HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 3 OCTOBER 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

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 **2 MINS**	verbal	Chair – Terry Moran
3. Minutes of the Meeting of the 5 September 2017 • To review, amend and approve the minutes of the last meeting	attached	Chair – Terry Moran
4. Matters Arising 4.1 Action Tracker	verbal attached	Chair – Terry Moran Director of Corporate Affairs - Carla Ramsay
4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
4.3 Board Reporting Framework 2017-18 • To review the current Board Reporting Framework and determine if any updates are required **5 MINS**	attached	Director of Corporate Affairs – Carla Ramsay
5. Chair's Opening Remarks **2 MINS**	verbal	Chair – Terry Moran
6. Chief Executive's Briefing • To receive the Chief Executive's briefing to the Board **5 MINS**	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 • Decide if any if any further actions and/or information are required	attached	Chief Nurse – Mike Wright
10. Avoidable Mortality – Structured Case Note Review Progress Report • Receive this report • Decide if any if any further actions and/or information are required	attached	Chief Medical Officer – Kevin Phillips

11. Quality Committee 29 August 2017 minutes and verbal update 25 September 2017 • Short briefing to the Board on key issues discussed at the Quality Committee and to raise any points of escalation to the Board **35 MINS**	attached	Quality Chair – Trevor Sheldon
PERFORMANCE		
12. Performance and Finance Report • To highlight the Trust's performance against the required standards	attached	Chief Operating Officer – Ellen Ryabov, Chief Financial Officer – Lee Bond
13. Borrowing Requirements 2017/18 • The Board to approve the loan application	attached	Chief Financial Officer – Lee Bond
14. Performance & Finance minutes 29 August 2017 verbal update 25 September 2017 • Short briefing to the Board on key issues discussed at the P&F Committee and to raise any points of escalation to the Board **25 MINS**	attached	Performance & Finance Chair – Stuart Hall
STRATEGY & DEVELOPMENT		
15. Estates Strategy including Backlog Maintenance and Sustainability • The Trust Board to approve the Estates Strategy 2017-2022	attached	Chief Financial Officer – Lee Bond
16. Digital Exemplar – Lorenzo • The Board are asked to approve the submission to NHS Digital, seeking support for the accelerated implementation of key technologies under the Lorenzo Digital Exemplar Initiative Fund umbrella.	attached	Chief Financial Officer – Lee Bond
17. Scan4Safety Trust Board charter • To seek permission for publication of the Scan4Safety Board charter as part of the commencement of the Scan4Safety programme implementation. **45 MINS**	attached	Chief Financial Officer – Lee Bond
ASSURANCE & GOVERNANCE		
18. Operating Plan	verbal	Director of Strategy and Planning – Jacqueline Myers
19. Winter Plan • To present the draft 2017/18 Winter Plan for discussion and approval, subject to the outstanding issues being resolved.	attached	Director of Strategy and Planning – Jacqueline Myers
20. Safeguarding Annual Report • The Board is asked to receive the annual reports for Safeguarding Adults and Safeguarding Children and Young People 2016/17 attached.	attached	Chief Nurse – Mike Wright
21. Emergency Preparedness Resilience and Response – annual assessment • To advise the Trust Board regarding the outcome of the 2017/18 EPRR assessment against core standards.	attached	Director of Strategy and Planning – Jacqueline Myers
22. Responsible Officer Report	attached	Chief Medical Officer -

• The Board to receive the report		Kevin Phillips
23. Standing Orders	attached	
• The Board to approve the use of the Trust seal		Director of Corporate Affairs – Carla Ramsay
23.1. Land Acquisition – Gladstone Street	attached	Chief Financial Officer – Lee Bond
• It is recommended that approval is given for Hull and East Yorkshire Hospitals NHS Trust to stop up the Public Highway known as Gladstone Street together with the associated costs.		
23.2. Development of a Molecular Imaging Centre including Radiopharmacy	attached	Chief Financial Officer – Lee Bond
• To seek, in accordance with Standing Orders, the formal approval of the Trust Board to the use of land on the Castle Hill Hospital site to facilitate the development of a Molecular Imaging Research Centre, including radiopharmacy by the Daisy Charity		
24. Board Assurance Framework	attached	Director of Corporate Affairs – Carla Ramsay
• The purpose of this report is to present the updated Board Assurance Framework (BAF) for 2017-18 from the September 2017 Committee discussions, to determine if there are any risk areas where this Committee can provide positive assurance and to give scrutiny to areas where there are gaps or a lack of assurance		
25. Charitable Funds Minutes 5 September 2017	attached	Chair of Committee – Andy Snowden
• Short briefing to the Board on key issues discussed at the Charitable Funds Committee and to raise any points of escalation to the Board		
26. Declaration of Interest – Fit and Proper Persons	attached	Director of Corporate Affairs – Carla Ramsay
• Assurance to the Board regarding Martin Veysey Fit and Proper Persons compliance		
27. Any Other Business	verbal	Chair – Terry Moran
28. Questions from members of the public	verbal	Chair – Terry Moran

29. **Date & Time of the next meeting:**
Tuesday 7 November 2017, 2 – 5pm the Boardroom, Hull Royal Infirmary

30 MIN

Attendance 2017/18

	4/4	2/5	25/5 Extra	6/6	4/7	1/8	5/9	3/10	7/11	5/12	Total
T Moran	✓	✓	✓	x	✓	✓	✓				6/7
C Long	✓	✓	✓	✓	x	✓	✓				6/7
L Bond	✓	✓	✓	✓	x	✓	✓				6/7
A Snowden	✓	✓	✓	✓	✓	✓	✓				7/7
M Gore	✓	✓	✓	✓	✓	✓	✓				7/7
S Hall	✓	✓	✓	✓	✓	✓	✓				7/7
M Wright	✓	✓	✓	✓	✓	✓	Jo Ledger				6/7
K Phillips	✓	✓	✓	✓	✓	Dr Purva	✓				6/7
T Sheldon	x	✓	✓	x	✓	✓	✓				4/7
V Walker	✓	✓	✓	✓	✓	✓	✓				7/7
T Christmas	✓	✓	✓	✓	✓	✓	✓				7/7
E Ryabov	✓	✓	✓	✓	x	✓	Michelle Kemp				5/7
In Attendance											
J Myers	✓	✓	✓	✓	✓	x	✓				6/7
S Nearney	✓	✓	x	✓	✓	✓	✓				6/7
C Ramsay	✓	✓	✓	✓	✓	✓	✓				7/7

Attendance 2016/17

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 5 SEPTEMBER 2017
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 S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Ms J Ledger	Deputy Chief Nurse (For Mr M Wright)
	Mr L Bond	Chief Financial Officer
	Mrs M Kemp	Operations Director (for Mrs E Ryabov)
	Prof. T Sheldon	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
	Prof. M Veysey	Associate Non-Executive Director (from 2.15 pm)
	Mrs S Bates	Deputy Director Quality Governance and Assurance (item 14)
	Dr Peter Moss	Director of Infection Prevention and Control (item 15)

ACTION

1. APOLOGIES

Apologies were received from Mrs E Ryabov, Chief Operating Officer and Mr M Wright, Chief Nurse

2. DECLARATIONS OF INTERESTS

2.1 Changes to Directors' Interests since the last meeting

None

2.2 To Consider and Conflicts of Interest Arising From This Agenda

None declared

3. MINUTES OF THE MEETING OF 1 AUGUST 2017

The minutes were approved as an accurate record of the meeting.

4. MATTERS ARISING

4.1 Action Tracker

The Trust Board confirmed the completed actions on the tracker document.

4.2 Any Other Matters Arising

There were no other matters arising from the minutes.

4.3 Board Reporting Framework

A new colour-code of green has been added to confirm items have been received by the Trust Board as scheduled. Ms Ramsay noted the additional IM&T item requested by Mr Bond for the October 2017 Trust Board meeting.

4. CHAIR'S OPENING REMARKS

Mr Moran welcomed Professor Martin Veysey to his first Trust Board meeting. Professor Veysey has been appointed as an Associate Non-Executive Director to the Trust Board and will be a member of the Trust's Quality Committee. He is a Professor and Honorary Consultant in Gastroenterology and Programme Director for the MBBS at the Hull York Medical School.

5. CHIEF EXECUTIVE'S BRIEFING

Mr Long noted the praise received by the Trust from the Secretary of State for Health, in respect of the Trust's Friends and Family Test results in June 2017 for outpatients. Mr Long gave his sincere thanks to the Trust's outpatient staff and support staff, including patient administration, for delivering high quality care in some of the Trust's more challenged working environments.

In relation to the section on the report on fire safety, Mr Long reported that Humberside Fire and Rescue has served an enforcement notice on the Trust with regard to fire safety audit completion. There is also a recommendation from the service that the Trust should complete these annually. The Trust is responding to the enforcement notice.

Professor Sheldon noted some caution connected with the section of the Chief Executive's report of the new complementary therapies being offered to survivors of cancer by qualified therapists donating their time and expertise. Professor Sheldon stated that support, including that offered by volunteers, still needs to be evidenced-based. Mr Long confirmed he is supportive of good projects, to which patients report a positive benefit, and understands the Professor Sheldon's point, that language and how support is presented, is important.

Mr Snowden noted the Chief Executive's recent blog and message to all staff on the Trust's intranet, Pattie, regarding fire safety. Mr Snowden saw that staff were leaving feedback soon after it was posted, which he believed was good evidence of 'ward to board' engagement and sought assurance that staff comments were responded to. Mr Snowden also noted how useful the new intranet is, and whether this would benefit from a wider discussion at the Board. Mr Nearney confirmed that over 7,000 staff accessed Pattie during its first 6 weeks and there is positive feedback on Pattie as a business tool. Mr Gore wished to pass on his thanks to Bonnie Grey in the Trust's Communications Team, who has worked passionately on this project. Mr Moran added his reflections and asked for consideration of a post-implementation review at an appropriate time.

Professor Veysey joined the meeting at this point and gave a brief introduction.

The agenda was taken out of order at this stage

15. RESPONSIBLE OFFICER REPORT AND INFECTION CONTROL ANNUAL REPORT

Mr Moran welcomed Dr Moss to the meeting to present the Infection Control Annual Report. The Responsible Officer report has been tabled at today's meeting and Trust Board members were asked to review this and provide any comments back to Mr Phillips with a copy to Mr Moran; pending any comments, the Board agreed for Mr Moran to approve the final version with Mr Phillips prior to the end of September 2017.

All

Dr Moss highlighted the following key points from the infection control annual report:

- The Infection Prevention and Control nursing team is currently undergoing a restructure to provide more resource across the Trust
- Medical Microbiology is a national shortage specialty and the report notes that the Trust did not have its own employed Consultant Microbiologist for parts of last year; cover arrangements were put in place. The Trust is hopeful of recruiting a suitable post-holder this calendar year.
- The Trust has successfully managed within its thresholds for mandatorily monitored infections and has arrangements in place to monitor new infection requirements this financial year. There had been greater national focus on reducing gram-negative bloodstream infections by 50%, which has now become an aspiration rather than a mandated target; however, the Trust is still working towards achieving this.
- The report notes the way in which the Trust manages outbreaks, which has proven to be effective and takes a pragmatic approach to contain and manage outbreaks.
- The Neonatal Intensive Care Unit has had two separate outbreaks in two years. Contributing to these are the physical facilities and the way in which they are used (i.e. infection prevention and control practices by staff).
- The Trust is performing well in anti-microbial stewardship and has had a forward-thinking approach to antibiotic prescription and usage for some time.
- There has been a positive change, brought on by staffing shortages, to have more bedside and ward presence from the Infection Control physicians where Consultant Microbiologists have not been available. This bedside input has been welcomed by Trust staff.
- Dr Moss noted the equipment contamination issue, for which to date the Trust has screened a number of patient and treated one, who was a patient from another Trust.

In response to questions from the Trust Board, Dr Moss noted that the requirement to have a Water Safety Committee is mandatory but noted in the report that it has been poorly attended. Dr Moss gave assurance that the Trust's practices are safe and are monitored at the Infection Reduction Committee. Dr Moss noted, in relation to the NICU issue, that this is on the Health Group's risk register. Assurance was given that the risk is being managed and would be escalated if needed through the Trust's risk management process and committee structure. Dr Moss noted that it was escalated through this route by the Infection Prevention and Reduction Committee (IPRC) to the Operational Quality Committee but feedback is awaited by the committee from this.

CR

Professor Veysey noted that the use of isolation facilities can come with risks to the mobilisation of patients and potentially longer lengths of stay. Dr Moss confirmed that there are standard operating procedures in place to identify and manage patients in single-bed rooms, and manage the balance of risks.

Mr Moran thanked Dr Moss for attending the meeting and thanked the Trust's staff for their hard work in preventing and managing infections.

Resolved:
The Board received and accepted the Infection Control Annual Report and will approve the Responsible Officer Report via the Chairman and Chief Medical Officer pending comments by the end of the month.

Dr Moss left the meeting at this stage

The agenda reverted to its order at this point

QUALITY

7. PATIENT STORY

Mr Phillips presented two patient stories to the Trust Board. The first was in respect of a patient who was awaiting a lung transplant, and whose condition was deteriorating. No-one in the Trust was getting back to the patient about arrangements or preparation for this procedure. The patient contacted the Patient Experience team, who became the patient's advocate, finding out the information he needed and liaising with the right departments and teams as required. There was a positive outcome to this in the end, but Mr Phillips raised the point from this story about Trust staff needing to remember their role as patient advocates.

The second story is a patient's father who has passed on their praise for one of the hospital's volunteers, John, at Hull Royal Infirmary. The patient's father was attending a clinical appointment with his daughter, and he is physically disabled. When they arrived, they were greeted by John, who arranged to take the patient's father to the clinic in a wheelchair. He reported that John was thoughtful and intuitive, and the way in which he did this was not patronising but was caring. He came back for them after the appointment, too. He passes on his thanks to John for being such a caring volunteer.

Mrs Walker reflected that this story is a lovely example of someone of a volunteer being an advocate for the patient. These stories are excellent reminders that everybody should be an advocate and put themselves in the patient's position. Professor Veysey noted that a named person of contact and advocate is what patients state as one of the most helpful aids to them.

8. QUALITY REPORT

Mr Phillips presented the report. He provided a verbal update in relation to the Serious Incidents section of the report. The data in the report relate to the period to 31 July 2017; in August 2017, the Trust declared two Never Events, which are the first ones since September 2016. The first was a wrong-site surgery Never Event (the wrong part of the correct site was operated on), and the second was a change in plan in knee replacement procedure. These are both under investigation and will come back to the Board in due course.

Following Dr Moss's presentation of the annual report, Mr Phillips noted that the Trust is under its thresholds for infections but are under close monitoring.

In relation to patient experience, the Trust has improved its performance in responding to complaints within 40 days and noted the praise regarding the Outpatients Friends and Family test, reported earlier.

The Trust submitted its response to the draft CQC well-led pilot report yesterday.

Mr Bond asked about the pilot taking place in relation to technology and interpreters and asked for an update on looking at new providers for face-to-face interpreters. Mrs Ledger confirmed that this has gone out to tender; the Trust is also looking at its own processes for use of face-to-face or telephone interpreters.

Mr Hall asked for an understanding of what learning from infections might look like, in respect of the outcomes from individual root cause analysis investigations. Ms Ramsay confirmed that there were some points of learning in last month's report that would illustrate this.

Professor Sheldon noted the positive progress made against timely responses to complaints but raised the need to understand learning from complaints and how this has impacted on care; this same principle can be applied to other areas, such as incident reporting – that the measurement is not as important as the learning and what can be done differently. Mr Phillips offered to review the way in which this is captured and reported to the Quality Committee.

KP

Mr Gore asked for further detail on the Serious Incident investigation process. Mr Phillips confirmed that patients and their relatives are invited to be part of the investigation process and receive the outcome. In relation to independence in the investigation process, all Serious Incident reports are scrutinised by the Trust's commissioners and feedback and further actions received back. Ms Myers confirmed that each Serious Incident is chaired by a Trust member of staff independent of the team where the incident occurred. Mr Moran recently spent time with the Governance team and was assured by the scrutiny and independent view provided by the Governance team as a report is completed and signed off.

Mr Gore asked if any of the recent Serious Incidents relating to treatment delays were related to the issues seen with clock-stops not correctly applied to patient pathways, and asked what the underlying issues with failed clock-stops is. Ms Kemp stated that training is the particular issue with applying clock stops properly and will cover this later on the agenda. Mr Bond confirmed that the Serious Incidents on treatment delay was not related to a clock stop. Mr Phillips also noted that other mechanisms are being looked at to pick up tracking access and similar issues. Lorenzo is enabling the Trust to find issues at an earlier stage, which with the previous system may not have come to light. Ms Kemp gave assurance that she had seen better cohesion recently between clinical administration, clinical operational and service delivery staff.

Mr Moran concluded this agenda item and supported the level of detail discussed at a public board meeting; the transparency of the Trust's approach to quality offers assurance.

Resolved:
The Board received and accepted the report.

9. NURSING AND MIDWIFERY STAFFING REPORT

Ms Ledger presented the report. She noted that a short-term reduction in elective capacity at Castle Hill Hospital had enabled the redeployment of some nursing staff, including to Hull Royal Infirmary. 130 newly qualified nurses are being pursued from this year's University graduate cohort. The Trust is following up with 15 nurses who have declined posts at the Trust since the last report. In terms of managing patient safety, the safety brief continues to be held four times a time. The red flags being reported are predominantly wards needing one-to-one support; the Trust is starting a Safer Care pilot this month, which will be reported back to the Board in due course.

Mr Phillips wanted to acknowledge the pressure on nursing staff, particularly at times when staff are moved to provide cover. Mr Nearney noted that this is a particular point of feedback from nursing staff; there are some parts of the Trust where there is not a clear career pathway for nursing and the Trust needs to balance its staffing needs and retention with finances;. The Trust is reviewing some areas in this regard. In addition, every quarter the Workforce Transformation Committee look at exit interviews and triangulates these with length of service, protected characteristics and the reasons why staff left, to try to stem staff losses in the future.

Professor Sheldon asked if there had been a drop in new student nurses enrolling this year, with this being the first year where the bursary no longer exists. Ms Ledger that 800 applications were received by the University, compared with circa 1,200 in previous years. The University is taking a cohort of 275 students this year.

In relation to the reduction in elective capacity at Castle Hill Hospital, Ms Ledger confirmed this is decision is not taken in isolation and is taken by the Executive tem with Operations Directors and also understand the impact on finances and other areas.

Resolved:
The Board received and accepted the report.

10. QUALITY IMPROVEMENT PLAN (QIP)

Mr Phillips presented this report. He noted that this is reviewed by the Quality Committee; some of the narrative is a work in progress. One of the key issues is getting greater 'buy-in' to the Lessons Learned Quality Improvement Project. The Trust is working with external agencies on some of the projects, particularly the transition from Children and Young People's services.

Mr Snowden asked the value-added of receiving the full QIP report at the Trust Board, given the scrutiny it receives at the Quality Committee. Board discussion determined that it is important the full Board has an understanding of the QIP, the projects within it, exceptions and significant risks. This could be done in summary format in future reports.

Ms Myers has some points of feedback regarding consistency between some statements that she will pick up with Mr Phillips.

Mr Gore noted that the QIP is a key source of assurance on the Board Assurance Framework. On this point, Professor Sheldon noted that the QIP report on projects and milestones are important; the Quality Committee has received assurance on progress made in projects, particularly in mortality, with some work still to do on understanding Duty of Candour requirements and clinician time and training for mortality case note reviews.

Mr Hall asked for clarity in respect of QIP 09 (Falls) where a milestone may not be deliverable. Ms Ledger confirmed this is being picked up by the Quality Committee.

Mr Moran stated that the Trust Board should be appraised of risks and areas of escalation on the QIP from the Quality Committee for future Trust Board meetings.

Resolved:
The Board received and accepted the report.

11. QUALITY COMMITTEE 31 JULY 2017 MINUTES AND VERBAL UPDATE 29 AUGUST 2017

Professor Sheldon reported that the Committee has asked for analysis of the severity of incidents, understanding that the increase reporting is due to a change in what is required to be uploaded to the national reporting system. He reported that the Safeguarding Annual Reports well received by the Committee. A particular risk issue is the distribution of trainee posts across the Yorkshire Deanery patch – the Trust will be raising this with the Deanery.

Resolved:
The Board received and accepted the report

PERFORMANCE

12. PERFORMANCE AND FINANCE REPORT

Ms Kemp presented the performance section of the report. Diagnostic waits to the end of July 2017 had 5.03% of patient waiting over 6 weeks. This equated to 396 patients out of circa 7,500 patients receiving diagnostics. The key pressures are CT and Cardiac CT. The 18-week Referral-to-Treatment target met the local trajectory with commissioners in July 2017. There were three 52-week breaches in the report; Ms Kemp updated that this figure is actually three for the month. All related to incorrect clock stops and the Performance and Finance Committee receive more detailed information on each breach.

The Emergency Department (ED) performance is 91.7% for July 2017, meeting the local trajectory. The Department is looking at how to progress to the 95% standard. There were circa 13,300 attendances to in ED in July, which is 1,700 attendances above the contracted figure.

In relation to cancer targets, the June 2017 data show there were pressures in the 31-day standard, with 7 breaches. For the 62-day standard, there were three specialities did achieve the standard in June 2017 but 7 tumour sites that did not. The Trust continues to work on this area. This evening, the Health Groups are holding an operational cancer meeting at Castle Hill Hospital to discuss current issues and each pathway continues to be scrutinised at the fortnightly cancer Performance and Access meeting. There were some breaches of the 62-day screening standard, which were largely complex patient cases and linked with patient availability.

Mr Phillips noted that the 104 day cancer standard has a small number of patients but these have gradually increased during the year. Ms Kemp confirmed that each step of the patient pathway is being scrutinised at the fortnightly performance meeting.

Mr Bond presented the Finance report, and provided an alternative breakdown of the current financial position, which was presented at this month's Performance and Finance Committee. The Trust is reporting a deficit position at the end of July 2017 of £8.3m, which is £6.0m above the Trust's plan. Within this deficit, there is a CRES issue of £1.7m, and a run-rate problem in the Health Groups of £3m. Urgent actions are needed to address this deficit position.

The current position poses a cash problem for the Trust. Mr Bond confirmed that the previous agreement with local commissioners to pay the Trust in tenths over the year rather than twelfths has been reversed by NHS England. The Trust's finance team is working through a cashflow forecast.

The Trust does not yet qualify for STF support. This can be recovered during the year. Whilst the Trust could release reserves to cover more of the deficit and move closer to qualifying for STF funding, this would not address the in-year issues. The Executive team meets monthly with the Health Groups, where the largest financial pressures are, and the ability to manage and address these issues is varied across the Health Groups. The main issues are some medical staffing issues that are driving some the unavoidable cost pressures, some grip and some non-pay issues.

Mrs Walker asked how the Trust's position compares nationally. Mr Bond noted that the national Quarter 1 financial figures have just been released, which state each Trust's figures year-to-date and the forecast year-end position; LB will

circulate these. Most Trusts in the north of England are meeting their targets. However, all three acute Trusts in this Strategic Transformation Partnership area have reported greater than planned deficits.

LB/RT

In relation to the FIP2 work, Mr Bond reported that this has put in further challenge and accelerated CRES schemes. Whilst achieving CRES is an issue, the larger issue for the Trust is the run-rate issue. Some of this is due to staffing; in relation to medical staffing pressures, circa 50% is due to Consultant posts and 50% due to middle grades, with a significant agency spend.

Ms Christmas noted that the Performance and Finance Committee had a detailed discussion on the STF payments and timing, and there is a handling strategy for this. Mr Bond stated that at this point in time, the Trust has £4.8m in reserves and could release this to cover the £3.4m requirement to claim STF funding. However, this would not address the underlying issues.

Mr Gore noted that the Audit Committee is paying close attention to cash and the risks that this might put the Trust on watch lists with suppliers, and whether any challenge could be put back to the commissioners regarding NHS England's decision.

Resolved:
The Board received and accepted the report.

13. PERFORMANCE AND FINANCE COMMITTEE MINUTES 31 JULY 2017 AND VERBAL UPDATE 29 AUGUST 2017

In addition to the key discussion points on the previous agenda item, Mr Hall noted that the Committee has asked for 62-day cancer data by tumour site. The Committee noted that of the breaches in May 2017, 45% were avoidable breaches and the Committee has asked for a remedial action per tumour site. The Committee is also receiving RTT data per specialty and has some of the detail of pressures in particular specialties.

Resolved:
The Board received and accepted the update.

14. YOUNG HEALTH CHAMPIONS

Mrs Bates presented this report. She provided further detail and good news stories regarding the Trust's support to volunteers and in particular, the success of the Young Health Champions trainee programme.

The Trust's work with local schools and colleagues to provide volunteering opportunities as Young Health Champions has also been successful. This has helped the Trust to promote careers in the health service and build up new partnerships to offer local young people volunteering and potentially employment opportunities. Departments across the Trust have been very supportive of young volunteers and providing high quality volunteering opportunities, including areas that have not had volunteers before.

Mr Snowden noted that the Trust's successes in growing its number of volunteers of all ages over the last two years and the opportunities it provides reflects the statement in the report that this is part of the Trust's Corporate Social Responsibility (CSR). It was agreed that the Trust should look at the way in which it captures its CSR contribution again.

CR

The Trust Board offered its congratulations for the growth in volunteers and the many successes of the Trust's volunteers. The Board offered its thanks to Mrs Bates, Rachel Pearce and Lou Beedle, and the Chief Executive, for providing the drive and support to bring greater successes in volunteering.

Mrs Bates confirmed that the Trust was connected to the Pathways to Medicine scheme. Mr Long asked for the connections with younger people and schools in Hull to provide greater opportunities to the parts of the city with the highest levels of deprivation.

Resolved:
The Board received and accepted the report.

15. RESPONSIBLE OFFICER REPORT AND INFECTION CONTROL ANNUAL REPORT

This item was taken earlier in the meeting.

16. WORKFORCE RACE EQUALITY STANDARD

Mr Nearney presented this report. The annual submission requirements are the set of workforce data and an action plan that aims to close the gap between the experiences of white staff and BME staff. A BME staff network was established last year and is starting to grow in numbers. The Trust agreed a new protocol to release staff to have time to attend. The network identified some coaching needs that are being supported, too.

The Trust has 8,800 staff, of whom circa 11% are from BME backgrounds. This is more than representative than the local population but BME staff are underrepresented in many staffing groups including senior clinical positions. This year's WRES data show that BME staff are less likely to be appointed at interview and more likely to be subject to formal HR proceedings. Staff from all backgrounds continue to experience bullying and harassment. The action plan is included in the paper. The Trust will continue to develop the BME network and increase engagement and numbers; the Executive Management Committee agreed to support the coaching strategy, which will link an individual to a senior manager for individual coaching to help break through the "glass ceiling" and also help connect senior staff to some of the issues. The Trust's role of Equality Ambassadors will be re-launched. The Trust continues to promote the Leadership Programme and promotes the uptake of externally funded leadership courses for BME staff.

Mr Snowden reflected that it is important to acknowledge that the Trust Is "behind the curve" in this area but he does hear a firm commitment to address a serious challenge. He suggested that it would be useful to have further time as a Board to explore more of the detail of this issue as part of the Trust's strategy in another session, as there is a lot of detail and ambition in the action plan to unpack.

CR

Professor Sheldon noted that the data on staff engagement demonstrate significant improvement and encouraged the Trust not to underplay its own achievements in this area.

Mr Moran asked if there was something about attracting candidates to the Trust from different backgrounds. He was disappointed that there were no applicants from a BME background in response to the recent Associate Non-Executive Director recruitment. He would want to ask how the Trust is promoting itself and seen as an opportunity that candidates from different backgrounds would want to consider.

Mr Moran thanked Mr Nearney and the Board for the candid nature of the data and the openness of the debate on this issue.

Resolved:
The Board received and accepted the report.

17. CULTURAL TRANSFORMATION PROGRESS REPORT

Mr Nearney presented this report. The Trust's most recent engagement score was 3.82 against a national average of 3.81, which is a decrease from the previous score. Mr Nearney stated that the Trust receives a steady response rate to the quarterly staff surveys and the Trust had been breaking in to top 20% of Trusts nationally; he was disappointed to drop back down to the national average. Mr Nearney highlighted some areas of the Trust where the engagement score has decreased and these are part of discussions in the monthly performance meetings with between the Health Group triumvirates and Executives.

The Trust Board commented that at more difficult times, such as where there have been increased staffing moves for patient safety and where finances are under pressure, there always will need to be a balance of staff engagement and operational delivery.

Mr Snowden noted in particular the impact that the question on having 'permission' to make service improvements might have on staff engagement. Mr Phillips noted that junior doctors have been relatively well engaged in previous surveys but have dropped down in these results. This would be useful to look at this in more detail, too.

Ms Myers added that the same staff engagement questions are asked as routine when the Improvement Team is starting an improvement project and these do see an improvement on the 'permission' on improvement. The team is about to do hard launch of the Trust's improvement materials and has seen increased requests for support.

Mr Long noted that the most recent results are lower but are not yet the start of a downward trend. The Trust has made some of the easier gains and it will be tough to make further increases; the Trust will need to be clear on what is distinctive about working here and need for further improvement. Mr Gore noted two of the limiting values reported by staff were "hierarchic" and "bureaucratic". He offered that this might be a necessary part of the NHS or may be something that needs a management response

Mrs Nearney added that the Board set the ambition three years ago to break in to top 20% of Trusts for staff engagement by December 18. It is important for the Trust to keep on course and to keep up the momentum of improvement, and to be seen as just as important as finance and quality. To support this, there is a programme of work that has had good engagement, including ACAS from the initial report in to Trust culture, and has the support of the Health Groups and Trade Unions.

Mr Moran concluded that it is important to keep focussed on this area and that this would be worth exploration in a future Board Development session.

CR

Resolved:

The Board received and accepted the report.

18. HEALTH AND SAFETY ANNUAL REPORT

Mr Bond presented this report. He noted that the Trust had reduced the number of RIDDOR-reportable incidents in the last three years, which is positive, but there has been an increase in non-reportable incidents such as staff slips, trips and falls. The Trust is focussing on training and trip hazards, also with a view to reducing claims. There is also focus on reducing work-related stress as part of national area of work.

Mr Moran noted the importance of this annual report and that Mr Bond has highlighted some areas of focus. A range of issues would be addressed in more detail at the appropriate Board committee. Mr Bond will also feedback on the issues of hoists on wards.

CR/LB

Mr Gore noted the improvement in reporting RIDDOR-reportable incidents within the required timeframe but 23% of incidents were reported late. Mr Phillips stated he will look at this with the governance team on timeliness of RIDDOR reports as well as the type of incidents being reported.

Resolved:
The Board received and accepted the report.

19. BOARD AND COMMITTEE DATES 2018/19

Ms Ramsay presented the draft schedule, which is required to be approved by the Board. Ms Ramsay confirmed the schedule of Trust Board meetings is published on the Trust's website.

Resolved:
The Board received and approved the schedule.

20. STANDING ORDERS

Ms Ramsay presented this report. The Board was asked to authorise the use of the Trust's seal in respect of seven contracts detailed in the report.

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

21. CHARITABLE FUNDS COMMITTEE MINUTES 31 MAY 2017

Mr Snowden presented this report and took these as read. The Charitable Funds Committee also met today and approved the annual accounts for 2016/17 and also approved the start of a programme of amalgamation in to fewer separate charitable funds.

Professor Sheldon noted caution on the item contained in the minutes of the gait trainer that is being offered for use in the Trust. Mr Bond noted that a clinical evaluation is being done. Professor Sheldon stated that it is important to understand the evidence base of equipment, including that which is being offered for free.

Mrs Walker was keen to encourage attendance at the upcoming WISHH charity fashion show fundraiser.

Resolved:
The Board received and accepted the update.

22. AUDIT COMMITTEE MINUTES 27 JULY 2017

Mr Gore presented the tabled minutes. The Committee received a detailed report on Clinical Audit, which gave positive assurance on following up audits and seeing improvements. The Committee also received a detailed report on the work in the Claims team and the good work being done to manage the Trust's position.

Resolved:
The Board received and accepted the update.

23. ANY OTHER BUSINESS

None

24. QUESTIONS FROM MEMBERS OF THE PUBLIC

None

25. DATE AND TIME OF THE NEXT MEETING:

Tuesday 3rd October 2017, 2.00 – 5.00 pm, Boardroom, Hull Royal Infirmary.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD ACTION TRACKING LIST (September 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2017						
01.09	Performance Report	STF position – How does the Trust compare nationally – Mr Bond to circulate	LB	Oct 2017		
02.09	Young Health Champions	Trust to review how it captures its corporate social responsibility	CR	Nov 2017		
03.09	Workforce Race Equality Standard	To be included in the Board development programme to allow more discussion	CR	TBC		
04.09	Cultural Transformation	To be included in the Board development programme	CR	TBC		
05.09	Health and Safety	Feed back to be received regarding issues relating to hoists on wards	LB	Oct 2017		
August 2017						
01.08	CEO Report	Service Resilience Report to be received	CR	Nov 2017		
02.08	Guardian of Safe Working Report	Non-Executive briefing to be set up	RT	Nov 2017		
03.08		Review of other Trust's medical safe staffing reports/Development of a Trust report	CR/KP	Dec 2017		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB			To be included in the IM&T Strategy
COMPLETED						
August 2017	BAF	Top 5 risks to be communicated in a more visual way	CR	Oct 2017		Included in BAF paper Oct 2017

Actions referred to other Committees

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

September 2017

2017 Doctors Conference

Over 170 people attended the Doctors Conference on Friday 15th September, at the University of Hull. Medics of all grades and specialties networked with one another and the Executive team to discuss issues which are currently affecting both our organisation and the NHS as a whole.

Key speaker, Roy Lilley, a prolific NHS blogger and commentator, and recognised by the Health Service Journal as one of the most influential people in the NHS today, addressed the conference for almost an hour. His talk challenged everyone in the room to consider how we work together to ensure the NHS continues to care for our children and grandchildren in a difficult financial environment; offering the optimistic view that change is possible if we're prepared to radically look at how we deliver some of our services.

A series of workshops on issues ranging from Human Factors, financial contracting for services, the WHO Surgical Checklist, the new ReSPECT initiative and Greatix, which encourages staff to learn from excellence, all received excellent feedback.

Missed appointments having a significant financial impact

In order to tackle the issue of patients failing to attend appointments, we have launched a poster campaign in outpatients to remind people of the real cost of missed appointments. Beyond the financial implications missed appointments have an impact on patients who may have been offered earlier slots.

This is an issue which we recognise requires action and we are working on ensuring the DNA rate improves.

Patient experience in our outpatient departments remains positive however. Only last month the Secretary of State wrote to the Trust congratulating staff on their excellent Friends and Family Test feedback.

Canine Partners bring cheer to hospital patients

For most hospital patients, visits to the ward tend to come from the doctor, a therapist, friends or loved ones. Elderly patients spending time on Ward 9 at Hull Royal infirmary, however, are now receiving visits from a new four-legged friend.

Nudel is an 14-month-old Labradoodle who is training to be an assistance dog with Canine Partners. Once a month, Nudel and her Puppy Parent, Mike Cormack, come on to the ward to raise a smile among patients and give Nudel herself experience of socialising in different environments.

Once fully trained, Nudel will be matched with an appropriate owner who requires help with daily tasks; often this is someone living with a long term health condition such as Multiple Sclerosis or Muscular Dystrophy, or it could be someone who has been injured in military service.

In the meantime, Nudel is serving as a welcome talking point among patients and staff, and bringing enjoyment to those patients who may be temporarily parted from their own pets.

The Royal College of Nursing is currently drawing up guidelines for medical institutions on how to use animal therapy safely and effectively in order to benefit patients. In a survey carried out last year, 82% of nurses surveyed by the RCN said animals could help patients be more physically active and 60% said they believed animals improved physical recovery.

Eye care experts receive an active introduction to Hull!
Local hospital staff gave national conference delegates arriving in Hull this September a more unusual welcome to the city.

Hundreds of eye specialists convened for the BIPOSA (British Isles Paediatric Ophthalmology and Strabismus Association) 11th annual conference, held in Hull in celebration of the 2017 City of Culture Year.

Healthcare staff gave a warm and healthy welcome to visitors in the form of a 5km run around the city centre. This gave us the perfect opportunity to show off some of the sights of our city on a route which took runners from Hull City Hall, where the conference was being held, through the old town and marina before heading back to the City Hall past Hull College and through Queen's Gardens.

Hats off to local knitters!
Staff at Hull Women and Children's Hospital have been overwhelmed by kindness following an appeal for help on facebook.

Ward Housekeeper, Sarah Hames, issued the call-out via the hospital's facebook page after the Labour and Delivery Ward began to run short of knitted hats for newborns.

Within hours, the appeal had been shared far and wide, reaching in excess of 215,000 people in the first 24 hours. And the buzz created by the post has now translated into hundreds of new baby hats, bundles of which are continuing to arrive daily at the Women and Children's Hospital.

Over 500 knitted hats have already been received since the original request was made two weeks ago.

"It's the greatest gift you can give"
One person could save or transform the lives of up to nine others – that was the message during Organ Donation Week (4-10 September) when Specialist Nurses encouraged people to discuss their wishes with loved ones.

Alex Wray, Raz Igasan and Sarah Plant, all Specialist Nurses in Organ Donation, work across the Emergency Department and two Intensive Care Units at Hull Royal Infirmary and Castle Hill Hospital. The team coordinates transplants between patients from this area and suitable matches across the country, and their work has contributed to some 381 people across the Yorkshire and Humber region receiving organ transplants in 2016/17.

Research carried out by NHS Blood and Transplant shows that more than 80% of people support organ donation but fewer than half (49%) have ever talked about it.

In a bid to raise awareness and get those conversations started between friends and loved ones this week, our team of unveiled a fire engine in partnership with Humberside Fire and Rescue, fully wrapped in the 'Yes I donate' branding.

Staff take part in Hull Marathon to raise money for patients' rooftop garden
Ward 26 at Castle Hill Hospital has been nominated as one of two Lord Mayor's Charities for 2017. Lord Mayor of Hull, Cllr John Hewitt, would like to raise money to provide a rooftop

garden for the cardiac patients spending time on wards 26 and 27, and staff and supporters are determined to make it happen.

Funds are already racing in after the ward put up two teams to run in the Hull Marathon and bBetween them, they have raised more than £600 through this one event.

Other fundraising ideas are also in the pipeline including cabaret nights and a music quiz, plus the Lord Mayor's Charity Ball on 13th April where, among other things, Chief Executive Chris Long will be raffled off to spend a day working with one lucky person in their department!

First timer or know the ropes? There's still more you can learn
Having a baby can be an exciting and daunting life event at the best of times. During September health experts from across the area came together to host a series of drop-ins to help new and expectant parents.

From hypnobirth and fitting a car seat correctly to using the new Fatima Allam Birth Centre, experts from various agencies, community and support groups convened for the HEY Baby carousel event. This was deemed to be a great success and may now be repeated again next year.

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 September we received 34 Moments of Magic nominations:

Elaine Pardoe and Dr Sameh	After my partner fell and badly cut his face, he was sent to plastics outpatients via MIU at Beverley. Between Elaine and Dr Sameh, they were able to assess his wound(s), clean him up, explain what they needed to do, take consent, take him to theatre to adminster local anaesthetic before stitching him up (very neatly and sensitively) and sending him on his way - all in a very short space of time too. Throughout the process, they treated him in a very respectful way, using humour appropriately to try and lighten what was a worrying time for him and explaining everything very clearly. The attention to detail was brilliant, cleaning and dressing other wounds on his arms and knees as well as dealing with the main issue he had attended with. Communication was excellent, he was asked multiple times whether he had any questions and to confirm he understood what was going to happen. All of the theatre staff put him at ease and even allowed me to sit in with him for support while he was sutured, and made me feel very welcome in doing so. As we left, we were even given a few dressing changes to take with us for some of his larger cuts. The team	**30/08/2017**

	genuinely made us both feel important and instilled a real sense of confidence. Two weeks later, his stitches have been removed and Dr Sameh made such a neat job, you can barely tell they were there. Thank you to the whole plastics outpatient team involved in his care that day, but in particular Elaine and Dr Sameh for treating us both with courtesy, kindness and respect.	
Leah Arnell	Leah was helping deal with a very difficult patient in A&E, the way she helped to defuse the situation, and calmed the patient is to be applauded. None of the other staff could get near the patient, she would not respond to any security staff or nursing staff, but Leah struck up a rapport with the patient and went above the normal expectations of the job.	**29/08/2017**
All the staff at the HRI day surgery unit	Its difficult seeing anyone unwell but when it is your own child its even harder. 11 years of nursing within this trust could not prepare me for the feelings of taking your child into the operating theatre to be anaesthetised. I wish to say a very big thank you to all the staff on the day surgery unit and especially the very attentive anaesthetist (I didn't catch his name fighting back the tears) He was very caring and nothing was too much for him, he supported me and my daughter and I felt at ease leaving her in his capable hands. thank you so very much my daughter has made a full recovery and I think the bowl of coco pops and toast helped her recovery. You are all Diamonds	**27/08/2017**
Sally Hill	There are many Moments of Magic when Sally Hill is around in Radiology Theatres at HRI. The team would like to nominate her for all the team building and fund raising work she does. Sally is our unofficial 'social secretary', organising dinners and nights out (usually with great discounts). Sally organises us all to bake (and buy, and eat) cakes for sale, as well as tombolas to raise funds for various charities. We like cake, and we love Sally for bringing us all (staff and patients) together in this way, and we want to nominate her to show her our appreciation.	**24/08/2017**
Sara Preston-Todd	Sara went out to see a patient in the community who had recently been through a really difficult time - her social-circumstance had changed, and she was feeling more isolated as her husband had gone into care. Sara had expected to see the patient for on-going rehab, but the patient was slumped in a chair and began to tell Sara than she felt as though she had lost all motivation, felt guilty about hers and her husbands situation, and didn't want to participate in further rehab.	**24/08/2017**

	Despite having a very busy diary, Sara spent a large slot of time doing positive-reinforcement and motivation work with the patient and a family member - and in the end, the patient had a renewed vigour, mobilised into her kitchen and completed the rehab work. The patient thanked Sara, and actually said that her visit had lifted her no-end and made her feel positive for the future. I think the psychosocial side of community work is often forgotten by people looking into community-teams - but it is often just as, sometimes more, important than the physical rehab. This is a moment of magic, as Sara chose to spend the extra time trying to help the patient - she could have easily felt pressured by her diary commitments, but her caring and compassionate side won vs caseload pressures! What should have been a 30 minute intervention, ended up being closer to 90 - but the extra time spent was worth it.	
Anna Clappinson and Victoria Phillips-McConville	The senior midwife on duty with two junior midwives during a night shift would like recognition to them for their passion, commitment and ability to work under pressure. Priotising their work load and supporting her when she was called to support a deteriating patient. The two junior staff managed the area and provided care to the senior midwives patients until she was in a position to provide the cares required.. As newly qualified midwives they showed true passion for the cae of women and their babies and provided the highest standard of care to all.	**23/08/2017**
Helen Lyon	Helen has recently been appointed as the junior sister for the 13th floor (Paediatrics). During her first week in the role there was a staffing shortfall on Paediatric High Dependency due to short-term sickness leaving a junior member of staff on a night shift without a nurse in charge. The senior sister was on annual leave. Having exhausted all other possible options Helen was contacted by the staff on PHDU. Helen was at her elderly mum's house getting her washed and ready for bed, after having recently being discharged from hospital after a fall. Despite the fact Helen was upset and concerned for her mum and that she had also had to let both of her daughters down with their pre-arranged plans, Helen agreed to come in to work and do the night shift so that the patient's on PHDU would be safe. Not only did Helen work that night shift but ended up covering the next two night shifts to cover the shortfalls due to sickness. Helen went over and above the call of duty, putting work and the safety of her patients above that of her own family. Without this act of dedication and kindness, the sick children on PHDU would not have received the care that they required	**21/08/2017**

	and their safety would have been compromised. Thank you Helen for this amazing moment of magic which was very much appreciated.	
Stoma Nurses	The stoma nurses have a very unique and difficult role to play in that nobody wants the wares that they peddle and yet they have to remain being professional and pleasant throughout their patient interactions. They need to be fully cognisant of each patient's mental and physical state at any time of the day. I have met ALL of the stoma nurses at Castle Hill and they ALL satisfy their roles in bucket loads. This is why I am nominating the Dept as a whole. Every stoma nurse knew when to approach me to help with a bag empty or change, or when to just give me some reassuring words and leave me to my sepsis lows. I was never pushed into doing anything I didn't feel up to and it was very clear that whenever I did feel up to it they would be there – absolutely - no problems at all! So, they were there with me from the day after my major bowel operation (during which I was given the temporary ileostomy), and during my very weak and down periods offering reassurance and emptying and changing the bag for me as required. This was at least one thing I could stop worrying about. Under their encouragement and guidance, I was fairly quickly able to empty and change my own bag as I regained mental and physical strength. I am now at home and have been visited a couple of times and receiving more assurance, advice and supplies. I have also visited them in their own Dept for further advice – it is freely given and I am made to feel welcome. I utterly despise my bag and have problems with it but I know if it gets too much then I can call the stoma nurses and they will be able to help me. I have not just been cast out of hospital and forgotten which is an immense relief. They make a very difficult job seem easy and they need to be recognised for the truly outstanding effort they put into every working day. Nobody wants a stoma and yet, thanks to this wonderful team, everyone goes away with the ability to empty and change it whereas just a few days before they couldn't even look at it and maybe were being physically sick whilst emptying and changing it. Thank you so much ladies and gentleman for your diligence, professionalism and genuine pleasantness.	**20/08/2017**
ED Team	On the night of the 19th aug I was coordinating the ED dept, within the 1st hour of the shift we received 4 trauma calls into the dept, and then a further 6 throughout the rest of the shift, with the rest of the areas including initial, majors and ECA also very busy. I would like to thank the whole ED team both doctors	**20/08/2017**

	and nurses (including the ICU nurse who was working with us for the shift... sorry I can't remember your name) for their hard work and commitment during this extremely busy shift, you all worked excellent as a team and where a credit to the dept	
Diane Clayton	Di Clayton on many occasions has helped several wards during staff shortages. Di has done so with a smile on her face and she has shown excellent team work as her place of work is The Patient Lounge; however she has stepped in on numerous occasions offering support to the wards and most importantly ensuring the patients receive high standards of care. Thank You so much for all your help and support, it is very much appreciated.	**19/08/2017**
Elaine, Nicky R, Angela, Claire M	My son Ryan broke his wrist on 11th august and had an appointment at the fracture clinic on Sunday the 13th. He was told he needed a certain type of cast then an xray to make sure its in place. Ryan was scared and in so much pain that day the staff was going to have there work cut out but they were amazing offering gas and air he refused as he had never had it before. Elaine ,Nicky R, Angela and Claire M you all deserve a gold medal working in the trust myself I can deal with a lot but when its your child it was upsetting to see. But Ryan braved it out with all of your support , comfort and explaining and you did it with compassion. And the xray was good , yesterday he had another xray and its still in place so no intervention needed. He is now smiling and happy he can go on holiday at the end of the month. Great team work by all i just wanted to do this for Ryan as I know he cant thank you all enough.	**19/08/2017**
Paul Walker	I was walking along the Surgical corridor at Castle Hill Hospital this morning on my way to C9 when I stopped to pick up a bit of plastic litter on the floor. A deep voice behind me boomed a friendly "Well done!" and congratulated me on taking the time. It was just lovely to meet Paul Walker from our Portering Team take a moment to let me know such a tiny thing was appreciated and to reflect on the kindred spirit of pride in our organisation. Thank you Paul - you made my day. I will never forget how good and kind our porters were when my son and mother were recent guests of our services staying at Hull Royal Infirmary. Our porters always were sensitive, positive, jovial and bright and provided a little levity during what were very serious stays for both of them. I know it may seem a little thing, but experiencing great care from all manner of staff over the little things as well as the big makes me proud indeed to be a part of our Trust and our	**18/08/2017**

