HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

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

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS		
1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 4 April 2017	attached	Chair
4. Matters Arising		
4.1 Action Tracker	attached	Director of Corporate Affairs
4.2 Any other matters arising from the minutes	verbal	Chair
4.3 Board Reporting Framework 2017-18	attached	Director of Corporate Affairs
5. Chair's Opening Remarks	verbal	Chair
6. Chief Executive's Briefing	attached	Chief Executive Officer
QUALITY		
7. Patient Story	verbal	Chief Medical Officer
8. Quality Report	attached	Chief Nurse
9. Nursing and Midwifery Staffing Report	attached	Chief Nurse
10. Fundamental Standards	attached	Chief Nurse
11. Draft Quality Accounts	verbal	Chief Medical Officer
PERFORMANCE		
12. Performance Report	attached	Executive Team
STRATEGY & DEVELOPMENT		
13. Financial Plan 2017/18	verbal	Chief Financial Officer
ASSURANCE & GOVERNANCE		
14. Board Assurance Framework 14.1 Board Assurance Framework year-end 2016/17 14.2 Draft Board Assurance Framework 2017/18	attached	Director of Corporate Affairs
15. Risk Policy	attached	Chief Medical Officer
16. Draft Annual Report	to follow	Director of Corporate Affairs

17. Minutes and summary reports from Board Standing Committees		Chair of Committee
17.1 – Performance & Finance 27.03.17, 24.04.17	attached	
17.2 – Quality 27.03.17, 24.04.17	attached	
17.3 – Audit 27.04.17	verbal	
18. Well Led Self-Assessment Framework	verbal	Director of Corporate Affairs
19. Guardian of Safe Working Report	attached	Chief Medical Officer
20. Standing Orders	attached	Director of Corporate Affairs

21. Any Other Business

22. Questions from members of the public

23. **Date & Time of the next meeting:**
Thursday 25 May 2017, 12:00pm - 1:00pm
(Extraordinary to approve the Annual Report and Accounts), the Boardroom, Hull Royal Infirmary

Attendance 2017/18

	4/4	2/5	6/6	4/7	1/8	5/9	3/10	7/11	5/12	Total
T Moran	✓									1/1
C Long	✓									1/1
L Bond	✓									1/1
A Snowden	✓									1/1
M Gore	✓									1/1
S Hall	✓									1/1
M Wright	✓									1/1
K Phillips	✓									1/1
T Sheldon	x									0/1
V Walker	✓									1/1
T Christmas	✓									1/1
E Ryabov	✓									1/1
In Attendance										
J Myers	✓									1/1
S Nearney	✓									1/1
C Ramsay	✓									1/1

Attendance 2016/17

	28/4	26/5	28/6	28/7	29/9	27/10	24/11	22/12	26/1	7/03	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	x	✓	x	✓	✓	✓	✓	✓	✓	✓	8/10
L Bond	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Gore	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	9/10
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Wright	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
T Sheldon	✓	✓	x	✓	x	✓	✓	✓	x	✓	7/10
V Walker	x	✓	x	✓	✓	✓	✓	x	✓	✓	7/10
T Christmas	✓	✓	x	✓	✓	✓	✓	✓	x	✓	8/10
E Ryabov	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
In Attendance											
J Myers	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	9/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	-	-	-	7/7
S Nearney	✓	✓	x	x	✓	✓	✓	✓	✓	✓	8/10
C Ramsay	-	-	-	-	-	-	✓	✓	x	✓	3/4

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 4 APRIL 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

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

NO. ITEM **ACTION**

1. CHAIR OPENING REMARKS

Mr Moran opened the meeting and thanked the Board for the time they had given up to meet with him before he commenced as Chairman on 3rd April 2017 and the warm welcome he had received. He was also grateful for the hand over conversation with Mr Ramsden prior to starting with the Trust and thanked him for his work as Chairman over the last 2 years.

Mr Moran spoke about the NHS 'Next Steps' document in relation to the Five Year Forward View and how the Trust would deal with the challenges and opportunities it highlighted.

2. APOLOGIES

Apologies were received from Prof. Sheldon, Non Executive Director

3. DECLARATIONS OF INTEREST

3.1 – CHANGES TO DIRECTORS' INTERSTS SINCE THE LAST MEETING

Mr Moran declared that he was currently working as a Non Executive Director at Mid Yorkshire NHS Foundation Trust and his term would end in June 2017. He also declared that he was the Chair of the charity 'Together for short lives' which helped children who required palliative care.

There were no other declarations made.

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

There were no declarations made.

3. MINUTES OF THE MEETING OF THE 7 MARCH 2017

Item 14 2017-18 Contract - the finance sentence to read: *This would guarantee the Trust an income equivalent 2016/17 outturn with an amount of growth built in for backlog issues in ophthalmology.*

Item 16.4 – Audit 07.02.17 – the statement should read: *Mr Gore stated that the Audit Committee had questioned the Trust's solvency and assurance had been given from the Chief Financial Officer that the Trust was viable from an accounting preparation perspective.*

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

4. ACTION TRACKER

Staff survey – Staff move to Castle Hill Hospital – Mr Nearney reported that he would be carrying out the questionnaires and report back to the June 2017 Board meeting.

5. MATTERS ARISING

Mr Gore asked if the Finance post in the Surgery Health Group had been filled and Mr Bond advised that it had but had left a vacancy in the Medicine Health Group. The advert for this vacancy was on the NHS Jobs website.

6. CHIEF EXECUTIVE'S BRIEFING

Mr Long presented his report to the Board and highlighted the 100 new apprentices and the ongoing work with the local population.

Mr Phillips updated the Board around 7 day services and the importance of recording accurately in the patient's notes.

Mrs Christmas asked if the security team had received the appropriate training following the introduction of Bodycams and Mr Bond assured her that they had.

Mr Moran commended the HR Team on the 44% response rate from members of staff completing the staff survey.

7. PATIENT STORY

Mr Phillips presented the item. A patient had complained about a ward that had been closed due to the flu virus and the lack of communication regarding the procedures in place when this happens. The Trust had written to the patient to apologise and explain the procedures.

Mr Phillips also reported that a patient had written to the Trust to thank the Fracture Clinic for their professionalism and compassion. There had been good communication and the patient felt well cared for.

There was a discussion around how the Trust could communicate with patients regarding closed wards and the possibility of a patient leaflet to explain.

8. QUALITY REPORT

Mr Wright presented the report and highlighted 2 serious incidents that had been declared in February 2017. He reported that the timeliness of completing serious incident investigations needed more focus and this was being reviewed.

Mr Wright stated that the Care Quality Commission Quality Summit had taken place in March 2017 and had been a positive experience. The summit had covered the Trust's improving position with time spent on what a 'good' score would look like and how it could be achieved. Mr Wright stated that the CQC were changing the way they assessed Trusts and these would become an

annual review for the Well – Led and one other standard.

The Quality Improvement Report incorporating all of the actions following the CQC inspection would be reviewed by the Quality Committee.

Mr Wright reported that the Safety Thermometer work was ongoing – 94.3% of patients were receiving harm free care and falls with harm remained low within the Trust. He advised that VTE assessments were being carried out and compliance was better than the Lorenzo scores and this gap was being reviewed.

Mr Wright spoke about MRSA bacteraemia and the two cases currently being investigated. One was attributable to the Trust and one had been attributed to a third party.

The Friends and Family Tests were very positive with 98.61% of the results being extremely likely to recommend the Trust to friends and family.

The Trust website was being developed to incorporate an audio visual element for patients to use.

There had been noticeable improvements regarding the Major Trauma Peer Review and the concerns noted would be reviewed and monitored at the Quality Committee. Mr Bond agreed that the service had improved and best practice tariff was now being received.

Mr Wright presented the assurance document which stated that the Trust had not had any Mixed Sex Accommodation breaches in 2016/17. The Board agreed to approve the document. The Chairman and Chief Executive to sign the document after the meeting.

There was a discussion around complaints and Mr Moran asked if the report could include the number of complaints as a percentage against activity. Mr Wright agreed to add this to his report for the next meeting.

Resolved:
The Board received the report and agreed to sign the mixed sex accommodation statement.

9. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright updated the Board regarding nursing and midwifery establishments and fill rates. He advised that Castle Hill had seen a drop in fill rates due to staff being transferred to Hull Royal Infirmary to cover night shifts.

Staffing was reviewed daily and an additional 138 posts had been recruited through the University. Mr Wright also mentioned annual leave and issues regarding sickness rates which were being addressed.

Mrs Walker asked about the international recruitment campaign and how nurses were looked after by the Trust. Mr Nearney advised that 83% of international nurses had been retained and a full care package including social events, schooling for children and buddy systems was in place.

Resolved:
The Board received the update and noted the current establishments and fill

rates.

10. STATUTORY SUPERVISION OF MIDWIVES

Mr Wright presented the report and advised that as of 31 March 2017 the statutory supervision of midwives was no longer law. Mr Wright reported that the Trust was proposing to continue with the current procedures (as these were working well) until a new national framework was introduced.

Resolved:

The Board received the report and agreed with the approach proposed.

11. PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted the 8 key areas that NHS England had set out in its Next Steps briefing document. She spoke about urgent and emergency care, primary care, improving diagnostics capacity in cancer services, mental health, funding, efficiency, patient safety and technology as the key areas going forward and how the Trust was aligning its priorities to accommodate them.

Mrs Ryabov reported that February 2017 performance had been impacted by diagnostic capacity resulting in a number of breaches. RTT had been impacted by emergency demand but there was a sense of more understanding from staff using business intelligence. Areas for concern were ENT, Ophthalmology, Rheumatology, Trauma and Orthopaedics and cardio thoracic. Mr Moran wanted assurance that patients on the waiting list were prioritised by clinical urgency and Mrs Ryabov assured him that they were. There were 52,000 patients on the list and the plan was to reduce this to 49,000 in 2017/18.

Fifty two week waits were discussed and Mrs Ryabov advised that the issues were around errors in the system, patient cancellations and ICU capacity.

A&E performance had been 82% in February following a challenging January. However March performance had risen to 94.6% which was having a positive effect on staff morale. Mr Moran thanked all staff working to achieve this performance on behalf of the Board. Mr Bond reported that due to this performance all fines that had been appealed had been upheld.

Cancer performance was doing well apart from the 62 day standard. This was due to access to CT scans. Mr Hall expressed his concern regarding the default position of sending patients for scans when they might not be necessary.

Mr Gore asked if the ODP vacancies were impacting on effective theatre utilisation and Mrs Ryabov stated that it was the front end of care were the main issues were, if this was done efficiently the patient flow would be much better.

Resolved:

The Board received the report and noted the Trust performance for February 2017.

12. STAFF SURVEY 2016/17

Mr Nearney presented the report and advised that there had been a 44% return rate with 32 key findings. The Trust had been compared to similar types of organisations for all 32 key findings and the number of scores in the top 20% had improved significantly.

One area of concern was engagement in the consultant group of staff and this was being addressed. Mr Nearney presented an action plan to review issues raised in the staff survey and to review consultant engagement. The Trust had a goal to be in the top 20% of Trusts by 2019.

Mr Snowden asked about disabled staff not feeling supported and what the main issues were. Mr Nearney reported that the issues were around the managing attendance policy and how this was viewed as a punishment for leave and not a policy to support staff. Mr Nearney advised that a conference was to be held to review disengagement of staff and what 'good' would look like. Mrs Walker requested that the plan be reviewed to show more outcome based actions.

Resolved:
The Board approved the action plan.

13. MORTALITY REPORT

Mr Phillips presented the report and advised that nationally there was a move away from SHMI and HMSR and more towards reviewing avoidable deaths and having structured case note reviews. Mr Phillips also added that accountability was key in preventing unavoidable deaths.

The Board discussed reports to be received on a quarterly basis showing themes and trends and any learning from the case note reviews. Mr Long added that mortality was being monitored by the Quality Committee on a regular basis.

Resolved:
The Board received the report and agreed to receive an update in July 2017.

14. FINANCIAL PLAN 2017/18

Mr Bond gave the presentation which set out the 2nd submission of the financial plan and reviewed the assumptions made.

Mr Bond reported that the Trust plan for 2016/17 was to reach a break even position which had been achieved. The Trust had reached a £14m deficit with £14m Sustainability Transformation Funding received to achieve the position.

The assumptions made for the 2017/18 plan included 1% pay rise, an increased clinical negligence insurance payment, the apprenticeship levy and recurrent outturn levels of the Health Groups at (£26.7m). The CRES target had been set at 3%. There was an overall reserve provision of £17.4m.

The plan for 2017/18 assumes income of £523m, expenditure of £537m leaving a deficit of £14m. The £14m would have to be covered by working capital loans to ensure creditors were paid for goods and services.

Mr Bond advised that NHS Improvement were sponsoring the FIP2 programme (Financial Improvement Plan 2) which used external consultancy firms to review cost reductions and improve outturns.

Mr Bond outlined the risks involved in signing the control total which included cost controls of the Health Groups, CRES delivery, recruitment issues and the impact of the Junior Doctor contract.

There was a discussion around signing up to the control total and whether the targets for 2017/18 were realistic and achievable. Mrs Walker was pleased that

the gap in the financial planning had reduced but expressed concern with utilising external companies to review cost savings. Mr Bond assured her that the Trust did not have to commit to all three phases of the programme but that it should at least look at the options. Phase 1 and 2

Mr Moran suggested that the Board adopt the position of giving authority to Mr Long and Mr Bond to discuss and agree the control total with NHS Improvement. This would be dependent on further work to the Financial Plan to assure the Board that the actions were robust and targets could be met to achieve the control total. The Board would be informed of any developments.

Resolved:
The Board received the presentation and agreed that Mr Long and Mr Bond would further review the financial plan and negotiate the control total with NHS Improvement with final approval by the Board. **CL/LB**

15. BOARD ASSURANCE FRAMEWORK 2017/18 OUTLINE

Ms Ramsay presented the report and highlighted the proposed process for formulating the new Board Assurance Framework. She advised that any risks from last year would be carried over and there would be input from all executive directors on each section.

Resolved:
The Board approved the process for formulating the 2017/18 Board Assurance Framework.

16. FIT AND PROPER PERSONS TEST – ANNUAL ASSESSMENT

Ms Ramsay presented the report which highlighted that all Board members had completed their 'Fit and Proper Persons Test' with no issues emerging. This process would be completed on an annual basis.

Resolved:
The Board received the report for assurance purposes.

17. FREEDOM TO SPEAK UP REPORT

Ms Ramsay presented the report which highlighted the role of the 'Freedom to Speak Up Guardian' and what was expected of Trusts. The report mapped out the measures already in place, the approach being taken and the different ways staff could get support. The Communications Team would be asked to ensure the information was promoted appropriately.

Mrs Walker asked whether a NED champion was required and Ms Ramsay advised that Mr Snowden as Vice Chair had in the past taken up the role. This would be discussed in more detail.

Resolved:
The Board received the report and approved the approach being taken.

18. BOARD REPORTS FROM STANDING COMMITTEES

18.1 - PERFORMANCE & FINANCE 27.03.17

The report was received for information.

18.2 - QUALITY 27.03.17

Mrs Walker reported that the committee would be reviewing issues relating to nutrition record keeping and the lead for dietetics would be

attending a future committee.

19. ANY OTHER BUSINESS

The Board was asked to complete a Board effectiveness review for the year 2016/17.

20.

QUESTIONS FROM MEMBERS OF THE PUBLIC

The Board thanked Alison Coggan (Hull Daily Mail) for all her help and

21. professionalism over the past years and wished her well in her future role.

DATE AND TIME OF THE NEXT MEETING:

Tuesday 2nd May 2017 – 2pm – 5pm, The Boardroom, Hull Royal Infirmary

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Chairman

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (May 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
January 2017						
01.01	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Jun 2017		Not yet due
01.03	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	Jul 2017		
COMPLETED						
Jan 2017	Action Tracker	Guardian for Safe Working report to be presented	HC	May2017		On Agenda

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

April 2017

Performance improvement

Staff working throughout our hospitals have helped to deliver huge improvements in recent months. One year ago, HEY was struggling at the bottom of Trust league tables, with substantial change yet to be realised. During w/c 20th March 2017, the national 95% 4hr ED performance target was met, placing us amongst the top performing Trusts in the country.

Improvements in patient experience, meanwhile, have resulted in a sustained reduction in patients complaints over the last three years, to the point where no complaints were received in the Emergency Department at all during February 2017.

This overall improvement correlates closely with better patient outcomes and is a step change towards sustainable performance. Massive improvements in embedding cultural change, timely discharge and a pull model from the acute assessment areas have been made, but we need to maintain this for months to know that change has been embedded.

Thanks have been extended to all staff via internal communications.

Cultural improvement

The recent Barrett values Cultural Survey was completed by over 1000 staff. The results show a significant positive shift in culture since we last surveyed in late 2014. The current culture is described by staff using the following values: Patient Safety, Short-term Focus, Care, Bureaucracy, Hierarchy, Accountability, Long Hours, Continuous Improvement, Results Orientation and Teamwork.

A culture that includes patient safety, continuous improvement, care and results orientation moves the Trust away from a cultural assessment that previously included target orientated and a greater number of limiting cultural factors. Barrett have told us that the improvement this indicates is almost twice as good as they would have expected in just two years. Cultural change takes time and we still have work to do but this is a very positive step in the right direction, and supports our recent staff survey and CQC performance.

New midwife-led *Fatima Allam Birth Centre* opens in Hull

The Fatima Allam Birth Centre offering facilities for mums-to-be seeking a natural birth opened within the Hull Women and Children's Hospital during April.

Design and construction of the midwife-led unit began in November 2016 and was completed towards the end of March. The birth centre comprises three individual rooms, each featuring a birthing bed, birthing pool, en suite bathroom and additional equipment, should it be needed.

The development of the centre was made possible through the generosity of Mrs Fatima Allam, who has donated £370,000 towards the overall £470,000 cost.

Baby steps to a bigger picture

Parents, proud grandparents and art lovers alike can recreate their own 'Born into a City of Culture' artwork at home.

The Trust has launched a series of six, limited edition postcards which will be produced over the course of this year. One postcard will be produced every two months, featuring scaled

down versions of midwives' handprints and baby footprints taken in the preceding two months. Once complete, the six postcards will together form an exact replica of the artwork, depicting trees throughout the seasons, which is currently taking shape in the Women and Children's Hospital.

Robotic gait trainer for rehabilitation
The Rehabilitation Medicine Department will shortly be loaning a robotic gait trainer for six months. HEY will be the first Trust in the country to have access to the G-EO System, an advanced piece of equipment which helps patients regain the ability to walk. The team will be seeking to purchase a trainer of this kind through a combination of capital investment and charitable donations

Nursing associates take up roles
Nineteen new nursing associates will take up their roles this month and begin training in our hospitals. They will study towards an academic qualification whilst working alongside our registered nurses to deliver hands-on care to patients. The aim of the role is to bridge the skills gap between healthcare assistants and the registered nursing workforce, and there are now 2,000 nursing associates across the country.

Hospital equipment gives family pets a new lease of life
Old and out of date hospital equipment is giving pets in Hull a new lease of life.

Surgical instruments, wound care packs and disposable sheets are just some of the items which have been donated to the PDSA Pet Hospital in Brunswick Avenue this week.

As modern medicine has advanced, the Trust has found itself with a range of items which are no longer required or have passed their used by dates.

Instead of throwing them away, however, the Trust has delivered four boxes full of items to PDSA veterinary nurses and surgeons, who will now use these items to care for sick and injured animals.

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 who 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 March 2017 we received 51 Moments of Magic nominations – in the words of our staff:

Mandy Oakley-Smith
Since Max Fax Outpatients lost their regular day surgery activity from October 2016 we have had regularly RTT meetings were we have continuously seen our DSU figures increase due to having no capacity to operate. Due to the hard work and dedication of Mandy Oakley Smith in Max Fax Waiting List she has managed to get the list from around 100 patients to below 50 patients - using her skills and knowledge of the service and using all available inpatient capacity (including empty DSU sessions) - she has ensured we kept lists as full and utilised as possible. Without her we wouldn't be in the position we are now! Thanks Mandy.
From Michael (Charge Nurse) and Mr S Crank (Consultant) 31/03/2017

Mathew Storey

Mathew volunteered to stay and work the on the fourth floor when he heard there was no SHO cover for the night. Mathew cancelled his training day the next day to enable him to cover the ward. All the nurses were extremely grateful as they realised that all the doctor jobs would be done in a proficient and timely manner - thank you for staying Mathew.

30/03/2017

Dawn Waddy

We had an incredibly hard night and been short staffed at 7.00am we had an arrest and as me and Dawn were first with the patient we started CPR after relevant checks. Dawn was extremely calm and confident all the way through; while waiting for the crash team to arrive we had talked each other through and took turns in compressions and giving the ambu bag. Through our team work then along with other staff we managed to get him back for a short while. Without Dawn this wouldn't have been possible. 30/03/2017

Jenny Wilson

After a busy night shift and being left short staffed, Jenny and myself decided to check on a very poorly patient to check he was ok, only to find he was having a cardiac arrest. The 2 remaining staff nurses who were busy putting patients back to bed so they didn't fall were obviously otherwise occupied. Jenny decided that we should start CPR on him until the crash team arrived. Jenny remained confident in what we were doing at all times and as we talked each other through when we would take over from each other and change over from doing compressions we did eventually get the patient back for a short while. I found working with Jenny to be true teamwork to its limit. 30/03/2017

Sam Mcphee

Sam was asked to do a bed watch on a mental health patient in ED. He was very professional and immediately built up a good rapport with a very challenging patient keeping him calm where others couldn't. He went above and beyond even transferring to the mental health unit with the patient to keep him settled and safe during transfer stating he was just doing his job. 29/03/2017

Josh Woolhouse & Bozhidar Tortopov

On Saturday 25th March, neighbours of mine were given an urgent appointment to visit the eye clinic by an optician in Driffield for 4:30pm latest. Unsure of their way to HRI and even more unsure of where to park and go to upon arrival, they got here late, flustered and anxious. The driver dropped off her husband at the Tower Block for his appointment while she went off to park. Two security guards within the Tower entrance came to the rescue, with one escorting the patient all the way to the eye clinic where a nurse specialist was waiting way beyond her hours. Meanwhile his wife arrived at the Tower entrance looking for him. The second security guard called through to the first one to come back and collect the patient's wife and take her to the eye clinic. They would never have found their way to the correct place, or indeed found each other again. They wanted me to thank the guards for their extra help and assistance in what was to them a strange place at a time of stress.

29/03/2017

Rebecca Snow

Becky our ward hygienist is very supportive in times of difficulty for both staff and patients, going beyond her roles and responsibilities to ensure patient safety, comfort and alerting nursing staff when something is wrong. She makes patients feel at ease and gives all staff encouragement throughout stressful situations. She’s kind and friendly and we are so glad she is a part of our team on ward 5! Thanks Becky. 29/03/2017

Janette Smith

I am very pleased to let you know about the excellent contribution that Janette showed today (6th March 2017) in my urogynaecology clinic. Janette has worked with me for many, many years and she consistently acts in the best interest of the patients, as well as runs the extra mile to help. Today I had a young lady in the urogynaecology clinic who was bothered by a hospital appointment in the surgical outpatient she received without much information regarding the appointment. She wasn't getting anywhere by ringing the hospital. I tried to look through her records and on the system regarding this appointment but could not find any relevant documentation to help this lady. However, Janette took the lead and went to our reception staff with this young lady and helped her out with the details of the clinic appointment. As a matter of fact,that clinic appointment was cancelled for the patient and indeed Janette saved this patient an unnecessary journey to the hospital and also reduced the her anxiety levels. Janette indeed deserves a well done for this Moment of Magic.

28/03/2017

Gabrielle Taft and Stacey Carrigan

I'd like to nominate Gabrielle and Stacey for a moment of magic as I recently contacted the histopathology department for some assistance with some histology reports I was chasing for patients and consultants. My (many!) queries were dealt with extremely quickly and I was emailed back with updates on all the queries I made. Whilst it may not seem like the biggest thing in the world, I thought it was certainty worth a mention. Sometimes in our jobs it’s the little things that make a big impact and a quick turnaround on a query can make a difference between a patient waiting longer than necessary for care as the quicker I get a query answered, the quicker I can answer a patients question. It put a smile on my face to see such great teamwork happening within the trust. Thank you so much to both of you!

28/03/2017

Clinical Skills Team

As trainers we attend the Clinical Skills Centre to deliver simulation courses for nurses. The centre is busy and has several courses running at once and is at full capacity. Whenever we have to contact the Clinical Skills Team to book facilities they go the extra mile to accommodate us in any way they can. Despite being fully committed to other courses they will pull all hands on deck to get a simulation area set up for us if possible and squeeze every last drop of capacity out of the facilities and their time. If it was not for their 'can do' attitude many of our courses would not have run and many nurses would have missed out on valuable learning. 27/03/2017

The Critical Care Outreach Team

I would like to nominate a team that spend many hours supporting all areas of the hospital night and day, often attending highly stressful events including cardiac arrests, trauma calls and paediatric emergencies. They also follow up the long term patients from critical care offering advice and listening to their concerns which is a great comfort to patients and families. They are always professional and supportive to all staff and maintain a great sense of humour. 27/03/2017

Louise Elliott

I would like to nominate Louise as she has worked very hard for our department often in her own time, night shifts in our department have become busier & Louise recognised that for both patient & staff safety we should audit the movement of patients in order to determine if more staff were needed/twilight for longer. Change is not always welcomed but she hasn't let that stop her standing up for what she believes in and she should be recognised for this, well done Lou!! 24/03/2017

Nigel
We had a busy night shift in ward 6 and at 0400h while Nigel (porter) was there, who just brought up a post op patient, helped us with another patient who had a fall in the bathroom. That was a great help for us all in the ward, thanks a lot, Nigel. 24/03/2017

Louise Oates
On 2 separate occasions Louise has assisted with the care of two patients with complex medical and mental health needs, she built up a rapport with the patients to enable them to receive the treatment they needed. Louise gave reassurance and kept the patients calm. Louise always has a positive attitude, is hard working and is a valued member of the team. 24/03/2017

Dawn Taylor and Joanna Melia
This member of staff, supported by Joanna Melia, Junior Sister Rowan Ward, has dedicated their own time to promote the safe sleeping week for newborn babies. They have had stands in Women and Children's Hospital and St Stephen's Shopping Centre to advise new and expectant parents how to keep their babies safe during sleep times, giving health advice and parenting advice. A bun sale was also arranged at the same time to raise money for the Lullerby Trust who support the safe sleeping campaign. Information boards have been developed on the maternity ward to capture those families in the hospital. 24/03/2017

Leanne Broadly & Deborah Chester
I would like to nominate Leanne Broadley and Deborah Chester for their kind gesture of support and team spirit; knowing I was on my own this morning they assisted me with breakfast which is usually done by two caterers on AAU. I was really touched by this gesture and felt they deserved a mention on moments of magic. 24/03/2017

Jordan Lewis
A disabled elderly lady with memory difficulties attended the Neurophysiology Department and arrived by Hospital Transport. Upon finishing her appointment, she was wheeled back into our reception and mentioned to our Apprentice Support Secretary that she hoped she would not be waiting for too long, as she was very excited about having fish and chips for her lunch back at the residential home. This lady was unaccompanied and had no refreshments with her at all. Jordan very kindly explained to her that he would do all he good to ensure she got back for her lunch and immediately telephoned Hospital Transport to enquire as to how long they would be. He then telephoned the care home to advise them of this lady's wishes and he was informed that it was not fish and chips on the menu, but he asked if they would be willing to arrange for her to have a plate of fish and chips upon her return. They advised they would see what they could do. Jordan made her a cup of coffee and advised he would try and get her home as speedily as possible. His care and compassion warms your heart. 23/03/2017

Julie Toner
Julie Toner is one of those housekeepers you meet that makes you feel calm and reassured. Even when the pressure is on she smiles and gives her very best. She has given me so much support each time; ask her to do anything to help and goes the extra mile. You are a national treasure at the Queens Centre. If you were my housekeeper I would feel so proud. People reading this may feel she is just doing her job, she is and she does it very well with extra topping and that's what we need - keep being you Julie and thank you for being such a great support not just within the Queens but Trust wide. 23/03/2017

Gary Forster
Just a great help whenever you need a little help. Assisted with a computer problem!!! 22/03/2017

Elaine Hua and Beth Walker
Our consultant had been away for the weekend and on Monday morning we discovered he was not going to make it back for his clinic because of an issue at Amsterdam airport and his flight being cancelled. His flight was meant to bring him back to Humberside airport where his car was parked but instead he had to get a return flight to Leeds landing at 9.30pm on Monday evening. As soon as 2 of our students Elaine Hua and Beth Walker got wind of this they immediately offered to go and collect Dr Prunetti from Leeds airport and drive him to Humberside airport to collect his car, in their own time on Monday evening. I couldn't have been more proud of them and it just proves to us that in the selection process we did indeed chose well, well done to them both and thank you 21/03/2017

Denise Rose
Not one moment can describe Denise, she is constant 'magic' ! She is always helpful, reassuring, rushed off her feet but happy to help you with a patient. She tries her hardest for everyone be it GPs, colleagues, and patients...the Eye Hospital would not be the same without her admirable contribution. Her efficiency and knowledge impresses all who have contact with Denise and it would not be an exaggeration to say she is the 'beating heart' of the Eye Hospital. We thank you Denise!! 21/03/2017

Mel Dickinson and Janine Smith
Working tirelessly as infection control link nurses. Designing posters, completing audits, continuing to keep a vigilant eye out on the unit, insisting good practices are adhered to. Thank you!!!!! 20/03/2017

Becky
Becky was on the night shift at A&E Majors on Saturday night which is trying time for all staff on that shift. She was looking after my relative and was absolutely brilliant. When she saw how serious his condition was she did everything she could to get him sorted and to get him the right care. I honestly believe Becky is the reason he recovered so quickly she is such a caring Nurse and deserves to be recognised. 20/03/2017

All staff on Ward 40 team
I would really like to nominate all of ward 40 HRI for such outstanding work that they do - really good team effort and working part of them, I found them so lovely helpful and very understanding - well done to everyone. 20/03/2017

Sara Howley
Sara has gone above and beyond her job role whilst Acting band 7. Always supporting staff even when she is not on duty, staying late most days to ensure the ward is safe. She has been an invaluable role model and endeavours to boost staff morale even when the going is tough. All the staff on ward 9 really appreciate all the effort and support she provides. 20/03/2017

Kath Ogilive
I would like to give a special mention to Kath Ogilvie from A&E who came to work an early overtime shift on AAU. Not only did Kath work extremely hard, giving great care and compassion to all of her patients, she showed great team work and commitment and ended up staying for a full 13hour shift, knowing that AAU would be short staffed. Kath is always a pleasure to work with and is a great credit to A&E. Thank you Kath for being a great nurse and team player 18/03/2017

Laura Burke
Laura is an absolute pleasure to work with, she is efficient and has excellent leadership qualities whilst working as an RMO, she ensures safety is maintained at all times and

communicates with the whole team to ensure everyone is kept up to date and patient safety is maintained. Laura is very patient, calm and supports her team well. She goes above and beyond what is expected of her role as registrar. 17/03/2017

Cheryl Romano
Every time she walks onto the ward. 17/03/2017

Nikki Edmondson
After ward 8 lost its manager there was low morale; staff were all struggling with work life. Nikki took over and from day 1 she boosted staff morale, built a stronger team and got the ward back on track! She's such a lovely person and definitely has time for all her staff. She is easily approachable and always makes you feel part of the team. The difference her impact has made to the ward is fantastic and I for one would like to thank her whole heartedly for making a knock out team! 17/03/2017

Troy Phelan
Troy Phelan is a wonderful person/colleague. Nothing is too much trouble. He makes sure that the blood is delivered in a very quick manner, you literally see him sprinting across the hospital grounds. Troy goes beyond the call of duty and is very approachable, reliable and hard working. 16/03/2017

Judith Hogg
Judith has looked after my Dad for quite some time now and he was visiting his routine appointment with the Haematologists, when he expressed how difficult he has been finding things lately and broke down (which is so hard to witness). Judith showed extreme and genuine compassion towards my Dad. My Mum and I felt that my Dad was made to feel not just a patient, but someone who really did matter to her. Judith found out exactly what my Dad was struggling with and has made positive steps towards helping him to overcome these hurdles, for this, we are eternally grateful. Thank you so much Judith, you`re an absolute star!! 16/03/2017

Ali Lamb
I would like to nominate Ali for a moment of magic as she is ALWAYS happy and upbeat. She gives each patient a boost of confidence and cheers them up with her crazy sense of humour. She is genuinely a warm hearted, caring person! She is a great friend as well as colleague and really brightens up ward 8! 15/03/2017

Julie Williams and Dr Ewan Masson
I would like to nominate Julie (Jules) Williams and Dr Ewan Masson. I am a long term patient of the endocrinology team and have always been treated as a patient not a number. More recently, due to continuing symptoms, I have been offered a trial of an additional drug to help with my symptoms. Dr Masson is an amazing consultant and will be missed when he retires however Jules is also equally amazing. Her communication skills are exceptional and she has gone above and beyond in helping me. I am under other services within the hospital and lessons could be learned from Jules and her kind and compassionate ways. She certainly ensures she works to the trust’s values and vision. 15/03/2017

Sarah Adamson
I would like to nominate Sarah Adamson as over the last few months my father has been very ill and without Sarah s support with reducing my hours I wouldn’t have been able to become my father's carer, take him to multiple hospital appointments and most importantly spend more precious time with him which to me is priceless. In addition to that Sarah always offers me emotional support and the opportunity to talk. Thank you, Sarah. 14/03/2017

Claire Whitteron
I had numerous staffing shortfalls and a patient who required one to one special. Claire offered her support despite only being on call she offered to stay and give that patient the care and attention they needed. I think Claire knew how desperate I was and I want to thank her for restoring my faith that there are still special people who will go above and beyond for their patients. 14/03/2017

John Sanderson
I just want to highlight the excellent patient care provided by the CT team at HRI on Friday 10th March. Without question they fitted in an extra patient directly following her ultrasound examination. This not only avoided the patient having to make a return trip to the hospital but it avoided the need for her to have a repeat cannulation, particularly important as the patient had poor venous access. The team couldn't have been more helpful. Thanks John, it was really appreciated 13/03/2017

Jayne
Jayne in cardiology outpatients always goes above and beyond her role. She is very caring. She is very through. She is a good listener. She is very trustworthy, compassionate. Works extremely hard. 13/03/2017

Barbara Hoyle
Working in the shop at Castle Hill main entrance is not just a voluntary retail position. Volunteers are asked for directions and asked to get medical help. Today we had a lady who had undergone major bowel surgery and had attended for a CT scan. The liquid she had to consume for the scan had caused her some bowel difficulties and she had already had to discard some clothing. She was extremely worried about the journey home. Barbara Hoyle very quickly and very discreetly attended the ward, spoke to the Sister and obtained some pads to ensure that the lady felt a little more safe on her return journey. Barbara offered to take her back to the clinical area for medical support however it was declined as the lady was happy with the help so far. Barbara has been a volunteer for many years. She turns up twice a week and gives us her time. She is a warm, kind and gentle lady and I really appreciate her. Thank you Barbara for going above and beyond what is expected of you and for providing the patient with discreet support and kindness. 13/03/2017

Julie Oglesby
We are a very busy colorectal surgical ward (ward 11) at Castle Hill. Recently we have had such busy shifts and very dependent patients. On one particular night shift we were so busy that staff didn’t get a proper break and we didn’t manage to even have a drink until 4am. Our auxiliary that night was Julie Oglesby and without question we would have not managed without her. Julie never stopped all night. Not once did she even sit and have a drink. The patients kept her busy with burst stoma bags, leaking wound bags and late night toileting. At one point we had 6 people all wanting the loo at the same time. It was relentless. Buzzers literally never stopped, so much so a patient asked me if there was a faulty buzzer because she had heard buzzing all night!! Along with all this we also had a confused lady on the ward who kept trying to walk off the ward or get into the wrong bed, so as well as doing all of the other jobs Julie also had to keep an eye on the wandering lady to ensure her safety. We all worked very hard that shift but I think special thanks need to go to Julie as she really got stuck in never stopped and never moaned about it. You did great Julie, and just wanted you to know how much I appreciated your help. More than deserving of a nomination.
12/03/2017

Jean Stowell
I would like to nominate Jean. She is an amazing team leader, hard working, a forward thinking person. She is so supportive to her team and her door is always open. Jean is

always happy and cheerful and keeps us all smiling throughout the day that is why we call her Queen Jean 12/03/2017

Mary Patterson
Having worked on ward 9 CHH with one member of staff for 15 years, Mary Patterson is a member of staff who leads the way for all new starters, She takes them under her wing and shows the great way to strive in their job roles, she learns them from the start how treat each patient as an individual and all patients love her and staff. She does fundraising for the ward and is fundraising for a second defibrillator for the community football teams. One in a million and a devoted member of staff, so I would like to nominate this wonderful member of staff 12/03/2017

Lizzie Chapman
Lizzie is always friendly and approachable on reception. I often see her interacting with the children and families whilst they are waiting. She gets them involved in activities and keeps them distracted. She is very friendly and great with the children. She will check up on them in the department and often comes to speak to them and say goodbye. 11/03/2017

Kay Brighton
Kay has been an amazing ward sister on Ward 10 HRI. She has made us all grow in our career since becoming new auxiliary staff within the trust. Very proud of working on winter ward under Kay and the rest of the team. She is always there to listen to us and support us in the first few weeks of being on ward 10. Thank you for supporting us all and being there - you are an amazing ward sister. 09/03/2017

AAU Staff
My brother came into ED with what looked like a virus and ended up in AAU during the night. I was on shift the next morning in the tower block and popped down to see if my brother was ok and to ask if he needed anything only to find he had died at the moment of me walking into AAU I saw the staff working hard to bring him back and as you could imagine I was hysterical. but I want to thank the staff that was on that morning, each and every one of them tried to comfort me from the nurses to the house keeper and the domestics - they all made a massive effort and their kindness will never be forgotten and I want to thank you all from the bottom of my heart for everything you all did. Thank you for giving me more time with my brother xx 09/03/2017

Linda and Graham Gedney
Two of our Hey volunteers Linda and Graham Gedney who sign post and reassure patients at the front reception of the Tower Block and I have to say do an amazing job. Last week the coffee shop at the foyer of HRI roof came in and Linda and Graham went straight to the rescue helping and trying to keep the public and the sandwiches safe!!! They stayed several hours to help the catering staff so they could continue to serve the patients, staff and public. They are always there in the foyer addressing any concerns or queries which confront them. I am so happy they volunteer at HEY as they offer a valuable service with their kind hearts and open minds. Thank you on behalf of us all at HEY!! Well done x 08/03/2017

Amanda Price
Mandy stood in as temporary ward manager to us here on Ward 100 for almost a year. In that time she always went above and beyond not only to help the patients on the ward but also the staff. She lit up everyone's day and will be missed, she deserves this recognition as times it was stress inducing, which often included her staying well beyond her hours to help cover the ward. 08/03/2017

Di Gallacher
I witnessed a true moment of magic this morning. Di Gallacher an auxiliary spent over an hour with a patient with dementia giving personal cares, such care and compassion was shown by Di, it was heart-warming. Di was seen writing information on a note pad for the patient to read as the patient is extremely deaf. The business of the ward did not stop Di making the patient feel really well cared for. By taking the time and patience a wound concern which may have been missed was raised to the nurse in charge. Di stayed with the patient whilst the wound was dressed and calmly explained the procedure to her patient. True nursing care was shown which made a patient with dementia feel safe and cared for
08/03/2017

Critical Care Staff
All members of staff on the intensive care units at Castle Hill Hospital and Hull Royal Infirmary deserve a very special mention for all their exceptionally hard work during recent months with the very high pressures placed upon the service during this time. Professionalism, dedication and care have not faltered during this time and they should all be proud. Well done! 06/03/2017

Diane Clark and Terena Rowe
I attended day surgery for a pre-op assessment during which I was looked after by Terena doing bloods, blood pressure etc and Diane doing my ECG. They are both lovely, hard working ladies who made me feel at ease throughout the appointment. 02/03/2017

Immunology and Allergy Team
I would like to nominate the whole of the immunology and allergy department. They are always friendly and helpful, nothing is too much for them. Even when their own team is short a member they will always be willing to jump in and help fellow clinics around them. They are a great bunch of people!!!!!!!!! 02/03/2017

Ward 9
I would like to nominate the nursing team from ward 9 HRI for the hard work that they are doing every day in spite of pressure of working critically short staffed on a daily basis. They are 100% committed to provide excellent care to all of their patients which was demonstrated in achieving almost one year with no pressure damage on the ward.
02/03/2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT APRIL 2017

Trust Board date	2nd May 2017	**Reference Number**	
Director	Mike Wright, Executive Chief Nurse	**Author**	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

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

QUALITY REPORT
APRIL 2017

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates

The Trust Board is requested to receive this report and:

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

TRUST BOARD QUALITY REPORT
APRIL 2017

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates

The Trust Board is requested to receive this report and:

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

2. PATIENT SAFETY

2.1 Never Events

There have been no Never Events reported since September 2016.

