HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD

TUESDAY 15 MAY 2018, THE BOARDROOM, HULL ROYAL INFIRMARY AT 9.00AM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

	OPENING MATTERS		
1.	Apologies	verbal	Chair – Terry Moran
2.	Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this Agenda	verbal	Chair – Terry Moran
3.	Minutes of the Meeting of 13 March/30 April 2018 • To review, amend and approve the minutes of the last meeting	attached	Chair – Terry Moran
4.	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker	attached	Director of Corporate Affairs – Carla Ramsay
	4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
	4.3 Board Reporting 4.3.1 Board Reporting Framework 2017-19 4.3.2 Board Development Framework 2017-19 • To review the current Board Reporting Framework and Board Development Framework and determine if any updates are required	attached attached	Director of Corporate Affairs – Carla Ramsay
5.	Chair's Opening Remarks	verbal	Chair – Terry Moran
6.	Chief Executive's Briefing • To receive the Chief Executive's briefing to the Board	attached	Chief Executive Officer – Chris Long
	QUALITY		
7.	Patient Story • To focus the Trust Board on quality of patient care	verbal	Chief Medical Officer – Kevin Phillips
8.	Quality Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and /or actions are required	attached	Chief Nurse – Mike Wright
9.	Nursing and Midwifery Staffing Report The Trust Board is requested to receive this report and: • Decide if any further information and /or actions are required	attached	Chief Nurse – Mike Wright

10.	Maternity CNST Incentive Scheme	attached	Chief Nurse – Mike Wright Head of Midwifery – Jan Cairns Clinical Lead Obstetrics – Jaishree Hingorani
11.	Mortality Reviews • The Trust Board is recommended to receive and accept this report,	verbal	Chief Medical Officer
12.	Quality Committee Minutes 12.1 26 March 2018/30 April 2018 Minutes • Receive the final minutes from the 26 March 2018 and the draft minutes from 30 April 2018 meeting • Committee Chair to highlight any areas of escalation to the Trust Board from the minutes	attached	Chair of Committee – Martin Veysey
	PERFORMANCE		
13.	Performance and Finance Report 13.1 – National Breast Screening Update • To highlight the Trust's performance against the required standards	attached verbal	Chief Operating Officer – Teresa Cope Chief Financial Officer – Lee Bond
14.	Tracking Access Update • The Board to receive an update	verbal	Chief Operating Officer – Teresa Cope
15.	Performance and Finance Committee Minutes 15.1 26 March 2018/30 April 2018 Minutes • Receive the final minutes from the 26 March 2018 and the draft minutes from 30 April 2018 meeting	attached	Chair of Committee – Stuart Hall
	STRATEGY AND PLANNING		
16.	Digital Communication Strategy – for approval 16.1 – Digital Exemplar Application The Trust Board is asked to: • Consider the contents of this paper and the attached business case • Approve the business case for investment and participation in the Lorenzo Digital Exemplar Programme • Acknowledge the potential additional financial risk to the Trust if DXC's costs are not fully met by NHS Digital • Recognise that should NHS Digital's funding not meet DXC costs the Trust has the ability to withdraw from the Exemplar process • Endorse the submission of the business case to NHS Digital.	attached attached	Chief Financial Officer Chief Financial Officer
	ASSURANCE AND GOVERNANCE		
17.	Statement of Elimination of Mixed Sex Accommodation • The Trust Board is asked to receive and approve the statement	attached	Chief Nurse
18.	Modern Slavery Statement • The Trust Board is asked to receive statement	attached	Director of Corporate Affairs

19.	Quality Accounts • Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication. • Note the key dates detailed in section 4 of this report	attached	Chief Nurse/Chief Medical Officer
20.	Guardian of Safe Working Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required	attached	Chief Medical Officer – Kevin Phillips
21.	Freedom to Speak Up Guardian • The Trust Board is requested to receive and accept this report.	attached	Director of Corporate Affairs – Carla Ramsay
22.	Standing Orders • To approve the use of the Trust seal	attached	Director of Corporate Affairs – Carla Ramsay
23.	Draft Audit Minutes 26 April 2018 • Receive the draft minutes from the April 2018 meeting	attached	Chair of Committee – Tracey Christmas
24.	Business Case – Energy Innovation Upgrade Schemes • If required, approve the submission of the FBC and a capital loan application of £13.9m for external review by both NHSI and the Project Appraisal Unit ("PAU") for consideration. • If the STP capital process has superseded previous discussions with NHSI regarding the approvals process, then approval to submit the application as part of the HC&V STP process is sought from the Board.	attached	Chief Financial Officer
25.	Board Assurance Framework 25.1 – BAF Year End 2017/18 • 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.	attached	Director of Corporate Affairs – Carla Ramsay
	25.2 – BAF 2018/19 • The Trust Board is asked to review the draft Board Assurance Framework as attached to provide input, review and agreement as a BAF for 2018-19, to describes the key strategic risks to the 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	attached	Director of Corporate Affairs – Carla Ramsay
26.	Fit and Proper Person - Declarations The Trust Board to review and confirm there is assurance that: • That all Board members have completed declarations of interest and meet the requirements • That annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances	attached	Director of Corporate Affairs – Carla Ramsay
27.	Any Other Business	verbal	Chair – Terry Moran
28.	Questions from members of the public	verbal	Chair – Terry Moran

29. **Date and time of the next meeting:**
Thursday 24th May 2018, 12pm – 1pm, The Boardroom,
Hull Royal Infirmary

Attendance

	2018						2019		
Name	**30/1**	**13/3**	**15/5**	**10/7**	**11/9**	**13/11**	**29/1**	**12/3**	**Total**
T Moran	✓	x							1/2
A Snowden	✓	✓							2/2
S Hall	✓	✓							2/2
V Walker	✓	✓							2/2
T Christmas	x	x							0/2
M Gore	✓	✓							2/2
T Sheldon	x	✓							1/2
C Long	✓	x							1/2
L Bond	✓	✓							2/2
M Wright	✓	✓							2/2
E Ryabov	✓	✓							2/2
K Phillips	✓	✓							2/2
In Attendance									
M Veysey	x	✓							1/2
J Myers	✓	✓							2/2
S Nearney	✓	✓							2/2
C Ramsay	x	✓							1/2
R Thompson	✓	✓							2/2

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
MINUTES OF THE TRUST BOARD
HELD ON 13 MARCH 2018
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr A Snowden	Vice Chair/Non-Executive Director (Chair)
	Mr K Phillips	Chief Medical Officer
	Mr M Wright	Chief Nurse
	Mrs E Ryabov	Chief Operating Officer (Acting CEO)
	Mr L Bond	Chief Financial Officer
	Mrs V Walker	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Prof T Sheldon	Non-Executive Director
	Prof M Veysey	Associate Non-Executive Director
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Corporate Affairs Manager (Minutes)
	Mrs A Wray	Specialist Nurse Organ Donation (Item 17)
	Mrs L Cleavy	Chair – Organ Donation Committee (Item 17)
	Mr I Smith	Consultant Anaesthetist – ICU (Item 17)
	Miss H Cattermole	Director of Medical Education and Acting Guardian of Safe Working (Item 20)
	Mr Muthu Kumar	Consultant Trauma & Orthopaedic Surgeon (Item 20)

NO. ITEM **ACTION**

1 Apologies

Apologies were received from Mr T Moran, Chairman, Mr C Long, Chief Executive Officer, Mrs T Christmas, Non Executive Director, Ms J Myers, Director of Strategy and Planning

2 Declaration of interests

There were no declarations made.

2.1 Changes to Directors' interests since the last meeting

There were no 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 30 January 2018

Item 6, page 3 – misspelt name should read Sallie Ward.
Item 8, page 3 – the word bacteraemia to be added after MRSA
Item 8, page 4 – incorrect statement. The infection had resulted in the closure of ICU2, HRI and not theatres.
Item 8, page 4 – sentence should read, "Patients with flu were also being managed appropriately."
Item 9, page 4 – 161 student nurses had been secured for interview

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

4 Matters Arising

Mr Wright assured the Board that the numbers around the 40 day turnaround of complaint responses had been checked manually and he was satisfied that they were now correct.

4.1 Action Tracker

Mortality Structured Case Note Reviews - Mr Phillips advised that he would report the outcome of the external review to the Board as soon as the information was available. **KP**

4.2 Any other matters arising from the minutes

There were no other matters arising from the minutes.

4.3 Board Reporting

4.3.1 Board Reporting Framework 2017 – 19

Ms Ramsay presented the document and advised that there had not been any amendments made.

4.3.2 Board Development Framework 2017 – 19

Mr Bond reported that the annual operating plan required to be signed off by the Board by the end of April 2018, so suggested using time in the March 2018 development session to agree the plan.

There was a discussion around the Board's strategic approach to the STP and whether this had been given appropriate time within the Board development planned sessions. Ms Ramsay agreed to discuss the approach to be taken with Mr Moran. Mrs Walker added that Hull CCG were running an event in March 2018 for lay members and Non-Executive Directors to which she was attending along with other members of the team. Feedback from this session would be received at the next Board Development meeting and formally signed off at the Board in April 2018.

Resolved:

The Board:

- Received and accepted the Board Reporting Framework 2017-19
- Agreed to formally receive the annual operating plan at the April 2018 Board meeting. **JM**

5 Chair's opening remarks

Mr Snowden welcomed Mrs Theresa Cope, the Trust's new Chief Operating Officer to the meeting. Mrs Cope was due to start with the Trust on a job share basis with Mrs Ryabov 1st April 2018.

6 Chief Executive's Briefing

Mrs Ryabov informed the Board of the sad news that Mr Pete Watson had died suddenly at the weekend. He had worked at the Trust for 2 years as the Operations Director for the Surgery Health Group and was well liked by his colleagues. Mrs Ryabov and Mr Wright had spoken with Pete's family and work colleagues had been offered support at this difficult time. The Board offered their condolences to Pete's family.

Mrs Ryabov presented the Chief Executive's Briefing and thanked all staff working in the urgent care services for coping under extreme pressure. She advised that staff had gone above and beyond what was required of them.

The CQC Well-Led inspection had taken place and the Trust had received broad feedback which had been mainly positive. The formal report would be received on 1st June 2018.

Mrs Ryabov also spoke about the Golden Hearts awards for staff and that 241 entries had been received. The ceremony would be held 15th June 2018 at the Hilton Hotel in Hull.

Prof. Sheldon asked about Operation Wintergreen and what had been the outcome of the exercise. Mrs Ryabov reported that the operation unblocked the hospital and had given a period of respite in a pressurised time to ensure patients were kept safe. Mr Hall added that the lessons learned would be discussed at the next Performance and Finance meeting in March 2018. **ER**

The Board discussed the Care Home Select programme which provides services to families and patients referred from hospital to a care home. Mrs Ryabov advised that the service had been welcomed by both staff and patients and their families.

Mr Phillips thanked all members of staff for nominating colleagues for moments of magic, there were 76 nominations in February 2018 and recognising the great work being carried out around the Trust.

Mrs Walker was impressed that the Trust was now offering women ultrasound images of their babies even though they had suffered a miscarriage.

The balanced scorecard was reviewed by the Board. Mr Snowden to discuss further with Ms Myers and Mr Long the possibility of a more strategic approach. **AS**

7 Patient Story

Mr Phillips reported on two patient stories. The first story was regarding a patient who had been put onto the waiting list to have their adenoids removed. The patient was due to be seen in September 2018 but was in a lot of pain resulting in visits to ED and regular GP visits. Following a conversation with PALS this was expedited and the patient is now being seen in April instead. Mr Phillips pointed out that because of the long wait the patient needed other procedures putting further pressure on the health system.

The second story related to a prisoner that had written thanking all staff involved regarding the exceptional care they had received for a complex broken bone procedure. Mr Phillips advised that the Trust had a duty of care to treat everyone and prisoners were not an exception.

The agenda was taken out of order at this point

17 Organ donation team update

Mrs Wray gave a presentation to the Board detailing the successes that the team had experienced in 2017/18. Referral rates had increased and there had been 21 organ donations received, resulting in life saving operations.

Mrs Wray spoke about Organ Donation week which had seen the launch of a wrapped fire engine in Organ Donation livery and visits to St Stephens and schools for networking purposes. The team had seen a 38% increase on the register with 6000 people signing up. The team had been shortlisted for clinical team of the year at the Trust's Golden Hearts awards.

Mrs Wray spoke about organ donation week in September 2018 and other initiatives in place for 2018/19.

Mrs Cleavy thanked the team for their hard work, a lot of which happened in their free time, so their dedication was appreciated. Mr Snowden thanked the team on behalf of the Board.

Mrs Cleavy asked if the Board would endorse funding for a memorial to mark the selfless gifts that donors provide and Mr Snowden agreed to add the item to the next Charitable Funds Committee agenda.

Resolved:
The Board received the report and agreed to discuss the memorial at the next Charitable Funds committee. **AS**

20 Guardian of Safe Working Report

Miss Cattermole presented the report and introduced Mr Muthu who would be producing the report quarterly for the Board. Miss Cattermole reported that there had been a spike of activity in February due to Operation Wintergreen but had mainly been business as usual in the last quarter.

There was a detailed discussion around monthly trend data being presented to highlight any pressurised areas to enable a responsive workforce and fill the gaps.

The report itself was discussed and Mr Snowden asked if a summary could be added at the beginning of the report which drew out any issues for the Board to consider. Prof Sheldon added that information around resolutions and outcomes would also be helpful.

Mr Bond asked how the Trust ensured that services were safe and the fill rates were appropriate. Mr Phillips reported that junior doctors were moved around to ensure departments were safe but the process was not as formalised as it could be. He advised that e-rostering would help once all departments were using the electronic system.

Mr Gore asked about how the Trust was enticing new Junior Doctors and Mr Nearney advised that Health Education England influenced the numbers of Junior Doctors allocated to the Trust. He added that good marketing and becoming a teaching Trust also helped entice new Junior Doctors. Mr Phillips added that new roles such as physician associates had also been established to help with fill rates. Mr Nearney stated that the recruitment of doctors remained challenging.
Mr Snowden thanked Miss Cattermole for her report and her work so far.
Mr Phillips agreed to give his observations in the next report to the Board. **KP**

Resolved:
The Board received and accepted the report.

8 Quality Report

Mr Wright presented the report and highlighted that the Trust had declared a Never Event relating to a patient receiving a root nerve block to the wrong side of their spine. The patient had received the correct side block on the same day and Duty of Candour obligations were met.

Mr Wright reported that the new list of Never Events for 2018/19 had been published with a number of changes such as spinal wrong site surgery being removed from the list. The Trust had previously declared this Never Event.

Mr Wright presented the current level of Serious Incidents being reported and this was slightly reduced compared to last year's numbers.

The Safety Thermometer spot check audits were ongoing. Mr Wright highlighted that VTE assessments were being carried out and performance was at 94.3%, however there were still issues around reporting assessments on the Lorenzo system.

Mr Wright reported that there had been 1 MRSA bacteraemia case and a number of E.coli breaches. The increase in E.coli cases had come about due to improved compliance with sepsis screening. Although the numbers were challenging, patients were being identified earlier and treated sooner.

The number of patients with flu was small and had occurred in younger patients who had not received the flu vaccination.

There had been an increase in complaints in February 2018 and the Patient Experience Team were reviewing this. Mr Wright spoke about the 40 day response to complainant letters and how this could be changed to 25 days to improve response times.

The Friends and Family Test had seen a dip in January and February 2018 but Mr Wright suggested that this was due to the system being under increasing pressure and this was being reviewed.

Resolved:
The Committee received and accepted the report.

9 Nursing and Midwifery Staffing Report

Mr Wright presented the report and advised that fill rates were stable and the safety briefs were still being held 6 x per day to ensure safe staffing levels. He reported that the winter ward would close in April 2018 and nurses would be redistributed but the situation was still challenging.

He spoke about immigrations issues regarding the international recruits. Each nurse had to pass an English language clinical competency exam before they were allowed to work at the Trust and some nurses had not passed this exam. Mr Wright advised that work was ongoing for the University of Hull to potentially provide the exam more locally.

Mr Wright advised that the North of England Group was reviewing recruitment, retention, safe care and how lessons could be shared between Trusts relating to nurse staffing. NHS England had reported that there was no extra funding for nurse staffing and each Trust would need to manage its own workforce.

Resolved:
The Board received and accepted the report.

10 Fundamental Standards Report

Mr Wright presented the report and advised that a presentation had been given at the Quality Committee in February 2018 detailing the methodology used and the results of the audits.

Mr Wright stated that he was proud of the work being carried out to improve fundamental standards and that the CQC had praised the Trust during their last visit. Prof. Veysey suggested promoting the good news story externally.

Mr Wright advised that work was ongoing to drive up the standards and that he would be targeting amber rated standards next.

Resolved:
The Committee received and accepted the report.

11.1 Quality minutes 29 January 2018/26 February 2018

Prof. Sheldon presented the minutes and reported that e-Observations had been discussed and the IT issues that were preventing the project being developed at a faster pace, VTE performance and the work of the Clinical Harms Group who were monitoring the Tracking Access patients.

The Research and Innovation Strategy was presented and this would be discussed in more detail at the next Board Development session and work was progressing well regarding the Trust and Humber Foundation Trust SLA agreement.

Resolved:
The Board received and accepted the minutes.

12 Performance and Finance Report

Mrs Ryabov presented the report and highlighted diagnostics as a concern. She advised that the trend showed 10% of patients breaching with 313 breaches in February 2018. The main issues were around cardiac CT and MRI. Prof. Sheldon stated that some referrals would be inappropriate and suggested that this be analysed to highlight any areas of concern. Mrs Ryabov reported that referrals were screened and some were rejected if not felt to be appropriate.

Endoscopy planned to increase their workload and were using locums to cover the staffing issues.

RTT performance January 80.69% which was mainly due to the amount of elective capacity being cancelled. The Trust continued to work with MBI, concentrating on specialities struggling with capacity and focussing

on front end issues to improve performance. Cardio thoracic performance was at 64% with issues around the lack of ITU and ENT was not only challenging for the Trust but also nationally.

52 week wait performance was mainly due to tracking access issues and Mrs Ryabov reported that NHS England planning guidance showed extra money would be given to Trusts reducing their 52 week waiters by 50%.

The Emergency Department was particularly challenging in month with lack of capacity and flow being the key issues. The Trust's performance was at its lowest in year at 77.7% but this was reflected nationally also. Prof. Veysey suggested that reporting monthly national data would help put the issues into perspective.

Mrs Ryabov spoke about the issues around lack of capacity, bed flow, having the winter ward open which was depleting nursing staff and community beds not being appropriate for patients with comorbidities.

There was lots of work being carried out to help the staff working in the difficult environment under great pressure.

Mrs Ryabov advised that the cancer 62 day standard was improving and that from May 2018 any late referrals would be the referring organisation's breach and not the Trusts.

Work was ongoing to reduce the cancer 104 days standard.

Finance
Mr Bond presented the item and advised that at Month 11 the Trust was £11.3m away from its plan but was expecting to hit the £15m revised outturn deficit at year end.

The Health Groups forecasts had improved with only Clinical Support Health Group struggling to hit their plan.

Mr Bond advised that he was in discussions with the Specialist Commissioners to agree the forecast outturn for 2018/19 and that this had not yet reached a solution.

Resolved:
The Board received and accepted the Performance and Finance report.

13 Tracking Access Update
Mrs Ryabov gave the update and advised that the Performance and Finance Committee had received regular updates.

In total 7743 patients had required clinical validation and 4632 of these had been completed. 900 patients had been dated for a review, 428 had been reviewed but not dated which left 1384 still requiring clinical review by the end of March 2018. Mrs Ryabov advised that a number of specialties may not be completed by the end of March 2018, but were working hard to complete them as soon as possible.

Resolved:
The Committee received and accepted the update.

14 Performance and Finance Committee minutes 29 January 2018/26 February 2018

Mr Hall presented the minutes and advised that Mr Moran, Mr Bond and himself had met with NHS Improvement to review the 2017/18 financial position. He reported that the run rate positions of the Health Groups had deteriorated but the rate was slower, their forecasts had improved and agency spend was below target.

There was a discussion at the Committee regarding minimum staffing requirements in ED and the model criteria to operate sufficiently. Work was ongoing to understand the issues and the actions needed to prevent recurrence. Mr Nearney added that e-Rostering would be key in ensuring gaps in staffing were covered.

Resolved:
The Committee received and accepted the minutes.

15 Financial Planning 2018/19

Mr Bond presented the report which gave the Board the latest position regarding the Trust's financial plan for 2018/19.

Mr Bond advised that the original plan assumed a control total of £5.6m surplus. The latest plan took into account that there had been a CNST reduction, an increase in STF funding which totalled a revised control total of £13.m surplus assuming that the Trust received its £16.7m STF funding.

Mr Bond stated that the Trust had not planned for a surplus and had an underlying position of circa £26m. Commissioner agreements were being finalised which would see the AIC contract continuing into year 2. There had been no contract offer from the Specialist Commissioner at the time of writing.

Mr Bond advised that if the Trust set an aspirational CRES target of 3% (this was being achieved at national level) this would release £17m leaving a deficit of £10m.

Mr Bond reported that the finance teams would be reviewing land revaluations and looking to secure working capital loans in year to secure financial stability over time.

There was a detailed discussion around signing the control total and Mr Hall expressed his concern that if the contract was signed off formally at the end of April 2018 this was already 1 month into the next financial year.

Resolved:
The Board received and accepted the report.

15.1 Capital Planning 2018/19

Mr Bond presented the paper which highlighted the Trust's capital requirements for 2018/19. The report covered 3 main areas equipment, backlog maintenance and IT requirements.

Discussions were ongoing with NHS Improvement regarding capital

funding as well as looking for support from the STP. Mr Bond advised that most funding would be from securing more loans and finance from depreciation. Recognising the land sale at Castle Hill Hospital was key.

Mr Bond also drew the Board's attention to the risks relating to old medical scientific equipment and not replacing kit.

There was a discussion around alternative sources of income and Mr Bond advised that these areas would be explored in more detail and reported to the Board where appropriate.

Resolved:
The Board received and approved the capital plan 2018/19.

15.2 Draft Operating Plan 2018/19
Mr Bond presented the Draft Operating plan for information to the Board. He asked the Board to submit any comments or questions to Ms Myers before the March 2018 Board Development session.

Resolved:
The Board received the plan and agreed to discuss it further at the March 2018 Development session. **JM**

16 Equality Diversity and Inclusion Strategy
Mr Nearney presented the strategy to the Board which set out the Trust's objectives around equality diversity and inclusion and how they would be achieved.

There was a discussion around a more user friendly content and an executive summary to help with ease of reading and highlighting key points. Mr Wright added that the content was useful when reviewing recruitment.

Mr Nearney advised that the actions would be monitored through the Equality Diversity and Inclusion Steering Group, the Executive Management Board and the Trust Board would receive annual reports regarding progress against the actions.

Resolved:
The Board received and approved the strategy.

18 Gender Pay Gap Report
Mr Nearney presented the report which set out gender pay gap information for Trust staff.

Mr Nearney advised that medial staff pay had an impact on the average data and this was reflected nationally also as the consultant workforce is predominantly male.

One of the drivers of the difference in bonus pay was around the Clinical Excellence Awards and the discretionary points accounted for 76% of all bonuses awarded. The ratio of male to female consultants was higher. Mr Nearney advised that the Trust was aware of the issues and was committed to reducing the gender pay gap. An action plan had been developed to address the issues.

Resolved:
The Board received and accepted the report.

20 National Staff Survey 2017 Results
Mr Nearney presented the report to the Board which highlighted the national staff survey 2017 results.

Resolved:
The Trust Board noted the contents of the report and supported the work to improve the working environment for staff and the culture of the organisation.

21 Standing Orders
Ms Ramsay presented the report to the Board which highlighted the use of the Trust seal since the last Board meeting.

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

22 Draft Audit Committee Minutes 27 February 2018
Mr Gore presented the minutes to the Board for information.

23 Draft Charitable Funds Minutes 15 February 2018
Mr Snowden presented the minutes to the Board for information.

24 Any other business
Mr Bond tabled a report which highlighted the 10 standards that required sign off by the Board relating to General Data Protection Regulations (GDPR). Each standard had been assessed and a response provided.

Areas of risk were continuity planning, disaster planning and unsupported systems. Mr Bond advised that there was work to do in these areas but the Audit and Information Governance Committees were monitoring progress.

Resolved:
The Board approved the responses given in each of the 10 standards.

Mr Snowden acknowledged that it was Prof. Sheldon's last Board meeting and thanked him on behalf of the Board for his contribution over the years.

25 Questions from members of the public
There were no questions from members of the public.

26 Date and time of the next meeting:
Tuesday 15 May 2018, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary

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

PRESENT

Mr T Moran CB	Chairman
Mr A Snowden	Vice Chair/Non-Executive Director
Mr C Long	Chief Executive Officer
Mr K Phillips	Chief Medical Officer
Mr M Wright	Chief Nurse
Mrs E Ryabov	Chief Operating Officer
Mr L Bond	Chief Financial Officer
Mrs V Walker	Non-Executive Director
Mr M Gore	Non-Executive Director
Mr S Hall	Non-Executive Director
Mrs T Christmas	Non Executive Director
Prof M Veysey	Non-Executive Director
Prof J Jomeen	Associate Non-Executive Director

IN ATTENDANCE

Mr S Nearney	Director of Workforce & OD
Ms J Myers	Director of Strategy and Planning
Ms C Ramsay	Director of Corporate Affairs
Mrs R Thompson	Corporate Affairs Manager (Minutes)

NO. ITEM **ACTION**

1 Apologies

Apologies were received from Prof Veysey, Non-Executive Director.

2 Declaration of interests

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda.

There were no declarations made.

3 Trust Operating Plan

Ms Myers presented the Operational Plan which had been reviewed by the Board and Health Group senior teams and the draft copy had been submitted to NHS Improvement for their feedback. The Trust had received positive feedback from NHS Improvement and the Trust's approach to the plan had been shared with other Trusts as a good example of how to develop an Operating Plan.

There was a discussion around the predicted workforce figures and Mr Moran asked for a breakdown of the workforce numbersin respect of management, administrative and estates for 2018/19 which were forecast to grow. Mr Nearney advised that the key areas were around Lorenzo staffing but agreed to supply the detailed analysis of the figures for the Board members.

Mr Moran asked the Board to review the key risks and asked if any other risks should be taken into account. Mr Gore stated that the Capital risk would need to be reviewed and Mr Bond advised that this would be made clear in the 2018/19 Board Assurance Framework.

Mrs Ryabov stated that the ED 90% performance improvement trajectory was challenging but that this would be based on system performance and not stand alone for the Trust.

Mr Bond reported that the revised financial control total was £10.2m deficit and that the Trust would be continuing with its aligned incentive contract with the Commissioners.

He stated that the largest risks to the organisation was the gap in the CRES programme, the Health Group run rates adding to the underlying deficit and Capital funding. ED performance and winter pressures were also included in the plan.

Resolved:
The Board received the Operating Plan which included the Financial Plan and approved it.

Trust Undertakings
Mr Bond advised that the Trust had received a letter from NHS Improvement which required the Trust to sign up (undertake) to produce a robust financial recovery plan by the end of October 2018 which would see the Trust return to a Use of Resource rating of 2 within a 3 year period.

Mr Bond reported that the plan would be developed with system partners. A response would be drafted to the letter in due course.

Mr Moran asked for a Board Development session to be held ahead of the October 2018 deadline so that the Board was fully aligned and supportive of the financial recovery plan.

4 Any Other Business
There was no other business discussed.

5 Date and time of the next meeting:
Tuesday 15 May 2018, 9.00am – 1.00pm, The Boardroom, Hull Royal Infirmary

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
March 2018						
01.03	Mortality Structured Case Note Reviews	A report detailing the results of the external review to be received	KP	July 2018		
02.03	CEO Briefing	Balanced scorecard to be reviewed	CL/AS/ JM			
COMPLETED						
March 2018	Board Development Programme	Trust Operating Plan to be approved 30.04.18	JM	April 2018		Approved
January 2018	Mortality Reviews	Report to be received quarterly	KP	May 2018		On the Board Reporting Framework
May 2017	Patient Story	Digital Communication Strategy to be received	LB	Mar 2018 to PAF	May 2018	To be included in the IM&T Strategy on Agenda

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
Charitable Funds Committee						
March 2018	Organ Donation	Organ Donation memorial to be discussed at the Charitable Funds Committee	AS	June 2018		

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

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

Overarching aims:

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

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

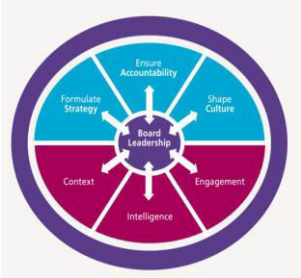
Board Development Dates 2017-19	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion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

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

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

Principles for the Board Development Framework 2017 onwards

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



Overarching aim:

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

Area 1 – High Performing Board

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

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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

MAY 2018 TRUST BOARD

1. KEY MESSAGES AND MEDIA STORIES

Restructure of NHS England and NHSi
NHS England and NHS Improvement are working together to integrate and align national programmes and activities, operating through single teams where appropriate. Regional teams will be led in each case by one regional director, working for both organisations. Seven regional teams will underpin this new approach.

The North East regional team would include Cumbria and the North East, West Yorkshire, Humber, Coast and Vale, and South Yorkshire and Bassetlaw. It is expected that a Regional Director will be identified early autumn with these new arrangements taking effect very shortly thereafter.

A formal proposal for the new geographical footprints is being presented shortly to the two boards, which will meet in common on 24 May. Views on these proposals are being sought and can be sent to england.jointworking@nhs.net or nhsi.jointworking@nhs.net by 17.00 on Tuesday 15 May 2018.

'Ditch those jammies': Campaign to #EndPJParalysis at Hull Royal Infirmary and Castle Hill Hospital
Patients coming into Hull Royal Infirmary and Castle Hill Hospital are being encouraged to take off their pyjamas as part of a national campaign.

The Trust launched #EndPJParalysis, a 70-day initiative running in hospitals from April 17 to June 26 to get patients wearing everyday clothes instead of nightwear.

Studies show keeping hospital patients in their pyjamas can result in reduced mobility, greater risk of falls, loss of independence and longer stays.

The trust is adopting the national initiative to achieve one million patient days of people up, dressed and back on their feet as part of the NHS's 70th anniversary celebrations.

Staff will download a special app to record the number of days a patient will be in their normal clothes to join hospitals around the country aiming to hit the one million target..

Nottingham University Hospitals achieved a 37 per cent reduction in falls, an 86 per cent drop in pressure injuries and an 80 per cent decrease in patient complaints after introducing #EndPJParalysis on its trauma ward. The average length of stay for patients was also reduced by 1.5 days.

Nurses help people with deadly allergies to wasp and bee stings
Patients vulnerable to anaphylactic shock are undergoing three years of treatment at the trust to build up tolerance to wasp and bee stings.

Anaphylaxis induced by venom triggers cells to flood the body with histamine, causing the blood pressure to crash and the person to collapse. Without treatment, their lives are at risk.

Nurses at Castle Hill Hospital see patients with potentially deadly allergies to wasp and bee stings at a dedicated allergen immunotherapy clinic every week. People who suffer reactions

to stings are usually referred either by their GP or A&E to the nurse-led allergy assessment clinic where a full history of the reaction is taken and tests determine the severity of their allergy.

Patients who can benefit are referred to venom immunotherapy for three years of treatment with injections to build up tolerance levels. Patients are given incremental doses of venom, taking into account their personal histories and reactions to their allergen. Some start off with an injection containing as little as one hundredth of a wasp sting, building up to two stings in each session.

A helping hand for hospital's most critically ill
A group of volunteers from Hessle who work tirelessly to raise funds to support people with epilepsy have presented thousands of pounds worth of equipment to the Trust.

Members of Hessle Epilepsy Society have presented staff on Hull Royal Infirmary's Intensive Care Unit (ICU) with two new Hamilton ventilators, used to help people who are too poorly to breathe for themselves, and a state of the art 'Mindray Sonosite' ultrasound scanner which can help doctors to pinpoint and then resolve potentially life threatening problems.

This is the latest in a string of donations made to the intensive care units at HRI and Castle Hill Hospital which collectively amount to more than £100,000. The charity's fundraising efforts, coupled with proceeds of sales from their charity shop on Tower Hill, have seen five beds, eight clocks, two bladder scanners and 22 bedside trolleys purchased in addition to today's ventilators and ultrasound scanner.

Many thanks to all of those who helped to raise these funds.

First baby born at Hull's Fatima Allam Birth Centre turns 1!
She was the first baby to open her eyes in the plush surroundings of the Fatima Allam Birth Centre and during April one-year-old Connie Houghton came back to celebrate.

Arriving at 4.49pm on April 10, 2017, and weighing in at 8lbs 9.5oz, Connie is one of over 340 babies born to date at the city's £470,000 midwifery-led unit, within Hull Women and Children's Hospital. Parents Ellen, 32, and Gareth, 34, who also have a son Charlie, now four, hadn't planned to use the birth centre but agreed to be the first family when Ellen arrived at the hospital in labour.

Work began on the construction of the birth centre in November 2016 after a donation of £370,000 from Fatima Allam and her family. The trust contributed £100,000 to the total cost of the centre.

Around 1,400 East Yorkshire women give birth each year without the need for medical intervention, supported by midwives, and the birth centre was created to meet the needs of women with low-risk pregnancies who wish to birth their babies naturally.

Students to help hospital team after they achieve record year for organ donations
A hospital team is marking its most successful year after a record number of families agreed to save lives.

We revealed in April that 35 families agreed their loved one's organs could be used to save a life last year compared to 13 in 2016/17. This meant 54 life-saving transplants could be carried out.

Trust staff also referred more patients to the organ donation team than other hospitals in the country, achieving a referral rate of 94 per cent compared to a national rate of 90 per cent.

Now, the team will visit the University of Hull on Wednesday to encourage students to sign the register and donate blood.

The success came after Alex Wray, specialist nurse for organ donation and the organ donation team worked tirelessly throughout 2017/18 to raise the profile of their work.

A branded fire engine, based at Bransholme, was launched and the team spoke to hundreds of members of the public to explain the importance of organ donation during a special event at St Stephen's. Lift wraps spreading the word about organ donation were also placed on the elevator doors in the tower block of Hull Royal Infirmary. The team also attended Health Expo 2017 at City Hall when TV presenter Peter Levy agreed to sign the organ donor register.

Hospital consultant invites public to learn about the threat of drug-resistant bugs
The public have a key role to play in preventing the spread of life-threatening infections, a hospital consultant says.

Consultant physician Dr Gavin Barlow gave a free public lecture on the need for people to protect antibiotics after seeing the problem worsen since joining Hull and East Yorkshire Hospitals NHS Trust in 2004. Dr Barlow, who leads the trust's work on antimicrobial stewardship, explained to people what antibiotics are, what they are used for and why they are so important to us.

He presented the lecture on Tuesday, May 1, at 2.30pm in the lecture theatre at Castle Hill Hospital.

Hull's Neonatal Intensive Care Unit undergoes major transformation
Our neonatal unit caring for the region's sickest babies has undergone a £45,000 transformation to protect vulnerable infants.

Work has just been completed to increase the floor space in the Neonatal Intensive Care Unit (NICU) at Hull Women and Children's Hospital caring for sick babies.

The unit is a regional specialist centre caring for premature infants and desperately ill newborn babies from Hull, Yorkshire and Northern Lincolnshire.

The new extension has been fitted with sliding doors so it can be partitioned off if a baby requires nursing in isolation. Parent and family facilities such as the bedrooms and the Kitching and dining areas have also been fully refurbished thanks to the generosity of family and the general public raising funds for the unit. Babies normally treated in the Red Room were nursed in other rooms on the unit while the area was fitted with new flooring, sinks, ceiling tiles and redecorated.

Staff are now planning to raise funds to refurbish the Blue Room, the area where seriously ill babies are nursed by the team. Visit www.hey.nhs.uk/babyunitfund for details on how you can help or support the staff.

Sweet success!
Nurses have praised the generosity of local people following an appeal to help patients undergoing cancer treatment.

Following a letter written to the Hull Daily Mail and a supporting appeal through social media last week, hundreds of bags of boiled sweets have been delivered to the Queen's Centre at Castle Hill Hospital in Cottingham.

Patients, visitors, staff and members of the public have been dropping off the goodies in varying quantities, from the odd quarter of humbugs right through to huge corporate deliveries.

Boiled sweets are offered to patients undergoing chemotherapy treatment to help mask the metallic taste it can sometimes cause.

2. MEDIA COVERAGE

The Communications team targets 80% positive coverage during any given month. During April, 48 articles out of 57 generated were positive (84%).

20 news releases issued from the Communications Office this month:

4 April - 'Ditch those jammies': Campaign to #EndPJParalysis at Hull Royal Infirmary and Castle Hill Hospital
5 April - Nurses help people with deadly allergies to wasp and bee stings
6 April - A helping hand for hospital's most critically ill - Donation to ICU from Hessle Epilepsy Society
9 April – First baby born at Hull's Fatima Allam Birth Centre turns 1!
10 April – Students to help hospital team after they achieve record year for organ donations
11 April - Overseas staff to cook up a treat to celebrate diversity in the NHS – Hospital hosts World Food Event
12 April - Driffield pig farmer is injected with wasp venom after anaphylactic shock
13 April - Man achieves beekeeping ambition despite deadly allergy to bee venom
16 April - Hospital staff join NHS campaign to #EndPJParalysis
18 April – Hospital consultant invites public to learn about the threat of drug-resistant bugs
18 April - Castle Hill nurse to retire after almost 50 years in the NHS
19 April – Hull's Neonatal Intensive Care Unit undergoes major transformation
20 April – "She's one in a million" - Nurse retires just days before her 75th birthday
20 April – Art competition launched to mark the NHS's 70th birthday
23 April – Sweet success! – Thanks from chemotherapy day unit staff after hundreds of bags of sweets are delivered for patients undergoing treatment
24 April – Practical demonstrations to help parents-to-be at special hospital event
24 April – Bereavement is everyone's business – Trust to host bereavement even for employers as part of Dying Matters Week
25 April – Pregnancy: What you need to know for the second trimester
26 April – Thieves steal memorabilia from hospital 'front room' helping patients with dementia
30 April - Hull midwives in the frame over International Day of the Midwife

Social media
Total "reach" for **Facebook** posts on all Trust pages in April: 592,053 (March: 386,877)

- Hull Women and Children's Hospital – 135,636 (March 139, 598)
- Hull and East Yorkshire Hospitals Trust – 106,485 (March 70,610)
- Castle Hill Hospital – 162,005 (March 62,578)
- HEY Jobs page – 33,044 (March 51,959)
- Hull Royal Infirmary – 154,883 (March 99,760)

Twitter
@HEYNHS

- 85,300 impressions (86,900 impressions in March)
- Followers 5,351 (5,286 in March)

@AllisonCoggan Fly-on-the-wall tweets only:

- Prostate clinic in radiology (April 26) – 14,900 (13,300 impressions for tissue viability in March)

3. MOMENTS OF MAGIC

Moments of Magic nominations enable staff and patients to post examples of great care and compassion as well as the efforts of individuals and teams which go above and beyond the call of duty. They illustrate our values at work and remind us that our workforce is made up from thousands of Remarkable People.

In March 2018 we received 36 Moments of Magic nominations:

What was the Moment of Magic?	Which member of staff was involved?	Where do they work?	Entry Date
Debra goes above and beyond her duties to help other staff members, she is a valued member of the team	Debra Chester	AMU	29/03/2018 21:24
She was a patient advocate as she brought up with the nurses, while on their break, that patients needed feeding at mealtimes.	Michelle France	H70 HRI	29/03/2018 13:47
He was observed providing excellent care and attention while feeding a vulnerable patient. He ensured he was at the patient's eye level, feeding him slowly and put the patient at ease throughout his mealtime.	Reece Clark	HRI H70	29/03/2018 13:44
Pip is a Nutrition Clinical Nurse Specialist. She is passionate about the service offered by the team she works within offers and she always strives to always ensure patient safety is maintained. Yesterday, Pip went to great lengths to facilitate the very complex discharge of a patient with a poor prognosis. The patient was frustrated with the 'system' and was threatening to discharge herself from hospital which would have compromised her safety. Pip liaised with several consultants, community service providers, the ward team and the OPAT team and the patient herself all in an effort to remove the obstacles that were preventing the patient's discharge. There is now a clear plan in place for the patient's safe discharge early next week.	Pip MacElhinney	Nutrition team, Admin Block, CHH	29/03/2018 12:41

Debbie (Debs) is a delight from the start of her shift to the end. She has such a smiley face, always warm and welcoming. Whenever Debs is on shift, she brightens up my day. Thank you for being so positive and happy.	Deborah (Debbie)	Domestic on Rowan Ward	29/03/2018 12:29
The amount the porters do day in & day out. I don't think enough gratitude goes to them. Jobs they do what people don't even think about & always in good spirits and a happy feel from them all! Great team & great work! No job is ever to much trouble.	All porters	Portering HRI	23/03/2018 20:04
Beth always helps whenever possible. Constantly checking that the staff and patients are ok. Great team player.	Bethany Watson	EAU	23/03/2018 16:51
In the time I have worked with Liz, I have known her to be kind, caring, and compassionate towards all staff and patients. Liz will go above and beyond to help anybody out, and is my first point of call when I need information for patients or how to go about something I'm not sure of.	Liz Barwick	ENT reception, CHH	23/03/2018 11:25
Phenomenal team working on the night of 19th March ensuring safe and exceptional care on AMU	Katie Williams, Gemma Warrener, Levi Catchpole, Stemi George, Hannah Wilkinson, Jay Wilson, Filipa Tabunag , Deborah Morgan, Sarah Hardy, Louise Oates, Jo Holman, Chris Montgomery, Nicola Kettley. Tony Oliver	AMU	20/03/2018 22:59
Dave and Gary are always on hand to help getting people home! Anyone that books patient transport will appreciate how difficult it is at times, especially when a patient has complex needs. They always act as the middle men and never complain! Despite patient transport being an extremely frustrating service currently, they always remain calm and cheerful! Thank you!	Gary Usher & Dave Wilkinson	Transport Managers	20/03/2018 08:03

My friend's father was rushed into A and E on Saturday 17/3/18. The doctor in A and E was so fantastic with all of us and took a great deal of time to discuss everything that was happening and what would happen. He had the unenviable task of discussing a DNR with us. It was discussed in a sensitive, caring and compassionate way. He made us feel that we were the most important people in A and E at that time. Once we were transferred to AMU later that day, the care from everyone was fantastic. Hazel looked after my friend father on the Saturday and again she was such a caring compassionate nurse and a credit to the team. Jodie was looking after us on Sunday and the time she took to ensure that we were updated with information was excellent. Her care of my friends father was fantastic. Care and compassion were evident in everything she did for us all. Nothing was too trivial for her to deal with. Again she is a credit to the AMU team. Sadly, my friend's father died later on Sunday, but we will never forget the kindness shown to us all during a harrowing 48 hours	Dr Austin (sorry no surname) A and E, Hazel - AMU Jodie Wilson AMU	A and E , AMU	20/03/2018 06:27
Lynda is always helping and she does it with a smile on her face. Nothing is ever too much for her. She has a bubbly personality she brightens up the ward.	Lynda Smirk	AAU	19/03/2018 23:05
She always has a smile on her face even when you can see there is a lot to do. Nothing is too much trouble. Always makes people laugh and is a pleasure to work with. Thanks Jo!	Jo Holman	AMU	19/03/2018 00:09
Fantastic team working under pressure, realising 15 discharges in one day whilst administering high standards of care to all the patients on ward 1.	Vicky Linford, Sophie Milner, Holly Bainton, Michelle Young, Becky Marshall, Betty Smith, Nicky Trough	Ward 1 HRI	18/03/2018 21:57

I had taken a patient for a kitchen assessment on Ward 110. During the activity my patient became unwell, I asked to members of staff for some help and they immediately came to our aid. They were very kind and very helpful as I do not work on their ward and my patient wasn't from their ward either. Thank you ladies my patient and I really appreciated your very kind manner, and help as you were both very calm, reassuring and just set about helping us both. You are both a credit to the NHS and keep caring the way you do as today you made a difference not just for the patient but also to myself. I would also like to thank my colleague Toni Lill who helped with transporting my patient back to the ward. I didn't even have to ask Toni for help she just came to my aid and volunteered her services. She is an amazing team player always willing to help a patient or colleague in their hour of need. You too Toni are a credit to the NHS.	Azizat Onaygia.Ophelia Sarpong. Toni Lill	Bank auxillarys and Physio Assistant ward 110	18/03/2018 15:41
Zoe is a great nurse, always supporting other staff in ED, very caring towards her patients and will always go that extra mile.	Zoe Sugden	ED	18/03/2018 05:19
I was running an extremely busy Induction of Labour Clinic. Without the help of Kerry, Claire, Jo, Donna and Carrie the clinic would have over-run by hours. We all worked so well as a team, each taking on appropriate roles as the situations changed and more challenges arose. All team members maintained a sense of humour and provided all the ladies in our care with the best level of care we could deliver. Care and compassion were paramount during this shift. Working with such an amazing group of ladies makes all the difference and I thank them for all their help.	Midwives Claire Hatfield, Kerry Coggin, Jo Minter. Midwifery assistants Donna Peters, Carrie Gelder.	Maple Ward	17/03/2018 16:25

I would like to nominate Donna Sykes for a moment of magic as I witnessed something remarkable, when I was on ward 10 I witnessed her helping to settle an elderly gentleman back in to bed and reassuring him that his wife is okay when he was becoming anxious about her not being able to get home safely. She showed great passion and such a caring nature that this should be recognised.	Donna Sykes	Portering Services HRI	16/03/2018 11:07
Michelle Tiffin is our volunteer on the patient lounge she is a pleasure to have working with us as she ensures that the patients are offered a drink and food and she is always cheerful and gives plenty of support to the staff. She stays late and has her own job to go to but Monday and Thursday evening she comes to help us we are so grateful for our volunteers they do a fabulous job	Michelle Tiffin	patient lounge	15/03/2018 19:52
I attended the Ultrasound department, HRI this morning for a scan. I was very apprehensive about this appointment and really wasn't looking forward to it! Aoife was fabulous! She explained everything to me and why I was having this procedure done which made me feel so at ease! Even during the scan I was reassured and comforted by her explaining what was going on. Aoife made me feel dignified and respected despite the nature of the scan. This lady really deserves this moment of magic! I was proud to say that I work within the same organisation as her!! Thank you so much!	Aoife Noonon	Ultrasound Department, Hull Royal Infirmary	15/03/2018 12:20
Ian is a very caring and approachable person which makes him so well matched with his role. I have required assistance with the patient experience team and received valuable advice, support and help from Ian. I cannot thank him enough. He acted quickly and precisely updating me at all times on any new progress and sympathising with my situation. He is caring and passionate about patient care and investigating when we believe it has gone wrong, whilst staying professional. Amazing advocate.	Ian Springett	Patient Experience Officer	15/03/2018 11:32

My father was recently a patient on H500. The staff were caring and considerate. Despite the challenges the staff have to overcome to deliver good care they achieved this with a ready smile. The nurses and doctors also made sure that the family were kept informed about my father's condition.	All staff	H500	12/03/2018 16:55
Angie has taken responsibility for providing a valuable link between the project group and the ID Ward, in supporting its forthcoming relocation. She has been both enthusiastic and committed to ensuring that important actions are completed. I am not sure how we would have managed if we hadn't had Angie working with us on the project. We just wanted to thank Angie for all her efforts and for often single-handedly taking the lead on a number of issues, which has been greatly appreciated by us. Thank you Angie x	Angie Johnson	Ward 20	12/03/2018 16:18
Came into work as short notice sickness on the ward. Swapped their shifts at last minute and covered their original shifts to ensure ward safety. Both staff members are outstanding workers and a credit to this trust.	Paula Vickers and Lyndsay Bowen	Ward 1	12/03/2018 02:10
Anna is one of our consultants for the Elderly who is extremely kind and considerate to her patients. I particularly feel that she deserves a moment of magic due as she always goes that little extra mile to make sure patients and relatives feel safe and happy	Anna Folwell	Elderly medicine ward 90	11/03/2018 17:33
When my sister was diagnosed with throat cancer, her consultant Mr Jose showed such care and compassion towards her. Mr Jose even did an extra day in theatre to ensure my sister got her treatment sooner as she was struggling breathing. I chuckled when the morning of her surgery she said to Mr Jose thank you for doing overtime for me. Mr Jose was truly there for my sister showed such care. Her surgery of about 11 hours was a success she spent 4 and a half weeks on ward 16 and once again they really did care for my sister, she has now come home from hospital and starts chemo and radiotherapy in just over a week's time. A big thank you Mr Jose you've saved my sister's life we will ever be grateful to you.	Mr Jemmy Jose	ENT outpatient	09/03/2018 19:03
I would like to nominate Magda because	Magda Kolodziej	Ward 31	09/03/2018

she is a brilliant staff nurse, as well as being caring and compassionate Magda has a great sense of humour and always keeps staff morale high. She has only been qualified for 18 months but has the knowledge of someone who has been qualified a lot longer, its a pleasure working with you :)			14:43
A fiercely independent but very hard of hearing elderly patient had surgery under local anaesthetic. His lift did not arrive to collect him from the ward and he wanted to walk home. Staff were concerned about him and did not want him to walk alone after he had just had surgery. The patient was adamant he wanted to leave and became quite upset. The staff on the ward without hesitation put money together to pay for a taxi for him. The housekeeper accompanied him in a taxi to escort him home and ensure he was ok. Another member of staff drove to pick up the housekeeper to bring her back to work. I watched all of this unfold and was moved to see the concern for the patient and the desire to get him home and comfortable with the minimum of fuss and before he became more upset. The staff present each took out some money and contributed to his taxi fare without a second thought. I was so impressed by the care and compassion they showed.	Di Kirk, Paula Wheeldon, Heather Leonard, Nikki Blake	DSU 3	09/03/2018 14:33
Recently, I ordered 10 patient hoists from a supplier. These were supposed to be delivered to wards and departments by the supplier. Due to an admin error by the supplier on two occasions, hoists were simply delivered to stores at HRI, unloaded and left. The lads in stores HRI went over and above to help me; they delivered the hoists to HRI and took hoists to ERCH and also CHH. I absolutely could not have managed without them (I realise that this is often said but it really is true.) They absolutely did not have to do any of this; it was extra to their workload. Very often, the 'behind the scenes' work-force are forgotten. Not this time - Thank you lads for a superb job. I am really very grateful to you!	Mark Dodsworth and Team	Stores HRI	09/03/2018 13:34

Julie is fairly new to endoscopy but has taken it like a duck to water! She is completely un phased at anything that is given to her, and always has a smile on her face. She moves list when needed, ringing patients and is always very organised. Thank you Julie for been such a team player especially on Tuesday when we all had to work together to help with the bed crisis. You're a star !	Julie Hewson	endoscopy HRI	09/03/2018 08:28
Paula has worked to develop information for staff along with a resource to aid communication for staff caring for the deaf community. Paula noted the issues experienced by the deaf community whilst working as a student / staff nurse in the Trust and also through the experiences of her family members. The simple but effective guidance and resources within the booklet has proven to be a valuable tool to staff caring for deaf patients. This has had a positive impact on the hospital experience of members of the deaf community.	Paula Vickers	Ward 1	08/03/2018 12:57
Becky is a very caring and hard working Nurse, she goes out of her way to help patients and staff all the time. Yesterday she went above and beyond to help a patient, and it also helped a male member of staff with the situation, showing compassion to the patient. All our team are very proud of her and we think she deserves a moment of magic.	Becky Robinson	PACU	07/03/2018 09:08
You deserve a moment of magic. You always go above and beyond your job role, always willing to help others. you are a great teacher and role model. I learn something new every shift I work with you. You make all the staff smile, We are lucky to have you working on the unit.	Carlos	Ward 40 HRI	05/03/2018 23:34
You all deserve a moment of magic for making me feel so welcome when I got moved onto your ward on Saturday night. It's always a little daunting when you get moved onto a ward and speciality. I have not worked on before. Right away I felt part of your team so thank you.	Kelly, Jill and Charlotte	Ward 100	05/03/2018 23:24

Jess is currently a student nurse on Cedar Ward and we feel Jess needs a moment of magic as she has been an absolute star whilst working within our team. There are lots of different reasons we could give for this, there is a main example this being when an elderly lady on the ward pulled her table closer to herself so she could eat her breakfast, unfortunately the lady pulled the tray that was on the table which resulted with the hot cup of tea and porridge going straight into her lap. Immediately Jess was there making sure the gown was lifted from the lady's lap until the curtain was pulled round, so the clothing could then be removed, her quick actions then stopped any unnecessary blistering, burning or pain. When Jess finishes her training and is a qualified nurse she would be an asset for the NHS, she is a fine example to be followed by other students. Jess you will be missed when you return to university in a few days....THANK YOU AND GOOD LUCK FOR THE FUTURE!!!	Jessica Walker	Cedar Ward	05/03/2018 11:29
Katie is truly exceptional co-ordinator of AMU, every shift she does all she can to ensure safe patient flow from ED to specialist bed bases whilst supporting her team of nurses and ensuring patient care is de4livered in what is a very busy environment.	Katie Williams	AMU	05/03/2018 04:32
I have just finished my final placement on ward 60 as a student nurse and I just want to say that I have NEVER worked with such a good team. From nurses, doctors, therapists, auxiliary nurses to ward clerks, domestics and caterers - the whole team went above and beyond for every single patient and relative. The standard of care I have witnessed on this ward is amazing and I am proud to say that I have worked alongside them. No matter how busy, or stressful the ward environment became, the morale was always high and patients would always comment on the high standard of care they received throughout their stay. Julie and Colin (ward sisters) are inspirational, they have absolutely mastered how to manage and motivate a team. They're approachability along with their knowledge and caring nature is	Ward 60	Ward 60, General Surgery, HRI	04/03/2018 20:06

admirable. Everyone who works on this ward should be very proud of themselves. The support I have received as a student was amazing, I felt like a welcome, valued member of the team from day 1 and was always pushed to reach my full potential. I'd love to list every member of staff and mention every little thing they have done that amazes me...but I'd be here for days! Each and every team member, no matter what their job role, goes above and beyond when supporting other team members, patients and their relatives. One person I would like to single out, is 6th floor co-ordinator Rachel - who supported me, working alongside me and showing me new things. Furthermore, a couple of times she went out of her way to offer me support and to check that I was okay when she sensed I was stressed. I hope in the future that someone is inspired by me, the same way that your team have inspired me to be the best nurse that I can be, Thank you for such an enjoyable 3 months.			
I was one of two duty matrons on Saturday 3rd March night shift, covering the tower block at HRI. I encountered some difficult and challenging situations on a number of wards, requiring security presence. The security supervisor and the guards themselves were really flexible and supported me, the nursing and the medical staff to ensure not only the safety of the patient involved but also the other patients and staff. Despite being on the end of some quite severe verbal abuse, they remained polite and professional at all times. A good example of team work under difficult circumstances.	Security team	HRI	04/03/2018 06:26
Ward 10 (winter ward) staff would just like to thank Linda Hall the ward caterer for all her hard work whilst we have been open! her attitude towards the patients is never anything short of incredible. Numerous occasions Linda has stayed behind, and rarely leaves on time. We feel she doesn't always get the recognition she deserves!	Linda Hall	Catering Ward 10	03/03/2018 16:23

So thanks again Linda!			
Nurse staffing was very difficult on Saturday 3rd March, both with short notice sickness and difficulties with staff getting to work due to the inclement weather. Kerry arrived on her own ward and was asked to go and support a different ward which she duly did, then she was moved to another ward who were also struggling, later on she was to returned to her own ward but there had been a previous plan for her to move in the afternoon to the sister ward to which she works on. She turned up to find she was then being dispatched to Hull Royal. Her head must have been spinning. All these moves occurred because the staffing was changing so quickly and it was difficult to keep up. Although it had been a difficult morning Kerry set off in the direction of HRI to assist. Thank you Kerry from your nursing colleagues who needed you assistance and were very grateful that you still came and supported them.	Kerry Clayton	C10	03/03/2018 15:35
26th February 2018 Emergency care was very busy with many surgical referrals from GP and within A&E. The Surgical registrar, although very busy, was very helpful in reviewing patients. Most particularly he was happy to review suspected surgical patients before they were seen by the ED doctors and put in management plans. This was very helpful in patients' flow within the department and significantly reduced the waiting time as there were many suspected surgical patients attending ECA on that day. Michael Heng who was the surgical registrar deserves a gold medal for his relentless effort on the day.	Mr Michael Heng	General Surgery HRI	03/03/2018 13:56

Sarah (PDA) went the extra mile as she stayed beyond her shift time to ensure a patient was safely discharged home at very short notice, this was at both the patients and the family's request. Sarah ensured all equipment and services were in place for the patient prior to her leaving the ward. I believe that Sarah showed true dedication, care and compassion to the patient and their families. Sarah is a valuable member of the DME team and a great team player. Thanks for all your help and support, it is very much appreciated.	Sarah Hague	Ward 90	03/03/2018 11:52
I would like to nominate staff nurse Joanne Ellis from ward 130 for her dedication to her team, for braving the weather in what was a horrendous journey in awful conditions from York to HRI for her shift. It took Jo 3 hours to get home after a 12 hour shift. which consisted of her car getting stuck in the snow for 30 minutes until 2 strangers come to her rescue, pushing it up the hill with her whilst another steered it, amongst other scary moments. Given the conditions and the fact schools were closed along her journey I feel she needs some recognition and a thank-you.	Joanne Ellis	Ward 130 paediatrics	03/03/2018 10:07
I feel Sue is an asset to this department, she is really supportive with everyone and has always got the time to help and has an amazing calming influence, Sue we love you, keep being you, you do an amazing job	Susan Smith	AMU	02/03/2018 11:46
Debra has really worked hard to ensure my mum received the right care at the right time. I believe she has gone above and beyond the expectations of her role and I am eternally grateful. She is an absolute star.	Debra Dyble	Medicine Health Group	02/03/2018 09:56
Joanne, support secretary in the nurse room in Neurology, Wilson Building, has been an absolute star in mentoring me and has been really understanding, being patient with each query I have. She is great!	Joanne Beadle	Neurology	01/03/2018 16:58

E Mail received today after Emma went above and beyond on Friday I hope I have the correct Emma Many thanks for your help on Friday I know it made you run late and I hope you were able to get some lunch before your list started I just wanted to let you know that Leeds are happy with the echo and the surgery is going ahead as planned tomorrow I have just spoken to the patient concerned and she also wanted to thank you as she felt you had gone above and beyond.	Emma Scott	ECg Department CHH	01/03/2018 15:03
I attended the Paediatric ENT clinic today. My daughter has learning difficulties. Tina at reception was completely fabulous with her, speaking to her as a valued individual, helping her relax and making everything much easier. Thank you!	Tina, ENT reception	ENT reception	01/03/2018 10:45

HEY LONG TERM GOALS - March 2018 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance March	Trend v Previous Month
R	Never Events	0	1	→
G	Complaints (QIP - closed within 40 working days)	90%	95.00%	↑
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	53	38	↑
G	Safety Thermometer - Harm Free Care	95%	92.56%	↓
R	Venous Thromboembolism (VTE) Risk Assessment (Q4 v Q3 1718)	95%	89.48%	↑
R	Mortality - HSMR (November 17)	<100	108.7	↓
G	Friends & Family Test - Inpatients (February 18 - Trust v National %)	95.80%	98.50%	↑
R	Friends & Family Test - Emergency Department (December 17 - Trust v National %)	84.70%	84.00%	↓

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

Workforce

RAG	Indicator	Target	Performance March	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	10.10%	↓
G	Staff Sickness	<3.9%	3.66%	↓
R	Staff Vacancies	<5.0%	5.68%	↑
R	Staff WTE in post (<0.5% from Plan)	7327	7256	↑
G	Staff Appraisals - AFC Staff	85%	84.80%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	91.20%	↑
G	Statutory/Mandatory Training	85%	88.20%	↑
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£4.0m	£5.9m	↑
G	Staff: Friends & Family Test - Place of Work (Q3 1718 v National)	59%	61%	↓
G	Staff: Friends & Family Test - Place of Care (Q3 1718 v National)	67%	71%	↓

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance March	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	90.70%	79.83%	↓
R	52 Week Referral To Treatment Breaches	0	0	25	↑
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	1.49%	10.52%	↑
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	95%	76.40%	↓
R	Cancer: ADJUSTED 62 Days Referral To Treatment (February Data)	85%	85.20%	80.00%	↓
G	Length of Stay	<5.2	-	5.1	↑
R	Clearance Times	12 weeks	-	12.2	↓
R	Waiting List Size	50,915	-	54,642	↑
R	Clinic Slot Utilisation	80%	-	56.90%	↓
R	Theatre Utilisation	90%	-	71.70%	↓
G	E-Referrals (Q2 target v current performance)	100%	-	100.0%	↑
R	Appointment Slot Issues	35% (TBC)	-	51.00%	↑

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

Finance

RAG	Indicator	Target	Performance March	Trend v Previous Month
R	Capital Expenditure	11.1	19.0	↑
R	Statement of Comprehensive Income Plan - Year to Date	-1.4	-7.1	↓
R	CRES Achievement Against Plan	10.5	13.4	↑
R	Invoices paid within target - Non NHS	95%	46%	↑
R	Invoices paid within target - NHS	95%	34%	↑
R	Risk Rating	3	3	↓

Category	No. of Risks Rated 15 and above
Corporate Non-Clinical Risks	4

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT MAY 2018

Trust Board date	15 May 2018	**Reference Number**	2018 – 5 - 8
Director	Mike Wright, Chief Nurse	**Authors**	Mike Wright, Chief Nurse Kevin Phillips, Chief Medical Officer Sarah Bates, Deputy Director Quality Governance Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

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

QUALITY REPORT
MAY 2018

EXECUTIVE SUMMARY

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

- Patient Safety Matters including Never Events and Serious Incidents
- Themes and Trends from Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission Inspection
- Learning from Deaths
- VTE

The Trust Board is requested to receive this report and:

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

QUALITY REPORT
MAY 2018

1. PURPOSE OF THIS REPORT

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The Trust Board is requested to receive this report and:

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This report covers the reporting period to the end of March 2018. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE)

In March 2018, the Trust declared a Never Event relating to a patient who received a fascia-iliac block to the wrong side. This is a 'Wrong Site Surgery' Never Event. The error was identified just as the local anaesthetic injection had begun and was stopped almost immediately. The procedure was safe to be commenced on the correct side, and Duty of Candour obligations have been met, also. The patient suffered no apparent harm. This incident is now under investigation and will reports its findings in due course.

The final number of reported Never Events within the Trust for 2017/18 is six. An urgent Never Events briefing was delivered to Trust Clinical teams on Wednesday 4 April 2018. The event was presented by the Chief Medical Officer and included a session from the Chief Executive as well two consultants who had been involved in Never Events previously. The event was well attended at both the Hull Royal Infirmary and Castle Hill sites and positive feedback was received. The event was filmed and is available for viewing via the Trust's Intranet.

The Trust is currently undertaking a thematic review on all six Never Events, which will be shared with the Board, NHS Improvement and the Commissioners on completion.

In March 2018, the investigation into the Never Event relating to the 'wrong route administration of medication' was completed. This incident related to a patient that was prescribed Intravenous (IV) Morphine Sulphate. Morphine Oral Solution (a different preparation of the drug for oral administration only) was administered intravenously to the patient, i.e. the wrong drug via the wrong route of administration. The patient suffered no apparent harm.

The investigation panel agreed that there was no evidence of any wilful intention to cause this patient harm. However, the panel considered that the major factors that resulted in this incident were knowledge-based, as a result of knowledge-based deficits of the two newly qualified nurses concerned. This was also compounded by human factors as the patient was in severe pain and the department was busy, so the nurses involved were trying to help both the patient and their colleagues by undertaking a task. However, they did not have the knowledge, skills or competence to administer this drug and the error was made. Support has been provided to the nurses concerned.

A series of recommendations have been made and incorporated into an action plan for the Trust. The actions focus on auditing the availability of the correct syringes to be used across the Trust for oral/enteral purposes, so that the correct equipment is available; to incorporate this case into training for newly registered nurses and for individual self-reflection and re-training for the staff and team involved. The Trust also released an urgent Quality Safety Bulletin in relation to this incident, which was launched at the Chief Executive's Briefing. The investigation report and action plan have been reviewed by the Trust Commissioners who have accepted both.

2.2 Serious Incidents declared in March and April 2018

In addition to the Never Event detailed above, the Trust declared four Serious Incidents in March 2018 and five in April 2018; all of these are in the process of being investigated fully. The current final figure of reported Serious Incidents for 2017/18 is 69, compared to 68 reported in 2016/17. However, as some of the 69 incidents are still under investigation, some may be considered for de-escalation if the investigation determines they do not meet the definition of a serious incident, so this figure may be subject to change.

The outcomes of all Serious Incident reports are reported to the Trust Board Quality Committee. A summary of the incidents is contained in the following tables:

2.2.1 Serious Incidents declared in March 2018

Ref Number	Type of SI	Health Group
2018/6116	1. Maternity/Obstetric Incident – unexpected birth resulting in admission to NICU and intracranial bleed	Family & Women's
2018/7001	2. Pressure Ulcer – deep tissue injury to sacrum	Medicine
2018/7009	3. Pressure Ulcer – grade 3 pressure ulcer to sacrum	Medicine
2018/7384	4. Maternity/Obstetric Incident – intrauterine death	Family & Women's

[1] In February 2018 a woman was admitted to obstetrics in the early stages of labour. The mother had a cervical suture in situ and was positioned for this to be removed. Once the suture was removed the woman delivered her baby very quickly. Unfortunately, this happened so quickly that the baby fell to the floor. This was a rapid delivery of an extremely preterm birth and the operator was unable to safely prevent the baby from falling to the floor. The baby was transferred to NICU for treatment.

[2] The patient was an inpatient at Hull Royal infirmary. The patient was admitted due to a sudden onset of chest pain. The patient has been reviewed by the Tissue Viability team and was found to have sustained a deep tissue injury to the sacrum.

[3] The patient was an inpatient at Hull Royal Infirmary. The patient has been reviewed by the tissue viability team on the 13/03/2018 as having a hospital acquired Grade 3 pressure ulcer to the sacrum.

[4] A woman was admitted to women's and children's hospital labour and delivery suite at 37 weeks pregnant and an intrauterine death was confirmed.

2.1.2 Serious Incidents declared in April 2018

Ref Number	Type of SI	Health Group
2018/8506	1. Treatment Delay – delayed review of test results	Medicine
2018/8976	2. Treatment Delay – delayed diagnosis of cancer	Clinical Support
2018/9014	3. Treatment Delay (Unexpected Death) – delayed diagnosis of cancer	Clinical Support
2018/9947	4. Maternity/Obstetric Incident – unexpected delivery of premature baby	Family & Women's
2018/10182	5. Awaiting classification – disposal of remains without family knowledge	Family & Women's

[1]The patient had samples of their thyroid gland taken for histology/cytology in July 2016, which showed suspicion of a malignancy. Despite the patient being seen in the neurology clinic and ENT for management of a different medical condition, the results of the histology/cytology were not accessed until requested by the GP in December 2017. The results were suspicious for thyroid cancer.

[2] The patient had an x-ray in June 2017 for symptoms of Chronic Obstructive Pulmonary Disease (COPD). The x-ray was at this time reported as normal. The patient was referred for a two week wait appointment by their GP in February 2018 following further chest symptoms and weight loss. An x-ray reported as suspicious for cancer. The x-ray from June 2017 was reviewed again and this showed that there was a suspicious mass that had not been reported previously.

[3] A patient with a history of probable asbestos exposure had a chest x-ray in April 2016, which showed a 7.6mm soft tissue nodule. The request was then to rescan the patient in 6 weeks to assess if this was a suspicious nodule or suspected infection. A repeat chest x-ray performed in May 2016 and was reported as normal. The patient received no further follow up. The patient presented through the 2ww route in July 2017 and a 7cm mass in left lung was diagnosed. Following review of both x-rays in October, it was determined that the results from May 2016 should have picked up the abnormality. The patient died in April 2018.

[4] A woman of 26 weeks gestation attended the Antenatal Day Unit with a history of back pain, mucous discharge and sharp tightening's; the diagnosis was UTI, antibiotics were prescribed and the woman was discharged home. The women attended the Maple Ward later the same day with worsening pain, bleeding and reduced foetal movements. Whilst awaiting medical review she delivered her premature baby into the toilet. The baby was transferred to NICU.

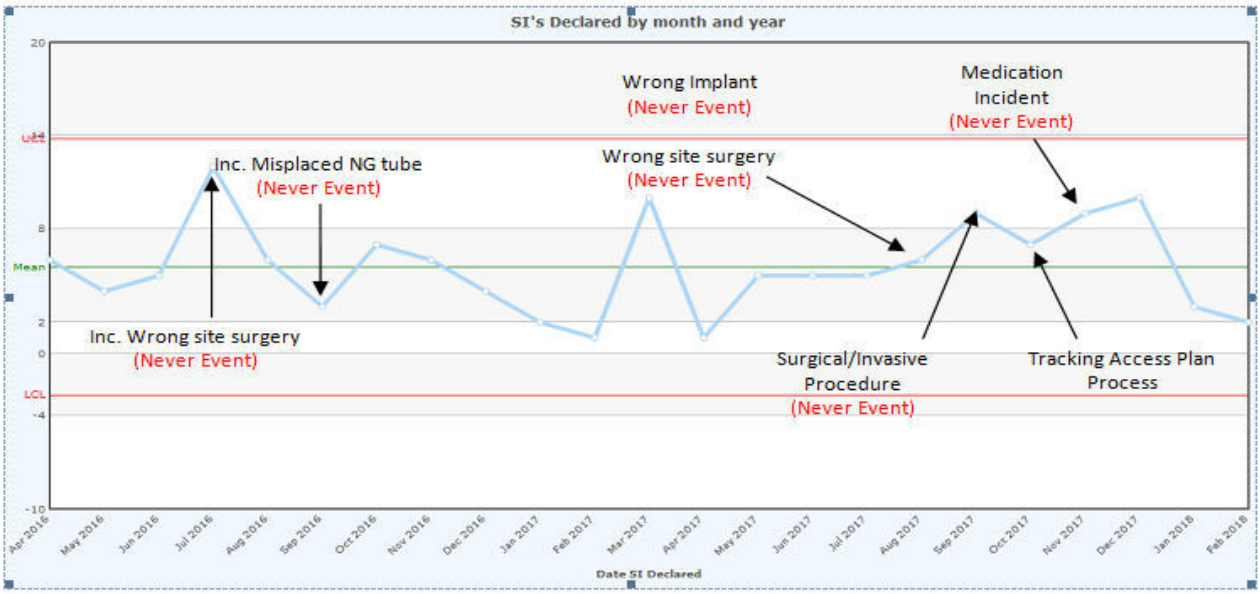
[5]Arrangements for the cremation of pregnancy remains took place without the knowledge of the parents as they had requested. This incident affects five patients

2.3 THEMES AND TRENDS ARISING FROM SERIOUS INCIDENTS

The themes and trends arising from serious incidents are presented to the Quality Committee monthly. The full report for 2017/18 is being compiled and will be presented in due course. The last report to the Quality Committee covered the period April 2017 to end of January 2018 and this is now summarised for the Trust Board.

As at 31 January 2018, the Trust had reported 60 SI's (including 4 Never Events) from 1April 2017.

The following SPC chart shows the Trust's SI reporting rate since (April 2016 to February 2018) with the Never Events and the Tracking Access Plan process SI highlighted specifically.



During the period 1 April 2017 to 31 January 2018 the Trust has completed 45 SI investigations (including 3 completed NE investigations).

2.3.1 Categories of Serious Incidents Declared (April 2017 to January 2018 inclusive)

The following table shows the categories of incidents reported in 20171/8, with comparison against previous years shown, also.

Serious Incident type	2014/15	2015/16	2016/17	2017/18	Comment
Treatment Delay	3	19	17	10	Prior to 2017/18 lost to follow up was included in treatment and care or delayed diagnosis. An overall process SI relating to the specific tracking access issue was declared and any related harms are now being reviewed at Clinical Harm Group.
Treatment Delay – lost to follow up *(extracted as own category from 2017/18)*	-	-	-	9	
Patient Fall	31	18	8	2	Positive reduction Falls Quality Improvement Project (QIP) in place
Delayed Diagnosis	10	17	2	0	0 reported however this may be as delayed diagnosis was historically also used to record lost to follow up
Pressure Ulcer	4	11	4	6	Pressure Ulcer QIP in place
Surgical/Invasive Procedure incident	1	10	2	7	This is an increase on last year's figure, however, 3 were the same type of SI relating to paediatric surgery.
Sub-optimal care of the deteriorating patient	3	9	8	9	Deteriorating Patient QIP in place
12 hour ED trolley breaches	9	7	0	0	Positive reduction – there have been none reported for 2 years, whereas this winter, the number of 12 hour trolley breaches

Serious Incident type	2014/15	2015/16	2016/17	2017/18	Comment
					declared by other Trusts has been significant
Drug Incident	7	3	2	1	There has also been a drug incident Never Event in 2017/18
Unexpected Death	9	3	10	7	For all SI's where the patient has died or died subsequently, a Structured Mortality Review will be undertaken as part of the SI investigation.. On completion of investigation if a SI has been determined as causing or contributing to the patient outcome the SI is re-categorised as Unexpected Death. These Sis(17/18) were originally reported as x1 obstetric incident x1 surgical invasive procedure x1 treatment delay (Lost to follow up) x2 treatment delay x2 Sub-optimal care
HCAI/Infection Control Incident	1	2	1	1	2017/18 Incident is under investigation and relates to decontamination in Sterile Services. 2016/17 incident was baby who contracted MRSA bacteraemia
Intrapartum Death	0	2	1	0	None reported 17/18
Never Event – Retained Foreign Object	1	2	0	0	No common links have been identified with the 4 surgical NEs reported this year, nor are they repeats of previous NEs
Never Event – Wrong Site Surgery	3	2	1	1	
Never Event – Misplaced Naso-gastric Tube	1	0	1	0	
Never Event – Wrong Implant	-	-	-	1	
Never Event – Surgical Invasive Procedure	-	-	-	1	
Never Event – Medication Incident	-	-	-	1	This is the first NE of this kind to occur in HEY. Nationally, this is a commonly reported NE, and most commonly reported occurring within ED departments (which is also where the Trust SI occurred). Immediate action was undertaken, a Quality Safety Bulletin was sent

Serious Incident type	2014/15	2015/16	2016/17	2017/18	Comment
					out with instructions on correct administration of oral medications, which is now displayed in clinical areas on CD cupboards.
Retained dressing (not a Never Event)	0	2	0	0	No 'near miss' NEs reported 17/18
Retained foreign object (not a Never Event)	0	1	2	0	
Wrong Site Surgery (not a Never Event)	0	1	0	0	
Unplanned NICU admission	2	0	2	2	From April 2017 cases of babies born with hypoxic brain injury need to be reported to NHS Resolution and considered as SIs. Both SIs from 17/18 have been reported to NHS Resolution.
Absconded Patient	0	0	3	0	No issues reported this year
Maternity/Obstetric Incident	-	-	-	3	Specific category for 17/18, maternity SIs have been reported every year (previously under other categories), and theme throughout is CTG monitoring
Others	9	2	5	0	SI category reporting is improved, no longer using 'other'
Totals	**93**	**111**	**68**	**60**	

2.3.2 Root Cause and Contributory Factors
The root cause (RC) and contributory factors (CF) for SIs completed 1 April 2017 to 31 January 2018 have been reviewed, and a summary of these is now provided.

2.3.2.1 Never Events
As at 31st January 2018, the three completed investigations to date all relate to surgical events. There were no common themes identified from them. However, the identified contributory factors were about communication failures, lack of a process, failure to follow due process and the failure of an existing control. Failure to seek support/advice was a factor in one of these incidents.

2.3.4 Surgical Events
In addition to the three surgical Never Events, there were two other surgical event investigations that were completed. There related to a lack of protocol and a protocol that was not followed. Failure to seek support and communication failure appeared in one case.

2.3.5 Hospital Acquired Pressure Ulcers
Of the completed investigations, poor communication between and within teams, including handover issues, have been identified as either a root cause and/or contributory factor in all. The majority of the CFs for these types of incidents relate to team issues, including training, misunderstanding of roles/responsibilities and how the teams work together. Individual factors for two of the cases identified pre-occupation/narrow focus (not same ward) and all five of the investigations identified patient factors of complex medical conditions.
In relation to clinical themes, a common factor in the development of these pressure

ulcers is nutritional care/failure to get specialist dietetic input.

2.3.6 Obstetric Incidents
Of the completed investigations, the most common root cause was communication failure. A lack of team working was identified for two cases, as were failure to escalate/delegate and lack of team openness. Two cases identified care handover problems and, in two cases, the policy/protocol was not up-to-date or not followed.

2.3.7 CTG Monitoring Within Maternity Services
The monitoring of Cardiotocographs (CTGs – fetal heart monitoring) continues to be a theme in SI's. The service now operates a 'fresh eyes' approach where CTG monitoring is periodically reviewed by other midwives with a view to reducing misinterpretation and, if necessary, obtain timely medical review and escalation.

The Health Service Investigation Branch (HSIB) of the Department of Health visited the Trust in November 2017 to investigate one of the cases of unexpected admission to NICU. This case was reported to NHS Resolution as a hypoxic brain injury. HSIB have recently fed back to the Trust; they do not have any concerns around the care given within this case and will not be pursuing any further investigation. The HSIB team has offered to meet with Trust staff to provide feedback.

2.3.8 Slips, Trips, Falls
There were no common contributory factors identified with the two SI's in this category.

2.3.9 Sub-Optimal Care of The Deteriorating Patient
The have been eight SI's completed into these types of incidents. Of the eight, seven relate to Medicine Health Group, and a common RC in these has been lack of awareness of policy or failure to follow due process. These occurred in ED (4) Stroke (2), Medical Elderly (1) Obstetrics (1). Identified team factors include, roles and responsibilities misunderstood, and issues with decision making. Individual staff factors were identified for 3 of the 7, and these were pre-occupation/narrowed focus and workload. Each of the 8 identified a patient with complex medical history and a complex condition. In relation to communication, poor communication between staff is a common CF.

2.3.10 Treatment Delay
Treatment Delay is a category which can cover many slightly differing types of treatment delays, across all services and HGs. However, a common theme running through the SIs completed is communication failures between teams, often including an inadequate communication system and inadequate or lack of process.

Regarding the inadequate communication system; a common theme relates to the use of paper-based systems. Where there are paper based systems, there is a risk of records not being kept, information being lost and action not then being taken. The Quality Team is linking in with the Innovation and Technology Team to advise them of incidents relating to paper systems as they are reported, so that specialities with issues with paper based systems can be identified and built into Lorenzo project plans.

2.3.11 Patients Lost to Follow-Up
There have been 9 SI's reported in relation to patients that were lost to follow-up cases in 2017/18, and these types of SI's have been reported in previous years.

Three Serious Incidents were declared within the Urology Service, in relation to patients that did not receive an expected follow up appointment. Following awareness of these cases, a review was undertaken within the Trust to determine if any other patients could have potentially come to harm as a result of not receiving an expected follow up. This led to the overall process SI being declared (Tracking Access), which remains an open SI investigation until the clinical validation

work is completed. A Clinical Harm Group is reviewing harms arising from lost to follow ups identified from the clinical validations, and this group will make decisions on further SI declarations.

2.1.12 Internal Reviews

During 2017 Dr Purva, Deputy CMO for Appraisal Revalidation Cultural Transformation and Quality, undertook a review of two themes of SIs; CTG within Obstetrics and a review of SIs occurring within 2016 where the patient died.

Dr Purva's summary of the 2016 SI's was that actions tended to focus on individuals' training and education, rather than a process change. Dr Purva's review of CTG as a theme agreed that a process change was needed to help prevent errors occurring and the recommendations from this review has been incorporated into a Family and Women's Health Group CTG Working Group.

2.1.13 Overall View

A continuing theme within SIs is poor communication. This has appeared as a root cause and contributory factor in the majority of SI's declared 2017/18. This theme was highlighted in the January 2018 Lessons Shared bulletin. Another element of communication is whether staff feel able to escalate their concerns. Work is underway to develop a 'Stop the Line' Policy, which is aiming to empower staff of all grades to speak out without fear of retribution when they witness unsafe or potentially unsafe practice.

2.1.14 Commissioners RCA Process

All completed Serious Incident reports are submitted to the Commissioners for their consideration. The Commissioners have a Serious Incident Panel Group that reviews the submitted reports. These determine whether sufficient investigation has taken place to provide assurance, that the root cause has been established, that recommendations linked to the root cause and any other contributory factors have been made and that an action plan has been agreed, which will address the recommendations.

The RCA review is sent back to the SI panel via the Risk Team. The SI panel has to respond to any queries made, such as requests for further information, additional assurance and sometimes a revised report and/or action plan may be requested if there are felt to be gaps in the SI report, although this is not a common issue.

The response from the panel is then presented at a monthly SI panel meeting. The same representatives from the commissioners' SI panel review group meet with HEY representatives (Deputy Director of Quality Governance and Assurance, Quality Governance Lead and members from the SI panel) and once the report and review have been discussed, if there are no further queries only then is the SI report closed. The commissioners then monitor the SI action plan until HEY submit the closed SI action plan with evidence to provide assurance.

2.1.15 Changes to the Operational Quality Committee (OQC)

The Trust Board will be aware that each SI investigation generates a number of recommendations and actions. These are then monitored for evidence of delivery by the Quality Team and Commissioners before being closed down. The learning points from all SI's are shared across all Health Groups each month. However, there is a need to strengthen this further, in order to test/assure that any due learning has become embedded and sustained. In view of this, changes are being made to the structure of the Operational Quality Committee. This is to enable each Health Group to present each of the SI's that has occurred in their area(s) of responsibility, to include the evidence of learning and sustainability. This will then enable the corporate teams and other Health Groups to confirm and challenge this. The idea is for this to be more rigorous, challenging and transparent. This will be reviewed over time to see if it is successful.

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 March 2017 are attached as **Appendix One**. 930 in-patients were surveyed on Friday 9th March 2018, with the results as follows:

- **94%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.96% [n=18]** 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 **98.04%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **90.5% (n=796)** 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 **5** patients; all of which were with pulmonary embolisms.
- New pressure ulcers remain relatively low **(n=5)**; all of which were at grade 2.
- There were **14** patient falls recorded within three days of the audit day; **10** of which resulted in no harm to the patient, **4** 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 **7/171** patients with a catheter **(4%)**. Of the **7** patients with infections, **4** were infections that occurred whilst the patient was in hospital **(2.3%)**. 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.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

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

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

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**38 (72% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1 (over threshold)**
MSSA bacteraemia	**44**	**36 (82% of threshold)**
Gram Negative Bacteraemia		
E.coli bacteraemia	**73**	**110 (over threshold)**
Klebsiella (new this year)	**14**	**Baseline monitoring period**
Pseudomonas aeruginosa (new this year)	**10**	**Baseline monitoring period**

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

4.1.1. *Clostridium difficile*

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

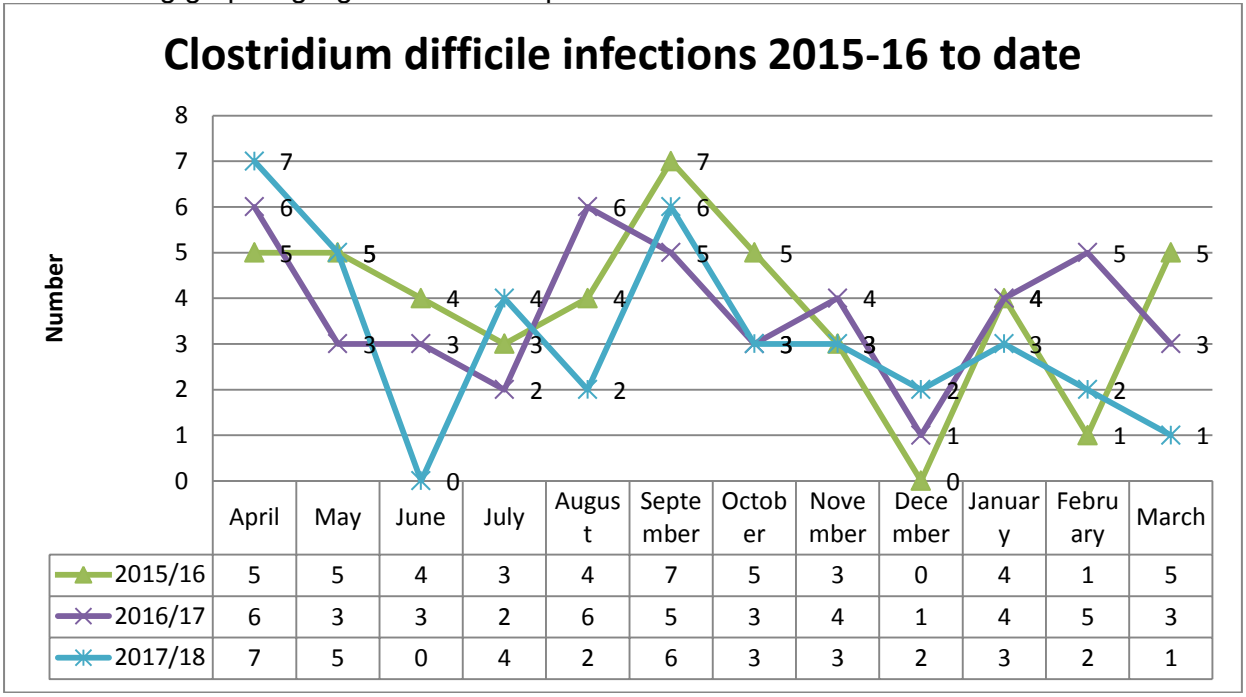
At year end 2017/18, the Trust reported 38 infections against an upper threshold of 53 (72% of threshold). This is an extremely positive result at year-end in comparison to comparable Trusts across the region that were more challenged in meeting their respective thresholds.

Two Trust apportioned *C. difficile* cases were reported during February 2018 and one Trust apportioned *C. difficile* case in March 2018, all in the Medical Health Group.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**38** (72% of threshold)	Of the 38 Trust apportioned C. difficile cases 36 have been subject to RCA investigation and reviewed by Commissioners. Of these 36 cases, 6 cases were determined as lapses in practice, with the lapses

			associated with suboptimal antimicrobial prescribing/ delay in sampling and poor communication. The two outstanding cases require review by Commissioners and will be presented in May 2018.

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



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	5	5	4	3	4	7	5	3	0	4	1	5
2016/17	6	3	3	2	6	5	3	4	1	4	5	3
2017/18	7	5	0	4	2	6	3	3	2	3	2	1

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

The Trust reported one case of MRSA Bacteraemia during the year and the Trust Board has been apprised of the details of this previously. The following table summarises the particulars of that case.

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

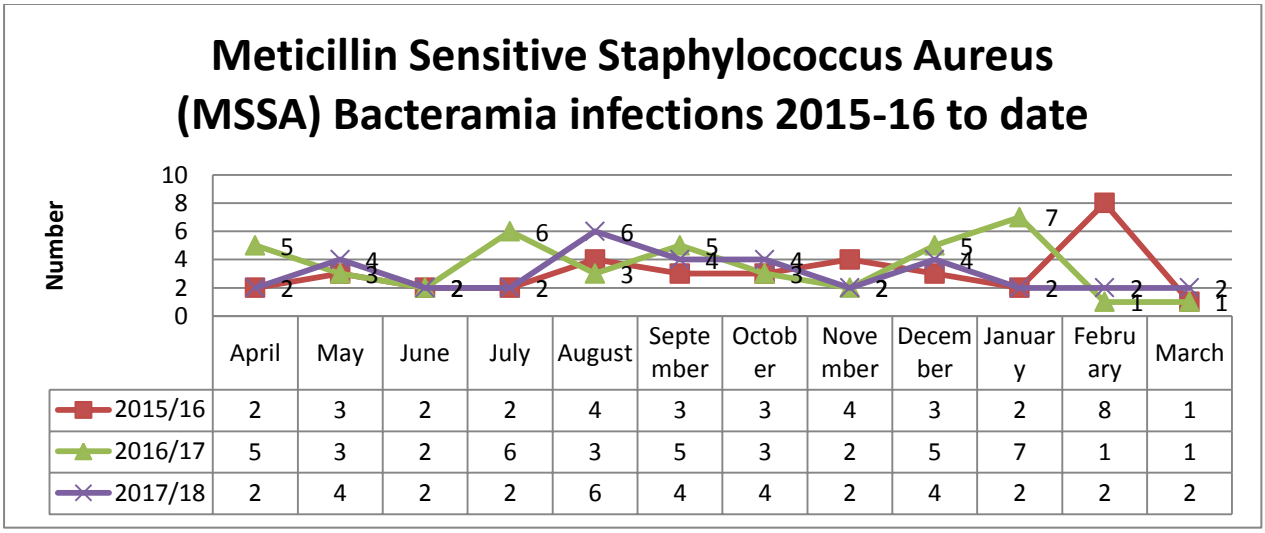
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

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

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

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	**44**	**36** (82% of threshold)	15 unavoidable 10 possibly avoidable 7 avoidable 4 cases awaiting completion of RCA process

MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection but at year-end 17/19, a reduction in MSSA bacteraemia numbers on the previous year's performance has been achieved, which is a positive outcome for patients. The need for continued and sustained improvements regarding this infection remains a priority. A key focus area for the Trust now is in relation to improving the care and management of patients with vascular access lines/cannulae. The following graph highlights the Trust's performance from 2015-16 to date:



4.1.4 *Escherichia-coli* Bacteraemia

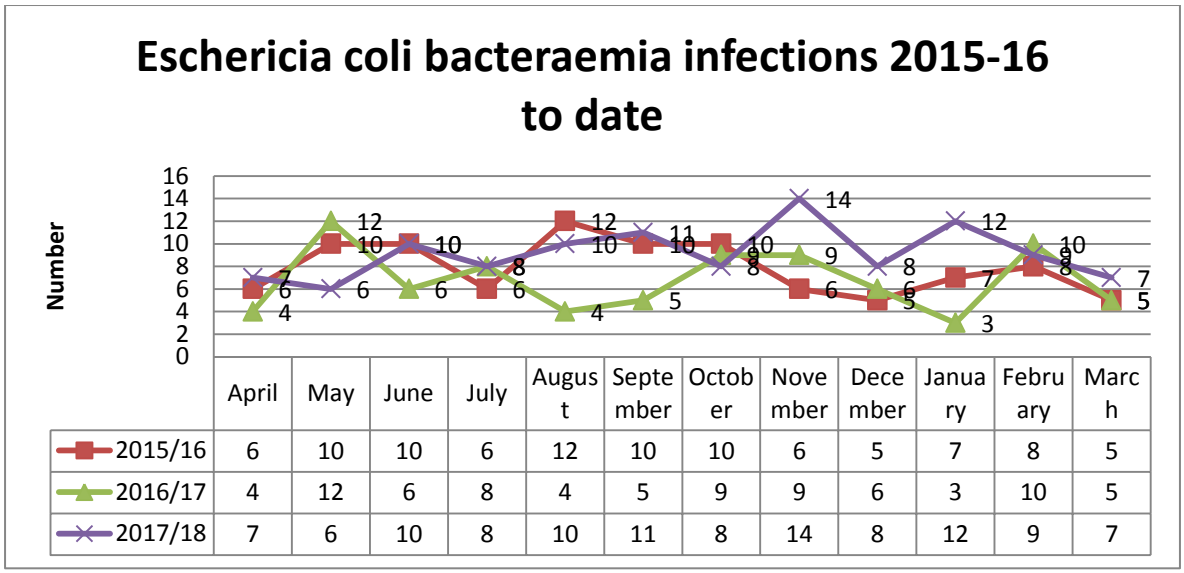
There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals. However, when strains of *E. coli* are outside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

E. coli is now the commonest cause of bacteraemia reported to Public Health England.
E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.
During 2017/18, Trusts were required by NHS Improvement to achieve a 10% reduction in E. *coli* bacteraemia cases. Achievement of reductions is expected to be collaborative through joint working with commissioners and joint action plans. A Trust improvement plan for E.*coli* and gram negative bacteraemia is in place. This will continue into 2018/19 and includes ensuring any due learning takes place.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	No. of cases investigated clinically	Outcome of Clinical Investigation (avoidable/ unavoidable)
E. coli bacteraemia	**73 (after 10% reduction)**	**110 (over threshold)**	110	10 x avoidable 14 x possibly avoidable 88 x unavoidable (the majority related to biliary sepsis)

As can be seen from the table above, most of these infections (80%) were deemed to be avoidable, which makes the thresholds very difficult to stay within.

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



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

A significant number of apportioned cases that account for the increase in cases identified are detected because of compliance with sepsis screening, both in the Emergency Department and for inpatients. Although increases are noted and the Trust breached the threshold at year end for this infection, patients are receiving improved quality of care because of earlier and targeted identification, treatment and appropriate management. This can only be positive for patients.

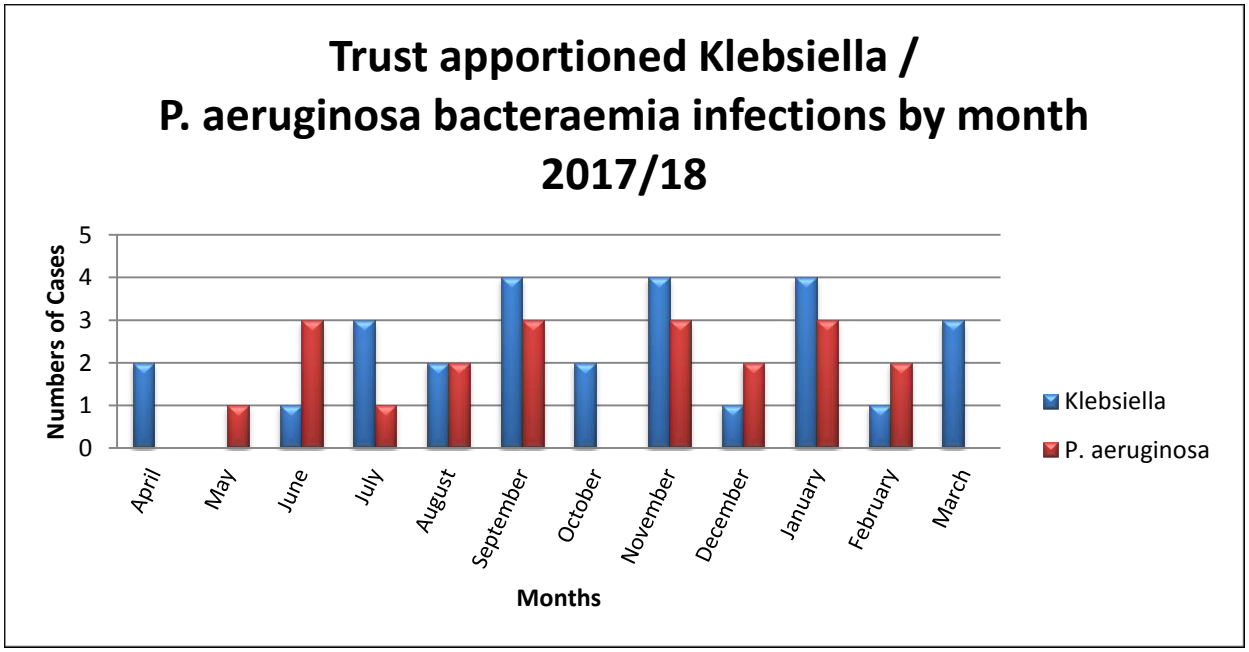
Trust and Community apportioned *E. coli* bacteraemia cases from November 2017 have also benefitted from an additional Infectious Diseases (ID) Consultant review. The review involves the collation of patient demographics, admission method, and speciality on admission. It also includes co-morbidities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

Reviewing cases since April 2017 and following a deeper dive into cases from November 2017, those deemed avoidable relate to hospital acquired pneumonia, management of vascular access devices and the management of urinary catheters, e.g. not removing them at the earliest opportunity when no longer needed and/or when a line infection is suspected. Ongoing surveillance continued until the end of April 2018, providing six-months of analysis of trends and issues associated with this type of bacteraemia.

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

NHS England and Public Health England (PHE) introduced a new set of measures from April 2017 to reduce the burden of gram negative bacteraemia. There is a requirement across the health economy to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021. This includes two additional organisms. Surveillance of *E. coli* bacteraemia continues. However, alongside this, Klebsiella and Pseudomonas aeruginosa bacteraemia cases are now reported to PHE.

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



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

In February 2018, Wards 8 & 80 at Hull Royal Infirmary were affected by outbreaks associated with diarrhoea and vomiting. Ward 80's outbreak resulted in a full ward closure, whereas ward 8's outbreak was limited to affected bays only. In both cases, Norovirus was confirmed with staff and patients affected. In addition, during February 2018, Ward 500 also experienced an outbreak of diarrhoea & vomiting, albeit short-lived, with a single case of *Clostridium difficile* reported. In March 2018, Ward 12 had a short-lived outbreak of diarrhoea and vomiting affecting one bay only. No causative organism was detected.

4.2.3 Influenza trends

The Trust's 'flu' vaccination programme was extended until the end of February 2018, in line with the increase in cases both locally and regionally. Up to the end of February 2018, 78% of Trust staff had received a flu vaccination.

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

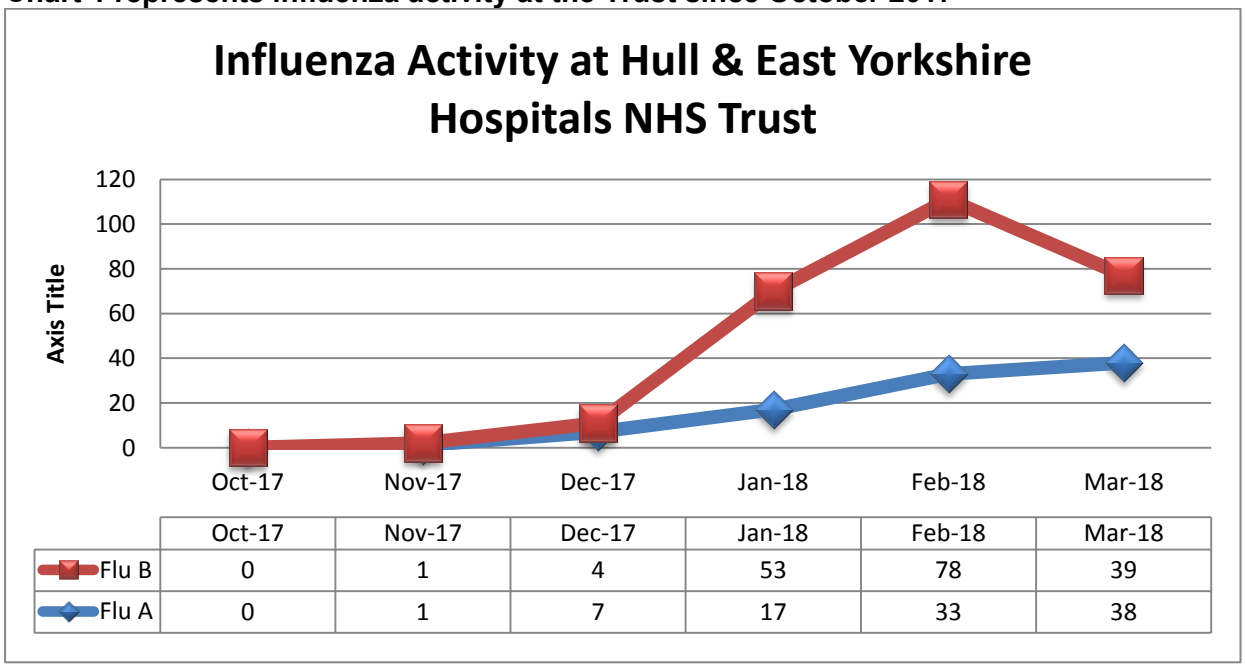
During January 2018, a shift occurred with a significant number of Influenza B cases reported, occurring mainly in younger patients and some 'at risk' patients that had not been vaccinated previously. Seventy cases of Influenza were reported during January 2018 with 73% of cases detected as Influenza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

During February and March 2018, the Trust continued to experience increased incidence of Influenza, with the largest peak occurring in February 2018 with a total number of Influenza cases reported as 111 for the month. Influenza B continued to dominate with 70% of the 111 cases reported as Influenza B. Increased compliance with screening across the Trust may also account for some of the increase. During March 2018, 77 cases of Influenza were reported by the Trust, mainly in patients presenting in ED/AAU with respiratory infection/flu like illness. In total, 38 cases of Flu A and 39 cases of Flu B were detected; there were three patient deaths noted associated with flu in patients with multiple comorbidities.

Yorkshire & the Humber have been particularly affected and the Trust has managed to isolate and/or cohort affected patients quickly. As such, there has been no evidence of onward patient to patient transmission resulting in bay/ ward closures, as has been experienced elsewhere in the region.

The following chart shows the trends with influenza, by type.

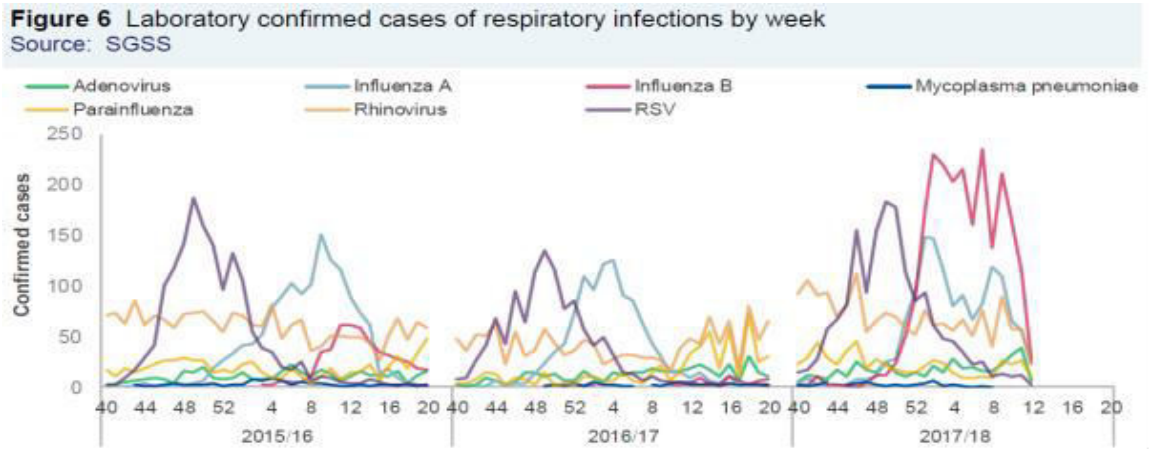
Chart 1 represents influenza activity at the Trust since October 2017



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Flu B	0	1	4	53	78	39
Flu A	0	1	7	17	33	38

Whilst difficult to read in detail, the following chart is provided to show the peak in Influenza B (red line) in 2017/18 across Yorkshire and The Humber compared to many fewer cases in the previous two years.