	NHS.	
Kat Henry	We had an extremely anxious patient on the ward who was worried about not getting home in time for her 4pm care call. The IDL wasn't completed until 2pm leaving a very short window to get the meds dispensed and get transport booked. Kat was on bed management that day and ensured the meds where dispensed and on the ward for 15:30 when the transport, arrived meaning that the lady arrived home In time for her first care call. Kat is always so helpful and does whatever she can to support the ward staff, while always remaining upbeat and never complaining! Thank you Kat from everyone on ward 5!	**18/08/2017**
All staff in Antenatal Clinic & Antenatal Day Unit	I would like to nominate my Team of Midwives, Midwifery Assistants, Doctors, Clerical and Ancillary staff within the Antenatal Outpatient Department. Working within an extremely busy area of the Maternity services this Team have worked together under unprecedented high levels of staff absence and high patient acuity and changes over the last few months, they have all proven what caring and hard working individuals they all are and deserve to be recognised for their tremendous efforts. As a new manager within the department they have also supported me 100%, and have proven that they are all true leaders within their own department which has influenced the positive responses we have been receiving from Women and their families. Thank you all - we are a great Team x	**16/08/2017**
Paddy	Today one of the porters, Paddy, was transferring a patient from ED to the ward who was upset and anxious that her sister was made aware of what was happening and where she was. On arrival at the ward the patient became a little more distressed and rather than leave the patient getting increasingly distressed Paddy got his mobile phone out, asked the patient for her sister's number dialled it and then handed the phone to the patient. This resulted in the patient letting all of her emotion out whilst chatting to her sister. on finishing the call she was much calmer and no longer distressed. Well done Paddy, you didn't have to do what you did but you did the right thing at the right time and made a huge difference to the well being of that patient. Very proud	**16/08/2017**
David Wright and Amanda Harrison	A huge well done to David Wright CSW endoscopy HRI for completing his care certificate , and to Amanda Harrison for supporting him with this. Great Job !!!!	**15/08/2017**

Karen Lamb	Karen has been there for myself personally from the day I started my housekeepers role. I didn't know the first thing about how to order items, which could of had catastrophic consequences if it weren't for Karen. If I had any difficulties Karen would do whatever she could to help, whether this meant loaning me stock until we received our order or being able to give me names and telephone numbers of contacts she knew would be able to assist Karen has always gone the extra mile. I think Karen being mentioned for a Moment of Magic is a fine way to say Thank you Karen it is greatly appreciated.	**15/08/2017**

Claire Whittleton	Claire is amazing with all patients and staff, however, I want to share how amazing she is with the ladies that arrive on the ward that are extremely anxious. The compassion that she gives really is outstanding she discusses what will be happening and what they should expect but does it in such a way the patients automatically feel at ease. if patients are tearful/scared she has the ability to comfort them which has an impact on the patients that are also in the area. We want Claire to know just how much we recognise what she does as she is moving on to pastures new. Good Luck Claire, not just Cedar Ward but the Trust will miss you dearly.	**15/08/2017**
Josh Woolhouse	Josh is always dependable, reliable & helpful. I know when Josh is on duty he will always support ECA . Friendly to patients, relatives & staff and a pleasure to work with. During one busy night shift he spent a long time ringing round the hostels to try obtain a bed a man who wasn't even a patient. Josh is a credit to the team.	**15/08/2017**
Glen Morris	Glen is an unsung hero within portering, no job is to much trouble for him. He always shows respect and caring towards the patients. He comes in to work and works as hard as he can for his whole shift, he is flexible and happy to swap shifts to help the service. He never moans about anything or anyone. I feel this type of staff should be recognised and praised. Well done Glen.	**14/08/2017**
Dr Sheeraz Khan	I would like to nominate Dr Sheeraz Khan for a moment of magic, he is always full of smiles and pleasantly gets on with his duties. Despite his workload during the shift he remains externally calm and is a pleasure to work with he remains approachable at all times. Following the sudden deterioration of a child on the ward Dr Khan coped remarkably well and once the	**13/08/2017**

	child was stabilized and transferred safely he returned to the ward to ensure the nurses felt well supported and did not require any further support, showing his caring nature. We are lucky to have Dr Khan as a senior member of our team.	
Natalie N	This lady works extremely hard always seems to be rushed off her feet but no job is too hard or too big for her. Very caring and kind passionate girl with a big heart. Wish her the world of luck - I hope everyone gets to experience the wonderful experience I received from her.	**12/08/2017**
Ash Ali	Thank you Ash for making me feel at ease in A&E when my husband had his stroke. no Question was to much, she was approachable and really supportive.	**10/08/2017**
Dr Chhokar	I would like to nominate Dr Chhokar for a moment of magic. Dr Chhokar always goes above on beyond for patients and has an excellent bedside manner. Dr Chhokar gives all of his patients clear and informative explanations offering reasuurance and support throughout consultations. Dr Chhokar is also a supportive colleague he has recently encouraged and supported me to gain a competency which will be of great value to my current role. Not only is Dr Chhokar helping me to achieve this competency which will help with patient care but he has also contacted various collegues to ensure I gain the competency following the correct regulated guidance. I just want to see a big thank you for all of your help	**08/08/2017**
Lewis Nozedar and Sarah Sidwell	Ward 9 staff & patients would like to nominate Lewis & Sarah for organising an exercise class on the ward. Following a discussion with the ward 9 HRI team & consultants we wanted to try something different that would be both enjoyable but also beneficial to the patients in engaging with the therapists. Lewis & Sarah then organised a group exercise class with the patients to music therapy. A group of around 10 patients participated including a bed bound patient this included kicking a ball, throwing a balloon to each other, using exercise bands and movement to music. The reaction from the patients was unbelievable, the smiles on their faces proved the benefits, the singing to music continued throughout the afternoon and they was all very quick to inform the their relatives & already looking forward to the next session. Staff too also witnessed the benefits as the mood lifted on the ward. Ward 9 would like to thank Sarah & Lewis for the time & effort taken to organise this and we really hope it	**07/08/2017**

	won't be the last	
Anne Burdis and her team	I feel that Anne Burdis and the Education & Development team should be recognised for their incredible success with the Trust Apprentice Programme. They have won several awards over the past few years yet recognition appears to be slow in coming. To give an idea, the team have won several accolades in the 2017 and 2016 Talent for Care Awards, along with several other regional events that I am aware of and much positive media interest around the trust Apprentices. (taking an interest as they have helped our department recruit apprentices); Talent for Care 2017 Intermediate Clinical Apprentice of the Year – Won Intermediate Non-Clinical Apprentice of the Year – Won Advanced/Higher Clinical Apprentice of the Year – Won Advanced/Higher Non-Clinical Apprentice of the Year – Won Support Staff Learner Awards – Won Learner who has made the most impact, the “Rising Star” – Runner up Employer of the Year – Runner up The 2016 Talent for Care awards was a pretty eventful night for the team as well... Intermediate Non-Clinical Apprentice of the Year – Won Advanced/Higher Non-Clinical Apprentice of the Year – Won Partnership of the Year - Won Ambassador/Mentor of the Year – Runner Up This is certainly a team effort by the Education Department but my understanding is that Anne Burdis heads up the team, with support from Debbie Elton and Dan Bond.	**07/08/2017**
Ashley Laverack and Emma Rugg	On his way into work on 04/08/17 Ashley found a lady sat on the floor clearly in distress near the hospital, still with hospital slipper socks on. Ashley stopped and asked the lady if she was ok and she shook her head still very upset. At this point Emma, also on her way to work stopped to assist Ashley and they managed to reassure the lady who spoke very little English, as they ascertained she was Romanian. They managed to escort the lady to back to the hospital where they left her in the capable hand of reception staff. Both staff showed compassion and thoughtfulness in getting this lady back to a place of safety, Well done!	**04/08/2017**
Denise Benfield, Lynn Foulson, Nanette Giger, Marilyn Kingdom, Becky Bramall, Debbie Kemp, Eileen Carrott, Jo	I would like to show appreciation to all the staff in POPD outpatients who work tirelessly to both juggle daycase procedures, phlebotomy services and general day to day clinic. No job is too big and their work ethic is commendable. They look after chronic children within hull and east Yorkshire and build such a repour to those children that the visit isn't "as scary now". They have had staffing changes both in sickness and holiday cover and still they smile. They have skilled	**03/08/2017**

	reliable bank staff who also have gone above and beyond hours and days to not only support the staff but the patient workload. whilst the reception team work tirelessly on the busy phone solving any and every query still with a smile as others walk in the door. no matter the challenge..including computer Lorenzo trouble. They are true asset to the department. The atmosphere and department runs because of them!!! They all should be proud.	
Louise Patterson	Louise constantly has a smile on her face, no matter what situation she is in and how stressed she is! she is honestly a credit to the ward and a fantastic nurse.	**03/08/2017**
Chelsea Muszynski	I would like to nominate Chelsea for a moment of magic. She has been covering in the Ecg admin office in the Cardiology department and I would like to say how helpful she has been. She replies to all my e mails and is always wanting to help if I need anything from her. She is always cheerful and has a smile on her face . I am sure all the Co-ordinators in the Cardiology Secretaries office would all agree with me	**02/08/2017**
Zoe Gregory	There is no one particular moment of magic but Zoe goes above and beyond her role of hygienist every day. She has been known to sit with patients with dementia, holding their hand, comforting them. Always friendly and cheerful to all the patients, nothing is too much trouble. She has also done endless fund raising for the ward and is a great team player, always willing to help anyone	**02/08/2017**
Jayne Hackett	I was working in triage in Emergency Care and Jayne was on reception. A patient had booked in with her assistance and he came up as green on the system (indicating that he did not require triage). On looking at the patient and glancing at the letter she used to obtain their details, Jayne thought the patient did not look well and immediately brought the patient to my attention by bringing me their letter in triage and asking that I assess them next. On assessing the patient, Jayne was right and he was not well at all. The patient ended up being transferred to resus for treatment and ultimately ended up admitted to intensive care. Jayne always goes above and beyond for our patients, whether it is flagging things up the nursing staff or getting a patient a blanket or a pillow for their comfort. She is always smiley, polite and kind with everyone she comes into contact with and makes the department a better place for it. Thank you Jayne!	**02/08/2017**

Nick Gregory	Last year Nick left our Programme as Programme Manager however still had involvement within the department due to being our new Business Manager. Unfortunately our new Programme Manager had been absent for a large period of time at once and during this time Nick stood up and stepped in to help the Programme and the newly appointed Data and Technical Manager to assure the smooth running of the programme, as well as dealing with his busy daily duties of being Business Manager. During this time Nick worked well over his hours, including sending emails early hours into the morning showing how committed and dedicated he is to the work that he provides. He has always gone above and beyond and has everyone else's best interests at heart, trying to cater to all, which is a very challenging task. He had to also tackle an issue with a lot of staff morale as this was running very low and within such a short period of time Nick was able to turn this around and enable everyone to feel part of a team again. There is so much that Nick has helped with over the last few months that it's hard to pick out or cut down to a reasonable size to type, however I would like to personally thank him for all of his efforts over this period, it has been greatly appreciated and I know that many others within the department would also agree.	**02/08/2017**
Susan Johnson	Sue is a Ward Clerk on Cedar Ward who never fails to make people smile, myself more than others. She is always rushing to collect patient notes, which at her age isn't always easy and will assist if assistance is needed. Even though the ward clerks office is at the other side of the waiting room we very much class Sue as a main part of our team.	**01/08/2017**

HEY LONG TERM GOALS - August 2017 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance August	Trend v Previous Month
R	Never Events	0	2	↑
G	Complaints (QIP - closed within 40 working days)	90%	92.30%	↑
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	53	18	↑
R	Safety Thermometer - Harm Free Care	95%	93.66%	↓
R	Venous Thromboembolism (VTE) Risk Assessment (Q1)	95%	92.13%	→
G	Mortality - HSMR (June 17)	<100	79.1	↓
G	Friends & Family Test - Inpatients (July 17 - Trust v National %)	95.90%	98.70%	↓
G	Friends & Family Test - Emergency Department (July 17 - Trust v National %)	85.90%	86.20%	↑

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	1
Corporate Non-Clinical Risks	3

Workforce

RAG	Indicator	Target	Performance August	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	10.20%	↑
G	Staff Sickness	<3.9%	3.75%	↑
R	Staff Vacancies	<5.0%	6.49%	↓
R	Staff WTE in post (<0.5% from Plan)	7164	7115	↑
R	Staff Appraisals - AFC Staff	85%	82.40%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	90.00%	↑
G	Statutory/Mandatory Training	85%	89.70%	↑
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£1.9m	£2.7m	↑
R	Staff: Friends & Family Test - Place of Work (Q4 1617 v Q1 1718)	66%	64%	↓
G	Staff: Friends & Family Test - Place of Care (Q4 1617 v Q1 1718)	80%	81%	↑

Category	No. of Risks Rated 15 and above
Corporate Staffing Risks	7
Corporate Clinical Risks	1

Performance

RAG	Indicator	Target	STF Trajectory	Performance August	Trend v Previous Month
G	18 Weeks Referral To Treatment (92%)	92%	85.90%	85.91%	↑
R	52 Week Referral To Treatment Breaches (zero)	0	0	2	↓
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	2.60%	8.24%	↑
G	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	92.00%	↓
R	Cancer: 62 Days Referral To Treatment (85%) (June Data)	85%	83.00%	80.20%	↓
G	Length of Stay (<5.2)	<5.2	-	4.7	↓
R	Clearance Times	12 weeks	-	13	→
R	Waiting List Size	51,592	-	55,131	↑
R	Clinic Utilisation	80%	-	60.10%	↑
R	Theatre Utilisation	90%	-	80.90%	↓
G	E-Referrals (Q2 target v current performance)	80%	-	86.0%	↑
R	Appointment Slot Issues (June)	35% (TBC)	-	37.76%	↓

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

Finance

RAG	Indicator	Target	Performance August	Trend v Previous Month
G	Capital Expenditure	3.7	5.6	↑
R	Statement of Comprehensive Income Plan - Year to Date	-2.8	-9.1	↑
R	CRES Achievement Against Plan	5.4	3.2	↑
R	Invoices paid within target - Non NHS	95%	44%	↓
R	Invoices paid within target - NHS	95%	34%	↑
R	Risk Rating	3	4	→

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT AUGUST 2017

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 - 8
Director	Mike Wright, Chief Nurse	**Authors**	Mike Wright, Chief Nurse Kevin Phillips, Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

Type of report	Concept paper		Strategic options		Business case	
	Performance	Y	Information		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	**Raises Equalities**	**Legal advice**	**Raises sustainability**		
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
AUGUST 2017

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- The National Reporting and Learning System (NRLS)
- Safeguarding Annual Reports
- Mortality

The Trust Board is requested to receive this report and:

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

TRUST BOARD QUALITY REPORT
AUGUST 2017

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- The National Reporting and Learning System (NRLS)
- Safeguarding Annual Reports
- Mortality

The Trust Board is requested to receive this report and:

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

This report covers the reporting period for the month of August 2017. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events

The Trust declared 2 Never Events in August; the first Never Events to be reported by this organisation since September 2016. A further Never Event has been declared in September, bringing the total this financial year to three. The Never Events are described in the table at section 2.1.1. All three are within the Surgery Health Group.

All three patients involved are aware of the incidents and each is being supported accordingly. Duty of Candour obligations have been met, also. Furthermore, the Care Quality Commission, NHS Improvement and the Trust's commissioners have each been advised of these incidents

Investigation panels have been formed and are now underway, led by the Chief Nurse and Chief Medical Officer. Debriefings have been held with staff involved and statements have been gathered. The Chief Medical Officer briefed all consultants at their conference on 15th September 2017 about these three incidents. A dedicated Quality and Safety Bulletin has been drafted and is about to be circulated in order to raise awareness across the organisation of these incidents. Whilst all theatres and anaesthetic staff have been advised of these matters already, the next audit afternoon planned for theatres in October 2017 is being dedicated to briefing sessions at both HRI and CHH. These will be led by Directors, in order to brief all staff more fully on the events and consider any associated measures to help prevent a recurrence.

2.1.1 Serious Incidents declared in August 2017

The Trust declared nine Serious Incidents in August 2017. All of these are in the process of being investigated fully. These are summarised in the following table, with the addition of the September Never Event.

Ref Number	Type of SI	Health Group
21593	**Never Event – Wrong implant fitted** During a total knee replacement, the patient received the wrong type of bearing in relation to the fitted implant.	Surgery
20044	**Never Event – Wrong Site Surgery** Wrong site operation undertaken on a patient's elbow	Surgery
22899 (September 2017)	**Never Event – Wrong Site Surgery** Wrong site operation undertaken on a patient's rib	Surgery
21253	**Treatment Delay** Patient did not receive a timely appointment within Gastroenterology and has presented back with advanced symptoms	Surgery
20927	**Obstetric Incident** Following a normal birth of twins a second placenta was not delivered until two days later.	Family and Women's
20889	**Treatment Delay** A ladies abnormal smear result were available before surgery but were not acted upon	Family and Women's
20776	**Treatment Delay** A patient had a chest x-ray showing abnormal results but these were not acted upon	Surgery
20025	**Treatment Delay/Unexpected Death** Potential delayed treatment as patient did not receive escalation to senior review	Medicine
19806	**Sub-optimal care/Unexpected Death** Patient had an unexpected stroke while an in-patient	Medicine
19593	**Hospital acquired pressure ulcer** Patient developed an unstageable pressure ulcer	Medicine

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 Trust Board will recall that this report contained benchmarking information previously that was prepared by the Improvement Academy at the Yorkshire and The Humber Academic Health Sciences Network. However, this stopped in March 2017. It has transpired subsequently that NHS Digital has removed the Safety Thermometer from the mandatory data submissions list, which now means this is not data that is required to be submitted centrally and is, therefore, optional for trusts to carry out.

This Trust gets good information about the four main categories of patient harm and trends therein and will continue to carry out the monthly audits to help drive improvements in patient care. Following discussion with NHS Improvement and the Care Quality Commission, each has suggested that they would expect trusts to be continuing with the ST work as part of aiming to improve continuously. This has helped to validate the Trust's decision.

In terms of presenting this information in the future, the HEY Improvement Team is assisting with the development of Statistical Process Control charts for this purpose and these will be included

in due course. There is no report for August 2017, due to an administrative error. However, this will be back on track for the September report.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2017/18 as at 31st August 2017

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

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**18 (34% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0**
MSSA bacteraemia	**44**	**16 (36% of threshold)**
E.coli bacteraemia	**73**	**41 (56% of threshold)**

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

4.1.1. *Clostridium difficile*

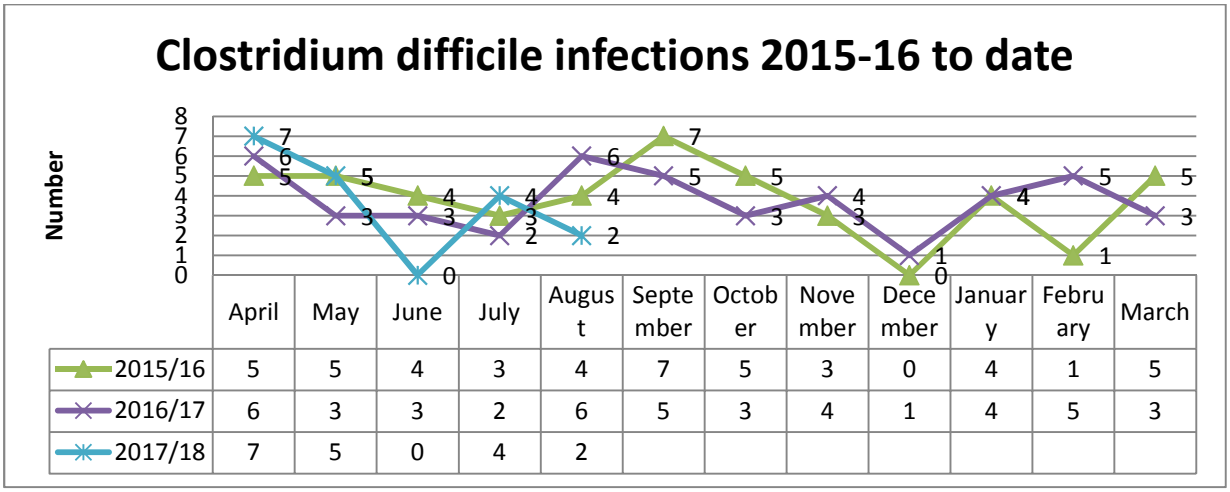
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and 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 shared collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

To date this financial year, at Month 5, the Trust is reporting 18 infections against an upper threshold of 53 (34% of threshold). Two Trust-apportioned *C.difficile* cases were reported during August 2017; one case in the Medical Health Group and one in the Clinical Support Health Group.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**18** (34% of threshold)	2 cases reported during August 2017 1 is subject to RCA investigation commenced 1 RCA completed and determined as no lapse in practice

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Cases to date x 1	Antibiotics implicated and not prescribed in line with Trust guidance. No prescribing advice sought from Infectious Diseases (ID)/ Microbiology	Review of RCA findings shared with medical/ nursing teams responsible for patient. Need for collaborative approach to patient management/ liaison with ID/ Micro for antimicrobial advice	ID team liaison with Oncology Medical Staff and undertaking ward round/ review of patients requiring antibiotics Training at ward level to medical/ nursing staff

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							

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

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

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

4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

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

However, MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds. MSSA can cause serious

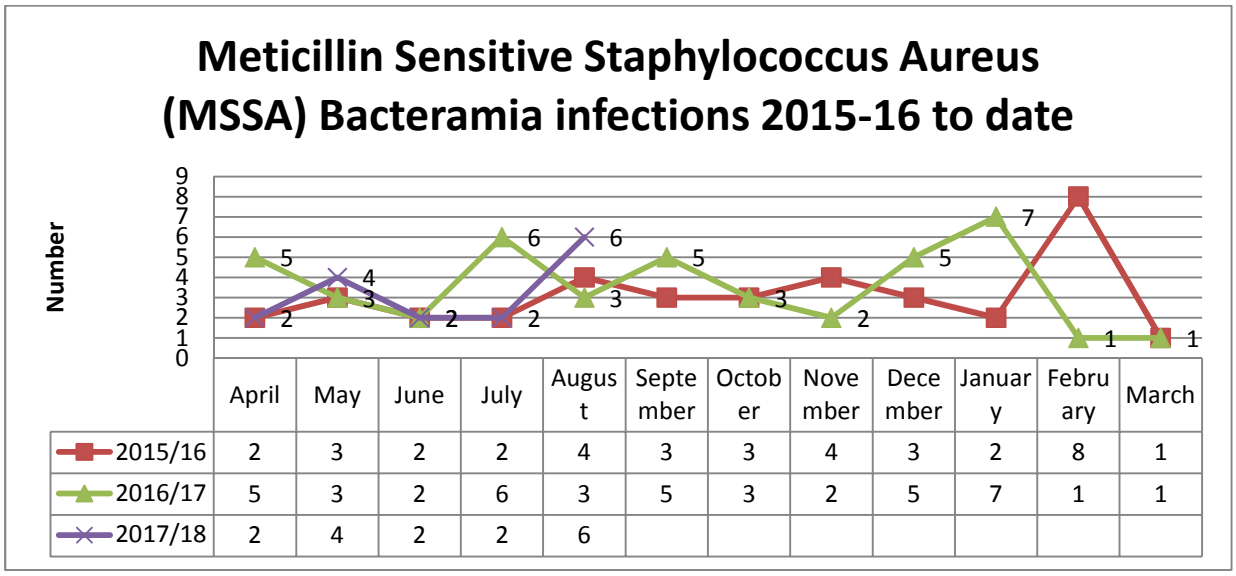
infections called septicaemia (blood poisoning) where it gets into the bloodstream. However unlike MRSA, MSSA is more sensitive to antibiotics and therefore easier to treat, usually.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	**44**	**16** (36% of threshold)	8 unavoidable 6 possibly avoidable 2 avoidable
Lapses in practice/ Evidence of suboptimal practice	**Reason for lapses in practice/ suboptimal practice**	**Lessons learned/ Identified learning**	**Actions**
Avoidable to date x 2	• Suboptimal insertion and ongoing management of peripheral cannula • Awaiting completion of RCA process	Review of RCA findings shared with medical/ nursing teams responsible for patient Clinical area including medical and nursing staff to have update on PVC insertion & management Patient with advanced cancer, noted to have cellulitis to forearm following cannula site infection.	Review of Peripheral Venous Cannula documentation/ Visual Indication of Phlebitis (VIP) charts/ localised education regarding insertion and management
Possibly avoidable to date x 6	• Blood culture taking technique • Possible sub optimal technique associated with PICC and insertion of duodenal stent (documented aseptic technique followed) • Post-operative deep tissue/wound infection but high risk bariatric surgery • Awaiting completion of RCA process	Review of RCA findings shared with medical/ nursing teams responsible for patient Review of technique amongst medical staff including juniors on unit Review of RCA findings and fed back to medical teams responsible for patient Major head and neck surgery with flap – post op wound MSSA positive Patient admitted with extensive skin rash but	Teaching and audit of practice should incidence occur again. Teaching and audit of practice should incidence occur again. Reinforce and mitigate risks associated with bariatric surgery

	• Awaiting completion of RCA process • Awaiting completion of RCA process	possible infected peripheral cannula site. MSSA cultured from cannula site Patient with advanced cancer, pleural effusion, respiratory consolidation on admission, requiring chest drain possibly source but not confirmed microbiologically	

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

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



4.1.4 *Escherichia-coli* Bacteraemia

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

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

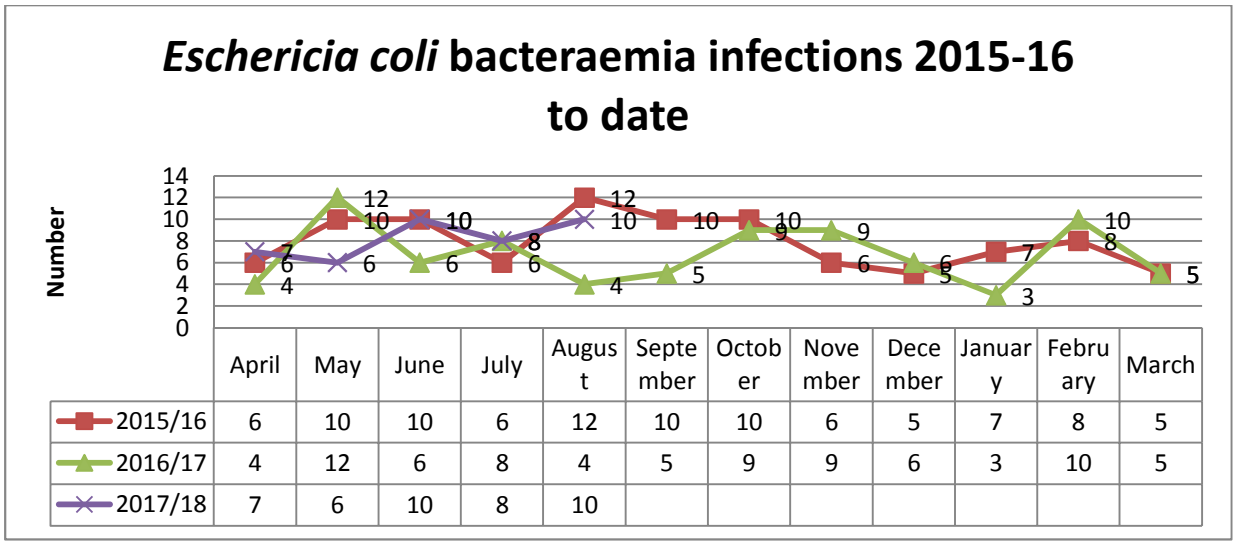
During 2017/18, Trusts will be required by NHS Improvement to achieve a 10% reduction in E. coli bacteraemia cases from the previous year's total. Achievement of reductions will be through collaborative working with commissioners and joint action plans as required by NHS

Improvement. A Trust improvement plan for *E.coli* and gram negative bacteraemia for 2017/18 has been drafted and shared with commissioners and this work is on-going. However, at Month 5, the Trust is already at 56% of its upper threshold with 41 cases, so the achievement of this objective is not looking likely at this time.

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)**	**41 (56% of threshold)**	41	1 x avoidable 3 x possibly avoidable 37 x unavoidable

***E. coli* bacteraemia cases**		
Source of Infection	**Number of Trust apportioned Cases**	**Additional Findings**
Biliary sepsis	12	Cholecystitis/cholangitis and also biliary malignancy
Urinary sepsis with or without indwelling catheter	11	3 with indwelling urinary catheters but complex ITU patients
Gastrointestinal	5	Perforated bowel/ peritonitis/ emergency GI surgery/
Respiratory	5	E.coli found in sputum – admitted with previous history of respiratory infections
Respiratory / Urinary	2	History of E.*coli* both in sputum and urine samples (2 bacteraemia results from same patient, separate admissions
Skin/ Soft tissue	2	Leg ulcers/ wounds culturing E.coli prior to admission
Hospital Acquired Pneumonia	1	Developed pneumonia during hospital admission (avoidable)
Osteomyelitis secondary to urinary source	1	Secondary to urinary source
Intravenous Drug User	1	Patient with infected abscess
Unknown	1	No known source identified

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

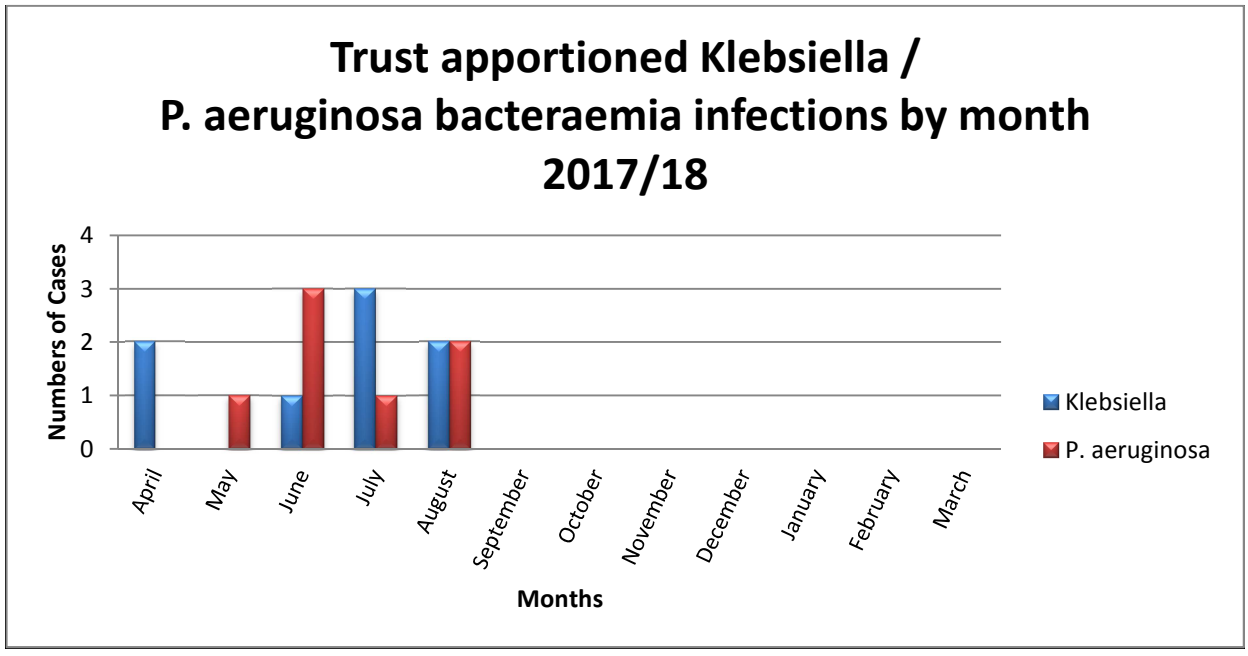


4.1.5 Gram negative bacteraemia – reporting for 2017/18

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

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

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



4.2 Infection Outbreaks

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

During August 2017, three wards had incidents involving patients with diarrhoea and vomiting; two occurring in medical elderly care areas and one in a renal ward, all resulting in bay closures

only. No causative organisms were identified. All areas were deep cleaned and reopened within 3-4 days.

4.2.1 Case of Pertussis (Whooping Cough) on Paediatric High Dependency Unit (PHDU)

A baby, admitted to PHDU via ED with respiratory deterioration on the 4th August 2017 was screened for Pertussis and found to be positive. Pertussis is highly infective. The baby had been isolated but staff had not instituted respiratory precautions initially until pertussis was considered as a possible diagnosis. The baby had a previous admission for apnoea (stopping breathing) episodes to PHDU via ED from the 24th July 2017 until the 31st July 2017. Liaison with Microbiology, Occupational Health and PHE followed. No other patients were exposed to the index case as the baby was isolated. However, a staff contact list was completed for all staff that had 1 hour or more cumulative contact with the baby, at less than 2 metres distance, with the inclusion of ED staff, too. This identified staff that met the criteria were provided with chemoprophylaxis and followed up by Occupational Health.

4.2.2 Case of Pseudomonas Aeruginosa Bacteraemia in the Neonatal Intensive Care Unit (NICU)

A Pseudomonas Aeruginosa bacteraemia was detected in a baby on NICU on 11th August 2017. The baby was born at 25-week's gestation and had multiple, complex health problems associated with extreme prematurity. The baby was very unwell at birth, regardless of the bacteraemia. Blood cultures were taken, which showed an evolving bacteraemia. A respiratory aspirate sample taken on 19th August 2017 also grew Pseudomonas aeruginosa, suggesting a respiratory source for the bacteraemia.

An incident meeting was held on the 23rd August 2017, including input from Public Health England. Sadly, the baby died on the 29th August 2017, with cause of death being associated with extreme prematurity and infection.

In line with national guidance regarding Pseudomonas Aeruginosa on augmented care units, an immediate investigation was undertaken to ascertain a possible source of the infection. No other babies on the unit were affected, although there had been a positive eye swab from another baby nursed on the unit previously, but this was not thought to be related.

Water systems were examined as potential sources of the infection as were environmental factors, although these all returned negative results. No further cases were detected on the unit. As such, the source of this infection was not able to be identified.

Water and environmental reviews will continue to be undertaken periodically on the unit as a safeguard.

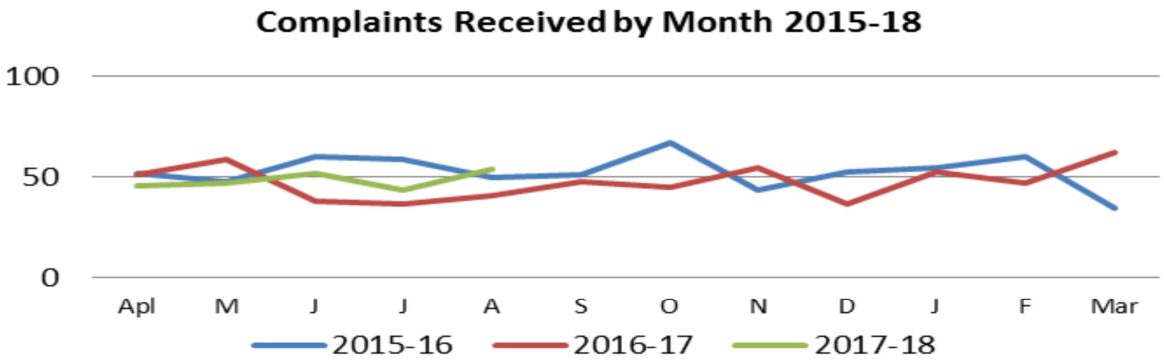
4.2.3 Influenza trends

There is nothing to report for August 2017 but preparations are in place ahead of flu vaccination season 2017/18, which is beginning presently.

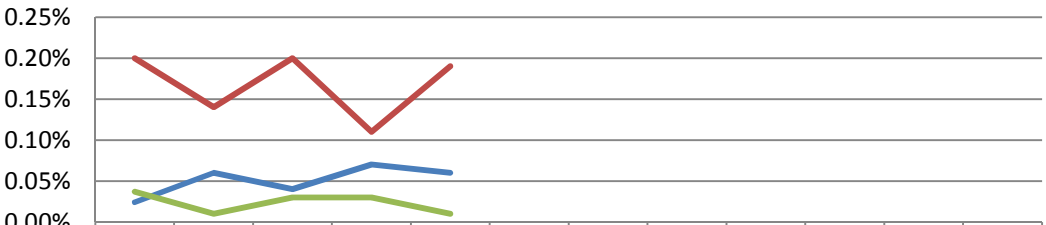
5. PATIENT EXPERIENCE

5.1 Complaints

The following graph sets out comparative complaints data from 2015 to date. There were 54 new complaints logged in August 2017, higher than for the same period in the previous two years and an increase from July 2017. There is no obvious reason for this trend but this will be monitored closely. Year to date, the rate of complaints received per month has been relatively stable.



Complaints as a Proportion of Episodes of Care



	Apl	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.02%	0.06%	0.04%	0.07%	0.06%							
IP Admissions	0.20%	0.14%	0.20%	0.11%	0.19%							
OP Activity	0.04%	0.01%	0.03%	0.03%	0.01%							

Although there has been a slight increase in complaints regarding inpatient care, there was no obvious theme. Complaints regarding outpatients remain low.

Complaints about 'treatment' continue to be the highest in number. The following table indicates the number of complaints by subject area that were received for each Health Group and corporate departments during the month of August 2017.

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancel	Discharge	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0
Clinical Support	0	0	0	1	0	1	2
Family and Women's	0	1	1	1	0	10	13
Medicine	2	0	3	1	2	15	23
Surgery	0	1	2	1	0	12	16
Totals:	2	2	6	4	2	38	54

5.1.2 Examples of outcomes from complaints closed this month:

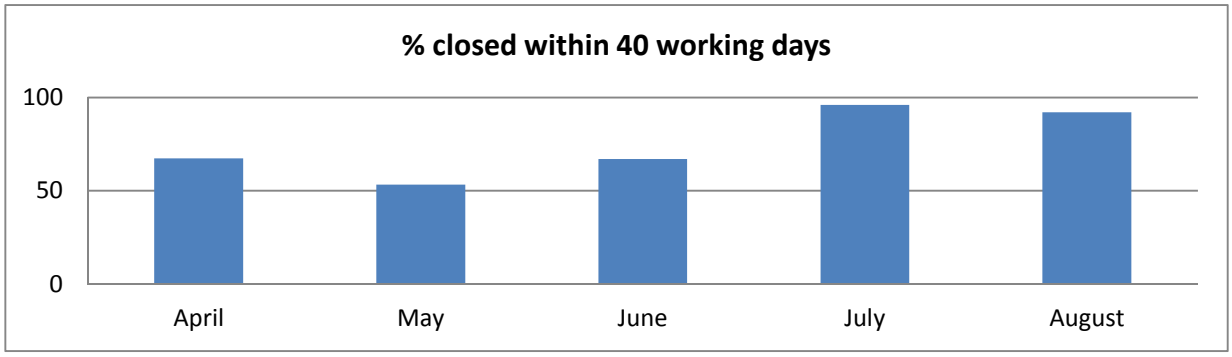
- A patient was very dissatisfied with the attitude of a consultant and asked not to be seen by him again.
  Action: The patient will be seen by a different consultant for the remainder of her consultations and treatment. The consultant has acknowledged his shortcomings in this regard and has apologised to the patient for any upset caused. The Medical Director for the health group will monitor this consultant's future patient interaction.

- The complainant believes that his wife was assaulted by security staff members whilst being returned to a ward after wandering away from the treatment area.
  Action: All actions taken by the staff involved were found to be lawful and appropriate. The complainant viewed the images on the video recording and agreed that no illegal force was used.

- The complainant was unhappy with elements of care during a procedure to deal with an ectopic pregnancy.
  Action: The Senior Matron has reminded staff that patients need to be made aware fully of the discharge process and that staff are to use single patient marker pens on patient dressings only to monitor any leakage. It has also been reiterated to staff that a cannula should only be removed in a clinical area.

5.1.3 Performance against the 40-day complaint response standard

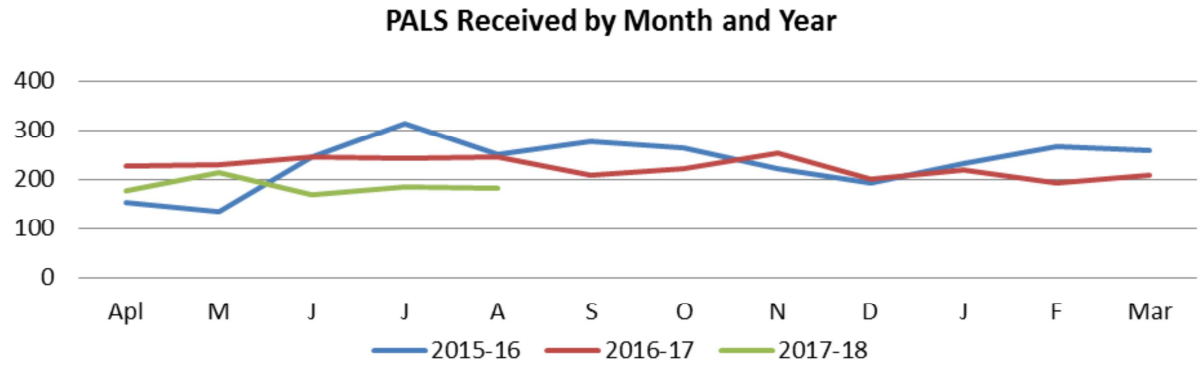
The following graph indicates the percentage of complaints closed within 40 working days of receipt. The Trust's target is for 90% of complaints to be closed within this timeframe. In the month of August, 92% of complaints were closed within 40 working days and, whilst this is a slight decrease from July, it shows an improvement over the previous quarter.



5.2 Patient Advice and Liaison Service (PALS)

In August 2017, PALS received 183 concerns, 28 compliments and 37 general advice issues, with an overall reduction when compared to the same period for the previous two years. The majority of concerns continue to be waiting times/cancellations, not satisfied with the treatment plan and cancellation of clinic appointments.

This graph shows that PALS contacts in 2017-18 have been relatively consistent each month, although over the last three months there has been a decrease in PALS contacts. It is possible that more of these have come in as complaints instead, which could explain the slight increase in complaints. There is no known explanation for the decrease; however staff will continue to monitor this.