There are no current ongoing investigations into Never Events.

2.2 Serious Incidents

A total of 69 Serious Incidents were reported in 2016/17. This is below the rate of reporting in 2015/16 which was 111. The Trust reported more Serious Incidents in 2015/16 than in any previous year. After this peak, the numbers of serious incidents (including never events) have reduced during 2016/17. The Trust feels that it has a low threshold for reporting that is balanced and has increased confidence that the right incidents are being reported. The Trust's commissioners support this view.

There were ten serious incidents declared in March 2017, which are summarised in the following table, are being reviewed currently. These are:

2.2.1 Serious Incidents declared in March 2017

Ref Number	Categorisation of SI	Health Group
6578	Fall resulting in unexpected death	Medicine
6615	Unexpected death	Medicine
6804	Paediatric death	Medicine
6981	Sub-optimal care of the deteriorating patient within	Medicine
7249	Grade 3 pressure ulcer on	Medicine
7685	PACS downtime – air conditioning issue	Clinical Support / IT
7696	Unexpected death (stroke patient) on	Medicine
8035	Sub-optimal care of the deteriorating patient	Family & Women's
8460	Treatment delay of metastatic disease	Family & Women's
8532	Unexpected death	Medicine

All of these are under investigation currently and matters of significance will be reported in future versions of this report.

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

The Trust completed 7 investigations into Serious Incidents in February 2017. These related to:

2.3.1 Venous Thromboembolism (VTE) incident: A patient was admitted with suspected pneumonia and was discovered to have a Deep Vein Thrombosis (DVT). The finding from this incident was that there was no signature on the drug card to indicate the Dalteparin (anticoagulation) was administered. The lack of compliance with the requirements of the CP26 Drug Policy, Section 2.10.2 (no signature) cast doubt as to whether the drug was given. The lessons identified were the need to adhere to the Trust's policy and reinforce the need to maintain documentation to the required standards.

Outcome for the patient: This patient sadly died, although the panel concluded that the possible missed dose of Dalteparin would not have impacted on the outcome of the patient.

2.3.2 Infection control incident: A baby contracted a Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia. There were several lessons to be learned as a result of this incident. These include the importance of ensuring excellent infection control procedures and being able to demonstrate this with appropriate challenge when practise is not as it should be and more regular audits. Standard infection prevention procedures need to be challenged all times.

Outcome for the patient: The patient recovered from the infection and has since been discharged from hospital. There are no apparent long term effects from the incident**.**

2.3.3 Maternity monitoring incident: There was a failure to recognise a clinical picture while monitoring the woman within the Antenatal Day Unit. Actions from this investigation focused on staffs use of Cardiotogoraph (CTG) monitoring and the escalation processes across the maternity admission areas.

Outcome for the patient: The baby continues to be followed up by a Consultant Neonatologist.

2.3.4 Delay in follow-up incident: A patient did not receive a follow up appointment for suspected sarcoma (cancer) following partial removal of a lump. The sample was also sent to external company for review and was not requested urgently via the pathology department. The learning from this investigation was that sample request cards must be completed accurately and be consistent with the medical records. The sample request card should have included information that the sample was a suspected cancer.

Outcome for the patient: The patient had a delay in receiving the appropriate treatment for the sarcoma on her back. This has led to further required treatment being delayed. The patient has subsequently received the appropriate treatment.

2.3.5 Pressure ulcer incident: An investigation into a hospital acquired pressure ulcer resulted in the following lessons learned. If staff had recognised the deterioration in the patient's mood and subsequent problems with mobility, measures could have been put in place, which may have prevented the skin damage from occurring. Also, there was an inconsistent approach on the ward to assessment, identification and management of the patient's skin. This was further compounded by the Specialist Tissue Viability plan that was put in place for this patient not being followed fully correctly alongside the use of inappropriate preventative measures, which caused further breakdown of the pressure damage to the patient.

Outcome for the patient: The patient sustained moderate harm. The patient's wound improved and the patient was discharge home with community support.

2.3.6 Treatment delay: A CT Scan was undertaken and incidental findings noted a lesion on the patient's kidney. This information was not followed up and the patient presented back some years later with renal malignancy with bone metastases. The incident demonstrated flaws in the previous radiology reporting systems. A new radiology report flagging system has been introduced successfully, which automatically lets the requester know the result is abnormal and need attention.

Outcome for the patient: The patient is now under the care of the Oncology and Orthopaedic teams and has completed a course of treatment.

2.3.7 Delay in diagnosis: A patient was admitted via the Emergency Department with symptoms of cauda equina syndrome (CES). The patient was symptomatic but diagnostic tests were not carried out in a timely manner and this led to a delay in the patient receiving neurosurgery. The incident recognised that the CES treatment protocol was not followed.

Outcome for the patient: The patient underwent the required surgery. The patient is currently undergoing rehabilitation at a neighbouring hospital and the long-term effects on the patient are not known fully at present.

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

From the 882 in-patients surveyed on Friday 7th April 2017, the results are as follows:

- **93.5%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.25% [n=11]** 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 **98.75%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **92.29% (n=814)** compliance. Clearly, this is more positive than is being reported (via Lorenzo) in the Integrated Performance Report and is improving steadily but these rates still need to improve further.
- VTE incidence on the day of audit was **4** patients; all of which were with pulmonary embolisms.
- New pressure ulcers remain relatively low **(n=3)**; all of which were at grade 2.
- There were **15** patient falls recorded within three days of the audit day; **13** of which resulted in no harm to the patient and **2** with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain relatively low at **5/161** patients with a catheter **(3.1%)**. Of the **5** patients with infections, **2** were infections that occurred whilst the patient was in hospital **(1.24%)**. This remains a focused area for the Trust.

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

The original intention behind the ST was for it to be a tool for local improvement. The reporting of ST results is a contractual requirement for the Trust and, also, they are used by the Care Quality Commission and NHS Improvement in their assessments of the Trust's performance. Originally, it was never intended for the ST data to be used as a performance management tool or a

benchmarking tool with other trusts. This is because not all trusts collect necessarily the same data, in the same way and to the same scale. Nonetheless, they are used in this way.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 28th February 2017

The Trust is required to report monthly on performance in relation to four key HCAI's. These are summarised in the following table along with the 2016/17 year-end performance against the upper threshold for each:

Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**45** **(85% of threshold)**
MRSA bacteraemia infections (post 48-hours)	**Zero**	**1** **(100% of threshold)**
MSSA bacteraemia	**46**	**44** **(96% of threshold)**
E.coli bacteraemia	**95**	**81** **(85% of threshold)**

Performance against these upper thresholds is now reported in more detail, by organism.

4.1.1. Clostridium *difficile*

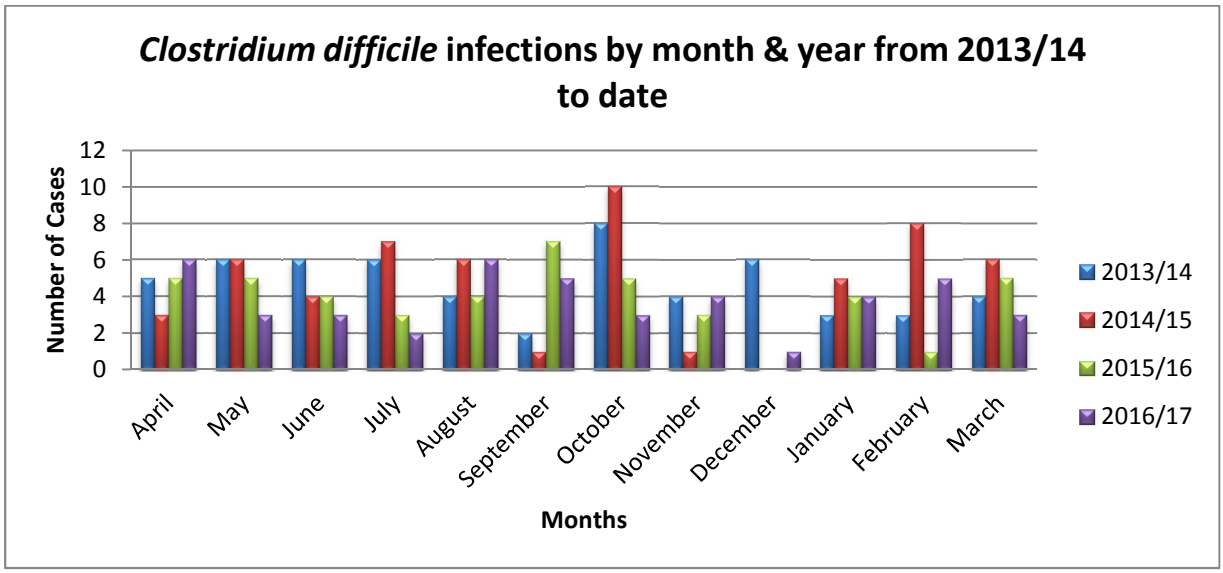
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a C.*difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and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

For rates attributable to the Trust, 3 cases were reported in March 2017. Total number of cases attributable to the Trust, reported during 2016/17 against an upper threshold of 53 for the year was 45. This represents a sustained reduction in cases year on year, which is really positive performance and is especially pertinent given the decision to close the dedicated C.*difficile* cohort area at CHH in July 2016 and nurse affected patients on base wards instead.

Root-cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised national reporting requirements for 2017/18.

The 3 cases reported during March 2017 were identified across Medicine and Surgery. These cases have been subject to root-cause analysis investigations and no lapses in care were identified. Sadly, one patient died within 30 days of diagnosis and the cause of death was attributed to C.*difficile* on this patient's death certificate. This patient's case will be subject to a Trust mortality review. The matter is under investigation by the Trust's commissioners as, while there were seemingly no identified lapses in care in relation to care provided at this Trust, the care received by the patient in Primary Care is under review.

The following graph highlights the Trust's performance from 2013/14 to date:

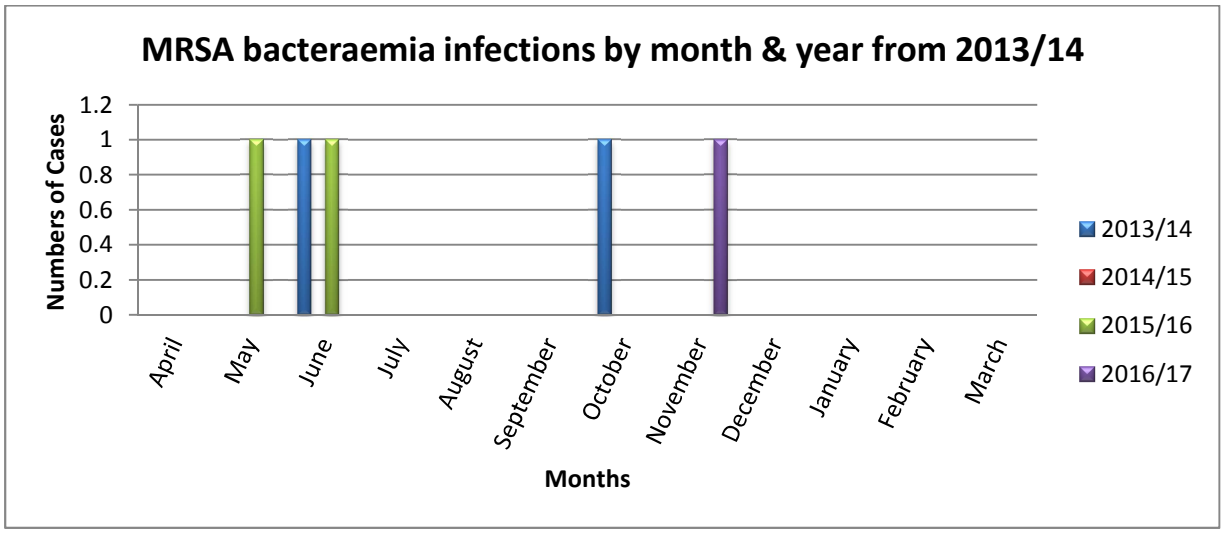


4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia
Staphylococcus aureus (also known as staph) is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and abscesses. If the bacteria enter the body through a break in the skin, they can cause life-threatening infections, such as blood poisoning (bacteraemia).

MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

There have been no further cases of Trust apportioned MRSA bacteraemia detected during March 2017. Since 1st April 2016, there has been 1 MRSA bacteraemia case attributed to the Trust, against a Zero Tolerance objective for 2016/17.

The following graph highlights that cases of this infection are now extremely rare, thankfully. The performance from 2013/14 to date and demonstrates the variability in numbers year on year.

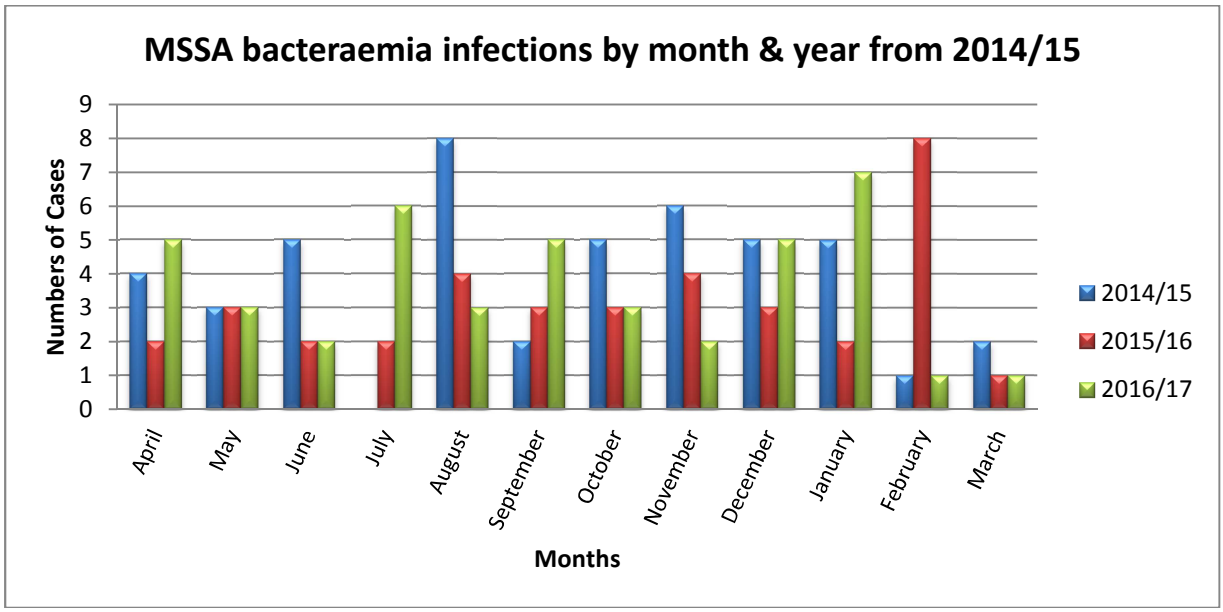


4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

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

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

MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection. Cases of patients with this infection are represented across Health Groups and provide an opportunity to investigate and further analyse any trends to improve practice. The Trust continues to see fluctuations in the number of cases reported throughout the year.



The case identified during March 2017 was detected in the Surgical Health Group and is undergoing review to determine root causes. Cases throughout the year have been complex and in patients with multiple morbidities and risk factors.

The need for continued and sustained improvements regarding this infection remains a priority. Actions on device/ line management continue and are considered key in reducing rates of this infection.

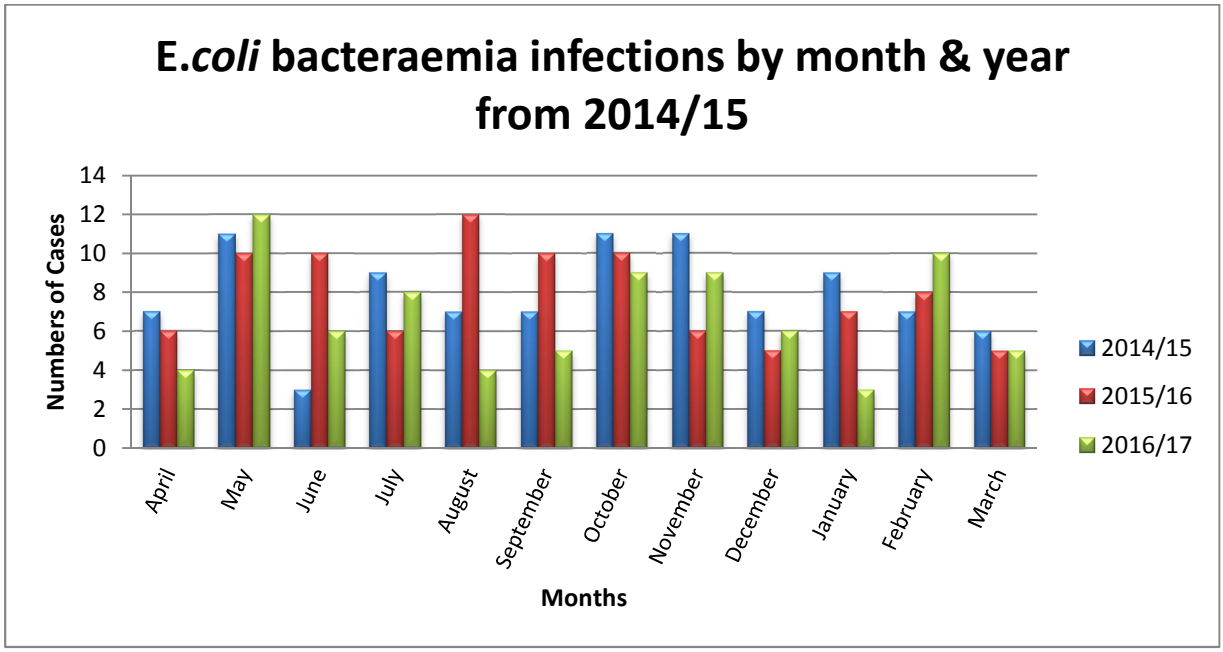
4.1.4 Escherichia-*coli* Bacteraemia

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

E.*coli* is now the commonest cause of bacteraemia reported to Public Health England. E.*coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example. There are no national thresholds for this infection.

E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Numbers are total numbers reported by the Trust onto the national Public Health England 'MESS' database. Most patients are admitted with this infection to hospital and have invariably acquired it whilst in the community. Sources of infection relate usually to a person's urinary tract, hepatobiliary (liver), respiratory system and/or a previous history of E.*coli* infection.

There were 5 Trust apportioned cases of E.*coli* bacteraemia during March 2017. Further surveillance of each case is ongoing and will determine risk factors and any possible lessons learnt for the Trust. There has been a 15% reduction in Trust apportioned cases during 2016/17 with year-end total of 81 against a threshold of 95, which is again positive news. The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:



4.1.5 Gram negative bacteraemias – new reporting for 2017/18

Gram negative bacteria are bacteria whose outer membrane contains a lipid that acts as an endotoxin. 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.

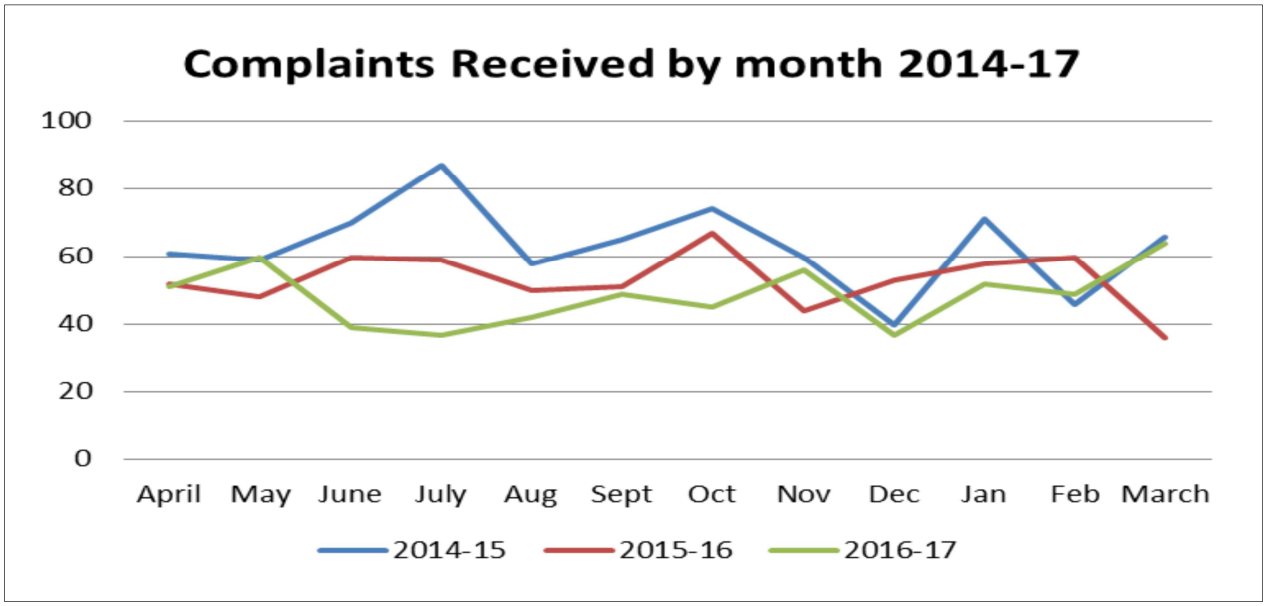
NHS England and Public Health England have introduced a new set of measures from April 2017 to reduce the burden of gram negative bacteraemias. This includes two additional organisms that have not been required to be reported on previously. Surveillance of *E. coli* bacteraemias continues. However, alongside these, Klebsiella and Proteus bacteraemia cases will be reported on in the future.

Surveillance of the three types of gram negative bacteraemia commenced during January 2017 and continued until the end of March 2017 in order to establish baseline levels. *E.coli* remains the predominant gram negative organism detected in blood cultures in this Trust during this period. The requirement for 2017/18 is to reduce the number of these infections by 10% and, by 2020/21, to have reduced the total burden of gram negative bacteraemia by 50%. The Trust Board will be advised of the significance of these and performance going forward.

5. PATIENT EXPERIENCE

5.1 Complaints

The graph below sets out comparative complaints data from 2014 to date.



There has been an increase in complaints received during March 2017. The reasons for this are unclear as there is no obvious pattern or trend and they cover all areas. The Patient Experience team has over the past twelve months reviewed the way complainants contact the organisation to raise concerns and has been active in making it more accessible for all to communicate. In March 2016, 22% of patients used electronic means (email/webpage) to contact the organisation, whereas in March 2017, 34% of complainants used electronic means rather than letter or telephone. This will need to be monitored over time as it may be possible that by opening up the access in this way may result in the Trust receiving more complaints.

5.1.1 Complaints by Episodes of Care

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

March 2017	Patient Contacts	Numbers of Complaints	%
Emergency Department	12,830	7	0.055%
Inpatient Admissions	13,763	28	0.2%
Outpatient Episodes	63,431	30	0.47%
Totals	**90,024**	**64**	**0.071%**

The following table indicates the number of complaints by subject received for each Health Group during the month of March 2017.

Complaints by Health Group and Subject (primary)	ATTITUDE	CARE AND COMFORT	COMMUNICATION	DELAY, WAITING TIMES CANCELLATIONS	DISCHARGE	TREATMENT	Total
Clinical Support - Health Group	0	0	0	0	0	3	3
Family & Women's Health Group	2	1	0	3	0	15	21
Medicine - Health Group	1	0	2	3	3	15	24
Surgery - Health Group	1	0	2	1	1	11	16
Totals:	4	1	4	7	4	44	64

Complaints about treatment continue to be the highest in number. The two key themes relate to patients that are not being happy with the treatment plan (14) and the outcome of the surgery undertaken (10). These complaints are all looked at individually and patient/family is offered a resolution meeting. The outcome of the investigation is shared fully with the complainant.

5.1.2 Examples of outcomes from complaints closed this month:

- A patient had experienced communication difficulties with a Staff Nurse.
  Action: The Ward Sister has arranged for Staff Nurse to receive further customer care and communication training.

- A relative reported delays in registering a patient's death due to no cause of death being given on the death certificate.
  Action: The patient's consultant has spoken with the doctor involved who completed the death certificate, to reiterate the importance of clear and factually correct information to be provided on death documentation. The doctor was asked to reflect on this within their supervision and apologised for the distress caused to the patient's family.

- A patient's drug card was lost, which resulted in them waiting six hours for pain relief.
  Action: Apologies were given and the Ward Sister has shared the complaint with staff involved for their reflective learning and to ensure they are aware of what to do in such circumstances in order that it does not happen again.

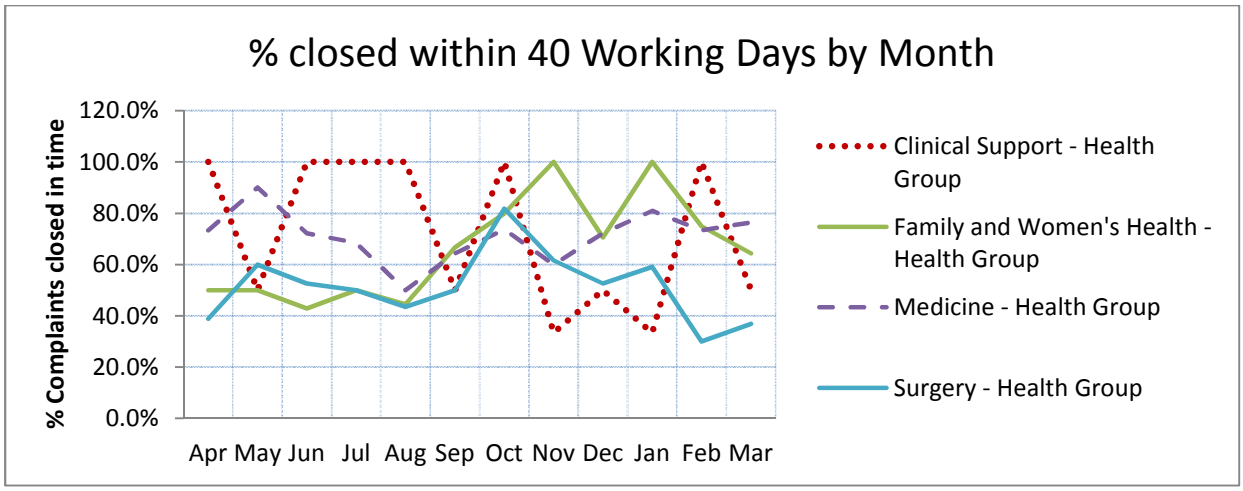
- A patient felt they were not given sufficient information regarding their injury.
  Action: A patient information leaflet is being developed by the physiotherapy staff to help prevent this in the future.

- A family member felt there was reluctance by staff answering the phones to give their names.
  Action: The Senior Matron has raised the issue of the telephone answering protocol with ward staff in that they provide their full title and surname in the future.

Of the closed complaints in March 2017, 18 were not upheld, 30 were partly upheld and 2 were upheld. One complaint was escalated for a Serious Incident investigation and one was not taken forward at this time at the request of the complainant as it was resolved quickly to the patient's satisfaction and therefore recorded as a PALS.

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

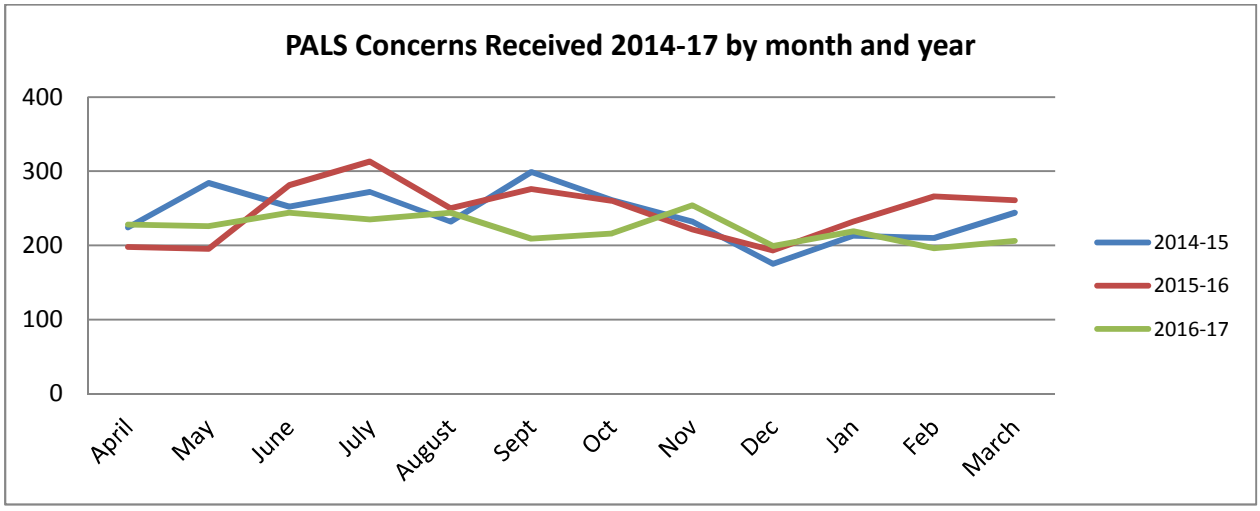
Health Group	Closed	Closed within 40 days
Clinical Support Health Group	2	1 (50%)
Family and Women's Health Group	14	9 (64.3%)
Medicine Health Group	17	13 (76.5%)
Surgery Health Group	19	7 (36.8%)
Total	52	30 (57.7%)



As can be seen from these data, this level of performance is unacceptable. In order to address this, the Chief Nurse has advised all health groups to get their performance back within the 40 day upper threshold before their May 2017 performance and accountability meetings otherwise they will go into weekly performance monitoring on this topic.

5.2 Patient Advice and Liaison Service (PALS)

In the month of March 2017, PALS received 205 concerns as well as 26 compliments, 87 general advice issues and 2 comments/suggestions. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of waiting times for appointments.



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

	ADVICE	ATTITUDE	CARE & COMFORT	COMMUNICATION	DELAY, WAITING TIMES AND CANCEL	DISCHARGE	ENVIRONMENT	TREATMENT	Total
Corporate Functions	2	0	0	4	2	0	1	0	9
Clinical Support	0	1	0	3	6	1	0	3	14
Family & Women's	1	6	0	5	24	0	0	11	47
Medicine	5	6	4	17	17	4	2	12	67
Surgery	1	5	1	11	36	1	2	11	68
Totals:	9	17	5	40	85	6	5	37	205

5.3 Compliments
The Trust has received a large number of compliments this month which include, praise for the Electronic cardiogram (ECG) department where the relative reported that her mother had an ECG and the process was 'slick and your staff were lovely. "We were in and out in 25 minutes and my mother was really buoyed up by how kind and efficient the two staff who had dealt with her had been".

A compliment was received for the Ambulatory Care Unit where a patient was referred by their GP with a possible Pulmonary Embolism (PE). The patient received a very thorough examination and whilst a PE was ruled out, another serious issue was diagnosed and the patient left with a full explanation and a plan of care.

A patient attended the Cardiology Day Unit (CDU) and reported the staff as being efficient but friendly. Even though there were some difficulties with the angiogram procedure, the sense of calm in the room helped the patient to remain calm, also. The patient reported the unit as being bright, clean and smart.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 8 cases under review by the PHSO currently. No new cases have been received during March.

5.5 Friends and Family Test (FFT) - March 2017 Data
The Patient Experience team has been collating FFT information in-house and analysing the data. From next month a new partner has been procured for this purpose.

The Trust's Friends and Family results for March for all areas, excluding the Emergency Department, indicate that there was a decrease in the number of responses for the month of March 2017 with 4,879 responding, compared to February when the Trust received 4,900 responses. From these, **97.17%** were extremely likely/likely to recommend the Trust to friends and family.

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

With regard to the paper feedback, 278 patients responded. Of these, **82.37%** said they were extremely likely/likely to recommend ED to friends and family. **8.27%** said they were extremely unlikely/unlikely to recommend.

With regards to SMS text messaging **91%** of patient gave positive feedback and **5%** gave negative feedback.

5.6 The Young Volunteers/ Young Health Champions
The young volunteers have been with the Trust for the last fourteen months and this has been a very positive experience for all concerned.

The team have met some incredible young adults who all have a personal story and a life goal to achieve.

Through the Young Health Champions the Trust is offering volunteering opportunities to young people, some of whom have learning disability, experience social difficulties, or are otherwise struggling to find employment.

Young Health Champions enables the Trust to showcase the variety of NHS careers available, in particular those that do not require a university education, as well as to inspire young peoples' career choices and offer some practical, hands-on experience.

Work carried out by Active Humber showed that many of the young people they worked with were unaware of the non-clinical support roles required within hospitals.

Individual hospital departments such as catering, pharmacy and linen services rose to the challenge of creating opportunities by devising specific traineeship programmes to equip these young people with some of the skills needed to adapt to a working environment.

Now the Trust is hosting over one hundred Young Health Champions aged sixteen and upwards across both hospital sites.

Further work is underway to extend such opportunities to more young people across Hull and East Riding, including bi-monthly sessions whereby local school pupils, colleges and our local university are invited in to hear more about NHS careers and voluntary experiences.

Initiatives run by the volunteers to receive feedback to improve our services at the Trust include:

- Friends and Family Test
- Patient Reporting and Action for Safe Environment (PRASE)
- Patient Led Assessment of the Care Environment (PLACE)
- Secret Shopper
- Patient Council
- Patient Information Leaflets (PILS)
- Signage Group and Way finding

Our moto is **"Born in Hull Raised by HEY"**

6.7 National Survey – Emergency Department 2016

The results of the CQC National patient survey of Emergency Departments 2016 have been received by the Trust. A total of 1,250 patients from the Trust were sent a questionnaire. 1,203 were eligible for the survey, of which 342 returned a completed questionnaire, giving a response rate of 28% compared to a national return rate of 26%. The overall survey shows significant improvements in the Trust's performance.

Key facts about the 342 patients who responded to the survey:

- 26% of patients have previously been to ED for the same condition or something related.
- 72% of patients say they have a long-standing condition.
- 38% of patients arrived at the trust by Ambulance.
- 68% of patients went home at the end of their ED visit.
- 65% of patients spent less than 4 hours in ED during their last visit.
- 41% were male; 59% were female.
- 11% were aged 16-39; 30% were aged 40-59; 43% were aged 60-79 and 15% were aged 80+

This survey has highlighted the many positive aspects of the patient experience.

- Overall: 84% of patients scored 7+ out of 10 for their experience.
- Overall: patients felt treated with respect and dignity, 84%.
- Doctors/nurses: always had confidence and trust 81%.
- The Emergency Department was fairly clean/very clean, 98%.
- Received test results before leaving the trust, 76%.
- Care: always enough privacy when being examined or treated 91%.

7. OTHER QUALITY UPDATES

7.1 Venous Thromboembolism Risk Assessments (VTE)

The Trusts performance in relation to the VTE risk assessments in April 2017 is overall 90.87% (95% target). This is an improving picture and work to improve this further continues.

7.2 Quality Improvement Programme (QIP)

The end position for the 2016/17 Quality Improvement Plan was presented to the April 2017 Operational Quality Committee. The QIP had an overall rating of amber/green as, although a number of projects have delivered quality improvements, a number of projects had not delivered fully on all of their objectives.

During March 2017, all of the individual projects have been reviewed. If their aims and objectives have been achieved they will therefore not appear in the revised 2017/18 Quality Improvement Plan. If the aims and objectives had not been met they are being carried forward as a project on the 2017/18 Quality Improvement Plan for further action and delivery. All of the 2017/18 projects have been reviewed to ensure they are outcome focused and that the milestones will ensure delivery of the plan. The 2017/18 QIP includes all required actions following the last CQC comprehensive inspection.

7 projects were closed from the 2016/17 Quality Improvement Plan because assurance had been received that the relevant milestones had been delivered and improvement demonstrated and therefore the project closed to be monitored as business as usual or the milestones for further monitoring were transferred into another project to ensure there was no duplication of projects on the plan. These were QIP01 Risk and Incident Management, QIP16 Resuscitation, QIP20 Duty of Candour, QIP26 Health Records and QIP29 Missed and Delayed Diagnosis. The overall Quality Improvement Plan for 2017/18 was also presented to the Operational Quality Committee and was approved. The delivery against the projects will be monitored on a monthly basis at the Operational Quality Committee and Quality Committee.

8. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

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

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

April 2017

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER April 2017

Absence of harm from

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

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 7th April both hospital sites. 882 patients were surveyed

93.5% 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.

1.25% (11) 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

98.75% 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 Sept 16 – April 17

	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17	April 17
Harm Free Care %	94%	94.7%	94.5%	95.8%	95%	94.6%	94.3%	93.5%
Sample: Number of patients	879	896	930	890	843	953	896	882
Total Number of New Harm	15	18	16	11	14	15	23	11
NEW HARM FREE CARE %	98.3%	98%	98.2%	98.6%	98.3%	98.5%	97.4%	98.7%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	4	0.45%	4	0	0
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**			814		92.29%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**			43		4.88%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**			25		2.8%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	46	5.22%	37	5	4
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.	43	4.88%	34	5	4
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	3	0.34%	3	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)	15	1.70%
Severity **No Harm**: fall occurred but with no harm to the patient	13	1.47%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.23%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	**161**	**18.25%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**5**	**0.57%**	**3.1%**
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital	**3**	**0.34%**	**1.86%**
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	**2**	**0.23%**	**1.24%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 12th May 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	2nd May 2017		**Reference Number**	2017 – 5 - 9		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

The last report on this topic was presented to the Trust Board in March 2017 (February 2017 position).

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

This report presents the 'safer staffing' position as at 31st March 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

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

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

[3] When Trust Boards meet in public

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

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

Fig 1: Hull Royal Infirmary

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

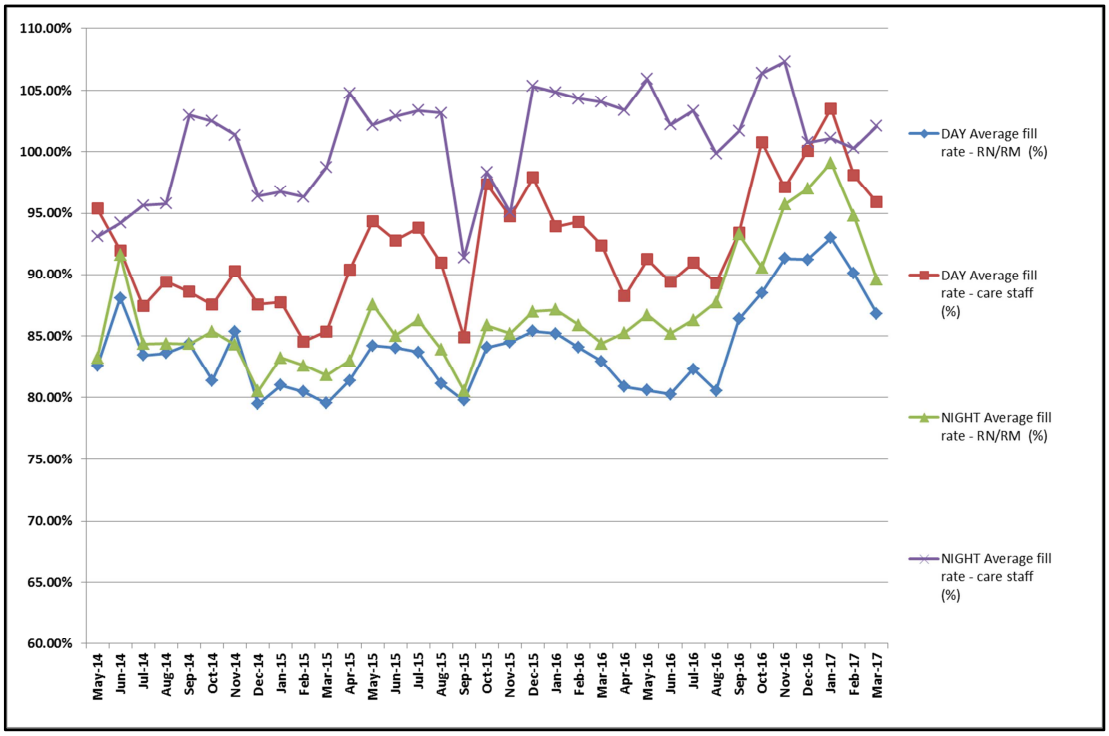
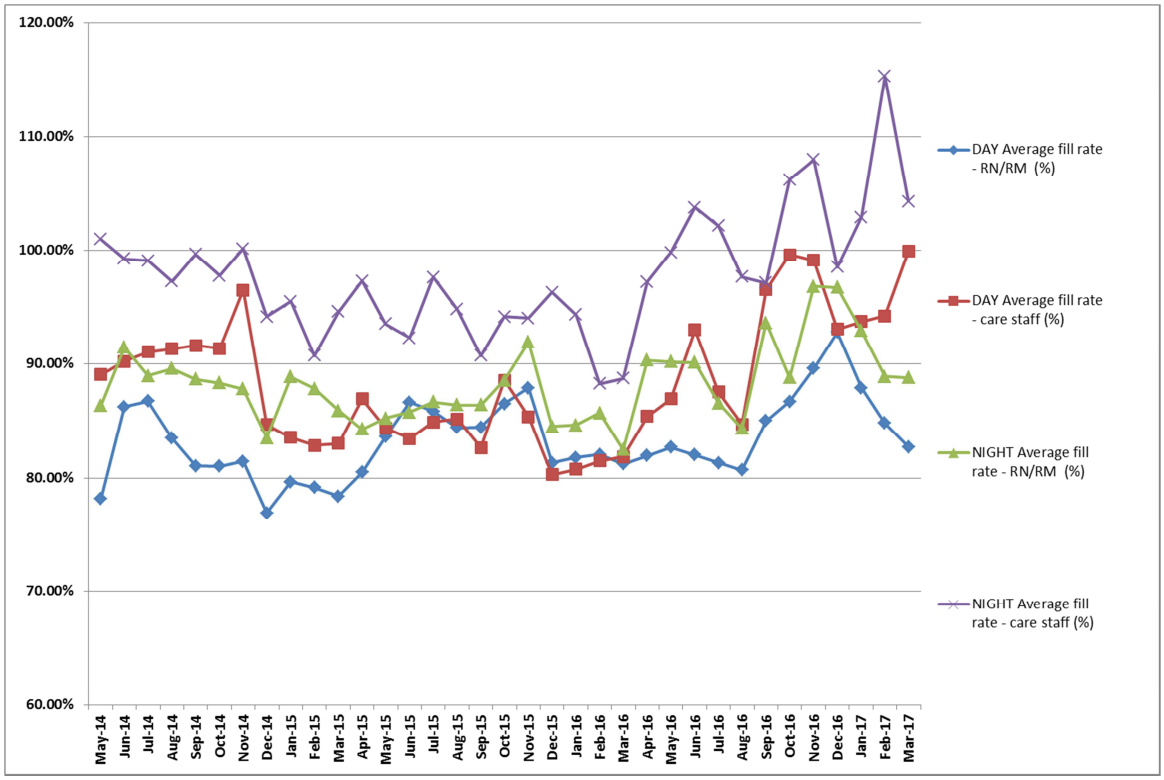


Fig 2: Castle Hill Hospital

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%



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

- Increase in annual leave allocation of approximately 2% overall in this month appears to be a contributory factor
- The continuing need to support the winter ward H10. However, this is due to close on 28th April 2017 whereupon staff will return to their substantive wards
- Vacancy rates
- Sickness levels
- There is also some compensation with HCA's being recruited to help fill RN vacancy gaps
- The needs for some patients to have 1:1 supervision due to their care needs

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

The Trust has successfully secured 20 placements as part of the National nurse associate pilot programme. The 20 applicants will commence the 2 year programme on 28th April 2017.

4. ENSURING SAFE STAFFING

The twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. However, as has been mentioned earlier in this report, the Trust is still running a winter ward (H10).

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

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

The SafeCare fully automated e-rostering system went live for the wards on Monday 24th April. It is anticipated that in the initial phase of the go live, staff will require some additional support; therefore floor walkers are in place for the initial roll out period to support staff in operating the new system.

The number of red alert declarations, when staff report that they feel staffing levels are not adequate, remains relatively small overall. Going forward, the Red Alert system will be replaced with a Red Flag alert system using nationally defined criteria, although this is not yet available.

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

- **Emergency Department - Registered Nurse Staffing** Having only recently recruited to almost full establishment last autumn, the Department has 11.76 wte (9.4%) vacancies. This is a slightly improved position in Registered Nurses in post, though it is recognised there is still a significant vacancy factor. There is a rolling advert in NHS jobs and the team is interviewing a number of staff external to the trust. Currently, 1.8 wte new recruits will commence in May. 14.0 wte of the University of Hull newly qualified nurses will join the department in September 2017. In order to mitigate the challenges in this department, the Teacher/Practitioner and lead Band 7 staff are rostered into the care delivery numbers regularly. Discussions are underway with the nurse bank to try and maximise its support, also. It is likely that some shifts may need to be put out to agencies if they cannot be filled in other ways, although this will be kept to an absolute minimum. Exit interviews are offered to all staff that have left/are leaving. The main reasons are to pursue alternative roles and, also, many are moving to work in minor injuries units as the workload is seemingly less onerous. The latest leavers have all left for promotions. There is a planned meeting in May with the Chief Nurse, the Nurse Director and Senior Matron to understand this further and to agree a more robust recruitment and retention plan.

- **Acute Medical Unit** (AMU). This unit has 10.64 wte (13.4%) vacancies currently with a further 4 wte predicted for April 2017. These have been advertised and interviews will be held in May.

- **Ward C16 (ENT, Plastics and Breast Surgery)** has 3.38 wte RN vacancies and 3.35 wte non-registered vacancies (24.22%) at present. Following recent recruitment, all posts have been recruited to; however, this does not address the short to medium term challenges. 2.0 wte RN Agency nurses are being used currently to bridge this gap, which is a cost pressure, but essential to maintain patient safety. The Senior Matron has concluded her cultural review on the ward, and is currently providing feedback to the team. It is hoped this will improve the retention rates on the Ward.

- **Neonatal Intensive Care Unit (NICU).** Recruitment and retention in this specialty is concerning with 12.13 wte RN vacancies (16.64%). 6 of these have been recruited to and more students are due to join in September. The staffing in the interim is being managed closely by the senior matron, with staff being flexed across all paediatric inpatient and outpatient areas according to patient need.

- **H70 (Diabetes and Endocrine)** has 9.81wte RN vacancies and 0.84 wte non-registered nurse vacancies (33.1%). This ward is supported in the interim by moving staff from Cardiology, Renal and Respiratory to assist. In addition, from May 1st 2017, 2 wte pool nurses are joining the team for a six month period. Staffing across the health group is balanced daily to help manage any risk. In addition, a Band 6 nurse will be seconded to the ward for a six month period to ensure there is continuation of senior nurse cover including weekends. This ward experienced some challenges recently with its previous leadership and associated care quality concerns, however, the new interim Senior Sister is having a very positive effect and it is hoped that this will help improve the ward's recruitment position.

- **Ward H4 -** Neurosurgery has 3.07 wte RN and 1.41wte non-registered nurse vacancies which equates to (14.0%). The ward is being supported by H40.

- **Ward H7 -** Vascular Surgery has 4.25 wte RN vacancies (12.4%). This group of patients often require specialist dressings. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.

- **Ward C9 -** Elective Orthopaedic Surgery has 3.88 wte RN and 2.1wte non-registered nurse vacancies (19.2%) There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 4.77 wte RN and 0.66 wte non-registered nurse vacancies (20.5%). The nursing staff are flexed between C10 and C11.

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

The National Quality Board guidance requires trusts to review N&M establishments a minimum of twice a year in order to ensure that these are appropriate and relevant to meet the current needs/acuity of patients. This was last undertaken in October 2016. The process is undertaken by senior nurses and midwives alongside sisters, charge nurses and heads of finance. The guidance requires trusts to use a validated establishment tool, where available, alongside professional judgement in determining required establishments.

This work has commenced and it was hoped to be able to present the results in this report. However, thus far, the work has identified the following issues that need resolving before concluding:

- The need for consistency in terms of how the uplift for annual leave, sickness and study leave are allocated and treated
- The need for consistency with how annual leave and bank holiday entitlement are calculated and allocated
- What is incorporated within each wards budgets as some of these are not immediately clear
- The reviews have also identified some inaccuracies in terms of how the acuity (patient dependency tools) are applied in some wards

This work will be concluded for the next report.

7. FOCUS ON NURSING AND MIDWIFERY SICKNESS LEVELS

The Trust Board is aware of the of the focused work the Chief Nurse is undertaking with the health group Nurse Directors in relation to N&M sickness levels. To date, this is showing the following:

7.1 Surgery Health Group

The table below is a summary report on the Nursing Sickness Levels for March 2017.

Surgery Health Group Nursing & Midwifery Mar - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	5.85%	4.94%
% Long Term	4.05%	3.27%
% Short Term	1.80%	1.67%
No. Sickess Hearings	4	1
Of which resulted in dismissal	2	0

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

- Weekly Sickness review per ward and department with Senior Matron and HR advisor
- Senior Matron for Staffing & Discharge Rota
- All Nurses on Long-term sick have been reviewed in line with the Trust attendance policy
  Review complete of all Nursing staff currently on the policy
- Action to ensure all staff have a referral to Occupational Health
- Confirmation at Sister / Charge Nurse Level of assurance of managing attendance as per policy

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

7.2 Medicine Health Group

Medicine Health Group Nursing & Midwifery Mar - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	4.77%	4.16%
% Long Term	2.09%	2.53%
% Short Term	2.68%	1.63%
No. Sickess Hearings	2	4
Of which resulted in dismissal	2	1

Within the Medicine Health Group, there is a discussion on a monthly basis with a Senior Sister and HR Advisor to go through all HR KPI's, including attendance rates for each of their members of staff. This is kept on an action plan and actions followed

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

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

7.3 Family and Women's Health Group

Family & Women's Health Group Nursing & Midwifery Mar - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	4.10%	4.92%
% Long Term	2.62%	3.37%
% Short Term	1.48%	1.24%
No. Sickess Hearings	1	0
Of which resulted in dismissal	1	0

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

7.4 Clinical Support Health Group

Clinical Support Health Group Nursing & Midwifery Mar - 2017	Health Care Assistants & Other Support Staff	Nursing, Midwifery & Health Visiting Staff
Target %	3.90%	3.90%
% Sickness	6.05%	3.32%
% Long Term	4.01%	1.78%
% Short Term	2.04%	1.54%
No. Sickess Hearings	5	0
Of which resulted in dismissal	4	0

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

7.5 Trust Wide

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

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

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

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

8. SUMMARY

Nursing and Midwifery staffing establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. The next establishment reviews will now be completed by the end of April 2017 and not March as planned originally. However, this is managed very carefully and in a way that balances the risks across the organisation. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses, although this position has improved in the short-term.

The new information that is now presented by ward will enable each of these to be scrutinised more closely to ensure that all reasonable efforts are being taken to deploy staff efficiently and, also, manage sickness/absence robustly.

9. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
April 2017

Appendix 1: HEY Safer Staffing Report – March 2017

HEY SAFER STAFFING REPORT MARCH-17

NURSE STAFFING

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES: DAY Average fill rate - RN/RM (%)	FILL RATES: DAY Average fill rate - care staff (%)	FILL RATES: NIGHT Average fill rate - RN/RM (%)	FILL RATES: NIGHT Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: RN / RM	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: CARE STAFF	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: OVERALL	ROTA EFFICIENCY [20-02-17 to 19-03-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY [20-02-17 to 19-03-17]: SICK RN & AN [3.9%]	ROTA EFFICIENCY [20-02-17 to 19-03-17]: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M12]: RN [WTE]	NURSING VACANCIES [FINANCE LEDGER M12]: AN [WTE]	NURSING VACANCIES [FINANCE LEDGER M12]: TOTAL [WTE]	NURSING VACANCIES [FINANCE LEDGER M12]: % [<10%]
MEDICINE	ED	ACUTE MEDICINE	NA	0									16.6%	6.6%	4.2%	14.58	-2.82	11.76	9.4%
	AMU	ACUTE MEDICINE	45	0	97%	96%	92%	82%	1039	5.4	3.0	8.4	14.2%	4.6%	5.4%	9.53	1.11	10.64	13.4%
	H1	ACUTE MEDICINE	22	0	83%	83%	103%	99%	609	3.0	2.4	5.3	19.0%	8.4%	0.0%	4.37	-0.96	3.41	10.8%
	EAU	ELDERLY MEDICINE	21	0	92%	105%	85%	118%	575	3.9	3.9	7.8	14.3%	3.4%	3.8%	2.14	1.89	4.03	16.5%
	H5 / RHOB	RESPIRATORY	26	0	81%	89%	96%	91%	596	5.1	2.9	8.0	15.5%	8.9%	0.0%	2.51	0.86	3.37	9.0%
	H50	RENAL MEDICINE	19	0	83%	97%	101%	101%	553	3.2	2.1	5.3	16.7%	5.6%	5.7%	-0.16	0.74	0.58	3.2%
	H500	RESPIRATORY	24	0	82%	104%	103%	96%	715	2.4	2.6	5.0	15.6%	4.6%	7.4%	3.41	2.53	5.94	20.5%
	H70	ENDOCRINOLOGY	30	0	82%	158%	62%	94%	896	2.4	2.4	4.8	8.7%	7.0%	0.0%	9.81	0.84	10.65	33.1%
	H8	ELDERLY MEDICINE	27	0	86%	107%	103%	104%	816	2.4	2.4	4.8	13.4%	4.5%	1.9%	1.68	0.17	1.85	6.2%
	H80	ELDERLY MEDICINE	27	0	82%	93%	102%	102%	815	2.6	2.2	4.8	11.9%	6.8%	0.0%	0.32	0.14	0.46	1.5%
	H9	ELDERLY MEDICINE	31	0	77%	99%	95%	98%	934	2.1	2.0	4.1	14.1%	7.6%	1.9%	1.63	-0.77	0.86	2.9%
	H90	ELDERLY MEDICINE	29	0	83%	93%	100%	100%	869	2.2	2.2	4.4	14.8%	5.1%	6.5%	3.44	-1.26	2.18	7.3%
	H11	STROKE / NEUROLOGY	28	0	72%	158%	67%	100%	856	2.3	2.0	4.3	16.8%	3.3%	0.0%	5.2	-1.03	4.17	12.6%
	H110	STROKE / NEUROLOGY	24	0	83%	126%	100%	100%	497	4.6	3.2	7.8	16.6%	2.3%	7.2%	3.74	0.6	4.34	12.9%
	CDU	CARDIOLOGY	9	0	92%	86%	100%		125	10.4	1.3	11.7	9.0%	4.8%	0.0%	-0.21	0.63	0.42	2.7%
	C26	CARDIOLOGY	26	0	83%	91%	80%	98%	735	4.0	1.6	5.7	17.6%	2.6%	3.1%	1.33	1.92	3.25	9.7%
	C28 /CMU	CARDIOLOGY	27	0	81%	108%	87%	68%	716	6.3	1.6	7.9	14.6%	5.3%	5.8%	1.19	0.73	1.92	4.1%
	H10	WINTER WARD	27	0	84%	100%	107%	113%	806	2.6	2.4	5.0	19.1%	9.4%	0.0%				
SURGERY	H4	NEURO SURGERY	30	0	82%	99%	88%	112%	806	3.0	1.9	4.9	20.0%	4.5%	5.1%	3.07	1.41	4.48	14.0%
	H40	NEURO HOB / TRAUMA	15	0	80%	101%	81%	105%	408	5.4	3.6	9.1	18.6%	5.7%	3.3%	2.66	-0.78	1.88	6.1%
	H6	ACUTE SURGERY	28	0	92%	86%	83%	194%	626	3.5	2.6	6.1	15.9%	1.3%	5.0%	1.91	1.45	3.36	10.8%
	H60	ACUTE SURGERY	28	0	95%	86%	91%	179%	712	3.3	2.2	5.5	17.7%	3.2%	3.3%	-0.12	0.37	0.25	0.8%
	H7	VASCULAR SURGERY	30	0	85%	79%	86%	99%	854	2.9	2.5	5.4	17.4%	5.8%	3.0%	4.25	0.08	4.33	12.4%
	H100	GASTROENTEROLOGY	24	0	83%	95%	92%	104%	810	2.5	2.1	4.6	16.4%	6.2%	3.1%	0.59	0.31	0.9	2.9%
	H12	ORTHOPAEDIC	28	0	82%	92%	88%	98%	764	2.9	2.6	5.5	16.7%	6.8%	4.1%	2.31	-0.34	1.97	5.7%
	H120	ORTHO / MAXFAX	22	0	91%	117%	100%	110%	617	3.5	2.8	6.4	15.7%	0.5%	0.0%	1.8	0.29	2.09	7.0%
	HICU	CRITICAL CARE	22	0	89%	114%	84%	64%	518	24.3	1.0	25.3	16.3%	8.0%	3.0%	6.08	1.16	7.24	6.5%
	C8	ORTHOPAEDIC	18	0	84%	123%	87%	81%	215	4.9	3.4	8.2	8.3%	7.1%	0.0%	1.63	-0.95	0.68	4.5%
	C9	ORTHOPAEDIC	29	0	83%	91%	80%	98%	735	4.0	1.6	5.7	15.1%	4.5%	0.0%	3.88	2.1	5.98	19.2%
	C10	COLORECTAL	21	0	80%	91%	74%	107%	461	4.3	2.4	6.7	17.9%	3.2%	0.0%	4.77	0.66	5.43	20.5%
	C11	COLORECTAL	22	0	89%	81%	91%	97%	605	3.8	1.6	5.4	13.3%	2.1%	0.0%	-0.02	1.5	1.48	5.7%
	C14	UPPER GI	27	0	86%	90%	85%	128%	701	3.4	1.9	5.3	13.6%	5.6%	0.0%	2.1	-1.11	0.99	3.4%
	C15	UROLOGY	26	0	82%	55%	87%	97%	592	4.5	2.7	7.3	12.5%	4.3%	0.0%	-0.91	-2.27	-3.18	-7.9%
	C27	CARDIOTHORACIC	26	0	87%	110%	91%	88%	686	3.9	1.8	5.7	14.4%	4.4%	8.9%	1.04	-0.5	0.54	1.7%
	CICU	CRITICAL CARE	22	0	82%	90%	86%	82%	491	21.0	1.7	22.8	17.4%	5.6%	6.2%	4.77	1.07	5.84	5.7%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	72%	129%	123%	78%	239	8.5	5.4	13.9	20.8%	5.4%	0.0%	3.38	3.35	6.73	24.22%
	H130	PAEDS	20	0	90%	25%	96%	83%	413	6.6	0.7	7.3	20.4%	2.5%	8.4%	-0.74	-0.57	-1.31	-5.47%
	H30 CEDAR	GYNAECOLOGY	9	0	85%	82%	97%		193	8.2	2.6	10.8	13.5%	3.0%	0.0%	-1.12	0.12	-1	-4.48%
	H31 MAPLE	MATERNITY	20	0	87%	93%	122%	100%	301	8.0	4.7	12.7	14.5%	3.4%	2.9%	7.53	2.50	10.03	13.69%
	H33 ROWAN	MATERNITY	38	0	89%	96%	87%	100%	675	4.8	2.7	7.4	15.4%	7.0%	0.0%				
	H34 ACORN	PAEDS SURGERY	20	0	90%	85%	98%	115%	340	7.8	2.0	9.8	16.9%	3.9%	0.0%	-0.75	-2.12	-2.87	-10.98%
	H35	OPHTHALMOLOGY	12	0	77%	53%	109%		234	7.9	1.6	9.5	20.5%	8.1%	5.0%	-0.12	1.84	1.72	8.50%
	LABOUR	MATERNITY	16	0	102%	91%	99%	92%	299	19.5	6.2	25.7	17.9%	6.0%	4.2%	-5.67	-2.36	-8.03	-11.90%
	NEONATES	CRITICAL CARE	26	0	85%	105%	72%	118%	638	10.3	1.3	11.6	13.4%	4.3%	7.9%	12.13	-1	11.13	16.64%
	PAU	PAEDS	10	0	90%		100%		97	14.8	0.0	14.8	19.4%	6.2%	0.0%	0.6	0	0.6	5.49%
	PHDU	CRITICAL CARE	4	0	99%	34%	100%		75	19.7	1.1	20.8	17.1%	6.3%	0.0%	3.07	0	3.07	19.54%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0	98%	94%	99%	84%	450	3.2	2.2	5.4	15.8%	2.8%	0.0%	0.5	-0.15	0.35	1.8%
	C29	REHABILITATION	15	0	85%	129%	100%	274%	450	3.3	4.9	8.2	11.5%	3.3%	0.0%	0.68	3.69	4.37	15.2%
	C30	ONCOLOGY	22	0	86%	108%	104%	100%	626	2.9	2.0	4.9	11.3%	1.6%	3.2%	0.09	0.01	0.1	0.5%
	C31	ONCOLOGY	27	0	82%	129%	102%	101%	727	2.7	2.1	4.8	17.9%	0.8%	0.0%	0.57	-0.55	0.02	0.1%
	C32	ONCOLOGY	22	0	96%	98%	99%	100%	604	3.0	1.8	4.7	16.8%	4.8%	3.4%	1.06	0.1	1.16	5.3%
	C33	HAEMATOLOGY	28	0	79%	143%	83%	137%	606	4.4	2.5	6.8	17.1%	6.9%	7.6%	-0.75	0.16	-0.59	-1.6%
		AVERAGE:	0		AVERAGE:				583	5.9	2.4	8.3	15.7%	4.9%	2.7%	124.78	14.79	139.57	7.3%
													TOTALS:			TOTALS:			

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

HEALTH GROUP	WARD	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED		6		4	2			2						0	12
	AMU	100%			1	1			1						0	2
	H1	100%				2			2						0	2
	EAU	100%	2			1			1						0	3
	H5 / RHOB	95%							0						0	0
	H50	95%			1	1			1						0	2
	H500	100%			1				0						0	1
	H70	100%	1		1	1			1						0	3
	H8	93%					3		3				1		1	4
	H80	92%	1		2	1			1						0	4
	H9	97%	3			1			1		1		1		2	6
	H90	96%	2		1		1		1				1		1	5
	H11	88%							0		2				2	2
	H110	93%	1	2	1	1		1	2		1				1	7
	CDU	100%							0						0	0
	C26	100%	1	1		3			3						0	5
	C28 /CMU	92%		1		2			2				1		1	4
	H10	92%		1	1				0		1				1	3
SURGERY	H4	100%							0						0	0
	H40	100%				1			1	1			1		2	3
	H6	92%	3	2		2			2				1		1	8
	H60	100%	1	1	1				0		1				1	4
	H7	100%			1				0		1				1	2
	H100	100%	1		1	3			3		1				1	6
	H12	91%	1	1	3		1		1		1				1	7
	H120	100%	1						0		1				1	2
	HICU	87%							0		1				1	1
	C8	100%	1	1					0						0	2
	C9	95%			2				0						0	2
	C10	100%							0						0	0
	C11	100%			1				0						0	1
	C14	100%			1				0						0	1
	C15	95%				1			1						0	1
	C27	100%							0						0	0
	CICU	100%			4				0						0	4
FAMILY & WOMEN'S	C16	100%	1	1	2				0						0	4
	H130	100%	1		1				0		1				1	3
	H30 CEDAR	100%		2					0						0	2
	H31 MAPLE	100%							0						0	0
	H33 ROWAN	100%		3					0						0	3
	H34 ACORN	100%							0						0	0
	H35	100%		2	1	1			1						0	4
	LABOUR	100%	6		1				0				1		1	8
	NEONATES	100%	2		1				0						0	3
	PAU	100%							0						0	0
	PHDU	100%							0						0	0
CLINICAL SUPPORT	C20	100%			1				0						0	1
	C29	87%							0		1				1	1
	C30	100%			1				0		1				1	2
	C31	100%				2			2					1	1	3
	C32	91%				3			3		1				1	4
	C33	100%	1			1			1		1				1	3
		97%														
		TOTALS:	50	36	18	35	30	5	1	36	1	16	0	7	1	25	150

Mar-17	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT PER DAY [CHPPPD]: Cumulative Count	RN / RM	CARE STAFF	OVERALL
SAFER STAFFING OVERALL PERFORMANCE								
HRI SITE	86.8%	95.9%	89.6%	102.1%	19956	4.7	2.4	7.1
CHH SITE	82.7%	99.9%	88.8%	104.3%	9692	4.9	2.2	7.1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

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

Trust Board date	2 May 2017	**Reference Number**	2017 – 5 - 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 January 2017. Good progress is being made and this report presents the position as of April 2017.

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

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

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

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. 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 January 2017. This provides a progress report up to April 2017.

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

Table 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 Department Senior Sister/Charge Nurse

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

Score	79% or less	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 is 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 Groups Governance Structures. In addition, it is a requirement that each action plan is discussed and progress reported and documented at monthly ward/unit meetings.

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in 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.

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 40’s “How are we doing?” board

Figure 1

3. CURRENT POSITION

Fifty Four Clinical areas have been reviewed consisting of Ward Areas, Critical Care Units & our Emergency Department. Table 1 illustrate the overall Trust position in relation to all of the fundamental standards. **Appendix One** provides an overview of individual ratings by clinical area, where applicable.

Current Trust Position for all Fundamental Standards: April 2017								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
27 Wards	15 Wards	2 Wards	40 Wards	18 Wards	9 Wards	12 Wards	8 Wards	25 Wards
21 Wards	29 Wards	8 Wards	11 Wards	21 Wards	4 Wards	12 Wards	12 Wards	22 Wards
6 Wards	8 Wards	44 Wards	3 Wards	15 Wards	29 Wards	21 Wards	21 Wards	7 Wards
0 Wards	0 Wards	0 Wards	0 Wards	0 Wards	9 Wards	8 Wards	8 Wards	0 Wards

Table 1

The following tables illustrate progress made in relation to each fundamental standard from December 2016 to April 2017, across the four Health Groups. Please note that in some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of 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			
July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	**Jan 17**	**April 17**
5	5	5	**4 Wards**	5	5	5	**6 Wards**	14	14	15	**10 Wards**	12	12	**12**	**7 Wards**
1	1	1	**2 Wards**	4	4	4	**3 Wards**	5	5	4	**9 Wards**	7	7	**6**	**7 Wards**
0	0	0	**0 Wards**	1	1	1	**1 Wards**	0	0	0	**0 Wards**	0	0	**1**	**5 Wards**
0	0	0	**0 Wards**	0	0	0	**0 Wards**	0	0	0	**0 Wards**	0	0	**0**	**0 Wards**

Progress since December: 42 reviews have been completed during this period. There are no areas rated as Red for this standard. The number of clinical areas rated as Blue has decreased, which relates to the changes made to the assessment process for this standard. The number of staff questions has increased in order to capture areas of concern raised following the recent CQC inspection, focusing specifically on safe staffing levels and escalation processes.

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			
July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	**Jan 17**	**April 17**
0	0	**0**	**0 Wards**	2	3	**2**	**3 Wards**	2	3	**4**	**5 Wards**	1	1	**2**	**7 Wards**
3	5	**5**	**6 Wards**	5	4	**5**	**5 Wards**	9	11	**13**	**11 Wards**	8	8	**9**	**7 Wards**
3	1	**1**	**0 Wards**	2	2	**2**	**1 Wards**	7	3	**1**	**2 Wards**	9	9	**8**	**5 Wards**
0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	1	1	**0**	**0 Wards**

Progress since December: 14 reviews have been completed during this period. The number of clinical areas rated Blue have increased in number; in Family & Women's, Medicine and Surgery. There are no areas rated Red. These improvements are related predominantly to enhancements made to patient areas such as ward day rooms. In addition, a significant amount of work has been completed in relation to improving written information for patient and carers. Additional ideas generated by staff and patient representatives that require review are:

- The establishment of a landline for patient use in the Queens Centre.
- The addition of a basket/holder for zimmer frames, so patients with limited mobility can move their belongings without having to wait for assistance.

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

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

Progress since December: 30 reviews were completed during this period. There are no areas rated Red. The number of Green-rated clinical areas has increased within Clinical Support but there has been a slight reduction in Green areas within the Medicine and Surgery Health Groups. The review of the current cleaning requirements across a seven day period continues. The Practice Development Matrons are working closely with the facilities department to ascertain if the domestic staff can take on any cleaning of equipment, which should support improved compliance in this area. A review of the current Nursing documentation in relation to this standard has also been completed during the last quarter. Compliance is currently being monitored in a number of clinical areas, the results of which will be reported back within the next Fundamental Standards Board Report.

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

Clinical Support				Family & Women's				Surgery				Medicine			
July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	**Jan 17**	**April 17**
4	4	**5**	**5 Wards**	5	5	**9**	**7 Wards**	14	14	**15**	**16 Wards**	11	12	**11**	**12 Wards**
2	2	**1**	**1 Wards**	5	5	**1**	**2 Wards**	4	4	**2**	**2 Wards**	8	7	**7**	**6 Wards**
0	0	**0**	**0 Wards**	0	0	**0**	**1 Wards**	1	1	**2**	**1 Wards**	0	0	**1**	**1 Wards**
0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**

Progress since December: 29 reviews have been completed during this review. The number of Blue-rated clinical areas has increased in the Surgery and Medicine Health Group with no clinical areas rated Red within this standard. However, there has been a slight increase in the number of Amber ratings within Family & Women's Health Group, which relates primarily to the lack of written information available to patients and carers with regards to safeguarding. This has since been rectified.

8. **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			
July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	**Jan 17**	**April 17**
1	1	**1**	**0 Wards**	3	3	**5**	**7 Wards**	5	5	**6**	**6 Wards**	1	0	**2**	**5 Wards**
3	3	**3**	**3 Wards**	6	6	**5**	**2 Wards**	4	3	**8**	**9 Wards**	5	9	**8**	**7 Wards**
2	2	**2**	**3 Wards**	1	1	**0**	**1 Wards**	10	11	**5**	**4 Wards**	12	9	**9**	**7 Wards**
0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	0	0	**0**	**0 Wards**	1	1	**0**	**0 Wards**

Progress since December: 17 have been completed during this period. There are no outstanding reviews for this standard. There has been an increase in the number of Blue-rated clinical areas. There are now no clinical areas rated Red for this standard. These improvements are related to improvements in 24hr monitoring of medication fridges and controlled drugs checks.

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

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

Progress since December: 28 reviews have been completed during this period, with no outstanding reviews for this standard. There has been a slight reduction in Blue-rated wards within Family & Women's Health Group but this rating remains stable for Medicine and Surgery. There has been no increase in Red-rated areas over this quarter.

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

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

Progress since December: 40 reviews completed during this period. There has been an increase in the number of Blue-rated scores within both the Medicine and Surgical Health Groups and a slight increase in Red-rated Scores within Family & Women's & Surgery. The Red and Amber-rated scores relate predominantly to incomplete documentation with regards to the re-assessment of patients` when they are transferred between clinical areas. In order to address this, the Chief Nurse commissioned a piece of work reviewing the current nursing documentation, this has now been completed and is ready for piloting, the results of which will be reported back within the next Fundamental Standards Board Report.

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

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

Progress since December: 92 reviews completed during this period. There are no outstanding reviews for this standard. There has been a decrease in Red-rated areas within the Medicine, Surgery and Clinical Support Health Groups. The Family & Women's has seen an increase in the number of Red-rated areas. There are two predominant reasons for the Red-rated scores within this standard. Firstly, poor compliance in relation to the completion of the Food and Hydration charts. Although staff members are entering what the patients are eating on a daily basis the current food chart requires the staff to calculate a score which is not always completed consistently. Secondly, although the nursing staff are activating an appropriate plan of care based on a comprehensive risk assessment, they are not 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. The clinical teams are working closely with the dieticians to improve compliance with this

standard specifically around documentation of individualised care and the completion of patient food and hydration charts.

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

13.

Clinical Support				Family & Women's				Surgery				Medicine			
July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	Jan 17	**April 17**	July 16	Oct 16	**Jan 17**	**April 17**
4	4	4	**2 Wards**	8	8	8	**5 Wards**	13	13	14	**10 Wards**	12	12	13	**8 Wards**
2	2	2	**4 Wards**	1	1	1	**4 Wards**	6	6	5	**9 Wards**	3	3	3	**5 Wards**
0	0	0	**0 Wards**	0	0	0	**1 Wards**	0	0	0	**0 Wards**	3	3	2	**6 Wards**
0	0	0	**0 Wards**	0	0	0	**0 Wards**	0	0	0	**0 Wards**	1	1	1	**0 Wards**

Progress since December: 49 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 all Health Groups and an increase in Green-rated areas. This is due to the changes that have been made to the audit tool for this standard. An environment check is now also completed as part of this standard, incorporating areas of concern raised following the recent CQC inspection.

14. OVERALL POSITION:

Good progress is being made against all of the fundamental standards, 38 of the 54 clinical areas reviewed now have no Red Standards; figure 2 illustrates the progress that has been made from a Trust perspective over the last quarter in the Red-rated domain.

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

- 8 clinical areas have one red standard
- 7 clinical areas have two red standards.
- 1 clinical area, C9 has 3 Red Standards; these are currently being reviewed in conjunction with the Ward Sister and Nurse Director.

Significant progress has been made by ward H70 since the last Trust Board Report. This area which is now under new leadership has reduced their four Red-rated fundamental standards to two, (Tissue Viability and Patient Centred Care), work continues to improve this position further.

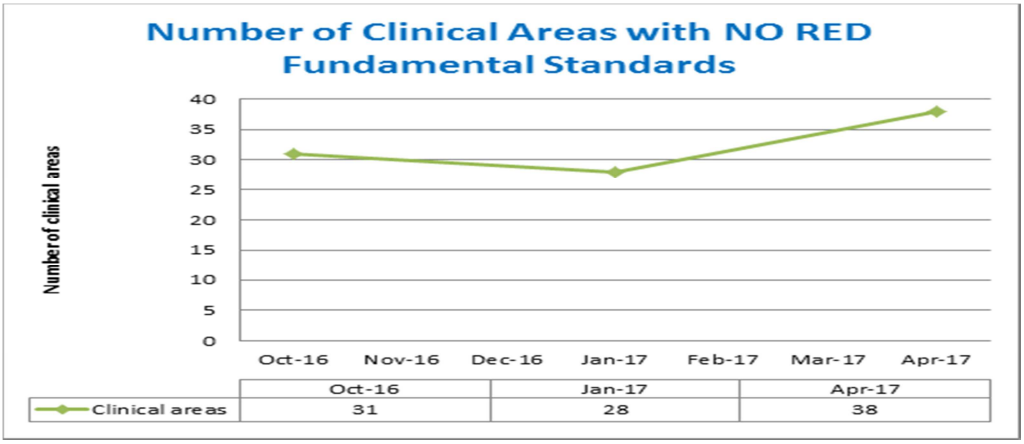


Figure 2

15. AREAS FOR IMPROVEMENT

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

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

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

16. SUMMARY

Although there are still a number of fundamental standards that are currently rated as red, significant progress has been made over the last three months to improve this position. A concentrated effort on improving the core standards that review Nutrition and Tissue Viability will remain a key priority of the Senior Nursing Teams.