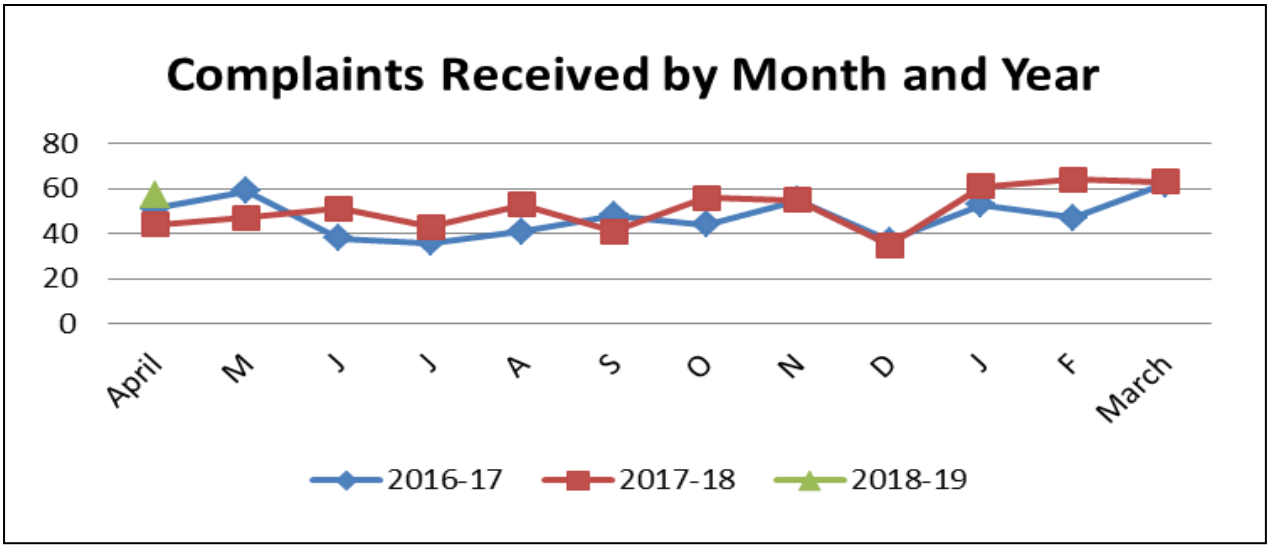
Chart 2 represents activity of respiratory infections including Influenza A & B across the Yorkshire & Humber region (PHE Field Epidemiology Service)

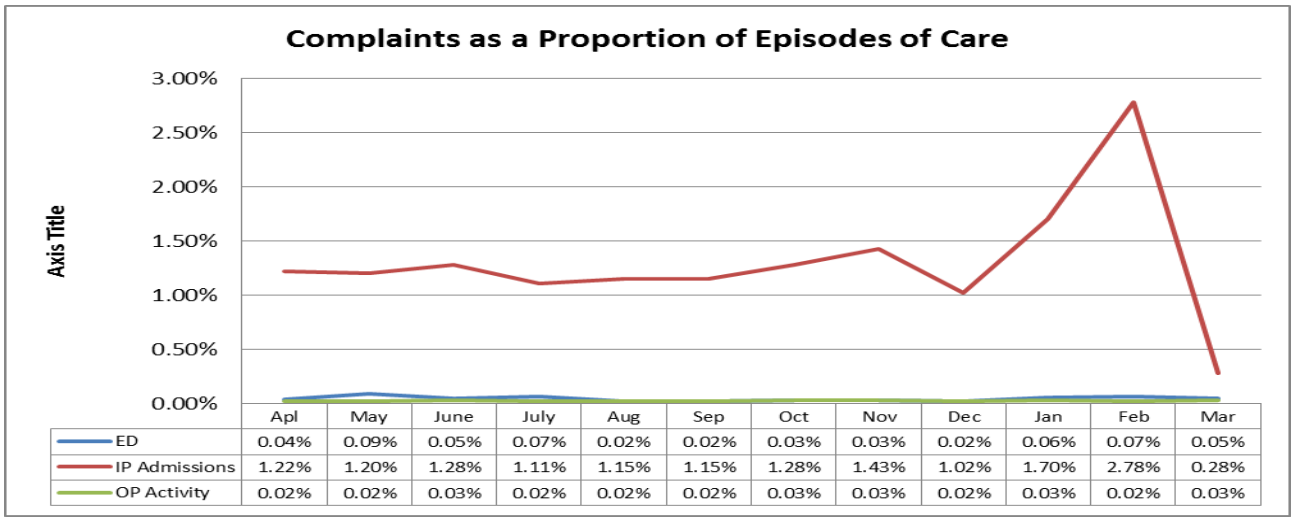


5. PATIENT EXPERIENCE

5.1 Complaints

The following graph sets out comparative complaints data from 2016 to date. There were 61 new complaints recorded in March 2018 and 57 complaints in April 2018. This is in line with the same period on the previous two years. The Patient Experience team has reviewed the complaints received to identify any themes and trends and have raised awareness with senior staff when several complaints have been received within a specific area.





	Apl	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.04%	0.09%	0.05%	0.07%	0.02%	0.02%	0.03%	0.03%	0.02%	0.06%	0.07%	0.05%
IP Admissions	1.22%	1.20%	1.28%	1.11%	1.15%	1.15%	1.28%	1.43%	1.02%	1.70%	2.78%	0.28%
OP Activity	0.02%	0.02%	0.03%	0.02%	0.02%	0.02%	0.03%	0.03%	0.02%	0.03%	0.02%	0.03%

The number of complaints for each Health Group and Corporate department during 2017/18 and for the month of April 2018 by subject area are indicated in the following tables.

Complaints Received by Health Group and Subject – 2017-18

Complaints by Health Group and Subject (primary)	Advice	Attitude	Care and Comfort	Communication	Waiting times & cancellation	Discharge	Safeguarding	Treatment	Total
Corporate Functions	0	1	0	2	0	0	1	0	4
Clinical Support	1	1	2	3	3	3	1	26	40
Family and Women's	0	9	1	10	9	1	0	115	145
Medicine	1	8	22	19	12	22	4	130	218
Surgery	0	8	7	12	16	7	1	154	205
Totals:	2	27	32	46	40	33	7	425	612

In 2017/18, 612 complaints were opened and 607 formal complaints were closed. This shows an increase on the 2016/17 number of formal complaints received, which was 581 and 579 closed. The Trust aims to close complaints within 40-working days. The complaints team has worked closely with the health groups to improve the closing of complaints, which has shown improvement. Of the 607 complaints investigated, 425 were regarding treatment issues. Concerns relating to the patient's treatment and not being satisfied with plan of care remains the highest category (126), with treatment /outcome of surgery at (84), incorrect diagnosis (61), treatment/outcome of treatment (53) and treatment delayed (31) being the top 5 sub-subjects. These subjects also received the highest number of complaints in 2016/17.

5 complaints were not investigated as each complainant had requested that it not be progressed; it was responded to as PALS or was escalated for a serious incident investigation. 223 complaints were not upheld, 278 partly upheld and 98 upheld.

Complaints Received by Health Group and Subject – April 2018

Complaints by Health Group and Subject (primary)	Advice	Attitude	Care and Comfort	Communication	Waiting times & cancellatio	Discharge	Safeguarding	Treatment	Total
Corporate Functions		0	0	0	0	0	0	0	0
Clinical Support		0	0	0	0	0	0	2	2
Family and Women's		1	0	0	0	1	0	10	12
Medicine		4	2	1	2	1	1	15	26
Surgery		2	0	0	1	0	0	14	17
Totals:		7	2	1	3	2	1	41	57

Medicine Health Group received the highest number of complaints in April 2018 with Specialist Medicine Division receiving 10 and ED 7. 55 complaints were closed this month, 14 upheld, 20 partly upheld and 21 not upheld. 7 complaints were re-opened.

5.1.1 Learning from complaints

Health groups have advised the following learning from complaints closed in the months of March/April 2018:

1. A relative expressed concerns due to miscommunication regarding treatment.
   Outcome: The patient did receive the correct and planned treatment; however, there had been a miscommunication with the patient and family about this. The consultant concerned apologised to the patient and family and reassured them that the treatment received was that recommended by UK guidelines for Head and Neck cancer patients.

2. A patient raised concerns regarding long term side effects experienced after radiotherapy treatment.
   Outcome: A resolution meeting was held and the patient reassured that these side effects were sometimes experienced by some patients and apologies extended that although this had been communicated with the patient prior to treatment, she had not been aware fully.

3. A relative expressed concern regarding care of a patient in the Queen's Centre.
   Outcome: A resolution meeting was held and the issues related to communication with the medical teams. The Clinical Lead has discussed with the clinicians concerned to raise awareness of the impact this had on the family and to promote learning.

4. A relative raised concerns regarding the care of his wife whilst an inpatient in the Queen's Centre.
   Outcome: The issues were investigated and mainly relating to communication when the patient was rapidly deteriorating. The Senior Matron has discussed with the teams, both medical and nursing, to ensure reflection and learning.

5. A relative raised concerns regarding delays in the pathology laboratory sending biopsy samples.
   Outcome: Senior Matron investigated the concerns raised. There were some delays due to annual leave of a Consultant Pathologist and the requirement for samples to be examined in our own laboratory first, prior to being referred to Birmingham. A plan has now been implemented in the Pathology Laboratory to ensure these tests are processed within the department in a timely manner.

6. A relative raised several concerns regarding the care of a patient on C31.
   Outcome: A resolution meeting was held and actions that resulted included the Senior Matron reiterating to all ward staff the importance of checking who they are speaking to when giving out information on the telephone. Senior Matron to ensure that staff are aware that family members can assist with feeding if required and staff to escalate if they are unable to help a patient with feeding. The Clinical Lead and Senior Matron were to raise the communication issues with all staff to ensure there is improvement. There was also an issue of negative behaviours of some of the non- registered staff on the ward, which is being addressed by the Ward Sister and Senior Matron.

7. A relative raised concerns regarding delay in treatment for his father.
   Outcome: this was investigated and the relative reassured that there were no delays in treatment. However the time taken between initial referral to treatment was in order to ensure that a correct diagnosis was made and that the patient was well enough to tolerate treatment before commencing palliative chemotherapy.

8. A relative expressed concerns relating to pathology testing and delays in the process.
   Outcome: a full investigation was undertaken and information and explanations given to the family.

9. A relative expressed concerns over her husband's care whilst an inpatient at the Queen's Centre but also relating to issues experienced in his care pathway prior to admission. **Outcome:** The relative was reassured that investigations were not undertaken sooner as there was no clinical indication to do so. The patient deteriorated suddenly following a clinical procedure that could not be anticipated and it was acknowledged that this must have been distressing for the family. Communication also featured within this complaint as the relative did not feel they were appropriately informed about the seriousness of her husband's illness. The team extended apologies for the poor communication. Despite the sudden deterioration, there should have been discussions with the family with regard to prognosis of this patient.

Other information
As a result of a complaint raised in 2017 by a relative of a patient on C33, a video has been produced featuring the patient's daughter discussing her concerns and how the ward's poor communication impacted on her mother and the family as a whole. This has been extremely powerful in supporting staff to see the consequences of their actions and omissions. It is now being used as a training tool within the Health Group (Communications days, Induction sessions) to ensure all staff learn from this patient's and her family's experience.

5.1.2 Performance against the 40-day complaint response standard
A review of the formula used for calculating how many complaints have been closed within 40-working days has been undertaken and it has been identified that there is a problem with the automated calculation methodology. This has been reported to the Trust Board previously.

In view of this, the Trust Board requested for Internal Audit to review the processes in order to obtained assurance around the methods used. This is now under way and the outcome of this will be reported to the Trust Board in due course. In view of this, the performance data for 2017/18 and April 2018 has been removed until full assurance on the data can be obtained.

5.2 Patient Advice and Liaison Service (PALS)
In the period 1 April 2017 to 31 March 2018, PALS received 2,296 concerns, 328 compliments, 27 comments or suggestions and 805 general advice issues. The concerns received are indicated by subject and health group in the following table.

PALS Received by Health Group and Subject – 2017/18

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Waiting times and Cancellatio	Discharge	Environment	Hotel	Special Needs	Safeguarding	Treatment	Total
Corporate Functions	85	25	0	38	19	2	9	24	1	1	4	208
Clinical Support	10	13	1	23	48	3	1	1	1	0	33	134
Family and Women's	34	40	4	55	274	7	2	1	0	1	145	563
Medicine	63	70	28	111	241	33	8	1	3	3	152	713
Surgery	41	49	15	60	344	18	4	0	0	0	147	678
Totals:	233	197	48	287	926	63	24	27	5	5	481	2296

April 2018 figures show that PALS received 223 concerns, 33 compliments, 96 general advice requests and 2 comments/suggestions. The following table indicates the subject received for each health group. Delays, waiting times and cancellations continues to be the highest number of concerns received (100) with Treatment the second highest (42).

PALS Received by Health Group and Subject – April 2018

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Waiting times and Cancellatio	Discharge	Environment	Hotel	Special Needs Safeguarding	Treatment	Total
Corporate Functions	5	7	0	5	0	1	1	5	0	1	0	25
Clinical Support	0	1	0	2	5	0	0	0	1	0	8	17
Family and Women's	5	1	1	8	27	0	0	0	0	0	10	52
Medicine	7	6	3	8	37	3	0	0	0	0	12	76
Surgery	4	1	0	4	31	0	0	0	0	0	12	53
Totals:	21	16	4	27	100	4	1	5	1	1	42	223

5.2.1 Outcomes from PALS cases

5.2.1.1 Delays in reporting results:

The Laboratory Manager in Cellular Pathology has advised PALS that all biopsies have to be tested by the Trust before sending to Birmingham as this centre will not accept a referral without an accompanying histology report. However, the Laboratory Manager has informed PALS that she is currently in the process of trying to introduce this test in-house, in the hope that tests can be performed and reported within 2 days as she is aware that therapy provided can make a significant difference to patients.

5.2.1.2 Paediatric/CT issues:

One area of concern was that no one had identified that a paediatric patient would need sedation for his CT appointment. Administration staff cannot make this decision and there is no protocol in place. It is not always straightforward which patients should have sedation and it is dependent on the patient and the examination to be undertaken. Paediatrics and radiology are now in talks to put together a protocol regarding a more joined-up approach to avoid further problems going forward.

5.3 Compliments

- A compliment was received from a patient who had an endoscopy. She stated that she was "scared stiff and having panic attacks". The patient reported that she was "given the most fantastic support from the nurse who completed the paperwork to the nurse that did the actual procedure. They took the time to calm me down and got me through at such a horrible time. They went above and beyond their jobs. I would like to thank them all so much for making me feel like a person and not just a number".

- A patient on Ward 6 at HRI who had surgery said "On behalf of my family and myself I wish to register our gratitude to the nursing and medical staff, cleaners, orderlies and housekeeping. Their care, kindness and total dedication helped me to recover from my surgery. Without their humour, professionalism and expertise, my recovery would not have been so smooth. The team on Ward 6 provided me with a level of care that far exceeded good and was approaching excellent. Nothing was too much trouble. They were always there to help, they were highly efficient, compassionate and above all caring in every circumstance. They are a total credit to the nursing and medical profession".

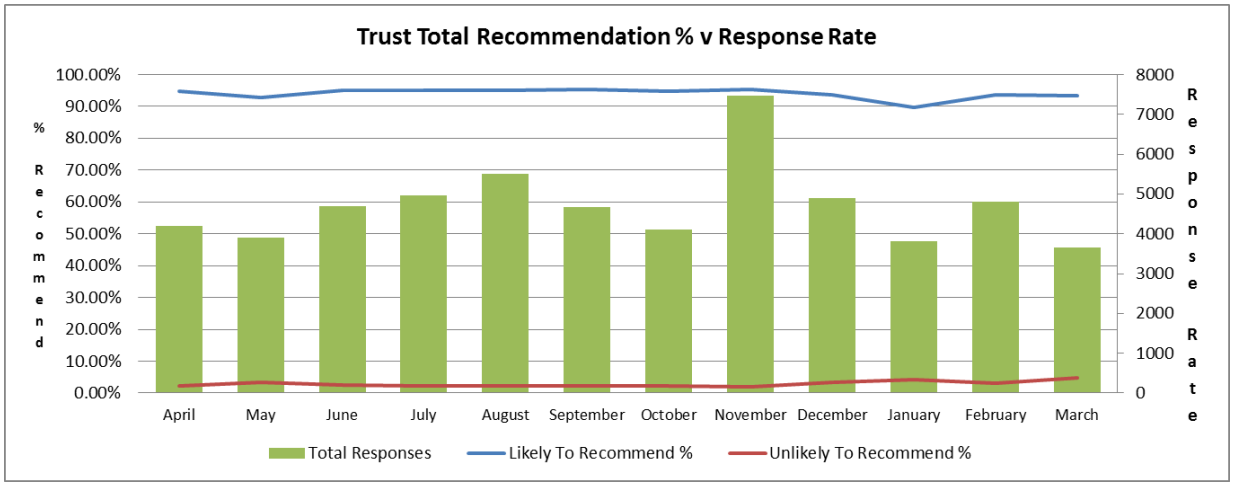
- The family of an elderly patient wrote to PALS to say how impressed they were with the care given to their father. The patient had been diagnosed with a subdural haematoma. They said "Mr Bahl and Specialist Nurse Sally Newton are a credit to your organisation. The care and compassion shown was exceptional. Through what has been an extremely stressful time they have shown empathy, compassion and were highly professional at all times".

- The patient wished to pass on her compliments to the Trust's switchboard staff for the speed and professional way they handled her call. She said she was put straight through to the cardiology secretary without any delay. Her experience with other hospitals had resulted in dropped calls, endless waiting and having to re-dial several times. The lady was keen to advise PALS of how pleased she was with the service.

5.3 Friends and Family Test (FFT)

The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for March 2018 with 3,665, compared to February 2018 when 4,816 were received. The March 2018 results indicated that **93.23%** of respondents were extremely likely/likely to recommend the Trust to friends and family, which is slightly below the nationally set-target of **95%.** The Patient Experience Team is working with wards to collect patient feedback on a daily basis.

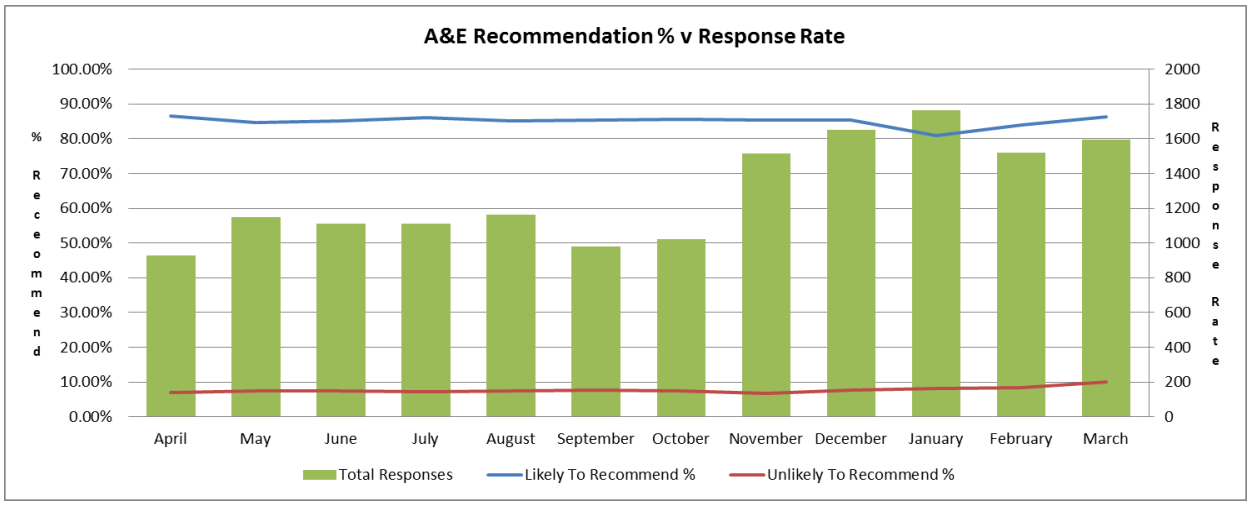
5.3.1 Trust Summary – all areas



5.3.2 Friends and Family Emergency Department (ED)

1,517 patients that attended the Emergency Department in February 2018 responded to the Friends and Family Test with **83.98%** of patients giving positive feedback and **8.31%** negative feedback. The remainder were neither positive nor negative. 1,593 patients who attended the Emergency Department in March 2018 responded to the Friends and Family Test with **86.25%** of patients giving positive feedback and **10.04%** negative feedback.

The following table highlights the increased response in the Emergency Department since the start of the Friends and Family Test since the implementation of the SMS text messaging service in November 2017.



The Trust figures for the month of April will not be available nationally until the 10th of April; however, there are indications that the Trust has an increase in responses for April.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 11 cases under review by the PHSO currently. During the month of March there has been one case closed which was partly up held. The main theme from the partly up held investigation highlighted poor performance when breaking bad news.

5.5 Patient Council
The Patient and Public Council continues to integrate within the services and areas across the Trust. The Council has recently allocated each of its members to a Health Group in order to link them more closely. Additionally, the Council is assisting with the PLACE visits and the PRASE initiatives, both of which are to raise the quality of the patient environment, patient safety and assurance. The Patient Council's main aim is to be the voice of the patient.

The responsibilities of the Council are:

- to represent the views of patients
- identify the need for working groups to assist the Patient Council
- receive and consider results of any patient and/or staff surveys
- consider information received from the Head of Patient Experience
- contribute to discussions regarding the efficiency and effectiveness of the Trust's use of resources
- consider presentations and updates from the Trust and others
- receive reports from specialist groups
- contribute to key meetings and committees
- contribute to evaluations of service, such as infection control
- introducing new ways to measure the experiences of patients
- participate in audits of care standards

5.6 Interpreters
Language Line Solutions (LLS) was appointed as contractor for all interpreter services, including British Sign Language, on 3 April 2018. The contract with LLS will run until 31 March 2021, with the option to continue for an additional 24 months. The Patient Experience Team has supported training to staff and visited wards and departments personally to give assistance when required.

200 cordless telephones with a speaker function have been purchased and distributed across all wards and departments to support staff in using telephone interpreting where appropriate. There has been an increase in the use of telephone interpreters, which is an efficient and cost effective solution for staff to communicate with patients who are not proficient in speaking English.

Face to face interpreting when needed for clinical purposes is still available to staff, or when the length of an appointment determines it to be more cost effective. Some languages have not been readily available initially e.g. Swahili, Mandarin, Dari; however LLS have now sourced professional interpreters for these languages. There have been requests for interpreters in Vietnamese, Kinyarwanda and several other rare languages and whilst these are not always possible in a face to face situation, telephone interpreters have been available.

Reports are expected from LLS in the next week that will indicate the languages spoken, the length of time the interpreter was required and the department making the booking. The reports are expected to demonstrate the change from a default position of face to face interpretation to telephone and the cost savings achieved. This will be reported further in the next Board report.

6. OTHER QUALITY UPDATES

6.1 Care Quality Commission (CQC) - Well-Led and Core Services Inspections

The Trust received an 'unannounced' Core Services inspection from the CQC from the 7th February to the 9th February 2018. Medicine, Surgery, Maternity and Outpatients were inspected. The Trust had an 'announced' Well-Led inspection from the 27th February to the 1st March 2018.

The Trust received the draft CQC Quality Report and corresponding Evidence Appendix for review and factual accuracy checks on the 24th April 2018. The Trust was required to respond by the 9th May 2018. The Trust responded within the designated timescales with a number of areas of challenge as well as a required action plan to address any breaches in regulations. It is not clear what timescales the CQC is now working towards. The Trust Board will be advised about this accordingly.

6.2 Update from Learning from Deaths reviews

The Trust continues to review all appropriate deaths. As part of the Trust's internal audit schedule, Mersey Internal Audit Agency (MIAA) undertook a baseline assessment on the Trust into how it identifies, investigates and learns from patient deaths. The Trust was awarded "Significant Assurance", which reflects the positive progress that has been made to date.

During Quarter 4 there were a total of **696** deaths within the Trust. The Trust undertook a full Structured Judgement Case-note Review on 16% of all in-hospital deaths during this quarter.

Total Number of Structured Judgement Reviews (Tier 1 and 2) undertaken in Q4	Number of Tier 1 reviews	Number of Tier 2 reviews
112	**96**	**9**

The following table provides information relating the National Quality Board minimal requirements for undertaking a Structured Judgement Case-note Review:

Criteria	Total number of deaths in Trust Q4	Number of reviews completed in Q4
All elective surgery procedures	**17**	**17**
All cases where a complaint was raised by the family/Next of Kin, in relation to care.	**3**	**3**
All cases where the patient was identified to have a severe mental illness	**5**	**5**

Themes identified from Structured Judgement Reviews in Quarter 4 2017/18

Negative/Positive	Theme Details	Actions taken to address
Negative	Inadequate documentation within case-notes relating to patient admission.	With the launch of the new ReSPECT advance care planning, the future audits will be reviewing this documentation and hopes that this will address documentation issues
Negative	Evident delays in escalation when the patient deteriorates / Escalation not documented within notes.	Deteriorating patient QIP work stream is looking at this as part of its action planning

Positive – Good Practice	Pre-alert given to A&E by Ambulance service, allowing the A&E team to prepare for arrival accordingly.	
Positive – Good Practice	Evidence of excellent communication with family/next of kin during the end of life phase.	
Positive – Good Practice	Multidisciplinary input available immediately.	

A second multi-agency review is to be undertaken in June 2018 and will concentrate on patients who had a Stroke related death within the Trust. The review team will include General Practitioners from both East Riding and Hull Clinical Commissioning Groups, as well as physicians from within the Trust.

6.3 Venous Thromboembolism (VTE)
The trust failed to meet the VTE target of 95% in 2017/18 with Health Groups results in the table below:

Health Group	**%**
Clinical Support	94.54%
Family and Women's Health	92.53%
Medicine	83.36%
Surgery	92.03%
Trust Total	**90.15%**

Source: Business Intelligence

The Chief Medical Officer and the Health Group Medical Directors are leading on the development and implementation of a Quality Improvement Programme (QIP) scheme, which will set improvement trajectories for all areas that require it.

7. RECOMMENDATION
The Trust Board is requested to receive this report and:

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

Mike Wright
Chief Nurse

Kevin Phillips
Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

Appendix One – Safety Thermometer February 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	15th May 2018		**Reference Number**	2018 – 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: BAF 1 and BAF 2	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is a standing agenda item at each Board meeting.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations)[1,2] and the Care Quality Commission. This report also includes the establishment reviews that were completed April 2018.

2. BACKGROUND

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

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

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*
[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing
[3] When Trust Boards meet in public

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

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%
Oct-16	88.51%	100.79%	90.58%	106.38%
Nov-16	91.30%	97.10%	95.70%	107.30%
Dec-16	91.23%	100.10%	97.00%	100.76%
Jan-17	93.00%	103.50%	99.10%	101.10%
Feb-17	90.10%	98.10%	94.80%	100.30%
Mar-17	86.80%	95.90%	89.60%	102.10%
Apr-17	85.20%	97.61%	89.15%	102.19%
May-17	83.70%	94.20%	89.20%	102.60%
Jun-17	90.40%	94.20%	93.90%	102.90%
Jul-17	84.00%	89.60%	91.30%	100.90%
Aug-17	78.40%	93.20%	88.00%	100.80%
Sep-17	77.50%	96.70%	87.60%	101.80%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	82.20%	95.90%	92.60%	103.20%
Dec-17	82.50%	93.50%	92.30%	100.30%
Jan-18	84.30%	93.00%	93.80%	101.00%
Feb-18	83.00%	89.00%	92.00%	97.00%
Mar-18	80.60%	83.20%	90.70%	88.90%

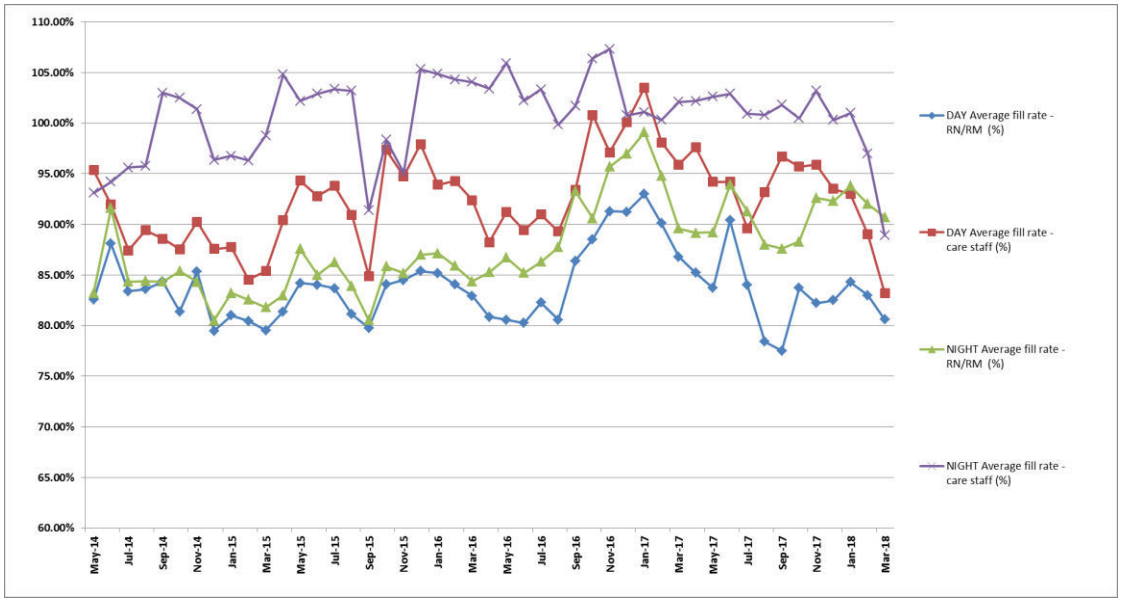
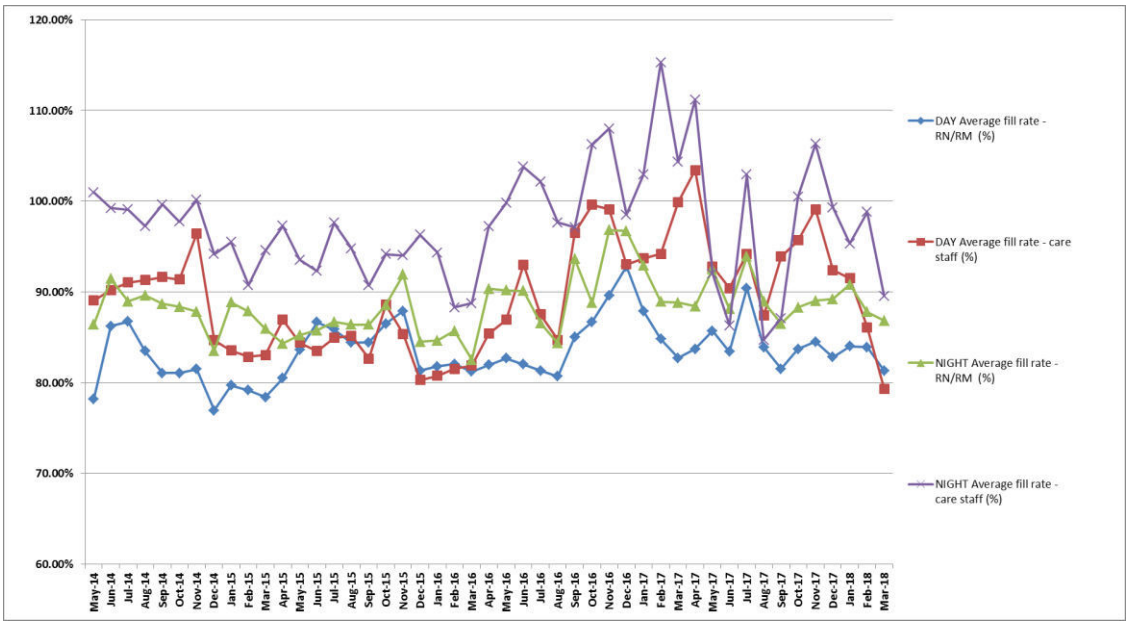


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%
Oct-16	86.70%	99.59%	88.79%	106.24%
Nov-16	89.60%	99.10%	96.80%	108.00%
Dec-16	92.79%	93.03%	96.70%	98.50%
Jan-17	87.90%	93.70%	92.90%	102.90%
Feb-17	84.80%	94.20%	88.90%	115.30%
Mar-17	82.70%	99.90%	88.80%	104.30%
Apr-17	83.71%	103.40%	88.41%	111.16%
May-17	85.70%	92.80%	92.50%	92.00%
Jun-17	83.40%	90.40%	88.10%	86.30%
Jul-17	90.40%	94.20%	93.90%	102.90%
Aug-17	83.90%	87.40%	88.90%	84.70%
Sep-17	81.50%	93.90%	86.50%	87.10%
Oct-17	83.72%	95.68%	88.29%	100.49%
Nov-17	84.50%	99.10%	89.00%	106.30%
Dec-17	82.80%	92.40%	89.20%	99.30%
Jan-18	84.00%	91.50%	90.80%	95.30%
Feb-18	83.90%	86.10%	87.80%	98.80%
Mar-18	81.31%	79.34%	86.82%	89.55%



As illustrated in the aforementioned tables, the fill rates for both HRI and CHH have dropped over the last two months; with CHH average day fill rates for Care Staff dropping below the desired 80% in March.

Analysis at high level indicates a greater number of clinical areas breaching the desired 17% maximum annual leave allocation,(as illustrated in appendix 2) compared to the previous month, which is likely to be related to ensuring all annual leave is taken prior to the end of the financial year. Work continues with the Senior Sisters/Charge Nurses to ensure that annual leave is distributed evenly across the financial year. From a more granular perspective, the following narrative provides a more comprehensive explanation as to why the fill rates have reduced during February and March 2018.

AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

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

- **H70 (Diabetes and Endocrine)** has 6.90 wte RN vacancies. This ward continues to be supported in the interim by moving staff in the Medical Health Group. Additional support has been provided from the Surgical Health Group and nurse bank, therefore reducing the current net vacancies to 2.67 wte in real terms.

- **Elderly Medicine [x5 wards]** have 15.78 wte RN vacancies. The specialty has over recruited by 10.04 wte auxiliary nurses to support the RNs in the ward areas to deliver nursing care with supervision. These are all within budget. The Senior Matrons are supporting the ward in the interim by moving staff in the Medical Health Group.

- **H5, RSU and H500 (Respiratory Services)** have 4.65 wte RN vacancies between them. Support continues to be provided from the Nurse Bank to ensure staffing levels are maintained at a safe level. Critical Care have released 2.0 wte RN's to work in the RSU. In addition there are 2.00 wte RNs on rotation from critical care working within the respiratory support unit. This has been favourably received by both clinical areas as it is offering a learning opportunity for the staff involved as well as improving the staffing numbers.

- **H11 and H110** have 11.37 wte RN vacancies. The impact of this shortfall is supported by part-time staff working extra hours, bank shifts and over filling of auxiliary shifts. Additional support is also being provided by Critical Care, who have released 2.0 wte. Registered nurses to support the HASU.

- **Winter Ward H10 -** supported through the temporary redeployment of staff from all of the Health Groups during February and March. As part of the winter plan, the ward closed as planned April 2018.

- **Ward H4 -** Neurosurgery has 5.08 wte RN, **H40** has 2.35 wte RN vacancies. The band 7's work closely together to minimise the impact of the vacancies.

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

- **Ward H12 & H120 –** Trauma Orthopaedics have 6.15 wte RN vacancies across the floor.

- **Ward C10 & C11 -** Elective Colorectal Surgery has 7.18 wte RN vacancies across both wards.

- **CICU –** Critical Care Unit at CHH has 5.35 wte vacancies with a further 5 leavers pending. Support is being provided by HICU.

- **Wards 30-33** – Oncology and Haematology have 11.95 RN vacancies. In order to ensure safety the service has closed 5 beds on C31 and staff are moved between the wards following assessment daily by the Senior Matron. A Registered Nurse from the Oncology Health Centre is working on the wards in order to support and C33 have over recruited non registered nurses to ensure patient safety. The Ward Sisters all undertake additional clinical shifts as required, in addition to their three rostered shifts weekly. We now have the second Senior Matron in post and therefore are fully established from a senior nurse perspective, in addition have extended the secondment into a Matrons' post of one of the Ward Sisters specifically to support the roll out and implementation of EPMA but also ensuring there is senior nurse presence, visibility and accessibility to ensure patient safety.

- **Ward C16** - The fill rates for non-registered staff on C16 are as a result of 4.04 wte vacancies. These are fully recruited to and we are waiting a start date, but during both February and March 2018, the ward bed base was reduced to 21 beds to ensure safe staffing levels with 2 registered nurses redeployed to support the Winter Ward so this was safe. In April 2018, the staff returned from the Winter ward and the beds on C16 were reopened and the ward is running 30 beds.

- **Cedar Ward HRI** - The fill rates for Cedar ward are reflective of the changes put in place for winter capacity. The ward supported the winter ward with 1.33wte registered nurses and the use of the ward was temporarily adjusted to take medical step down patients, alongside gynaecology emergencies. Due to the nature of this patient cohort, the 9 beds and 11 trolleys were replaced with 16 in-patient beds to reflect the slower turnover of medical patients. The fill rates reflect the lower staffing ratio required to staff this safely. Cedar Ward returned back to business as usual in April 2018.

- **Ward 35** - fill rates for non-registered nurses have been affected by vacancies and sickness absence, combined with redeployment to alternative departments to support the workforce when it has been safe to do so.

- **Paediatrics** have not recruited into their non-registered posts as they were hopeful of using the money for Nursing Associate posts, but it seems unlikely that Paediatrics will benefit from this in the near future. This, along with sickness absence in a small cohort of staff has impacted on the fill rates, but an agreement has been made to recruit into these posts.

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

April as the winter ward is now closed and staff have returned back to their normal ward base.

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

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

4. RECRUITMENT AND RETENTION

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns and rotational programmes. Following successful interviews, the Trust is currently pursuing 140 student nurses who are due to complete their training in September 2018.

A proposal to support the recruitment of an additional 15 Nursing Associate Trainees and 15 Nurse Apprentices has been endorsed by the Trust Board. Both cohorts will commence their training with the University of Hull in September 2018. The initial recruitment campaign will be focused towards existing Trust staff, in an endeavour to provide a structured career pathway for non-registered staff that wish to progress their career.

Work has also commenced between the Trust, the University of Hull and Hull College to develop a career pathway for young people who wish to enter a career in Nursing. It is envisaged that all three organisations will work together to provide the building blocks, which will enable the student to obtain both the academic and clinical requirements needed to enter the nursing profession.

The Trust now has twenty four international recruits that have joined the Trust over the last ten months. Thirteen of the recruits have now passed the OSCE (Objective Structured Clinical Exam), which is the final stage in the process of obtaining an NMC PIN number. The thirteen are now deployed onto a mixture of wards, ICU and in theatres. In addition a further recruit already had a NMC PIN number on arrival.

There are a further three recruits scheduled for OSCE resits on 16 May 2018 and a further two that need to be booked for their resits. In addition five recruits are being booked for their OSCE on the 23 May 2018.

Plans are now in place for a further sixteen recruits to join the Trust during the next three months.

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

- Improving retention by understanding why staff leave and what can be done to address that beforehand.
- Focused work with those approaching 55-year age/early retirement to see if anything can be done to persuade such staff to stay on, including part-time and flexible hours
- Considering more flexible working opportunities in general
- Looking at skill mix; as one key reason for leaving is due to the apparent lack of career progression opportunities
- Undertaking time/motion work to understand the roles and tasks that RN's are doing compared to that of the non-registered workforce and other healthcare professionals, the initial results of the pilot completed during April should be available for review in early June.
- Review of nursing shift patterns (underway currently)
- Undertake staff surveys about what would make the difference to help keep nurses working here.

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

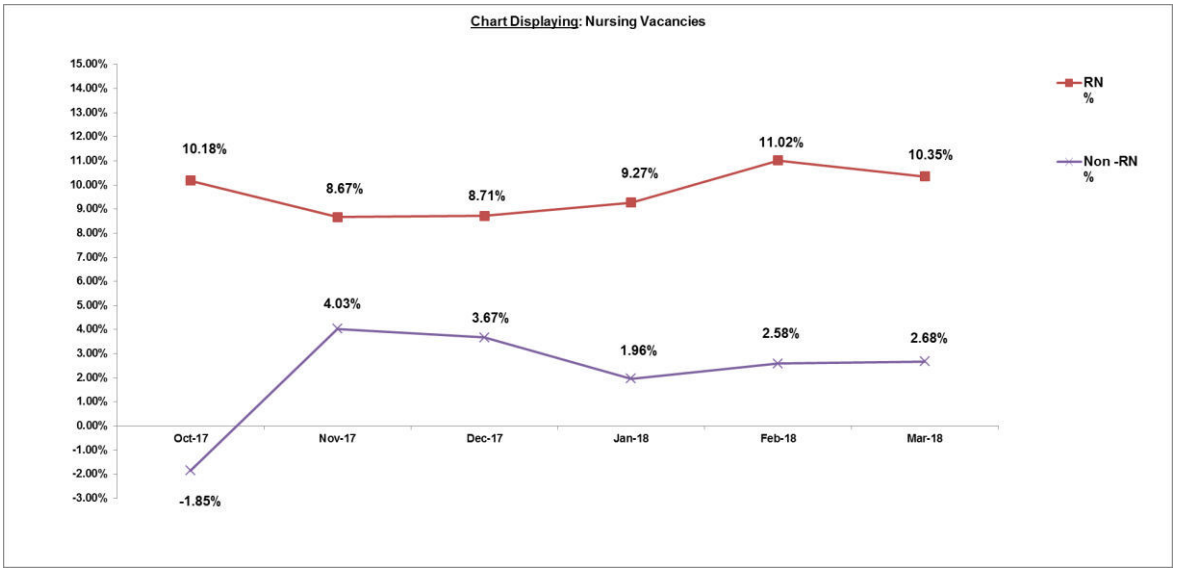
The Chief Nurse chairs the North of England Workforce Group. This group is currently focusing on the following:

- Age profiles and workforce supply.
- Best practice on retention, including how best to support new registrants.

4.1 Current Vacancy Position for Registered and Non Registered Nurses.

The following table illustrates a summary of the Vacancy position for both Registered and Non-Registered nurses (wards and ED) since October 2017.

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.59	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.29	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.04	1276.47	509.93	1786.4	7.28%
Jan-18	118.31	9.27%	10.00	1.96%	128.40	1276.47	509.93	1786.4	7.19%
Feb-18	140.67	11.02%	13.17	2.58%	153.84	1276.47	509.93	1786.4	8.61%
Mar-18	132.15	10.35%	13.66	2.68%	145.80	1276.47	509.93	1786.4	8.16%



In summary, as illustrated above, the RN vacancy rate on the Trust's wards, ED and ICU is 132.15 wte against an establishment of 1276.47 wte (10.35%).The non-registered workforce vacancies are 13.66 wte (2.68%) although a number of wards have over recruited to support the RN vacancies, as mentioned earlier in this report.

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

5. ENSURING SAFE STAFFING

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

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

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

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

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

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

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

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

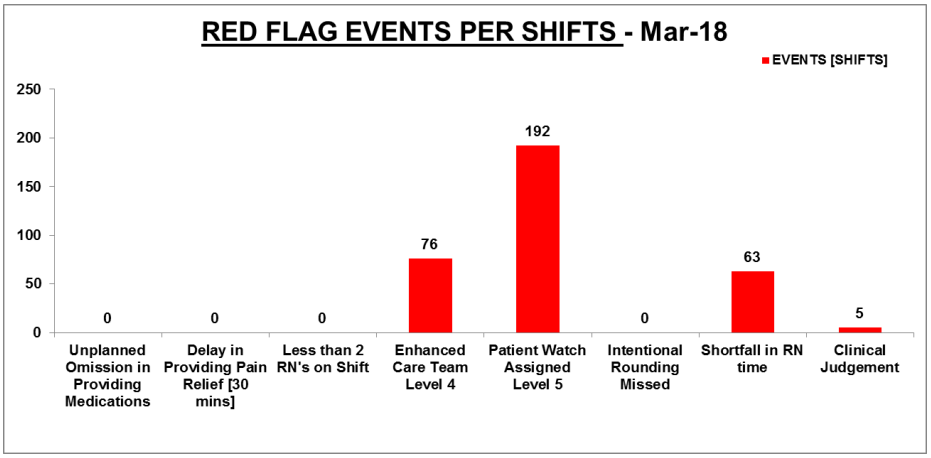
[4] NICE 2014 - Safe staffing for nursing in adult inpatient wards in acute hospitals

The ‘red flags’ suggested by NICE, are:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
- Pain: asking patients to describe their level of pain level using the local pain assessment tool.
- Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
- Placement: making sure that the items a patient needs are within easy reach.
- Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

The following table illustrates the number of ‘Red Flags’ identified during March 2018. Please note that the Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time.

Mar-18	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	**0**	**0%**
	Delay in Providing Pain Relief [30 mins]	**0**	**0%**
	Less than 2 RN's on Shift	**0**	**0%**
	Enhanced Care Team Level 4	**76**	**23%**
	Patient Watch Assigned Level 5	**192**	**57%**
	Intentional Rounding Missed	**0**	**0%**
	Shortfall in RN time	**63**	**19%**
	Clinical Judgement	**5**	**1%**
	TOTAL:	**336**	**100%**



As illustrated above, the most frequently reported red flag is related to the requirement for 1:1 supervision for patients. As indicated in the previous Board

Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which has now completed its pilot phase. Additional work has been commissioned by the Chief Nurse in order to further validate the results obtained through the pilot and will be presented to the Executive Management Committee in due course.

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

7. 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 2017. The process is undertaken by senior nurses and midwives alongside sisters, charge nurses and heads of finance. The guidance requires trusts to use a validated establishment tool, where available, alongside professional judgement in determining required establishments. This process was concluded during April 2018 and is presented in **Appendix 3**.

As indicated in Appendix 3, information obtained using the Safer Nursing Care Tool (SNCT) and Professional Judgement appears to present a shortfall of 5.16 wte (cell p55).

In reviewing the budgets the following issues have been resolved

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

Narrative is provided in appendix 3 justifying all establishment changes following the review. The majority of the establishment uplifts relating to the Surgical Health Group Wards were part of the Elective Bed Base Reconfiguration, which was undertaken October 2017. The reduction in the overall nursing budget which is presented in cell Y 55, relates predominantly to the closure of ward 8 at CHH and was realised by the Surgical Health Group as part of their 2017/2018 CRES , therefore the budgets have already been disestablished.

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

8. SUMMARY

Nursing and midwifery establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. This is all managed very carefully and in a way that balances the risk across the organisation and will continue to be so. The challenges remain around recruitment and with regard to the supply of registered nurses. However, the Trust continues to make positive progress in relation to the implementation of robust recruitment and retention initiatives as outlined within the body of this report.

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

9. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
May 2018

Appendix 1: HEY Safer Staffing Report – February 2018
Appendix 2: HEY Safer Staffing Report – March 2018
Appendix 3: HEY Ward Establishment Review – March 2018

HEY SAFER STAFFING REPORT FEBRUARY-18

NURSE STAFFING

FILL RATES

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)
MEDICINE	ED	ACUTE MEDICINE	NA	0				
	AMU	ACUTE MEDICINE	45	2	106%	78%	107%	100%
	H1	ACUTE MEDICINE	22	23	80%	90%	100%	98%
	EAU	ELDERLY MEDICINE	21	10	92%	92%	67%	85%
	H5 / RHOB	RESPIRATORY	26	3	73%	95%	95%	86%
	H50	RENAL MEDICINE	19	8	65%	81%	101%	104%
	H500	RESPIRATORY	24	1	70%	94%	98%	99%
	H70	ENDOCRINOLOGY	30	9	73%	91%	70%	117%
	H8	ELDERLY MEDICINE	27	2	65%	97%	102%	108%
	H80	ELDERLY MEDICINE	27	0	63%	99%	100%	100%
	H9	ELDERLY MEDICINE	31	23	63%	115%	98%	100%
	H90	ELDERLY MEDICINE	29	2	65%	112%	100%	100%
	H11	STROKE / NEUROLOGY	28	48	50%	126%	100%	78%
	H110	STROKE / NEUROLOGY	24	5	61%	106%	66%	90%
	CDU	CARDIOLOGY	9	0	75%	28%	100%	
	C26	CARDIOLOGY	26	7	84%	79%	76%	93%
	C28 /CMU	CARDIOLOGY	27	4	74%	82%	85%	96%
SURGERY	H4	NEURO SURGERY	30	12	76%	105%	78%	123%
	H40	NEURO HOB / TRAUMA	15	26	85%	104%	114%	99%
	H6	ACUTE SURGERY	28	2	91%	74%	77%	104%
	H60	ACUTE SURGERY	28	0	94%	101%	93%	95%
	H7	VASCULAR SURGERY	30	0	81%	95%	89%	102%
	H100	GASTROENTEROLOGY	24	12	79%	104%	81%	109%
	H12	ORTHOPAEDIC	28	8	75%	89%	81%	144%
	H120	ORTHO / MAXFAX	22	3	88%	103%	80%	118%
	HICU	CRITICAL CARE	22	1	93%	186%	90%	86%
	C9	ORTHOPAEDIC	35	2	80%	80%	97%	100%
	C10	COLORECTAL	21	0	85%	55%	77%	104%
	C11	COLORECTAL	22	6	88%	74%	88%	111%
	C14	UPPER GI	27	2	87%	72%	79%	112%
	C15	UROLOGY	26	4	92%	77%	94%	102%
	C27	CARDIOTHORACIC	26	2	91%	83%	95%	100%
	CICU	CRITICAL CARE	22	0	91%	105%	90%	72%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	82%	66%	98%	67%
	H130	PAEDS	20	0	90%	34%	87%	68%
	H30 CEDAR	GYNAECOLOGY	9	0	69%	46%	103%	69%
	H31 MAPLE	MATERNITY	20	0	94%	86%	107%	98%
	H33 ROWAN	MATERNITY	38	0	88%	82%	86%	97%
	H34 ACORN	PAEDS SURGERY	20	1	86%	108%	98%	54%
	H35	OPHTHALMOLOGY	12	0	95%	36%	107%	
	LABOUR	MATERNITY	16	1	97%	88%	101%	91%
	NEONATES	CRITICAL CARE	26	0	85%	94%	89%	50%
	PAU	PAEDS	10	0	104%		91%	
	PHDU	CRITICAL CARE	4	0	114%	62%	102%	
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	7	104%	88%	103%	185%
	C29	REHABILITATION	15	159	101%	90%	100%	90%
	C30	ONCOLOGY	22	8	94%	101%	105%	103%
	C31	ONCOLOGY	27	0	89%	97%	101%	100%
	C32	ONCOLOGY	22	0	84%	97%	101%	105%
	C33	HAEMATOLOGY	28	0	82%	148%	81%	120%
	TOTAL:		403		AVERAGE or TOTAL:			

CARE HOURS PER PATIENT DAY [CHPPD] [hrs]

HEALTH GROUP	WARD	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL
MEDICINE	ED	1106	4.5	2.3	6.8
	AMU	580	2.6	1.6	4.3
	H1	552	3.6	3.0	6.6
	EAU	562	2.5	1.7	4.2
	H5 / RHOB	514	2.8	2.0	4.9
	H50	660	2.3	2.4	4.6
	H500	828	2.0	2.0	4.0
	H70	748	2.2	2.2	4.4
	H8	728	2.2	2.3	4.5
	H80	853	1.9	2.4	4.3
	H9	795	2.0	2.2	4.2
	H90	775	2.0	2.3	4.4
	H11	504	3.5	2.8	6.4
	H110	91	11.1	1.8	12.9
	CDU	639	3.9	1.5	5.4
	C26	615	6.2	1.5	7.6
	C28 /CMU	742	2.7	1.9	4.6
SURGERY	H4	350	6.5	3.7	10.2
	H40	669	3.0	2.4	5.4
	H6	671	3.2	2.3	5.5
	H60	802	2.9	2.1	5.0
	H7	693	2.6	2.2	4.8
	H100	731	2.8	2.5	5.3
	H12	563	3.3	2.9	6.3
	H120	476	25.1	1.9	27.0
	HICU	734	3.3	1.8	5.1
	C9	412	4.6	1.7	6.3
	C10	521	3.8	1.7	5.5
	C11	609	3.3	1.6	4.9
	C14	585	3.7	2.0	5.7
	C15	666	3.9	1.4	5.4
	C27	453	21.6	2.0	23.6
	CICU	403	4.4	2.3	6.8
FAMILY & WOMEN'S	C16	443	5.4	1.1	6.6
	H130	279	4.9	2.0	7.0
	H30 CEDAR	289	7.0	4.1	11.2
	H31 MAPLE	1043	2.8	1.4	4.2
	H33 ROWAN	314	7.3	1.8	9.0
	H34 ACORN	286	4.8	0.9	5.7
	H35	244	22.5	6.3	28.8
	LABOUR	574	11.9	0.9	12.8
	NEONATES	98	13.4	0.0	13.4
	PAU	61	23.4	2.0	25.5
	PHDU	355	3.9	3.4	7.3
CLINICAL SUPPORT	C20	419	3.5	4.3	7.8
	C29	548	3.0	1.9	4.9
	C30	616	2.6	2.3	4.9
	C31	530	2.9	1.9	4.8
	C32	573	4.4	2.3	6.7
	C33	AVERAGE or TOTAL:	557	5.7	2.2	7.9

ROTA EFFICIENCY [22-01-18 to 18-02-18]

HEALTH GROUP	WARD	ANNUAL LEAVE [11-17%]	SICK RN & AN [3.9%]	MAT LEAVE [%]
MEDICINE	ED	18.7%	5.3%	2.3%
	AMU	17.0%	3.5%	2.6%
	H1	14.4%	5.6%	0.4%
	EAU	12.0%	3.7%	4.6%
	H5 / RHOB	22.4%	1.2%	3.3%
	H50	16.4%	7.1%	0.0%
	H500	18.2%	5.3%	0.0%
	H70	16.5%	6.2%	0.0%
	H8	16.9%	2.1%	4.1%
	H80	18.1%	5.3%	7.4%
	H9	14.8%	4.4%	4.6%
	H90	15.6%	6.8%	3.5%
	H11	15.9%	9.8%	0.0%
	H110	17.2%	9.9%	0.0%
	CDU	14.1%	16.5%	1.8%
	C26	15.2%	3.4%	12.8%
	C28 /CMU	20.2%	3.5%	0.0%
SURGERY	H4	17.1%	7.4%	3.6%
	H40	18.2%	6.0%	0.0%
	H6	15.3%	5.3%	2.6%
	H60	16.7%	2.6%	2.1%
	H7	16.9%	3.7%	0.0%
	H100	15.6%	7.3%	8.5%
	H12	16.2%	8.3%	2.8%
	H120	17.0%	1.9%	0.0%
	HICU	16.6%	5.2%	2.7%
	C9	14.5%	5.8%	2.0%
	C10	13.1%	3.1%	2.5%
	C11	13.4%	5.4%	4.4%
	C14	17.6%	1.5%	9.1%
	C15	12.5%	2.8%	3.3%
	C27	17.5%	1.6%	8.0%
	CICU	14.5%	7.4%	1.3%
FAMILY & WOMEN'S	C16	13.7%	7.4%	12.8%
	H130	17.6%	4.7%	0.0%
	H30 CEDAR	13.2%	13.5%	3.5%
	H31 MAPLE	16.3%	6.8%	0.0%
	H33 ROWAN	16.1%	1.9%	1.4%
	H34 ACORN	18.6%	7.6%	0.8%
	H35	20.1%	1.4%	20.8%
	LABOUR	14.9%	3.6%	1.7%
	NEONATES	17.1%	6.9%	7.7%
	PAU	18.9%	5.2%	10.3%
	PHDU	15.0%	0.0%	0.0%
CLINICAL SUPPORT	C20	18.5%	10.8%	0.0%
	C29	14.0%	8.6%	0.9%
	C30	17.1%	8.9%	5.3%
	C31	15.9%	6.8%	8.8%
	C32	14.5%	5.1%	0.0%
	C33	15.5%	5.2%	4.6%
	AVERAGE or TOTAL:	16.3%	5.6%	3.6%

NURSING VACANCIES [FINANCE LEDGER M11]

HEALTH GROUP	WARD	RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]
MEDICINE	ED	5.17	5.5%	-0.13	-0.6%	5.04	115.34
	AMU	8.94	20.2%	0.24	1.0%	9.18	67.57
	H1	1.76	12.1%	0.33	4.2%	2.09	22.51
	EAU	1.78	9.3%	-5.15	-39.1%	-3.37	32.27
	H5 / RHOB	5.29	21.4%	1.40	10.6%	6.69	37.84
	H50	0.31	2.1%	0.43	5.1%	0.74	23.54
	H500	3.36	19.8%	0.89	7.3%	4.25	29.10
	H70	8.90	44.4%	0.92	7.6%	9.82	32.22
	H8	0.90	5.4%	-0.54	-4.1%	0.36	29.78
	H80	2.63	15.8%	-1.16	-8.8%	1.47	29.78
	H9	4.82	29.0%	-1.04	-7.9%	3.78	29.78
	H90	4.65	28.0%	-2.35	-17.9%	2.30	29.78
	H11	6.89	30.6%	1.57	14.8%	8.46	33.16
	H110	5.68	25.2%	-0.16	-1.4%	5.52	33.64
	CDU	0.01	0.1%	0.63	21.6%	0.64	15.74
	C26	3.07	11.9%	-0.39	-4.9%	2.68	33.73
	C28 /CMU	3.30	8.6%	0.69	7.2%	3.99	47.78
SURGERY	H4	5.08	23.3%	0.45	4.3%	5.53	32.28
	H40	1.35	6.5%	1.28	11.5%	2.63	31.95
	H6	3.91	20.5%	1.11	10.4%	5.02	29.74
	H60	0.56	2.9%	0.38	3.6%	0.94	29.74
	H7	6.52	30.0%	1.09	8.3%	7.61	34.89
	H100	1.75	9.2%	-0.66	-5.5%	1.09	31.23
	H12	5.35	24.5%	-2.67	-20.3%	2.68	35.00
	H120	2.48	14.9%	0.35	3.0%	2.83	28.42
	HICU	1.50	1.4%	-1.40	-19.1%	0.10	112.20
	C9	1.91	8.8%	0.22	1.9%	2.13	33.39
	C10	2.54	13.9%	0.71	9.1%	3.25	26.08
	C11	3.16	17.3%	1.79	22.9%	4.95	26.08
	C14	0.92	4.5%	0.04	0.4%	0.96	29.38
	C15	1.41	6.9%	1.64	13.5%	3.05	32.71
	C27	1.77	7.5%	-0.66	-7.7%	1.11	32.22
	CICU	7.03	7.6%	-0.34	-4.5%	6.69	100.50
FAMILY & WOMEN'S	C16	4.04	21.8%	2.47	22.2%	6.51	29.65
	H130	0.21	1.0%	2.02	38.7%	2.23	26.59
	H30 CEDAR	0.27	3.6%	0.12	3.1%	0.39	11.33
	H31 MAPLE	-0.46	-1.0%	-1.97	-7.3%	-2.43	73.34
	H33 ROWAN						
	H34 ACORN	-0.82	-4.0%	-0.46	-8.8%	-1.28	26.00
	H35	1.38	12.4%	3.76	138.8%	5.14	13.84
	LABOUR	9.21	18.4%	1.59	11.6%	10.80	63.84
	NEONATES	2.02	3.0%	0.00	0.0%	2.02	74.51
	PAU	-1.24	-11.9%	0.00	0.0%	-1.24	10.44
	PHDU	-1.64	-14.1%	0.00	0.0%	-1.64	11.66
CLINICAL SUPPORT	C20	1.58	13.1%	2.48	30.2%	4.06	20.22
	C29	-0.53	-4.0%	2.11	13.4%	1.58	28.89
	C30	2.51	18.0%	1.51	18.9%	4.02	21.97
	C31	2.26	16.2%	1.33	11.3%	3.59	25.74
	C32	2.17	15.5%	2.68	28.0%	4.85	23.57
	C33	5.01	18.3%	-3.98	-49.8%	1.03	35.44
	TOTAL:	140.67	11.0%	13.17	2.6%	153.84	1786.40

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

HIGH LEVEL

HEALTH GROUP	WARD	SAFETY THERMOMETER HARM FREE CARE [%]	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]
MEDICINE	ED				3
	AMU	100%	2		2
	H1	100%			
	EAU	100%		1	
	H5 / RHOB	96%		2	
	H50	100%	1	1	1
	H500	100%			
	H70	93%	4	2	
	H8	100%			2
	H80	100%	1	2	1
	H9	96%		2	
	H90	100%		3	1
	H11	96%	1		
	H110	100%	2		1
	CDU	100%		1	
	C26	100%	1	2	
	C28 /CMU	96%			
SURGERY	H4	100%		1	
	H40	100%	2	1	1
	H6	100%	2	3	
	H60	100%	1	1	1
	H7	92%	1	1	
	H100	95%		1	
	H12	96%			1
	H120	100%		1	
	HICU	80%		1	3
	C9	92%			
	C10	100%			1
	C11	100%	2		
	C14	95%			
	C15	100%			
	C27	100%			1
	CICU	100%	1		
FAMILY & WOMEN'S	C16	100%	2	1	1
	H130	100%		1	
	H30 CEDAR	100%			
	H31 MAPLE	100%	3	2	1
	H33 ROWAN	100%			
	H34 ACORN	100%			2
	H35	100%			2
	LABOUR	100%		5	1
	NEONATES	100%			3
	PAU	100%			
	PHDU	100%			1
CLINICAL SUPPORT	C20	93%			1
	C29	100%			
	C30	100%		1	
	C31	95%			
	C32	100%		3	
	C33	100%			
	TOTALS:	98.3%	48	26	39	31

FALLS

HEALTH GROUP	WARD	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL
MEDICINE	ED	1			1
	AMU	1	1		2
	H1	2			2
	EAU	1			1
	H5 / RHOB				0
	H50	1			1
	H500	2			2
	H70	1			1
	H8				0
	H80				0
	H9	7	1	1	9
	H90	2			2
	H11	3			3
	H110	2	1		3
	CDU				0
	C26	1			1
	C28 /CMU	1			1
SURGERY	H4	2		1	3
	H40				0
	H6				0
	H60				0
	H7	3	1		4
	H100	5			5
	H12	1			1
	H120				0
	HICU				0
	C9				0
	C10	1			1
	C11			1	1
	C14	1			1
	C15				0
	C27				0
	CICU				0
FAMILY & WOMEN'S	C16				0
	H130				0
	H30 CEDAR				0
	H31 MAPLE				0
	H33 ROWAN				0
	H34 ACORN				0
	H35				0
	LABOUR				0
	NEONATES				0
	PAU				0
	PHDU				0
CLINICAL SUPPORT	C20				0
	C29	2			2
	C30				0
	C31	1			1
	C32				0
	C33				0
	TOTALS:	41	4	3	48

HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]

HEALTH GROUP	WARD	1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL
MEDICINE	ED				1		1
	AMU				1		1
	H1						0
	EAU						0
	H5 / RHOB						0
	H50						0
	H500						0
	H70	1	1				2
	H8						0
	H80						0
	H9						0
	H90						0
	H11		2		1		3
	H110						0
	CDU						0
	C26						0
	C28 /CMU						0
SURGERY	H4						0
	H40		2				2
	H6						0
	H60						0
	H7		2		1		3
	H100						0
	H12						0
	H120						0
	HICU				5		5
	C9		2				2
	C10						0
	C11						0
	C14				1		1
	C15						0
	C27	1					1
	CICU						0
FAMILY & WOMEN'S	C16						0
	H130						0
	H30 CEDAR		1				1
	H31 MAPLE						0
	H33 ROWAN						0
	H34 ACORN						0
	H35						0
	LABOUR						0
	NEONATES						0
	PAU						0
	PHDU						0
CLINICAL SUPPORT	C20	1					1
	C29						0
	C30		1				1
	C31						0
	C32						0
	C33					1	1
	TOTALS:	3	11	0	10	1	25

QUALITY INDICATOR TOTAL

HEALTH GROUP	WARD	QUALITY INDICATOR TOTAL
MEDICINE	ED	5
	AMU	7
	H1	2
	EAU	2
	H5 / RHOB	2
	H50	4
	H500	2
	H70	9
	H8	2
	H80	4
	H9	11
	H90	6
	H11	7
	H110	6
	CDU	1
	C26	4
	C28 /CMU	1
SURGERY	H4	4
	H40	6
	H6	5
	H60	3
	H7	9
	H100	6
	H12	2
	H120	1
	HICU	9
	C9	2
	C10	2
	C11	3
	C14	2
	C15	0
	C27	2
	CICU	1
FAMILY & WOMEN'S	C16	4
	H130	1
	H30 CEDAR	1
	H31 MAPLE	6
	H33 ROWAN	0
	H34 ACORN	2
	H35	2
	LABOUR	6
	NEONATES	3
	PAU	0
	PHDU	1
CLINICAL SUPPORT	C20	2
	C29	2
	C30	2
	C31	1
	C32	3
	C33	1
	TOTALS:	169

Feb-18	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	83.0%	89.0%	92.0%	97.0%	18947	4.4	2.2	6.6
CHH SITE	83.9%	86.1%	87.8%	98.8%	8503	4.7	2.1	6.8

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.59	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.29	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.04	1276.47	509.93	1786.4	7.28%
Jan-18	118.31	9.27%	10.00	1.96%	128.40	1276.47	509.93	1786.4	7.19%
Feb-18	140.67	11.02%	13.17	2.58%	153.84	1276.47	509.93	1786.4	8.61%

APPENDIX 1

HEY SAFER STAFFING REPORT MARCH-18

NURSE STAFFING – HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES DAY: Average fill rate - RN/RM (%)	FILL RATES DAY: Average fill rate - care staff (%)	FILL RATES NIGHT: Average fill rate - RN/RM (%)	FILL RATES NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CHPPD: RN / RM	CHPPD: CARE STAFF	CHPPD: OVERALL	ROTA EFFICIENCY [19-02-18 to 22-03-18]: ANNUAL LEAVE [11-17%]	ROTA: SICK RN & AN [3.9%]	ROTA: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M12]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN Est. [WTE]	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	FALLS: MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED	ACUTE MEDICINE	NA	1									19.4%	4.9%	2.8%	5.69	6.1%	-0.13	-0.6%	5.56	115.34		2		3	1			1						0	6
	AMU	ACUTE MEDICINE	45	3	94%	62%	106%	96%	1193	4.6	2.3	6.9	17.8%	3.5%	1.8%	8.94	20.2%	0.24	1.0%	9.18	67.57	100%				3			3		1				1	4
	H1	ACUTE MEDICINE	22	10	70%	94%	99%	97%	640	2.5	1.8	4.3	14.1%	5.1%	4.8%	1.76	12.1%	0.86	10.8%	2.62	22.51	100%		1					0		1		1		2	3
	EAU	ELDERLY MEDICINE	21	7	88%	92%	68%	84%	634	3.4	3.0	6.4	16.9%	2.9%	4.3%	2.78	14.6%	-5.15	-39.1%	-2.37	32.27	100%			1	2			2						0	3
	H5 / RHOB	RESPIRATORY	26	5	70%	85%	97%	87%	602	2.6	1.7	4.3	17.1%	2.2%	3.3%	4.29	17.4%	1.40	10.6%	5.69	37.84	96%		2					0						0	2
	H50	RENAL MEDICINE	19	18	67%	88%	97%	101%	553	3.0	2.3	5.3	17.8%	5.6%	0.0%	0.31	2.1%	0.43	5.1%	0.74	23.54	100%			1				0						0	1
	H500	RESPIRATORY	24	2	65%	90%	97%	95%	719	2.2	2.3	4.6	18.2%	2.2%	0.0%	0.36	2.1%	0.89	7.3%	1.25	29.10	100%		1		1			1						0	2
	H70	ENDOCRINOLOGY	30	23	73%	97%	72%	87%	919	2.2	2.3	4.5	16.7%	2.3%	0.0%	6.90	34.4%	0.92	7.6%	7.82	32.22	93%	2	1	2	1			1		1		1		2	8
	H8	ELDERLY MEDICINE	27	7	68%	95%	101%	98%	819	2.3	2.3	4.5	18.4%	2.6%	4.1%	0.90	5.4%	-0.34	-2.6%	0.56	29.78	100%	1	1					0						0	2
	H80	ELDERLY MEDICINE	27	8	62%	100%	99%	97%	828	2.1	2.3	4.5	14.8%	5.7%	10.2%	2.63	15.8%	-1.16	-8.8%	1.47	29.78	100%		2	1	2		1	3						0	6
	H9	ELDERLY MEDICINE	31	16	61%	87%	101%	98%	946	1.9	2.4	4.3	16.6%	2.0%	4.8%	4.82	29.0%	-1.84	-14.0%	2.98	29.78	96%		1		4			4						0	5
	H90	ELDERLY MEDICINE	29	9	69%	99%	98%	98%	888	2.1	2.2	4.3	18.6%	6.9%	3.5%	4.65	28.0%	-2.35	-17.9%	2.30	29.78	100%		1		3			3		1				1	5
	H11	STROKE / NEUROLOGY	28	13	49%	112%	97%	76%	833	2.1	2.3	4.3	15.5%	11.6%	2.0%	5.89	26.2%	1.57	14.8%	7.46	33.16	96%		1	1	4			4						0	6
	H110	STROKE / NEUROLOGY	24	1	58%	78%	66%	85%	540	3.6	3.1	6.7	15.8%	10.6%	0.0%	5.48	24.3%	0.02	0.2%	5.50	33.64	100%	3		1	3			3						0	7
	CDU	CARDIOLOGY	9	0	54%	26%	94%		136	7.7	1.2	9.0	10.6%	5.9%	6.7%	0.01	0.1%	0.63	21.6%	0.64	15.74	100%							0						0	0
	C26	CARDIOLOGY	26	15	75%	70%	77%	93%	699	3.8	1.4	5.2	20.4%	6.8%	10.2%	2.12	8.2%	-0.39	-4.9%	1.73	33.73	100%	1	1		1			1						0	3
	C28 /CMU	CARDIOLOGY	27	9	80%	83%	83%	96%	694	6.2	1.5	7.7	21.6%	5.9%	0.0%	4.10	10.7%	1.33	13.9%	5.43	47.78	96%	1						0						0	1
SURGERY	H4	NEURO SURGERY	30	5	69%	74%	80%	96%	802	2.8	1.8	4.6	18.0%	3.5%	7.2%	5.08	23.3%	0.45	4.3%	5.53	32.28	100%		2		1			1						0	3
	H40	NEURO HOB / TRAUMA	15	27	77%	92%	102%	92%	341	6.8	4.0	10.8	20.0%	0.0%	5.1%	2.35	11.3%	1.28	11.5%	3.63	31.95	100%	1						0						0	1
	H6	ACUTE SURGERY	28	1	88%	67%	82%	90%	730	3.1	2.2	5.2	15.2%	3.7%	3.8%	3.91	20.5%	1.11	10.4%	5.02	29.74	100%		1		1			1						0	2
	H60	ACUTE SURGERY	28	1	91%	98%	84%	100%	720	3.1	2.5	5.6	16.1%	1.6%	3.9%	1.56	8.2%	0.38	3.6%	1.94	29.74	100%	7		1	1			1				1		1	10
	H7	VASCULAR SURGERY	30	0	79%	92%	94%	89%	857	3.0	2.2	5.2	14.9%	0.0%	5.0%	5.52	25.4%	1.09	8.3%	6.61	34.89	92%		1					0		1				1	2
	H100	GASTROENTEROLOGY	24	0	80%	95%	84%	97%	792	2.6	2.0	4.6	15.2%	8.0%	4.0%	0.75	3.9%	0.57	4.7%	1.32	31.23	95%		2		1			1		2				2	5
	H12	ORTHOPAEDIC	28	5	71%	88%	81%	89%	811	2.7	2.5	5.2	16.7%	2.8%	5.5%	3.67	16.8%	-2.67	-20.3%	1.00	35.00	96%	2						0		1				1	3
	H120	ORTHO / MAXFAX	22	1	91%	84%	77%	85%	625	3.4	2.9	6.4	20.9%	0.0%	2.0%	2.48	14.9%	0.35	3.0%	2.83	28.42	100%		2		1			1						0	3
	HICU	CRITICAL CARE	22	0	88%	152%	87%	81%	512	24.4	1.8	26.2	17.1%	2.7%	5.7%	1.18	1.1%	-0.40	-5.5%	0.78	112.20	80%	1		1				0		1		1		2	4
	C9	ORTHOPAEDIC	35	2	78%	78%	97%	87%	742	3.5	1.9	5.5	14.8%	2.0%	8.5%	1.91	8.8%	0.22	1.9%	2.13	33.39	92%	1	2	1		1		1		3				3	8
	C10	COLORECTAL	21	0	83%	71%	86%	88%	551	3.9	1.7	5.5	15.0%	2.6%	1.7%	3.54	19.4%	-0.25	-3.2%	3.29	26.08	100%							0						0	0
	C11	COLORECTAL	22	3	87%	76%	85%	95%	579	3.8	1.8	5.5	13.2%	4.9%	10.8%	3.64	20.0%	0.79	10.1%	4.43	26.08	100%			1				0						0	1
	C14	UPPER GI	27	3	86%	69%	89%	99%	734	3.3	1.5	4.8	18.0%	9.0%	3.4%	-0.08	-0.4%	0.04	0.4%	-0.04	29.38	95%	2	1		1			1						0	4
	C15	UROLOGY	26	1	92%	86%	90%	95%	594	4.1	2.3	6.4	15.2%	3.3%	4.3%	1.97	9.6%	0.44	3.6%	2.41	32.71	100%		1	1	1			1						0	3
	C27	CARDIOTHORACIC	26	1	83%	86%	87%	100%	745	3.7	1.4	5.2	18.2%	7.7%	2.0%	1.93	8.2%	-0.66	-7.7%	1.27	32.22	100%						1	1		1				1	2
	CICU	CRITICAL CARE	22	0	86%	65%	85%	37%	448	23.0	1.7	24.7	15.7%	1.6%	6.9%	5.35	5.8%	0.66	8.7%	6.01	100.50	100%							0						0	0
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	85%	52%	89%	60%	485	3.9	2.0	5.9	12.9%	0.9%	13.0%	4.04	21.8%	2.47	22.2%	6.51	29.65	100%		1		1			1						0	2
	H130	PAEDS	20	0	86%	47%	88%	55%	380	6.9	1.6	8.5	17.9%	2.5%	0.3%	0.21	1.0%	2.02	38.7%	2.23	26.59	100%		1					0						0	1
	H30 CEDAR	GYNAECOLOGY	9	0	91%	57%	107%		325	4.7	2.4	7.1	16.2%	16.6%	8.5%	0.27	3.6%	0.12	3.1%	0.39	11.33	100%		1					0		1				1	2
	H31 MAPLE	MATERNITY	20	0	86%	92%	108%	98%	407	5.6	3.4	9.0	17.4%	6.6%	0.0%	-0.46	-1.0%	0.23	0.9%	-0.23	73.34	100%		2					0						0	2
	H33 ROWAN	MATERNITY	38	0	91%	92%	86%	98%	1162	2.8	1.5	4.3	16.2%	1.7%	2.1%							100%							0						0	0
	H34 ACORN	PAEDS SURGERY	20	1	81%	109%	99%	57%	277	8.8	2.3	11.1	13.4%	7.1%	3.6%	-0.02	-0.1%	-0.46	-8.8%	-0.48	26.00	100%							0				1		1	1
	H35	OPHTHALMOLOGY	12	0	91%	25%	108%		308	5.0	0.6	5.6	10.2%	2.5%	18.2%	0.18	6.6%	3.76	138.8%	3.94	13.84	100%							0						0	0
	LABOUR	MATERNITY	16	1	95%	95%	95%	101%	307	21.0	5.8	26.8	15.8%	4.1%	1.7%	8.21	59.9%	-0.61	-4.5%	7.60	63.84	100%	2						0						0	2
	NEONATES	CRITICAL CARE	26	0	87%	79%	90%	97%	625	12.4	1.0	13.5	19.0%	4.1%	5.6%	1.73	22.9%	0.00	0.0%	1.73	74.51	100%			3				0						0	3
	PAU	PAEDS	10	0	97%		90%		122	11.8	0.0	11.8	14.7%	1.6%	15.6%	-0.76	-7.3%	0.00	0.0%	-0.76	10.44	100%							0						0	0
	PHDU	CRITICAL CARE	4	1	91%	30%	97%		79	21.9	0.9	22.8	21.9%	2.0%	0.0%	-0.64	-5.5%	0.00	0.0%	-0.64	11.66	100%							0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	5	98%	86%	100%	89%	403	3.7	3.2	6.9	18.5%	11.0%	0.0%	1.58	19.3%	2.48	30.2%	4.06	20.22	93%		1					0						0	1
	C29	REHABILITATION	15	86	87%	86%	100%	99%	461	3.4	4.1	7.5	17.2%	2.9%	1.7%	-0.53	-4.0%	2.78	17.7%	2.25	28.89	100%							0						0	0
	C30	ONCOLOGY	22	40	91%	97%	93%	100%	631	2.8	1.9	4.7	18.3%	0.7%	5.6%	2.51	18.0%	1.51	18.9%	4.02	21.97	100%			2	2			2						0	4
	C31	ONCOLOGY	27	0	77%	85%	91%	92%	634	2.7	2.3	5.0	17.8%	9.9%	9.2%	2.26	16.2%	1.33	11.3%	3.59	25.74	95%		2	1	2			2						0	5
	C32	ONCOLOGY	22	0	90%	100%	100%	86%	616	2.9	1.7	4.6	20.7%	1.8%	0.0%	2.17	15.5%	2.68	28.0%	4.85	23.57	100%		1		1			1						0	2
	C33	HAEMATOLOGY	28	5	74%	77%	72%	73%	635	4.2	2.4	6.6	17.5%	2.7%	4.7%	5.01	18.3%	-4.98	-62.3%	0.03	35.44	100%			1				0						0	1
		TOTAL:		336	AVERAGE or TOTAL:				614	5.6	2.2	7.8	16.8%	4.4%	4.6%	132.15	10.4%	13.66	2.7%	145.81	1786.40	98.3%														
																					TOTALS:	48	26	33	22	38	1	2	41	0	14	0	5	0	19	141

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

Mar-18 SAFER STAFFING OVERALL PERFORMANCE	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
HRI SITE	80.6%	83.2%	90.7%	88.9%	20725	4.5	2.2	6.7
CHH SITE	81.3%	79.3%	86.8%	89.6%	9524	4.5	2.0	6.5

Month	RN Vacancies	RN %	NON-RN Vacancies	Non -RN %	Total [wte] Vacancies	RN [wte] Establishment	NON-RN [wte] Establishment	Total Nursing Establishment	% Total Vacancies
Oct-17	129.92	10.18%	-9.43	-1.85%	120.59	1276.47	509.93	1786.4	6.75%
Nov-17	110.64	8.67%	20.56	4.03%	131.29	1276.47	509.93	1786.4	7.35%
Dec-17	111.23	8.71%	18.72	3.67%	130.04	1276.47	509.93	1786.4	7.28%
Jan-18	118.31	9.27%	10.00	1.96%	128.40	1276.47	509.93	1786.4	7.19%
Feb-18	140.67	11.02%	13.17	2.58%	153.84	1276.47	509.93	1786.4	8.61%
Mar-18	132.15	10.35%	13.66	2.68%	145.80	1276.47	509.93	1786.4	8.16%

HEY WARD STAFFING ESTABLISHMENT REVIEW - MARCH 2018

GENERAL INFORMATION				CURRENT ESTABLISHMENT [Budgeted WTE] [1]			CURRENT IN POST [WTE]			CURRENT VACANCIES [WTE]			STAFFING TOOL	ESTABLISHMENT REVIEW [Mar-18] [Includes additional 0.6 WTE for supervisory] [2]	VARIANCE [1] - [2] [Headcount WTE] [Negative = shortfall]	PROFESSIONAL VIEW [WTE]			REQUIREMENT (WTE)			EXTRA BUDGET REQUIRED [£] [Inclusive of 22% uplift]			COMMENTS [Reasons for variances, decision, etc.]
HEALTH GROUP	WARD / DEPT	BEDS	SPECIALITY	RN	Non-RN	TOTAL	RN	Non-RN	TOTAL	RN	Non-RN	TOTAL				RN	Non-RN	TOTAL	RN	Non-RN	TOTAL	Extra RN	Extra Non-RN	TOTAL	
MHG	ED	NA	Acute Medicine	93.31	20.96	114.27	87.62	21.09	108.71	5.69	-0.13	5.56	NICE	114.27	0.00	93.31	20.96	114.27	0.00	0.00	0.00	0	0	£0.00	
MHG	AMU	45	Acute Medicine	44.19	23.38	67.57	35.25	23.14	58.39	8.94	0.24	9.18	SNCT	67.57	0.00	44.19	23.38	67.57	0.00	0.00	0.00	0	0	£0.00	
MHG	EAU	21	Elderly	19.11	13.16	32.27	16.33	18.31	34.64	2.78	-5.15	-2.37	SNCT	32.27	0.00	19.11	13.16	32.27	0.00	0.00	0.00	0	0	£0.00	
MHG	H1	22	Acute Medicine	14.57	7.94	22.51	12.81	7.08	19.89	1.76	0.86	2.62	SNCT	22.51	0.00	14.57	7.94	22.51	0.00	0.00	0.00	0	0	£0.00	
MHG	H5 + HOB	26	Respiratory	24.67	13.16	37.83	20.38	11.76	32.14	4.29	1.40	5.69	SNCT	37.83	0.00	24.67	13.16	37.83	0.00	0.00	0.00	0	0	£0.00	
MHG	H500	24	Respiratory	16.96	12.14	29.10	16.60	11.25	27.85	0.36	0.89	1.25	SNCT	29.10	0.00	16.96	12.14	29.10	0.00	0.00	0.00	0	0	£0.00	
MHG	H50	19	Renal	15.11	8.43	23.54	14.80	8.00	22.80	0.31	0.43	0.74	SNCT	23.54	0.00	15.11	8.43	23.54	0.00	0.00	0.00	0	0	£0.00	
MHG	H70	30	Endocrinology	19.53	13.16	32.69	12.63	12.24	24.87	6.90	0.92	7.82	SNCT	34.20	1.51	21.04	13.16	34.20	1.51	0.00	1.51	45,385	0	£45,384.56	Uplift to support 3 registered nurses on a night shift 7/52 given acuity of patients on ward 70
MHG	H8	27	Elderly	16.62	13.16	29.78	15.72	13.50	29.22	0.90	-0.34	0.56	SNCT	29.78	0.00	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	H80	27	Elderly	16.62	13.16	29.78	13.99	14.32	28.31	2.63	-1.16	1.47	SNCT	29.78	0.00	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	H11	28	Neurology / Stroke	22.52	12.14	34.66	16.63	10.57	27.20	5.89	1.57	7.46	SNCT	34.66	0.00	22.52	12.14	34.66	0.00	0.00	0.00	0	0	£0.00	
MHG	H110	24	Stroke	22.52	11.12	33.64	17.04	11.10	28.14	5.48	0.02	5.50	SNCT	33.64	0.00	22.52	11.12	33.64	0.00	0.00	0.00	0	0	£0.00	
MHG	H9	31	Elderly	16.62	13.16	29.78	11.80	15.00	26.80	4.82	-1.84	2.98	SNCT	31.48	1.70	16.62	14.86	31.48	0.00	1.70	1.70	0	33,218	£33,218.00	Uplift in the number of non registered nurses to provide additional supervision to patients with a High Risk of falls - this will be reviewed following completion of the ECT pilot.
MHG	H90	29	Elderly	16.62	13.16	29.78	11.97	15.51	27.48	4.65	-2.35	2.30	SNCT	29.78	0.00	16.62	13.16	29.78	0.00	0.00	0.00	0	0	£0.00	
MHG	C26	26	Cardiology	25.79	7.94	33.73	23.67	8.33	32.00	2.12	-0.39	1.73	SNCT	33.73	0.00	25.79	7.94	33.73	0.00	0.00	0.00	0	0	£0.00	
MHG	C28 + CMU	27	Cardiology	38.18	9.60	47.78	34.08	8.27	42.35	4.10	1.33	5.43	SNCT	47.78	0.00	38.18	9.60	47.78	0.00	0.00	0.00	0	0	£0.00	
MHG	CDU	11	Cardiology	12.82	2.92	15.74	12.81	2.29	15.10	0.01	0.63	0.64	SNCT	15.74	0.00	12.82	2.92	15.74	0.00	0.00	0.00	0	0	£0.00	
SHG	HICU	22	Critical Care	104.78	7.32	112.10	103.60	7.72	111.32	1.18	-0.40	0.78	ICS	112.10	0.00	104.78	7.32	112.10	0.00	0.00	0.00	0	0	£0.00	
SHG	H4	30	Neurosurgery	21.84	10.44	32.28	16.76	9.99	26.75	5.08	0.45	5.53	SNCT	32.28	0.00	21.84	10.44	32.28	0.00	0.00	0.00	0	0	£0.00	
SHG	H40	15	Neurosurgery	20.46	10.55	31.01	18.11	9.27	27.38	2.35	1.28	3.63	SNCT	30.91	-0.10	21.61	9.30	30.91	1.15	-1.25	-0.10	34,564	-24,425	£10,139.40	Uplift to support 4 registered nurses 27/7 - to meet acuity levels with regards to Neurosurgical HOB patients and Trauma Centre requirements - Skill mix reviewed reduction in non registered nurses to support uplift in RN establishment.
SHG	H6	26	Acute Surgery	19.11	10.63	29.74	15.20	9.52	24.72	3.91	1.11	5.02	SNCT	30.91	1.17	19.11	11.80	30.91	0.00	1.17	1.17	0	22,862	£22,861.80	Uplift to support 2 non registered nurses on a night shift
SHG	H60	26	Acute Surgery	19.11	10.46	29.57	17.55	10.08	27.63	1.56	0.38	1.94	SNCT	29.97	0.40	19.11	10.86	29.97	0.00	0.40	0.40	0	7,816	£7,816.00	Uplift to support 2 non registered nurses on a night shift
SHG	H7	29	Vascular	21.84	13.16	35.00	16.32	12.07	28.39	5.52	1.09	6.61	SNCT	35.00	0.00	21.84	13.16	35.00	0.00	0.00	0.00	0	0	£0.00	
SHG	H12	28	Orthopaedic	21.84	13.16	35.00	18.17	15.83	34.00	3.67	-2.67	1.00	SNCT	35.00	0.00	21.84	13.16	35.00	0.00	0.00	0.00	0	0	£0.00	
SHG	H120	22	MaxFax / Ortho	16.96	11.80	28.76	14.48	11.45	25.93	2.48	0.35	2.83	SNCT	28.42	-0.34	16.62	11.80	28.42	-0.34	0.00	-0.34	-10,219	0	-£10,219.04	Transfer of Maxofacial services to CHH ward 14 as part of Surgical Bed Base Reconfiguration.
SHG	H100	23	Gastroenterology	18.71	11.80	30.51	17.96	11.23	29.19	0.75	0.57	1.32	SNCT	30.48	-0.03	18.68	11.80	30.48	-0.03	0.00	-0.03	-902	0	-£901.68	
SHG	CICU	22	Critical Care	92.82	7.05	99.87	87.47	6.39	93.86	5.35	0.66	6.01	ICS	100.50	0.63	92.94	7.56	100.50	0.12	0.51	0.63	3,607	9,965	£13,572.12	
SHG	C8	18	Orthopaedic	10.47	3.97	0.00	10.47	3.97	14.44		0.00	0.00	SNCT	0.00	0.00	0.00	0.00	0.00	-10.47	0.00	0.00	-314,686	0	-£314,686.32	Ward Closed as part of Surgical Bed Base Reconfiguration
SHG	C9	29	Orthopaedic	21.84	11.55	33.39	19.93	11.33	31.26	1.91	0.22	2.13	SNCT	34.40	1.01	21.77	12.63	34.40	-0.07	1.08	1.01	-2,104	21,103	£18,999.28	Increase in bed base to support reconfiguration of Elective bed base at CHH
SHG	C10	21	Colorectal	18.25	7.83	26.08	14.71	8.08	22.79	3.54	-0.25	3.29	SNCT	26.08	0.00	18.25	7.83	26.08	0.00	0.00	0.00	0	0	£0.00	
SHG	C11	22	Colorectal	18.25	7.83	26.08	14.61	7.04	21.65	3.64	0.79	4.43	SNCT	27.10	1.02	19.27	7.83	27.10	1.02	0.00	1.02	30,657	0	£30,657.12	RN uplift to support gynae activity within the HOB 2/7 as part of Elective Bed Base Reconfiguration
SHG	C14	27	Upper GI	20.32	9.16	29.48	20.40	9.12	29.52	-0.08	0.04	-0.04	SNCT	29.48	0.00	20.32	9.16	29.48	0.00	0.00	0.00	0	0	£0.00	
SHG	C15	26	Urology	19.71	10.44	30.15	17.74	10.00	27.74	1.97	0.44	2.41	SNCT	30.15	0.00	19.71	10.44	30.15	0.00	0.00	0.00	0	0	£0.00	
SHG	C27	26	Cardiothoracic	23.60	8.62	32.22	21.67	9.28	30.95	1.93	-0.66	1.27	SNCT	32.35	0.13	23.73	8.62	32.35	0.13	0.00	0.13	3,907	0	£3,907.28	
F&W	H30	9	Gynaecology	16.70	5.64	22.34	16.43	5.52	21.95	0.27	0.12	0.39	SNCT	22.34	0.00	16.70	5.64	22.34	0.00	0.00	0.00	0	0	£0.00	
F&W	H31+H33	57	Maternity	46.26	25.08	71.34	46.72	24.85	71.57	-0.46	0.23	-0.23	BRP	71.34	0.00	46.26	25.08	71.34	0.00	0.00	0.00	0	0	£0.00	
F&W	H34	20	Paediatric	20.78	5.22	26.00	20.80	5.68	26.48	-0.02	-0.46	-0.48	PV	26.00	0.00	20.78	5.22	26.00	0.00	0.00	0.00	0	0	£0.00	
F&W	H35	12	Ophthalmology	11.17	3.40	14.57	10.99	-0.36	10.63	0.18	3.76	3.94	SNCT	14.57	0.00	11.17	3.40	14.57	0.00	0.00	0.00	0	0	£0.00	
F&W	H130	20	Paediatrics	21.37	5.22	26.59	21.16	3.20	24.36	0.21	2.02	2.23	PV	26.59	0.00	21.37	5.22	26.59	0.00	0.00	0.00	0	0	£0.00	
F&W	L&D	19	Maternity	50.13	13.46	63.59	41.92	14.07	55.99	8.21	-0.61	7.60	BRP	63.59	0.00	50.13	13.46	63.59	0.00	0.00	0.00	0	0	£0.00	
F&W	NICU	26	Critical Care	66.58	5.22	71.80	64.85	5.22	70.07	1.73	0.00	1.73	PV	71.80	0.00	66.58	5.22	71.80	0.00	0.00	0.00	0	0	£0.00	
F&W	PAU	10	Paediatric	10.44	0.00	10.44	11.20	0.00	11.20	-0.76	0.00	-0.76	PV	10.44	0.00	10.44	0.00	10.44	0.00	0.00	0.00	0	0	£0.00	
F&W	PHDU	4	Paediatric	11.66	0.00	11.66	12.30	0.00	12.30	-0.64	0.00	-0.64	PV	11.66	0.00	11.66	0.00	11.66	0.00	0.00	0.00	0	0	£0.00	
F&W	C16	30	ENT / Breast	18.51	11.14	29.65	14.47	8.67	23.14	4.04	2.47	6.51	SNCT	29.65	0.00	18.51	11.14	29.65	0.00	0.00	0.00	0	0	£0.00	
CS	C20	15	Infectious Disease	12.02	8.20	20.22	10.44	5.72	16.16	1.58	2.48	4.06	SNCT	19.42	-0.80	11.48	7.94	19.42	-0.54	-0.26	-0.80	-16,230	-5,080	-£21,310.64	Transfer of ward to new facility with reduced number of beds
CS	C29	15	Rehabilitation	13.14	15.75	28.89	13.67	12.97	26.64	-0.53	2.78	2.25	SNCT	27.51	-1.38	11.85	15.66	27.51	-1.29	-0.09	-1.38	-38,772	-1,759	-£40,530.84	Review of Nurse to Patient Ratio and acuity supporting the reduction of RN - this has been completed following an increase of non registered nurses following the previous establishment review
CS	C30	22	Oncology	13.98	7.99	21.97	11.47	6.48	17.95	2.51	1.51	4.02	SNCT	21.83	-0.14	13.89	7.94	21.83	-0.09	-0.05	-0.14	-2,705	-977	-£3,682.04	No changes made to nursing establishments changes are related to previous budget setting
CS	C31	27	Oncology	13.98	11.76	25.74	11.72	10.43	22.15	2.26	1.33	3.59	SNCT	28.08	2.34	17.64	10.44	28.08	3.66	-1.32	2.34	110,005	-25,793	£84,212.16	Skill Mix review completed. RN establishment to be uplifted to provide additional RN twilight shift to meet patient acuity.
CS	C32	22	Oncology	13.98	9.59	23.57	11.81	6.91	18.72	2.17	2.68	4.85	SNCT	21.83	-1.74	13.89	7.94	21.83	-0.09	-1.65	-1.74	-2,705	-32,241	-£34,946.04	No changes made to nursing establishments changes are related to previous budget setting
CS	C33	28	Haematology	27.45	7.99	35.44	22.44	12.97	35.41	5.01	-4.98	0.03	SNCT	35.22	-0.22	27.28	7.94	35.22	-0.17	-0.05	-0.22	-5,110	-977	-£6,086.52	No changes made to nursing establishments changes are related to previous budget setting
TOTALS:		1165		1293.82	510.12	1789.50	1161.67	496.46	1658.13	132.15	13.66	145.81		1794.66	5.16	1288.32	506.34	1794.66	-5.50	0.19	5.16	-165308.00	3712.6	-£161,595.40	

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

THE CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) INCENTIVE SCHEME - MATERNITY SAFETY ACTIONS

Meeting date	15.05.2017		**Reference Number**	2018 – 5 - 10		
Director	Mr Colin Vize, Medical Director, Family and Women's Health Mike Wright, Executive Chief Nurse		**Author**	Janet Cairns Head of Midwifery Lisa Pearce Divisional General Manager		
Reason for the report	To provide self-assessment evidence of compliance with the achievement of the maternity safety actions					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing	√	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to approve the submission of the Trust's self-assessment to NHS Resolution by the required date of 29 June 2018					
2	**KEY PURPOSE:**					
	Decision		Approval	√	Discussion	
	Briefing		Assurance	√	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					√
	Valued, skilled and sufficient staff					√
	High quality care					√
	Great local services					
	Great specialist services					√
	Partnership and integrated services					√
	Financial sustainability					√
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y/N	**Legal advice taken?** Y/N	**Raises sustainability issues?** Y/N		
5	**TRUST BOARD/BOARD COMMITTEE REVIEW** (if applicable)					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

THE CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) INCENTIVE SCHEME - MATERNITY SAFETY ACTIONS

1. PURPOSE OF THE REPORT

The purpose of this report is to seek the approval of the Trust Board to submit an application to apply for a 10% reduction on its annual clinical negligence premia for maternity services. A self-assessment has been undertaken by the Trust against ten pre-determined standards and this needs to be submitted to NHS Improvement and NHS Resolution by 29 June 2018. Prior to this, the submission requires Trust Board approval.

The Trust Board is requested to accept that the evidence provided demonstrates compliance with 8 out of 10 of the maternity safety actions, and that the self-certification is accurate and has been validated by the Head of Midwifery, Clinical Lead for Maternity Services, Divisional General Manager, the Medical and Nurse Directors of the Family and Women's Services Health Group. The Chief Nurse, as the Executive Maternity Safety Champion, has provided additional support and challenge to this. The two areas of non-compliance have actions in place to deliver the required standards by August 2018 and December 2018 respectively and the details of these are included in the submission.

2. INTRODUCTION

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST). This is administered by NHS Resolution (formerly the NHS Litigation Authority). Due to the 'high-risk' nature of maternity services by definition, specific premia are calculated for these services.

'Safer Maternity Care'[1] published in 2016 set out a vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030. This plan was structured around the five key drivers for delivering safer maternity care, which are as follows:

- **Focus on leadership:** create strong leadership for maternity systems at every level.
- **Focus on learning and best practice:** identify and share best practice and learn from investigations.
- **Focus on teams:** prioritise and invest in the capability and skills of the maternity workforce and promote effective multi-professional team working.
- **Focus on data:** improve data collection and linkages between maternity and other clinical data sets, to enable benchmarking and drive a continuous focus on prevention and quality.
- **Focus on innovation:** create space for accelerated improvement and innovation at local level.

[1] DEPARTMENT OF HEALTH AND SOCIAL CARE (2016) – Safer Maternity Care; next steps towards the national maternity ambition.

3. SAFER MATERNITY CARE

There are a number of initiatives supporting the delivery of safer maternity care. These include work by:

- The respective Royal Colleges (Obstetricians and Gynaecologists, and Midwives)
- MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths).
- NHS Resolution has contributed significantly by reviewing maternity mortality and morbidity cases, recommending where and how services and the wider system can focus efforts for improvement and raising national awareness about these.

The Trust is engaged actively in all of these initiatives.

4. THE CNST INCENTIVE SCHEME

The aim of the CNST scheme is to incentivise the implementation of good practice across all maternity units. A supplement to 'Safer Maternity Care' and the National Maternity Safety Strategy – 'Progress and Next Steps' was published in 2017. This outlined an incentive to support further the implementation of best practice to improve safety. NHS Resolution launched this new scheme and has built provision for an incentive fund into its pricing for 2018/19. Trusts that are able to demonstrate compliance with ten criteria will be entitled to at least a 10% reduction in their CNST maternity contributions. To encourage this additional focus, the Department of Health re-set the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth to 2025, bringing this forward by five years.

By meeting the ten criteria, Trusts are likely to deliver safer maternity services and are likely to be expected to have fewer cases of brain injuries or other harm, which can lead to negligence claims. Trusts' compliance with the criteria will be assessed through a verification process that will be completed centrally (nationally) by the end of June 2018. Following this, NHS Resolution will confirm which trusts have been successful in achieving the discount.

The incentive scheme will apply to acute trusts only in 2018/19 and will be evaluated during the year to determine whether and how it should be developed in future years.

5. FINANCIAL IMPLICATIONS

If the Trust is successful in its application, this will result in a circa £568k saving against its CNST contributions. Trusts not yet able to demonstrate full compliance with some or all of the criteria will be eligible for being considered for a smaller discount, providing they agree to use the funds to take action towards meeting the criteria, which may include an offer to 'buddy' with a qualifying trust that will provide support.

The Women's Services CRES allocation target for 2018/19 is £568k, which is dependent on the full delivery of this scheme. There is a risk that this target will not be achieved if NHS Resolution does not agree with the self-certificated assessment and evidence. A point of note is that 80% of the maternity services budget is staffing to ensure compliance with nationally recommended midwife to birth ratios. Therefore, this makes the delivery of this level of CRES extremely challenging otherwise.

The self-assessment for this Trust has been conducted by a multidisciplinary group of senior midwives, neonatologists, obstetricians, HR Business Partner, Business managers and the Governance team. The self-assessment has been validated by the

Family and Women's Health Group Triumvirate Senior Team. The full self-assessment table is provided at Appendix One in the format required by NHS Resolution. However, the assessment results are summarised in the following table:

Criterion	Description	Self-Assessment	Comments
1	National Perinatal Mortality Review Tool	Compliant	
2	Maternity Services Data Set	Compliant	
3	Transitional Care	Compliant	
4	Medical Workforce planning	Compliant	
5	Midwifery Workforce planning	Non – Compliant	The service is commencing the Birthrate Plus® assessment from 24th May 2018 and takes three months to complete. Completion due end August 2018.
6	Saving Babies Lives Care Bundle	Compliant	
7	Patient Feedback	Compliant	
8	Multidisciplinary Training	Non – Compliant	The service will be compliant by December 2018
9	Trust Safety Champions	Compliant	
10	NHS Early Resolution Notification Scheme	Compliant	

As can be seen from this table, the Trust is not compliant fully currently with Criterion No. 5. This is because the evidence based Birthrate Plus® assessment will not commence until 24th May 2018. This takes three months to complete (end August 2018). To meet the standards, this had to have been completed by the end of April 2018. However, it is hoped that the fact that the Trust has commissioned this work with definitive timescales, that this will be considered favourably by the national assessment team.

The Trust is also not fully compliant with Criterion No. 8. This is because of service delivery needs and the fact that the previously agreed levels of training targets that the Trust was working to have been increased as part of this incentive scheme. However, it is anticipated that the Trust will be compliant with this indicator by December 2018.

An action plan has been developed to ensure that, going forward for 2018/19, all staff groups will be compliant with the requisite 90% training by 31 December 2018. Midwifery attendance at training is impacted by service delivery needs and, on occasion, staff have had to be withdrawn at short notice due to acuity or short notice staff sickness to ensure safe service delivery. Nonetheless, full attention will continue to be given to this. Progress against the training compliance will be managed and monitored via the speciality governance meeting and the Women's Services Division performance meeting. Compliance and any variation from plan will be monitored through the Family and Women's Health Group monthly Escalation report to the Operational Quality Committee.

6. RISKS

As the Trust is not yet fully complaint with all ten of the standards, it is unclear how this will be treated by NHS Resolution. Nonetheless, it is hoped that there may be some latitude afforded to the Trust when the evidence is considered. The Trust Board will be notified of the outcome of the assessment in due course. Meanwhile, the Trust Board

can be assured that Maternity Services will continue to address all of the required elements to the best of its ability and as soon as is reasonably practicable.

7. RECOMMENDATIONS

The Trust Board is requested to approve the submission of the Trust's self-assessment to NHS Resolution by the required date of 29 June 2018.

Janet Cairns, Head of Midwifery
Lisa Pearce, Divisional General Manager
Jaishree Hingorani, Clinical Lead for Maternity Services

Supported by:

Colin Vize, Medical Director – Family and Women's Health Group
Mike Wright, Executive Chief Nurse

May 2018

Appendix 1

Board report on Hull and East Yorkshire Hospitals NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions.

