health Group had been advised to submit a project outline to the Capital Resource Allocation Committee (CRAC) for capital funding consideration, however Mr Haire had been asked to present this request at the Charitable Funds Committee.

Following discussion it was agreed that Mr Haire would enquire as to how many children used the facility and that a service demand report should be prepared. The Health Group should submit a project concept paper in support of the case of need.

A Garden of Positivity

It was noted that funds of circa £17k had been raised by staff and patients for the garden of positivity project, in a relatively short period of time.

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Retinal Camera
It was noted that the WISHH charity was supporting the family fundraising appeal for £100k to purchase a retinal camera for the Trust.

A response for additional funding from the HELP for Health charity had been received. The HELP for Health charity had suggested that for every £4 received from the Trust's Charitable Funds they would donate £1, up to a maximum contribution of £5k. There was a discussion surrounding the response and it was agreed that this matter would be brought back to a future Committee meeting informed by the progress made in respect of fundraising.

Fundraising for Wi-Fi System
It had now been agreed on the items that were to be purchased for the Queens Centre from the funds that were initially raised to install Wi-Fi in the Queens Centre. These items included computers for dayrooms, IPads, recliner chairs and 25 televisions.

Supporting patients with limited English
It had been identified that there had been a good uptake in the use of the 6 IPads previously funded through Charitable Funds to support patients with limited English. Additional appliances would be requested in agenda item 12 of this Committee meeting.

Resolved
The Committee:
- Received the report and accepted the contents
- Agreed to receive information and a service demand report in relation to paediatric improvements **DH**

8 ADMINISTRATION CHARGE 2018/19
The paper was presented to the Committee by Mrs Roberts who advised on the administration charge for 2018/19.

Resolved
The Committee received the report and agreed the administration charge for 2018/19.

9 DRAFT BUDGET 2018/19
Mrs Roberts presented the draft budget 2018/19 paper to the Committee for approval in accordance with good practice.

Resolved
The Committee:
- Received the report and accepted the contents
- Agreed the draft budget for 2018/19 subject to the outcome of the discussion in agenda item 12 of this meeting.

10 FINANCIAL REPORT AS AT 31 DECEMBER 2017
Mrs Roberts presented the Financial Report to the Committee and advised on the financial position of the charitable funds as at 31 December 2017.

For Quarter 3, 2017/18 a total income of £635k had been received, which was £401k more than expected. This included £250k to fund the Helipad at Hull Royal Infirmary and donations totalling £70k. Total expenditure for the period was £444k which was in line with the estimate. The investment portfolio and cash reserves were valued at £1.971m.

The Committee were advised that Brown Shipley had been informed of the intention to disinvest the Charitable Funds managed portfolio with the company. Brown Shipley has since responded with an alternate proposal; however it was noted that this included investments in non-ethical companies. It was agreed that the disinvestment with Brown Shipley should proceed and the monies be reinvested with COIF.

Mrs Roberts agreed to clarify the details of fund number F17110 in appendix C, Expenditure Transactions over £100.00 in Quarter 3.

Resolved
The Committee:
- Received the report and accepted the contents
- Agreed disinvestment with Brown Shipley should proceed and reinvest with COIF. **DR**
- Clarification of fund number F17110 to be received **DR**

11 FUND BALANCES AND SPENDING PLANS

Mr Haire presented the Fund Balances and Spending Plans paper to the Committee and gave an overview of the current position.

It was advised that as at 31 December 2017 the charity had £1.768m available for spending.

Two requests for funding were received:

Kingstown Radio – Annual Grant
It was noted that a 3 year funding request from Kingstown Radio had previously been approved at this Committee. The Committee were advised on the funds that the payment for the final year instatement would be allocated from.
The funding request was approved.

Provision of IPads to support the Interpreter Service
The Committee had previously approved a funding request to support the supply of IPads to assist people with limited English skills communicate within the Trust. Due to the success and demand of this service, further funding was sought to increase the supply. The Committee were asked to support the addition of another 6 IPads at the cost of £1,644.
The funding request was approved.

Mr Snowden commented that the structure of the report was good. It was requested for an outcomes report to be produced which would give further details on the benefits noted after funding had been granted. Mr Haire agreed to bring a paper on the outcomes of funding requests over £5k to the next Committee meeting.

There was some discussion around the work that Mr Haire had carried out to merger some of the smaller funds. Mr Haire agreed to report on the fund mergers at a future Committee meeting.

Resolved
The Committee:
- received and accepted the report
- Approved the bids for general charitable funds as noted above
- Outcomes report to be presented at the next meeting **DH**
- Funds merger report to be presentedat future meeting **DH**

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12 WISHH CHARITY: GOING FORWARD

Mr Bond presented the paper to the Committee and gave an overview of the current and future position of the WISHH charity and the relationship between the Trust and WISHH. He emphasised that, it had never been envisaged that individual trustees would generally be involved in fundraising.

It was advised that Mr Bond, Mr Haire and Mr Snowden had met with Mrs Lockwood (Chair of the WISHH charity) to discuss the strategic direction of the WISHH charity.

Whilst various options were being explored the provision of a "management capacity" to enable the charity to function effectively as a fundraising body was the preferred option. The Committee agreed that they were happy to receive a charitable funds request proposing increased management support for the WISHH charity, subject to receiving a business case. Mr Bond agreed to enquire about the options available to provide fundraising staff for WISHH and the engagement of the Trust volunteer network to encourage the involvement of a volunteer team.

It was agreed that this information would be reported back to the WISHH charity trustees with a further meeting organised in due course.

Resolved

The Committee:

- Received the report and accepted the contents
- Agreed to meet with the Chair of the WISHH charity and trustees **LB**
- Receive information on the additional fundraising staff options **DH**

13 ART IN HEALTH STRATEGY

Mr Haire tabled a paper in relation to the Art in Health Strategy. It was agreed that this agenda item would be deferred for discussion until the next Committee meeting.

14 CHAIRS SUMMARY OF THE MEETING

Mr Snowden summarised the meeting.

15 ANY OTHER BUSINESS

At a previous Trust Board meeting the Organ Donation Team had attended and advised that they wished to commission an Organ Donation memorial at the Trust. Mr Haire agreed to liaise with the Organ Donation Team regarding the request.

Mr Haire informed the Committee that a group of midwives had set a target to raise £10k by selling memorabilia of the baby footprint campaign.

Resolved

Mr Haire to discuss the commissioning of a memorial with the Organ Donation Team. **DH**

16 DATE AND TIME OF THE NEXT MEETING

TBC, Hull Royal Infirmary

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