17. 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
April 2017

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

FUNDAMENTAL STANDARDS April 2017

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C20	99%	April 18	90%	July 17	90%	Sept 17	100%	Mar 18	94%	Nov 17	94%	June 17	82%	July 17	94%	Dec 17	97%	Mar 18
C29	91%	Jan 18	91%	Jan 18	86%	Oct 17	97%	Feb 18	92%	Nov 17	**84%**	Oct 17	**80%**	Aug 17	87%	Sept 17	96%	Feb 18
C30	96%	April 18	90%	May 17	**86%**	May 17	97%	Dec 17	84%	Aug 17	89%	Oct 17	82%	Aug 17	**87%**	Sept 17	94%	Dec 17
C31	96%	Mar 18	91%	Mar 17	84%	Sept 17	100%	Mar 18	94%	April 17	80%*	July l 17	85%	Sept 17	83%	Sept 17	95%	Mar 18
C32	96%	Mar 18	89%	Jan 18	91%	Dec 17	100%	Mar 18	87%	July 17	88%	July 17	**89%**	Dec 17	88%	Sept 17	94%	Dec 17
C33	89%	Jan 18	91%	Jan 18	**87%**	May 17	92%	Sept 17	86%	May 17	84%	April 17	90%	Mar 17	72%	June 17	92%	Dec 17

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	100%	June 17	95%	April 18	86%	July 17	90%	Nov 17	92%	Aug 17	80%*	May 17	98%	Jan 18	82%	Aug 17	94%	Dec 17
Cedar H30	88%	Sept 17	93%	Mar 17	80%	Oct 17	97%	Dec 17	95%	Feb 18	80%*	April 17	88%	June 17	87%	Sept 17	100%	Mar 17
H31	96%	April 18	93%	Dec 17	**80%***	May 17	88%	Sept 17	86%	Oct 17	96%	April 17	99%	Jan 18	NA		93%	Nov 17
H33	94%	Jan 18	90%	May 17	80%*	May 17	98%	Nov 17	95%	Jan 18	100%	April 17	99%	Jan 18	NA		96	Jan 18
ACORN	95%	April 18	91%	Oct 17	80%*	April 17	100%	Feb 18	100%	Mar 18	80%*	June 17	78%	May 17	**89%**	Dec 17	96%	Mar 18
H35	89%	Dec 17	95%	May 17	89%	Sept 17	100%	Oct 17	93%	April 17	86%	April 17	96%	Feb 18	92%	Sept 17	92%	Dec 18
H130	95%	Jan 18	95%	Mar 18	**80%**	May 17	100%	Feb 18	97%	Mar 18	100%	April 18	90%	Nov 17	**75%**	June 17	88%	Aug 17
Labour	95%	Jan 18	NA		**80%***	April 17	100%	Nov 17	96%	Dec 17	100%	Sept 17	99%	Jan 18	NA		98%	Jan 18
NICU	**90%**	Jan 18	88%	April 17	**80%***	Mar 17	97%	Mar 18	100%	Mar 18	100%	Mar 18			97%	Mar 18	98%	Mar 18
PHDU	95%	June 17	93%	Oct 17	**80%***	April 17	94%	Nov 17	100%	Oct 17	80%*	June 17	86%	Aug 17	**96%**	Mar 18	93%	Dec 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C8	92%	Jan 17	91%	Mar 17	**80%***	June 17	89%	Jun 17	95%	Nov 17	**80%***	May 17	85%	July 17	**96%**	Mar 18	100%	April 17
C9	90%	Dec 17	85%	Oct 17	**80%***	April 17	96%	Jan 18	88%	April 17	**68%**	May 17	77%	May 17	**65%**	June17	100%	June 17
C10	89%	Mar 17	95%	May 17	88%	Sept 17	94%	Oct 17	91%	Nov 17	**80%***	May 17	83%	Aug 17	94%	Dec 17	96%	Mar 18
C11	96%	Oct 17	91%	Jan 18	81%	July 17	95%	Dec 17	87%	May 17	**80%***	Aug 17	82%	July 17	86%	Sept 17	89%	Dec 17
C14	91%	Jan 18	93%	Jan 18	80%*	Feb 17	100%	Aug 17	89%	Aug 17	**86%**	June 17	81%	July 17	82%	Sept 17	95%	Mar 18
C15	100%	April 17	93%	Mar 17	80%*	April 17	87%	May 17	88%	April 17	**52%**	May 17	82%	Aug 17	79%	June 17	94%	Dec 17
C27	99%	Mar 18	93%	Mar 17	89%	Sept 17	100%	Mar 18	94%	Aug 17	**74%**	May 17	93%	Nov 17	**87%**	Sept 17	91%	Dec 17
CICU1	98%	April 18	94%	May 17	100%	April 17	100%	April 17	99%	Oct 17	82%	May 17	96%	June 17	91%	Dec 17	97%	Mar 18
CICU2	990%	April 18	95%	Sept 17	85%	Sept 17	100%	April 17	100%	Oct 17	**96%**	April 18	95%	April 18	95%	Mar 18	92%	Dec 17

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	95%	Mar 18	95%	Mar 18	**80%***	Feb 17	100%	Dec 17	92%	Aug 17	**80%***	April 17	75%	May 17	**80%**	**Aug 17**	92%	Dec 17
H40	92%	Sept 17	93%	Oct 17	86%	Oct 17	100%	Dec 17	89%	Aug 17	**80%***	April 17	73%	May 17	**67%**	June 17	94%	Dec 17

H6	95%	Mar 18	93%	Dec 17	**80%***	Feb 17	95%	May 17	90%	Nov 17	**76%**	April 17	94%	Dec 17	**67%**	June 17	90%	Dec 17
H60	95%	Mar 18	95%	April 17	**86%**	July 17	97%	Jan 18	96%	Oct 17	**81%**	Sept 17	96%	Mar 18	**86%**	June 17	95%	Mar 18
H7	89%	Dec 17	97%	Mar 18	**80%***	June 17	97%	Mar 18	91%	Aug 17	**80%***	April 17	**96%**	Mar 18	**93%**	Dec 17	100%	June 17
H12	92%	July 17	90%	Feb 17	80%*	June 17	97%	Dec 17	91%	Aug 17	90%	July 17	90%	Oct 17	**98%**	Mar 18	96%	Mar 18
H120	95%	Mar 18	90%	Feb 17	**86%**	Sept 17	96%	Dec 17	91%	Aug 17	**77%**	June17	80%	Oct 17	**98%**	Mar 18	95%	Mar 18
H100	100%	April 17	84%	April 17	**80%***	July 17	100%	Dec 17	82%	April 17	**80%***	April 17	84%	Mar 17	85%	June 17	90%	Dec 17
HICU1	89%	Jan 18	94%	July 17	92%	Sept 17	97%	April 17	95%	Nov 17	80%*	Aug 17	92%	Jan 18	**93%**	Dec 17	95%	Mar 18
HICU2	89%	Jan 18	NA		92%	Sept 17	97%	April 17	97%	June 17	80%*	April 17	91%	Jan 18	**84%**	Sept 17	93%	Dec 17

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	93%	Jan 18	**91%**	July 17	92%	May 17	100%	June 17	89%	July 17	94%	Aug 17	**92%**	Dec 17	88%	Sept 17	94%	Dec 17
C26	100%	Mar 17	93%	Mar 17	86%	Sept 17	100%	Mar 18	91%	Aug 17	80%*	April 17	81%	July 17	86%	Sept 17	95%	Mar 18
C5DU	93%	Dec 17	95%	Oct 17	97%	Oct 17	100%	June 17	98%	Feb 18	100%	April 17	98%	Mar 18	100%	Mar 18	96%	Mar 18

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
MAU	85%	July 17	80%	May 17	80%*	Jan 17	100%	Oct 17	82%	May 17	**79%**	April 17	**82%**	Sept 17	**100%**	June 17	83%	April 16
H1	93%	Oct 17	95%	June 17	**82%**	Aug 17	91%	Aug 17	87%	July 17	80%*	July 17	**86%**	July 17	**89%**	Jan 18	100%	May 17
H200/EAU	96%	Mar 18	95%	Mar 18	**80%***	July 17	100%	Jan 18	92%	May 17	**80%***	June 17	86%	Oct 17	**81%**	Sept 17	89%	dec 17
H5	95%	May 17	84%	May 17	**84%**	Jan 17	100%	Feb 18	89%	July 17	84%	June 17	**87%**	Sept 17	**89%**	Dec 17	92%	Dec 17
H50	97%	May 17	90%	Dec 17	**80%***	July 17	100%	Mar 18	96%	Mar 18	**96%**	Jan 18	**86%**	Oct 17	**87%**	Sept 17	96%	Mar 18
H500	94%	Jan 18	82%	May 17	**83%**	April 17	92%	Dec 17	88%	May 17	**80%***	April 17	89%	Jan 18	**88%**	Sept 17	96%	June 17
H70	95%	Mar 18	80%	May 17	**80%**	Sept 17	100%	Oct 17	81%	May 17	**69%**	July 17	**74%**	Feb 17	**83%**	Sept 17	**85%**	Sept 17
H8	93%	Dec 17	97%	Mar 18	81%	Feb 17	**96%**	May 17	94%	Dec 17	80%*	April 17	95%	Mar 18	83%	Sept 17	85%	Sept 17
H80	95%	Mar 18	94%	Sept 17	80%	July 17	100%	Mar 17	90%	Dec 17	83%	July 17	49%	July 17	**75%**	June 17	81%	Sept 17
H9	85%	Oct 17	91%	Dec 17	80%*	April 17	100%	Mar 18	94%	Aug 17	97%	Sept 17	93%	Jan 18	81%	Sept 17	83%	Sept 17
H90	85%	Oct 17	91%	Oct 17	80%*	Mar 17	90%	Dec 17	89%	Nov 17	**86%**	April 17	87%	Oct 17	70%	June 17	84%	Sept 17
H11	88%	Sept 17	**81%**	May 17	80%*	Jan 17	97%	Mar 87	83%	April 17	**67%**	April 17	**76%**	June 17	92%	Dec 17	90%	Dec 17
H110	94%	Dec 17	**89%**	Mar 17	80%*	Mar 17	100%	Oct 17	85%	May 17	**69%**	May 17	78%	June 17	94%	Dec 17	93%	Nov 17

EMERGENCY MEDICINE HRI

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

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

Integrated Performance Report 2017/18

April 2017

March data

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

Integrated Performance Report - April 2017

RESPONSIVE

Description	Aggregate Position	Trend	Variation

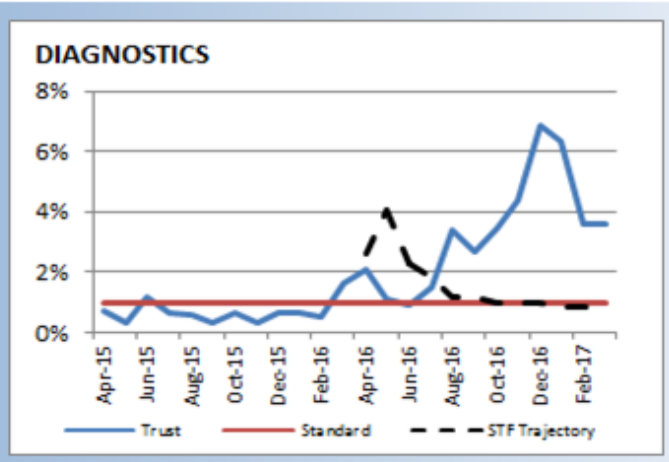
Diagnostic Waiting Times: 6 Weeks

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

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target with performance of 3.59% in March

Sustainability and Transformation trajectory is 0.8% the Trust also failed to meet this trajectory

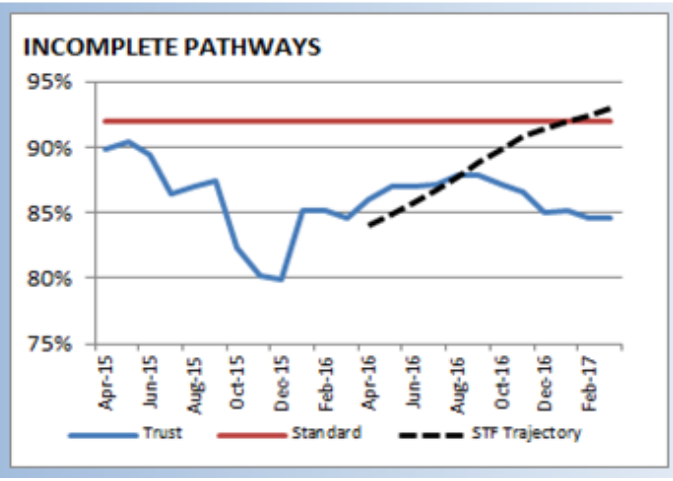


Referral to Treatment Incomplete pathway

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

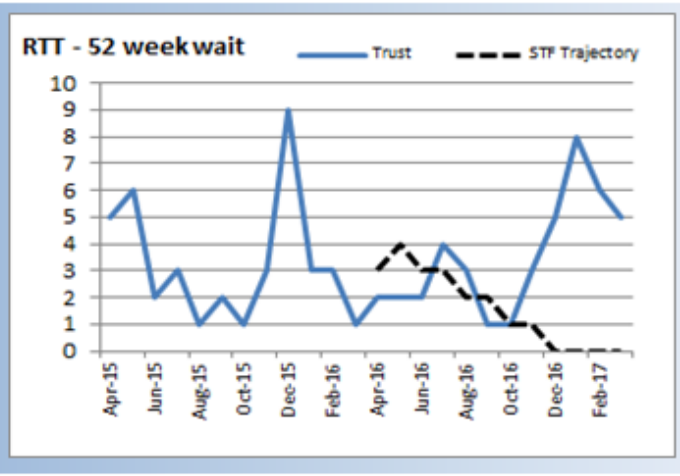
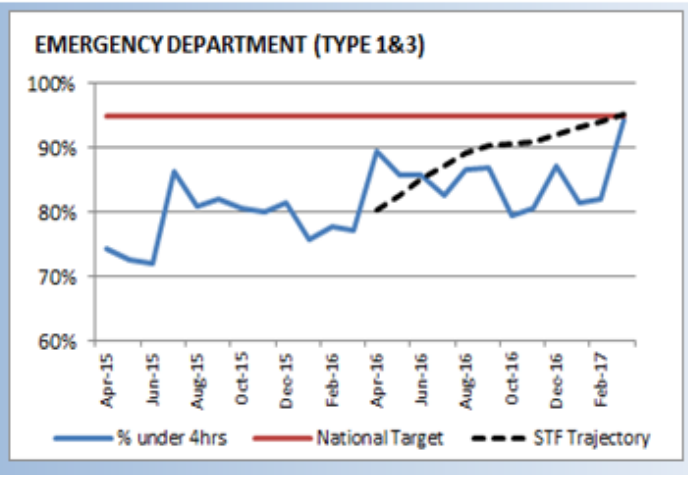
The Trust failed to achieve the March Sustainability and Transformation trajectory of 92.9%

March performance was 84.6%



Integrated Performance Report - April 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Referral to Treatment Incomplete 52+ Week Waiters	The Trust aims to deliver zero 52+ week waiters	The Trust failed to deliver the national standard of zero breaches with 5 breaches for March The Trust also failed to achieve the STF trajectory of zero breaches during March		
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 has remained below the national 95% threshold with performance of 94.4% for March which was also below the agreed Sustainability and Transformation trajectory of 95.1%		There has been significant improvement during March. Performance improved by 12.4% compared to February performance of 82.0%.

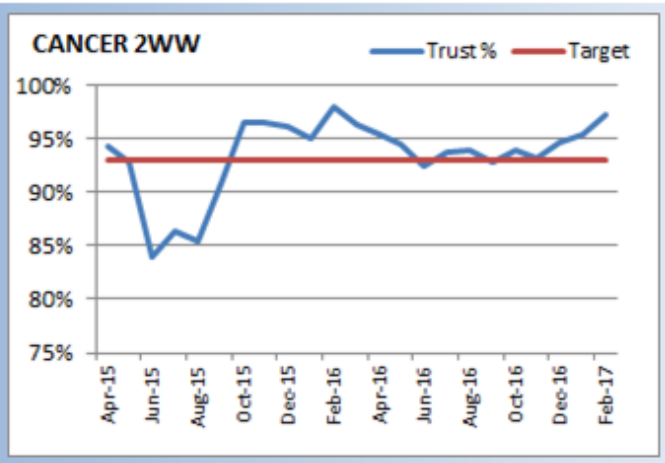
RESPONSIVE

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%.

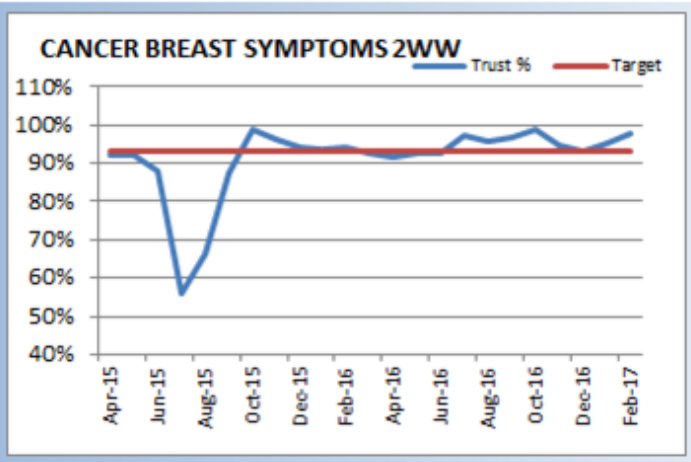
February performance achieved the 93% standard at 97.3%



Cancer: Breast Symptom Two Week Wait Standard

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

February performance achieved the 93% standard at 98.1%



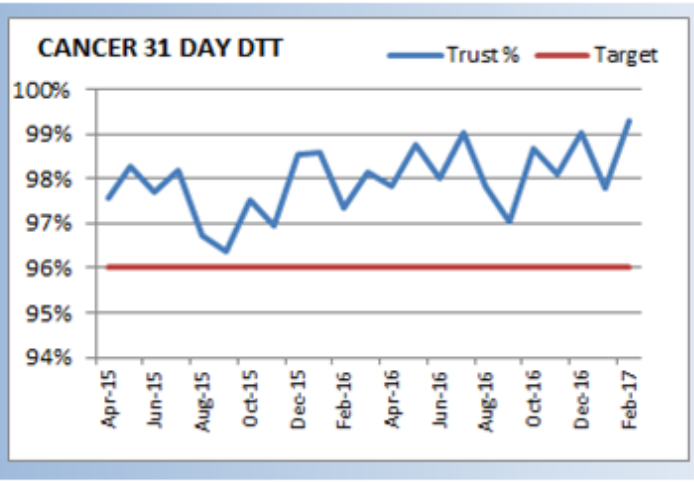
RESPONSIVE

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%.

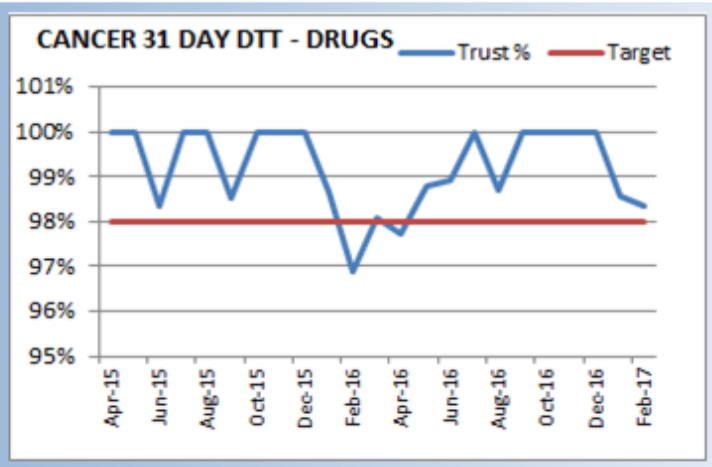
February performance achieved the 96% standard at 99.3%



Cancer: 31 Day Subsequent Drug Standard

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

February performance achieved the 98% standard at 98.4%



Integrated Performance Report - April 2017

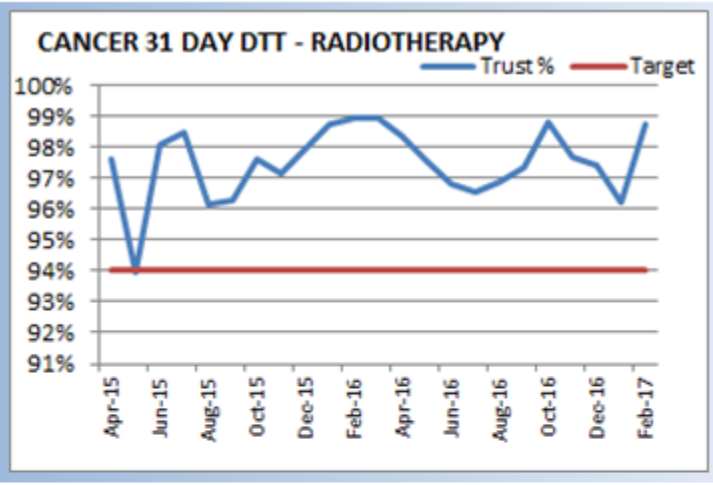
RESPONSIVE

	Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy Standard

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

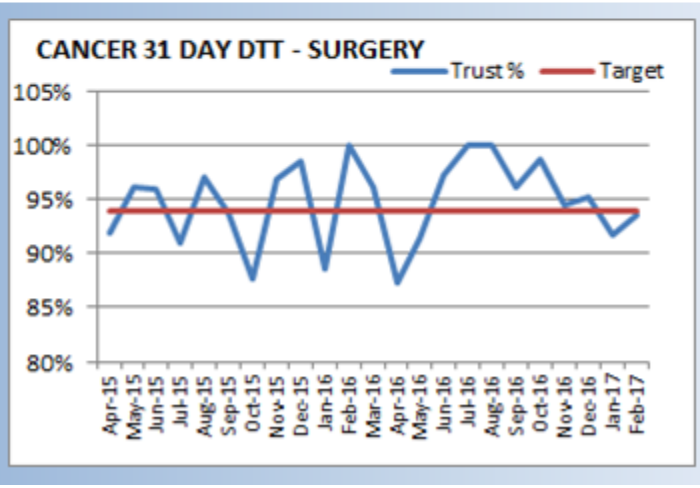
February performance achieved the 94% standard at 98.7%



Cancer: 31 Day Subsequent Surgery Standard

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

February performance failed to achieve the 94% standard at 93.5%



Integrated Performance Report - April 2017

RESPONSIVE

Description	Aggregate Position	Trend	Variation

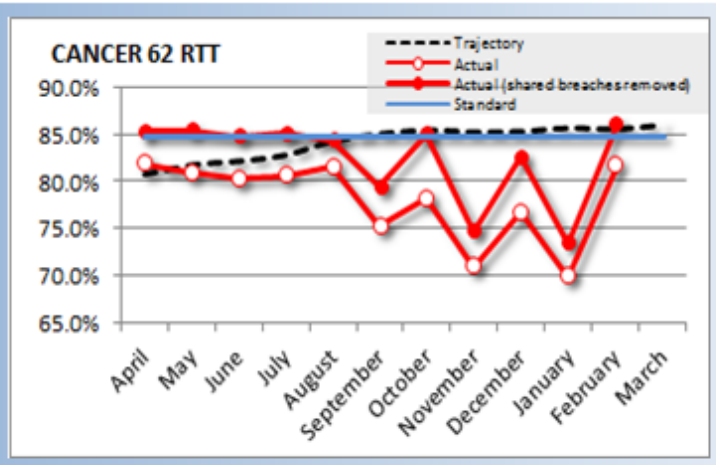
Cancer: ADJUSTED - 62 Day Standard

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

Sustainability and Transformation trajectory is 85.7%

The adjusted position allows for reallocation of shared breaches

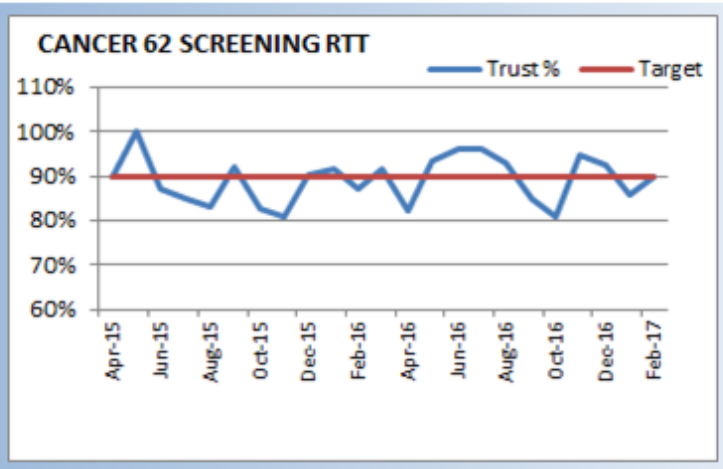
February achieved the STF trajectory of 85.7% with performance of 86.2%



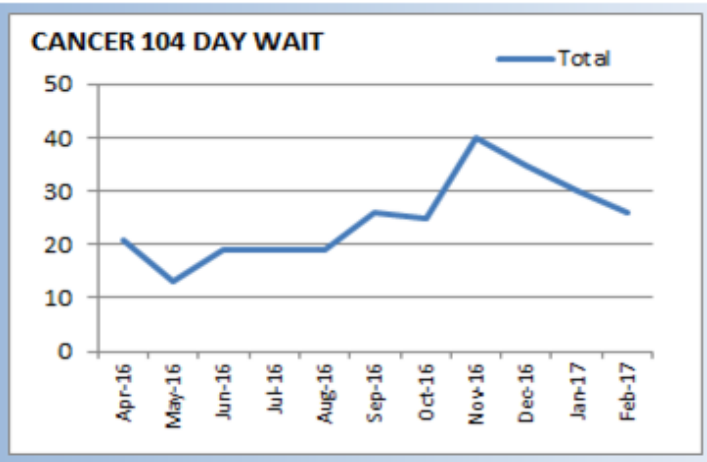
Cancer: 62 Day Screening Standard

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

February performance failed to achieve the 90% standard at 89.7%

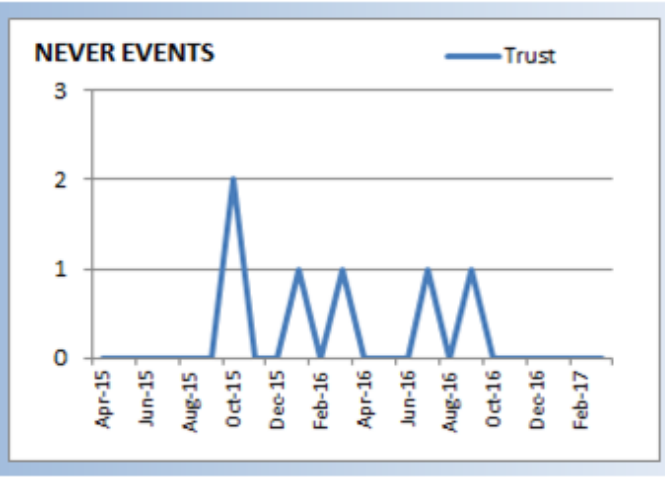
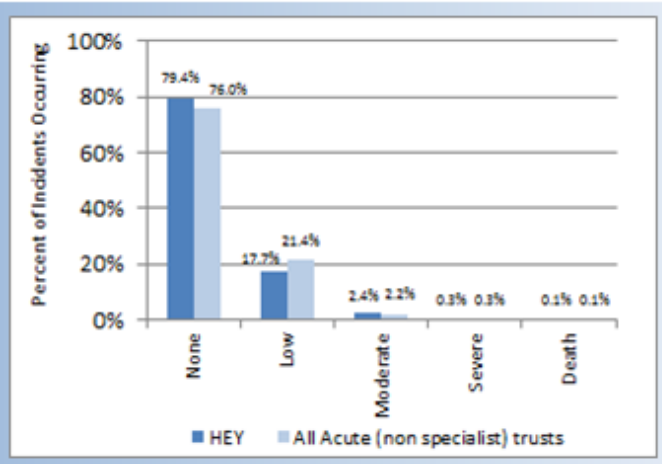


RESPONSIVE

Description	Aggregate Position	Trend	Variation
Cancer 104 Day Waits	There were 26 patients waiting 104 days or over during February		

Integrated Performance Report - April 2017

SAFE

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

Integrated Performance Report - April 2017

SAFE

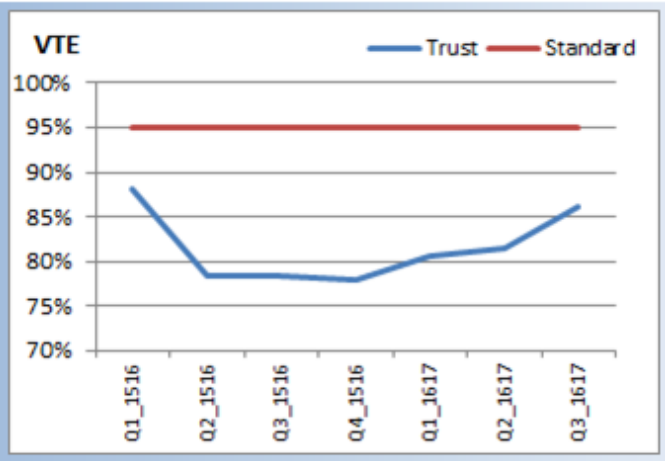
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 86.15% for Q3 2016/17.

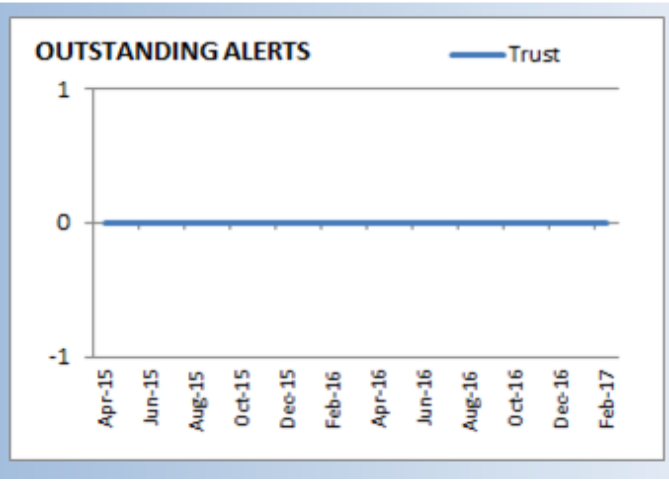


Patient Safety Alerts Outstanding

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

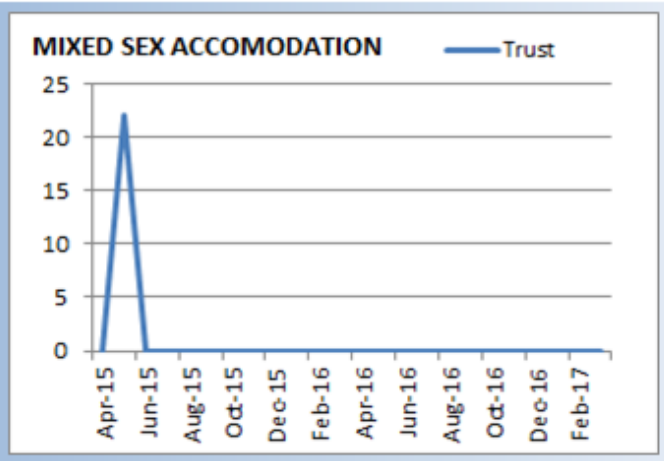
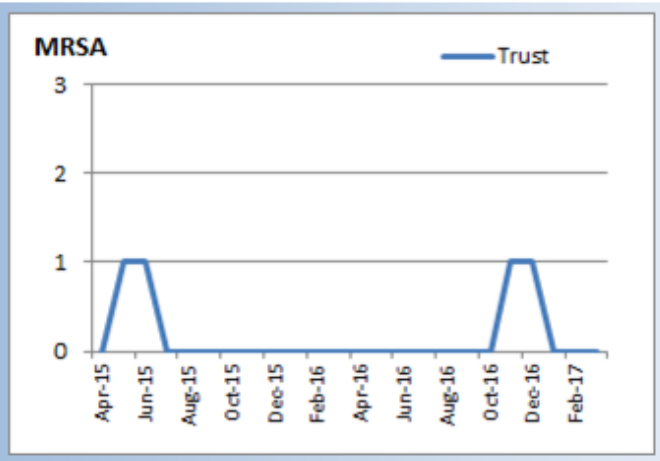
There have been zero outstanding alerts reported at month end for March 2017.

There have been no outstanding alerts year to date.