Family & Women's Health Group – Women's Services Division.
Date: 9 May 2018

Background

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. NHS resolution is supporting this work by trialling the CNST incentive scheme for 2018/19. The scheme is absolutely discretionary and subject to available funds. Maternity safety is an important issue as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. The expectation is that trusts will be able to demonstrate the required progress against **all 10** of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia). Total value to HEY £568k

SECTION A - Evidence of progress against 10 safety actions

Safety action 1 - National Perinatal Mortality Review Tool	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The national Perinatal Mortality Review Tool (PMRT) was launched for use by all Trusts in England in March 2018. The PMRT was commissioned by the Department of Health as part of the national work to achieve the Secretary of State's ambition to reduce the stillbirth and neonatal death rate by 50% by 2025. There is a PMRT review Group established to undertake these reviews. All stillbirths since January 2018 have been reviewed and data submitted via the online tool. The evidence available to support this action includes: • Terms of Reference for the Perinatal Mortality Review Group (PMRG) • Minutes from the reducing stillbirth meeting agenda item, 2017.07.08, Learning from stillbirth reviews • Cases submitted to the on-line tool • Action plan following review of cases	**YES**

Safety action 2 - Maternity Services Data Set	Evidence of Trust's progress	Action met? (Y/N)
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Maternity Services Data Set (MSDS) has been developed to help achieve better outcomes of care for mothers, babies and children. The MSDS is a patient-level data set that re-uses clinical and operational data for purposes such as commissioning and clinical audit. It captures key information at each stage of the maternity service care pathway in NHS-funded maternity services. The data collected include mother's demographics, booking appointments, admissions, screening tests, labour and delivery along with baby's demographics, and screening tests. The attached scores relate to the data submitted in relation to October, November and December 2017. So while these will not be taken into account for the assessment this summer, it gives an indication of where you are now. In some cases your score varies between months and has not always increased. Your next submission of January 2018 data by the end of March 2018 counts for the category of making data submissions for each of the last three months. January, February and March 2018 data will be used for the assessment. The MSDS submission for HEY is based on what has been developed on the development server and tested in relation to the MSDS uploads for February and March. All fixes and developments will be promoted into the live server after submission to the February MSDS (due 31/03/2018). In January 2018 submission highlighted a number of errors, both in assumptions around what should be submitted and also the quality of some of the data. From this information services developed a series of data quality reports to correct issues on the Lorenzo Maternity System. These reports are owned mainly by Maternity Services. The development team have also changed our submission methodology following contact with NHS Digital and tested this on our development server. Information Services have been submitting test submissions for February onto Open Exeter and also running self- checks on the data to ensure all 10 of the CNST criteria are met.	**YES**

	The evidence to support this action includes: • NHS digital compliance scores which relate to the data submitted in relation to October, November, December 2017 and January 2018 which indicates the position of the Trust at that point in time, prior to the submission of January 18 data to be submitted at the end of March. • Compliance benchmarking against the 10 criteria submitted at the end of March. This is the required evidence for the Trust to be able to demonstrate progress on at least 8 out of the following 10 criteria. The Trust is demonstrating compliance with 10 out of 10 criteria	
Safety action 3 – Transitional Care	**Evidence of Trust's progress**	**Action met? (Y/N)**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	Keeping mothers and babies together should be the cornerstone of newborn care. Transitional Care (TC) supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require admission to the neonatal unit. Implementation of TC has the potential to prevent admissions to the neonatal unit, and also to provide additional support for small and/or late preterm babies and their families. TC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home. Although TC for babies had been provided previously on the post natal ward by midwives, an agreement was made that a dedicated area on the postnatal ward would be provided for the TC model of care to be delivered. The operational policy for TC was approved in November 2017. This area is staffed and managed by Neonatal Nurse and Medical team with midwifery in reach for the mothers. **Avoiding Term Admissions Into Neonatal units programme (ATAIN)**. It has been identified that nationally over 20% of admissions of full term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together reduces the harm caused by separation. Maternity and neonatal services should work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so. The midwifery team are currently undertaking an e-learning module which	**YES**

	addresses the key learning needs identified through Atain, with a focus on five key areas: • Respiratory conditions • Hypoglycaemia • Jaundice • Asphyxia (perinatal hypoxia–ischaemia). • Raising awareness of the importance of keeping mother and baby together This programme has been available on HEY247 since April 2018 currently out of 219 midwives, 69 have undertaken the full programme which is 31% The evidence to support this action includes: • Transitional Care Operational Policy • Minutes form the obstetrics and gynaecology governance approving the SOP • Data from Badger showing the increase in TC activity recording following the implementation of this model.	
Safety action 4 – Medical workforce planning	**Evidence of Trust's progress**	**Action met? (Y/N)**
4). Can you demonstrate an effective system of medical workforce planning?	The RCOG has created a workplace planning tool as part of NHS Resolution's new Clinical Negligence Scheme for Trusts (CNST) incentive scheme. Safe maternity care requires safe staffing and there are clearly workforce pressures in units across England. Long-term workforce planning is needed to address the current gaps in middle-grade rotas to avoid consultants and trainees having to act down and across from other sessions. Pulling obstetric staff from other sessions compromises safety and care for women in other areas of the service and reduces training opportunities for the next generation of consultants. The RCOG has therefore asked NHS Resolution to support Trusts to achieve adequate staffing levels and workforce planning as one of the safety actions within their new Clinical Negligence Scheme for Trusts (CNST) incentive scheme. As a first step, Trusts have to provide data on the proportion of middle-grade sessions on the labour ward filled by other staff from other sessions.	**YES**

	Trusts need to demonstrate that fewer than 20% of sessions are filled by consultants acting down as a proxy for workforce planning. We will also be monitoring whether Trusts are pressuring trainees to fill sessions, or using short-term locums, to fulfil their CNST requirements. The evidence submitted to demonstrate compliance with this standard is an audit that was performed over a four week period between 5 March 2018 and 1 April 2018. The findings of the audit have been submitted to the Royal College of Obstetricians and Gynaecologists. The audit was looking at whether any of the shifts were covered by the intended registrar or by a replacement doctor covering another activity. The audit demonstrated that there were times, due to short notice leave, e.g. sickness, that the service had to reallocate junior doctor resources from a different activity or source a junior doctor to provide an additional activity paid as a locum. The audit also demonstrated that there were no middle grade shifts covered by consultants over the four week period. The evidence available to support this standard is: • Four week period audit data	
Safety action 5 – Midwifery workforce planning	**Evidence of Trust's progress**	**Action met? (Y/N)**
5). Can you demonstrate an effective system of midwifery workforce planning?	The service is undertaking Birthrate Plus® commencing May 2018 (due for completion end August 2018). There is funding built into the budget from 18/19 to ensure this assessment can be undertaken annually. Birthrate Plus® is a nationally recognised tool available for maternity services. It is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour, but also includes measurements across the whole maternity pathway. Data collection for 3 months will provide a reliable and valid case-mix along with other intrapartum and ward activity. The intrapartum case-mix has the major impact on the midwifery establishment and it is recommended to collect current data, rather than use figures from a previous study. The required dataset for the birth centre will be available from current activity and stats. Assessment of outpatient and community	**NO**

	services does not require intensive data collection and will be based on a typical weekly profile of clinics and day units, plus annual activity for community. Staffing levels, deployment and skill mix are key elements of a safe and quality service. In maternity, workforce planning poses a unique set of problems: each care 'episode' spans around 6-7 months, crossing hospital and community settings, involving a series of scheduled appointments but a high likelihood of additional unscheduled care and often involving an unexpected inpatient admission as well as the birth itself. This pathway is in the main provided by midwives whose role and responsibilities are defined in statute and which cannot therefore be legally delegated. However midwives work alongside a range of clinicians: GPs, obstetricians and paediatricians and deliver care with the support of colleagues from nursing, care assistant/support workers and others. This all means that traditional nursing based approaches to determining appropriate numbers and deployment will not work. The Birthrate Plus® Team will provide the following services: • Planning & scoping of maternity/midwifery services with midwifery management team • Provision of all material needed both for training, data collection and analysis • On & offsite support to ensure robust data • Data validation & analyses both on & off site • Feedback and confirmation of final results with midwifery & skill mix recommendations The Birthrate Plus® Team will report findings including presentation of ratios for future planning purposes The current midwife to birth ratio was determined following a previous Birthrate Plus® assessment, midwifery staffing levels are described in the Chief Nurse staffing papers for the Trust Board. The Maternity Services Staffing Levels and Escalation Guideline identifies 'Red Flags' for staffing and service shortfalls, and stipulates that the role of the Labour Ward Coordinator (LWC) should not take patients as part of the workload, and will act in a supernumerary status. The evidence to support this action includes: • Concept paper to undertake Birthrate Plus® • E-Mail confirmation of approval to procure Birthrate Plus® • Maternity Services Staffing Levels and Escalation Guideline • E-roster identifying supernumerary status of Labour Ward Coordinator	

	• Health Group operation plan workforce plan Section 9.1 & Appendix 4 • Women's Services Division operational workforce plan Section 10.2 • Labour Ward Rota Tool	
Safety action 6 – Saving Babies Lives Care Bundle	**Evidence of Trust's progress**	**Action met? (Y/N)**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The Yorkshire & Humber (Y&H) Stillbirth Recommendations were published in September 2015. The recommendations included 4 key areas for improvement: Risk Reduction, Bereavement Care, Stillbirth Investigations and Subsequent Pregnancies. Maternity services have regularly submitted data to the Y&H clinical network regarding compliance with implementation of the recommendations. National developments include the National Bereavement Care pathway (NBCP) which aims to improve the bereavement care parents receive after pregnancy or baby loss and is supported by the All Party Parliamentary Group on Baby Loss. Hull is in wave one of the pilot sites for implementation of this. In February 2017 the maternity services appointed a Bereavement Midwife who is leading on all aspects of the stillbirth recommendations. The maternity services submit a survey quarterly to the Y&H Clinical Network. This survey collates regional compliance with the Saving Babies Lives' Care Bundle and compares results to a national benchmark. The survey addresses the following elements. • **Reduce smoking in pregnancy** - Every woman accessing maternity services should have a Carbon Monoxide (CO) reading recorded at booking and at 36 weeks (non-smokers) and at every contact for smokers. Compliance with documentation of CO readings in January 2018 was 88.9% • **Growth Assessment Protocol (GAP)** - Identification and surveillance of pregnancies with fetal growth restriction. Including the use of customised growth charts and implementation of the Growth Assessment Protocol. o In 2017 compliance with providing customised growth charts for women was 100%. o In 2017 compliance with the guideline for the Growth Protocol was 90%. • **Fetal Movements** - Raising awareness of Fetal Movements amongst women to ensure they fully understand the importance of detecting and reporting reduced fetal	**YES**

	movement ○ Maternity services have achieved compliance with this in May 2018 with implementation of a checklist for management of pregnancies where women report reduced fetal movements • **Effective fetal monitoring in labour -** There are numerous opportunities for all staff to be compliant with cardiotocograph training (CTG). The sources available are: • K2 – on-line Perinatal training programme • Royal College Obstetricians & Gynaecologists (RCOG) eLfH, online training https://stratog.rcog.org.uk/tutorial/electronic-fetal-monitoring/efm-8195) • Midwives Mandatory Training Day 2 • Any Perinatal Mortality / CTG teaching session in house • Any external CTG study sessions The compliance to April 18 CTG training for midwifery staff is 80% The compliance to April 18 CTG training for medical staff is 90% Since the implementation of the Stillbirth Care Bundle the maternity services has seen a reduction in stillbirths. • April 2016 – March 2017 total stillbirths = 25 • April 2017 – March 2018 total stillbirths = 10 The evidence available to support this action includes: • Stillbirth Care Bundle (SCB) update • Agenda for Operational Quality Committee February 2018 where SCB update was presented • Yorkshire and Humber Survey 8 – regional compliance and national benchmarking with the care bundle • Stillbirth Care Bundle Analysis of provider responses of the Care Bundle Survey • Obstetric Governance meeting minutes with approval of the checklist for reduced fetal movements • Reduced fetal movements checklist • Yorkshire and Humber Maternity Dashboard	

Safety action 7– Patient Feedback	Evidence of Trust's progress	Action met? (Y/N)
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Better Births, which was published in February 2016, set out a Five Year Forward vision for NHS maternity services in England. The Humber Coast and Vale Local Maternity System (HCV LMS) executive group was established in March 2017 with the responsibility to lead the development and delivery of the national maternity transformation programme 'Better Births' through the HCV LMS Delivery Plan. The LMS Board agreed that establishment of work streams would include • Choice and personalisation • Maternity Voices Partnership HEY Maternity services regularly act on user feedback, and currently are working towards completion of the actions from the Picker Survey undertaken in February 2017 (Published January 2018). The Picker Institute was commissioned by 68 trusts to undertake the Maternity Survey 2017. A total of 394 patients from HEY Trust were sent a questionnaire in May 2017, 386 patients were eligible for the survey 146 returned a completed questionnaire, giving a response rate of 37.8%. Areas which scored significantly worse: • **Choice of place of birth** ○ The Fatima Allam Birth Centre (FABC) opened in April 2017 and now has a core team of midwives working there, births are increasing as women become more aware of choices • **Continuity of carer** ○ This is part of the national maternity transformation plan as outlined in Better Births and currently the FABC is developing a model of care based around the continuity of carer model. The National Maternity team is visiting the unit in June to review developments of this	**YES**

	• **Ability for partners to stay overnight in hospital** ○ The antenatal and postnatal inpatient areas are piloting an extended visiting programme which facilitates partners staying overnight. The service undertook an engagement event in January 2018 and invited women who were expecting a baby or had given birth in the last 2 years. The aim was to gain feedback identifying • What was good? • What made it good for you? • What would make a difference to you and your family to make it better? The session enabled women and partners to have their say on how local maternity services are provided. The session was very well attended by approximately 25 mums and one partner, feedback was provided by all the women. The feedback has been incorporated into the action plan from the Picker survey. The maternity service contributes to the Friends and Family test and regularly display results in clinical areas. Results are also included in the Quality Performance Report for the Health Group. The service will be undertaking a user experience event with the *Whose Shoes? Maternity Experience event* which comprises scenarios sourced from all perspectives in the form of engaging conversation starters to explore key challenges and opportunities and help generate locally owned solutions. NHS England recommends 'establishment of independent formal multidisciplinary committees, 'Maternity Voices Partnerships', formerly Maternity Services Liaison Committees (MSLCs), to influence and share in local decision-making. **'**Existing MSLCs have recommended changing to be known as Maternity Voices Partnerships.' All women in the local area should be able to participate in an MVP by giving feedback or becoming service user members of an MVP. Partners and families may also wish to give feedback or join a partnership. Hull and the East Riding of Yorkshire host the Maternity Services Forum (previously the MSLC for Hull and East Yorkshire) with an associated work plan. This has now been changed to the Hull Maternity Voices in Partnership (Hull MVP) . This is a newly	

	formed MVP with the purpose of improving birth services for women in Hull, from antenatal to postnatal, based on service user feedback. The first MVP Board meeting was held 25 April 2017. Draft Terms of Reference are to be agreed **Birth Preparation and Parent Education Service** This service was transferred to HEY for delivery from 01.04.2017 as part of the requirements for Better Births, improving service integration, personalisation and supporting women and their partners in readiness for labour, delivery and parenting. The service has been evaluated positively by service users (96%) and feedback is used to continually review and improve delivery. The monthly 'Hey Baby Carousel' has proven to be very successful with parents-to-be having the opportunity to 'drop in' and meet a range of providers and partners at the market-place event, including safety, healthy lifestyles, maternity, health visiting and voluntary sector services. Women can also receive flu and pertussis vaccinations and their Mat B1 form. The carousel facilities, speaking with women and their partners about engagement and the principles of the Maternity Voices Partnership. The evidence available to support this action includes: • Picker survey 2017 • Picker survey 2017 Action plan • Friends and family extract from performance report • Hull MVP Terms of reference draft • Hull MVP agenda • MSF Meeting notes • MSF minutes	
Safety action 8 – Multidisciplinary Training	**Evidence of Trust's progress**	**Action met? (Y/N)**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within	Maternity multidisciplinary training is covered by either a face to face taught session YMET (Yorkshire Medical Emergency Training) or "Skills Drills" in clinical areas covering maternity emergencies in different settings. Cardiotocograph (CTG) training is provided in various formats as described in Safety Action 6 – Stillbirth care bundle compliance As part of the ambition to halve maternal and perinatal mortality and intrapartum brain injuries, the Department of Health identified a training fund administered through Health	**NO**

the last training year?	Education England (HEE). The service received £49.000 to organise a broad range of multidisciplinary training, complementing the existing training framework. This has been delivered with a variety of sessions including CTG master classes, Human Factors Training, Maternity emergencies in the Community setting. Training and Resilience training. Individual attendance at each in house training session is recorded on a spread sheet. The data shows the overall compliance for all disciplines as at April 2018. The compliance is for the staff members that have attended both CTG and YMET training as at April 2018. Up to this point the service has never measured compliance at a 90% standard; therefore an action plan has been developed to ensure that going forward for 2018/19 all staff groups will be compliant with the requisite 90% training. For the maternity services in HEY the training year runs from January to December. Attendance at training is impacted by service delivery needs and on occasion staff has to be withdrawn at short notice due to acuity or short notice staff sickness to ensure safe service delivery. The evidence available to support this action includes: • Training compliance summary • YMET training dates • Action plan • In house training records	
Safety action 9 – Trust Safety Champions	**Evidence of Trust's progress**	**Action met? (Y/N)**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The Head of Midwifery and the Consultant Obstetric Lead will meet regularly with the Chief Nurse to update on maternity issues. The dates are booked for 2018/19 and an agenda has been developed. The HoM will be invited to the Trust Board to discuss any relevant issues if required. The evidence available to support this action includes: • Maternity Safety Champion Agenda 2017 • Maternity Safety Collaborative Email	**YES**

Safety action 10– NHS Early Resolution Nofication Scheme	**Evidence of Trust's progress**	**Action met? (Y/N)**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	The current system for delivering compensation can be costly, legal costs are disproportionate and cases often end up in litigation prematurely. Figures from NHS Resolution indicate that 33% of annual expenditure comes from obstetrics, which represents 10% of claims received. The bulk of this cost involves brain injury at birth. The aim of early notification is to put more resources into the early investigation of claims, so that early decisions can be made and explained to the family and healthcare staff. NHS resolution has identified some early indicators to incentivise improvements in maternity safety which are aligned with elements of the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts national quality improvement programme. Since 1 April 2017 it has been a requirement for the trust to report all maternity incidents likely to result in severe brain injury. A set criterion has been determined regarding the types of cases, which need to be submitted. **Process:** • Data is submitted to the RCOG Each Baby Counts programme. • The trust legal services department is informed within 14 days of the incident that a notifiable severe brain injury incident under the Early Notification Scheme has occurred using the Early Notification report form • The trust legal services department should then report the incident to NHS Resolution within 30 days of the incident. The evidence available to support this action includes: • NHS Resolution Early Notification Reports April 2017 – April 2018	**YES**

Evidence Summary Table

Safety Action 1	Evidence available	Action Met	Further action required
Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	• Terms of Reference for the Perinatal Mortality Review Group (PMRG) • Minutes from the reducing stillbirth meeting agenda item, 2017.07.08, Learning from stillbirth reviews • Cases submitted to the on-line tool • Action plan following review of cases	**YES**	
Safety Action 2	**Evidence available**	**Action Met**	**Further action required**
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Evidence of compliance with 10 of the following criteria: • Have you submitted MSDS in all of the last three months (i.e. data relating to January - March 2018)? • Did your latest submission contain booking appointments in the month? • Did your latest submission contain method of delivery for at least 80% of births? • Did your latest submission contain at least 80% of HES births expectation (unless reason understood)? • Did your latest submission contain all of the tables 501, 502, 404, 409? • Did your latest submission contain all the tables 401,406,408,508,602 (unless justifiably blank)? • Did your latest submission contain valid* smoking at booking for at least 80% of bookings? • Did your latest submission contain valid baby's first feed for at least 80% of births? • Did your latest submission contain valid in days gestational age for at least 80% of births? • Did your latest submission contain valid* presentation	**YES**	

	at onset for at least 80% of deliveries where onset of labour recorded?		
Safety Action 3	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	The evidence to support this action includes: • Transitional Care Operational Policy • Minutes form the obstetrics and gynaecology governance approving the SOP • Data from Badger showing the increase in TC activity recording following the implementation of this model.	**YES**	**See Section B**
Safety Action 4	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate an effective system of medical workforce planning?	The evidence available to support this standard is • Four week period audit data from 5 March 2018 to 1 April 2018	**YES**	
Safety Action 5	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate an effective system of midwifery workforce planning?	The evidence to support this action includes: • Concept paper to undertake Birthrate Plus® • E-Mail confirmation of approval to procure Birthrate Plus® • Expression of Interest for Midwife to undertake data collection for Birthrate Plus® • Maternity Services Staffing Levels and Escalation Guideline • E-roster identifying supernumerary status of Labour Ward Coordinator • Health Group operation plan workforce plan Section 9.1 & Appendix 4 • Women's Services Division operational workforce plan Section 10.2 • Labour Ward Rota Tool	**NO**	**See Section B**

Safety Action 6	Evidence available	Action Met	Further action required
Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The evidence available to support this action includes: • Stillbirth Care Bundle (SCB) update • Agenda for Operational Quality Committee February 2018 where SCB update was presented • Yorkshire and Humber Survey 8 – regional compliance and national benchmarking with the care bundle • Obstetric Governance meeting minutes with approval of the checklist for reduced fetal movements • Reduced fetal movements checklist	**YES**	
Safety Action 7	**Evidence available**	**Action Met**	**Further action required**
Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	The evidence available to support this action includes: • Picker survey 2017 • Picker survey 2017 Action plan • Friends and family extract from performance report • Hull MVP Terms of reference draft • Hull MVP agenda • MSF Meeting notes • MSF minutes	**YES**	
Safety Action 8	**Evidence available**	**Action Met**	**Further action required**
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	The evidence available to support this action includes: • Training compliance summary • YMET training dates • Action plan • In house training records	**NO**	**See Section B**

Safety Action 9	Evidence available	Action Met	Further action required
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	The evidence available to support this action includes: • Maternity Safety Champion Agenda 2017 • Maternity Safety Collaborative Email	**YES**	
Safety Action 10	**Evidence available**	**Action Met**	**Further action required**
Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	The evidence available to support this action includes: • NHS Resolution Early Notification Reports April 2017 – April 2018	**YES**	

SECTION B – Further Action required

Safety Action 3	Further action required
	All midwives to complete the ATAIN online training programme by March 2019
Safety Action 5	**Further Action required**
	Birthrate Plus® full assessment will commence 24 May 2018, funding agreed in budget 18/19 to undertake a Birthrate Plus® assessment on an annual basis
Safety Action 8	**Further action required**
	Introduce standard of 90% compliance for training with immediate effect (2018/2019) Labour Ward Practitioners to ensure and monitor delivery of 90% standard by coordinating with the service leads to ensure attendance and follow up non-attendance with immediate effect (2018/2019) Training compliance to be incorporated into quarterly report via the performance meetings with the Triumvirate with immediate effect (2018/2019).

NB. The completion of these actions will not require any additional funding

SECTION C: Trust Board Sign-off

For and on behalf of the Board of Hull and East Yorkshire Hospitals NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Signature: ...……

Position: ……..

Date: …….

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

MINUTES OF THE QUALITY COMMITTEE
HELD ON
MONDAY 26 MARCH 2018

PRESENT:	Prof. T Sheldon	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Prof. M Veysey	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs J Ledger	Deputy Chief Nurse
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Mrs A Green	Lead Clinical Research Therapist
	Dr M Purva	Deputy Chief Medical Officer
IN ATTENDANCE:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies** Apologies were received from Mr M Wright, Chief Nurse and Mr K Phillips, Chief Medical Officer	
2	**Declarations of Interest** There were no declarations of interest received.	
3	**Minutes of the meeting of 26 February 2018** • Mrs Bates to be added to the 'present' list. • **Item 4.8** – Mrs Walker trained research nurses but had not been a research nurse as stated in the minutes. Following these changes the minutes were approved as an accurate record of the meeting.	
	3.1 Matters arising from the minutes Mrs Walker stated that she had not yet received the Clinical Lead meeting dates and Mrs Thompson agreed to chase these for her.	**RT**
	Mrs Walker also mentioned the engagement between Humber FT and the Trust and Mrs Bates advised that the teams were working together and the relationship was much better, although the Service Level Agreement was not yet in place. The mortality case note review was discussed and Mrs Bates advised that Mr Johnson would be meeting with Prof. Veysey to determine what would be presented to the Committee meetings in the future. There was a discussion around a proposed safety committee and Mrs Bates advised that the governance structure of the committees was being reviewed to bring all the work streams together, not overlap objectives and more focus.	

3.2 Action Tracking List
NRLS Date – Mrs Bates advised that the Trust was still waiting for further information and would share with the Committee once received. **SB**

Ms Ramsay reported that each contract with external companies was robustly managed by the relevant area and the contracting teams with governance arrangements in place. Mr Corral added that the Boots contract was monitored closely at the Health Group governance meetings. Prof. Veysey stated that the Patient Experience and how this was captured was important and how quality improvements were put into place to respond to patient needs.

3.3 Any other matters arising
Dr Purva agreed to circulate a report relating to the deteriorating patient before the next meeting. **MP**

3.4 Workplan 2017/18
The Committee asked for Fundamental Standards to be added to the workplan as a quarterly report. Ms Ramsay advised that this had been included on the 2018/19 workplan which would be presented next meeting. **CR**

4.1 Serious Incidents Themes and Trends
Mrs Bates presented the report and highlighted that the Trust had declared another Never Event which totalled 6 for the year. She reported that NHS Improvement were going to carry out an internal review and a quality summit.

The Trust had also set up an event for all senior medical staff to attend to discuss the Never Event and how the Trust avoids them in the future. Ms Ramsay added that Mr Wright was arranging for two consultants who had been involved in Never Events to speak to their peers about the investigations and what had happened since the events had happened.

Mrs Bates advised that all policies and procedures and training were in place. The Committee discussed the 'stop the line' initiative and how the whole team is responsible for making sure all the checks had been completed before commencing with the surgery. Dr Purva reported that a cultural change was needed and staff must be confident enough to speak up. She also spoke about making it impossible to start the process unless all the checks had been carried out.

Mrs Walker added that although it was good to have a no blame culture there should still be actions and consequences to ensure compliance with the checks. She added that overall it was positive that the Trust was reporting and being transparent and that there should be an ongoing organisational development programme.

Dr Purva was working on embedding the checklist process in theatres, to provide learning to enable implementation in other areas.

Resolved:
The Committee received and accepted the report.

4.2 Quality Improvement Programme
Mrs Bates presented report and advised that the new QIP for 2018/19 was being developed and would include recommendations from the CQC.

Mr Snowden highlighted falls prevention training and Mrs Ledger reported that the training was for all medical staff but the teams were focussing on the high risk areas first.

Mrs Walker highlighted the QIP 22 which related to nutrition and the Committee members discussed the advantages of doctors having more nutrition training.

Resolved:
The Committee received and accepted the report.

The agenda was taken out of order at this point

4.5 VTE Performance Update
Mrs Bates presented the update and advised that performance had also been discussed at the Operational Quality Committee as it was still an issue in some areas.

Mrs Bates advised that the Medical Directors for each Health Group had been asked to review their own areas and provide analysis of any outliers. Prof. Sheldon asked that a report with detailed analysis to be reviewed by the committee with persistent areas of non-compliance highlighted.

Resolved:
The Committee received the update and requested detailed analysis of any persistent areas of non-compliance. **KP**

4.3 C Section Report
Mrs Bates updated the committee and advised that an analysis of c sections both elective and non-elective was being carried out as part of the Maternity Case Review.

The Committee discussed the increasing rate and that the Trust was receiving more patients with more complex problems.

Resolved:
The Committee received the update and requested a report following the Maternity Case Review detailing any outcomes. **KP**

4.4 30 Day Readmission Update
Mrs Bates presented the item and advised that this was monitored on a monthly basis by the contracting team.

Work was ongoing to review any mortality following the first 48 hours after discharge with the primary care physicians as well as unnecessary early discharges and case note documentation accuracy.

There had been a case note review and the outcomes of this would be included in the next board report in May 2018. No avoidable issues

came out of the investigation. Work was also ongoing with health and community partners to review discharge processes to ensure appropriate transfer of patients out of the hospital.

Resolved:
The Committee received and accepted the update.

5.1 Integrated Performance Report
The Committee discussed Cancer 62 day screening and the Trust's ethical responsibility to patients. Ms Ramsay suggested that the committee members receive the exception report prepared by the Chief Operating Officer which gave more details.

Mrs Ledger advised that any patient delays were discussed at the Performance and Activity meeting which was held weekly. Mrs Bates added that the Harm Committee would also review delays that could cause harm.

Resolved:
The Committee received and accepted the report.

5.2 Operational Quality Committee
Mrs Ledger presented the report and highlighted the work ongoing regarding standardising the consent forms, the deteriorating patient and the wound management relating to poor skin care.

She reported that tissue viability was still an issue and Mrs Walker asked that the wound management report could be received at the Quality Committee following receipt at the Operational Quality Committee.

Resolved:
The Committee received and accepted the report.

5.3 Clinical Harm Group
Mrs Bates updated the Committee and advised that 151 patients were receiving a second review. A total of 109 patients reviewed had received minor harm due to the issue, but there had been no major harms or avoidable deaths reported.

Resolved:
The Committee received and accepted the report.

5.4 Workforce update report
The report was received by the Committee for information. Allocation of Junior Doctor training places was discussed and the appraisal rates. Dr Purva confirmed that appraisal rates would achieve 90%.

Retention was also discussed and Mrs Ledger reported that a programme targeting nurses due to retire was being explored.

Resolved:
The Committee received and accepted the report.

5.5 Quality Report March 2018
The Committee received the report which had previously been received

at the March Board meeting. There was a discussion around the timings of the report being received at the Committee and Ms Ramsay reported that the sequencing would catch up in 2018/19.

Mrs Bates drew the 40 day turnaround of complaints to the Committee's attention and reported that the figures had been checked manually for accuracy following an error and were now recorded on the electronic system.

Resolved:
The Committee received and accepted the report.

6 Learning from Deaths Policy

Mrs Bates presented the policy stating that the policy now included flowcharts detailing the process.

The Committee discussed how lessons would be shared after each review and the process to review outcomes ad embed learning. The roles and responsibilities section needed to be more robust with Chief Medical Officer overview and Non Executive monitoring via the Quality Committee.

Mrs Bates and Mrs Ledger agreed to take back the comments from the committee and review the survey letter that went to patient families following a patient death. **SB/JL**

Resolved:
The policy was approved by the committee following the suggested changes were made.

7 Board Assurance Framework (BAF) 2017/18

Ms Ramsay presented the BAF, which had been updated following comments from the previous meeting and the Board meeting. She reported that the 2018/19 BAF would be discussed in more detail at the Board Development session in March 2018.

Resolved:
The Committee received and accepted the report

8 Terms of Reference (TOR)

Ms Ramsay presented the TOR and highlighted the proposed changes. Mortality and learning from deaths had been added as well as Mr Nearney attending the meeting quarterly to present updates regarding the People Strategy. There were also some changes to job titles and the Deputy Chief Medical Officer was added as a member.

There was a discussion around inviting the Triumvirate members and it was agreed that this would be by invitation. The committee also discussed having patient representatives in the future.

Resolved:
The Committee received and accepted the changes to the TOR.

9 New Chair of the Committee – Introduction

Prof Sheldon introduced Prof Veysey as the new chair of the committee.

Prof Veysey thanked Prof Sheldon, on behalf of the committee for his chairmanship and challenge.

Prof Veysey stated that he would like to see more linkage between the Board Committees and less overlap of work streams. He stated that Non Executive Directors should be curious, see the right information but also wanted the team to ask them for help if necessary.

Prof Veysey asked to meet with operational staff and attend the Operational Quality Committee. Mr Snowden added that the NEDs could also attend other sub committees such as mortality and patient experience. Mrs Thompson to provide dates of all sub committees. **RT**

10 Any other business

There was no other business discussed.

11 Date and time of the next meeting:

Monday 30th April 2018, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

Hull and East Yorkshire Hospitals NHS Trust
Minutes of the Quality Committee
Held on 30 April 2018

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Prof J Jomeen	Associate Non-Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Dr M Purva	Deputy Chief Medical Officer
	Mrs G Gough	Deputy Chief Pharmacist
In Attendance:	Mrs K Southgate	Head of Compliance
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Corporate Affairs Manager

No **Item** **Action**

1 Apologies

Apologies were received from Mrs S Bates, Deputy Director of Quality, Governance and Assurance, Mrs A Green, Lead Clinical Research Therapist and Mr D Corral, Chief Pharmacist

Prof. Veysey welcomed Prof. Jomeen to the meeting.

2 Declarations of Interest

There were no declarations made.

3 Minutes of the meeting of 26 March 2018

Trevor Sheldon joined the meeting at 10.15am and it was asked that this be recorded in the minutes.

Following this change the minutes were approved as an accurate record.

3.1 Matters Arising from the minutes

Mrs Walker reported that she had attended a clinical lead meeting which had been a small membership but productive and informative. There was a discussion around how some clinical leads had good engagement and met regularly but that this varied from Health Group to Health Group. Mr Phillips added that there was an element of silo working but that he met with clinical leads on a regular basis. Mrs Walker was keen to attend more clinical lead meetings in the future.

Prof. Veysey reported that Mr Hall, the Chair of the Performance and Finance Committee would become a member of the Quality Committee in May 2018. He added that this would ensure a visible profile through the Committee structure and triangulate any issues for escalation to the Board.

3.2 Action Tracking List

Mr Phillips agreed to provide a report relating to C Sections to the May 2018 meeting. **KP**

3.3 Any Other Matters Arising

There were no other matters arising.

3.4 Workplan

The Committee reviewed the Workplan and agreed to add in more items relating to the patient's perspective. It was agreed that Mr Phillips would present a positive and a negative patient story at each meeting and Mr Wright would approach the Patient Council for a representative to attend the meeting. Ms Ramsay advised that the Terms of Reference would need to be reviewed in light of these changes.

There was a detailed discussion around the timing of the Quality Report that is received at the Trust Board and the fact that the Quality Committee did not see it first due to timings. It was agreed that at the end of June the Committee would receive the May 2018 data before its submission at the Board in July 2018.

It was agreed that the patient experience annual report should be received by the Committee as well as more workforce related reports reviewing the impact on quality of care.

Resolved:

The Committee received and accepted the Workplan with the following additions:

- Patient Experience Annual Report
- Workforce Reports – Impact on Quality of Care

4.1 Serious Incidents

Mrs Southgate presented the report and highlighted the Never Event staff event which was well attended in March 2018. The Trust was showing to be an outlier as it was reporting 6 Never Events to date. The Trust was being scrutinised by NHS Improvement and the CQC.

There was a discussed around the 'stop the line' initiative and how confident staff are to challenge senior medics when procedures are taking place. Dr Purva advised that the Trust had appointed 10 consultant champions to review the WHO checklist compliance and share learning.

Mrs Walker added that she had attended the Never Event session and had found it to be informative and the messages regarding unacceptable behaviour clear and powerful. Prof Jomeen added that it was important that leaders were clear on what they were accountable for.

Mr Wright spoke about behaviours and a Serious Incident that had involved 2 nurses that had performed a procedure that they should not have carried out. He also reported on another Serious Incident that related to a patient that had been moved a number of times and had developed a pressure ulcer as a result of poor care. He added that in difficult cases it was sometimes difficult to identify the learning and what the key learning points were due to the obscure nature of the incident and staff behaviours.

Resolved:

The Committee received and accepted the report.

4.2 Quality Improvement Programme

Mrs Southgate presented the report and advised that the 2017/18 programme would be closed down and a 2018/19 programme opened. The QIP would be scrutinised at the Operational Quality Committee each month

where actions would be closed, revised or added accordingly.

Mrs Walker asked about QIP 12 and the relationship with Humber FT NHS Trust. Mr Wright advised that work was ongoing between the two Trusts, but suggested that he meet with Mrs Walker outside of the meeting to discuss further. Prof. Jomeen added that the issues face at the Trust were being impacted by wider national issues.

Resolved:
The report was received and accepted by the Committee.

4.3 Draft Quality Accounts

Mrs Southgate presented the Quality Accounts that had been tabled at the meeting. She reported that the document would be submitted to the Trust's stakeholders tomorrow and asked that the Committee members emailed any comments to the Compliance Team.

The document contained mandated information and included actions and recommendations from the CQC inspection.

The Quality Accounts would be presented to the Trust Board in May 2018 and it would be requested that the Board delegate responsibility to the Quality Committee to approve them at its June 2018 meeting.

Resolved:
The Committee received and agreed to review the Quality Accounts and offer any comments/feedback to the Compliance Team.

4.4 Annual Report and Effectiveness Review

Ms Ramsay advised that a more detailed questionnaire would be circulated to all of the Board Committees to identify what is working and identify areas of improvement.

The outcomes of the reviews would be included in the Trust's Annual Report.

The Annual Report of the Committee would also be included in the Trust's Annual Report.

Resolved:
The Committee received and accepted the update.

4.5 Mortality Case Note Reviews

Mrs Southgate presented the report and advised that the Trust had received significant assurance from its Internal Audit team relating to the structured case note review process. She added that the CQC had also given positive feedback and was sharing learning with other Trusts.

Mr Phillips added that there was good engagement from the CCG leads and work was ongoing with the GPs.

Resolved:
The Committee received and accepted the report.

5.1 Integrated Performance Report – including VTE Report and areas of non- compliance

Mr Phillips presented the section relating to VTE assessment performance. He reported that the Medical Directors of each Health Group had been tasked with reviewing their areas to identify areas of non-compliance and put actions in place to resolve the issues. He added that the Hospital Improvement Team had also been tasked with helping in this area. Prof Veysey requested a report detailing any actions in place to drive up performance to be received at the Committee.

The Friends and Family staff survey results were discussed and Mr Wright agreed to provide a more detailed report reviewing the results. It was agreed that the report should be supplied in September 2018 which would allow time for the results to settle down following winter pressures.

Resolved:

The Committee received the report and agreed:

- To receive a detailed VTE performance report to include plans in place to recover the compliance position **KP**
- A Friends and Family staff survey report in September 2018 **MW**

5.2 Operational Quality Committee Report

Mr Wright presented the report and highlighted topics discussed such as the Consultant leads checklist, VTE, pre-operation marking procedures and blood transfusion training.

He also reported that a drive to speed up the process around issuing death certificates had begun with the ideal timescales being within 24 hours for non-coroner cases.

Mrs Walker asked how well attended the OQC meetings were and Mr Wright advised that attendance was good with healthy challenge and debate.

Resolved:

The Committee received and accepted the report.

5.3 Clinical Harm Group

Mr Wright updated the Committee and reported that most of the tracking access backlog had now been cleared with only a small number of specialties having patients yet to clear. He added that in the majority of cases only low levels of harm had been reported so far.

There was a discussion around the appropriateness of the follow up appointments as a result of this investigation and Mr Wright advised that a piece of work would be undertaken to look at this further. Prof Veysey added that the learning from the exercise should be shared.

Resolved:

The Committee received and accepted the update.

5.4 Non Clinical Quality Group Minutes

Ms Ramsay presented the minutes and advised that the group met on a quarterly basis and was tasked with the health and safety of staff and non-clinical aspects of quality. Ms Ramsay added that the capital costs and

relative risks to the infrastructure were discussed at the meeting which could potentially impact on quality of patient care.

Mr Snowden asked if the minutes could include a front page summary to highlight any quality issues to the Committee. He also asked that Mr Phillips and Mr Wright review the minutes from their perspective also.

The Committee discussed e-prescribing and e-observations and the fact that they had not been implemented in a timely way due to the wifi coverage and network capabilities. Ms Ramsay added that the capital risk on the Board Assurance Framework was being reviewed robustly to ensure this was captured.

Prof Veysey agreed to escalate the timeliness of the e-observation and e-prescribing implementation to the Board.

Resolved:
The Committee received the minutes and agreed:

- Quality issues to be highlighted in a summary sheet to the Committee **CR**
- Prof. Veysey to raise the IM&T and Network upgrade at the next Board meeting **MV**

6 Board Assurance Framework

Ms Ramsay presented the report and advised that the 2017/18 BAF would now be carried over (were appropriate) to the 2018/19 BAF which was currently in draft and would be circulated in the next 2 weeks.

Ms Ramsay asked for comments and feedback from Committee members once the report was circulated.

Resolved:
The Committee received and accepted the report.

7 Any Other Business

Prof. Veysey suggested that the Committee would start at 9am for all future meetings. The Committee members agreed.

8 Chairman's Summary to the Board

Prof. Veysey agreed to summarise the meeting to the Board.

9 Date and time of the next meeting:

Tuesday 29 May 2018 – 9am – 11am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2018/19

May 2018

March 2018 data

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

Integrated Performance Report - May 2018

RESPONSIVE

Description	Aggregate Position	Trend	Variation

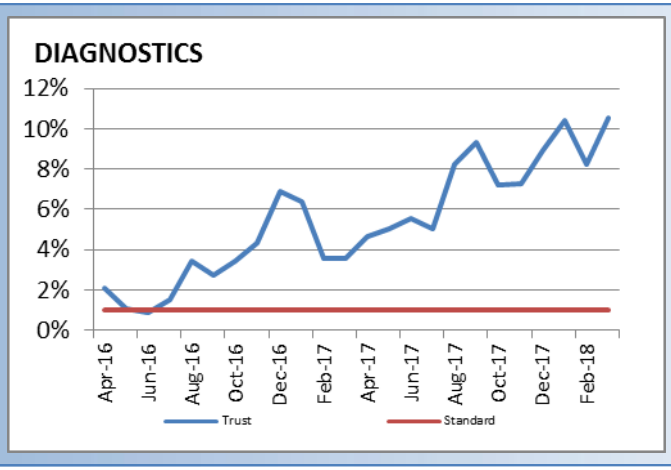
Diagnostic Waiting Times: 6 Weeks

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

The latest available performance is March 2018

Diagnostic waiting times has failed to achieve target with performance of 10.52% in March

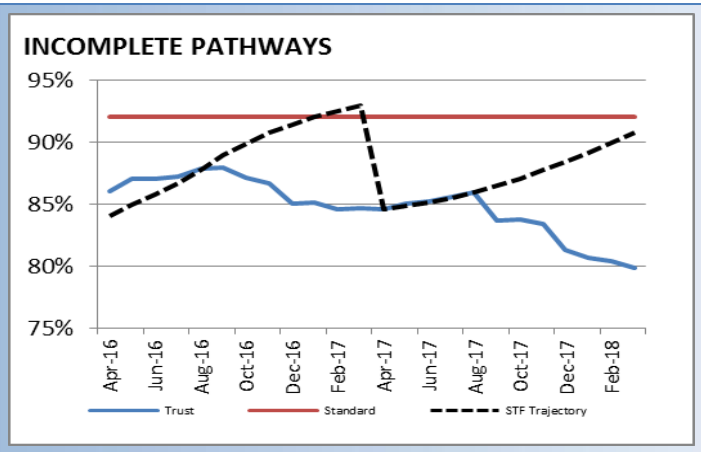


Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the March Improvement trajectory of 90.7%

March performance was 79.83%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

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

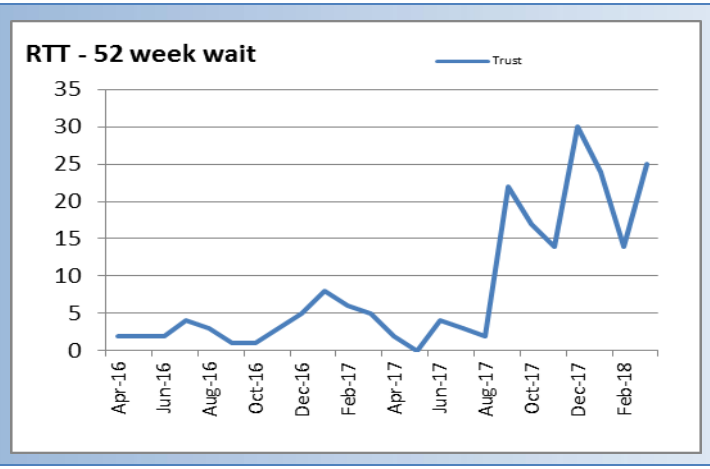
RESPONSIVE

	Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The Trust failed to achieve the national standard of zero breaches with 25 breaches during March.



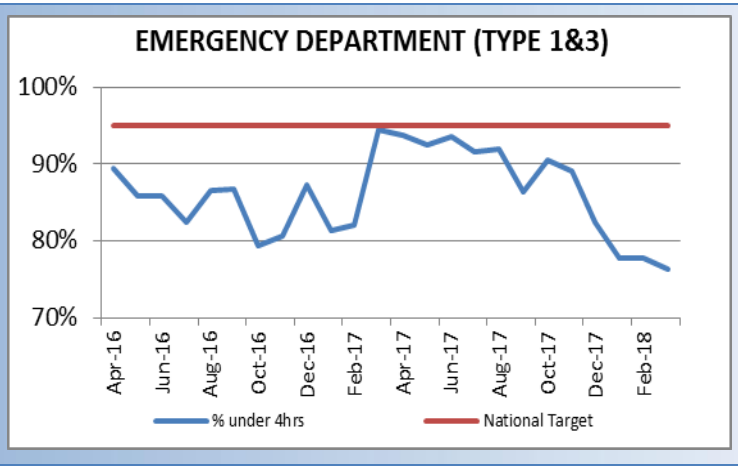
ED Waiting Times (HRI & ERCH)

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

ED performance including ERCH attends failed to achieve national 95% threshold with performance of 76.4% for March.

ERCH activity is now contracted to CHCP and has been included for reporting purposes only.

As of 7th October ERCH performance does not include weekend activity, due to System1 recording. From 1st April 2018 System1 has been fully rolled out at ERCH.



Performance has decreased 1.3% during March from the February position of 77.7%.

Integrated Performance Report - May 2018

RESPONSIVE

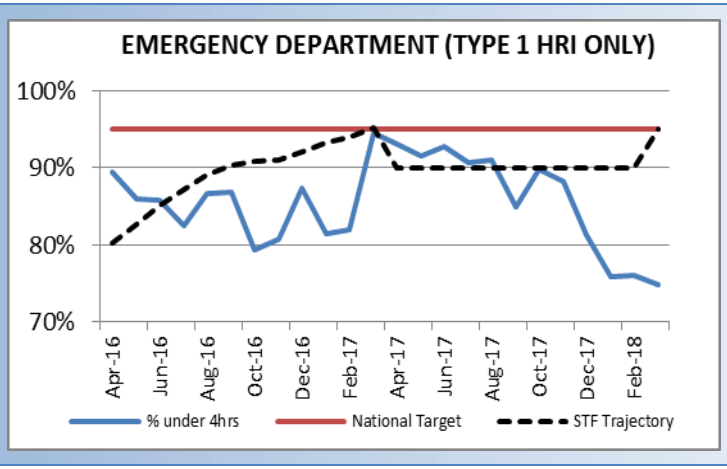
Description	Aggregate Position	Trend	Variation

ED Waiting Times (HRI only)

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

ED performance for HRI attendances failed to achieve the STF Improvement trajectory of 95.0% with performance of 74.8% for March.

This has failed to achieve the national 95% threshold.

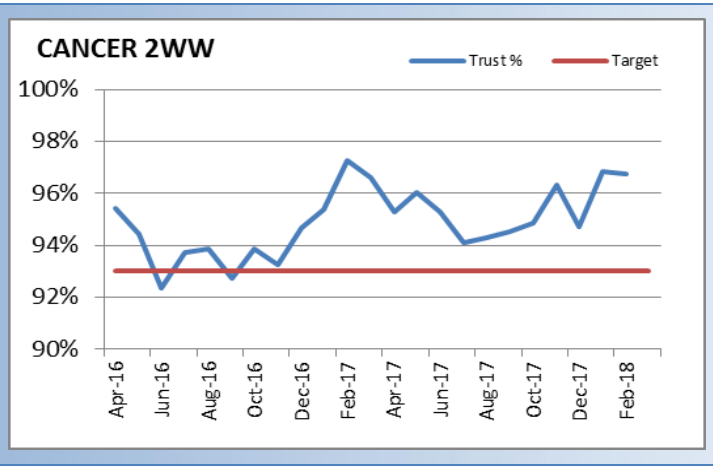


Performance has decreased 1.3% during March from the February position of 76.0%.

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 96.8%



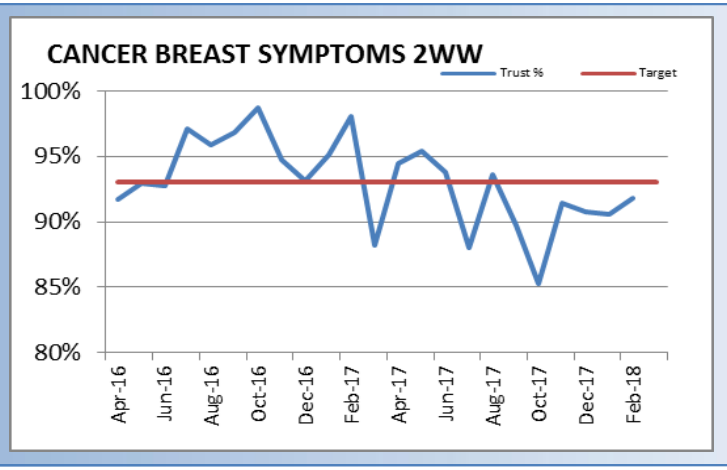
RESPONSIVE

Description	Aggregate Position	Trend	Variation

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.

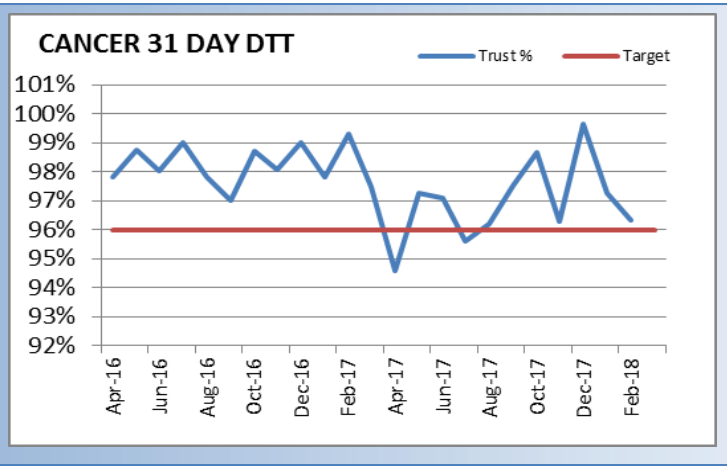
February performance failed to achieve the 93% standard at 91.8%



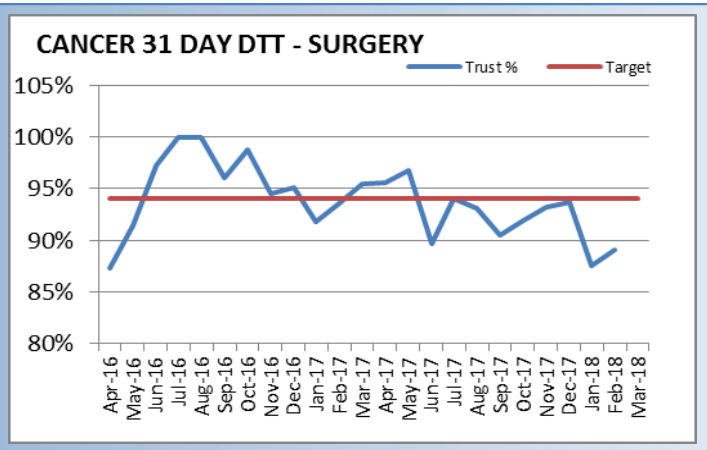
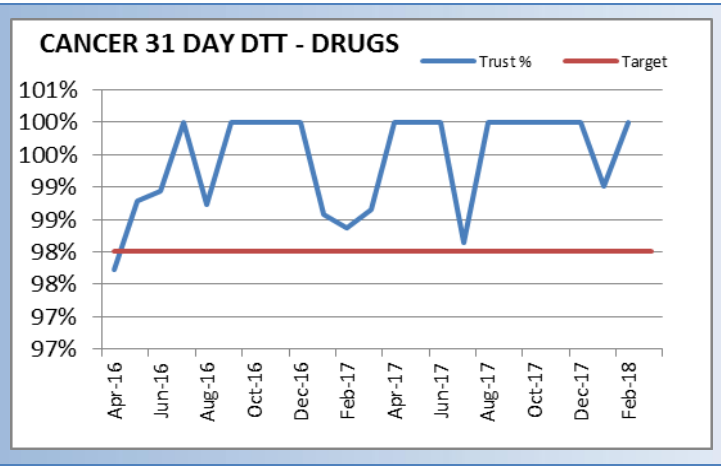
Cancer: 31 Day Standard

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 96.3%



RESPONSIVE

	Description	Aggregate Position	Trend	Variation
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 89.0%		
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 100%		

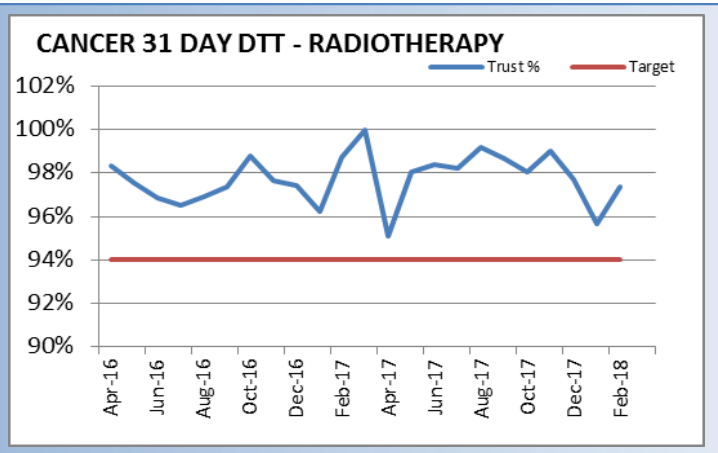
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy

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

February performance achieved the 94% standard at 97.4%

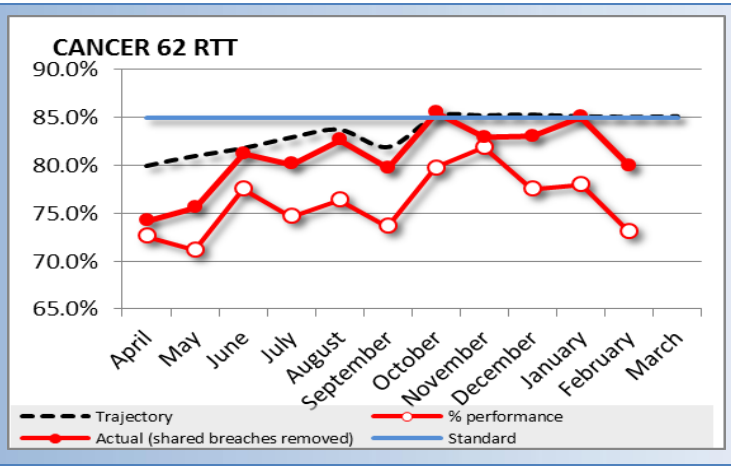


Cancer: ADJUSTED - 62 Day Standard

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

The adjusted position allows for reallocation of shared breaches

February performance failed to achieve the STF trajectory of 85.2% with performance of 80.0%



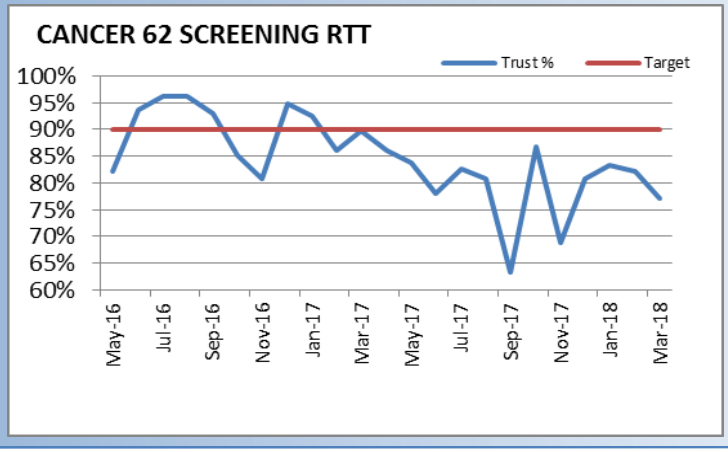
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 62 Day Screening Standard

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

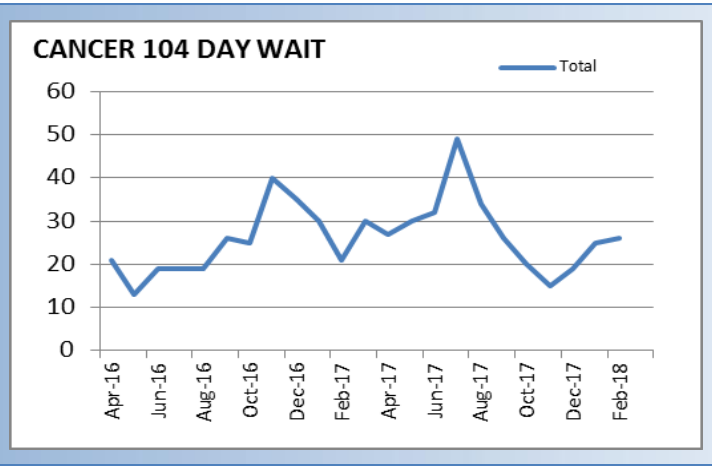
February performance failed to achieve the 90% standard at 77.1%



Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 26 patients waiting 104 days or over at the end of February



RESPONSIVE

Description	Aggregate Position	Trend	Variation

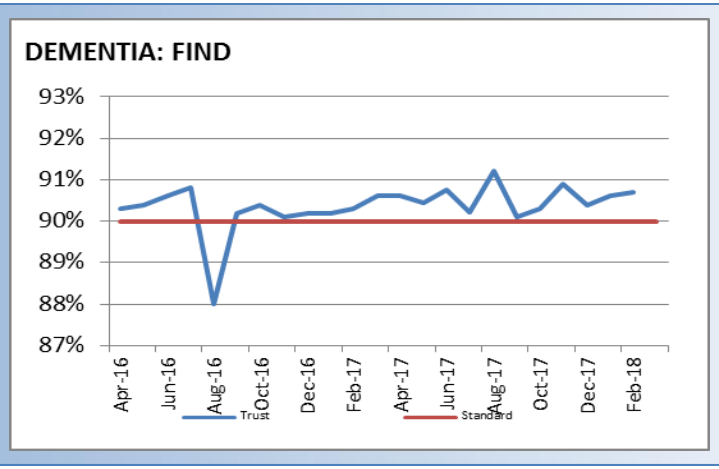
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is February 2018.

The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 90.7%



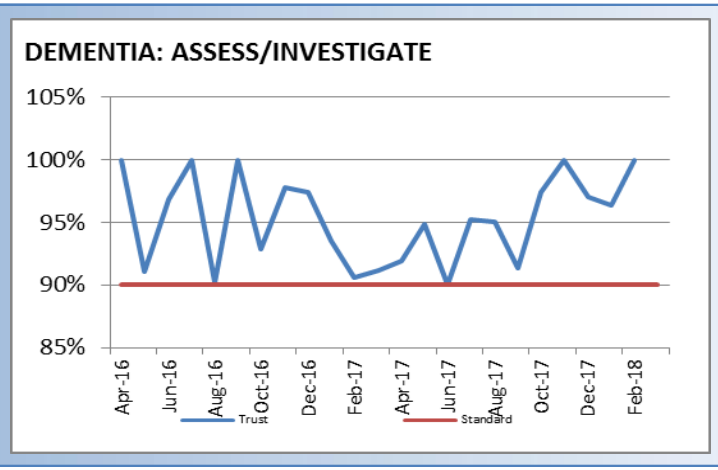
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is February 2018

The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 100%



RESPONSIVE

Description	Aggregate Position	Trend	Variation

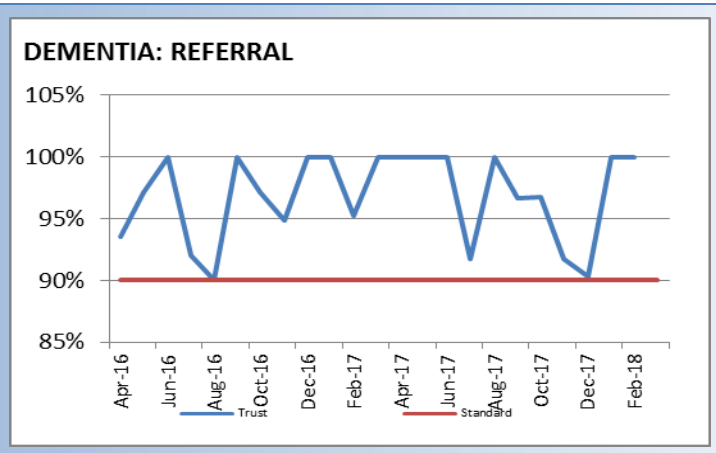
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is February 2018.

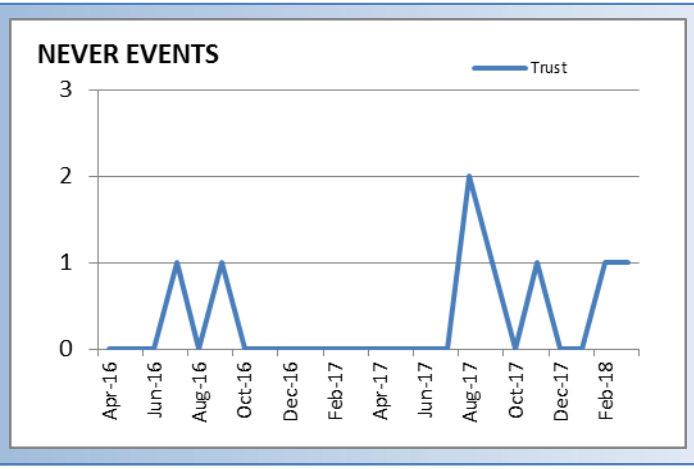
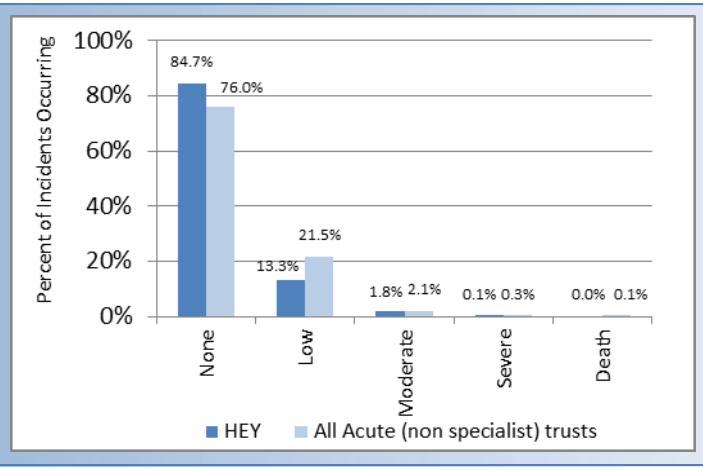
The standard for this indicator is to achieve 90%.

Performance for February achieved this standard at 100%



Integrated Performance Report - May 2018

SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Event	Occurrence of any Never Events	The latest available performance is March 2018 The Trust has reported 6 Never Events year to date. There was 1 case reported during March.		Further information is included in the Board Quality report
Potential under-reporting of patient safety	Number of incidents reported per 1000 bed days	The latest data available for this indicator is April 2017 to September 2017 as reported by the National Reporting and Learning System (NRLS). The Trust reported 9,677 incidents (rate of 58.55) during this period. This rates the Trust in the highest 25% of reporters		

SAFE

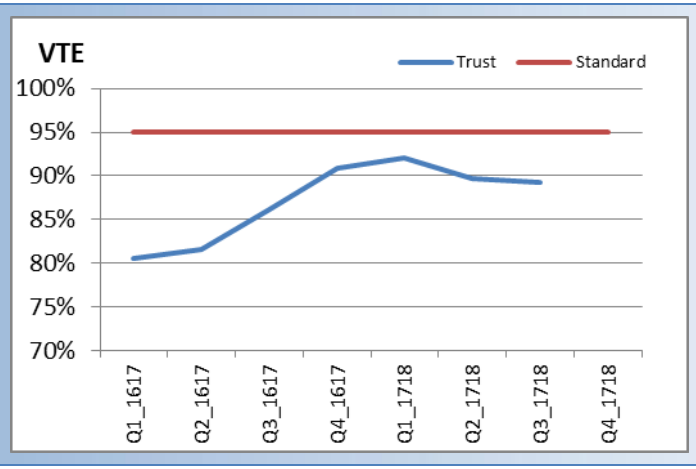
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 89.22% for Q3 2017/18.

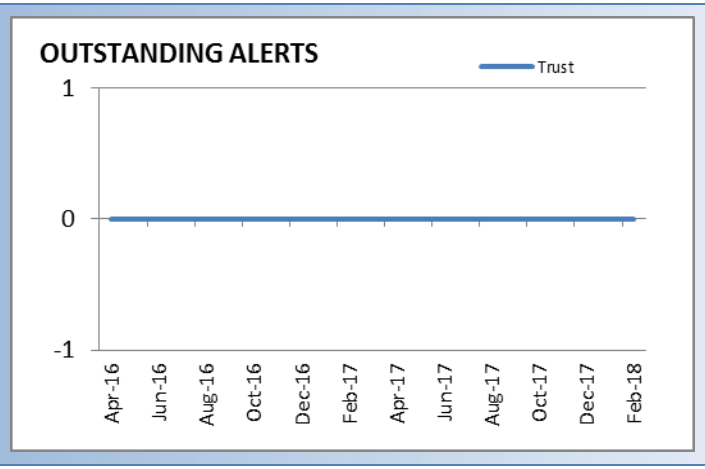


Patient Safety Alerts Outstanding

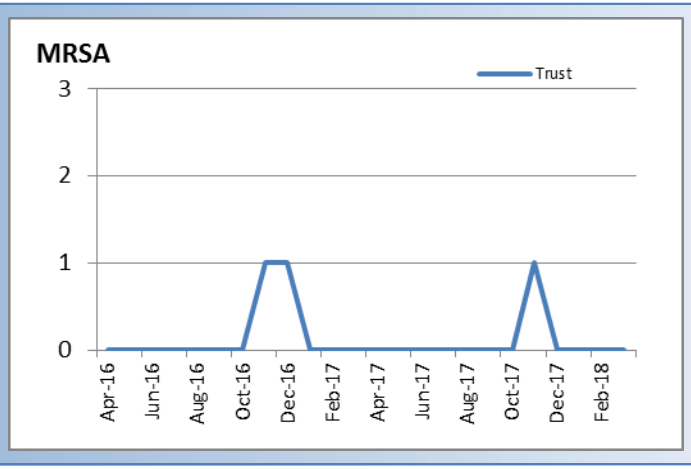
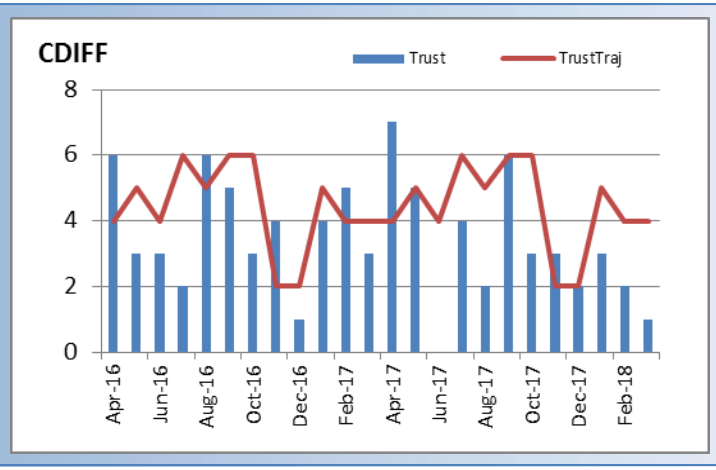
Number of alerts that are outstanding at the end of the month

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

There have been no outstanding alerts year to date.



SAFE

Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 1 case of acute acquired MRSA bacteraemia during 2017/18. There have been no cases reported during March 2018.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2017/18 is no more than 53 cases	There have been 38 cases year to date There was 1 incident reported during March which achieved the monthly trajectory of no more than 4 cases		

SAFE

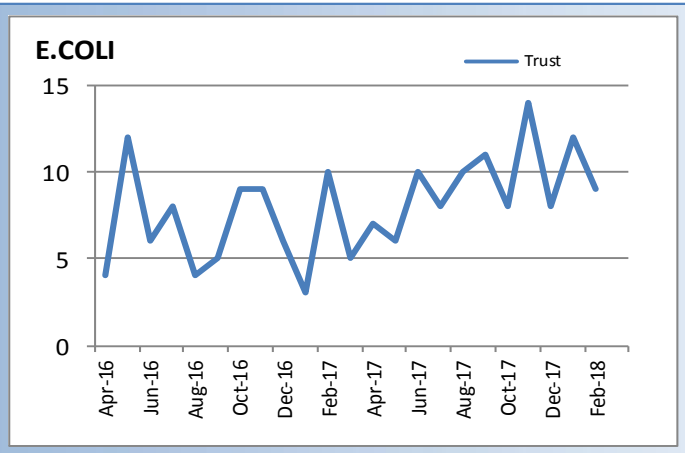
Description	Aggregate Position	Trend	Variation

Escherichia Coli

Number of incidence of E.coli bloodstream infections

There have been 110 cases year to date

There were 7 incidents reported during March.

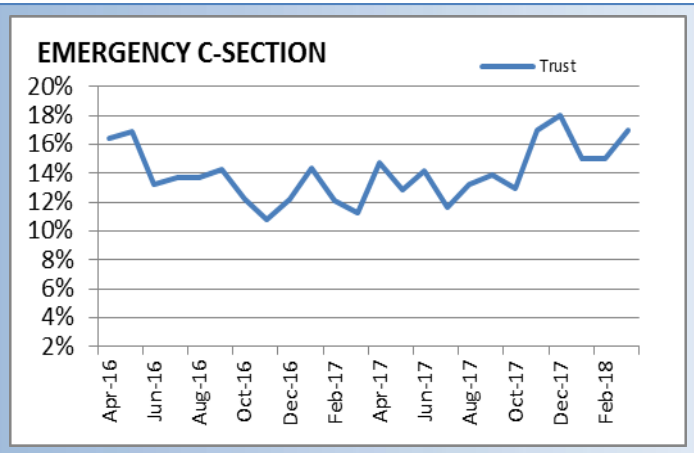


Emergency C-section rate

Maternity: Emergency C-section rate per month

The Trust aims to have less than 12.1% of emergency C-sections

Performance for March failed to achieved this standard at 17%



Further information is included in the Board Quality report

EFFECTIVE

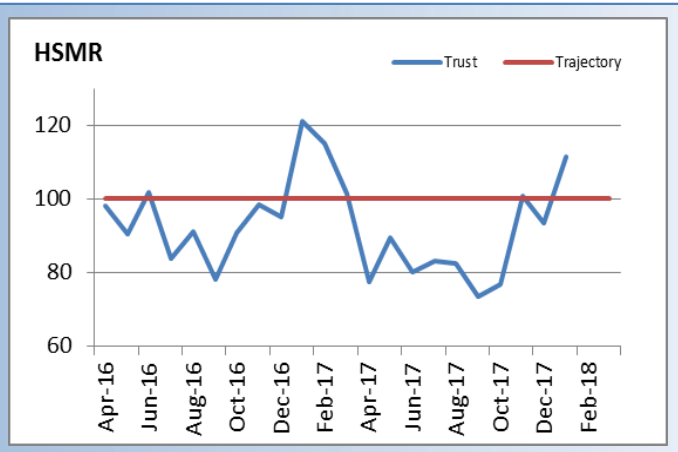
Description	Aggregate Position	Trend	Variation

HSMR

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

January 2018 is the latest available performance

The standard for HSMR is to achieve less than 100 and January 2018 failed to achieve this at 111.5

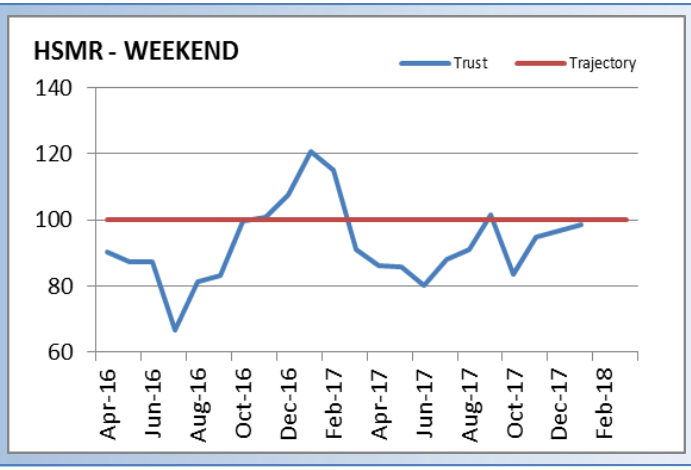


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

January 2018 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and January 2018 achieved this at 98.4



EFFECTIVE

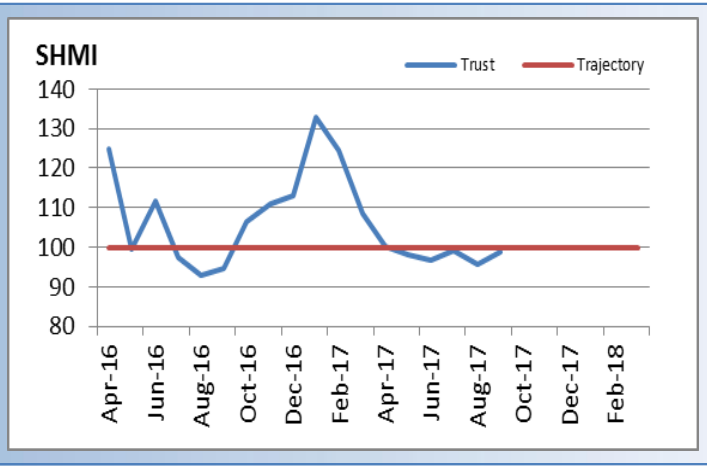
Description	Aggregate Position	Trend	Variation

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 2017 is the latest published performance

The standard for SHMI is to achieve less than 100 and September 2017 achieved this at 99.0

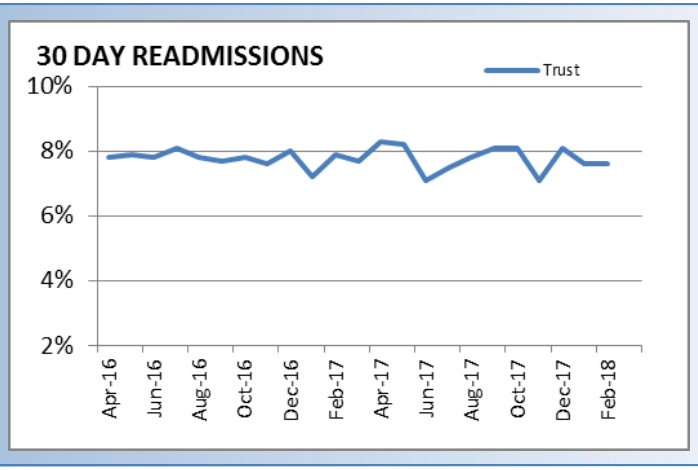


30 DAY READMISSIONS

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

The latest available performance is February

The readmissions performance is measured against the peer benchmark position for 2016/17 to achieve less than or equal to 7.4%. The Trust failed to achieve this measure with performance of 7.6%.



CARING

Description	Aggregate Position	Trend	Variation

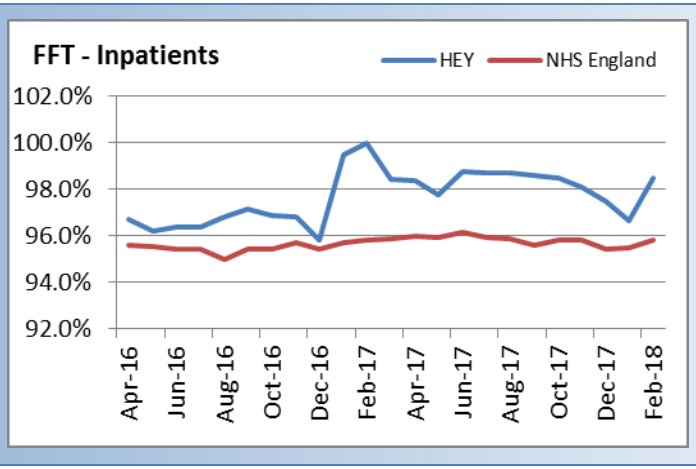
Inpatient Scores from Friends and Family Test - % positive

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

Performance for February was 98.5%

The latest published data for NHS England is February 2018.

March performance will be published on 10th May 2018.



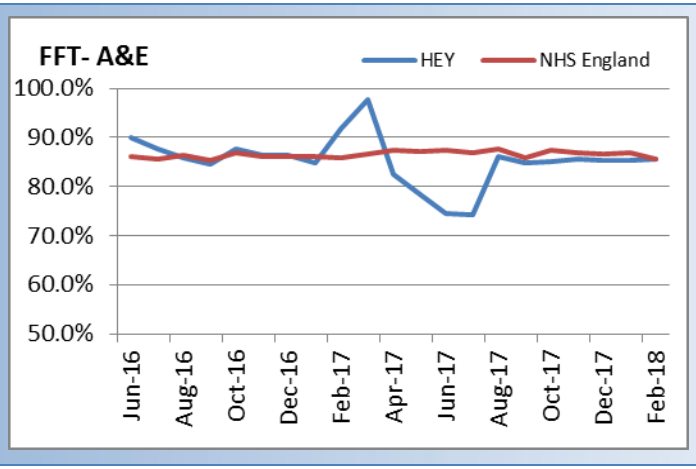
A&E Scores from Friends and Family Test - %

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

Performance for February was 84.0%

The latest published data for NHS England is February 2018.

March performance will be published on 10th May 2018.



CARING

Description	Aggregate Position	Trend	Variation

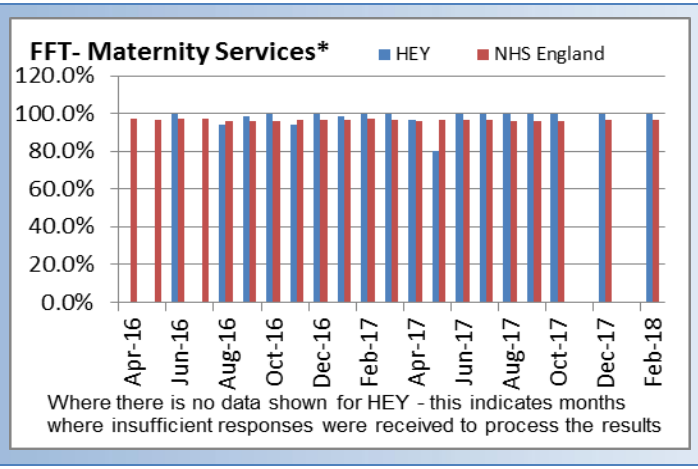
Maternity Scores from Friends and Family Test - % Positive

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

Performance for February was 100%

Months with no data for HEY is due to insufficient responses

March performance will be published on 10th May 2018.

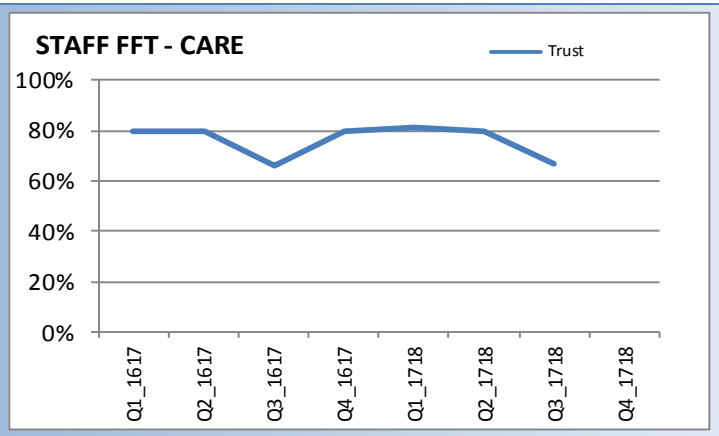


* Question relates to Birth Settings

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 annual staff survey replaces Q3 and shows 59% of surveyed staff would recommend the Trust as a place to work, this has decreased from the quarter 2 position of 62%.



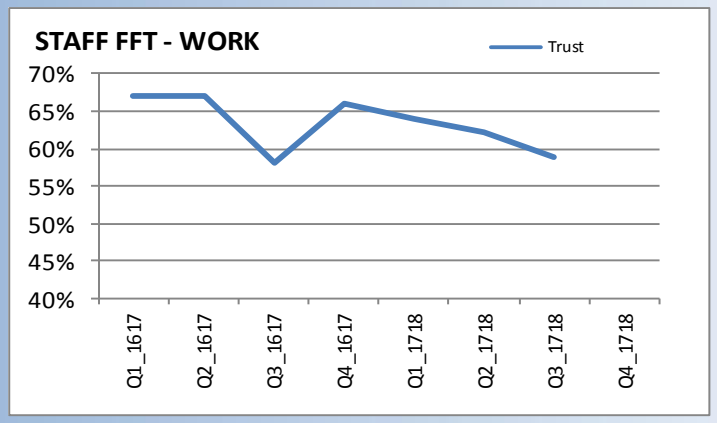
CARING

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 annual staff survey replaces Q3 and shows that 67% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has decreased from the quarter 2 position of 79%.

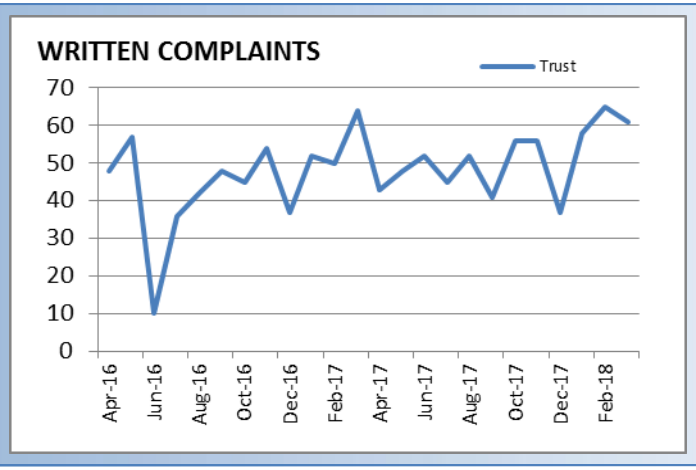


Written Complaints Rate

The number of complaints received by the Trust

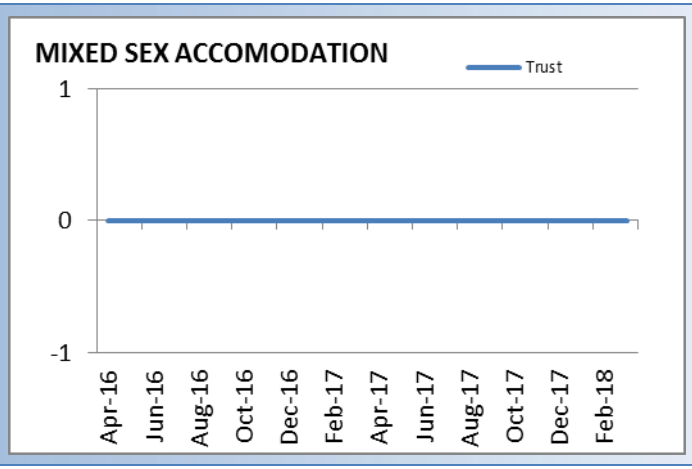
The latest available performance is March 2018

The Trust received 61 complaints during March, this has decreased from the February position of 65 complaints



There have been 614 complaints year to date

CARING

Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches	Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.	There were no occurrences of mixed sex accommodation breaches throughout March 2018.	

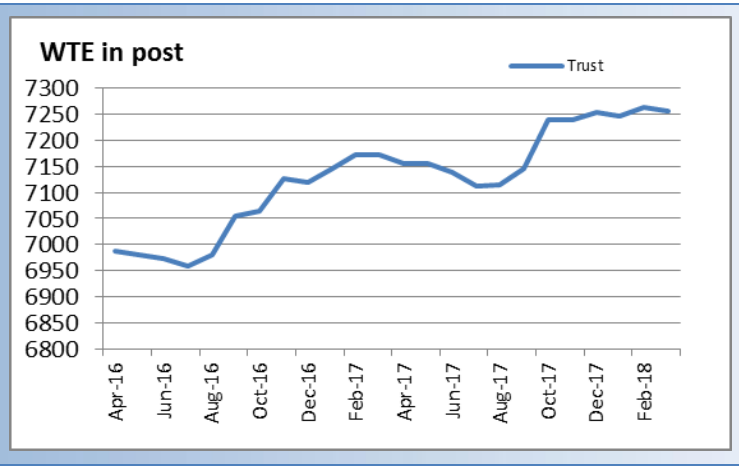
Description	Aggregate Position	Trend	Variation

WTEs in post

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

Lastest data available is March 2018

Trust level WTE position as at the end of March was 7256

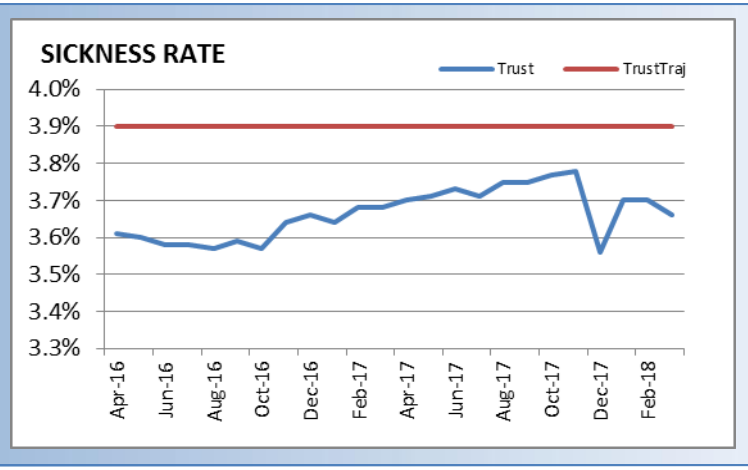


Sickness Absence Rates

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

Lastest data available is March 2018

Performance for March achieved the standard of less than 3.9% with performance of 3.66%



ORGANISATIONAL HEALTH

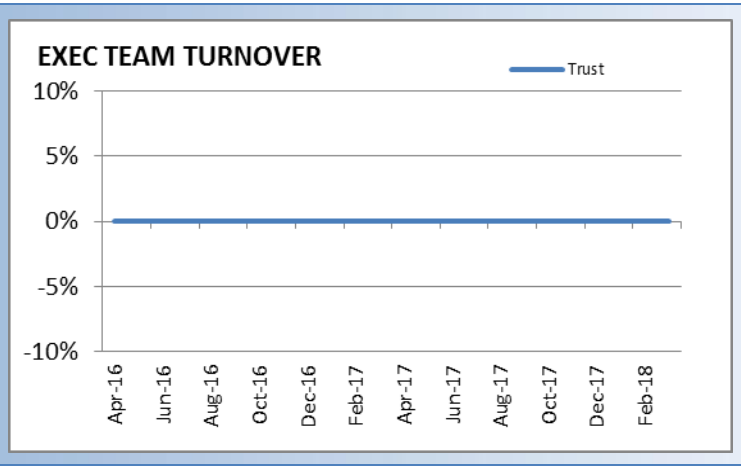
Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

Lastest data available is March 2018

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



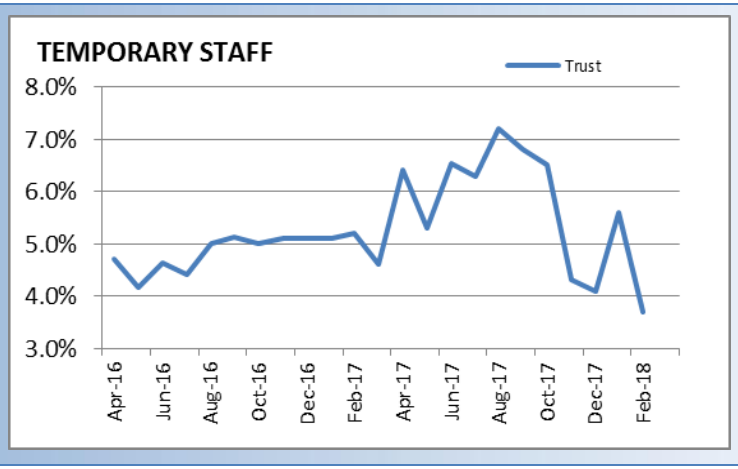
Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

Lastest data available is February 2018

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

February performance was 3.70%



FINANCIAL SUMMARY: 12 MONTHS TO 31st MARCH 2018

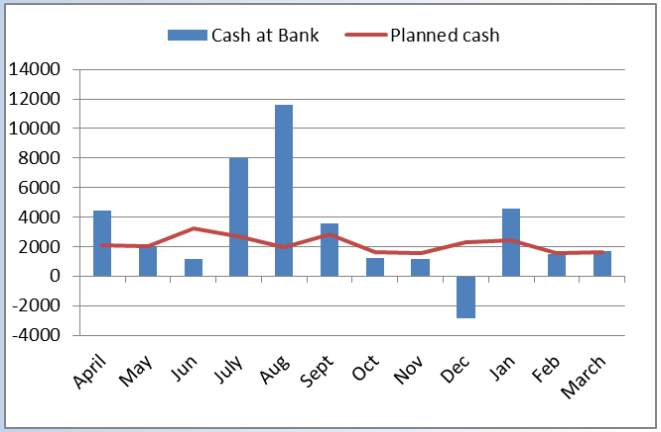
1. At the end of March, the Trust is reporting a year to date adjusted deficit of £7.1m which is £7.5m away from the plan.
2. This position includes £4.0m deficit due to non-receipt of STF funding since the quarter 2 award. Excluding STF the Trust is £3.5m away from plan, with a £15m deficit. This is in line with the revised forecast position agreed with NHSI in January 18.
3. The position has improved due to late receipt of additional STF funding of £3.7m
4. The Trust has a gross contract income gain of £10.5m . After adjusting for the allocation of £12.3m of income to HGs under the income allocation policy, there is a net shortfall of £1.8m which is a £0.3m improvement in the month. It should be noted that an element of the income received was non recurrent and increases the underlying deficit of the Trust.
5. The Trust has a CRES shortfall at month 12 of £2.7m. This is 82% delivery, above the internal target the Trust had set of a minimum of 80% delivery. The in month improvement on CRES delivery is £0.1m.
6. The Full year effect of the CRES programme is £11m which is 73% delivery.
7. HG run rate positions have deteriorated in month by £1.4m which is in line with previous forecast.
8. Overall Surgery HG deteriorated by £0.2m from month 11 forecast due to increased non pay expenditure and movements on stock. Medicine moved by £0.1m on medical staffing. F&WH and CSS were in line with the month 11 forecast.
9. Agency spend to the end of March is £10.0m which is below planned levels (£11.0m). This is above the agency cap of £9.5m but is a £3.1m reduction on the previous years agency spend. The in month position showed spend of £0.7m against a plan of £1m. The overall variable pay position, however, is similar to the same period last year.
10. The reported capital position at month 12 shows gross capital expenditure of £19.0m. This is in line with the Trusts CRL and CDEL limits.
11. The cash position is extremely challenging and the Trust has now received its final tranche of deficit support loan funding. Requirements for exceptional working capital are being modelled as to whether it is required early in 2018/19.
12. The underlying deficit has worsened slightly in year from an assessed £24.7m in 16/17 to £25.7m.

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of March we had £1.699m cash on our balance sheet.
We have drawn revenue support loans of £10.899m, £6.899m during March. A further £7.177m of loans were drawn during the year to support the capital programme, giving total borrowings of £18.076m for 2017/18.
In 2018/19 the Trust has the option to apply for an "exceptional working capital" loan should the financial position not improve in line with plans and payment profiles from Commissioners are not as anticipated. Latest forecasts show we would be likely to need such a loan in May/June 2018.
The BPPC performance for NHS and non NHS is below 50% and is a direct result of the Trusts poor financial performance.

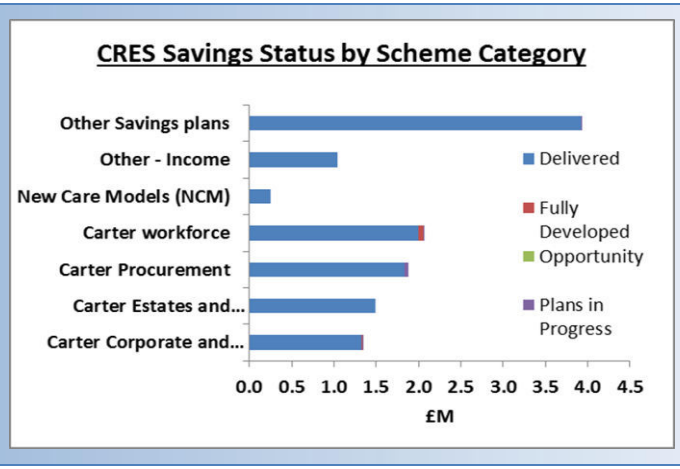


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

The Trust has delivered £11.9m of savings against a target of £15.0m for 2017/18, an adverse variance of £3.9

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



Description	Aggregate Position	Trend	Variation

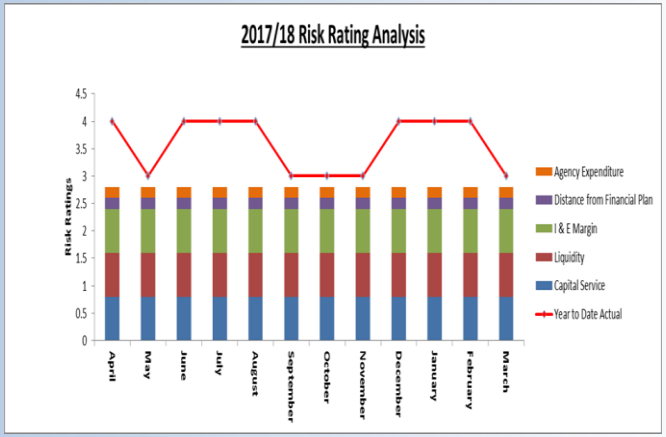
Risk Rating

Financial Sustainability Risk Rating

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

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

As at month 12 the Trust is reporting a deficit of £7.1m against a planned position of £365k surplus. This has resulted in liquidity , Capital servicing , I&E margin being rated as a 4, with the the distance from plan being a 3 and the agency metric being rated a 2, this culminates in an overall risk rating of 3.

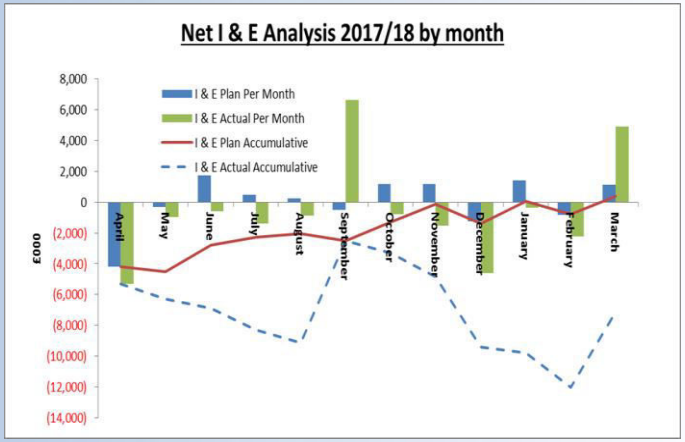


Income & Expenditure

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.

As at month 12 the Trust has delivered a deficit of £7.13m against a planned surplus of £365K (£7.5m adverse)



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE
MEETING HELD 26TH MARCH 2018

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

No	Item	Action
1	**Apologies** Apologies were received from Tracey Christmas, Non-Executive Director	
2	**Declarations of interest** There were no declarations of interest declared.	
3	**Minutes of the meeting 26 February 2018** **Item 5** – the Trust to become a digital exemplar and not buy one. **Item 7.1** – Resolved should read the Committee and not the Board. **Item 10.1** – the Trust was reporting a deficit of £9.8m. Following these changes the minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** Mrs Ryabov advised that the IDL task and finish group had not yet been set up but that she would update the Committee when it was in place.	**ER**
	There was a discussion around the Easter break and rota cover and Mr Hall agreed to review this with Mr Bond to ensure cover was sufficient.	
	Mr Bond reported that the emergency funding bid for a new MRI scanner had not been successful.	
	Mr Bond advised that Ms Myers would be leading on the RCA investigation relating to the Tracking Access issue. Once completed the findings would be presented to the Committee.	**JM**
	Mrs Ryabov confirmed that referrals had not increased in endoscopy but that the service had reduced their resource capacity.	
	Mr Gore asked about the status of the SPV and Mr Bond advised that NHS Providers had produced a helpful guide which was generally supportive of this type of arrangement.	
	4.1 Follow up ratios Mrs Drury presented the information which highlighted the Trusts new to follow up ratios and compared them with its relevant peer group.	

Mrs Drury did ask that the Committee treat the figures with caution as a lot of work had been put in to clear the Tracking Access issues between April and November 2017. Mrs Drury added that the way in which national pricing policy operates effectively dis-incentivises follow ups. In overall term the Trust is performing better than its peers.

Resolved:
The Committee received and accepted the information relating to follow up ratios.

5 Action Tracker

Mr Bond reported that the Fire Enforcement Notice had been lifted from the Trust. However he stressed that this was conditional on the Trust completing the remedial improvement works which necessitated the notice in the first instance.

Mr Bond reported that additional capital funding would be required to enable the Trust to complete these works. Mr Bond agreed to update the Committee at the end of April 2018. **LB**

Mr Nearney agreed to bring the e-Rostering business case to the Committee in April 2018. **SN**

Mr Bond agreed to bring an efficiency report on non-pay costs (over a 3 year period) relating to Orthopaedics to the meeting in April 2018. **LB**

6 Workplan 2017/18

The workplan was received by the Committee. Ms Ramsay advised that there had been no amendments to it since the last meeting.

6.1 Workplan 2018/19

The workplan was received by the Committee. The Committee discussed more benchmarking information, the balanced scorecard, Length of Stay, variable pay and job vacancies as items to be discussed in 2018/19.

7.1 Performance Report

Mrs Ryabov presented the report and highlighted that the Emergency Department was still significantly challenged and she had provided a comparison performance report against peers for the Committee's information.

Mrs Ryabov advised that the Trust was establishing a task and finish group which would be led by Dr Purva from April 2018. The issues remained the same being flow out of the department and long waits for doctors which also had an impact on Ambulance handover timings. There were also patients in the resuscitation department longer than they should be and were not flowing through the department as efficiently as they should.

RTT performance was 80.3%. One of the key issues was with ICU capacity and cardio thoracic cancelling patients resulting in the overall list size increasing.

Mr Hall asked what the expectation would be regarding the list size in the future and Mr Bond advised that the Trust still had a trajectory to reduce the list size in 2018/19.

Mrs Ryabov added that a review of outpatients and clinic utilisation would be taking place in 2018. **ER**

The Committee agreed to escalate RTT and the demand and capacity issues to both the Quality Committee and the Board. **SH**

Mrs Ryabov advised that there had been 14 breaches of 52 week waits but these were mainly due to cardio thoracic, tracking access issues, or more complex patients.

The breast pathology standard had not been met due to a shortage of medical cover after a doctor had left the Trust.

A total of 9 patients had failed to meet the 31 day cancer standard, which was being reviewed as performance of the standard had declined in the last 5 months.

Performance against the 62 day standard continued to improve and extra funds had been received from the Cancer Alliance to help. The 62 day screening standard had 4 breaches in the reporting period.

There were 6 breaches of the operations cancelled and rebooked within 28 days standard but it was hoped that this would reduce when the elective capacity returned to pre-winter levels.

Resolved:
The Committee received and accepted the report.

7.2 – Tracking Access Update
Mrs Ryabov gave the update and Mr Bond asked at what point would all the errors relating to Tracking Access be eliminated. Mrs Ryabov advised that there should not be any more Tracking Access issues and that the staff were being performance managed where necessary.

Mrs Ryabov reported that there were less than 1000 clinical reviews to be completed with only a small number of specialties not being completed by the end of March. MBI, the organisation who had been working with the Trust to ensure all actions were in place would leave the Trust at the end of March 2018 and a final report would be presented at the Committee once completed. The Clinical Harm group were continuing to monitor closely the clinical review process and any harms reported.

Mrs Ryabov asked if any of the Non Executive Director's would want to be a designated member of the Performance and Activity meetings and receive 18 week and RTT training as part of this. Mr Hall was nominated as the Non Executive lead.

Resolved:
The Committee received and accepted the update.

7.3 Diagnostic Recovery Plan
Mrs Ryabov presented the report and stated that the Trust had not met its standard of 1% or less for the last 2 years.

The reason for this has been due to capacity issues, increased referrals and shortages of key staff. This has resulted in the performance against the standard being in excess of 10%.

The Neurophysiology service has 2 substantive consultant vacancies and has failed to recruit in the January 18 recruitment campaign. The service is failing its 6 week diagnostic performance and the key to achievement of the standard would be to recruit to the vacancies.

The endoscopy service had identified a number of required actions to improve their position, which was improving. In the short term, these include the appointment of a locum consultant in Gastroenterology, the appointment of a non-medical endoscopist, the appointment of two replacement colorectal surgeons, a review of the timetable to ensure full utilisation of all sessions.

Mrs Ryabov also advised that throughput should improve in radiology now the new CT scanner was in place.

Resolved:
The Committee received and accepted the report.

7.4 Lessons Learned – Operation Wintergreen
Mrs Ryabov presented the report and advised that something had to happen due to the increasing level of risk in the hospital and Operation Wintergreen was actioned. This meant that there were more doctors on the front door and non urgent procedures were cancelled.

Mr Bond asked if Mrs Ryabov would do the same thing again and she advised that the Trust did not get the outcomes required but that doing nothing had not been an option. Mr Bond added that learning from the exercise and any future initiatives should be added into the winter plan and financial plan.

Resolved:
The Committee received and accepted the report.

8.1 Variable Pay Report
Mr Nearney presented the report and advised that the Trust was reporting £9.2m against a target of £9.9m.

Mr Nearney advised that he was meeting with the Health Groups in April to review variable pay costs and the Trust was looking to recruit a Specialist Recruitment Manager to target hard to reach areas.

Mr Bond asked what the target for variable pay was for 2018/19 and Mr Nearney advised that it was £8.9m.

Resolved:
The Committee received and accepted the report.

9.1 Demand Report
Mrs Drury updated the Committee on all referrals at week 49 and compared with last year the figures showed a cumulative reduction of 9340 referrals (4.3%)

She reported that GP referrals, NHS Hull CCG has seen a 6.7% reduction in GP referrals (4,419) during the first 49 weeks of the year and NHS East Riding CCG there had been a 2.5% reduction compared with last year (1214).

GP referrals to Orthopaedics are significantly lower than last year, with 827 (14.9%) lower in NHS Hull CCG and 252 (7%) lower in NHS ERY CCG and this reduction was due to a pathway change regarding access to Orthotics, changes to referral behaviours and the impact of the MSK triage services (Hull CCG).

In East Riding, however, the GP referrals had started to increase as the targeted work with GP practices to reduce referrals to Spire was starting to have an impact.

Elective Inpatient and day cases were 4.7% (3898 cases) below plan and the specialites with significant variances were: plastic surgery, oral surgery, orthopaedics and gastroenterology, upper GI and colorectal surgery.

The main areas of overtrade are in elective activity are Neurosurgery 6.7% (+98) and Urology at 8% (+339).

Overall the ED performance for Type 1 for February is 76% with a system position of just short of 87%. Overall the cumulative YTD position for the ED is 92.4%.

An analysis of the age profile indicates that compared with last year, there is a 7% increase in the number of over 65year olds presenting in ED which could be seen as one indicator of complexity. There has been a significant improvement in coding, resulting in less blank condition codes this year, making the comparison at condition level difficult.

In month 11 non elective inpatient activity excluding Obstetrics is 0.5% below planned levels (220 spells). Surgery HG activity is 4.8% below plan 501 spells (predominantly relating to Upper Gastrointestinal, abdominal pain hrgs). Medical non-elective admissions are 0.4% below plan, CSS HG report 9.8% above planned levels across Oncology and Clinical Haematology and F&WH are 1.9% above plan.

There was a discussion about the acuity of patients and that the increase in the over 65's meant sicker patients who stayed in hospital longer.

Resolved:
The Committee received and accepted the report.

10.1 Corporate Finance Report
Mr Bond reported that at the end of February the Trust was reporting a year to date adjusted deficit of £12m which was £11.3m away from plan.

Excluding STF funding the Trust was £4.9m away from plan. The Trust income gain was £8.8m, which after pass through drugs and devices was a net shortfall of £2.2m showing a £0.5m improvement in month.

The overall forecast for CRES was 83%.

Health Group run rates had deteriorated in the month by £1.7m which were all in line with forecast except Clinical Support which had worsened by £0.4m.

The Committee discussed the non-pay issues in pathology (£0.2m) but these were non recurrent and related to booking in procedures.

Resolved:
The Committee received and accepted the report.

10.2 CRES 18/19
Mr Evans presented the CRES plan for 2018/19 and reported that there were no transformation schemes and work was ongoing with the Health Groups to review this further. Mr Evans also stated that the vacancies within the Trust were impacting on cost improvement schemes.

Mr Gore stated that if a service was struggling to achieve elective outputs because of vacancies this needed to be taken into account and services be honest about what they could achieve.

Resolved:
The Committee received and accepted the report.

10.3 Digital Strategy 2018-2023
Mr Bond presented the strategy to the Committee which highlighted the requirements for the next 5 years and what level of support would be needed to have a network fit for purpose.

The Committee discussed the cost of implementing the strategy and the priorities around patients accessing their own records safely and having visible pathways to make discharges more efficient. Mr Bond added that information sharing in the future would be wider than just GPs and would include local authorities, the police and other relevant organisations.

Mr Bond also detailed the Digital Exemplar initiative which the Trust had expressed an interest in. He reported that DXC and NHS Improvement are currently working with the Trust to produce a programme of work and an investment case to be presented to the Board. Mr Bond advised that this process was being developed and he would produce a further report to the Committee in April 2018.

Resolved:
The Committee received the report and agreed that the Digital Strategy should be presented to the Board. **LB**

10.4 Q3 Service Line Reporting
Mr Bond presented the report and highlighted that the main area of concern was the Surgery Health Group who were showing a loss of £13.7m during the period.

Mr Bond advised that 3 specialties from each of the Health Groups would be reviewed in detail to understand the key issues. He added that the Finance Teams with the Health Groups would be focussing on contribution.

Resolved:
The Committee received and accepted the report.

10.5 Organisational Efficiency
Mr Evans presented the report which showed a dashboard in development which would inform the Committee how productive the Trust was.

Mr Gore asked if the dashboard could have retrospective information and produce average data such as number of theatre lists carried out. Mr Evans advised that it was still in draft and could be developed further as new items were required. The dashboard would be produced on a monthly basis and presented at each Committee meeting in the future. **SE**

Resolved:
The Committee received and accepted the report.

11.1 Board Assurance Framework
Ms Ramsay presented the report which had been updated following the previous committee and Board meetings. Ms Ramsay added that the risk ratings might change once the year end figures had been released.

Ms Ramsay reported that the BAF would be discussed in more detail at the next Board Development session.

Resolved:
The Committee received the report and agreed to discuss the risk ratings in more detail at the Board Development session on 27th March 2018.

11.2 Terms of Reference
Ms Ramsay presented the updated draft Terms of Reference and advised that Mr Nearney had been added as a member of the Committee.

Mr Bond confirmed that the Capital Resource Allocation Committee reported jointly into the Performance and Finance Committee and the Executive Management Committee.

There was a discussion around a Non Executive Director sitting on both the Quality Committee and the Performance and Finance Committee to gain wider experience in all Trust matters.

Mr Hall asked if there could be some reference to productivity benchmarking in the Terms of Reference.

Resolved:
The Committee received and approved the changes to the Terms of Reference.

11.3 Capital Resource Allocation Committee
Mr Bond presented the minutes of the meeting to the Committee.

Mr Bond reported that the Trust's capital allocation would be spent by the year end. Mr Hall asked about the new Max-Facial and Infectious Diseases departments and Mr Bond agreed to arrange a viewing for the Committee members.

Resolved:
The Committee received and accepted the report.