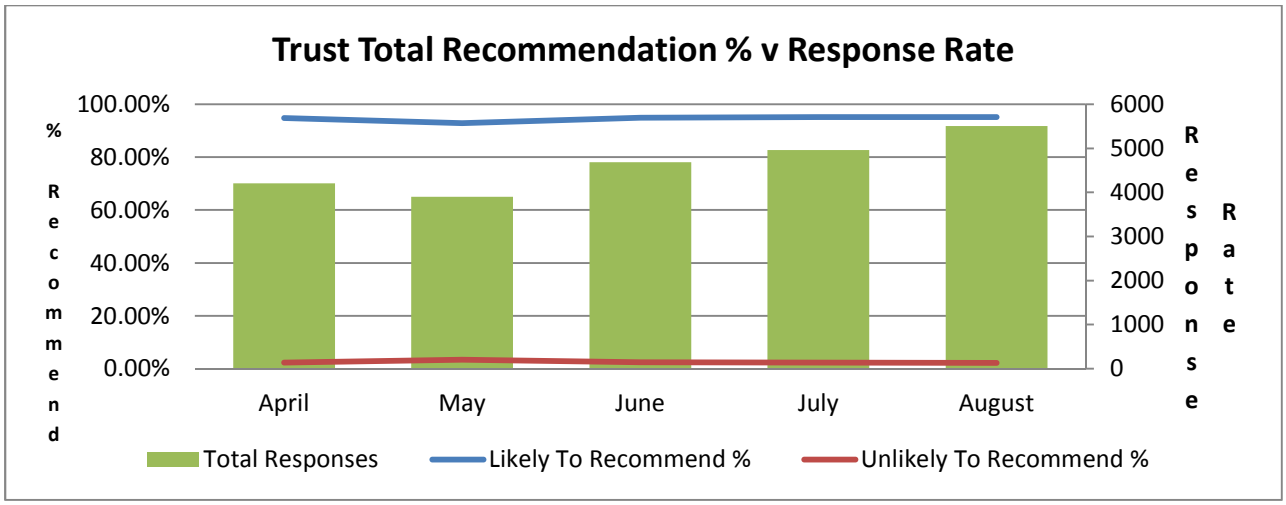
PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times and Cancellations	Discharge	Environment	Hotel Services	Treatment	Total
Corporate Functions	4	0	0	4	3	0	0	4	1	16
Clinical Support - Health Group	0	0	0	3	1	0	0	0	1	5
Family & Women's Health Group	1	1	0	8	17	0	1	0	9	37
Medicine - Health Group	1	3	3	16	22	1	1	0	13	60
Surgery - Health Group	1	3	1	10	31	0	1	0	18	65
Totals:	7	7	4	41	74	1	3	4	42	183

5.3 Friends and Family Test (FFT) – August 2017

The Trust's Friends and Family results for all areas, including the Emergency Department, indicate that there was an increase in the number of responses for the month of August 2017 with 5,506 responding, compared to July 2017 when 4,958 responses were received. The results indicate that **95.13%** were extremely likely/likely to recommend the Trust to friends and family.

5.3.1 Trust Summary

	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Responses	Likely To Recommend %	Unlikely To Recommend %
April	3438	544	80	45	68	28	4203	94.74%	2.28%
May	3138	484	92	54	95	36	3899	92.90%	3.36%
June	3890	557	76	46	79	37	4685	94.92%	2.48%
July	3992	724	79	50	82	31	4958	95.12%	2.28%
August	4523	715	90	60	94	24	5506	95.13%	2.14%

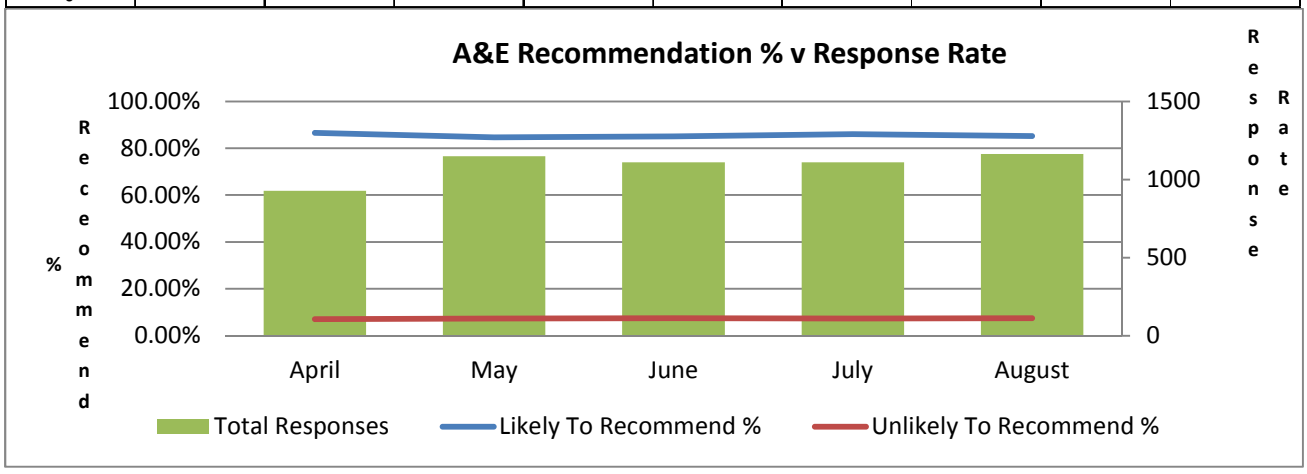


5.3.2 Friends and Family Emergency Department (ED)

1,164 patients that attended the Emergency department in August 2017 responded to the Friends and Family Test with **85.14%** of patients giving positive feedback and **7.47%** negative feedback.

5.3.2.1 Emergency Department Responses

	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Responses	Likely To Recommend %	Unlikely To Recommend %
April	664	138	32	27	48	18	927	86.52%	7.12%
May	811	161	54	37	67	18	1148	84.67%	7.40%
June	769	174	47	36	63	20	1109	85.03%	7.48%
July	770	185	37	37	64	17	1110	86.04%	7.30%
August	775	216	49	37	74	13	1164	85.14%	7.47%



Although paper responses were low for the month of August 2017 in ED, the SMS text messaging again had a high percentage of respondents and is proving to be a very successful method of receiving feedback. The Patient Experience Team continues to help wards with their Friends and Family boards by providing monthly reports. The Patient Experience Team will continue to work closely with staff to ensure they receive support with the Friends and Family test.

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 12 cases under review by the PHSO currently. During the month of August 2017, there has been one new case opened and there do not appear to be any themes linked to previous complaints.

5.5 Adult Volunteers
The Trust continues to recruit volunteers. This month, the Mortuary and Bereavement Service has taken on its first volunteer, which will hopefully lead to future volunteers. The Department of Nuclear Medicine has also recruited a volunteer that has recently retired from substantive employment at the Trust.

The Patient Experience Department has introduced recently an induction day for new Hospital Volunteers, which includes training on such topics as: infection control, safeguarding, information governance and the Trust's vision and values.

5.3 Compliments
The Trust received many compliments this month for each health group, which have been sent to the management teams to share with their staff groups. Examples of compliments received are as follows:

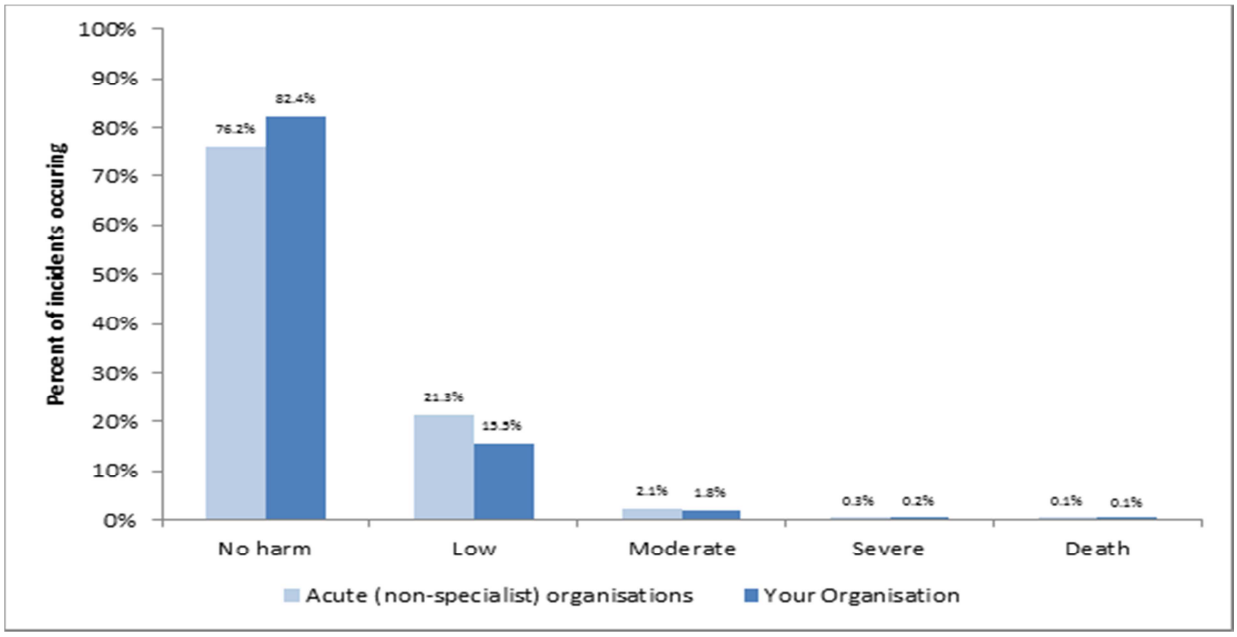
- **Maxillofacial Department -** After undertaking dental surgery to remove my wisdom teeth, I would just like to compliment the staff and nurses that helped make my operation so relaxed and positive. On the day, I had to face a few of my biggest fears and I voiced the fears to the staff and they did their upmost to make me feel comfortable and give me confidence. Please pass these compliments on to whom they may concern.

- **The Pain Clinic -** A patient attended the Pain Clinic at East Riding Community Hospital and wanted to pass on her sincere compliments to the staff there. Specific thanks were given for the acupuncture undertaken by Helen and Clare. "They are both lovely caring and attentive and the rest of the team have been exceptional". The patient felt that the whole team was helpful and courteous.

- **Cardiology -** A patient wanted to pass on his gratitude after being admitted to Castle Hill Hospital following a heart attack. "I was seen by the surgeons in the Catheter Lab before being cared for by the team on Ward 28. Everyone was brilliant. I cannot thank them enough for everything they did. Everyone was compassionate and understanding while demonstrating a high degree of professionalism. The food was great too!"

- **Ward 16 Castle Hill Hospital -** A patient wanted to thank the staff on Ward 16 Castle Hill Hospital for making her stay in hospital a pleasurable one. Everyone made her feel welcome and felt the atmosphere was a happy one for a patient to be in. The patient felt reassured by the Consultant and her breathing had improved. The patient wanted the staff to know that she felt reassured about her future treatment going forward and that she felt she was in safe hands.

6. OTHER QUALITY UPDATES
6.1 The National Reporting and Learning System (NRLS)
Last month, it was reported to the Trust Board that the Trust had improved its reporting position on the NRLS database. This is the database where all trusts report their incident rates. The Trust is now in the upper quartile of reporters nationally. The latest data with regard to severity ratings from October 2016 – March 2017 is shown below (it is hoped that this will now be released monthly from October 2017) and places the Trust in a relatively favourable position overall.

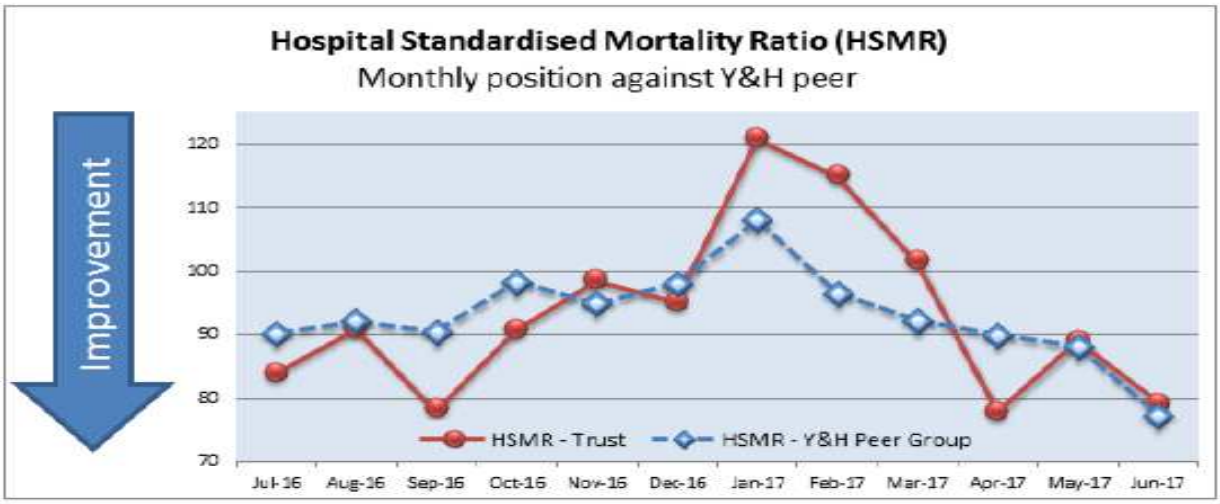


6.2 Safeguarding Annual Reports

The Adult and Children's Safeguarding Annual Reports for 2016/17 have been presented to the Operational Quality Committee and Quality Committee. Both committees were significantly assured by the content of the reports and the progress that has continued in 2016/17. Particular recognition needs to go to Kate Rudston, Assistant Chief Nurse for her excellent leadership of these very challenging and complex areas and the improvements she has brought to both services.

6.2 Hospital Standardised Mortality Rates (HSMR)

It was reported to the Board that the Trust has seen a significant rise in its HSMR in December 2016, January and February, 2017 for both weekday and weekend periods. The work looking at auditing the patients that died during this period is continuing and should be completed shortly and the Trust Board will be advised of the conclusions from this work. The latest HSMR data has shown that the Trust is now showing a downward trend and lower than average HSMR, which can be seen in the following table.



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

August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	3 October 2017		**Reference Number**	2017 – 10 – 09		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

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

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

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

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

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

The inclusion of all of these additional sets of data is in its early stages. However, they help to provide context and perspective when considering staffing levels and their impact on patient care and outcomes.

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

Fig 1: Hull Royal Infirmary

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

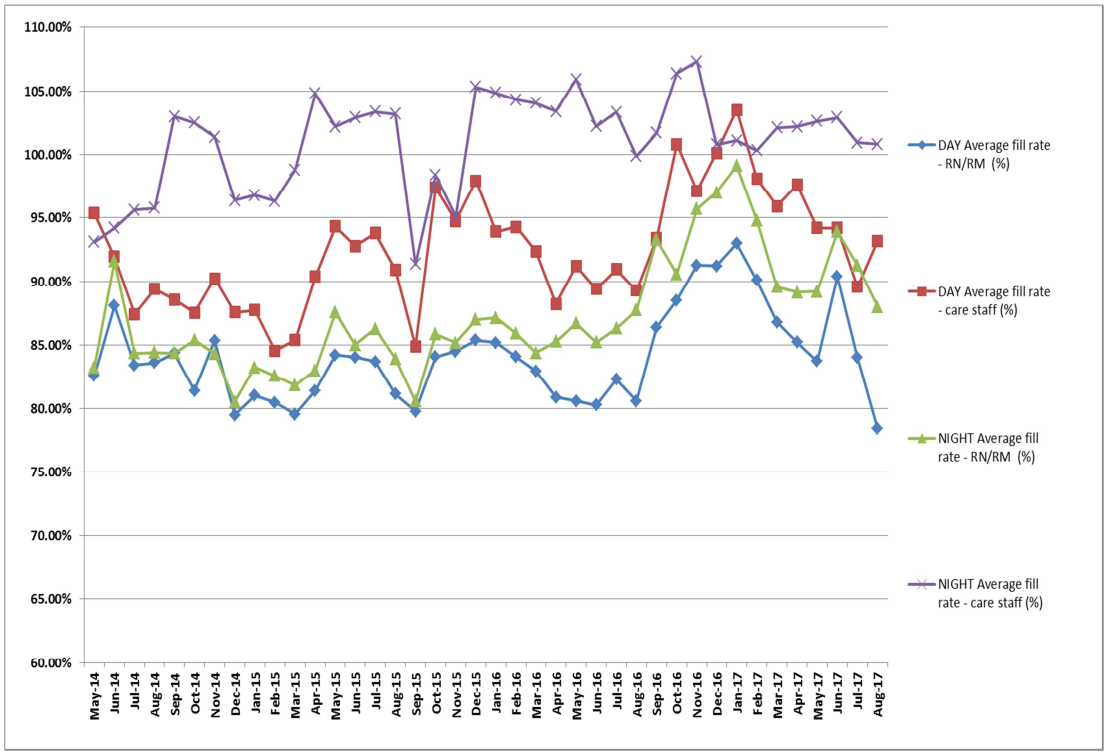
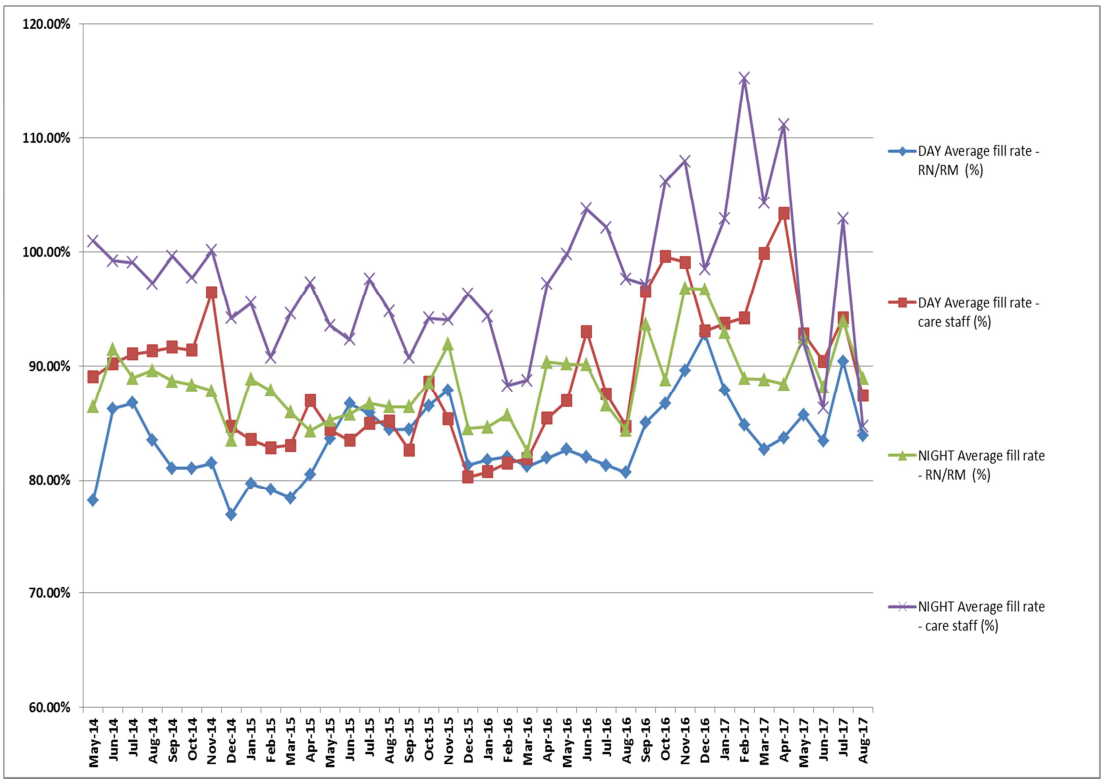


Fig 2: Castle Hill Hospital

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%



As can be seen, fill rates for registered nurses in particular are showing concerns in a number of areas. This is for a variety of reasons, including:

- Vacancy rates
- Sickness and maternity leave

- Nursing staffing levels being at their lowest point for the year due to attrition over the year and whilst awaiting the annual intake from the University in October
- Annual leave being at peak levels during the summer holidays.

The Trust Board has been advised already of actions that have been taken to date to balance emerging shortfalls, including:

- The closure of 20 beds within Surgery at CHH and the consolidation of beds and wards teams.
- 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 area).
- 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

However, further action is being considered to secure more reasonable staffing levels until the new recruits arrive. The Chief Nurse has asked all Health Groups to consider their activity, capacity and demand priorities with a view to ensuring that nurse staffing levels are safe and adequate. In addition, the Medicine Health Group has been asked to consider closing a ward temporarily until safer staffing levels can be assured on its wards. This is under review presently.

None of these are popular things to have to do and may generate challenges elsewhere. However, it is also not acceptable to have insufficient nurses to care for and manage sick people. These decisions must be risk-based and be prioritised so that the safest possible patient care can be delivered.

Work continues with recruitment of the new Registered Nurses from the University of Hull and 130 nurses are now due to start at the Trust from October. Those that have their Nursing and Midwifery Council PIN number will be able to be included in the RN fill rates numbers straight away. Those waiting for their PIN numbers will commence as non-registered healthcare assistants and be paid as such until they acquire their legal registration status. Nonetheless, these are new registered nurses that will require inducting, support and nurturing as they take on their new and significant responsibility and accountabilities as registered nurses.

With regards to the recruitment of nurses from the Philippines, the first nurse has arrived and has settled in well. A further 4 are due to commence during October, with a further 5 in November. In addition, a further 20 are in the pipeline, with a possible December 2017 arrival date. There are still delays in obtaining sponsorship approval from the NMC for these nurses to commence employment in the UK, which has reduced the cohort numbers. However, the Chief Nurse and Director of Workforce and OD are in regular contact with the NMC's employer liaison service and this is helping to get some of these nurses' applications processed more quickly.

Appendix 2 shows the current vacancy levels by ward and, also, what the future is starting to look like once the new recruits arrive. It is important to advise the Trust Board that, even though this will all help, some significant shortfalls remain in some wards thereafter. This poses an even greater challenge as winter approaches when there will be the inevitable requirements to commission an extra 'winter' ward. This

will all require a fine balance to be struck each day and will be managed through the usual safety brief processes.

In terms of strategic context with nursing staffing, the future supply of registered adult nurses remains the number one 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.

In order to try and help address this, there are a number of options that the Chief Nurse and his team are considering. These include:

- Improving retention by understanding why staff leave and what can be done to address that beforehand.
- Focused work with those approaching 55/early retirement to see if anything can be done to persuade such staff to stay on
- Considering more flexible working opportunities
- Looking at skill mix; as one big reason for leaving is due to the apparent lack of career progression opportunities
- Undertaking some time/motion work to understand the roles and tasks that RN's are doing compared to that of the non-registered workforce
- Review of nursing shift patterns (underway currently)
- Undertake some staff surveys about what would make the difference to help keep nurses working here.
- Restricting annual leave allocation during peak holiday periods, especially towards the end of the summer school holidays.
- The possibility of pursuing an alternative entry point to nurse training using the apprenticeship route. However, this would require funding from the Trust to support in terms of paying the apprenticeship salary and backfill costs. Options to look at this more closely are being developed. Nonetheless, this is not a short-term solution.

In order to bring the Trust Board up to date fully on the range of strategic issues facing the future supply of registered nurses, the Chief Nurse is proposing that more time should be undertaken at a Trust Board Development session to consider these and the potential solutions.

4. ENSURING SAFE STAFFING

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

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

- The numbers, skill mix, capability and levels of experience of the staff on duty
- Harm rates (falls, pressure ulcers, etc.) and activity levels
- The self-declaration by the shift leader on each ward as to their professional view on the safety and staffing levels that day
- The physical layout of the ward

- The availability of other staff – e.g. bank/pool, matron, specialist nurses, speciality co-ordinators and allied health professionals.
- The balance of risk across the organisation

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

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

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

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

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

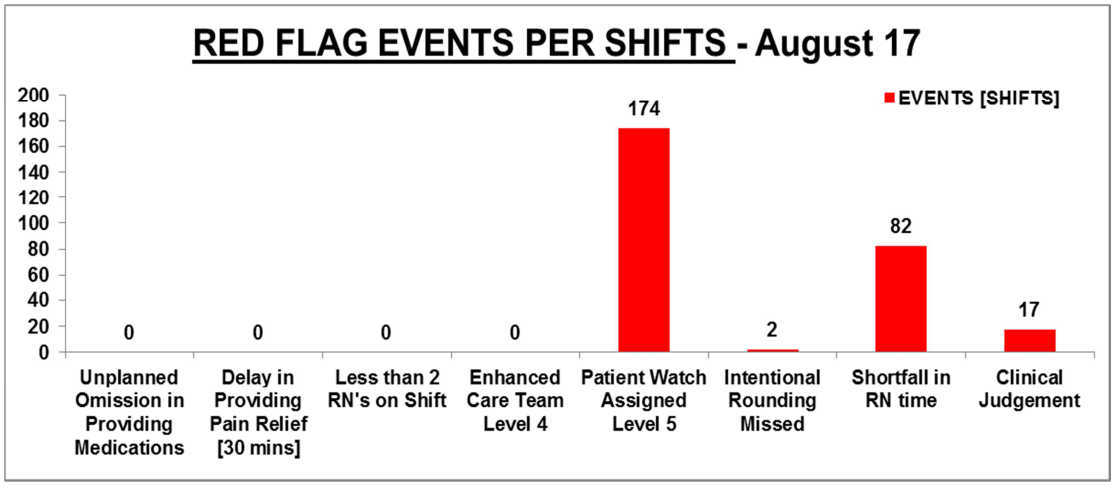
The 'red flags' suggested by NICE, are:

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

The following table illustrates the number of Red Flags identified during 2017. Please note that the Trust is not yet able to collect data on all of these categories as the systems required to capture them are not yet available, e.g. e-prescribing. This is accepted by the National Quality Board. In addition, work is required to ensure that any mitigation is recorded accurately, following professional review. The sophistication of this will be developed over time.

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

Aug-17	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	0	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	0	0%
	Enhanced Care Team Level 4	0	0%
	Patient Watch Assigned Level 5	174	63%
	Intentional Rounding Missed	2	1%
	Shortfall in RN time	82	30%
	Clinical Judgement	17	6%
	TOTAL:	**275**	**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 Report, this will be addressed through the implementation of the Enhanced Care Team, which has now commenced as a three-month pilot that will report on its impact in December/January.

6. AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

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

- **H11** have 7.77 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. There are also newly appointed RNs that will join the ward in October. The Senior Matron is reviewing the position continuously with the ward sister.

- **Emergency Department - Registered Nurse Staffing** - The Department has 16.88 wte RN vacancies. The recruitment drive continues in ED, Senior nurses are also helping to backfill. It is likely that some shifts may need to be put out to agencies if they cannot be filled in other ways, although this will be kept to an absolute minimum. The department has successfully appointed a further 3.0 wte RNs from outside of the Trust, all of whom are experienced nurses.

- **H70 (Diabetes and Endocrine)** has 9.96 wte RN vacancies. This ward continues to be supported in the interim by moving staff in the Medical Health Group and

additional support has also been provided from each of the other Health Groups, therefore reducing the current vacancies to 3.0 wte. The ward has also successfully recruited 2.0 wte RNs who are already working within the ward following rotation from other Health Groups.

- **Elderly Medicine [x5 wards]** has 22.14 wte RN vacancies. The specialty has over recruited by 10.0 wte auxiliary nurses to support the RNs in the ward areas to deliver nursing care with supervision. The Senior Matrons are supporting the ward in the interim by moving staff in the Medical Health Group.

- **Ward C16 (ENT, Plastics and Breast Surgery)** has 5.12 wte RN vacancies and over-established for non-registered vacancies at present. The RN vacancies have all been appointed to. New staff will commence in post during September and October 2017.In order to support the Ward, short term plans have been agreed to provide temporary cover.

- **Neonatal Intensive Care Unit (NICU).** Recruitment in this specialty has previously been of concern, and there are currently 7.92 wte RN vacancies. All of these posts have been recruited to, and the staff will join the Trust in September 2017, following completion of their training. The staffing in the interim is being managed closely by the senior matron, with staff being flexed across all paediatric inpatient and outpatient areas according to patient need. The Health Group is looking at ways in which it can improve the retention of the staff in this specialty.

- **Ward H4 -** Neurosurgery has 5.88 wte RN and 3.03 wte non-registered nurse vacancies, the ward is being supported by H40.

- **Ward H7 -** Vascular Surgery has 4.52 wte RN vacancies. This group of patients often require specialist dressings. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.

- **Ward H12 & H120 –** Trauma Orthopaedics have 8.75 wte RN vacancies across the floor. There is a plan to support with staff from C14 as this will assist in the relocation of maxilla-facial patients to this ward in November 2017.

- **Ward C9 -** Elective Orthopaedic Surgery has 3.65 wte RN and 1.03 wte non-registered nurse vacancies. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 6.54 wte RN registered nurse vacancies. The nursing staff are flexed between C10 and C11.

The inability to recruit sufficient numbers of registered nurses in order to meet safer staffing requirements remains a recorded risk. This had been held previously at rating 12 (Moderate - Major and Possible - ID 2671) on the Risk Register, although every reasonable effort to try and mitigate this risk is being taken on a daily basis. However, in view of current pressures, this has been increased to 16 (Likely 4 x Severity 4) until staffing levels stabilise more.

7. 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 risks across the organisation. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses. However, the organisation may need to reduce further its bed base temporarily in order to keep wards and patient safe. This will continue to be reviewed daily.

8. RECOMMENDATION

The Trust Board is requested to:

- Consider having a presentation and discussion at a Trust Board development session in relation to the future supply of registered nurses and the strategic options therein.
- Receive this report
- Decide if any if any further actions and/or information are required.

Mike Wright
Executive Chief Nurse
September 2017

Appendix 1: HEY Safer Staffing Report – August 2017
Appendix 2: HEY Nursing and Midwifery Ward Establishments – Vacancy Position

HEY SAFER STAFFING REPORT AUGUST-17

NURSE STAFFING

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

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES: DAY Average fill rate - RN/RM (%)	FILL RATES: DAY Average fill rate - care staff (%)	FILL RATES: NIGHT Average fill rate - RN/RM (%)	FILL RATES: NIGHT Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: RN / RM	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: CARE STAFF	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: OVERALL	ROTA EFFICIENCY [07-08-17 to 03-09-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY [07-08-17 to 03-09-17]: SICK RN & AN [3.9%]	ROTA EFFICIENCY [07-08-17 to 03-09-17]: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M5]: RN [WTE]	NURSING VACANCIES [FINANCE LEDGER M5]: AN [WTE]	NURSING VACANCIES [FINANCE LEDGER M5]: TOTAL [WTE]	NURSING VACANCIES [FINANCE LEDGER M5]: % [<10%]	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED	ACUTE MEDICINE	NA	0									17.7%	3.3%	3.5%	16.88	0.66	17.54	16.2%		1		2				0									0	3
	AMU	ACUTE MEDICINE	45	6	96%	76%	87%	104%	1018	5.0	3.2	8.1	18.8%	4.1%	4.2%	9.17	-0.14	9.03	12.0%	96%				2			2		1				1	3
	H1	ACUTE MEDICINE	22	18	75%	97%	100%	101%	627	2.6	1.8	4.4	21.6%	4.7%	0.0%	2.84	1.13	3.97	18.2%	100%				1			1						0	1
	EAU	ELDERLY MEDICINE	21	13	86%	109%	84%	87%	436	4.2	4.5	8.7	17.9%	8.3%	3.4%	5.42	-0.41	5.01	18.7%	100%				1			1						0	1
	H5 / RHOB	RESPIRATORY	26	4	88%	93%	97%	92%	590	2.7	1.8	4.4	18.1%	5.0%	2.1%	2.49	1.20	3.69	10.6%	100%		2					0						0	2
	H50	RENAL MEDICINE	19	9	77%	103%	102%	99%	570	3.1	2.1	5.2	20.3%	5.8%	0.0%	1.71	0.39	2.10	11.1%	100%			2	2			2						0	4
	H500	RESPIRATORY	24	1	69%	93%	102%	99%	726	2.3	2.4	4.8	15.6%	4.7%	3.7%	4.36	0.99	5.35	18.8%	91%		3		1			1	1					1	5
	H70	ENDOCRINOLOGY	30	32	57%	105%	58%	83%	898	2.1	2.0	4.1	17.6%	8.7%	0.2%	9.96	0.76	10.72	33.8%	90%	4		4	1			1		1				1	10
	H8	ELDERLY MEDICINE	27	22	59%	122%	102%	101%	821	2.1	2.5	4.5	16.8%	3.6%	3.2%	4.06	-0.44	3.62	12.2%	100%				1	1		2						0	2
	H80	ELDERLY MEDICINE	27	8	56%	111%	100%	104%	812	2.0	2.5	4.5	14.4%	17.0%	0.0%	5.19	0.64	5.83	19.6%	100%							0		1				1	1
	H9	ELDERLY MEDICINE	31	14	67%	115%	100%	100%	938	1.9	2.2	4.1	14.1%	5.1%	2.2%	1.82	-0.36	1.46	4.9%	100%		3		3	1		4		1				1	8
	H90	ELDERLY MEDICINE	29	7	63%	113%	100%	105%	864	2.1	2.3	4.4	13.7%	2.2%	3.3%	5.65	-1.35	4.30	14.4%	92%				1			1			1			1	2
	H11	STROKE / NEUROLOGY	28	1	53%	162%	100%	100%	848	2.0	2.3	4.3	19.0%	1.2%	0.0%	7.77	1.76	9.53	31.4%	92%	3	1		2			2						0	6
	H110	STROKE / NEUROLOGY	24	5	59%	140%	102%	91%	519	3.6	3.1	6.6	14.2%	4.6%	10.0%	6.28	-0.15	6.13	19.4%	100%		1					0						0	1
	CDU	CARDIOLOGY	9		84%	88%	97%		121	9.3	1.0	10.3	18.1%	9.3%	0.0%	0.86	0.48	1.34	10.1%	100%							0						0	0
	C26	CARDIOLOGY	26	21	76%	89%	79%	103%	713	3.8	1.6	5.4	15.5%	3.1%	12.0%	1.51	0.77	2.28	6.8%	96%	2			4			4						0	6
	C28 /CMU	CARDIOLOGY	27	12	77%	71%	83%	48%	688	6.1	1.3	7.5	16.1%	11.1%	3.0%	3.39	-0.11	3.28	7.3%	100%	3	1		1			1						0	5
SURGERY	H4	NEURO SURGERY	30	0	81%	79%	78%	103%	763	2.9	1.8	4.7	17.0%	3.5%	3.9%	5.88	3.03	8.91	27.6%	100%	2	2					0						0	4
	H40	NEURO HOB / TRAUMA	15	2	74%	96%	98%	96%	326	6.6	4.2	10.9	18.1%	7.6%	0.0%	3.99	0.09	4.08	13.5%	100%							0						0	0
	H6	ACUTE SURGERY	28	6	91%	80%	75%	202%	701	3.0	2.3	5.3	17.4%	5.9%	3.6%	3.91	2.47	6.38	21.5%	100%	1	1					0						0	2
	H60	ACUTE SURGERY	28	5	91%	80%	88%	188%	713	3.1	2.2	5.3	16.9%	1.0%	2.1%	1.56	1.38	2.94	9.6%	100%	6	1					0						0	7
	H7	VASCULAR SURGERY	30	0	76%	78%	85%	107%	831	2.8	2.4	5.3	18.2%	4.2%	0.8%	4.52	-1.11	3.41	10.3%	100%	1	1		2			2					1	1	5
	H100	GASTROENTEROLOGY	24	24	92%	102%	79%	106%	758	2.4	2.2	4.6	17.7%	3.2%	5.8%	3.95	0.82	4.77	16.0%	100%				1			1		1				1	2
	H12	ORTHOPAEDIC	28	14	73%	92%	79%	139%	707	2.9	3.1	6.0	17.0%	6.8%	3.8%	8.19	-1.15	7.04	20.7%	100%		2	1	1			1						0	4
	H120	ORTHO / MAXFAX	22	1	84%	101%	88%	108%	571	3.6	2.9	6.4	15.9%	4.1%	0.0%	0.56	2.35	2.91	10.5%	100%			1				0		1				1	2
	HICU	CRITICAL CARE	22	0	86%	102%	87%	39%	515	24.2	1.0	25.2	18.1%	3.9%	3.3%	7.29	1.62	8.91	7.9%	100%			3				0		2				2	5
	C8	ORTHOPAEDIC	18	0	78%	75%	93%	60%	194	4.5	2.3	6.9	15.9%	13.1%	0.0%	1.32	-0.23	1.09	7.5%	100%							0						0	0
	C9	ORTHOPAEDIC	29	0	91%	83%	99%	88%	643	3.5	2.2	5.6	15.2%	7.5%	0.0%	3.65	1.03	4.68	15.7%	100%	1	1	1				0					1	1	4
	C10	COLORECTAL	21	1	88%	54%	95%	97%	366	5.1	2.1	7.2	20.3%	6.8%	0.0%	6.54	2.59	9.13	36.4%	100%							0						0	0
	C11	COLORECTAL	22	1	84%	79%	94%	114%	473	4.2	2.3	6.5	20.1%	2.7%	0.0%	1.50	1.79	3.29	13.7%	100%	2						0						0	2
	C14	UPPER GI	27	1	86%	59%	84%	111%	674	3.4	1.4	4.8	17.5%	8.2%	0.0%	3.89	1.52	5.41	18.9%	100%			1	1	1		2						0	3
	C15	UROLOGY	26	0	90%	67%	78%	92%	561	4.4	2.4	6.8	19.4%	2.6%	4.9%	2.00	0.75	2.75	10.0%	100%				1			1						0	1
	C27	CARDIOTHORACIC	26	0	92%	78%	95%	100%	746	3.9	1.3	5.2	16.5%	2.0%	3.6%	1.87	1.34	3.21	10.2%	100%		1					0		1				1	2
	CICU	CRITICAL CARE	22	0	83%	71%	80%	15%	381	21.8	1.5	23.3	16.4%	5.1%	4.0%	7.29	1.62	8.91	9.1%	100%			1				0						0	1
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	72%	133%	109%	62%	264	7.3	4.5	11.8	20.0%	10.6%	2.8%	5.12	-0.06	5.06	17.5%	100%	2		1				0						0	3
	H130	PAEDS	20	1	74%	36%	78%	56%	272	8.6	1.3	9.9	19.8%	0.6%	8.3%	0.25	2.02	2.27	8.9%	100%			2				0						0	2
	H30 CEDAR	GYNAECOLOGY	9	0	83%	51%	105%		123	12.0	3.1	15.1	19.1%	9.3%	0.0%	-1.00	0.12	-0.88	-3.9%	100%							0						0	0
	H31 MAPLE	MATERNITY	20	0	92%	94%	122%	105%	325	7.0	4.4	11.4	14.2%	4.6%	1.6%	2.94	1.75	4.69	6.6%	100%							0						0	0
	H33 ROWAN	MATERNITY	38	0	91%	84%	85%	98%	1131	2.8	1.5	4.3	18.0%	5.8%	2.0%					100%	1						0						0	1
	H34 ACORN	PAEDS SURGERY	20	0	90%	43%	99%	72%	259	10.2	1.5	11.7	16.6%	7.4%	0.0%	0.02	0.54	0.56	2.1%	100%		1	1				0						0	2
	H35	OPHTHALMOLOGY	12	0	91%	53%	96%		174	10.7	2.1	12.8	21.7%	5.4%	0.0%	-0.15	1.53	1.38	6.8%	100%		2					0						0	2
	LABOUR	MATERNITY	16	0	81%	85%	92%	86%	305	16.8	6.1	22.9	16.0%	2.1%	4.2%	-1.47	-1.93	-3.40	-5.3%	100%		4	2				0						0	6
	NEONATES	CRITICAL CARE	26	0	79%	85%	82%	81%	612	11.6	1.0	12.6	17.7%	1.7%	6.2%	7.92	0.00	7.92	11.9%	100%			1				0						0	1
	PAU	PAEDS	10	0	88%		94%		53	26.2	0.0	26.2	23.4%	2.2%	3.2%	0.76	0.00	0.76	7.3%	100%							0						0	0
	PHDU	CRITICAL CARE	4	0	103%	107%	97%		70	21.3	1.4	22.7	24.2%	5.9%	0.0%	-1.48	0.00	-1.48	-11.8%	100%							0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0	100%	96%	102%	90%	419	3.4	2.1	5.5	15.6%	15.3%	5.0%	2.24	0.96	3.20	16.6%	100%	1		1	2			2						0	4
	C29	REHABILITATION	15	34	85%	105%	100%	73%	430	3.4	4.2	7.6	19.9%	4.9%	0.0%	1.53	2.42	3.95	15.1%	93%							0						0	0
	C30	ONCOLOGY	22	0	83%	119%	102%	111%	625	2.7	2.1	4.8	22.4%	12.3%	2.1%	2.50	0.03	2.53	14.5%	100%	1			3			3						0	4
	C31	ONCOLOGY	27	3	87%	98%	100%	97%	769	2.3	2.0	4.3	13.2%	6.5%	0.0%	-0.33	1.33	1.00	5.0%	100%		1		1			1					1	1	3
	C32	ONCOLOGY	22	0	98%	93%	100%	105%	638	2.9	1.6	4.5	21.5%	5.6%	0.8%	-0.37	0.12	-0.25	-1.4%	100%			1				0						0	1
	C33	HAEMATOLOGY	28	9	79%	135%	91%	145%	625	4.3	2.1	6.4	16.5%	8.7%	2.1%	3.17	-1.99	1.18	3.6%	95%				2	1		3						0	3
		TOTAL:	275		AVERAGE:				564	6.2	2.3	8.5	17.8%	5.9%	2.4%	178.92	32.57	211.49	12.4%	98.9%														
														TOTALS:					TOTALS:		49	31	28	25	34	4	0	38	1	9	0	2	2	14	136

Aug-17	DAY Average fill rate - RN/RM (%)	DAY Average fill rate - care staff (%)	NIGHT Average fill rate - RN/RM (%)	NIGHT Average fill rate - care staff (%)	CARE HOURS PER PATIENT PER DAY [CHPPPD]: Cumulative Count	RN / RM	CARE STAFF	OVERALL
SAFER STAFFING OVERALL PERFORMANCE								
HRI SITE	78.4%	93.2%	88.0%	100.8%	19024	4.5	2.4	6.9
CHH SITE	83.9%	87.4%	88.9%	84.7%	9330	4.7	2.0	6.7