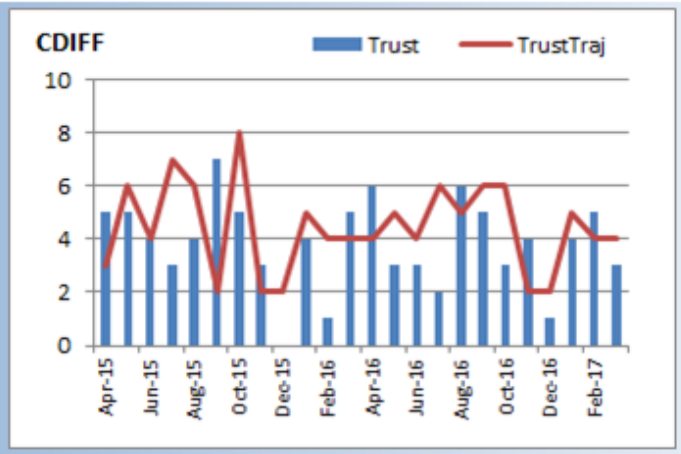
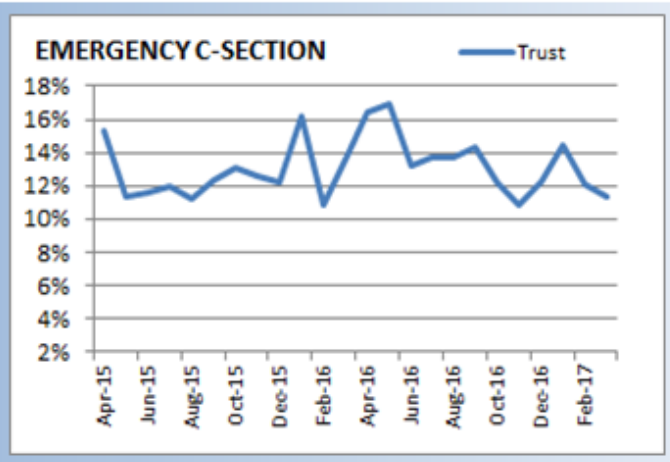
Integrated Performance Report - April 2017

SAFE

	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 March 2017.		
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 2 cases of acute acquired MRSA bacteraemia year to date There were no cases reported during March		Further information is included in the Board Quality report

Integrated Performance Report - April 2017

SAFE

	Description	Aggregate Position	Trend	Variation
Clostridium Difficile	The Clostridium difficile target for 2016/17 is no more than 53 cases	There have been 42 cases year to date There were 3 incident reported during March which achieved the monthly trajectory of no more than 4 cases		
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 March achieved this standard at 11.3%		

EFFECTIVE

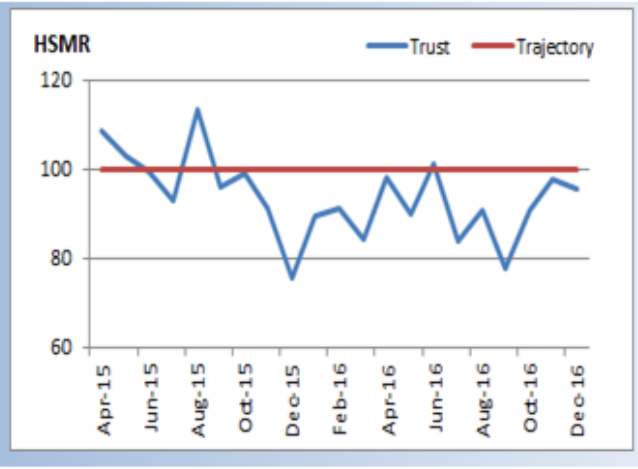
Description	Aggregate Position	Trend	Variation

HSMR

HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups

December 2016 is the latest available performance

The standard for HSMR is to achieve less than 100 and December 2016 achieved this at 95.4

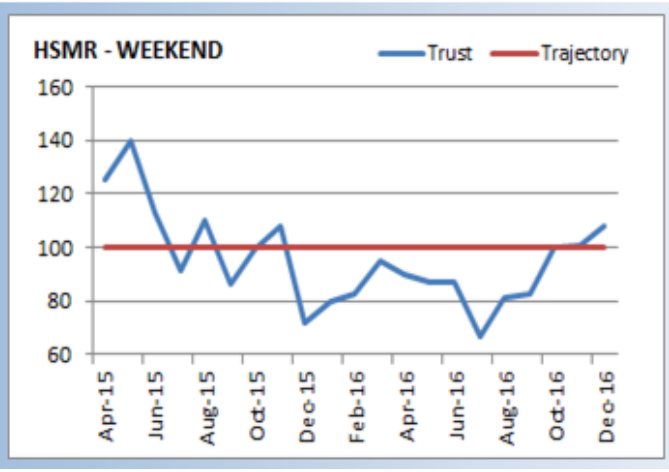


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

December 2016 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and December 2016 failed to achieve this at 108



EFFECTIVE

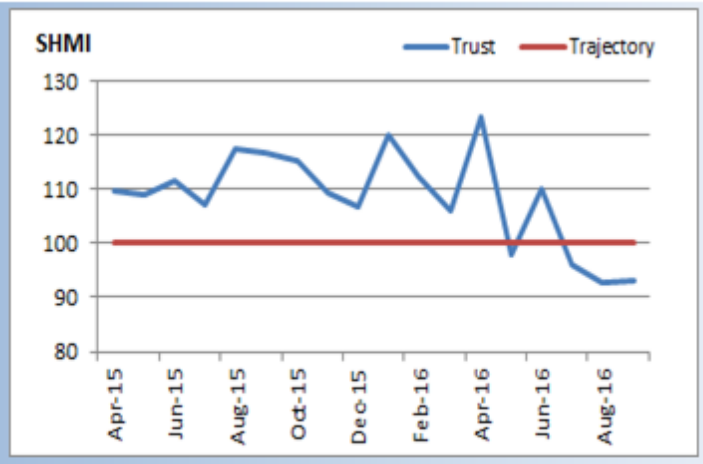
Description	Aggregate Position	Trend	Variation

SHMI

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

September 2016 is the latest published performance

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

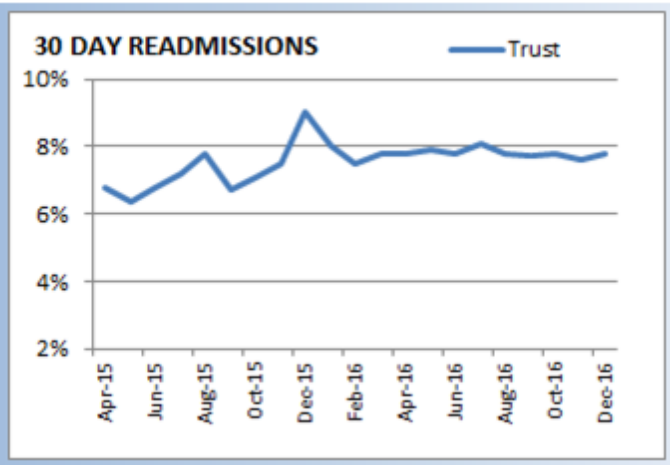


30 DAY READMISSIONS

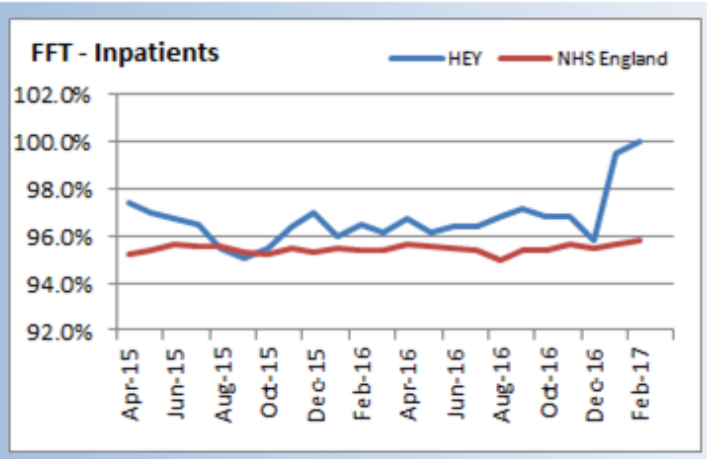
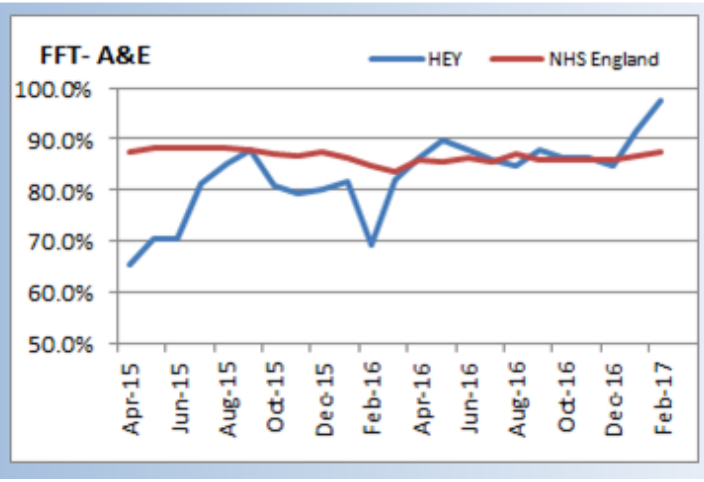
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is December 2016

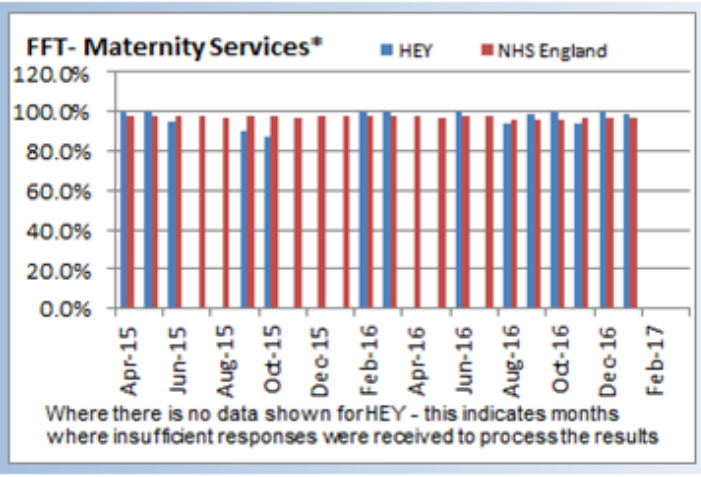
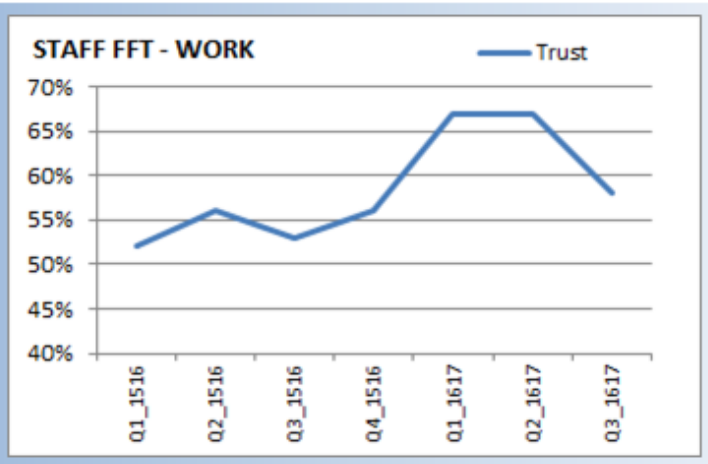
The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than or equal to 7.8%. The Trust achieved this measure with performance of 7.8%.



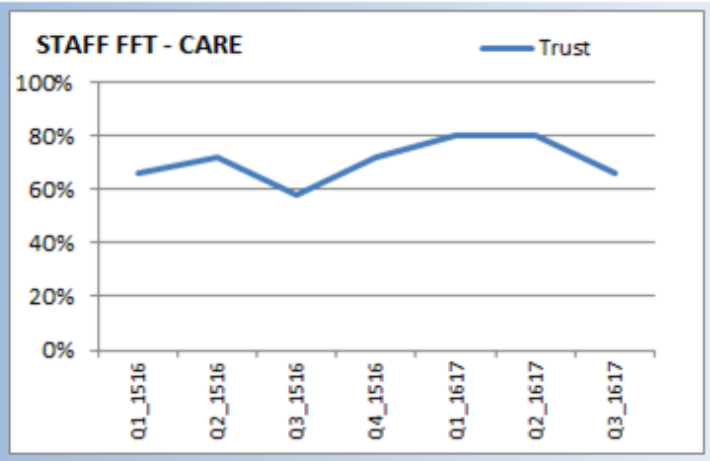
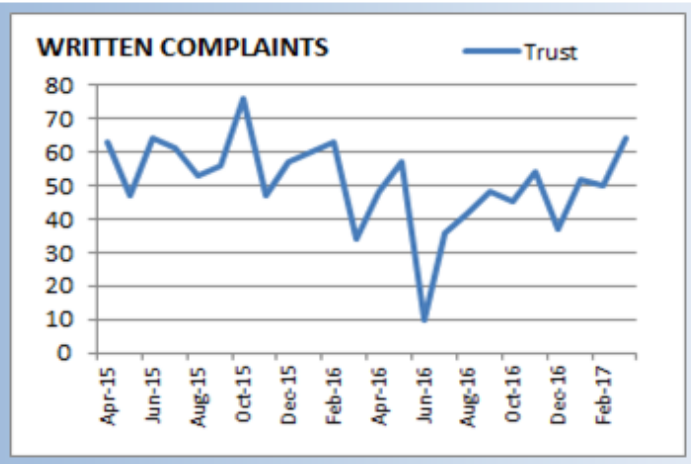
CARING

	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 February was 100% The latest published data for NHS England is February 2017. March 2017 will be published 11th May 2017.		
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for February was 97.58% The latest published data for NHS England is February 2017. March 2017 will be published 11th May 2017.		

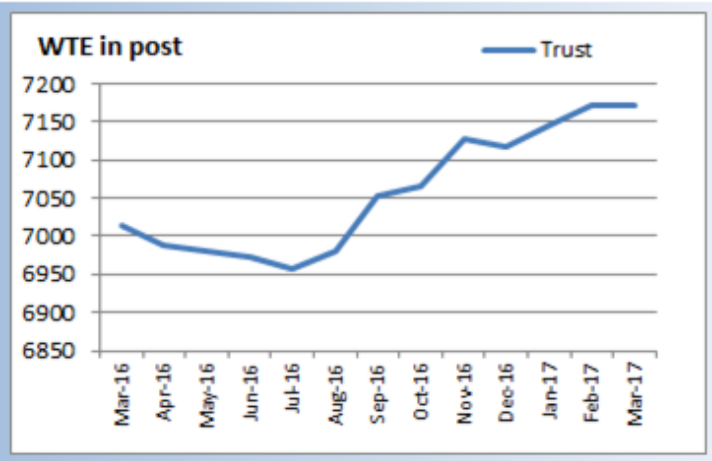
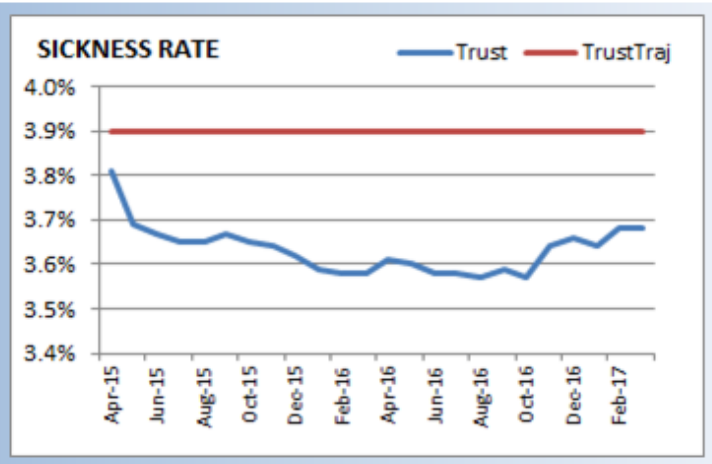
CARING

	Description	Aggregate Position	Trend	Variation
Maternity Scores from Friends and Family Test - % Positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for February was 100% The latest published data for NHS England is February 2017. March 2017 will be published 11th May 2017. Months with no data for HEY is due to insufficient responses		* Question relates to Birth Settings
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?	The latest Friends and Family Test position is quarter 3 2016/2017 shows that 58% of surveyed staff would recommend the Trust as a place to work, this has deteriorated from the quarter 2 position. Quarter 3 performance is part of the 2016 annual staff survey.		The overall response rate for quarter 3 was 44%

CARING

	Description	Aggregate Position	Trend	Variation
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?	The latest Friends and Family Test position is quarter 3 2016/2017 shows that 66% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has deteriorated from the quarter 2 position. Quarter 3 performance is part of the 2016 annual staff survey.		The overall response rate for quarter 3 was 44%
Written Complaints Rate	The number of complaints received by the Trust	The Trust received 64 complaints during March, this is an increase on the February position of 50 complaints		There have been 543 complaints year to date

ORGANISATIONAL HEALTH

	Description	Aggregate Position	Trend	Variation
WTEs in post	Contracted WTE directly employed staff as at the last day of the month	Trust level WTE position as at the end of March was 7172 .1		
Sickness Absence Rates	Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.	Performance for March achieved the standard of less than 3.9% with performance of 3.68%		

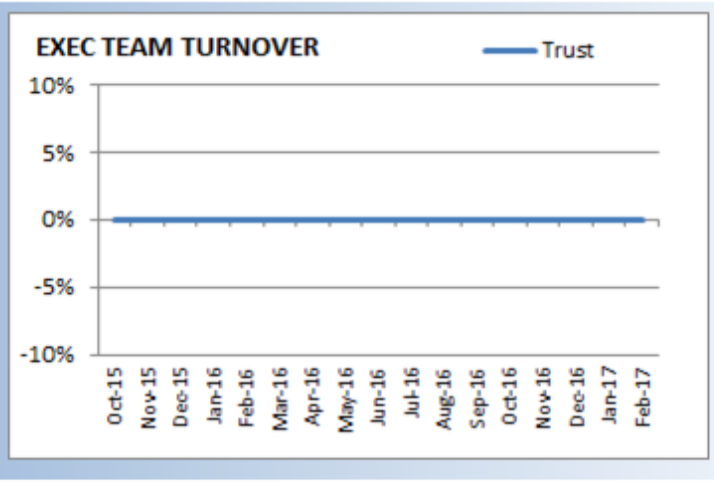
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

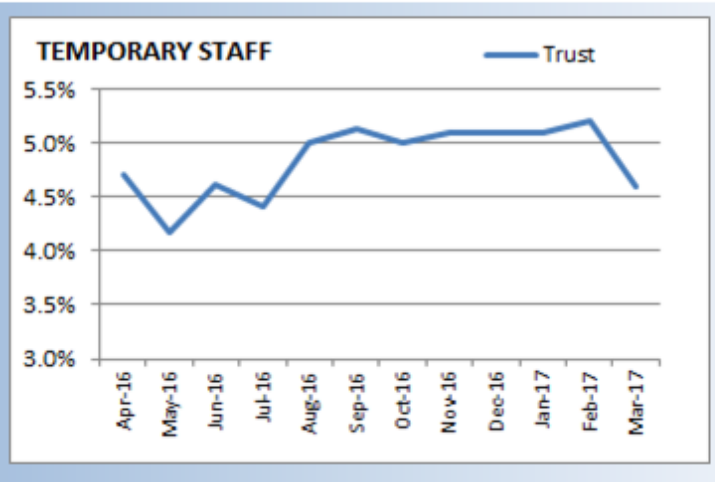


Proportion of Temporary Staff

% of the Trusts pay spend on temporary

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

March performance was 4.6%



FINANCIAL SUMMARY: 12 MONTHS TO 31st MARCH 2017

1. The Trust has delivered against all 3 of its statutory financial targets. Delivery of break-even, Capital Resource Limit and External Financing Limit.

2. At the end of month 12 the Trust is reporting a surplus of £70k. This is based on delivering a Trust surplus of £35k which is then matched by £35k of incentive funding from NHSI.

3. The position is based on the Trust receiving the full £14m STF funding as per NHSI guidelines. The Trust has had formal confirmation of achievement of the first 3 quarters of the year and the final quarter funding is based solely on delivering the financial plan and hence has been built into the position.

4. Health Group positions are £14.7m overspent. This is £1.5m increase in month and £0.6m above the month 11 Health Group forecasts. Surgery, Clinical Support and Family & Women's all saw deterioration against forecasts with half the increase relating to Surgery Health Group. The deterioration was partially offset by an improvement in the Corporate position.

5. The Trust has only been able to report that it has delivered its plan due to receiving additional education income (£0.4m), reductions in PDC (£0.3m) and depreciation (£0.2m) and use of non recurrent reserves (£0.8m).

6. The Trust had already agreed income positions with its main Commissioners but saw a small increase in overall income above forecast by £0.3m relating to peripheral CCGs and non contract activity. Actual trading was high in month in PBR excluded drugs and devices, blood and Wet AMD that did create some pressure on the expenditure position but this was contained within the overall income contingency reserve.

7. The Trust's cash position remains weak. This is impacting on supplier relationships and has impacted on the Trust's performance against the Better Payment Practice Code. The Trust was £157k below its External Financing Limit.

8. As per previous months the non delivery of CRES is a significant concern with the month 12 position showing a £4.2m shortfall against a £19.2m plan. This is a delivery level of 78%. Offsetting this, the Trusts financial plan included a risk provision (reserve) totalling almost £5m recognising the risk inherent within the CRES program. In addition, the plan made a further £5m allowance against the risk of non delivery of the RTT recovery plans. In total the Trust is forecasting a deficit of approximately £6.2m against the planned activity targets. **The bigger issue is the growth in the Health Group cost base above budgeted levels without delivering the funded levels of activity. This is particularly an issue in Surgery but to a smaller extent also FWH.**

9. Agency spend totalled £13.1m for the year, £3.6m above the £9.5m NHSI set target.

10. Accounts are currently being prepared. Notification of any additional reward monies will be received prior to finalisation.

11. The financial plan for 2017/18 has been agreed at Health Group level but large deficit in identified and deliverable CRES of £10.3m. The Trust will join the FIP2 programme to provide help and support.

12. The control total for 2017/18 has not yet been agreed. NHSI expects the Trust to deliver another £2.5m of improvement.

ORGANISATIONAL HEALTH

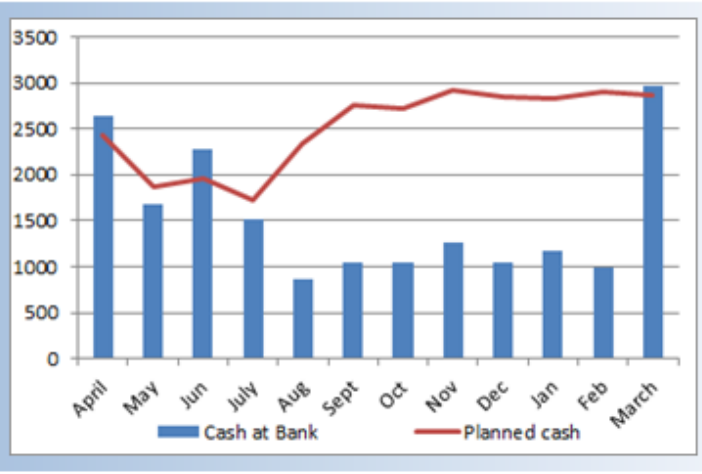
Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of March was £2.971m, of which £2.956m was held in bank accounts and £0.015m held as petty cash.

The Trust achieved its statutory EFL target with an undershoot of £0.157m . There is still intense pressure on cash and the Trust is still unable to meet obligations to suppliers as they fall due. Further pressure is expected in quarter 1 of 2017/18 when invoices from capital expenditure in the last quarter of 2016/17 starts to filter through financial systems.

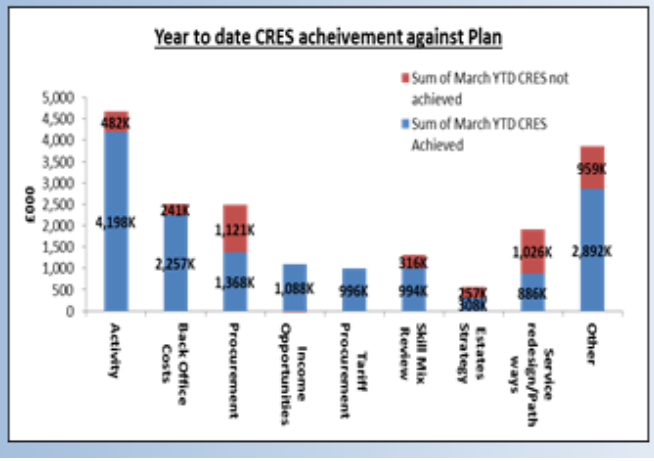


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 12 the Trust has achieved £15.0m of CRES savings against a plan of £19.2m, an adverse variance of £4.2m.

The breakdown of the CRES programme by major work streams is shown on the chart with the red and blue combined reflecting the overall plan as at January, the blue section being that which has been achieved and the red being that which has not.



The Health groups have been tasked with finding additional schemes to cover their CRES shortfall along with developing plans for 17/18

ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

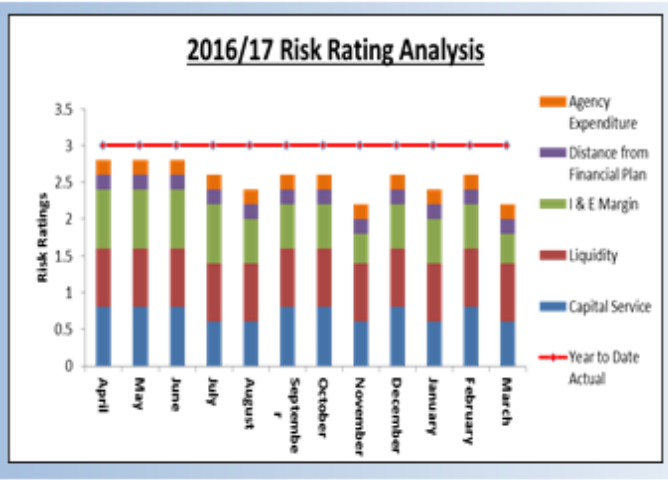
Risk Rating

Financial Sustain-ability Risk Rating

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

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

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst (this is a change from previous rating metrics which had 4 as the best score and 1 the worst). The Trust risk rating is currently 3.



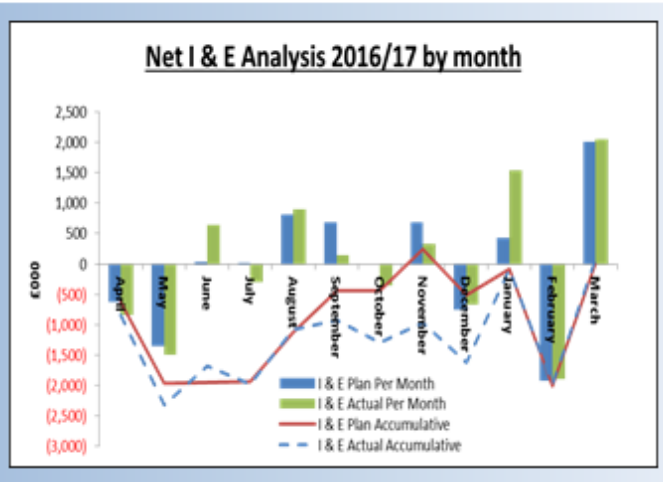
The Trust did improve some of its individual risk rating metrics in month 12 with I & E margin becoming a 2 and the achievement of plan metric becoming a 1, however the overall risk rating remains a 3 with liquidity (rated 4) a concern.

Income & Expenditure

Net income and Expenditure

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

At month 12 the Trust exceed expectations in month 12 and finish the year having achieved a £70K surplus, which is £70K above plan.



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 4 2016/17

Trust Board date	2 May 2017	**Reference Number**	2017 – 5 – 14.1
Director	Chairman – Terry Moran	**Author**	Director of Corporate Affairs – Carla Ramsay
Reason for the report	The purpose of this report is to present quarter 4 and therefore year-end ratings for each risk on the Board Assurance Framework, as reviewed and recommended by the Audit Committee, for Trust Board approval		

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

1	**RECOMMENDATIONS** The Trust Board is asked to review the BAF and to confirm or propose changes to the recommended ratings for Q4 as a year-end position.					
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** This paper reflects assurance and updates received throughout Quarter 4 at the Trust Board and its committees. The Audit Committee has reviewed this as a key system of internal control prior to recommendation to the Trust Board.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 4 2016/17

1. PURPOSE OF THIS REPORT

The purpose of the paper is for the Trust Board to review the Board Assurance Framework risks at Quarter 4 and confirm a year-end position.

2. KEY ISSUES

- The proposed year-end position is that three Board Assurance Framework (BAF) risk areas have met their target risk rating
- Of the remaining six risk areas, three are high level risks and three are medium level risks
- The proposed highest-rated risk at year-end is F1, which relates to addressing the Trust's financial deficit, which is proposed to remain at a risk rating of 20, per the rating agreed in Q3. The second high-level risk is Q3 relating to workforce and the impact of patient care, proposed to remain at risk rating 16, which has been its rating throughout 16-17. The final high-level risk area is P1 relating to the impact of the STP, proposed to remain at risk rating 16, which has been its rating during the year.
- Risk Q1 relating to CQC regulatory requirements is recommended to move from a rating of 12 to 8, in light of the CQC Comprehensive Inspection report published in February 2017 and the Quality Summit held in March 2017, which did not contain any 'inadequate measures' and confirms the Trust's journey of improvement
- Risk Q2 relating to lessons learned is recommended to move from a rating of 16 to 12, as there is evidence of work within the organisation and an overall Quality Improvement Plan that has had impact at local level
- Risk H1 relating to patient experience is recommended to move from a rating of 9 to 8, which is the target rating, as a result of improvement seen during Q4 and the year
- Risk H2 relating to cultural transformation is recommended to move from a rating of 12 to 8, which is the target rating, as staff are reporting and improvement in engagement and culture

3. BOARD ASSURANCE FRAMEWORK (BAF)

There are nine risks on the Board Assurance Framework. Six risks were reviewed and updated in quarter two with the lead Director. For quarter three, 3 risks have been updated with the lead Director. As a year-end position, for all risk areas, the mitigating actions and assurance received have been reviewed and updated against papers received at Trust Board and Board Committees in Quarter 4.

The changes during Quarter 4 and as a year-end position:

- Risk Q1 relating to CQC regulatory requirements is recommended to move from a rating of 12 to 8, in light of the CQC Comprehensive Inspection report published in February 2017 and the Quality Summit held in March 2017, which did not contain any 'inadequate measures' and confirms the Trust's journey of improvement. Positive assurance was received by the Trust Board and the Quality Committee from the outcome of this report, and Trust Board members were in attendance at the Quality Summit to understand the Trust's position on a journey of improvement. It is recommended that there is a new risk area on the BAF for 17-18 to pick up on the key themes from the CQC report that will move the Trust from 'requires improvement', to 'good' to 'outstanding' within three years.
- Risk Q2 relating to lessons learned is recommended to move from a rating of 16 to 12, as there is evidence of work within the organisation and an overall Quality Improvement Plan that has had impact at local level – i.e. work in teams and wards to learn from incidents. There is also increased confidence in the Trust's Serious Incident processes by commissioners. It is therefore felt that there has been some impact in mitigating this risk but it is acknowledged by the new Quality Improvement Plan that there is further work on a culture of learning across the organisation, which is a focus for 17-18

- Risk H1 relating to patient experience is recommended to move from a rating of 9 to 8, which is the target rating, as a result of improvement seen during Q4 and the year. Specifically, the Trust's FFT scores for the Emergency Department have improved, the number of complaints for the full year compared with last year has fallen and the Trust received favourable results from the national patient survey. Where patients do give feedback, such as the FFT, it is very positive overall. It is felt that this is sufficient to move the likelihood indicator for this risk from 3, to 2, which is the target score. There is still work to do on timeliness of complaint response, which has improved but not to an excellent or consistent level, and there are consistent themes in PALS issues that also match to one of the two areas that the Trust scored badly in the national patient survey, which is communication and information about discharge.
- Risk H2 relating to cultural transformation is recommended to move from a rating of 12 to 8, which is the target rating, as staff are reporting and improvement in engagement and culture. This is seen in the National Patient Survey results received by the Trust Board in March 2017, which showed significant improvement in a number of scores. The engagement score improved from the previous survey an in-year cultural surveys and have shown a greater engagement score than the national survey. The risk was that staff did not report improvement, but improvement has been seen this year. There is further work to do around organisational culture, with a focus still on reducing reports of bullying and a stretch target set on staff engagement for two years' time.

There are some risks that are not proposed for a changed risk-rating in Q4 as a year-end position:

- Risk Q3 relating to workforce and impact on patient care is recommended stay at a risk rating of 16 – there is positive assurance noted and further progress made in Q4, however the impact of this work will not be seen largely until 2017-18 and the overall level of risk around workforce remains high, despite successes in individual areas noted, such as critical care and ED; there has been no change to the corporate risks relating to this area in Q4
- Risk G1 relating to an impact on the Trust's Single Oversight Framework (SOF) rating as a result of waiting times is recommended to stay at its current rating of 12; although the Trust did not meet all the NHS Constitutional waiting times standards, the year-end position has not impacted the Trust's SOF risk rating. The Trust Board has been updated with the year-end negotiated position with commissioners and the way in which this has fed in to a local contract model for 2017-18, based on continuing to improve waiting times but working constructively with commissioners to reduce demand and improve patient pathways.
- Risk P1 relating to the impact of the Strategic Transformation Partnership (STP) is recommended to remain at its current rating of 16. Whilst the position has not worsened during the year, the nature of a strategic partnership development takes time and full Trust Boards are becoming more engaged as the programme moves in to 2017-18. There is still a lack of clarity around the impact of issues within the local health economy, however, the Trust Chief Executive now leads the acute STP work stream and the Trust is involved in the locality work closest to the Trust. This remains a key risk area for the 2017-18 BAF.
- Risk F1 relating to addressing the Trust's financial deficit is recommended to remain at risk rating 20, to which it was increased in Q3. Whilst there is positive assurance in Q4 on the year-end financial position and achieving the Trust's control total, this has been achieved through non-recurrent measures. The Trust will also receive 100% STF support funding, 70% of which was linked with financial performance. However, this year-end position has not addressed the underlying financial deficit that the Trust will be taking in to 17-18, therefore the risk rating is proposed to remain the same whilst control measures are in place, and is a key risk area to take in to 17-18.
- Risk F3 relating to capital programme being sufficient and not impacting on clinical quality is proposed to remain at a risk rating of 8, to which it was reduced in Q3 and is its target risk rating. As detailed at the Performance and Finance Committee and the Trust Board during Q3, the risk that the capital programme is not sufficient and has an impact on clinical quality has been mitigated and managed throughout the year. The capital programme has been sufficient to meet requirements in-year. In addition, the number of high-rated corporate risks

relating to F3 reduced from 6 to 4 in Q3. There have been no updates in Q4 that would change this position, therefore the risk rating is proposed to remain at 8, the target risk rating.

The BAF is attached at appendix 1 for review.

Appendix 2 sets out the BAF risk and cross references this to papers received at the Board. This enables the Board to review whether its agenda is sufficiently focussed to those areas of greatest risk. Appendix 3 shows the link to the corporate risk register as at the end March 2017.

4. RECOMMENDATIONS

The Trust Board is asked to review the BAF and to confirm or propose changes to the recommended ratings for Q4 as a year-end position.

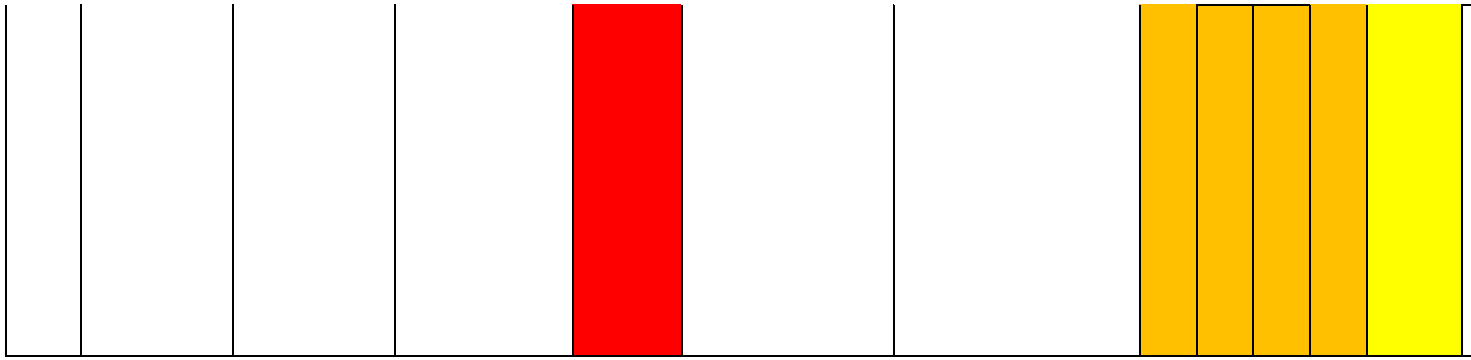
Carla Ramsay
Director of Corporate Affairs
April 2017

Appendix 1

BOARD ASSURANCE FRAMEWORK Q4 – 2016/17

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Mitigating Actions Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q1	Chief Medical Officer, Chief Nurse Quality Committee	5 risks • Crowding and physical space issues (2) • Safeguard-ing training compliance (1) • Reduction in trained staff in blood transfusion labs (compliance risk) (1) • Paediatric access to dietary assessment (1)	**The Trust is non-compliant with CQC regulatory requirements** There is a risk that the Trust does not achieve the fundamental standards and that regulators and service users may have concerns about the quality and safety of our patient services.	**20** **L-4** **X** **S-5**	• QIP established • Fortnightly QIP meetings chaired by CMO to monitor achievement of milestones • QIP programme reviewed at Operational Quality Committee and deviations from plan escalated • Internal inspection programme in place during Q1 • NHSI involved in 'health check' • Governance toolkit developed to support staff to prepare for inspection • Fortnightly Charge Nurse meetings with ward sisters	Informal feedback from the CQC identified areas where further work needs to be undertaken. This includes embedding checking procedures, adherence to escalation procedures, documentation and staffing. A review has been undertaken of the QIP following informal CQC feedback and the QIP has been updated. This will be reviewed on receipt of the formal CQC report **Leads**: CN, CMO and Deputy Director of Quality Governance **Completion**: March 2017 – confirmed and submitted to CQC by 31 March 2017 deadline	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**8** L2 X S4	**4** **L1** **X** **S4**	**Positive assurance** • Informal feedback received from the CQC following the comprehensive inspection at the end of June 2016 identified a number of areas where positive improvements had been made • Review by Internal Audit that the QIP was complete and accurate – reported to the Audit Committee at May 2016 meeting • Internal reports giving significant assurance during 2015/16 – Fit and Proper persons, discharge planning, safe staffing levels, performance management arrangements and lessons learnt • Internal Audit provided positive feedback on the Duty of Candour arrangements (May 2016) • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days • QIP programme reviewed – areas with progress made that are now business as usual now removed; deteriorating patient programme provisionally closed ; overall programme rating amber/green • CQC Comprehensive Inspection report published February 2017 and Quality Summit held March 2017; no areas of 'inadequate;' and improvement in several key areas. Whilst overall rating remains 'requires improvement' the Quality Summit confirmed the Trust is on a positive journey to 'good' and 'outstanding'. • Updated QIP submitted to the CQC in response to the report, to take account of all 'must do' and 'should do' actions



Further assurance required

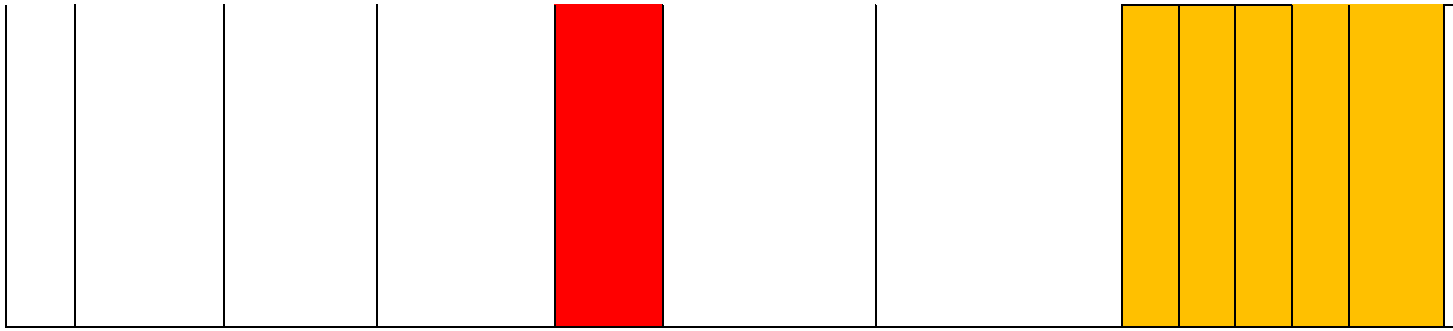
- Year-end position on the Quality Improvement Plan shows some areas still requiring work, and pick up on CQC theme of compliance – VTE, WHO Checklist

Q – High Quality Care												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q2	Chief Medical Officer Quality Committee	0 risks	**Lessons learned** There is a risk that the Trust does not learn from adverse events and that errors continue to occur which could affect patient care and safety	**20** **L4** **X** **S5**	• Learning lessons QIP project group established • Monthly Lessons learned newsletter • Quality Bulletin • Lessons Learned Intranet site • Monthly SI summary report distributed to Health Groups • Analysis of incidents and trends • Use of videos to replicate incidents in order to improve learning • Application of Root cause analysis techniques and training • Operational Quality Committee • Health Group Governance meetings • Health Group performance reviews • Clinical Incident Review Creating a Learning Environment **(**CIRCLE) • Table top RCA's being piloted for some SI's • Trialling PDSA cycles for learning	• At the end of Q2 there was a reduction in the number of SIs reported when compared to 2015/16 .The themes and trends in incidents and Serious Incidents (SIs) are continuing from 2015/16 into 2016/17. Further review and analysis required • Revised incident reporting system launched April 2016. The national coding structure implemented at the same time is causing some concerns when analysing themes and trends and is being reviewed **Lead:** Director of Governance **Completed:** December 2016	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**12** **L2** **X** **S4**	**4** **L2** **X** **S2**	**Positive assurance** • Significant Assurance – internal audit, lessons learned review, March 2016 • Positive feedback received from staff who attended the learning lessons workshops (May 2016) which included the training video of the Never Event retained vaginal swab • Positive feedback received from CQC that staff were aware of the Lessons Learned Bulletin and the safety brief and that work had been undertaken to improve learning from incidents including human factors training • Information about changes in practice now being included in the Board's Quality report related to complaints and Never Events/Serious Incidents • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days. • Training videos produced and PDSA cycle being introduced • Fewer Serious Incidents declared year-to-date • Improvements to structured case review for lessons learned with mortality and patient deaths • QIP for Lessons Learned still on track to deliver against milestones for March 2017 – rated green at year-end • No further Never Events declared in the last quarter of 2016-17 and no recurring themes of Never Events seen in 16-17 • Commissioners have given the Trust 'significant assurance' during Q4 for its Serious Incident process **Further assurance required** • QIP on lessons learned at year-end notes that repeat SIs have occurred in year for example pressure ulcers and further work is required. This year has focused on the quality of investigations as well as communication methods. Embedded learning will be the focus for 2017-18. • Whist there is a range of evidence of local work on lessons learned and teams taking action to review incidents and learn from them, there is still work to do around a culture of learning in the organisation