12 Items delegated to the Board
There were no items to be delegated to the Board.

13 Any other business
There was no other business discussed.

14 Date and time of the next meeting:
Monday 30 April 2018, 2pm – 5pm, The Boardroom, Suite 19, CHH

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE
MEETING HELD 30 APRIL 2018

PRESENT:	Mr S Hall	Non Executive Director (Chair)
	Mr M Gore	Non Executive Director
	Mrs T Christmas	Non Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD
	Ms C Ramsay	Director of Corporate Affairs
IN ATTENDANCE:	Mr M Simpson	Digital Director (Item 11.2 only)
	Mr J Wood	Director of Operations (Item 7.1 only)
	Mrs A Drury	Deputy Director of Finance
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies
Apologies were received from Mr S Evans, Deputy Director of Finance

2 Declarations of Interest
There were no declarations made.

The agenda was taken out of order at this point

11.2 Digital Exemplar Application
Mr Simpson presented the report which highlighted the Trust's successful bid to become a digital exemplar. The Trust was one of 3 Trusts to be successful and a share of the funding would mean that ED, AMU, elderly care, oncology and theatre pathways would become the key areas of the project.

The project would be a 2 year intensive optimisation programme with a planned order and a challenging pace. Mr Simpson reported that the benefits of the scheme would be operational improvements and exemplar status amongst other Trusts with the opportunity to share knowledge and expertise.

There was a discussion around the benefits of the scheme and Mrs Christmas asked about staffing levels following the increase in staff relating to the Lorenzo implementation. Mr Simpson advised that the processes put into place would be fully digital removing any need for paper notes and lists.

Mrs Ryabov asked about the roll out plan for other pathways and Mr Simpson reported that once the 5 year plan was implemented the benefits for other areas would be assessed.

Resolved:
The Committee received the application and gave approval for the report to be presented to the Trust Board for approval in May 2018.

3 Minutes of the meeting held 26 March 2018

The minutes were approved as an accurate record of the meeting held 26 March 2018.

4 Matters Arising from the minutes

There was a discussion around minimum staffing rotas and annual leave /conference/training leave particularly in holiday seasons. The Committee agreed that the Audit Committee was monitoring this item and would take assurance from the outcomes of internal audit investigations.

There had been a task and finish group established in the Emergency Department and Dr Purva was spending 2 days per week in ED supporting this work. The outcomes of the group would be shared with the Committee when available. **ER**

Mr Gore reported that he had spent time with the Hospital Improvement Team at the Mecure hotel who were reviewing clinic utilisation with the aim to improve referral to treatment times.

4.1 Fire notice – Capital funding request update

Mr Bond reported that NHS Improvement were aware of the Trust's request for capital funding relating to the recent fire notice and this would be discussed further with them. There was no further update at this stage.

5 Action Tracker

- The outpatient clinic utilisation revised dashboard would be presented to the Committee in May 2018. **ER**
- Mr Bond advised that the organisational efficiency dashboard would be presented to the Committee in May 2018. **LB**
- The Root Cause Analysis following the tracking access issues had been started and Mrs Bates was leading the investigation. The results of the investigation would be presented the Committee once completed.
- Mr Nearney had discussed leadership and succession planning with the Chairman – this item could be removed from the Tracker. **SN**
- Mrs Ryabov agreed to update the Committee once the IDL task and finish group was established. This item to be removed from the Tracker.
- Mr Bond advised that the formal benchmarking report relating to non-pay costs in orthopaedics would be circulated by Mr Bond to Committee members. **ER** **LB**

6 Workplan 2018/19

The quarterly Hospital Improvement Team update had been moved to May 2018 and the efficiency dashboard would be added to the workplan. **CR**

7.1 Performance Report

Mrs Ryabov presented the report and highlighted that ED performance was still proving to be challenging at 74.8%. This was still an issue nationally also

It was Mrs Ryabov's intention to set up and Urgent Care Pathways

Group which would give Health Groups designated actions to help with pressures in the system. The issues identified were pressures on the system such as not recruiting sufficiently, more sick people over the winter period and not getting patients back into the Community quickly enough.

Mr Hall asked what the target levels were for 2018/19 and Mrs Ryabov reported that the submitted trajectory was to deliver 90% for the full year. She added that this was based on system performance and not just the Trust. To achieve STF funding the whole system would have to get above 95%.

Mrs Ryabov reported that ambulance handover performance was at 84% in February 2018 and an agreed recovery plan was being developed. She added that the Trust was the 2nd largest ambulance receiver in the region and that this should be taken into account.

Referral to treatment time performance was at 79.8% with cancellations in March 2018 impacting on the performance. Mrs Ryabov reported that the national position regarding RTT was that Trusts could not allow their waiting lists to grow. Mr Gore commended the Dermatology Service who had made good progress in reducing their backlog.

Mrs Ryabov reported that there was still work to do around 52 week wait breaches but these had been significantly impacted by the tracking access issues.

The breast symptomatic performance was improving slightly but there were problems with reporting due to lack of capacity. A review was taking place to identify the issues that was making the service unsustainable.

The 31day subsequent performance was impacted by, bed shortages, complex patients and patient choice. Due to the small numbers of patients involve this standard could easily be missed.

The 62 day standard performance was at 80.2% adjusted. This had been impacted by the Easter holiday and late referrals from NLAG.

Performance was also poor in 62 day RTT, 62 day screening and elective procedures cancelled on the day and not rebooked within 28 days.

7.3 Mrs Ryabov agreed to send the Health Group performance trajectories to Mrs Thompson for circulation to the Committee members. **ER/RT**

Diagnostics

Mr Wood attended the meeting to update the Committee regarding diagnostic performance. He reported that the six week target for diagnostics has not been met for approximately two years. This has primarily been due to breaches in Radiology and is linked to increased number of referrals with a static number of scanners. In the last 6 months a number of other diagnostic modalities have seen an increase in the number of breaches. These have been due to capacity issues, increased referrals and shortages of key staff. This has resulted in the performance

against the standard being in excess of 10%.

The service has 2 substantive consultant vacancies and has failed to recruit in the January 18 recruitment campaign and the service is failing its 6 week diagnostic performance with a backlog of 130 patients. The key to achievement will be to recruit to vacancies. The service had been using a locum from Scotland but had appointed recently a substantive member of staff.

The Endoscopy service has seen a consistent increase in the number of month end breaches during the past 12 months. This is primarily due to a capacity and demand imbalance. More specifically there has been an increase in demand for certain procedures, a change in the case-mix of the types of referrals received each month and a reduction in capacity due to changes in on-call rotas and also a reduction in the available workforce due to sickness and resignations.

The service has responded to these breaches by undertaking additional activity during the evening and also at the weekends, as well as working to utilise any spare sessions during the working week at premium pay. Short-term investment from the Cancer Alliance and NHS England has helped to increase capacity, along with the utilisation of vacant consultant post monies.

A trajectory for CT was developed in late 2017 and shows that it could take another 12 months to reach a 1% breach performance (approx.90 breaches).

Mr Hall asked for clarification if the services categorised under endoscopy had a timed baseline and performance was assessed against this. Mr Wood confirmed that it was.

The diagnostic target will remain under pressure and not achieving until at least Q3 in 2018/19.

Resolved:
The Committee received and accepted the Performance Report.

- Mrs Ryabov to forward the Health Group performance trajectories to Mrs Thompson for circulation to the Committee members. **ER**

7.2 Tracking Access Report

Mrs Ryabov presented the update and advised that the final report would be presented to the Committee in May 2018. She confirmed that all the clinical validation was due to be finished by the end of April. The intention is for all patients who need to be seen or treated will have a date by the end of Q1 but it may be that the actual date to see them will be beyond that. The Trust would expect all patient episodes to be concluded by the end of Q2.

The clinical review of all patients cannot be concluded until all patients have been seen and then reviewed and therefore this work was ongoing.

Mrs Ryabov reported that to date the level of harm in the majority of cases had been low, with the exception of 3 urology cases being declared as Serious Incidents.

Resolved:
The Committee received the update and agreed to receive the final report at the May 2018 Committee meeting.

8.2 Agency Report

Mr Nearney presented the report and advised that at month 12 there had been no significant changes and the Trust had saved £800k in 2017/18.

The majority of the spend had been on medics at a cost of £6m to theTrust. Mr Nearney reported that the Surgery Health Group had spent £2.4m on agency costs mainly in theatres but that there had been an improvement on theatre times and scheduling. The Medicine Health Group had spent £3.6m which was mainly on medics in ED, elderly medicine and acute services. There were 3 key areas within Clinical Support and these were AHPs, consultants and junior doctors, the Health Group was £1.4m overspent. The Family and Women's Health Group was performing well but there were still issues in the breast screening service and Corporate Patient Admin was overspent by £850k.

Resolved:
The Committee received and accepted the report.

8.1 Variable Pay Report

Mr Nearney presented the report which showed a £8.8m overspent on pay budgets including overtime, bank, agency and additional sessions. Mr Nearney spoke about the Trust potentially appointing a specialist recruitment manager who would concentrate on the recruitment of hard to fill posts.

Mr Gore stated that a number of consultants had tweeted about working for the Trust and that this was an excellent way to attract staff.

Resolved:
The Committee received and accepted the report.

8.3 Job Vacancy Report

Mr Nearney presented the report which and highlighted 45 vacancies which was just over 10%.

Mr Nearney advised that the Trust would be seeking to develop a partnership with a leading University Teaching Trust in Pakistan with the aim to bring Junior Doctors and Associate Consultants to Hull.

There had been issues around the OSCE language qualification with overseas nurses but this had now been resolved with 9 new nurses that had passed the exam to allow them to work in the Trust.

Mr Nearney also reported that the nurse associate and apprentice roles had been factored into the budgets for 2018/19.

Resolved:
The Committee received and accepted the report.

9.2 Demand and Capacity Planning 2018/19

Ms Myers attended the meeting to report on the approach being taken to manage demand and capacity in 2018/19. A mathematical model was being used to determine the level of activity required to achieve a list size.

Ms Myers added that the current model could meet current outpatient requirements but not clear the backlogs. The plans had been developed with the Health Groups with workshop sessions held to work through the capacity issues and ensuring maximum utilisation of resource to sustain activity. The Trust was encouraging its staff to be more creative, working through a number of outcomes using the model, whilst understanding the financial constraints, waiting list backlogs and CRES targets.

Mr Bond added that work was ongoing with local health partners as there had to be strategic change to ensure patients could also be managed efficiently in the Community.

Resolved:

The Committee received and accepted the update.

9.1 Demand Report

Mrs Drury reported that overall referalls were 4.7% lower than last year and this downward trend had been a feature all year.

GP referrals, NHS Hull CCG has seen a 7.2% reduction in GP referrals (5,019) and East Riding CCG 's rate of reduction is 2.6% (1,347).

Despite this reduction in referrals, there had been minimal impact on the overall waiting list position and this was due to the backlog of outpatient activity on the Trust waiting lists as well as the reduction in outpatient activity delivered compared with last year, as had been noted in previous reports.

Performance against the contract continued to highlight that the elective admitted activity is lower than contract. Overall the variance was 4.7% lower than plan which is over 4000 spells.

Grouping together bowel scope activity, colorectal and gastroeneterology – the variance is over 1500 cases (8%) and this has been due to medical staffing capacity and delays in the bowel scope programme. It is anticipated that activity will be much higher in 2018/19 as these were non-recurrent capacity issues that will be addressed this year. The service have already indicated that they expect to deliver more than the contract next year, as part of their capacity review.

Oral surgery accounts for 570 cases – again due to medical staffing vacancies and this is expected to increase for 2018/19 following recent succesful appointments.

The other main specialties contributing to this variance are in Plastic Surgery and Orthopaedics – both with a variance of circa 700 cases each. Whilst there has been less elective activity delivered in these specialties compared with last year, both have seen increases in non-elective cases that appears to have impacted on electives in 2017/18.

Work to date has identified opportunities for increasing capacity into 2018/19.

Outpatients overall activity is 1.3% below plan for follow-ups (including procedures) and 8% below plan for new outpatients.

Overall ED activity was above contracted levels by 0.6% (760 attendances).

Against the contract, the overall variance for non-elective admissions (excluding maternity) is 0.8% below plan. Compared with 2016-17 levels, using the same methodology, there is a 0.6% increase in non-elective admissions.

The overall contract trading position as if all commissioners were on a PbR basis is an overtrade of £10.3m before the application of contract adjustments. The AIC element of this is £0.7m overtrade but with the sepsis, BPT & other counting and contracting adjustments it is expected to reduce an undertrade of circa £0.4m.

The AIC approach will continue into 2018/19 and, along with other system partners, the priorities will continue to be non-elective pathways to improve flow and reduce pressures on Trust and hopefully the Trust will see benefits from the investment in the ICC and the newly formed Urgent Care Centres.

Mr Gore asked if the Committee could receive Appendix 1 of the report every month and Mrs Drury agreed this could be included in her report.

Resolved:
The Committee received and accepted the report and agreed to receive Appendix 1 relating to elective inpatients and daycases. **AD**

11.1 Board Assurance Framework
Ms Ramsay presented the report and advised that the same report had been received at the Audit Committee and the Quality Committee for review.

Ms Ramsay advised that she would be meeting with the Executive Team to discuss the 2018/19 BAF risk ratings and the mitigating actions in place. Risks would be based upon the Trust's strategic goals and aims.

Resolved:
The Committee reviewed the document and agreed to email any comments to Ms Ramsay before the 8th May 2018 for inclusion in the Board report. **All**

10.1/ Corporate Finance Report/CRES 2017/18/Financial Plan
10.2/ 2018/19/Health Group Expenditure Budgets
10.3 Mr Bond reported that the Financial Plan and Health Group Budgets had been discussed at the Board meeting that morning and had been presented to the Committee for information. The financial plan had been approved by the Board at the meeting 30 April 2018.

At the end of the year the Trust was reorting a year to date adjusted

deficit of £7.1m which is £7.5m away from plan.

The full year effect of the CRES programme is £11m which is 73% delivery.

The Health Group run rate positions have deteriorated in month by £1.4m which was in line with previous forecast.

There was a discussion around the fact that the Trust was already a month into 2018/19 and that the CRES schemes were still being finalised with the Health Groups. The Committee also discussed the efficiencies of core services and how these could be maximised going forward.

Resolved:
The Committee received and accepted the Corporate Finance Report/CRES 2017/18 report/Financial Plan 2018/19 and the Health Group Budgets 20181/9.

10.5 NHS Improvement – Trust Undertakings

Mr Bond reported that the Trust had received a letter from NHS Improvement requesting a financial recovery plan and the Trust's approach to the next financial year.

Mr Bond advised that work was ongoing to prepare the response.

Resolved:
The Committee received the update and agreed to receive the financial recovery plan once completed.

10.4 Procurement Strategy Update includingScan4Safety Update

Mr Bond presented the Procurement Strategy update which highlighted national procurement initiatives current local activity against targets, and the wider procurement requirements from NHSI.
The Trust continues to share information monthly with NHSI relating to the Carter review. Prices are sent for uploading in the Purchasing Price Index Benchmarking tool (PPIB). The findings and possible savings identified by sharing information nationally are highlighting possible savings, which are being investigated by the procurement team. The Trust's initial experience is that suppliers will not change prices if we are tied into a contract. As such we have not yet identified any savings although analysis is still on going.

Mr Gore asked if the top 25 PPIs could be circulated to the Committee members. Mr Bond agreed to do this outside of the meeting.

Mr Bond also reported that the Chief Nurse was working with the ward sisters to review stock levels held on the wards but that the highest stocked areas were usually the highest throughput areas.

There was also a discussion around merging buying power with other Trusts but in most areas the gains would be minimal.

Mr Bond also updated the Committee regarding the Scan4Safety initiative and that there had been a trial on one of the wards involving barcodes and time and motion work. An internal business case to take

the project forward would be presented to the Executive Management Committee in due course. Mr Hall asked Mr Gore as the NED lead for this project to report back on the business case.

Resolved:
The Committee received and accepted the report. Mr Gore to provide further information relating to the Scan4Safety programme. **MG**

11.3 Capital Resource Allocation Committee
The minutes of the meeting held 4th April 2018 were received for information.

11.4 Lord Carter of Coles Committee
The minutes of the meeting held 3rd April 2018 were received for information.

12 Items Delegated by the Board
There were no specific items delegated by the Board.

13 Any Other Business
Mr Hall asked that all Committee papers were submitted to Mrs Thompson in a timely manner for the next meeting, although he did acknowledge the difficulties of year end workloads.

14 Date and time of the next meeting:
Monday 30 May 2018, 1pm – 4pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

DIGITAL STRATEGY 2018 - 2023

PAF date	15 May 2018	**Reference Number**	2018 –5 - 16
Director	Lee Bond Chief Finance Officer	**Author**	Martyn Smith Director of IT & Innovation
Reason for the report	To present the Digital Strategy 2018-2023 for review and approval by Trust Board.		

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

1	**RECOMMENDATIONS** The Board is asked to approve the new Trust Five Year Digital Strategy – 2018-2023.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW** Trust Board approval following PAF review.					

NHS
Hull and East
Yorkshire Hospitals
NHS Trust

DIGITAL STRATEGY

2018 to 2023

Setting the Standard: Technology to
Transform the Business of Healthcare

Remarkable people.
Extraordinary place.

Contents

1. EXECUTIVE SUMMARY

NHS policy recognises that technology has the potential to fundamentally transform the way the NHS delivers healthcare, driving out waste and inefficiency, improving clinical effectiveness and productivity, reducing variation and risk, improving outcomes, enabling new care models and empowering patients to play an active role in managing their own health and wellbeing. We know that technology plays a huge role in supporting our people to deliver even better care and is therefore a core enabler that runs through each of our strategic goals. We believe by putting the patients at the heart of our digital strategy we can continue to deliver enhanced, ever-more safer services for patients, better job satisfaction for our people and greater value for the taxpayer by increasing efficiency and effectiveness, and also by avoiding costly mistakes.

This new Digital Strategy represents the second phase of the Trust's technology modernisation programme. Sections 4 to 8 describe how it builds upon the significant achievements since the 2011 Information Management and Technology (IM&T) Strategy was approved, how it responds to national policy, how it supports the Sustainability and Transformation Partnership (STP) priorities and its Local Digital Roadmap (LDR) and how it makes a positive contribution to the Trust's Transformation Programme. It complements the Trust's clinical service and quality improvement strategies alongside of the People and Estate Strategy.

This Strategy signpost's the evolution of our digital services over the next five years. It creates a framework for the organisation's digital work programme; it describes the key developments which will give our staff the tools and capabilities to successfully embrace the challenges of the future, sets out an ambitious infrastructure upgrade programme and acknowledges the investment challenges to achieve this. Sections 10 to 15 refer. Finally, Sections 16 and 17 describe the governance framework and the security, business resilience and affordability challenges that increasing dependency on digital systems and electronic information brings.

Of necessity this Strategy sets out to address a range of clinical and corporate priorities and challenges. Fundamentally though, the Strategy has patients at its heart. Its core objective is to use technology to make every patient's journey through our hospitals as safe as possible, and to make every working day as easy and rewarding as possible for our staff. Section 2 summarises the key benefits this Strategy delivers to these stakeholders.

The Digital Strategy is one of a number of interdependent strategies, underpinning the dynamic programme of change necessary to support delivery of the Trust vision and strategic goals set out in Section 4.

2. MAKING A DIFFERENCE: WHAT WILL THE STRATEGY MEAN FOR PATIENTS AND STAFF?

This section set out how the Digital Strategy, when fully implemented, will have a significant positive impact on our patients and the working lives of our staff.

OUR PATIENTS	OUR STAFF
Helping to make your stay with us as safe and quick as possible by using technology to support your care	**One password to remember to access all your systems with a single log-in**
Giving you confidence that anyone who contributes to your health and wellbeing knows about you and your uniqueness	**Log-in that lets you move from device to device without losing your place in the system**
Making sure that our doctors and nurses can see the information they need about your treatment, when they need it, wherever they are working	**Quicker, safer decisions; everyone with a legitimate need can instantly see the information they need**
Joining things up and removing boundaries; sharing key information quickly between hospitals, GPs, community services, Social Services and others involved in your care	**Auto prompts and alerts (e.g. allergy checks that reduce the risk of prescribing error)**
Fewer delays and less frustration waiting for things to happen	**Information to hand when needed; no more delays waiting for paper records; no more searching for drug charts, observation charts, etc**
Putting you in control; giving you secure on-line access to your health record, appointments, correspondence and results	**Do-once-and-share: no more duplication and repetition; once entered, information is available to all clinical staff; automatic population of key documents**
User-friendly technology such as "Patients Know Best" to make it easy for you to reach out for advice and support when you need it, without having to come to hospital	**Access from anywhere means that medical staff no longer need to be on the ward to carry out certain tasks such as authorising drugs, completing Immediate Discharge Summaries**
Offering e-consultations to save you the inconvenience of travelling to hospital	**Reducing delays by sharing information with other care providers**
Helping you to look after yourself and giving you confidence to take the right action, at the right time to keep you out of hospital	**Improved WiFi, new digital telephone and video services and NHSMail all helping to keep you connected and supporting agile working**
Keeping your information safe and secure; only giving you control over who can see your records	**Freeing up time to care; productivity gains within your team and more efficient use of Trust resources**
Free WiFi when you are at hospital to keep you connected with your friends and family	**Empowering patients – seeing patients who have more access to their health and clinical information**
	Greater possibilities of e-consultations with patients and between colleagues
	Getting It Right First Time

3. OVERVIEW OF THE DIGITAL STRATEGY – 2018 to 2023

In November 2011 the Trust Board approved a five year Information Management and Technology (IM&T) Strategy which set out an ambitious programme of investment in new systems and infrastructure which would ensure that the Trust was able to meet its national policy obligations and would support and underpin the delivery of the Trusts overall Strategic objectives. Key to that was a new data network and the replacement of the Trust's Patient Administration System, Clinicom PatientCentre, with Lorenzo, a next generation Electronic Patient Record (EPR) developed under the aegis of the National Programme for IT (NPfIT).

This Strategy takes account of current policy, of the emergent Sustainability and Transformation Partnership Local Digital Roadmap (LDR). It creates a framework for the organisation's Digital work programme and contextualises how that will support the Trust in achieving its objectives. This strategy demonstrates the range and complexity of the Trust's Digital programme and describes the strategic context within which the Digital Strategy has been developed. It signposts the direction of travel for technology over the next five years and sets out the ambition to build upon our investment in technology, to develop a workforce with the skills they need to successfully embrace the challenges of the future and to exploit the transformational opportunities that technology enables.

The current Lorenzo contract ends in 2021, at which point responsibility passes to the Trust. This transition will need to be planned and provisioned for.

This Strategy is not solely about clinical systems and solutions. It also strives to keep pace with, and grasp emerging opportunities relating to the 'Corporate' systems and services which support the business, such as Financials, Procurement, Estates, Electronic Staff Record (ESR) and Records Management. We will look to exploit technologies which have the potential to reduce costs and improve operational effectiveness such as the use of Cloud services, adoption of NHS Mail and procurement partnerships. Throughout the life of this Strategy we will focus on improving data security and business resilience for our critical systems.

Key Strategy Objectives

Delivering sustainable, impactful transformation through technology, eliminating waste and duplication, improving efficiency and business resilience

Paper-free-at-the-point-of-care, underpinned by the Lorenzo electronic care record, incorporating e-prescribing and medicines administration, e-Observations and escalations

Digital pathways for all patients, from e-Referrals to e-Discharge, eliminating paper process delays, reducing risks and enhancing clinical effectiveness and patient safety

Patients and carers able to view their own record on-line and making it easy for them to access support, advice and have e-consultations on line

Achievement of HIMMS Level 7 for electronic records and full compliance with the Acute Digital Maturity Assessment

Fully upgraded data network and unified communications service, supporting agile working, clinical mobility, NHS Mail and One-Password Single-Sign on for all staff

Drive value from ICT investment through adoption of new technologies, such as cloud services, and opportunities for consolidation and partnering of ICT services

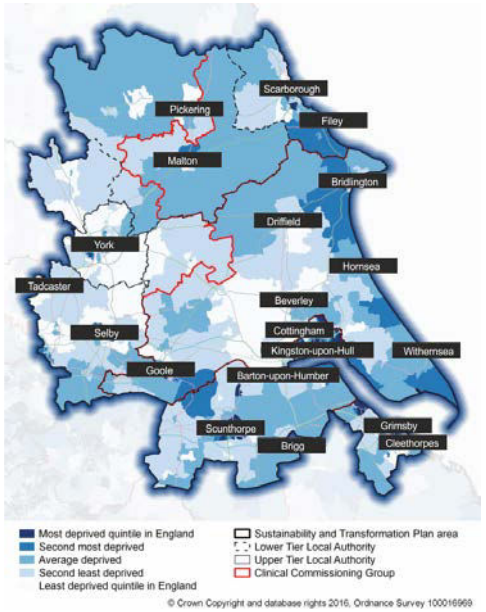
Compliance with national Digital policy, including Accessible Information Standards; Cyber Security; Information Governance and General Data Protection Regulations

The key risks to the delivery of this strategy are:

- **the availability of capital investment funds for new technologies,**
- **the affordability and provision of sufficient IM&T resources to develop, deploy, maintain and support the technology portfolio**
- **developing and nurturing a workforce with the capability, skills and capacity to meet the ambition set out in this strategy.**

4. TRUST PROFILE

The Trust operates from two main sites, Castle Hill Hospital and Hull Royal Infirmary and provides a full range of acute services to the people of Hull and East Yorkshire area. It is a university teaching hospital and a partner in the Hull York Medical School. The Trust is part of The Humber Coast and Vale STP which covers a diverse rural, coastal and urban community with a population of 1.4m. As depicted in the map right, the Humber, Coast and Vale footprint covers six CCG boundaries, six local authority boundaries as well as services provided by 3 acute providers and a number of health and social care organisations.



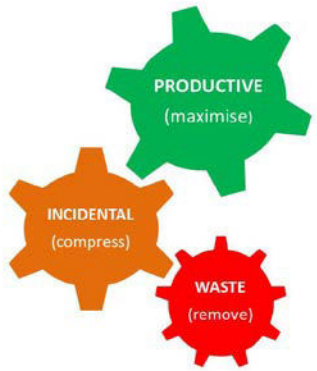
Hull & East Yorkshire Hospital Trust has an extensive service portfolio providing the full range of planned and general hospital services to a catchment population of 600,000 in the Hull and East Riding of Yorkshire area. It is a Major Trauma Centre, a Centre for Cardiology and Cardiothoracic Surgery and hosts the Queens Centre for Oncology and Haematology on the Castle Hill campus. It provides specialist services across the STP footprint, extending to North Yorkshire, North and North East Lincolnshire, a region that has a catchment population of up to 1.8 million.

Hull itself is a city of about 270,000 people. It was identified as the 2nd most deprived local authority in England in 2015. The health of people is generally worse than the England average, with a lower life expectancy for men and women.

The East Riding of Yorkshire itself is a predominantly rural area of 340,000 people. The geography makes it difficult for some people to access services.

The Trust Strategic Vision is **"Great Staff, Great Care, Great Future"** which shapes and supports the following **Values and Long Term Goals**:

5. TRANSFORMING THROUGH TECHNOLOGY: DELIVERING THE DIVIDEND



National Policy places great store in the role of technology in modernising and transforming the way we work and how we care for our service users. Over the life of this Strategy we will deliver a significant digital dividend.

Our vision is to build a workforce with the digital skills they need to prosper in the changing environment, to deploy products and services that meet the objectives set out in the 5 Year Forward View, that remove friction and frustration for our staff, our partners and our service users, thereby enabling all stakeholders to adapt to change more easily.

Below are the core technology related initiatives which directly contribute to the transformational challenges as set out in National Policy and by Lord Carter of Coles. This is not an exhaustive list of projects or optimisation activities that teams will be working on during the life of this Strategy. They are however the key initiatives where work is planned or ongoing and collectively they illustrate how technology supports collaborative working and can make a profound difference to how we work.

Transforming Patient Pathway Management

Reconstructing Clinical Administration, built around pathways, exploiting the instant availability of information where needed, removing the reliance on paper processes, avoiding task handoff, improving visibility and decision making, reducing clinical risk.

End-to End Digital Transactions

Referrals direct into Lorenzo via the national e-Referrals Service; Treatment recorded and reported digitally; Information collected once and shared with whoever needs it to carry out tasks, Immediate Discharge Summaries and Outpatients letters direct into GP Systems.

Empowering Patients

Sharing and engaging with patients, to help them take control and to support self-managed care.

Using Patient's Know Best (PKB) we will give all patients the option of receiving real-time on-line access to their appointments, letters, test results and hospital record.

Transfer of Care

The new G2 Speech Voice Recognition and Digital Dictation System provides the opportunity to transform how we produce and issue letters. In future, letters dictated by Clinicians directly into G2 can be electronically signed-off and instantly pushed into GP systems and made available to patients, on-line, via Patient's Know Best.

In additional to reducing the transaction cost of letters, Transfer of Care processes will be significantly enhanced by the speed of information flow across the care landscape, available to whoever needs it.

Reducing Risk – e-Observations

NerveCentre e-Observations will be live across Castle Hill by 31/3/18. It will be rolled-out across HRI as soon as possible. This will enable the electronic alerting and escalating of deteriorating patients to doctors. We will embed e-Obs results into Lorenzo.

When fully deployed e-OBS will make a significant contribution to the care of sick patients, removing delays in escalation, improving clinical care to deteriorating patients, reducing nursing time taken to carry out observations, eliminating paper records, enhancing staff productivity and freeing up time to care.

GS1 - Scan4Safety

GS1 global standards are a significant enabler for patient safety, providing the base information to ensure Right Patient, Right Drug, Right Dose, Right Route and Right Time.

GS1 supports improved safety, efficiency and cost control.

Our new system, when fully implemented, provides visibility and traceability across the full patient journey of clinical procedures performed, what equipment is used, which devices are implanted, what medications administered, by whom and when, all of which can be recorded in the patient electronic record.

Making it Easier: Lorenzo Lite

We will develop a Trust internal Lorenzo-Lite Read-Only Viewer. We will decommission the link to the (pre-Lorenzo) electronic patient information and make that available in the Viewer. Clinical staff will be able to see historic and current information about their patient without logging into Lorenzo. This has the potential to enhance outpatient efficiency

Records Management

HEY has over 1.2m hospital records in circulation.

Although the transition to electronic records is gathering pace, safely removing the need for Casenotes will take time. In the interim, HEY has invested in the iFIT Intelligent Casenote Tracking System which will improve traceability and availability of hospital records and will generate significant savings from reduced handling costs.

Supporting & Sharing

Via our in-house developed Lorenzo-GP Viewer, we share key patient information with GP's, enabling them to monitor progress and outcomes, including ED attendances, for their practice patients.

We will enrich the Lorenzo-GP Viewer to include alerts of abnormal scan results and will work with STP partners to extend the Viewer into other care providers such as NLAG, CHCP and Humber FT.

Making it Easier: Single Sign-On

We know that our staff get frustrated at how long it takes to log onto multiple systems. In 2018 we will implement a one-Password solution for staff to access the systems they need to do their job. We want to link this to Smart cards so that staff can 'tap and go' (just like 'tap and pay') when they are using Lorenzo.

Safer Prescribing

Lorenzo Electronic Prescribing and Medicines Administration (e-PMA) will significantly reduce prescribing errors and missed doses. ePMA removing the reliance of paper records, eliminates the risk of lost drug cards, makes prescribing information available whenever and wherever and has the potential to significantly enhance staff productivity.

Hospital Avoidance

Maximising the use of the eRS Advice and Guidance Service to eliminate unnecessary referrals.

Using CISCO Virtual Waiting Room to provide e-consultations, virtual clinics and give support to patients without the need for costly and disruptive hospital visits.

Digital Pathology

Replacement of the current Laboratory Information System, in partnership with York.

Extending digital reporting into Cellular Pathology to support the cancer transformation alliance and improve the resilience and effectiveness of the service. It enables the wider formation of a Cellular Pathology network beyond STP boundaries.

Extending digital reporting into Clinical Haematology will improve the efficiency of the diagnostic service and will enable medical consultant staff to link with the laboratory service more efficiently.

These innovative developments and productivity improvements will be supported by the introduction of Laboratory to Laboratory connectivity and drive towards the vision of a single Pathology Record across the STP.

Collaborative Image Reporting

The STP has made a successful bid to NHS England for the procurement of a Pan-STP image sharing and workflow management system during 2018.

The solution will link the current Enterprise Imaging Systems at York, NLAG and HEY Trusts and will enable workflow to be assigned to, and diagnostic images viewed and reported by, clinicians from all Trusts, irrespective of their base. This improves clinical effectiveness, reduces reporting delays and supports workforce transformation.

Modernising Medicines Supply Chain

The Regional Medicines Supply Chain Collaboration is a project involving 9 Trusts (the 3 local 'STP' Trusts plus the 6 'WYATT' STP Trusts) working together to modernise medicines procurement and management.

This collaborative project aims to drive innovation, automation and modernisation of the medicines supply chain and will see medicines supplied directly to end users by an out-sourced provider. Additionally, it is hoped to be an enabler for future innovation and efficiencies, for example the provision of more ready-to-administer products.

The process is currently (March 2018) in 'competitive dialogue' stage with potential providers, though to the approval of the final business case by participating Trusts.

Self-Service API's / FHIR

HL7 is embedded for exchanging information between internal and external systems. We will continue to open records for sharing, embracing the new Fast Healthcare Interoperability Resources (FHIR) and Application Programming Interface (API) as they mature.

FHIR and API are critical enablers for enhanced interoperability and wider sharing of care data and records. These new tools will open systems and data sharing beyond traditional 'trigger based' messages towards an open sharing architecture.

Reducing Risk – Task Management & Activity Flagging

Lorenzo has the ability to alert clinicians and clinical teams to tasks and activities that need performing and checks that need carrying out.

When deployed, Task Management functionality will push actions into individual clinical staff and team Lorenzo in-boxes, improving response times, speeding up clinical and operational decision making, reducing pathway delays and eliminating the risk of missed activities.

NHSMail2

Following approval by the Executive Management Committee in September 2017, HEY will adopt the national NHSMail2 service by the end of Q1 2018.

This will reduce costs, support employee mobility, will enable the Trust to introduce ESR Self Service. Looking ahead, the NHSMail2 platform has the potential to link to, and exploit the mobility capabilities of Office365.

Expanding e-Rostering

We want to extend the e-Roster system to other groups of staff to both help us deliver the "Carter" recommendations and make a measureable contribution to HEY's Digital Maturity score.

Other staff groups include AHP (Allied Health Professionals) the rest of the nursing clinical areas such as Endoscopy and some back office staff. Rollout of e-Roster also includes the development of Bank resources and the utilisation of the relevant Bank software.

Business Intelligence (BI)

The availability of high quality, real-time intelligence is critical to effective and impactful clinical and operational decision making.

To enhance the richness, flexibility and influence of our BI system we will expand the range of corporate and clinical data feeds into BI, develop forecasting models and predictive analytics and will increase the sharing of key data with other agencies

Infrastructure

We aim to reduce the cost of ownership, or the need for capital investment for new systems by exploiting Cloud / Off-Site Hosting opportunities for our systems. We will review partnering opportunities with the University of Hull to exploit the benefits of their new, commercial Data Centre, which is scheduled for opening in 2018.

We will work with our partners to take advantage of collaboration and consolidation opportunities.

6. THE 2011 STRATEGY – LOOK BACK

The key National Policy drivers at that time were the NHS White Paper, *'Equity and excellence: Liberating the NHS (July 2010)'*, and the NHS IM&T Strategy *'The Power of Information: Putting all of us in control of the Health and Care Information we need (May 2012)'*. The latter document described how the provision of high quality clinical information will transform the way patients are treated and how information technology can help modernise and change the way care is provided throughout public health, healthcare and social care in adult and children's services in England.

The 2011 Trust Information Management and Technology Strategy set out a five year investment programme via which the Trust would both address local imperatives and respond positively to national policy. The Strategy was based upon the following principles:

- ***Systems are integrated to provide one true source of fully electronic information***
- ***Information is entered once, shared widely and is accessible whenever and wherever required***
- ***Technology supports effective clinical collaboration within the Trust and throughout the wider health economy***
- ***Systems and technologies will enhance clinical effectiveness, improve outcomes and enhance service user experience***
- ***Information, relevant to the specific needs of each user group, is available regardless of time or location***
- ***That systems are user friendly, flexible, robust and support new ways of working***

National IM&T Strategy required Trusts to develop their IM&T capabilities further in order to meet national expectations for new Electronic Patient record (EPR) systems, paperless working, increased digitisation and the use of electronic correspondence and communication across the whole health and social care continuum.

Lorenzo was the centrepiece of the IM&T Strategy, around which all other developments are positioned. HEY committed to deploying the NPfIT Lorenzo Regional Care (LRC) solution and, following the Cabinet Office major systems review in 2011/12, a new national contract for Lorenzo was agreed, which enabled the Trust to commit to Lorenzo with confidence. Approval of the Investment Case by the Trust Board in April 2013, together with approval to proceed by the (then) Health and Social Care Information Centre (HSCIC) culminated in a successful Trust wide go-live on 8th June, 2015. Alongside of Lorenzo, there have been a number of other important systems developments, all of which support the principles set out above.

The box right summarises the key achievements since the 2011 IM&T Strategy was approved.

Key achievements

Implementation of core Lorenzo throughout the Trust including ED, Requests and Results, Clinical Documents, Lorenzo Maternity, Lorenzo Advanced Bed Management (F&W), Lorenzo Electronic Prescribing (Ward 29) and Lorenzo GP e-viewer

Introduction of bedside e-Observations across 50% of the Trust

Implementation of Trust wide Business Intelligence system, linked to Lorenzo

Achievement of National Policy target for paperless e-Discharges to GP's

New, Trust wide voice recognition and digital dictation system

Implementation of a Trust Wide Managed print device service

Replacement network and unified voice and video service at Castle Hill.

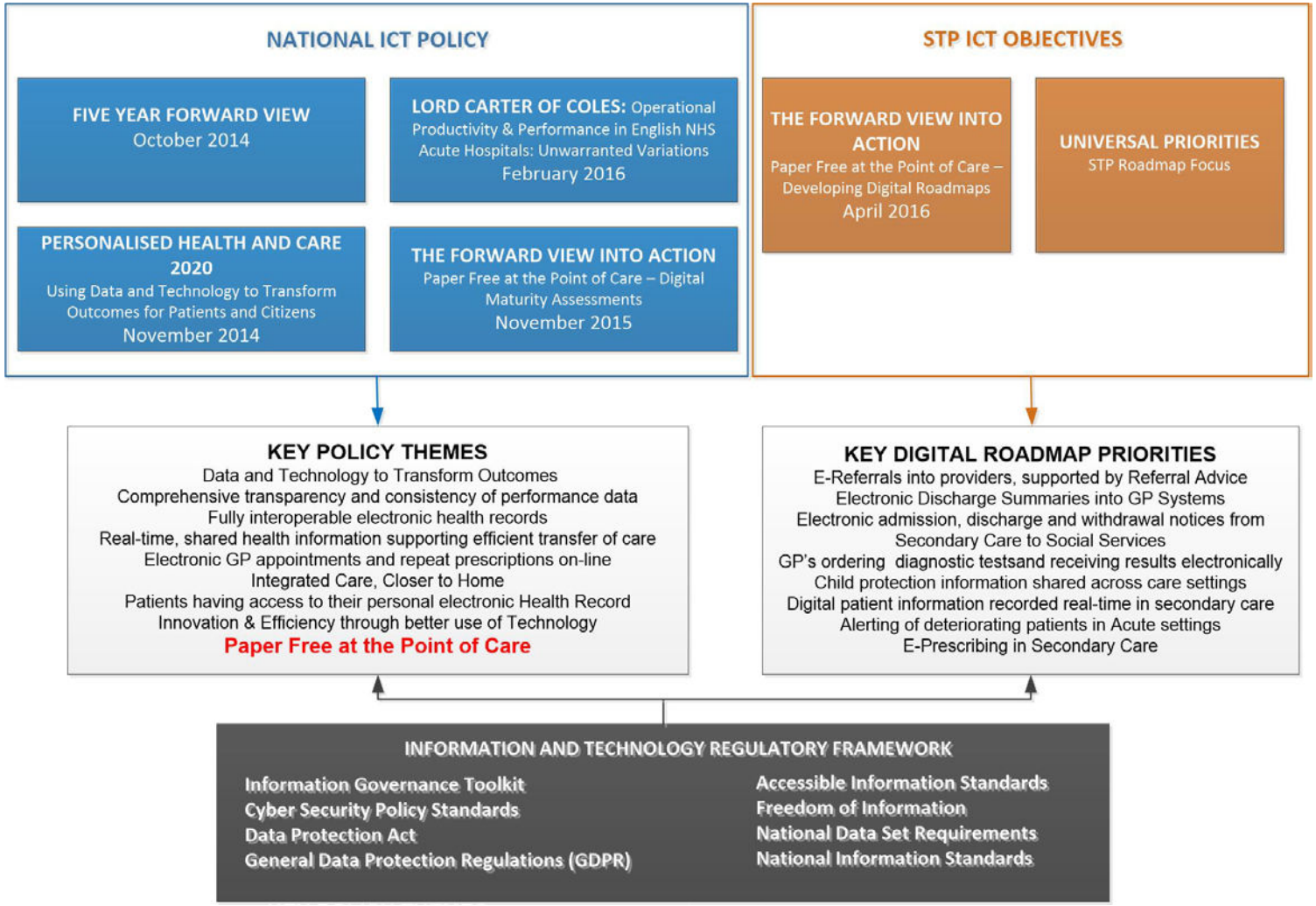
Patient WiFi Service launched at Castle Hill

Integration of Patient Administration into the Corporate ICT Directorate

In-house systems integration capability developed

7. NATIONAL POLICY CONTEXT

There have been a number of key policy initiatives since the Trust's previous strategy was approved. However, NHS technology strategy has not changed fundamentally since 2011 and continues to focus on: using Data and Technology to support sharing, improve efficiency, eliminate waste, enhance productivity, empower innovation and service re-design and transform outcomes. Recent national policy is more granular and explicit in terms of mandating what must be done. It also now places increased emphasis on organisational capacity and capability, security, governance, business resilience and delivering value. The main influences which shape our Digital Strategy are therefore:



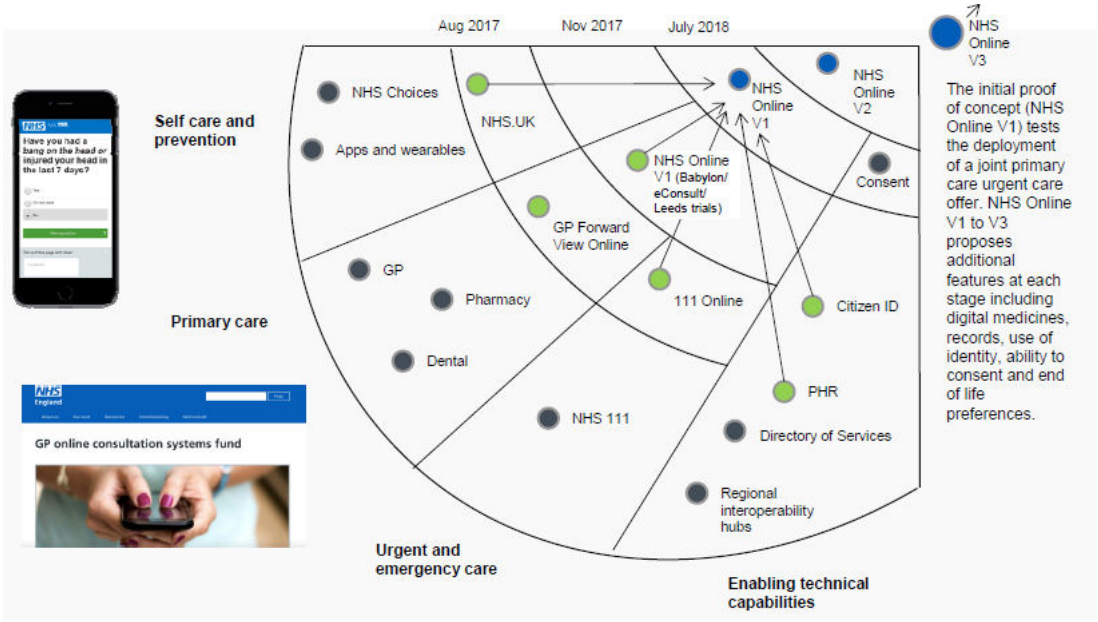
Digitisation is a key enabler to achieving national, STP and Trust visions and goals:

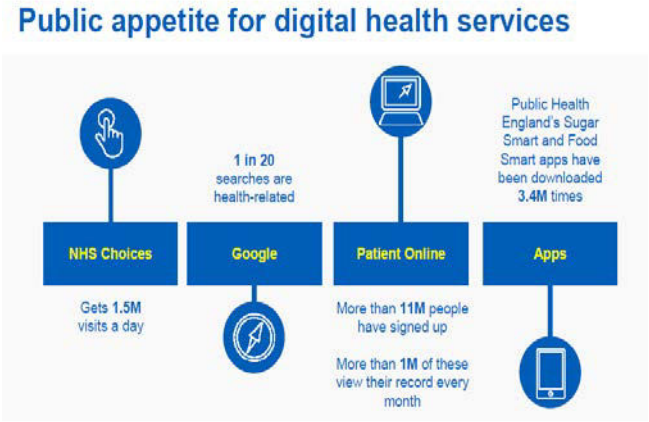
- ***An Integrated Shared Record*** – providing care professionals with a single electronic environment to access and share real time information about the treatment and care of service users, removing the limitations of paper records and enabling interactive care and rapid, informed decision making;
- ***Out-of-hospital care models*** – enabled by access to secure, relevant and accurate and comprehensive information, anywhere care is given
- ***Self-managed Care*** – empowering citizens by providing an interactive and secure environment within which service users can access their own personal records, interact with their care professionals and can take an active and empowering role in their own health and well-being;
- ***Prevention*** – giving service users access to meaningful, helpful advice and guidance, whenever and wherever needed;
- ***Sustainable Hospital Care*** – by maximising the transformational dividend from technology, eliminating waste, inefficiency, duplication and unnecessary tasks and removing barriers and delays.

This Strategy sets out the way on which Hull & East Yorkshire Trust will address and deliver on national policy obligations, governance expectations and its own internal technology priorities. The initiatives and aspirations set out in this new Digital Strategy complement the STP priorities. By working closely with our partners through the local Digital Roadmap Programme Board we already contribute significantly to the direction of travel for STP level technology investments and developments. We will continue to further those relationships and promote a positive approach to future Digital Transformation in the region, for example the opportunity to connect our instance of Lorenzo to Humber Foundation Trust's instance.

8. NHS DIGITAL WORK PROGRAMME

NHS Digital is the Government Department responsible for driving progress with the 'digital agenda' in all its guises. Its aim is to help achieve the objectives set out in the *Five Year Forward View*: to improve health outcomes; to increase efficiency; to improve the patient experience. In addition to providing oversight of all NHS organisations response to compliance with national policy, NHS Digital is also charged with developing national digital services to meet the growing demand for access to support on-line such as access to health based information services, links to health apps, access to personal health records and to help patients manage conditions on-line. See box right.





A key tenet of the NHS Digital Work Programme is to widen digital participation and inclusion. The diagram left shows how NHS Digital will progressively consolidate national digital services into one single point of entry (NHS Choices) that will provide the same digital experience for patients, no matter which device or service they enter the system on.

It is important that STP wide developments, together with organisation specific developments, are supportive of and complementary to, the NHS Digital work programme. All STP partners are responsible for implementing both collaborative and organisation specific technologies and services that encourage and support patient digital engagement.

For HEY this means Trust wide availability of patient wifi services, making information available to our staff 'on the move', staff able to access 'total' information about the patient and other digital services as part of carrying out their role and delivering care, staff able to access information and systems real-time, creating shared records accessible by all care-givers and able to support 'joined-up' care pathways, eliminating the restrictions, delays and risks around paper based systems, achieving paper-free at the point of care, enabling patients to access their hospital appointments, results and records digitally, offering e-consultations to avoid unnecessary hospital visits and enabling and empowering patients to play a role in managing their own care.

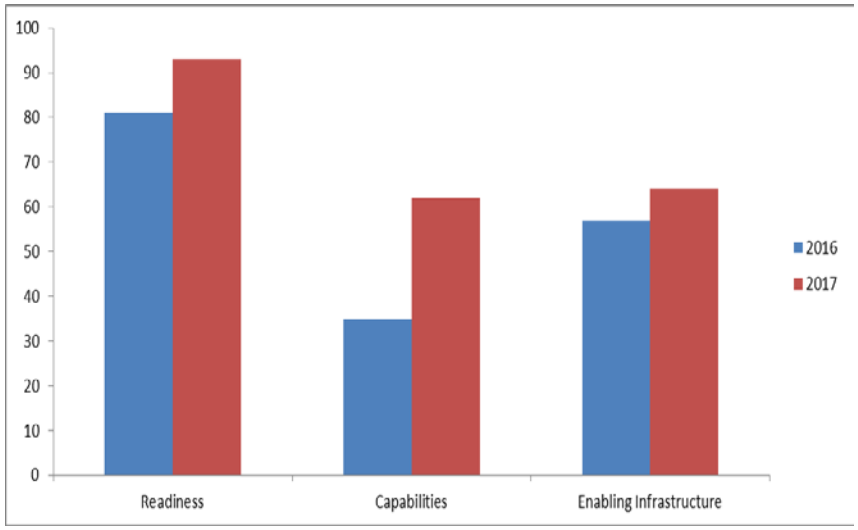
The HEY Digital Strategy makes a positive contribution to these objectives. For service users and their carer's, Hull & East Yorkshire Hospitals in-hospital digital services will support the objectives set out in the *Five Year Forward View* and will complement their out of hospital digital experience.

9. TRUST DIGITAL MATURITY REVIEW

In December 2015 NHS England launched the Digital Maturity Assessment (DMA) which was designed to measure each Trust's readiness to meet the challenges set out in the *Five Year Forward View and Personalised Health and Care 2020*. Specifically, were Trusts ready to deliver the following national policy objectives:

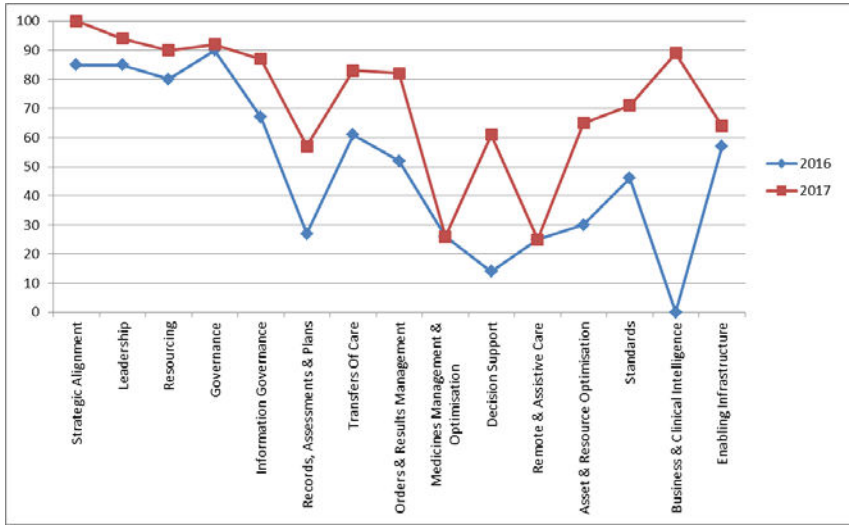
- ***Using Data and Technology to Transform Outcomes***
- ***Integrated Care, Closer to Home***
- ***Innovation & Efficiency through better Use of Technology***
- ***Interoperability: Joined up Systems; Shared information***
- ***Paper Free at the Point of Care:***
    - ***Readiness: Are providers set up effectively to deliver?***
    - ***Capabilities: Do providers have the digital capability?***
    - ***Infrastructure: Are the underpinning technological enablers in place?***

The results of the national assessment were published in early 2016. An updated follow-up DMA, with additional questions, was published in September 2017. It was designed to:



- ***Track progress made since the first round of self-assessments and the reasons behind it***
- ***Support planning, prioritisation and investment decisions within providers and STP footprints***
- ***Provide a* means of baselining / benchmarking levels of digitisation nationally**

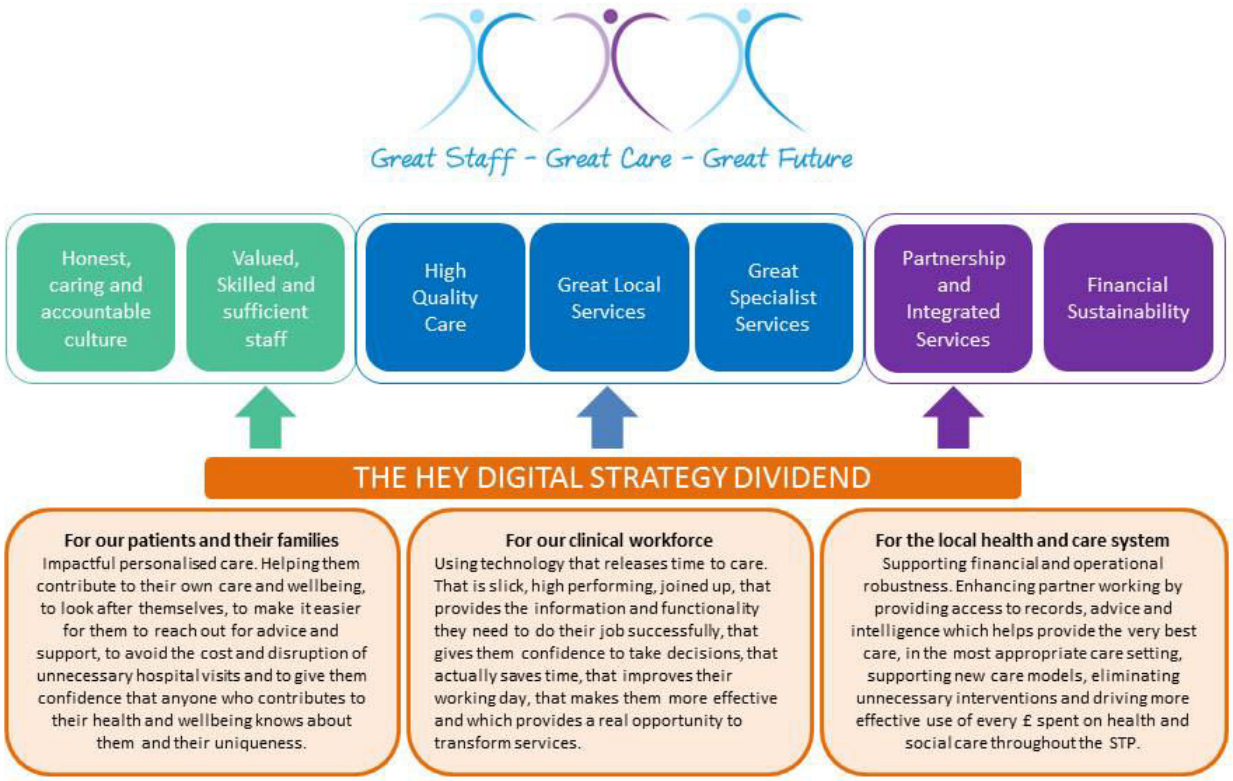
The updated Trust position (shown right) was completed with input from the Chief Consultant Information Officer, Nurse Director – Surgery Health Group, Senior Principal Pharmacist (e-Prescribing Project), Chief Pharmacist, Clinical Director Therapy & Therapeutics and Senior Scientist (Pathology). In summary:



- Lorenzo has had a significant positive impact on our scores
- There has been a 77% improvement in our digital capabilities index
- The biggest capability gains relate to Records, Assessments and Plans; Orders and Results Management; Decision Support; Asset & Resource Optimisation and Standards. Business Intelligence was not evaluated in 2016
- **Areas remaining static and requiring further progress are:**
    - **Medicines Management:** requires the full rust wide roll-out of ePMA
    - **Remote & Assistive Care:** requires e-consultations, remote monitoring, condition self-management tools (eg Patients Know Best)
    - **Infrastructure:** requires Trust wide network replacement, full roll out of Patient WiFi and increased Disaster Recovery/Business Continuity emphasis

10. LOOKING FORWARD - THE NEW TRUST DIGITAL STRATEGY: 2018 TO 2023

This Strategy sets the blueprint for our digital services over the next five years. It represents the second phase of the Trust's technology modernisation programme and builds on the progress so far. The Strategy supports the Trusts visions and goals and will make a positive contribution as depicted below:



The heart of the 2011 Strategy was to implement Lorenzo. Since go-live in June 2015 Lorenzo has become embedded in day-to-day working. Being able to access more information, cohesively, in one place, and sharing that more widely to improve clinical and operational decision making and transfers of care has made a difference. However, there is much more to achieve through our investment in Lorenzo and the complementary systems that sits alongside it. The formative phases have been about stabilising, embedding and optimising Lorenzo. As we move into the second phase of our digital vision, our focus is:

- ***To become a truly digital organisation, driving value, performance, clinical excellence and operational sustainability***
- ***To make a positive difference, to working lives of staff, to care partners and to those needing our services.***
- ***To be outward looking & collaborative, underpinned by accessible, relevant, shared intelligence***
- ***To deploy and exploit safe, secure, feature rich, high performing, and transformational technology.***

- ***To have patient focussed systems and information, which support self-management, integrated care and new care models***
- ***To give service users confidence that anyone who contributes to their health and wellbeing knows about them and their uniqueness***
- ***To make it easy for service users to reach out for advice and support, however and wherever they need it.***

We have not yet fully exploited the significant positive impact technology can have on the lives of our staff and our patients. In tandem with other Trust developments, Lorenzo can open up new ways of working, internally and with our care partners, empowering clinicians and service users to think differently about how and where care and support is given and received. We know that through technology we can unlock the potential to break free from traditional ways of providing care and support. We know that technology can drive sustainability internally, across the STP and the wider NHS and Social Care landscape. Physical and technical boundaries can deprive people from getting the right care when and where they need it and reduce the efficacy and patient experience that goes with the service. We know that we can use technology to free patients from the inconvenience of unnecessary hospital visits, enhancing self-management, improving wellbeing and empowering patients to take control.

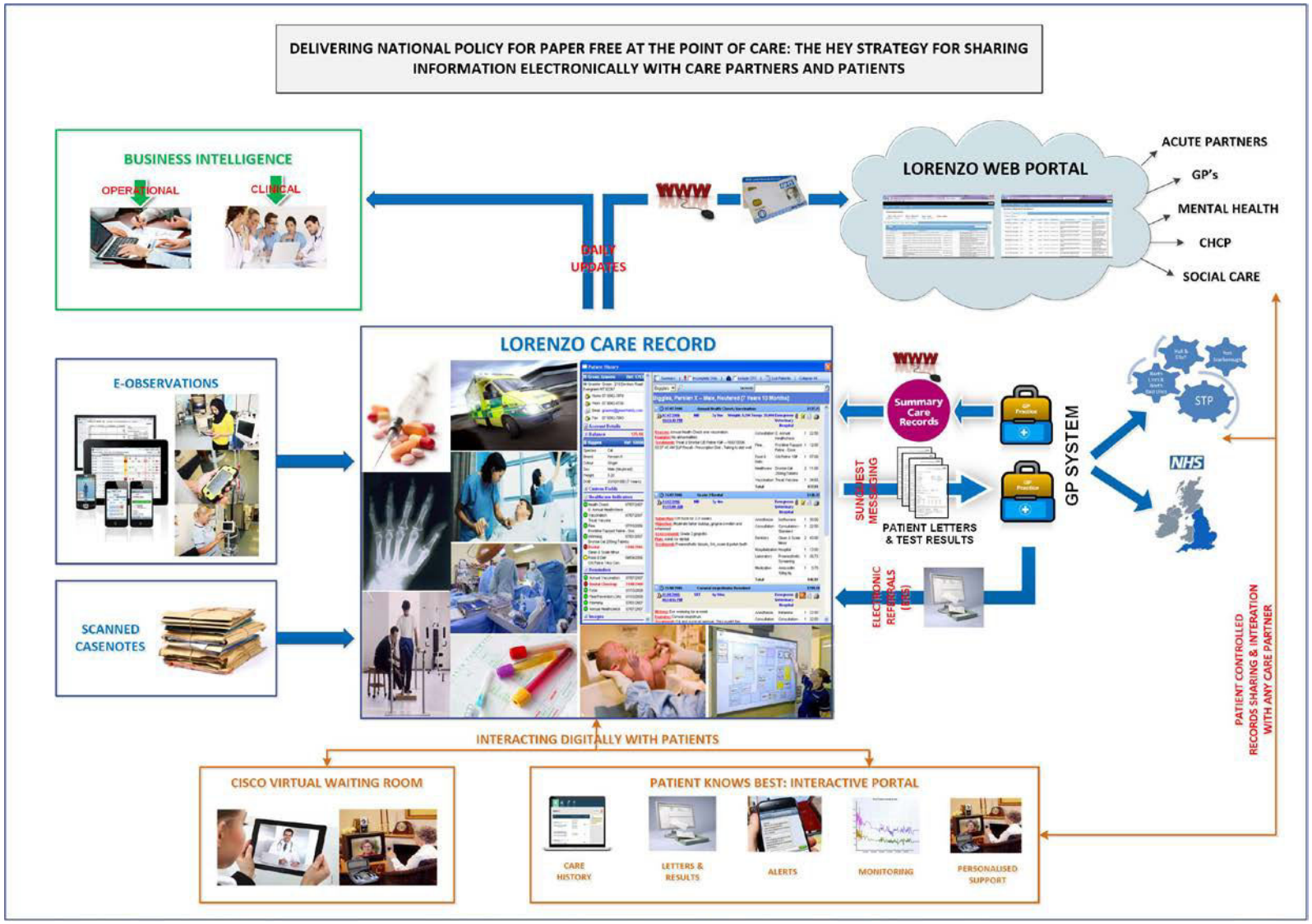
This Strategy is not simply about doing away with paper and sharing records 'digitally'. It is a mandate for changing the way we think and transforming how we work and how we care for our service users. Ultimately our vision for the future is to deliver a service to patient's that does away with the traditional boundaries, be they organisational, technical or human.

We aspire to become a leader in the use of technology, to remove boundaries through Digital Transformation, enabling information to flow seamlessly with the service user, through primary, secondary and social care services and beyond, supporting personalised care for every unique individual, wherever and whenever they need it.

The following sections describe how, ***over the life of this strategy we will build on progress to date and create a digital environment which will:***

- ***make a tangible, measurable and significant contribution to the Trust achieving its Vision, Values and Long Term Goals;***
- ***contribute to the delivery of The Humber Coast and Vale STP service development priorities, support collaboration and mutual accountability and support the achievement of the following key objectives: Health & Wellbeing; Care & Quality; Finance & Efficiency;***
- ***enable the Trust to achieve National Digital Policy objectives***

For Hull & East Yorkshire Hospitals, the foundation for sharing key patient information quickly, securely and comprehensively is our unified electronic care record, with Lorenzo at its heart. This is depicted in the box overleaf.


DELIVERING NATIONAL POLICY FOR PAPER FREE AT THE POINT OF CARE: THE HEY STRATEGY FOR SHARING INFORMATION ELECTRONICALLY WITH CARE PARTNERS AND PATIENTS
BUSINESS INTELLIGENCE
OPERATIONAL
CLINICAL
DAILY UPDATES
WWW
LORENZO WEB PORTAL
ACUTE PARTNERS
GP's
MENTAL HEALTH
CHCP
SOCIAL CARE
E-OBSERVATIONS
SCANNED CASENOTES
LORENZO CARE RECORD
WWW
Summary Care Records
GP SYSTEM
STP
NHS
SUNQUEST MESSAGING
PATIENT LETTERS & TEST RESULTS
ELECTRONIC REFERRALS (MRS)
PATIENT CONTROLLED RECORDS SHARING & INTERATION WITH ANY CARE PARTNER
INTERACTING DIGITALLY WITH PATIENTS
CISCO VIRTUAL WAITING ROOM
PATIENT KNOWS BEST: INTERACTIVE PORTAL
CARE HISTORY
LETTERS & RESULTS
ALERTS
MONITORING
PERSONALISED SUPPORT

11. FUTURE DEVELOPMENT OF THE LORENZO CARE RECORD

The extant IM&T Strategy was approved in November 2011. Lorenzo is the cornerstone of that strategy, 'going-live' throughout the Trust on 8th June 2015. Lorenzo sits at the heart of the 'business', is fully embedded into clinical workflow and feeds our bespoke Business Intelligence service, via which clinical and operational reports are produced and shared with care partners to support more efficient and coherent clinical management. It is the key system for managing our patient's care journey in the Trust, for managing activity, for planning, enacting and recording clinical treatment and for national and corporate reporting.

Via Lorenzo we have expanded and digitised the information we share with GP's, improving the visibility, timeliness and richness of information about their patients. Alongside of the e-transfer of Immediate Discharge Summaries from Lorenzo directly into GP systems, and the ongoing programme for outpatient e-correspondence, HEY has developed a GP-Lorenzo viewer via which, subject to appropriate security checks, GP's can view key patient information. Lorenzo has also allowed us to integrate the Summary Care Record (SCR) into our clinical assessment processes, achieving the highest number of SCR patient medication and allergy 'lookups' nationally.

The functional development and enhancement of Lorenzo is ongoing and, over the life of this Strategy, we will:

- ***Complete the Trust wide deployment of Lorenzo Electronic Prescribing and Medicines Administration (ePMA)***
- ***Decommission CAYDER and adopt Lorenzo Advanced Bed Management (ABM) throughout the Trust. This will provide slicker, integrated and intuitive pathway management, from referral to discharge, integrated into the EPR, with actions visible, traceable and reportable. Our vision is to enable care partners from outside of the Trust to interact with ABM, enhancing co-ordinated care models and improving patient flow.***
- ***Develop a Lorenzo-Lite Portal for our staff to easily and quickly access key clinical information and to enable the current links to the old Patient Administration System to be decommissioned***
- ***Implement Lorenzo Task Management to improve oversight and accountability along the patient journey***
- ***Commit to Lorenzo Theatres, bringing theatres into the heart of the EPR, supporting integrated resource allocation, contributing towards GS1 compliance and enabling ORMIS to be decommissioned***
- ***Complete the roll-out of NerveCentre e-OBS throughout the Trust, positioning e-OBS alongside of Lorenzo through enhanced integration.***
- ***Build on the digitisation 'proof of concept' initiatives in Breast, Cardiology and ED and drive paperless working throughout outpatients and inpatients***
- ***Continue to build a richer Lorenzo care record through integration of key 3rd party clinical systems, including the adoption of Fast Healthcare Interoperability Resources (FHIR) Standards***
- ***Support the wider data sharing across the STP community through promotion of the use of the enhanced Summary Care Record.***
- ***Manage the transition process at the end of the Lorenzo Local Service Provider (LSP) Contract which expires in June 2021***

In 2016 the Government launched the Global Digital Exemplar (GDE) Programme. A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. NHS England is currently supporting 16 digitally advanced acute trusts, seven Mental Health Trusts and three Ambulance Trusts to become Global Digital Exemplars over two to three and a half years. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

In autumn 2017, NHS Digital launched the Lorenzo Digital Exemplar Programme (LDE), via which Trusts using the Lorenzo EPR, provided by DXC under the Local Service Provider (LSP) contract, could apply to become a Lorenzo Digital Exemplar in their use of technology enabled adaptive change. This complements the Global Digital Exemplars programme in that it requires successful Exemplar's to inspire and help educate others by demonstrating how successful adoption of technology can deliver both improved patient outcomes and increased operational effectiveness.

An LDE Expression of Interest Bid was approved by the Trust Board in October 2017, which is underpinned by a commitment to provide resources and funding to meet the ambition set out in the bid, the core objectives of which are to:

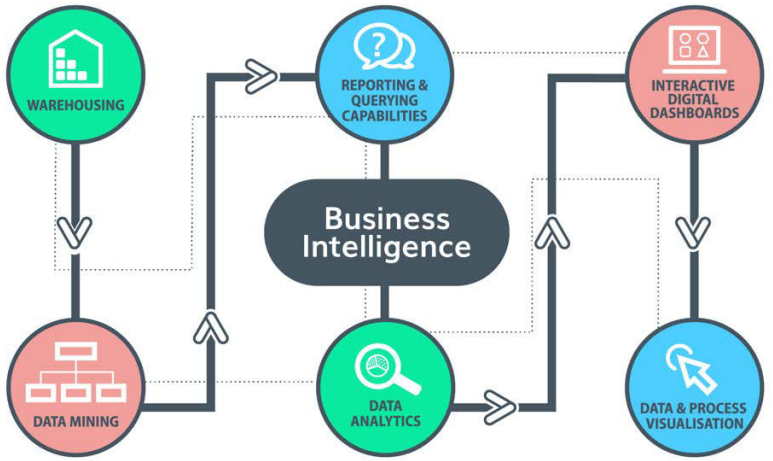
- ***Accelerate the pace of transformational change throughout the Trust, delivering significant benefits, quicker.***
- ***Deliver an electronic patient-centric care record which supports effective clinical management, 'joined-up' care and clinical excellence throughout the STP***
- ***Maximise the dividend from technology; eliminate the reliance on paper records; deliver end-to-end electronic processes from referral to discharge***
- ***Extend the scope of e-records sharing with care partners. We will examine the feasibility of bridging our instance of Lorenzo and Humber Foundation Trust, who also use Lorenzo. This would enhance end to end care between our two organisations, reducing paper transactions and enabling a holistic view of patients with complex physical and mental health requirements***
- ***Deploy technology which supports interaction with service users, gives patients access to their electronic hospital records, correspondence and results and supports assisted self-care and admissions avoidance***
- ***Achieve HIMSS Level 7 capability***

In December 2017 Hull and East Yorkshire Hospitals NHS Trust was selected by NHS Digital to become one of four national Lorenzo Digital Exemplars alongside of Royal Papworth Hospital NHS Foundation Trust, North Staffordshire Combined Healthcare NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust. These four Trusts will share circa £10m of support funding, which is provided in the form of resources from DXC. The planning phase is underway, following which an Investment Case, Benefits Case and Mobilisation Plan will be submitted for approval to the Trust Board and to NHS Digital.

The LDE award is reflective of the success that the Trust has had with its Lorenzo implementation. We are already making digital transformation a reality in the Queens Centre for Oncology and Haematology. This specialised hospital is mobilising to become an entire digital hospital by summer 2018. The success of this programme will not only transform our oncology services, where e-prescribing of specific medications is already ahead of the wider Trust, but it will serve as a beacon of success for the rest of the Trust to aim for. It captures the essence of the vision and willingness of HEY to reap the benefits of being a Lorenzo Digital Exemplar.

12. DEVELOPING BUSINESS INTELLIGENCE CAPABILITY

The 2011 strategy set out a vision to implement a Data Warehouse prior to implementing our new EPR in preparation for handling the large amounts of data generated by Lorenzo. Alongside this, a review was undertaken around what technologies and systems were available to support the provision of real time reporting, complemented by dashboards to aid operational decision making and performance.



The Trust invested in a third party Data Warehouse and Business Intelligence (BI) system to give the organisation a foundation from which to store all of its data from various sources and build its reporting capability. That system, Acute Health Data Enterprise (AHDE) from Insource, provides HEY with the tools and capability to meet its national and local reporting obligations, including national activity datasets, and to provide a suite of internal reports and dashboards to support effective governance and performance management.

As at 2017 the Data Warehouse holds over 800 tables of data, including datasets from Lorenzo, including:

- ***Referrals***
- ***A&E***
- ***Outpatients***
- ***Inpatients (Wards, Critical care etc)***
- ***Clinical Coding***
- ***Maternity***
- ***RTT***
- ***DTOCs***
- ***Radiology***
- ***Pathology***
- ***Clinical Correspondence (letters)***
- ***Specialty specific Lorenzo Clinical Data Capture (CDC) Forms***
- ***Commissioning datasets***
- ***SLAM (Finance and Contracting Activity System)***
- ***Datix (Risks & Complaints System)***

Acute Health Data Enterprise (AHDE) is the prime system for supplying the organisation with a suite of information, reports and dashboards. In a typical month our reports are viewed by over 350 unique users, examining around 20,000 individual report views. Of these reports, 40% are data quality operational monitoring reports which contain Patient Identifiable Details (PID). HEY has supplemented the core AHDE product by creating a real-time flow of information from Lorenzo. A suite of over 600 reports / dashboards are in use across the organisation, many of which are used daily to aid operational processes and support decision making:

- real-time dashboards for ***A&E,*** including ***Patient Journey Analytics*** (ribbon graphs)
- real-time ***Bed Management*** updates to aid patient flow management
- a portal for ***GP's*** to access their patients current status, test results and correspondence
- ***Referral-to-Treatment (RTT)*** dashboard, including forecasting (approved by the IST and shared nationally as best practice)
- ***Demand and Capacity*** Models

Becoming a Digital hospital will result in increased demand on BI Reporting services to provide insightful information to aid day-to-day decision making, as well as give an overview on overall performance. Looking ahead, our strategy is to build on the foundations that have been laid, through the expansion of datasets being fed into the warehouse

and BI Reporting system, and to align Activity, Financial, Workforce and Quality metrics from one source. ***Over the life of this Strategy we will expand the range of data feeds into the Data Warehouse & BI system to include:***

- ***New Radiology Information System***
- ***EPMA (e-prescribing)***
- ***Advanced Bed Management & Whiteboards***
- ***Theatres & Scan-4-Safety System***
- **E-observations**
- **Finance Costing information**
- **Workforce information**
- **Patient flow/pathways**
- ***Clinical Indicators & Activities***
- **Other Quality/Safety metrics**
- **Additional clinical data (via CDC forms)**
- ***Care Plans***

Through our Data Warehouse and BI reporting system the organisation has access to a rich suite of information to aid decision making both at an operational and strategic level. In addition to increasing the range of data and expand the reporting suite, ***over the life of this Strategy we will address the requirement to:***

- **Develop better forecasting models**
- **Develop and adopt predictive analytics,**
- **Introduce more data linkages between systems**
- **Increase the sharing of datasets with other agencies**

Alongside of these local developments, some significant national strategy drivers dictate what the Trust needs to be in a position to do. ***Over the life of this Strategy we must:***

- ***Reduce reliance on manual data submissions through the means of manual returns and move to automation of data uploads via datasets.*** There is a drive to have information flowing more frequently from Trusts directly into national repositories such as SUS/HES, and therefore Trusts have to ensure they have robust systems in place to manage this process going forward
- ***Respond to and implement change existing datasets.*** The priorities that have been set are:-
  - Emergency Care Dataset (ECDS)
  - Maternity Dataset (MSDS)
- ***Migrate to SNOMED CT as a single coding structure throughout health and social care by 2020.*** This will have a significant impact on Trust processes and reporting.

Finally, in order to support the demands of users in an increasingly digital age for richer, more complex and more bespoke information, it is vital that the IM&T workforce develops and maintains the specialist skills required and have access to the latest business products and tools. This requires investment in resource, products, tools and training. Over the life of this Strategy, we will develop and maintain a highly skilled and motivated workforce through:

- ***Investment in bespoke training packages for staff to use SQL and other programming tools to develop systems and apps***
- ***Investment in technologies and software such as Microsoft Power BI (an industry wide standard) as a tool to analyse and present data***
- ***Launch an education programme for our key staff on the use of Business intelligence to support decision making***

13. TECHINCAL DEVELOPMENTS: INFRASTRUCTURE & SERVICES

Our aspiration to be an exemplar in the use of technology, to improve the working lives of our staff, to make it easier for them to do their jobs, to remove the drudgery of repetition, to eliminate time wasted on inefficient or unnecessary tasks, is predicated upon having access to technology which makes it possible to achieve this vision. The systems, applications and developments set out in this Strategy all require modern, resilient, high-performing infrastructure which makes it easy for users to access and exploit those services.

The 2011 Strategy included a commitment to fully replace the Trust's ageing data network and telephone system, which together provide the data and voice services upon which the Trust relies in order to function. The total combined capital cost of the investment is circa £7m. All existing network components are being replaced and connected to a new, higher bandwidth, backbone with enhanced links between sites. The wifi service is being replaced with greater capacity and reach, including the provision of a guest wifi service. The old telephone system is being replaced with a new, digital, unified communications service which becomes a constituent part of the network. In future, voice, video and messaging will be software applications delivered over the network. The replacement programme commenced in 2016/17, focussing initially on the Castle Hill campus which is now 60% complete. A new guest wifi service was launched in October 2017 and will be progressively rolled out across the whole Trust alongside of the new network.

Alongside of the core infrastructure, this Strategy will address the needs of users as digital services become ubiquitous. Having access to computers, being able to log onto personalised services quickly and easily, delivering a consistent and portable user experience are all now critical to staff carrying out their roles effectively and safely.

Over the life of this Strategy therefore, we will:

- ***Complete the total replacement of the Trusts Data Network and Telephone across all Trust buildings and sites.***
- ***Roll-out patient wifi services, in line with national policy, to all areas of the Trust***
- ***Complete the transition to a fully digital Trust wide unified voice and video service, supporting MDT's and virtual clinics***
- ***Decommission the in-house Exchange service and transition to NHS Mail by 30th June 2018***
- ***Procure and implement the Yorkshire and Humberside Public Sector Network (YHPSN) solution as a replacement for N3***
- ***Procure and deploy a Single Sign-On 'one password' solution for staff, linked to Smart cards, using 'tap and go' to speed up access to spine authenticated systems (eg Lorenzo / SystmOne / ESR)***
- ***Deploy Windows10 across the desktop environment and continue to refresh our desktop estate to enable new applications to be successfully deployed. Alongside of that we will commit to reviewing the costs and benefits of deploying a 'virtual desktop' solution to both support agile working and reduce the lifecycle replacement cost of desktops***
- ***Review the opportunities and benefits of off-site cloud hosting services in line with emerging NHS Digital Policy***
- ***Improve and evolve our Cyber Security approach; enhance our current technical defences to include software asset and security patch management; create a dedicated IT security management team***
- ***Develop our Business Resilience governance framework and Disaster Recovery capability***

14. DEPARTMENTAL SYSTEMS: KEY STRATEGIC DEPLOYMENTS

A core tenet of our digital vision is that Lorenzo is the prime system via which we collect data, manage patient pathways and report on activity. Silo'd departmental system are not permitted, and the ongoing development of Lorenzo will take precedence over procuring new systems. However, there will always be a need for other major clinical or patient facing systems where they are unique to a clinical service, are critical to the safe and effective running of that clinical service and have functionality which cannot be replicated in Lorenzo. The following strategic system deployments have been identified as priority requirements. This is not a definitive list and may in future be affected by, for example, NHS policy, STP plans or supplier decisions to cease supporting existing systems.

SYSTEM / SERVICE	PROJECT STATUS	BACKGROUND / CONTEXT
Clinical Imaging Capture and Reporting	Project in-flight	Following the award in 2017of a 10 year contract with AGFA as part of an eight Trust Yorkshire collaborative, HEY will deploy a next generation hardware platform and Enterprise Imaging (EI) solution to replace its current PACS. The full work programme will be completed in 2018/19. A workflow and image sharing solution will be implemented across the STP to improve reporting turnaround, operational efficiency, clinical effectiveness and patent safety.
Cardiology Management System	Project in-flight	The current CMS (GE CARDDAS) goes end-of-life in December 2018. A procurement exercise is underway following approval of the OBC and the project will be completed by the end of Q3 - 2018.
Scan4Safety	Project in-flight	Following approval of the OBC in 2017 HEY has procured the Genesis Scan4Safety solution to improve care and safety by tracking and tracing consumables, implants, etc used in treatment of patients. This is a new national initiative and does not replace an existing system.
Patient's Know Best (PKB)	Pre-Approval Phase	PKB is the system of choice for the Trust to meet its Accessible Information and Records Sharing obligations for patients. In addition to being a secure vehicle for records sharing, it supports self-managed care and enables service users to interact with care givers without the need for hospital visits. A Business Case is being prepared. Subject to approval, deployment is planned for Q2 2018.
Diabetes SystmOne	Pre-Approval Phase	HEY will decommission the current Diabetic Department system and adopt the SystmOne. This enables more cohesive management of the treatment programme and supports STP wide plans for Diabetic care
Lorenzo Theatres	Pre-Approval Phase	HEY intends to decommission the current ORMIS system and deploy the fully integrated Lorenzo Theatres solution. This supports more coherent management of the patient throughout their acute journey and improved control of theatre resources.
Pathology Laboratory Information System (LIS)	Planning Phase	HEY will need to replace the LIS during the life of this strategy. Discussions are underway with STP partners, led by the Head of Pathology, to establish a LIS procurement collaborative and future operating model. This will drive economies of scale and provide the basis for a single Pathology Record.

15. CAPITAL PROGRAMME 2018 – 2021

The IM&T Capital Programme provides investment in new systems, developments and services. It funds major projects such as the new Network & Telephony system, the replacement of the Cardiology and Pathology clinical systems, Lorenzo e-Prescribing, Lorenzo Theatres, NerveCentre e-Observations and the Patients Know Best system.

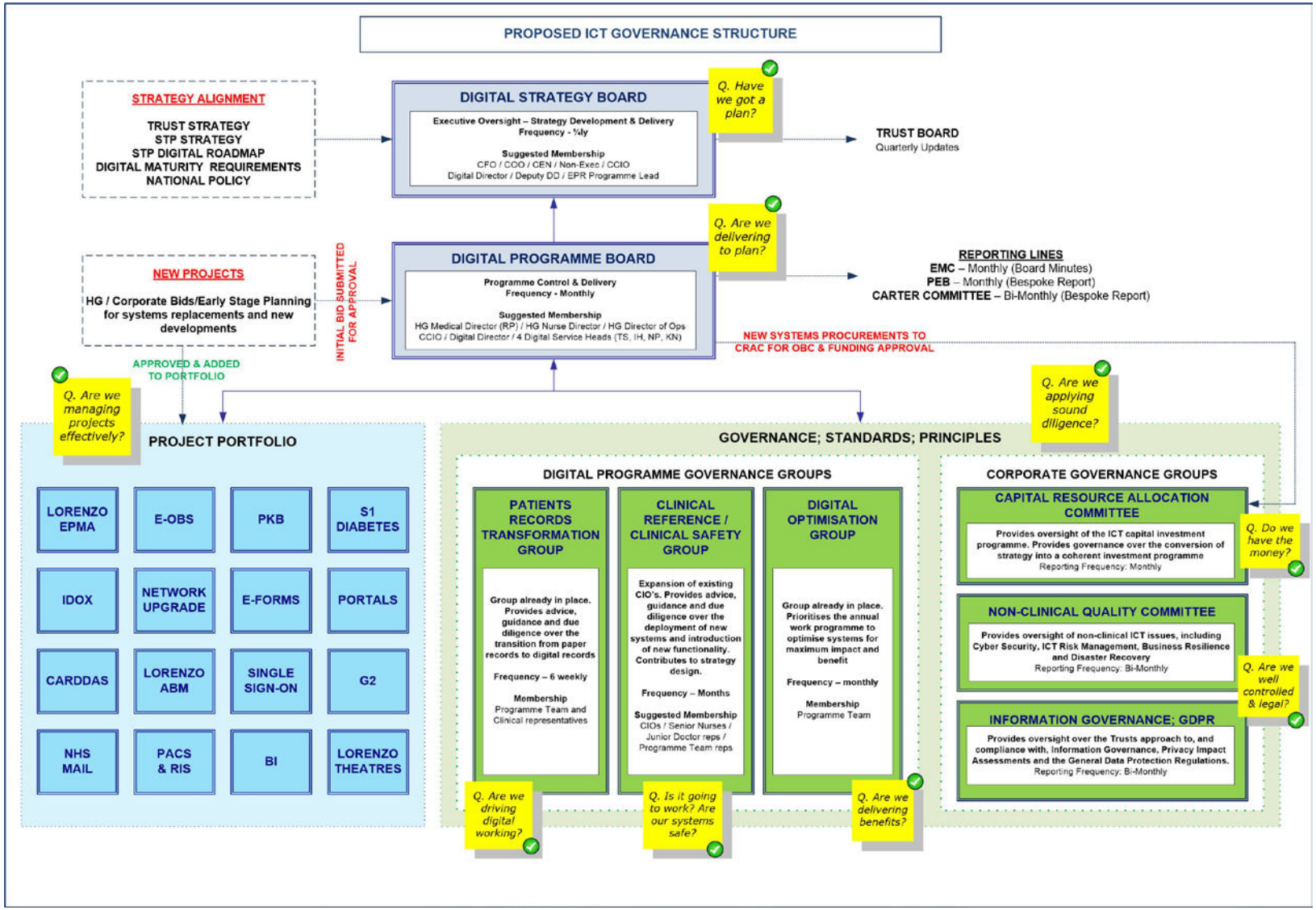
It also funds developments and upgrades to existing systems, such as the Lorenzo-Lite e-viewer, Business Intelligence reporting developments, enhanced Lorenzo integration and the new Pathology NPEX Lab-2-Lab Connectivity system.

The final component of the Capital Programme provides investment for a rolling programme of infrastructure upgrades and replacements which enables a phased decommissioning programme for end-of-life servers and desktops hardware and also to meet year on year capacity increases.

Looking ahead, the outline Capital Investment programme reflects the vision and intentions set out in this Digital Strategy. It will be refined as procurement intentions and costs become clearer. The IM&T Capital Programme is reviewed and approved by the Trust Capital Resource Allocation Committee and is subject to affordability review in the context of overall Trust finances.

16. COMPLIANCE AND GOVERNANCE FRAMEWORK

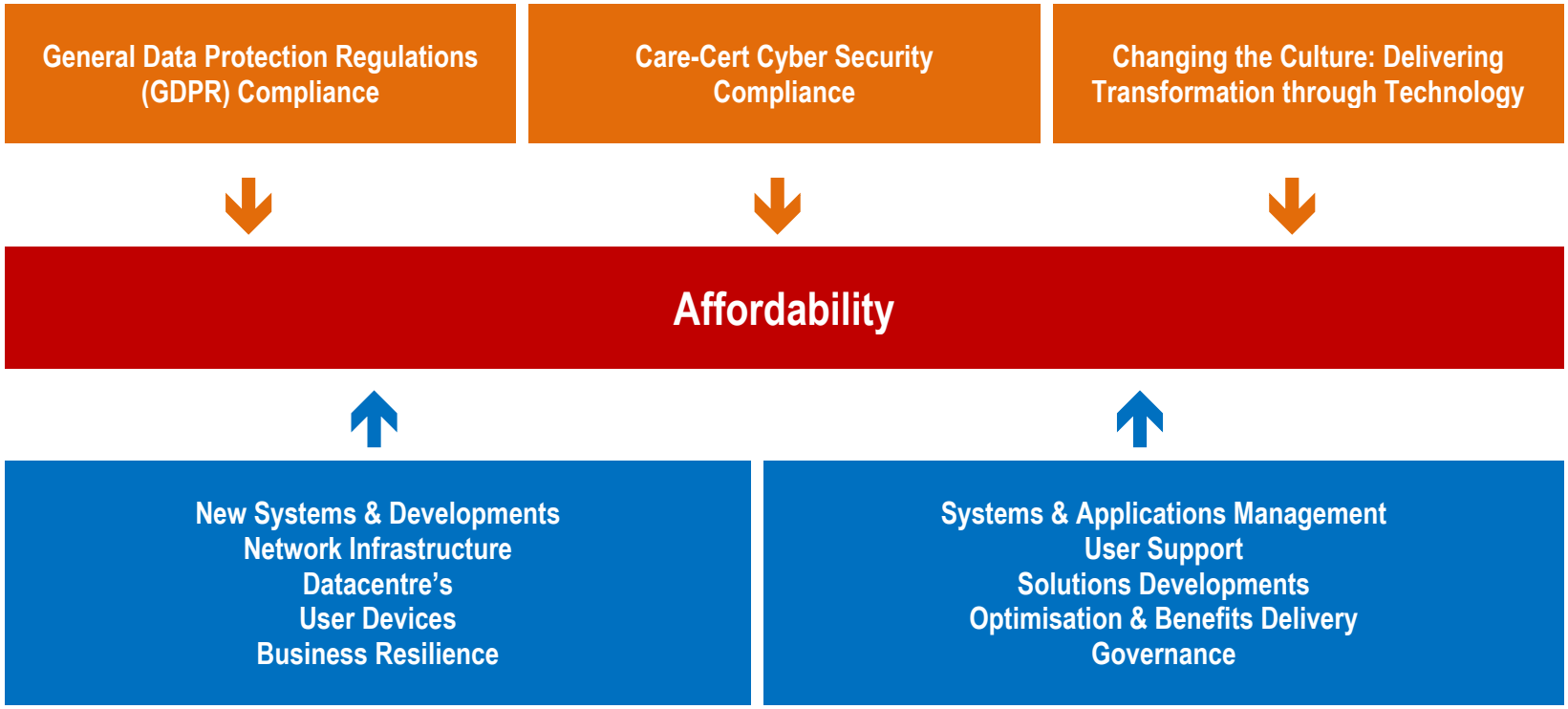
The governance framework depicted below provides effective oversight and development of the Digital Strategy and of the delivery of its core components and projects. This will be reviewed by the Trust's new Digital Director in Q1 of 2018/19.



17. STRATEGIC CHALLENGES AND RISK's

Our Digital Strategy sets out an ambitious programme of investments and developments which will enable the Trust to comply with relevant Policy, to play a leading role in the achievement of the STP Digital Roadmap and which delivers the digital technologies which underpin the Trusts vision and goals. Technology is pervasive and is now critical to running our 'business'. We rely on our systems being secure, safe, always available, with problems resolved quickly 24 hours a day. This criticality is reflected in emerging legislation, with an increased focus on the security of data, the protection of business systems and the resilience of the Trust in the face of increased cyber-risks.

To meet these obligations requires significant investment and resources, set against a background of financial pressure and affordability throughout the NHS. The biggest technology related ***challenges*** facing the Trust are therefore:



ICT risks are managed at System, Project, Programme and Corporate level. There are many specific risks to the achievement of this Digital Strategy but fundamentally, the ability to successfully comply with GDPR and Cyber-Security obligations and to exploit the transformational opportunities from technology is dependent upon investment in systems, infrastructure and human capacity. Affordability is therefore the single biggest ***risk*** to our ability to deliver the Digital Strategy, as summarised in the tableau below.

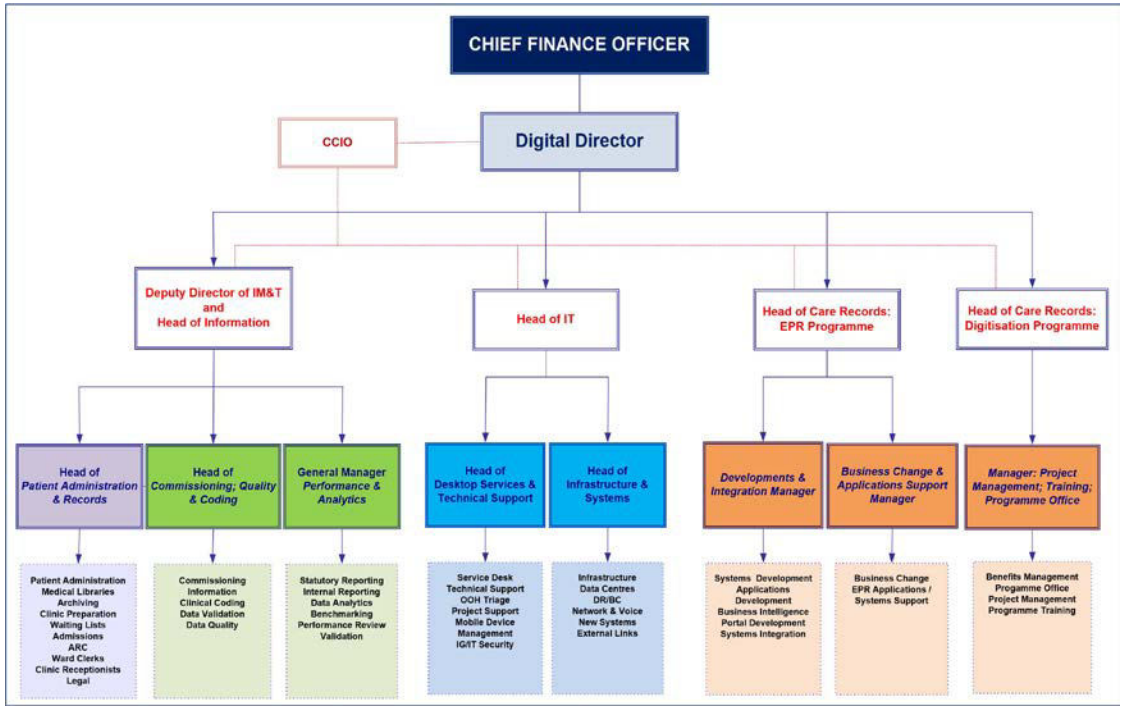
	Affordability Challenge	Mitigating Actions
Financial Risk: Capital Investment	• The ICT Capital Investment Programme is IRO £14m over the next 3 years, and has an affordability gap of IRO £8m. • Fixed term project posts need to be made permanent when the project moves into Business As Usual. Circa £560k of project support costs are currently charged to Capital. • Technology is a catalyst for change, but technology is often an enabler for change and does not generate a pay-back itself. • Cash releasing benefits are not guaranteed: the impact on staff is not always positive; not everyone will embrace new technology; not everyone will change the way they work.	• Prioritise projects with a quicker payback. • Rigorously pursue and implement transformational opportunities. • Mandate the adoption of, and adherence to, new working practices (ie adoption of digital forms). • Re-phase or slow down the procurement and deployment of new products and systems in line with capital funding availability. • Re-invest a proportion of cash-releasing benefits into ICT capacity.
Financial Risk: Revenue Costs	• New systems and technologies are invariably costlier to maintain and support. • New technology does not inevitably make life easier. • National Policy dictates that more data is collected as part of the treatment process, all along the care pathway. This may be more complex and onerous. • Product functionality does not always deliver a user friendly solution. • ICT Support costs will increase in line with the increased technical complexity and the interdependency of multiple systems. There is a need for more stringent testing, assurance and reporting regimes, with extra support demands. • User expectations outstrip technical support capacity. • Not all systems are supported out-of-hours (OOH). • There are insufficient ICT staff to support OOH rotas which incorporate the breadth of skills or speed of response needed. • The total ICT resource shortfall to deliver the expectations in this strategy is currently IRO 35 wte's.	• Accept and plan for the dis-benefit of new technologies • Over time, adapt the Strategy to recognise that some functional desirables will be technically difficult or unaffordable. • Review ICT technical resources deployed throughout the Trust and develop consolidation plans Pursue STP partnering / consolidation opportunities • Review the criticality of all Trust systems. Determine the level of risk acceptance and obtain sign-off by the Trust Board. Establish a priority restore programme based on that.

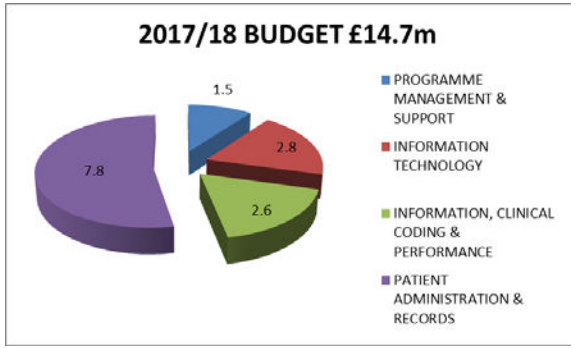
18. IM&T DIRECTORATE PROFILE

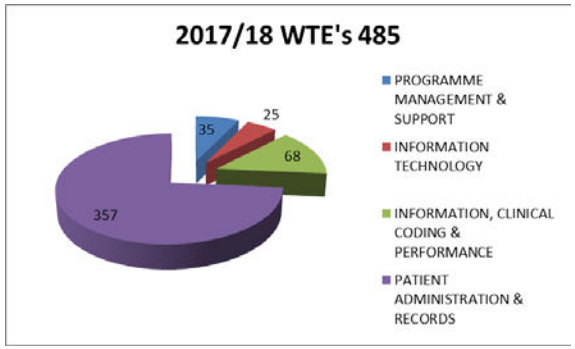
The Trust's IM&T service sits within the Corporate Services Directorate, reporting to the Chief Finance Officer. Following the launch of Lorenzo in June 2015, Patient Administration was subsequently transferred into IM&T from Clinical Support in April 2016 in order to create a coherent framework via which to drive the transition from paper based records to a digital care record based around Lorenzo. IM&T is structured across three service lines:

- ***IT***
- ***Programme Management, Development & Support***
- ***Information, Clinical Coding, Performance and Patient Administration***

The current structure and high-level operational metrics are set out below. The structure will be reviewed following the appointment of the new Digital Director.







The Corporate IM&T service is responsible for the Digital Strategy and for deploying, managing and supporting the Trust's core infrastructure, Data Centres, Lorenzo EPR and most corporate systems. Corporate IIM&T is not currently responsible for the following major clinical systems: Oncology; Pharmacy; Pathology and Radiology. The governance benefits from consolidating departmental systems management under a single corporate umbrella will be reviewed as part of the Digital Strategy.

19. GLOSSARY

API	**Application Programming Interface**: a set of functions, procedures and clearly defined methods of communication between various software components that allows the creation of applications which can access the features or data of another system, application, or other service.
BI / AHDE	**Business Intelligence Acute Health Data Enterprise** is the system which HEY uses to meet internal and external reporting obligations, from statutory and non-statutory submissions through to performance dashboards and analytics.
CareCERT	NHS Digital has been commissioned by the Department of Health to develop a Care Computer Emergency Response Team (**CareCERT**). CareCERT provides advice and guidance to support health and social care organisations to respond effectively and safely to cyber security threats.
CLINICOM / PatientCentre	**CLINICOM / PatientCentre** is the Trust EPR that was implemented in 1999 and replaced by Lorenzo on 15th June, 2015. Key information from CLINICOM / PatientCentre is available to Trust clinicians alongside of Lorenzo, giving them access to around 18 years of patient information electronically.
CLOUD	**Cloud computing** is the practice of using a network of remote servers, hosted on the Internet to store, manage, and process data, rather than a local server or a personal computer.
DATASETS	**NHS National Datasets** define a standard set of information that is generated from care records, from any organisation or system that captures the base data. They are structured lists of individual data items, each with a clear label, definition and set of permissible values, codes and classifications. From this, secondary uses information is derived or compiled, which can then be used to monitor and improve services. Organisations are mandated to implement and to ensure that information systems have the ability to comply with Data Set requirements by specific due dates. Key recent Datasets are the 2017 Emergency Care Dataset (ECDS) and the 2018 Maternity Services Dataset.
DMA	The **Digital Maturity Self-Assessment** is a survey which measures how well providers in England are making use of digital technology to achieve a health and care system that is paper-free at the point of care. It was initially launched in 2016 and will be repeated annually. It helps individual organisations identify key strengths and gaps in provision of digital services at the point of care and provides insight into how well the country is doing as a whole.
e-PMA / IPPMA	**Lorenzo Electronic Prescribing and Medicines Administration system (e-PMA)** was formally known as In-Patient Prescribing and Medicines Administration. The Lorenzo e-PMA application provides a fully integrated 'end-to-end digital approach to patient-centred medication management. It supports compliance with relevant regulations. Prescribers have accurate and current information about patients to inform their decisions, and the solution is underpinned by recognised standard drug databases. Combined with decision support, this helps prescribers and other clinicians reduce avoidable medical errors, and promotes cost-efficient and clinically effective prescribing.
EPR	The NHS defines the **Electronic Patient Record** as "an electronic record of periodic health care of a single individual, provided mainly by one institution" The implementation of an EPR enables a Trust to create a 'whole hospital record' via which staff can access and record key information relating to pathway management (from referral to discharge) and the treatment process across all hospital services and departments. The Trust EPR is Lorenzo Regional Care.
e-RS	The **NHS e-Referral Service (e-RS**) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, book it in the GP surgery at the point of referral, or later at home on the phone or online. The e-RS replaced Choose & Book and from April 2018 and is the mandated mechanism for referrals into acute Trusts from April 2018.
ESR	The **Electronic Staff Record (ESR)** is an integrated 'hire to retire' workforce management solution for NHS Organisations. ESR functionality extends beyond core HR and Payroll. It is the core tool for both managers and employees. Self Service functionality gives every ESR user the ability to manage their own data.
FHIR	**Fast Healthcare Interoperability Resources (FHIR)** is a draft standard describing data formats and elements and an application programming interface (API) for exchanging electronic health records. FHIR builds on previous data format standards from HL7 but is easier to implement because it uses a modern web-based suite of API technology. FHIR is aims to facilitate interoperation between legacy health care systems, to make it easy to provide health care information to health care providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems.
GDE	A **Global Digital Exemplar** is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible. NHS England is supporting selected digitally advanced Mental Health, Acute and Ambulance Trusts to become GDE's.

GDPR	The **General Data Protection Regulation (GDPR)** is a legal framework for the collection and processing of personal information of individuals within the European Union (EU). GDPR sets out the principles for data management, the rights of the individual, and can impose fines that can be revenue based. The General Data Protection Regulation covers all organisations that deal with the data of EU citizens, so it is a critical regulation for corporate compliance. It builds on and complements the requirements of the Data Protection Act and NHS Information Governance Standards.
G2 Speech	**G2 Speech** is the Trust's Digital Dictation and Voice Recognition reporting system. It is linked to Lorenzo and is in use across all specialties. It is the default system used to produce clinical correspondence.
GS1 / SCAN-4-SAFETY	**GS1** sets standards for identifying, capturing and sharing information about products, assets, services, people, locations, etc. GS1 standards deliver improved patient safety, regulatory compliance and operational efficiencies. The Department of Health has mandated that every service and product procured by an NHS Acute Trust in England must be compliant with GS1 standards by 2019/20. HEY has procured a **GS1 Scan-4-Safety** system from Genesis and has appointed a GS1 Programme Manager to oversee the implementation of this new service.
HIMMS	The **Healthcare Information and Management Systems Society (HIMSS)** is an American not-for-profit organisation dedicated to improving health care in quality, safety, cost-effectiveness, and access through the best use of information technology and management systems. HIMMS has developed a set of standards and certification criteria for EPRs / EHRs and have created an 8-stage model (0 - 7) that measures healthcare organisations on their progress towards achieving the ideal paperless patient record environment (Stage 7) with maximum interoperability between systems and incorporating electronic prescribing.
HSCIC	**Health & Social Care Information Centre (HSCIC)** is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service (England). The organisation is an executive non-departmental public body of the Department of Health and was re-branded as NHS Digital on 1 August 2016. See **NHS Digital**.
HSCN	The **Health and Social Care Network (HSCN)** is a new data network for health and care organisations which replaced N3. It provides the underlying network arrangements to help integrate and transform health and social care services by enabling them to access and share information more reliably, flexibly and efficiently. HEY will be purchasing its HSCN service under the **Yorkshire & Humberside Public Services Network (YHPSN)** umbrella. See **YHPSN**.
iFIT	**iFIT (Intelligent File and Inventory Tracking)** is a multi-purpose tracking and logistics management solution developed by Idox Health. iFIT significantly reduces the costs of managing medical records. iFIT is GS1 compliant and supports Scan4Safety.
LDE	The **Lorenzo Digital Exemplar** Programme complements the National **GDE** Programme but is specific to Trusts who have implemented Lorenzo Regional Care under the national contract. The LDE Programme aims to support a selected group of Lorenzo Trusts to become leaders in the use of digital technology and information to deliver exceptional care and operational efficiently. In common with the GDE, LDE Trusts will share their learning and experiences to enable other Lorenzo Trusts to follow in their footsteps as quickly and effectively as possible.
LDR	**Local Digital Roadmaps** set out how local health and care systems will achieve the commitments of the Five Year Forward View and Personalised Health and Care 2020 to use information and technology and make sure patient records are digital and interoperable by 2020.
LORENZO	**Lorenzo Regional Care** is the Trusts Electronic Patient Record (EPR). Lorenzo is linked to key clinical systems so that clinicians can see key information relating to each patient. It is the key system for managing each patient's care in the Trust, from referral to discharge, for recording clinical treatment and for reporting purposes.
N3	**N3** is the national broadband network for the English National Health Service (NHS), connecting all NHS locations and 1.3 million employees across England. N3 was preceded by NHSnet and BT have deliver and managed N3 since 2004. N3 delivers national services such as Choose and Book (now ERS), the NHS Care Records Service, Electronic Prescriptions and the NHS Picture Archiving and Communications System. A new **Health and Social Care Network (HSCN)** will replace N3 the national healthcare network. It will be delivered by multiple suppliers, each adhering to an agreed set of standards. See **HSCN**.
NHS CHOICES	**NHS Choices (www.nhs.uk)** was launched in 2007 and is the official website of the National Health Service in England.
NHS CONNECTING FOR HEALTH	**NHS Connecting for Health (CFH) Agency** was part of the UK Department of Health and was formed on 1 April 2005, having replaced the former NHS Information Authority. It was part of the Department of Health Informatics Directorate, with the role to maintain and develop the NHS national IT infrastructure. It adopted the responsibility of delivering the NHS National Programme for IT (NPfIT)**.** CFH ceased to exist on 31 March 2013, and some projects and responsibilities were taken over by Health and Social Care Information Centre.