APPENDIX 2

NURSING MIDWIFERY WARD ESTABLISHMENT- VACANCY POSITION

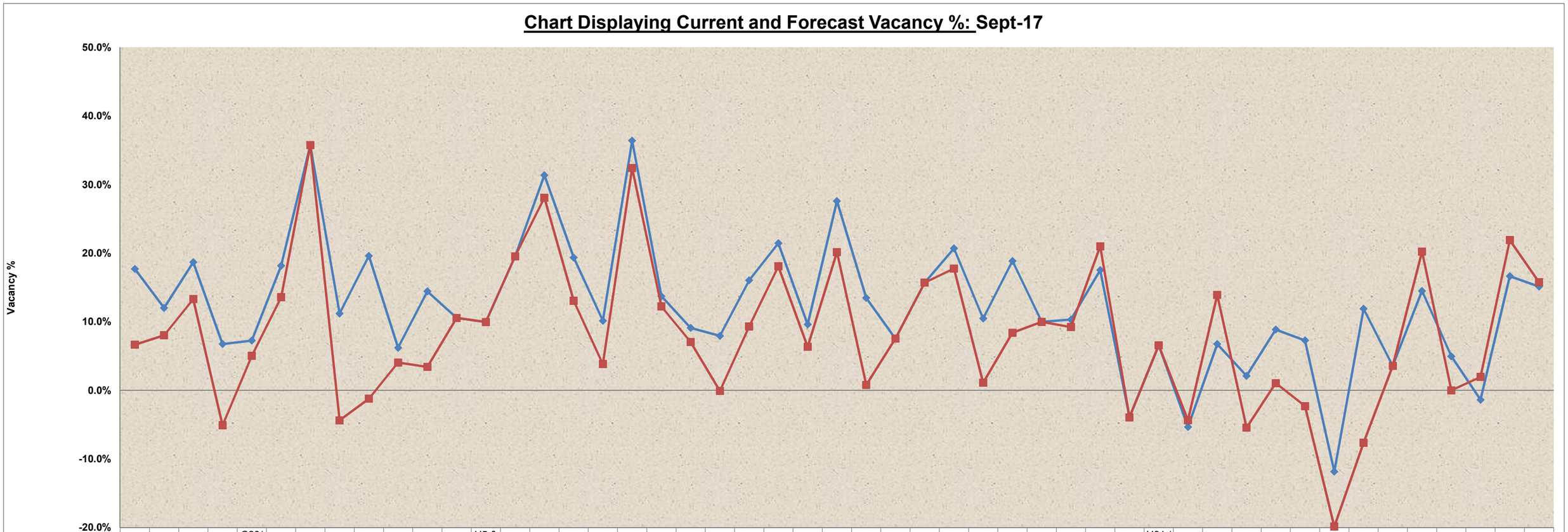
NURSING & MIDWIFERY VACANCY TRACKER: SEPTEMBER 2017				VACANCY POSITION [MONTH 5] [AUG-17]					STARTERS [SEPT-17]			LEAVERS [SEPT-17]			REVISED VACANCY FORECAST [SEPT-17]				DETAILS [SEPT-17][ONLY RECORD STARTERS AND LEAVERS IN- MONTH]
				ESTAB.	RN	HCA	TOTAL	%	RN	HCA	TOTAL	RN	HCA	TOTAL	RN	HCA	TOTAL	%	
HEALTH GROUP	SPECIALITY	WARD	BEDS	WTE	WTE	WTE			WTE	WTE		WTE	WTE		WTE	WTE			
ASSESSMENT UNITS	Emergency Department	ED	NA	108.60	18.58	0.66	19.24	17.7%	15.00	0.00	15.00	3.00	0.00	3.00	6.58	0.66	7.24	6.7%	
	General medicine	AMU	45	75.07	9.17	-0.14	9.03	12.0%	3.00	0.00	3.00	0.00	0.00	0.00	6.17	-0.14	6.03	8.0%	
	Geriatric medicine	EAU	21	26.81	5.42	-0.41	5.01	18.7%	1.00	2.44	3.44	2.00	0.00	2.00	6.42	-2.85	3.57	13.3%	3 x band 2 for winter ward, 1 student awaititng PIN
MEDICINE	Cardiology	C26	26	33.73	1.51	0.77	2.28	6.8%	4.00	0.00	4.00	0.00	0.00	0.00	-2.49	0.77	-1.72	-5.1%	
		C28/CMU	27	45.18	3.39	-0.11	3.28	7.3%	1.00	0.00	1.00	0.00		0.00	2.39	-0.11	2.28	5.0%	
	General medicine	H1	22	21.87	2.84	1.13	3.97	18.2%	1.00	0.00	1.00	0.00	0.00	0.00	1.84	1.13	2.97	13.6%	
		H70	30	31.69	10.97	0.36	11.33	35.8%	0.00	0.00	0.00	0.00	0.00	0.00	10.97	0.36	11.33	35.8%	
	Geriatric medicine	H8	27	29.79	3.21	0.13	3.34	11.2%	2.00	2.64	4.64	0.00	0.00	0.00	1.21	-2.51	-1.30	-4.4%	x 2 band 2 for winter ward - x 2 Students awaiting PIN
		H80	27	29.78	4.58	1.26	5.84	19.6%	6.00	2.00	8.00	1.80	0.00	1.80	0.38	-0.74	-0.36	-1.2%	5 awaiting PIN, 1 x RN starting - 2 RN leaving end of septemeber - x 2 band 2 for winter
		H9	31	29.78	2.21	-0.36	1.85	6.2%	0.00	1.64	1.64	1.00	0.00	1.00	3.21	-2.00	1.21	4.1%	band 2 for winter ward
		H90	29	29.78	5.65	-1.35	4.30	14.4%	0.00	3.28	3.28	0.00	0.00	0.00	5.65	-4.63	1.02	3.4%	band 2 for winter ward.
	Nephrology	H50	19	18.94	1.00	1.00	2.00	10.6%	0.00	0.00	0.00	0.00	0.00	0.00	1.00	1.00	2.00	10.6%	
	Respiratory medicine	H5 & RSU	26	34.84	2.67	0.80	3.47	10.0%	0.00	0.00	0.00	0.00	0.00	0.00	2.67	0.80	3.47	10.0%	
		H500	24	28.46	5.56	0.00	5.56	19.5%	0.00	0.00	0.00	0.00	0.00	0.00	5.56	0.00	5.56	19.5%	
	Stroke Medicine	H11	28	30.38	7.77	1.76	9.53	31.4%	1.00	0.00	1.00	0.00	0.00	0.00	6.77	1.76	8.53	28.1%	
		H110	24	31.64	6.28	-0.15	6.13	19.4%	2.00	0.00	2.00	0.00	0.00	0.00	4.28	-0.15	4.13	13.1%	
SURGERY	Cardiothoracic surgery	C27	26	31.62	1.87	1.34	3.21	10.2%	3.00	0.00	3.00	1.00	0.00	1.00	-0.13	1.34	1.21	3.8%	
	Colorectal surgery	C10	21	25.08	6.54	2.59	9.13	36.4%	1.00	0.00	1.00	0.00	0.00	0.00	5.54	2.59	8.13	32.4%	
		C11	22	23.96	1.50	1.79	3.29	13.7%	1.00	0.00	1.00	0.64	0.00	0.64	1.14	1.79	2.93	12.2%	
	Critical Care	CICU	22	97.87	7.29	1.62	8.91	9.1%	5.00	0.00	5.00	2.00	1.00	3.00	4.29	2.62	6.91	7.1%	
		HICU	22	112.10	7.29	1.62	8.91	7.9%	12.00	0.00	12.00	2.00	1.00	3.00	-2.71	2.62	-0.09	-0.1%	
	Gastroenterology	H100	23	29.73	3.95	0.82	4.77	16.0%	2.00	0.00	2.00	0.00	0.00	0.00	1.95	0.82	2.77	9.3%	
	General surgery	H6	28	29.74	3.91	2.47	6.38	21.5%	2.00	0.00	2.00	1.00	0.00	1.00	2.91	2.47	5.38	18.1%	
		H60	28	30.57	1.56	1.38	2.94	9.6%	1.00	0.00	1.00	0.00	0.00	0.00	0.56	1.38	1.94	6.3%	
	Neurosurgery & Major Trauma	H4	29	32.28	5.88	3.03	8.91	27.6%	3.00	0.00	3.00	0.00	0.60	0.60	2.88	3.63	6.51	20.2%	
		H40	15	30.26	3.99	0.09	4.08	13.5%	4.00	0.00	4.00	0.00	0.16	0.16	-0.01	0.25	0.24	0.8%	
	Trauma & orthopaedics	C8	18	14.44	1.32	-0.23	1.09	7.5%	0.00	0.00	0.00	0.00	0.00	0.00	1.32	-0.23	1.09	7.5%	
		C9	29	29.78	3.65	1.03	4.68	15.7%	0.00	0.00	0.00	0.00	0.00	0.00	3.65	1.03	4.68	15.7%	
		H12	28	34.00	8.19	-1.15	7.04	20.7%	1.00	0.00	1.00	0.00	0.00	0.00	7.19	-1.15	6.04	17.8%	
		H120	22	27.76	0.56	2.35	2.91	10.5%	1.00	1.60	2.60	0.00	0.00	0.00	-0.44	0.75	0.31	1.1%	
	Upper GI surgery	C14	27	28.68	3.89	1.52	5.41	18.9%	3.00	0.00	3.00	0.00	0.00	0.00	0.89	1.52	2.41	8.4%	
	Urology	C15	28	27.53	2.00	0.75	2.75	10.0%	1.00	0.00	1.00	1.00	0.00	1.00	2.00	0.75	2.75	10.0%	X2 leavers total 1.0 wte x1 starter wte
	Vascular surgery	H7	30	33.04	4.52	-1.11	3.41	10.3%	1.00	0.00	1.00	0.64	0.00	0.64	4.16	-1.11	3.05	9.2%	
FWHEALTH	Breast surgery	C16	30	28.85	5.12	-0.06	5.06	17.5%	0.00	0.00	0.00	0.00	1.00	1.00	5.12	0.94	6.06	21.0%	
	Gynaecology	H30	15	22.34	-1.00	0.12	-0.88	-3.9%	0.00	0.00	0.00	0.00	0.00	0.00	-1.00	0.12	-0.88	-3.9%	Shows over established but 1 wte has left.
	Obstetrics	H31 / H33	58	71.34	2.94	1.75	4.69	6.6%	0.00	0.00	0.00	0.00	0.00	0.00	2.94	1.75	4.69	6.6%	
		LW	16	63.61	-1.47	-1.93	-3.40	-5.3%	0.00	0.00	0.00	0.00	0.64	0.64	-1.47	-1.29	-2.76	-4.3%	
	Ophthalmology	H35	8	20.42	-0.15	1.53	1.38	6.8%	1.00	0.00	1.00	2.46	0.00	2.46	1.31	1.53	2.84	13.9%	All three posts are retirements 2 part time, 1 full time.
	Paediatric surgery	H34A	22	26.49	0.02	0.54	0.56	2.1%	2.00	0.00	2.00	0.00	0.00	0.00	-1.98	0.54	-1.44	-5.4%	
	Paediatrics	130	20	25.59	0.25	2.02	2.27	8.9%	2.00	0.00	2.00	0.00	0.00	0.00	-1.75	2.02	0.27	1.1%	
		PAU	6	10.44	0.76	0.00	0.76	7.3%	1.00	0.00	1.00	0.00	0.00	0.00	-0.24	0.00	-0.24	-2.3%	
		PHD	4	12.49	-1.48	0.00	-1.48	-11.8%	1.00	0.00	1.00	0.00	0.00	0.00	-2.48	0.00	-2.48	-19.9%	
		NICU	26	66.57	7.92	0.00	7.92	11.9%	13.00	0.00	13.00	0.00	0.00	0.00	-5.08	0.00	-5.08	-7.6%	
CLINICAL SUPPORT	Clinical haematology	C33	28	33.13	3.17	-1.99	1.18	3.6%	0.00	0.00	0.00	0.00	0.00	0.00	3.17	-1.99	1.18	3.6%	C33 starters - 0. C33 Leavers - 0.
	Clinical oncology	C30	22	17.45	2.50	0.03	2.53	14.5%	0.00	0.00	0.00	1.00	0.00	1.00	3.50	0.03	3.53	20.2%	C30 Starters - 0. C30 Leavers - Houchen 1 wte.
		C31	27	20.11	-0.33	1.33	1.00	5.0%	1.00	0.00	1.00	0.00	0.00	0.00	-1.33	1.33	0.00	0.0%	C31 Starters - Venables 1 wte. C31 Leavers - 0.
		C32	22	18.34	-0.37	0.12	-0.25	-1.4%	0.00	0.00	0.00	0.61	0.00	0.61	0.24	0.12	0.36	2.0%	C32 Starters - 0. C32 Leavers - Whittle 0.61 wte to C20.
	Infectious diseases	C20	15	19.22	2.24	0.96	3.20	16.6%	0.61	0.00	0.61	0.50	1.12	1.62	2.13	2.08	4.21	21.9%	C20 - Whittle 0.61 wte from C32. C20 Leavers - Mcnamara 0.5 wte. NA's Harrison & Pick 1.12 wte leavers
	Rehabilitation	C29	15	26.09	1.53	2.42	3.95	15.1%	0.00	0.00	0.00	0.16	0.00	0.16	1.69	2.42	4.11	15.8%	C29 Starters - 0. C29 Leavers - Cunningham reduced by 0.16 wte.
		Grand Totals:	1,158	1727.26	180.37	32.10	212.47	12.3%	98.61	13.60	112.21	20.81	5.52	26.33	102.57	24.02	126.59	7.3%	

KEY:		
		10% OR GREATER
		OVER ESTABLISHED

APPENDIX 2

NURSING MIDWIFERY WARD ESTABLISHMENT- VACANCY POSITION

Chart Displaying Current and Forecast Vacancy %: Sept-17



	ED	AMU	EAU	C26	C28/ CMU	H1	H70	H8	H80	H9	H90	H50	H5 & RSU	H500	H11	H110	C27	C10	C11	CICU	HICU	H100	H6	H60	H4	H40	C8	C9	H12	H120	C14	C15	H7	C16	H30	H31 / H33	LW	H35	H34A	130	PAU	PHD	NICU	C33	C30	C31	C32	C20	C29
Current Vacancy	17.7%	12.0%	18.7%	6.8%	7.3%	18.2%	35.8%	11.2%	19.6%	6.2%	14.4%	10.6%	10.0%	19.5%	31.4%	19.4%	10.2%	36.4%	13.7%	9.1%	7.9%	16.0%	21.5%	9.6%	27.6%	13.5%	7.5%	15.7%	20.7%	10.5%	18.9%	10.0%	10.3%	17.5%	-3.9%	6.6%	-5.3%	6.8%	2.1%	8.9%	7.3%	-11.8	11.9%	3.6%	14.5%	5.0%	-1.4%	16.6%	15.1%
Forcast Vacancy	6.7%	8.0%	13.3%	-5.1%	5.0%	13.6%	35.8%	-4.4%	-1.2%	4.1%	3.4%	10.6%	10.0%	19.5%	28.1%	13.1%	3.8%	32.4%	12.2%	7.1%	-0.1%	9.3%	18.1%	6.3%	20.2%	0.8%	7.5%	15.7%	17.8%	1.1%	8.4%	10.0%	9.2%	21.0%	-3.9%	6.6%	-4.3%	13.9%	-5.4%	1.1%	-2.3%	-19.9	-7.6%	3.6%	20.2%	0.0%	2.0%	21.9%	15.8%

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AVOIDABLE MORTALITY – STRUCTURED CASE NOTE REVIEW PROGRESS REPORT

Trust Board date	3 October 2017	**Reference Number**	2017 -10 - 10
Director	Kevin Phillips – Chief Medical Officer	**Author**	Chris Johnson - Outcomes Manager
Reason for the report	The purpose of this report is to provide the Trust Board with the progress with the work undertaken in regard to avoidable mortality and structured case note reviews.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive the updates and decide if any further action/assurance is 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):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is monitored at the Board Quality Committee.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AVOIDABLE MORTALITY – STRUCTURED CASE NOTE REVIEW
PROGRESS REPORT

1. PURPOSE

The purpose of this report is to provide the Trust Board with the progress with the work undertaken in regard to avoidable mortality and structured case note reviews.

2. PROGRESS AVOIDABLE MORTALITY

A total of 160 Structured Judgement Mortality Reviews have been undertaken. Since the process became mandatory (April 1 2017) a total of 94 reviews have been completed, of which 7 cases required a Tier 2 review.

3 cases have been escalated to the Triumvirate, 2 of which were not declared as a Serious Incident. The latest case is still awaiting decision.

3. HOSPITAL STANDARDISED MORTALITY RATIO SPIKE

During January and February 2017, the HSMR (Hospital Standardised Mortality Ratio) peaked. While it is acknowledged that these are winter months, the Trust still peaked above the national average.

Structured Judgement Reviews are currently underway to determine if sub-optimal care could have contributed to the HSMR spike in Pneumonia and COPD. Doctors from within Chest Medicine have received training and have begun undertaking the SJR reviews.

.

4. SEPSIS

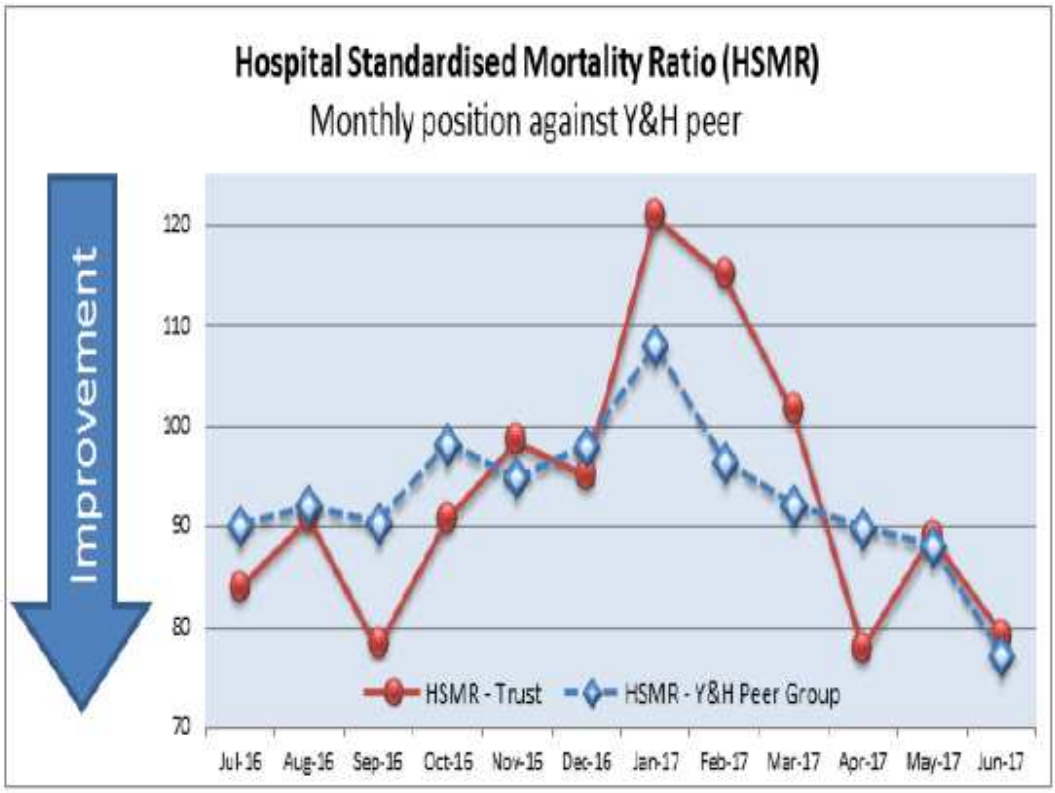
To ensure that Sepsis cases receive a Structured Judgement Review, the Clinical Outcomes Manager has agreed with Sepsis specialist Dr Kate Adams on a process that will ensure cases are routinely reviewed. A sample of 10 Sepsis cases per month will receive a full SJR, to be undertaken by Sepsis specialist nurses and Doctors. The QIP for avoidable mortality has also been changed to reflect this.

5. REVIEW ESCALATION

In instances where a Tier 2 review identifies potential sub-optimal care, all cases will now be brought to the attention of the Mortality Committee. The case will also be sent to the Triumvirate (via the Risk Department) for a decision to be made regarding the declaration of a Serious Incident. A Serious Incident Decision form (SID) will be completed by a member of the Triumvirate to detail the reasoning behind the overall decision on SI status.

6. HSMR

The HSMR has fallen in June 2017, forming part of the overall fall since the spike that occurred in December 2016 and January 2017. There was a small spike in May 2017 but this has since fallen.



7. RECOMMENDATIONS

The Trust Board is requested to receive the updates and decide if any further action/assurance is required.

Chris Johnson
Outcomes Manager
September 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE HELD ON 29 AUGUST 2017
THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	(Chair) – Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mr A Snowden	Non-Executive Director
	Mr K Phillips	Chief Medical Officer
	Dr M Purva	Deputy Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs J Ledger	Deputy Chief Nurse (on behalf of Mr M Wright)
	Mr D Corral	Chief Pharmacist
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
IN ATTENDANCE:	Mrs K Rudston	Assistant Chief Nurse
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No. **Item** **Action**

1 **APOLOGIES**
Apologies were received from Mr M Wright – Chief Nurse

2. **DECLARATIONS OF INTEREST**
There were no declarations of interest.

3. **MINUTES OF THE MEETING HELD 31ST JULY 2017**
The minutes were accepted as an accurate record of the meeting.

3.1 Matters Arising
Prof. Sheldon raised the cancer 104 day wait standard and asked how this was being managed. Ms Ramsay assured the committee that this was being monitored closely at the Performance and Finance Committee and that a request for more detailed understanding of the waiting time and impact on patients for Non-Executive Directors is being progressed.

Mr Phillips advised that there were further details to follow regarding the Trust's emergency caesarean rate.

Mrs Walker requested further information regarding the FIP2 report and any impact assessments regarding quality of care. Ms Ramsay assured her that the Performance and Finance Committee would be receiving a presentation from the FIP2 team regarding their exit strategy.

The agenda was taken out of order at this point – the following agenda item was taken as a matter arising

6.1 Themes Emerging from National NRLS Data
Mrs Bates updated the Committee and advised that there was no current benchmarking data relating to the severity of incidents and how they are distributed. Mrs Bates advised that the reporting data would soon be available on a monthly basis instead of 6 monthly as it is now. Mrs Bates to present the benchmarking information at the next meeting in September

2017. **SB**

Pressure ulcers were discussed and Mr Phillips advised that a high number of patients came into the hospital already with pressure ulcers and that it was important to clarify which ones were attributable to the Trust.

Resolved:
The Committee received the report and agreed to receive further benchmarking information at the next meeting.

The agenda return to order at this point

3.2 Action Tracking List
The action tracking list was reviewed by the Committee. Mr Phillips advised that the Fresenius report was not yet available but would bring it back to the Committee when it was. **KP**

3.3 Any Other Matters Arising
None

3.4 Workplan
The workplan was reviewed and accepted by the Committee.

4. REDUCE AVOIDABLE DEATHS

4.1 Mortality Report (Gap Analysis, HSMR)
Mr Phillips presented the report which detailed the progress against the requirements from the new National Quality Board's "Learning from Deaths" guidance, including the Trust's new case note review process, and highlighted any gaps against the national requirements.

Prof. Sheldon asked if the Trust should have a medical examiner and Mr Phillips advised that he undertook that role. It was good practice to have one but not an obligation for the Trust. Prof. Sheldon asked Mr Phillips to check the status of whether the Trust does need a medical examiner and provide assurance of this to the committee. **KP**

There was a discussion around patients with severe mental health issues and how their care would be managed by the whole health economy, which impacts on the way in which mortality reviews would be carried out. Mrs Bates advised that this was a national problem and the Trust was part of a Mortality Steering Group with the CCG's and Humber Mental Health where this was discussed. One of the main issues was definition and coding of "severe mental health" illness.

The Committee discussed avoidable deaths and how these are identified and categorised. Mr Phillips advised that he was working with the Health Groups to ensure a more systematic and standardised process was adopted and this would be represented in a flow chart as part of the Trust's Mortality Review policy. The Committee requested sight of a copy of the policy once approved for their own knowledge and understanding of the review process. **KP**

The Committee reviewed the gap analysis in detail and there was concern raised regarding the red rating of the 'patients who had died within 30 days post-discharge from inpatients'. Mr Phillips advised that sometimes it was

very difficult to know that a patient had died unless a medical professional involved with the death lets the hospital know. He advised that he was working with the Chair of Hull CCG (Dr Roper) to work more closely with the GPs and Mrs Bates added that the IT systems could also play a part in identifying these patients.

Dr Purva advised that there was slow uptake on case review training from the consultants and Chris Johnson had been training on a 1:1 basis to help with work pressures. Dr Purva stated that more resource was needed to get the training done more efficiently.

There were a number of issues discussed such as inconsistency due to not enough reviews being carried out, a perception that the standardised process takes longer than processes that specialities have developed for their own Mortality and Morbidity reviews, and how consultants could feel threatened by the process.

Prof. Sheldon asked that once the processes were embedded it would be useful to see a report showing lessons and any changes in behaviours reflecting learning. Mrs Walker added that she would like to see a mortality development session for Board members to discuss the issues. **CR**

Resolved:
The Committee received the report and agreed to circulate the updated Mortality Policy once approved for knowledge development and evidence of how the national guidance is being met. **KP**

5. REDUCE AVOIDABLE HARM

5.1 – Serious Incidents – July 2017

Mrs Bates presented the report and advised that compared to last year the number of serious incidents had reduced.

There was a discussion around pressure ulcers and Mrs Ledger reported that the Chief Nurse was meeting with Charge Nurses to ensure training was up to date and competencies reviewed. Enhanced student training was being implemented. She also advised that RCAs were carried out on all grade 2 and above pressure ulcers. There was work ongoing regarding management issues, consistency of approach when reviewing patients, understanding changes in clinical presentation and also good communication on shift changes and handovers.

Dr Purva advised that work was ongoing regarding the maternity serious incidents and an educational action plan was in place. Ms Bates added that the CCGs had complimented the Trust on their management of the serious incident investigation process and would receive the training that Trust staff get to ensure a system wide understanding of the RCA process.

Mr Phillips advised that a Never Event had been declared which had been identified as wrong site surgery. The patient had been informed and the investigation process initiated.

Mr Snowden asked if any common themes had been identified and if any useable learning was available. Mrs Bates advised that no common themes had emerged from recent incidents. Mr Snowden asked if the report could include the learning from the incidents in the future. Mrs

Bates agreed to present a 6 monthly lessons learned report and this would be received at the February 2018 committee.

Resolved:
The Committee received the report and agreed to receive a lessons learned report in February 2018. **SB RT**

The agenda was taken out of order at this point

7.2 Integrated Performance Report
The Standardised Hospital Mortality Index (SHMI) performance was discussed and it was noted that the weekend rate had increasing over winter in line with the weekday rate, however the increase was not concerning.

Mrs Bates advised that the team were reviewing three areas where there may be a higher-than-expected number of deaths: acute MI, COPD and pneumonia, to understand the increases and highlight any trends. Mr Phillips added that the coding and deprivation index were also taken into account when looking at the SHMI and the expected number of deaths. Mrs Bates advised that any learning from the three areas would be reported at the Committee.

The Committee also noted that the diagnostic wait time performance was getting worse as was 62 day cancer. Both areas were being reviewed at the Performance and Finance Committee and the Board.

RTT was improving slowly and Mrs Bates advised that the figures for the Friends and Family testing in ED were not accurate as the SMS text messaging figures had not yet been included.

Resolved:
The Committee received and accepted the report.

The agenda returned to its order at this point

5.2 Quality Improvement Programme (QIP)
The Committee reviewed the QIP and discussed a number of key areas.

Mrs Walker asked about QIP 12 and the improvements being made regarding Children and Young people's mental health support. Ms Rudston advised that she was meeting Hilary Gledhill (Director of Nursing) at Humber FT NHS Trust to discuss formalising the service level agreement which would include an operational working group.

Prof. Sheldon expressed concern regarding the low levels of e-learning compliance relating to falls and Mrs Ledger reported that this was being reviewed and broken down by discipline to ensure the key areas where there were issues are being addressed.

Resolved:
The Committee received and accepted the report.

5.3 Quality Impact of CRES
Mr Phillips presented the report which highlighted that there had not been

any schemes submitted for executive review over £100k so far this financial year.

There was a discussion around risks being managed if the savings proved to be substantial and Ms Ramsay advised that there would be a Board development session around risk appetite to discuss this further.

Resolved:
The Board received and accepted the report.

7.2 Operational Quality Committee
The Operational Quality Committee summary was presented to the Committee. Mrs Walker asked how well the committee was attended and Ms Ramsay advised that it had good representation from all relevant areas and had been quorate.

Mrs Bates advised that there had been an issue with the distribution of Junior Doctors by the Deanery and Mr Phillips, Chris Long and Simon Nearney would be meeting with the Deanery to discuss this further. This would also be discussed at the Board meeting in September 2017.

Prof. Sheldon requested that an agenda item relating to Duty of Candour be put on the next agenda to allow the Committee to understand further the Trust's process and compliance in this area. **SB**

Resolved:
The Committee received the report. Mrs Bates to provide a Duty of Candour update at the next meeting.

7.3 – Healthcare Delivery Improvement Group
Dr Purva advised that she would be providing a report to the September 2017 meeting.

7.4 Draft Safeguarding Annual Report
Ms Rudston presented the report and highlighted the key priorities faced by the Trust following the CQC inspection in 2016.

The Trust now had compliant levels of Safeguarding Children level 3 training and the Trust had introduced ward rounds as well as staff referrals increasing due to better awareness. She advised that the recording system was robust with information being read quickly. All relevant staff were being trained in modern slavery and genital mutilation and the child death review process was robust.

The key actions for 2017/18 were working with the Lorenzo team to ensure flagging of patients was more robust, how patients were transferred from the Emergency Department to paediatrics and reviewing quality of referrals from social care. Ms Rudston was also developing the Trust's Domestic Abuse Strategy. Mrs Walker asked if the serious incidents relating to safeguarding were cross referenced into the serious incident report and Mrs Bates confirmed that they did.

Mr Snowden was keen to maximise stakeholder feedback and Ms Rudston advised that the Trust worked with the councils, police and other agencies and were appropriate feedback was obtained. She advised that working

with the local economy and health partners was key.

Adult safeguarding had a positive start to the year and the Trust's internal auditors had given significant assurance to a recent audit carried out on the service. Prevent training was being embedded and the CQC had given positive feedback following their recent inspection. There was work ongoing with Humber FT NHS Trust to finalise the service level agreement to include mental health training of staff. There had been an increase in adult referrals made and these had been appropriate, the main cause being neglect.

Mrs Walker thanked Ms Rudston for the comprehensive report and asked if it would be appropriate to have a Non-Executive Director as a safeguarding champion in the Trust. Ms Ramsay agreed to raise the issue at the NED meeting that day. **CR**

There was a discussion around a local strategic view and how safeguarding could be captured and communicated between partners. Ms Rudston agreed to develop a safeguarding update report which would include care homes, social care and the health sector and how referrals are captured and communicated efficiently. **KR RT**

Resolved:
The Committee received and accepted the report.

8. BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the Board Assurance Framework, for which the Trust Board had agreed Q1 risk ratings. The BAF assurance sections had been updated from feedback at last month's Committee meeting, as captured in the covering report, and also detailing the updates made through the Performance and Finance Committee, for the Committee's awareness.

Key points of feedback to capture in the updated BAF from today's meeting are: the mortality review process – positive assurance on increasing compliance with national requirements and work still in progress, and detailing the specific impact on medical engagement including resources and accessing training.

Mrs Walker asked for feedback in relation to the Trust's balanced scorecard and a view of the top risks in the Trust. Mrs Ramsay confirmed she is working with the Trust's Business Intelligence team on this, and a first attempt is included in September's Board pack.

9. ANY OTHER BUSINESS

There was no other business discussed.

10. CHAIRMAN'S SUMMARY TO THE BOARD

The Chairman agreed to summarise the meeting at the Board in September 2017.

11. DATE AND TIME OF THE NEXT MEETING:

Monday 25 September 2017, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2017/18

September 2017

August data

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

RESPONSIVE

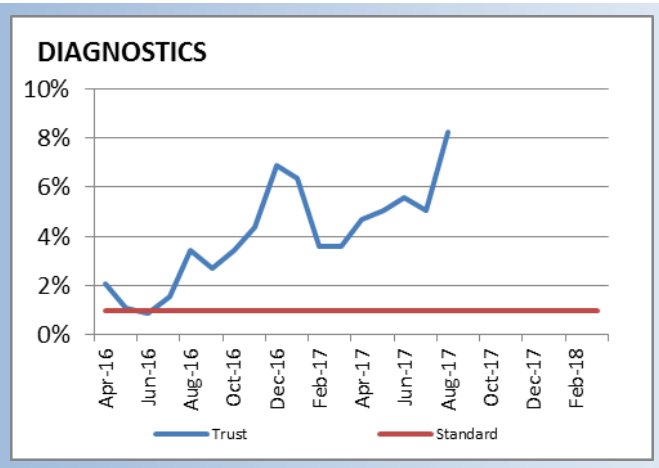
Description	Aggregate Position	Trend	Variation

Diagnostic Waiting Times: 6 Weeks

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

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target with performance of 8.24% in August

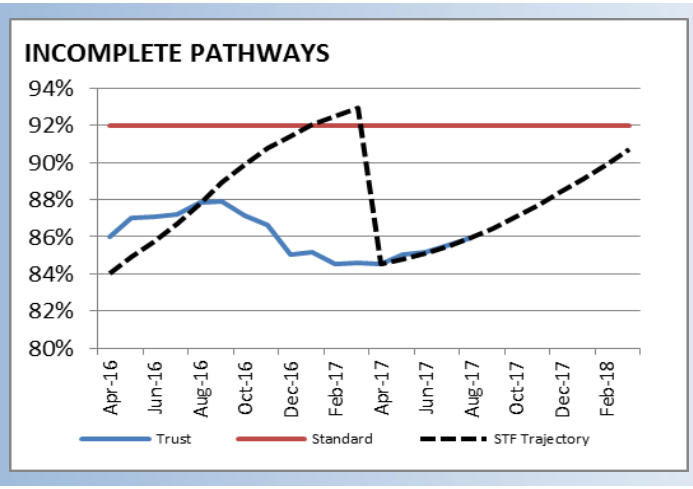


Referral to Treatment Incomplete pathway

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

The Trust achieved the August Improvement trajectory of 85.9%

August performance was 85.91%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During August there were 9 specialties that failed to meet the STF trajectory

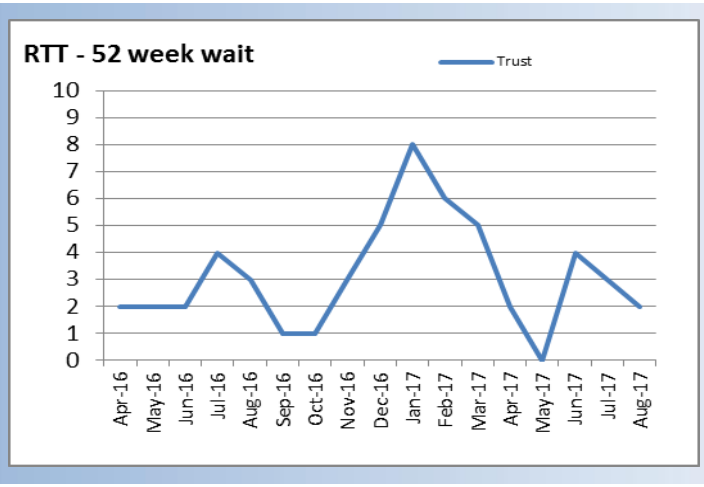
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

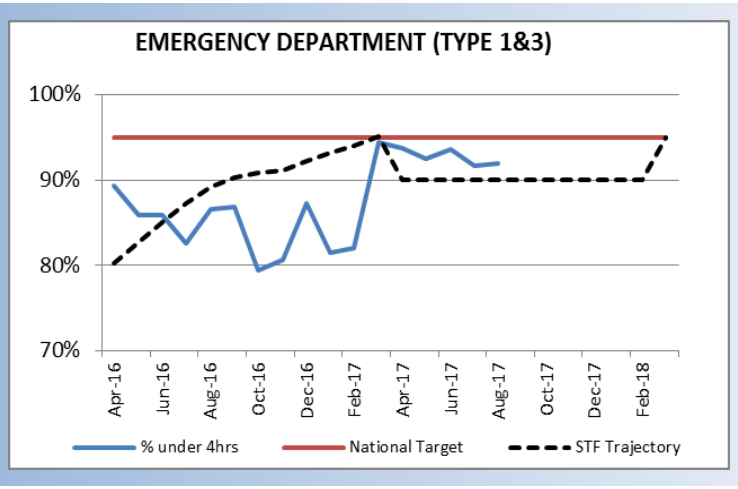
The Trust failed to achieve the national standard of zero breaches with 2 breaches during August.



A&E Waiting Times

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

A&E performance achieved the Improvement trajectory of 90.0% with performance of 92.0% for August. This has failed to achieve the national 95% threshold.



Performance has increased by 0.3% during August compared to July performance of 91.7%.

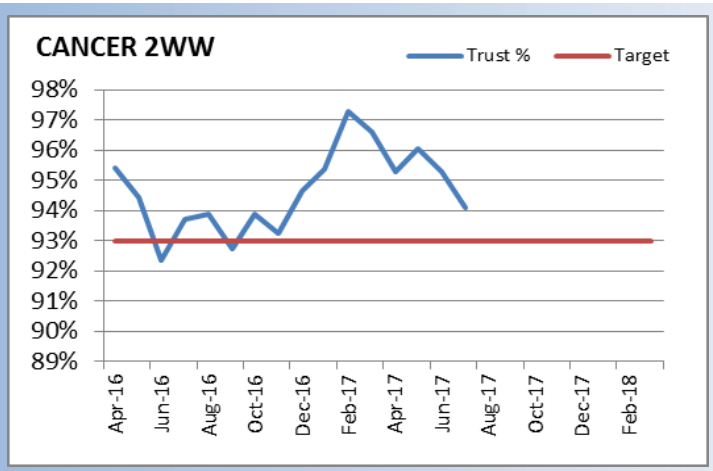
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: Two Week Wait Standard

All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.

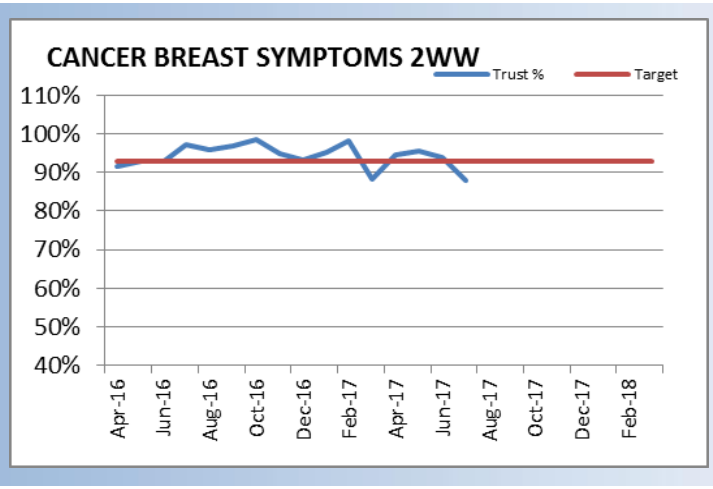
July performance achieved the 93% standard at 94.1%



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.

July performance failed to achieve the 93% standard at 88.0%



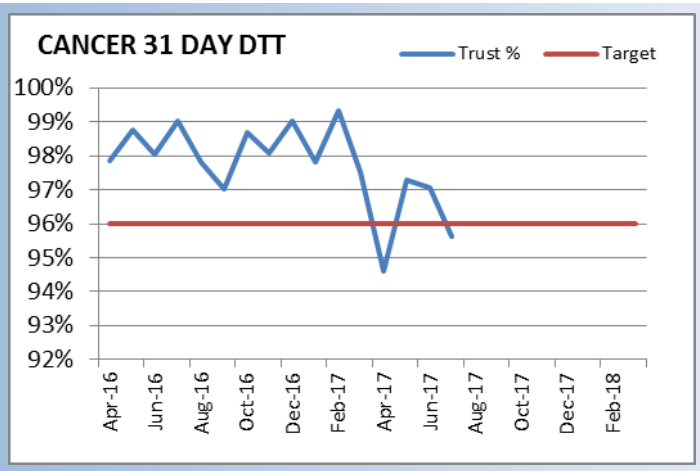
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Standard

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

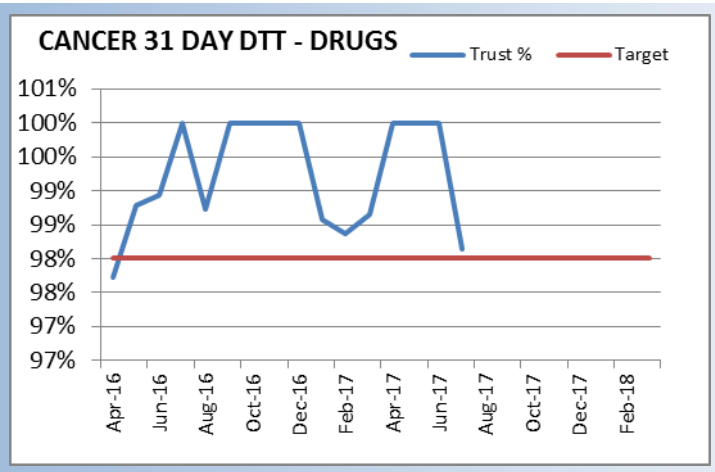
July performance failed to achieve the 96% standard at 95.6%



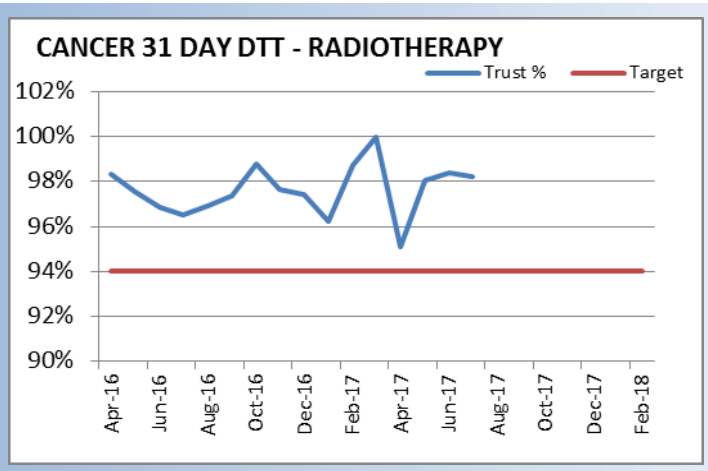
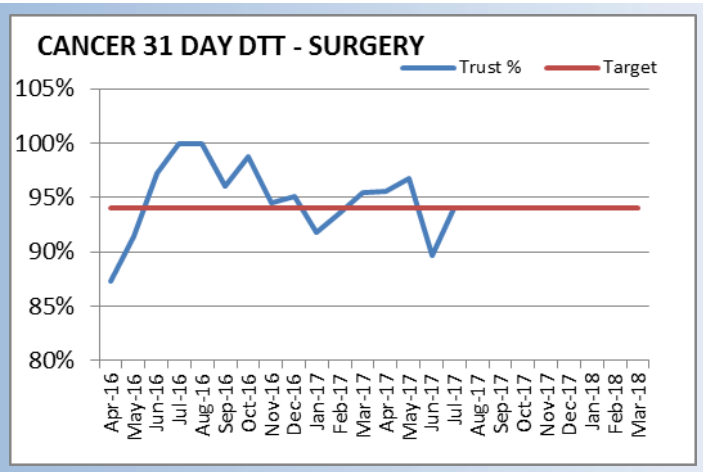
Cancer: 31 Day Subsequent Drug Standard

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

July performance achieved the 98% standard at 98.1%



RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	July performance achieved the 94% standard at 98.2%		
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%.	July performance achieved the 94% standard at 94.0%		

Integrated Performance Report - September 2017

RESPONSIVE

Description	Aggregate Position	Trend	Variation

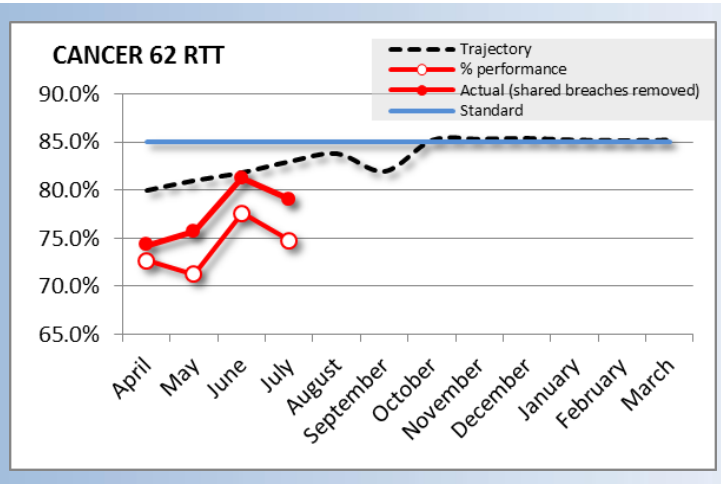
Cancer: ADJUSTED - 62 Day Standard

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

Sustainability and Transformation trajectory is 80.0%

The adjusted position allows for reallocation of shared breaches

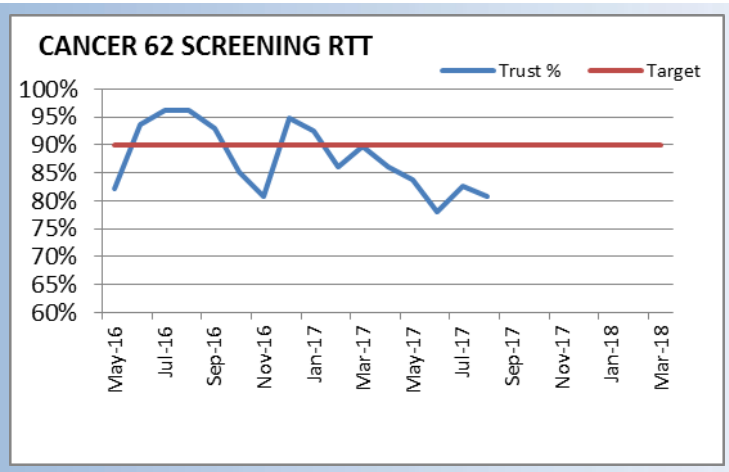
July provisional performance failed to achieve the STF trajectory of 83.0% with performance of 79.0% awaiting confirmation of reallocation of breaches



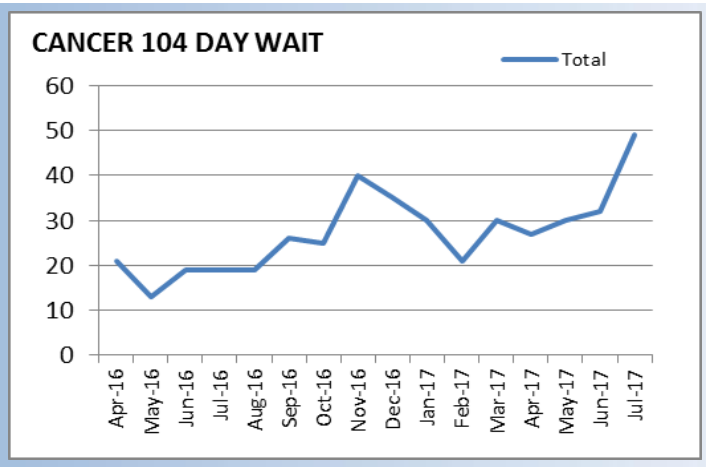
Cancer: 62 Day Screening Standard

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

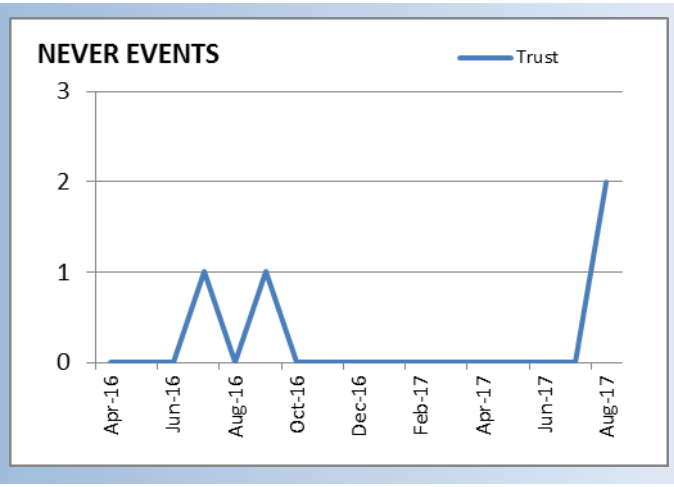
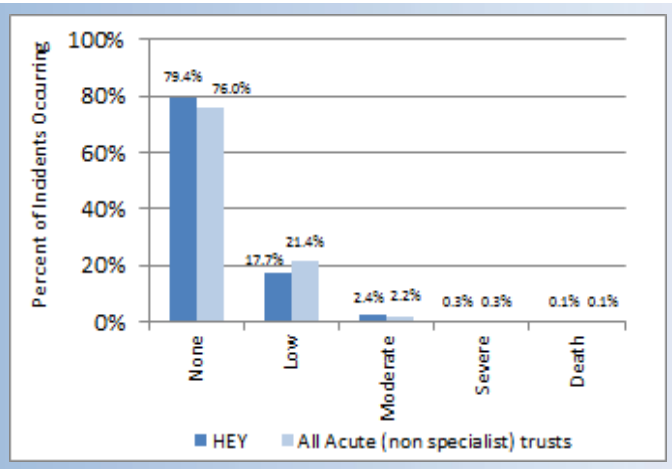
July performance failed to achieve the 90% standard at 80.7%



RESPONSIVE

Description	Aggregate Position	Trend	Variation
Cancer 104 Day Waits	There were 49 patients waiting 104 days or over during July		

SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Events	There were 2 Never Events reported during August		Further information is included in the Board Quality report
Number of incidents reported per 1000 bed days	The latest data available for this indicator is April 2016 to September 2016 as reported by the National Reporting and Learning System (NRLS). The Trust reported 5,546 incidents (rate of 32.71) during this period.		