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Mitigating Actions Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q3	Director of Workforce and OD Workforce Transformation Committee	6 risks • Recruitment and retention of skilled/ sufficient nursing staff (2) • Recruitment are retention of skilled medical staff (4)	**Workforce** There is a risk that the Trust is unable to recruit to the numbers of staff required to deliver high quality and safe services	**20** **L5** **X** **S4**	• Overseas recruitment programme for nursing staff • 'Values' based recruitment now implemented in Trust recruitment process • Recruitment and retention premia for designated posts • Apprentice scheme • New roles in place – 27 Advanced Practitioner posts in a number of services to off-set shortages in junior doctors • Development of non-registered nursing staff • Innovative recruitment strategies, utilising social media and active advertising campaigns to attract skilled and experienced staff in place • Ward establishments review twice a year • New roles e.g. ward based A&C Personal Assistants, Ward Hygienists and Discharge Facilitators • Move from agency to local short-term additional payments for staff in critical care	• Working with Universities and Health Education England to develop new 2 year programmes for Advanced Practitioners and Physicians Associates **Lead:** S Nearney **Completion**:31.9.17	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**6** **L3** **X** **S2**	**Positive assurance** • Monthly nursing and midwifery staffing report to Board • Significant assurance – internal audit, Recruitment • Significant assurance – internal audit, Safe staffing levels, 2015/16 • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • Staff sickness levels below Trust target of 3.57% (October 2016), 0.33% below the target, and continues decrease in staff sickness rate • Mandatory training levels above Trust target of 88.1% (September 2016) 3.1% above the target • Staff turnover below Trust target of 9.2% (September 2016) 0.1% below the target • Staff FFT results showing continuous improvement over each quarter; quarterly analysis received November 2016 • People Strategy approved at May 2016 Trust Board • Senior Responsible Officer report and assurance received by the Trust Board November 2016 • Improvement made in staffing levels in particular areas, leading to reduced agency spend in high-cost areas, specifically critical care and recruitment to vacancies in ED and critical care • Successful recruitment of higher number of graduating nurses from 16-17 cohort – over 100 interviews and job offers made for Autumn 2017 start, with commencement in employment as unqualified nurses within their destination areas while awaiting registration **Further assurance required** • Recruitment to high-rated risk areas • Effect of recruitment programmes in 17-18 to increase numbers against establishment – graduating nurses and overseas nurses will not impact numbers in 16-17

H – Honest, Caring and Accountable Culture												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H1	Chief Nurse Quality Committee	0 risks	**Patient Experience** There is a risk that patients receive and report a poor experience through complaints, PALS, Family and Friends Test and the National Patient Survey. The impact of this poor experience is loss of confidence and trust in the care provided for new and existing patients along with reputational damage for the Trust	**16** **L4** **X** **S4**	• Ward audit programme • FFT being used as improvement tool 'You said we did'. • Patient Council established • Complaint Policy • Inpatient survey top quartile for improvements in patient experience • Intentional Rounding in ED every 2 hours • Two hourly Board Rounds in ED, led by Emergency Physician in Charge • Monthly Health Group Performance reviews	• Response times to complaints. Further work needs to be undertaken to improve response times to complaints within 40 days **Lead** :HG Medical Directors Completed:30.11.16	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**	**8** **L2** **X** **S3**	**8** **L2** **X** **S4**	**Positive assurance** • Quality Report to every Trust Board including lessons learned • Patient Stories presented at every Trust Board • The FFT report for September 2016 identifies • Average score of 4.75 • Trust information indicates 94.9% patients likely to recommend the Trust (2.1% unlikely to recommend) • ED information indicates 87.9% likely to return and 6.6% would not return • PHSO – Complaints about acute trusts 2014-15 identified Trust has a low conversion rate of 1.61 per 10,000 clinical episodes • 17% decrease in the number of complaints received when comparing 2015/16 to 2014/15 • No. of complaints responded to over 40 days improved in Q3 and Q4 • FFT report within March 2017 Quality Report shows increase in FFT scores in ED (91.6% would recommend) and an improvement over national FFT scores for ED, with an increased response rate also following SMS FFT introduction • National Patient Survey results brought to the Trust Board in March 2017. The Trust has performed significantly better in 12 areas in comparison to other large acute Trusts nationally and significantly worse in 2 areas. • The Trust has received fewer formal complaints in 16-17 than in previous years



Further assurance required

Health Groups are not meeting the Trust's standard of responding to complaints within 40 days – improvement seen in November 2016 of 78% of complaints closed within 40 days against target of 90% - need to continue improvement – remains an issue as at March 2017 Trust Board

National Patient Survey and PALS issues raised throughout the year highlight information, communication and discharge information as an area of improvement

Other key PALS concern is delays and waiting times – this also requires improvement (linked to BAF risk on NHS Constitutional Standards)

H – Honest, Caring and Accountable Culture												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H2	Chief Executive Cultural and Transformation Committee	0 risks	**<u>Cultural Transformation</u>** Staff do not continue to report an improvement in the Trust's culture (via the cultural survey and the national staff survey)	**25** **L5** **X** **S5**	• Professionalism and Cultural Transformation Committee • The Trust has implemented a Staff Advisory Liaison Service (SALS) where staff can report bullying incidents in a safe environment • FFT (staff) survey • Line Manager cultural briefing sessions • People Strategy which identifies 7 goals which will connect to individuals and service objectives • Health and Wellbeing Strategy 2016-18 launched	• Leadership programme to be launched **Lead** :L Vere **Completion**: 1.3.17 • PaCT Training V2 commenced **Lead** :M Purva **Completion**: 31.3.18 • Medical engagement programme in development – first session arranged 16 December 2016 **Lead** : K Philips **Completed first session Dec 16** • Values survey to be repeated in Jan 2017 **Lead** :L Vere **Completion**: 31.1.17 – completed April 2017	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**8** **L2** **X** **S4**	8 L2 X S4	Positive assurance • Barrett Values survey (To be repeated in Jan 2017) • New values approved (April 2015 Board) • New Trust goals in place (April 2016) • Positive feedback from GMC and Deanery following Junior Doctors review • PaCT training undertaken by 6,500 staff • Remarkable People campaign has doubled nurse recruitment numbers on last year • Equality and Diversity Steering group established • BME staff network commenced in Sept 2016 • FFT survey completed by 1600 staff (Q2 2016/17). Overall engagement score improved to 3.9 (out of 5). This would place the Trust in the top 20% of Trusts nationally. • Q2 staff FFT results received by the Trust Board November 2016 – increase in engagement and staff recommending treatment at the Trust • National staff survey received at March 2017 Trust Board – Trust engagement score increased to 3.77 and 2016 results had the Trust in the top 20% for 13 key findings, In the middle 60% for 7 key findings and in the bottom 20% for 12 key findings- significant improvement on previous years **<u>Further assurance required</u>** • Staff charges for catering and car parking are potential barriers to the identified risk. • Further action on Medical engagement programme • Stretch target set to have an engagement score of 3.88 • Still work to do on staff reporting bullying and harassment and

G – Great Performance and Reliability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
G1	Chief Operating Officer Performance and Finance Committee	6 risks • Capacity in Radiology (2) • Ophthalmo -logy delays (3) • Medical outliers (1)	**<u>NHS Constitution standards</u>** There is a risk that the Trust will not improve on its current TDA Oversight Category – Single Oversight Framework rating of 3 (requires support)	**16** **L4** **X** **S4**	• Increased management support • Emergency Care Improvement Programme (ECIP) support • IST support from NHSI for RTT • Action plans for emergency care recovery including ED • Action plan for RTT recovery • Action plan for Cancer recovery • Agreed trajectories with NHSI • SAFER bundles agreed and implemented. • Urgent and Emergency Care Programme established	• RTT is not expected to deliver fully against trajectories • Trajectories are being updated with commissioners for 18 weeks - year-end position with commissioners will impact on this area • **Lead:** Chief Operating Officer • **Completed – year-end position agreed with commissioners**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	4 L2 X S2	**<u>Positive assurance</u>** • Operating plan approved at April 2016 Trust Board • Some improvement seen in Q3 ED performance due to changes in pathways and resources • Q4 ED performance improvement and good position maintained over winter, particularly in comparison with the national picture • Full-year support funding given (70% on financial performance and 30% on waiting times performance) given significant increase in activity in-year with recognised impact on capacity • More work undertaken on capacity and demand during 16-17 to understand underlying waiting list positions and waiting list sizes needed for sustainable list sizes (work supported by IST team, reported to Trust Board March 2017) **<u>Further assurance required</u>** • Internal audit - Performance reporting/Management - April 2015 Significant assurance – corporate. Limited assurance – Health Group • Understanding impact of year-end financial agreement on trajectories • Internal Audit report identified limited assurance for medical staffing planned absence management (June 2015)

P – Partnership and integrated services												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
P1	Director of Strategy and Planning Trust Board	0 risks	**Sustainability Transformation Plan (STP)** There is a risk that the emerging plan will not be developed with sufficient Trust input and will herald changes to the provider sector that are either unrealistic or pose risks to the achievement of the Trust's long term goals	16	Ensuring meaningful engagement by Trust leaders in all STP development activities. Developing a close working relationship with the STP leadership team and providing support in the drafting of key STP documents and shaping the Acute Trust Provider Alliance CE0 now Chair and senior responsible officer for Hull and East Riding System Board	• Full understanding of activity and financial flows to support to support creation of new models of primary and community care • Impact of reconfiguration of urgent care services in North and North East Lincs. and sustainability of acute services at NLaG.	**16** **L4 X S4**	**16** **L4 X S4**	**16** **L4 X S4**	**16** **L4 X S4**	**12** **L3 X S4**	**Positive assurance** • Humber Coast and Vale STP document received by the Trust Board, as with all partner organisations, in December 2016 • Financial model for activity and income flows 2016 – 2021 built • Governance structure includes Trust in relevant membership . **Further assurance required** • Full impact of activity of the financial model across 5 years and between organisations. • STP project management only just starting to engage full stakeholder Boards in strategic discussions

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F1	Chief Finance Officer Performance and Finance Committee	4 risks •Surgery, Medicine and Clinical Support Health Groups all have high-rated risks relating to CRES identification and delivery (3) •Surgery HG risk of CQUIN delivery and income (critical care discharges) (1)	**Financial Deficit** There is a risk that the Trust will not resolve the financial deficit	**25** **L5** **X** **S5**	• Financial plan agreed with NHSI • Robust performance management arrangements with Health Groups • Contingency reserve • Close monitoring of CQUIN schemes	• The Trust is not delivering the planned level of elective activity at the end of Q1 **Lead:** Operations Director Surgery **Year-end income position agreed with commissioners** • Agency spend on medical staff **Lead:** Medical Directors **Completed – reported monthly at P&F** CRES programme and identification of further schemes **Lead**: Health Group triumvirates **Completion**: Ongoing	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**20** **L4** **X** **S5**	**20** **L4** **X** **S5**	**10** **L2** **X** **S5**	**Positive assurance** • Forecast break even position (at month 5) • Delivery of the financial plan at the end of quarter 1, 2016/17 and securing the first quarter payment from the Sustainability and Transformation fund. • Control total achieved at year-end but through the use of non-sustainable measures; the Trust goes in to 17-18 with an underlying financial deficit • STF funding received in full (70% based on financial performance) • CRES achievement 78% of target in 16-17 and gap covered by planned contingency **Further assurance required** • Closing the gap on the unidentified CRES • Health Group overspends • Agency spend by HGs • Winter costs • Under-trade against income plan

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F3	Chief Finance Officer Performance and Finance Committee	4 risks • Imaging equipment (2) • Ageing telephone system (1) • Decontamination equipment (1)	**Capital Programme** There is a risk that the capital programme is insufficient to meet all of the identified priorities and therefore has the potential to impact on the delivery of clinical services (both volume and quality of services).	**16** **L4** **X** **S4**	• Medical Equipment group meets regularly to prioritise programme for replacement • CRAC committee meets monthly and manages in-year emerging pressures • on the committee • Where clinical risk is deemed to be so significant arrangements are put in place by CRAC/EMC to provide service using alternative methods (e.g. IRT3 taken out of use)	Expenditure being managed within capital budget	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**8** **L2** **X** **S4**	**8** **L2** **X** **S4**	**8** **L2** **X** **S4**	**Positive assurance** • Monthly Performance and Finance Committee and updates to the Board • No incidents reported resulting in Serious Incident/RCA investigations. • Agreed plan in place for 2016/17 with Health group support. Risk assessment process built into our reporting structure. Capital committee to oversee this issue on monthly basis **Further assurance required**

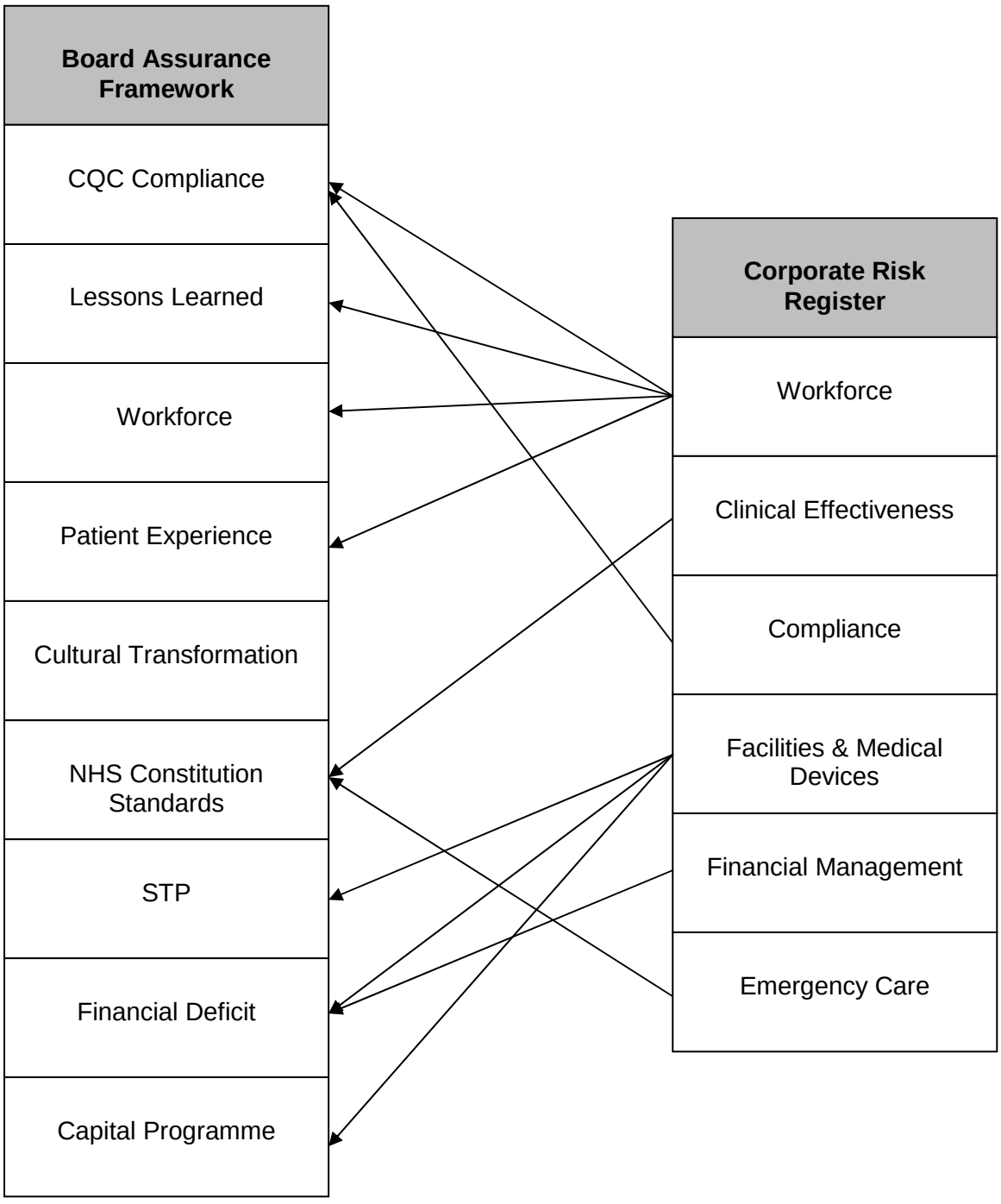
Appendix 2

Board Assurance Framework risks and Trust Board agendas

No	BAF Risk	Trust Board
Q1	CQC	Quality Report (monthly April 2016 – March 2017) Integrated Performance Report (monthly April 2016 – March 2017) Board Assurance Framework (April, July, October 2016, January 2017) Chair Opening Remarks (April, 2016 November 2016, February 2017) Chief Executive's Report (March 2017) Portfolio Board Report (May 2016) Infection Prevention and Control Annual Report (September 2016)
Q2	Lessons Learned	Portfolio Board Report (May 2016) Quality Accounts (June 2016) Quality Report (monthly April 2016 – March 2017)
Q3	Workforce	Nursing & Midwifery Report (monthly April 2016 – March 2017) Equality Objectives 2016 – 20 (April 2016) Transforming HEY's Culture – Progress Report (May and November 2016) People Strategy Report (April 2016) Chief Executive's opening Remarks - Success at the Apprenticeship Awards, (April 2016) Chairman's opening remarks - Junior Doctors Strike (July 2016) Workforce Race Equality Standard 2016 Return (July 2016) Guardian of Safe Working Hours – Junior Doctors in Training (September 2016) Modern Slavery Statement (September 2016) Responsible Officer Report (October 2016) Agency spend (November 2016) National Staff Survey (March 2017)
H1	Patient Experience	Patient Story (April 2016, November 2016, December 2016, January 2017, February 2017, March 2017) Corporate performance report (monthly April 2016 – March 2017) Quality Report (monthly April 2016 – March 2017)
H2	Cultural Transformation	Cultural Transformation – Progress Report (September and November 2016) National Staff Survey (March 2017)
G1	NHS Constitution	Integrated Performance Report (monthly April 2016 – March 2017) Emergency Department Report and Action Plan (April 2016) Operational and Financial Plan 2017/18, 2018/19 (December 2016) Winter Plan (November 2016)
P1	STP	Trust Strategy (April, May, July, September and November 2016) Sustainability and Transformation Plans (April, October and December 2016)
F1	Financial Deficit	Corporate Finance Report (monthly April 2016 – March 2017) Annual Accounts 2015/16 (May 2016) Standing Orders/SFIs (September 2016) Capital Developments Update (September 2016) Charitable Funds Annual Accounts (November 2016) Financial Plan 2017-18 (December 2016, January 2017, February 2017, March 2017)
F3	Capital Programme	

Appendix 3

Relationship between Board Assurance Framework and the Corporate Risk Register



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18 DRAFT

Meeting date	Tuesday 25 April 2017	**Reference Number**	2017 – 5 – 14.2
Director	Terry Moran - Chairman	**Author**	Carla Ramsay - Director of Corporate Affairs
Reason for the report	The purpose of this report is to provide a draft Board Assurance Framework for 2017-18 for discussion, input and agreement by the Trust Board		

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

1	**RECOMMENDATIONS** The Trust Board is asked to review the draft Board Assurance Framework as attached to provide input, review and agreement as a BAF for 2017-18 that describes the key strategic risks to delivery of the Trust's strategic goals and to form the assurance and strategic discussions of the Board including its committees for the forthcoming year					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: All	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board Assurance Framework details the key risks to achieving the organisation's goals. It is set annually Trust Board and has been populated as a draft document through a consultation process with Executive Management Committee (particularly for Corporate Risk Register risks that should be included against the BAF risk areas), through the Trust Board Committees and through Director input.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18 OUTLINE

1. PURPOSE OF THIS REPORT

The purpose of this report is to present the draft Board Assurance Framework for 2017-18 for review and agreement. It is presented at the Trust Board as a final draft to determine whether the BAF details what the Trust Board considers to be the key strategic risks to delivery of the Trust's strategic goals that will form the focus of assurance and strategic discussion by the Trust Board and its committees in 2017-18.

2. BACKGROUND

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

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

3. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

The Trust Board approved the Trust's strategy in April 2016. This set out seven long-term strategic goals for the organisation; the BAF is based on risks to achievement of these 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

The Trust Board agreed a process in April 2017 by which the BAF for 2017-18 would be drafted.

The BAF should capture the key strategic issues that would prevent the Trust from achieving the above seven strategic goals.

The BAF at Appendix A is a final draft. It requires the scrutiny and input of colleagues to ensure it identifies the correct risks, controls and mitigation. The BAF as attached has review by the Executive Management Committee (EMC) and Trust Board Committees (Quality, Performance and Finance and Audit) and is based on the key strategic discussions points from the most recent Trust Board and Committee meetings and a review of the year-end position of the 16-17 BAF.

The draft has been populated with corporate risks, where these link to draft BAF areas, from the Corporate Risk Register discussed by the EMC in April 2017, for the flow of corporate risks up to the BAF as part of the agreed 'ward to board' risk escalation process (Appendix B). For completeness, the Corporate Risk Register is attached at Appendix C. Reading across the Corporate Risk Register, the key corporate risks are currently of the following types:

- Staffing levels (relating to specific clinical specialties)
- CRES identification and delivery
- Equipment and supplies and resilience
- Service capacity/availability (linked to specific specialities)

- Specific Trust-wide operational clinical issues

The Corporate Risk Register is largely populated with risks relating to specific specialities, with some Trust-wide corporate risks also included. The Trust Board should provide its feedback as to whether any single risk or collection of similar risks raises a new organisation-wide risk that risks delivery of a strategic objective, and therefore should be placed on the BAF, or whether these risks are correctly captured as being part of, but not the only element of, a BAF risk area.

4. RECOMMENDATIONS

The Trust Board is asked to review the draft Board Assurance Framework as attached to provide input, review and agreement as a BAF for 2017-18 that describes the key strategic risks to delivery of the Trust's strategic goals and to form the assurance and strategic discussions of the Board including its committees for the forthcoming year

Carla Ramsay
Director of Corporate Affairs

April 2017

APPENDIX A

BOARD ASSURANCE FRAMEWORK 2017-18

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement		**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan to focus on a forward-looking Board, with a defined set of accountabilities at Health Group and corporate service level, which supports achievement and positive enforcement of behaviours and organisational culture	Clarity as to full set of accountabilities, deliverables and acceptable standards given the progress made in the last two years is still required and an understanding of cascade/ communication and acceptance of the same; this needs to be at Health Group leads and cascaded down, as well as support service leads					**4 x 1 = 4**	**<u>Positive assurance</u>** Receipt of detailed staff survey report and action plan – analysis of where work is needed to make further impact on staff engagement; positive messages from most recent results; best results for the Trust in a long time for the number of questions in the top 20 percent of Trusts **<u>Further assurance required</u>** Use of positive messages from most recent results to engender further confidence in staff engagement and staff feelings of job satisfaction

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There is a recurring risk of under-recruitment and under-availability of staff to key staffing groups There is a risk that the Trust continues to have shortfalls in medical staffing *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence	F&WHG: neonatal staffing SHG: theatre and critical care staffing Clinical Support HG: Radiology staffing to meet current and increasing demand Clinical support HG: blood transfusion trained staff Clinical Support HG: junior doctor levels	**5 (impact)** **5 (likelihood)** **= 25**	People Strategy in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment Remarkable People, Extraordinary Place campaign – targeted recruitment to staffing groups/roles Overseas recruitment and University recruitment plans in 17-18 Golden Hearts – annual awards and monthly Moments of Magic – valued staff	Need clarity as to what 'sufficient' and 'skilled' staffing looks like and how this is measured: 1) measured for daily delivery of a safe service (nursing measures already in place), particularly medical staff 2) measured in terms of having capacity to deliver a safe service per contracted levels 3) measured in terms of skills across a safe and high quality service					5 x 2 = 10	**<u>Positive assurance</u>** **<u>Further assurance required</u>** Delivery of medical staff revalidation – to give a measure of competent and skilled staff Use of appraisals across the Trust as a means of valuing staff – staff survey reports that appraisals are not fully valued across the Trust Measures to understand whether staffing body is 'skilled' and 'sufficient'

GOAL 3 – HIGH, QUALITY CARE

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

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18 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	Clinical support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: management of medical and medical outliers on Cedar Ward F&WHG: availability of paediatric surgeons inc. emergency care F&WHG: ophthalmology service issues F&WHG: breast screening equipment and breast pathology issues	**5 (impact)** **4 (likelihood)** **= 25**	Trajectories set against sustainable waiting lists for each service, which are more affordable to commissioners, and move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Work to resource and implement improvements that have demonstrated they work, such as the FIT model Capacity and demand work in cancer pathways	Consistency of operational performance (links to BAF1) Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories					5 x 2 = 10	**Positive assurance** **Further assurance required** Effectiveness of accountability framework and improved consistency of delivery Role of external agencies in supporting ED in particular (links to BAF7) – these may change during 17-18 as new service developments come on line external to the Trust and as the STP and placed-based plans look at service configurations

		further work										

GOAL 5 – GREAT SPECIALIST SERVICES

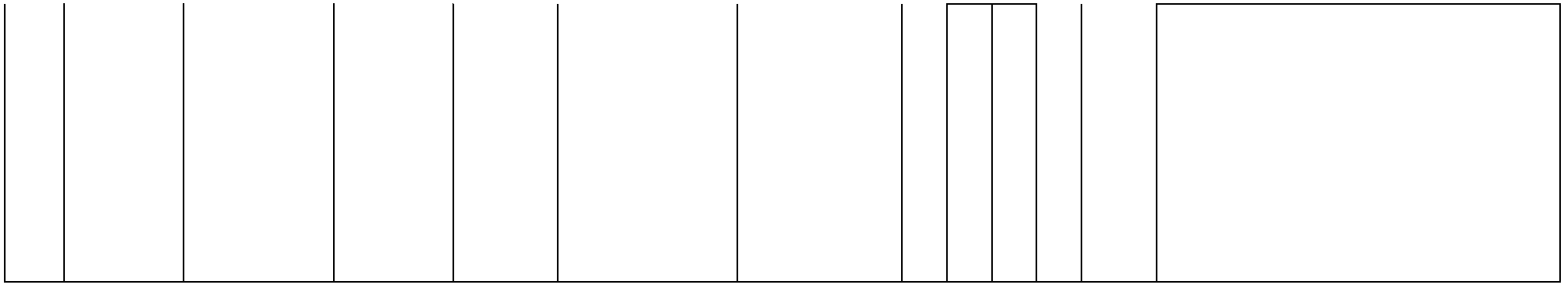
BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk*: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships *What could prevent the Trust from achieving this goal?* Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP		**4 (impact)** **4 (likelihood)** **= 16**	Trust CEO chair of Acute Trust STP workstream Trust has membership of relevant STP Committees and STP Board Trust has relationship with NHS England as specialised commissioner	Build in STP/ use of Board Development sessions to Trust Board agendas and work plan Need to understand role of Trust and regulators in this work, which may be additional to formal STP structures Understanding of specialised commissioning workplan to confirm Trust strategy on specialised services, including sufficient population base, financial standing of each service and whether Trust outcomes are of high enough quality					4 x 2 = 8	**Positive assurance** **Further assurance required**

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part		**4 (impact)** **4 (likelihood)** **= 16**	The Trust has the leadership of the local acute work stream in the STP The Trust is part of local placed-base plan developments The Trust is talking with partner organisations on opportunities in the local health economy The Trust has a seat on the two local Place-Based STP groups	The role of the public, NEDs and more widely, Trust Boards in understanding, developing or driving change through the STP Issue of clarity of strategy between STP, STP workstreams and place-based plans and Trust positioning within these					4 x 2 = 8	**Positive assurance** **Further assurance required**

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2017-18 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	SHG risk – risk to delivering sufficient CRES SHG risk – risk to income from critical care CQUIN, which continues in 17-18 Clinical Support HG – continuity of supplies during cashflow issues Corporate risk: telephony resilience Corporate risk: IM&T resilience	**5 (impact)** **4 (likelihood)** **= 20**	Detailed briefings to senior managers and Trust-wide to explain the level of challenge and responsibly throughout the organisation Budgets re-based with Health Groups for 2017-18, requiring accountable officer sign off, to take account of increase spend and cost pressures with a view to eliminating over-spends in 17-18 Strengthen governance around CRES planning and delivery, including a new escalation process up to the Trust Board Committee level (linked with BAF1) HG held to account on financial and performance delivery at monthly Performance reviews FIP2 diagnostic to understand Trust-wide potential for additional savings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities – may link to FIP2 diagnostic New governance structure with local system partners to try to manage demand	Embedding CRES delivery and financial management requirements in Health Groups, rather than await escalation of issues Assurance from local health economy on demand management Assurance over grip and control of cost base					5 x 1 = 5	**<u>Positive assurance</u>** **<u>Further assurance required</u>** Gap in CRES identification of £10m at start of 17-18 Introduction of service line reporting planned during 17-18 – assurance would be to see positive impact of SLR on understanding and reducing cost base



APPENDIX B - OPERATIONAL, CORPORATE RISK REGISTERS AND THE BOARD ASSURANCE FRAMEWORK

Ward to Board Escalation

1. Operational Risk Register (ORR)
Formed of: ward, speciality, divisional, health group (HG) and corporate functions (CF) risks
Managed by Health Groups/Corporate Functions via DATIX

At the point an operational risk reaches a score of 15 or above (high-rated risk), or a HG/CF believes it is beyond their management and/or is a trustwide* risk, it is escalated* to Operational Quality Committee (OQC) OR Non Clinical Quality Committee (NCQC) for consideration for adding to the Corporate Risk Register.
*e.g non-compliance with a national patient safety alert
*either via HG escalation report or through Risk Team

2. Corporate Risk Register (CRR)
Managed by OQC and NCQC, who decide what is recommended for acceptance on to the CRR and severity ratings etc.
Risk Team will send CRR to OQC/NCQC in form of monthly report.
Updates from committee to Risk Team who will update corporate risk register onto DATIX

Corporate Risk Register recommendations from OQC and NCQC sent to EMC for read-across of risks. EMC to: accept a risk on the Corporate Risk Register, or refer risk back for local management, or refer risk back for further detail

EMC to also consider each accepted Corporate Risk against the Board Assurance Framework (BAF) and determine whether any new Corporate Risk provides positive assurance or poses a risk to the achievement of the Trust's strategic goals. If so, the specific area of the BAF to be escalated to the Trust Board Quality Committee (for clinical goals) or to the Trust Board Performance and Finance Committee (for resource or performance goals) for review

3. Board Assurance Framework (BAF)
Managed by Trust Board. The BAF describes the key risks to achieving the Trust's strategic goals, and the positive assurance received by the Trust Board as to how these goals are being achieved
BAF to show the ORR and CRR risks linked to each BAF as part of report. Trust Board receives regular updates on progress with BAF, which will include issues escalated by the Trust Board's Quality or Performance and Finance Committees
Deputy Director of Governance and Director of Corporate Affairs to meet regularly to review the ORR, CRR and BAF and report on significant shifts on each register.

Linked to BAF risks on DATIX

Notes on implementation
Need to add to DATIX for ORR and CRR – approval and escalation process, action plans, control measures, assurance on controls
Ward to Board escalation is shown. Board to Ward communication achieved through HG and Corporate Function representation at OQC (clinical risks), Non-clinical Quality Committee (non-clinical risks) and EMC
HG and Corporate Functions need to share any updates back through governance structures.
Existing Corporate Risk Register to be used to 'group' together the types of risks within DATIX under the Trust's 7 strategic goals

APPENDIX C – CORPORATE RISK REGISTER (AS PRESENTED TO EMC ON 18 APRIL 2017)

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
11/04/2016 Surgery Health Group	Registered Nurse and ODP vacancies	Condition: Surgery Health Group has significant registered nurse and ODP vacancies across wards, theatres and critical care. Cause: Difficulties in recruitment, limited availability of bank and agency staff. University course now completed annually and ODP course now 3 year duration. 6 New Registrant ODP appointed from Oct 17 cohort Current Registered Vacancies: 92.7 WTE. 24 ODP [HRI 18] CHH 4] New Agency Restrictions: 1st April 2017 may reduce the availability of Agency Staff under new contract. Consequence: This has an impact on the level of care that can be provided to deliver safe patient care. Reduced bed capacity (closed beds)limited ability to provide theatre access for elective surgery.	1) Twice daily safety brief 2) Block booking of agency staff. 3) Current staff working overtime. 4) Band 7s, Matron and Divisional Nurse Manager all working clinical shifts to support. 5) Senior Nurse to complete a workforce review by August 2016 6) Reduction in elective bed base to support acute bed base 7) Focused nurse / ODP recruitment, European recruitment 8) 30 nurses from the Philippines commencing May 2017 9) Associate nurse role out registered and NMC phase 2 rollout will assist with theatres and critical care. 10 Secondment of theatre staff onto the ODP course [x3 applied] 11 Option to recruit to RN and support with anaesthetic nurse module
31/05/2016 Surgery Health Group	Inability to deliver appropriate efficiency schemes	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2016-17. Failure to deliver key financial targets could result in withdrawal of non-recurrent support funding. Delays in authorising expenditure due to additional controls presents clinical risk.	Devolved CRES targets/accountability. Challenge through monthly divisional performance meetings. Created CRES efficiency matrix tool to enable divisions to focus on key areas of opportunity. Introduction of regular operational and efficiency meeting in 2016-17. Commencing specialty level reviews and benchmarking process. Re-aligning financial/business support in the Health Group to support delivery.
05/10/2016 Surgery Health Group	CQUIN delayed discharges risk financial risk of not achieving 250k of income	To reduce delayed discharges from Adult Critical Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow and to remove delayed discharges of 4 hours or more within daytime hours. There is a national standard that all discharges should be made within 4 hours of a clinical decision to discharge being taken within daytime hours. The service have been unable to achieve the standard in Q1 and Q2 and is not on track to deliver the planned reduction of 30% delayed discharges by Q4. This will mean that there is a high risk of reduced patient experience and high risk to income (CQUIN payment) The Hull and East Yorkshire Hospitals NHS Trust have been categorised as a Tier 2 organisation and will on average gain £240,000. This is reliant on achieving the CQUIN in Q4.	An action plan has been devised to tackle any issues throughout Q3 and to ensure full compliance in Q4. Please see attached document. Quarterly reports are provided to health group board regarding the position.

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

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
18-Jan-2017 Breast Surgery	Shortage of Breast Pathologist	The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also. There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.	Negotiations are to be had with Nottingham to outsource some of the Pathology work. Trust grade doctors to support solitary Consultant Pathology to explore recruiting more Advanced Practitioners Pathology to explore recruiting more Consultants
16-Nov-2016 Gynaecology	Cedar Ward - Patients out with their own Specialty	The risk is the inability to provide safe and effective care to patients on Cedar Ward (Ward 30) within the Women's and Children's Hospital. The cause of the risk is the use of extra capacity for medical and surgical patients out with their own Specialty. The consequence of the risk is staffing levels are unable to provide quality care to Gynaecology inpatients and day cases. Loss of privacy and dignity for women utilising the day case area with bedded inpatients in there. The use of triage nurse from Friday night to Monday morning limiting the availability of this nurse for the Gynaecology inpatients.	Monitor on a daily basis and report to patient placement meetings to ensure patient safety is not compromised and that patient's are in the right place at the right time.
01-Apr-2015 Acute Paediatric Medicine	Inability to access dietetic reviews for Paediatric patients	condition - Lack of dietetic input to children as both inpatients and within MDTs cause - Substantive dietetic team reduced by 2/3 due to Maternity leave consequence - children do not receive a timely dietetic review	Service working with dietetic lead to look at robust future arrangements F&WHG paying for locum dieticians as available Dietetic team prioritising work
29-Apr-2016 Neonatal Services	Shortfall in Neonatal staffing	Condition - acute staffing shortfall and increased proportion of inexperienced staff over the summer period of 2016 Cause - Combination of retirement of experienced staff, maternity leave and the national shortage of suitably qualified nurses Consequence - potential inability to staff the full 26 cots on the neonatal unit leading to increase in in-utero transfers	The children's service have looked to mitigate by: - a) Rolling recruitment program b) Secondment of nurses from paediatric wards to NICU over summer period c) Suspension of all non-essential training d) ANPs, Neonatal Outreach and other staff undertaking additional shifts.
16-Dec-2014 Ophthalmology	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. This capacity risk has increased recently as a result of the time to treatment for patients requiring injections increasing to 10 weeks, rather than the recommended 48 hours. Additional causes to this risk are: 1. The significant expansion in the numbers of retinal diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service	On a weekly basis the service meet to discuss capacity and plans are made to create additional capacity where needed. The service are currently trying to recruit to a number of medical staffing posts. The posts are currently out to advert. A nurse practitioner was recently appointed to provide support to the nurse injection service.

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

Opened & Specialty	Title (Policies)	Description (Policies)	Controls in place
		made for these staff.	being implemented in Spring 2017
18/04/2017 Corporate risk Quality Governance and Assurance	Consent	There is a lack of robust systems for the updating, management and monitoring of consent forms within the Trust.	A Task and Finish Group has been set up to review consent, and to also work towards a Trust-wide solution of managing consent through Lorenzo
18/04/2017 Corporate risk Quality Governance and Assurance	Patient Safety Alert – Restricted use of open systems for injectable medication	The Trust cannot be assured it is compliant with this PSA, which needs to have actions completed by June 2017.	Meetings are being arranged with Governance, Pharmacy and HG staff to work on solutions towards compliance. Monitored at Operational Quality Committee
18/04/2017 Corporate Functions Planning	Emergency Preparedness	Whilst HEY NHST has undertaken Table Top exercises during 2016 (June, September and October) and participated in other Live exercises (Leeds Teaching Hospitals, July 2016 and Humberside Airport, December 2016), a Trust focused exercise last took place in 2007. This was highlighted to NHS E during the 2016/17 Core Standards annual assurance exercise	Amulti-agency Live Exercise is now planned for June 2017. A Project Group has been established which includes key Trust staff plus all emergency service partners and is co-ordinating the planning of the exercise. The exercise will test the Trusts response to a major contamination exercise and will involve 60 casualty volunteers. This is a medium risk for the organisation as participation in other live exercises and table top exercises minimises the risk. The risk can be removed once the June exercise has taken place.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

UPDATED RISK POLICY

Trust Board Date	2 May 2017		**Ref**	2017 – 5 - 15	
Director	Kevin Phillips – Chief Medical Officer		**Author**	Deputy Director of Quality Governance and Assurance – Sarah Bates Risk Manager- April Daniel	
Reason for the report	To present the Trust's updated Risk Policy for approval. The Risk Policy sets out the Trust's overall approach to risk and the policy through which the Trust manages risk. It is a key system of internal control. The policy has been updated with the agreed 'ward to board' risk escalation process, to link the risk register to the Board Assurance Framework, and has also been simplified by removing elements relating to incident management out in to a separate policy. This policy focusses purely on risk management.				
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to review and approve the Risk Policy.					
2	**Key purpose**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC OBJECTIVES**					
	• 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					✓
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** The policy has been reviewed at the Executive Management Board. The Audit Committee have ratified the document as a key control and governance mechanism within the organisation, and recommend approval by the Trust Board. In accordance with Standing Orders, the Trust Board approves the organisation's risk policy.					