NHS DIGITAL	**NHS Digital (formerly HSCIC)** uses information and technology to improve health and care. NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. NHS Digital is an executive non-departmental public body, sponsored by the Department of Health.
NHSMail / NHSMail2	**NHSMail** is a secure email service approved by the Department of Health for sharing patient identifiable and sensitive information. Any organisation commissioned to deliver NHS healthcare or related activities can use NHSMail. NHSMail 2 is the latest version, delivered on behalf of the NHS by Accenture. NHSmail2 supports staff mobility and removes the need for individual NHS organisations to maintain and manage their own Exchange services.
NPfIT	The National Programme for IT (NPfIT) was an initiative launched in 2003 by the Department of Health in England to move the National Health Service (NHS) in England towards a single, centrally-mandated electronic care record for patients and to connect 30,000 general practitioners to 300 hospitals, providing secure and audited access to these records by authorised health professionals.
NCSC	The **National Cyber Security Centre** as set up to help protect the country's critical services from cyber-attacks, manage major incidents, and improve the underlying security of the UK Internet through technological improvement and advice to citizens and organisations. The NCSC has developed guidance on how organisations can protect themselves in cyberspace, including the 10 steps to effective cyber risk management. This is the control framework against which NHS organisations are measured.
NERVECENTRE e-OBS	**NERVECENTRE** is the system clinical staff will use to carry out electronic beside observations of vital signs. It reduces clinical risk and supports operational efficiency by eliminating paper observations charts. It automatically calculates Early Warning Scores, provides early warning of deteriorating patients and alerts clinical staff to the need for intervention.
PKB	**Patient's Know Best (PKB)** is a user friendly system which allows patients to see their medical records, correspondence, test results, appointments on-line, securely. PKB supports on-line interaction between doctors and patients and enables them to take an active role in managing their own health and wellbeing.
SCR	The **NHS Summary Care Record (SCR)** is an electronic patient record, a summary of National Health Service patient data held on a central database covering England, the purpose of which is to make patient data readily available anywhere that the patient seeks treatment, for example if they are staying away from their home town or if they are unable to give information for themselves. Since 2010 the record has been available, holding only the essential medical information relating to medication, allergen and drug reactions. Clinicians in HEY can launch the SCR from within a patients Lorenzo record, enabling easy rapid validation of medication and allergy history. HEY carries out circa 17,000 SCR checks per month.
SNOMED CT	**SNOMED Clinical Terms (CT)** is a structured clinical vocabulary for use in an electronic health record, for clinical documentation and reporting. It is the most comprehensive and precise clinical health terminology product in the world. SNOMED is mandated for adoption in Primary care in 2018 and Secondary care in 2020. Lorenzo will need to be developed in order to accommodate the collection and reporting of SNOMED CT.
SSO	**Single sign-on (SSO)** is an authentication process that allows a user to access multiple applications with one set of login credentials. The SSO application brings together all separate systems passwords for a user under a single and In effect it gives the user a 'one password for all' experience.
VIRTUAL WAITING ROOM	The **Virtual Waiting Room** system support electronic consultations and support to the patient when needed, avoiding unnecessary hospital visits.
YHPSN	The **Yorkshire & Humberside Public Services Network** is a collaborative of public sector organisations who came together to procure a secure computer network for central and local government across Yorkshire and the Humberside. The YHPSN is recognised as being the largest and most holistic regional network project in England. By combining individual networks into a unified regional network it has already saved the Region between £35 and £40 million, and not only do the savings continue to be made but the operational improvements and efficiencies add significantly to the effective delivery of public services across the Yorkshire and Humber Region. YHPSN are leading the procurement of a HSCN for virtually all public sector organisations (Local Authorities, Police, Health, Transport, Fire & Rescue) across the Region. HEY joined the YHPSN in April 2017.

20. POLICY REFERENCES

Equity and Excellence: Liberating the NHS (July 2010): https://www.gov.uk/government/publications/liberating-the-nhs-white-paper

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

The Five Year Forward View (2014): https://www.england.nhs.uk/2014/08/5yfv/

The Forward View into Action – Digital Maturity Assessments (November 2015): https://www.england.nhs.uk/digitaltechnology/info-revolution/maturity-index/

The Forward View into Action – Developing Digital Roadmaps (April 2016): https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/

Carter Review (February 2016): https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

Personalised Health and Care 2020: https://www.gov.uk/government/publications/personalised-health-and-care-2020

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

LORENZO DIGITAL EXEMPLAR BUSINESS CASE

Meeting date	15 May 2018	**Reference Number**	2018 – 5 – 16.1
Director	**Lee Bond** Chief Financial Officer **Dr Mark Simpson** Digital Director	**Author**	**Jackie Railton**, Head of Strategic Planning **Neil Proudlove**, Head of Care Records **Malcolm Thornton,** Business Change, Benefits Realisation and Training Manager **Tracy Harley**, Head of Finance
Reason for the report	The purpose of this paper is to provide the Board with an update on progress with the Lorenzo Digital Exemplar Programme and to seek approval of the business case.		

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

1	**RECOMMENDATIONS** The Trust Board is asked to: i. Consider the contents of this paper and the attached business case ii. Approve the business case for investment and participation in the Lorenzo Digital Exemplar Programme iii. Acknowledge the potential additional financial risk to the Trust if DXC's costs are not fully met by NHS Digital iv. Recognise that should NHS Digital's funding not meet DXC costs the Trust has the ability to withdraw from the Exemplar Programme v. Endorse the submission of the business case to NHS Digital.					
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): Regulations 10, 20 and 24					
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Approval to progress the business case was given at the Performance and Finance Committee on 30 April 2018					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

LORENZO DIGITAL EXEMPLAR BUSINESS CASE

1. PURPOSE OF PAPER

The purpose of this paper is to provide the Board with an update on progress with the Lorenzo Digital Exemplar Programme and to seek approval of the business case.

2. BACKGROUND

The Lorenzo care records system was implemented within the Trust in June 2015 and is an enterprise wide, comprehensive Electronic Patient Record (EPR). It is a clinically centric system, rather than a traditional patient administration system, which is based upon the premise of data being entered once and shared multiple times, wherever and whenever needed, in order to support decision-making and resource planning. Lorenzo contains the functionality to enable more effective clinical and operational management throughout the acute patient journey and has the ability to link to primary care and other systems in order that key information can be electronically shared amongst professionals with a legitimate clinical need to see the data.

In 2017 NHS England announced the launch of the Lorenzo Digital Exemplar (LDE) programme which uses existing funds in the contract between the Department of Health and Social Care and DXC Technology (supplier of the Lorenzo EPR system) to support Trusts in:

- Moving their organisations up the Healthcare Information and Management Systems Society (HIMSS) digital maturity scale;
- Maximising their return on investment in Lorenzo and creating greater clinical value from its use;
- Creating a transformation roadmap for using technology to underpin new ways of working and becoming an organisation that is positioned to successfully promote collaboration, leadership and innovation; and
- Support organisations in striking the right balance between improving quality, managing the costs of care and delivering better outcomes for patients.

In October 2017 the Board approved the submission of an Expression of Interest to NHS England for support to become a Lorenzo Digital Exemplar. In March 2018 the Trust was advised that it had been shortlisted to progress to the Mobilisation stage of the Programme along with Royal Papworth Hospitals Trust, Warrington Acute Hospitals Trust and North Staffordshire Community and Mental Health Trust.

Each Trust has been working with DXC on the development of their Digital Transformation Plans and business cases for investment, including determining the level of DXC and Trust support required and their associated costs.

At this point in time, NHS Digital has indicated that circa £9m in support funding is available. The value of the award will be dictated by how many Trusts are successful and the requirements of their business cases. NHS Digital funding will be provisioned in the form of support services from DXC. Trusts are expected to fund the provision of their own resources.

3. PROGRESS TO DATE

The Trust has identified a series of pathways which would be developed under the Digital Exemplar Programme. These pathways will develop a transformation blueprint based upon optimised and increased Lorenzo functionality and extended integration for roll-out across remaining pathways. The five key care pathways are:

- Unplanned Pathway – Emergency Department/Acute Medicine Unit
- Unplanned Pathway – Elderly Care
- Outpatients Optimisation
- Oncology Pathways
- Planned Breast Pathway (including Theatres).
- Lorenzo Theatres

Development of these pathways as part of the Exemplar Programme would enable the Trust to bring forward elements of its Digital Strategy and thereby accelerate transformational change and the realisation of significant benefits. The timetable proposes a two year intensive programme of optimisation, with a further year of support from DXC, the suppliers of Lorenzo, to review, validate and consolidate the optimisation work.

4. DEVELOPMENT OF THE BUSINESS CASE

In order to progress within the Exemplar Programme, the Trust must have a robust, Board approved business case which will be scrutinised by NHS Digital to ensure that the following funding criteria are met:

- HIMSS Level 7 – Demonstrate ability to achieve HIMSS Level 7 or show a clear line of sight and progress towards achieving HIMSS Level 7 within the programme.
- Operational Improvements – Show how the Trust can optimise the value from Lorenzo investments, specifically improving patient flow across care pathways for the benefit of patients, staff and the wider system.
- Fast Followers – Generate evidence from Lorenzo deployment/s focusing on the implementation and optimisation process to generate learning and act as a reference site for other departments/services internally and for other care providers externally.
- Implementation – Demonstrate how the Trust will develop blueprints to include implementation approach and optimised processes, enabled for a core set of pathways and/or capabilities.
- Benefits – cash releasing, non-cash releasing and societal.

In developing the business case, the Project Team considered a range of options which are outlined in Section 4.1 of the attached Business Case, discounting those that were incompatible with national policy, the Trust's Digital Strategy and the Humber Coast and Vale digital roadmap. It was concluded that only the delivery of a fully optimised programme would realise efficiencies and benefits for clinical staff, patients and the organisation. The two options for delivery of the fully optimised programme are:

- **Trust-resourced Digitisation Programme**
  The Trust would seek to deliver the digitisation programme over a 5-6 year period, making incremental improvements to the functionality and development of the Lorenzo system. The Trust would be required to fund DXC's costs as well as the additional staffing costs associated with a significant change programme which would see the Trust move from paper-based systems and processes to a fully digitised and integrated system.

Compliance with national policy, the STP digital roadmap and HIMSS requirements would be achieved over a longer timeframe, as would the integration of key system developments. This would necessitate longer term investment in developments such as the iFIT casenote tracking system which is required until the medical records system has become fully digitised.

- **Participation in the Lorenzo Digital Exemplar Programme**
  The LDE Programme provides an opportunity for the Trust to gain project management, business change, product, technical and transformational expertise from DXC Technologies, funded by NHS Digital, thereby reducing the overall staffing costs to the Trust. This expertise will be used to supplement the Trust investment required to accelerate a number of key developments from the Trust's Digital Strategy.

  The partnership approach will develop a transformational blueprint upon which the Trust's IM&T service can build for the future, taking the techniques, knowledge, skills and lessons learned forward into the wider Digital Strategy.

  Participation in the LDE Programme would enable the Trust to accelerate the digitisation programme which would be delivered within 2 years, with a further year of DXC support, enabling the qualitative and financial benefits of the digitisation programme to be delivered earlier.

The qualitative assessment of the two options against an agreed set of benefits criteria demonstrated that participation in the LDE programme would deliver the highest level of quality benefits.

Benefit	Weighting	Option 1 Trust resourced digitisation programme		Option 2 LDE Programme	
		Average score	Weighted score	Average Score	Weighted Score
1. Patient benefits	20	4.00	80	7.60	152
2. Service and operational benefits	30	4.20	126	7.20	216
3. Clinical benefits	30	3.60	108	8.00	240
4. Organisational benefits	20	3.80	76	7.40	148
Total	**100**		**390**		**756**
Ranking			**2**		**1**

As part of the financial appraisal of the options, an analysis was undertaken based on the discounted cash flow of each option.

DISCOUNTED CASHFLOW					
		Option 1 Trust resourced digitisation programme		Option 2 LDE Programme	
Year	DCF	Cashflow £000	NPV £000	Cashflow £000	NPV £000
Year 0	1.00	(214)	(214)	(548)	(548)
Year 1	0.97	(1,396)	(1,348)	(1,242)	(1,199)
Year 2	0.93	(1,226)	(1,142)	(402)	(374)
Year 3	0.90	(933)	(838)	(110)	(99)
Year 4	0.87	(396)	(343)	60	52
Year 5	0.84	(73)	(61)	489	409
Year 6	0.81	92	74	695	561
Year 7	0.78	439	342	775	604
Year 8	0.75	695	522	855	643
Year 9	0.73	775	562	936	679
Year 10	0.70	855	599	996	697
TOTAL			(1,846)		1,426

This illustrates that Option 2 (LDE Programme) delivers the best value for money overall within the 10 year time frame as the benefits arise earlier than Option 1, resulting in a £1.4m cash benefit. This is compared to a deficit position of £1.8m in Option 1 and therefore Option 2 was the preferred option.

Having reviewed the level of resource required to deliver the LDE Programme, it is anticipated that the Trust's costs over a 10 year period will total £1.6m capital and £6.4m revenue. The revenue costs will be offset by savings on staffing costs and on non-pay expenditure associated with licence fees and lease costs of other systems which will be impacted by the digitisation programme, resulting in a surplus to the Trust of £2.3m by 2028.

The total value of cash releasing and non-cash releasing benefits over the 10 year term of the business case is £24m (Appendix 2).

DXC consultancy costs are estimated at £3.24m. At this stage it is not known whether NHS Digital will fund all of DXC's costs. There is a risk to the Trust that, if all 4 Exemplar organisations receive an equal allocation of funding, then each Trust would only receive c. £2.2m, leaving HEY with a £1.m shortfall to address.

5. RECOMMENDATION

The Trust Board is asked to:

i. Consider the contents of this paper and the attached business case
ii. Approve the business case for investment and participation in the Lorenzo Digital Exemplar Programme
iii. Acknowledge the potential additional financial risk to the Trust if DXC's costs are not fully met by NHS Digital
iv. Recognise that should NHS Digital's funding not meet DXC costs the Trust has the ability to withdraw from the Exemplar process
v. Endorse the submission of the business case to NHS Digital.

Lee Bond
Chief Financial Officer
15 May 2018

Dr Mark Simpson
Digital Director

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

LORENZO DIGITAL EXEMPLAR BUSINESS CASE

1. PURPOSE OF PAPER

The purpose of this paper is to set out the case for investment to enable the Trust to become a Lorenzo Digital Exemplar. The investment will enable the Trust to accelerate the pace of transformational change set out in its Digital Strategy 2018-2023 and, through the adoption of technology, deliver improved patient outcomes and increased operational effectiveness.

2. INTRODUCTION

The Lorenzo care records system was first introduced to the UK under the National Programme for IT in the 2000s. It is an enterprise wide, comprehensive Electronic Patient Record (EPR). It is a clinically centric system, rather than a traditional patient administration system, which is based upon the premise of data being entered once and shared multiple times, wherever and whenever needed, in order to support decision-making and resource planning. Lorenzo contains the functionality to enable more effective clinical and operational management throughout the acute patient journey and has the ability to link to primary care and other systems in order that key information can be electronically shared amongst professionals with a legitimate clinical need to see the data.

The Trust implemented Lorenzo in June 2015.

In 2017 NHS England announced the launch of the Lorenzo Digital Exemplar (LDE) programme which uses existing funds in the contract between NHS Digital and DXC Technology (supplier of the Lorenzo EPR system) to support Trusts in:

- Moving their organisations up the Healthcare Information and Management Systems Society (HIMSS) digital maturity scale;
- Maximising their return on investment in Lorenzo and creating greater clinical value from its use;
- Creating a transformation roadmap for using technology to underpin new ways of working and becoming an organisation that is positioned to successfully promote collaboration, leadership and innovation; and
- Support organisations in striking the right balance between improving quality, managing the costs of care and delivering better outcomes for patients.

As an early adopter of Lorenzo and a leader in its development, the Trust submitted an Expression of Interest in October 2017. The bid was successful and the Trust was selected alongside Royal Papworth Hospitals Trust, Warrington Acute Hospitals Trust and North Staffordshire Community and Mental Health Trust, to proceed to the Mobilisation stage of the Lorenzo Digital Exemplar programme.

Each Trust has been working with DXC on the development of their Digital Transformation Plans and business cases for investment, including determining the level of DXC and Trust support required and their associated costs.

The following sections of this document set out the strategic context in which this business case has been developed and the Trust's response to the national and local context. It compares the options to deliver the Trust's Digital Strategy and describes how the realisation of the Trust's Digital Strategy would be accelerated through the LDE programme, enabling optimisation of the Lorenzo Care Suite and the transformation of five key care pathways:

- Unplanned Pathway – Emergency Department/Acute Medicine Unit
- Unplanned Pathway – Elderly Care
- Outpatients Optimisation
- Oncology Pathways
- Planned Breast Pathway (including Theatres).
- Lorenzo Theatres

3. STRATEGIC CONTEXT

3.1 NATIONAL CONTEXT

3.1.1 NHS Five Year Forward View (NHS, 2014)

The NHS Five Year Forward View identified three key challenges for health and care:

- *The Health and Wellbeing Gap* – If the nation fails to get serious about prevention, then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness.

- *The Care and Quality Gap* – Unless we reshape care delivery, harness technology and drive down variations in quality and safety of care, patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

- *The Funding and Efficiency Gap* – If we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of poorer services, fewer staff, deficits, and restrictions on new treatments.

The gaps are exacerbated by the lack of integration across care services, hospital, community and home, clinical and social care, formal and informal settings.

The Five Year Forward View gave a commitment to exploit the information revolution and set out an ambition for "fully interoperable electronic health records, so that patients' records are largely paperless. Patients will have full access to these records and be able to write into them."

3.1.2 Personalised Health and Care 2020: A Framework for Action (National Information Board, 2015)

Personalised Health and Care 2020 builds on the commitments in the Five Year Forward View to use data and technology more effectively to transform outcomes for patients and citizens.

It describes how, as financial pressures grow, and the gap between expectations, demand and resources increases, the need for the care system to make use of the best available technologies has become increasingly urgent. To ensure sustainability, health and care needs to move from a model of late disease management to early health. Information technology plays an essential and rapidly expanding role in empowering people to take charge of their own health, by providing information, support and control.

The Framework describes how better use of technology and data is a prerequisite for supporting and enabling the key developments needed to reshape the health and care system. These are:

- The personalisation of care, including individual well-being, self-care, personal commissioning and, in the longer term, the impact of genomics;

- The development of new models of care and integration of services, particularly across the divides between family doctors and hospitals, physical and mental health, and clinical and social care, with the objective of providing better, safer services more efficiently;
- More effective management of service access, through the provision of alternative sources of information, supporting self-care and better signposting to direct individuals who need professional care to the appropriate service;
- The reshaping of the workforce, by improving information flows and access to systems, so that skills and capabilities are enhanced, leading to a step-change in staff productivity.

The Framework sets out an ambition that by 2020 all care records will be digital, real-time and interoperable.

3.1.3 Next Steps on the NHS Five Year Forward View (NHS, 2017)

This document set out the NHS' main national service improvement priorities and key deliverables for 2017/18 and 2018/19. In addition to specifics around urgent and emergency care, primary care, cancer and mental health, the document set out expectations in terms of harnessing technology and innovation to enable patients to take a more active role in their own health and care, while also enabling NHS staff and their care colleagues to have instant access to patient records from wherever they are, or to access remote advice from specialists. The document also outlines plans for the digitisation of hospitals.

3.1.4 Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variation (Lord Carter of Coles, 2016)

The NHS is expected to deliver efficiencies of 2-3% per year, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021. Lord Carter's review looked at productivity and efficiency in English non-specialist acute hospitals using a series of metrics and benchmarks to enable comparison. The review concluded that there was significant unwarranted variation across all of the main resource areas and estimated that this unwarranted variation was worth £5billion in terms of efficiency opportunity. The report makes 15 recommendations designed to tackle this variation and help Trusts improve their performance to match the best.

The report emphasises the need for hospitals to improve the use of modern digital technology to improve the access and accuracy of the data needed to manage performance and aid decision-making, and encourages Trusts to optimise their IT systems to allow the capture of patient data across a variety of care settings – acute, community and care homes.

3.2 LOCAL CONTEXT

3.2.1 Humber Coast and Vale Sustainability and Transformation Plan

The Humber Coast and Vale area faces a number of challenges including significant variations in health outcomes in the diverse rural, urban and coastal communities, an unprecedented demand for services, a long-term shortage of skilled staff and a potential funding gap of more than £420million by 2020/21.

The Sustainability and Transformation Plan for the Humber Coast and Vale area sets out a vision for a system that will:

- Support everyone to manage their own care better
- Reduce dependence on hospitals; and
- Use resources more efficiently.

Four priority areas of improvement are at the heart of the Sustainability and Transformation Plan:

- **Place-based care** - including increased investment in primary care provision and the development of local teams to co-ordinate and deliver as much care as possible in the community. Urgent and emergency care services will be transformed to ensure that people are able to access the level of service that is appropriate to their need.
- **Creating the best hospital care** – with improvements to the quality of hospital services, the development of specialised services, shared support services and a consistent level of maternity care.
- **Supporting people with mental health problems** – with an emphasis on treatment in the community and the avoidance of unnecessary hospitals stays.
- **Strategic commissioning** – implementing a model that has a real focus on prevention, wellbeing, self-care and delivering outcomes that matter for patients.

Technology is seen as a key enabler to the transformation of health and care services within the Humber Coast and Vale system. The local digital roadmap has four key areas of focus:

- **Integrated shared record** – to provide a single electronic environment to access and share information about the treatment and care of service users, enabling information empowered interactive care and rapid decision-making.
- **Connectivity** – to ensure fast, reliable and real time access: any time, any place, anywhere.
- **Citizen empowerment** – provide an interactive and secure environment within which service users can access their own personal records, interact with their care professionals and can take an active and empowered role in their own health and well-being.
- **Efficient and safe** – professionals and patients are confident that systems effectively support decisions about care and data is secure, relevant and accurate.

The Trust is working with our partners through the local Digital Roadmap Programme Board to deliver the digital transformation required. Key digital roadmap priorities include:

- E-referrals into providers, supported by Referral Advice
- Electronic discharge summaries into GP systems
- Electronic admission, discharge and withdrawal notices from secondary care to Social Services
- GPs ordering diagnostic tests and receiving results electronically
- Child protection information shared across care settings
- Digital patient information recorded real-time in secondary care
- Alerting of deteriorating patients in acute settings
- E-prescribing in secondary care.

3.3 TRUST RESPONSE TO STRATEGIC CONTEXT

3.3.1 Trust Strategy 2016-2021

The Trust's Strategy was developed in response to the national and local challenges highlighted in the NHS Five Year Forward View and the Humber Coast and Vale Sustainability and Transformation Plan. It acknowledges that the organisation has struggled to achieve and sustain performance against the national standards for waiting times, has an increasing outpatient follow up backlog, is struggling to recruit and retain staff in a number of key areas and has a worsening financial position with a recurrent under-achievement on cash releasing efficiency savings.

In order to deliver the Trust's vision of Great Staff, Great Care, Great Future, the Trust has adopted seven long term goals:

- An 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.

The Strategy sets out how the Trust will achieve these goals through the adoption of best practice, undertaking and realising the benefits from a programme of transformational change and focussing on increased efficiency and productivity across the organisation, at the same time as controlling costs.

3.3.2 HEY Digital Strategy 2018-2023

The Trust's Digital Strategy builds on its previous Information Management and Technology Strategy which included the implementation of Lorenzo and measures to move the organisation towards paperless working, increased digitisation and the use of electronic correspondence and communication across the local health and social care system. The Digital Strategy is consistent with the publications mentioned previously in sections 3.1 and 3.2.

The new Digital Strategy has been informed by key policy themes, both nationally and locally, as well as information and technology regulatory requirements. It creates a framework for the organisation's digital work programme and contextualises how that will support the Trust in achieving its objectives.

The Strategy signposts the direction of travel for technology over the next five years and sets out the ambition to build upon our investment in technology, to develop the workforce with the skills they need to successfully embrace the challenges of the future, and to exploit the transformational opportunities that investment offers.

The key strategic objectives within the HEY Digital Strategy are:

- Achievement of HIMMS Level 7 for electronic records and full compliance with the Acute Digital Maturity Assessment.
- Elimination of paper-based records, underpinned by the Lorenzo electronic care record, incorporating e-prescribing and medicines administration, e-Observations and escalations.
- Digital-by-default pathway management of all patients, from e-Referrals to e-Discharge, delivering on national policy objectives and eliminating paper process delays and risks.
- Patients and carers able to interact digitally with Trust clinicians.
- Delivering sustainable transformation through technology.
- Fully upgraded data network and unified communications service, supporting agile working, clinical mobility, NHS mail and One-Password Single-Sign-On for all staff.
- Drive value from ICT investment through adoption of new technologies, such as cloud services, and opportunities for consolidation and partnering of ICT services.
- Compliance with national Digital policy, including Accessible Information Standard, Cyber Security, Information Governance and General Data Protection Regulations.

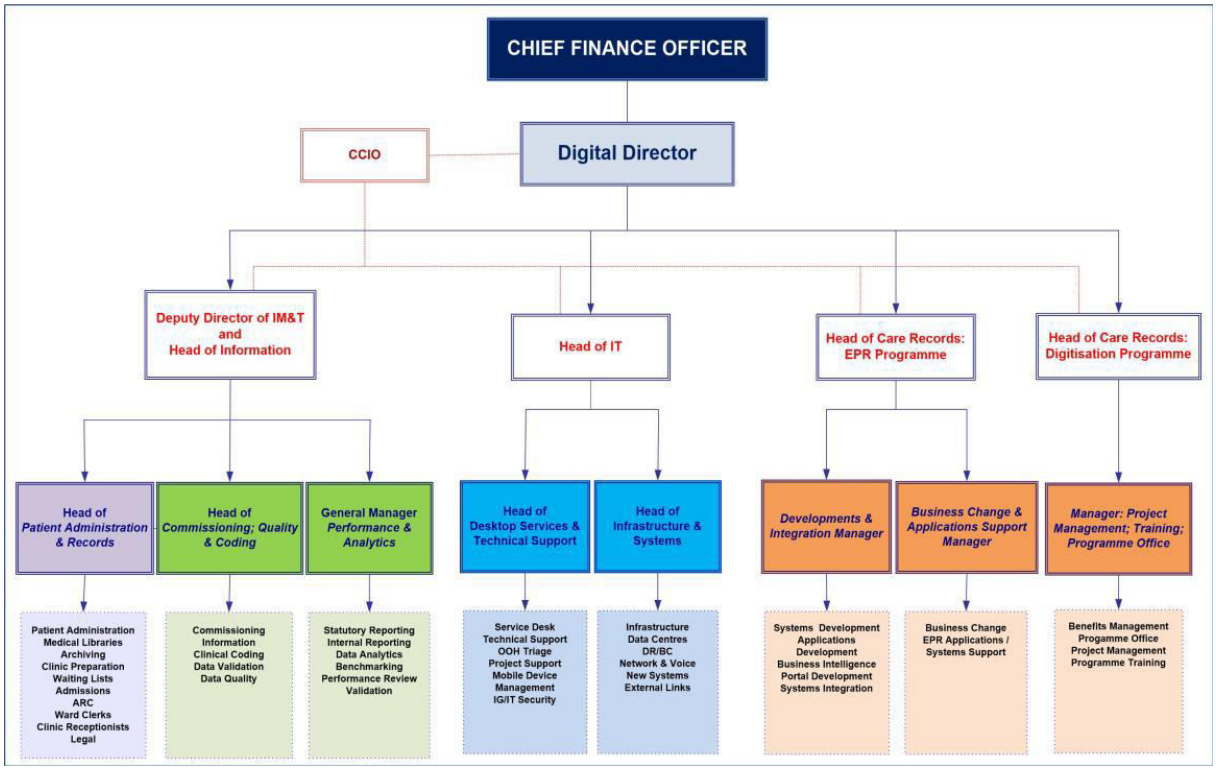
3.4 CURRENT SERVICE PROVISION

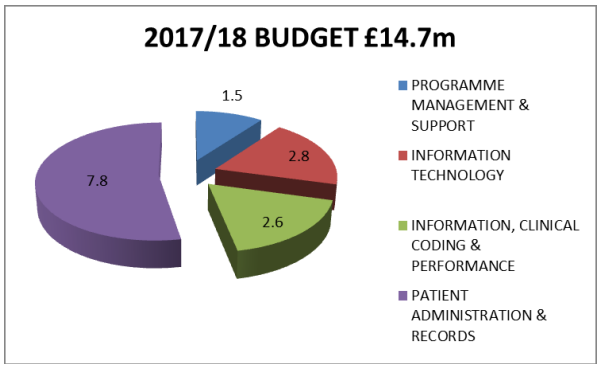
3.4.1 IM&T SERVICE

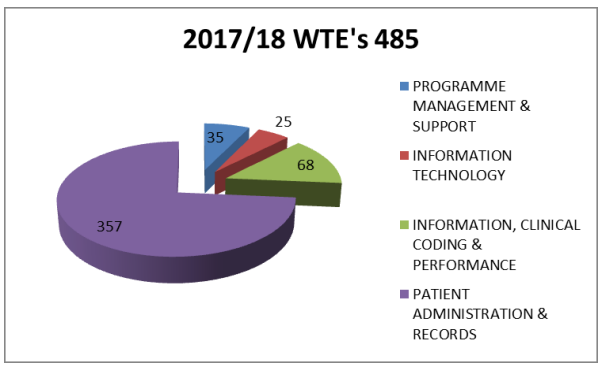
The IM&T Service is structured across three service lines:

- Information Technology (IT)
- Programme Management, Development and support
- Information, Clinical Coding, Performance and Patient Administration.

The current structure and high level operational metrics are detailed below. The IM&T Service has an annual budget of £14.7m (2017/18) and a workforce of 485 wte. It is responsible for the implementation and delivery of the Trust's Digital Strategy and for deploying, managing and supporting the Trust's core infrastructure, Data Centres, Lorenzo EPR and most corporate systems. It is not currently responsible for the major clinical systems within Oncology, Pharmacy, Pathology and Radiology.







3.4.2 IMPLEMENTATION OF LORENZO

As indicated above, Lorenzo was implemented within the Trust in June 2015 and sits at the heart of the organisation. It is fully embedded into the clinical workflow and feeds the Trust's bespoke Business Intelligence service through which clinical and operational reports are produced and shared with care partners to support more efficient and coherent clinical management of patients and service users. Lorenzo is the key system for managing the patient's care journey in the Trust, for managing activity, for planning, enacting and recording clinical treatment and for national and corporate reporting.

To date the Lorenzo Programme has delivered a number of the core building blocks required to support the Trust and National requirements for digitised records. These are detailed below.

Lorenzo Functions	Capability
Care Management (Patient Administration System)	Core Patient Administration capability providing the ability to book, track and monitor patient progress from referral to discharge.
Emergency Care	Management of patients within emergency care including electronic floor plans, patient tracking, self-check-in integration and electronic transmission of care summaries to GPs
Requests and Results	Enhanced Pathology and Radiology request and result capability and extension of electronic requesting
ePMA and TTO (Electronic Prescribing and Administration)	Introduction and roll out of electronic prescribing and medicines administration continues.
Maternity Care	Maternity care functionality which is fully integrated into the patient's central electronic record.
Clinical Data Capture Forms and Digitised Structured Data	Ability to develop bespoke structured clinical data capture forms allowing real-time clinical data recording and analytics capability.
Clinical Notes and Documents	Ability to generate notes and documents, with enhanced merge and cite capabilities and the transmission of correspondence to GPs electronically
Advanced Bed Management and Lorenzo on the wall.	Initial capability and foundations to bring the patient's progress and status information into the core electronic record

Lorenzo Enhanced Functions	Capability
Enhanced Integration	Provision of in house integration capability, introduction of a new Integration Engine and replacement of old proprietary interfaces with new HL7 International Standard compliant interfaces. Extended integration to wider Trust Systems e.g. e-Observations.
Enhanced Business Intelligence	Incorporating disparate systems within the care record has provided the opportunity for enhanced BI reporting across the patient journey.
GP Portal	Provision of a practice based, web-based portal view of core Lorenzo patient information to improve care continuity between HEY and GP Practices.

In addition to the capabilities directly linked to the core Lorenzo Programme, the development of HEY's wider digital record has continued. A number of new systems are being implemented and procured to further enhance HEY's capabilities; these systems will integrate and share core Lorenzo patient information through the use of the integration engine.

Other System	Capability
eObservations Nerve Centre	Ability to record patient observations, assessments and escalations via hand held digital devices with the capability to view, monitor and respond remotely. Continued roll-out during 2018/19.
G2 Digital Dictation and Voice Recognition	Provision of digital dictation and speech recognition capabilities to directly dictate in predefined templates or any clinical or non-clinical system.
Patient Know Best (PKB)	PKB is the system of choice for the Trust to meet its Accessible Information and Records Sharing obligations for patients. In addition to being a secure vehicle for records sharing, it supports self-managed care and enables service users to interact with care givers without the need for hospital visits. A Business Case is being prepared. Subject to approval, deployment is planned for Q2 2018
Clinical Image Capture and Reporting	Following the award in 2017of a 10 year contract with AGFA as part of an eight Trust Yorkshire collaborative, HEY will deploy a next generation hardware platform and Enterprise Imaging (EI) solution to replace its current PACS. The full work programme will be completed in 2018/19. A workflow and image sharing solution will be implemented across the STP to improve reporting turnaround, operational efficiency, clinical effectiveness and patent safety.
Cardiology Management System	The current CMS (GE CARDDAS) goes end-of-life in December 2018. A procurement exercise is underway following approval of the OBC and the project will be completed by the end of Q3 – 2018.
Scan4Safety	Following approval of the OBC in 2017 HEY has procured the Genesis Scan4Safety solution to improve care and safety by tracking and tracing consumables, implants, etc used in treatment of patients. This is a new national initiative and does not replace an existing system.
Lorenzo Theatres	HEY intends to decommission the current ORMIS system and deploy the fully integrated Lorenzo Theatres solution. This supports more coherent management of the patient throughout their acute journey and improved control of theatre resources.
Pathology Laboratory Information System (LIS)	HEY will need to replace the LIS during the life of this strategy. Discussions are underway with STP partners, led by the Head of Pathology, to establish a LIS procurement collaborative and future operating model. This will drive economies of scale and provide the basis for a single Pathology Record.
Diabetes SystmOne	HEY will decommission the current Diabetic Department system and adopt the SystmOne. This enables more cohesive management of the treatment programme and supports STP wide plans for Diabetic care.
IFiT Case note Tracking (Intelligent File and Inventory Tracking)	A GS1 compliant software solution designed to support the management of healthcare records, and improve information governance and auditability. Creation, tracking, requesting, filing and destruction will be undertaken in iFIT. The introduction of RFID technology provides automated tracking of case notes in real time.

Other System	Capability
Internal Portal (Lorenzo Viewer)	Provision of a web based Portal view of key Lorenzo information allowing a locally defined view of key patient summary information and provision of access to records for business continuity.
Cisco Virtual Waiting Room (eConsultations)	Capability to run virtual consultations, providing opportunity for care closer to home and reduced need for face-to-face hospital attendances.

As demonstrated above, the Trust has made significant progress in the adoption and implementation of core Lorenzo functionality and has an ambitious programme for developing Lorenzo further, including integration with a range of other systems. However, at this stage, Lorenzo remains predominantly a processing tool. Whilst the Trust has some digital capability as outlined above, a significant number of processes are still being driven and supported by paper-based documents. In order to become a fully digital organisation, the Trust needs to change the way data is captured by increasing the level of digitisation and changing working practices.

3.5 CASE FOR CHANGE

3.5.1 TRUST DIGITAL MATURITY REVIEW

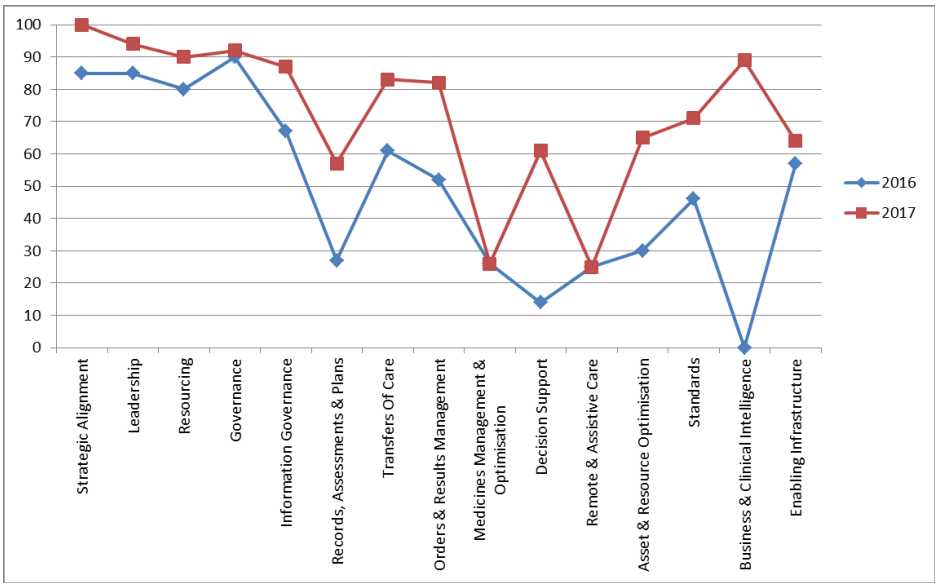
In December 2015 NHS England launched the Digital Maturity Assessment (DMA) which was designed to measure each Trust's readiness to meet the challenges set out in the *Five Year Forward View* and *Personalised Health and Care 2020*. The DMA looked at the readiness of Trusts to deliver national policy themes, ie:

- Using Data and Technology to Transform Outcomes
- Integrated Care, Closer to Home
- Innovation and Efficiency through Better Use of Technology
- Interoperability: Joined Up Systems, Shared Information
- Paper Free at Point of Care:
    - Readiness: Are providers set up effectively to deliver?
    - Capabilities: Do providers have the digital capability?
    - Infrastructure: Are the underpinning technological enablers in place?

The results of the national assessment were published in early 2016. An updated follow up DMA, with additional questions, was published in September 2017. It was designed to:

- Track progress made since the first round of self-assessments and the reasons behind it
- Support planning, prioritisation and investment decisions within provider organisations and STP footprints
- Provide a means of baselining/benchmarking levels of digitisation nationally.

The revised Trust position, submitted in October 2017, is shown below.



In overall terms, the self-assessment showed that:

- The implementation of Lorenzo had had a significant positive impact on the Trust's scores
- There had been a 77% improvement in the Trust's digital capabilities index
- The biggest capability gains related to Records, Assessments and Plans: Orders and Results Management; Decision support; Asset and Resource Optimisation and Standards.
- Areas remaining static and requiring further progress were:
    - Medicines Management – requiring a full Trust roll out of electronic prescribing
    - Remove and Assistive Care – requiring e-consultations, remote monitoring, condition self-management tools
    - Infrastructure – requiring Trust-wide network replacement, full roll out of patient Wifi and increased emphasis on Disaster Recovery/Business Continuity.

3.5.2 HIMSS SELF-ASSESSMENT

It is the Trust's ambition to achieve HIMSS Level 7 compliance. The current self-assessment against the HIMSS framework is attached. Whilst our ePMA and e-Observations programmes are in progress and cover several of the 'in progress' items at Levels 2 and 3, there are significant gaps at Level 6 in relation to enhanced error removal within prescribing and Closed Loop Medication Administration. At Level 7 the Trust is non-compliant with Electronic Medical Records, including medical device recall management, as well as Data Sharing requirements.

3.5.3 DELIVERY OF THE TRUST'S DIGITAL STRATEGY

As outlined in Section 3.3.2 above, the Trust has set a clear ambition to build on its investment in technology and to exploit the transformational opportunities that the new technology offers. The Strategy describes how the functional development and enhancement of Lorenzo will be taken forward, including:

- Completing the Trust-wide deployment of Lorenzo Electronic Prescribing and Medicines Administration (ePMA)
- Decommissioning CAYDER and adopting Lorenzo Advanced Bed Management (ABM) throughout the Trust

- Developing a Lorenzo-Lite portal for staff to easily and quickly access key clinical information
- Implementing Lorenzo Task Management to improve oversight and accountability along the patient journey
- Committing to Lorenzo Theatres, brining theatres to the heart of the Electronic Patient Record (EPR), supporting integrated resource allocation, contributing to GS1 compliance and enabling the current theatre management system (ORMIS) to be decommissioned
- Completing the roll out of NerveCentre e-OBS throughout the Trust, positioning e-OBS alongside Lorenzo through enhanced integration
- Continuing to build a richer Lorenzo care record through integration of key third party clinical systems, including the adoption of Fast Healthcare Interoperability Resources (FHIR) Standards
- Supporting the wider data sharing across the STP community through promotion of the use of the enhanced Summary Care Record; and
- Driving paperless working throughout the organisation.

Delivery of the Trust's Digital Strategy is reliant upon the Trust having sufficient capital and revenue resources available to meet the level of investment required.

3.5.4 Trust Financial Performance

The Trust continues to be challenged in relation to its financial position with an overall underlying deficit position is £25.6million before any inflationary adjustments relating to 2018/19. In 2018/19 the trust is targeting a savings programme totalling almost £20m. This is a significant challenge for the organisation and would, if delivered in full, be the highest savings figure delivered in a single year by the organisation.

The size of the underlying financial deficit requires a longer term programme of financial recovery which includes significant recurrent savings from clinical services and non-clinical support services. This business case will contribute to this program with the 5 pathways identified. The ability of the Trust to replicate the "blueprints" generated by this case in other areas of the Trust will be a key component of the longer term financial recovery being developed by the Trust.

The Trust has developed a Capital Programme to cover the 3 year period 2018/19 to 2020/21. It is based on assessments received and reviewed at the Trust's Capital Resource Allocation Committee (CRAC) and is based on a 'do minimum' scenario. This includes replacement of the existing IT network and essential system replacements to meet nationally mandated timescales for system architecture and capability. The Capital plan contains a significant level of risk and does not provide for any developments or expansion in capacity in order to accelerate the delivery of the Digital Strategy.

As a result of constraints in capital funding the ability of the Trust to finance the capital elements of the LDE are extremely limited and are dependent on the contribution from NHS Digital towards DXC costs being made to the value of £3.24m. The expectation throughout this case is that the external costs to DXC will be fully funded by NHS Digital.

3.5.5 IM&T Services Capacity

Throughout past deployments the Trust's IM&T expertise and capacity has fluctuated in-line with implementation demands and the expertise required. The core IM&T team utilises a combination of short term and/or secondment opportunities, where possible, in order to meet peaks in resource requirements, only seeking recurring funded support for systems when they become operational.

However, to be able to deliver the digitisation programme outlined in the Digital Strategy at the scale and pace required, the Trust would require significant investment in staffing resource as there is insufficient capacity within the existing IM&T team.

4. OPTIONS APPRAISAL

A project team was established to consider the options available to the Trust to deliver the digitisation programme. The Project Team comprised:

- Digital Director
- Deputy Director of IM&T and Head of Information
- Head of Care Records EPR Programme
- Head of Care Records Digitisation Programme
- Head of Strategic Planning
- Head of Finance (Corporate Directorates)
- Business Change, Benefits Realisation and Training Manager.

4.1 Description of the Options

As identified in Section 2, Lorenzo contains the functionality to enable more effective clinical and operational management throughout the acute patient journey and has the ability to link to primary care and other systems in order that key information can be electronically shared amongst professionals with a legitimate clinical need to see the data.

In assessing the options, the Project Team considered the scale of the challenge and the level of resources required to deliver the optimisation of the Lorenzo Care Suite and the transformation of care pathways, in particular:

- Unplanned Pathway – Emergency Department/Acute Medicine Unit
- Unplanned Pathway – Elderly care
- Outpatients Optimisation
- Oncology Pathways
- Planned Breast Pathway (including Theatres).
- Lorenzo Theatres

The Project Team considered a range of options, including:

- Full digitisation programme funded from Trust resources
- Full digitisation programme funded from Trust resources, with NHS Digital funding to support DXC's costs
- Pared down programme funded from Trust resources which would see the digitisation of a reduced number of care pathways
- Pared down programme funded from Trust resources, with NHS Digital funding to support DXC's costs
- Do nothing/maintain the status quo.

The do nothing/maintain the status quo option was discounted at the long list stage as no further progression of the digitisation programme would be contrary to national policy and the Trust's own Digital Strategy.

Similarly, the two options for a pared down programme would still require significant staffing resources to support the digitisation of some care pathways, but would mean a continuing reliance on paper-based processes. The Trust would not be able to achieve HIMSS compliance, would be unable to meet the requirements of the Humber Coast and Vale digital roadmap, and would not realise the level of efficiencies and benefits that could be realised with a fully integrated and digitised system. For these reasons, the Project Team discounted

the options to deliver a pared down programme and looked instead at the options for delivering a fully optimised programme.

Option 1: Trust-resourced Digitisation Programme
Under this option, the Trust would seek to deliver the digitisation programme over a 5-6 year period, making incremental improvements to the functionality and development of the Lorenzo system. The Trust would be required to fund DXC's costs as well as the additional staffing costs associated with a significant change programme which would see the Trust move from paper-based systems and processes to a fully digitised and integrated system.

Compliance with national policy, the STP digital roadmap and HIMSS requirements would be achieved over a longer timeframe, as would the integration of key system developments. This would necessitate longer term investment in developments such as the iFIT casenote tracking system which is required until the medical records system has become fully digitised.

Option 2: Participation in the Lorenzo Digital Exemplar Programme
The Lorenzo Digital Exemplar (LDE) Programme provides an opportunity for the Trust to gain project management, business change, product, technical and transformational expertise from DXC Technologies, funded by NHS Digital, thereby reducing the overall staffing costs to the Trust. This expertise will be used to supplement the Trust investment required to accelerate a number of key developments from the Trust's Digital Strategy.

The partnership approach will develop a transformational blueprint upon which the Trust's IM&T service can build for the future, taking the techniques, knowledge, skills and lessons learned forward into the wider Digital Strategy.

Participation in the LDE Programme would enable the Trust to accelerate the digitisation programme which would be delivered within 2 years, with a further year of DXC support, enabling the qualitative and financial benefits of the digitisation programme to be delivered earlier than under Option 1. With the funded DXC support option 2 costs less and will be implemented earlier generating savings and patient benefits earlier than option 1.

4.2 Benefits Criteria
A qualitative assessment of the two options was undertaken against an agreed set of benefits criteria. These were:

- Delivers patient benefits/outcomes
- Delivers service and operational benefits/outcomes
- Delivers clinical benefits/outcomes
- Delivers organisational benefits/outcomes.

The qualitative assessment of the options was undertaken on an individual basis by each member of the evaluation group, a sub-group of the Project Team. In order to remove any bias by individual members of the group, the average scores were used for the assessment (see below).

Benefit	Weighting	Option 1 Trust resourced digitisation programme		Option 2 LDE Programme	
		Average score	Weighted score	Average Score	Weighted Score
1. Patient benefits	20	4.00	80	7.60	152
2. Service and operational benefits	30	4.20	126	7.20	216
3. Clinical benefits	30	3.60	108	8.00	240
4. Organisational benefits	20	3.80	76	7.40	148
Total	**100**		**390**		**756**
Ranking			**2**		**1**

When examined from a purely qualitative perspective, Option 2 (Participation in the LDE Programme) received the highest quality score. With DXC's accelerated timescales, expertise, support and transformational knowledge option 2 will provide a higher quality transformational programme allowing the Trust to deliver more efficient and effective pathways that will be of greater benefit to clinicians and patients over a much quicker timescale. DXC will be able to accelerate delivery of transformation drawing on DXC services and product teams to ensure the Trust is exploiting the technical opportunities to deliver maxim benefit for the Trust. The accelerated timescales will ensure those greater benefits can be delivered earlier.

4.3 Financial Appraisal of the Options

In order to ascertain which option would provide the best value for money, an analysis was undertaken based on the discounted cash flow of each option.

DISCOUNTED CASHFLOW					
		Option 1 Trust resourced digitisation programme		Option 2 LDE Programme	
Year	DCF	Cashflow £000	NPV £000	Cashflow £000	NPV £000
Year 0	1.00	(214)	(214)	(548)	(548)
Year 1	0.97	(1,396)	(1,348)	(1,242)	(1,199)
Year 2	0.93	(1,226)	(1,142)	(402)	(374)
Year 3	0.90	(933)	(838)	(110)	(99)
Year 4	0.87	(396)	(343)	60	52
Year 5	0.84	(73)	(61)	489	409
Year 6	0.81	92	74	695	561
Year 7	0.78	439	342	775	604
Year 8	0.75	695	522	855	643
Year 9	0.73	775	562	936	679
Year 10	0.70	855	599	996	697
TOTAL			**(1,846)**		**1,426**

This table illustrates that Option 2 (LDE Programme) delivers the best value for money overall within the 10 year time frame as the benefits arise earlier than Option 1, resulting in a £1.4m cash benefit. This is compared to a deficit position of £1.8m in Option 1.

The preferred option is therefore Option 2.

5. THE PREFERRED OPTION

The preferred option is for the Trust to be a participant in the Lorenzo Digital Exemplar Programme. The Programme takes a holistic, end to end approach to transformation and will enable the Trust to accelerate the pace of technological change, and inspire and educate others by demonstrating how successful adoption of technology can deliver both improved patient outcomes and increased operational effectiveness.

Key features of the LDE programme include:

- The development and implementation of digital patient pathways in the 5 key areas outlined in Section 5.1 which will then be used as a "blueprint" to extend digital working across other treatment pathways (inpatients and outpatients) in other specialties in the Trust.
  A "digital patient pathway" refers to the replacement or elimination of paper-based processes for the capture, storage, access, utilisation and sharing of patient treatment and supporting data by providing IT-enabled solutions and the associated transformation of business processes.

  Each pathway will undergo a comprehensive business analysis phase to determine the scope and nature of the Lorenzo optimisation opportunities that can be deployed to deliver digital transformation. Following this analysis, a design and validation phase will develop and implement the revised digital pathway using the IT enablers and processes identified during the analysis phase.

  The IT enablers available to each pathway include, but are not limited to, the following:

  - Deployment of existing and new Lorenzo functionality, as appropriate, in each patient pathway (e.g. CDC Forms, Clinical Notes and Charts, Advanced Bed Management, "Lorenzo on the Wall", Electronic Prescribing and Medicines Administration (ePMA), Lorenzo Activities, and other bespoke product changes).

  - Lorenzo Integration optimisation by developing new system integration solutions with other patient treatment systems (internal and external to the Trust) to enable, for example, real-time, two-way data sharing and messaging between these systems (e.g. NerveCentre e-Observations, Ambulance Service systems, G2 Speech Report and Voice Recognition system, GP Systems, Patient Knows Best system, Transfer of Care systems).

  - The deployment of new DXC mobile applications, when these become available, that will revolutionise the way clinical and support staff treat and interact with their patients at all stages of the treatment pathway and in the wider health community (e.g. Clinical Aide, Nurse Aide, Patient Aide).

  The knowledge and experience gained in the design and implementation of the 5 digital pathways will be used to develop deployment "blueprints" to extend these into other specialties and treatment pathways.

- The deployment of the Lorenzo Theatres module to replace the existing ORMIS Theatres system.

- The deployment of additional computer hardware and digital devices to enable and support the new "paper-lite" business processes and the Theatres system replacement.

5.1 Key Benefits

The preferred option will deliver the qualitative benefits detailed in the table below.

Requirement	Qualitative Benefit
1. Patient benefits/outcomes	• Clinical records available at time of consultation • Easier access to appointment bookings • Reduction in number of outpatient attendances to hospital through the use of patient self-management services and the remote capture of patient data for patients with long term conditions • Provision of remote clinical services enabling care delivery closer to home • Improved patient experience and reduced waiting times
2. Service and operational benefits/outcomes	• Improvement in data capture, leading to reduction in level of reworking and errors • Enhanced tracking of patient progress and earlier intervention resulting in reduction in unplanned emergency admissions • Reduction in number of face to face consultations through development of virtual clinics • Potential to contribute to further reductions in DNA rates • Supports outpatient service transformation • Supports mobile workforce • Improved information governance and security • Improved and enhanced business intelligence to aid decision-making at an operational and strategic level
3. Clinical benefits/outcomes	• Shared care planning across organisational boundaries – collaboration between clinicians, the patient and wider multi-disciplinary team • Enables clinical transformation eg right advice by the right person at the right time • Supports patient pathway development • Improved clinical safety through improved monitoring, leading to earlier intervention when alerted by patient or deterioration in the patient's condition is detected. • Access to clinical record – right place, right time, first time • Contributes to better informed decisions, reducing clinical risk.
4. Organisational benefits/outcomes	• Supports compliance with GDPR requirements • Contributes to achievement of the Trust's Digital Strategy – in particular 'Paper free at the point of care' • Contributes to achievement of CRES eg reduction in costs associated with handling paper records • Reduction in number of unnecessary outpatient follow up appointments for patients with long term conditions • Supports delivery of other Trust strategies • Supports achievement of HIMSS Level 7 capability

In addition, the preferred option will deliver significant financial (cash releasing and non-cash releasing) benefits, which form part of the financial evaluation and are detailed in Appendix 2.

The LDE Programme is not the only element that is driving transformation and benefits realisation. The Trust has its Digital Strategy to drive innovation in the way patient care is delivered to patients. The LDE programme is a critical building block that provides the digital core that will support and drive other innovations in patient care in the future.

The combined LDE Programme and the Digital Strategy will realise further benefits to the wider patient community through remote clinical services, easier access to appointment booking, and reduced patient attendance to outpatients through the use of patient self-

management services and the remote capture of patient data for patients with long term conditions such as Diabetes and Cystic Fibrosis.

By enabling the data to be captured in Lorenzo, clinicians have access to information about patient status and make care decisions without the need for a face to face meeting, without the need for the use of a consulting room in the hospital, without the need for the patient to spend time waiting to see a clinician for a routine check-up and without the use of paper. Making data a strategic asset is the core enabler to the Trust becoming and behaving as a fully digital organisation.

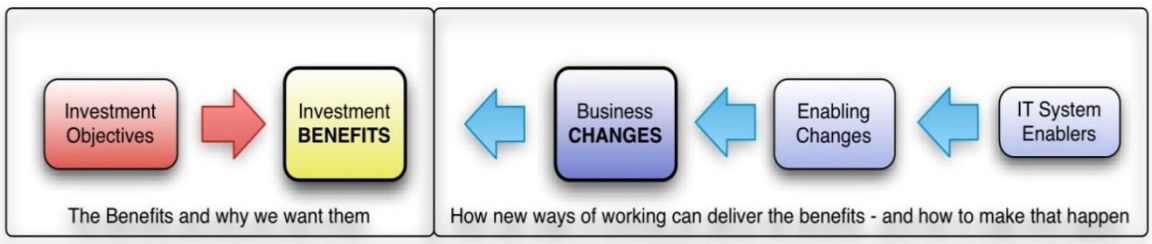
5.2 Benefits Realisation

The Trust recognises that this LDE programme, and the wider Digital Strategy, is fundamentally about clinicians and patients, providing the technology-based tools for our teams to consistently deliver high quality care, excellence in patient experience and outcomes, and to exploit opportunities to change the way we do business. This is not an IT project. The LDE programme is one of profound transformational change. The LDE programme will have an impact on the working lives of the majority of those Trust staff who currently use Lorenzo and other clinical and patient systems.

The Trust applies an integrated approach to business change and transformation and Benefits Realisation to ensure all key objectives are included within a *Benefits Realisation Plan*, and in turn reflected in the Business Change plans and arrangements for Project Evaluation and Post-Implementation Review.

The Benefits Realisation Plan at Appendix 3 summarises the benefits to be achieved from the LDE programme. The criteria against which the benefits will be assessed are given, together with the data required to measure success.

The Benefits Realisation Plan, and the business changes and service transformation to deliver it, are provided by the development of a *Benefits Dependency Network*. The development of this will show how the objectives of the investment lead to the identification of the benefits to be realised from the project, and the relationship between these benefits and the business and service transformation changes that will need to be implemented to realise them. Furthermore, it identifies the enabling changes provided by the new systems that will also need to be delivered. This relationship is shown in the following diagram:



The key elements of the business change process work that will be undertaken are summarised below:

- **Current State Capture** – documenting the “As Is” process
    - Working closely with end user teams, using Standard Operating Procedures (SOPs) where available, the current processes will be agreed and recorded.

- **Business Analysis**
    - The current state is reviewed and proposed business changes and I.T. enablers documented. Any expected benefits are captured and proposed future ways of working considered.

- **Future State Definition**
    - The proposed future state processes are defined and documented – the “To Be” process; any expected benefits are also captured at this stage.
    - After discussions with user departments the benefits and future states are agreed and signed off.

- **Implement**
    - The future states are then used to finalise the change activities such as training required, process testing, additional IT requirements, go-live support requirements, supporting materials required, user access requirements, etc.
    - The new business process and IT enablers are deployed

- **Post-Implementation Review** includes the following key activities:
    - Measuring the success of the project in achieving its planned business objectives
    - Monitoring the progress of benefits realisation to assess whether the benefits outlined in the business case have been achieved
    - Costs and financial benefits to date, compared to forecasts from the business case
    - The effectiveness of revised business operations (functions, and processes)
    - Business and user satisfaction
    - Identifying any necessary remedial actions
    - Recording the lessons learned in order to improve the performance of subsequent projects
    - Disseminating the lessons learned from the project.

5.3 Workforce Implications

The development and implementation of the LDE programme will require investment in additional staff resources for the IM&T Team, both in terms of recurring and non-recurring resource. For the two year implementation plan, additional project managers and business change managers will be required, on a non-recurring basis.

To provide on-going support, development and maintenance of the digital solutions, additional staff will be required by the IM&T team on a recurring basis. These include a configuration specialist, system developer, information analyst, I.T. technical resources and end-user trainers. The resource requirement, timings and costs of these staff are summarised below and the costs have been included in the financial case.

Programme Roles	Grade		Average wte in post									
			2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Senior Clinician	Con	Capital	0.15	0.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Junior Doctor	F2	Capital	0.14	0.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Manager	8a	Capital	0.09	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Senior Nurse	7	Capital	0.14	0.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
AHP	7	Capital	0.09	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Clinical Support	7	Capital	0.14	0.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Project Manager	6	Capital	0.83	1.67	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Business Change Manager	6	Capital	0.38	1.46	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Admin & Clerical	4	Capital	0.14	0.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Integration Lead	7	Recurrent	0.83	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Configuration Specialist	6	Recurrent	0.83	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
System Developer	6	Recurrent	0.83	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Information Analyst	6	Recurrent	0.33	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Trainer	5	Recurrent	0.50	2.83	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
System Administrator	4	Recurrent	0.25	1.33	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.50
IT Staff	4	Recurrent	0.21	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
			5.90	**12.86**	**9.00**	**9.00**	**9.00**	**9.00**	**9.00**	**9.00**	**9.00**	**9.00**

A full programme of recruitment and training will be undertaken to ensure that the Trust has the right staff with the right level of knowledge and skills to successfully deliver the programme.

Key clinical and non-clinical end users of Lorenzo and other clinical systems will play an active role in the development, testing and validation of the revised digital patient pathway processes. As this work will be over and above their normal working day responsibilities, the cost of this additional resource has been added to the costs in the financial case, on a 'cost of back-fill' basis.

All clinical and non-clinical end-users of Lorenzo and other clinical systems will require additional training in the use of the revised digital pathway processes and system functionality, and in the use of any new technology (mobile devices, data capture devices, etc.) required to deliver these processes. Given the significant business transformation the LDE programme will deliver, the commitment of the Trust workforce required to support this requirement cannot be underestimated.

Delivery of the LDE Programme will result in savings in staffing resource, both cash and non-cash releasing. The table below sets out the whole-time equivalent savings that will be realised from the removal of paper records and the processes associated with their creation, handling and storage. This equates to 50 wte at Band 2 over 10 years, predominantly from posts within the medical records and patient administration service. These areas currently have a high turnover of staff. The reductions in wte would be managed through redeployment of permanent staff into vacant posts and the appointment of temporary staff until full digitisation is achieved. In anticipation of a fully digitised patient record, the patient administration service has standardised job specifications to enable greater flexibility in the deployment of staff.

WTE Reductions	Grade	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Library and Medical records staff	2	0.00	2.00	6.00	11.00	20.00	22.00	24.00	26.00	28.00	29.00
Out-Patient Clinic Preparation	2	0.00	1.00	2.00	4.00	8.00	12.00	14.00	16.00	18.00	20.00
Scanning and filing CAS Cards	2	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
		0.00	**4.00**	**9.00**	**16.00**	**29.00**	**35.00**	**39.00**	**43.00**	**47.00**	**50.00**

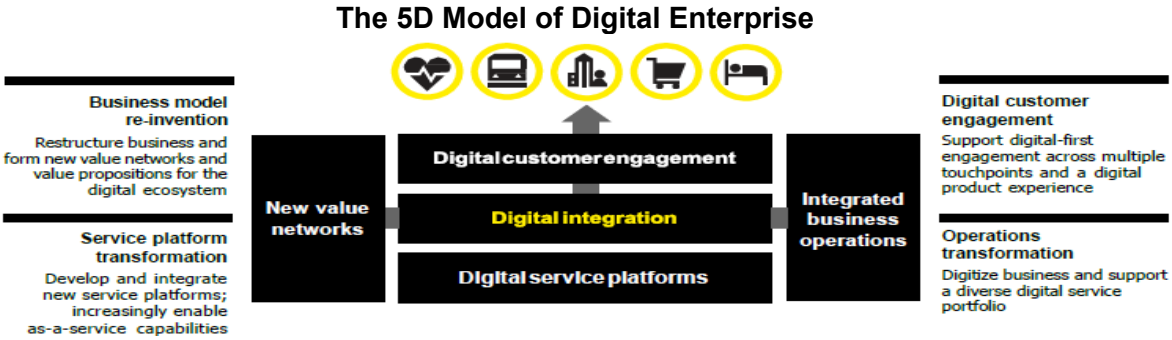
In addition to planned reductions in posts, with the removal of paper records, a proportion of clinical and administrative time per day will be released eg reduced need for clinic preparation, requesting of casenotes, etc. In the case of clinical staff, this will allow for an increase in 'time to care' and for administrative and secretarial staff, in supporting clinical

staff in the delivery of care and the electronic tracking of patients through the care pathway. These savings are detailed in appendix 3.

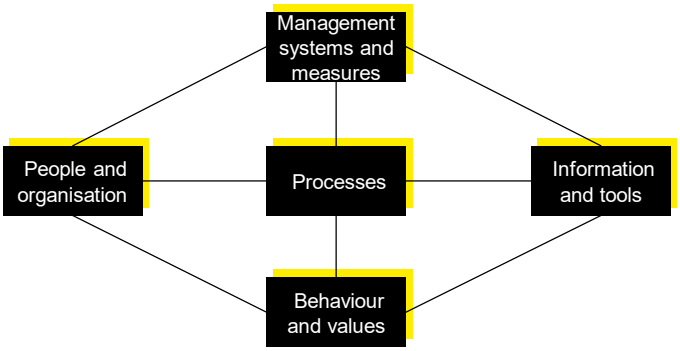
5.4 Method of Delivery

5.4.1 Tranformation Approach

The LDE Programme is about achieving business transformation. The transformation approach will use the "Business Diamond" model and the "5 Domain Model" (5DM) of Digital Enterprise. DXC Transformation expertise will be available to the Trust to develop, agree and implement a blueprint for a digital way of working.



Business Diamond Model



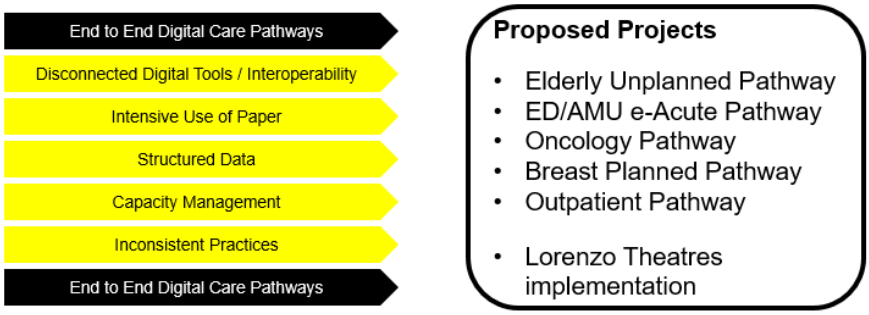
Making data a strategic asset, removing the dependence on paper to drive processes and changing the way data is captured to avoid rework and errors will mean the right information will be available to Clinicians and Patients at the point of care. The combination of improved productivity, changes to ways of working, and access to useful and valuable data will transform the way the Trust is able to deliver services to patients in and away from the physical environment of the hospital setting.

Clinicians, nursing and support staff who are making a direct impact on people's lives will benefit from consistently available and uniform access to patient information. Everyone must have the same level of service and access to data in the Digital Environment of the 5D model otherwise inconsistent working practices and operational inefficiencies will continue to persist.

The basis of the transformation has already started. The initial LDE mobilization and engagement has enabled a vision of transformation for the 5 pathways to be developed. During the LDE programme a roll out plan will be developed to ensure that the blueprints can be implemented across the majority of the remaining pathways by 2023. Any additional recurrent and non-recurrent resource to roll out beyond the LDE programme will be identified within the overall Digital Strategy Business Case. The DXC transformation methodology that will be adopted will underpin the transformation success, and success is dependent on a

truly collaborative working relationship with DXC, our own clinicians and joint working with the other Trusts in the LDE Programme to share learning and approach.

Proposed Pathways and Drivers for Change



These 5 pathways will generate repeatable blueprinted processes underpinned by technology and enhanced integration to deploy across the wider organisation after the initial LDE programme. The target of the 5 pathways is pragmatic. It is recognised as not realistic to take a big bang approach to changing the way the organisation works today. These 5 pathways will allow the DXC transformation team to work with the Trust's clinicians to define new ways of working, new processes, improved outcomes and benefits.

5.4.2 Programme Management

The LDE Programme will be undertaken on a phased basis (see Section 5.5) and delivery of the Programme will be overseen by the Trust's Digital Strategy Board and NHS Digital.

The planning and implementation of the Programme will be managed by the Digital Programme Board whose membership will consist of:

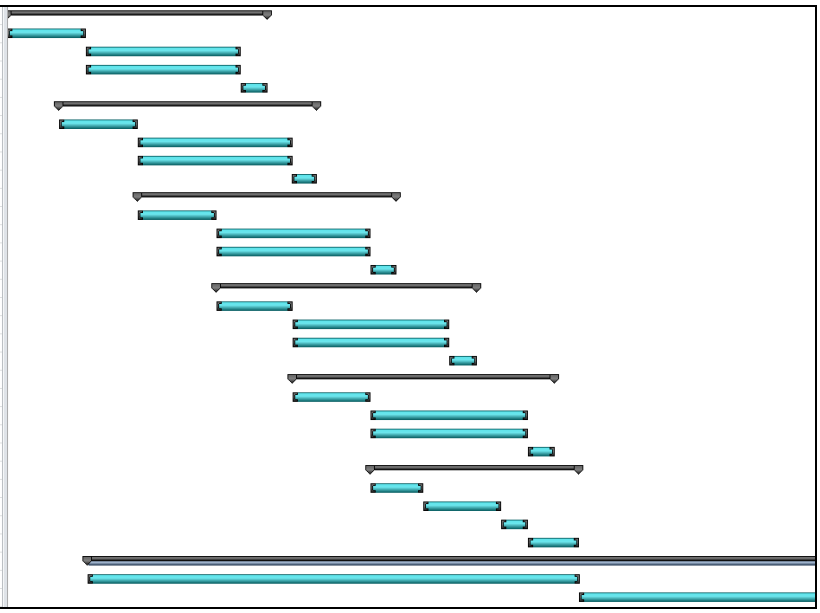
- Digital Director
- Deputy Director of IM&T and Head of Information
- Head of Care Records EPR Programme
- Head of Care Records Digitisation Programme
- Head of Finance (Corporate Directorates)
- Business Change, Benefits Realisation and Training Manager
- Head of Information Technology
- Head of Patient Administration and Records
- Systems Developer, Information Services
- Nursing representative
- Clinical representative

5.5 Implementation Plan

Subject to approval by the Trust Board, the business case will be submitted to NHS Improvement and NHS Digital on 17th May 2018. If approved by NHS Improvement and NHS Digital, it is anticipated that the LDE programme will commence in June 2018.

The implementation plan for the delivery of the 5 key pathways and the deployment of the Lorenzo Theatres system is shown in the diagram below.

Unplanned Pathway ED/AMU	**Fri 01/06/18**	**Mon 01/04/19**
Analysis	Fri 01/06/18	Fri 31/08/18
Design and Validation	Sat 01/09/18	Thu 28/02/19
Interface Developments	Sat 01/09/18	Thu 28/02/19
Deployment	Fri 01/03/19	Mon 01/04/19
Unplanned Pathway Elderly Care	**Wed 01/08/18**	**Wed 29/05/19**
Analysis	Wed 01/08/18	Wed 31/10/18
Design and Validation	Thu 01/11/18	Tue 30/04/19
Interface Developments	Thu 01/11/18	Tue 30/04/19
Deployment	Tue 30/04/19	Wed 29/05/19
Outpatients Optimisation	**Thu 01/11/18**	**Fri 30/08/19**
Analysis	Thu 01/11/18	Thu 31/01/19
Design and Validation	Fri 01/02/19	Wed 31/07/19
Interface Developments	Fri 01/02/19	Wed 31/07/19
Deployment	Thu 01/08/19	Fri 30/08/19
Oncology Pathways	**Fri 01/02/19**	**Mon 02/12/19**
Analysis	Fri 01/02/19	Tue 30/04/19
Design and Validation	Wed 01/05/19	Thu 31/10/19
Interface Developments	Wed 01/05/19	Thu 31/10/19
Deployment	Fri 01/11/19	Mon 02/12/19
Planned Breast Pathway	**Wed 01/05/19**	**Mon 02/03/20**
Analysis	Wed 01/05/19	Wed 31/07/19
Design and Validation	Thu 01/08/19	Fri 31/01/20
Interface Developments	Thu 01/08/19	Fri 31/01/20
Deployment	Sat 01/02/20	Mon 02/03/20
Lorenzo Theatres	**Thu 01/08/19**	**Tue 31/03/20**
Stage 1	Thu 01/08/19	Mon 30/09/19
Stage 2	Tue 01/10/19	Tue 31/12/19
Stage 3	Wed 01/01/20	Fri 31/01/20
Stage 4&5	Sat 01/02/20	Tue 31/03/20
Roll-out	**Mon 03/09/18**	**Fri 31/03/23**
Optimisation of key functionality	Mon 03/09/18	Wed 01/04/20
Pathway roll-out complete 2023	Wed 01/04/20	Fri 31/03/23



A period of two years will be required to deploy the initial LDE programme, and a further one year of DXC support will be provided to review, validate and consolidate this work. After this three year period, the Trust's IM&T team will roll-out the digital pathway "blueprints" to other patient pathways in other specialties.

It is envisaged that this work will be completed and benefits realisation will be maximised by Year 5 of the LDE programme, ie 2023.

The scope of the work covered by the LDE Programme is detailed in the table below.

Pathway	Lorenzo Optimisation Scope	Integration Optimisation Scope
Unplanned Pathway ED AMU	Emergency Care, Requests and Results, Electronic Prescribing and TTO, Electronic Observation Recording, Clinical Data Capture Forms, Clinical Notes, Advanced Bed Management and Patient Flow, Lorenzo on the Wall Floor Plans, Clinical Charts and Indicators, Care Activities and Patient Transport Service Requests.	Lorenzo Integration with: Electronic Observations, Transfer of Care (Letters to GPs Electronically), Digital Dictation and Voice Recognition integration, Data Sharing with Mental Health and Social Care, Enhanced ED Kiosk integration, Summary Care Record integration (medications), YAS/EMAS Pre arrival messages, Pharmacy, Patient Knows Best (Patient Portal), enhanced Radiology and Pathology Integration for Results Acknowledgement.
Unplanned Pathway Elderly Care	Electronic Prescribing and TTO, Requests and Results , Electronic Observation Recording, Clinical Data Capture Forms, Clinical Notes, Advanced Bed Management and Patient Flow, Lorenzo on the Wall Floor Plans, Care Plans, Clinical Activities and Charts, Clinical Indicators, Discharge Hub, Patient Transport Services Clinical Aide App (Mobile Working)	Lorenzo Integration with: Electronic Observations, Transfer of Care (Letters to GPs Electronically), Digital Dictation and Voice Recognition integration, Data Sharing with Mental Health and Social Care, enhanced ED Kiosk integration, Summary Care Record integration (medications) YAS/EMAS Pre arrival messages, Pharmacy, Patient Knows Best (Patient Portal), enhanced Radiology and Pathology integration for Results Acknowledgement, Synertec mailing enhancements, PTS and Cardiology integration.

Pathway	Lorenzo Optimisation Scope	Integration Optimisation Scope
Outpatient Pathway	Electronic Prescribing and TTO, Requests and Results , Electronic Observation Recording, Clinical Data Capture Forms, Clinical Notes, Patient Flow, Lorenzo on the Wall Floor Plans, Care Plans, Clinical Activities and Charts, Clinical Indicators, Patient Transport Services, Electronic Clinic Outcomes and Internal Referrals. Clinical Aide App (Mobile Working)	Lorenzo Integration with: Electronic Observations, Transfer of Care (Letters to GPs Electronically), Digital Dictation and Voice Recognition integration, Data Sharing with Mental Health and Social Care, Enhanced OPD Kiosk integration, Summary Care Record integration (medications), Pharmacy, Patient Knows Best (Patient Portal), enhanced Radiology and Pathology integration for Results Acknowledgement and other diagnostics, Synertec mailing enhancements and Somerset Cancer and MDT, PTS , SystmOne and Auditbase integration.
Oncology Pathways	Electronic Prescribing and TTO, Requests and Results , Electronic Observation Recording, Clinical Data Capture Forms, Clinical Notes, Advanced Bed Management and Patient Flow, Lorenzo on the Wall Floor Plans, Care Plans, Clinical Activities and Charts, Clinical Indicators, Patient Transport Services, Electronic Clinic Outcomes and Internal Referrals, Virtual Appointments Clinical Aide App (Mobile Working).	Lorenzo Integration with: Electronic Observations, Transfer of Care (Letters to GPs Electronically), Digital Dictation and Voice Recognition integration, Data Sharing with Mental Health and Social Care, Enhanced OPD Kiosk integration, Summary Care Record integration (medications), Pharmacy, Patient Knows Best (Patient Portal), enhanced Radiology and Pathology integration for Results Acknowledgement, Synertec mailing enhancements and Somerset Cancer, MDT, Aria and Social Care integration.
Planned Breast Pathway	Electronic Prescribing and TTO, Requests and Results , Electronic Observation Recording, Clinical Data Capture Forms, Clinical Notes, Advanced Bed Management and Patient Flow, Lorenzo on the Wall Floor Plans, Care Plans, Clinical Activities and Charts, Clinical Indicators, Patient Transport Services, Electronic Clinic Outcomes and Internal Referrals, Virtual Appointments Clinical Aide App (Mobile Working) Lorenzo Theatres.	Lorenzo Integration with: Electronic Observations, Transfer of Care (Letters to GPs Electronically), Digital Dictation and Voice Recognition integration, Data Sharing with Mental Health and Social Care, Enhanced OPD Kiosk integration, Summary Care Record integration (medications), Pharmacy, Patient Knows Best (Patient Portal), enhanced Radiology and Pathology integration for Results Acknowledgement, . Synertec mailing enhancements and Somerset Cancer, MDT, Aria, Breast Screening and Social Care integration.
Lorenzo Theatres	Roll- out across Trust following Breast pilot.	ORMIS Interface decommissioned

5.6 Roll-out beyond LDE

Throughout the LDE process and implementation, a mechanism will be put in place to roll-out to other pathways/processes/specialties. This will happen in two ways:-

1. Where part of a pathway can be digitised through optimisation of current functionality (eg outpatients), and there is a Trust-wide benefit in expediting a rapid roll-out to other specialties, a proposal will be taken to the Digital Programme Board and Digital Strategy Board for approval to implement and roll-out as specific projects. The Trust will not delay roll-out of functionality where there are obvious benefits and efficiencies, and in order to maintain standardisation, where appropriate.

2. The business analysis phase of the LDE pathway implementation will identify the blueprint that will enable the roll-out across further specialty pathways to ensure benefits are maximised at the earliest opportunity.

5.7 Fast Followers

The Trust has an established record of willingness to share and support other Lorenzo Trusts. The LDE Programme at Hull and East Yorkshire Hospitals will enhance and extend this ability. The Trust will work in partnership with DXC and NHS Digital to ensure that developments (either technical or operational processes) and experiences are shared with the wider Lorenzo community. The Trust will seek to ensure that progress during the LDE programme is regularly presented at the Lorenzo User Group, providing opportunities for Trusts to hear first-hand experiences and provide the ability for Trusts to take advantage of LDE opportunities as early as possible. In addition the Trust will make itself a Digital Exemplar for visiting Trusts and would welcome site visits and hold workshops on the use and benefits of digital technology.

6. FINANCIAL CASE

As outlined in Section 5 above, the Lorenzo Digital Exemplar Programme (Option 2) is the preferred option and this section sets out the financial evaluation of that option. It is based on a number of assumptions:

- Commencement of the LDE Programme in June 2018
- Appointment of temporary staff (funded through capital) for two years
- Appointment of permanent staff (funded through revenue) for project implementation and to support the continuing implementation and deployment to other specialties and patient pathways.
- DXC costs fully funded by NHSI (£3.24m). These would be paid direct to DXC by NHSI and therefore do not feature in the financial tables. The tables outline the Trust's costs only.

6.1 Capital Expenditure

The table below shows the capital expenditure of the preferred option (inclusive of VAT). The total capital investment of £1.6m includes the cost of project management staff, software, licences, and hardware.

Total Capital Cost (Including VAT)

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Tangible Assets											
Land											
Buildings											
Plant & Machinery											
Medical & Scientific Equipment											
Transport Equipment											
Information Technology	293	293	0	0	0	0	0	0	0	0	586
Furniture & Fittings											
Intangible Assets											
Software	38	0	0	0	0	0	0	0	0	0	38
Licences & Trademarks	60	334	0	0	0	0	0	0	0	0	394
Patents											
Development Expenditure	157	412	36	0	0	0	0	0	0	0	605
Total Capital Cost	**548**	**1,039**	**36**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,623**

Capital charges to 2028, which assumes an average asset life of 7 years, total £1.8m and are detailed below:

Capital Charges											
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value											
Opening Book Value	548	1,509	1,319	1,088	857	626	395	162	6	(0)	6,509
Depreciation	(78)	(226)	(231)	(231)	(231)	(231)	(233)	(156)	(6)	0	(1,623)
Closing Book Value	470	1,283	1,088	857	626	395	162	6	(0)	(0)	4,886
PDC Dividends	(8)	(49)	(42)	(34)	(26)	(18)	(10)	(3)	(0)	0	(190)
Total Capital Charges	**(86)**	**(275)**	**(273)**	**(265)**	**(257)**	**(249)**	**(243)**	**(159)**	**(6)**	**0**	**(1,813)**

6.2 Financial Benefits

The table below summarises the value of cash releasing and non-cash releasing that will be realised from the LDE programme. Appendix 2 provides the detail to these figures.

The cash-releasing benefits comprise both the legacy I.T. system displacement costs and the cost savings associated with removing paper and supplier printed documents from clinical pathways and business processes. As such, these cash savings represent only the most certain, and most prudent, items that have been identified to support the business case.

Benefit	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Year 4 (£'000)	Year 5 (£'000)	Year 6 (£'000)	Year 7 (£'000)	Year 8 (£'000)	Year 9 (£'000)	Year 10 (£'000)	**Total** (£'000)
Cash		90.2	420.5	590.9	962.6	1,169.0	1,249.2	1,329.4	1,409.6	1,469.8	**8,691.2**
Non-Cash	152.7	495.3	946.7	1,444.4	1,942.2	2,058.1	2,058.1	2,058.1	2,058.1	2,058.1	**15,271.7**
Total	**152.7**	**585.5**	**1,367.2**	**2,035.3**	**2,904.8**	**3,227.0**	**3,307.3**	**3,387.5**	**3,467.7**	**3,527.9**	**23,962.9**

The non-cash releasing benefits comprise the value of the productivity and efficiency gains of clinical staff (i.e. medical, nursing, AHPs) and non-clinical staff (i.e. ward clerk, medical secretary, waiting list) realised from the time savings that digitised clinical pathways and associated business processes. All of these staff groups will no longer have to search for, retrieve, write and chase paper and other manual patient records. Furthermore, they will have faster access and be able to retrieve clinical information at all points along the digitised patient pathways. These time savings will enable these staff to focus more time on direct patient treatment activities, with concomitant benefits to patients.

The transformation of existing manual, paper-based patient treatment pathways into end-to-end digital pathways across all specialties, treatment areas and our other health provider partners will enable the Trust to realise additional efficiency, productivity and patient benefits not identified above.

NHS Digital have set a mandatory requirement that this investment case, including total costs and financial benefits, should demonstrate an absolute value for money (aVFM) ratio (or "return on investment") of at least 2.40. The actual aVFM of this investment case using the costs and benefits detailed in section 6 is 16.3.

6.3 Statement of Comprehensive Income

The table below details predicted net operational costs (including VAT) from the proposed option and the impact on the Trust's Statement of Comprehensive Income.

Expenditure on additional staffing to support the LDE Programme will be offset by reductions in permanent posts in medical records and patient administration (as detailed in section 5.3) resulting in a £2.56m surplus by 2028.

Non-pay expenditure will be predominantly on licence fees which will be offset by savings on licence fees and lease costs for other systems as the digitisation programme is rolled out (eg iFIT), resulting in a surplus of £1.56m.

Revenue savings over the 10 years of this business case total £4.1m which, after taking account of capital charges of £1.8m, results in a surplus to the Trust of £2.3m.

By year 10 (2027/28) the revenue savings will represent circa £1M of recurring benefit.

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income											
	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Operating Expenses											
Pay											
Medical Staff											0
Nursing & Midwifery Staff											0
Scientific, Therapeutic & Technical Staff											0
Senior Managers & Managers	(115)	(160)	(160)	(160)	(160)	(160)	(160)	(160)	(160)	(160)	(1,555)
Administrative & Clerical	(27)	(137)	(147)	(147)	(147)	(147)	(147)	(147)	(147)	(147)	(1,340)
Administrative & Clerical WTE reductions	0	80	181	321	582	702	782	862	943	1,003	5,456
Healthcare Assistants & Other Support Staff			0	0	0	0	0	0	0	0	0
Maintenance & Works Staff			0	0	0	0	0	0	0	0	0
Other Employees											0
Total NHS Staff Pay	**(142)**	**(217)**	**(126)**	**14**	**275**	**395**	**475**	**555**	**636**	**696**	**2,561**
Non NHS Staff											
Total Pay	**(142)**	**(217)**	**(126)**	**14**	**275**	**395**	**475**	**555**	**636**	**696**	**2,561**
Non-Pay Expenditure											
Clinical Supplies & Services											
General Supplies & Services											
Establishment Expenditure	0	10	45	75	100	100	100	100	100	100	730
License Fees	(21)	(151)	(216)	(216)	(159)	(159)	(159)	(159)	(159)	(159)	(1,558)
License Fees retraction	0	0	195	195	195	195	195	195	195	195	1,560
Lease savings	0	0	0	0	86	172	172	172	172	172	946
Purchase of Healthcare from Non-NHS Bodies											
Professional fees											
Education + Training											
External Contract & Consultancy Services											
Information Technology - interfaces	(40)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(112)
Total Non-Pay Expenditure	**(61)**	**(149)**	**16**	**46**	**214**	**300**	**300**	**300**	**300**	**300**	**1,566**
Operating Expenses Total	**(203)**	**(366)**	**(110)**	**60**	**489**	**695**	**775**	**855**	**936**	**996**	**4,127**
Non Operating Items											
Depreciation	(78)	(226)	(231)	(231)	(231)	(231)	(233)	(156)	(6)	0	(1,623)
PDC Dividends Payable	(8)	(49)	(42)	(34)	(26)	(18)	(10)	(3)	(0)	0	(190)
Total Non Operating Items	**(86)**	**(275)**	**(273)**	**(265)**	**(257)**	**(249)**	**(243)**	**(159)**	**(6)**	**0**	**(1,813)**
Retained Surplus / (Deficit) for the Year	**(289)**	**(641)**	**(383)**	**(205)**	**232**	**446**	**532**	**696**	**930**	**996**	**2,314**

6.4 Source of Funding

The Trust costs associated with the implementation of the LDE Programme will be funded from a combination of the Trust's capital and revenue plans.

7. RISK PLAN

A risk appraisal has been undertaken for the LDE Programme option. The risk appraisal involved:

- Identifying all potential business and service risks associated with this option
- Assessing the impact and probability of the risk upon the option
- Calculating a risk score
- Identifying mitigating actions
- Recalculating the risk score post mitigating actions.

The programme will take the lessons learned from the initial Lorenzo implementation through into the LDE programme. The key lessons learned where additional focus and support will be provided are as follows:

- Appreciation and preparation for the scale of change, both cultural and operational
- Ensuring robust engagement and involvement with operational teams
- Ensure that training and processes adherence and mandated
- Follow-up and super-user support is in place and sufficient for the scale of change
- Operational commitment to delivering and supporting the programme of work

The key risks to delivery of the LDE option are detailed below:

Risk/issue description	Impact score	Likelihood score	Risk	Mitigating actions/issue resolution plan	Residual Risk
There is a risk that benefits are not achieved due to poor engagement and staff reluctance in adapting to the changes to current processes and therefore find alternative ways of working which could then have a clinical safety impact, affect capacity and capability.	4	3	12 (Moderate)	The Trust Board and Executive will mandate the adoption of the Digital way of working, the principle of "paper-lite" working will be non-negotiable. This mandate will be monitored through the Digital Strategy Board and any noncompliance managed and escalated to the Executive as appropriate. Benefit delivery to be monitored by the Digital Programme Board and where non- compliance is affecting benefit delivery and clinical safety appropriate escalations will be actioned. Utilise the Business Diamond and 5 Domain model of Digital Enterprise supported by NHS Digital and DXC. Adopt a transformational approach of Vision, Shape, Transform and Realise. Close monitoring of benefit achievement and robust reporting to the Digital Programme Board and NHS Digital. Ensure engagement through Business Change workshops, comprehensive training, guidance, support and focussed communications with all services involved in the LDE Programme.	6 (Low)
There is a risk that cash and non-cash releasing benefits are overstated.	4	2	8 (Moderate)	Prudency has been used when calculating benefits to ensure identified cash releasing benefits are achievable. Benefit plans will be agreed with the Digital Programme Board and benefit owners within the Health Groups will be identified.	6 (Low)
Unavailability of appropriate Trust staff so increasing resource costs - There is a risk that the Trust will not be able to provide sufficiently skilled and knowledgeable personnel to support the Project and will have to source staff externally at an increased cost.	4	2	8 (Moderate)	The known recruitment profile has been established following production of the project resource plan, this plan will be enacted Existing experienced staff will be utilised / transferred to LDE where possible with short term backfill contracts used for BAU work. Availability of DXC specialist resources will reduce the need for HEY to recruit sufficiently skilled and knowledgeable resources.	6 (Low)
There is a risk that there are competing priorities for Trust resources, which may impact the delivery of the project.	4	4	16 (High)	The known recruitment profile has been established following production of the project resource plan, this plan will be enacted Ensure sufficient resources are allocated, recruited and ring fenced to deliver the Programme.	9 (Moderate)

Risk/issue description	Impact score	Likelihood score	Risk	Mitigating actions/issue resolution plan	Residual Risk
Increased product costs due to the requirement for additional product changes over and above those already identified.	3	2	6 (Low)	A significant number of product changes have already been identified following a review of the LDE deliverables. LDE deliverables and timescales have taken account of currently known product changes.	4 (Low)
There is a risk that the financial allocation from NHSD does not cover all of DXC's costs, potentially a shortfall of (c.£1m)	4	3	12 (Moderate)	Trust is one of four whose bid has been selected for LDE Programme. Trust would review the programme with NHSD and DXC and would seek further funding from NHD to cover the DXC costs. The Trust would not commit to funding the shortfall and further risk and any scope reduction would have to have its viability assessed. Business case demonstrates that cash and non-cash releasing savings will be realised, therefore favourable to support under the LDE. HEY Trust already acknowledged by NHS Digital as an early adopter and leader in the development of Lorenzo.	9 (Moderate)

Management of risks and issues will be a joint activity for the Trust and DXC during the LDE Programme. The Trust and DXC Project Managers will agree the ownership of risks and issues and the responsibility for their management. The DXC Project Manager is responsible for identification, quantification and impact of risks and issues that are the responsibility of DXC.

8. POST IMPLEMENTATION REVIEW

A post implementation review will be in Year 4 of the LDE Programme following completion of DXC's work to review, validate and consolidate the deployment of the 5 initial digital pathways and prior to the Trust roll-out of the digital pathway 'blueprints' to other patient pathways in other specialties.

9. RECOMMENDATION

The Trust Board is asked to:

i. Approve the business case for investment and participation in the Lorenzo Digital Exemplar Programme
ii. Acknowledge the potential additional financial risk to the Trust if DXC's costs are not fully met by NHS Digital
iii. Recognise that should NHS Digital's funding not meet DXC costs the Trust has the ability to withdraw from the Exemplar process
iv. Endorse the submission of this business case to NHS Digital.

Lee Bond
Chief Financial Officer

Dr Mark Simpson
Digital Director

15 May 2018

HEY MIMSS Self-assessment

LDE will increase HIMSS maturity within Level 2, Level 3, Level 5 and Level 6.

Level		HIMSS Level Capabilities	Status
Level 1	All Three Ancillaries Installed	Laboratory	
		Pharmacy	
		Radiology	
Level 2	CDR, Controlled Medical Vocabulary, CDS, HIE Capable	Major ancillary clinical systems feed data to a clinical data repository (CDR) that provides physician access for reviewing all orders and results	
		The CDR contains a controlled medical vocabulary, and the clinical decision support/rules engine (CDS) for rudimentary conflict checking	
		Information from document imaging systems may be linked to the CDR at this stage	
		The hospital may be health information exchange (HIE) capable at this stage and can share whatever information it has in the CDR with other patient care stakeholders	
Level 3	Clinical Documentation, CDSS (error checking)	Nursing/clinical documentation (e.g. vital signs, flow sheets, nursing notes, eMAR) is required and is implemented and integrated with the CDR for at least one inpatient service in the hospital; care plan charting is scored with extra points	
		The Electronic Medication Administration Record application (eMAR) is implemented	
		Medical image access from picture archive and communication systems (PACS) is available for access by physicians outside the Radiology department via the organization's intranet	
Level 4	CPOE Clinical Decision Support (clinical protocols)	Computerized Practitioner Order Entry (CPOE) for use by any clinician licensed to create orders is added to the nursing and CDR environment along with the second level of clinical decision support capabilities related to evidence based medicine protocols	
		If one inpatient service area has implemented CPOE with physicians entering orders and completed the previous stages, then this stage has been achieved	
Level 5	Full R-PACS (Picture Archiving and Communications System)	A full complement of radiology PACS systems provides medical images to physicians via an intranet and displaces all film-based images	
		Cardiology PACS and document imaging are scored with extra points.	
Level 6	Physician Documentation (templates), Full CDSS, Closed Loop Medication Administration	Full physician documentation with structured templates and discrete data is implemented for at least one inpatient care service area for progress notes, consult notes, discharge summaries or problem list & diagnosis list maintenance	
		Level three of clinical decision support provides guidance for all clinician activities related to protocols and outcomes in the form of variance and compliance alerts	
		The closed loop medication administration with bar coded unit dose medications environment is fully implemented	
		The eMAR (electronic Medical Administration Record) and bar coding or other auto identification technology, such as radio frequency identification (RFID), are implemented and integrated with CPOE and pharmacy to maximize point of care patient safety processes for medication administration	
		The "five rights" of medication administration are verified at the bedside with scanning of the bar code on the unit does medication and the patient ID.	

LDE will increase HIMSS maturity across all Level 7 capabilities.

	HIMSS Level 7 Capabilities	Status
Electronic Medical Records (EMR)	Complete EMR	
	Paper charts are no longer used to deliver and manage care	
	Mixture of discrete data, medical images, document images available within EMR	
	Medical device recall management	
Data Sharing	Sharing data along care pathway	
	Clinical data can be readily shared in a standardised, electronic manner as appropriate	
	Sharing of data between EMR and community based Electronic Health Register (HER)	
	HIE (Health Information Exchange)	
	95% or more Computerised Physician Order Entry (CPOE)	
	NON-SCORED CPOE-enables infusion pumps (7 to 10 years notice)	
	NON-SCORED: Implementation and use of Anesthesia Information System (5 years notice)	
Clinical & Business Intelligence	Data Warehousing - Outcomes Reports	
	Data Warehousing - Quality Assurance	
	Business Intelligence - analyse patterns of clinical data to improve quality of care	
	Business Intelligence - analyse patterns of clinical data to improve patient safety	
	Business Intelligence - analyse patterns of clinical data to improve care delivery efficiency	
	Data Mining Capability - Compliance Reporting	
Summary Data Continuity	A&E	
	Ambulatory	
	In Patients	
	Out Patients	
Data Safety & Security	Provide an overview of the data privacy and security program	

Hull & East Yorkshire Hospitals NHS Trust
LDE Programme Benefits

Ref	Benefit Area	Description	Benefit Type	When Realised	2018/19 Year 1 (£'000)	2019/20 Year 2 (£'000)	2020/21 Year 3 (£'000)	2021/22 Year 4 (£'000)	2022/23 Year 5 (£'000)	2023/24 Year 6 (£'000)	2024/25 Year 7 (£'000)	2025/26 Year 8 (£'000)	2026/27 Year 9 (£'000)	2027/28 Year 10 (£'000)	10 Year Total (£'000)	Rationale
LDE.01	Records Management	Reduction in Medical Records/ Scanning Staffing by removing the management of paper records/ casenotes (i.e. filing, retrieval, tracking, scanning)	Cash Releasing	Year 2		40.1	120.3	220.6	401.1	441.2	481.3	521.5	561.6	581.6	3,369.4	2.00 wte saving starting in Year 2, rising to 29.00 wte at Year 10. Band 2 staff at £20,056 pa.
LDE.02	Records Management	Reduction in Out-Patient Clinic Preparation Staffing by removing the management of paper records/ casenotes in clinics (preparing, copying, filing, tracking, transport)	Cash Releasing	Year 2		20.1	40.1	80.2	160.4	240.7	280.8	320.9	361.0	401.1	1,905.3	1.00 wte saving starting in Year 2, rising to 20.00 wte at Year 10. Band 2 staff at £20,056 pa.
LDE.03	Emergency Department	Removal of dedicated post for scanning and filing CAS Cards and other paper records	Cash Releasing	Year 2		20.1	20.1	20.1	20.1	20.1	20.1	20.1	20.1	20.1	180.5	1.00 wte Band 2 post.
LDE.04	Emergency Department	Reduction in paper/ printing costs of dedicated E.D. forms/ documents	Cash Releasing	Year 2		10.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	210.0	E.D. spend on pre-printed forms/ documents from 3rd party suppliers equals £50.0K pa (source: Supplies Department). Save 50%.
LDE.05	In-Patient/ Out-Patient Pathways	Reduction in paper/ printing costs of dedicated In-Patient/ Out-Patient forms/ documents	Cash Releasing	Year 3			20.0	50.0	75.0	75.0	75.0	75.0	75.0	75.0	520.0	Other Clinical Department spend on pre-printed forms/ documents from 3rd party suppliers equals £100.0K pa (source: Supplies Department). Save 75%.
LDE.06	IM&T Costs	Displaced System Costs of the IFIT system.	Cash Releasing	Year 5					86.0	172.0	172.0	172.0	172.0	172.0	946.0	IFIT (casenote Tracking System) no longer required after 4 year contract ends. 50% Year 5, 100% after.
LDE.07	IM&T Costs	Displaced System Costs of the ORMIS Theatre system.	Cash Releasing	Year 3			128.0	128.0	128.0	128.0	128.0	128.0	128.0	128.0	1,024.0	ORMIS Theatres System no longer required from Year 3.
LDE.08	IM&T Costs	Displaced System Costs of the Cayder PSG system.	Cash Releasing	Year 3			67.0	67.0	67.0	67.0	67.0	67.0	67.0	67.0	536.0	Cayder Patient Status at a Glance System no longer required from Year 3.
LDE.20	In-Patient/ Out-Patient Pathways	Reduction in Nursing time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 1	152.7	381.8	763.7	1,145.5	1,527.3	1,527.3	1,527.3	1,527.3	1,527.3	1,527.3	11,607.7	2,900 wte Nursing Staff. Each wte Nurse to save 7.5 minutes per day. Average annual cost per wte £31,600
LDE.21	In-Patient/ Out-Patient Pathways	Reduction in AHP staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 2		7.0	17.6	35.1	52.7	70.2	70.2	70.2	70.2	70.2	463.5	200 wte AHP Staff. Each wte AHP to save 5.0 minutes per day. Average annual cost per wte £31,600
LDE.22	In-Patient/ Out-Patient Pathways	Reduction in Medical Secretary staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 2		6.2	15.5	31.0	46.6	62.1	62.1	62.1	62.1	62.1	409.8	250 Med Sec Staff. Each Secretary to save 5.0 minutes per day. Average annual cost per wte £22,350
LDE.23	In-Patient/ Out-Patient Pathways	Reduction in Waiting List staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 2		0.5	1.2	2.5	3.7	5.0	5.0	5.0	5.0	5.0	32.8	20 Waiting List Staff. Each wte to save 5.0 minutes per day. Average annual cost per wte £22,350
LDE.24	In-Patient/ Out-Patient Pathways	Reduction in Ward Clerk staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 2		1.5	3.7	7.4	11.0	14.7	14.7	14.7	14.7	14.7	97.0	62 Ward Clerk List Staff. Each wte to save 5.0 minutes per day. Average annual cost per wte £20,050
LDE.25	In-Patient/ Out-Patient Pathways	Reduction in Junior Medical staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Non-Cash Releasing	Year 2		31.2	77.9	155.8	233.8	311.7	311.7	311.7	311.7	311.7	2,057.0	550 Junior Medical Staff. Each Doctor to save 2.5 minutes per day. Average annual cost per wte £51,000
LDE.26	Advanced Bed Management	Patient Flow Data Entry clerk time savings from ABM	Non-Cash Releasing	Year 2		67.1	67.1	67.1	67.1	67.1	67.1	67.1	67.1	67.1	603.9	3.00 wte Band 3 A&C Staff saving. Band 3 cost pa equals £22,350

Cash Releasing		**90.2**	**420.5**	**590.9**	**962.6**	**1,169.0**	**1,249.2**	**1,329.4**	**1,409.6**	**1,469.8**	**8,691.2**
Non-Cash Releasing	**152.7**	**495.3**	**946.7**	**1,444.4**	**1,942.2**	**2,058.1**	**2,058.1**	**2,058.1**	**2,058.1**	**2,058.1**	**15,271.7**
Total	**152.7**	**585.5**	**1,367.2**	**2,035.3**	**2,904.8**	**3,227.0**	**3,307.3**	**3,387.5**	**3,467.7**	**3,527.9**	**23,962.9**

Benefits Realisation Plan – Financial

Benefit Area	Description	Benefit Type	Key Performance Indicator (Target Value)	Baseline Measurement	Measurement (Source of Evidence)	Benefit Owner (Monitoring/ Management Assurance)	Target Realisation Date(s)
Records Management	Reduction in Medical Records/ Scanning Staffing by removing the management of paper records/ casenotes (i.e. filing, retrieval, tracking, scanning)	Financial - Cash Releasing	Reduce Medical Records/ Scanning Staff by 29.0 wte	38.0 wte Medical Records/ Scanning Staff as at April 2017	Funded Establishment Budget Report	Medical Records Manager	Phased reduction by 2.0 wte in Year 2 to 29.0 wte in Year 10
Records Management	Reduction in Out-Patient Clinic Preparation Staffing by removing the management of paper records/ casenotes in clinics (preparing, copying, filing, tracking, transport)	Financial - Cash Releasing	Reduce Out-Patient Clinic Prep Staff by 20.0 wte	35.0 wte Clinic Prep Staff as at April 2017	Funded Establishment Budget Report	Medical Records Manager	Phased reduction by 1.0 wte in Year 2 to 20.0 wte in Year 10
Emergency Department	Removal of dedicated post for scanning and filing CAS Cards and other paper records	Financial - Cash Releasing	Reduce ED Scanning/ Filing post by 1.0 wte	1.0 wte ED Scanning/ Filing post as at April 2018	Funded Establishment Budget Report	ED Service Manager	Year 2
Emergency Department	Reduction in paper/ printing costs of dedicated E.D. forms/ documents	Financial - Cash Releasing	Reduce ED forms/ document costs by 50%	£50K spend pa as at March 2018	Supplies Dept.	ED Service Manager	Year 2 - 20% Year 3 on - 50%
In-Patient/ Out-Patient Pathways	Reduction in paper/ printing costs of dedicated In-Patient/ Out-Patient forms/ documents	Financial - Cash Releasing	Reduce In-Patient/ Out-Patient forms/ document costs by 75%	£100K spend pa as at March 2018	Supplies Dept.	Service Managers	Year 3 - 20% Year 4 - 50% Year 5 on - 75%
IM&T Costs	Displaced System Costs of the IFIT system.	Financial - Cash Releasing	Reduce system costs by 100%	£172K pa system costs as at April 2018	Budget Report	I.T. Budget Holder	Year 5 - 50% Year 6 on - 100%
IM&T Costs	Displaced System Costs of the ORMIS Theatre system.	Financial - Cash Releasing	Reduce system costs by 100%	£128K pa system costs as at April 2018	Budget Report	I.T. Budget Holder	Year 3 on - 100%
IM&T Costs	Displaced System Costs of the Cayder PSG system.	Financial - Cash Releasing	Reduce system costs by 100%	£67K pa system costs as at April 2018	Budget Report	I.T. Budget Holder	Year 3 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in Nursing time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 7.5 minutes per day per wte Nurse post	2,900 wte Nurse posts as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 1 - 10% Year 2 - 25% Year 3 - 50% Year 4 - 75% Year 5 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in AHP staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 5.0 minutes per day per wte AHP post	200 wte AHP posts as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 2 - 10% Year 3 - 25% Year 4 - 50% Year 5 - 75% Year 6 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in Medical Secretary staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 5.0 minutes per day per Medical Secretary	250 Medical Secretary staff as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 2 - 10% Year 3 - 25% Year 4 - 50% Year 5 - 75% Year 6 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in Waiting List staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 5.0 minutes per day per Waiting List Clerk	20 Waiting List staff as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 2 - 10% Year 3 - 25% Year 4 - 50% Year 5 - 75% Year 6 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in Ward Clerk staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 5.0 minutes per day per wte Ward Clerk	62 wte Ward Clerk staff as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 2 - 10% Year 3 - 25% Year 4 - 50% Year 5 - 75% Year 6 on - 100%
In-Patient/ Out-Patient Pathways	Reduction in Junior Medical staff time required to search, retrieve, write, chase paper/ manual records. Faster access and retrieval of clinical information at all points on the patient pathway.	Financial - Non Cash Releasing	Save 2.5 minutes per day per Junior Doctor	550 Junior Doctors as at April 2018	Staff Establishment Report	Digital Director	Phased reduction as follows: Year 2 - 10% Year 3 - 25% Year 4 - 50% Year 5 - 75% Year 6 on - 100%
Advanced Bed Management	Patient Flow Data Entry clerk time savings from ABM	Financial - Non Cash Releasing	Save time equivalent to 3.0 wte data entry clerks	3.0 wte Data Entry Clerks as at April 2017	Staff Establishment Report	Digital Director	Year 2 on - 100%

Benefits Realisation Plan – Qualitative benefits

Benefit Area	Description	Benefit Type	Key Performance Indicator (Target Value)	Baseline Measurement	Measurement (Source of Evidence)	Benefit Owner (Monitoring/ Management Assurance)	Target Realisation Date(s)
Patient Benefits	Reduction in number of outpatient attendances to hospital through the use of patient self-management services and the remote capture of patient data for patients with long term conditions	Qualitative	Increase the number of remote out-patient appointments for patients with LTCs to 20% of appointments	Annual No. of Out-Patient appointments for LTC patients as at March 2018	BI Report	Digital Director	Year 4 on
Patient Benefits	Contribution to Reduced waiting times for 1st appointment	Qualitative	Reduce 95th Percentile for the average waiting time for 1st out-patient appointment to 18 weeks	Average 95th Percentile for the average waiting time for 1st out-patient appointment as at April 2018 = 21 weeks	BI Dashboard	Digital Director	Year 1
Service and Operational Benefits	Improvement in data capture, leading to reduction in level of reworking and errors	Qualitative	Improve data quality of APC, Out-Patient and ED SUS+ data for Ethnic Category to >99%	Average DQ value for Ethnic Category as at April 2018 = 95.3%	BI Dashboard	Digital Director	Year 2 on
Service and Operational Benefits	Enhanced tracking of patient progress and earlier intervention resulting in reduction in unplanned emergency re-admissions	Qualitative	Reduce emergency re-admissons by 1.0% (i.e. 110)	No. of emergency re-admissions for 12 months to April 2018 - 11,400	BI Analyser	Digital Director	Year 3 on
Service and Operational Benefits	Reduction in number of face to face consultations through development of virtual clinics	Qualitative	Increase the number of virtual clinics to 1% of total annual follow-up appointments (i.e. 5,000)	Total follow-up appointments for 12 month period ended February 2018 = 509,000	BI Analyser	Digital Director	Year 3 on
Clinical Benefits	Improved clinical safety through improved monitoring, leading to earlier intervention when alerted by patient or deterioration in the patient's condition is detected.	Qualitative	Improve accuracy of NEWS scores from 90% to 100% and reducing late recording by 80%	Accuracy of NEWS score improved from 90% to 100%; Late Recording reduced from 17% to 5%	Clinical Observations Audit	Nursing Director	Year 3 on
Organisational Benefits	Reduction in number of unnecessary outpatient follow up appointments for patients with long term conditions	Qualitative	Increase the number of remote out-patient appointments for patients with LTCs to 20% of appointments	Annual No. of Out-Patient appointments for LTC patients as at March 2018	BI Report	Digital Director	Year 4 on

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
Eliminating mixed-sex accommodation (EMSA)

Meeting date	15 May 2018		**Reference Number**	2018 – 5 - 17		
Director	Chief Nurse – Mike Wright		**Author**	Chief Nurse - Mike Wright		
Reason for the report	The purpose of the report is to apprise the Board of the 2017/18 of the Trust's declaration of compliance for eliminating mixed-sex accommodation (EMSA)					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing	✓	Review	

1	**RECOMMENDATION** The Trust Board is asked to: • Note the contents of the EMSA statement of compliance • Approve the EMSA statement of compliance Once approved the statement will be signed on behalf of the Board by the Chairman and Chief Executive Officer and uploaded to the Trust's website					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **C1 – Dignity, respect and compassion**					
	Assurance Framework	**Raises Equalities Issues?** No	**Legal advice taken?** No	**Raises sustainability issues?** No		
5	**BOARD/BOARD COMMITTEE REVIEW**					

ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

DECLARATION OF COMPLIANCE 2017/18

Hull and East Yorkshire Hospitals NHS Trust is able to confirm that mixed sex accommodation has been virtually eliminated in all of its hospitals.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Hull and East Yorkshire Hospitals NHS Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. Apart from a few exceptions for clinically justifiable reasons, patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

Wards within the Trust are grouped according to their clinical specialties. This allows patients with similar conditions to be cared for in one area with staff that are experienced in this type of care. This means that men and women may be on the same ward but will not share sleeping, bathing or toilet facilities.