SAFE

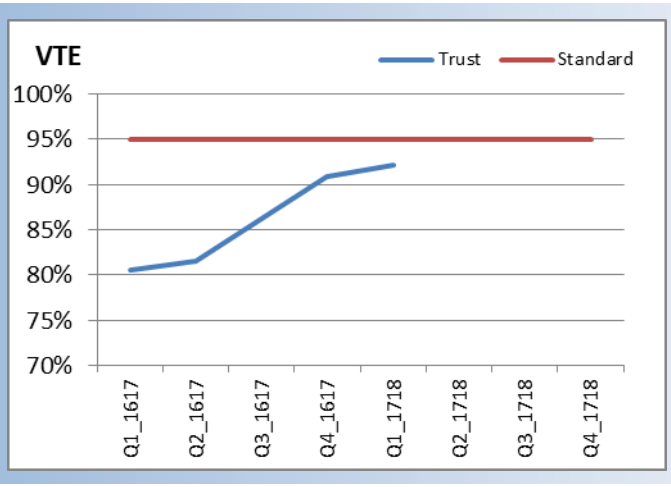
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 92.13% for Q1 2017/18.

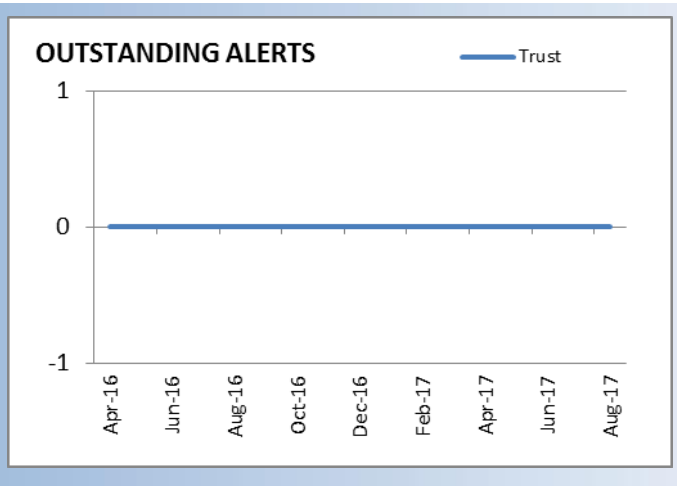


Patient Safety Alerts Outstanding

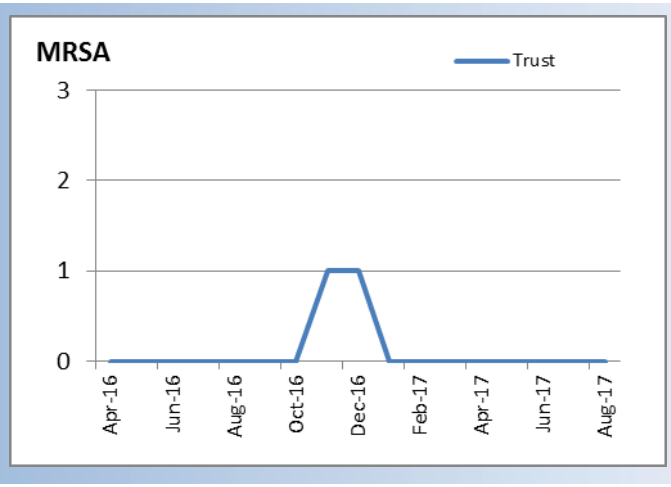
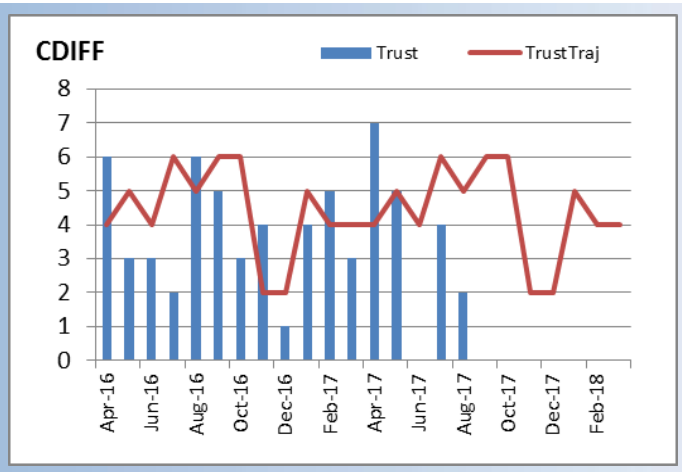
Number of alerts that are outstanding at the end of the month

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

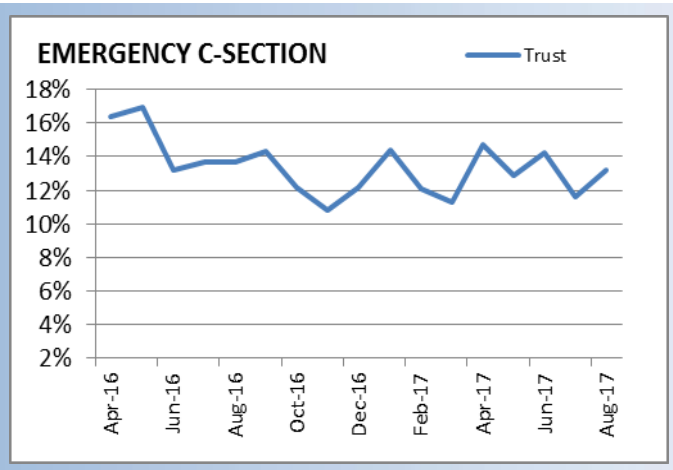
There have been no outstanding alerts year to date.



SAFE

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

SAFE

Description	Aggregate Position	Trend	Variation
Emergency C-section rate	Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for August failed to achieve this standard at 13.2%		Further information is included in the Board Quality report

EFFECTIVE

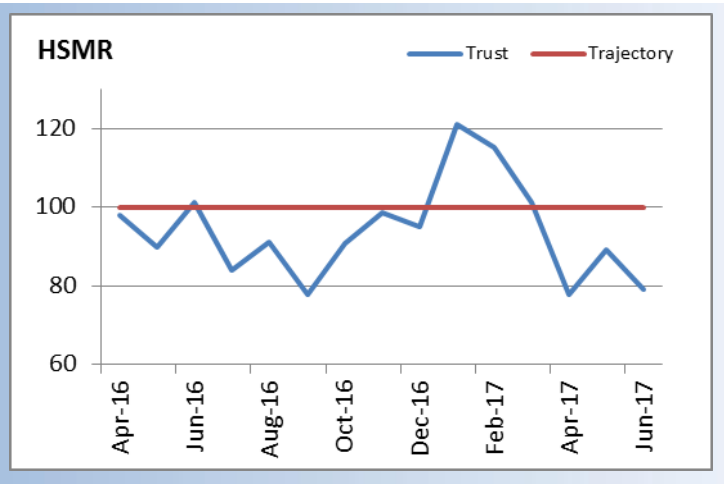
Description	Aggregate Position	Trend	Variation

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) groups

June 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and June 2017 achieved this at 79.2

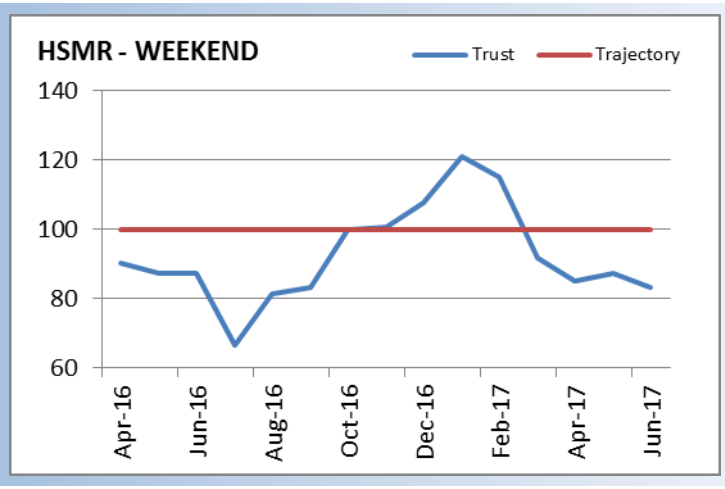


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

June 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and June 2017 achieved this at 83.1



EFFECTIVE

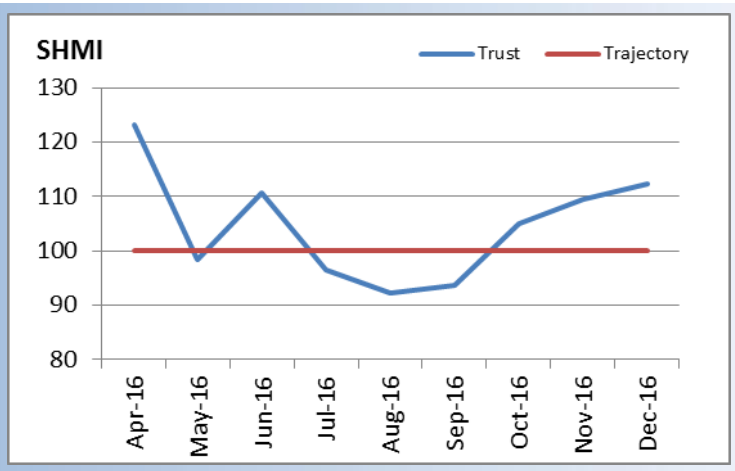
Description	Aggregate Position	Trend	Variation

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.

December 2016 is the latest published performance

The standard for SHMI is to achieve less than 100 and December 2016 failed to achieve this at 112

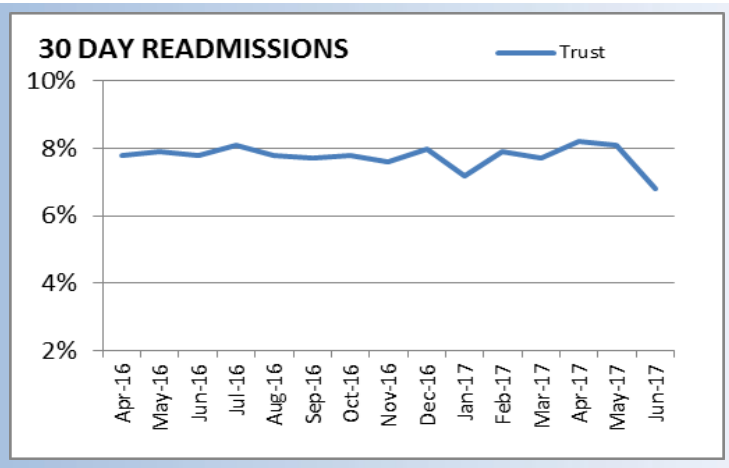


30 DAY READMISSIONS

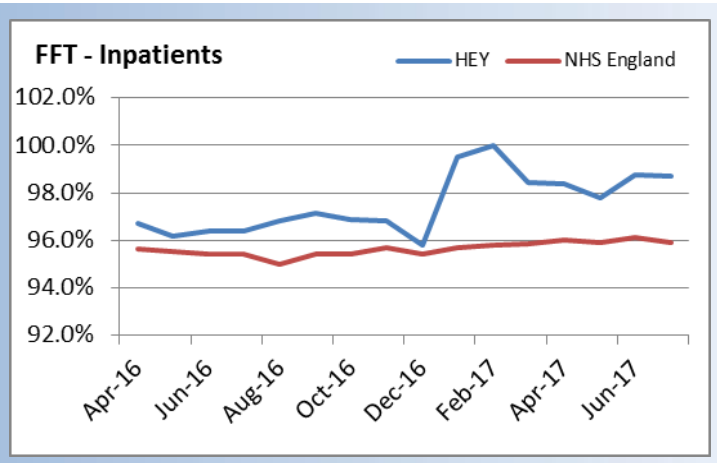
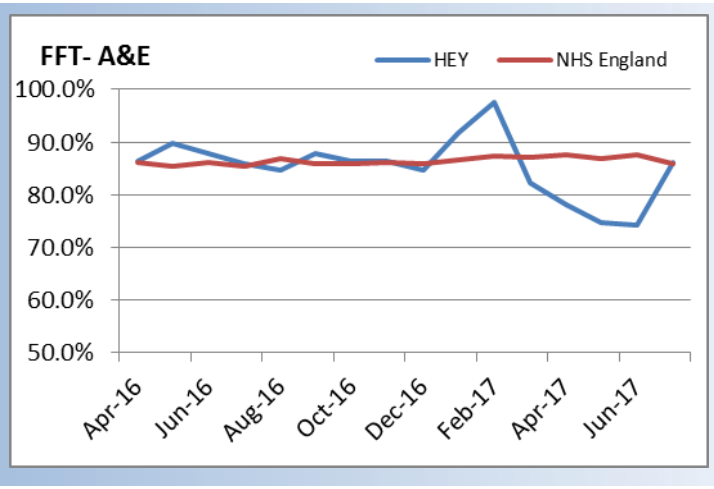
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is June 2017

The readmissions performance is measured against the peer benchmark position for 2016/17 to achieve less than or equal to 7.4%. The Trust achieved this measure with performance of 6.8%.



CARING

	Description	Aggregate Position	Trend	Variation
Inpatient Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for July was 98.7% The latest published data for NHS England is July 2017.		
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for July was 86.2% The latest published data for NHS England is July 2017.		

CARING

Description	Aggregate Position	Trend	Variation

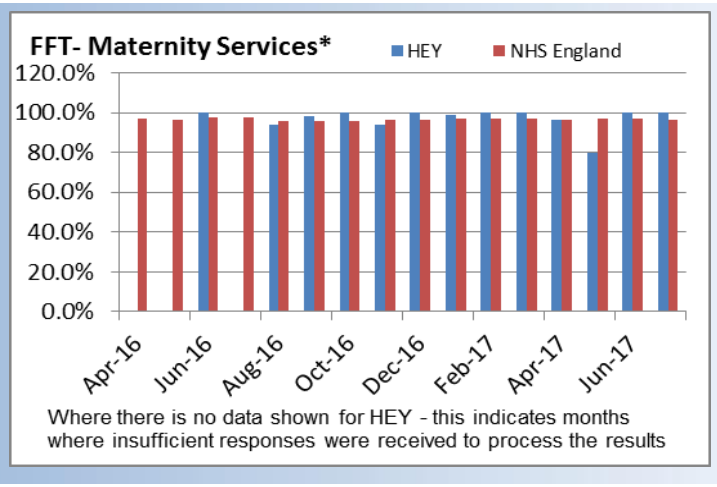
Maternity Scores from Friends and Family Test - % Positive

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

Performance for July was 100%

The latest published data for NHS England is July 2017.

Months with no data for HEY is due to insufficient responses

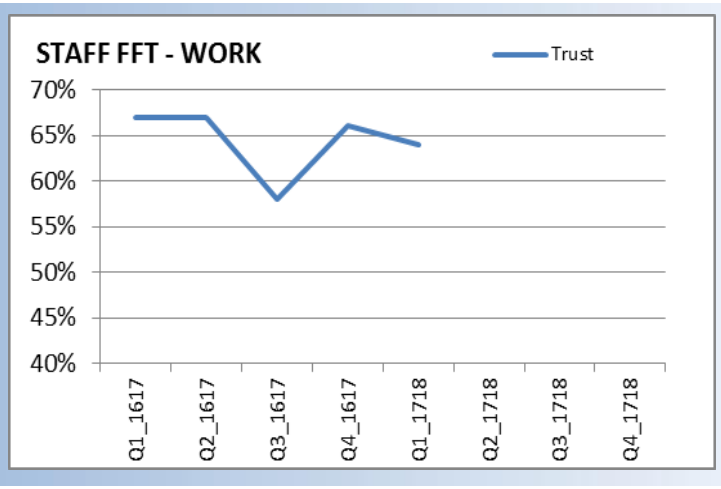


* Question relates to Birth Settings

Relative Position in Staff Surveys

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

The latest Friends and Family Test position is quarter 1 2017/2018 shows that 64% of surveyed staff would recommend the Trust as a place to work, this has decreased from the quarter 4 position of 66%.



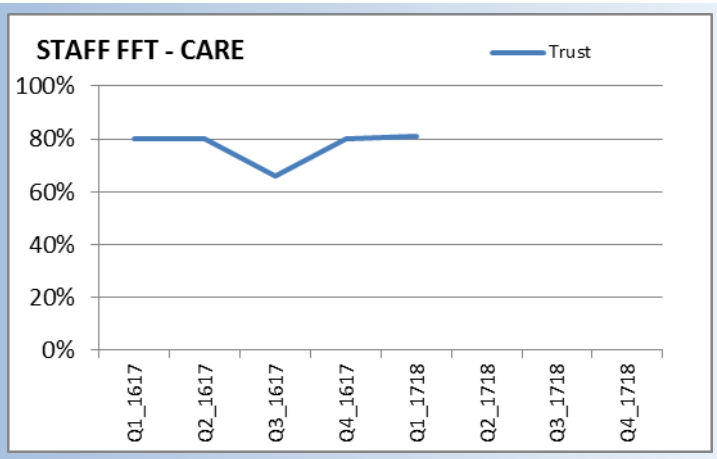
CARING

Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

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

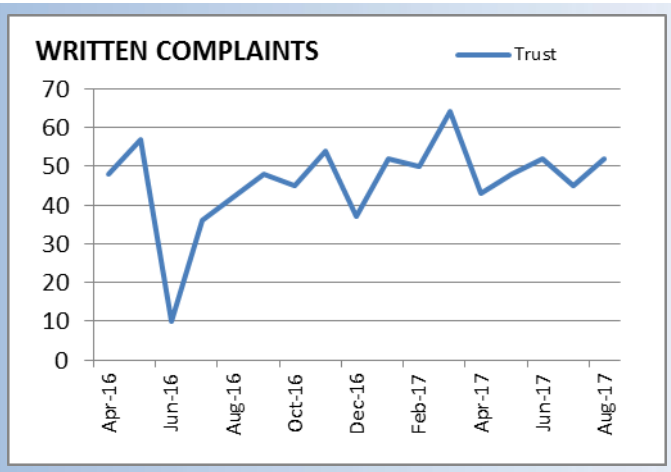
The latest Friends and Family Test position is quarter 1 2017/2018 shows that 81% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has improved from the quarter 4 position of 80%.



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 52 complaints during August, this is a increase on the July position of 45 complaints

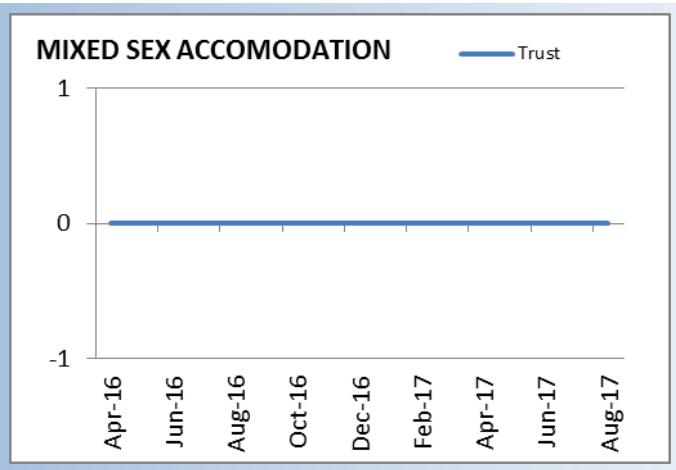


There have been 240 complaints year to date

CARING

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

Mixed Sex Accommodation Breaches



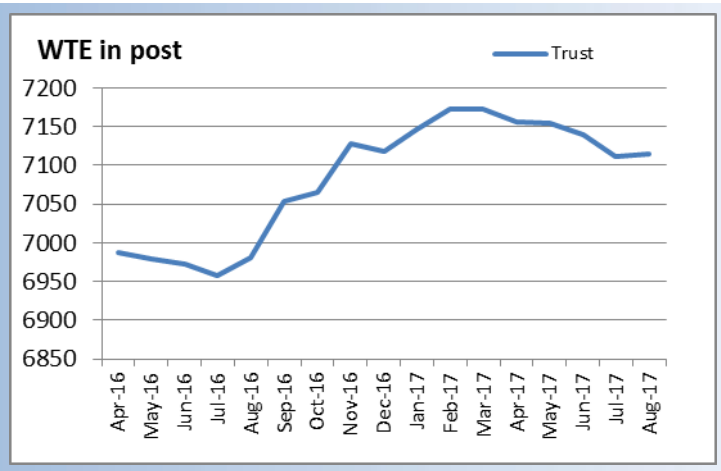
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

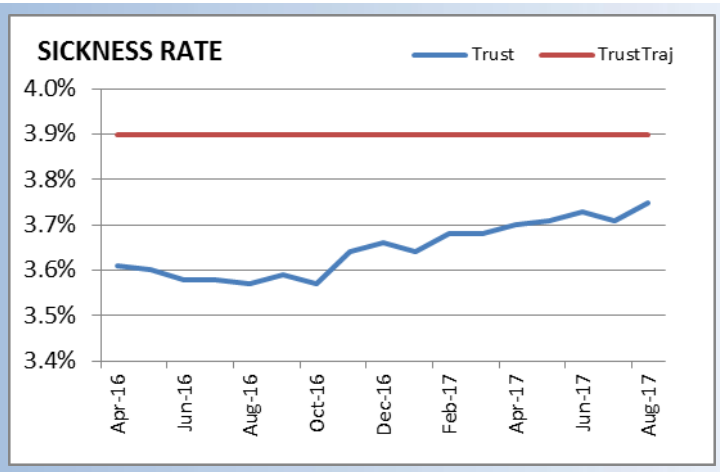
Trust level WTE position as at the end of August was 7115



Sickness Absence Rates

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

Performance for August achieved the standard of less than 3.9% with performance of 3.75%



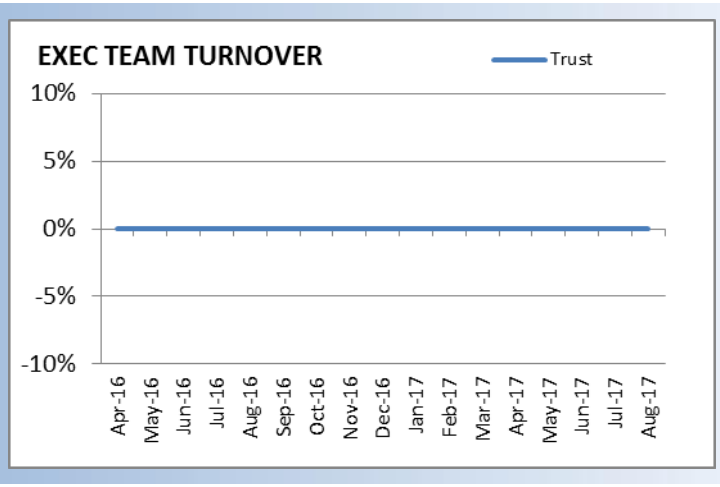
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

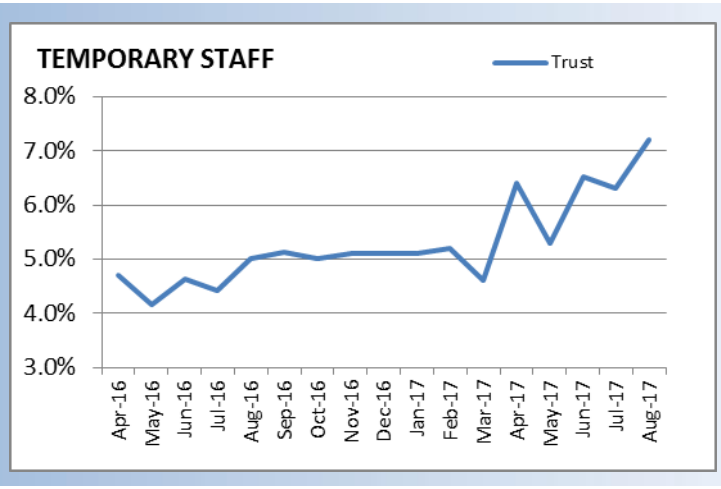


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

August performance was 7.20%



FINANCIAL SUMMARY: 5 MONTHS TO 31ST AUGUST 2017

1. At the end of month 5 the Trust is reporting a deficit of £9.1m. This is £7.1m above the planned deficit of £2.0m.

2. The deficit includes non receipt of £3.4m of STF income for non delivery of the financial plan to month 5. The Trust can regain this funding if it moves back to its financial plan in later months.

3. The Trust has a gross contract income gain of £3.2m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs there is a nett shortfall of £1.4m which is an adverse movement of £0.3m in the month.

4. The Trust has a CRES shortfall at month 5 of £2.2m. The Trust has released 5/12ths of its CRES reserve (£0.6m) to reduce this to a deficit of £1.6m.

5. Health Group run rate positions have deteriorated in month by 0.1m, an improvement on previous months. It is imperative that health groups maintain this and improve overall cost base, both run rate and CRES. Medicine's increase was lower than the previous trend due to reduced rate of medical pay spend but their main pressures continue to be related to the staffing of the ground floor models.. Surgery's overspend saw little change in month (0.01m) indicating some improvement in the trend and this was mainly in Orthopaedic implants. Clinical Support HG continue with pressures in Radiology outsourcing (£0.2m) and medical agency staffing to cover vacancies and sickness. Family and Women's HG pressures are continuing at a slightly lower rate of increase at 0.1m movement in the month and overall are mainly in Medical staffing related to vacancies and sickness and CRES delivery.

6. Agency spend to the end of August is £4.4m which is slightly below planned levels.

7. General reserves of £1.9m have been released to partially offset the run rate and income pressures

8. Overall forecasts have improved by £1.3M due to income gains of £0.6m , improved Health Group forecasts of £0.4m and £0.3m reserve assumptions. The financial information indicates a problem of £6.7m by year end if current trends continue. This is based on Health Groups being £10.7m overspent and £2.6m short on income, offset by the release of £6.7m of reserves. Immediate actions need to be identified to offset this potential £6.7m risk.

9. In line with published NHSI guidance the Trust is still reporting that it will achieve its year end financial plan. As indicated above this is extremely challenging and requires urgent action.

10. The Trust cash position is gradually worsening from the initial gain of the advanced contract payments in tenths since the NHSE advised CCGs to revert to payment in 12ths for the remainder of the contract term due to national pressure on cash reserves. Together with the deficit position, including non receipt of STF funding, this places additional pressure on the Trust and loan applications are being prepared for expected draw down in November.

11. As reported last month, there is an additional risk to the Trust forecast position relating to 0.5% of the CQUIN payment from CCGs (£1.6m) . Following published guidance CCGs have been advised to withhold payment if Trusts cannot confirm that this is held in a reserve and not being used to deliver the financial control total. Given the block nature of our main contract it is not clear whether this is a risk to the Trust. A National debate is ongoing between NHSI & NHSE over the treatment of these monies across the Acute sector.

12. The Trust has spent £5.9m of capital at month 5 and is forecasting to spend £19.9m during the financial year in line with plan, which includes the agreed extra £1m for ED Primary Care Streaming.

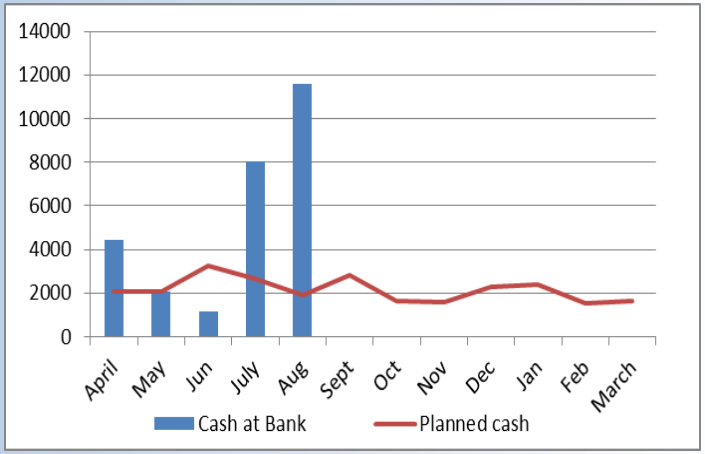
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of August was £11.592m, of which £1.573m was held in bank accounts, £0.019m in petty cash, and £10m on deposit with the National Loans Fund (NLF). Most supplier accounts were paid up to date in July and August, using additional cash we received from Commissioners and we retained a balance of £10m to pay suppliers during September. The cash position for Q3 & Q4 will be challenging. Commissioners will realign contract payments, meaning we will receive £9m less, causing significant pressure on relationships with our suppliers and careful management will be needed to ensure the operational impact is minimised. To relieve the pressure we are are exploring the possibility of a temporary borrowing facility with the Department of Health.

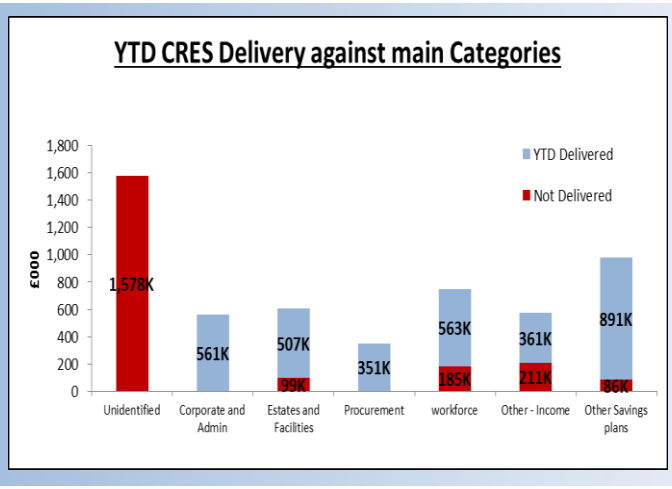


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 5 the Trust has delivered £3.2m of CRES savings against a CRES ytd plan of £5.4m (£2.2m adverse variance)

The Trust is forecasting delivery of £11.5m of savings against a plan of £15.0 (£3.5m adverse). Having worked closely with Deloitte the Trust expects to identify new schemes and revise its forecast to a more favourable one in coming months.



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

Description	Aggregate Position	Trend	Variation

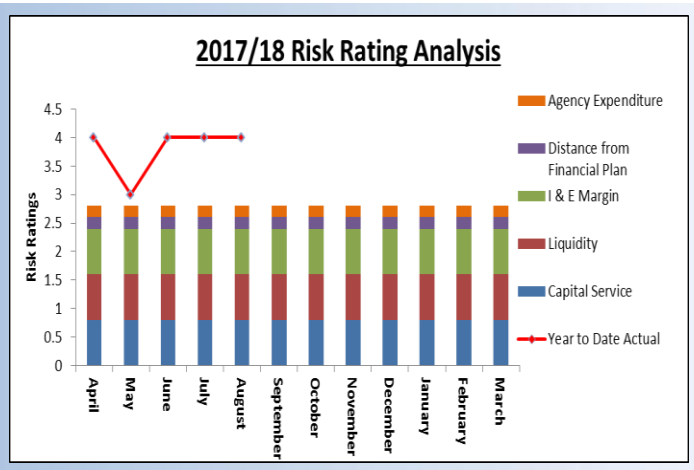
Risk Rating

Financial Sustainability Risk Rating

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

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

As at month 5 the Trust is reporting a deficit of £9.1m against a planned deficit £2.0m (£7.1m adverse) this has resulted in Liquidity, Capital servicing, I&E Margin and Distance from plan all being rated as a 4, resulting in an overall risk rating of 4.

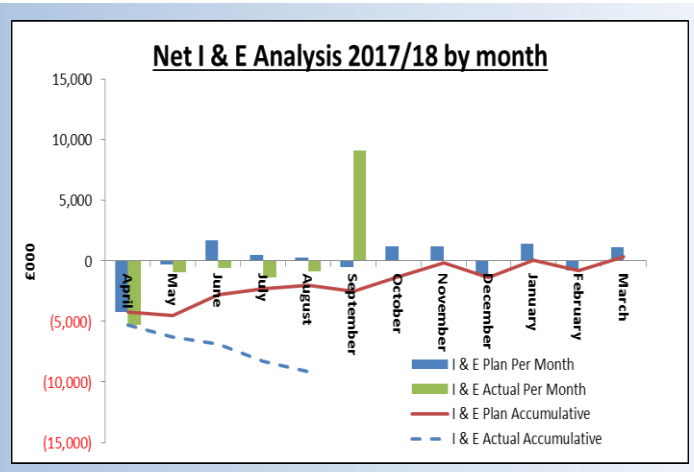


Income & Expenditure

Net income and Expenditure

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

At month 5 the Trust has delivered a deficit of £9.1m against a plan of £2.0m deficit (£7.1m adverse). The plan for 17/18 is to deliver a surplus of £0.3m, this includes STP funding.



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 - 13
Director	Lee Bond – Chief Financial Officer	**Author**	Samantha Graves – Business Planning Accountant
Reason for the report	The purpose of this report is to request Trust Board approval for the application of an Uncommitted Loan.		

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

1	**RECOMMENDATIONS** The Board is asked to support the application process for an Uncommitted Loan and to sign the Board Resolution.					
2	**KEY PURPOSE:**					
	Decision		Approval	X	Discussion	
	Information		Assurance	X	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					X
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y/N	**Legal advice taken?** Y/N	**Raises sustainability issues?** Y		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

UNCOMMITTED LOAN

1. PURPOSE

The purpose of this report is to request Trust Board approval for the application of an Uncommitted Loan.

2. INTRODUCTION

The Trust previously had an Interim Revolving Working Capital Support Facility (IRWCSF) in place. This enabled the Trust to drawdown funds to assist in the cash flow financing on a monthly basis. The current facility was withdrawn in February 2017 when the Trust converted it to a permanent Revenue Loan at a lower interest rate. The Department of Health are no longer awarding IRWCSF, instead they are issuing Uncommitted Loans on a monthly basis up to the value of the Trust's NHSI reviewed cash requirement.

3. UNCOMMITTED LOAN

The Trust has been notified that the Department of Health is making loan facilities available to replace IRWCSF where these were converted to Revenue Loans. This will be in the form of an Uncommitted Loan.

Financing will be considered against a monthly 'cash equivalent' requirement. The cash equivalent figure may include cash required to fund a Trust's SOCI planned deficit position, revenue loan repayments on debts, and where control totals are agreed, cash in advance of STF payment.

Interest on Uncommitted Loans are variable, but are currently set as follows:

1.5% - for Trusts who have agreed their 17/18 control total
3.5% - for Trusts who have not agreed their 17/18 control total
6% - for Trusts who are in Special Financial Measures.

As the Trust has agreed a control total, the interest rate for the Uncommitted Loan will be 1.5%. The interest payments have been included in the Trusts Financial Plans for 2017/2018 submitted to NHSI in March 2017.

Detailed review of the Trusts cash flow and forecast SOCI deficit position show the Trust will require a £4.2 million Uncommitted Loan in Quarter 3. This is based on there being no significant deterioration from the Month 5 position and assuming the Trust achieves plan at Month 6. The £4.2m represents the outstanding STF to month 6. Going forward the requirement for subsequent loans will need to be reviewed on a monthly basis.

In order for the loan transfer to occur the Trust must complete:

- A signed and dated Facility Agreement supported by a Board Resolution. The required Board Resolution is attached at Appendix 1.
- A 13 week cash flow showing the amount of cash required

The Performance & Finance Committee understand the Trust's forecast cash position at Month 6 and recommend the approval for the application of the Uncommitted Loan

4. RECOMMENDATION

The Board is asked to support the application process for an Uncommitted Loan and sign the Board Resolution minute.

Lee Bond
Chief Financial Officer
September 2017

Hull and East Yorkshire Hospitals NHS Trust

Board Resolution

Statement from the Chair and Chief Executive of Hull and East Yorkshire Hospitals NHS Trust regarding the Trust Board approval of an Uncommitted Loan Agreement.

A paper has been presented to the Trust Board on 3 October 2017 for scrutiny regarding the proposed loan.

This recommends that an Uncommitted Loan totaling £4.2million is taken, repayable by 2020.

We confirm the Board have accepted this recommendation and therefore approve the Uncommitted Loan on behalf of the Trust.

We also:

a) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

b) Authorise the Chief Finance Officer to execute the Finance Documents to which it is a party on its behalf; and

c) Authorise the Chief Finance Officer to sign and/ or dispatch all documents and notices (including the Utilisation Request) in connection with the Finance documents to which it is a party on its behalf.

d) Confirm our undertaking to comply with the Additional Terms and Conditions

We certify that a paper has been presented to the Trust Board for scrutiny regarding the proposed Finance Documents and that this has been circulated to all Trust Board members.

Terry Moran -Chair, Hull and East Yorkshire Hospitals NHS Trust

Signature:

Chris Long - Chief Executive, Hull and East Yorkshire Hospitals NHS Trust

Signature:

Dated:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE MEETING MINUTES
HELD ON 29 AUGUST 2017

PRESENT:	Mr S Hall	Chair – Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Ms M Veitch	Deputy Chief Operating Officer (on behalf of Mrs E Ryabov)
	Mrs L Harding	Head of HR Advisory Service (on behalf of Mr S Nearney)
IN ATTENDANCE:	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Dr C Armistead	Deloitte (for item 8.3)
	Ms A Lodge	Deloitte (for item 8.3)
	Mr P Lobb	Deloitte (for item 8.3)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No. **Item** **Action**

1. APOLOGIES
Apologies were received from Mrs E Ryabov – Chief Operating Officer and Mr S Nearney – Director of Workforce and OD

2. DECLARATIONS OF INTEREST
There were no declarations of interest.

3. MINUTES OF THE MEETING HELD ON 31 JULY 2017
The minutes were approved as an accurate record of the meeting.

4. MATTERS ARISING FROM THE MINUTES
The procurement strategy to be added to the workplan on a quarterly basis.

The agenda was taken out of order at this point

8.3 Review of FIP2 Progress – Deloitte
The Deloitte Team attended the meeting to give an update regarding their exit programme.

They spoke about the Health Group engagement as they had spent time with the business managers and corporate teams to give project management support. They were also working closely with Mr Evans who has been identified the Trust's CRES programme lead.

Mr Hall asked how the programme would be managed after the team had left and Ms Lodge advised that the development and plans and structures were in place to allow the Health Groups to carry on. Mr Lobb advised that handover was critical and that it would require effort on behalf of the Health Groups. Dr Armistead advised that 95% of the projects were completed with 12 outstanding and these would be monitored closely at

the Productivity and Efficiency Board.

Mr Gore asked for the key areas of focus and Ms Lodge stated that basic procurement savings and product discount was one area, bed closures and service provision and more transformational programmes to drive down length of stay were others. The theatre capacity programme was also key.

There was a discussion around the Transformation Team and how it would need to drive through the programmes following Deloitte's departure. Mr Bond assured the committee that the team would include financial improvements made as a result of improvement programmes, with the ability to measure performance within their support and reporting.

The recommendations from the Deloitte team were:

- Ensure the CRES programme and Project Management Office were in place
- Review run rates as well as CRES in the Health Groups
- More capacity required in the Trust's Business Intelligence team to provide analysis of data

Mr Lobb reported that working with the Trust overall had been good and that the team had been made very welcome, with good engagement from most areas.

Resolved:
The Committee received the update and requested:

- A list of schemes and the savings in the next CRES report **SE**
- Health Groups to be invited to the Committee to discuss their CRES and run rate positions **RT**

Dr C Armistead, Ms A Lodge and Mr P Lobb left the meeting at this stage

The agenda reverted back to order at this point

5. ACTION TRACKING LIST

Getting it Right First Time

Ms Veitch advised that Mr Watson and Mrs Kemp were developing a GIRFT strategy and Mr Hall agreed to speak them regarding a report to the committee. Mrs Drury added that GIRFT was being reviewed across the Strategic Transformation Partnership (STP) also. **SH**

Avoidable breaches per tumour site

Mss Veitch to email this information to the Committee. **MV**

6. WORKPLAN 2017/18

The workplan was reviewed by the Committee. An update on the Procurement Strategy will be added quarterly. **RT**

7. DEMAND REPORT – MONTH 4

Mrs Drury advised that referrals had seen a reduction of 4.6% to end July 2017 compared to last year's figures. Similar reductions were being seen across commissioners, including the South Bank and York. The overall

contract position was a 1.6% reduction in new outpatient referrals and a 2.2% reduction in follow ups. Mr Bond asked why the Trust was not using the reduction in referrals to catch up with follow up appointments and Mrs Drury advised that this was due to activity still being up against plan.

The Emergency Department attendances were 4% up resulting in approximately 379 attendances per day. Non-elective admissions were below contract by 1.8% and this was predominantly in the Surgery Health Group. A number of areas were being reviewed around the reduction in non-elective admissions: elderly medicine and the impact of the FIT model, any impacts relating to the new zoning system and seasonal trajectories compared to last year's profile. Mrs Drury also reported that there would be a review of the orthopaedics case mix and case complexity, which would look back 3 years.

Mr Gore asked about activity volume changes. Mrs Drury advised that some of areas have a decrease in activity figures but are seeing an increase in complex case mix, causing problems when scheduling theatres.

Resolved:
The Committee received and accepted the update.

8. FINANCE

8.1 Corporate Finance Report

Mr Bond presented the report and advised that at the end of month 4 the Trust was reporting a deficit of £8.3m which was £6m above the planned deficit of £2.3m.

The Health Group run rate positions had deteriorated in month by £0.6m. There was a detailed discussion around how this would be recovered to hit the year-end target. Mr Bond had already released reserves and would need to release more to help the Trust achieve its financial plan and receive the STF funding. The Committee held a discussion as to the timing vs. benefit of releasing reserves and qualification for STF funding.

Mr Bond advised that extra support was being sought for the Health Group financial teams to ensure the CRES savings relating to FIP2 programme were kept on track after the Deloitte team had left to achieve the efficiencies identified.

Resolved:
The Committee received and accepted the report. Mr Bond agreed to provide the simplified breakdown of the finances on a monthly basis to the Committee. **LB**

8.2 - CRES REPORT

Mr Evans presented the report and advised that the Trust had a shortfall of £1.67m at month 4. The Trust had released £500k of CRES reserves to reduce this to a deficit of £1.17m. There was still £4.2m to be identified if the target is to be achieved.

There were a number of CRES schemes yet to be realised by the Health Groups. There was a discussion around not declaring schemes to the

FIP2 team and Mrs Christmas was concerned that this would hinder the financial planning. Mr Bond advised that some schemes are under development and might need further work to ensure that they were robust prior to implementation and savings being realised.

There was a discussion regarding the Health Groups attending the Performance & Finance meetings to discuss their CRES schemes further. This is in relation to understanding the Health Group's plans following Deloitte's departure and a view on CRES for 2018/19. **RT**

Resolved:
The Committee received and accepted the report.

8.3 - REVIEW OF FIP2 PROGRESS – DELOITTE
This agenda item was taken earlier in the meeting

9. PERFORMANCE REPORT

Ms Veitch presented the report and advised that Emergency Department performance in July was 91.69% and still above the 90% target. The position had deteriorated slightly with issues around long waits (especially out of hours), reduced bed availability and issues around flow. A recent example was a significant number of trauma cases received in a 24 hour weekend period and how this had prompted the development of a new escalation trigger. Work is still ongoing on this.

There had been ED staffing resource issues due to annual leave and sickness and Ms Veitch confirmed that the demand and capacity planning, coupled with the Department's Consultant self-rostering arrangements, had contributed to rotas not being robust enough to safeguard performance.

There were still issues around ambulance turnaround times and discussions with Yorkshire Ambulance Services were being held.

RTT had hit trajectory for July but was still below the standard of 92%. Work on the theatre timetable was having positive results.

The 52 week breaches were due to incorrect clock stops and Ms Veitch advised that this was being reviewed at each PandA meeting. Mr Bond asked if the correct training was being given and when did this become a competence issue. Ms Veitch advised that staff were being challenged and the Health Groups held accountable. Mr Hall requested that he attend a PandA meeting to discuss this further. **SH/RT**

The Trust had missed its 62 day cancer standard in June. This was mainly due to issues around outpatients and diagnostics. Mr Bond asked for more clarity around the 104 day cancer graph. Ms Veitch confirmed that many of the long waiters where patients who had been confirmed as not having cancer but had not been removed from the Cancer PTL. Work is ongoing within Cancer PANDA to address this and the figures in the report.

There had been diagnostic improvements in MRI/CT resulting in a waiting list reduction. There would be a deep dive into this area in the Health Group accountability meetings to review and understand the peaks in

performance.

Mr Hall asked for more information around the increase in demand for 2 week wait cancer referrals. Mrs Veitch agreed to provide this. **MV**

Resolved:
The Committee received and accepted the report and asked for further information relating to the increase in demand for urgent cancer referrals.

10. AGENCY SPEND PROGRESS REPORT

Mrs Harding presented the report and advised that the agency spend for the Trust was below plan at £3.4m against the target of £3.6m. She advised that medical spending was still higher than the plan and that this was not likely to improve in the short term. It was due to the number of medical staffing vacancies.

The biggest gap not budgeted for was in the Clinical Support Health Group which had a number of specialist areas difficult to recruit to which meant that due to acute pressures these had to be backfilled and were very expensive. Mr Bond advised that in some cases were agency staff could not be sought, the whole service might have to be outsourced.

Resolved:
The Committee received and accepted the report.

11. PEOPLE STRATEGY – PROGRESS REPORT FROM THE WORKFORCE TRANSFORMATION COMMITTEE

Mrs Harding presented the report which highlighted that 180 nurses had been interviewed and 125 secured and would start working for the Trust in September 2017. International recruitment was also ongoing with 13 new recruits starting in September and 15 in October 2017. A number of initiatives were in place to ensure that all the new recruits, especially the overseas nurses, were made welcome.

Mrs Harding advised that the new Apprenticeship Programme was being developed but there was still a lot of work to do. The job roles would include nursing.

The Leadership Programme was discussed and Mrs Harding reported that a number of general managers were attending this in-house programme, which developed skills in line with the Trust objectives and values.

Mr Gore asked for more information around exit interviews and Mrs Harding advised that she would forward the Committee members a report that had been presented to the Workforce and OD Committee giving more details. Mr Gore also asked for a focus on retention in the next quarterly report to be submitted. **LH**

Resolved:
The Committee received and accepted the report.