CP362 – RISK POLICY AND PROCEDURES

Broad Recommendations / Summary

Effective risk management is the foundation on which the Trust delivers its objectives. It is the key system through which all risks; clinical, organisational and financial risks, are managed to ensure benefits to patients, staff, visitors and other stakeholders. This policy describes how staff will fulfil their role in risk assessment and the production of risk registers. All risks regardless of nature or origin will be managed via this process.

Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate risk control mechanism and most importantly, ensures that the agreed action is taken. The Trust has a legal requirement to give assurance that risks in the organisation are identified and appropriately managed.

CP362 – RISK POLICY AND PROCEDURES

1 PURPOSE / LEGAL REQUIREMENTS / BACKGROUND

This document sets out the arrangements in place to ensure that risk is managed in a systematic and co-ordinated way in order to:

- Demonstrate the way in which the Trust Board discharges its duty to have in place a policy of risk management
- Proactively identify, assess, prioritise, treat and monitor all risks;
- Provide a safe environment for patients, staff and visitors;
- Ensure that staff make an effective contribution to managing risks in their designated areas;
- Reduce risk to the lowest practicable levels within available resources;
- Achieve greater transparency in decision making enabling strategic investment decisions to be targeted to key risks;
- Ensure that risk management processes are adopted in the development of business plans;

The risk management systems and processes set out in this document will apply to risk in any context. The document applies to:

- All staff who are employed by the Trust, contractors, volunteers and individuals providing services on Trust property e.g. staff from other NHS organisations.
- Line managers who also have responsibility for co-ordinating risk management activities within their areas and for identifying any matters that might impact on other areas or the organisation as a whole
- Directors who have a specific responsibility for designated areas of risk management.

2 POLICY / PROCEDURE / GUIDELINE DETAILS

2.1 Risk Management Approach

Hull and East Yorkshire Hospitals NHS Trust has three levels of risk registers. The process for the three levels of risk is shown on the next page.

Strategic risks (Board Assurance Framework)

The risks that, if realised, would fundamentally affect the way in which the organisation exists or conducts its business. These risks may have a detrimental effect on delivery of the organisation's stratergies and thus achievement of its key business objectives. This risk realisation could lead to material failure, loss or lost opportunity. Strategic risks are detailed in the Trust's Board Assurance Framework (BAF), managed by the Trust Board and mapped against the Trust's strategic objectives.

Corporate Risks (Corporate Risk Register)

These risks are risks which sit between the operational risk register and the BAF. They are significant risks which may impact on the delivery of the BAF.

A rating of 15 or above is the trigger for the risk to be considered for acceptance onto the Corporate Risk Register (CRR). These risks are reviewed by the Operational Quality Committee or Non-Clinical Quality Committee and if added to the CRR through review by Executive Management Team if they are determined to be significant enough to require additional overview and challenge at a Trust-wide committee as they pose a risk across the Trust or to more than one part of the organisation..

The risk would still be managed and updated by the area it sits under, but it would appear on the corporate risk reports to these committees. These are recorded on DATIX.

It is important to remember that adding a risk to the corporate risk register is not transferring the responsibility of the management of the risk from the area it sits within. Acceptance onto the corporate risk register demonstrates that the operational 'risk appetite' has been reached, and the overseeing committee has decided that the risk requires a higher level of oversight and scrutiny within the Trust. Entry onto the corporate risk register also provides 'ward to board' escalation, as the corporate risk register will be reviewed alongside the Board Assurance Framework.

Not all high risks have to be accepted onto the corporate risk register.

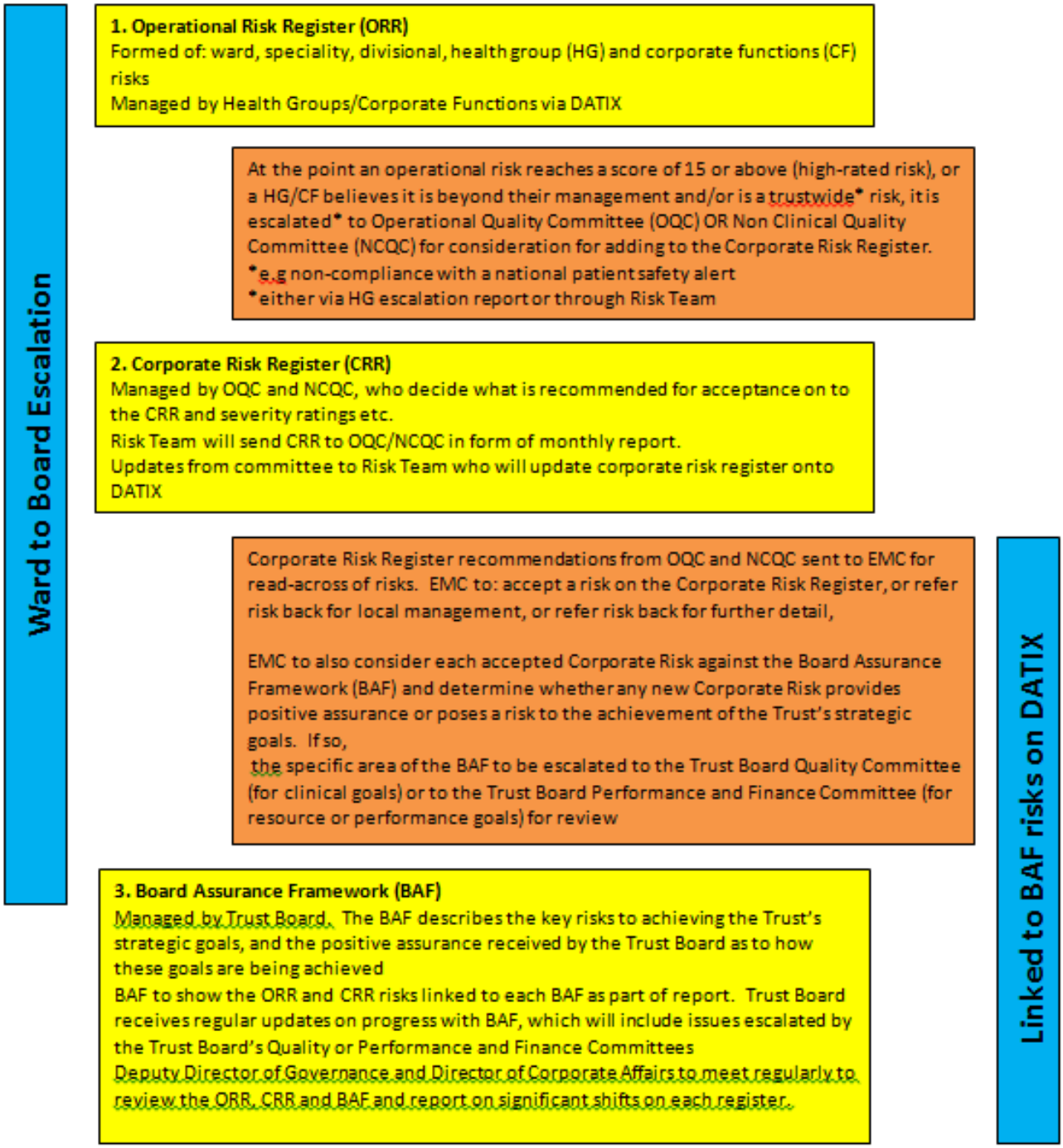
Operational risks
The risks associated with the key business processes at speciality/divisional/Health Group (HG) level or within corporate functions. These are recorded on DATIX and managed at a local level by HGs or corporate departments.

Risk Assessment Forms for local risk assessments
Risk assessment forms and advice are available from the Trust's intranet site in the 'Safety' section for when areas want to undertake a risk assessment of a particular hazard, or for assessments such as for pregnant staff members at work. The Safety Team are available for help and advice on both the process or individual assessments, and are contactable either by e-mail (Ian Stanley or Dave Bovill) or phone on either 468170 / 468169 @ CHH.

If any of these risk assessments are undertaken and a risk is identified that cannot be resolved with immediate or swift action, should be escalated through for consideration onto the operational risk register (DATIX).

All risks are categorised using the same matrix and framework. This can be found at **Appendix 3**.

Chart 1: Trust process for escalation from operational risk register onto corporate risk register and board assurance framework.



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2.2 Risk Assessment Process

2.2.1 Risk Rating

Effective risk assessment is a core element in good safety management systems. Information on assessing risk can be found at Appendix 4.

The risk assessment ratings are based on the risk matrix shown at Appendix 3, which is defined as

Likelihood X Severity = Risk Rating

Each risk should be assessed using this matrix. Within DATIX the risks are assessed using this matrix at three stages,

Initial risk rating - at the time the risk is identified and added to the risk register. This is with the existing controls in place.

Current risk rating- this score is reviewed and amended each time the risk is reviewed. This score should change as actions are added, situations improve or deteriorate

Target risk rating - this is the target, set at the point when the risk is added to the risk register and reflects the level of risk that the Trust is willing to accept. The risk action plan (risk treatment plan), alongside any gaps in controls that require addressing, should be aiming to reduce the risk to this level.

2.2.2 Owning and reviewing a risk on DATIX

For the risk register to remain a dynamic tool, risks need to be reviewed and updated on a regular basis. Risks should be owned by the area where the risk sits, and reviewed at an appropriate level. The timeframes depend on the type and rating of the risk. Operational risks should be reviewed as changes to the risk take place. However, minimum requirements are in place according to their rating as detailed below:

Low (≤6): A review date of no longer than 6 months must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date.

Moderate (8-12): A review date of no longer than 3 months must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date. The risk can be managed and monitored at a local level by the Line Manager.

The risk should be managed at a Divisional/Specialty/Department level by the Risk Owner.

High(≥ 15): A review date of no longer than 1 month must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date.

The risk should be escalated to the Health Group triumvirate/Directorate Level by the Risk Owner. The Health Group/Directorate risk registers will be reviewed by the Health Group/Directorate Governance committee to determine which risks should be escalated to the Corporate Risk Register (CRR).

2.2.3 Training & Education

For training on risk management please visit the Trust Education and Development site (HEY 24/7) or contact a member of Governance Directorate.

2.2.4 Implementation

The latest ratified version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

3 PROCESS FOR MONITORING COMPLIANCE

Report	Committee	When produced	Content
HG Escalation Reports	Operational Quality Committee (OQC)	Monthly	Items relating to governance, including escalating new high risks
Risk Report (clinical and non-clinical)	OQC	Monthly	**Risk** Incidents Serious Incidents Duty of Candour Central Alert Broadcast System
Risk Report (with a focus on non-clinical elements)	NCQC	Bi-monthly	**Risk** Incidents Serious Incidents Central Alert Broadcast System
Corporate Risk Report	OQC Non-clinical Quality Committee	Monthly Bi-monthly	Corporate Risk Register
Corporate Risk Report Linked with Board Assurance Framework	Executive Management Committee Executive Management Committee	Monthly Quarterly	Corporate Risk Register – review and agree content of CRR Review of CRR to escalate/mitigate corporate risks against BAF strategic risks
Board Assurance Framework	Trust Board	Quarterly	Board Assurance Framework including Corporate Risks

4 REFERENCES

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5 APPENDICES

Appendix 1 - Duties
Appendix 2 – Definitions
Appendix 3 - Risk Matrix and Framework for the Categorisation of Risk Issues
Appendix 4 – Additional guidance on the Risk Assessment Process

Document Control			
Reference No:	CP362	**First published:**	January 2016
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Document Managed by Name:	April Daniel	**Ratification Committee:**	Trust Board
Document Managed by Title:	Risk Manager		
Consultation Process			
Operational Quality Committee, Non-clinical Quality Committee, Executive Management Committee, Trust Board			
Key words (to aid intranet searching)			
129; CP129 incident; incident reporting; datix; SI; serious; serious incident; risk; risk team; 213; claims; claim; negligence; clinical negligence; liability; liabilities; NHSLA; EL; PL; EL/PL; 309; analysis; improvement; incidents; complaints; claims; harm; investigation; action; 350; CP350; board assurance framework; corporate; risk register			
Target Audience			
All staff	Clinical Staff Only	Non-Clinical Staff Only	
Managers	Nursing Staff Only	Medical Staff Only	

Version Control			
Date	**Version**	**Author**	**Revision description**
January 2016	V1	Mark Green	New policy - Replaces CP213 Policy For The Management Of Clinical Negligence, Liabilities To Third Parties And Property Expenses Scheme Claims, CP309 Analysis And Improvement Following Incidents, Complaints And Claims Policy, CP350 Serious Incident/Never Event Management Policy and CP129 Incident Reporting Policy
March 2016	V1.2	Mark Green	Amendment of investigation timescale from 14 days to 28 days. Approved at Operational Quality Committee, March 2016
April 2017	V2	April Daniel	Elements relating to incident management, lessons learned and aggregation of data removed. This is now a standalone Risk Policy.

Appendix 1 – Duties and Risk and Risk Management Responsibilities

The responsibilities for risk and risk management are at the levels of the organisation to which the risks belong. As such it is the responsibility of the Board and Senior Management Team to undertake the strategic and corporate risk management activities, and for the Health Groups and Directorates to undertake the operational, and project risk management activities. These responsibilities and the Trust risk management goals will be built into individuals' objectives and personal development plans.

Trust Board
The Trust Board is charged with approving the Trust's Risk Management Policy. The Trust Board is responsible for identifying and assessing the risks to the achievement of the strategic objectives and receiving assurance that these are being controlled. This will include receiving the Corporate Risk Register and developing and maintaining the Board Assurance Framework, which underpins the Statement on Internal Control.

Chief Executive
The Chief Executive has overall accountability for all governance and risk management arrangements, both clinical and corporate, within the Trust. To ensure that the fraudulent use of resources is appropriately reported and investigated.

Chief Medical Officer
The Chief Medical Officer is responsible for quality governance (including risk management, R&D, Clinical Audit & Effectiveness, Caldicott Guardian). Joint chair of Operational Quality Committee.

Chief Nurse
Chief Nurse is responsible for the implementation of the Trust's Quality Strategy across the Health Groups, in conjunction with the Chief Medical Officer. Joint chair of Operational Quality Committee.

Other Directors
Responsible for facilitating, co-ordinating and monitoring risk in relation to areas of specific responsibility, including development of a risk register, and for achievement of risk pooling standards for which they have lead responsibility. Chief Finance Officer is the Chair of the Non-Clinical Quality Committee.

Non-Executive Directors
In addition to scrutinising risk management arrangements at the Trust Board, non-executive directors have specific responsibilities via the Trust Board Quality, Audit and Performance and Finance committees.

Deputy Director of Quality Governance and Assurance
The Director of Governance and Corporate Affairs is the nominated Director with responsibility for developing and overseeing the organisation's Risk Management Policy.

Director of Corporate Affairs
Responsible for the management of the Trust Board Assurance Framework.

Audit Committee
The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust in support of its objectives and activities. The existence of an independent committee of Non-Executive Directors is a central means by which the Board ensures effective internal control arrangements are in place.

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

Health Group Triumvirates
Lead responsibility for the implementation of the Trust's risk management policy and framework within the Health Groups and ongoing monitoring. Responsible for bringing to the attention of the Operational Quality Committee the risks and control measures identified in the Health Group's risk register.

Quality Governance and Assurance Directorate
The Quality Governance and Assurance Directorate is responsible for the central co-ordination and management of risk management.

The Quality Governance and Assurance Directorate is also responsible for providing training and training packages, education and awareness on risk management issues relating to risk and safety, and providing advice and practical assistance to Health Groups /Directorates, Specialty Teams and departments on risk management issues. In addition, the department is responsible for the provision of information on claims and incidents to Health Groups and Trust Committees.

Risk Manager
To support the Director of Governance in the implementation of the Risk Management Policy

Trust Safety Manager
To alert the Trust to any risks relating to Health and Safety. To make relevant reports to external bodies to meet the Trust's Statutory obligations e.g. Health & Safety Executive.

Line Managers / Departmental Heads
Line managers are responsible for the on-going identification and assessment of risk and that action plans are developed and implemented. Line managers are also responsible for ensuring that all staff are informed of and understand their responsibilities with regard to effective risk management. This will include reporting of incidents and attendance at mandatory and risk management training. This will enable risk management to become part of everyday activities so that lessons are learned from the investigation of complaints, and incidents, that changes are made as a result, and that appropriate monitoring and audit programmes are in place. Line managers are responsible for ensuring that risk is discussed at a ward (or equivalent) meeting and that any unresolved risks are reported to Specialty/Divisional/ Health Group/Directorate meetings as appropriate and are recorded on the risk register. This will include identifying risks that might impact on other areas or the organisation as a whole.

Quality and Safety Managers and Quality Facilitators
Each Health Group has a team of either/and Quality and Safety Managers and Quality Facilitators. This team is responsible for delivering cascade training in relation to risk management to the Health Groups. In addition to this, the team are responsible for ensuring that the Health Group is supported in meeting central corporate requirements.

All Staff
Risk is inherent in everything that the organisation does. Therefore, <u>all staff</u> have a duty to maintain a safe environment, safe systems of work and practices in order to deliver high quality services. The identification and reporting of hazards, incidents and near misses, which might affect themselves or others is an integral component of this duty. Every member of staff will be aware of how to report hazards and incidents that exist within their area, and how these will be dealt with.

Appendix 2 – Definitions

DEFINITIONS

Risk
Risk is the chance of something happening that will have an impact on day to day activities or the wider goals, objectives or strategies of the organisation. Risk is measured in terms of severity and likelihood.

Risk Management
Risk management is the process by which risks are identified, prioritised, treated and monitored. It is the process of identifying risks which could prevent successful achievement of strategic and operational objectives. It is a proactive approach which involves:

- addressing all activities of the organisation
- identifying barriers to the achievement of aims and objectives
- assessing these barriers in terms of severity and likelihood
- taking action to eliminate the risks that can be eliminated
- acting to reduce the impact of the risks that cannot be eliminated
- putting into place mechanisms to absorb the consequences of residual risks that remain e.g. insurance, pooling schemes

Risk Register
A risk register is a repository of risk information that enables the organisation to understand its risk profile. This Trust uses DATIX as its risk management system. It is a dynamic and living document which is populated through the organisation's risk assessment and evaluation process. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. The risk register contains both operational and strategic risks. This allows significant risks to be highlighted and risk treatment plans to be developed.

Hazard
A hazard is something that has the potential to cause harm, damage or loss. A hazard can develop over time and can often lie dormant before combining with other factors to result in an incident or near miss.

Strategic Risk
Those risks that could prevent the Trust meeting its strategic objectives. These are managed via the Board Assurance Framework. E.g.: *Failure to achieve strong, respected and impactful leadership throughout the organisation.*

Corporate Risk
These are high rated risks which have reached the Trust's risk appetite and the Trust feels that these risks may impact on the delivery of the Trust strategic objectives, and so requires a higher level of oversight and scrutiny through the Trust committee structures.

Operational Risk
A risk arising from execution of the Trust's business functions. It is a very broad concept which focuses on the risks arising from the people, systems and processes through which a company operates. In practice, these will be the day-to-day risks placed onto the Trust's risk register at

specialty and divisional level. E.g.: *Ageing hematology analyzers threaten the necessary throughput within Pathology.*

DATIX
DATIX is the Trust's risk management database. It is where the operational and corporate risk registers are held.

Initial Risk Score
Inherent risk before controls have been applied.

Residual Risk Score
Current risk, taking into consideration the existing control measures

Gaps in Controls
Where are we failing to put controls in place? Where are we failing to make them effective?

Target Risk Score
Projected, realistic and anticipated level of risk to be achieved by the end of the current financial year.

Risk Appetite
Every organisation will have a different perception of the level of risk it is comfortable with and needs to be clear about what is and is not acceptable. An organisation's risk appetite is defined as 'the amount and type of risk that an organisation is prepared to seek, accept or tolerate.'

Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but may have more appetite for opportunity such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation.

Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board.

Control Measures
An action undertaken to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

Gaps in Control
Where there are gaps in the existing controls in place to manage the risk.

Assurances
The information we have to know and understand that the controls in place are being implemented and are effective. E.g monitoring reports to committees, or confirmation of work being completed

Gaps in Assurance
Where there are gaps in assurance, i.e. we do not have the evidence to support that the controls are in place and effective.

Risk Control
A score of 1 to 5 to determine

1 – Risk is fully under control
2 – Risk is adequately controlled

3 – Action to control risk adequately has started
4 – Action to control risk is agreed but no action started
5 – No actions to control risk identified.

Appendix 3 - TRUST'S APPROVED RISK MATRIX / FRAMEWORK FOR THE CATEGORISATION OF RISK ISSUES

Risk Rating Matrix:

To determine the overall **risk** rating, the **severity** should be multiplied by the **likelihood**

		LIKELIHOOD				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
SEVERITY	1 Negligible	1 Very low risk	2 Very low risk	3 Very low risk	4 Low risk	5 Low risk
	2 Minor	2 Very low risk	4 Low risk	6 Low risk	8 Moderate risk	10 Moderate risk
	3 Moderate	3 Very low risk	6 Low risk	9 Moderate risk	12 Moderate risk	15 High risk
	4 Major	4 Low risk	8 Moderate risk	12 Moderate risk	16 High risk	20 High risk
	5 Catastrophic	5 Low risk	10 Moderate risk	15 High risk	20 High risk	25 High risk

Example:

If a severity of 2 is multiplied with a Likelihood of 3 then you would have an overall risk rating of 6 - Yellow with a review date of 6 months i.e.

S		L		
2	x	3	=	6 Yellow - Review in 6 months

Guidance on Severity	Staff	Patient
Negligible	No / negligible injury or adverse outcome	No / negligible injury or adverse outcome
Minor	Lost time up to 3 days	Minor cuts / sprain / strain requiring first aid, short-term distress or change in condition requiring medical review, but no follow up treatment
Moderate	Lost time up to 4 weeks	Fracture / injury likely to cause impairment, distress lasting for a number of days, change in condition requiring continuing treatment, or increased length of stay
Major	Long term sickness over 4 weeks	Injury likely to cause permanent incapacity involving one or more individuals e.g. major nerve lesion, or injury involving major internal organs
Catastrophic	Death of one or more individuals	Death of one or more individuals

Guidance on Likelihood	
Rare	Cannot believe that this will ever happen
Unlikely	Do not expect will happen, but small chance
Possible	May occur occasionally
Likely	Likely to occur on many occasions
Almost Certain	Expected to occur in most circumstances and is a persistent issue

Risk rating	Risk scenario	Guidance
1 – 3	Very low risk	• No further action needed.
4 – 7	Low risk	• Yellow risks are generally easily resolved locally at ward or departmental level. • Report unresolved risks at specialty or equivalent meeting. • If risk unresolved at specialty meeting, report to Divisional/Directorate meeting. Identify trends.
8 – 12	Medium risk	• Management action needed to reduce risk, as soon as reasonably practical. Amber risk issues should be investigated by the manager responsible for the service. • Report unresolved risks to Divisional/Directorate meeting. Identify trends.
15 – 25	High-risk	• High-risk scenario. Immediate action needed. High risks need to be escalated to senior management in order that they are considered for inclusion onto a corporate risk register.

Framework for the categorisation of risk issues

Table below gives some examples that most appropriately describes the severity and frequency of the identified risk issue. Use this information to calculate the category of risk on table above.

TABLE 1: SEVERITY – Likely outcome of risk issue

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices	Multiple breeches in statutory duty Prosecution Complete systems change

		rating if unresolved		Low performance rating Critical report	required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix 4 – Additional guidance on risk assessment

Appendix 4.1 – How to assess a risk

This section describes the types of risks that may be identified and the overall Trust approach to risk assessment. The Trust follows national guidance on risk assessment processes. There are 5 steps as shown below:

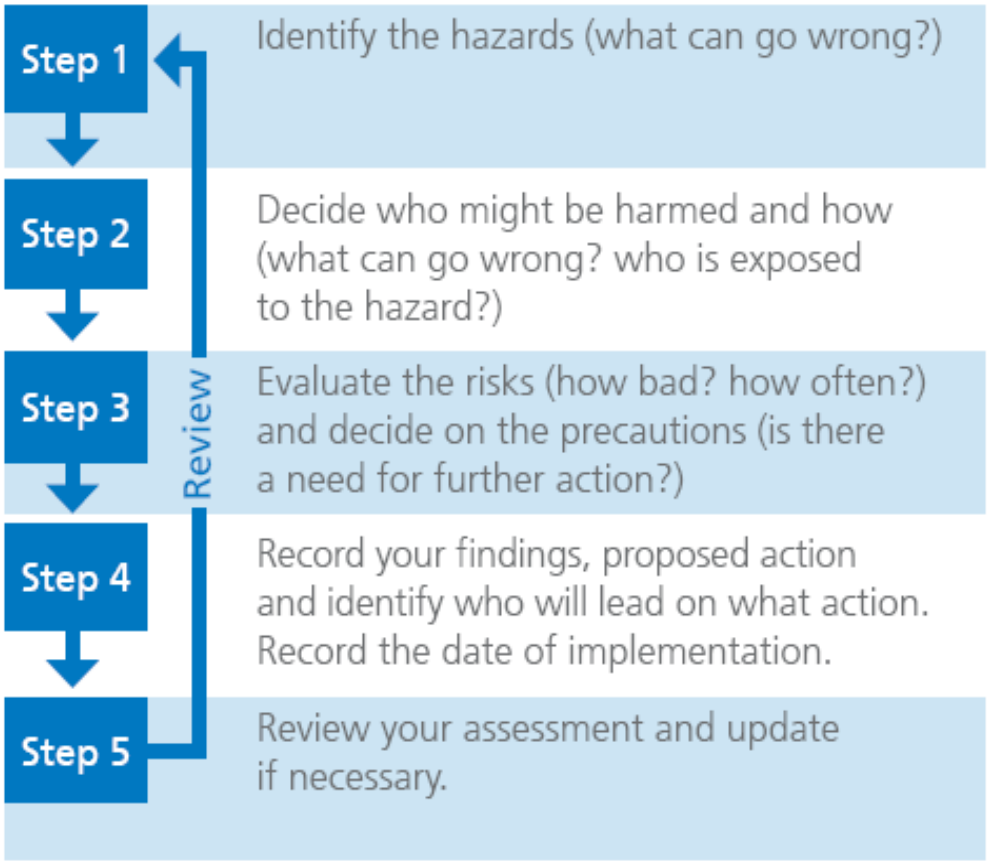


Figure 3: *Five steps to risk assessment*

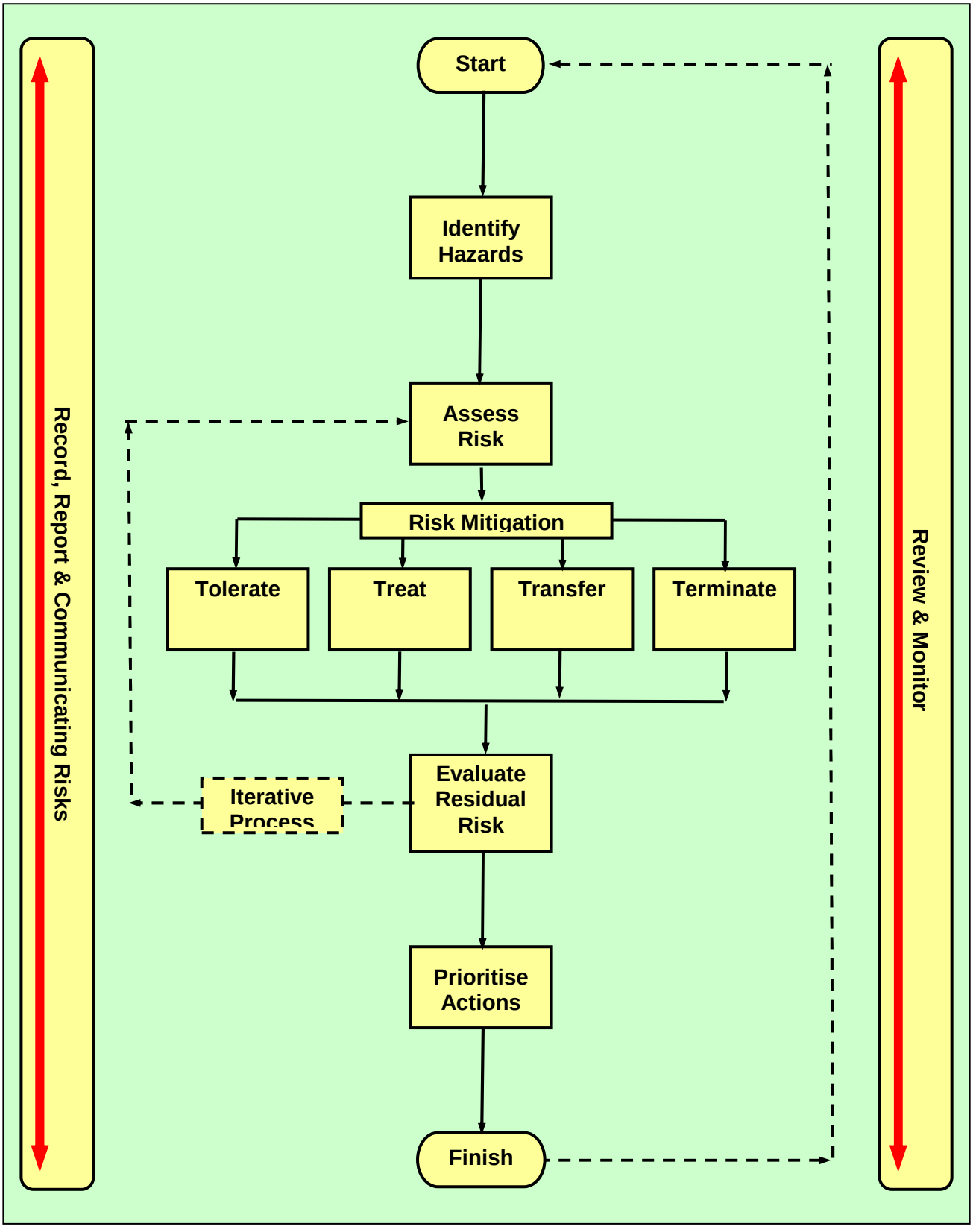
Identify the hazards (what can go wrong?)
To prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong. Consider the activity within the context of the physical environment, and the culture of the organisation and the staff who perform the activity.

Decide who might be harmed or what the impact will be on the organisation (assets, environment and reputation) and how. Take into account things that have gone wrong in the past and near-miss incidents.

Learn from the past, e.g.
1. Walk around the workplace and talk to staff.
2. Map or describe the activity to be assessed.
3. The risk assessment may require a multi-disciplinary team to ensure that all areas of the activity or task to be assessed are considered.

Evaluate the risks (how often? how bad?) and decide on the precautions (is there a need for further action?)
Consider both the likelihood (how often?) and severity (how bad?). Is there a need for additional action? The law requires everyone providing a service to do everything reasonably practical to protect patients and staff from harm.

1. Identify the **current** controls/precautions that are in place to prevent the risk from causing harm or loss.
2. Use the Risk Matrix Tool (Appendix 3) to grade the risk.
3. Decide whether further precautions need to be taken to reduce the risk and if action is required, determine what changes need to be made.
4. Re-evaluate the risks assuming the precautions (controls) have been taken (to check the expected impact of the proposed changes).



Appendix 4.2 Guidance on completing Risk Registers

4.2.1 Risk Register monitoring includes:

- Ensuring that risk descriptions convey risks clearly and concisely.
- Making sure that risk descriptions describe both the hazard and the impact of the risk.
- Ensuring that the controls described on the risk register are current and relevant to the risk.
- Identifying the source of the risk on the risk register (e.g. incident report, risk assessment, claim, complaint, internal/external audit, staff or patient feedback, gap analysis against external guidance and policy, etc).
- Training staff to use the Risk Assessment Procedure to grade risks; in particular using the severity descriptions to grade risks.
- Ensuring that action plans to address risks are appropriately described.

4.2.2 Objectives for completing risk registers

The key objectives for completing risk registers are listed below:

Ensure that risks are described succinctly and include a description of the hazard, and risk or issue in terms of impact, i.e.

- Impact on the safety of patients, staff or public (physical/ psychological harm)
- Adverse publicity/ reputation
- Business objectives/ projects
- Business/Service interruption Environmental impact
- Finance including claims
- Quality/ complaints/ audit
- Human resources/ organisational development/ staffing/ competence
- Statutory duty/ inspections, etc.

4.2.3 Recording a risk

When adding a risk to DATIX you will need to record a risk title and risk description

Risk Title

The title should accurately describe the 'risk' not the situation. Some examples of good versus poor risk titles are shown in Table 1.0 on the next page.

Risk Description

To enable a consistent approach to defining risks staff should consider using a standardised description of risk. The recommended description comprises a clear expression of the event(s) with cause and effect statements, for example:

• *There is a risk that… [an event]*
• *The risk is caused by… [specific or generic]*
• *The effect (and consequent cost/patient safety/performance impacts) will be…*

This is also known as the 3 C's – Condition, Cause & Consequence

Table 1.0: Examples of good versus poor risk title

Poor risk title	Good risk title
Surgery to incorrect site	Lack of Trust-wide safe site surgery protocol leads to increased risk of surgery to incorrect site leading to harm to patients
Recruitment and retention of staff	Failure to recruit cardiac ICU nurses leads to over-reliance on bank and agency staff resulting in increased staff costs leading to increased financial risk
Unable to meet referral wait target	Lack of available bed capacity causes the Trust to not achieve waiting target resulting in increased financial loss.
Also avoid in risk description writing an essay and combining lots of risks in one description…	
RISK OF ELECTIVE CANCELLATIONS - including short-stay patients/extended periods in recovery/A&E breaches due to delayed discharges. Reasons include TTAs not being written up in advance, lack of predicted discharge dates, outliers from other specialties and poor communication between nursing and medical teams. Other risks include Infection outbreaks reducing bed capacity available for non-elective and elective demand.	This risk description has several risks embedded within it. Describing risks in this way makes it impossible to apply the severity of risk descriptions in the Risk Assessment Procedure accurately. Consequently, the organisation does not have a clear understanding of the component parts of the risk and how urgently they need to be addressed. So it is important to avoid embedding several distinct risks in one risk description.

Source of risk

Identify the source of the risk on the risk register. Some examples of sources of risks are shown below:

- Risk assessments
- Incident reports
- SI investigations
- Staff feedback/observations
- Complaints and claims
- Gap analysis against national policy or external standards
- External/Internal/Self audit
- Walk arounds
- Business Case Analysis

NB: Identifying the source of the risk is essential to ensure that the organisation is capturing risks from a range of different sources.

Controls in place

Describe the controls **currently in place** to manage the risk. It is important to note the following two points when describing risk controls; (i) every control should be relevant to the risk you have described and actually in place at the time of writing, so ask yourself the question 'does this control materially impact on the risk? and, (ii) controls should be restricted to things that are **already in place** to mitigate or manage a given risk.

Table 2.0: Distinguishing between Controls, Assurances, and Action Plans

Key learning point
Sometimes staff confuse controls, assurances and action plans when completing the risk register. i. Controls are things that are **already in place** to manage the risk. ii. Assurances are the evidence that you use to demonstrate that the controls/systems currently in place are effective. ii. Action Plans describe how, going forward, you plan to reduce or eliminate the risk or gaps in controls and/or assurances you have described.
Consider the following illustrative example: **Risk:** Action plans to reduce clinical coding problems do not deliver expected financial gains **Controls:** (i) Redesign and restructure of clinical coding function completed (ii) Coding audit software to measure financial gains purchased (iii) Contract in place with an external software house to provide comparative analysis of coding data (iv) Clinical coders recruited and in place (v) Clear coding definitions set against tariff **Assurances:** Performance pack (depth of clinical coding report) reported to Operational Quality Committee and Trust Board. **Action plans:** Implement the clinical coding strategy, including measurement metrics so that improvements can be evidenced over time.

When describing assurances on the risk register remember that an assurance is evidence that the controls/systems that are in place to control the risk are working effectively. Assurances can be either internal or external. Internal assurance can be provided by describing the key performance indicators and monitoring arrangements that are in place evidencing that a control is working. For example, KPI's relating to coding activity, Quality Scorecard monitoring, self-audits which demonstrate policy compliance etc.

External assurance provides independent evidence that a control is effective and therefore generally provides a stronger source of assurance to the Trust Board. Examples of external assurance include Internal Audit Reviews, external audits or reviews (CQC, NHSLA, etc.), evidence of compliance with other external standards etc.

Action plans and review dates

Once the risk has been scored, produce an action plan that clearly describes what actions will be taken to reduce or manage the risk. When reviewing risks that appeared on your last risk register submission it is important to ensure previous action plans are reviewed and updated on the registers. Completed or mitigated risks will be archived.

Action plans should have a nominated ‘risk lead’ for every action and a ‘review date’, i.e. a date upon which progress towards completing the actions will be reviewed. Hence the review dates associated with new action plans should project forwards from the date that the risk register is completed. Review dates are important because they enable the organisation to monitor progress towards reducing the risk over time.

Closing a risk

When a risk has been reduced or eliminated through the successful implementation of action plans, the following process should be applied to archive it.

The current risk rating should be amended to illustrate that the action plans have controlled the risk. That is to say, the current risk rating should be low green (1-6) prior to contemplating the archiving of a risk from the risk register. Close the risk by adding the date of closure to the ‘Date Closed’. The risk is still available for review if needed but is now archived.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE

Meeting Date:	27 March 2017	**Chair:**	S Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Workplan – The Committee discussed how assurance would be received regarding Health Group Cash Releasing Efficiency Schemes
- Mr Bond updated the Committee regarding the Trust's Financial Plan
- Performance – ED performance was improving. Extra triage staffing was in place and working well
- RTT – performance 85.55% against a target of 92%. List size had increased.
- 52 week waits – 6 patients with incorrect clock stops
- Cancer performance – remains challenging – ICU capacity and diagnostic waiting times being the main concerns
- Finance – At month 11 the Trust was reporting a deficit of £2m which was in line with the plan.
- CRES – Month 11 showed a £4.3m shortfall against the plan of £17.3m
- Agency Report – Agency spend at month 11 was £12m
- Financial Improvement Planning – Executive Directors meeting with external company for the initial presentation of the programme
- Mr Bond updated the Committee regarding the Trust's capital planning

Decisions made by the Committee:

- Review of 52 week waiters – Analysis of the type of patients and any themes or trends emerging.
- Formal CRES escalation process to be developed

Key Information Points to the Board:

- The Trust is working through issues relating to IR35 and Personal Service Contracts, the legislation for which changes on 6th April 2017.