There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

How well are we doing in meeting these standards?
The Trust has made physical changes to many inpatient accommodation areas to provide privacy screening/partitioning and additional toilet and bathing facilities. Toilet and bathroom signage has also been improved and this work continues.

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust is required to pay a financial penalty of £250 for each of these breaches. In 2017/18, there were no breaches of these standards.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2017/18.

INFORMATION FOR PATIENTS AND SERVICE USERS

'Same gender-accommodation' means:

- The **room where your bed is** will only have patients of the same gender as you, and;
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both male and female patients on the ward but, apart from a few exceptions for clinically-justifiable reasons such as in intensive care or high dependency areas, they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through sleeping areas that are designated for people of the opposite gender to you.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to X-ray or the operating theatre).

Also, it is most likely that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting one other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed space/area.

If you need help to use the toilet or take a bath that requires special equipment to help secure your care and safety (e.g. you need a hoist or special bath), then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time as you.

The NHS and Hull and East Yorkshire Hospitals NHS Trust will not turn patients away just because a "right-gender" bed is not immediately available for them. The patient's clinical need(s) will always take precedence.

What do I do if I think I am in mixed sex accommodation?
If you think you are in mixed accommodation and shouldn't be then please speak with the nurse in charge of the ward or area. This will be taken extremely seriously by staff and action will be taken to explain the reasons behind this and assurance will be provided that you will be moved to a same gender area/bay as soon as is reasonably practicable.

The Trust also wants to know about your experiences. Please contact the Patient Advice and Liaison Service (PALS) on telephone **01482 623065** or via email at: pals.hey@hey.nhs.uk if you have any comments or concerns about single gender accommodation. Thank You.

Signed:

Terry Moran
Chairman

Chris Long
Chief Executive

15 May 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

MODERN SLAVERY STATEMENT
TRUST SUBMISSION 2017-18

Trust Board date	15 May 2018		**Reference Number**	2018 – 5 - 18		
Director	Simon Nearney – Director of Workforce and OD		**Author**	Sarah Dolby - HR Advisor - Employment Policy and		
Reason for the report	To share the Modern Slavery Statement 2017-18 for Board agreement and to update the Board on the steps the Trust has taken, and planned for next year, to make further progress in this area					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Trust Board is asked to approve the attached Modern Slavery Statement for 2017-18, and for its publication the Trust's website and inclusion in the annual report					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): 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 Trust Board is required to sign a Modern Slavery Statement annually and to publish this on the website and from this year, to include it in its annual report.					

Hull and East Yorkshire Hospitals NHS Trust

Modern Slavery Statement
Trust Submission 2017-18

1 PURPOSE

The purpose of this paper is to share the Modern Slavery Statement for the financial year 2017/2018 and also to inform the Trust Board about what steps the Trust has taken this year in order to make further progress towards meeting the obligations of the Modern Slavery Act 2015.

2 BACKGROUND

Following the introduction of the Modern Slavery Act in 2015, there is a statutory requirement for the Trust to produce an annual statement describing what steps have or are being taken to tackle modern slavery (or state that no action has been taken if this is the case).

The expectation is that the Trust builds on the statements year on year, in order for the statements to evolve and improve over time.

Previously there has been no precise detail of what should be covered within the Modern Slavery Statement. However, in Autumn 2017, the Home Office published guidance which recommends that organisations report on the following six areas of activity:

1. Organisational structure and supply chains
2. Organisational policies
3. Assessing and managing risk
4. Due Diligence
5. Performance Indicators
6. Training

The Home Office guidance was supported by an independent report produced by Ergon[1] in April 2017.

Based on the revised guidance, the Trust's 2017/2018 Modern Slavery Statement provides more information on the six areas above.

The Trust's past Modern Slavery Statements are published on the Hull and East Yorkshire Hospitals NHS Trust internet site (under 'Corporate Documents', 'Other Documents').

3 THE PROPOSED STATEMENT FOR 2017/2018

The proposed Statement (see Appendix 1) is attached stage. This has been reviewed by the Workforce Transformation Committee and Modern Slavery Working Group as a draft.

The Action Plan (see Appendix 2) is provided as an update for the Board on ongoing activities in order for the Trust to meet our obligations under the Modern Slavery Act 2015. The Action Plan will continue to evolve over time as our knowledge in this area grows. The Steering Group will use the Action Plan to track any ongoing work that is taking place in relation to modern slavery and also use it to highlight where there are currently gaps that could be improved upon.

[1] 'Modern slavery statements: One year on' http://ergonassociates.net/

The formal Statement needs to be approved and signed by the Trust Board, and must be published within six months of the end of the financial year on the Trust's website with a link in a prominent place on the homepage. The 2017/2018 Statement will also be included in the Trust's 2017/2018 Annual Report.

4 RECOMMENDATION

The Trust Board is asked to approve the attached Modern Slavery Statement for 2017-18, and for its publication the Trust's website and inclusion in the annual report

Sarah Dolby
HR Advisor - Employment Policy and Resourcing

Simon Nearney
Director of Workforce and Organisational Development

May 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

MODERN SLAVERY STATEMENT
FOR THE FINANCIAL YEAR 1 APRIL 2017 TO 31 MARCH 2018

1. Introduction

This statement sets out the steps that the Hull and East Yorkshire Hospitals NHS Trust have taken for the financial year; 1 April 2017 to 31 March 2018, to ensure that modern slavery (i.e. slavery and human trafficking) is not taking place in any part of its own business or supply chains.

2. Organisational Structure and Supply Chains

Hull and East Yorkshire Hospitals NHS Trust is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire.

The Trust employs just over 8000 staff, has an annual turnover of over £500m and has two main sites; Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

The Trust's organisational structures are available on the Trust's internet site https://www.hey.nhs.uk/download/structure/ for the:

- Board Committee Structure
- Executive Management Committee Structure
- Executive Structure
- Health Group Structure

2.1 Supplies and Procurement Department

The Supplies and Procurement Department is made up of the Stock Purchasing Team (NHS Supply Chain), Non-Stock Purchasing Team (Buyers), Contracts Team and Stores Team.

The overall aim of the Supplies and Procurement Department is to reduce costs and ensure all goods and services are covered by a robust cost effective contract, whilst adhering to the Trust's 'Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions[2]'.

The 'Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions' regulate the way in which the proceedings and business of the Trust are conducted and summarise the requirements in relation to tenders and quotations, as below:

Value of Goods/Services	Tender/quotation requirement
Less than £10k (including VAT)	Use NHS supply chain and established contracts where possible otherwise obtain a quotation
Between £10k and up to £50k (including VAT)	Obtain a quotation
£50k to £106k (including VAT)	Undertake a local tender exercise
More than £118,133k (including VAT)	Tender exercise using EU procurement procedures

[2] Standing Orders and Standing Financial Instructions, https://www.hey.nhs.uk/about-us/corporate-documents/

The Trust currently purchases approximately £27m worth of stock from NHS Supply Chain[3] on an annual basis. As NHS Supply Chain provides healthcare products and supply chain services to the NHS as a whole, they have a robust code of conduct which they expect their suppliers to adhere to. The code of conduct states that all of the NHS Supply Chain's suppliers should support the principles of the United Nations' Global Compact, UN Universal Declaration of Human Rights as well as the 1998 International Labour Organisation Declaration on Fundamental Principles and Rights at Work, in accordance with national law and practice.

In addition to the code of conduct, NHS Supply Chain published their approach to ensuring their suppliers are compliant with the Modern Slavery Act 2015 in October 2016[4].

The Trust spends approximately £55m per year on non-stock products (i.e. not ordered through NHS Supply Chain), which are managed by the Non-Stock Purchasing Team (Buyers). The team are responsible for ensuring that goods are ordered against agreed contracts.

The Contracts Team are responsible for ensuring that the correct contracts are in place to obtain goods and services at competitive prices for the Trust in line with the 'Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions' and other relevant current legislation.

The tendering process within the Trust requires organisations to complete a 'Selection Questionnaire (SQ)'. Following the introduction of the requirements under the Modern Slavery Act 2015, the SQ documentation has been updated to include the following:

Section 7: Modern Slavery Act 2015: Requirements under Modern Slavery Act 2015

Question	Response
7.1 Are you a relevant commercial organisation as defined by section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act")?	Yes ☐ N/A ☐
7.2 If you have answered yes to question 7.1 are you compliant with the annual reporting requirements contained within Section 54 of the Act 2015?	Yes ☐ Please provide the relevant url … No ☐ Please provide an explanation

The tender documentation also requires external companies to submit contingency plans, covering a range of issues, so that in an event of a failure there is a plan in place. The Trust scores contingency plans and this becomes part of the overall decision as to whether a tender is accepted. The Trust will review whether any provisions can be added into contingency plans relating to modern slavery (see Action Plan for timescales).

The Trust is currently putting a process in place to quantify the number of organisations that, through the tender documentation, state they are compliant with the Modern Slavery Act 2015. The Trust intends to have this set up in order that this can be reported on in the Trust's 2018/2019 Modern Slavery Statement.

[3] https://www.supplychain.nhs.uk/about-us/what-we-do/
[4] The UK Modern Slavery Act 2015, Monday 17 October 2016, https://www.supplychain.nhs.uk/news/company/the-uk-modern-slavery-act-2015/

As stated above, the Trust undertakes a huge amount of business with suppliers providing goods or services. Where possible the Trust has robust processes in place to ensure that the external companies used are compliant with current legislation. However, the Trust recognises that where orders are placed outside the tendering process, there is an increased risk that the companies providing goods or services are not compliant with the Modern Slavery Act 2015.

That being said, for all orders placed outside the tendering process, a 'Purchase Order' is completed and sent to the external company. The conditions of the 'Purchase Order' state: "Where no valid agreement exists for the items listed above the following NHS Terms and Conditions shall prevail (as applicable):

- NHS Terms and Conditions for the Supply of Good (Purchase Order Version) or NHS Terms and Conditions for the Provision of Services (Purchase Order Version)."

The Trust is in the process of exploring whether the above conditions include reference to Modern Slavery (see Action Plan for timescales).

3. Organisational Policies

Trust policies are subject to a thorough consultation process, which involves new and amended policies being discussed at relevant committees/groups, for example, the Trust's Policy Sub Group, (which is attended by a mix of staff side and management side representatives both medical and non-medical). Policies then go through a ratification process prior to being published on the Trust's intranet site.

All Trust policies are available to staff via the Trust's intranet and are available to the public through a Freedom of Information request. The Trust is committed to reviewing policies on a regular basis and in line with changes to legislation.

The Trust has a number of internal policies and procedures in place (shown below) to help safeguard against modern slavery, and will continue to review these as appropriate and ensure that modern slavery is referenced where appropriate.

3.1 General Policies

Raising Concerns at Work (Whistleblowing) Policy

This policy provides staff with information about how to raise concerns about dangerous or illegal activity in the Trust. There are legal protections built in to whistleblowing to encourage staff to speak up without repercussions on their employment.

To support this policy, a flowchart outlining 'How to Raise Concerns' was developed and published on the Trust's intranet in 2017. The document provides an overview of the different means in which a person can raise a concern about patient safety or staff welfare.

Risk Policy and Procedures

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.

The policy provides employees with information on how to identify risks, assess 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.

3.2 Recruitment Policies

Recruitment and Selection Policy (excluding Medical and Dental Staff)
The purpose of this policy is to promote the Trust as an employer of choice, and maintain a framework of fair, efficient and cost effective recruitment and selection procedures that are compliant with relevant legislation.

The policy provides staff with the assurance that the Trust is devoted to preventing slavery and human trafficking in its corporate activities, this includes due diligence with regard to recruitment and selection and that the Trust adheres to the National NHS Employment Checks Standards, which includes vigilant pre-employment screening.

Recruitment and Selection - Medical and Dental Consultant Staff
This policy is designed to ensure that there is a consistent approach to recruitment, selection and the appointment of Consultants, ensuring that they are recruited in a way that:

- Is free from unlawful bias
- Is compliant with relevant legislation
- Ensures that candidates demonstrate values shared by the Trust
- They demonstrate evidence of their compliance with the 4 domains of the General Medical Council's Good Medical Practice
- Portrays the Trust in a positive and professional manner
- Reflects the Trust's commitment to equality and diversity and flexible working practices

The policy also confirms that the Trust adheres to the National NHS Employment Checks Standards.

Pre-Employment Checks Policy (incorporates Criminal Record Checking Policy)
This policy provides a framework for the effective management of pre-employment checks required for the appointment of employees and engagement of agency, volunteer and honorary staff. The policy provides further detail of the NHS Employment Checks Standards and confirms that no person shall commence employment or be engaged in a role without the required checks taking place.

Engaging Temporary Workers (Bank and Agency) Policy
Following the publication of the NHS Improvement (NHSI) Agency Rules in March 2016[5], the Trust developed this policy to set out the expectations, roles and responsibilities that must be adhered to for authorising, sourcing, booking and paying temporary workers.

Within the Agency Rules, NHSI reminded trusts of their ultimate responsibility to ensure all agency workers engaged in employment at their organisation comply with the standard NHS Employment checks. The Trust's policy complies with this.

Health and Safety at Work Policy
This policy states that contractors are expected to conform to the relevant health, safety and welfare statutory requirements including giving due attention to any Codes of Practice and / or appropriate Guidance Notes issued by the HSAC / HSE or other authoritative bodies. This includes the Trust's own safety policies and procedures.

[5] NHS Improvement Agency Rules, March 2016
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/510391/agency_rules__23_March_2016.pdf

3.3 Safeguarding Policies

The NHS has a broad range of policies relating to Safeguarding. The policies provide guidance to staff on recognising the signs of modern slavery and provide advice on what to do in such cases:

- Chaperone Policy
- Guidance on the Medical Assessment of Children with Concerns of Neglect Guideline
- Investigation and management of children who have been sexually abused
- Management of Female Genital Mutilation (FGM) Policy
- Managing Allegations against Staff (Children and Adults) Policy
- Patient Visitors Guidelines
- Safeguarding Children - Court Statements Guideline
- Safeguarding Children - Escalation of Concerns Guideline
- Safeguarding Children - In Whom Illness is Fabricated or Induced Guideline
- Safeguarding Children - Management of Children and Young People who Do Not Attend (DNACancel) their Appointment Guideline
- Safeguarding Children – Managing Allegations or Concerns Against Staff Guideline
- Safeguarding Children and Adults Supervision Policy
- Safeguarding Children Policy
- Safeguarding of Adults at Risk Policy

The Trust has strengthened its safeguarding arrangements for adults and children, with the Trust's regulator and commissioners confirming that good assurance is received from the Trust in this area. This route is starting to be used to raise and report concerns regarding modern slavery identified by Trust staff.

4. Assessing and Managing Risk

4.1 Due Diligence

The Trust is committed to preventing slavery and human trafficking in its corporate activities, and to ensuring that its supply chains are free from slavery and human trafficking. The Trust also has a responsibility to ensure that workers are not being exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

4.1.1 Recruitment

The Trust adheres to the National NHS Employment Checks Standards, which among others includes pre-employment checking which seek to verify that an individual meets the preconditions of the role they are applying for.

4.1.2 Supply Chains

The Trust expects that the supply chains it works with have suitable anti-slavery and human trafficking policies and processes in place, and where possible this has now been built into key documentation e.g. tender documentation.

Throughout 2017 and continuing into 2018, areas within the Trust have continued to extend a significant amount of effort into requesting affirmation from suppliers that they comply with the Modern Slavery Act 2015. The Trust is exploring how this information can be captured in a central location.

There are 14 active agencies who supply ODPs and Nurses to the Trust as and when required. Over the past year the Trust has contacted all 14 agencies to obtain assurance that they are compliant with the Modern Slavery Act 2015. The Trust will continue to chase responses.

A process for receiving assurances from suppliers used within the Estates, Facilities and Development Directorate has been established to ensure the Trust can report on this in the 2018/2019 statement.

4.1.3 Incident Reporting

The Trust has a robust incident reporting system, managed by the Risk Team, where modern slavery concerns can be raised, which are then brought to the attention of the Safeguarding Team. The Safeguarding Team will then investigate the concern and determine whether a safeguarding alert should be made against the appropriate organisation. During 2016 the importance of having a robust reporting system was reaffirmed, when a human trafficking concern was raised and passed onto the safeguarding team, who followed up and dealt with the concern as required.

From 1 April 2017 to 31 March 2018, within the Trust there were 4 safeguarding concerns reported and followed up on as appropriate.

4.1.4 Training

In April 2015 Modern Slavery was embedded into the Trust's mandatory Safeguarding training for all staff, which forms part of the Trust's key performance indicators.

As of March 2018 in excess of 90% of Trust staff are compliant with the required training.

In addition, the Trust also provides a 'Modern Slavery and Human Trafficking' voluntary eLearning module to help frontline healthcare staff identify and support victims of human trafficking. Promotion of this additional training will take place as part of the awareness-raising programme (see Action Plan for timescales).

Modern Slavery is also embedded into other relevant training programmes including Recruitment and Selection.

4.1.5 Awareness-Raising Programme

Following the obligation to produce the modern slavery annual statement, a Steering Group formed within the Trust, made up of key colleagues who represent the areas where there are potential links to modern slavery (HR/Procurement/Risk/Facilities/Training). The Steering Group facilitates the work that needs to be undertaken to ensure that the Trust is meeting its obligations under the Modern Slavery Act 2015. The Steering Group also reviews and updates this modern slavery statement on an annual basis and identifies new actions to further embed the requirements of the Modern Slavery Act 2015 in the Trust.

There is also a local partnership working group in place to specifically look at the processes for referral, led by the Safeguarding Adult Board and in which the Trust is represented.

Safeguarding Champions have been identified across the Trust, which provides individuals with an understanding of the fundamentals for good safeguarding (which includes modern slavery and human trafficking). The Safeguarding Champions ensure consistency of expertise in all teams, act as a role model in the workplace, provide information in order for staff to identify people at risk of harm and take action and ensure documentation is completed correctly, accurately, timely and forwarded to the right place.

Information relating to modern slavery has been included in Trust communications on four occasions over the past year to help raise awareness.

Due to changes in staffing which impacted on the Steering Group and resource issues, the planned awareness campaign in 2017 was postponed. The Group however, plan to hold the campaign in 2018.

4.2 Risks
Whilst due diligence shows that the Trust has a number of robust steps on place to safeguard against modern slavery, there continues to be a range of risks associated with modern slavery.

For example:

- Due to resourcing issues, the Trust is unable to contact every past supplier of goods or services to request that they are compliant with the Modern Slavery Act 2015. However, processes are either in place or being set up to obtain and record this information e.g. through the inclusion of the modern slavery section in the 'Selection Questionnaire'.

- Although the Trust provides training to staff on modern slavery and there are clear pathways to follow when a safeguarding issue is identified, the Trust cannot be assured that every single staff member would feel empowered and confident to recognise the signs of modern slavery and raise the concern. However, as stated in section 3.1, a human trafficking concern was raised in 2016 through the Trust's Patient Advice and Liaison Service (PALS). In addition to this, when a query regarding a tender came up in relation to modern slavery, the staff member knew who to contact (i.e. Modern Slavery Group) to clarify some information received. Therefore whilst, there is still room to improve on raising awareness of modern slavery within the Trust, there are examples where non clinical staff have recognised and raised a concern.

- Some of the Trust's key policies that have links to modern slavery, do not always reference modern slavery clearly, if at all. Therefore the Modern Slavery Steering Group will review which policies need to include more information relating to modern slavery and work with the relevant departments to update them (see Action Plan for timescales).

The Action Plan in Appendix 1 identifies the steps that need to be taken, in order for the Trust to continue to raise awareness of the modern slavery agenda.

The Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed	_____	Signed	_____
	Mr Terry Moran Chairman		Mr Chris Long Chief Executive
Dated	_____	Dated	_____

APPENDIX 2

MODERN SLAVERY ACTION PLAN
UPDATED APRIL 2018

OPEN ACTIONS:

Date Raised	Description	Owner	Comments	Due Date
August 2016	Obtain assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015	ALL	• Agencies supplying ODPs / Nurses to the Trust have been contacted. Outstanding responses have been chased. • Suppliers within Estates and Facilities have been contacted and outstanding responses are being chased.	Review at each meeting
April 2018	Identify contacts within Capital Development, Medical Staffing and Workforce Planning to assist with obtaining assurances from suppliers	ALL	• Engaging temporary workers – is modern slavery part of the framework agreement?	Review at each meeting
December 2016	Compile list of responses received from suppliers/agencies and create mechanism for annual review	ALL	• Currently all statements of assurance received have been saved electronically within individual departments. • Review how this can be stored centrally.	Review at each meeting June 2018
April 2018	Review Trust corporate policies and include references to modern slavery where appropriate	ALL	• Review list in June 2018 meeting. • SD to lead on contacting relevant departments to update policies as appropriate.	March 2019
April 2018	Awareness-Raising Programme	ALL	• SD to engage with Communications team. • Review progress with JP re posters. • Group to arrange campaign. • Review Modern Slavery Steering Group attendees and identify other areas to engage with e.g. risk. • Promote voluntary modern slavery e-learning as part of the awareness-raising programme.	March 2019
February 2017	Modern slavery training	JP/BG	• Review safeguarding presentation – update required SP for the children's safeguarding training.	Review at June 2018

Date Raised	Description	Owner	Comments	Due Date
			• Review whether links to Salvation Army modern slavery training are available following a period of being offline. If live, add to HEY247.	meeting
April 2018	Supplies and Procurement: • Identify a volunteer to take part in the Modern Slavery Steering Group • Review whether any provisions can be added into contingency plans • Set up process to quantify the number of organisations that, through the tender documentation, state they are compliant with the Modern Slavery Act 2015 • Review whether the NHS Terms and Conditions for the Supply of Good (Purchase Order Version) or NHS Terms and Conditions for the Provision of Services (Purchase Order Version) include reference to Modern Slavery	JL		Review at June 2018 meeting
Dec 2016	Link in with Modern Day Slavery Pathway for Hull and Wilberforce Institute for the study of Slavery and Emancipation	ALL	• Consider how the Trust can work in partnership with relevant agencies.	Review at June 2018 meeting
February 2017	Action Plan to be shared with WTC/Diversity and Inclusion Steering Group quarterly	SD	• Share in April 2018, July 2018, October 2018, January 2019.	Ongoing

COMPLETED ACTIONS:

Date Raised	Description	Owner	Comments	Due Date
August 2016	All new nursing agencies will be asked for assurance at the point they supply staff to the Trust	JB	• Process has been set up to do this as and when required	Closed
December 2016	Set up shared folder	SD		Closed
August 2016	Update Recruitment and Selection training (incl. overview of modern slavery/key contacts)	SD	• Updated December 2016	Closed
August 2016	Review the process for changing bank details in ESR (re could staff be forced to change bank details?)	SD	• ESR self-service allows staff to change bank details electronically without notifying payroll • Agreed that this can be dealt with through raising awareness of modern slavery	Closed
December 2016	Put up posters around the Trust to raise awareness	ZD/JP	• Posters have been put up in key areas (nursing, PALS etc.)	Closed
February 2017	Modern slavery training	ZD/JP/BG	• Midwives now have a one hour mandatory training session on modern slavery • Review safeguarding presentation – all Safeguarding Adults Training has been reviewed and includes references to Modern Slavery • The new 'Modern Slavery and Human Trafficking' eLearning course is now available on HEY247	Closed Closed Closed
December 2016	Update Trust's Safeguarding intranet	ZD/JP	• Key contacts updated including police contact	Closed
August 2016	Supplies to amend Pre-Qualification Questionnaire	TBC	• SD to chase Supplies for update and ask for volunteer to attend meetings – the PQQ has been updated (section 7) to include: – "Are you a relevant commercial organisation as defined by section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act")?"	Closed

			– "If you have answered yes to question 7.1 are you compliant with the annual reporting requirements contained within Section 54 of the Act 2015?"	
August 2016	Agree Modern Slavery Statement for 2016/2017 to national timescales and monitor ongoing work being done nationally	All	• 2016/2017 Statement to be produced by the end of June 2017. Statement approved in May 2017 and will be published on the Trust internet site (under Corporate Documents) and will also be contained within Trust's Annual Report	Closed
August 2016	Raising awareness re Modern slavery.	SD/JP/ZD/BG	• Comms on a monthly/quarterly basis for eNews (incl. sharing Salvation Army modern slavery training) – Articles on modern slavery have appeared in Trust comms in April 2017, May 2017, August 2017 and September 2017 • Share Flex newsletter with group	Ongoing
December 2016	Arrange awareness campaign	All	• Confirm availability of planned training dates • Additional meeting to be arranged to organise campaign asap	Closed – will be reopened in 2018
February 2017	Undertake further work in its supply chain, to identify and understand any significant risks	All	• Supplies to work with the Steering Group	Closed
December 2016	Obtain assurance from Hand Car Wash who clean Trust vehicles	AM	• The Trust Property Manager has confirmed that the hand car wash situated on Anlaby Road is privately run on private land and therefore has no connection with the Trust, although they have provided assurance by email.	Closed
December 2016	Modern slavery concern raised by Patient Experience	SD		Closed
August 2017	Letter from Siemens asking the Trust for assurance that obligations are met in accordance with the Modern Slavery Act 2015	SD/JL/DS	• Signed letter returned to Siemens	Closed

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

Trust Board date	May 2018		**Reference Number**	2018 – 5 - 19		
Director	Sarah Bates, Deputy Director Quality Governance and Assurance		**Author**	Leah Coneyworth, Compliance Team Manager		
Reason for the report	The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2017/18 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication in June 2018.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to: • Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication in June 2018 • Note the key dates detailed in section 3 of this report					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): Regulation 17 – Good Governance					
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY ACCOUNTS 2017/18

1. PURPOSE OF THE PAPER

The purpose of this paper is to inform the Trust Board of the process for approving the final Quality Account for 2017/18 and to seek approval for responsibility to be delegated to the Quality Committee for final ratification of the Quality Accounts before publication in June 2018.

2. QUALITY AND SAFETY PRIORITIES

The quality and safety priorities for 2018/19 were approved following consultation in February 2018 with patients, staff, Trust members and stakeholders. The agreed quality and safety priorities for 2018/19 are:

Safer Care (Patient Safety)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired infections
- To reduce avoidable hospital acquired pressure
- To reduce avoidable acute kidney injury
- To reduce avoidable patient palls

Better Outcomes (Clinical Effectiveness)

- To improve the early recognition and treatment of people with sepsis
- To improve the care of people with mental health problems
- To reduce avoidable mortality
- To improve the process of transition between paediatric and adult care services
- To improve handover arrangements

Improved Experience (Patient Experience)

- To listen to and act on patient experience to improve services

3. QUALITY ACCOUNTS

3.1 Draft

The first draft of the 2017/18 Quality Accounts is attached at Appendix A. The draft includes performance data which will be updated when the end of year data is available which then may also change the overall status of achievement. There are also some sections highlighted in red which do not include all the information as yet, this will be included when the information is available. The draft will continue to be updated with up to date information, data and any amendments made to content e.g. errors, additional content and any suggested changes.

3.2 Stakeholder Statements

The Quality Committee approved the first draft of the Quality Accounts for distribution to key stakeholders on 08 May 2018. The key stakeholders are the main commissioners (NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group), Healthwatch Hull, Healthwatch East Riding of Yorkshire, Hull Overview and Scrutiny Committee (OSC) and East Riding OSC.

The stakeholders have 30 days to provide a 500 word statement each on the content of the Quality Accounts. The deadline for the stakeholders to return their statements is 05 June 2018. Once all statements have been received the Trust will respond with its statement, all of which will be included in the Quality Accounts before publication.

3.3 Limited Assurance Review

Grant Thornton has performed an initial limited assurance review of the Trust's Quality Account for 2017/18 and it has been confirmed that the document is in line with the legal requirements and has a good outcome; however the Trust is yet to finalise the sections which are currently reported as to be confirmed due to the availability of data. The Trust continues to update the draft Quality Account to ensure all gaps are completed. Grant Thornton will review the final draft and will complete their audit as well as provide a signed limited assurance statement for inclusion in the final Quality Account.

4. NEXT STEPS

- March to June – internal audit to be undertaken an assessment to ensure the Trust has met all requirements before publishing the quality accounts
- May 2018 – The Compliance Team will continue to complete the draft Quality Account, ensuring all information is included as required
- May 2018 – Trust Board to provide delegated responsibility to the Quality Committee for final ratification and approval before publication
- June 2018 - deadline for the stakeholder statements to be returned
- June 2018 – the Compliance Team will review the statements, consider any suggested amendments and respond with the Trust statement
- June 2018– submit the final version to the Quality Committee for final sign off before for publication
- June 2018 – publication of the 2017/18 Quality Accounts on NHS Choices and send to the Secretary of State and NHS England in adherence to the legal requirements

5. RECOMMENDATIONS

The Trust Board is recommended to:

- Confirm delegated responsibility to the Quality Committee for final ratification of the Quality Accounts before publication.
- Note the key dates detailed in section 4 of this report

Leah Coneyworth
Compliance Team Manager
May 2018

Hull and East Yorkshire Hospitals NHS Trust

Great Staff - Great Care - Great Future

Quality Account 2017/18

Contents

What is a Quality Account?

What is a Quality Account?

The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a Quality Account look like?

Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). This toolkit can be accessed via https://www.gov.uk/government/news/quality-accounts-toolkit.

The Quality Account must include:
Part 1 (Introduction)

- A statement from the Board (or equivalent) of the organisation summarising the quality of NHS services provided

Part 2 (Looking back at the previous financial year's performance)

- Organisation priorities for quality improvement for the previous financial year
- A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

Part 3 (Looking forward at the priorities for the coming financial year)

- A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience
- A series of statements from Stakeholders on the content of the Quality Account

Providers are able to add additional sections and information; however the Quality Account must have an introduction, it must then look back at previous performance and then look forward at the priorities for the coming financial year.

What does it mean for Hull and East Yorkshire Hospitals NHS Trust?

The Quality Account allows NHS healthcare organisations such as Hull and East Yorkshire Hospitals NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas e.g. service delivery and to inform the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare organisation it is scrutinising each and every one of its services, providing particular focus on those areas that requires the most attention.

How will the Quality Account be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 30 June 2018. Hull and East Yorkshire Hospitals NHS Trust also makes its Quality Account available on the website **http://www.hey.nhs.uk/about-us/corporate-documents/**

If you require any further information about the 2017/18 Quality Account please contact:
The Compliance Team on **01482 468098** or e-mail us at **quality.accounts@hey.nhs.uk**

Part 1: Introducing our Quality Account

This section includes:

- A statement on quality from the Chief Executive, Chris Long
- An overview of some of our success stories from 2017/18

Statement on Quality from the Chief Executive

Welcome to Hull and East Yorkshire Hospitals NHS Trust's 2017/18 Quality Account…

I am pleased to present Hull and East Yorkshire Hospitals NHS Trust's sixth Quality Account. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2018/19. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.

In Part 5 of this report (pages 75 to 80) we set out the quality and safety improvement priorities for 2018/19. These priorities were identified through consultation with staff, Trust members, Health & Well Being Boards, Healthwatch, Clinical Commissioning Groups and the local community. As a result, the following quality and safety improvement priorities were identified:

Safer Care (Patient Safety)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired infections
- To reduce avoidable hospital acquired pressure
- To reduce avoidable acute kidney injury
- To reduce avoidable patient palls

Better Outcomes (Clinical Effectiveness)

- To improve the early recognition and treatment of people with sepsis
- To improve the care of people with mental health problems
- To reduce avoidable mortality
- To improve the process of transition between paediatric and adult care services
- To improve handover arrangements

Improved Experience (Patient Experience)

- To listen to and act on patient experience to improve services

Many staff and our stakeholders have been involved in the development of the Quality Account. Comments from the stakeholders on the content of the Quality Account are included in full in Part 6 of this report (pages 82 to 84). We welcome involvement and engagement from all staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2017/18 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

Chris Long
Chief Executive

Overview of 2017/18 – Celebrating Success

The following table provides an overview of our successes during 2017/18. Some of the year's highlights include:

May 2017	**Accreditation for GI Physiology** The Gastrointestinal (GI) Physiology Department based at CHH became the Trust's first 'Physiological' discipline to be granted accreditation under the Improving Quality in Physiological Services (IQIPS) programme and only the third GI Physiology Service in the UK to be awarded accreditation status. IQIPS has been developed to improve, promote and recognise good quality practice across eight physiological disciplines, namely Audiology, Cardiac Physiology, Gastrointestinal Physiology, Neurophysiology, Ophthalmic and Vision Science, Respiratory and Sleep Physiology, Urodynamics and Vascular Science. Accreditation is delivered and managed by The United Kingdom Accreditation Service (UKAS). The IQIPS programme seeks to validate and recognise success, raise the profile of physiological services, and drive up quality by aspiring towards excellence and sharing good practice.	
	Getting snug on Ward 26 at Castle Hill Hospital Staff on Ward 26, Castle Hill Hospital have been working to help improve patients' emotional well-being by transforming an unused space into somewhere patients now want to spend time and socialise	
June 2017	**Regional Arthroplasty Centre opened** A new, international centre of orthopaedic excellence opened at Castle Hill Hospital. The Trust worked alongside long-time partner and multi-award winning healthcare company, JRI Orthopaedics, to establish its first UK Centre of Excellence for joint replacement. The Hull and East Yorkshire Regional Arthroplasty Centre (HEYRAC) will have a key role in clinical research, sharing of best practice and the development of new hip replacement products and surgical techniques.	
July 2017	**Dementia Friendly Garden** The Southwood Dementia Friendly Garden was opened and is located between wards 8 and 9 at Castle Hill Hospital; the courtyard area has been transformed to provide a tranquil and picturesque area for patients to take time out, spend time with relatives and visitors, and for staff to spend their breaks. The garden incorporates a 'Wizard of Oz' theme and is complete with lion, tin man, and scarecrow and ruby slippers.	

September 2017	**Cosy Makeover for Fracture Clinic, HRI** The Fracture Clinic waiting room might not be the first place you'd expect to find antique furniture and a fireplace but thanks to the creative efforts of one member of staff, these additions are helping to enhance the care we provide.	
November 2017	**A Sight to behold** A multi-sensory sculpture created as part of the 2017 City of Culture 'Creative Communities' project was unveiled in the Hull and East Yorkshire Eye Hospital. "A Sight to Behold" was led by Hull and East Riding Institute for the Blind (HERIB) and created by artist Jemma Brown, working with visually impaired people from across the region.	

Part 2: Review of our Quality Achievements

This section includes:

- An overview of the 2017/18 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2017/18 priorities

Overview of 2017/18 – Performance against Priorities

The following table provides an overview of performance against all targets during 2017/18. We recognise that not all of our quality and safety improvement priorities for 2017/18 have been achieved in full; however significant improvement in some areas is demonstrated and we will continue to work and further improve on these areas during 2018/19.

Key

	Target achieved
	Target was not achieved, but improvements were made on the previous year
	Target was not achieved, performance remained the same or deteriorated
	Targets were discontinued*

*The reasons why the targets were discontinued can be found on pages 10 to 29, detailed on the relevant priority area pages.

Quality and Safety Improvement Priority	Target	Status
Medication Safety	Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hours	
	Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	
	10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	
	Introduction of a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled	
Deteriorating Patient (Adult)	Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient	
	Reduction in failure to escalate Serious Incidents	
Avoidable Hospital Acquired Pressure Ulcers	To have no avoidable hospital acquired Stage 3 pressure ulcers	
	To have no avoidable hospital acquired Stage 4 pressure ulcers	
	To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	
	To have no more than 23 avoidable hospital acquired SDTI	
	To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers	
	100% compliance with 14 day completion of the root cause analysis investigation	
	100% compliance with duty of candour - written	
	100% compliance with duty of candour - verbal	
Nutrition and Hydration	90% of wards rated amber or above using the Trust's Fundamental Standards audits	
	100% of wards to achieve 90% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration	
	85% of wards achieve compliance with the monthly census audit for fluid balance management	
	85% of wards achieve compliance with the monthly census audit for flood and hydration chart	
Avoidable Patient Falls	To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	
	50% of clinical staff in the identified high risk areas to have completed the falls prevention e-learning by the end of March 2018. The following wards were identified as the high risk areas:	
	HRI Ward 9	
	HRI Ward 90	
	HRI Ward 8	

	HRI Ward 80	
	HRI EAU	
	CHH Ward 29	
	CHH Ward 31	
	Allied Health Professionals	
Venous Thromboembolism (VTE)	Achieve 95% compliance with the VTE Risk Assessment	
	Achieve 0 VTE Serious Incidents	
	To increase the number of doctors completing the VTE e-learning module	
Avoidable Hospital Acquired Infections	To have 0 hospital acquired MRSA bacteraemia	
	To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53	
	To continue to reduce the number of Hospital acquired MSSA to <=46	
	To continue to reduce the number of Hospital acquired E. Coli to <=95	
Sepsis	2a – Timely identification of sepsis in emergency departments and acute inpatient settings	TBC
	2b – Timely treatment for sepsis in emergency departments and acute inpatient settings	TBC
	2c - Antibiotic review	TBC
	2d – Reduction in antibiotic consumption per 1,000 admissions	TBC
Resuscitation Equipment and Checklists Compliance	Achieve 95% compliance with the completion of the daily resuscitation equipment checks	
	Achieve 95% compliance with the completion of the weekly resuscitation equipment checks	
	Achieve 95% compliance with the completion of the monthly resuscitation equipment checks	
	Achieve 0 incidents reported relating to missing equipment	
Avoidable Mortality	To review all deaths where family, carers or staff have raised a concern about the quality of care provision	
	To review all deaths of patients who are identified to have a learning disability and/or severe mental illness	
	To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures	
	To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis	
Compliance with National Standards for Interventional Procedure Checklists	Achieve full implementation of the improvement project	
Learning Lessons	Baseline established for cultural survey with expected improvements made on baseline by year end	
Patient Experience	Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate	

The following section of the Quality Account provides a more detailed account on achievements and areas for further improvement for each of the priorities above.

Medication Safety

Medication errors can occur with the prescribing, dispensing, storage, handling or administration of medicines. Medicines remain the most common therapeutic intervention in healthcare. It is important that individual patients get as much benefit out of medicines as possible and resources are used wisely and effectively.

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hours*
- Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time
- 10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy
- Introduction of a 'safety net' system to help focus resource on those patients admitted more than 72 hours ago whose medicines have not been reconciled

*The target was discontinued because medicines reconciliation is continually monitored and reported each day, and any patients whose medicines have not been reconciled are targeted individually to ensure medicines reconciliation is completed. Pharmacy resources have to balance a range of roles including support with in-patient medication issues as well as safe & timely discharge.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve reconciliation of medicines on admission to hospital for 70% of our patients within 24 hours	46%	53%	
Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	81%	89%	
10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	1 hr 43 mins	1hr 45 mins	
Introduction of a 'safety net' system to help focus resource on those patients admitted more than 72 hours ago whose medicines have not been reconciled	No baseline	Introduced	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The Trust has continued to implement the medication safety improvement project during 2017/18 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2016/17 quality improvement plan. This was to ensure that patients receive medicines reconciliation in a timely manner, improving the discharge process to ensure timely and safe supply of medicines prior to leaving hospital by trained staff supported by the Trust Drug Policy, and a range of other projects introduced to improve the safe and effective use of medicines within the Trust. The changes made were embedded with pharmacy support to ward areas and to continue to improve the management of medicines across the Trust.

Although the target of 70% for medicines reconciliation on admission to hospital within 24 hours was not achieved, it is important to recognise that medicines reconciliation for patients during their hospital stay is regularly above 90%. The

Trust has also introduced a safety net system to help focus resource on those patients admitted more than 72 hours ago whose medicines have not been reconciled. Along with the introduction of a monthly medicines management ward audit undertaken jointly by the ward pharmacist and senior nurse, and embedded a system of reporting and governance for the results.

Other achievements include:

- Electronic prescribing was successfully introduced to ward 29 at the Queens Centre, CHH.
- All pharmacy audits were completed and signed off in the required timescale
- The Trust discharge policy was reviewed and ratified
- Improvement work on ward 9 at HRI was undertaken with pharmacy support on the morning drug administration round to identify any drugs not available and facilitate ordering in a timely manner. This resulted in a reduce number of missed doses.
- Working with the HEY Improvement team, Pharmacist transcribing was piloted on ward 9 at CHH and showed improvements in discharge planning & patient flow, and an increase in the number of morning discharges.
- A medicines management technician was introduced in the surgical admissions lounge at CHH to undertake medicines reconciliation.
- A new piloted report from Cayder was trialled to identify patients who have been admitted for <20 hours, this enabled pharmacy teams to target patients and improve medicines reconciliation.
- The reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time target has been achieved.

The project for reducing dispensing errors by improving the working environment in the pharmacy at HRI has been closed due to the need for detailed plans and infrastructure costs.

The target of reducing by 10% the average waiting times for discharge prescriptions dispensed in the hospital pharmacy has not been achieved. The reasons for this are multifactorial but include an increased intake of new staff requiring training, temporary shortage of Accuracy Checking Technicians in the dispensary, and later arrival of discharge prescriptions into the pharmacy. We plan to improve this by:

- Training more Accuracy Checking Technicians to perform the 'final check' on discharge prescriptions
- Promoting the role of the dispensary co-ordinator bleep holder, so wards can contact pharmacy on a dedicated number to assist with discharges
- Proposing the purchase of a customised tracker system to help us capture and report more accurate data
- Using pharmacist prescribers to help write discharge prescriptions
- Newly trained pharmacists being part of ward teams to screen discharge prescriptions on the ward, facilitating the discharge process
- Increasing the number of trained Pharmacy Assistants to dispense discharge prescriptions
- Closely monitoring discharge prescription turnaround times to identify improvements
- Introducing e-rostering to ensure staff working hours are matched to demand

Further improvements identified:

Further improvements in medicine optimisation have been identified and it is therefore a quality and safety priority for 2018/19 (see page 76) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page68.

The focus for further improvements will be:

- Extension of electronic prescribing to the wards in the Queen's Centre at CHH supporting efficiency and patient safety, including a review of infusion functionality
- Review of current pre-packs available on wards to facilitate a more efficient discharge
- Project to assess if more patient's own drugs can be used whilst in hospital
- Project (5th floor at HRI) on utilising, and potentially expanding, number of pharmacists transcribing discharge prescriptions to contribute to improving morning discharge figures and improving patient experience
- Improving the knowledge and awareness on VTE prevention by pharmacists undertaking an e-learning package, with a view to roll out to other professions by the Thrombosis Committee
- Improve safe use and prescribing of insulin
- Support adult cystic fibrosis patients by the introduction of an annual medication review
- Introduction of Biosimilar Adalimumab to maximise the use

Deteriorating Patient – Adult

Early recognition of a patient's deterioration through better assessment, escalation and early treatment of patients will enable appropriate planning and improved patient care.

What we aimed to achieve in 2017/18:

The aim of this project is to ensure early identification of a patient's deterioration and to ensure the correct treatment and escalation plans are in place and documented.

This priority aimed to achieve the following specific targets by the end of March 2018:

• Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient*

** Due to the nature of the audit and the range of elements reviewed a decision was made in-year to assess this element against the number of serious incidents linked to deteriorating patient.*

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Improved results against the baseline clinical observation audit of the recognition of the deteriorating patient	13	No data	
Reduction in failure to escalate Serious Incidents	=>12	11	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The Trust continued to focus on training and awareness raising as part of the deteriorating patient project. Over 3,000 relevant and available staff were trained on NEWS (National Early Warning Score – assessment and escalation) and over 1,000 on sepsis and Observations (SOBs). Whilst this has not seen the desired reduction in Serious Incidents, progress has still been made. It is however, acknowledged that this has not be at the pace expected across all areas of the organisation. Key achievements however, have included the launch of face to face and online training tools, an outreach link established on each ward and a review of the relevant policies and procedures in line with new national guidelines.

Further improvements identified:

It has been identified that further improvement on the early recognition of deteriorating patients is required and it is therefore a quality and safety priority for 2018/19 (page 76) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be:

- Continued roll-out of e-observations against the pace of installation of WiFi across the hospital sites
- Continued focus on the development of the training and awareness packages available across the Trust

Avoidable Hospital Acquired Pressure Ulcers

Pressure ulcers occur when an area of skin is placed under pressure and the skin and tissue starts to break down. Pressure ulcers can cause great pain, skin damage and can be very distressing for patients. They are proven to represent a major burden of sickness and impact on the individual's quality of life.

What we aimed to achieve in 2017/18:

The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers.
This project aims to ensure that appropriate risk assessments, plans of care highlighting required nursing interventions and meaningful evaluations are undertaken by knowledgeable staff, for every patient, and that, through this avoidable skin damage is prevented.

This priority aimed to achieve the following specific targets by the end of March 2018:

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

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To have no avoidable hospital acquired grade 3 pressure ulcers	1	4	
To have no avoidable hospital acquired grade 4 pressure ulcers	0	1	
To have no more than 8 avoidable hospital acquired unstageable pressure ulcers	13	12	
To have no more than 23 avoidable hospital acquired SDTI	35	34	
To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers	52	56	
100% compliance with 14 day completion of the root cause analysis investigation	81%	67%	
100% compliance with duty of candour – written	83.3%	80%	
100% compliance with duty of candour - verbal	93.3%	92%	

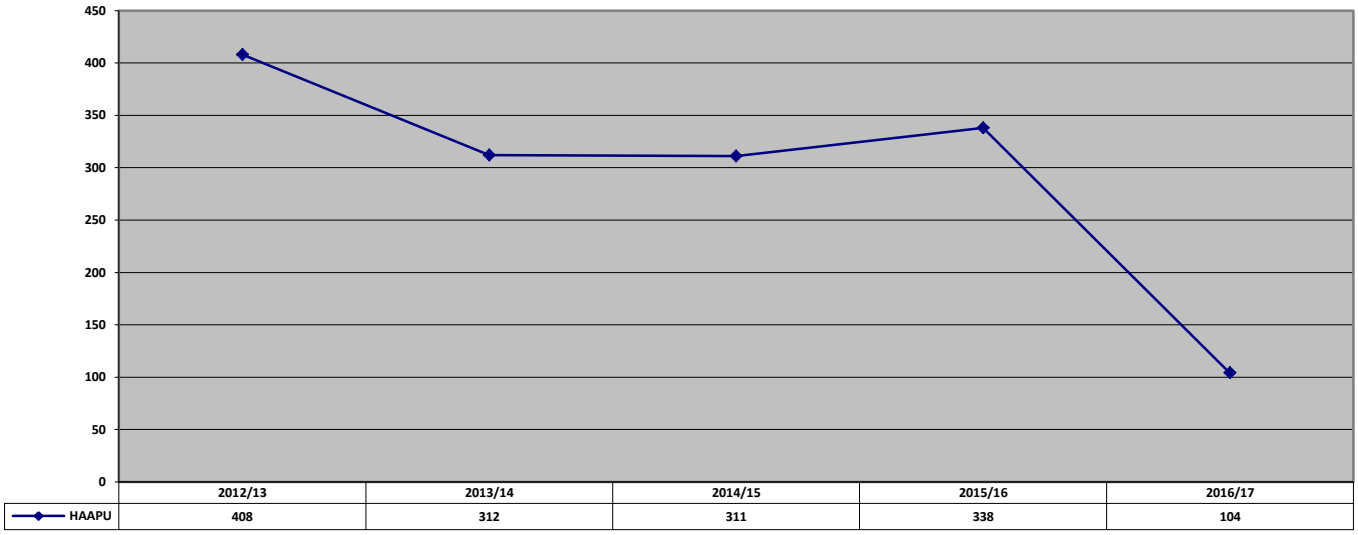
The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of this project was to prevent all patients developing avoidable hospital acquired pressure ulcers. This project aimed to ensure that all patients receive appropriate risk assessments, a plan of care highlighting required nursing interventions and meaningful evaluations which are undertaken by knowledgeable staff. This project monitored the CQC Duty of Candour requirements to improve the patient's experience of open and honest communication should a hospital acquired pressure ulcer occur.

Whilst not all performance measures were met for this project a significant reduction in pressure ulcers has been seen over the life of this project. As detailed in the following graph:

This graph is currently being updated with 2017/18 figures



	2012/13	2013/14	2014/15	2015/16	2016/17
HAAPU	408	312	311	338	104

Further improvements identified:

It has been identified that further improvement on reducing the number of avoidable pressure ulcers is required and it is therefore a quality and safety priority for 2018/19 (page 77) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be:

- The review of specific mattresses – pilot and then tendering process in 2018
- Storage and tracking of mattresses
- Surgical Site Infections in Maternity
- Leg Ulcer training and competencies
- Threshold of the Tissue Viability Fundamental Standards audits increased to drive up quality of care
- Student Nurse training and the development of the 'High Five' Ward Rounds (now including medical staff)
- Training Needs Assessment for all Sisters and Senior Matrons amended to include the requirement to complete the higher level tissue viability training on an annual basis
- The development of a strategic local group (chaired by the Hull and ER CCGs) reviewing a joint approach to improving skin care across health and social care
- Wound Management process amended to include the requirement that all patients with pressure damage, either community or hospital acquired is reviewed by a Sister/Senior Matron daily

Nutrition and Hydration

Nutrition and hydration are essential elements of patients' care. Adequate nutrition and hydration helps to sustain life and good health. It reduces the risk of malnutrition and dehydration while patients are receiving care and treatment in hospital and provides patients with the nutrients they need to recover.

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018

- 90% of wards rated amber or above using the Trust's Fundamental Standards audits
- 100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration*
- 85% of wards achieve compliance with the monthly census audit for fluid balance management*
- 85% of wards achieve compliance with the monthly census audit for flood and hydration chart*

**targets were discontinued because the methodology changed in-year to become more integrated with the Trust's Fundamental Standard audits*

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
90% of wards rated amber or above using the Trust's Fundamental Standards audits	79.6%	91.3%	
100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration	89.5%	No data	
85% of wards achieve compliance with the monthly census audit for fluid balance management	No baseline	No data	
85% of wards achieve compliance with the monthly census audit for flood and hydration chart	No baseline	No data	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

In March 2017 a Nutritional Prevalence Audit (census) was completed, with a specific aim of reviewing the compliance with Trust nursing staff in relation to their requirements within the HEY Nutrition and Hydration Policy. A number of actions were identified, all of which have been completed. When the audit was completed again in March 2018, improvements were noted in several areas, including a 10% improvement in weighing patients daily.

The Trust's Nutrition Policy was also updated and amended to reflect required changes identified by the census and this was approved in December 2017.

The Trust also undertook a review of the questions included in the Nutrition and Hydration Fundamental Standards and provided increased support and training by senior nursing staff to those wards scoring poorly. The Trust achieved 91.3% of wards rated amber or above using the Trust's Fundamental Standards audits at the end of the year, which was an improvement on the baseline of 79.6%.

Further improvements identified:

It has been identified that further improvements on nutrition and hydration are required in order to ensure further and sustained improvement. It is therefore a quality and safety priority for 2018/19 (see page 76) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be to improve patient's nutrition by achieving and monitoring the required actions / improvements from the March 2018 Nutritional Prevalence Re-Audit and developing any required actions to improve compliance with the Nutrition Fundamental Standards.

Avoidable Patient Falls

A fall is defined as an unplanned or an unintentional descent to the floor, with or without injury, regardless of the cause. A patient falling in hospital is one of the most common patient safety incidents reported to the National Reporting and Learning System (NRLS). Patient falls in hospital are a common cause of injury; increased length of stay, hospital acquired infections and can have a longer term impact on a person's well-being. Some falls cannot be prevented without unacceptable restrictions to patients' rehabilitation, privacy and dignity; many falls can and should be prevented.

What we aimed to achieve in 2017/18:

The aim of this project will be to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factoral Assessment Tool (MFAT), which will drive forward improvements in falls prevention through the completion of e-learning.

This priority aimed to achieve the following specific targets by the end of March 2018:

- To reduce further the number of patient falls per 1000 bed days for patient falls rated moderate or above
- 50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018*

*In December the target was revised to focus on the high risk areas only

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	6.39	0.17	
50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018. The high risk areas were identified as follows:			
Ward 9 HRI	No baseline	50%	
Ward 90 HRI	No baseline	60%	
Ward 8 HRI	No baseline	80.6%	
Ward 80 HRI	No baseline	51.3%	
EAU HRI	No baseline	61%	
Ward 29 CHH	No baseline	16%	
Ward 31 CHH	No baseline	62%	
Allied Health Professionals	No baseline	17.3%	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The Trust has continued to implement the avoidable patient falls improvement project during 2017/18 following further embedding of the falls improvement work and continuing to reduce the number of avoidable falls and increase the learning from incidents, resulting in significant improvements.

Achievements against the delivery of this project have been identified through compliance with National Institute of Clinical Excellence (NICE) guidance which has driven through the improvement in falls prevention through the improved completion of MFAT and the completion education along with the focusing on the outcomes for the patient following a fall and to learn lessons from the root cause analysis.

The falls e-learning staff training package target was set at achieving 50% of clinical staff to have completed this initially, however this training was not a compulsory element for all staff and was therefore proving difficult to achieve due to other education demands and clinical demands. It was also felt that a more targeted approach was required and that it should target the high risk areas (areas with more falls) and the allied health professionals staffing group who work with these patients on a daily basis. Seven wards were identified along with the staffing group (as reported in the table above).

The reduction in the number of patient falls per 1000 bed days (rated moderate harm or above) has been mostly successful with only two out of the twelve months not meeting the target. The full roll-out of the weekend mobility plan was completed, also.

A review of medical records for patients who had experienced a fall with a harm level of moderate or above was completed. The review was to ensure the escalation process for the declaration of Serious Incidents related to falls was robust. The review accepted the decisions made not to declare an SI for the cases reviewed, with the exception of 1 case which is currently undergoing further consideration within the Senior Corporate Nursing Team. On the basis of this review and the recommendations of the report to the Falls Prevention Committee, further processes to obtain ongoing assurance have been developed, trailed and escalated for approval. This includes the development of falls specific serious incident decision form.

Various audits were undertaken including looking at the processes for the monitoring of the checks for injury and medical examination after a fall, Datix was altered to capture this – include an explanation on how DATIX was changed. The requirement to analyse this data has been added to the Falls Prevention Committee work plan once sufficient data has been collected.

Further improvements identified:

It has been identified that further improvements reducing the number of avoidable patient falls are required in order to ensure further and sustained improvement. It is therefore a quality and safety priority for 2018/19 (see page 77) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be:

- Re-audit undertaken using the census tool to identify compliance with the accurate completion of falls risk assessment, clinical appropriateness use of the bedrails and individualised care plans
- Development of 'fall prevention' poster campaign
- Auditing processes for the monitoring of the checks for injury and medical examination after a fall established
- Complete the re-evaluation of the falls prevention care bundle, Which includes redesign of the MFAT and the introduction of an improved bed rails assessment
- Revised documentation to be tested in various areas
- Meeting with patient experience to explore the use of volunteers to work with patients in prevention of falls
- Explore a method of ensuring mobility aids are available 24/7
- Development of a staff information poster
- Approval and introduction falls specific SID
- Review of NICE guidance to ensure compliance
- Bedside vision assessment to be developed in a proportionate format
- Update e-learning in line with changes to nursing documentation

VTE

Venous Thromboembolism (VTE) is a blood clot within a vessel. It happens when a blood clot forms and blocks a vein or an artery, obstructing or stopping the flow of blood. It most commonly occurs in the deep veins of the legs. This is known as Deep Vein Thrombosis (DVT).

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 95% compliance with the VTE Risk Assessment
- Achieve 0 VTE Serious Incidents
- To increase the number of doctors completing the VTE e-learning module

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 95% compliance with the VTE Risk Assessment	92.5% (Q4)	89.22% (Q3)	
Maintain 0 VTE Serious Incidents	2	0	
To increase the number of doctors completing the VTE e-learning module	986	1541	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The aim of this project was to ensure patients are risk assessed appropriately for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements. This project has been in the Quality Accounts and part of the QIP for two years. Whilst progress has been made and Health Groups have implemented changes performance fluctuates between 85-90%. The Trust must comply with a target of 95% and this has not been achieved. Following escalation and discussion at the Operational Quality Committee it was felt that they have exhausted the possibilities available to them to reach this target and need further support to understand barriers and it was agreed that dedicated improvement support is required from the HIP teams skills and knowledge to determine the barriers to progressing to achieving the target of 95%. Therefore this was closed as a quality and safety priority and the Quality Improvement Plan for 2017/18 and transferred to the HEY Improvement Team.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However, there are still improvement activities that will take place during 2018/19 which will be led by the Chief Medical Officer and it will be delivered by the HEY Improvement Team (HIP).

The focus for further improvements will be:

- Undertake further improvement work to determine what the barriers are to achieving the target of 95% of patients receive a VTE risk assessment within 24 hours of admission to hospital and working with the Health Groups to take the required steps to address the barriers identified and progress towards achieving the target

Avoidable Hospital Acquired Infections

What we aimed to achieve in 2017/18:

The aim of this project is to ensure compliance with the updated Health & Social Act (2012): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections.

This priority aimed to achieve the following specific targets by the end of March 2018:

- To have 0 Hospital acquired MRSA bacteraemia
- To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53
- To continue to reduce the number of Hospital acquired MSSA to <=46
- To continue to reduce the number of Hospital acquired E. Coli to <=95

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To have no hospital acquired MRSA bacteraemia	2	1	
To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53	45	38	
To continue to reduce the number of Hospital acquired MSSA to <=46	44	36	
To continue to reduce the number of Hospital acquired E. Coli to <=95	81	110	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The key improvements achieved for this project were based on the improvement and review of several processes related to infection and prevention and control, including staff engagement and training. These included reviewing the process and documentation for VIP charts, continence management training scoping, development of two new policies for IPC in Theatres and current intranet content review.

Further improvements identified:

It has been identified that further improvements on Avoidable Hospital Acquired Infections are required and it is therefore a quality and safety priority for 2018/19 (see page 76) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be to continue to reduce hospital acquired infections by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHSi Urinary Tract Infection Collaborative Project.

Sepsis

Sepsis occurs when the body's response to an infection causes damage to its own tissues and organs which can lead to shock, organ failure and death, especially when Sepsis is not identified in a timely manner and treated appropriately.

The Sepsis Six is a series of actions that must be taken within an hour when a patient is diagnosed with Sepsis. The Sepsis Six are designed to treat the condition and if they are applied quickly, they enhance the chance of survival.

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018:
CQUIN Indicators:

- 2a – Timely identification of sepsis in emergency departments and acute inpatient settings
- 2b – Timely treatment for sepsis in emergency departments and acute inpatient settings
- 2c - Antibiotic review
- 2d – Reduction in antibiotic consumption per 1,000 admissions

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
2a – Timely identification of sepsis in emergency departments and acute inpatient settings	Inpatient – 92% Emergency Department – 96%	TBC – data available May 2018	
192b – Timely treatment for sepsis in emergency departments and acute inpatient settings	Inpatient – 80% Emergency Department – 80%	TBC – data available May 2018	
2c - Antibiotic review	No baseline – new performance indicator for 2017-18	TBC – data available May 2018	
2d – Reduction in antibiotic consumption per 1,000 admissions 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions - 2% reduction on baseline 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions - 1% reduction on baseline 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions - 1% reduction on baseline	1. 54926.73 per 1,000 admissions 2. 643.53 per 1,000 admissions 3. 782.89 per 1,000 admissions	TBC – data available May 2018	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

Significant progress has been made on this project through the year. Sepsis pathways have been introduced Trust-wide, including the more recent launch of the paediatric pathway. This has been accompanied by bespoke training sessions and supplemented with increased awareness with partners, for example, Yorkshire Ambulance Service.

Throughout the year the project has progressed strongly with all milestones being met. As well as completing the milestones, evidence suggests that these have had a positive impact on sustained performance and in meeting the overall aim of the project.

It is evident from participation in regional and national forums and meetings that other Trusts have non clinical data collectors managing the CQUIN. The CQUIN data within Hull and East Yorkshire Hospitals NHS Trust is only collected and validated by clinicians. This policy has been validated, as the Medical Director for Clinical Effectiveness for NHS England has recently written to the Trust's Chief Executive congratulating the Trust on being one of the Trusts in England to have achieved the most significant improvement in Sepsis care and outcomes.

The unique training package on Sepsis and basic observations introduced last year by the Sepsis Team has now been made mandatory for all qualified nurses and midwives within the Trust. This is a key element in achieving the Trust's vision for improving the care of the deteriorating patient and to our knowledge. In recognition of this the Trust has recently been asked to present at the Westminster Health Forum. The Team have also presented a poster at a national Sepsis conference and an international patient safety conference.

In the absence of national guidelines as part of this project the Trust has developed specific Sepsis pathways for Paediatrics and Maternity incorporating the early warning scores relevant to these areas. The maternity pathway was rolled out in September 2017 and the Paediatric pathway was launched in March 2018. A specific set of Maternity antibiotic guidelines have also been developed to ensure that their infection management is in line with the antibiotic stewardship principles of the rest of the Trust.

Further improvements identified:

It has been identified that further improvements on sepsis are required and it is therefore a quality and safety priority for 2018/19 (see page 78) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be:

- The focus for 2018/19 will be on the consolidation of training and awareness both internally and with partner organisations. In addition, the project will seek to improve coding of sepsis.

Resuscitation Equipment and Checklists Compliance

What we aimed to achieve in 2017/18:

The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards.

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 95% compliance with the completion of the daily resuscitation equipment checks
- Achieve 95% compliance with the completion of the weekly resuscitation equipment checks
- Achieve 95% compliance with the completion of the monthly resuscitation equipment checks
- Achieve 0 incidents reported relating to missing equipment

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 95% compliance with the completion of the daily resuscitation equipment checks	93%	79%	
Achieve 95% compliance with the completion of the weekly resuscitation equipment checks	No baseline	79%	
Achieve 95% compliance with the completion of the monthly resuscitation equipment checks	95%	100%	
Achieve 0 incidents reported relating to missing equipment	0	0	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

During the year, the Trust developed and implemented a new template for monthly and daily resuscitation checks and supported the implementation of several 'bespoke' audits for various departments within the Trust that require a slightly different resuscitation trolley. In addition, a review of incidents reported found that there had been none reported within the year that related to missing or out of date equipment on a resuscitation trolley. The results from the monthly audits were reviewed and in general showed an overall improvement in compliance with the daily and monthly checks since the monthly audits commenced in May 2015.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However the focus for further improvements will be to continue to embed the new processes which should, in turn, show improvement in performance overall and a further period of review in 2017/18, against the same standards, will allow the Trust to compare and determine the success of the improvements made during this period. The Resuscitation Committee will continue to monitor the results of the annual audit and address any concerns that are highlighted through Datix, training sessions or an arrest.

Avoidable Mortality

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018:

- To review all deaths where family, carers or staff have raised a concern about the quality of care provision.
- To review all deaths of patients who are identified to have a learning disability and/or severe mental illness*
- To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.
- To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.

*LeDeR review undertaken separately to SJR

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
To review all deaths where family, carers or staff have raised a concern about the quality of care provision.	No baseline	100%	
To review all deaths of patients who are identified to have a learning disability and/or severe mental illness	No baseline	No data	
To review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures.	No baseline	100%	
To review all deaths where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis.	No baseline	100%	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The avoidable mortality project has made significant progress during 2017/18. Key areas of improvement have focused on:

- Engagement into the project from all Trust specialities; incorporating 90 trained reviewers that can undertake Structured Judgement Reviews
- Identifying patients that meet the national minimal criteria for case-note review, via the Business Intelligence system
- The publication of the first Themes and Trends report which provides information Trust wide and at Health Group level to improve patient care
- Development of a family/Next of Kin engagement questionnaire to inform of the Trust approach to mortality to review.
- The development and utilisation of an internal "Learning from Deaths Policy"
- The development and trial of a mortality "initial screen" form, on trial in Diabetes and Stroke – feedback from the trial will be reviewed as part of the 2018/19 programme
- A feedback mechanism designed to ensure all relevant Consultants and Doctors involved in a patients care receive a completed mortality review, for reflection and learning purposes.

- A mechanism to allow all monthly death statistics to be sent to the mortality lead for each speciality, for discussion within the Morbidity and Mortality meeting.
- Development and implementation of “Problems in Healthcare” section of mortality proforma utilised into Lorenzo
- Process developed and implemented on the completion of multi-agency mortality reviews.
- A new process in place to ensure all elective surgery deaths are reviewed, as per the national requirement.
- The procurement of a dedicated governance analyst role to support the Clinical Outcomes Manager and to assist in the development of learning lessons.
- The creation and implementation of the Trust Learning from Death dashboard.

Further improvements identified:

It has been identified that further improvements on avoidable mortality are required and it is therefore a quality and safety priority for 2018/19 (see page 78) and it will also be included in the Trust’s Quality Improvement Plan for 2018/19. For more information on the Trust’s Quality Improvement Plan see page 68.

The focus for further improvements will be:

- Development of a standardised “Quarterly themes and trends” report template, to be completed by each Speciality on a quarterly basis
- Mortality Review-Quality Assurance Process embedded
- Process agreed and implemented to allow the identification of patients who match the “Deteriorating Patient” criteria
- Initial Mortality Screening form developed and trialled within a number of specialties. Following review and approval by the Health Groups this screening form will then be rolled out within the Health Groups
- E-learning package designed for use in training Structured Judgement reviewers and implemented for all staff to access on HEY247

Compliance with National Standards for Interventional Procedure Checklists

What we aimed to achieve in 2017/18:

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

This priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve full implementation of the improvement project*

**Target discontinued due to the closure of this project in September 2017*

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve full implementation of the improvement project	No baseline	No data	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

This project was initially aimed at overall clinical checklist compliance however early in the year it was agreed that this was too wide a remit and the aim modified to focus only on WHO Checklist compliance and a separate Quality Improvement Project was developed to focus on reducing mortality and morbidity, including wrong site surgery, haemorrhage and infection, through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) Project in all specialities across the Trust. Following further review by the Trust, it was agreed that the HEY Improvement Team would lead on a project for the creation and implementation of NatSSIPs across the organisation, termed as Phase 1. Phase 1 included:

- Project scope for the rollout and sustainability of NatSSIPs
- Governance process in place for the ratification of local checklists (LocSSIPs)
- Agreed Key Performance Indicator (KPI) for expected level of compliance organisationally
- Local Safety Standards for Invasive Procedures Policy
- Standardised core surgical checklist (NatSSIP)
- NatSSIPs training programme
- Auditing process and programme

Phase 1 was delivered successfully in February 2018 with sustainable processes in place for the continuation of NatSSIPs within the organisation.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However there are still improvements activities that will take place during 2018/19 which will be led by the SSIPs Steering Group and it will be monitored by the Surgery Health Group.

The focus for further improvements will be the delivery of Phase 2 of the project will ensure the continual compliance and education of NatSSIPs within the organisation by ensuring the auditing programme for NatSSIPs performance

continues with remedial actions in place where standards are not being met, continual engagement with teams regarding their performance of NatSSIPs against the corporate standards and ongoing support for teams providing advice, training and information on the use of NatSSIPs.

Learning Lessons

What we aimed to achieve in 2017/18:

The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry.

The priority aimed to achieve the following specific targets by the end of March 2018:

- Baseline established for cultural survey with expected improvements made on baseline by year end

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Baseline established for cultural survey with expected improvements made on baseline by year end	No baseline	Completed	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The Trust has continued to develop and deliver a number of mechanisms for learning lessons, including monthly Safety Bulletins and Lessons Shared newsletters. The Trust launched a new Intranet site during the year. A section was created to provide an in house resource to assist staff learning. In addition, training programmes have been developed including the Learning, Candour and Accountability programme as well as developments through the Hey Improvement Team of structured and bespoke improvement methodology. The Trust has undertaken training with the Improvement Academy on the Measuring and Monitoring Safety Framework. This has been utilised in a number of projects throughout the year including Avoidable Mortality, Falls, Pressure Ulcers and Sepsis.

The Trust continues to investigate Serious Incidents, Claims and Complaints which have been utilised internally to develop robust governance reports to assist Health Groups and specialities in their learning. Themes and trends reports are being produced and work is ongoing with the Organisational Development Team to review the culture of learning in the Trust.

Further improvements identified:

This project will not be carried forward into 2018/19 as a quality and safety priority. However there are still improvements activities that will take place during 2018/19 which will be led by the Quality Governance Lead.

Patient Experience – listening to patients and acting on their feedback

Patient, family and carer experience is very important to the Trust. Listening to and acting on the feedback provided by patients, relatives and carers is crucial to learning lessons and to further improve our services. The Trust wants all patients to have the best possible experience when they come in contact with any of our services.

What we aimed to achieve in 2017/18:

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

The priority aimed to achieve the following specific targets by the end of March 2018:

- Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2016/17	Performance 2017/18	Status
Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate	61.60%	92.85%	

The following sections provide detail on what has been achieved in the delivery of the priorities e.g. what went well and also what was not achieved and has been identified as requiring further improvement.

Improvements achieved:

The Trust has continued to implement the Patient Experience improvement project during 2017/18 aiming to seek and act on feedback from our patients their relatives and careers. Many improvements have been made during 2017/18 to enhance how the Trust encourages, listens to the patient's voice and deals with feedback from patients, relatives and carers. The patient and public council are now linked to each individual health group to ensure the patient's voice is heard.

A survey was undertaken regarding complaint handling; from this a database was created to ensure a quality of the service by reviewing regularly, looking at themes and trends to show areas for improvements and key areas which have already improved. Unfortunately the number of returned surveys is very low; however the team are reviewing different methods of collecting this information to improve response rates. The Patient Experience Strategy was presented to the Trust Board and incorporated into the Trust People Strategy and a supporting work plan was developed to ensure the delivery of the Patient Experience Strategy objectives. The work plan has reached its requirements and will develop further during the next 12 months. The Falls Committee is utilising the volunteer's service to support its work to reduce avoidable patient falls on the wards. Positive and negative patient stories are shared at each Trust Board meeting as a different way of providing feedback to the Executive Team on patient experiences and to set the scene for the Board meeting. The patient stories have also been shared with Yorkshire Humber and PEN who welcomed the ideas and asked for the network to feedback.

The new providers for the interpreting service has been agreed and embedded. Development of interpreters using telephone interpreting service and 'Browse Aloud' service for the visually impaired has been completed and applied to most hand held devices throughout outpatients. The interpreters policy has been ratified and supporting tools will be implemented from the 1st April 2018 including a further 6 Ipads for use in departments.

The Trust continues to grow its list of valued volunteers, surpassing the target set, which is extremely encouraging. At the start of 2015, the Patient Experience Team embarked on a major piece of work to improve our volunteer service. It was recognised the added value that volunteers bring into our organisation and provided opportunities for the public to volunteer in different departments other than clinical areas.

Patient Experience has been working to ensure the recruitment process is clearer and quicker for volunteers whilst remaining safe and that core principles of the Lampard enquiry (2015) are upheld when recruiting. Recent advertising at the local job centres, GP surgeries, health clubs and the NHS jobsite has seen an increase of 500 volunteers since the new approach has been adopted.

The Trust has also introduced a Volunteer Induction which is run every month to give reassurance to the volunteer and the departments. The Induction includes a talk from the infection control team and the fire safety team. Each volunteer has access to the Trusts education website which includes mandatory training.

The Emergency Department (ED) has also welcomed the volunteers who provide support and reassurance to the patients and their families, providing refreshments and offering reassurance to them during what can be a very stressful time. The main reception at Hull Royal Infirmary has its own bank of volunteers, Monday to Friday providing sign posting and reassurance. Some patients find added value from the volunteers who help them with the check in service.

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 – improving the range of involvement of Patient Council members
- Patient Information Leaflets (PILS)
- Signage Group and Way finding

Further improvements identified:

The patient experience priority has been identified as a quality and safety priority for 2018/19 (see page 80) and it will also be included in the Trust's Quality Improvement Plan for 2018/19. For more information on the Trust's Quality Improvement Plan see page 68.

The focus for further improvements will be:

- Reduce the spend on interpreters by 15%
- To re-introduce 'you said, we did' boards around the Trust
- To maintain a level of 450 active volunteers within the Trust
- Develop a bank of volunteers to support wards and patients with the tower block
- Introduction of virtual BSL interpretation
- Liaise with the Falls lead nurse to consider how the volunteer service can support staff effectively in minimising falls
- Complaints team to provide bespoke training for each ward on the handling of concerns from patients and visitors to reduce the number of formal complaints

Part 3: Review of our Quality Performance

This section includes:

- Trust performance for 2016/17 and 2017/18 against the NHS Outcomes Framework quality indicators and planned actions the Trust intends to/has taken to improve performance
- Learning from Deaths
- Seven Day Services
- An overview of the patient safety incident reporting rates and actions taken to improve incident reporting across the organisation
- An overview of serious incidents and never events and actions taken to learn lessons
- Trust compliance with the national patient safety alerts
- NHS Staff Survey Results and Cultural Transformation

The NHS Outcomes Framework: Quality Indicators

What is the NHS Outcomes Framework?

Measuring and publishing information on health outcomes are important for encouraging improvements in quality. The White Paper*: Liberating the NHS* outlined the Coalition Government's intention to move the NHS away from focusing on process targets to measuring health outcomes.

The NHS Outcomes Framework reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. Performance against the quality indicators that are relevant to Hull and East Yorkshire Hospitals NHS Trust are detailed below. They relate to:

- Summary hospital level mortality (SHMI)
- Patient reported outcome measures (PROMS)
- Readmission rate into hospital within 28 days of discharge
- The Trust's responsiveness to the personal needs of our patients
- Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- The C.Difficile infection rate, per 100,000 bed days
- The number of patient safety incidents reported and the level of harm
- Friends and Family Test for patients for Accident and Emergency and Inpatients

The Hull and East Yorkshire Hospitals NHS Trust considers that this data is as described for the following reasons:

- Performance information is consistently gathered and data quality assurance checks made as described in the next section.

The table below details performance against the Summary hospital level mortality (SHMI):

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
• the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period*	112				
• the banding of the SHMI for the Trust for the reporting period*	1				
• the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	24.6%				

*Most recent data on HSCIC for period April 2015 - March 2016, published in September 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Avoidable mortality was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 24.
- Avoidable mortality has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 78.

The table below details performance against the Patient Reported Outcome Measures (PROMs):

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
• groin hernia surgery	58.6				
• varicose vein surgery	93.3				
• hip replacement surgery	85.9				
• knee replacement surgery	85.8				

* Most recent (Provisional) data From NHS Digital covers April 2016 - September 2016, published in February 2017

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust will focus its attention to improving compliance with the PROMs and improving outcomes for patients. A consultant lead and a Governance lead has been assigned to monitor compliance with the PROMS targets and to undertake improvement work. Further information on actions taken and achievements will be reported in next year's Quality Account.

The table below details performance against the Readmission rate into hospital within 28 days of discharge

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
• the percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	9.6%				
• the percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	7.3%				

* Taken from CHKS for period April 2016 to February 2017

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Add actions

The table below details performance against the Trust's responsiveness to the personal needs of our patients

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.	67.5				

* Most recent data from HSCIC covers April 2015 - March 2016, published in August 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Patient experience was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 29.
- Patient experience has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 80.

The table below details performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
Friends and Family Test – Question Number 12d – Staff – The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	79.3%				

* Most recent data from NHS England covers April 2016 - September 2016 (Cumulative), published in December 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust continues to undertake improvement work to improve the NHS Staff Survey results for staff engagement, bullying and harassment and experiences of working for Hull and East Yorkshire Hospitals NHS Trust. An update on the work undertaken during 2017/18 can be found on page 46.

The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Prescribed Information	2016/17		National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	82.8%				

* Most recent data from NHS England covers April 2016 - September 2016 (Cumulative), published in December 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- VTE was a quality and safety priority for 2017/18 and whilst progress has been made and Health Groups have implemented changes performance against the target for 95% of patients receive a VTE risk assessment within 24 hours of admission to hospital fluctuates between 85-90%. It was felt that the Health Groups have exhausted the possibilities available to them to reach this target and need further support to understand barriers and it was agreed that dedicated improvement support is required from the HIP teams skills and knowledge to determine the barriers to progressing to achieving the target of 95%. Therefore this was closed as a quality and safety priority and the Quality Improvement Plan for 2017/18 and transferred to the HEY Improvement Team. During 2018/19 the HEY Improvement Team will focus on identifying what the barriers are to achieving the target and work with the Health Groups to take the required steps to address the barriers identified and progress towards achieving the target.

The table below details performance against the C.Difficile infection rate, per 100,000 bed days

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	12.9				

* Most recent data from Gov.uk Statistics covers April 2015 - March 2016, published in July 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Avoidable hospital acquired infections was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 20.
- Avoidable hospital acquired infections has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 77.

The table below details performance against the number of patient safety incidents reported and the level of harm

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
• the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,	32.71				
• the number and percentage of such patient safety incidents that resulted in severe harm or death	0.4%				

* Most recent data from Gov.uk Statistics covers October 2015 - March 2016, published in September 2016

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Learning lessons was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 28.

The table below details performance against the Friends and Family Test for patients for Accident and Emergency and Inpatients

Prescribed Information	2016/17	2017/18	National Average	Best performer	Worst performer
Friends and Family Test – Patient - The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all Acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2) Accident and Emergency (types 1 and 2)	88.2%				
Inpatients	97%				

* Most recent data from NHS England covers April 2016 – December 2016 (Cumulative), published in May 2017.

The Hull and East Yorkshire Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by:

- Patient experience was a quality and safety priority in 2017/18. Actions taken and improvements achieved during 2017/18 can be found on page 29.
- Patient experience has been identified as a quality and safety priority again for 2018/19. Key areas for improvement which the avoidable mortality project will focus on are detailed on page 80.

Learning from Deaths

What is learning from deaths?

While most hospitals undertake some form of mortality review, historically there has been a wide variation in terms of methodology, scope, data analysis, and contribution to learning. The establishment of a consistent process of reviewing care through a structured analysis of patient records it aims to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm.

How is the Trust implementing learning from deaths?

In October 2016 Hull and East Yorkshire Hospitals NHS Trust adopted the Structured Judgement Review (SJR) methodology to undertake case note reviews.

Developed by the Improvement Academy and Royal College of Physicians, Structured Judgement Review (SJR) blends traditional, clinical-judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but a rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The object of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where there may be gaps, problems or difficulty in the care process.

The SJR has been designed to aid current review and investigation methodologies, rather than to replace. The Trust has a robust Serious Investigation framework that incorporates the Structured Judgement case note review; therefore a number of investigational techniques are adopted in order to determine if sub-optimal care contributed to a patient's death.

Learning from deaths update

This section provides an update against the prescribed information for learning from deaths as detailed in the 'Detailed requirements for quality reports 2017/18' which was published in January 2018. This was as a result of the publication of the revised 'National Health Service (Quality Accounts) (Amendment) Regulations 2017'.

Prescribed Information		Trust update
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure	During 2017/18, 2418 of Hull and East Yorkshire Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 546 in the first quarter • 518 in the second quarter • 607 in the third quarter • 747 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure	By April 1st, 2018, 353 case record reviews and 10 investigations have been carried out in relation to 2418 of the deaths included in item 27.1. Any Serious Incident investigation where the patient has died will incorporate a full case note review. In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Prescribed Information		Trust update
		• 3 in the first quarter • 2 in the second quarter • 5 in the third quarter • 0 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this	10 representing 0.41% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: • representing 0.12% for the first quarter • representing 0.08 % for the second quarter • representing 0.20% for the third quarter • representing 0% for the fourth quarter. These numbers have been estimated by consideration of all Serious Incidents that occurred within the reporting period, where patient death was likely to be due to problems in the care provided.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3	The following themes were identified from case reviews and investigations, where problems in care were more likely than not to have contributed to the patient death: • Failure in Communications – including inadequate communication systems. • Delay in the recognition of a deteriorating patient. • Lack of awareness of agreed policy/procedure
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4)	The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include: • Lessons learned newsletters and global emails circulated to inform staff of lessons learned • Lesson learned seminars held • Focused audits on case note documentation standards • Introduction of Advanced Care Practitioners to grand ward-rounds
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period	No assessment of impact of the actions as described in 27.5 was completed.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	0 case record reviews and 0 investigations completed after 01/04/2017 which related to deaths which took place before the start of 2017/18.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this	0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Learning Lessons

Identifying good practice is equally as important as identifying poor practice. Good practice should be celebrated and shared, as it can often be replicated and utilised elsewhere in the Trust. The following good practice processes have been identified within the Surgery Health Group mortality reviews:

Multidisciplinary input sought and available in good time. Including fast access to Specialist input whilst the patient is in the Emergency Department.

Excellent, Multi-disciplinary care delivered in ICU, including comprehensive family involvement.

Excellent communication with the patient's family during the End of Life care phase, involving the family when necessary and showing a good degree of compassion.

Themes and trends identified from the review of Surgery Health Group deaths follow the same themes and trends that are identified by other review methodologies, such as Serious Incident Investigations and patient complaints. The main themes and trends identified are summarised below:

A lack of staff communication evident within the patient case-notes

Patchy, inconsistent documentation within the patient case-notes during the patient stay.

A delay in the recognition of patient deterioration

Improving Quality

Quality Improvement must remain at the heart of the Structured Judgement Review. The Trust has undertaken over 300 reviews which has allowed for themes and trends to be identified. An example of issue identification and quality improvement is as follows:

Issue Identified – Documentation

One of the recurring themes identified from the Structured Judgement Review is the lack of proper and consistent documentation within the patient case-notes.

Investigation

To further explore possible solutions for improvement, the Clinical Outcomes Manager undertook a small-scale, focussed documentation audit on a sample of patients on the Orthopaedic ward, who had a fractured neck of femur. The audit examined the quality of documentation within the case-notes specifically on the 4th, 5th and 6th day post-operatively.

Results

It was found that documentation was up to standard up until the 4th or 5th day post-operatively, after which, documentation became patchy and inconsistent. The audit results and summary were shared with the Orthopaedic team for discussion.

Action/Change

Changes are now being made to the Orthopaedic documentation booklet to improve the consistency of regular documentation. Advanced care practitioners are now utilised within grand ward rounds and this has improved the culture around proper and consistent documentation, in-line with national standards. This has had a very positive impact on the culture of ward-rounds.

Re-audit
A re-audit is planned to ensure that the implemented changes have had a positive impact on documentation on the Orthopaedic ward. The possibility of replicating this method throughout the Trust could have a positive impact on documentation standards for other Specialities.

Next Steps
The Trust has made a considerable amount of progress on improving how it learns from patient death. The Structured Judgement Review methodology has embedded and flourished across the Specialities and provided a platform for mortality to be discussed in a structured and transparent way.

MIAA (Mersey Internal Audit Agency) awarded the Trust "Significant Assurance" after undertaking a mortality review baseline assessment and recognising the positive steps taken by the Trust to not only align itself with national recommendations, but also to exceed.

To maintain this positive momentum the Trust will continue to actively review patient death and explore further ways to improve the quality of care delivered to patients, including further collaborative work with the Clinical Commissioning Groups, including General practice and mental health services.

Seven day Services in the NHS

What does it mean to provide seven day services?

Seven day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. The seven day services programme is designed to improve hospital care with the introduction of seven day consultant-led services that are delivered consistently over the coming years.

10 clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are the four standards that all NHS Trusts adopt and implement by 2020. Implementation of these standards is monitored by NHS Improvement.

The four standards are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – On-going review by consultant twice daily if high dependency patients, daily for others

What do seven day services mean to patients?

Implementation of the four priority clinical standards will ensure patients:

- don't wait longer than 14 hours to initial consultant review
- get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- get access to specialist, consultant-directed interventions
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

Monitoring of the Clinical Standards at Hull and East Yorkshire Hospitals NHS Trust

The Trust has undertaken a stocktake of progress against compliance with the four priority clinical standards and is working to achieve full compliance.

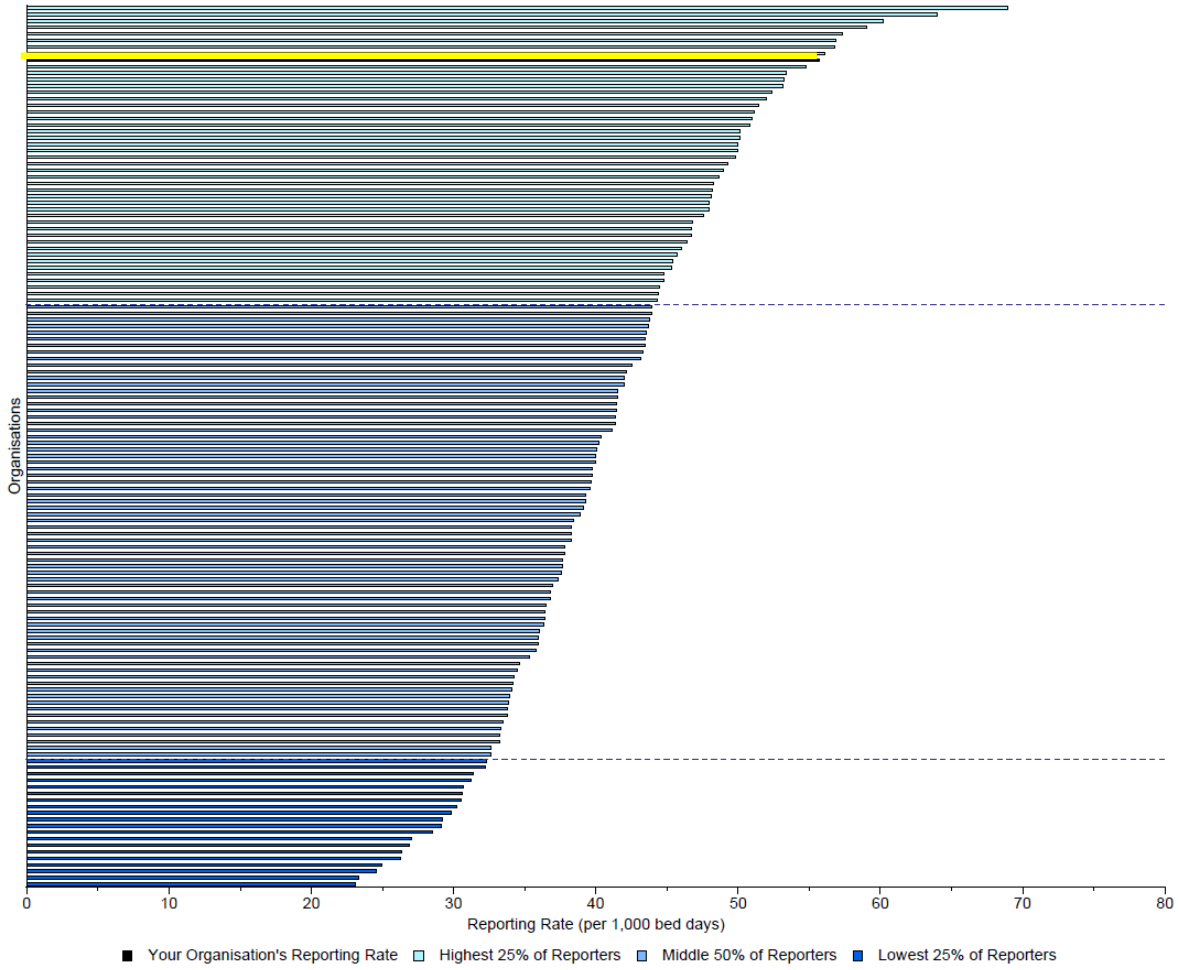
Standard	Compliance	Actions to address
Standard 2 Time to First Consultant Review	Partial compliance	Review of medical staffing resource in key areas. Improved identification and flagging of patients within the electronic patient administration system.
Standard 5 Diagnostic Services	Partial compliance (critical and urgent care times met, only partially compliant for non-urgent patients)	Recruitment to vacant posts and review of staffing rotas to enable extension of diagnostic services.
Standard 6 Consultant-directed interventions	Fully compliant	
Standard 8 On-going review	Partial compliance	Review of medical staffing resource in key areas, including recruitment to vacant posts and review of job plans.

Patient Safety Incidents

The Trust aims to provide care that is safe, effective and high quality for all patients and service users. One of our priorities is 'Lessons Learned' with the aim to actively learn lessons from patient safety incidents, Serious Incidents (SIs) and never events. Learning lessons allows us as an organisation to understand the causes of the incidents and to take the appropriate action to avoid reoccurrence. To be able to learn lessons from patient safety incidents we need to ensure the organisation has a strong incident reporting culture (i.e. a high level of incident reporting), which is a sign of a good patient safety culture.

Figure 1 is taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report published September 2017 and shows the Trust to be in the highest quartile of reporters having previously been below average for reporting of patient safety incidents. This increase in reporting is due to a review into the incidents the Trust reports to the NRLS and a review of the coding within the Risk Management System.

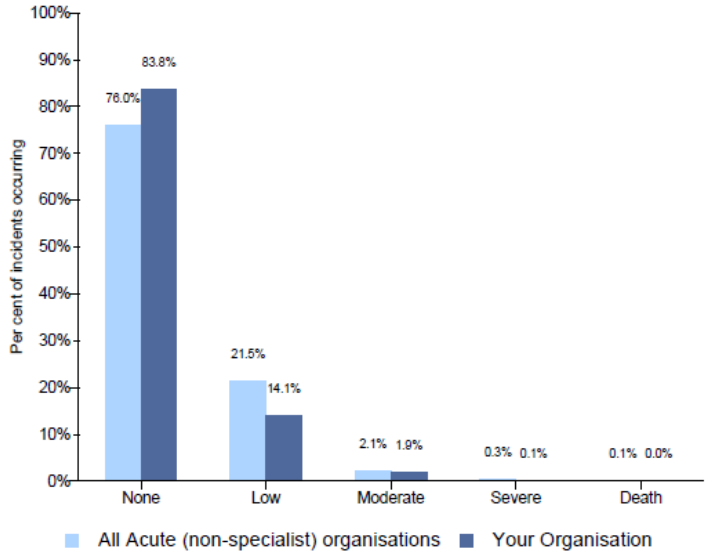
Figure 1: Patient safety incidents per 1000 admissions for the period of 1 October 2016 to 31 March 2017



*Hull and East Yorkshire Hospitals NHS Trust is highlighted in above

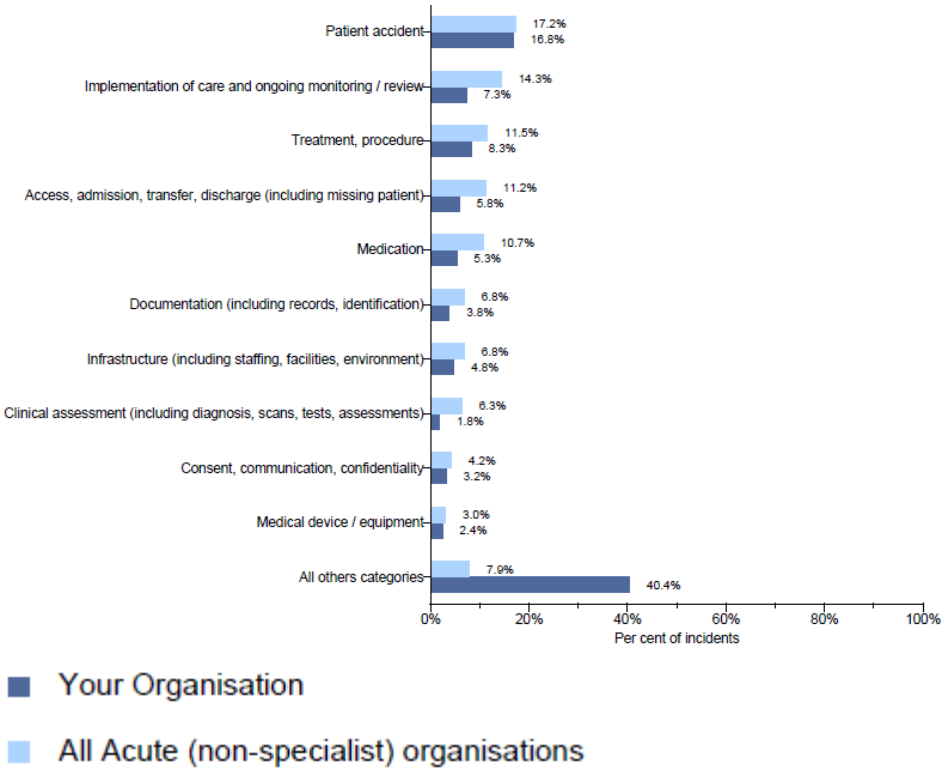
Figure 2 shows the incidents reported by degree of harm, comparing Trust performance with that of Acute (non-specialist) organisations and is taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report published September 2017.

Figure 2: Incidents reported by degree of harm for Large Acute organisations for the period between October 2016 and March 2017



The Trust appears to be reporting in line with the cluster on degree of harm. The top 10 types of patient safety incident reported between October 2016 and March 2017 are detailed in **Figure 3** below showing the top 10 types of incidents reported within our reporting cluster compared against the number reported by the Trust.

Figure 3: Top patient safety incidents reported by %



The above graphs are taken from the recently published NRLS report.

During 2017 significant work was undertaken to review the incident reporting process within the organisation however this will not be apparent until the NRLS report to be published in 2018 has been released. The work included a review of the incident form, coding and how incidents are investigated. The changes have resulted in

- Reduction in the number of incidents with investigations taking more than 28 days
- Review and revision of coding structures within the system
- Review of the types of incidents reported to the NRLS and the mapping to the NRLS codes
- Review of the incidents coded to 'other' to the correct type of coding.

Serious Incidents and Never Events

In organisations as large and complex as the NHS, things will sometimes go wrong. Incident reporting is one of the key methods for alerting other parts of the organisation to issues that, if left unattended, may pose a risk in future to service users or the health and safety of staff, visitors, contractors and others that may be affected by its operations.

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death on hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Total number of Never Events and Serious Incidents declared in each year:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total Never Events declared	3	4	5	4	2	6
Total Serious Incidents declared	8	32	88	107	67	63
Total*	**11**	**36**	**93**	**111**	**68**	**69**

* Excludes any which have been de-escalated from Serious Incident status

Types of Serious Incident and Never Events declared during 2015/16, 2016/17 and 2017/18

Serious Incident type	2015/16	2016/17	2017/18
Treatment Delay	19	17	11
Treatment Delay – lost to follow up *(extracted as own category from 2017/18)*	0	0	8
Unexpected Death	3	9	10
Patient Fall	18	8	2
Sub-optimal care of the deteriorating patient	9	8	8
Pressure Ulcer (3 or 4)	11	4	8
Absconded Patient	0	3	0
Delayed Diagnosis	17	2	1
Drug Incident	3	2	1
Retained foreign object (not a Never Event)	1	2	0
Surgical/Invasive Procedure incident	10	2	7
Unplanned NICU admission	0	2	4
HCAI/Infection Control Incident	2	1	1
Intrapartum Death	2	1	0
Never Event – Misplaced NG Tube	0	1	0
Never Event – Wrong Site Surgery	2	1	3
Never Event – Wrong Implant	0	0	1
Never event – Surgical Invasive Procedure	0	0	1
Never Event – Medication Incident	0	0	1
Never Event – Retained Foreign Object	2	0	0
Retained dressing (not a Never Event)	2	0	0
Wrong Site Surgery (not a Never Event)	1	0	0
12 hour ED trolley breaches	7	0	0
Others	2	5	2
Totals	111	68	69

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) reduced during 2016/17 and 2017/18. The Trust feels that this shows a balance of reporting, and increased confidence that we are reporting the right incidents.

The Trust declared 6 Never Events in 2017/18 more than in any other reporting period; four relating to wrong site surgery, one a wrong implant and one a wrong route administration of medication. Following this increase in Never Events the Chief Executive delivered a briefing to the Trust's Clinical teams in April 2018, which included plans to deliver a 'Stop the Line' campaign to enable and empower all staff to stop a procedure if they witness unsafe acts.

During 2017/18 the Trust has further developed on the improvements made during 2016/17 in regards to their Serious Incident processes and methods for investigation. The Trust continues to put in place new processes for escalation and declaration of serious incidents, have reviewed templates for serious incident reports, and improved relations with our Commissioners to create a more open, transparent and honest dialogue on our SIs.

Hull and East Yorkshire Hospitals NHS Trust believes, at the end of 2017/18 that while we still have Serious Incidents and Never Events occurring, it remains committed to providing the best care to our patients and our responses to the Serious Incidents and Never Events are much improved and the learning and actions arising from the investigations is helping to improve the patient safety within the organisation.

Patient Safety Alert Compliance

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the National Reporting and Learning System and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

NHS Improvement issue three types of alert, Warning Alerts issued in response to new or under-recognised patient safety issues which ask healthcare providers to take constructive action to reduce the risk of harm occurring; Resource Alerts issued in response to already well-known issues which ask health care providers to plan implementation of new resources and Directive Alerts, issued because a specific, defined action to reduce harm has been developed which can be widely adopted through standardisation of practice or equipment.

Coordination of patient safety alerts is carried out by the Risk Management Team who work with various Trust departments and Health Groups to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

NHS England NPSAS alerts issued 2017/18 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	06-Apr-17	06-Oct-17	Action complete and matter resolved
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	05-Jul-17	16-Aug-17	Action complete and matter resolved
NHS/PSA/RE/2017/004	Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks	11-Aug-17	11-Dec-17	Action complete and matter resolved
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	27-Sep-17	08-Nov-17	Action complete and matter resolved
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannula after procedures	09-Nov-17	09-Aug-18	Action required: On-going
NHS/PSA/W/2018/001	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	09-Jan-18	20-feb-18	Action complete and matter resolved

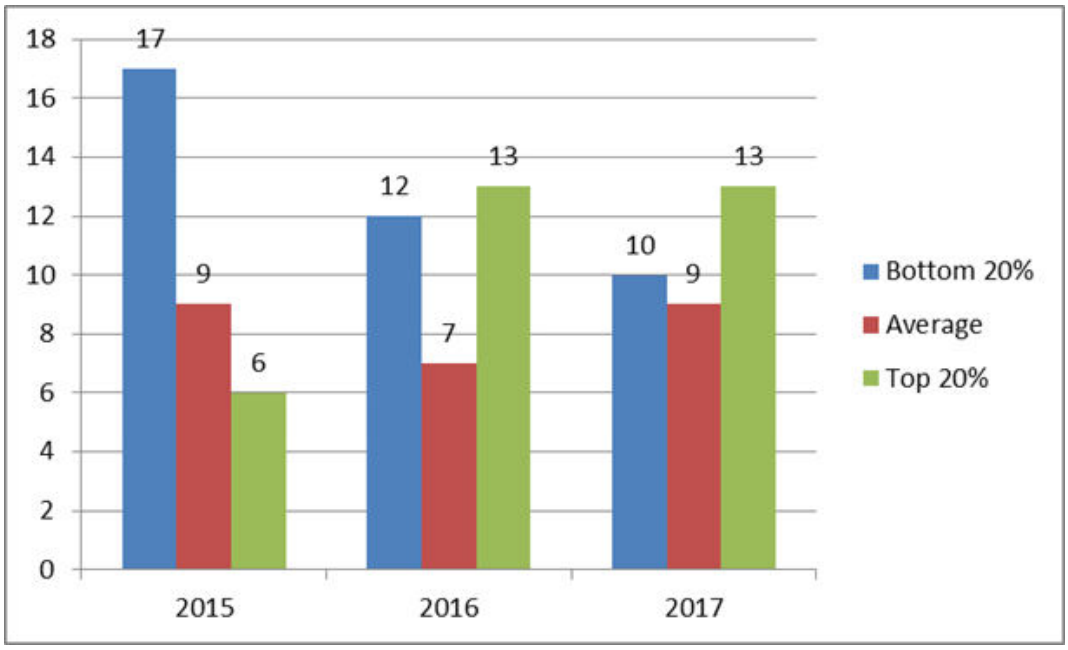
NHS Staff Survey and Cultural Transformation

NHS Staff Survey Results 2017

Hull and East Yorkshire Hospitals NHS Trust undertook the NHS National Staff Survey 2017. The survey was undertaken between 9 October and 1 December 2017. The response rate for the Trust was 42% (3451 staff), against a national average of 43%.

The National Staff Survey comprises 32 key findings and a measure of staff engagement. Each key finding is comprised of a cluster of questions, which can be found in the full version of the Trust's report, which was published in March 2018. Performance against these key findings has improved significantly over the past three years. Trusts can see how they benchmark against other organisations and whether their scores are in the worst 20% of organisations, average or in the top 20% of organisations.