12. CAPTIAL RESOURCE ALLOCATION COMMITTEE

Mr Bond presented the report and highlighted the following risks: the relocation of the maxillofacial service as there had been problems with

the contractors and the Trust's reputation; the relocation of the infectious diseases service as the tender estimate had been over budget; non-achievement of securing STP capital bid for imaging equipment; issues around asbestos on site.

The contracts for the sale of land at Castle Hill Hospital had now been signed.

Resolved:
The Committee received and accepted the update.

13. BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report which had been updated since the last committee and the Q1 ratings presented at the August Board meeting. She advised that there would be a risk appetite session at a future Board development day.

There were a number of comments that were requested to be added to the risks which were: the well led pilot response from the CQC, a skill shortage strategy, the Deloitte exit plan, infrastructure (fire) recommendations and the necessity to access loans due to changes in payments from the CCG.

Mr Hall wanted to include the impact of the failure to implement e-rostering and more information around the workforce risk profile.

Resolved:
The Committee received the report and agreed to review the changes at the next meeting in September 2017.

14. ITEMS DELEGATED BY THE BOARD

There were no items to discuss.

15. ANY OTHER BUSINESS

15.1 Contract approval for the supply of Link 2 – IT hardware and software

Mr Bond presented the contract which detailed the purchasing of Dell equipment through the NHS supply chain framework. The contract value is such that the Trust's Scheme of Delegation requires Committee approval. Mrs Christmas asked why the Trust used the credit card if there was a contract in place and Mr Bond advised that the items were called off on an ad hoc basis and paid for on the card when the invoices were received.

Resolved:
The Committee approved the contract and Mr Hall signed it on behalf of the Performance & Finance Committee.

16. DATE AND TIME OF THE NEXT MEETING:

Monday 25 September 2017, 2pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

ESTATE STRATEGY

Trust Board Date	3 October 2017	**Reference Number**	2017 – 10 - 15
Director	Duncan Taylor Director of Estates, Facilities and Development	**Author**	Mark Green Head of Information & Governance
Reason for the report	The purpose of the paper is to present the Estate Strategy 2017 – 2022 to the Trust Board for approval.		

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

1	**RECOMMENDATIONS** The Trust Board is asked to approve the Estate Strategy 2017 – 2022.					
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 15 – Premises and equipment					
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** Y		
5	**BOARD/BOARD COMMITTEE REVIEW** The Estate Strategy has been presented to the Capital Resource Allocation Committee and the Executive Management Committee for approval.					

NHS
Hull and East Yorkshire Hospitals
NHS Trust

Estate Strategy 2017 – 2020

Providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

Estates, Facilities and Development

Contents

Foreword

We are delighted to be sharing the Estate Strategy, which embraces the Trust's clinical service and quality improvement strategies in addition to the people and information management and technology strategies.

This strategy responds to these challenges and describes how the estate will be developed and in some circumstances rationalised. The strategy also reflects the tremendous enthusiasm of the workforce and the desire to do the best for the population we serve, providing high quality, affordable and safe services in fit for purpose facilities.

This strategy sets out to articulate the direction of travel over the next 3 years acknowledging that further work will be undertaken to develop the detailed delivery plans.

The independent report by Lord Carter of Coles (February 2016), recommends reducing operational and running costs through the sharing of best practice and reducing the percentage of non-clinical floor area in addition to reducing empty/underutilised floor space.

Duncan Taylor
Director of Estates, Facilities & Development

Chris Norman
Deputy Director of Estates, Facilities & Development

A further independent report by Sir Robert Naylor, (March 2017), highlights the amount of surplus land owned by NHS Trusts. It also recommends incentivising the disposal of this surplus land by offering matched treasury capital to the value of the surplus land capital receipts.

The strategy will also have to be cognisant with developing clinical strategies in particular those decisions made as a result of the Sustainability and Transformation Plan (STP).

The risks to the delivery of this strategy are the availability of a skilled workforce and sufficient capital investment. These risks will be considered at each annual review when the progress against the strategy is evaluated.

Our key strategic objectives are:

- Achieve the targets set by Lord Carter (page 7)
- Reduce the size of the estate through the demolition of old and inefficient building stock (pages 12 & 13)
- Identify surplus land for disposal (pages 16 & 17)
- Identify future development zones (pages 18 & 19)
- Implement feedback systems for Patients, Staff and Visitors (page 21)
- Provide safe and high quality services and facilities (page 22 & 23)
- Reduce CO_2 emissions in line with the national target (page 24)
- Implement a staff development programme (page 25)

Trust Profile

Hull & East Yorkshire Hospitals NHS Trust (HEY) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire, operating from two main sites, Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). Services include:

- A full range of urgent & planned general hospital services
- The Queens Centre for Oncology & Haematology
- Centre for Cardiology & Cardiothoracic Surgery
- Major Trauma Centre
- A range of other specialist services

Terry Moran CB
Chairman

Chris Long
Chief Executive

Provides primary services to a population of 600,000 people in the Hull & East Riding of Yorkshire area

Backlog Maintenance to condition B +10 years
£48 million

Provides specialist services to a catchment population of between 1.05 million and 1.8 million people extending from Scarborough to Grimsby & Scunthorpe

We are also:

- A University Teaching Hospital
- A partner in Hull York Medical School

Land area of
53.5 Hectares
(132 acres)

Gross Internal Area (GIA) of **198,096m2**

Trust planned income 2017/18
£555 million

The Trust employs **8810** staff (7155 whole time equivalents)

Directorate Profile

EF&D	3 operational services ISO 14001 accredited in 2016	Porters undertook **231,804** tasks in 2016/17	Switchboard handled **1,452,000** calls in 2016/17
Capital Programme for 2017/18 £13million	Direct Workforce of 560 (480.2 wte) at April 2017	Annual Revenue Budget for 2017/18 £35million	131 Blocks across two main sites in 2016

The Trust Strategy

The Trust Vision is:

"Great Staff, Great Care, Great Future"

The Vision is supported by:

- **The provision of the best facilities and environment we can give to ensure a positive experience of delivering services**
- **Creating an environment where our staff will be Great Staff and they will deliver Great Care. It is that which will ensure that our Future is Great.**

The Trust Long Term Goals

The Trust Strategy clearly defines our priority goals and our measures for success as well as our approach to achieving them. Henceforth it will set the agenda for our annual objectives and plans. To support our operational teams in achieving the ambitious improvements we have set in this strategy, we have created a portfolio of improvement programmes. Using project management tools and techniques and service improvement methods, these programmes will support our teams to design, test and measure and spread new ways of working in pursuit of our goals.

Our Contribution

The Estates, Facilities and Development directorate's contribution is important to the Trust's delivery of it's ambitious long term goals. The directorate contributes actively towards the delivery of the Trust Strategy whilst remaining vigilant to the recommendations of the Lord Carter NHS Productivity review. It will also look to take advantage of the opportunities of the more recent Sir Robert Naylor review, especially the incentivised disposal of surplus land.

• Improved staff morale and engagement • Improve our learning to enhance patient and staff safety	Honest, Caring & Accountable Culture	
• Reduce vacancies and staff turnover • Develop new roles to enhance service delivery	Valued, skilled & sufficient workforce	
• Top 20% of Trust's PLACE scores • Improved Dementia friendly facilities • Provide new Infectious Diseases ward • Relocation of services to improved facilities	High Quality Care	
• Further development of elective facilities at Castle Hill Hospital • Further development of acute facilities at Hull Royal Infirmary • Provision of Open Wi-Fi service	Great Local Services	

	Great Specialist Services	• Creation of new helipad adjacent to the Emergency Department • Installation of PET/CT Cyclotron at Castle Hill Hospital
	Partnership and integrated services	• Support the development and delivery of the Sustainability and Transformation Plans (STP) • Improve IT networks in order to integrate with other local providers
	Financial sustainability	• Reduce our overall estate size • Modernise our services to reduce costs and improve performance • Installation of Water Borehole • Delivery of Energy Reduction scheme

Estates, Facilities and Development

External Factors Influencing the Strategy

Sustainability and Transformation Plans STP's

Population based geographical footprints have been created and are required to collectively agree their 5 year 'Sustainability and Transformation Plans' (STPs). STPs are expected to cover the whole range of service provision for their population. They must include plans for integration with local authority social care provision and take account of agreed health and wellbeing strategies. They should address mental and physical health from primary care through to specialised services. Funding nationally has been set aside for investment into health to the value of £3.9billion, which will increasingly be allocated on the basis of STPs. Our Trust sits within the Humber Coast and Vale footprint which covers the populations of Scarborough, York, Hull the East Riding and North and North East Lincolnshire.

The Humber Coast and Vale areas of focus are:

- Helping people stay well
- Place-based care
- Supporting people with mental health problems
- Creating the best hospital care
- Strategic Commissioning
- Helping people through cancer

Humber Coast & Vale STP geographical footprint

Lord Carter Efficiency Review

The Trust is working through the recommendations of the Lord Carter Efficiency Review in addition to pursuing our own analysis of opportunities for increasing productivity and reducing costs.

The review requires Trust's to have plans in place by 2017 to:

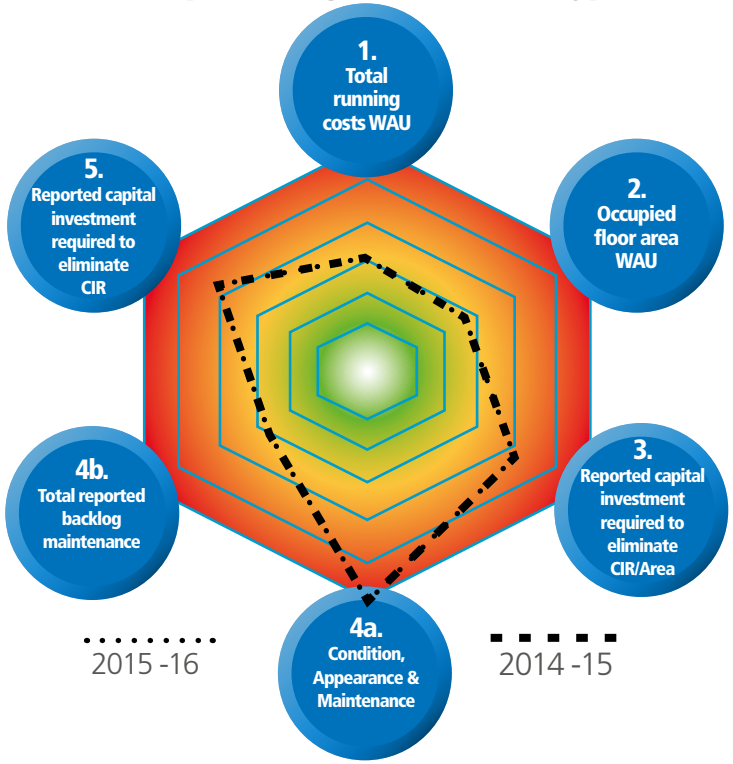
reduce **non-clinical space to a maximum of 35%** of the overall Trust footprint.	ensure that **empty / underused areas would not exceed 2.5%** of the overall Trust footprint.	**reduce energy consumption** by investing in energy efficiency schemes.
April 2017: **33.28%**	April 2017: **1.99%**	2015/16: Upper Quartile
achieve median benchmark in **Soft FM costs** such as cleaning and patient food services.	achieve the median benchmark for **Estates & Facilities** running costs.	secure delivery of the plan by **April 2020**
2015/16: Upper Quartile	2015/16: Upper Quartile	

> **"Trusts are considered good if their total estates and facilities running cost metric is lower than £320/m². If all Trusts achieved this median this would save £1bn/year"**

Operational productivity and performance in English NHS acute hospitals.

An independent review by Lord Carter of Coles

Trust metrics plotted against the trust type median

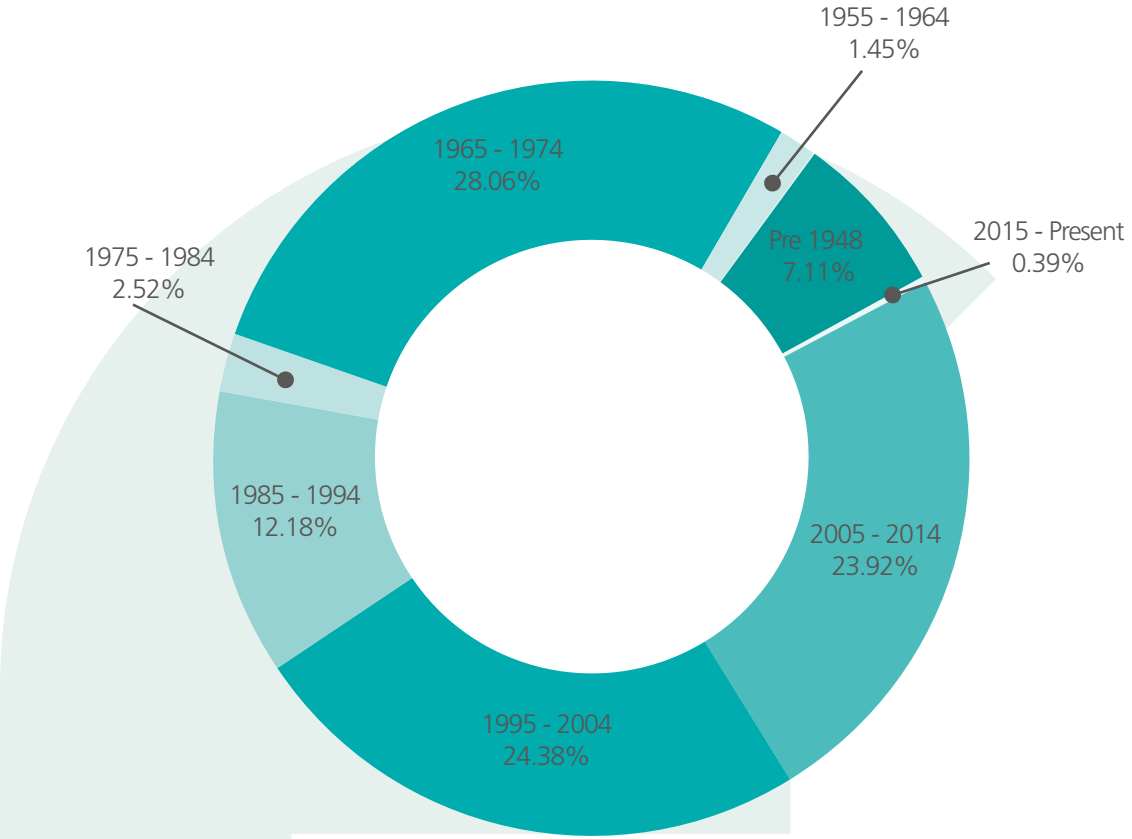


Estate Condition

It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. Each NHS Trust is duty bound to review the condition of the estate every 5 years. The Trust undertakes yearly reviews of 20% of the estate every year. The review includes the following facets; physical condition, statutory compliance and disability discrimination act (DDA).

Any area where the condition or compliance falls below 'condition B', will have the investment requirement to bring the defect back to 'condition B'. Physical condition B is defined as sound, operationally safe and exhibits only minor deterioration, whereas statutory compliance B is defined as complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature.

Trust Building Age Profile by GIA (M2)



Please note: All costs associated to backlog exclude the recommended 40% uplift to allow for preliminaries and are the current Cost to B plus 10 years. PFI's and buildings not maintained by the Trust are excluded from these figures.

Total Trust Backlog **£48M**

Physical Condition **£43M**

High and Significant Risk **£17M**

Statutory Compliance **£2.9M**

High and Significant Risk **£2.4M**

DDA **£2.1M**

In light of recent events the Trust is working with local Fire Safety regulators to review its current preventative and protective measures. Any costs associated with additional safety requirements are currently unknown but not limited to additional automatic detection in ceiling voids, additional ventilation fire dampers, evacuation routes, etc.

Hull Royal Infirmary, Tower Block

The Hull Royal Infirmary Tower Block opened in June 1967, and has played a significant part in the provision of healthcare to the local economy for the last 50 years. It can be seen from the information below that it is a considerable problem with regards to the Trust backlog maintenance in both risk and cost. However, clinically, it is the nucleus for all emergency admissions including operating theatres, critical care facilities, wards and clinical support services (e.g. Radiology and Pharmacy). Recently there has been significant investment into the Tower Block which means that it will most likely remain for the foreseeable future. This building is responsible for 54% of the Trust high and significant backlog and therefore the Trust needs to develop and approve an effective backlog maintenance reduction programme.

26.9% of Trust's overall GIA (42,405m^2)

Total Backlog bill of **£19.4m** (41.8% of Trust)

23 wards

87% is clinical space

16 floors and **2,258** rooms

9 operating theatres

2 Adult Intensive Care Units

Emergency Department and Acute Admissions Units

Prioritised Backlog Maintenance Investment Profile

The Naylor Report (March 2017) builds on the foundations of the Lord Carter Report (2016) in relation to productivity and operational costs. It also recognises that the NHS has not focused sufficiently on estates rationalisation as a vehicle for moving to a more efficient, lower cost estate. It further recommends that providers be incentivised to dispose of surplus land. The review calls for additional capital to address backlog maintenance in the form of a '2 for 1' offer, in which providers are given additional treasury capital to match the disposal proceeds.

The Naylor Report suggests that "the backlog maintenance of the critical estates has risen faster than the overall average. Following discussions with NHS Trusts, we believe these figures to be understated because there has been no real incentive to report the situation accurately".

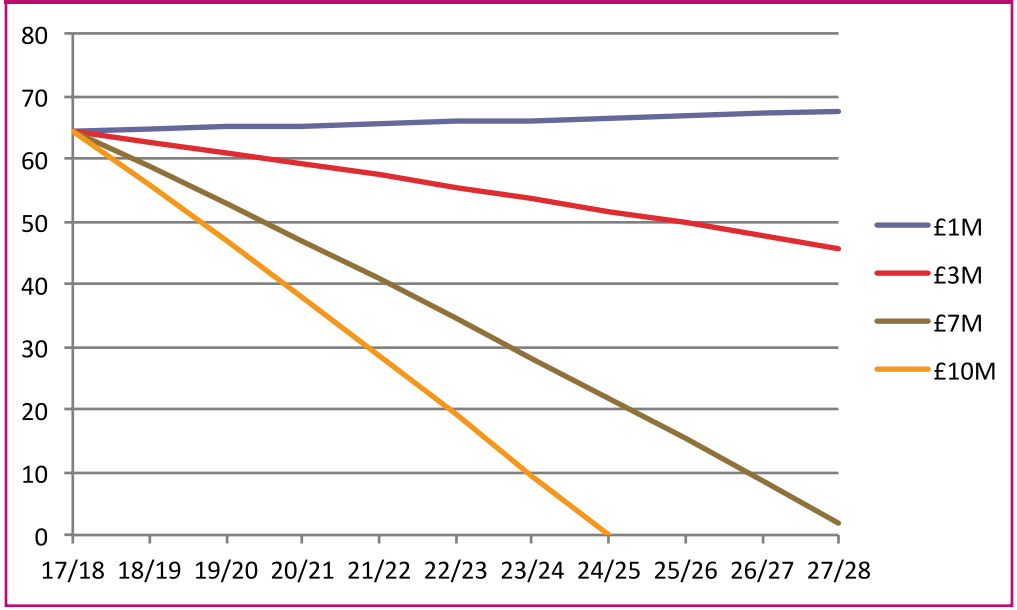
In order to ensure the Trust is best positioned to take advantage of any land disposal proceeds, an external review was commissioned to undertake a thorough review of the Trust's backlog position. The management consultants had undertaken a similar commission in 2009.

The work included a review of the risk profiling and the inclusion of a clinical weighting. It was concluded that the overall backlog position was £64.4 million when associated project costs (decanting, design team, etc.) were included. A further risk was identified with regards to the age of plant and services in the North and South Blocks at the HRI. The plant and services are between 50 and 55 years old, which are well beyond their normal useful life of 30 years.

A programme has been developed which requires a minimum investment of £7 million per annum. The programme has been developed to limit the impact on the delivery of clinical services.

A lesser annual investment will not realise a sensible reduction in the Trust's backlog position and increase the risk of catastrophic, unplanned failure of critical plant and facilities.

Backlog investment profiles



Programme Content

- Refurbishment of two operating theatres per annum
- Refurbishment of two wards per annum
- Refurbishment of major lifts throughout the programme
- Strengthen Statutory Compliance
- Improved Patient and Staff environment
- Replacement of ageing engineering infrastructure

Estate Rationalisation

What do we want to achieve?	How will we measure it?	How can we achieve it?
A more efficient, lower cost estate	• Annual backlog condition appraisal • ERIC • Reduced operating costs	• Demolitions of old/inefficient building stock • Space utilisation surveys
Lord Carter recommendation on empty and underutilised areas and clinical/non clinical space ratio metric	• Lord Carter dashboard	• Demolitions of old/inefficient building stock • Space utilisation surveys • Support increased productivity in clinical areas

Haughton Building (West): to be demolished mid 2017

Finance Building: demolished mid 2017

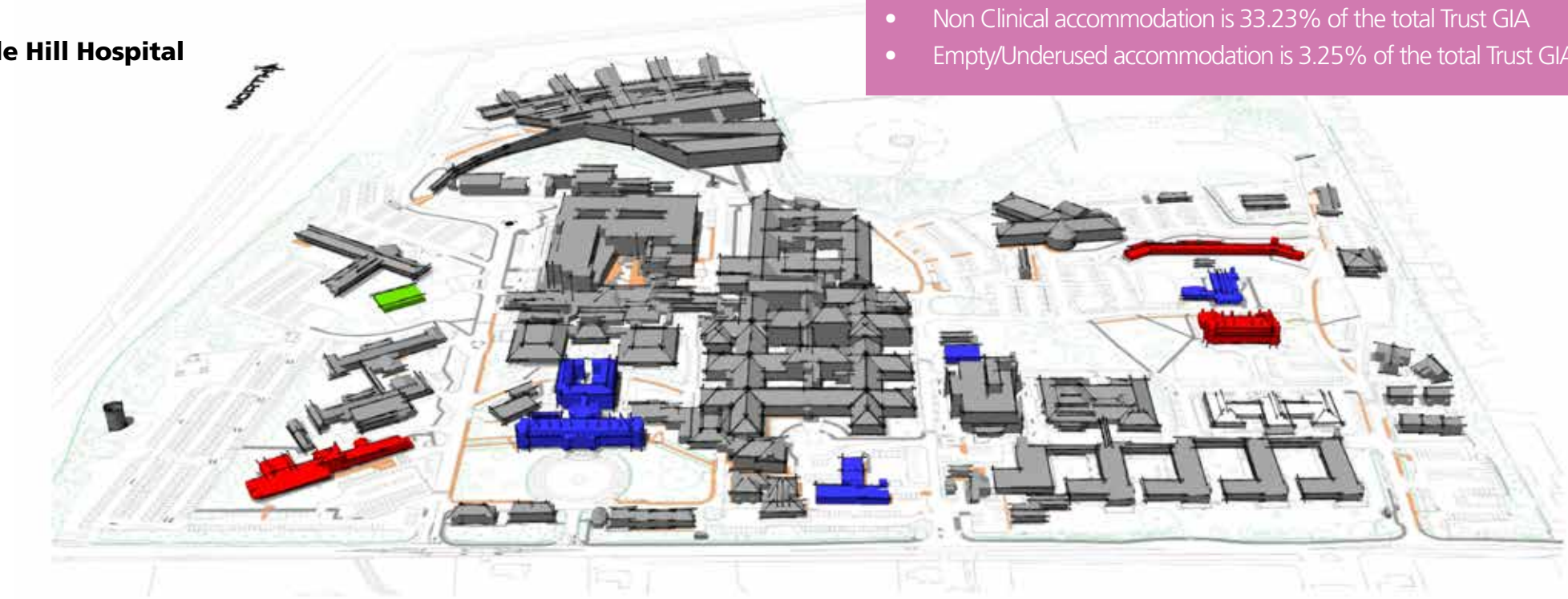
Estate Rationalisation Programme

The Trust has commenced on an ambitious demolition programme in order to reduce operating and property costs. This programme will contribute towards the delivery of some of the Lord Carter recommendations and is monitored via the Lord Carter dashboard. The programme is currently in two phases with the Phase 2 due for completion in late 2019. Further opportunities to rationalise the estate will be identified through an evidence based space utilisation programme and opportunities arising from service reconfigurations as a consequence of decisions made by the Humber, Coast and Vale Sustainability and Transformation Plan.

Prior to commencement of Phase 1, the Trust's position was:

- Gross Internal Area (GIA) of 198,096m2
- Total Physical Condition Backlog £43,035,839 (£17,354,867 High & Significant Risk)
- Total Statutory Compliance Backlog £2,876,937 (£2,357,504High & Significant Risk)
- Total DDA Backlog £2,090,637
- Non Clinical accommodation is 33.23% of the total Trust GIA
- Empty/Underused accommodation is 3.25% of the total Trust GIA

Castle Hill Hospital



Please note: All costs associated to backlog exclude the recommended 40% uplift to allow for preliminaries and are the current Cost to B plus 10 years.
PFI's and buildings not maintained by the Trust are excluded from these figures.

Completion of Phase 2 it will deliver the following:

- Reduction in Gross Internal Area (GIA) of 18,343m2
- Reduction in Physical Condition Backlog £5,661,345 (£2,650,511 High & Significant Risk)
- Reduction in Statutory Compliance Backlog £79,413 (£31,412 High & Significant Risk)
- Reduction in DDA Backlog £201,908
- Non Clinical accommodation is 31.03% of the total Trust NUA
- Empty/Underused accommodation is 0.71% of the total Trust NUA

Key

- Phase 1 demolition completion late 2017
- New development completion late 2017
- Phase 2 demolition completion late 2019

Hull Royal Infirmary

Capital Development

What do we want to achieve?	How will we measure it?	How can we achieve it?
Delivery of the backlog maintenance programme and energy reduction projects	• Annual backlog condition appraisal • ERIC • Reduction in energy costs	• Programme of demolitions of old building stock • Deliver the backlog maintenance programme • Deliver energy reduction projects
Provide buildings, services and surroundings that are high quality, fit for purpose, safe and affordable	• Peer review of designs • Project scorecards/feedback • PLACE • CQC Inspections	• Establish clear standards and ensure these standards are attained • Projects delivered to an agreed budget and timescale • Dedicated team focusing on environment improvement
Support clinical developments in line with the Trust's Clinical Strategy and determined by STP and national policies	• Deliver capital programme on time • Assist with delivery of STP • Post project reviews	• Provide technical advice and support for clinical teams to deliver their clinical strategy • Flexible enough to react to developments and changes to strategy and policy
Provide efficient and cost effective procurement of construction solutions	• Provide best value • Benchmarking • Post project evaluation • Lessons Learned	• Broad range of procurement routes available e.g tender, MTC, frameworks • Use best practise guidance, HBN's etc. • Use innovative solutions to improve programme or reduce cost e.g. modular/off-site manufacture

The Trust will continue to invest in state of the art technologies and both medical and scientific equipment. These investments will support the trust in attracting and retaining experienced and skilled medical staff thus supporting the Trust's People Strategy.

Capital Programme 2017 – 2019

The Capital Programme for 2017/18 and 2018/19 provides investment in medical and scientific equipment. It also invests in backlog maintenance and compliance schemes which will contribute towards a reduction in the Trust's overall backlog maintenance position.

The programme is also funding the continuing works associated with the improvements and resilience of the IM&T infrastructure. Additional information is available in the IM&T Strategy

	2017/2018 (£000s)	2018/2019 (£000s)
Medical & Scientific equipment replacement	4,583	4,750
Backlog Maintenance and compliance	4,510	2,800
IM&T Infrastructure	3,000	3,300
New developments/ refurbishments (clinical)	4,368	0
New developments/ refurbishments (non-clinical)	795	0
Other allocations	2,138	0

Creative and innovative solutions for new construction and refurbishment of the estate have been applied. An old medical admissions unit converted into open plan administrative suite, providing accommodation for circa 96 staff including hot desks, meeting facilities and staff welfare facilities.

Property Services

What do we want to achieve?	How will we measure it?	How can we achieve it?
Release of surplus land	• Capital receipts • Improvement of existing car parking infrastructure (HRI)	• Hull 2020 partnership • Hull Local Plan (HLP) • Partnerships with NHS organisations and other Public Sector bodies • STP opportunities provided by the Naylor Report
Outsourcing of Residential Accommodation	• Contract awarded to external partner	• Implementation of approved Residential Accommodation Strategy

Key

- HEY Trust Land (Main Hospital Site)
- HEY Trust Land (Land South of Castle Road)
- Phase 1 Land Sale

Castle Hill Hospital

Land to the South of Castle Road – identify development opportunities for further residential accommodation, clinical, leisure and recreational use

Following the publication of the Naylor Report (March 2017) the Trust will continue to work on opportunities to dispose of surplus land and buildings, whilst following the guidance Health Building Note (HBN) 00-08. This will ensure that surplus land is disposed of at the best price, to allow re-investment back into the Hull and East Yorkshire Hospitals NHS Trust.

There is an added dimension to the Hull Royal Infirmary 'surplus land' as it is currently used for the car parking and delivery of clinical care, both of which would require to be re-provided.

21% of the Trust GIA is provided by PFI facilities:

- Phase V CHH (contract ends 2032)
- Women's & Children's Hospital HRI (contract ends 2033)
- Queens Centre CHH (contract ends 2036)

Castle Hill Hospital
17.4 hecatres of surplus land

Hull Royal Infirmary
4.3 Hecatres of surplus land

Hull Royal Infirmary

Land to the west of Argyle Street – redevelopment opportunity to provide car parking facilities, residential accommodation and support the delivery of the Hull Local Plan.

Future Development Zones

What do we want to achieve?	How will we measure it?	How can we achieve it?
The identification of development zones that will encompass decisions both locally and those of the STP	• Development zones identified following estates rationalisation	• Space utilisation surveys providing unequivocal data on the utilisation of rooms and buildings • Maximise clinical and non-clinical use of the most operationally expensive buildings (PFI) • Demolition of old/inefficient building stock

Development zones can be achieved as a result of demolitions and more ambitious schemes to vacate and demolish older and obsolete buildings. These development zones provide differing options to the Trust.

Retail front entrance opportunities and re-engineered drop off and collection areas for those service users that have mobility problems and disabilities.

Opportunities for the development of new state of the art clinical accommodation with links to current facilities via existing hospital streets, which will improve the overall patient experience

Further opportunities for partnership working with neighbouring Trust's and other public sector services for shared facilities or even surplus land sales.

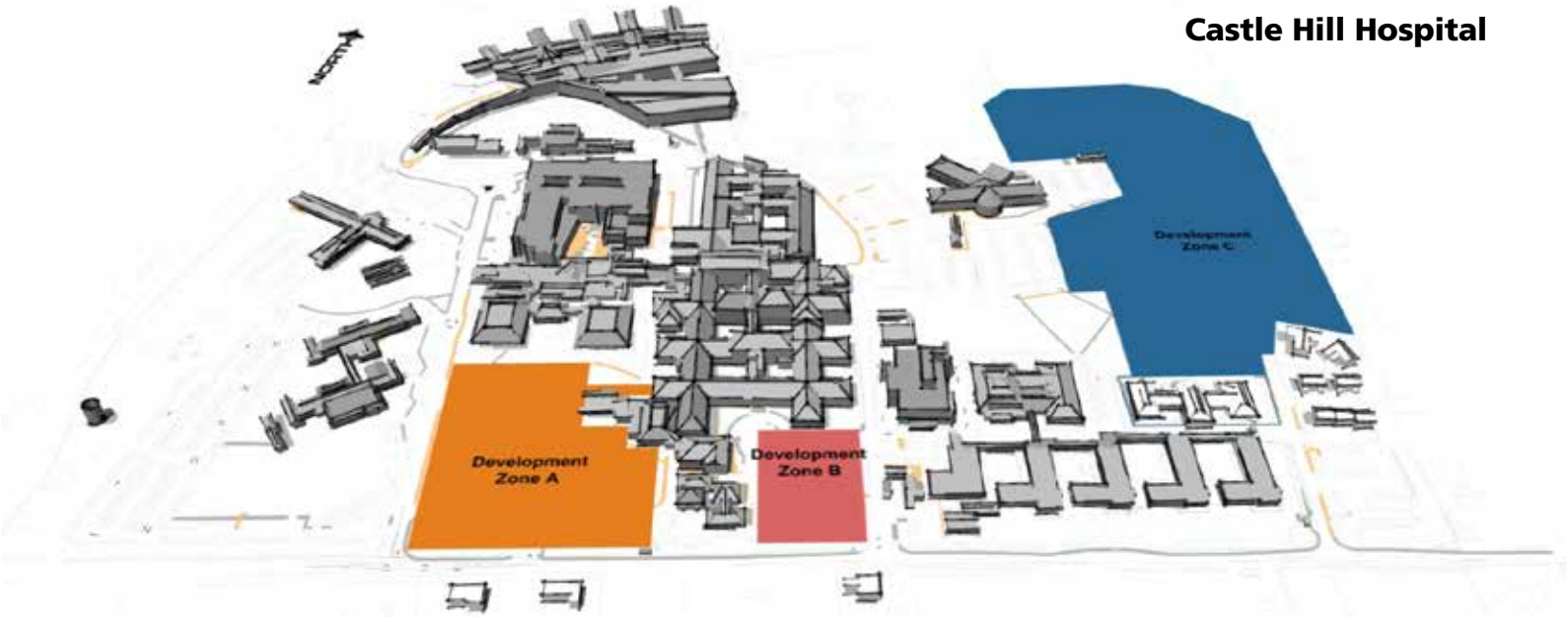
Enabling the Trust to respond to decisions based on clinical strategies and developments as determined by the STP.

new text for
below

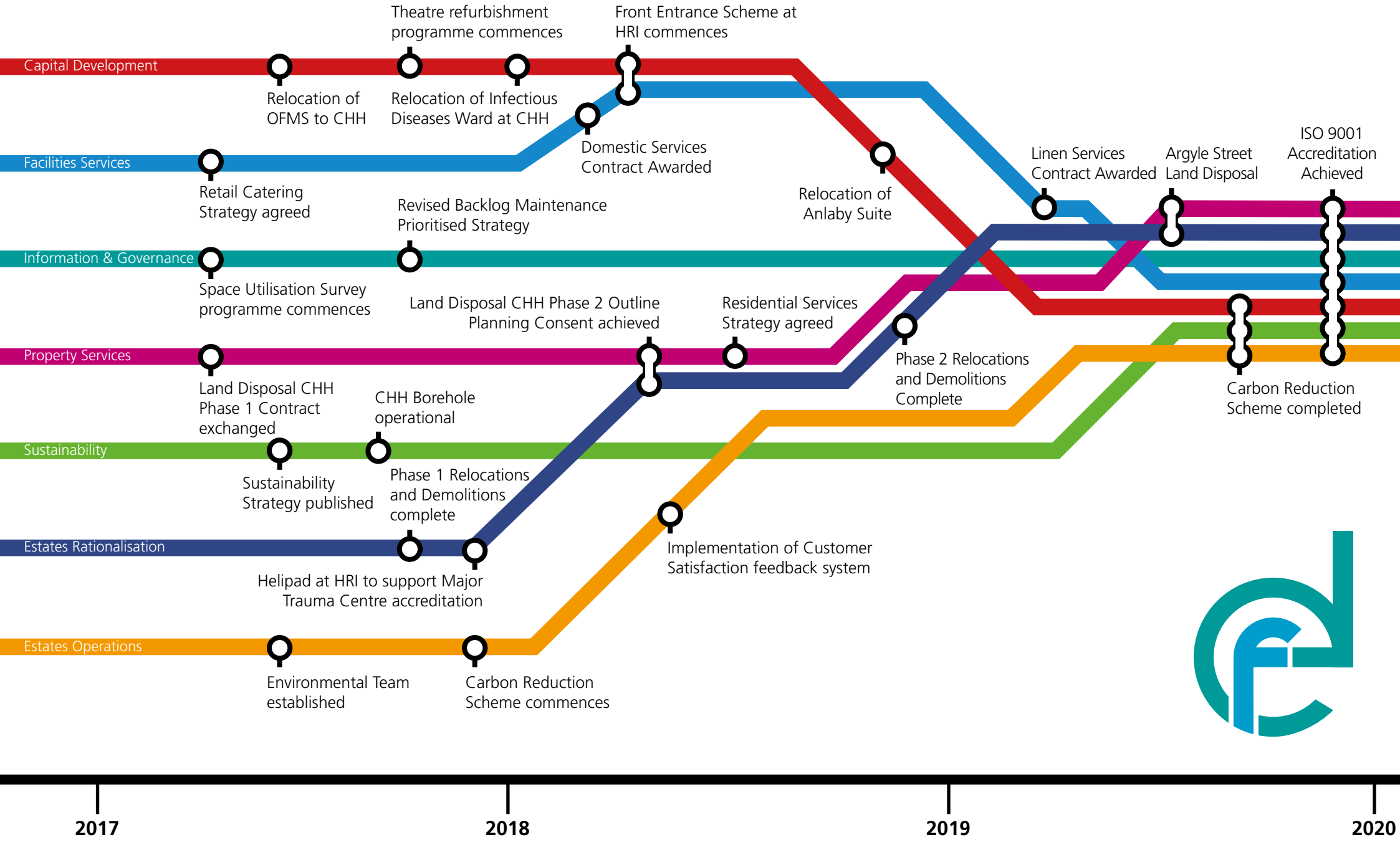
In conjunction with the demolition works scheduled for the Hull Royal Infirmary and Castle Hill Hospital sites and any land disposals at the respective hospital sites it is important that future development zones are identified. The Trust Strategy makes reference to the centralisation of Children's services which can be accommodated into an extended Women and Children's Hospital. There is also provision of a development site for the front retail development unit if plans progress to delivery and construction. Whilst no developments have been identified for the Castle Hill Hospital, site areas that have development potential have been illustrated along with direct connections to existing hospital streets for two of the three development zones.

Hull Royal Infirmary

Castle Hill Hospital



Estate Strategy Timeline



Customer Satisfaction

What do we want to achieve?	How will we measure it?	How can we achieve it?
Obtain feedback from service users and other stakeholders to inform service improvements	• Quarterly reports presented by services at the EF&D Quality and Performance Committee. • Evidence of feedback influences service improvement • Improvement in Patient Led Assessments of the Care Environment (PLACE) scores • Benchmarking with Peer Groups for PLACE scores • Public/Patient Group feedback	• Estates and Facilities services implementing user feedback mechanisms • Introduction of manned telephone Helpdesk for all Estates & Facilities services • Senior management 'walkabouts' • Learning from incidents, events and feedback • Feedback from 'Link Listeners'

We continuously reduce operating costs without impacting service quality and safety; however we rarely seek the views of our stakeholders and the impact of these changes. Our main stakeholders are staff, patients and visitors. Going forward we intend to seek their views on current service provision and where appropriate consult on proposed significant changes to service provision. We will also incorporate the customer feedback in our service transformations. We also need to ensure that our facilities and services meet the needs of service users including those with mobility, sensory and psychological impairments.

Our recent PLACE scores:		2015/16	Trend	2014/15
Condition, Appearance & Maintenance	%	88.33%	↑	80.49%
Cleanliness	%	97.40%	↑	95.78%
Food	%	90.39%	↓	93.84%
Privacy, Dignity & Wellbeing	%	79.31%	↓	80.64%
Condition, Appearance & Maintenance	%	88.33%	↑	80.49%
Dementia	%	64.66%	↑	49.62%
Disability	%	71.03%	N/A	Not collected

How do you rate our service?

Good

Average

Poor

Estates Operations

What do we want to achieve?	How will we measure it?	How can we achieve it?
An estate that is maintained to a high standard and is compliant with statutory legislation and NHS guidance	• Compliance Assessment & Analysis System • Audit programmes	• Address improvement opportunities identified through CAAS audits • Develop robust action plans to address any issues and benefits identified in audits
Establish the baseline of customer satisfaction for repairs and defects. Agree an improvement target by mid- 2018	• Customer satisfaction data (Customer & Stakeholder Test, CST)	• Develop and implement actions from CST data • Identify and deliver quality and improvement training as necessary
Improve performance and quality for building and engineering services	• External Benchmarking • Data Validation	• Review Contracts (Merging with Public Sector bodies - partnership working) • Targeted investment in plant and equipment • Review working practices/skill mix • Review preventative maintenance regimes

Facilities Services

What do we want to achieve?	How will we measure it?	How can we achieve it?
Provide a sustainable and profitable Catering Service with an increased catering retail performance year on year	• Profit and Loss accounts (weekly and monthly) • Sales/Product Analysis • Sales targets	• Increased sales • Reduction in operating costs • Improved procurement of provisions • Development of staff
High quality and effective contract services	• Contractor KPIs • Model Hospital	• Explicit tender specifications including; activity scheduling, innovative use of technology, payment by results and partnership work.
Provision of a 'hotel standard' facilities management service which is safe, clean and high quality	• PLACE • Friends and Family Test feedback • Fundamental Standard Audits • Customer Feedback score cards • PALS/Complaints • Lord Carter Dashboard	• Implementation of a 'Hotel' quality rating system • Focus on quality over cost • Improve monitoring and response to environment related issues • Establish an integrated Facilities Helpdesk

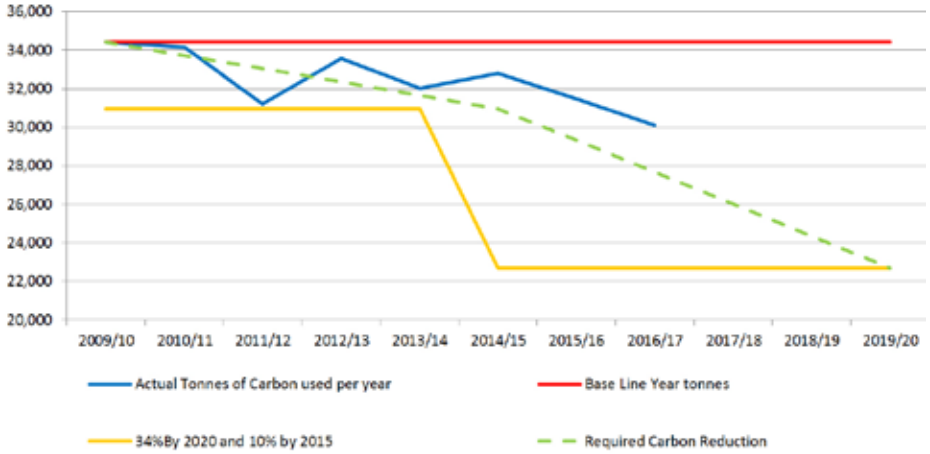
Sustainability *(further detail available in Sustainability Policy)*

What do we want to achieve?	How will we measure it?	How can we achieve it?
Reduce the amount of waste going into landfill and increase the level of recycling	• Auditing and monitoring of waste streams	• Ensuring correct waste segregation • Educating Staff
Reduce CO_2 emissions	• Site and CO_2 audits • Monitor and review consumption	• Optimising and improvement of operational efficiency of plant equipment • Investment in energy efficiency schemes • More sustainable transport solutions
Improve utility usage performance	• Lord Carter dashboard • ERIC	• Investment in energy efficiency schemes • Reduce distribution losses • Work in partnership with the Local Authority
A safe secure estate	• Reduction in security incidents	• Partnership working with the Police • Violence and aggression campaigns • Targeted resources • Analysis of incident themes and trends • Upgrade hardware and infrastructure

UK Government Carbon Reduction Targets

34%
by 2020
80%
by 2050

The Trust's Carbon Reduction Performance against the UK Government's National Targets



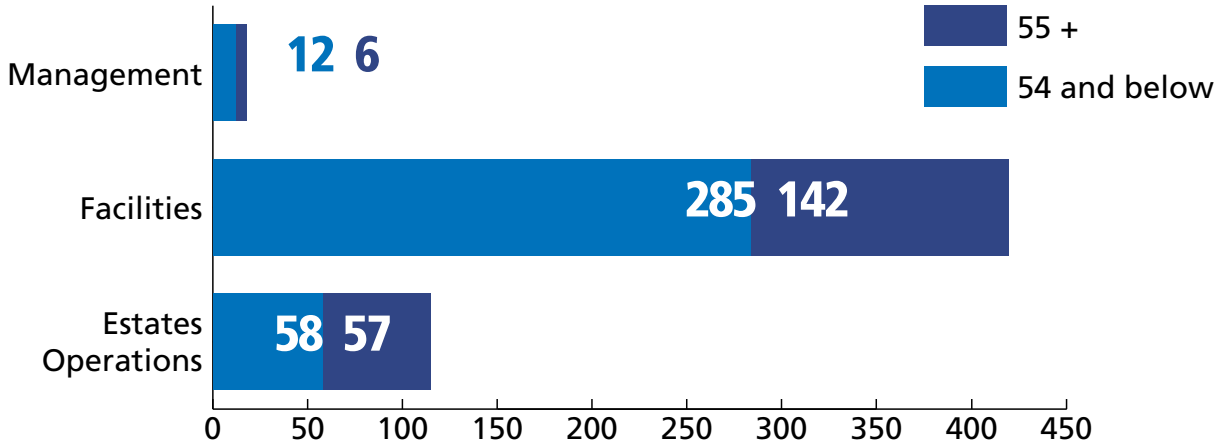
Workforce

What do we want to achieve?	How will we measure it?	How can we achieve it?
Develop a robust, multi-skilled and motivated workforce with continuous career and learning development whilst ensuring optimum employee engagement	• Performance and measurement of HR KPI's o Appraisals o Training o Absence o Turnover • Trust wide Staff Survey • Barrett Cultural Values Assessment	• Undertake a skills audit and workforce retirement plan • Clear career pathways for new and existing staff • Good communication and promotion of management visibility • Support for staff health and well-being initiatives • Recognition of staff through Moments of Magic & Golden Hearts Awards
Expand current apprenticeship appointments for the muliti-disciplinary roles within the directorate. Working with local partners, creating placements and therefore expanding the the experience and scope of the apprentice roles.	• Increase in apprenticeship appointments within the directorate • Local NHS Partnering apprenticeship rotation established • Be and organisation of choice for new apprentice	• Appointment of apprentices into the new roles • Work with local NHS partners in creating multi-organisational placements. • Develop a Multi-Organisational Apprenticeship Academay

42.6%

of the directorate workforce are aged 55+ years of age

Age profile for Estates, Facilities & Development Personnel 55 years of age and above



Information & Governance

What do we want to achieve?	How will we measure it?	How can we achieve it?
High standards of data quality and consistency	• Improved accuracy and reliability of information to support decision making	• Review of all systems and their benefits and ability to integrate with other systems • Employment of data analysts
Support the reduction of the estate footprint for both clinical and non-clinical facilities	• ERIC • Lord Carter Dashboard	• Using space utilisation surveys and working with clinical and non-clinical teams to identify opportunities to rationalise the estate
Standardised document management arrangements	• Unified electronic folder arrangements in place • Managed archiving system established	• Employment of a Records Officer • Approved document management procedure
All services ISO 9001 accredited	• External accreditation achieved	• Structured programme implemented
Strengthen risk management in the directorate	• Reduction in EL/PL claims • Reduction in incidents and themes • Risk register populated and controls to manage risks in place	• Identify themes and trends from incidents and claims and mitigate future occurrences • Identify and manage all risks • Timely response to all central alerts

Handheld PDA's for "Real Time" asset linked job scheduling and customer feedback.