Matters escalated to the Board for action:

Matters referred to other Board Committees:

A recent peer review of the service had raised concerns about the provision of sufficient hyper acute beds on the Stroke Unit. This item would be referred to the Quality Committee for further review.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE MINUTES
MEETING HELD 27 MARCH 2017

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
IN ATTENDANCE:	Mr S Nearney	Director of Workforce & OD
	Mrs M Veitch	Programme Director for Urgent and Emergency Care
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Assistant Trust Secretary

No.	Item	Action
1	**APOLOGIES FOR ABSENCE** Apologies were received by Mrs Ryabov, Chief Operating Officer	
2	**MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2017** The Chair proposed the following amendments: • Page 4, first paragraph – amendment of the word "starring" to "starting". • Page 4, first paragraph, 3rd sentence – to insert Income & Expenditure between "with" and "reserves". • Page 6, item 8, first paragraph, final sentence to read, "There had been a cohort of patients without a ticking clock, that had now been validated", • Page 8, second paragraph to be amended to – "The Chair thanked Mr Vize for providing this detailed understanding of the issues. The Chair emphasised today's discussion is to show support to the service in managing these issues and reflected that similar pressures are being seen elsewhere in the region." Following these alterations, the minutes were approved as an accurate record of the meeting held on 27 February 2017.	
3	**ACTION TRACKING LIST** **Hospital Improvement Plan –** Mr Hall to write to Mrs Joyce to invite her to the next meeting and clarify the items to be discussed. **Regional position regarding agency spend** – Mr Nearney advised that he would bring a report to the June 2017 meeting. **Wait for first clinician** – Mrs Veitch advised that the Hospital Improvement Planning Team had produced a report showing outcomes of PDSAs regarding the wait for first clinician. Mrs Veitch agreed to share this with the Committee members. **Outpatient Reviews due to Clinical Research** – Ms Ryabov to provide the Committee with the information.	**SH** **SN** **MV** **ER**
4	**WORKPLAN 2016/17** The Committee reviewed the workplan and agreed that a different	

approach to Health Group attendance at the Committee was required. CRES was discussed and each Health Group would report firstly to the Executive Team and then to the Performance & Finance Committee if any issues were not resolved.

5 MATTERS ARISING

Mr Bond advised that the Financial Plan for 2017/18 had reserves totalling £22.8m and the executive team were currently validating them. The majority of the reserves had been agreed.

6 FINANCIAL PLAN 2017/18 UPDATE

Mr Bond updated the Committee regarding the negotiations relating to the 2017/18 financial plan. There were a number of options to review and Mr Bond sought approval to negotiate the most advantageous plan for the Trust whilst taking into account the risks and ensuring delivery was achievable.

The Non Executives were clear that the Trust should not sign up to a plan that wasn't deliverable.

Resolved:

The Committee received the update and noted the risks involved.

7 PERFORMANCE REPORT

Mrs Veitch presented the report and highlighted that the Emergency Department 4 hour performance had been 82% in February 2017 against a target of 94%. She reported that the figure had improved to 94% in March 2017 due to the embedding of the Emergency Care programme. She advised that overnight working was still an issue but day shifts seemed to be on top of things. Social care admissions were being dealt with quickly and the discharge lounge was being used when patients were not admitted. Social care patients were still a concern as social care was covered between 9am and 5pm but there was less cover out of hours.

Mr Gore asked if this performance was sustainable and Mrs Veitch advised that numbers of patients was still high but the clinical teams were engaged and new processes working well. Failed discharges were causing frustration but the new bed template and more accurate bed state were helping to sustain good performance.

Referral to treatment times performance was at 84.5% against a target of 92%. The list size had increase by 4000 patients. Mrs Veitch advised that a 'confirm and challenge' review was taking place to assess the situation and develop a recovery plan. There was a discussion around ICU capacity and access to theatres.

There had been 6 x 52 week waiters in month and admin staff were to received further training to reduce occurrence of 'pop up' patients.

Cancer targets still remained challenging with a number of breaches mainly due to lack of ICU capacity and increased demand on diagnostics. Mrs Veitch advised that more engagement with the GPs was required and Mr Hall requested further information regarding the

% of diagnostic referrals from GPs.

Mr Gore expressed his concern regarding the stroke performance target. Mr Bond advised that a recent peer review of the service had raised concerns about the provision of sufficient hyper acute beds on the Stroke Unit. This item would be referred to the Quality Committee for further review.

Resolved:
The Committee received the report and agreed to refer the issues raised by the recent peer review to the Quality Committee. **SH**

8 CORPORATE FINANCE REPORT

Mr Bond reported that at month 11 the Trust was reporting a deficit of £2m which was in line with plan. This meant that the Trust would be successful in receiving quarter 3 and 4 STF monies.

The Health Groups were overspent by £13.2m, the position was offset by an improvement in the corporate position. The non delivery of CRES was still an issue with the anticipated outturn being £4.4m which is 23% below plan. The Trust would not deliver its RTT recovery plans and was forecasting a deficit of £5.6m against the planned activity targets.

The Trust was still on plan due to releasing reserves and only had £0.97m left to cover the remainder of the year.

Mr Bond expressed his concern at the BPPC performance which was 20% by value. He advised that this was very low and could incur late payment interest in some cases.

Mr Bond highlighted the fact that the Surgery Health Group income and expenditure position had deteriorated in line with plan forecast. Medicine, Clinical Support Services and Family and Womens Health Groups had all seen in-month deteriorations in excess of forecast which raises concerns over the overall level of financial grip and control at Health Group level.

Mr Bond also reported that the 'Getting it right first time' (GIRFT) follow up review was being carried out in orthopaedics and would report back to the next meeting the outcomes.

Resolved:
The Committee received the report and agreed to receive GIRFT review outcomes **LB**

8.1 – CRES 2016/17

Mr Bond presented the report and advised that at month 11 the Trust had delivered £13.1m of savings against a year to date target of £17.3m. He reported that the CRES programme is key to enable the Trust to deliver its break even position.

Resolved:
The Committee received the report.

8.2 – AGENCY REPORT (FINANCE)
Mr Nearney presented the report which was showing a spend of £12m at month 11 with a forecasted year end figure of £13m. Controls had been put into place to challenge all requests for agency admin and clerical staff as a further measure to reduce costs.

There was a discussion around working through issues relating to IR35 and Personal Service Contracts, the legislation for which would be changing on 6th April 2017.

Resolved:
The Committee received the report and noted the issues relating to IR35 and Personal Service Contracts.

8.3 – PATIENT LEVEL COSTING
Mr Bond presented the report which highlighted patient level costing outputs being utilised in a number of clinical areas. Mr Bond advised that model would be continually improving but relied heavily on clinical buy in and a clinical champion was being sought.

Resolved:
The Committee received the report and agreed to receive updated information on a regular basis. **LB**

8.4 – CRES ESCALATION PROCESS
Mr Bond reported that a formal escalation process had been developed which would mean that the Health Groups would firstly discuss any shortfalls with the Executive Team at the performance meetings. Any issues not resolved following the meetings would result in escalation to the Performance & Finance Committee for further scrutiny.

8.5 – FINANCIAL IMPROVEMENT PROGRAMME WAVE 2
Mr Bond presented the report which outlined a financial improvement programme managed by NHS Improvement. He advised that the Executive Team would be meeting with the Trust's prospective partners to discuss the programme and invited the Non Executive Directors to attend to give their views. He asked that the Committee delegated contract signature to him on behalf of the Trust Board should the Trust decide to go ahead with the programme. Mr Gore asked if the programme would compliment the Carter programme and Mr Bond advised that it would.

Resolved:
The Committee received the report and agreed to delegate responsibility of signing the contract to Mr Bond should the Trust go ahead with the programme. **LB**

9 CAPITAL RESOURCE ALLOCATION COMMITTEE
Mr Bond presented the report. He advised that £3m of the Capital budget had been deferred to 2017/18.

A business case was being prepared regarding the front entrance re-design. This would be presented to the Committee and the Board for

approval in due course.

10 ITEMS DELEGATED BY THE BOARD

Items delegated by the Board were discussed in items 6,7 and 8.

11 ANY OTHER BUSINESS

There was no other business discussed.

12 DATE AND TIME OF THE NEXT MEETING:

Monday 24 April 2017, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

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

Key issues discussed:

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

Decisions made by the Committee:

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

Key Information Points to the Board:

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

Matters escalated to the Board for action:

Matters deferred to other Board Committees:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	27 March 2017	**Chair:**	A Snowden	**Quorate (Y/N)**	

Key issues discussed:

- Workplan - themed in line with Trust Strategy quality elements
- The vision for Quality Governance presentation – To bring together quality initiatives and patient experience
- Quality Improvement Programme
  - How incidents are reported to NRLS
  - Nutrition - Record keeping
  - VTE – Trust compliant – sustaining the 95% score
- Operational Quality Committee – Naso gastric tubes Never Event and subsequent roll out of training programme was discussed
- Integrated Performance Report – Assurance given around C-Section rates
- Update from Healthcare Delivery Improvement Group – Dr Purva updated the committee regarding the WHO Checklist roll out and clinical engagement
- Major Trauma Report – Good practice and areas to improve were discussed

Decisions made by the Committee:

- Member of the dietetics team to attend a committee meeting to discuss nutrition
- Lessons learned newsletter to be added as a monthly agenda item
- WHO Checklist – New checklists and feedback report to be received

Key Information Points to the Board:

- Major Trauma Report – Trust response and follow up actions to be discussed at the Quality Committee – The Board to be aware of how the Trust had improved and the further work required.

Matters escalated to the Board for action:

Matters referred to other Board committees:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON MONDAY 27 MARCH 2017
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr A Snowden	Vice Chair/Non Executive Director
	Mrs V Walker	Non Executive Director
	Mrs J Ledger	Deputy Chief Nurse (For Chief Nurse)
	Mr K Phillips	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
IN ATTENDANCE:	Mrs S Bates	Interim Deputy Director of Quality, Governance and Assurance
	Ms G Gough	Deputy Chief Pharmacist
	Ms N Gilchrist	Physiotherapy Manager
	Dr M Purva	Deputy Chief Medical Officer
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES **ACTION**

Prof. T Sheldon – Non Executive Director, Mr M Wright – Chief Nurse, Mr D Corral – Chief Pharmacist and Mrs A Green – Lead Clinical Research Therapist

2. MINUTES OF THE MEETING HELD 27 FEBRUARY 2017

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

Item 4 of the minutes – Quality Impact of CRES – It was asked that this minute was clarified and Mrs Bates advised that by working leaner and more proactively this would generate savings and drive the quality agenda.

3. ACTION TRACKING LIST

Summary of key challenges – This list was included in the CQC presentation.
Documentation Review – It was agreed that Mr Phillips, Mrs Bates and Ms Ramsay would capture the scope of the issues and produce a report. Mr Phillips suggested that the Non Executive Directors arrange a visit to Harrow Street to see the scale of records kept. **KP/SB/CR**
Serious Incident Framework – Mrs Bates agreed to circulate the framework to the Non Executive Directors. **SB**

WORKPLAN

Ms Ramsay presented the workplan which had been revised and themed under the quality strands of the Trust Strategy. These 4 strategic goals would inform purposeful discussion around the quality agenda. Mrs Walker stated that patient experience should be explicit on the workplan and not hidden in work streams. Ms Ramsay agreed and advised that she would review the Terms of Reference with this in mind. Mrs Walker also added that she would still like to see the quality impact on the patient's journey and learn more about how the patient feels when issues occur. Mrs Bates advised that the Trust had a number of data sets and feedback from patients and needed to use this information more proactively. Mr Snowden added that the Non Executive Directors would be happy to offer ideas relating to the quality agenda.

Mr Phillips stated that patients can view their care very differently and the Trust should concentrate on reducing avoidable harm overall and improve the processes and flow through the hospital.

4. MATTERS ARISING

Mrs Bates advised that the Quality Accounts and the Annual Report would be two separate documents and would not be merged into one.

5. THE VISION FOR QUALITY GOVERNANCE

Mrs Bates gave a presentation which highlighted the different areas on work being undertaken in the Trust and how all of the areas could be brought together under the Quality Improvement Programme. The aim of the Trust would be to change ways of working, share learning and have accountability. The programme was about embedding good practice and effective procedures and making them 'business as usual'.

Mrs Walker suggested 'Quality Champions' working within the organisation to promote quality and share learning. Mrs Ledger wanted all staff to understand quality and what was required of them. She advised the expectations of staff could form part of the launch of the new Quality Improvement Programme.

Mrs Bates reported that the Trust was working closely with Bradford NHS Trust as they had implemented a similar plan.

Resolved:

The Committee received the presentation and agreed to feedback any comments or ideas to Mrs Thompson. **RT**

Mrs Bates would bring back the Quality Improvement Programme and Framework to be approved by the Committee **SB**

6. ITEMS DELEGATED BY THE BOARD

There were no specific items delegated by the Board.

7. RECEIVED FOR ASSURANCE:

7.1 – QUALITY IMPROVEMENT PROGRAMME (QIP)

The QIP was presented for information and Mrs Bates highlighted the improved performance in risk and incident management and the low NRLS reporting figures. She advised that not all Trusts reported the same things so comparison of the figures could be difficult. She reported that the VTE assessment compliance figure was over 90% and work was ongoing to sustain this performance.

There was a discussion around nutrition performance and Mrs Ledger advised that the issues were around record keeping and not that patients were not being fed.

Resolved:

It was agreed that the Committee would invite a nutrition lead to discuss the issues and what plans were in place to address them to a future meeting. **TMc**

7.2 – INTEGRATED PERFORMANCE REPORT

The Committee received the report and the C-Section performance rates was questioned by Mr Snowden. Mr Phillips advised that the targets within the report had been analysed and were not endorsed. Mr Phillips reported that the national average for this indicator was 14% and not 12% as stated in the report.

7.3 – OPERATIONAL QUALITY COMMITTEE REPORT

The report was presented to the Committee for information and assurance.

Mrs Walker expressed her concern regarding the use of an unlicensed skin preparation product. Mrs Bates reassured Mrs Walker that the product being used was the same formula as the licensed product (which was being sold at an inflated price) and the risks were being managed appropriately.

7.4 – HEALTHCARE DELIVERY IMPROVEMENT GROUP

Dr Purva reported that work was ongoing rolling out the new WHO checklist in theatres at Castle Hill Hospital. She advised that there were a fewer number of questions on the new checklist and no tick boxes to encourage clinical staff to complete tasks rather than concentrate on filling in the form. Dr Purva stressed the importance of clinical engagement and embedding good practice.

Resolved:

The Committee agreed to receive an update at the Quality Committee in April 2017. **MP**

7.5 – MAJOR TRAUMA REPORT

Mr Phillips presented the report which highlighted good practice and the areas of concern. He advised that the Trust had come a long way since the previous review and 95% of Best Practice Tariff had been achieved last month. Mr Phillips reported that the Trust had compiled a response to the report and this would be presented to the committee at a later date.

Mrs Walker asked about the increase in the death rates within the report and Mr Phillips advised that the data had been analysed to review which deaths were avoidable and how the Trust could learn from the investigations.

Resolved:

The Committee agreed that the report, the Trust response and any action Plans following the review would be presented to a future meeting.

7.6 – RADIOLOGY UPDATE

An update was received regarding the radiology reporting system and the improving acknowledgement rate.

7.7 – SERIOUS INCIDENTS – FEBRUARY 2017

The Serious Incidents declared in February 2017 were received by the Committee. Mrs Bates advised that the Commissioners had given significant assurance relating to the Trust' incident management.

7.8 – LESSONS LEARNED NEWSLETTER

The Committee received the newsletter and agreed that the newsletter should be a standing agenda item each month.

8. ANY OTHER BUSINESS

There was no other business discussed.

9. CHAIRMAN'S SUMMARY

Mr Snowden agreed to summarise the meeting to the Board.

10. DATE AND TIME OF NEXT MEETING:

Monday 24 April 2017 – 9.15am – 11.00am, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

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

Key issues discussed:

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

Decisions made by the Committee:

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

Key Information Points to the Board:

- Quality Accounts

Matters escalated to the Board for action:

Matters referred to other Board Committees:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING 2016-2017

Trust Board date	2 May 2017		**Reference Number**		2017 – 5 - 19	
Director	Kevin Phillips – Chief Medical Officer		**Author**		Helen Cattermole - Consultant Trauma & Orthopaedic Surgeon	
Reason for the report	This paper provides an annual summary of staffing levels, gaps and vacancies among junior medical staff at Hull and East Yorkshire Hospitals NHS Trust, together with a plan to improve these gaps.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board is asked: • to note the findings of this report, which should be regarded as a baseline for future reports • to support the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.					
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 Framework – Quality, performance and risks are understood**					
	Assurance Framework Ref: BAF 2 Staffing	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is received annually by the Trust Board.					

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING 2016-2017

Executive summary

This paper provides an annual summary of staffing levels, gaps and vacancies among junior medical staff at Hull and East Yorkshire Hospitals NHS Trust, together with a plan to improve these gaps. This data is based on a snapshot of junior doctors in training posts on 1 March 2017, as the new Terms and Conditions of Service 2016 are still being rolled-out and Trust systems are still being adapted to the fluid situation.

The Trust has made huge progress in a very short space of time, and this has been recognised by the junior doctors.

It is not possible at this time to provide complete assurance to the Board that the levels of junior medical staffing are safe; work is still underway to provide the new information that would lead to this assurance. I am assured, however, that this work is well-supported by the Trust, and that systems are being constructed or adapted to provide the information required for monitoring of safe staffing levels and safe working patterns.

The Board should regard this paper as a baseline for future work, and is requested to support the development of a coherent strategy for the medical workforce.

Introduction

The purpose of this paper is to provide an annual summary of the staffing levels, gaps and vacancies among junior medical staff at Hull and East Yorkshire Hospitals NHS Trust. The paper also discusses the plan to improve these gaps.

This report is produced by the Guardian of Safe Working Hours, using data provided by the Trust, in accordance with the 2016 Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training. It is a requirement of these TCS that the Guardian Annual Report is included in the Trust's Quality Account.

The TCS were only finalised in July 2016, following the industrial action earlier in the year and the adjustments made after the involvement of ACAS. This Trust, along with most Trusts nationally, decided to adopt the national timetable for implementation of the new contract; the short lead time between publication of the final details and the contract start date has meant that many departments, particularly the Medical Staffing Department and the Medical Education Department, have had to work extremely hard and extremely fast to make sure that all the TCS could be met by the deadline for each phase of the contract roll-out. Even so, after the first doctors started on the 2016 TCS (7 Dec 2016 in this Trust), new information, guidelines and instructions have continued to be issued by NHS Employers, and this Trust has had to adapt continuously to a fluid situation.

The approach this Trust has taken to the implementation of the 2016 TCS has been praised, on more than one occasion since the doctors transferred, by junior doctor representatives of the BMA, and by the Trust's BMA Industrial Relations Officer.

Key achievements of this Trust in the initial adoption of the 2016 TCS:

- Oversight of all new contract issues by a newly-formed committee with senior representation from Human Resources, Payroll, Medical Education, and all Health Groups
- Appointment of a Guardian of Safe Working, with contracted time and administrative support
- Purchase of an electronic system for exception reporting; roll-out and training of both junior doctors and supervising consultants
- Revision of all junior doctor rotas to ensure they are compliant with the rules laid down in the new TCS
- Senior medical commitment to the roll-out of the electronic rostering system to include junior doctors across the Trust
- Overhaul of payroll systems to accommodate the new way trainee pay is calculated under the new TCS
- Timely production of work schedules, an entirely new concept for junior doctors, which has involved collaboration from both Medical Staffing and Medical Education to set out in a single document for the first time, exactly how a junior doctor in a particular post will work and receive training. This is a huge undertaking, particularly as each work schedule has to be personalised for each trainee in post.
- All trainees starting on the new TCS have received information about their post in good time, in accordance with the standards laid down in the HEE Code of Practice. This is unusual for Trusts in this region; many have not been able to meet these standards.
- Establishment of a Junior Doctor Forum with junior representation from all Health Groups

This report was prepared using data available on 1 March 2017. At this point, it should be noted that, in this Trust, and in common with most Trusts nationally, the first doctors to go on to the new contract started work under these TCS on 7 December 2016. Seventy Foundation Level 1 doctors started on the new TCS at that stage, with the next cohort of 57 doctors transferring on 1 Feb 2017. Information from trainees on the new contract, such as that available from exception reports, comes from only a small number of trainees, and is not representative of the situation across the organisation as a whole. (A further, large cohort of junior doctors will start on the new TCS in August 2017 and all but a very few trainees will be on this contract by October 2017.)

Most importantly for the purposes of this report, until the advent of the new TCS, this Trust had not previously centralised its data collection for junior doctors. As the requirements for compliance with the new TCS have evolved and become available (e.g. the required information for this report was only made available in late November 2016), the Trust has had to completely overhaul a number of Trust systems, including data collection, finance and human resources management systems, to accommodate the new requirements. This work is not yet complete, so this paper should be regarded as work in progress, which will be built on in the coming months.

This report therefore only represents a fraction of the year, and until longitudinal data is available, all data presented is a snapshot of the situation on 1 March 2017.

High level data

Number of doctors / dentists in training posts (total):	441 on 1 March 2017
Number of doctors / dentists in training on 2016 TCS (total):	127
Vacancy rate among doctors in training posts (all contracts):	15.4%
National medical vacancy rate for comparison	7% (including consultants)

(BBC FOI request to Office for National Statistics Feb 2016)

It is acknowledged that data on vacancy rates in the NHS is limited (*Workforce Planning in the NHS, The Kings Fund 2015; Workload, recruitment retention and morale, BMA 2016)*; since 2015 NHS digital has started to collect experimental data based on NHS Jobs advertisements, and has found a significant difference between information collected in this way, and vacancies shown on ESR. The experimental data shows the number of adverts for each staff group but, at the moment does not show a national vacancy rate for each group.

Annual data summary

This section should demonstrate vacancies among the medical training grades over the course of the whole year, however for reasons outlined in the introduction above, it is only possible to produce this data as a single snapshot on 1 March 2017. Systems are now in place within the Trust to start collecting this data prospectively from April 2017.

Trust doctor vacancies are not shown in this section. These doctors are not on the new TCS, and the data regarding this group of doctors has historically been difficult to capture due to a myriad of job titles, duties and grade fluidity. However, these doctors provide an enormous contribution to the service and in particular to ensuring that rotas are safe and compliant. Vacancies in this group of doctors have a huge effect on trainees, and for this reason work is underway to collect robust data on this staff group. This should be available for the next annual report.

Table showing establishment and current vacancies among training grade doctors

	Establishment						Vacanices						
Department	F1	F2	CT/ST1	GPSTR	ST	**Total**	F1	F2	CT/ST1	GPSTR	ST	**Total**	% Filled
Academic	0	5	0	0	0	5	0	0	0	0	0	0	100.0
Acute Medicine	0	6	9	0	6	21	0	0	2	0	3	5	76.2
Anaesthetics	4	4	19	0	29	56	0	0	4	0	3	7	87.5
Breast Surgery	2	0	0	0	2	4	0	0	0	0	1	1	75.0
Cardiology	2	1	4	1	9	17	0	0	2	1	3	6	64.7
Cardiothroacic Surgery	0	3	0	0	3	6	0	0	0	0	1	1	83.3
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0
Dermatology	1	0	0	1	0	2	0	0	0	0	0	0	100.0
Elderly Medicine	5	4	6	7	6	28	0	0	4	1	2	7	75.0
Emergency Medicine	0	12	8	5	13	38	0	0	0	0	4	4	89.5
Endocrinology	3	0	2	0	4	9	0	0	2	0	2	4	55.6
ENT	1	1	2	1	5	10	0	0	0	0	0	0	100.0
Gastroenterology	3	0	2	0	5	10	0	0	1	0	1	2	80.0
General Practice	0	18	0	0	0	18	0	0	0	0	0	0	100.0
General Surgery	0	1	1	0	0	2	0	0	1	0	0	1	50.0
Haematology	1	0	2	0	3	6	0	0	2	0	1	3	50.0
Histopathology	0	0	0	0	4	4	0	0	0	0	1	1	75.0
HIV/GUM	0	1	0	0	0	1	0	0	0	0	0	0	100.0
Infectious Diseases	2	0	2	0	4	8	0	0	1	0	1	2	75.0
Lower GI Surgery	7	0	2	0	3	12	0	0	0	0	0	0	100.0
Neurology	2	2	4	0	5	13	0	0	3	0	0	3	76.9
Neurosurgery	1	1	2	0	4	8	0	0	0	0	0	0	100.0
Obstetrics & Gynaecology	0	2	7	4	11	24	0	0	4	0	1	5	79.2
Oncology	3	1	3	4	6	17	0	0	2	1	2	5	70.6
Ophthalmology	1	1	2	0	4	8	0	0	0	0	0	0	100.0
Oral & Maxillofacial Surgery	0	0	10	0	3	13	0	0	3	0	0	3	76.9
Paediatric Emergency Medicine	0	0	6	0	1	7	0	0	0	0	0	0	100.0
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	0	0	1	1	92.9
Paediatric Surgery	0	0	2	0	0	2	0	0	1	0	0	1	50.0
Paediatrics	3	4	3	4	9	23	0	0	0	0	0.4	0.4	98.3
Palliative Care	0	0	0	2	0	2	0	0	0	0	0	0	100.0
Plastic Surgery	0	0	3	0	6	9	0	0	0	0	1	1	88.9
Psychiatry	5	5	0	4	0	14	0	0	0	3	0	3	78.6
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	0.0
Radiology	0	0	8	0	14	22	0	0	0	0	2	2	90.9
Renal Medicine	2	1	2	0	5	10	0	0	1	0	3	4	60.0
Respiratory Medicine	6	2	2	2	8	20	0	0	0	1	3	4	80.0
Rheumatology	3	0	1	3	3	10	0	0	0	1	0.4	1.4	86.0
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	100.0
Trauma & Orthopaedics	0	5	3	1	9	18	0	0	0	0	0	0	100.0
Upper GI Surgery	7	0	2	0	3	12	0	0	0	0	0	0	100.0
Urology	1	3	3	0	3	10	0	0	0	0	0	0	100.0
Vascular Surgery	5	0	1	0	3	9	1	0	0	0	0	1	88.9
TOTAL	**70**	**84**	**130**	**39**	**203**	**526**	**1**	**1**	**33**	**8**	**37.8**	**80.8**	**84.6**

Issues, obstacles and actions taken for each area with vacancies

Clinical Support Health Group

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Chemical Pathology	1 StR	50	HEE gap	None required	Supernumerary for training
Haematology	2 CT 1 StR	50	HEE gap	Rota redesigned to mitigate effects. Trust doctors employed, 1 gap remaining (Trust doctor advertised). Maternity leave and night restrictions in two Trust replacements, ad hoc internal locum cover for this, long term locum being sought	Shared rota with Oncology
Histopathology	1 StR	75	HEE gap	None required	Supernumerary for training
Infectious Diseases	1 CT 1 StR	75	HEE gap HEE gap	CT vacancy impacts medical rota at HRI Ad hoc internal and external locums for acute shifts StR gap covered by consultants acting down	
Oncology	2 CT 1 GP StR 1 StR	70.6	HEE gap HEE gap HEE gap	Rota redesigned to mitigate effects. Trust doctors employed, 1 gap remaining (Trust doctor advertised). Maternity leave and night restrictions in two Trust replacements, ad hoc internal locum cover for this, long term locum cover being sought	Shared rota with Haematology
Radiology	2 StR	90.9	HEE gap	Rota redesigned. Some junior posts are usually supernumerary for training, gaps moved to this level so service unaffected.	Supernumerary cover reduced

Family & Women's Health Group

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Breast Surgery	1 StR	75	HEE gap	Trust doctor appointed to fill gap	
Obs & Gynae	4 CT 1 StR	79.2	HEE gap HEE gap	Rota adjustments have been made to accommodate gaps. Two Trust doctors in post. 1 x MTI doctor employed. Advertising for Trust doctors Trust doctor employed	
Paeds Neonates	1 StR	92.9	HEE gap	Advertised for Trust doctor, internal locum used to cover shifts	
Paeds Surgery	1 CT	50	HEE gap	Advert for Trust doctor, internal and external locums for acute shifts	
Paediatrics	0.4 StR	98.3	LTFT trainee	Medical Staffing liaising with HR Business Partner to start advertising to fill gap	Historically Trust has not filled LTFT gaps
Plastic Surgery	1 StR	88.9	HEE gap	Trust doctor employed pre-emptively	

Medicine Health Group

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Acute Medicine	2 CT 2 StR	76.2	HEE gap HEE gap	ACPs used to cover CT gaps, 1x MTI doctor Service decided not to advertise, internal and external locums for acute shifts	
Cardiology	2 CT 1 GP StR 3 StR	64.7	HEE gap HEE gap HEE gap	1 x MTI at CT level Internal locums for gaps at this level Trust doctors and Clinical Fellows used to cover gaps at StR level	
Elderly Medicine	4 CT 1 GP StR 2 StR	75	HEE gap HEE gap HEE gap	1 x MTI at CT level Long term locums and Trust doctor x 1 to fill gap ACPs used in support at this level 1 x MTI doctor Remaining vacancy does not affect acute rota, daytime work covered by service	EAU has no permanent establishment as covered by locums at all times
Emergency Medicine	4 StR	89.5	HEE gap	Service decided not to advertise, internal and external locums for acute shifts ACPs used in support at all levels	Full complement of StRs expected in August for the first time ever!
Endocrinology	2 CT 2 StR	55.6	HEE gap HEE gap	2 x MTI doctor at CT level 1 x Trust doctor Remaining vacancy does not affect acute rota, daytime work covered by service	

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Neurology	3 CT	76.9	HEE gap	1 x external locum being appointed 2 x MTI doctors expected April Ad hoc internal and external locums for acute shifts in interim	Neurology doctors cover Stroke service and neuro rehab at CHH 2 x MTI doctors recently moved internally
Renal Medicine	1 CT 3 StR	60.0	HEE gap HEE gap	Locum cover for CT MTI doctor x 1, Medical Staffing liaising with HR Business Partner to start advertising to fill gap, ad hoc internal locums in interim	 1 x MTI doctor left on 28 Feb
Respiratory Medicine	1 GP StR 3 StR	80.0	HEE gap HEE gap	1 x MTI doctor covers GP StR 2 Trust doctors appointed Vacancy does not affect acute rota, daytime work covered by service	
Rheumatology	1 GP StR 0.4 StR	86	HEE gap LTFT trainee	1 WTE covered by MTI x 1 0.4 gap not recruited	 Historically Trust has not filled LTFT gaps

Surgery Health Group

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Anaesthetics	4 CT 4 StR	87.5	HEE gap HEE gap	Vacancies consolidated on to one rota Internal locums from junior and senior doctors in Trust	
Cardiothoracic Surgery	1 StR	88.3	HEE gap	Ongoing advert	Candidates have been appointed and have withdrawn repeatedly
Gastroenterology	1 CT 1 StR	80.0	HEE gap HEE gap	Advertised for Trust doctor, long term agency locum in post Trust doctor appointed	
General Surgery	1 CT	0.0	HEE gap	Advertised repeatedly for Trust doctors, agency approached to recruit on our behalf, internal and external locums for acute shifts in interim	
OMFS	3 CT	76.9	HEE gap	3 Trust doctors in post	
Vascular Surgery	1 F1	88.9	Sickness	Agency locum Advert out for Trust doctor – recurrent advert and interview process	Short notice transfer to less onerous post for health reasons. HR working with business to review rotas at this level

Corporate Health Group

Department	Training Vacancies	% filled	Reason for vacancies	Action taken	Comments
Psychiatry	3 GP StR	78.6	HEE gap	None; no effect on HEY rotas as all work undertaken in Mental Health Trust	Humber NHS Foundation Trust request that no cover is sought for these posts
Public Health	1 F2	0.0	HEE gap	None; no effect on HEY rotas as all work undertaken in Local Authority	Supernumerary for training

Commentary on tables

As these are training grade posts, the overwhelming majority of vacancies are due to HEE gaps. Causes of HEE gaps include:

- recruitment issues
- overprovision of training posts to allow for flexibility in training numbers
- trainees who have withdrawn from rotations
- gaps caused by trainees taking time out of programme (research, maternity leave, sickness)
- gaps caused by trainees going to different organisations to meet specific training needs

Recognising the difficulties these gaps cause Trusts, the HEE Code of Practice was updated in November 2016. HEE have committed to providing information to employers and doctors at least twelve weeks before a doctor is due to start in post. This should enable earlier identification of vacancies and allow Trusts to seek permission for local recruitment at an earlier stage than was previously the case. The Code of Practice also improves junior doctor work-life balance by giving adequate notice of placements and rotas, and allows them to submit leave requests in good time.

Plan for management of junior doctor workforce gaps

"What is measured improves" - Peter Drucker

There is a substantial amount of work to be done (some of which is already underway in the Trust) to improve the data we hold about the junior doctor workforce, the work they are doing, the way that they work, and how gaps in that workforce have an effect on the service as well as the doctors themselves.

Over the next year, using systems that are already in place, there should be improvement in the Trust's understanding of the:

- Establishment and vacancy rate of the non-training grade junior doctor workforce (work underway in Medical Staffing in conjunction with the finance teams within the Health Groups)
- Safety of the current junior doctor rotas (via the exception reporting system)
- Training opportunities and training received in each post (via the work schedule and exception reporting system)

Other existing systems will require more investment to supplement this information:

- E-rostering is in its infancy on many medical rotas, and needs embedding in the organisational culture to allow the system to be interrogated as a reliable source of data
- Sickness absence, and the use of internal and external locums needs to be recorded accurately on the e-roster system across all departments
- A system upgrade (expected April 2017) will allow actual hours worked by doctors to be recorded on the e-roster system, and record agreed time off in lieu. **This information is key to understanding whether rotas are safe for both patients and doctors.** It is not clear at present whether this information will be able to be recorded by the doctor themselves or will require additional staff support to record this.

The Trust needs to develop a robust medical staff bank to allow internal locum cover to be recorded and included in the safety calculation, as well as capturing department spend on internal locums. Work has commenced on developing a medical staff bank but there is a considerable amount of work required for this to be a success.

The Trust will need to monitor junior doctor recruitment episodes, both in terms of number of episodes and also outcome. There is plenty of anecdotal evidence that recruitment of junior doctors is difficult in this region and this Trust in particular, but the data is not readily available to quantify this. Collecting this information should be relatively straightforward but would be a new process for the Trust.

It is clear from the evidence in this report, that the trainee workforce cannot be considered in isolation, nor can junior doctors (both training grades and non-training grades) be managed separately from other staff groups. There is already considerable work being done within the Trust to consider the consultant workforce and, in particular, to look at how this group of senior doctors can work more effectively over the course of a week. Naturally, changes to the senior doctor working week will impact on the junior doctors, but any workforce strategy will need to consider other staff groups, particularly where they have, or could have, an effect on the working pattern or training of the junior doctors. Examples of things that should be considered in such a strategy are:

- Avoidance of professional or divisional 'silos' and use of multi-professional, co-ordinated teams e.g. Hospital at Night. This team should cover all specialties on both sites (and does this at CHH) but currently only covers medical specialties at HRI.
- Use of the specialist non-medical workforce. There should be a clear strategy across the Trust for the use of:
    - Nurse Practitioners
    - Advanced Clinical Practitioners
    - Physician Associates
    - Etc.

  Responsibilities and competencies should be comparable for each staff group across all Health Groups within the Trust. For example there are wide variations in prescribing, authority, out of hours working, and ability to participate in a multi-professional rota between staff with the same job title working in different areas of the Trust.
- Use of other non-medical staff.
    - Phlebotomy services are variable, unpredictable and have the greatest impact on the most junior doctors. Efforts have been made over the years to solve this problem but the solution remains elusive
    - Nursing staff with cannulation skills would be of enormous benefit to patient care and safety, particularly when the junior doctor workforce is spread so thinly. The availability of nursing staff with these skills is variable. Uptake of training is low, and maintenance of certification is a recurrent and significant issue.
    - Clinical support workers with phlebotomy, cannulation and catheterisation skills seem to have disappeared from the Trust but would be valuable to support the junior doctor workforce by removing jobs that are of low educational value
    - Consideration of novel non-medical roles to support junior doctors in selected clinical areas e.g.
        - Clerical assistants for areas with high and rapid patient turnover

        - Support staff working to protocol in acute admission areas preparing patients for clinical assessment
- Reconsideration of 'rules' and cultural norms which impact on junior doctor work e.g.
    - Preparation of IDL
    - Number of doctors required on duty in a particular area (taking into account changes in non-medical workforce)
    - Prescribing
    - Protection of breaks
    - Resting during or after night-shifts
- Clear understanding of line management for junior doctors, as this is explicit in the new contract and currently differs between Health Groups
    - Understanding of roles
    - Training for role

Summary

In summary, the Trust has made significant progress on meeting the requirements of the 2016 TCS and this should be recognised by the Board. The information required for me to make an overall statement about the level of junior medical staffing within the organisation is not available at the time of writing this report, as, historically, information about non-training grades has not been collected centrally by the Trust. I am also not able to comment on longitudinal changes to the data as the information on the training grades has only been available for a matter of months. Exception reporting will, in future, be a way of obtaining information about workload for junior doctors, but, at the moment, this is not representative of the experience of the entire junior doctor body and the low numbers of reports mean that any conclusions will not be statistically significant.

It is possible for me to comment that the Trust is committed to meeting all the requirements of the 2016 TCS and to ensuring that the organisation is a safe place to work and train. There is still much work to be done, but the Trust has invested in systems and processes to monitor the workload and working patterns of the junior doctors so that safe working can be managed effectively.

Questions for consideration

The Board is asked to note the findings of this report, which should be regarded as a baseline for future reports

The Board is also asked to support the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.

Helen Cattermole MB ChB, FRCS (Tr & Orth), Dip IMC RCS (Ed), PG Dip Med Ed, FASE, FHEA

Consultant Trauma & Orthopaedic Surgeon

Guardian of Safe Working Hours

Hull and East Yorkshire Hospitals NHS Trust

March 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	2 May 2017	**Reference Number**	2017 – 5 - 20
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Assistant Trust Secretary – Rebecca Thompson
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to authorise the use of the Trust's Seal.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - Governance					
	Assurance Framework Ref:	**Raises Equalities Issues?** N		**Legal advice taken?** N		**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** Approval of the Trust's seal is reserved to the Trust Board.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

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

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE
2017/01	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction – Form of Agreement – New scope wash facility to old perfusion block 16 – Castle Hill Hospital	12.04.17
2017/02	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction – Form of Agreement – Upgrade and refurbishment of Westwood suite to minor surgery – Castle Hill Hospital	12.04.17

5 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Assistant Trust Secretary
April 2017