Our performance in 2018 shows that fewer of our key findings feature in the bottom 20% of organisations while those in the top 20% have remained the same. Performance against the 32 key findings over the past three years is summarised in the graph as follows:



Top five ranking scores:

1. % staff experiencing discrimination at work
2. % staff believing the organisation offers equal opportunities for career progression or promotion
3. % staff experiencing bullying harassment or abuse from patients
4. % staff experiencing physical violence from patients
5. Fairness and effectiveness of procedures for reporting errors

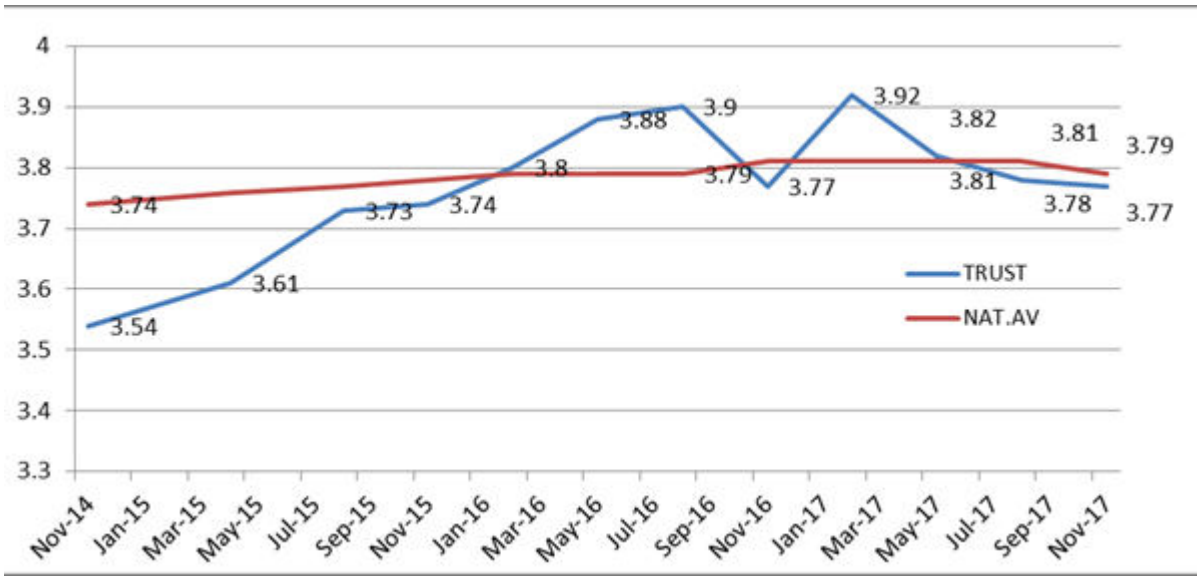
Bottom five ranking scores:

1. Effective use of patient/service user feedback
2. % staff reporting most recent experience of bullying and harassment
3. % staff reporting most recent experience of physical violence
4. % staff experiencing bullying or harassment from staff
5. % staff agreeing that their role makes a difference to patients

The Trust's overall score for engagement in 2017 (3.77) has remained the same as in 2016 and is just below the national average for Trusts, 3.79. It is worth noting however that while the Trust's score has stabilised the national score has deteriorated from 3.81, as many organisations struggled to maintain their position.

The overall score for engagement comprises nine questions with the maximum score possible being 5. The Trust has improved against the three questions relating to pride in the organisation, remained the same against those relating to staff ability to improve their services and deteriorated against motivation and enthusiasm at work.

The trend scores for overall engagement since 2014 are as follows, where this graph shows the Trust average compared with the national average.



The Trust is required to report the results against the two following key findings:

Staff Survey Question	Ranking compared with Acute Trusts in 2016	Ranking compared with Acute Trusts in 2017
KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months (lower the score the better)	31% Highest (worst) 20%	28% Although the Trust score has improved from 2016 it remains in in the bottom 20% for this question
KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion (higher the score the better)	88% Top 20% (higher than average)	89% Remains in top 20% (higher than average)

Cultural Transformation

At the March 2015 Trust Board meeting an approach to Transforming the Culture of the Trust was agreed. Since that time the CQC which had previously identified cultural issues, including bullying, has specifically noted improvements to the working culture at the organisation. The report from the June 2016 described the organisation as being on the cusp of good. Furthermore, a cultural assessment tool, the Barrett Values Indicator has described the cultural improvement at the Trust as twice that which they would have expected to see in the 30 months since we last ran the Barrett survey in 2015.

The Trust has a People Strategy 2016/18 which sets out the vision for our workforce. It outlines how Hull and East Yorkshire Hospitals NHS Trust working with partners manages, leads and develops the workforce in order to deliver the Trust's vision, values and priorities as set out in the Trust Strategy 2016/21. The Strategy covers 7 strategic workforce themes. Underneath each theme are set actions which form part of the People Strategy programme plan for 2017/18 which is led and managed by the Workforce Transformation Committee. The 7 themes are:

- Recruitment and retention of staff
- Leadership capacity and capability
- Innovation, learning and development
- Equality and Diversity
- Health and wellbeing
- Employee engagement, communication and recognition

- Modernising the way we work

An update against the work undertaken against the delivery of the People Strategy programme plan for 2017/18 is detailed as follows.

Recruitment and retention of staff

- The remarkable people recruitment campaign has resulted in successful recruitment of a significant number of nurses locally and internationally
- The Trust has an award winning apprenticeship programme. The Trust has over 200 members of staff utilising an apprenticeship standard in a wide range of services (Pharmacy, Nutrition, Business Administration, Physiotherapy, Estates, Pathology and Mortuary). 93% of our apprentices secure employment or a place within higher or further education. Since the introduction of the Apprenticeship Levy (April 2017), over 100 apprenticeships have commenced, which demonstrates a committed investment of over £1m so far
- The Trust has an excellent volunteer and young volunteer programme which has over 500 people participating in. Volunteers contribute to a number of departments across the organisation and undertake various roles including the completion of friends and family test with patients, Patient Reporting and Action for Safe Environment (PRASE), Patient Led Assessment of the Care Environment (PLACE), reviewing of Patient Information Leaflets (PILS0 and attendance at the Signage Group
- The shortage of NHS professionals is well documented and in addition to recruiting and trying to improve retention, the Trust has put in place a number of new roles to enable doctors, nurses and therapists to focus on their registered duties. New roles include Nutritionist, Recreational Assistants, Discharge Assistants, Patient Trackers, increased the scope of Ward Administrators and Advanced Clinical Practitioners covering Junior Doctor shortfalls

Leadership capacity and capability

- Three new leadership development programmes have launched in 2017/18 to support our existing and aspiring leaders, building upon previous programmes. These are the Great Leaders Annual Development Programme, New Leaders Programme and the Talent Development Programme
- The Trust has 15 accredited coaches and is developing 32 more. A new Mentorship programme also commenced in January 2018

Innovation, learning and development

- Newly reconfigured library service and facilities were opened at HRI in May 2017
- New Learning and Development Centre opened in September 2017 at Castle Hill Hospital
- A new Surgical Skills Training Centre is due to commence building works in May 2018

Equality and Diversity

- A key improvement area for the Trust since 2014 has been staff reporting issues of bullying and harassment. This work has also been enhanced with the development of the Equality and Inclusion Strategy 2017/20 which is being delivered by the Equalities Steering Group and the adoption of the Workforce Race Equality Standard (WRES), which seek to ensure no member of the workforce is disadvantaged based on the ethnic background, gender, sexual orientation, disability or age. The Trust has an agreed action plan to deliver the WRES standards
- Over time the Trust has seen its performance improve against these indicators. In 2015 38% of staff reported that they had experienced some form of bullying and harassment from colleagues. In 2016 this dropped to 31% and in 2017 it is it was 28%. This is one of the most improved scores for the Trust in the 2017 survey. Despite this it remains worse than the national average, which is 25%.
- In an organisation where we have a zero tolerance policy on bullying and harassment this is an area that continues to require focus as we strive to provide a positive working environment for staff. In terms of reporting of bullying and harassment issues, in 2016 43% of staff said they had reported issues and in 2017 this has fallen to 42%, but again it remains below the national average of 45%, which suggests more work is required to encourage staff to come forward.
- Where discrimination is concerned only 8% of staff survey respondents (282 people in total) say they have experienced some form of discrimination from colleagues in the last 12 months, ahead of the national average of 12%. 89% of staff reported that they believe the Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, sexual orientation, disability or age. This is better than the national average, 85%.

- The Trust established the BME Staff Network in 2016 and the membership has increased to 50. The Trust has also commenced an LGBT Staff Network
- The Trust continues to deliver the Equality, Diversity and Inclusion training programme and it forms part of the Trust's recruitment and selection training and the Trust's mandatory training programme

Health and wellbeing

- The Health and Wellbeing programme is well developed and is being managed by the Health and Wellbeing Committee. The Trust surveyed staff and asked what they would like to see within the health and wellbeing programme. The programme is designed largely to provide staff with information so they can "self-help" but also signposts them to various regional and national activities and information sources
- The Trust has also provided meditation, salsa, mindfulness, weight management and yoga classes
- The Trust has a choir and various sporting teams such as football and running
- The Trust has focussed on healthy eating and reducing the number of patients and staff that smoke
- The Trust offers "health checks" for staff and are undertaking some work specifically on managing and reducing stress
- A fast track physiotherapy service is available for staff experiencing musculoskeletal problems. 150 staff have accessed the service so far which has also improved staff attendance
- 73% of frontline staff is vaccinated. The Trust has always achieved the national target for flu vaccination.

Employee engagement, communication and recognition

- The Chief Executive held nine culture and leadership briefings during the 2017/18 for all Trust managers. The sessions covered the Trust's progress to date and areas of development, as well as setting out the Trust's goal to be rated as 'Outstanding' by the CQC by 2022. The sessions also reinforced the expectations of a HEY Leader and the positive working culture needed to maintain and continually improve our services.
- The Trust is one of very few Trusts nationally that enables staff to receive 2 days additional annual leave per year (1 day for the flu jab and 1 day for completion of all mandatory training and 100% attendance)
- The Golden Hearts awards were celebrated in June 2017. Over 300 staff attended the event which recognised individuals and teams in 16 categories including best leader, team and service improvement
- Moments of Magic nominations continue to increase. In 2017 the Trust received more nominations from staff recognising their colleagues for good work than in any previous year. These are now shared with the Trust Board in every public meeting.
- To enhance the recognition of good work and share important learning from excellence the Trust has launched Greatix, as the antidote to Datix. Staff have begun posting their examples of good project work and service improvement on the Trust intranet and a formal process for sharing this work has been agreed

Part 4: Statements of Assurance from the Board

This section includes:

Statements of assurance from the Board (the contents of these statements are prescribed).
Statements include:

- **Review of services**
- **Participation in clinical audit**
- **Participation in clinical research**
- **Goals agreed with commissioners**
- **What others say about the Trust – Care Quality Commission**
- **Quality Improvement Plan**
- **Care Quality Commission – Duty of Candour**
- **Data quality, information governance and clinical coding error rates**

Statements of Assurance from the Board

Review of services

During 2017/18 the Hull and East Yorkshire Hospitals NHS Trust provided 43 NHS services within 4 Health Groups and 15 Divisions.

The Hull and East Yorkshire Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 43 of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2017/18.

Participation in clinical audits

During 2017/18, 46 national clinical audits and 4 national confidential enquiries covered NHS services that Hull and East Yorkshire Hospitals NHS Trust provides.

During that period Hull and East Yorkshire Hospitals NHS Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below details the national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust was eligible to participate in and those which we participated in during 2017/18. For those national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust participated in the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are listed in the last column:

Audit:	Participated	% of Cases Submitted
Peri- and Neonatal		
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	Yes	Deadline of 30 April for data submission
National Maternity and Perinatal Audit (NMPA)	Yes	Deadline of 30 April for data submission
Children		
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	Yes	Deadline of 30 April for data submission
Paediatric Pneumonia (British Thoracic Society)	Yes	100%
Blood and Transplant		
National Comparative Audit of Transfusion Associated Circulatory Overload	Yes	100%
Re-Audit of the 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	Yes	100%
Acute care		
National Emergency Laparotomy Audit (NELA)	Yes	10%
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	Deadline of 30 April for data submission

Audit:	Participated	% of Cases Submitted
Sentinal Stroke National Audit Project (SSNAP)	Yes	Deadline of 30 April for data submission
Procedural Sedation in Adults (RCEM)	Yes	100%
Fractured Neck of Femur (RCEM)	Yes	100%
Pain in Children (RCEM)	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	100%
Diabetes in Pregnancy Audit	Yes	100%
Diabetes Footcare Audit	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Ulcerative Colitis and Crohn's Disease (National Inflammatory Bowel Disease - IBD Audit)	Yes	Deadline of 30 April for data submission
UK Cystic Fibrosis Registry (adults)	Yes	Deadline of 30 April for data submission
National Chronic Obstructure Pulmonary Disease (COPD) Audit	Yes	Deadline of 30 April for data submission
UK Parkinson's Audit	Yes	100%
Stress Urinary Incontinence Audit (BAUS)	Yes	Deadline of 30 April for data submission
National Ophthalmology Database Audit	No	The Trust does not have the relevant software but runs its own independent Departmental Cataract Surgery outcomes audit. Getting It Right First Time (GIRFT) was happy with this approach
Neurosurgical National Audit Project	Yes	Deadline of 30 April for data submission
Elective procedures		
Hip, Knee, Ankle, Elbow and Shoulder Replacements, Implant Performance, Hospital Performance and Surgeon Performance (National Joint Registry)	Yes	Deadline of 30 April for data submission
National Bariatric Surgery Registry	Yes	Deadline of 30 April for data submission
National Vascular Registry (elements include Carotid Interventions Audit, National Vascular	Yes	Deadline of 30

Audit:	Participated	% of Cases Submitted
Database, Abdominal Aortic Aneurysm, Peripheral Vascular Surgery/VSGBI Vascular Surgery Database)		April for data submission
Adult Cardiac Surgery Audit (ACS)	Yes	100%
Nephrectomy Audit (BAUS)	Yes	Deadline of 30 April for data submission
Urethroplasty (BAUS)	Yes	Deadline of 30 April for data submission
Percutaneous Nephrolithotomy (PCNL) (BAUS)	Yes	Deadline of 30 April for data submission
Radical Prostatectomy Audit (BAUS)	Yes	Deadline of 30 April for data submission
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	Deadline of 30 April for data submission
National Audit of Percutaneous Coronary Interventions (NAPCI) / Coronary Angioplasty	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	Deadline of 30 April for data submission
Cardiac Rhythm Management (CRM)	Yes	Deadline of 30 April for data submission
National Cardiac Arrest Audit (NCAA)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	Deadline of 30 April for data submission
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	Deadline of 30 April for data submission
Oesophago-gastric Cancer (National OG Cancer Audit)	Yes	Deadline of 30 April for data submission
National Prostate Cancer Audit	Yes	Deadline of 30 April for data submission
Trauma		
Major Trauma (Trauma and Audit Research Network)	Yes	Deadline of 30 April for data submission
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs Following Major Injury (NCASRI)	Yes	Deadline of 30 April for data submission
Older People		

Audit:	Participated	% of Cases Submitted
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Dementia	Yes	100%
National Audit of Inpatient Falls (Part of the Falls and Fragility Fracture Audit Programme (FFAP))	Yes	100%
National Hip Fracture Database (Part of the Falls and Fragility Fracture Audit Programme (FFAP))	Yes	Deadline of 30 April for data submission
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Cancer in Children, Teens and Young Adults	Yes	100%
Heart Failure	Yes	80%
Peri-Operative Diabetes Study	Yes	70%
Maternal, Newborn and Infant Clinical Outcome Review Programme		
MBRRACE-UK surveillance data collection system	Yes	100%

The reports of 25 national clinical audits were reviewed by provider in 2017/18 and Hull and East Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed actions
National Diabetes Inpatient Audit (NaDIA)	• To introduce a formalised foot risk assessment sheet
National Audit of Breast Cancer in Older People (NABCOP)	• No further action required
National Audit of Cardiac Rhythm Management (CRM) devices	• To meet with the Cardiac Physiologists to discuss the best method of ensuring that acute complications are recorded and uploaded • To disseminate the results of the audit to the Cardiac Physiologists and to remind the staff of the importance of submitting complete data.
National Audit of Dementia (NAD)	• To implement 'John's Campaign', enabling carers to stay with patients beyond regular visiting hours (including meal times and overnight) • To carry out a Quality Improvement Programme to improve the recording of dementia / delirium screening on discharge documentation • To introduce nutritional assistants on the Department of the Medical Elderly wards, to better ensure that the nutritional needs of patients are met • To provide further training to ward staff to ensure that patients and carers are offered the Butterfly Scheme and John's Campaign • To raise awareness of the Butterfly Scheme and John's Campaign around the wards through the use of posters and communications • To meet with the intranet team to discuss options for publicising the Dementia Champions through the intranet
National Audit of Inpatient Falls (NAIF) (Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in May 2018
National Bowel Cancer Audit	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in May 2018
National Diabetes Audit : Core Audit	• To review the pathway for insulin pump patients, to ensure that insulin pumps are prescribed appropriately • To expand the Diabetes Specialist Nurse team to release additional DSN

Audit	Proposed actions
	resource and support the management of complex Type 1 patients • To implement System One as a replacement to ProWellness. In relation to the National Diabetes Audit, this will make the data much more reliable and accessible and so improve the usefulness of the audit data
National Heart Failure Audit	• No further action required
National Hip Fracture Database (NHFD) (Part of the Falls and Fragility Fracture Audit Project (FFFAP))	• To define criteria for peri-operative medical assessment, delirium assessment and 120 day follow up • To liaise with the anaesthetic lead regarding nerve blocks
National Joint Registry (NJR)	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018
National Lung Cancer Audit (NLCA)	• To investigate the data submission issues relating to the work of the Lung Cancer Nurse Specialists and multi-disciplinary team discussion
National Neonatal Audit Programme (NNAP)	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018
National Oesophago-Gastric Audit	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in May 2018
National Paediatric Diabetes Audit (NPDA)	• To plan a schedule of regular patient education sessions
National Prostate Cancer Audit	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in May 2018
National Diabetes Footcare Audit (NDFA)	• To capture all cases of re-ulceration or multiple ongoing ulceration into the audit. • To review the Lorenzo podiatry referral page to encourage output referals and education to team • To review staff resource over next 24 months to aim to enable additional resource for ward foot checks
National Emergency Laparotomy Audit (NELA)	• To arrange a meeting with Department of the Medical Elderly regarding the assessments given to patients aged 70 years and over • To employ a data entry clerk
National Pregnancy in Diabetes Audit (NPID)	• To raise awareness amongst the team regarding preconceptual care and referral to the 'MOT' • To improve glycaemic outcomes in pregnancy by reviewing processes of care in clinic • To discuss the possibility of having a 'Diasend' machine in the clinic, to review glucose readings • To raise the issue of preconceptual diabetes care with Public Health, through the Diabetes Network Board • To review the management of gestational diabetes patients, and to establish whether current arrangements are affecting the care of women with T1 / T2 diabetes
Paediatric Intensive Care Audit Network (PICANET)	• No further action required

Audit	Proposed actions
Sentinel Stroke National Audit Programme (SSNAP)	• To remind all staff of the need to ensure documentation of the reasons for why a patient does not fit the Royal College of Physicians criteria for thrombolysis, where applicable • To discuss the pathway for pre-alerts with the Ambulance Service. • To implement a system to enable the Stroke Co-Ordinator to highlight any patients that have been unable to give a formal swallow assessment. • To adjust working patterns to provide occupational therapy every day rather than Monday to Friday only • To remind staff of the importance of mood and cognition screening for each patient. • To remind staff to discharge patients from the care of Speech and Language Therapy promptly when no further therapy is required.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Treat As One (Mental Health in General Hospitals)	• To develop an Enhanced Care Team for 1 to 1 supervision including patients with mental health needs
Inspiring Change (Acute Non-Invasive Ventilation)	• To revise the operational policy to meet NCEPOD recommendations • To develop a proforma to ensure the use of acute non-invasive ventilation acts as a flag to consider referral to palliative care services
Maternal, Newborn and Infant Clinical Outcome Review Programme	
Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018
Perinatal Mortality Surveillance Enquiry - Term, Singleton, Intrapartum Stillbirth and Intrapartum Related Neonatal Death	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018
Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015	• Outcomes form to be presented at the Clinical Effectiveness, Policies and Practice Development Committee in June 2018

An update regarding the implementation of the proposed actions identified as a result of a national clinical audit reports published in the 2016/17 Quality Account is provided below to demonstrate the improvements made to quality. Actions taken in response to reports published in 2017/18 will be included in the Quality Account for 2018/19.

Audit	Proposed actions	Progress
National audit		
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	• To review the process for documentation of first consultation with parents	• Update awaited from lead
National Emergency Oxygen Audit	• To liaise with Education and Training to establish how safe use of oxygen training could be made mandatory and available to be completed online • To create a safety bulletin on the subject of oxygen prescribing, in order to raise awareness of the issue • To discuss a potential pilot scheme with the Acute Medical Unit and Ward	• An e-learning package has been developed and is awaiting final approval • This will be produced to coincide with the launch of the e-learning package and revised oxygen policy • This has been discussed but has not been implemented to date

	1, which would involve attaching laminated signs to every oxygen point to serve as a reminder to ensure that all oxygen is prescribed in accordance with the Trust Oxygen Therapy Policy. • To carry out an audit in order to establish whether the above results in an improvement • To review and update the Trust Oxygen Therapy Policy	• This will be undertaken once the pilot in the Acute Medical Unit has taken place • The policy has been updated in line with the British Thoracic Society guidelines and recommendations
National Bowel Cancer Audit	• To undertake a review of 2 year mortality data	• Data has been collected and is awaiting analysis
Cardiac Arrhythmia (Cardiac Rhythm Management)	• To provide ongoing education to highlight the importance of primary prevention in suitable patients. • To hold fortnightly multi-disciplinary team meetings (MDT) to discuss patients that may be suitable for CRM	• There is a monthly Journal club where all cardiology trainees and consultants meet • There is a weekly MDT to discuss patients that may be suitable for ICD therapy
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	• To review how insulin pumps are recorded on the Twinkle database and through the National Paediatric Diabetes Audit. • To provide a training session for users of Twinkle at a multi-disciplinary team meeting	• This has been communicated to the whole team • A 'how to' guide has been written to ensure data is entered correctly
National Pregnancy in Diabetes Audit	• To carry out a local audit of glucose control • To contact Public Health, Clinical Commisioning Groups and Family Planning clinics to discuss potential further actions	• An audit is underway • The results are to be discussed at the local maternity network board
National Diabetes Footcare Audit	• To clarify the definition of 'ischemia' with the national audit team, to better understand our figures • To ensure that patients who present direct to the Emergency Department or ward are captured in the audit • To raise awareness of the audit with community staff in order to increase participation • To raise a query with the national team around amputation as an outcome	• The national team have provided a clearer definition • Actions complete
National Diabetes Inpatient Audit	• To reduce prescription errors through the introduction of a new drug chart incorporating a specific section on insulin and highlighting the importance of giving oral agents with meals • To reduce the number of hypoglycaemic events through the introduction of a new prescription chart to emphasise the correct timing of diabetes medication • To highlight patients on insulin in hospital, to ensure timing of insulin is	• A new drug chart (incorporating a specific section on insulin and highlighting the importance of giving oral agents with meals) has been implemented. This aims to reduce the number of hypoglycaemic events – data is awaited to determine if this has happened

	with a meal • To improve the timeliness of diabetes foot assessments and ensure that they are properly completed and documented	• There is a diabetes specific foot check document in use on Ward 7
National Cardiac Arrest Audit (NCCA)	• To share learning from the NCCA dataset, including ceilings of care and the prescription of appropriate resuscitation in the Consultant mandatory update training. • To develop links with Primary Care to improve communication relating to DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions. • To develop a strategy for the Trust and local healthcare providers to implement the ReSPECT (Recommended Summary Care Plan for Emergency Treatment) document	• The ReSPECT process was released nationally at the end of February 2017. The Trust as the lead organisation, has worked with other local healthcare providers to develop an implementation strategy for ReSPECT within the Hull and East Riding locality. Partner organisations include Both Hull and the East Riding Clinical Commissioning Groups (CCGs), City Health Care Partnership, Dove House Hospice and Humber Foundation Trust. To allow adequate time to train staff and develop policies and procedures the launch date of the 9 April 2018 was agreed. • It is planned to utilise the patient records system (Lorenzo) within the Trust to document that a ReSPECT decision is in place. This will aid communication to primary care via the Immediate Discharge Summary, alert Emergency Department staff via the Emergency Department records if readmitted and have an alert icon on the patients records to inform all staff. This is to allow staff to begin conversations about previous ReSPECT decisions and to ask for the patient held records. • With developments in the Advanced Summary Care Records it is hoped communication of decisions in Primary Care can be communicated to the acute setting by utilising this facility
Paediatric Asthma (British Thoracic Society)	• To provide asthma pathway education at junior doctor induction • To undertake nursing education via specialist nurses and teacher practitioners on the use of asthma treatments.	• Training has been provided at junior doctor induction • 2 training sessions have been provided
Vital Signs in Children (College of Emergency Medicine)	• To produce and distribute laminated cards that include reference ranges for paediatric vital signs • To remind the paediatric charge nurse of the need to complete full observations within 15 minutes of triage • To ensure that staff members circle any abnormal vital signs, and clearly document any actions that are taken to rectify them • To ensure that staff members record	• All nursing and medical staff members now carry vital signs cards for reference • The paediatric charge nurse actively encourages prompt observations to be completed following triage. • Both the paediatric charge nurse and the paediatric emergency medicine consultant actively encourage and regularly monitor that abnormal vital signs are documented and rectified, and

	the time that observations are carried out on the door of the cubicle and also in the comments section of Lorenzo • Any questions that juniors ask regarding a patient's care are now recorded on a question form, which is kept with the patient notes • To reconsider the use of an early warning score when more validation work has been carried out	that the time of observations is recorded appropriately. • The paediatric emergency medicine consultant reminds junior medical staff of this process on a regular basis. • There is still no Early Warning Score validated for use in children, however validation is ongoing for the Paediatric Observation Priority Score (POPS), developed in Leicester
Procedural Sedation in Adults (College of Emergency Medicine)	• To disseminate results, highlighting areas for improvement • To design a new sedation proforma for use with both adults and children • To design a new Patient Advice Sheet to be given for Adult patients • To design a new Patient Advice Sheet to be given for Paediatric patients • To re- audit once the new proforma has been implemented	• A sedation pathway has been designed and implemented within the Emergency Department. Staff have been educated on how to use the pathway. The pathway also includes a patient advice sheet for adults. A separate Standard Operating Procedure for children was developed at the same time – the proforma is the same, as is the advice sheet. Emergency Department staff completed the RCEM Sedation audit in January 2018.
VTE Risk in Lower Limb Immobilisation (College of Emergency Medicine)	• To discuss an appropriate anti-coagulation for patients waiting longer than 48 hours to be seen in the fracture clinic	• Update awaited from lead
PICANET (Paediatric Intensive Care Audit Network)	• To discuss a business case for providing family psychological support at the Paediatric Governance meeting	• Various options for psychological support are currently being considered
End of Life Care Audit	• To include a section in the End of Life guidance regarding the recognition that a patient may be dying • To develop an individualised End of Life care plan or prompt sheet featuring sections on communication with nominated persons, needs and concerns of the patient/ nominated person, and the holistic assessment • To discuss the possibility of having a lay member on the Trust Board with a responsibility for End of Life care with the Chief Nurse • To introduce the 7 day face-to-face (i.e. non-telephone) service • To discuss opportunities for the funding of an end of life facilitator post with commissioners • To implement Sage and Thyme Communication skill training across the Trust to improve the level of basic communication skills	• The updated Trust Guideline for the Management of the Dying Patient was ratified in May 2017, which includes a section on the recognition of likelihood of dying. • The care plan has been developed and through a series of consultations. Awaiting final ratification of the document before implementation • A Non-Executive Director is now responsible for End of Life Care. • Since September 2016, the Palliative Care Team have operated 7 days a week (including bank holidays) from 8am until 6pm, with out of hours cover being provided via bleep. • Currently, there is no funding available • Sage and Thyme Communication Sklill training is held monthly, with courses being accessed via online booking
National Clinical Audit for Rheumatoid and Early	• To perform a local re-audit on standards 2 – 5 in order to better	• A local audit has been undertaken, which showed the Trust performed well against

Inflammatory Arthritis	establish how the service is performing • To recruit another nurse to assist with providing the helpline and emergency clinics	NICE guidance • An additional nurse has been recruited
Sentinel Stroke National Audit Programme (SSNAP)	• To design and implement a patient survey aimed specifically at Stroke patients • To undertake a peer review, to better understand staff shortages • To develop business cases to address staffing shortfalls, as identified by both the organisational audit and the peer review	• Update awaited from lead
National Hip Fracture Database	• To liaise with the Elderly Medicine Consultants with regard to the perioperative assessment and middle grade medical position • Nerve blocks can be performed by trauma coordinators. Arrange training for other co-ordinators to conduct nerve block procedures. • To liaise with the Elderly Medicine consultants with regard to hip fractures as an inpatient • To define what follow-up arrangements are, as per best practice tariff, at 120 days	• Action complete • Action complete • Action complete • Follow up arrangements have been confirmed with the NHFD team – they can be by letter or telephone call to the patient
National Vascular Registry	• To review the pathway for Abdominal Aortic Aneurysm care • To review the pathway of carotid care • To review the pathway of critical limb ischaemia care	• Update awaited from lead

The reports of 202 local clinical audits were reviewed by Hull and East Yorkshire Hospitals NHS Trust in 2017/18. For an update on the progress of the actions identified as a result of local clinical audits completed in 2017/18 and proposed actions for 2018/19, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: quality.accounts@hey.nhs.uk or reviewed online via the Quality Account page at http://www.hey.nhs.uk/about-us/corporate-documents/

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull and East Yorkshire Hospitals NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 7,312.

Commitment to research as a driver for improving the quality of care and patient experience

The Trust is committed to providing the best possible care to patients and recognises the value of high quality peer-review research as a fundamental tool in the successful promotion of health and well-being for the population it serves. To achieve this, the Trust has focused on research activity which addresses NHS priorities, is of national and international quality and is cost-effective.

Every study the Trust participates in will, in some way, have a direct or indirect benefit to institutions, staff, patients, carers, policy makers and academics. The collective benefits for our population of participating in research include more personalised, protocol driven care with often more frequent oversight of clinical outcomes and safety assessments. Frequently, research participation allows for increased interactions between clinical staff and patients, providing more time to make assessments of patients' needs and anxieties and therefore supporting a trusting relationship to flourish.

Research portfolio and activity

The Trust was involved in processing 105 clinical research studies of which 96 commenced during the reporting period 2017/18. This compares with 177 new submissions and 133 commencing in 2016/17. The Trust used national systems to manage the studies in proportion to risk. Of the 96 studies given permission to start, 76 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 231 studies actively reporting accruals (patient recruitment) under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 171 portfolio studies reporting accruals for the period 2016/17.

The number of recruits into the Trust portfolio studies for the periods 2016/17 and 2017/18 was 9,118 and 6,599 respectively. A target of 6,000 patient accruals has been set for 2018/19. The largest topic area of portfolio adopted studies across 2017/18 is Oncology (Cancer) and Haematology with 39 studies between them. The top five therapeutic areas of Trust research in 2017-18 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (39)
2) Cardiovascular (23)
3) Gastroenterology and Hepatology (11 each)
4) Musculoskeletal (9)
5) Renal Disorders (9)

70% of commercial portfolio studies completed in 2017/18 recruited on time and to an agreed target. This has helped the Trust maintain a strong relationship with pharmaceutical and medical device companies that allows us to be part of offering novel technologies and treatment to our patients in more and more therapeutic areas.

In the last year, over 140 publications, abstracts and book chapters have resulted from our involvement in portfolio and non-portfolio research across nine specialty areas (Vascular, Diabetes, Oncology, Haematology, Dermatology, Rheumatology, Cardiology, Hepatology and Renal). This shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Research impact

Demonstrating specific project outcomes and impact through research for the population we serve is fundamental. Below are some examples of the difference research participation has made to patient outcomes and changes in service delivery at Hull and East Yorkshire Hospitals NHS Trust:

Public Health Cohort studies:

For the second year running, the Trust was the top recruiter in Yorkshire and Humber for the 'Yorkshire Health Study' with over 3,600 participants in 2017/18. The study will continue to run until December 2018 and is the largest long term health study in Yorkshire. It aims to capture information on a large scale with the hope of finding the best treatments to keep Yorkshire healthy, and prevent and treat disease in the future. It focusses specifically on eating, drinking, and smoking habits as well as current illnesses and mobility in the context of locality and socio-economic status.

Diabetes and Endocrinology

In collaboration with local Diabetes charity the Trust has led work looking into the Service Users' Perspectives on Accessing Type 2 Diabetes Mellitus Services within Hull and East Riding. Capturing the perceptions of nearly 3,000 type 2 diabetes service users in Hull and the East Riding has provided further insight into the reasons for not meeting NICE guidelines on reducing the risk of associated diabetes complications.

The study report was published in September 2017 and the combination of questionnaire and focus group data provides a detailed insight into the views and perspectives of services users who may not be satisfied with their T2DM services, who may experience challenges managing their T2DM and who want to provide a more detailed and experiential

account of their interaction with health professionals. Issues such as mental wellbeing, isolation and loneliness were just some of the themes to emerge.

A series of recommendations have been put forward for consideration by healthcare providers and commissioners including; ensuring clear support and guidance is made available to the patient and family at the point of diagnosis, providing consistent and up to date information on self-care management, ensure all patients are given access and opportunities to participate in clinical research in T2DM, improving access to specialist services, provide automatic feedback on blood tests and a clear explanation of the results, increasing and embracing the use of technology, a focus on joined up care and training of staff within care homes as well as ensuring a focus on people with T"DM under the age of 40.

Alongside the large cohort studies, the team have continued to successfully recruit to time and target in a number of commercial clinical trials available.

Academically the research unit continues to attract high quality medical staff and PhD students to work as research fellows but also have a real presence nationally as a centre that delivers high quality research.

Haematology Research Department:
The haematology department run several ongoing basic science projects investigating risk factors for leukaemia and developing novel therapeutic approaches for leukaemia.

In collaboration with chemistry the team have obtained £10k from 'help for health' to continue to support the in-house study, portfolio-adopted "Cell separation technology" which is recruiting ahead of schedule (71 patients).

Dr Sahra Ali has submitted and been awarded a Bloodwise Grant and has been working with her team to set up 'A National Prospective Registry-Based cohort study to monitor the diagnosis and management of acute leukaemia in Pregnancy'. To developmental work has bene undertaken in 2017-18 and the registry will be open to collect data later in 2018.

Vascular Surgery Research:
Professor Ian Chetter, Chair of Surgery Hull York Medical School continued to undertake the appointment as Royal College of Surgeons Surgical Specialty Lead for Vascular Surgery.

The role acts as key link between designated Surgical Trials Centres and National Clinical Research Networks within Vascular surgery and is supported by funding for three years to develop multi-centre clinical trials and act as a conduit for interested clinicians and to provide a forum for discussion of proposals that can be processed through funding bodies.

Dan Carradice and George Smith, Senior Lecturers in Vascular Surgery, HYMS have secured from HYMS 3 PhD Students in the Vascular Lab to be appointed for 3 years from October 2018. Further to this, Dan Carradice was awarded an NIHR Public and Patient Involvement Grant to support the development of future diabetic foot research.

Amy Harwood, Postdoctoral Research Fellow won the 20th Annual Journal of Vascular Nursing Writing Award for article "*Intermittent claudication a real pain in the calf*"—Patient experience of diagnosis and treatment with a supervised exercise program published in the September 2017 issue of the *Journal of Vascular Nursing*.

The award was established in 1999 to recognize excellence in writing. The editor, in collaboration with the JVN Editorial Board, nominates articles based on the following characteristics: Content, Originality, Clarity, Applicability/Practicality, and Significance.

Cardiothoracic Surgery Research:
The Cardiothoracic research and clinical department have won three national awards from the Society for Cardiothoracic Surgery in the UK (SCTS) for 2018.

Mr Zaheer Tahir, a cardiothoracic research fellow undertaking his higher doctorate degree at HYMS, won the Ronald Edwards Medal for the best scientific oral presentation for his work looking at the In-vitro effect of dichloroacetate on human internal mammary arteries. The project, part of a larger project looking at the pharmacological properties of

drugs used in samples taken from cardiac surgery patients, is supervised by Professor Mahmoud Loubani, Mr Chaudhry and Dr James Hobkirk from the University of Hull.

Mr Ahmed Habib, a senior thoracic surgical registrar at Castle Hill, won the best thoracic surgical movie prize for a short film on keyhole Diaphragmatic Plication surgery performed by Professor Loubani. The procedure helps to improve the breathing symptoms caused by diaphragm muscle paralysis in selected thoracic patients.

Finally, Saumil Shah, a medical student at HYMS won the Patrick G. Magee Student Prize for his work looking at outcomes following emergency re-opening of cardiac surgical patients at Castle Hill Hospital. The study was supervised by both Mr Yama Haqzad (a cardiothoracic trainee in the Yorkshire Deanery) and Prof Loubani. The results of the project will help determine predictors of post-operative short and long-term outcomes in patients following cardiac surgery.

The academic and clinical department have collected over ten national and international awards for their work in the last five years and the support it has for the next generation of surgeons indicate that this trend will likely continue for many years to come.

Academic Cardiology:
Projects making a difference: the report from the HOT study (home oxygen therapy in heart failure)led by Professor Andrew Clark has been picked up by Department of Health and being considered as part of evidence reviews informing the next iteration of NICE guidance on heart failure.

Renal Research:
Professor Sunil Bhandari and his research team at Hull & East Yorkshire Hospitals NHS Trust have continued to lead on the hugely important multi-centre STOP-ACEi study in which 39 sites in the UK contribute participant recruitment. In the STOP-ACEi trial, 410 patients with CKD stage 4 or 5 who are receiving treatment with ACEi and/or ARBs are randomly allocated to either continue their ACEi/ARB treatment or to stop their ACEi/ARB treatment. This study is needed before this treatment strategy can be put into routine clinical practice. This study is supported by an NIHR HTA grant and co-ordinated by Birmingham Clinical Trials Unit. Nephrologists worldwide are eagerly anticipating the final results soon with nearly 400 of the target 410 patients already achieved.

Research suggests that in some people with advanced CKD (stage 4 or 5) who are progressing to complete kidney failure and are receiving treatment with an ACEi and/or ARB, stopping these drugs leads to stabilisation and improvement of kidney function and can decrease or delay the need for dialysis treatment. This indicates that in some patients the very tablets that are being used to protect the kidneys may be contributing to a harmful decline in their function by some currently unknown mechanism.

Professor Bhandari was also a co- author of Renal Association UK Anaemia Guidelines 2017.

Hepatology Research:
Dr Lynsey Corless and her team instigated and led the recent COMMANDS study. The study has led to a change in clinical practice for non-alcoholic fatty liver disease (NAFLD).

The study showed that using a care pathway and rational investigations to guide community diagnosis and risk assessment is beneficial to patients and acceptable and useful for general practitioners. The team has now successfully rolled out the service change to all GP practices in the Trust catchment area.

Dr Corless was awarded an Early Career Leadership award by the NIHR national Hepatology specialty group in February 2018, for her work leading development of a trainee clinical research curriculum. This initiative aims to ensure that tomorrows Consultants have the necessary skills to offer their patients participation in clinical research, wherever they practice.

Top Recruiting sites:
Many of our research team are able to offer more opportunities for our patients to get involved in clinical research and this is helping position our Trust amongst the top recruiting sites in some of this research. For example: Oncology – ARISTOTLE, Neo-AEGIS and SCOPE 2 trials, Cardiology – HOMAGE trial, Renal – STOP-ACEI trial, Rheumatology – ACHILLES trial

Goals agreed with our commissioners

This statement will be updated with quarter 4 data in June 2018 if available before publication.

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

Use of the CQUIN payment framework

A proportion of Hull and East Yorkshire Hospitals NHS Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

There are no local Clinical Commissioning Group (CCG) schemes as there are several national CQUIN schemes mandated to all Trust's to deliver in 2017/18 and 2018/19.

The breakdown of the National CQUIN indicators is based on 2.5% of contract value of which:

- 1.5% mandated for 7 national schemes (£5m) equally weighted across each of the schemes
- 1% spilt (£3m) between 0.5% engagement with the STP and 0.5% of the CQUIN scheme will also be held within the risk reserve, If a provider delivers its control total in 2016/17

National CQUIN schemes 2017/18 and 2018/19 for CCGs include:

- NHS Staff Health and Wellbeing
- Proactive and Safe Discharge
- Reducing impact of serious infections
- Improving services for people in A/E with mental health
- Advice and Guidance
- NHS e Referral
- Preventing ill health from tobacco/alcohol

2017/18 National Achievement:

As at the end of Quarter 3 the Trust has achieved the majority of its National CQUIN schemes with the exception to Sepsis scheme. There are four parts to the species scheme and the Trust has received partial payment due to failing to deliver on all 4 elements: Timely treatment of sepsis in the Emergency Department and acute inpatient settings. The Trust has lost a small amount of income every quarter in this scheme to the value of £90k to date. Submission at Quarter 4 due 30th April 2018 the Trust believes it will achieve all schemes with an underachievement in Sepsis as per previous quarters. Sepsis has only slightly missed the required percentage achievement and has received acknowledgment nationally for a Trust that has seen significant improvements in Sepsis across the Trust.

NHS England Specialised Services (NHSE):

The Trust receives a CQUIN value of 2.8% (£3.04m)

The CQUIN payment will be based on actual contract expenditure; however CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Tariff Payment System and all other expenditure contracted on "pass through" basis. CQUIN funding for Operational Delivery Networks previously paid via a 0.1% top slice of the 2.5% acute payment will continue to be made in addition to the 2.8% CQUIN payment outlined

The NHSE specialised schemes include a continuation of 2016/17 schemes: Hep C, HIV, spinal network, enhanced supportive care, and haematrak. New schemes include medicines optimisation and local benchmarking of local prices in HIV.

Public Health England (PHE) has built into the screening services hosted by HEYHT a CQUIN reporting Health Inequalities for each programme. Armed Forces (AF) CQUIN includes use of the covenant, systems and process to identify AF personnel, promote the Trust as AF friendly organisation, employment opportunity to AF in the Trust.

2017/18 NHSE Achievement:
The Trust has achieved all the PHE and Armed forces CQUIN schemes to date and the majority of the NHSE specialised CQUIN schemes to date. There is under achievement in the Heamatrack to a value of £5000, Medicines optimisation at £10.5k and approximately £330k for underachievement of the Hep C CQUIN Schemes. Total income loss of approx. £350k.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from the following email address: quality.accounts@hey.nhs.uk

What others say about the Trust

About the Care Quality Commission

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services. The CQC Operating Model was revised and in June 2017 the CQC confirmed they will focus on eight core services and four additional services. The additional services may be inspected depending on the level of activity and risk.

The eight core services are:
- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients

The four additional services are:
- Gynaecology
- Diagnostic Imaging
- Rehabilitation
- Spinal Injuries

When inspecting these eight core services, the CQC will focus on the following five key questions:
- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

The CQC continue to use the ratings as detailed in their Operating Model; they are an important element of the CQC approach to inspection and regulation. The ratings are outstanding, good, requires improvement and inadequate.

You can find more about the CQC and the standards here: www.cqc.org.uk

Statement on Compliance with the Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against Hull and East Yorkshire Hospitals NHS Trust

during 2017/18.

Hull and East Yorkshire Hospitals NHS Trust has not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission inspected Hull and East Yorkshire Hospitals NHS Trust in February 2018

The Care Quality Commission (CQC) undertook a well-led inspection in February 2018. The unannounced element was undertaken between 07 and 09 February 2018 and the announced element between 27 February and 01 March 2018. The inspection covered the Maternity, Medicine, Surgery and the Outpatient core services across Hull Royal Infirmary and the Castle Hill Hospital. The Trust has received draft reports from the inspection in February 2018; however the content and ratings are embargoed until the factual accuracy has been completed by the Trust and the CQC has published the final report. The final report is likely to be available in June 2018. This section will be updated following receipt of the final inspection reports.

A breakdown of the Trust's current ratings from the June 2016 inspection is detailed in the tables below.

Table 1 - Overall rating for Hull and East Yorkshire Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led
Overall domain for the Trust	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Overall Trust rating	Requires Improvement				

Table 2 – Ratings for Hull Royal Infirmary (HRI)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency Care	Good	Good	Good	Requires Improvement	Good	Good
Medical Care	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good*	Requires Improvement	Requires Improvement
Children and Young People	Requires Improvement	Good	Good	Good	Good	Good
Outpatients	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for HRI	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Table 3 – Ratings for Castle Hill Hospital (CHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for CHH	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Quality Improvement Plan

The Quality Improvement Plan (QIP) is a high level plan which defines the improvement goals the Trust is working towards for improving quality and safety across the organisation. The plan includes the must do and should do actions from the CQC re-inspection in May 2015, comprehensive inspection in June 2016, well-led inspection in February 2018, areas of work the Trust is pursuing to improve, quality and safety priorities as detailed in the Quality Account and the Trust's 'Sign up to Safety' Pledges.

The Sign up to Safety Pledges are:

1. Put Safety First - Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally
2. Continually Learn - Make our organisation more resilient to risk, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are
3. Honesty - Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. Collaborate - Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. Support - Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

The table below details the quality improvement projects for 2017/18 and those that are linked to the pledges.

Key

	Improvements achieved – objectives achieved and or project closed
	Improvement made compared to last year. Project carried forward onto the 2018/19 plan for further monitoring
	No improvements made. Project carried forward onto the 2018/19 plan for further action and monitoring

Ref	QIP Project	Aim	Source	Status
QIP02	Learning Lessons	The aim of this project is to assist the organisation with a change in culture from one of assurance to one of enquiry	Sign up to safety and Quality Account	Closed
QIP04	Safeguarding	The aim of this project is to build on the improvement work undertaken during 2016/17 and continue to further improve the safeguarding arrangements for Adults and Children	CQC	Closed
QIP05	Medication Safety	The overall aim of this project is to ensure a multi-disciplinary, person-centred approach to ensuring our patients receive the right medicines, at the right dose at the right time. This will be supported by an accurate record of medications on admission to the hospital by ensuring medicines are reconciled as soon as possible, ideally within 24 hours of admission. This will reduce the potential for harm and contribute to the delivery of a safe and effective medication process for our patients	Sign up to safety, Quality Account and CQC	Re-opened
QIP06	Deteriorating Patient (Adult)	The aim of this QIP is to ensure that all Registered Nurses have undertaken both the NEW's on-line training and have been assessed as competent to complete Clinical observations on patients and can demonstrate an awareness of the importance of accurate fluid balance recording	Sign up to safety and Quality Account	Re-opened
QIP08	Infection Control	The aim of this project is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections	CQC	Re-opened

QIP09	Falls	The aim of this project will be to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention through the completion of e-learning	Sign up to safety and Quality Account	Re-opened
QIP10	Avoidable Pressure Ulcers	The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers. This project will aim to ensure that appropriate risk assessments, a plan of care highlighting required nursing interventions and meaningful evaluations are undertaken by knowledgeable staff, for every patient	Sign up to safety and Quality Account	Re-opened
QIP11	Maternity Services	The aim of this project is to ensure the improvement work undertaken to address the areas for improvement identified following the June 2016 CQC inspection are embedded across the service.	CQC	Closed
QIP12	Children and Young People with Mental Health Needs	The aim of this project is to improve the management of children and young people who have been admitted onto the 13th floor who are at risk of self-harm and suicidal intent.	CQC	Re-opened
QIP14	VTE	The aim of this project is to ensure patients are appropriately risk assessed for VTE within 24 hours of admission and to demonstrate that the Trust is compliant with the relevant contractual requirements	Sign up to safety and Quality Account	Closed
QIP15	Sepsis	The aim of this project is to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients leading to the implementation of the sepsis pathway across the organisation. The focus of the project will be on all patients meeting the new definition of sepsis, completing the sepsis 6 bundle within an hour	Quality Account and CQC Mortality Outlier Alerts	Re-opened
QIP16	Resuscitation Equipment and Checklists Compliance	The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards	CQC	Closed
QIP22	Nutrition and Hydration	The aim of this project is to ensure that all wards are rated amber and above using the Trust's Fundamental Standards Ward audits which will ensure that all patients have an appropriate personal nutritional needs assessment completed and receive an appropriate care plan or referral to a dietician where required	Sign up to safety, Quality Accounts and CQC	Re-opened
QIP23	Dementia	The aim of this project is to continue to review and promote Dementia Care across the Trust through a variety of multi - disciplinary events, policy review and further dementia friendly assignments	CQUIN and CQC	Re-opened
QIP24	Children and Young People Services	The aim of this project is to continue to improve the overall children and young people services and facilities on the 13th floor	CQC	Closed
QIP28	Patient Experience	The aim of this priority is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes	Sign up to safety, Quality Account and CQC	Re-opened
QIP30	Avoidable Mortality	The aim of this project is to aid the organisation in the delivery of the national objective of a standardised	Sign up to safety and Quality Account	Re-

		approach to review of hospital mortality. This project will prepare the organisation for a programme of work underway in NHS England's Patient Safety Domain, in relation to, standardising retrospective case record review (RCRR) for in-hospital deaths		opened
QIP34	Critical Care	The aim of this project is to ensure that the Critical Care Service provides a high quality, fit for purpose facility by ensuring the service is adequately staffed with an appropriate skill mix in line with relevant national requirements	CQC	Closed
QIP35	Five Steps for Safer Surgery (WHO Checklist)	The aim of the project is to reduce mortality and morbidity, including wrong site surgery, haemorrhage and infection, through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) in all specialities across the Trust.	CQC	Closed
QIP36	Transition from Children's to Adult Services	The aim of this project is to ensure there are effective and robust processes in place for young people who transition to the adult care services.	Sign up to safety and CQC	Re-opened
QIP37	ReSPECT	The aim of this project is to implement the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) with a supporting education package to ensure the ReSPECT process is fully embedded across the organisation	Trust action	Closed
QIP38	Consent	The aim of this project is to review and strengthen the governance arrangements regarding the development, approval and the central monitoring of the Trust consent forms. The project will also commence the development work of the transfer of the Trust consent forms onto Lorenzo	Trust action	Re-opened
QIP39	Outpatients	To ensure the Trust has a robust leadership and governance structure for all Outpatient Services to deliver consistent, high quality care and address all concerns relating to Outpatients from the 2015 and 2016 CQC Comprehensive Inspections	CQC	Re-opened
QIP41	Getting it Right First Time (GIRFT) – Paediatric Surgery	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Paediatric Surgery	Trust action	Re-opened
QIP42	Getting it Right First Time (GIRFT) – Ophthalmology	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of Ophthalmology	Trust action	Re-opened
QIP43	Getting it Right First Time (GIRFT) – ENT	The aim of this project is to ensure there is an effective and well led response to the recommendations and actions arising from the GIRFT review of ENT	Trust action	Closed

Underpinning the overall Quality Improvement Plan is a detailed work plan for each improvement area which sets out the objective of the project, the targets to be monitored and achieved, key milestones and improvement goals.

The Quality Improvement Plan is supported by robust governance arrangements which monitor the delivery of the plan and each of the improvement areas. Progress is reported by the lead for each improvement area at a monthly Quality Improvement Programme meeting chaired by the Chief Medical Officer. This is subsequently reviewed at the Trust's Operational Quality Committee chaired by the Chief Nurse on a monthly basis. This enables independent challenge and assurance. The Trust Board's Quality Committee maintains an overview of the delivery of the Quality Improvement Plan.

The areas identified in the 2017/18 Quality Improvement Plan were due to be improved by the end of March 2018. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2018 Operational Quality Committee. Achievements made against the Quality Account priorities in the plan are all detailed in this Quality Account report (see pages 10 to 29).

All improvement areas which require further action and monitoring because they were either, not fully improved or some improvements were made but require further monitoring to ensure they are embedded into practice were all carried forward onto the 2018/19 Quality Improvement Plan. Further information on the 2018/19 Quality Improvement Plan will be provided in next year's Quality Account.

A full copy of the Quality Improvement Plan can be found on http://www.hey.nhs.uk/about-us/cqc/

Care Quality Commission - Duty of Candour

What is Duty of Candour?

The Care Quality Commission (CQC) introduced the new Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

How is the Trust Implementing Duty of Candour?

The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature.

Duty of Candour is monitored within the Trust's Quality Governance and Assurance Department, who ensures that response to patients and their representatives, is sent in a timely manner, and to check the quality and content of letters, to ensure that information sent to patient and their representatives is open and honest.

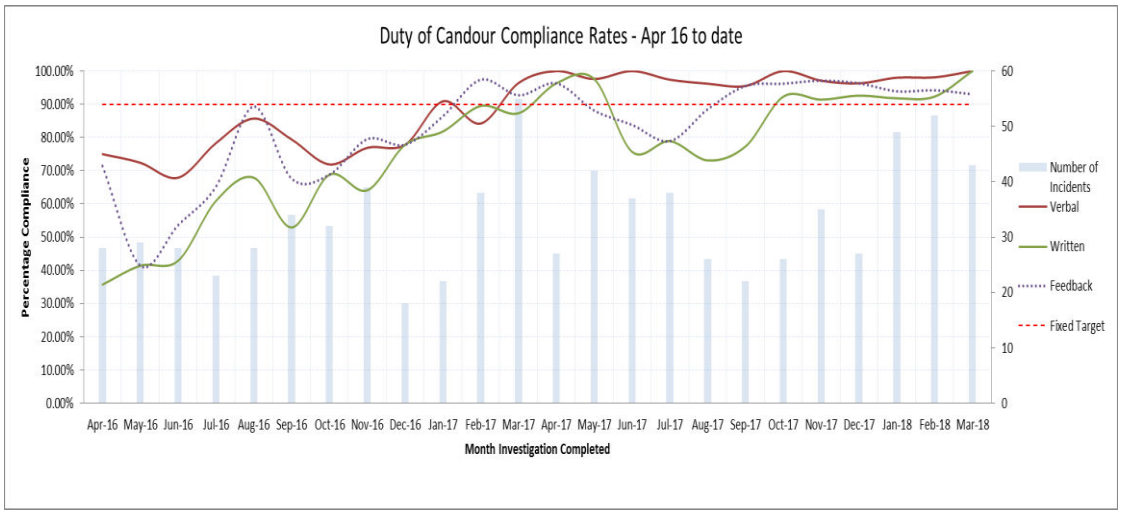
What is the Trust's compliance with Duty of Candour?

The Care Quality Commission assessed the Trust in June 2016 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements. The Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust expects that a verbal apology is given within 10 days of the incident occurring, that a written apology is also given within 10 days of the incident occurring, and that a written explanation of the incident is sent within 10 days of the completion of the incident investigation. This compliance is monitored to a target of 90% compliance, allowing for those incidents which require more time to provide an open and honest apology and response.

This graph shows from April 2016 to March 2018; each element of the duty of candour compliance, monitored against the 90% target (fixed target).

Chart 1: Duty of Candour compliance rates



Data Quality

NHS number and general practice code validity

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2017/18 to the Secondary Users service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was:
99.11% for admitted patient care;
99.86% for outpatient care; and
99.94% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care

Information Governance Toolkit

The Information Governance Toolkit (IG Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance. It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisations and between organisations.

The Information Governance Assurance Statement is a required element of the IG Toolkit and is re-affirmed by the annual submission with a minimum of level two compliance demonstrating the organisation has robust and effective systems in place for handling information securely and confidentially.

Hull and East Yorkshire Hospitals NHS Trust's Information Governance Assessment Report overall score for 2017/18 was 73%. Thirteen standards were reaching Level 2 and above. The IG Toolkit was audited and assessed as achieving Significant Assurance.

Clinical Coding Error Rate

Hull and East Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. The recommendations below are drawn from the internal specialty audits performed during 2016/17 and 2017/18.

The following table provides an update on the implementation of the recommendations from 2016/17:

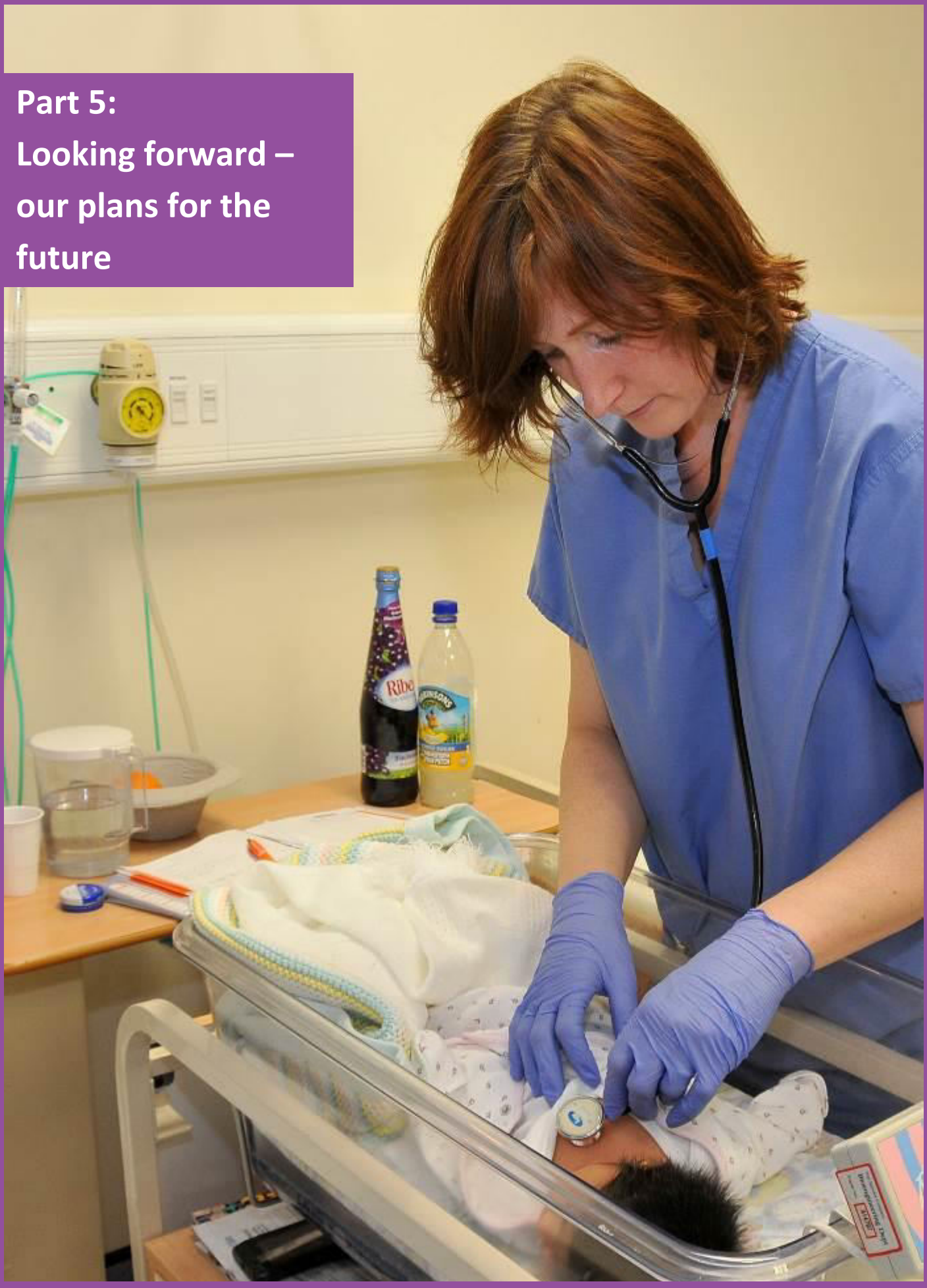
Recommendation	Priority	Progress Update	Status
R1 - Engagement should be encouraged with clinicians across all specialties with examples of good coding and bad coding to highlight where any problems are occurring and why, and the impact this has coding outcomes	High	Concentrate on surgical specialties and increasing the number of coding validation sessions being done. The number of validation sessions has remained steady however more clinicians are keen to assist and be contacted on an ad hoc basis.	On-going but with good engagement in CTS, Urology, Oral surgery, Colorectal
R2 - Continue to achieve 95% for flex and 100% for freeze dates of each month post implementation of Lorenzo.	High	Maintain targets throughout Lorenzo implementation phase. Flex dates took longer to come back to pre-Lorenzo levels than anticipated.	Complete
R3 - Post Lorenzo implementation look to achieve higher levels of completion at flex 97% and be regularly 85-90% complete by early income reporting.	Medium	Targets met every month for 12 months	Complete

R4 - Improve case note quality by monitoring the state of the case notes and assessing the availability of information and report any issues.	Medium	Case note quality forms part of the audit reports and is reported to the speciality as part of audit feedback	Complete
R5 - Achieve Level 3 in all internal specialty audits. Level 3 = 95% primary diagnosis, 90% secondary diagnosis, 95% primary procedure, 90% secondary procedure.	Medium	To ensure coding quality regular audits should be of the highest standard achievable. Audits will assess the training needs of individual staff members and training will be delivered to fill knowledge gaps.	Incomplete
R6 - Improve coding depth in all areas through regular coding audit and clinical engagement.	Medium	Where possible, coding depth across all specialties should meet or exceed peer. Where this is not the case investigations and audits should be carried out to ensure the level achieved is accurate.	Complete. Trust average risen from 5.1 to 5.7 throughout 2017/18
R7 – Ensure coders are maintaining standards and receive regular audit feedback	Medium	Regular feedback post audit	Complete
R8 – Histology results should be checked in a timely fashion.	Medium	Encouraged to make better use of daily histology report.	Incomplete
R9 - Adjust proforma in preparation for HRG4+	Medium		Complete

The following table provides an update on the implementation of the recommendations from 2017/18:

Recommendation	Priority	Progress Update	Status
R1 - Engagement should be encouraged with clinicians across all specialties with examples of good coding and bad coding to highlight where any problems are occurring and why, and the impact this has coding outcomes	High	Concentrate on surgical specialties and increasing the number of coding validation sessions being done. The number of validation sessions has remained steady however more clinicians are keen to assist and be contacted on an ad hoc basis.	Ongoing but with good engagement in CTS, Urology, T+O, Oral surgery, Stroke, Colorectal
R2 - Achieve Level 3 in all internal specialty audits. Level 3 = 95% primary diagnosis, 90% secondary diagnosis, 95% primary procedure, 90% secondary procedure.	High	To ensure coding quality regular audits should be of the highest standard achievable. More regular spot checks introduced to identify and address training needs more quickly.	On-going
R3 – Histology results should be checked in a timely fashion.	High	Encouraged to make better use of daily histology report. Introduced as a specific objective for team leaders to achieve on appraisal.	Incomplete
R4 - Improve coding depth in targeted areas through regular coding audit and clinical engagement.	High	Trust wide coding depth has risen, some areas however remain low, and Obstetrics in particular, and regular meetings to address documentation are being introduced.	On-going
R5 – Improve coding extraction skills, for primary and secondary diagnoses.	High	Training in extraction skills given to staff	Complete
R6 – Improve quality of documentation in T+O to include patient history, post-surgery documentation and typed op notes.	Medium	Encouraged to make better use of daily histology report.	Complete
R7 – Improve communications with Stroke team to avoid conflicting information between case notes and discharge letters	Medium	Introduce regular validations and case note checks	Complete

Part 5: Looking forward – our plans for the future



This section includes:

- Information on how the Trust consulted on the 2018/19 quality and safety improvement priorities
- Information on each quality and safety improvement priority, including what the Trust wants to achieve, what targets will be used to monitor performance and where progress and performance will be reported to for escalation and/or assurance

Our Plans for the Future – Consultation

For 2018/19 the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2017/18
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2017/18
- Looking at national priorities and local priorities that have been agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN)
- Looking at what our regulators have identified as priorities, such as compliance with the CQC Fundamental Standards
- Review of the NHS Outcomes Framework (15 patient safety collaboration priority areas) and sign up to safety priorities

In order to seek the views of our staff, Trust patient members, stakeholders and our local community on what they thought the priorities should be for 2018/19 the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff and patient members and stakeholders, for their feedback on the content of the 2017/18 Quality Account and to consult on the 2017/18 priorities. This year 192 people completed the online survey in February and March 2018.
- Relevant committees were also asked for their comments and ideas:
  - Operational Quality Committee for consultation on all priorities and approval of the 2018/19 priorities
  - Quality Committee for approval of the 2018/19 priorities
  - Trust Board for ratification of the 2018/19 priorities

The Trust has identified these quality improvement priorities for 2018/19 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2018/19

Safer Care (Patient Safety)

- To improve nutrition and hydration
- To improve medicine optimisation
- To improve care, management, detection and treatment of the deteriorating patient
- To reduce avoidable hospital acquired infections
- To reduce avoidable hospital acquired pressure
- To reduce avoidable acute kidney injury
- To reduce avoidable patient palls

Better Outcomes (Clinical Effectiveness)

- To improve the early recognition and treatment of people with sepsis
- To improve the care of people with mental health problems
- To reduce avoidable mortality
- To improve the process of transition between paediatric and adult care services
- To improve handover arrangements

Improved Experience (Patient Experience)

- To listen to and act on patient experience to improve services

Safer Care (Safe, Caring, Responsive and Well-led)

1. Nutrition and Hydration

What do we want to achieve?

The aim of this project is to improve patients' nutrition by achieving and monitoring the required actions / improvements from the March 2018 Nutritional Prevalence re-audit and developing any required actions to improve compliance with the Nutrition Fundamental Standards.

How will we measure this priority?

- 100% of wards to achieve a minimum of 80% compliance on the Nutrition Fundamental Standard: Amber (Baseline 91.3%)
- 100% of wards to achieve a minimum of 80% compliance with completion of Food Record Charts on the Matrons Handbook (Baseline TBC)
- 100% of wards to achieve a minimum of 80% compliance with completion of Fluid Balance Charts (Paper Copies) on the Matrons Handbook (Baseline TBC)

How will we monitor and report on progress?

This project will be monitored through the Nutrition Steering Group Committee with leadership from the Senior Nursing Team, Surgery Health Group.

2. Medicine Optimisation

The aim of this project is to ensure our patients receive the right medicines, at the right dose at the right time as well as compliance with best practise guidance and regulations.

How will we measure this priority?

- 80% of pharmacists to have undertaken e-learning module "VTE prevention in secondary care" (available on HEY247) by March 2019 (Baseline 16%)

How will we monitor and report on progress?

The project will be monitored by the Safer Medication Practice Committee with leadership from the Chief Pharmacist.

3. Deteriorating Patient

What do we want to achieve?

The aim of this project is to ensure that the Trust's Deteriorating Patient Policy is fully implemented and patient's observations are taken and recorded in line with Trust policy and escalated for medical reviews in a timely manner.

How will we measure this priority?

This project is under development in response to the receipt of the draft CQC inspection report from February 2018 – project measures to be confirmed in May 2018

How will we monitor and report on progress?

The project will be monitored by the Operational Quality Committee with leadership from the Deputy Nurse.

4. Avoidable Hospital Acquired Infections

What do we want to achieve?

The aim of this project is to reduce the number of avoidable hospital acquired infections by ensuring compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) by focussing on the review of the Trust's Infection Prevention and Control Care Bundle and participation in the NHS Improvement Urinary Tract Infection Collaborative Project.

How will we measure this priority?

- To have 0 Hospital acquired MRSA bacteraemia (Baseline 1)
- To continue to reduce the number of Hospital acquired Clostridium Difficile to <=52 (Baseline 38)

- To continue to reduce the number of Hospital acquired MSSA to <=46 (Baseline 36)
- To continue to reduce the number of Hospital acquired E. Coli to <=73 (Baseline 110)

How will we monitor and report on progress?
The project will be monitored by the Infection Prevention and Control Committee with leadership from the Director of Infection Prevention and Control and Lead Nurse Infection Prevention & Control.

5. Avoidable Hospital Acquired Pressure Ulcers

What do we want to achieve?
The aim of this project is to reduce the number of avoidable hospital acquired pressure ulcers. It is also to embed the existing clinical and governance processes for the management of pressure ulcers by ensuring that nursing staff are compliant with training and that lessons are learnt from Root Cause Analysis investigations and incidents.

How will we measure this priority?
- 85% compliance for nursing staff with mandatory tissue viability training in all clinical areas (Baseline 78.5%)
- All root cause analysis investigations of hospital acquired pressure sores completed within 14 days (Baseline 55.6%)
- Fully quorate at Trust's Wound Management Committee (Baseline - not quorate)

How will we monitor and report on progress?
The project will be monitored by the Wound Management Committee with leadership from the Health Group Nurse Directors.

6. Acute Kidney Injury

What do we want to achieve?
The aim of this project is to increase compliance with NICE Quality Standard 76 – Acute Kidney Injury, which if successful will have a positive impact on patient mortality, morbidity and length of stay, thereby reducing costs per patient. The project aims to increase compliance specifically the following Quality Statements from NICE Quality Standard 76:
- Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition.
- Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level and urine output monitored.
- Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.

How will we measure this priority?
TBC

How will we monitor and report on progress?
TBC

7. Patient Falls

What do we want to achieve?
The aim of this project is to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the Multi Factorial Assessment Tool (MFAT). It will also focus on the outcomes for the patient following a fall to learn lessons from the root cause analysis investigations completed along with the achievement of compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention.

How will we measure this priority?
- To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above (Baseline 0.17)
- To further reduce the number of patient falls per 1000 bed days for patient falls (Baseline7.47)
- Continue to achieve =>50% of clinical staff in the identified high risk areas to have completed the falls prevention e-learning
- To reduce the number of falls resulting in a fracture neck of femur (Baseline TBC)

How will we monitor and report on progress?
The project will be monitored by the Falls Committee with leadership from the Assistant Chief Nurse and the Chair of the Falls Committee.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Better Outcomes (Effective, Safe and Caring)

1. Sepsis

What do we want to achieve?

The aim of this project is to continue the education and increase awareness of staff within the Trust around sepsis and the management of patients on the sepsis pathway across the organisation. In addition, the focus will be on the development of appropriate coding for patients.

How will we measure this priority?

- The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.
- The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.
- Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours.
- There are three parts to this indicator.
  1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions
  2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions
  3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions

How will we monitor and report on progress?

This project will be monitored through the Operational Quality Committee with leadership from the lead consultant and nurse for Sepsis.

2. Mental Health

This project is under development in response to the receipt of the draft CQC inspection report from February 2018 – project aim and measures to be confirmed in May 2018

What do we want to achieve?

TBC

How will we measure this priority?

TBC

How will we monitor and report on progress?

TBC

3. Avoidable Mortality

What do we want to achieve?

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

How will we measure this priority?

- Continue to review all deaths of patients where family, carers or staff have raised a concern about the quality of care provided (Baseline 100%)
- Continue to review all deaths of patients who are identified to have a learning disability and / or severe mental health (Baseline 100%)
- Continue to review all deaths of patients subject to care interventions from which a patient's death would be wholly unexpected (Baseline 100%)
- Continue to review all deaths of patients that underwent elective procedures during their last episode (Baseline 100%)
- Continue to review a sample of 10 deaths per month where learning will inform the organisations quality improvement work (Baseline 100%)

How will we monitor and report on progress?
This project will be monitored through the Mortality Committee with leadership from the Chief Medical Officer and the Clinical Outcomes Manager.

4. Transition between Paediatric and Adult care

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

How will we measure this priority?

- Embedding of the procedural document ensuring the effective transition for young people to adult services (Baseline of implemented)

How will we monitor and report on progress?
This project will be monitored through the Transition Steering Group with leadership from the Head of Outpatient Services.

5. Handover

What do we want to achieve?
The aim of this project is to develop a handover process that supports learning and integrates patient care with Junior Doctor training and development through a daily handover session for Junior Doctors, with senior clinical involvement, across the medical services where admissions, cases and treatments are discussed and responsive actions put in place if concerns are raised.

How will we measure this priority?

- Delivery of the Handover quality improvement project (No baseline – new project for 2018/19)

How will we monitor and report on progress?
This project will be monitored through the Operational Quality Committee with leadership from the Consultant in Infectious Diseases.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Improved Experience (Caring, Responsive and Well-led)

1. Patient Experience

What do we want to achieve?

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

How will we measure this priority?

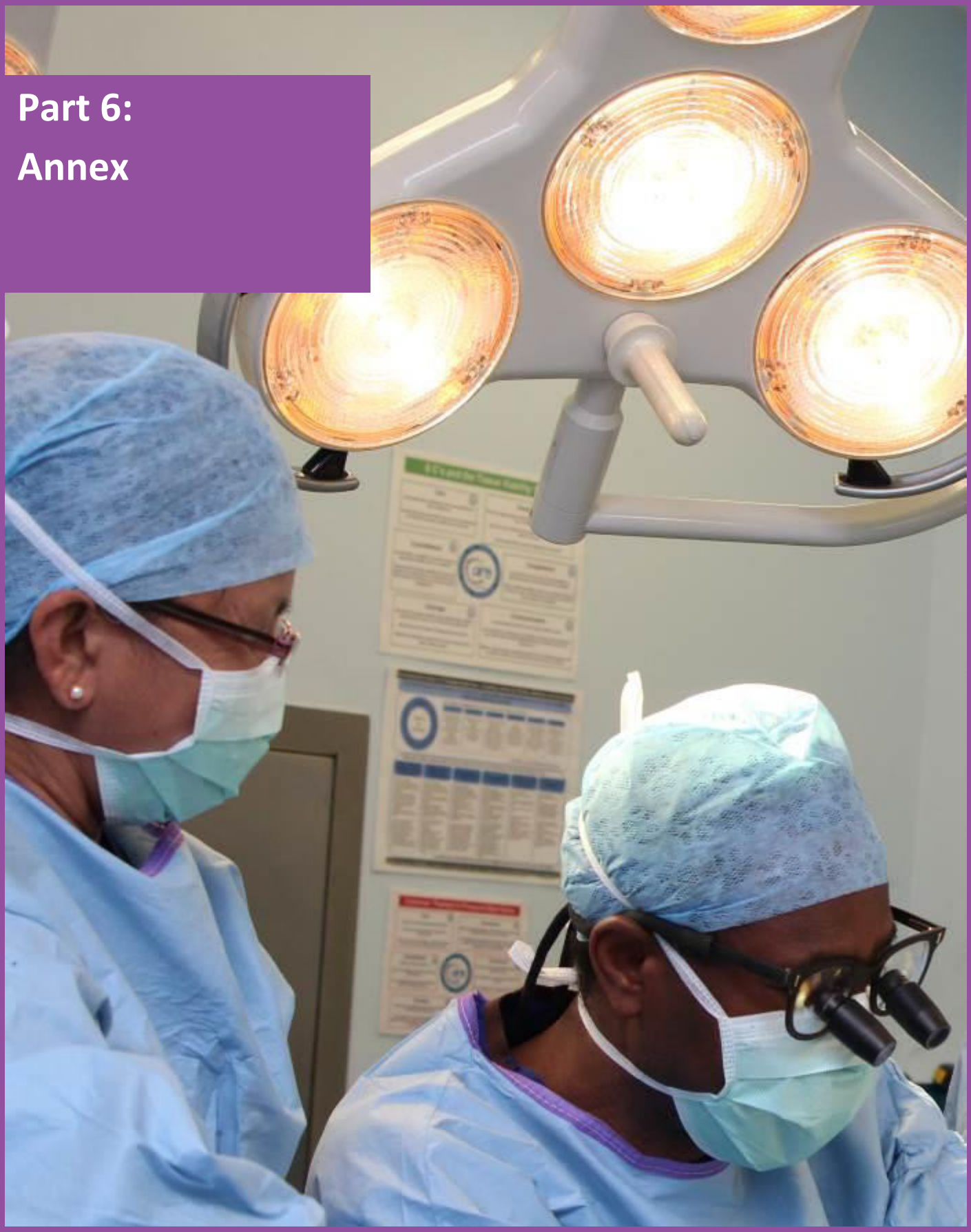
- Continue to achieve =>85% of formal complaints closed within the 40 day target and actions recorded where appropriate (Baseline 92.85%)
- To reduce the number of repeat complaints by 20% (Baseline TBC)

How will we monitor and report on progress?

This project will be monitored through the Patient Experience Committee with leadership from the Deputy Director of Governance and Assurance and the Head of Patient Experience and Engagement.

All of the priorities will also be monitored through the use of a monthly progress report and a performance dashboard to the Quality Improvement Programme meeting. Areas of concern will be escalated to the Operational Quality Committee. Further reports will also be presented to the Quality Committee of the Trust Board.

Part 6:
Annex



This section includes:

- Statements on the content of the Quality Account from our Stakeholders
- Trust response to the Stakeholder statements
- Statement of Directors responsibility
- Statement of assurance from the Independent Auditors
- Abbreviations
- Information on how to provide feedback to the Trust on the Quality Account

Statements from Key Stakeholders

This section will be added in June 2018 following receipt of all stakeholder statements.

The first draft of the Trust's 2017/18 Quality Account was forwarded to key stakeholders on the 081 May 2018 with a request for statements of no more than 500 words to be received before the 05 June 2018. The key stakeholders are:

- NHS Hull Clinical Commissioning Group
- NHS East Riding of Yorkshire Clinical Commissioning Group
- Healthwatch Kingston Upon Hull
- Healthwatch East Riding of Yorkshire
- Hull City Council Overview and Scrutiny Committee
- East Riding of Yorkshire Overview and Scrutiny Committee

As required in the Department of Health guidance, different organisations were requested to comment on specific questions.

The commissioners were asked to:

- Confirm in a statement, to be included in the provider's Quality Account, whether or not they consider the document contains accurate information in relation to services provided and set out any other information they consider relevant to the quality of NHS services provided;
- Take reasonable steps to check the accuracy of data provided in the Quality Account against any data they have been supplied during the year (e.g. as part of a provider's contractual obligations)

The Local Healthwatch and the Overview and Scrutiny Committees were asked to consider:

- Whether the Quality Account is representative
- Whether is gives a comprehensive coverage of the provider's services
- Whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to the Quality Account

The statements received can be found below. No amendments have been made to these statements.

Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group

Healthwatch Kingston upon Hull

Healthwatch East Riding of Yorkshire

Hull City Council Overview and Scrutiny Committee

East Riding of Yorkshire Overview and Scrutiny Committee

Trust Response to the Statements

This section will be added in June 2018 following receipt and review of all stakeholder statements.

The Trust would like to thank all stakeholders for their comments on the 2017/18 Quality Account. We are pleased that the statements from our stakeholders demonstrate the collaborative commitment we share in improving the quality of services we provide and the outcomes for our patients and that stakeholders are in agreement that the quality and safety improvement priorities for 2018/19 are the right ones.

All statements received from our Stakeholders have been included in the Quality Account. The Trust has made a number of amendments to the Quality Accounts following additional comments and queries from the Stakeholders to further improve the information contained within the report.

A recommendation for change was noted from the formal stakeholder statements. The Trust would like to respond to these via this section of the Quality Account.

Statement of Directors' Responsibility

This section will be added in June 2018 following approval by the Auditors and sign off by the Trust Board before publication.

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Independent Auditor's Report

This section will be added in June 2018 following approval by the Auditors and sign off by the Trust Board before publication.

Abbreviations and definitions

3G Audit	All wards in the Trust are audited by the 3G (Great Ward, Great Staff, Great Care) assessment process. The 3G audits assess all wards against a number of quality and safety standards
AAU	Acute Assessment Unit
AKI	Acute Kidney Injury
Aria	An electronic prescribing system
Care Bundle	Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections
C.Difficile	Clostridium difficile infection is a type of bacteria which may live in the bowel and can produce a toxin that can affect the digestive system
CHH	Castle Hill Hospital
Clinical Audit	This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done
Clinical Outcomes	A clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease
COPD	Chronic obstructive pulmonary disease - is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease
CQC	Care Quality Commission – the organisation that regulates and monitors the Trust's standards of quality and safety
CQUIN	Commissioning for Quality & Innovation – a payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative
DATIX	DATIX is the Trust wide incident reporting system
Deteriorating Patient	A patient whose observations indicate that their condition is getting worse
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
e-Learning Package	A training programme that individuals or groups can complete online
ED	Emergency Department
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care
Friends and Family Test	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care

Health Groups	Health Groups are the areas of the Trust delivering care to our patients. There are four Health Groups; Clinical Support, Family and Women's, Medicine, and Surgery. These four Health Groups are headed by a Consultant (Medical Directors) who is the Accountable Officer. They are supported in their role by a Director of Nursing and an Operations Director
HEYHT	Hull and East Yorkshire Hospitals NHS Trust
Hospital Episode Statistics (HES)	HES is a data warehouse containing details of all admissions into NHS hospitals in England
HRI	Hull Royal Infirmary Hospital
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio – is an indicator of whether death rates are higher or lower than would be expected
Lorenzo	The Trust's electronic patient record system
Medication Errors	An incorrect or wrongful administration of a medication, e.g. a mistake in the dosage of medication
MRSA	Methicillin-resistant Staphylococcus Aureus is a type of bacterial infection that is resistant to a number of widely used antibiotics
MSSA	Methicillin-sensitive Staphylococcus Aureus
National Patient Safety Agency Alerts	Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices
Never Event	A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'
NEWS	The National Early Warning Score has been developed to provide a single, standardised early warning system across the NHS which should help to identify patients most at risk and enable their care to be escalated appropriately in order to prevent further deterioration and possible respiratory or cardiopulmonary arrest.
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.
NIHR	The National Institute for Health Research commissions and funds research in the NHS and in social care
NHS	National Health Service
NHS England	NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system
NHS Hull CCG	NHS Hull Clinical Commissioning Group
NHS Outcomes Framework	This framework has been developed to provide national level accountability for the outcomes that the NHS delivers. Its purpose is threefold: to provide a national level overview of how well the NHS is performing, wherever possible in an international context; to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes
NRLS	National Reporting and Learning Service
Outliers	Patients who have been in the wrong speciality bed, for a non-clinical reason. For example, a Medial Elderly patient on a Gynaecology ward.

PaCT	Professionalism and Culture Transformation
PALS	Patient Advice and Liaison Service – where patients, carers and or relatives are able to raise concerns regarding care and treatment and other services provided by the Trust
PAWS	Paediatric Advanced Warning Score. An early warning scoring system for the initial assessment of children in the emergency department
Sign up to safety pledges	The Pledge made by the Trust to reduce all avoidable deaths and avoidable harm
Pressure Ulcer	Open wounds that form when prolonged pressure is applied to the skin. Patients who spend prolonged periods of time in a bed are prone to such ulcers. A pressure ulcer can be avoided if the appropriate preventative actions are taken
Quality Account	The Quality Account is a report based upon the quality of the service provided and is used to highlight key areas to the local communities and stakeholders
QIP	Quality Improvement Plan
RAMI	Risk Adjusted Mortality Indicator
Root Cause Analysis	RCA is a method of problem solving that tries to identify the root causes of faults or problems
Sepsis	Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
Serious Incident (SI)	An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern
Skin Care Bundle	The SKIN bundle must be applied/used in conjunction with the Pressure Ulcer Prevention and/or Pressure Ulcer Treatment Care Plan for every patient who is assessed as at risk from pressure ulceration or has existing damage.
Stakeholders	A group of people who have a vested interest in the way Hull and East Yorkshire Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care.
TBC	To Be Confirmed
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors
Vital Signs	Vital signs are measures of various physiological statistics and are an essential part of care. Vital signs are normally the recording of body temperature, pulse rate (or heart rate), blood pressure, and respiratory rate
VTE	Venous Thromboembolism – a blood clot within a vein

How to provide Feedback

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information which is meaningful to you and reflects, in part, the aspects of quality that matter most to you.

We would appreciate it if you could spare 10 minutes to complete our feedback survey which can be found on our website: **www.hey.nhs.uk/about-us/quality-accounts**

Alternatively you can e-mail your comments to: **quality.accounts@hey.nhs.uk**

However, if you prefer pen and paper, your comments are welcome at the following address:

The Compliance Team
Quality Governance and Assurance Department
Suite 19
Castle Hill Hospital
Cottingham
HU16 5JQ

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING JAN-MAR 2018

Meeting date	15 May 2018	**Reference Number**	2018 -5 - 20
Director	Chief Medical Officer – Kevin Phillips	**Author**	Guardian of Safe Working Hours - Nagarajan Muthukumar
Reason for the report	**PURPOSE OF THIS REPORT** The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate		

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

1	**RECOMMENDATION** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework BAF 2	**Raises Equalities Issues? No**	**Legal advice taken? No**	**Raises sustainability issues? No**		
5	**BOARD/BOARD COMMITTEE REVIEW**					

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING JAN-MAR 2018

EXECUTIVE SUMMARY

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

- Junior doctor working hours
- Exception reports, where appropriate
- Rota gaps
- Locum usage
- System-wide junior doctor issues, where appropriate

The Trust Board is requested to receive this report and:

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

1. PURPOSE OF THIS REPORT

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

- Junior doctor working hours
- Exception reports, where appropriate
- Rota gaps
- Locum usage
- System-wide junior doctor issues, where appropriate

The Trust Board is requested to receive this report and:

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

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from Jan-Mar 2018 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. HIGH LEVEL DATA

Number of doctors / dentists in training (total):	516 (establishment) 408.5 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	408.5
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee (max; varies between HGs)

All trainees in the Trust are now on the 2016 terms and conditions of service (TCS) and have received their work schedules. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work
- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hours adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.

The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

3. JUNIOR DOCTOR WORKING HOURS

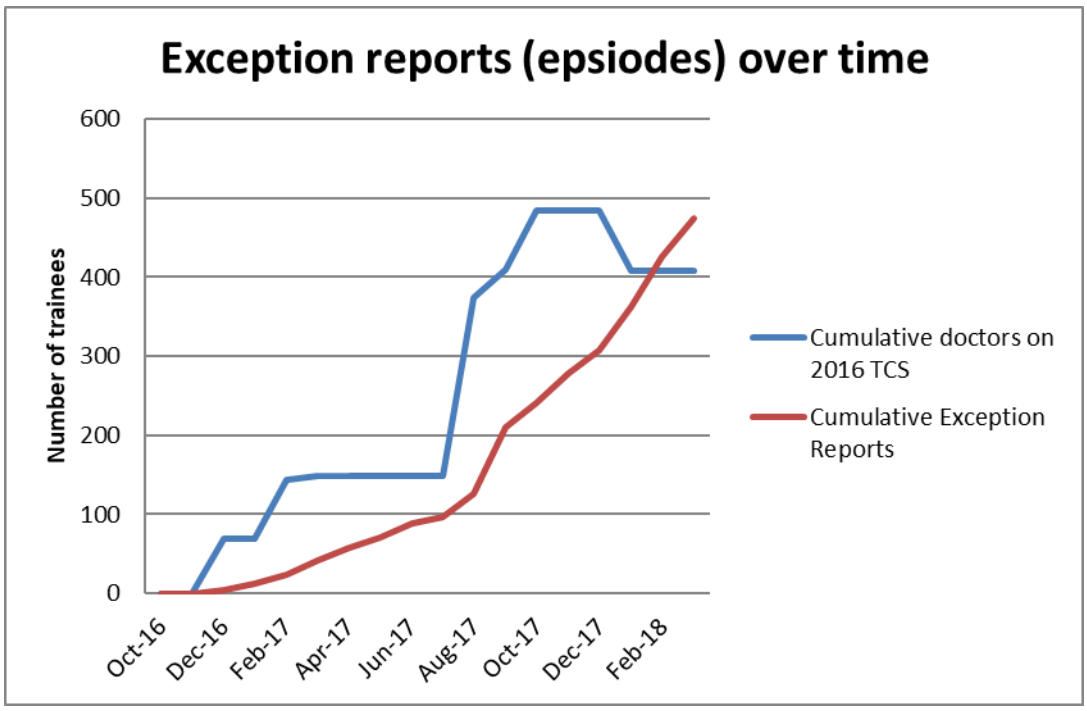
The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.

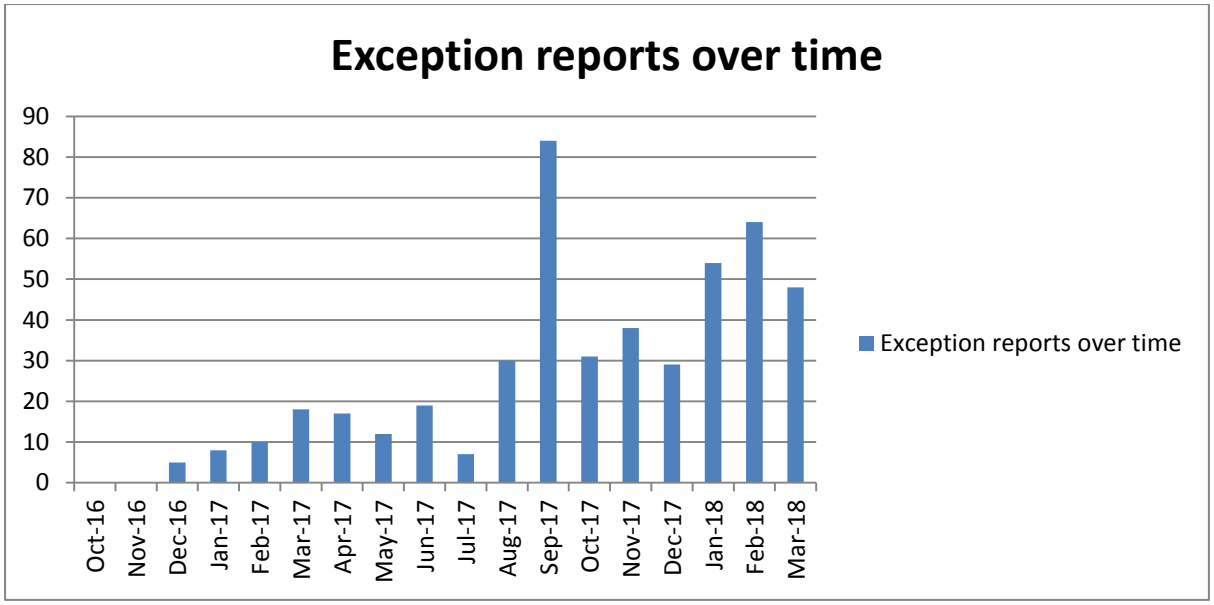
In all cases the data below is presented in relation to exception report EPISODES, since a single exception report may contain a number of episodes of concern.

There were 166 exception report episodes submitted between 1 January and 31 March 2018 and 11 carried forwards from the previous quarter. The number of reports has shown a steady rise in tandem with the number of doctors on the contract.

Exception reports

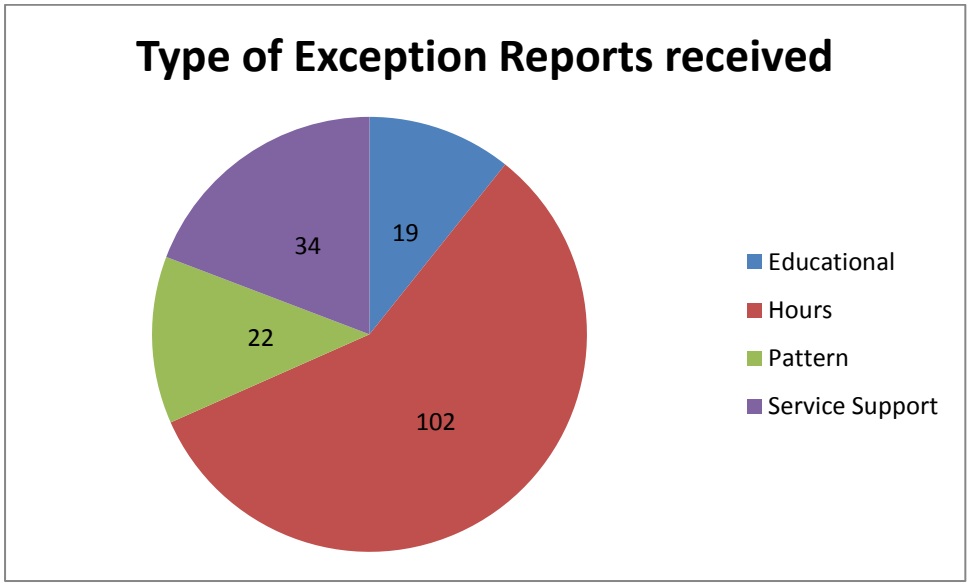
Exception report episodes over time





Types of exception reports received 1 Jan – 31 Mar 2018

The types and proportions of exception report received has stayed remarkably constant in each quarter to date, however there is an expected trend towards more educational exception reports being submitted as trainees become familiar with the system.



Exception reports (episodes) by specialty 1 Jan 2018 – 31 Mar 2018

Specialty (Where exception ccurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
AAU	0	10	10	0
Acute Surgery (HRI)	0	21	16	5
Anaesthetics		1		1
Cardiology		5	3	2
Chest	0	1		1
Colorectal surgery		4		4
Critical Care		1	1	
DME	2	9	3	8
Emergency Medicine	5	2	7	
Endocrinology		25	12	13
Gastroenterology		12		12
General Medicine (HRI)		2	2	
Haematology		5	4	1
Medicine Nights		4		4
Neonates		1		1
Neurology	2		2	
Neurosurgery		1	1	
Obstetrics and Gynaecology		1	1	
Oncology		5	5	
Trauma & Orthopaedics		23	17	6
Paediatric Emergency Medicine		6		6
Paediatric Surgery		2	2	
Rheumatology		2	2	
Surgery nights CHH		3		3
Upper GI Surgery		6	3	3
Urology		11	2	9
Vascular Surgery	1	4	1	4
	Total	**177**		**177**

Exception reports (episodes) by grade 1 Jan 2018- 31 Mar 2018

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT1		7	6	1
CT2		6	4	2
F1	6	78	48	36
F2		42	16	26
GPSTR		3	2	1
ST2		1	1	
ST3		8		8
ST4		9	9	
ST5		1	1	
ST6		11	8	3
ST7	5		5	
TOTAL -177	**11**	**166**	**100**	**77**

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

We are seeing a gradual increase in exception reports from other grades, as time goes on and as they get used to the contract and the exception reporting mechanism. Numbers are small, however, and it is not possible to draw conclusions from these reports yet.

Exception reports (episodes) by rota 1 Jan 2018- 31 Mar 2018

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
(2016) Rota 30 - Orthopaedics SpR		1	1	
Rota 1 - A&E F2		2	2	
Rota 124b General Surgery (Uro/ENT) SHO		14	2	12
Rota 134 - Orthopaedic F2		17	12	5
Rota 14 - Medicine SHO blp 431		12	1	11
Rota 18 - Medicine F1		28	18	10
Rota 23 - Vascular Surgery F1	1	7	4	4
Rota 25 - Acute-Elective Surgery F1		29	17	12
Rota 2C - A&E SHO (PEM)		3		3
Rota 4 - Medicine F1		12	4	8
Rota 4B - Medicine F1		4	4	
Rota 5 - Medcine SHO (blp 215)		3	2	1
Rota 52 - O&G SpR		1	1	
Rota 57 - Paediatric Neonates (SpR)		1		1
Rota 6 - RMO		14	4	10
Rota 60 - Paediatric F1		2		2
Rota 75 - Anaesthetics ICU1		1	1	
Rota 8 - Onocology/Haematology SHO		6	5	1
Rota 2 - A&E SpR	5		5	
Rota 135 - Orthopaedic & Plastic Surgery CT		5	5	
Rota 132 - Paediatric Emergency Medicine		3	3	
Rota 18B - Medicine F1		1	1	
Rota 20 - Cardiology SpR		5	3	2
total	**6**	**171**	**95**	82

Exception reports (episodes) - response time 1 Jan 2018- 31 Mar 2018

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
CT1		5	1		1	
CT2		6				
F1	12	2	33		37	
F2	3	7	17		15	
GPSTR		2	1			
ST2			1			
ST3					8	
ST4					9	
ST5			1			
ST6	5		2		4	
ST7			5			

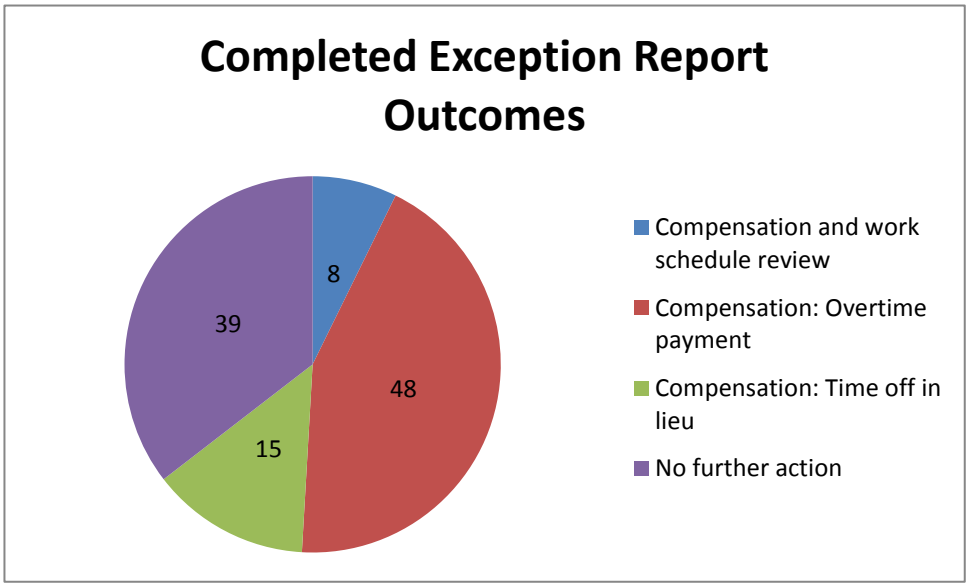
The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.

This is shown in the table below:

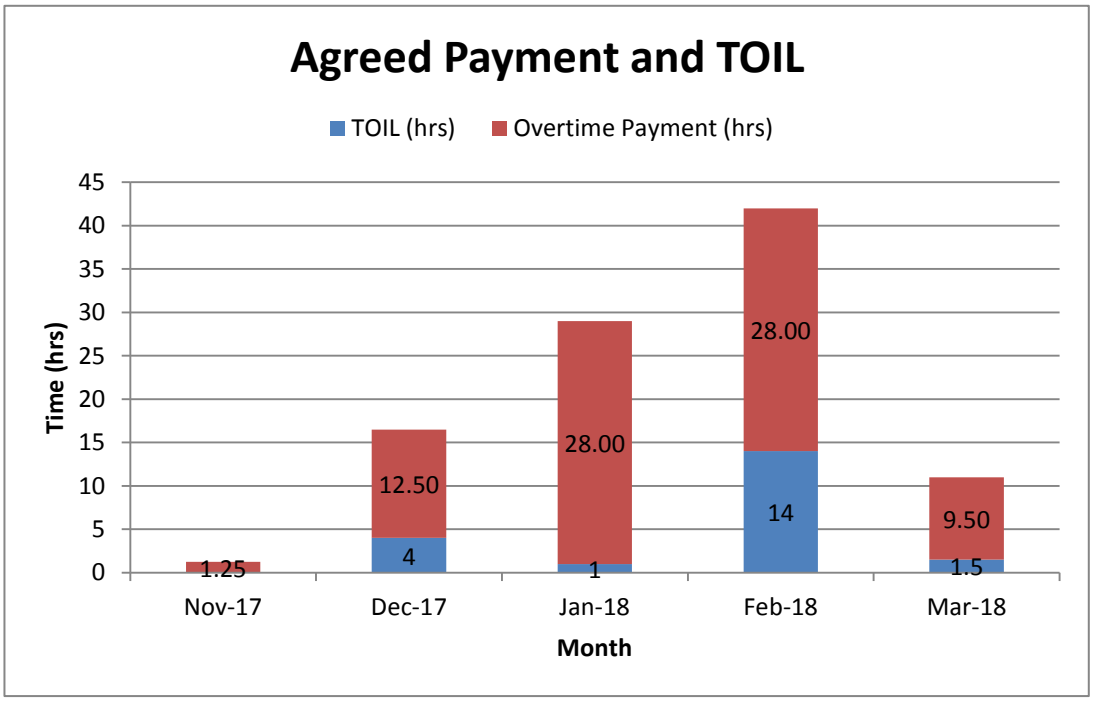
Department (base dept)	No of reports	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports
Anaesthetics	1					1	
Breast Surgery	5			1		4	
Cardiology	5			2		3	
Chest	1					1	
Colorectal Surgery	6		1			5	
Critical Care	1	1					
DME	18	4	2	9		3	
Emergency Medicine	7	2		5			
Endocrinology	25			12		13	
ENT	3					3	
Gastroenterology	12			4		8	
Haematology	5	4	1				
Neonates	1					1	
Neurology	5			4		1	
Neurosurgery	1		1				
Obs & Gyn	1	1					
Oncology	5		5				
Trauma Orthopaedics	22	1	9	8		4	
Paediatric Emergency Medicine	6					6	
Paediatrics	2					2	
Plastics	1		1				
Psychiatry	6			6			
Rheumatology	2					2	
Upper GI	19	7	1	5		6	
Urology	10		2	3		5	
Vascular Surgery	7			1		6	
Total	**177**	**20**	**23**	**60**		**74**	

Outcomes of completed exception reports 1 Jan 2018- 31 Mar 2018



This shows broadly similar proportions of time versus payment compared to the last quarter. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Patterns and responses

Patterns of exception reports have been seen and dealt with as follows:

Endocrinology
Rota gaps leading to trainees having to stay over to complete routine ward work was the main cause for this department having a high number of exception reports.

Trauma & Orthopaedics
Rota gaps leading to trainee having to stay over to complete routine ward work was the main cause for this department having a high number of exception reports. Excessive workload also led to 2 exception reports relating to "educational" category. One report was escalated to health group management hierarchy due to the potential for immediate safety concern.

Acute General Surgery
F1 trainees rotate to acute general surgery from Upper GI surgery, colorectal surgery, and vascular surgery so these reports often have to be considered together and are hard to separate out. Low staffing levels was the main reason again. However excessive workload as well as late ward rounds also contributed to a minority of the reports most of which were under the "hours" category although 3 related to missing educational opportunities.

DME
There were a total of 7 reports in this department although they accounted for 18 episodes. More importantly 2 of them were deemed to have breached safe working hours incurring a fine.

Gastroenterology
Staffing shortage and excessive workload led to 12 episodes being reported.

Trainees in psychiatry placements

The Trust has a number of Foundation trainees in psychiatry placements. These trainees are employed by this Trust, but have their placements in Humber Foundation Trust, who are responsible for the working hours, work patterns and training opportunities during the length of the placement. We have had to work collaboratively with colleagues in Humber FT to produce work schedules for these trainees.

Monitoring of trainees in GP placements

Historically, and nationwide, hours monitoring of Junior Doctors working out of the Trust on placement at local GP practices has never taken place. The posts were unbanded, as there was an expectation that trainees worked 40 hours Mon-Fri. Foundation trainees in GP placements are now on the 2016 TCS and are able to exception report. This change has required a significant amount of negotiation to confirm individual GP practice timetables so that work schedules can be issued. The Trust has now also worked with the training practices to agree a Memorandum of Understanding to ensure that any extra payments as a result of trainees working outside of their core hours is able to be repaid by the practice concerned.

There have been no exception reports from general practice this quarter.

Hours Monitoring Exercises

No longer required as all Junior Doctors are now on the 2016 Terms and Conditions of Service.

Work schedule reviews

There are no current Work Schedule reviews taking place. However, as part of the preparation for the August rotation, Medical Staffing will be reviewing all rotas for compliance and making changes as per direction from each Health Group as required.

a) Locum bookings January to March 2018

i) Bank January to March 2018

The Trust currently has an informal medical bank in place which strives to fill as many shifts internally as it can. With the successful creation of a Nurse and Clerical Bank the Trust is looking at creation of a formal Medical Bank in line with the 2016 TCS. We are currently exploring a number of options internally and externally on the best way to support this work. The work on this project will be fed through to the Guardian by the Medical Staffing Operations Group.

The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade				
Grade	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
F1*	216	0	2080.75	0
F2	103	21	888.25	179.5
CT/ST-2/GPSTR	1300	299	12487.25	2704.25
ST3+	479	8	5129	91
TOTAL	**2098**	**328**	**20585.25**	**2974.75**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

Locum Bookings (bank) by department				
Speciality	Number of shifts requested	Number of shifts Worked	Number of hours requested	Number of hours worked
Acute Medicine	377	6	3632.25	67.5
Acute Surgery	5	0	40	0
Anaesthetics	55	2	428.5	25
Cardiology	126	0	1136	0
Cardiothoracic Surgery	17	0	199	0
Chest Medicine	83	14	775.6	117
Colorectal	143	4	1831.3	46
Elderly Assessment Unit	209	59	1286.75	304.75
Elderly Medicine	126	83	1034.5	618
Endocrinology	20	0	193.75	0
ENT	59	10	633.75	107.5
Gastroenterology	8	0	84.75	0
General Surgery	3	0	54	0
Haematology	4	0	88	0
Neonates	8	0	96	0
Neurology	72	8	633.5	64
Neurosurgery	90	12	1021.1	155
Obstetrics & Gynaecology	24	0	242	0
OMFS	59	27	739	343
Oncology	98	0	1114.5	0
Ophthalmology	18	0	162	0
Ortho/Plastics	1	0	16	0
Orthopaedics	266	72	2741.5	747.5
Paediatric Surgery	10	0	59.5	0
Paediatrics	4	0	51.5	0
Plastics	1	0	15	0

Renal Medicine	2	2	16	16
Rheumatology	26	2	301.25	25
Upper GI	21	14	248	171
Urology	68	13	805.5	167.5
Vascular	68	0	666.5	0
Winter Pressures	27	0	238.25	0
TOTAL	**2098**	**328**	**20585.25**	**2974.75**

**Bank doctors are booked by the Emergency Department directly so Medical Staffing does not hold this information at the moment.*

ii) Agency January to March 2018

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	530	253	5001.25	2248.5
Cardiology	93	2	812.5	20
Care of the Elderly	20	2	231	23.5
Chest Medicine	68	43	690	406
Emergency Medicine	853	307	7079.92	2646.42
Endocrinology	14	0	122	0
ENT	101	35	892	291.5
Gastroenterology	3	0	34.25	0
General Medicine	106	58	841.75	444
General Surgery	236	133	2747.91	1559.91
Haematology	92	1	698	11
Neonatal Medicine	109	41	1084	360.5
Neurology	51	5	486.5	50.25
Neurorehabilitation	9	2	67.5	15
Neurosurgery	183	23	1951.17	277.67
Obstetrics and Gynaecology	22	11	254	131.5
Oncology	51	19	608	225

OMFS	25	0	191.5	0
Orthopaedic and Trauma Surgery	362	242	3422.76	2253.26
Paediatric Surgery	41	12	389.46	132.46
Paediatrics	31	2	325.5	24
Plastic Surgery	1	1	24	24
Rheumatology	45	13	493.5	143
Urology	56	15	661.75	176.75
Vascular Surgery	125	55	1068	522
Intensive Care	2	0	17	0
TOTAL	**3229**	**1275**	**30195.22**	**11986.22**

**The Emergency Department books its own agency locums through the same agency.*

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	208	91	1975.25	900
F2/CT/ST-2/GPSTR	2225	801	20507.92	7311.67
ST3+	796	383	7712.05	3774.55
Total	**3229**	**1275**	**30195.22**	**11986.22**

Locum bookings (agency) by reason				
Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Extra Cover	386	192	3360.83	1658.33
Pregnancy/Maternity Leave	17	14	200.5	168
Sick	85	47	801.5	430
Vacancy	2642	1016	24972.39	9657.89
Paternity Leave	20	6	207.5	72
Compassionate/Special Leave	3	0	34.75	0
Other	65	0	487.5	0
Study Leave	11	0	130.25	0
Total	**3229**	**1275**	**30195.22**	**11986.22**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they are having to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover; for example sickness is not mentioned as a reason for seeking cover. This has probably been included in the catch-all term 'vacancy' but will need to be teased out in future.

iii) Emergency Department

The Emergency Department books its own bank doctors directly; these figures are currently reported slightly differently.