Electronic Sensors used to provide evidence based Space Utilisation data.

Directorate Compliance Framework

What do we want to achieve?	How will we measure it?	How can we achieve it?
An improved compliance rating with regulatory and legislative requirements, achieving an overall rating of 85% for the aggregated technical domains, ensuring that there are no amber of red rated sub-domains	• Periodic reviews of each technical domain with the staff responsible for delivery and compliance using the Compliance Framework	• Develop, monitor and complete action plans generated by the Compliance Framework • Ensure all Authorising Engineers, Authorised Persons and Competent Persons are trained for their duties and are appointed in writing. • Ensure Annual Reports are compiled and communicated in order that the Board is sighted on matters associated with compliance. • Ensure that robust mechanisms are implemented to reduce risks, e.g. Permit to Work systems.

The Compliance Framework provides organisations with a self-assessment capability to determine their level of compliance against legislative and regulatory standards. The Framework also identifies 5 sub-domains in order that more focuses scrutiny can be undertaken when identifying strengths and weaknesses. This allows organisations to identify areas of improvement and measure progress towards improved compliance targets. We are looking to benchmark ourselves against other Acute Trusts who are using the same Compliance Framework so that we can contribute positively and share and learn from best practice amongst our peers.

	Accountability	Process	Monitor & Review	Capability	Outcomes
Asbestos	• Board understand professional responsibilities • Approved Policy • Robust risk management and governance arrangements in place	• Operational procedures developed and widely understood • Risk Assessments in place • As fitted drawings available • Permit to work systems in place • Risk assessment and building records are maintained and updated appropriately • Fully documented planned preventative maintenance in place • Systems maintained and validated in accordance with best practice	• Monitor and review systems in place • Independent assurance provided to the Board	• Appointment of key staff e.g. Authorised persons • Sufficient trained and competent staff • Sufficient budget allocation available • Access to up to date legislation and guidance • Risks identified and managed • Periodic appraisals of key personnel by the external Authorising Engineers	• Key Performance Indicators developed and reported to Board • Evidence of root cause analysis and learning from incidents and near misses • Benchmarking against other organisations
Asset Management					
Contingency Planning					
Contractor Management					
Decontamination					
Electrical Systems					
Facilities Infection Control					
Fire Safety					
Health, Safety & COSHH					
Lifts					
Mechanical Systems					
Medical Devices					
Medical Gas Systems					
Safe & Accessible Buildings					
Security Management					
Sustainability					
Ventilation					
Waste Management					
Water Systems					

Estates, Facilities and Development

Version 2017 / v 2

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

SUBMISSION OF A BID TO THE LORENZO DIGITAL EXEMPLAR INITIATIVE

Trust Board date	3rd October, 2017	**Reference Number**	2017 – 10 - 16
Director	Lee Bond Chief Finance Officer	**Author**	Martyn Smith Director of IT & Innovation
Reason for the report	To seek approval from the Board for the submission of a bid to the Lorenzo Digital Exemplar Fund		

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

1	**RECOMMENDATIONS** The Board are asked to approve the submission to NHS Digital, seeking support for the accelerated implementation of key technologies under the Lorenzo Digital Exemplar Initiative Fund umbrella.					
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): **Contributes to CQC compliance**					
	Assurance Framework	**Raises Equalities Issues? N**	**Legal advice taken? N**		**Raises sustainability issues? N**	
5	**BOARD/BOARD COMMITTEE REVIEW** N/a					

TRUST BOARD, 3rd OCTOBER, 2017

BRIEFING PAPER: SUBMISSION OF A BID TO THE LORENZO DIGITAL EXEMPLAR INITIATIVE

1. Introduction

On 16th August the Department of Health invited a small number of Trusts using the Lorenzo EPR, who wish to become a Digital Exemplar in their use of technology adaptive change, to submit an Expression of Interest (EOI) to the new Lorenzo Digital Exemplar Programme.

As an early adopter of, and a leader in the development of Lorenzo, HEY will submit the attached EOI, subject to approval by the Trust Board. The deadline for submission is Friday 6th October.

If successful, HEY will be expected to accelerate the pace of technological change, inspire and educate others by demonstrating how successful adoption of technology can deliver both improved patient outcomes and increased operational effectiveness.

2. The Process

There are three stages to the bidding process:

- ***Expressions of Interest:*** submission of a proposal which articulates our vision, objectives, scope and value proposition of becoming a Lorenzo Digital Exemplar.

- ***Mobilisation:*** DXC (formerly CSC) and NHS Digital will work with shortlisted Trusts to define what being a Digital Exemplar truly means, clarify measure of success and critical actions to achieve those. Outputs will be: a Digital Roadmap; an Implementation and Transformation Plan and an Investment Case for submission to NHS Digital for the implementation phase. DXC support requirements will be agreed at this point and a Memorandum of Understanding will be signed.

- ***Implementation:*** Trusts with the strongest Investment Case will be selected and will proceed to the Implementation phase, working with NHS Digital and DXC to turn plans into action.

NHS Digital has indicated that circa £10m in support funding is available. The value of award will be dictated by how many Trust are successful. Further clarity is required on how funding will be provisioned, but is likely to be in the form of support, services and products from DXC, funded by NHS Digital. Trusts will be expected to fund the provision of their own resources.

3. The HEY Bid Vision

The attached structured Bid provides detailed information about all aspects of the proposed programme. In essence, the vison for the HEY Exemplar Programme is to:

- Evolve Lorenzo from a transactions processing tool and repository for records, into a truly holistic care tool, supporting paper free, empowering digital-by-default working, enabling alerting and task management and supporting real-time decision support along the care continuum both inside the Trust and with care partners
- Maximise the dividend from technology and accelerate the transition away from paper based records; deliver end-to-end electronic processes from referral to discharge and fundamentally transform 'back-office' clinical administration.
- Create a technical landscape that unfetters care givers from data entry, puts relevant and timely intelligence in the hands of those that need it, whenever and wherever they need it, irrespective of organisational boundaries and releases time to care.
- Extend the scope of e-records sharing with care partners
- Deliver a coherent, patient centric care record supporting more effective clinical management, 'joined-up' care and clinical excellence both within and throughout the STP
- Implement technology which underpins and enable the adoption of new care models
- Deploy new technology which empowers patients to contribute to their own care record, which supports assisted self-care and admissions avoidance
- Achieve HIMSS Level 7 capability
- Accelerate the roll-out of e-Prescribing (e-PMA), Advanced Bed Management and e-observations throughout the Trust
- Deploy Lorenzo Theatres and GS1 Scan-for-Safety technology

4. Recommendations

The Trust Board are asked to:

- Note the opportunity to bid for support to become a Lorenzo Digital Exemplar

- Approve the submission of an Expression of Interest to NHS England.

Martyn Smith
Director of It & Innovation
28/09/17

Lorenzo Digital Exemplar Initiative

Expression of Interest Form:

Organisation details	
NHS Trust(s)	Hull & East Yorkshire Hospitals
Project Representative Name	Martyn Smith; Director of IT & Innovation
Project Representative Contact details	martyn.smith@hey.nhs.uk 07786 334377
Executive Sponsor Name	Lee Bond; Chief Finance Officer
Executive Sponsor Contact details	lee.bond@hey.nhs.uk 01482 678043

Instructions:

Please populate the below form and return to the following address csclsppmo@nhs.net by no later than 17.00 on 06/10/2017. The Expressions of Interest will then be subject to an objective selection process managed by NHS Digital in partnership with NHS England and NHS Improvement. Notification of selection or otherwise should be made by NHS Digital to the named Project Representative by 27/10/2017.

NHS Digital reserves the right to ask the submitting Trust to provide further clarification (including, but not limited to, additional support documentation and possibly a presentation) prior to making a final selection. NHS Digital's decision as to the selection shall be final, and NHS Digital reserves the right to cancel or vary this project at any time.

Please address any questions to the following NHS Digital representatives: Mike Barton (mike.barton@nhs.net) and Rob Longstaff (rob.longstaff@nhs.net)

Please be aware that all questions, and their responses, may be shared with other Lorenzo Trusts.

On completion of the Mobilisation Phase a Memorandum of Understanding (MOU) between the Trust and Department of Health will be used to confirm Implementation Phase expectations.

Mandatory Information Required:

1) The Strategic Aims and Objectives:

- Articulate your vision of a Digital Exemplar. What would success look like for:
  - Your clinical workforce
  - Your patients, service users and their families
  - Your local health and care system
- Outline the high level aims and objectives of the programme
- Provide a brief summary of how the programme will contribute to the achievements of the organisation's and STP's strategic objectives

(Please answer in 1000 words or less) 736

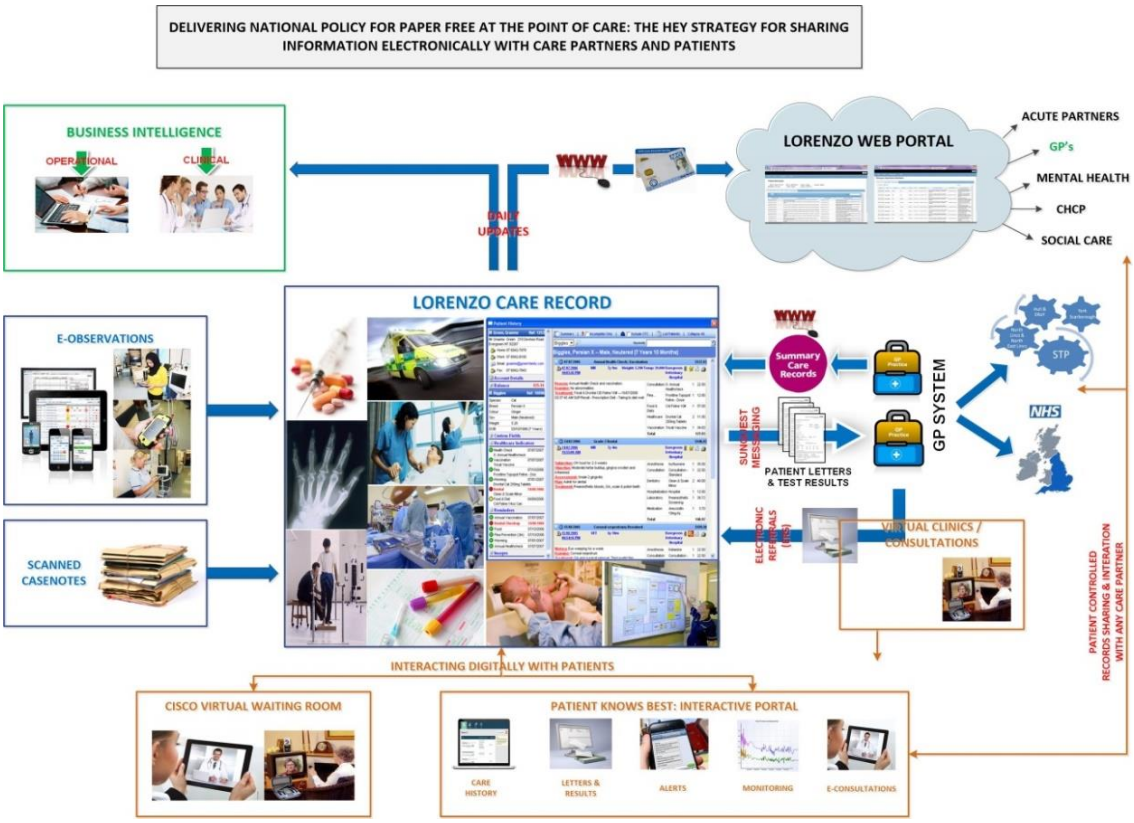
The core objectives of the HEY Exemplar Bid are:

- Achieve HIMSS Level 7 capability
- Deliver a coherent, patient centric care record supporting more effective clinical management, 'joined-up' care and clinical excellence both within and throughout the STP
- Maximise the dividend from technology and accelerate the transition away from paper based records; deliver end-to-end electronic processes from referral to discharge
- Accelerate the roll-out of e-Prescribing (e-PMA) & Advanced Bed Management throughout the Trust
- Accelerate the roll-out of e-observations to support clinical decision support
- Deploy Lorenzo Theatres and GS1 Scan-for-Safety technology
- Integrate and embed key 3rd party systems into Lorenzo to support the concept of a feature rich, holistic care record
- Extend the scope of e-records sharing with care partners
- Provide access for patients to e-records, e-correspondence, etc
- Deploy new technology which supports interaction with service users, supports assisted self-care and admissions avoidance
- Provides the technology which underpins and enables the adoption of new care models

The ambition and scope of the HEY Exemplar Programme is:

- To evolve Lorenzo from a transactions processing tool and repository for records, into a truly holistic care tool, supporting paper free, empowering digital-by-default working, enabling alerting and task management and supporting real-time decision support along the care continuum both inside the Trust and with care partners
- To empower patients to contribute to their own Lorenzo care record
- To provide easily accessible solutions that support self-management
- To develop an enriched Lorenzo Lite-viewer to support real time shared records across the STP
- To maximise the potential of the technology to fundamentally transform 'back-office' clinical administration.
- To create a technical landscape that unfetters care givers from data entry, puts relevant and timely intelligence in the hands of those that need it, whenever and wherever they need it, irrespective of organisational boundaries and releases

time to care. This is depicted as follows:



In practice, this bid will mean:

- For our **clinical workforce**: using technology that is slick, high performing, joined up, that provides the information and functionality they need to do their job successfully, that gives them confidence to take decisions, that actually saves time, that improves their working day, that makes them more effective and which provides a real opportunity to transform their services.
- For our **patients, service users and their families**: to help them contribute to their own care and wellbeing, to help them look after themselves, to avoid unnecessary hospital visits, to make it easier for them to reach out for advice and support and to give them confidence that anyone who contributes to their health and wellbeing knows about them and their uniqueness.
- For the **wider local health and care system**: to enhance partner working by providing access to records, advice and intelligence which helps provide the very best care, in the most appropriate care setting, supporting new care models, eliminating unnecessary interventions and driving more effective use of every £ spent on health and social care throughout the STP.

This bid supports the STP's strategic objectives set out below:

Objective	Aspiration
Safer care	Reduce gaps in health outcomes in Hull and ER. Increase the proportion of people who feel supported to manage their long-term condition.
Access and treatment in the right care setting	Care needs are met in the right place, at the right time with the right outcomes. Work towards having the lowest death rates for the top three causes of death.
Better life quality	Reduce significant inequalities across Hull and East Riding. Give all children a healthy, happy start to life. Support good mental and physical health for all and independence for our elderly population.
Qualified, sufficient and motivated staff	Continually improve the culture & quality of front line staff. Make work a healthy place to be.
Financially sustainable	Address anticipated system deficit of £166 million, over the next 4 years.
Strong System Leadership	Clear and effective communication across the whole system, at all levels, including outwardly with patients and residents.

Through the vision of our Medical Director of Clinical Support, we are already making digital transformation a reality in our Queens Building. This specialised Oncology 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.

This bid is not about sharing records 'digitally'. It is about changing the way we think and transforming how we work.

Ultimately our vision for the future is to deliver a service to patient's that does away with the traditional boundaries that our existing care settings define, be they organisational, technical or human.

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.

Future goals need to widen the Digital Transformation boundaries to outside those that exist now; information should flow seamlessly from the patient, through primary and secondary care services and beyond into a support model that delivers services a customised solution for a unique individual.

Systems of engagement can start to overcome these traditional boundaries and the wealth of information that we need to share and assimilate.

Future services need to be defined by different parameters that show we have started to think in a diverse way and transform to a service delivery model that puts about the patient at the core of their health.

2) Programme Description:

Describe the key components, scope, deliverables and outputs of your proposed change programme that will enable you to become a Digital Exemplar. Provide timeframes for deployment of these key components

(Please answer in 1000 words or less) 968

This Exemplar Bid, if successful, will accelerate the pace of transformational change throughout the Trust and will deliver significant benefits, quicker. It is underpinned by:

- A commitment by Hull & East Yorkshire Hospitals Trust to provide resources and funding to meet the timescales and ambition set out in the bid;
- HEY acknowledges that the Lorenzo product family is driven by the Product Development Roadmap and quarterly releases. This bid takes account of that. Notwithstanding that process, there will need to be a commitment from DXC to deliver HEY specific product enhancements, at pace, in order to support the transformation plan. Specifically these are:
    - *Enhanced G2 integration*
    - *Enhanced ABM functionality*
    - *Enhanced results acknowledgement*
    - *Push API developments*
    - *Enhanced workflow and usability (Task Management)*

The specific deliverables from the HEY Exemplar Programme are listed below. The current timescales for delivery are shown afterwards.

- **e-PMA (electronic in-patient prescribing)** – to complete the roll out of Lorenzo e-PMA across the full Trust estate, at pace, and to fully embed electronic prescribing and medicines management into clinical practice and the electronic patient record
- **Lorenzo Advanced Bed Management (ABM)** – to fully exploit the potential of ABM. ABM has been deployed into 3 wards in the Women's and Children's hospital. We wish to enhance its functionality to provide slicker, integrated and intuitive pathway management from referral to discharge, as a permanent part of the EPR, with all actions visible, traceable and reportable. The identified enhancements are a key enabler to roll-out ABM at pace. 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. A feature rich ABM will deliver tangible savings by enabling the current CAYDER system to be de-commissioned.
- **e-Acute Pathway** – build on the success of Lorenzo Emergency Care in the Trust, our vision is to exploit and extend the reach of the Emergency Department multi-layered floorplan to establish a unified, fully digitised, paperless Emergency Care & Acute Assessment model spanning the ground floor of the Hull Royal Infirmary Tower Block. This interactive, real time decision

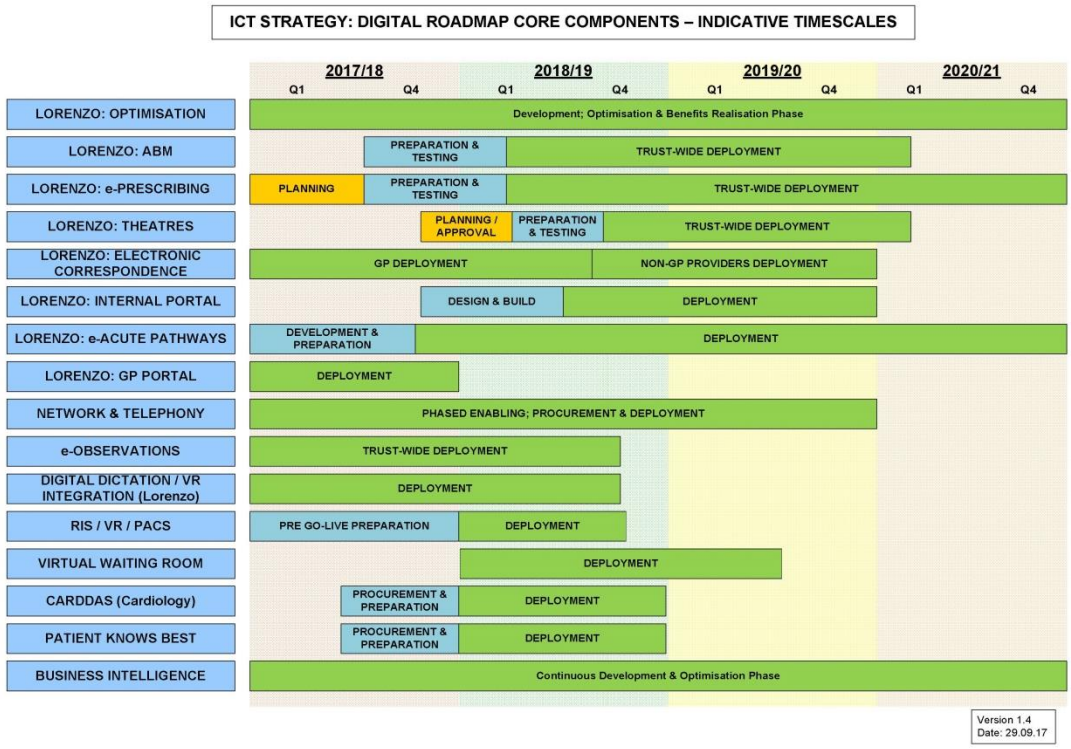
support solution will drive enhanced care and improved efficiency.

- **e-correspondence** – our vision is for clinicians to dictate seamlessly from G2 directly into Lorenzo, authorising in real-time and triggering correspondence to be instantly pushed into GP systems and the Patient Portal. This will eliminate delays in letter production, provide an enhanced service to patients, GPs and other care partners and will reduce the internal administration overhead. A successful bid would enable DXC to build a more feature rich integration model to meet the (already identified) Trust requirements.
- **e-patient health and well-being hub** – we recognise that sharing records with patients is not of itself, transformational. We want to go beyond simply giving patients access to their record. Our vision is to empower our service users to be at the heart of, and in control of, their own care. Our solution of choice is Patients Know Best (PKB). PKB provides the technology to enable HEY to meet its obligations for electronic sharing of records with patients. Working in partnership with Lorenzo, PKB will also:
    - enable patients to contribute to their own care record
    - enable the use of intelligent templating and e-forms to support more intuitive and interactive health & wellbeing management
    - support real time in-reach and interaction with care givers
    - PKB is being reviewed across the STP to support patients with long term illnesses
- **Virtual Waiting Room** – utilising the Trusts new CISCO Virtual Waiting Room system to provide personalised support, help admissions avoidance and improved patient experience.
- **e-Obs** – our vision is to work with DXC to position our NerveCentre e-OBS alongside of Lorenzo through enhanced integration.
- **GS1 Scan for Safety Project** – initially focussing on consumables management within Theatres, this project will drive improved safety, traceability and assurance

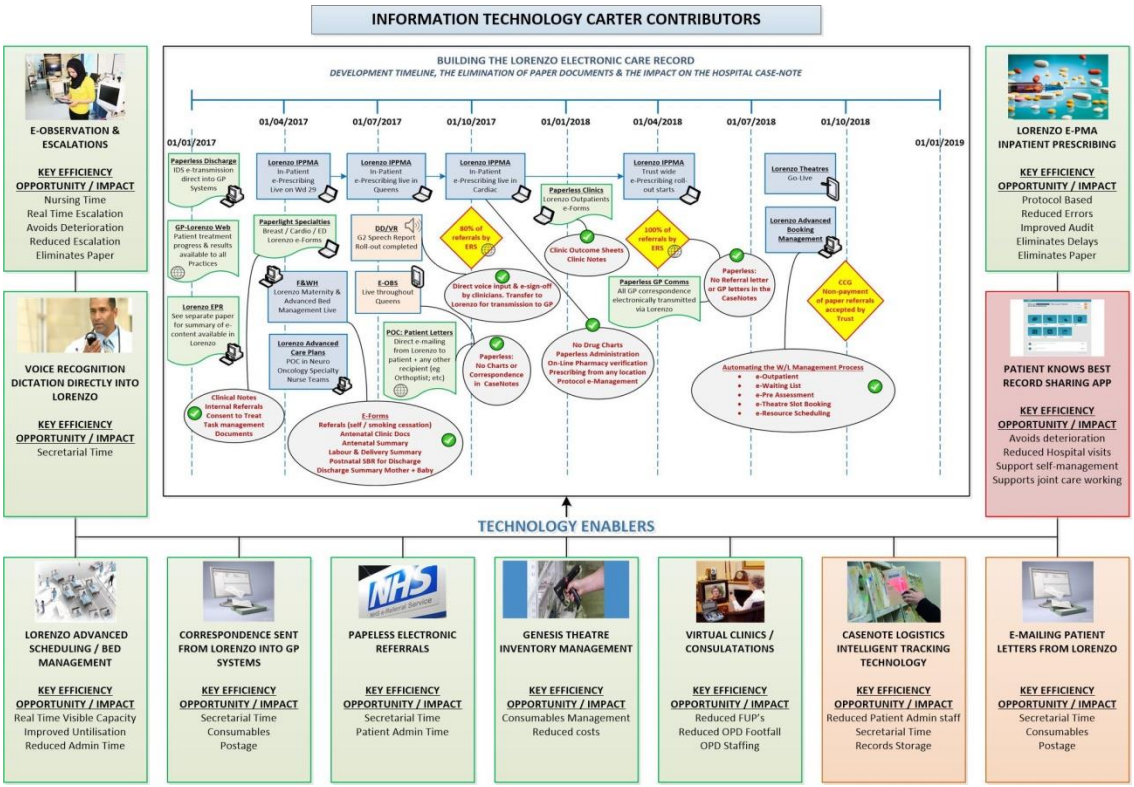
Our bid is not just about accelerating our existing programmes. Transformation will be further enhanced by other solutions that integrate the suite of products, reducing hand-offs and increasing data fluidity throughout our organisation:

- **Lorenzo Theatres** – bringing theatres into the heart of the EPR, supporting integrated resource allocation and contributing towards GS1 compliance
- **Wider data sharing** across the LDR through promotion of the use of the enhanced Summary Care Record. A first target for this is the bridge between our instance of Lorenzo and Humber Foundation Trust, who also use Lorenzo. While the infrastructure is already in place to enable this, we will initiate the programme to encompass 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.
- If successful, HEY would want to explore with DXC any opportunities to deploy emerging new technologies that support further transformation of our capabilities and will support the improvement of overall performance as identified in the CQC review (see Section 4). This may include, for example, use of the new Clinical Aide App to support ward rounds and give clinicians Lorenzo 'at a glance' wherever they are.

Current timeframes are set out below. A successful bid will accelerate the delivery of these projects. The detailed mobilisation planning phase will determine the extent of the time dividend delivered by the bid.



The combination of these developments, working coherently, driving digital-by-default practices, will support partnership working across the STP. Within HEY itself, the internal developments, together with national developments such as ERS, will have a profound effect on how we carry out our business as we transition to paper-free at the point of care:



The collective impact of a successful bid on our 'day-to-day' business is that it will enable HEY to implement a fundamentally different, optimised clinical administration model, built around specialties, exploiting the investment in digital tools, improving eyes-on management of patient status and progress, eliminating delays, avoiding task hand-offs and driving significant financial savings.

3) Value Proposition

Building on the outlined vision, describe the future state and the benefits for patients (and families/carers), staff and the service and how this will improve patient related and clinical outcomes:

- Provide a high level description of the intended outcomes and benefits including impact on current plan.
- Describe how the programme will specifically improve patient related and clinical outcomes.
- Include a description of the performance indicators and outcome measures to be used to determine achievement/progress

(Please answer in 500 words or less) 422

Our vision is of a digital organisation, driving the Trust towards HIMSS Level 7 compliance, providing a coherent, patient centric, electronic care record. It will result in the following outcomes and benefits to its patients, service users, clinical workforce and the wider local health and care system:

- The extension and use of digitally supported approach to health care delivery (e.g. from end-to-end electronic care pathways), to support the reduction of clinical risk, the greater convenience for patients and the improvement of the patients' experiences.
- Help clinicians more effectively diagnose patients, reduce medical errors, and provide safer care to patients. For example, enabling safer, more reliable prescribing. Improve the recording vital signs and patient observations data to reduce serious incidents and unavoidable harm to patients.
- Improving the productivity, efficiency and effectiveness of clinical staff, by providing accurate, real-time and complete information about patients at the point of care, thereby increasing the time for direct patient care and treatment, and improving clinical decision making.
- Improving patient and provider interaction and communication. The use of better information and the improvement of communication among the multidisciplinary teams should reduce patients' concerns and increase their confidence in the care that they are being given. This, in turn, should improve their satisfaction with the service that they are receiving.
- Reducing costs through decreased paperwork, improved safety, reduced unnecessary interventions and appointments, and improved health. Realise more efficiencies in clinical decision making associated with, for example, length of stay and out-patient clinic utilisation.
- Improved data availability and sharing of patient information across the full care provider spectrum, including the wider health community and also improving the availability of patient access to their own records.
- Make a significant contribution to enabling the adoption of new care models,

supporting admissions avoidance and care closer to home.

These outcomes and benefits will be evidenced and supported by a range of performance indicators and outcome measures to demonstrate achievement, including:

- Health outcomes in Hull and East Yorkshire. The STP's strategic objectives include a commitment to reducing gaps in health outcomes in Hull and East Yorkshire.
- CQC ratings associated with the overall rating, and key patient treatment performance indicators including Emergency Department breaches; serious untoward incidents; recording patient observations and responding to patient risk; Summary Hospital-level Mortality Indicator; Patient satisfaction; Waiting Times/ RTT performance.
- Actual Cost and efficiency (time) savings from the Lorenzo Investment Case Benefits Programme.
- Significant Productivity and Performance contribution to the Trust Carter Programme, including quantifiable and evidenced delivery of cash-releasing savings
- Results from Patient satisfaction surveys including "Friends and Family".

4) Current Status

- Quality and Productivity: This should include a current assessment of the quality of service delivery including current CQC ratings, progress against most recent CQC recommendations, key performance indicators/outcome measures.
- Digital Maturity: Include a reflection on current capabilities and the gap to be closed in becoming an exemplar and delivering the vision

(Please answer in 1000 words or less) 993

Lorenzo: Progress to date

The extant IM&T Strategy was approved in November 2011. Lorenzo is the cornerstone of that strategy, 'going-live' in all clinical areas of the Trust on 8th June 2015. Lorenzo sits at the heart of the 'business' and is fully embedded into clinical workflow. Lorenzo feeds our bespoke Business Intelligence service, from which key clinical and operational reports are produced and shared with care partners to support more efficient and coherent clinical management. In addition to the structured transfer of IDS's from Lorenzo into GP systems (and the ongoing programme for outpatient correspondence), the Trust has created a GP-Lorenzo Lite viewer via which key patient status information and correspondence is available to all GP Practices on a daily basis.

Post go-live metrics up to 14th September are:

- Circa **11,000** registered users; **5,500** individuals log in per month creating around **190,000** total logins
- Integration Engine processes **800,000** messages per day; **659,200,000** since go-live, with **99.9999997%** success rate
- **329,688** Emergency Department contacts
- **408,627** In-Patient episodes across **215,842** Access Plans
- **2,545,139** Out-Patients processed
- **33,971** Ward Attenders

- **1,082,548** referrals
- **2,424,000** Pathology Orders Processed
- **627,000** Radiology Orders Processed
- **667,000** electronic IDS Created
- **290,000** SCR Access Via Lorenzo

The current Deployment Unit (DU) landscape is:

June 8th 2015

- Care Management, Clinical Documents, Emergency Care, Requests and Results and (TTO Pilot)
- Implemented new Integration Engine and Developed 15 new HL7 Interface Adaptors
- Implemented new BI System and development of all associated National and Local extracts and reports

May 8th 2017

- Advanced Bed Management (live in Family & Women's Hospital)

May 16th 2017

- Maternity

July 2017

- ePMA (live on Ward 29)

Since the Strategy was approved, our vision has been to maximise penetration and impact of Lorenzo. The formative phases have been about stabilising, normalising and optimising Lorenzo. As we move into year three of our Lorenzo journey, 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.
- 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.

Care Quality Commission Review

The results of the last CQC review are:

DOMAIN	ASSESSMENT
Are services at this trust safe?	**Requires improvement**
Are services at this trust effective?	**Requires improvement**
Are services at this trust caring?	**Good**
Are services at this trust responsive?	**Requires improvement**
Are services at this trust well-led?	**Requires improvement**
Overall rating: Room for Improvement	

Key themes that the will be improved within a Digital Environment and positively impacted by this bid are below, along with technology solutions already identified:

Theme	e-Obs	ABM	ePMA	Other
Electronic flagging systems – Improved awareness of Mental Health, Dementia, etc	✓	✓	✓	
Record keeping – recurring theme of poor record keeping re nutrition, observations, falls etc.	✓	✓		Enhanced Integration
Handover and responsiveness - improved communications and visibility of information		✓	✓	Enhanced Integration
Decision Support Tools - to support MDTs, Ward and Board rounds, etc		✓	✓	Virtual Consultations Clinical Aide
Medication – gaps and errors in recording of medicine administration, signing off of drugs charts incomplete			✓	
Safeguarding information – the identification, data collection and reporting of safeguarding needs to improve		✓		Enhanced integration of Lorenzo Shared Records
Safer Surgery – elimination of 'never events', embed WHO checklists				Lorenzo Theatres
Outpatients – eight (8) reported incidents linked to delays in patients appointments – use of technology to increase visibility, avoid 'hand-offs' and underpin effective end-to-end pathway management				Advanced Booking Mgmt
Ability to Audit – visibility and auditability of records and actions	✓	✓	✓	

Digital Maturity Assessment

In December 2015 NHS England launched the Digital Maturity Assessment (DMA) which was designed to measure 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 national policy themes of:

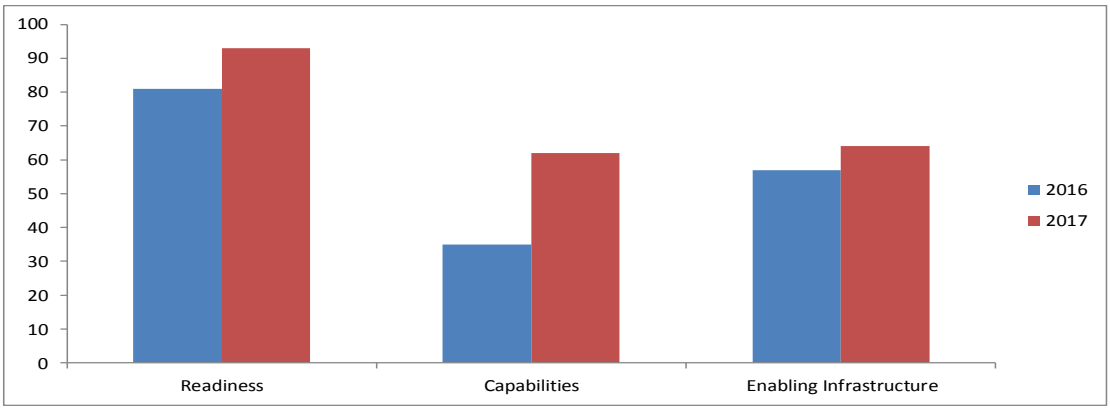
- Using Data and Technology to Transform Outcomes
- Integrated Care, Closer to Home
- Innovation & Efficiency through better Use of Technology
- Interoperability: Joined up Systems; Shared information

- Paper Free at the Point of Care

A follow up DMA, with additional questions, was published in September this year, with a submission deadline of October 20th. The updated DMA has the following objectives:

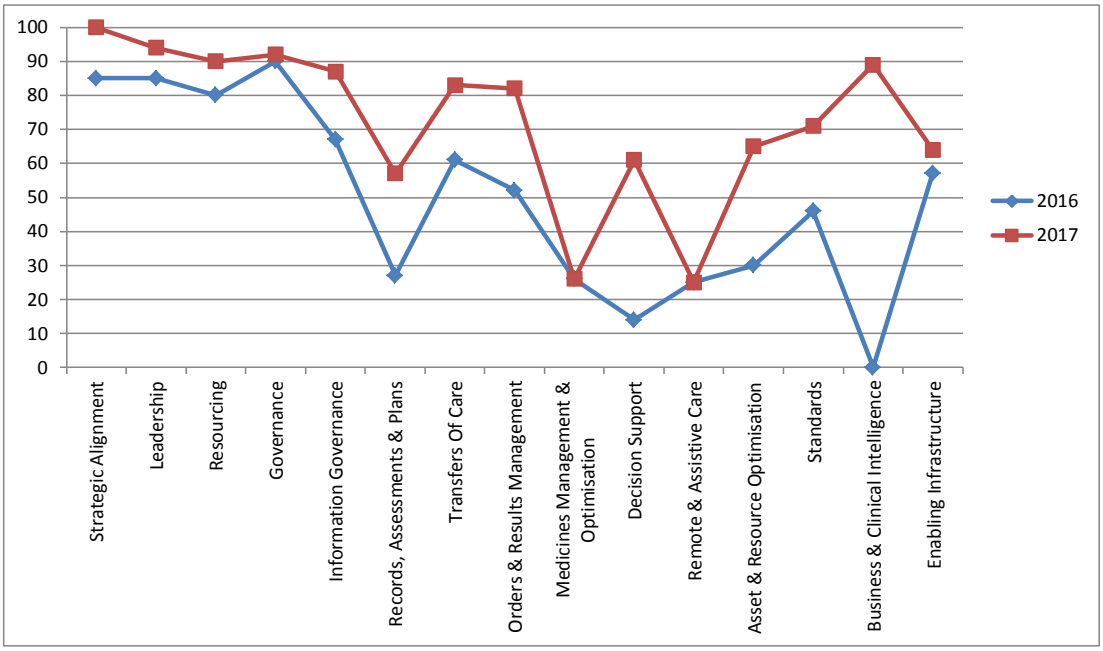
- Track progress made since the first round of self-assessments and the reasons behind it
- Support planning, prioritisation and investment decisions within providers and STP footprints
- Provide a means of baselining / benchmarking levels of digitisation nationally

HEY has completed and submitted the updated DMA, which shows significant improvement in each of the three categories:



These improvements are underpinned and driven by the ongoing investment in technology and infrastructure. Lorenzo is a significant contributory factor. The scores against each of the fifteen domains are shown below. Note that Business & Clinical Intelligence is a new section not measured in 2016.

HEY Digital Maturity Assessment: Progress since 2016



HIMSS Self-Assessment

A key objective of the Exemplar bid is to help HEY achieve HIMSS Level 7 compliance achieving a green status on all elements of the framework. The HIMSS framework is shown below. This section is derived from the high level published criteria for each HIMSS level.

Key:	
	To Do
	In Progress
	In Place

Level		HIMSS Level Capabilities	Status
Level 1	All Three Ancillaries Installed	Laboratory	In Place
		Pharmacy	In Place
		Radiology	In Place
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	In Place
		The CDR contains a controlled medical vocabulary, and the clinical decision support/rules engine (CDS) for rudimentary conflict checking	In Progress
		Information from document imaging systems may be linked to the CDR at this stage	In Place
		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	In Progress
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	In Progress
		The Electronic Medication Administration Record application (eMAR) is implemented	In Progress
		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	In Place
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	In Place
		If one inpatient service area has implemented CPOE with physicians entering orders and completed the previous stages, then this stage has been achieved	In Place
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	In Place
		Cardiology PACS and document imaging are scored with extra points.	In Place
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	In Place
		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	To Do
		The closed loop medication administration with bar coded unit dose medications environment is fully implemented	To Do
		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	To Do
		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.	To Do

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	

The self-assessment shows the areas that need be targeted for future Level 7 accreditation.

Our ePMA and e-Observations programmes are in progress and cover several of the In-Progress items at level 2 and 3.

At level 6, the gaps are around enhanced error removal within prescribing and closed Loop Medication Administration. Roll-out of Lorenzo e-PMA and GS1 Scan-for-Safety will significantly improve our capabilities in bridging this gap.

At level 7, the opportunities are shown in the sharing of data between Lorenzo and the wider community through the Heath Information Exchange. Our objective is to build on our GP Portal, promote wider use of the Summary Care Record throughout the LDR organisations and implement Patients Know Best to address this deficiency.

5) Organisational Readiness

Please provide a high level description of how you will further develop and enhance your organisational readiness for digitally enabled transformation:

- A description of the proposed governance arrangements for this programme, and how this aligns to the Trust's and STP's governance arrangements.
- A brief description of the executive, service and clinical sponsorship and leadership arrangements for this programme.

- Describe the approach to implementing transformational change, including how the programme will transition to business as usual and the approach to monitor and manage outcomes and benefits realisation.

(Please answer in 1000 words or less) 997

Programme Governance

- **Lorenzo Programme Board**: The Lorenzo Programme has, since its inception, had a robust governance structure, overseen by a Programme Board, underpinned by Project Boards for key elements of the Programme. The Programme Board meets monthly.

  The Programme Board is chaired by the Trust Chief Consultant Information Officer (CCIO), has membership drawn from each of the four Health Groups, senior representatives from the IM&T Directorate, senior DXC representatives and NHS Digital.

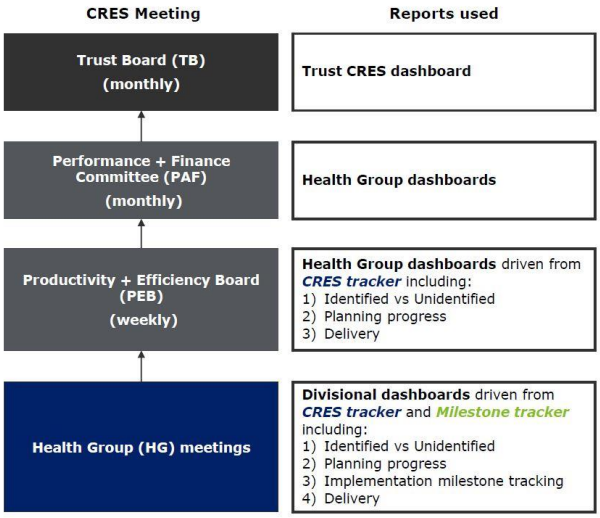
  Each Project Board is chaired by either the Trust CCIO (eg ePMA) or a senior clinical representative from the 'owning' Health Group (eg e-OBS). Membership comprises senior officers from Health Groups and the IM&T Directorate. Each Project Board reports to the Programme Board.

  This governance structure will remain in place for the lifecycle of the Programme and will accommodate bid progress reporting.

- **HEY Carter Committee**: this Committee is chaired by the Trust Chief Financial Officer (CFO), with senior membership from directorates and services across the Trust. Its remit is to ensure that there is a focus on the Carter Recommendations and provides oversight of the overall programme. The Director of IT & Innovation is a member of the Carter Committee and is responsible for reporting overall progress on the delivery of benefits from the IM&T programme.

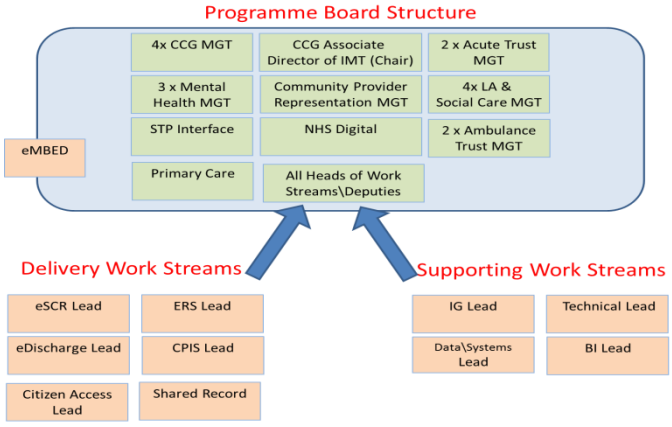
  It is envisaged that overall benefits reporting relating to those projects / components that make up the exemplar bid will be via the Carter Committee.

- **HEY Productivity and Efficiency Board (PEB)**: this group is chaired by the Executive Director of Operations, reports to the monthly Performance & Finance Committee and is responsible for managing the delivery of the Trust's Cash Releasing Efficiency Savings (CRES) Programme. Project level progress reports relating to the Exemplar programme will be made to the PEB. This will increase visibility and accountability over benefits delivery. The CRES accountability framework is shown below:



- **Lorenzo Optimisation Committee**: This group oversees the creation and delivery of the Lorenzo Optimisation Plan. If the bid is successful, the group will review and reframe the current plan in light of revised project timescales.

- **Digital Roadmap Programme Board**: HEY is a member of this STP level steering group which oversees the development of the technical agenda to support the STP's strategic objectives. Senior members of the HEY IM&T service, together with Mark Simpson (CCIO) are both members of the Programme Board and its underpinning workstreams.



Exemplar Bid Sponsorship

- This submission has the support of the Trust CEO and CFO.

- The indicative capital cost of the projects within this bid have been incorporated into the Trust's provisional 3 year Capital Programme and were presented to the September Capital Resources Allocation Committee, chaired by the Trust CFO.

- The Exemplar Bid was presented to the full Trust Board on 5th October and was approved for submission to NHS Digital.

- The Trust CCIO, supported by CIO's from each Health Group, demonstrates the commitment to clinical sponsorship and leadership of the Programme.

- The Medical Director of Clinical Support, Russell Patmore, has equipped his Health Group with the drive and velocity to deliver an entirely digital hospital. This success will allow us to springboard a new way of thinking and sponsoring change within our organisation: teams are ready and waiting for the opportunities that transformation will bring to ways of working and delivering care with patients at the centre.