Locum Bookings (bank) by 1st January 2018 to 31st March 2018 AGENCY					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Emergency Medicine	517	329	517	4429.5	2877.5
Total					

Locum Bookings (bank) by 1st January 2018 to 31st March 2018 INTERNAL					
Speciality	Number of shifts requested	Number of shifts Worked	Number of shifts given to internals	Number of hours requested	Number of hours worked
Emergency Medicine	1302	673	785	10011.6	5093.1

b) Locum work carried out by trainees January to March 2018

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Base Speciality	**Grade**	**Number of hours worked**	**Number of hours rostered per week**	**Opted out of EWTD**
Public Health	F2	269.75	24:00	Yes
Orthopaedics	F2	199	46:15	No
Cardiology	CT1	188.25	47:15	No
Neurology	CT1	138.5	46:45	Yes
Acute Surgery	ST2	131	44:45	Yes
General Practice	F2	120.75	40:00	Yes
Acute Medicine	F1	106.5	45:45	Yes
Colorectal Surgery	ST5	100.5	46:45	No
Oncology	CT1	99.75	46:30	No
Upper GI Surgery	F1	95	47:15	Yes

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Especially at F2 level, doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis. The appointment of rota co-ordinators is in progress across the Trust as part of the roll-out of e-roster for medical staff, and entry of this data will be a key part of their role.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has EWTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of these rules however Medical Staffing are not responsible for overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required.

Vacancies – table showing vacancies among medical training grades and by rota on 16th April 2018. Detailed below are 2 tables indicating the rota establishment and WTE in post as of 16/04/2018 and Doctor in Training establishment and WTE in post as of 16/04/2018.

Hull East Yorkshire Hospitals NHS Trust - Junior Doctor Rota Establishment eff. 16.04.2018

	Trainee Establishment							Rota Establishment						In Post							
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Fill Rate	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled 29.01.2018	% Filled 16.04.2018
Academic	0	5	0	0	0	5	100.0%	0	5	0	0	0	5	0	5	0	0	0	5	100.0	100.0
Acute Medicine	3	6	9	0	6	24	62.5%	3	6	9	0	6	24	3	6	7.5	0	2.5	19	85.4	79.2
Anaesthetics	4	4	19	0	27	54	78.5%	4	7	16	0	32	59	0	4	14	0	25	43	79.7	72.9
Breast Surgery	2	0	1	0	2	5	80.0%	2	0	1	0	2	5	2	0	0	0	2	4	100.0	80.0
Cardiology	2	1	4	1	9	17	76.5%	2	1	4	1	9	17	2	1	4	0	9	16	97.1	94.1
Cardiothroacic Surgery	0	3	0	0	3	6	66.7%	0	3	0	0	9	12	0	1	0	0	9	10	100.0	83.3
Chemical Pathology	0	0	0	0	2	2	100.0%	0	0	0	0	2	2	0	0	0	0	1	1	50.0	50.0
Dermatology	1	0	0	1	0	2	100.0%	1	0	0	1	0	2	1	0	0	1	0	2	50.0	100.0
Elderly Medicine	5	3	6	7	6	27	68.9%	5	3	6	7	6	27	3	3	4	5	4.5	19.5	83.3	72.2
Emergency Medicine	0	12	8	5	13	38	80.0%	0	12	7	5	6	30	0	12	6	3	6	27	95.0	90.0
Endocrinology	3	0	2	0	4	9	66.7%	3	0	2	0	4	9	3	0	1	0	3	7	77.8	77.8
ENT	1	1	2	1	5	10	80.0%	1	1	3	1	6	12	1	1	2	1	6	11	91.7	91.7
Gastroenterology	3	0	2	0	5	10	80.0%	3	0	2	0	5	10	3	0	2	0	4	9	80.0	90.0
General Practice	0	18	0	0	0	18	88.9%	0	19	0	0	0	19	0	16	0	0	0	16	89.5	84.2
General Surgery	0	1	0	0	0	1	100.0%	0	1	2	0	0	3	0	1	0	0	0	1	33.3	33.3
Haematology	1	0	2	0	3	6	100.0%	1	0	2	0	6	9	1	0	2	0	4	7	77.8	77.8
Histopathology	0	0	0	0	4	4	25.0%	0	0	0	0	4	4	2	0	0	0	2	4	50.0	100.0
HIV/GUM	0	1	0	0	0	1	100.0%	0	1	0	0	0	1	0	1	0	0	0	1	100.0	100.0
Infectious Diseases	2	0	2	0	4	8	50.0%	2	0	2	0	5	9	2	0	1	0	1	4	55.6	44.4
Lower GI Surgery	7	0	2	0	3	12	71.7%	7	0	2	0	3	12	5	0	2	0	2.5	9.5	95.8	79.2
Neurology	2	2	4	0	5	13	92.3%	2	2	4	0	6	14	2	2	4	0	6	14	92.9	100.0
Neurosurgery	1	1	2	0	4	8	100.0%	1	1	6	0	11	19	1	1	4	0	8	14	68.4	73.7
Obstetrics & Gynaecology	0	2	7	4	11	24	86.7%	0	2	6	4	11	23	0	2	6	4	10	22	88.6	95.7
Oncology	3	1	3	4	5	16	81.3%	3	1	6	4	12	26	3	1	3	2	11	20	84.6	76.9
Ophthalmology	1	1	0	0	7	9	66.7%	1	1	0	0	7	9	1	1	0	0	5	7	88.9	77.8
Oral & Maxillofacial Surgery	0	0	10	0	2	12	75.0%	0	0	10	0	6	16	0	0	7	0	2	9	62.5	56.3
Paediatric Emergency Medicine	0	0	7	0	0	7	78.6%	0	0	7	0	0	7	0	0	7	0	0	7	100.0	100.0
Paediatric Neonatal Medicine	0	0	7	0	7	14	78.6%	0	7	0	0	7	14	0	0	0	0	8	8	85.7	57.1
Paediatric Surgery	0	0	2	0	0	2	100.0%	0	0	2	0	4	6	0	0	2	0	1	3	100.0	50.0
Paediatrics	3	4	3	2	8	20	83.0%	4	4	3	2	8	21	2	2	3	2	8	17	88.1	81.0
Palliative Care	0	0	0	2	0	2	75.0%	0	0	0	2	0	2	0	0	0	1.5	0	1.5	75.0	75.0
Plastic Surgery	0	0	3	0	6	9	88.9%	0	0	4	0	7	11	0	0	3	0	7	10	100.0	90.9
Psychiatry	5	5	0	0	0	10	100.0%	5	5	0	4	0	14	5	5	0	0	0	10	78.6	71.4
Public Health Medicine	0	1	0	0	0	1	100.0%	0	1	0	0	0	1	0	1	0	0	0	1	0.0	100.0
Radiology	0	0	0	0	24	24	87.5%	0	0	0	0	24	24	0	0	0	0	19.4	19.4	91.7	80.8
Renal Medicine	2	1	2	0	5	10	70.0%	2	1	2	0	5	10	1	1	2	0	5	9	100.0	90.0
Respiratory Medicine	6	2	2	2	8	20	75.0%	6	2	2	2	8	20	6	2	2	2	8	20	87.5	100.0
Rheumatology	0	0	1	3	3	7	65.7%	0	0	1	2	3	6	0	0	1	2	2.5	5.5	75.0	91.7
Stroke Medicine	0	0	0	0	1	1	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0
Trauma & Orthopaedics	0	5	3	1	9	18	80.6%	0	12	4	1	15	32	0	5	3	0	13	21	75.0	65.6
Upper GI Surgery	7	0	2	0	3	12	83.3%	7	0	2	0	3	12	6	0	1	0	3	10	95.8	83.3
Urology	1	3	2	0	3	9	100.0%	1	3	2	0	5	11	1	3	1	0	5.5	10.5	95.5	95.5
Vascular Surgery	5	0	1	0	3	9	77.8%	5	0	1	0	3	9	4	0	0	0	2	6	77.8	66.7
TOTAL	**70**	**83**	**120**	**33**	**210**	**516**	**79.2%**	**71**	**101**	**120**	**36**	**250**	**578**	**60**	**77**	**94.5**	**23.5**	**205.9**	**460.9**	**84.6**	**79.7**

Increased vacanices since last report	
Decreased vacancies since last report	
No change in vacancies since last report	

Hull East Yorkshire Hospitals NHS Trust - Junior Doctor Trainee Establishment eff. 16.04.2018

	Trainee Establishment						Trainee In Post						
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	100.0%
Acute Medicine	3	6	9	0	6	24	3	5	4.5	0	2.5	15	62.5%
Anaesthetics	4	4	19	0	27	54	4	4	12.5	0	21.9	42.4	78.5%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	80.0%
Cardiology	2	1	4	1	9	17	1	1	4	0	7	13	76.5%
Cardiothroacic Surgery	0	3	0	0	3	6	0	1	0	0	3	4	66.7%
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	2	2	100.0%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	100.0%
Elderly Medicine	5	3	6	7	6	27	3	3	3	5	4.6	18.6	68.9%
Emergency Medicine	0	12	8	5	13	38	0	11	4	3	12.4	30.4	80.0%
Endocrinology	3	0	2	0	4	9	3	0	1	0	2	6	66.7%
ENT	1	1	2	1	5	10	1	1	1	1	4	8	80.0%
Gastroenterology	3	0	2	0	5	10	3	0	2	0	3	8	80.0%
General Practice	0	18	0	0	0	18	0	16	0	0	0	16	88.9%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Haematology	1	0	2	0	3	6	1	0	2	0	3	6	100.0%
Histopathology	0	0	0	0	4	4	0	0	0	0	1	1	25.0%
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Infectious Diseases	2	0	2	0	4	8	2	0	0	0	2	4	50.0%
Lower GI Surgery	7	0	2	0	3	12	5	0	1	0	2.6	8.6	71.7%
Neurology	2	2	4	0	5	13	2	3	2	0	5	12	92.3%
Neurosurgery	1	1	2	0	4	8	1	1	2	0	4	8	100.0%
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	6	4	8.8	20.8	86.7%
Oncology	3	1	3	4	5	16	3	1	2	2	5	13	81.3%
Ophthalmology	1	1	0	0	7	9	1	1	0	0	4	6	66.7%
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	7	0	2	9	75.0%
Paediatric Emergency Medicine	0	0	7	0	0	7	0	0	5.5	0	0	5.5	78.6%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	4	0	7	11	78.6%
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	0	2	100.0%
Paediatrics	3	4	3	2	8	20	2	2	3	2	7.6	16.6	83.0%
Palliative Care	0	0	0	2	0	2	0	0	0	1.5	0	1.5	75.0%
Plastic Surgery	0	0	3	0	6	9	0	0	3	0	5	8	88.9%
Psychiatry	5	5	0	0	0	10	5	5	0	0	0	10	100.0%
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Radiology	0	0	0	0	24	24	0	0	0	0	21	21	87.5%
Renal Medicine	2	1	2	0	5	10	1	1	2	0	3	7	70.0%
Respiratory Medicine	6	2	2	2	8	20	6	2	0	2	5	15	75.0%
Rheumatology	0	0	1	3	3	7	0	0	1	1	2.6	4.6	65.7%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0.0%
Trauma & Orthopaedics	0	5	3	1	9	18	0	3.5	3	0	8	14.5	80.6%
Upper GI Surgery	7	0	2	0	3	12	6	0	2	0	2	10	83.3%
Urology	1	3	2	0	3	9	1	3	2	0	3	9	100.0%
Vascular Surgery	5	0	1	0	3	9	4	0	1	0	2	7	77.8%
TOTAL	70	83	120	33	210	516	61	74.5	83.5	22.5	167	408.5	79.2%

Combining the information about trainees (on the 2016 TCS) with the locally employed doctors (Trust doctors – not on the 2016 TCS) allows a much better picture of the effect of vacancies on the rotas overall. Most rotas are staffed with a mixture of Trust doctors and trainees, so concentrating on one group only gave a misleading picture of the difficulties some departments are having on filling their rotas and running the departments.

Gaps in Trust doctor numbers have an adverse effect on training. Usually, patient safety is maintained by moving doctors from shift to shift, or ward to ward, but this comes at the expense of training.

This information can be used to explain heavy locum usage in some specialties; these are usually the specialties with the biggest problem of rota gaps in one particular tier. For example, Trauma & Orthopaedic rotas are less than 50% filled at F2 level, therefore the locum spend in this department is one of the largest.

Qualitative information

Implementation of the new contract

All junior doctors are now on the 2016 Terms and Conditions of Service. Most of them received their work schedules on time.

Junior Doctor Forum

The Junior Doctor Forum is well-established. Unfortunately, there has been a fall in the number of trainees attending the Forum and it has not been quorate on a couple of occasions. The reasons for this are not clear. An open Junior Doctor Forum was conducted in February 2018 to stimulate interest in the work of the Forum and to promote discussion of the contract among trainees who have not previously been involved. This gave an opportunity for the few trainees who attended to voice some of their views on issues affecting them.

The minutes of the Forum are available on the junior doctor pages of Pattie, along with other items of interest to trainees.

Rota administrative support

It was mentioned in the last quarterly report that data about junior doctors needs to be captured in real time at department level and entered on to the e-rostering system as it happens. This is to allow service planning, to place trainees in the correct environment for their training and service, to capture where vacancies exist and where these have been filled. There is already an investment into rota administrative support at this level, but, particularly where rotas are large and/or complex, health groups need to be sure that the administrative support is adequate for the multiple tasks required. This will allow proactive management of potential staffing level shortfalls which could have implications in the delivery of patient care.

Issues arising

In the short period the current Guardian has been in the post, it is obvious that most common cause for the exception reports filed by junior doctors in training appears to be rota gaps either in the same tier or other tiers. This has led on occasions to some potential safety concern situations. There have been attempts by the Trust to fill these gaps by recruitment but this has been and still remains a challenge. This could be related to the fact that there has been a well documented downward trend in the number of doctors applying for substantive posts after completion of foundation training over the last few years as well as the difficulty in recruiting into the non training posts which could have mitigated the shortfalls in the rota.

Since the implementation of the 2016 Contract for junior doctors, there has been a gradual increase in the understanding of the purpose, scope, objectives and working of the exception reporting system both amongst the trainees as well as the educational supervisors. However meeting the tight time schedule for addressing the reports remains a challenge. There have been some supervisors who have raised concerns regarding the time required to carry out this function.

The data quality relating to junior doctor workforce will need to continue to improve to provide a more accurate picture of the issues that affect junior doctors in training.

Actions taken to resolve issues

The Health Groups receive regular reports on the exception reports to identify trends and investigate any emerging patterns. Any reports that raise immediate safety concerns are looked at and flagged up to the health groups if needed by the supervisors or the Guardian.

Summary

The Trust continues to make good progress in developing systems and processes that will allow the Guardian to monitor safe working hours. Exception reporting seems to be a good early-warning system to indicate where there may be issues. However this information needs triangulating with other sources to gain a complete understanding of system problems and to develop appropriate and robust solutions.

Questions for consideration

The Trust Board is requested to receive this report and:

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT

Meeting date	15 May 2018		**Reference Number**		2018 – 5 - 21	
Director	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian		**Author**		Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian	
Reason for the report	The purpose of the report is to provide a quarterly update from the Freedom to Speak Up Guardian					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive and accept this report. .					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W2 –** Governance					
	Assurance Framework Ref: BAF 1	**Raises Equalities Issues?** Y	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Freedom to Speak Up Guardian is required to report quarterly to the Trust Board; this is to ensure the Guardian can report issues directly to the Board as well as to keep the Board appraised of speaking up in the organisation					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FREEDOM TO SPEAK UP GUARDIAN QUARTERLY REPORT

1. PURPOSE OF THE PAPER

To provide a quarterly report from the Freedom to Speak Up Guardian as part of the Trust's processes to enable staff to raise concerns.

2. INTRODUCTION

All Trusts from 1 April 2017 were required to have a Freedom to Speak Up Guardian in place. The Trust Board agreed an outline position as to how the Guardian role would be used within the Trust; the main purpose of the Guardian role is to be part of continuing to develop a positive culture that supports staff to raise concerns and to make continuous improvement to a culture that supports the highest standards of care and openness.

3. FREEDOM TO SPEAK UP GUARDIAN

This report covers the financial year 1 April 2017 – 31 March 2018, inclusive of the quarter 4 data not yet reported to the Trust Board.

3.1 Main activities

The main activities during this time period have been to promote the role of the Freedom to Speak Up Guardian (FTSUG), to network and learn from other Trust's about the use of the role, and to review key findings that have been published by the National Freedom to Speak Up Guardian, Dr Henrietta Hughes.

Available on Pattie is an updated page on the Freedom to Speak Up Guardian role, the route available to support staff in speaking up, and an introductory video. Further written guidance on the difference between different speaking up routes (grievance, whistleblowing, etc) has also been uploaded as guidance to staff and managers from a national best practice guide.

The FTSUG has continued to attend staff meetings to introduce the role, and also attended the induction training day for newly qualified midwives.

3.2 National Freedom to Speak Up Guardian

The National Freedom to Speak Up Guardian runs half-yearly national conferences, which all Guardians are required to attend. The most recent conference held in March 2018shared practice from other Guardians.

The national guardian's office also requests data from each Trust Freedom to Speak Up Guardian. The national office is undertaking a data cleansing exercise with to capture the full year's data from each Freedom to Speak Up Guardian and HEY is participating fully in the data collection process.

3.3 Local Data

The National Guardian's Office also sets out a requirement to report to the Trust Board the number of contacts that the Freedom to Speak Up Guardian has received.

From 1 April 2017 – 31 March 2018, the FTSUG has been contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	4
Contacted directly by the member of staff	4
Requesting advice for a colleague	2
Contacted via SALS	2
Signposted by manager	1
Signposted by Occupational Health	1
Signposted by a FTSUG in another NHS Trust	1
Total	**15**

The contacts with the FTSUG April 2017 year to date have come from the following areas:

Quarter	**No. contacts**	**Service area**	**Health Group/ Corporate services**
Apr - June 2017	7	All individual services – no repeated issues	6 - Medicine 0 - Clinical Support 1 – Surgery 5 – Corporate 1 – F&W 2 – Not specified
July - Sept 2017	1		
Oct 17 – Dec 2017	6		
Jan 18 – Mar 18	1		
Total	**15**		

The following types of concern were raised:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	5
Concerns about HR process involving the member of staff – concerns about fair treatment	4
Concern about patient safety	3
Concerns about workload	0
Concerns about inappropriate behaviour	2
Concerned about role within the Trust	1
Unspecified – contacted for general support	0
Totals	15

3.4 Uses of the FTSUG role

In addition, the FTSUG has attended the following meetings to discuss and promote the role to staff teams:

- Local Negotiating Committee (LNC – medic staff side)
- Joint Negotiation and Consultation Committee (JNCC – staff side)
- Cancer and Clinical Support Governance Meeting
- New Midwives Induction x 2
- Black and Minority Ethnic Staff Network

The FTSUG will brief the Board verbally with some examples as to how speaking up has made a difference in the organisation.

The FTSUG has joined the Equality and Diversity Steering Group and the Workforce Transformation Committee as an attendee, to feed in to the key actions being taken in the organisation around staff culture and organisational development. This has been valuable in being able to feed in the soft intelligence and 'feel' from the organisation about speaking up and the ways in which staff report their concerns.

In addition, the Trust has a network of Professionalism Champions, who are members of staff who take on a voluntary role in their own work area to support staff who are concerned about professional behaviours within a team. The FTSUG attended two of their recent development meetings and the Professionalism Champions are happy to be a network for speaking up ambassadors as part of their Champion role. The FTSUG has set up a basic data capture form in accordance with guidance from the National Guardian's office to be able to understand issues coming up from the Champions.

The Chief Executive, Chief Nurse and the Director of Workforce and OD have also cited the Guardian role in responses to staff as a source of further guidance and support, should they wish to make contact, which is positive promotion of the role.

In terms of next steps for the Guardian role, 2018-19 will focus on:
- Further promotion of the Guardian role to staff as part of the Stop the Line campaign being championed by the Executive team
- Continued promotion of the role through team brief and other Trust-wide communications including examples as to where speaking up has made a difference
- Development of network of the Professionalism Champions and speaking up across the Trust

4. 'READ ACROSS'

The Trust has several data sources that already capture where staff are speaking up about issues of concern.

When presenting the first Freedom to Speak Up Guardian's report to the Trust Board, the Board agreed the following principles:
- That the Guardian's role can help 'sense-check' organisational culture, to see if staff feel increasingly enabled to raise concerns about patient safety and staff welfare, and also report if staff are being treated detrimentally as a result of raising concerns
- That the Trust Board did not want the Guardian to start producing lengthy reports to try to cross-refer numerous data sources
- That the Guardian should not work on rumour or conjecture, or read correlation or causation into issues falsely

4.1 Staff Advice and Liaison Service

One such source is the Staff Advice and Liaison Service (SALS). SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. SALS received 22 contacts in the remaining quarter of 2014/15, 57 contacts in 2015/16 and 51 contacts in 2016/17.

Across the same data reporting period as the FTSUG data above (April 2017 – November 2017), 33 SALS concerns have been raised.

Time period	No. contacts	Service area	Health Group/ Corporate services
Jan 15 - Mar 15	22	Radiology (6) A&E (5) Ophthalmology (5) Portering (4) Cardiology (3) ICU (3) Obstetrics (3) Therapies (4) Bank/pool (3) Orthopaedics (2) Others not specified or only raised once	30 - Medicine 30 - Clinical Support 26 – Surgery 25 – Corporate 28 – F&W All others not specified
Apr 15 - Mar 16	57		
Apr 16 – Mar 17	51		
Apr - Sept 17	22		
Oct 17 – Mar 18	11		
Total 2017-18	**33**		

The SALS contacts April 2017 – March 2018 principally related to the following:

Type of concern	Number of contacts
Concerns about bullying behaviour	17
Concerns about HR process involving the member of staff – concerns about fair treatment	3
Concern about patient safety	2
Concerns about workload	1
Concerns about inappropriate behaviour	0
Concerned about role within the Trust	0
Not specified – calling for general support	10
Totals	33

4.2 'Read across'

On this basis of providing a 'read-across' of data, between these data sources and the individual concerns that the Guardian has reviewed to date, the Guardian has also reviewed the following:

- Each ward dashboard appendix to the Quality report to the Trust Board from April 2017
- The latest Safer Staffing report to the Trust Board
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The detail of all SALS cases 2017-18 year to date – role of staff member and department working in
- The headline National Staff Survey data, as above
- The Trust's whistleblowing case data

There are no new issues emerging from the Guardian's work or read-across that the organisation is not already aware of.

4 RECOMMENDATION

The Trust Board is requested to receive and accept this report

Carla Ramsay
Director of Corporate Affairs
May 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	15 May 2018	**Reference Number**	2018 – 5 – 22
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson Director of Corporate Affairs – Carla Ramsay
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to authorise the use of the Trust's seal. The Trust Board is also asked to approve some changes to Trust Standing Orders, which are being recommended by the Audit Committee, which also form changes to Trust Board Committee Terms of Reference, also requiring Trust Board approval.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): W2 - Governance					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Approval of the Trust's seal and amendments to standing orders are reserved to the Trust Board.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

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

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2018/07	Hull and East Yorkshire Hospitals NHS Trust and City Fibre Metro Networks Limited – 2 x Wayleave Agreement relating to Hull Royal Infirmary – Installation of fibre links.	3 April 2018	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs
2018/08	Hull and East Yorkshire Hospitals NHS Trust and Northern Gas Networks Limited – Grant of easement relating to the stopping up of a length of highway at Gladstone Street, Hull.	3 April 2018	Lee Bond – Chief Financial Officer and Carla Ramsay – Director of Corporate Affairs

3 CHANGES TO STANDING ORDERS

The Trust Board Committees have undertaken an annual review of their Terms of Reference.

3.1 Quality Committee

The Quality Committee reviewed their Terms of Reference in March 2018 and approved some updates. The following updates are proposed as additions to Trust Standing Orders, specifically the Scheme of Delegation to the Quality Committee:

These are additions within the main duties of the Quality Committee in the Scheme of Delegation; the full section with updates will read as follows so that the Trust Board can see the proposed changes in context. The proposed changes are ***bold and in italics***:

- Monitor delivery of Trust strategies as delegated by the Board to this committee.
- Advise the Board on appropriate quality and safety indicators and benchmarks for inclusion in the Trust's Corporate Performance Report and keep these under regular review.
- Propose Quality Accounts priorities for consideration by the Board and maintain oversight of delivery.
- Scrutinise performance against quality targets, highlighting risks and exceptions to the Board.
- Regularly review compliance with Care Quality Commission requirements and receive assurance that agreed actions are being progressed.
- ***Regularly review progress with the Trust's Quality Improvement Plan, as the Trust's over-arching plan on driving improvement in quality of care, including any issues highlighted by the Care Quality Commission***

- To assure the Board that where there are risk and issues that might jeopardise the Trust's ability to deliver excellent quality care that these are being managed in a controlled and timely way.
- Receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality.
- Monitor the information being received from patient feedback ***and adverse incidents*** to demonstrate that the Trust is learning and making improvements.
- Learning and compliance from national and local reviews.
- ***Regularly review outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths***
- ***To receive regular updates on the delivery of the People Strategy and its link with quality and safety***

3.2 Performance and Finance Committee

Similarly, the Performance and Finance Committee recently reviewed its terms of reference and made some changes to its main responsibilities, which need to be amended in Standing Orders.

Additions within the main duties of the Performance and Finance Committee for Financial Performance ; the full section with updates will read as follows so that the Audit Committee can see the changes in context (numbering is per Standing Orders). The additions are ***bold and in italics***:

Financial Performance

3.6 To seek assurance that the organisation has a robust and effective financial planning and performance management systems in place.

3.7 To seek assurance on the production and implementation of long term financial plans (including capital) having regard to relevant national guidance, commissioning plans, and resource availability both internally and within the local health economy in order to support the Board in its decision making.

3.8 To consider loan applications prior to recommending approval by the Trust Board

3.9 To seek assurance that controls are in place and operating effectively to mitigate the risks to the successful delivery of financial performance, including cash releasing efficiency schemes (***CRES***) and agency caps.

3.10 To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken

3.11 To seek assurance that agreed recovery plans are implemented in a timely fashion and resulting in improved outcomes

3.12 To receive assurance that Service Line Management is in place and Patient level costing is being developed and used to support delivery of the Trust's financial objectives

3.14 To receive assurance on the work being undertaken in relation to the Lord Carter review

3.15 To receive regular assurance on the People Strategy, the Trust's current workforce figures and the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce

3.3 Other Changes

The only other proposed amendment to Standing Orders and Standing Financial Instructions is the replace the job title ***Director of Governance*** with ***Director of Corporate Affairs*** to reflect the job role in which the Trust Secretary role now sits following the retirement of the Director of Governance in December 2016.

4 RECOMMENDATIONS

The Trust Board is requested to authorise the use of the Trust's seal. The Trust Board is also asked to approve some changes to Trust Standing Orders, which are being recommended by the Audit Committee, which also form changes to Trust Board Committee Terms of Reference, also requiring Trust Board approval

Rebecca Thompson
Corporate Affairs Manager

Carla Ramsay
Director of Corporate Affairs

May 2018

Hull and East Yorkshire Hospitals NHS Trust
Minutes of the Audit Committee
Held on 26 April 2018

Present:	Mrs T Christmas	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mr P Sethi	Grant Thornton
	Mr G Kelly	Grant Thornton
	Mr G Baines	MIAA
	Mr D Davies	MIAA
	Mrs D Roberts	Deputy Director of Finance
In Attendance:	Mrs A Newlove	Claims Manager (Item 8 only)
	Mr P Taylor	Partner DAC Beachcroft LLP (Item 8 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies

Apologies were received from Mrs Bates, Deputy Director of Quality Governance and Assurance

2 Declarations of Interest

There were no declarations received.

The agenda was taken out of order at this point

8 CNST – the rising cost of claims

Mrs Newlove set the scene for the committee and advised that the Claims Team was working proactively to reduce the number of claims and reduce costs associated with claims. She reported that the team challenged expert opinion by understanding clinical services and identifying root causes to turn cases around. The Trust had a good relationship with NHS Resolution and DAC Beachcroft to ensure good investigations outcomes.

Mr Taylor from DAC Beachcroft advised that the Trust was not alone in the steady rising of claims which was mainly due to more litigious patients, a change in the discount rate, improved life expectancy and more care claims.

Mr Taylor reported that on average 54% of all legal costs go to the solicitors so a number of initiatives such as having an early notification scheme and mediation available had been set up to avoid long, costly cases.

Mrs Newlove advised that the claims were reported by specialty and risks and root causes were shared with clinicians to help avoid recurrence.

Resolved:

The Committee received the presentation and thanked Mr Taylor and Mrs Newlove for the update.

Mr Taylor and Mrs Newlove left the meeting.
The agenda returned to order at this point.

3 Minutes of the meeting 27 February 2018

Item – 4.2 – Action Tracker – Mr Kelly's name was spelt incorrectly. Following this correction the minutes were approved as an accurate record of the meeting.

4 Matters Arising

There was a discussion around the IT Service and how control for all systems would be pulled back under the control of the IM&T team. Mr Bond advised that this matter was built into Mr Simpson's objectives for the year as was a simulation of a catastrophic cyber attack or other such event. Mr Hall asked if the identification of critical systems would also be reviewed and Mr Bond advised that it would.

Mr Gore asked about the Board Assurance Framework and specifically the capital risk rating and Mr Bond advised that this risk would be reviewed and clarified at the next Board meeting.

4.1 Action Tracker

Mr Bond agreed to bring back information relating to the single source waiver relating to a taxi firm to the next meeting. **LB**

4.2 Workplan

Ms Ramsay reported that the credit card expenditure would be received in July which would capture 2017/18 Q3 and Q4 and 2018/19 Q1.

Ms Ramsay also advised that the risk management update would be received in July 2018.

5 Committee Minutes

5.1 Performance and Finance

Mr Gore asked about how SPVs and how they were being received within the NHS. Mr Bond advised that a number of Trusts had SPVs in place and Ms Ramsay added that the legal frameworks had been debated in Government recently.

5.2 Quality Minutes

Mr Bond asked about VTE performance and what was being done to resolve the issues. Mr Sethi advises that Grant Thornton would be checking VTE performance as part of the Quality Account work being undertaken.

Never Events were discussed as the Trust had now declared 6 in year. Ms Ramsay reported that this was not out of line with key providers, but still unacceptable to have the level reported.

Mr Hall asked about the relationship between Humber Foundation Trust and the SLA not yet in place and Ms Ramsay advised that the process had taken time but was related to a very specific service. There were no issues to escalate.

5.3 Charitable Funds

Mr Hall asked about the progress of the business case relating to the Brocklehurst building and Mr Bond advised that this was still in the development stages and would be presented to the Performance and Finance Committee when available.

6 External Auditors

6.1 – Progress Report and Sector Update

Mr Sethi reported that the final accounts audit had started with the Value For Money audit concentrating on the 3 main areas of the financial position, delivering the cost improvement programme (CRES) and delivery of the performance targets.

Mr Sethi reported that the VFM panel discussing the going concern status of the Trust had agreed to disclose a material uncertainty due to the Trust being reliant on cash support going forward. Mr Bond assured the committee that this was a standard paragraph and the Trust was not alone in this situation. Mr Kelly added that cash support for the Trust would be a key area for the Auditors when reviewing VFM qualification.

Mr Sethi also advised that work was ongoing with the Quality Accounts and the main focus would be around C Difficile and VTE performance indicators.

Mr Sethi drew the Committee's attention to the sector update and highlighted the reducing ED admissions and learning from Vanguards for interesting reading.

Resolved:
The Committee received and accepted the report.

6.2 – Benchmarking Review – Annual Report 2016/17

Mr Kelly presented the report which highlighted a number of Trust's annual reports and benchmarked the quality of information within them.

Mr Kelly added that the reports are usually long due to the statutory information required to be reported. Mr Kelly advised that the Trust's report was excellent with only fine tuning required. He added that how the Trust deals with strategic risks, reflecting staff and key stakeholder views would enhance the document as well as including outcomes and results of improvement works in place.

Mr Kelly wanted to personally thank Ms Ramsay for her input into preparing the report and her engagement and input on the Annual Report process.

Resolved:
The Committee received and accepted the report.

7 Internal Auditors

7.1 – Internal Audit Progress Report

Mr Baines presented the report and advised that the majority of audits had been given significant assurance with the exception of bank, agency and locum staffing and consultant job planning.

Mr Baines did state that much progress had been made regarding consultant job plans to ensure that they were on the electronic system, but that quality assurance was required as well as a consistency review. A job plan consistency panel had been established to provide assurance.

The Committee requested that Mr Phillips attend the July 2018 meeting to discuss this matter further. It was asked that Mr Phillips provided assurance around annual leave sign off procedures and any gaps in assurance. **CR/TC**

Significant assurance was given to audits relating to the combined financial systems, ESR, Contracting and the mortality framework. The Committee acknowledged all of these areas and Mr Bond wanted to personally thank the Contracting team for their hard work.

Resolved:
The Committee received the report and Mrs Christmas and Ms Ramsay to prepare a brief for the Chief Medical Officer to attend the meeting in July 2018. **CR**

7.2 Outstanding Audit
Mr Baines presented the report which highlighted the work being carried out to close down outstanding audit actions.

Mr Bond asked about the 11 high risk areas highlighted in the report and Ms Ramsay advised that there were a number of risks attached to the Patient Property Policy, which once approved would close the majority of the risks.

There was a discussion around job planning and medical staffing absence management, both areas were still work in progress.

Mr Gore asked about the risks to the IT services within Pathology and Mr Baines agreed to ask the MIAA IT team to ensure all actions were in place to enable the follow up actions to be closed.

Mr Baines thanked Ms Ramsay for her hard work in chasing down outstanding actions. He added that the process was robust and was being managed well since her involvement.

Resolved:
The Committee received and accepted the report.

7.3 HEY Assurance Statement
Mr Baines presented the statement which highlighted the audit based upon the Trust's Board Assurance Framework. He reported that the rag rating was green throughout and had good process in place. Mr Baines had also benchmarked the report against other Trusts assurance frameworks.

Resolved:
The Committee received and accepted the report.

7.4 – Annual Report and Opinion Statement
Mr Baines presented the report which gave the overall opinion and assessment of the individual assurances gained.

He reported that the Trust had been given a moderate assurance opinion but that the ratings had changed slightly. Mr Bond challenged the opinion and felt that the Trust was closer to substantial but Mr Baines stated that a number of high risks and a follow up reports not being robustly covered had led to the opinion and wouldn't be changed at this stage. Mr Baines added that a commentary could be added by the Trust regarding the opinion to put any issues into the correct context. Mr Kelly added that this commentary should also be included in the Annual Governance Statement.

Resolved:
The Committee received and accepted the report.

7.5 Internal Audit Plan
Mr Baines presented the Internal Audit Plan which had been received in draft at the previous meeting and was for formal approval only. Mr Baines added that the audit fees were the same as the previous years and that the team working on the audits would also remain the same.

Resolved:
The Committee received and accepted the report.

7.6 Counter Fraud Annual Report
Mr Davies presented the report which gave the Committee assurance that the workplan had been delivered for 2017/18. He reported that the document would be used by the Commissioners as evidence and gave positive comments around the overall green rating.

The report detailed all the work undertaken as well as any referrals made and cases resolved throughout the year.

Mr Bond asked if there was anything more the Trust should be doing and Mr Davies advised that the Trust was in line with assessments against the standards and there were no further issues to address.

Resolved:
The Committee received and accepted the report.

9 Draft Annual Report including:
9.1 Draft Annual Governance Statement
9.2 Audit Committee Annual Report
Ms Ramsay presented the item and informed the Committee that work was in progress and was on track for production and timescales. The Annual Report was still in draft format but would be checked for accuracy and consistency before being presented at the extra ordinary Board meeting in May 2018. Ms Ramsay thanked colleagues for their timely submissions.

Ms Ramsay requested that the Audit Committee members read the documents and submitted any comments to her.

Resolved:
The Committee received and accepted the draft Annual Report, the draft Annual Governance Statement and the Audit Committee Annual Report.

10 Draft Annual Accounts
Mrs Roberts presented the draft accounts that for 2017/18 that were now submitted to the Auditors for review. She advised that the accounts had been prepared on a going concern basis and once audited would be presented to the Audit Committee and the Board for approval on 24 May 2018.

Mrs Roberts also presented the accounting policies which had been reviewed and were the same as last years except for a few very minor changes.

The net impact of the property, plant and equipment revaluation was £2m (1%) and this had been included in the accounts. The Trust was consolidating charitable funds and these were not material in the accounts. The Trust was currently establishing its independent Charity.

Mr Gore asked if the Health Groups had delivered their year end targets and Mr Bond reported that with the exception of the Clinical Support Health Group the Health Groups had delivered their recover actions to ensure the additional income was received from the Commissioners.

Mrs Christmas thanked Mrs Roberts and the finance teams for all their hard work in preparing the year end accounts.

Resolved:
The Committee received the draft Accounts and approved the minor changes to the Accounting Policies.

11 Update on Financial Overview and Going Concern

Mr Bond presented the report and advised that the Trust accounts had been prepared on a 'going concern' basis.

Mr Bond highlighted a number of risks including Health Group expenditure, delivery of the CRES and any money linked to achieving performance targets.

Resolved:
The Committee received and accepted the report.

12 Annual Review of Standing Orders and Standing Financial Instructions

Ms Ramsay presented the item and reported that each board committee had reviewed its terms of references and that the changes made had been reflected in the Standing Orders and Standing Financial Instructions.

Resolved:
The Committee received and accepted the changes

13 Quality Accounts

Ms Ramsay presented the report which showed the timeline from producing the draft, issuing to stakeholders, auditing of the Accounts to publication of the finished version. The Quality Accounts would be published on 30 June 2018.
Once published the Quality Accounts would inform the Trust's Quality Improvement Plan and be monitored through the Quality Committee with regular reviews at the Trust Board.

A copy of the draft Quality Accounts would be circulated once available.

Resolved:
The Committee received and accepted the update report.

14 Information Governance Toolkit Report

Ms Ramsay presented the report which had previously been reviewed at the Committee. She asked that the Committee members formally approve the IG Toolkit Report which would be published on the Trust's website following the meeting.

Resolved:
The Committee received and approved the report.

15 Legal Fees 2017-18

Ms Ramsay presented the report which was in line with the budget although Q4 invoices had not yet been received to be added to the total.

Ms Ramsay advised that in 2018-19 the Trust had in place a fixed income contract that had been negotiated with Capsticks LLP which included all legal advice other than extra ordinary cases. This should result in a recurrent cost saving for the Trust.

Resolved:
The Committee received and accepted the report.

16 Business Interests Policy

Ms Ramsay presented the policy which had been reviewed and strengthened in line with recommendations from the Internal Auditors.

One of the areas that had been strengthened was the declarations around private practice and that the consultants would now have to give a nil return where applicable. The Chief Medical Officer was now writing to all medical staff to encourage declarations and nil returns whilst giving an explanation of what to declare and the reasons why.

Information regarding private practice was also being captured in consultant job plans.

Resolved:
The Committee received and approved the updated policy.

17 Board Assurance Framework

Ms Ramsay presented the report which highlighted the Q4 year end risk ratings.

Goal 6 was discussed which related to the STP and how the Trust was engaging with the process. It was agreed that this would be discussed further in the Trust Board and that Mr Bond and Ms Myers would re-visit the STP risk. Mr Gore stated that any money that the Trust would not receive due to the Trust's engagement and involvement with the STP should be highlighted within the risk rating.

The Committee also discuss goal 7.1 which related to the Trust achieving its Financial Control total. Mr Bond stated that the risk should not reflect the revised control total but the original one. He also reported that a letter from NHS Improvement had been received relating to the Trust's financial situation and that he would circulate this to members of the Committee.

Mr Sethi mentioned the interest being paid on late payments to debtors and Mr Bond advised that the cash position was being managed and there were policies in place to mitigate the risks.

Resolved:
The Committee received the report and agreed to discuss the individual

risks at the relevant committees at the end of April 2018.

18 Board Expenses Q3 and Q4 2017-18

Ms Ramsay presented the report to the Committee which highlighted Board expenses for Q3 and Q4 2017-18. There were no issues or any areas of concern to note.

Resolved:
The Committee received and accepted the report.

19 Effectiveness of the Audit Committee

Ms Ramsay presented the report which showed progress against the recommendations made by the Trust's internal auditors in December 2016. She reported that overall good progress had been made.

Resolved:
The Committee received and accepted the report.

20 Risk Management Review

Ms Ramsay reported that she was working with Mrs Bates to review the Risk Management workplan and set processes and principles for reporting purposes. The review would be presented to the Committee at its July 2018 meeting.

Resolved:
The Committee received the update.

22 Any Other Business

Mrs Christmas reported that Mr Hall would be leaving the membership of the Audit Committee to become a member of the Quality Committee instead. She thanked Mr Hall on behalf of the Committee for his contributions to the Audit agenda.

Mr Hall requested an invitation to the July 2018 meeting for the item relating to VTE from the Chief Medical Officer. **SH**

23 Date and time of the next meeting:

Extra-ordinary meeting, Thursday 25 May 2018,
11am – 12pm, The Committee Room, Hull Royal Infirmary

FULL BUSINESS CASE
(Executive Summary Extract)
THE DEVELOPMENT OF THE ENERGY INNOVATION UPGRADE SCHEMES

Trust Board	15 May 2018	**Reference Number**	2018 – 5 - 24
Director	Duncan Taylor Director E,F&D	**Author**	Paul O'Meara Head of Finance E,F&D
Reason for the report	The purpose of this FBC Executive Summary paper is to seek approval from the Trust Board to progress with the development of the energy innovation upgrade schemes and to delegate approval of the full FBC to the Performance and Finance Committee in order to meet the original NHSI submission date by the end of May.		

Type of report	Concept Paper		Strategic Options		Business Case	✓
	Performance		Information		Review	

1	**RECOMMENDATION** 1. If required, approve the submission of the FBC and a capital loan application of £13.9m for external review by both NHSI and the Project Appraisal Unit ("PAU") for consideration. 2. If the STP capital process has superseded previous discussions with NHSI regarding the approvals process, then approval to submit the application as part of the HC&V STP process is sought from the Board.					
2	**KEY PURPOSE:**					
	Decision	✓	Approval	✓	Discussion	
	Information		Assurance		Delegation	✓
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW**					

FULL BUSINESS CASE

(Executive Summary Extract)

THE DEVELOPMENT OF ENERGY INNOVATION UPGRADE SCHEMES

1. EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The purpose of this Full Business Case ("FBC") is to update the previously approved Outline Business Case ("OBC"). This case concerns the development of an energy innovation upgrade scheme on both the Hull Royal Infirmary ("HRI") and Castle Hill Hospital ("CHH") sites.

1.1.2 Previous discussions with NHSI have indicated an approvals process requiring a number of steps. Initial approval of a £13.9m capital loan application by NHSI would be followed by an application to the Department of Health ("DoH") and the Independent Trust Financing Facility ("ITFF") for final approval.

1.1.3 The Trust understands that there is a backlog of capital business cases currently sat in the approvals pipeline. Recent guidance from NHSI states that all capital requests must now be prioritised as part of the local STP process. Only at that point will they be submitted to the NHSI and then to DoH for consideration.

1.1.2 The energy solutions to be considered will utilise the latest energy efficient technology and provide the sustainable infrastructure to deliver the Trust's obligations to reduce carbon emissions and to meet its energy conservation targets. The preferred scheme would assist the Trust:-

- in working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by the National Sustainable Development Strategy
- to reduce energy costs and create efficiency savings
- in contributing to the vision set out by Lord Carter of Coles in his report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" published in February 2016
- in following the best practice guide, as set out by Lord Carter of Coles, to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as published in October 2017
- acting on the recommendations of the Sir Robert Naylor Report of March 2017 in reducing backlog maintenance
- meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development

1.1.3 Energy consumption by the Trust has been increasing as a result of new and extended development on the hospital sites, and new medical technologies being introduced which are increasingly energy reliant. Such energy usage is consuming an increasing proportion of Trust resources and it is proposed that improving the energy infrastructure will go some way to readdress the balance.

1.1.4 The table overleaf shows the total actual energy costs for HEY from financial years 2015/16 to 2017/18 and a forecast for 2018/19.

Summary of HRI & CHH site Energy Costs from 2015/16 to 2018/19

	2015/16	2016/17	2017/18	2018/19
	Actuals £000's	Actuals £000's	Actuals £000's	Forecast £000's
Electricity	2,608	2,904	3,140	3,633
Gas	1,936	1,882	1,675	1,792
Total	**4,544**	**4,786**	**4,815**	**5,425**

1.1.5 The table shows that the cumulative expenditure on both gas and electricity has been steadily rising since 2015/16. The marked increase in the forecasted energy spend figure, particularly electricity, for 2018/19 is due to:-

- the impact of the EU's Industrial Emissions Directive (2016) which has seen the increased closure of many UK electricity generation plants with coal fire power stations particularly targeted to help reduce emissions in energy generation. This has reduced supply and increased buyer competition resulting in the wholesale cost of purchasing energy to also rise
- the supply of alternative sources of energy, such as wind and solar power, are still not mainstream and hence still expensive
- increased costs in supplying energy to sites
- other increases have come from government policies and taxes

1.1.6 The price rises would have been even more significant if the Trust hadn't used an energy broker to purchase and risk manage both its electricity and gas supply.

1.1.7 These figures show that by investing in new energy infrastructures there is scope for significant savings to be made. In the case of electricity some of the schemes looked at are energy self-generating with no supply to site overhead costs. Therefore, it is imperative that the Trust looks at ways of reducing its energy costs thereby contributing to improvements in the Trust's financial position and delivery of its DoH control total.

1.2 The Strategic Case

1.2.1 This Section of the FBC addresses the strategic reasons for the business case in working towards achieving the following:

- working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by the National Sustainable Development Strategy
- to reduce energy costs and create efficiency savings
- contribute to the vision set out by Lord Carter in his report 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations' published in February 2016
- in following the best practice guide to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as published in October 2017
- acting on the recommendations of the Sir Robert Naylor Report of March 2017 in reducing backlog maintenance
- meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development

1.2.2 The Trust is committed to reducing its energy costs and carbon emissions and has already taken some steps to improve energy performance and save carbon through:-

- insulation programme at the Hull Royal Infirmary and the Castle Hill Hospital, consisting of insulation improvements in the boiler house and steam distribution system. Others include lighting improvements and upgrades to the building management systems on both sites. Energy savings achieved to date of 1% to 1.5% from 2010 onwards.
- the refurbishment of an existing second hand 700kWe natural gas CHP at the Hull Royal Infirmary in 2009.

1.2.3 The Climate Change Act 2008 sets out the UK's legally binding targets for CO_2 emission reductions. The Committee for Climate Change is an expert, independent statutory public body created by the Climate Change Act 2008 to assess how the UK can best achieve its emissions reductions target for 2020 and beyond.

1.2.4 The table below shows the Trust's Annual CO_2 Performance Return figures, measured against the baseline year of 2009/10, from which the national target reduction of 34% is measured. *The CO_2 figures for 2017/18 will be included in this table once they have been validated*.

Year of Return	Total CO2 Tonnes	Change in CO2 from 2009/10	Annual %age Reduction from Baseline
2009/10	34,417	baseline	
2010/11	34,154	(263)	-1%
2011/12	31,213	(3,204)	-9%
2012/13	33,570	(847)	-2%
2013/14	32,017	(2,400)	-7%
2014/15	32,798	(1,619)	-5%
2015/16	31,469	(2,948)	-9%
2016/17	30,098	(4,319)	-13%
CO2 Reduction Target by 2020		**(11,702)**	**-34%**

1.2.5 The figures show that HEY, based on using the existing energy infrastructure and minimal investment, is not on trajectory to meet the 34% CO_2 target of a reduction of 11,702 tonnes by 2020.

1.2.6 The Trust has evaluated further opportunities to drive savings through efficient, low carbon energy generation, the main one being the option to install further Combined Heat and Power ("CHP") capacity at HRI and a new CHP at CHH. A feasibility study on these options has already been completed by Ove Arup and Partners Limited (August 2012) and a high level energy survey in support of the proposed options has been completed by Sinclair Knight Merz (August 2012) ("SKM"). These reports are attached under Appendix 3a and 3b. A further feasibility study was completed by the Carbon and Energy Fund (March 2016) ("CEF") to establish the case for investment at HEY's HRI and CHH sites. The CEF feasibility report is attached as Appendix 4. A further feasibility was undertaken during April 2018, to help support the FBC, by NIFES Consulting Group, which confirmed and updated the findings of the previous reports.

1.2.7 The case for change can be summarised as the need to:-

- reduce carbon emissions in line with national policy
- replace the ageing heat and boiler plant at HRI
- use Combined Heat and Power engines that utilise a single fuel to self-generate electricity
- reduce exposure to changes in market prices by energy self-generation
- realise energy cost savings and contribute to an improved financial position for the Trust and as part of the Humber, Coast and Vale STP
- secure heat, hot water and steam generation in the long term for both sites to support future development

- ensure compliance with the recommendations set out in the reports published by both Lord Carter of Coles and Sir Robert Naylor

1.3 The Economic Case

1.3.1 The feasibility studies described in Section 1.2.6 have assisted the Trust in determining the best way forward and potential optimum solutions for their two hospitals; HRI and CHH. These reports set out the current plant configuration and energy base line position and identified potential solutions for improving energy plant resilience, energy fuel supply resilience, energy performance and energy efficiency, leading to substantial reductions in carbon emissions and overall utility cost.

Hull Royal Infirmary

1.3.2 The HRI is located in Hull centre and is comprised of buildings of a mixture in age surrounding the dominant building; a 50 year old fifteen storey tower block.

1.3.3 The site requires heat only for space heating and hot water. Due to the history of the site (in the past there were sterilisation activities and laundry activities on site) most of the heat is generated through steam raised in a central energy plant. The boiler house contains 50 year old steam raising boilers converted from coal firing to natural gas and oil dual fuel burners alongside an ageing 700 kWe CHP.

1.3.4 Analysis indicates that the site can accommodate a new larger 1.562MWe CHP engine and benefit from the renewal of the ageing boiler plant.

Castle Hill Hospital

1.3.5 CHH is a former isolation hospital set in a rural landscape of over 41 hectares and is located approximately six miles to the east of HRI. The buildings are a mix of ages with some modern buildings forming core clinical service areas. CHH has seen significant expansion in the last 20 years with new Cardiology and Oncology blocks, and is now a similarly sized hospital from an energy usage point of view to HRI.

1.3.6 A new energy centre was installed approximately ten years ago and contains 4 steam raising boilers. Other than the aspired addition of a CHP system, this leaves little or no requirement for further refurbishment of heat raising services. While there is currently no existing CHP system at CHH, it was anticipated by the Trust that this hospital site could accommodate 1.6 – 2 MWe of CHP engine capacity.

Options

1.3.7 The scope of the proposed capital works based on the findings of the feasibility studies by Arup, SKM and the CEF considered the following projects under each of the short-listed options:-

Summary of the Energy Capital Scoped Projects

Project	Capital Project breakdown:
1	The replacement of the combined CHP plant for HRI inclusive of a new absorption chiller system.
2	A new CHP plant for CHH inclusive of a new absorption chiller system.
3	Replacement of ageing and obsolete boiler plant at HRI
4	LED lighting replacement and upgrading of fittings at HRI
5	LED lighting replacement and upgrading of fittings at CHH
6	Installation and integration of a Building Management System at both HRI and CHH

1.3.8 The potential savings generated from the energy capital scoped projects under 1.3.7 have been subjected to further scrutiny at FBC. The table below separates the savings by scheme:-

Summary of the Energy Project Savings	FBC - Revised Saving Figures				
Capital Works Scheme	HRI	CHH	Net	VAT	Gross
	£000's	£000's	£000's	£000's	£000's
Combined Heat and Power Unit (CHP)	(723)	(823)	**(1,547)**	(309)	**(1,856)**
Boilers	(118)		**(118)**	(24)	**(142)**
Absorption Chiller Systems (ACS)	(65)	(66)	**(131)**	(26)	**(157)**
LED Lighting Replacement Upgrade	(124)	(88)	**(212)**	(42)	**(254)**
BMS	(88)	(50)	**(137)**	(27)	**(165)**
Total Capital Works Scheme Savings	**(1,118)**	**(1,027)**	**(2,145)**	**(429)**	**(2,574)**

1.3.9 Following a review of available options the minimum four short-listed options that were considered for further evaluation included:-

- **Option 2: "**Do minimum" – included despite being ranked 7th in the long list of options as this provides a benchmark for value for money ("VFM") throughout the appraisal process. This option included the replacement of the HRI ageing and inefficient boiler plant (almost 60 years old) as identified on the Trust Risk Register.

- **Option 4:** Trust investment, via a DH Capital Loan, in the energy solution for HRI and CHH combined; operated and maintained by a mix of HEY staff and external contractors. This option would deliver a proposed technical solution, financed through a DH Capital Loan Facility.

- **Option 6:** Third Party, investment by means of a contractor through open competition and through the CEF framework for HRI and CHH combined; financed, implemented, operated and

maintained through the CEF performance agreement by an external contractor.

- **Option 8:** Trust investment, with the support of a DH Capital Loan for HRI and CHH combined; managed through the CEF framework; implemented, operated and maintained through the CEF performance agreement by an external contractor.

1.3.10 The “do nothing” option was discounted at an early stage as it was not considered a feasible solution as this will not assist the Trust in improving its energy resilience nor will it contribute to energy savings or carbon reductions. There is a real risk in doing nothing that the Trust will fail to meet its national obligation in the reduction of carbon emission targets. This option also lacks compliance with the recommendations within both the Lord Carter of Coles reports as well as the Sir Robert Naylor report on reducing backlog maintenance.

1.3.11 Options 6 and 8 would deliver a proposed technical solution through an Energy Services Performance Agreement (PA”) with a preferred supplier and either financed with 3rd party private funding or a DH Capital Loan routed through the PA. These options include the implementation, operation and maintenance needs of the Trust’s energy infrastructure.

1.3.12 For Options 4, 6 and 8 - the energy solution is created through a combination of the original base recommendations from the Arup and SKM reports and tailored by the suppliers’ innovative suggestions.

1.3.13 The table below summarises the Option Appraisal results:-

Options Appraisal Summary of the Short-Listed Options

Heading	Option 2	Option 4	Option 6	Option 8
	"Do Minimum" Trust/ DH Capital Loan	Trust / DH Capital Loan	3rd Party / CEF Framework	Trust / DH Capital Loan / CEF Managed
Qualitative benefits score	22.1	86.5	77	77
Rank	**4**	**1**	**2**	**2**
NPV	(2,071)	11,910	1,086	4,012
Rank	**4**	**1**	**3**	**2**
Affordability	No	Yes	Yes	Yes
Rank	**4**	**1**	**3**	**2**
Risk score	26.5	53	61	61
Rank	**4**	**3**	**1**	**1**
Overall ranking	**4**	**1**	**3**	**2**

Preferred option		**Yes**		

1.3.14 Option 4, the DoH Capital Loan financed solution, is the recommended preferred option as it ranks 1st overall in the options appraisal summary.

1.3.15 Option 4 delivers all the energy capital scoped projects described under Section 1.3.7.

1.3.16 Option 4 delivers the highest NPV which represents the highest return on the investment.

1.3.17 In reviewing the OBC to FBC the strategic drivers for the project have not changed to make any alterations to the rankings of the short-listed options. The economic appraisal made in the OBC therefore remains valid. Option 4, the DoH Capital Loan financed solution remains the preferred option.

1.4 Commercial Case

1.4.1 The commercial case describes the Trust's proposed approach to the procurement route and key legal and commercial issues in delivering the preferred option.

1.4.2 Under the OBC options, the Trust had considered the following for the procurement routes for this project:-

- Procure 22+
- YORbuild Construction Framework
- Scape Group Framework
- Traditional OJEU Tendering (if let as one package)
- Individual contractor design and build packages.

1.4.3 The proposed work tendered for under the ITT can be broken down into five stand-alone packages which when costed are under the current OJEU threshold (effective from 1st January 2018) for construction works of £4.6m before VAT. Therefore Individual Contractor Designed and Build Packages is the preferred route of procurement.

1.4.4 Whilst the procurement strategy, route and evaluation criteria set out in the OBC hasn't changed to FBC the tendering selection of the preferred bidders, due to the tight timescales of the FBC submission and the uncertainty of when the DoH is likely to provide feedback on the capital loan financing application, the "best and final offers" are still to be completed.

1.4.5 In order to meet the timescales laid out in the Project Management Plan the Trust has agreed to proceed at risk with regards to scheme designs and the tendering process despite the uncertainty around the capital loan application approval from the DoH.

1.5 The Financial Case

1.5.1 The purpose of this Section is to set out the likely financial implications of the preferred Option 4, DH Funded Capital Loan, as identified in the Economic Case and as set out in the Commercial Case.

1.5.2 A full financial assessment review of the preferred Option 4 has been carried out between the OBC and FBC stage to evaluate and determine the financial impact of the energy project schemes.

1.5.3 A summary showing the capital cost of the project and the life-cycle replacement (LCR) for the preferred Option 4 is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	Installation Period Aug '18 to Sept '19		Total Capital Works	Total LCR
	Aug '18 to Mar '19	Apr'19 to Sept '19		
	£000's	£000's	£000's	£000's
External Engineering Works Costs				
CHPs installation HRI and CHH sites	2,359,253	2,162,600	4,521,853	690,000
Absorption cooling and systems	242,513	565,863	808,376	231,674
Lighting retrofit	1,768,909	589,636	2,358,545	incl. in maintenance
Controls BEMS	555,520	139,380	694,900	200,000
Boiler	859,242	858,986	1,718,228	340,000
sub total External Engineering Works	**5,785,437**	**4,316,465**	**10,101,902**	**1,461,674**
Professional Fees	503,600	362,300	865,900	
sub total Capital Costs	**6,289,037**	**4,678,765**	**10,967,802**	**1,461,674**
sub total Optimism Bias (6.6%)	**290,000**	**434,600**	**724,600**	
sub total Capital Works	**6,579,037**	**5,113,365**	**11,692,402**	**1,461,674**
VAT @20% (excl. fees)	1,215,087	950,213	2,165,300	292,335
Total Capital Works (incl. VAT)	**7,794,124**	**6,063,578**	**13,857,702**	**1,754,009**

1.5.4 The preferred option is based on the assumption that the energy upgrade funding would be through a DH Capital Loan funded route. The loan term covers 25 years with the assumed interest repayments through the UK Debt Management Office of 2.71%. The original OBC figure was 2.62%.

1.5.5 The total capital loan repayment would be £13.9m with a total loan interest payment of £4.9m. The original OBC figures were £13.7m and £4.7m respectively. The increases are due to additional CHP installation works and the increase in interest rates.

1.5.6 The technical guidance included in the HMT's Green Book has been followed in calculating the optimism bias figure for the project. This is currently 6.6% (reduced from the OBC figure of 11.05%) and has been reviewed on a scheme by scheme basis rather than a percentage risk of the capital works. This figure represents £870k (including VAT) of risk. The OBC risk figure was originally £1.4m (including VAT).

1.5.7 The risk figure will be further refined once the project schemes enter into the detailed design and tender award process. The current risk percentage of 6.6% is within the HMT's Green Book adjustment ranges for optimism bias for this particular type of project. The current risk by scheme is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	Total Capital Works	Optimism Bias
	£000's	£000's
External Engineering Works Costs		
CHPs installation HRI and CHH sites	4,521,853	40,000
Absorption cooling and systems	808,376	105,000
Lighting retrofit	2,358,545	180,000
Controls BEMS	694,900	40,000
Boiler	1,718,228	289,600
General		70,000
sub total External Engineering Works	**10,101,902**	**724,600**
VAT @20%	2,020,380	144,920
Total (incl.VAT)	**12,122,282**	**869,520**

1.5.8 The highest risk value is for the potential demolition and asbestos removal of the HRI boiler-house chimney.

1.5.9 A summary showing the incremental impact on the Statement of Comprehensive Net Income is shown in the table below:-

Statement of Comprehensive Income Summary							
Trust (DH Capital Loan Funded) Preferred Option 4	Year 1 £000's	Year 2 £000's	Year 3 £000's	Year 4 £000's	Year 5 £000's	Year 6 £000's	Total 25 Years £000's
SAVINGS							
Energy Savings (incl.VAT)	(1,493)	(2,574)	(2,379)	(2,438)	(2,499)	(2,562)	(86,667)
sub total Energy Savings	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
EXPENDITURE							
Operating & Maintenance Costs	252	434	445	456	467	592	15,661
HEY In house Staffing Costs	54	93	96	98	101	103	3,145
HEY In house Non Pay Costs	33	57	59	60	62	63	1,923
Loan interest	188	364	350	335	320	306	4,882
Depreciation	272	543	543	543	543	547	14,735
Capital charges	0	0	0	0	0	0	378
sub total expenditure	798	1,492	1,492	1,492	1,493	1,611	40,724
Savings attributable to Trusts SoCI	(695)	(1,082)	(1,146)	(1,212)	(1,279)	(1,230)	(45,943)

1.5.10 The table shows that the total gross savings on energy costs over the 25 year life of the project, including inflation, will be £86.7m.

1.5.11 The table also shows that the total revenue expenditure over the life of the project will be £40.7m.

1.5.12 Over the 25 years the cumulative net incremental saving (including inflation) to the Trust will be £46m.

1.6 The Management Case

1.6.1 This Section of the FBC addresses the 'achievability' of the investment in an energy infrastructure for HEY. Its purpose, therefore, is to set out the actions that would be required to ensure a successful delivery in accordance with best practice.

1.6.2 The proposed project is a core element to the success of the estate strategy for the immediate and long term vision for HEY. The proposed development programme will involve:-

- the Outline Business Case approval process
- project stakeholder engagement throughout
- potential planning applications dependent on the selected solution
- potential public consultation if necessary
- production of a loan capital financing application between OBC and FBC stages working in conjunction with NHSI
- the Full Business Case approval process
- Performance Agreement exchange
- successful scheme implementation.

1.6.3 A project management structure has been put in place with an aim to deliver this project through to operational service. The provisional timetable, dependent on capital loan approval, is:-

Activity	Key Milestones
FBC Submission to Trust Board	May-18
FBC and Loan Application Submission to NHSI	Jun-18
NHSI FBC Recommendation to DoH / ITFF	Jul-18
DoH / ITFF Response to Loan Application	end of Aug-18
Project Design Period	May-Jul-18
Project Tender and Award Period	Jul-Aug-18
CHH & HRI Lighting Replacement	Sep-18 to Apr-19
CHH CHP Installation	Aug-18 to Sep-19
HRI CHP Replacement	Aug-18 to Aug-19
HRI Boiler House Replacement	Aug-18 to Jul-19
BEMS and Controls	Sep-18 to Mar-19
Anticipated Completion Date	Sep-19

1.7 Conclusions and Recommendations

Conclusions

1.7.1 The Trust believes that the existing energy infrastructure at both the HRI and CHH sites is no longer fit for purpose and is unable to adequately meet demand, that it is inefficient and will not assist the Trust in achieving key targets described in both the National and Local Strategies.

1.7.2 This FBC demonstrates that following both internal and external reviews there is an opportunity to deliver significant savings for HEY. By implementing the Energy Innovation Upgrade Scheme it also helps support the Trust in delivering an improved financial position.

1.7.3 The FBC proves that the preferred Option 4, DH Capital Loan funded, is both economically and financially the best investment route for the HEY Energy Innovation Upgrade Scheme.

1.7.4 The FBC clearly demonstrates that the following key investment objectives would be achieved if the capital loan was approved:-

Investment Objectives of the HEY Energy Scheme		Preferred Option 4 Delivers:
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets	Reductions in carbon emissions of 7,138 tonnes per annum
2	To reduce energy costs and create efficiency savings	Affordable and demonstrates VFM by reducing energy costs and producing cash flow net annual savings of £1m +
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.	Would reduce energy costs £/m2 by using resources in a more cost effective manner
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	Replaces ageing and outdated heat and energy plant, new and replacement CHP's and lighting upgrades. Reduces backlog maintenance by £3.5m.
5	Follows the best practice guide to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as publiished in October 2017.	Schemes support : demand reduction (lighting & boilers) / energy management (BMS) / energy generation (CHPs)
6	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	Would meet key strategic objectives of the HEY Estates Strategy 2017-2022 by providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

Recommendations

1.7.5 It is recommended that the Trust Board approves the Executive Summary of the FBC for the energy innovation upgrade schemes.

1.7.6 Agree to delegate approval of the FBC to the Performance and Finance Committee at the end of May in order to meet the original timescales agreed with NHSI.

1.7.7 If required to do so, support the submission of the FBC and, if appropriate, a capital loan application of £13.9m for external consideration by both NHSI and the Project Appraisal Unit ("PAU").

1.7.8 Alternatively, if the STP process is now the route for all capital business cases, then this case should be forwarded through that route with the Trusts full support.

1.7.9 Further detail may be required by the NHSI and DoH in answer to outstanding queries to complete their FBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI/PAU and DoH/ITFF in their requests.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 4 2017/18

Trust Board date	15 May 2018	**Reference Number**	2018 – 5 – 25.1
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 Board Committee meetings in April 2018, for Trust Board approval		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing		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	
	Briefing		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: 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 2017/18

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. BACKGROUND

The Trust Board agreed its Board Assurance Framework at the May 2017 Board meeting. The Board agreed 9 areas that would the key risks to making progress against the Trust's seven strategic goals.

These nine areas have been subject to regular review by the Performance and Finance Committee and Quality Committee at each of their meetings throughout the year. The Audit Committee has maintained regular oversight of the Board Assurance Framework as a key system of internal control throughout the year and has not raised any issues with the Trust Board.

The internal auditors review the Board Assurance Framework annually as part of their mandatory internal audit work. The internal auditors have confirmed that the Board Assurance Framework meets the Department of Health requirements.

3. BOARD ASSURANCE FRAMEWORK (BAF) YEAR-END POSITION

Of the nine risks areas on the Board Assurance Framework, all have received elements of positive assurance during the year. As risks to the Trust's long-term strategic goals, the amount of positive assurance has not moved the risk rating throughout the year against many risk-ratings. This is indicative of the risk environment in which the Trust works, with elements of the long-term risks taking longer than a year to mitigate, and also dependent on external factors. A particular example of this is BAF 2 on staffing levels, which is particularly impacted by national NHS staff shortages and a pension scheme that enables many nursing staff to retire at age 55.

The suggested year-end position for the Board Assurance Framework is as follows:
BAF 1 – staff engagement: 12 risk-rating (no change all year)
BAF 2 – retirement rates and staff shortages: 20 risk rating (no change all year)
BAF 3 – high quality care and CQC rating: 12 risk rating (no change all year)
BAF 4 – meeting NHS Constitutional targets: 20 risk rating (increased in Q4)
BAF 5 – tertiary patient flows: 8 risk rating (moved from 16 in Q1-Q3 – reached target risk rating)
BAF 6 – partnership in STP: 16 risk rating (no change all year)
BAF 7.1 – meeting financial plan: risk 25 (escalated in Q3 and maintained in Q4)
BAF 7.2 – infrastructure: risk 10 (no change all year)
BAF 7.3 – reputational risk due to cash position: risk 12 (mitigated in Q2 from 16 and maintained in Q3 and Q4)

The Board is asked to review these suggested year-end positions, which come following Board Committee review and Board members' input in April 2018.

For the ratings that have changed in year, the rationale for the year-end position is:

- BAF 4 – meeting NHS Constitutional targets: the Trust was meeting its local trajectories for ED and RTT during the first half of the financial year, and was making progress towards the 62-day cancer targets. The Trust met the 31-day cancer targets in the first half of the year. However, the position for RTT, ED and diagnostics was impacted during Q4 and winter pressures in particular, which would be the rationale for the risk increase in Q4. It is not suggested that the risk rating increases to 'almost certain' as there were a number of performance indicators that the Trust did meet during 2017-18, however the position against most of the NHS Constitutional targets deteriorated in Q4.

- BAF 5 – risk to tertiary patient flows: the Trust has worked on its position within the STP during 2017-18, and has had a particular focus on the relationship with its neighbouring acute Trust, from which the majority of tertiary patients flow. The Trust has also been working closely with NHS England, as the commissioner of tertiary patient flows. The Trust has confirmed the long-term future of pancreatic cancer surgery at HEY with NHS England. The Trust is recognised as the key hospital partner for adult services with its neighbouring acute Trust and the Humber Acute Services Review has now commenced to support the long term sustainability of hospital services across the Humber footprint
- BAF 7.1 – meeting financial plan. This was escalated to 25 in Q3 and is recommended to remain as such in Q4 and year-end. The Trust's reported financial performance was in December 2017 was such as to indicate that the Trust would almost certainly not fully meet its financial plan in 2017-18. Whilst the Trust agreed an updated financial plan in Q4 with its regulator and has met this, the risk related to the Trust's ability to manage its financial position in-year, which it has not done to the full extent of meeting its financial plan.
- BAF 7.3 – reputational risk due to cash position: this was mitigated and reduced in Q2 down to a risk rating of 12, which the Trust has maintained for the rest of the year. The Trust has managed its cash position and relationship with suppliers at this level of risks to the Trust from Q2 onwards.

There remaining risk areas have seen positive assurance during the year, but it is not felt that this is sufficient to move any of the other risk areas up or down at year-end. The Board may wish to debate this position.

The proposed year-end BAF is attached at appendix 1 for review.

The Corporate Risk Register as at January 2018 is cross-referenced in the specific column in the Board Assurance to show the level of corporate risk that is carried against the strategic risk areas of the Board Assurance Framework. The Corporate Risk Register is being updated as a year-end position and includes greater risks on the Trust's capital, infrastructure and estates position and includes the risk for managing the Tracking Access issue.

4. RECOMMENDATIONS

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

Carla Ramsay
Director of Corporate Affairs
May 2018

APPENDIX A

BOARD ASSURANCE FRAMEWORK 2017-18 UPDATED FOLLOWING BOARD COMMITTEE MEETINGS APRIL 2018

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Failure to develop and deliver an effective staff survey action plan would risk achievement of	None	**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Board Development Plan to focus on a forward-looking Board, with a defined set of accountabilities at Health Group and corporate service level, which supports achievement and	Clarity as to full set of accountabilities, deliverables and acceptable standards given the progress made in the last two years is still required and an understanding of cascade/ communication and acceptance of the same; this needs to be at Health Group leads and cascaded down, as well as support service leads	**12**	**12**	**12**	**12**	**4 x 1 = 4**	**<u>Positive assurance</u>** Receipt of detailed staff survey report and action plan – analysis of where work is needed to make further impact on staff engagement; positive messages from most recent results; best results for the Trust in a long time for the number of questions in the top 20 percent of Trusts Approach agreed in April 2017 regarding the Freedom to Speak Up Guardian role, and how this will feed back issues on staff culture and behaviour to the Trust Board; quarterly reports received at Trust Board on FTSUG role – no new Trust-wide concerns raised to date Verbal update May 2017 that Barratt (cultural work) had told the Trust that the pace of cultural improvements made were twice that as would normally be seen in a two-year timeframe July 2017: positive engagement and feedback from office moves to CHH Progress continues towards the People Strategy and areas for improvement identified from latest staff surveys and WRES data – use of latest data to support current actions and identifying new areas of work Quarterly updates on People Strategy now received at Performance and Finance Committee Detailed staff engagement session at Trust Board Development session October 2017 Receipt of national staff survey results March 2018 Trust Board – Trust engagement score remained same and national average fallen; Trust showed improvement across scores

		this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence			positive enforcement of behaviours and organisational culture Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff Integrated approach to Quality Improvement						**Further assurance required** Use of positive messages from most recent results to engender further confidence in staff engagement and staff feelings of job satisfaction Progress made towards narrowing the gap of experiences between BME and white staff, per WRES data and report to Trust Board November 2017 Trust Board – some engagement scores have decreased in most recent quarterly survey

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* There is a risk that retirement rates in the next 5 years will lead to staffing shortages in key clinical areas There is a risk that staff shortages in specific areas will continue and increase There is a risk that the Trust continues to have shortfalls in medical staffing *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need Failure to analyse available data for future retirements and shortages and act on this intelligence	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse and theatre vacancies Cancer and Clinical Support HG: junior doctor levels Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing	**5 (impact)** **4 (likelihood)** **= 20**	People Strategy 2016-18 in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices, Advanced Clinical Practitioners being deployed to cover Junior Doctor and nursing roles, in addition to new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Overseas recruitment and University recruitment plans in 17-18 Golden Hearts – annual awards and monthly	Need clarity as to what 'sufficient' and 'skilled' staffing looks like and how this is measured: 1) measured for daily delivery of a safe service (nursing measures already in place), particularly medical staff 2) measured in terms of having capacity to deliver a safe service per contracted levels 3) measured in terms of skills across a safe and high quality service	**20**	**20**	**20**	20	5 x 2 = 10	**Positive assurance** Discussion with HYMS and stakeholders with a view to increasing medical student training posts locally by circa 50%, including recruitment of local students Guardian of Safe Working Nov 17: further progress made on data collection and exception reporting on safe working; junior doctors successfully moved to new contract. Trust has worked to fill rota gaps since Aug 17 Positive assurance received in Nov 2017 on the intake of graduate nurses and international recruitment – anticipate improvements in fill rates Twice-yearly review of nursing and midwifery establishments presented June and December 17; detailed understanding of risks and how these are being mitigated Monthly 'Moments of Magic' reported by Chief Executive Service Resilience report requested from Dec 2017 to understand impact of staff and resources on maintaining core services – includes medical and other staffing Increased fill rates in December 2017 as new cohort of staff start to receive PIN numbers Updates to Trust Board on progress made towards People Strategy – focus on recruitment and understanding of vacancy position Quarterly reporting on People Strategy and vacancies at Performance and Finance – more detailed understanding of vacancies and where impacting the most; tied to managing HG spent and agency spend Positive assurance on early recruitment from Sept 18 graduate cohort from University of Hull

			Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologist		Moments of Magic – valued staff Health Group Workforce Plans in place to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training					**Further assurance required** Delivery of medical staff revalidation – to give a measure of competent and skilled staff Use of appraisals across the Trust as a means of valuing staff – staff survey reports that appraisals are not fully valued across the Trust Measures to understand whether staffing body is 'skilled' and 'sufficient' Nursing and midwifery (qualified and unqualified staff) sickness levels are an area of focus (July 17) – currently above Trust target; nursing fill rates at lowest point in financial year (October 2017) Guardian of Safe Working Nov 17: new gaps on rotas due to fill rates through the Deanery – need to be filled by Trust actions and additional costs Assurance on implementation of e-rostering and electronic job plans from a benefits realisation/service capacity optimisation point of view Audit Cttee Oct 17 – focus in quarterly updates to P&F on People Strategy re: work on staff retention Longer-term strategy for nursing and midwifery discussed at Trust Board Development November 2017 – solutions will come at a cost to the Trust

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There is a risk that the Trust does not move to a 'good' then 'outstanding' CQC rating in the next 3 years *What could prevent the Trust from achieving this goal?* Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like That the Trust does not further develop its learning culture That the Trust does not increase its public, patient	Corporate risk: management of consent policy and patient records Corporate risk: Restricted use of open systems for injectable medication MHG: Hyper Acute Stroke Unit capacity Corporate risk: Move to ReSPECT process CCSHG: lack of compliance with blood transfusion competency assessments	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) being updated in light of latest CQC report QIP being reviewed ton ensure actions are correct and include sufficient stretch to reach good and outstanding Trust taking part in CQC well-lead pilot – will give an opportunity for the Trust to test out part of new inspection methodology and also have further insight in to part of what 'good' and 'outstanding' look like	Needs organisational engagement – CQC commented that Trust has the right systems and processes in place but does not consistently comply or record compliance Need to build in feedback from CQC around greater involvement of patients in pathway review/development Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)	**12**	**12**	**12**	**12**	4 x 1 = 4	**<u>Positive assurance</u>** CQC report and Quality Summit going in to 16-17 – steer on how to move to 'good' and support of stakeholders to do so Strategy refresh programme will include consideration of strategic goals and supporting strategies, to ensure these reflect the ambition to move to 'good' and 'outstanding' as part of the Trust's strategic and supporting plans Open and transparent reporting on current quality measures, including 12 month data. Good progress overall, and highlights to specific areas of work Participation in the CQC well-led pilot – identified positive areas of progress made Updated QIP presented to the Trust Board in Sept 17 – reworked to provide more stretch and new milestones identified to make further progress; monitored in more detail and regularly by the Quality Committee Positive assurance on progress made towards new Mortality Review national requirements and understanding of progress still to make QIP reviewed monthly by Quality Committee – regular scrutiny on progress Trust Board development on mortality and avoidable death guidance – good start to reviews and compliance with national requirements Never Event session arranged during Q4 (delivered in April 2018); raise issues of Never Events directly with clinical and non-clinical staff; make clear support to staff who raise concerns and support to Stop the Line campaign

		and stakeholder engagement, detailed in a strategy									**Further assurance required** Some QIP areas have a greater impact on organisational development and are the ones needing more progress such as Lessons Learned QIP Four Never Events year-to-date (December 2017); impact on patients, services and potential regulatory attention. Increased to 6 Never Events by year-end – unsure of external follow-up at this stage Trust will be receiving its first inspection under the new CQC regime – PIR received November 2017 Nov 17 - Tracking access issues and current performance pressures in RTT, diagnostics and cancer have a potential impact on quality of care - scale of risk being quantified at present and will be subject to Board Development sessions for more detailed understanding Dec 17 – more information on tracking access issues; potential for patient harm being assessed at present. Detailed action plan being put in place to address underlying issues.

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet national waiting time targets against 2017-18 trajectories standards and/or fails to meet updated ED trajectory for 17-18,also diagnostic, RTT and cancer waiting time requirements *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce waiting times to achieve sustainable waiting list sizes and there is a question on deliverability of reduced waiting times and pathway redesign in some areas The level of activity on current pathways for full 18-week compliance is not affordable to commissioners ED performance is improved and new pathways and resources are becoming more embedded, but performance is affected by small	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology service due to capacity F&WHG Capacity of intra-vitreal injection service	**4 (impact)** **4 (likelihood)** **= 16**	Trajectories set against sustainable waiting lists for each service, which are more affordable to commissioners, and move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Work to resource and implement improvements that have demonstrated they work, such as the FIT model Capacity and demand work in cancer pathways	Consistency of operational performance (links to BAF1) Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	**16**	**16**	**16**	**20**	4 x 2 = 8	**<u>Positive assurance</u>** Trust meeting ED 4-hour target from the start of 2017/18 and meeting RTT trajectory at start of 2017/18 Detailed understanding of Radiology capacity and underlying/contributing factors at July 2017 Performance and Finance Committee Detailed presentation by Emergency Department team July 2017 on sustainable changes made within ED to sustain, and continue to improve, ED waiting times Producing winter plan much earlier per Operating Plan guidance received in Q4; will plan on what work will not be undertaken in winter to manage capacity and knock-on effect on waiting times, in advance of winter Feedback from external consultancy firm – tracking access issues being well managed and Trust pro-active in understanding and addressing the underlying issues **<u>Further assurance required</u>** Effectiveness of accountability framework and improved consistency of delivery Role of external agencies in supporting ED in particular (links to BAF6) – these may change during 17-18 as new service developments come on line external to the Trust and as the STP and placed-based plans look at service configurations Sufficient diagnostic capacity being available to meet demand and to receive onward investment to meet future demand alongside equipment replacement requirements and staffing issues, as well as manage in-year impact of diagnostic capacity on cancer pathways and waiting times; to understand any risks relating to patient care or patient hard Nov 17 – impact due to current pressures in diagnostics, cancer and RTT, with additional tracking access issues – discussed at Board Development sessions; recovery in some areas being seen but not yet improved to trajectory Jan – Mar 18 performance data shows position with impact of winter – not meeting full suite of NHS Constitutional standards – position against RTT 9% below local trajectory agreed for March 2018 and ED performance not at 95% improvement trajectory and is below 90% for year-end.

		differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes										Jan – Mar 18 – seeing some impact on Constitutional standards from Tracking Access issued

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk*: There is a risk that changes to the Trust's tertiary patient flows change to the detriment of sustainability of the Trust's specialist services In addition, there is a risk to Trust's reputation and/or damage to relationships *What could prevent the Trust from achieving this goal?* Actions relating to this risk will be taken by other organisations rather than directly by the Trust – the Trust may lack input or chance to influence this decision-making Role of regulators in local change management and STP	None	**4 (impact)** **4 (likelihood)** **= 16**	Trust CEO chair of Acute Trust STP workstream Trust has membership of relevant STP Committees and STP Board Trust has relationship with NHS England as specialised commissioner	Ongoing discussions and evolution of STP and Trust's role within it	**16**	**16**	16	8	4 x 2 = 8	**Positive assurance** Trust Board time out held 25 May 2017 – examined issues regarding patient flows and position with tertiary patient flows for the stability of Trust clinical services Trust Board time out October 2017 – time spent on strategy regarding partner organisations Meetings with the new STP chair have held with Chief Executives of the local acute Trusts and with the Chairman Trust Board development sessions on strategy refresh Jan – Mar 18 – including specialist service issues, STP discussions and STP statement Long-term future of pancreatic cancer surgery at HEY agreed with NHS England specialist commissioners NLaG Baord has recognised HEY as its key hospital partner for adult services Humber Acute Services Review commenced to support the long term sustainability of hospital services across the Humber footprint **Further assurance required** Role of STP and impact on Trust strategy/forward planning – access to capital funding, service transformation possibilities, partnership working Jan 18 performance data shows position with impact of winter – not meeting Constitutional standards

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**4 (impact)** **4 (likelihood)** **= 16**	The Trust has the leadership of the local in-hospital work stream in the STP The Trust is part of local placed-base plan developments The Trust is talking with partner organisations on opportunities in the local health economy The Trust has a seat on the two local Place-Based STP groups Mapping out internal governance and contribution to all STP workstreams and how this feeds in to Trust decision-making		**16**	**16**	16	16	4 x 2 = 8	**Positive assurance** Trust Board development sessions on strategy refresh Jan – Mar 18 – including specialist service issues, STP discussions **Further assurance required** STP NED event held x 2 – start of engagement process but few tangible outcomes at present Issue of clarity of strategy between STP, STP workstreams and place-based plans; roles of each organisation and commissioner/regulator involvement changing

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2017-18 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	SHG risk: risk to delivering sufficient CRES and achieve financial balance 17-18 MHG risk: risk to achieving CRES in 17-18	**5 (impact)** **4 (likelihood)** **= 20**	Detailed briefings to senior managers and Trust-wide to explain the level of challenge and responsibly throughout the organisation Budgets re-based with Health Groups for 2017-18, requiring accountable officer sign off, to take account of increase spend and cost pressures with a view to eliminating over-spends in 17-18 Strengthened governance around CRES planning and delivery, including a new escalation process up to the Trust Board Committee level (linked with BAF1) HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings FIP2 diagnostic to understand Trust-wide potential for additional savings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities – may link to FIP2 diagnostic New governance structure with local	Assurance from local health economy on demand management Assurance over grip and control of cost base; underlying run-rates increasing pressures Patient safety vs. variable pay costs increased during 17-18 (linked with BAF 2)	**20**	**20**	**25**	**25**	5 x 1 = 5	**<u>Positive assurance</u>** June 17 - contract with Deloitte to identify and set up more detailed PMO arrangements for CRES identification and tracking July 17 - control total and financial plan now agreed with NHSI, per delegated action at April 2017 Trust Board Sept 17 – progress made by Deloitte, reported to P&F Committee, on additional CRES identification and pace; Deloitte provided recommendations to strengthen CRES process; noted that the Trust has identified relevant opportunities for CRES Oct 17 – detailed discussion on FIP2 at Performance and Finance Committee, including attendance of Health Groups, impact and outstanding position for 17-18; underlying run-rate issues slowing but not addressed Dec 17 – some reductions in non-elective pathways seen to date ?commissioner management of referral demands Feb- Mar 1818 – Trust looking able to meet revised control total at year end **<u>Further assurance required</u>** August 17 - gap in CRES identification in 17-18 Oct 17 - gaps in CRES delivery to date and increased corporate risks on CRES Introduction of service line reporting planned during 17-18 – assurance would be to see positive impact of SLR on understanding and reducing cost base Dec 17 – underlying deficit increased in-year as reported to the Trust Board; CRES delivery currently below 80% for the financial year. Question on any Trust's ability to remove costs when delivering same level, or increased level, of service. Q3 submission to be returned to the centre to show updated position against control total Jan 18 – Trust under scrutiny by NHSI on financial plan delivery; revised control total agreed for year-end. Will be taking raised level of risk in to 18-19

					system partners to try to manage demand Regular CRES and efficiency reviews and tight grip on CRES programme				

Risk Appetite
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**5 (impact)** **2 (likelihood)** **= 10**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Recourse Allocation Committee to manage equipment replacement and equipment failure requirements		**10**	**10**	**10**	**10**	5 x 1 = 5	**<u>Positive assurance</u>** Signed-off capital plan for 2017/18 – Trust addressing what it can afford to in infrastructure Capital Resource and Allocation Committee meeting summary to Performance and Finance Committee – assurance on delivery of capital plan and prioritisation to date June 17 - successful practice Major Incident including key stakeholder organisations and lessons learned Oct 17 – Audit Committee received positive assurance regarding external resilience against cyber attack Oct 17 – updated Estates Strategy approved by Trust Board, with review of backlog maintenance and capital requirements at P&F Cttee – scale of capital issue detailed Jan 18 – digital exemplar and focus on cyber-security, to increase trust resilience **<u>Further assurance required</u>** Gap in completion and upload of all service-level business continuity plans Longer-term view of capital requirements and access to sufficient capital funding to address this +/- STP requirements/support/plans Enforcement Notice served by Humberside Fire and Rescue service on fire safety audits Availability of funds if significant failure requires significant investment Oct 17 and Feb 18 – Audit Committee noted actions being taken to further improve internal IT security Mar 18 – view forming of capital programme available in 18-19 and role of STP in capital planning – will increase pressure on capital programme

Risk Appetite

Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a reputational risk as a result of the Trust's ability to service creditors on time, with the onward risk that businesses refuse to supply *What could prevent the Trust from achieving this goal?* Lack of sufficient cashflow	Cancer and Clinical Support HG – continuity of supplies during cashflow issues	**4 (impact)** **5 (likelihood)** **= 20**	Judicious management of cash balances to ensure suppliers are paid on as timely a basis as possible Cash management actions being taken to maximise cash availability Detailed monitoring of cash position, Better Payment Practice and any impact on patient care, at the Performance and Finance Committee Review of cash position and loan opportunities reviewed and approved at the Performance and Finance Committee Relief funding application signed off by Trust Board in October 2017 and January 2018		**20**	**12**	**12**	**12**	4 x 1 = 4	**<u>Positive assurance</u>** Cash flow improved in Q2 due to receipt of STF funding Cash loan application in October 2017 to assist cashflow position Cash loan application In January 2018 to assist liquidity position Cash position managed further in Q4 to year-end, with intervention with HG to understand monthly spend and anticipate cash requirements **<u>Further assurance required</u>** Need to sell land and/or explore issue with the Department of Health as to how the Trust can inject cash Two local CCGs no longer able to pay Trust across tenths in 2017-18 – need to update cashflow projections

<u>Risk Appetite</u>
Is a plan for mitigating this risk required?
Are there further actions that the Board needs to see to mitigate this risk to an acceptable level?
To what extent is risk mitigation in the area in the Trust's control and influence?
Is the risk at an acceptable level?

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2018-19 DRAFT

Meeting date	15 May 2018		**Reference Number**	2015 – 5 – 25.2		
Director	Carla Ramsay – Director of Corporate Affairs		**Author**	Carla Ramsay - Director of Corporate Affairs		
Reason for the report	The purpose of this report is to provide a draft Board Assurance Framework for 2018-19 for discussion, input and agreement by the Trust Board					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing		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 2018-19, to describes the key strategic risks to the 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	
	Briefing		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 - governance					
	Assurance Framework Ref: All	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board Assurance Framework details the key risks to achieving the organisation's goals. It is set annually Trust Board and has been populated as a draft document for Board review and agreement.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2018-19 DRAFT

1. PURPOSE OF THIS REPORT

The purpose of this report is to present the draft Board Assurance Framework for 2018-19 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 2018-19.

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) 2018-19

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 discussed the principles for the 2018-19 Board Assurance Framework at the Trust Board Development session in April 2018. This included a discussion on the use of the Board Assurance Framework to help shape the agenda and strategic discussions of the Trust Board and the Board's risk appetite.

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 draft. It requires the review of the Board to ensure it identifies the correct risks, controls and mitigation. It is linked to the year-end position from the 2017-18 Board Assurance Framework and discussions with Executive colleagues about the types and level of risk being taken in to 2018-19 against the Trust's strategic goals.

Each BAF risk area has been reviewed from 2017-18 and the risk area detailed specifically for 2018-19. This takes account of the risk environment going in to 2018-19, such as the Trust's financial position and financial plan, the updated waiting time requirements from the Operational Planning Guidance, going in to the second year of an Aligned Incentives Contract with local commissioners, and the developing role of the Trust in the STP.

The draft BAF also includes a draft statement on risk appetite against each BAF area, for the Board's review and agreement. This is taken from discussions at Trust Board Development and Board Committees to determine how the Board might shape discussions about mitigating risks in

each of these areas – for example, where would the Board be prepared to take some risks but in what ways might these be limited

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 March 2018, for the flow of corporate risks up to the BAF as part of the agreed 'ward to board' risk escalation process. 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
- Service capacity/availability (linked to specific specialities)
- Specific Trust-wide operational clinical issues

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 2018-19 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

May 2018

APPENDIX A

BOARD ASSURANCE FRAMEWORK 2018-19 AS PRESENTED TO THE MAY 2018 TRUST BOARD

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 (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not	None	**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Chief Executive cultural briefings 2017 and focus in 2018 on management behaviours and 'stop the line' Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores Continuous examples and feed back to staff as to how speaking up makes a difference	**12**				**4 x 1 = 4**	**<u>Positive assurance</u>** **<u>Further assurance required</u>**

		to engage Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first			engage, develop and inspire staff Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the People Strategy							

Risk Appetite

The Trust has been managing and mitigating the level of risk posed by staff culture since 2014, and has been on a journey of improvement on staff engagement. There needs to be a renewed focus on staff culture to bring about a new level of improvement. The appetite for risk is high, insofar as the Trust has worked in a high-risk environment regarding staff culture, which has been mitigated over time as a result of acknowledging the poor staff culture in 2014 and putting a robust plan in place to engage with staff ever since. The Trust wants to mitigate this to a lower-level risk in respect of the impact that poor engagement and poor behaviours have; the Trust is not prepared to take risks with staff culture where this jeopardises patient care or staff welfare.

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 a lack of skilled and sufficient staff could compromise the quality and safety of clinical services *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 on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse and theatre vacancies Cancer and Clinical Support HG: junior doctor levels Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologist	**5 (impact)** **3 (likelihood)** **= 15**	People Strategy 2016-18 in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices (including nursing); Advanced Clinical Practitioners and Physicians Associates being deployed and recruited to cover Junior Doctor and nursing roles, in addition the Trust has introduced new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 18-19; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at	Need clarity as to what 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs	**15**				5 x 2 = 10	**Positive assurance** **Further assurance required**

					monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training Nursing safety brief several times daily to ensure safe staffing numbers on each day Employment of additional junior doctor staff to fill junior doctor gaps Regular reports to the Trust Board from the Guardian of Safe Working							

Risk Appetite

There is a link between patient safety and finances; the Trust draws a 'red line' as compromising quality of care and has part of the overspent position in 2017-18 was to maintain safety of services due to staffing shortfalls. The Trust needs to reduce the risk to its financial sustainability posed by quality and patient safety but without compromising the Trust's position on patient safety. The Trust is putting a plan in place to encompass new clinical training roles and build these in to workforce plans, so is demonstrating a good appetite to adapt and change to further mitigate this risk. The Trust will need to show some agility and willingness to invest as part of this risk appetite.

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 is not able to make progress in continuously improving the quality of patient care *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like That the Trust does not increase its public, patient and stakeholder	Corporate risk: management of consent policy and patient records Corporate risk: Restricted use of open systems for injectable medication MHG: Hyper Acute Stroke Unit capacity Corporate risk: Move to ReSPECT process CCSHG: lack of compliance with blood transfusion competency assessments	**3 (impact)** **3 (likelihood)** **= 9**	Setting expectations on a safety culture in the Trust – Never Event session to be followed up by Chief Executive briefings sessions and the 'Stop The Line' campaign Quality Improvement Plan (QIP) was updated in light of latest CQC report and will be further updated when new CQC report is published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance 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)	**9**				3 x 2 = 6	**<u>Positive assurance</u>** **<u>Further assurance required</u>**

		engagement, detailed in a strategy										

Risk Appetite

The Trust remains focussed on delivery of high quality services for its patients; the Trust does not want to compromise patient care and does not have an appetite to take risks with quality of care. The Trust acknowledges that the risk environment is increasing in relation to the Trust's financial position and ability to invest in services, and that the Trust has an underlying run-rate issue to address.

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 operational planning guidance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 18-19, with an associated risk of distress caused to patients and the ability of the Trust to secure STF monies. *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce its list size compared to the position at 31 March 2018; this will require targeted work by each specialty ED performance did improve following a period of intensive support and improvement focus but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmolo-gy service due to capacity F&WHG Capacity of intra-vitreal injection service	**4 (impact)** **4 (likelihood)** **= 16**	Trajectories set against sustainable waiting lists for each service, to 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 Capacity and demand work in cancer pathways	Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	**16**				4 x 2 = 8	**Positive assurance** **Further assurance required**

		backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to make further gains										

Risk Appetite

A range of plans are being put in place to further manage these issues in to 2018-19. This will need further focus in 2018-19, including the completion of the work and investigation relating to the tracking access issue. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. The Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope of the Aligned Incentives Contract where the activity comes under the local commissioners' contracts, and fit within the funding from NHS England for specialised commissioning services. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes.

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 reductions in the Trust's patient population for (some) of its specialist services may present sustainability challenges. *What could prevent the Trust from achieving this goal?* Actions relating to this risk may be taken by other organisations than the Trust and the Trust may struggle to influence these decisions, particularly in relation to patient populations beyond the Humber geography.	None	**3 (impact)** **4 (likelihood)** **= 12**	The Trust chairs the HCAV STP Hospital partnership Board The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is a member of the Yorkshire and Humber Oversight Group for Specialised Commissioning	Ongoing discussions and evolution of the STP and also its links to local health economy programmes of work	**12**				4 x 2 = 8	**Positive assurance** **Further assurance required** Improved RTT delivery for specialist contract services

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

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 Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**4 (impact)** **4 (likelihood)** **= 16**	The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is playing a key role in the Humber Acute Review (CEO and DOSP) The Trust is playing a key role in the STP workforce workstream (DOWOD) The Trust has a seat on the Hull Place Board (CEO) The Trust is participating in the East Riding Place Based initiatives The Trust has a partnership meeting with CHCP		**16**				4 x 2 = 8	**Positive assurance** **Further assurance required** Involvement at an operational planning and delivery level with the Hull and East Riding Place based Plans Clarity on NED leadership role in STP (strong show of engagement from HEY NEDS in events held)

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2018-19 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	SHG risk: risk to delivering sufficient CRES and achieve financial balance 17-18 MHG risk: risk to achieving CRES in 17-18	**5 (impact)** **4 (likelihood)** **= 20**	Health Group budgets revisited for 2018-19 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES. Weekly Productivity and Efficiency Board (PEB) in place; outputs monitored by Performance and Finance Committee HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Year 2 of Aligned Incentives Contract with local commissioners; consistent approach to income Investment in staffing shortfalls and recruitment to drive reductions in variable pay	Continued assurance from local health economy on demand management Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position	**20**				5 x 3 = 15	**Positive assurance** **Further assurance required**

Risk Appetite

The Trust is willing to review any CRES proposal and has a robust Quality Impact Assessment in place to understand any change posed to quality and safety as a result of a new CRES scheme. The Trust will not put in significant CRES schemes that would compromise patient safety. The aim of any CRES scheme is to maintain or ideally improve quality.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**5 (impact)** **4 (likelihood)** **= 20**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Recourse Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Remedial fire works undertaken in the short-term	Insufficient funds to manage the totality of risk at the current time Programme enables the Trust to run on a day-to-day basis but is not addressing the root causes sufficiently, such as fire safety – the level of risk increases as the Trust manages 'as is'	**20**				5 x 2 = 10	**Positive assurance** **Further assurance required**

Risk Appetite

The Trust is balancing a number of risks in relation to capital; the amount of capital available to the Trust is very limited compared with the calls on capital that the Trust has quantified –i.e. backlog maintenance, equipment replacement, capital development requirements for safe patient environments, quality of sanitary accommodation; the longer the Trust manages its estates as it is, the increase of non-compliance risks with regulatory requirements

HULL AND EAST YORKSHIRE HOSPTIALS NHS TRUST
FIT AND PROPER PERSONS

Trust Board date	15 May 2018	**Reference Number**	2018 – 5- 26
Director	Carla Ramsay – Director of Corporate Affairs	**Author**	Carla Ramsay – Director of Corporate Affairs
Reason for the report	To provide assurance that all Board members have completed declarations of Interests and meet the requirements of Care Quality Commission (CQC) Regulation 5: Fit and Proper Persons.		

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

1	**RECOMMENDATIONS** The Trust Board to review and confirm there is assurance that: • that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons • that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W3 – Leadership and culture –** reflect vision and values and encourage openness					
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** Presented annually to the Trust Board for confirmation and assurance					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
FIT AND PROPER PERSONS

1. PURPOSE

To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.

2. BACKGROUND

In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non Executive Directors.

The Trust Board confirm compliance annually for all Board members and Trust Directors. In addition, arrangements are in place through the Disclosure and Barring Service to ensure that the Trust is informed of any subsequent issues that may be a cause of concern in relation to Board members.

3. PROCEDURE

At the end of every financial year all Board members and Trust Directors are asked to complete a declaration of interest form which includes the Fit and Proper Person declaration. Any material issues included on the declarations are reviewed by the Chairman and/or Director of Corporate Affairs to determine if it is relevant to the individual remaining a Fit and Proper Person.

Any changes in, or conflicts of, declared interests are entered onto the declaration register held by the Director of Corporate Affairs and reported in the Trust's Annual Report as well as to the Trust Board in-year. Board members' interests are also published on the Trust's website and kept up to date as interests change.

Appendix A details the most recent completed declarations by Board members and Trust Directors, for review by the Trust Board for assurance. Appendix B details declared interests of Trust Board members. Appendix C contains the Fit and Proper Person Assessment criteria, for reference.

4. RECOMMENDATION

The Trust Board to review and confirm there is assurance that:

- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Carla Ramsay
Director of Corporate Affairs
May 2018

APPENDIX A

FIT AND PROPER PERSON DECLARATIONS FOR BOARD MEMBERS AND TRUST DIRECTORS COMPLETED 2018

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Mr Terry Moran	Chairman	✓	No	No
Mr Andy Snowden	Non-Executive Director/Vice Chair	✓	No	No
Mrs Vanessa Walker	Non-Executive Director	✓	No	No
Mrs Tracey Christmas	Non-Executive Director	✓	No	No
Mr Martin Gore	Non-Executive Director	✓	No	No
Mr Stuart Hall	Non-Executive Director	✓	No	No
Prof. Martin Veysey	Non-Executive Director	✓	No	No
Prof. Julie Jomeen	Associate Non-Executive Director	✓	No	No
Mr Chris Long	Chief Executive Officer	✓	No	No
Mr Mike Wright	Chief Nurse	✓	No	No
Mr Kevin Phillips	Chief Medical Officer	✓	No	No
Mr Lee Bond	Chief Financial Officer	✓	No	No
Mrs Ellen Ryabov	Chief Operating Officer (job share)	✓	No	No
Ms Teresa Cope	Chief Operating Officer (job share)	✓	No	No
Ms Jacqueline Myers	Director of Strategy and Planning			
Mr Simon Nearney	Director of Workforce	✓	No	No
Ms Carla Ramsay	Director of Corporate Affairs	✓	No	No

APPENDIX B

DECLARATIONS OF BOARD MEMBERS' INTEREST

Any declarations of interest made by Board members in 2018 and currently on the Trust's Register of Business Interests

Name	Role	Declared interest
Mr Terry Moran	Chairman	None
Mr Andy Snowden	Non-Executive Director/Vice Chair	Director Trinity Wharf Management Company, Hull Sole Proprietor Andy Snowden and Associates Associate, Phoenix Consultancy USA (training and development contracts with the NHS)
Mrs Vanessa Walker	Non-Executive Director	Director Wetcover Ltd Chair Hull and East Yorkshire Mind Trustee – Pickering and Ferens Homes Elected member, East Riding of Yorkshire Council
Mrs Tracey Christmas	Non-Executive Director	Cousin works for KPMG
Mr Martin Gore	Non-Executive Director	Board member Together Housing Financial Advisor – UK Anti-Doping Agency
Mr Stuart Hall	Non-Executive Director	Partner is a member of the Yorkshire Clinical Senate
Prof. Martin Veysey	Non-Executive Director	Honorary Consultant contract with York Teaching Hospital NHS Foundation Trust Programme Director MBBS at Hull York Medical School Wife is a trainee nurse practitioner at Leeds Teaching Hospitals NHS Trust
Prof. Julie Jomeen	Associate Non-Executive Director	Dean, Faculty of Health Sciences, University of Hull
Mr Chris Long	Chief Executive Officer	None
Mr Mike Wright	Chief Nurse	None
Mr Kevin Phillips	Chief Medical Officer	Undertakes private practice at Spire Hull and East Riding
Mr Lee Bond	Chief Financial Officer	Director of WISHH (Working Independently to Support Hull Hospitals) Charity Lives with Deputy Chief Nurse
Mrs Ellen Ryabov	Chief Operating Officer	Director ER Healthcare Consulting Sister works on Trust's staff admin bank
Ms Jacqueline Myers	Director of Strategy and Planning	✓

Ms Teresa Cope	Chief Operating Officer (job share)	Trustee with Cornerhouse (Yorkshire) Hull
Mr Simon Nearney	Director of Workforce	Director Cleethorpes Town FC (CTFC Ltd)
Ms Carla Ramsay	Director of Corporate Affairs	Trustee – The Warren of Hull (youth work charity)

APPENDIX C

FIT AND PROPER PERSON DECLARATIONS

DETAIL OF WHAT DECLARATIONS MUST BE MADE

Disclosure	Y/N
Have you been convicted of a criminal offence in the UK or elsewhere?	
Do you consent to the Trust obtaining an automatic annual notification under the DBS?	
Are you on the Safeguarding (children and adults) barred list?	
Have you been prohibited from holding office under the Companies Act or the Charities Act?	
Do you have undischarged creditors?	
Do you have a debt relief order?	
Are you an undischarged bankrupt?	
Do you have a bankruptcy restriction order?	
Are there any reasons related to health that mean that you are unable to fulfil your role?	
Have you ever been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals?	
Do you have an outstanding referral to your professional body for an issue relating to a CQC regulated activity?	
Are there any other factors that you consider your employer should be aware of that could impact on the Fit and proper persons Test?	