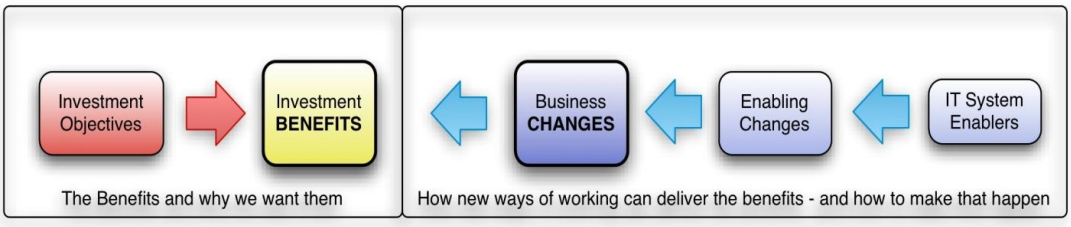
Business/ Transformational Change Approach

The Trust has developed a mature Business Change approach over a number of large, complex I.T. programmes. The key steps involved are:

- Detailed future state processes and SOPS are developed and refined with subject matter experts, process owners, clinical, administrative, and management staff.
- Any constraints or issues associated with the current 'ways of working' are either resolved or a suitable 'work around' process is developed where possible
- Benefits are identified, documented and quantified to enable them to be realised post go live.

The Trust applies an integrated approach to Benefits Realisation and Change Management to ensure all key objectives are included within the Benefits Realisation Plan, and in turn reflected in the arrangements for Programme Evaluation and Post-Implementation Review.

The Benefits Realisation Plan, and the business changes and service transformation to deliver it, are provided by the development of a Benefits Dependency Network. This will show how the objectives of the investment lead to the identification of the benefits to be realised from the programme, and the relationship between these benefits and the business and service transformation changes needed to realise them. Furthermore, it identifies the enabling changes provided by the programme. This relationship is shown in the following diagram:



The Benefits Realisation Plan summarises the benefits to be achieved, the assessment criteria, together with the data required to measure success and any assumptions.

Progress with the project will be monitored, reviewed and reported on a regular basis to show delivery against programme milestones and benefits realised against

programme objectives and planned benefits.

Deployment testing activity will be based upon the agreed, signed-off future state processes. Test scenarios and underpinning detailed test scripts will be process-based and reflect an end-to-end pathway for the patient information.

Within the testing phases of the programme, any system issues raised will be triaged according to their impact on the end business process or benefits sought from the programme.

Since our successful Lorenzo implementation in 2015, we have continued to develop and refine our use of the approach across the Trust. Our library of Standard Operating Procedures (SOPs) covers over 80 end-to-end pathways and sets a high standard of process and ways of working that are a valuable resource to any other Trust seeking to learn from our experiences and good practice.

We can contribute to the validation and adoption of Blueprints that can be implemented across the NHS as well as continuing to learn from our colleagues, as we seek to continually improve.

Our Business Change approach was successful in bringing our whole staff along a significant journey, contributing to our ongoing successful use of Lorenzo. Here too, experiences can be shared with our colleagues and the wider NHS.

6) Stakeholder Engagement

- Briefly describe the approach to stakeholder engagement and management for this programme.
- Provide details of national and regional forums where your organisation is a key contributor and how the CIO/CCIO and other programme leaders will be ambassadors in relation to this programme.

(Please answer in 500 words or less) 492

Supporting the National Lorenzo Programme

- We are passionate advocates for Lorenzo.
- Mark Simpson (Trust CCIO) is a longstanding contributor to, and clinical leader within, the national programme. Mark is currently the Chairman of the Lorenzo User Group (LUG) and sits on the DXC/LSP Programme Board.
- HEY are viewed by DXC as a 'reference site' for Lorenzo and over the last two years we have regularly hosted visits from other Lorenzo Trusts to showcase what is possible, specifically in the areas where HEY has had conspicuous success: Requesting & Results, Emergency Care and Business Intelligence. These include:
    - Derby
    - Morecambe Bay

- Papworth
- Sheffield
- Salisbury
- Barnsley
- NHS Digital – Trust Service Management
- South Warwickshire
- Warrington and Halton
- DXC Australian Delegation
- DXC Sweden Delegation

- HEY regularly presents progress and developments at the Lorenzo User Group, sharing experiences and ideas with fellow Lorenzo Trusts. HEY actively contribute to DXC and NHS Digital Lorenzo forums and Chairs the Lessons Learned group for release management. HEY is first of type (FOT) for the emailing patient's innovation fund and being considered FOT for the ED/AMU innovation fund development.

- HEY has an established approach to Benefits Realisation and reports quarterly to NHS Digital and the LSP Programme Board when requested.

- HEY is a longstanding member of the North Yorkshire & Humberside Directors of Informatics Forum (NYHDIF) and is a contributor to bi-monthly meetings and to the annual NYHDIF Conference.

Stakeholder Engagement

At present the key stakeholder group is our **Consultant Information Officer Forum, comprising** four CIO's representing the four Health Groups. This group is chaired by the CCIO and includes senior representative from the IM&T Team. It meets fortnightly to monitor progress with projects, raise issues on behalf of the clinical workforce, discuss and advise on emerging project or product issues, ratify actions and contribute to the overall direction of the programme.

The Exemplar Programme is a significant piece of work, building upon the initial Lorenzo deployment of 2105. We recognise the need to find a balance of benefits between the organisation and its stakeholders, to ensure cooperation, to address the needs of stakeholders, to reduce negativity and to help implement the programme successfully. We will update the original Lorenzo "stakeholder analysis" to ensure that we:

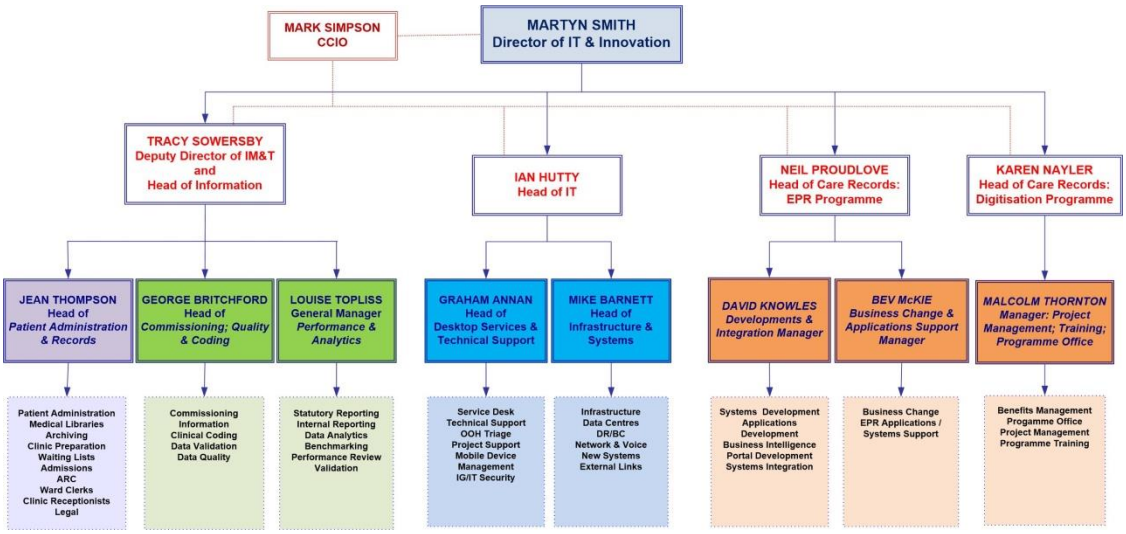
- identify all Internal and external stakeholders whose knowledge, commitment or action is needed to realise the benefits of the programme
- determine the views held by each stakeholder/ stakeholder group in terms of "what's in it for me?", and any dis-benefits they perceive
- understand the business change activities as they affect each stakeholder group and their motivation to achieve or resist these changes
- understand the actions needed to gain the required involvement and commitment of all the stakeholders
- develop action plans to enable or encourage the necessary involvement
- A communications plan will be formulated to address the concerns of key groups and to ensure the commitment of these groups is maintained to deliver a successful programme.

7) Resourcing and Estimated Requirements

- Given the expectation set out in the Guidance Notes please provide a high level overview of your overall resource commitment to become a digital exemplar and how you will sustain this going forward
- Provide a reflection on current capabilities/capacity and estimate the resource requirements in terms of finance and human resources to deliver this programme

(Please answer in 500 words or less) 289

IM&T Senior Management Structure



The Lorenzo Programme Team

HEY has a core Programme team comprising of staff with a wealth and breadth of experience across:

- Programme and Project Management
- Business Change and Benefits Realisation
- Dedicated Clinical support, Pharmacist and technicians, Lead Nurse, Midwife (CSO), CCIO, CIOs and NICOs
- Integration, iForms and Systems Development
- BI and Health Informatics / Analysts

Many team members have frontline NHS Clinical and Management backgrounds ensuring a balance between structured deployment and operational awareness in its deployment approach. HEY philosophy is to maintain a highly skilled knowledgeable core team supplemented by experienced staff on a temporary basis, as relevant to specific deployments.

The Core Lorenzo team is as follows:

- Head of Department and Programme Managers 1.4 WTE
- Benefits Management 1.0 WTE
- Business Change and Applications Manager 1.0 WTE
- Applications Support and Configuration 7.0 WTE

- Business Change Managers 3.0 WTE
- Project Managers 4.0 WTE
- Pharmacy and Nursing 4.0 WTE
- Trainers 4.3 WTE
- PMO 3.5 WTE
- BI, iForms and Systems Development 10.0 WTE

In order to support the pace and concurrency of deployments, together with the extent of business change if the Digital Exemplar was successful, it is calculated that the following resource uplift will be required to supplement the existing core team:

- Business Change Managers 3.0 WTE
- Benefits 1.0 WTE
- Project Managers 4.0
- Trainers 3.0 WTE
- Pharmacy and Nursing 2.0 WTE
- Applications Support and Configuration 3.5 WTE
- PMO 1.0 WTE
- BI, iForms and Systems Development 2.0 WTE

It is expected that some of these resources (potentially Project Management, Business Change, and Benefits Delivery) will be supplied by DXC as part of the Exemplar Bid offering. This requires further clarification.

The final resourcing model will be firmed up as part of the planning and mobilisation phase should the bid be successful.

8) Learning and Sharing

Describe how other trusts could benefit from a Lorenzo trust being a digital exemplar.
In becoming a Digital Exemplar, describe how you would:

- Provide outcomes and benefit measures for this and the wider Lorenzo programme.
- Input into the design/assurance of any blueprints covering business processes, operating procedures, implementation and change lessons etc.
- Work with Fast Follower Lorenzo Trust(s) to validate and adopt “Blueprints” that will underpin a spread strategy across Lorenzo Trusts and wider NHS.
- Share knowledge, lessons and experience, work across organisation/ communities/ networks for the benefit of the wider NHS.
- Work with NHS Digital and DXC who will be required to evaluate the project, providing access to key staff when requested, access to information and attendance at key meetings.
- Ensure IP can be made available to others
- Develop capability internally

(Please answer in 1500 words or less) 372

We are keen to share our understanding and lessons learned from our wide implementation of technology with Lorenzo and non-Lorenzo Trusts as we feel we truly exemplify a Trust that has bought into becoming a digital organisation and one that is

seeking to build on our solid foundations.

By working closely with the partners through the local Digital Roadmap Programme Board we already contribute significantly to our STP plans and developments. We aim 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 of Lorenzo.

Our implementation of Patients Know Best will be a trail blazer in our STP area. We consider this to be a real game changer that starts to realise our ambitions and vision to keep the patient at the heart of their own health. Due to its very nature, once we're connected through this tool, significant opportunities open up to support wider primary, community, social care and mental health services across the patch and really start to drive benefits into patients' lives. "End–to–end" will really start to mean that, across all touch points in a patients' health and wellbeing, so that every interaction is fully informed and integrated with every relevant piece of information is available, at the touch of a button or screen.

We will be key players in this evolution, expanding our own GP Portal, working with GPs to ensure technology solutions meet their needs and can be enhanced through integration with wider systems where possible.

We are fully committed to sharing our experience and developments with other Trusts. We regularly share templates, CDC forms, advice and guidance, and potential benefits with other Trusts.

We have a track record of supporting other Trusts through site visits, telephone and WebEx advice and are always willing to contribute to system developments. We have supported go-lives at other Trusts, staff from HEY have been placed on site at other Trusts during go-live periods to offer support, guidance and direction.

HEY is very proud of its achievements and would be delighted to share positively the experience gained from the successful exemplar programme for the benefits of others.

9) Key Challenges

What do you see as the key challenges of a Digital exemplar programme and what would you like to see in place to address these challenges?

(Please answer in 500 words or less) 277

Fundamentally, successful delivery of the Lorenzo Exemplar Programme is dependent upon two components:

- **PRODUCT:** Lorenzo must consistently deliver a user experience of high performance, functional richness, intuitive seamless working and relevance to clinical teams and supporting staff. There are a number of HEY specific product enhancements which will help unlock the potential for Lorenzo. We expect these to be provisioned under the Exemplar agreement. Without these it will be difficult to exploit Lorenzo to its full potential or push beyond its current footprint.

- **PEOPLE:** Allowing Lorenzo to evolve organically over time is not sustainable. HEY's aspiration is to deliver impactful, meaningful, transformational IT at pace, delivering the largest possible dividend to stakeholders. Rapid adoption and penetration is dependent upon staff having the time, space and commitment to be trained and to be confident with these new systems. In the Programme itself, there must be sufficient skilled resources in place to deliver products at pace, to train and support users across the Trust when they need it, to maximise availability of systems and to drive the achievement of benefits.

Since the approval of the IM&T Strategy in 2011 and the commitment to Lorenzo, HEY has a track record of supporting and driving IM&T investments to achieve maximum penetration and benefit. The original Programme Team remains in place but will need to be supplemented in order to deliver HEY's obligations under this bid.

The financial ramifications of a successful Exemplar Bid for HEY are acknowledged and have been taken account of in the planning of the Trust Capital Programme through to 2020/21. Those indicative figures cover the costs of products, infrastructure and staffing as far as we are able to at this stage.

10) Please provide any other information relevant to the submission:

(Please answer in 500 words or less) 151

At the time of writing, Lorenzo has been in place for 127 weeks and has become embedded in day-to-day working. Although there has been significant and notable 'wins' it remains a processing tool for the patient pathway, not an enabler for change.

The single biggest challenge therefore is to deliver the 'wow' factor with Lorenzo. Lorenzo is the key system via which we 'run' the business, but it is someway off being a truly transformational product. We know it can do so much more than transactions processing. We know that, in tandem with other Trust developments, it can open up new ways of working both internally and with our care partners. We know that collectively, it can empower clinicians and service users to think differently about how care and support is given and received.

With commitment from DXC and the support of NHS Digital we know we can deliver transformational IT.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

SCAN4SAFETY TRUST CHARTER BACKGROUND INFORMATION

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 - 17
Director	Lee Bond – Chief Financial Officer	**Author**	Rachael Ellis - Scan 4 Safety Programme Director
Reason for the report	To seek permission for publication of the Scan4Safety Board charter as part of the commencement of the Scan4Safety programme implementation.		

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

1	**RECOMMENDATIONS** A Board Charter for HEY Trust has been developed for publication for the commencement of the Scan4Safety initiative. The endorsement by the Trust's board further strengthens our position to deliver patient safety and financial stability. It is recommended that you approve the publication of the Trust Board charter					
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**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

SCAN4SAFETY TRUST CHARTER BACKGROUND INFORMATION

1. INTRODUCTION AND BACKGROUND TO SCAN4SAFETY

In January 2016, the Department of Health appointed six NHS Trusts to act as demonstrator sites under the Scan4Safety initiative. The six Trusts have received support and a share of £12 million of Department of Health funding. The six demonstrator sites have been tasked with demonstrating improved patient safety, significant efficiencies and cost savings by adopting GS1 and PEPPOL standards. The barcode technology used in major industries such as aerospace and retail is being introduced to the NHS in England to improve patient safety. Barcodes are being placed on all products which are implanted such as breast implants and replacement hips. It has also been applied to medication and surgical tools.

The 6 demonstrator sites are:

- Derby Teaching Hospitals NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- North Tees and Hartlepool NHS Foundation Trust
- Plymouth Hospitals NHS Trust
- Royal Cornwall Hospitals NHS Trust
- Salisbury NHS Foundation Trust

The Scan4Safety programme has 4 key elements:

- **Patient** –improving safety, improving care
- **Product** –everything recorded, everything accounted for
- **Place** –everything trackable, everything traceable
- **Process** –simplifying processes, releasing time to care

The Scan4Safety project is underpinned by GS1 technology (often referred to casually as barcoding systems) and requires “Core Enablers” which are Patient, Product, Place. The outputs are based on “Primary Use Cases” which are Inventory Management, Product Recall and Purchase to Pay.

2. WHAT BENEFITS WILL SCAN4SAFETY BRING?

The benefits range across many factors including:

1. **Patient Safety**
   Being able to track all patients, spending less time looking for patients. We will deliver significant patient safety benefits and reduction in clinical risk through assured and reliable traceability of products, patients and locations. Once fully implemented and in steady state we expect our NHS Litigation Authority will reduce substantially. (Leeds NHS Trust expects their NHS Litigation Authority fees to reduce by £300,000 per annum once rollout is complete.)

2. **Stock and Inventory Management**
   Much improved control of when, where and the how many products are being used. This will also capture the waste and the obsolete stock.

3. **Patient Level Costing**
   Proving a full breakdown showing all costs which the individual patient has incurred. This could include drugs, implants, consumables, theatre time, ward costs and staffing attributed. This will allow the Trust to improve its budget forecasts, identify savings opportunities and improve our coding.

4. **Traceability of products**
   Full traceability by product code, lot and batch number ensuring full traceability should any product recalls take place.

5. **Theatre Utilisation**
   The transparency provides the option of considering how to best utilise theatre times. Surgeons and theatre staffing teams can be reviewed and compared for the same procedure. This allows greater intelligence for future planning. The combination of barcoding patients and consultants could allow the Trust to analyse variation in clinical practice and identify optimal practices for theatre utilisation

6. **Clinical practice analytics**
   The data which will become available will allow scenario based reviews to analyse the clinical practices that take place. It will also identify areas which could benefit from improvements to working practices (related to patients / consumables / waste / instruments) It also provides actual data for considering new “standards” of clinical working.

7. **Demand aggregation**
   Aggregation of product based on actual usage can be a very powerful negotiating and bargaining option for our procurement team to agree further benefits for leverage of pricing and delivery.

3. WHY A TRUST CHARTER IS IMPORTANT

The commitment of the senior executives across all of the disciplines both clinical and non-clinical brings together a sense of common purpose, moving towards common goals for benefits which are wide ranging and are pertinent to bringing best use of resources and improved patient care.

It also galvanises the commitment of the senior executives from with the Trust for all employees, patients and members of the public to see at a glance both the aim to improve and the focus of putting patients at the forefront of all of our decisions.

LEE BOND
Chief Financial Officer

28 September 2017

GS1 and PEPPOL Charter

We the Trust Board of Hull and East Yorkshire NHS Trust fully support the ongoing implementation and deployment of the GS1 / Scan4Safety & PEPPOL programme and standards adoption across the Trust.

Hull and East Yorkshire Hospitals NHS Trust

We firmly believe that the GS1 / Scan4Safety & PEPPOL will contribute to offering the following benefits:

- Putting Patients First
- Getting It Right First Time
- Using Our Resources Wisely
- Accurate Data To Make Good Decisions

We are fully committed to the programme and will provide active input to our implementation and promotion of the benefits of GS1 / Scan4Safety and PEPPOL regionally and nationally.

SCAN4SAFETY
Patient. Product. Place. Process.

PEPPOL
PAN-EUROPEAN PUBLIC PROCUREMENT ONLINE

GS1 UK

Terry Moran
Chairman

Chris Long
Chief Executive

Mike Wright
Chief Nurse

Jacqueline Myers
Director of Strategy & Planning

Trevor Sheldon
Non-Executive Director

Kevin Phillips
Chief Medical Officer

Carla Ramsay
Director of Coroprate Affairs

Martin Gore
Non-Executive Director

Ellen Ryabov
Chief Operating Officer

Duncan Taylor
Director of Estates & Facilities

Andy Snowden
Non-Executive Director

Lee Bond
Chief Financial Officer

Vanessa Walker
Non-Executive Director

Stuart Hall
Non-Executive Director

Simon Nearney
Director of Workforce and OD

Tracey Christmas
Non-Executive Director

Martin Veysey
Associate Non-Executive Director

Goal 1: Honest, caring and accountable culture | Goal 2: Valued, skilled and sufficient staff | Goal 3: High Quality Care
Goal 4: Great Local Services | Goal 5: Great Specialist Services | Goal 6: Partnership and Integrated Services | Goal 7: Financial Sustainability

Great Staff - Great Care - Great Future

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Extraordinary place.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

Meeting date	3 October 2017	**Reference Number**	2017 – 10 - 19
Director	Jacqueline Myers – Director of Strategy and Planning	**Author**	Jacqueline Myers – Director of Strategy and Planning
Reason for the report	To present the draft 2017/18 Winter Plan for discussion and approval, subject to the outstanding issues being resolved.		

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

1	**RECOMMENDATIONS** That the Trust Board: 1. Approves the 2017/18 Trust Winter Plan 2. Note the current state of the system winter plan and the plans to challenge this 3. Note the current financial impact and the need to seek to reduce this or acquire additional external funding.					
2	**KEY PURPOSE:**					
	Decision		Approval	x	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					
	Valued, skilled and sufficient staff					X
	High quality care					X
	Great local services					X
	Great specialist services					
	Partnership and integrated services					x
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW** Executive Management Committee 19 September 2017 Performance and Finance Committee 25 September 2017					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

DRAFT

TRUST WINTER PLAN

2017/18

1 PURPOSE

This plan sets out the actions that the Trust will take to manage increased workloads over the winter period both safely and efficiently. The plan has been developed with Health Groups and Corporate Directorates, and in consultation with partners in the local health economy.

In common with last year's Winter Plan, which complemented the much wider work of the Urgent and Emergency Care (UEC) Programme to increase the performance and resilience of our Acute pathways, the 2017/18 plan will reference ongoing work in this area, such as the 90 day challenge 'Sunday is the new Wednesday', which is looking to rebalance clinical and operational arrangements to meet needs of acute activity levels on Sundays.

Also of relevance are the emerging Place Based Plans in Hull and East Riding and the Improved Better Care Fund initiative, whilst not winter specific, should have a (limited) positive impact by this coming Winter.

2 PLAN OBJECTIVES

The Trust has a comprehensive Winter Plan which covers all key winter specific issues. The objectives of the Winter Plan are as follows:

- To ensure that the Trust has appropriate resources and processes in place to cope with increased workloads over the winter period
- To ensure that the Trust has appropriate escalation arrangements in place to cope with significant peaks in demand
- To ensure that the Trust works effectively and efficiently with partner organisations during the winter period
- To ensure that the Trust's performance against Emergency Department (ED) performance indicators continues to improve
- To minimise the extent to which increases in emergency workloads adversely affect the provision of cancer services and performance against other waiting time targets
- To ensure that the Trust has appropriate arrangements in place for dealing with severe weather events, such as snow and flooding
- To ensure that the Trust has appropriate arrangements in place for dealing with a severe seasonal influenza outbreak

The key feature of winter pressures is an increase in demand for acute medical and elderly care beds. This is driven not by increased admissions, but by longer lengths of stay, and by increased bed closures due to infection.

An explicit principle in this year's plan is that the Medicine Health Group will plan to contain peaks in demand within their increased winter bed base. A Standard Operating Procedure will be developed for those occasions when demand exceeds medical bed capacity. This will identify which patients should be considered for outlying and which ward should be used first and thereafter.

Winter typically does not see an increase in ED attendances, there is however both an increase in acute medical admissions and length of stay. Emergency Department attendances usually peak in Q2 and are lowest in Q4 and this was the case in 2016/17.

3 LEARNING FROM LAST WINTER

Summarised below are a number of positive initiatives implemented last winter of 2016 / 17:

- UEC Improvement Programmes: pre-hospital, in-hospital, and discharge pathway redesign and improvement
- Revised Operational Flow arrangements: Director of the Day and General Manager to work with Site Team to oversee flow and manage operational issues
- Surge and Escalation Process: responsive engagement of all system partners in managing surge
- Collective Decision Making: senior system partner involvement ensured decisive decisions when increased support was required when responding to demand
- Clear Media Messages: single point of contact established, key messages collectively agreed and timely Hull Daily Mail campaign, 'Help our A & E'
- Preparedness of the Winter Ward: advance planning, preparation and leadership ensured effective utilisation, safe staffing and positive patient experience
- AMU Reconfiguration: initiatives improved flow to, through and out of AMU resulting in increased available medical beds and more timely movement from ED
- Utilisation of Community Beds: capacity was used throughout the winter and supported the surge and escalation process

4 PROJECTED WORKLOADS AND BED REQUIREMENTS FOR WINTER 16/17

4.1 Baseline Position and approach to calculating Winter bed requirements

The Medicine current baseline position is 406 beds (September 2017) excluding, as in previous years, the day beds in Cardiology.

The model we use to assess the demand for beds in Winter is to monitor the actual use of beds across the year and calculate the amount of beds required to meet that demand at the 90% percentile. We look at the Midday and Midnight bed occupancy in both assessment and inpatient beds. Every year demand for beds in the Medicine Health Group peaks in Q4. We therefore use the 90th percentile for Q4 in the previous year as our standing point, and then conduct a sensitivity analysis of any factors which may change the demand into the coming year.

4.2 Output of the Winter Bed Modelling **Table 1**

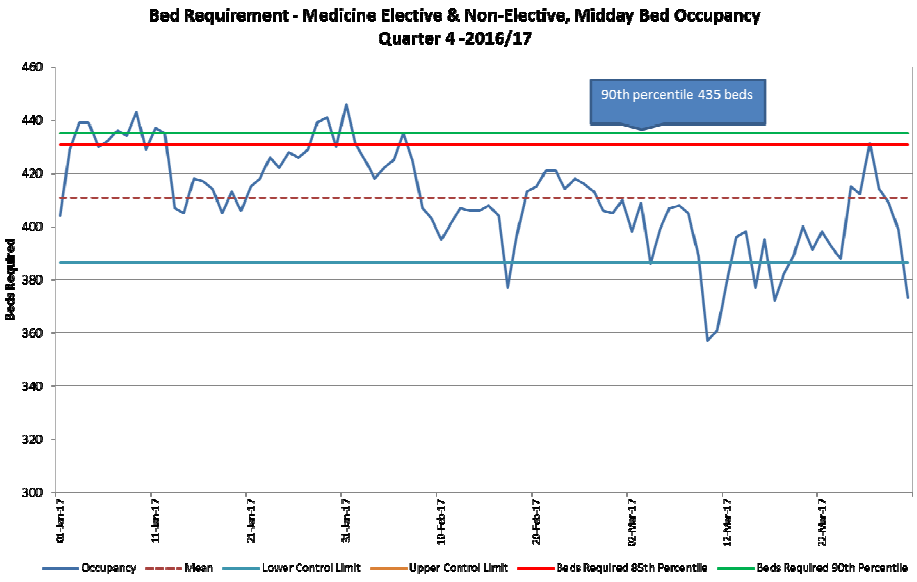


Table 1 above shows that in Q4 of 16/17, the 90th percentile of demand for medicine beds at midday was 435. The figure for midnight was 429. By contrast for Q1 of 2017/18 the 90th percentile had dropped to 407.

4.3 Sensitivity Analysis

Discussions with key players have identified the following areas for consideration as part of the sensitivity analysis:

- Any changes in activity trends
- Impact of embedding of new ways of working introduced as part of the Urgent and Emergency Care Programme; specifically the Frailty Intervention Team (FIT) and the new medical model in the Acute Medical Unit (AMU).
- Relatively low levels of infection in 2016/17 and outlook for 2017/18

4.3.1 Activity trends

A comparison of Medicine Health Group inpatient activity in quarter 1 of 2016/17 v quarter 1 of 2017/18 reveals the following:

1. Admissions were slightly up this year by 63.
2. However, bed days consumed was down by 2,001.
3. This is as a result of a lower average length of stay which is down 0.25 days this year
4. The length of stay change is in turn due to a change in case mix as there are fewer elderly medicine admission and more general medicine admissions in the mix and the average length of stay in elderly medicine is higher.

On the basis of this analysis it is not necessary to include additional beds in the demand model to take account of an increase in activity, providing the new ways of working are maintained.

4.3.2 Impact of new ways of working

The overall reduction in use of bed days thought to be due to the impact improvements made in the UEC Programme, including the introduction of the FIT in ED and the new medical model in the AMU.

Continued delivery of these models in of course dependent on the required specialist workforce being available and resource being available to fund it. During quarter 4 of 2016/17 and quarter 1 and 2 to date of 2017/18, the FIT been available at the weekends some of the time and this impact is reflected in the bed modelling. If this service were to be available for weekdays only over the winter period this work is likely to increase the demand for inpatient beds.

In view of the uncertainty in regard to whether FIT session frequency will be maintained, 8 beds have been added to the forecast demand, which is 2% of the medicine bed base.

4.3.3 Impact of Infection

Incidence of infections which require patients to be isolated increase in the Winter Months: usually in the form of Norovirus or Influenza. Last winter incidence of these infections was relatively low

Based on much higher levels of Influenza infection in Australia at the moment (during their 2017 winter) we are being warned that we may face a similar challenge this coming winter. The effectiveness of the coming season's 'Flu vaccination will also have

a bearing on the situation.

Forecasting the impact of this on our bedbase is impossible to do accurately. As part of the sensitivity analysis we have added 3 beds to the demand to allow for an 3 additional beds to be closed due to infection

4.5 Medical Bed Demand Forecast for 2017/18

Drawing together the modelling and further analyses set out above, the forecast demand for beds for Winter 2017/18 is as follows:

To meet the demand for beds 90% of the time based on Q4 2016/17	435
To allow for less regular deployment of FIT at weekends	8
To allow for higher rates of bed closure due to infection	3
Total	**446**
Currently available beds	**406**
Gap for Winter	**-40**

5 PROPOSED WINTER PLAN ACTIONS for 2017/18

In order to respond to this increase requirement for beds, the Health Groups and Corporate Directorates have reviewed their winter plans and determined a set of actions to be implemented this coming Winter and these are set out below:

5.1 Medicine Health Group

Additional acute medical beds 'The Winter Ward'
Ward 10 at Hull Royal Infirmary (HRI) will be used as a winter ward for the 5 month period from 27th November 2017 to Wednesday 11th April 2018, providing an additional 27 beds. This will allow clearance from the Easter Bank Holiday 2018.
The Medicine Health Group is liaising with the Nursing Directorate and the other Health Groups to ensure appropriate arrangements are in place prior to the additional ward being opened. Medical cover will be provided by 2 junior doctors and 1 Consultant. Action is being taken to recruit locum junior doctors who have previously worked at the Trust. Consultant cover will be provided by existing members of staff on a rota basis. Plans have also been agreed to create an experienced team of nurses for the ward, primarily through redeployment of existing members of staff from all 4 Health Groups. A Standard Operating Procedure is developed for the winter ward. It has been agreed that for the coming winter, the ward will accept new patients directly from the Acute Medical and Ambulatory Care Units. A Project Team has been established to oversee implementation and is meeting on a weekly basis.

The Clinical Support Health Group will support the winter ward with additional therapy and pharmacy input. This support will be fully provided 5 days per week, with a more limited service being provided at weekends as per current arrangements with other wards. Additional staffing will be provided in part through use of agency and overtime.

The Facilities Team has developed plans to support the Trust Winter Plan and Winter Ward with catering, portering, transport and cleaning. Provision has been made to cover set up costs for the Winter Ward.

Acute Medicine
ACU will review opening times with a view to extended days, along with a review of patient pathways to support increased usage of ACU.
AMU will continue with the three zone medical model (two at weekends) and will have

three level one HOB beds in place following recruitment in September / October 2017.
The APIC, count-down clocks and Board rounds are to continue.
Clinical Lead / Director to review if a GP can work within the ACU.

Emergency Medicine
The EPIC / RAT, count-down clocks and Board rounds are to continue. Second triage nurse will be supported. Two new ED consultants expected from 30th August 2017. The Integrated model in Emergency Care will continue supported by Nurse Practitioners, Physiotherapists, Mental Health workers, ED medical / nursing staff & GP's. Three new GP's have been recruited, start dates are awaited.
Essential staffing and service support will be required and additional portering support will be necessary for the Emergency Department.
Emergency department to have a 30 minute speciality response, along with no speciality GP patients attending ED unless acutely unwell.

DME / Frailty model
OPD clinics to be reviewed regarding extra capacity / review of GP admission patients during clinic hours.
FIT model to continue during week, review of extending working hours along with working weekends.
Discharge Co-ordinators required on all wards at weekends.

Respiratory Medicine
Respiratory medicine will review the number of HOB beds with a view to increasing if possible.
ARAS team to review extended working, evenings and weekends.

Medicine medical staffing
Following discussion at EMC, it has been agreed that current acute medical staffing rotas will be retained through the coming winter period. Although there are strategic ambitions to develop a self-sufficient Acute Physician rota and to implement new models of emergency assessment in some service areas (eg Gastroenterology and Neurology) these are not considered to be achievable in the short term. Specialist Physician input to the acute medical rota will therefore continue to be provided for the foreseeable future.

5.2 Surgery Health Group
The medical rotas will be in place with appropriate senior (Consultant and Registrar) cover. The specialties have a system and history of internal cover for sickness. Nursing rotas will be reviewed with senior leadership available across the period.
All surgical beds will remain open as we are able to staff them.

The new theatre timetable begins on 2 October 2017, as does the transfer of 6 more trauma beds to Ward 120. This will allow a quicker turnaround for trauma cases and reduce issues regarding delays in getting patients with a fractured neck of femur to theatre in a timely manner and bed availability.

As required the SHG will review all theatre, endoscopy and outpatient activity on a daily / weekly basis and amend plans as required to enable safe a trust wide response to pressures.

Critical Care has a current maximum of 44 beds across sites. There are 22 in HRI and 22 in CHH. There are 30 beds in HOB areas.

In extremis the service would look to:

- staff the ICU beds to care for level 3 patients
- staff the HOBs to look after level 2 and Level 1+

- Use 10 recovery spaces, utilising theatre monitors for level 3 or 2 patients

In these circumstances skills would be scarce and need supplementing with recovery nurses, HOB nurses and general nurses backfilling HOBs. The skill mix would be diluted and risk would be raised.

The SHG intends to continue with outpatient and endoscopy sessions except where individual consultant leave occurs. If required these sessions would be stepped down except for cancer clinics, 2WW and urgent endoscopy. This would free up clinic staff and medical staff. This would free up between 5 – 15 PAs for each specialty in consultant time. This could be used for Ward Rounds, working into Ed or as required. It would also free up approximately double this in nursing time available to supplement in Wards etc.

The SHG will amend the requirements as necessary due to medical winter pressures. There will be a full staffing rota for senior decision making.

5.3 Clinical Support Health Group

Clinical Support will support the Trust Plan, as in previous years, and will ensure additional physiotherapy, occupational therapy and pharmacy support is in place throughout the winter to support timely patient flow and discharge. 7 day a week radiology and pathology support to acute pathways is in place all year round.

The Health Group is also planning to increase staffing to support the HRI ground floor and focus staffing on key specialities such as DME to maximise discharge arrangements.

5.4 Family and Women's Health Group

The Health Group will provide in-patient capacity for patients stepping down from the n acute bed base, including oncology at CHH. This will be available subject to elective workload on H30 and H35 at HRI and C16 at CHH.

Due to the constraints on funding available to support the Winter Plan, the Health Group is not planning to staff H30 or the recently closed bay on H35 to open at the weekend across the Winter period. Opening these beds at the weekend in response to extreme pressure may be considered as part of a Director led response, but would be subject to a safe plan being agreed and would potentially lead to an overspend and/or impact on elective work.

5.5 Patient Transport

Additional funding will be available for enhanced patient transport provision over the winter months to facilitate speedy discharge to support the YAS provision.

5.6 Enhanced patient flow management arrangements

For Winter 2016 /17, an enhanced patient flow management model was implemented. It was led by a Director of the Day supported by a General Manager of the Day. In addition the site Management Team was fully established. Key features include:

- Revised command and control arrangements, led by the Director of the Day, who is freed of normal duties
- Allocated lead managers for zoned portions of the bed base
- Twice daily meetings with ED team
- Daily reporting of tomorrow's discharges at 16:30 each day

- Weekly progress meeting to review 'stranded patients'

In preparation for Winter 2017/18, the Deputy Chief Operating Officer and Deputy Chief Nurse are undertaking a full review of the arrangements in place and will implement improvements as indicated by the review to ensure the whole system is functioning optimally. This work will be complete in time for the start of the Winter period.

6 CHRISTMAS AND NEW YEAR PLANS

The Medicine Health Group has reviewed the staffing profiles for all its specialities, with the aim of bolstering consultant support in preparation for, and over, the bank holiday weekends. Many outpatient clinics scheduled for Friday 22rd December, Wednesday 27 th December and Friday 30th December will be cancelled in order to release consultants to provide assessment unit and ward based senior decision making support which will help to expedite patient discharges. Urgent or cancer-related outpatient clinics will not be stood down.

In addition to this intervention, DME will benefit from having additional Consultant support on Christmas Day and New Year's Day; and Medicine will benefit from having a 4th and 5th RMO rota-ed to work both bank holiday weekends. Cardiology will also ensure that there are Consultants in reaching into CHH over the bank holiday period.

Surgery plans to undertake as a minimum cancer, trauma / emergency and urgent cases from Christmas Eve until 8th January. The surgeons have been given until 1 October to plan their leave and theatre sessions for the period.

The Family and Women's Health Group and Clinical Support Health Group have both confirmed that plans are in place for all services (including Breast, Plastics, ENT, Ophthalmology and Dermatology) to ensure appropriate cover is available during this period. The medical staffing rotas have been reviewed and are covered to appropriate levels; and all usual emergency cover will be in place. Planned elective gynaecology activity during the 2 week December / January holiday will be reduced.

The Medicine Health Group are also presently liaising with the Surgical and Family and Women's Health Groups to identify whether additional medical inpatient capacity can be generated by utilising any available ward H30 capacity, and / or decanting stable HRI surgical patients to CHH and re-allocating the released capacity for medical admissions. More work is required to finalise these arrangements.

7 ESCALATION PLAN

7.1 The actions taken to deal with significant peaks in demand are set out in the Trust's Escalation Plan. In accordance with national guidance, the plan is based around 4 levels of escalation as follows:

OPEL 1	**Steady State / Low levels of Pressure**
OPEL 2	**Moderate Pressure**
OPEL 3	**Severe Pressure**
OPEL 4	**Extreme Pressure**

Examples of the actions to be taken in periods of extreme pressure (OPEL 4) include:

- Establish Control Team, (consisting of Director of Operations, Director of Nursing, Medical Director and Ops Support within hours, and On Call Director, Manager and Duty Matron out of hours) to command, control and coordinate tactical response to crisis through to de-escalation
- All clinical on-call teams to attend the hospital for instructions from the Control Team.
- All inpatients to be reviewed with a view to discharge
- Initiate system leader's conference with directors from key partners to activate a community health and social care response.

7.2 System Escalation Plan

The Hull and East Riding System Partners will undertake a daily assessment of the System pressure level utilising the same 4 level system. At levels 3 and 4 system leaders will be convened via conference call to agree the system response.

8 EMERGENCY PREPAREDNESS

8.1 Cold Weather Plan

The Trust has in place a Cold Weather Plan that sets out actions taken at the four Cold Weather Alert levels up to a major emergency. The approach is based on the established Heatwave Plan and is linked to the Met Office weather warning system, which has been in place for ten years.

This plan includes the support of Yorkshire 4x4 Response, managed by the Trust Transport Manager (HRI x608958), to transport key staff and patients when appropriate.

8.2 The Flu Plan

The Trust Pandemic 'Flu Plan was updated in 2015/16 and was signed off by the Trust Resilience Committee.

The Trust has a 'Flu Vaccination Plan and has a proven record in terms of achieving and exceeding national targets for the vaccination of staff.

NHS England has introduced a CQUIN for 2017 -19, improving staff health and wellbeing, through increased uptake of flu vaccinations. The 2017 / 18 target is to vaccinate 70% of staff by the end of December 2017. This will increase to 75% of staff in 2018 /19.

8.3 Norovirus

The Trust has a well-established outbreak response, including the management of outbreaks of Norovirus (Winter Vomiting Bug), which has been shown to be effective in limiting the spread and timespan of outbreaks and therefore their impact on bed availability.

A protocol for health and social care assessments and discharges to care homes to take place in wards closed for infection outbreaks, has been in place since Winter 2016/17.

During October and November 2017, the Infection and Prevention Team will be undertaking a Norovirus Management Publicity Campaign to highlight the important of early reporting and action to minimise spread of the virus.

8.4 Business Continuity

Over the last two years there has been significant investment in both time and resource into the development of a structured approach to business continuity across the organisation. ISO 22301 standards have been adopted, resulting in the roll out of a

business continuity system, based on best practice and in line with Civil Contingencies Act (2004) statutory requirements. Good progress has been made in a number of service areas (eg Radiology, Pathology, Estates Operations and IM&T) and revised ISO compliant Business Impact Assessments (BIA'S) and Business Continuity Plans (BCPs) have been produced and have been uploaded onto the Trust intranet.

8.5 Major Incident Response

The Trust's Major Incident Plan was revised and updated in 2016.
Desktop training sessions are held regularly to ensure key members of staff are familiar with action to be taken in the event of a major incident.
A multi-agency live major incident exercise was held in June 2017 to test the Trust's major incident response.
All members of the Trust Executive team have attended Strategic Leadership in Crisis training. This has been extended to Directors and 1st on call managers In excess of 60 staff have received this training.

9 PARTNER ORGANISATIONS

9.1 The system winter plan

A system wide plan has been developed, involving the following partners:

- City Healthcare Partnership CIC
- East Riding Council
- East Riding CCG
- Hull City Council
- Hull CCG
- Hull and East Yorkshire Hospitals NHS Trust
- Humber Foundation NHS Trust

A draft system winter plan was been developed and it describes its impact on the plans of our partners as having the impact of 25 additional beds. A summary of the plans is as follows:

Additional East Riding active recovery beds	15
Improved configuration of community beds and investment in the team	7
Additional end of life support beds	3
Total	25

Our review of these plans, however, indicates that the changes on which the 7 beds rely have already been enacted and therefore cannot be counted as additional capacity against the forecast demand for the winter to come.

In regard to the 18 additional beds, it is understood that there are some planned community bed closures in the Hull and East Riding patch and this is not a net figure of the number of additional/fewer beds that will be in place for this Winter. Partners have been asked to provide a full picture of the planned changes, based on what is available today versus what will be available in the December 2017 – April 2018 period.

Some changes, whilst not providing additional beds, may have a beneficial impact, for example closing beds in Withernsea but opening them in Beverley or Holderness will have a net benefit to this Trust. It is also understood that there are alternatives to community bed provision to care for patients in the community and facilitate discharge or avoid admission.

9.2 Delayed transfers of care

During Winter 2015/16 we agreed with partners that the target number of patients on

the Discharge Hub active list which were 'medically fit for discharge' would be no greater than 50. This is currently being achieved but further assurance is needed that this can be maintained over the Winter period.

Work is ongoing with partner organisations in the local health economy to establish a robust and shared understanding of the different causes of delayed transfers and the scale of potential improvement in the short and longer term. There are, however, numerous systemic factors (eg care home capacity) that could affect the timeliness of transfers and complex discharges, so there is a risk that the position will deteriorate.

10 IMPACT OF PLANS ON BED REQUIREMENTS

The anticipated impact on inpatient bed requirements of the proposed Winter Plan is summarised in the following table:

Action	**Impact on Medical Beds**
Use of Ward H10 as an additional winter ward	27
System community beds and packages	tbc
Total	**27**
Requirement	40
Gap	-13

11 APPRAISAL OF OPTIONS FOR RESPONSE TO THE GAP IN BEDS

11.1 Analysis

Compared to previous years, the remaining gap is relatively small and is driven by there being no agreed impact of the system winter plan at this stage. Further work is needed to agree this with partners. If this is not successful there are no easy solutions to bridging this gap, all the options have potential downsides in terms of deliverability, or financial, performance or quality impact. Five options have been identified:

1. Prevail upon our partners to agree plans which equate to a net increase of 13 beds of capacity in the community.
2. Trust to purchase further community bed capacity
3. Create an additional acute medical ward
4. Reduce elective activity at CHH and create a step down facility for patients on the medically discharged list.
5. Allow patients to outlie at times of peak demand.

11.2 Option 1

This option is considered the most appropriate course of action as it does not raise financial, performance or quality concerns for the Trust and we know there are suitable patients for step down to a more appropriate community setting or to home with domiciliary care support.

Its downside, however, is that it is not within the Trust's gift to deliver. Work is ongoing via the A&E Delivery Board to resolve this.

11.3 Option 2

In 2016/17, The Trust purchased 8 'time to think' beds. This cost £100k for 5 months. Subject to more funding being made available, further beds could be purchased in both Hull and East Riding.

11.4 Option 3

This option would be extremely difficult to deliver given the pressure on nursing numbers and the lack of a suitable location on the HRI site. It could only conceivably be achieved by compromising another service such as gynaecology or ophthalmology and would also stretch acute medical cover leading to inefficiencies in length of stay.

11.5 Option 4

This option could be delivered but would have a significant financial and performance impact as it would require a reduction in elective activity on the CHH site. Since last Winter the beds on the CHH corridor wards have been reduced by 15 and whilst this has been managed to avoid an impact on operational performance in surgery, it reduces the available spare capacity to utilise for medical outliers.

A recent attempt to create a therapy led ward on the CHH site for medically discharged patients highlighted that these patients often have significant care needs. As such if this option were to be adopted, there would be work to do on the staffing model and also a need to agree a safe model of medical cover.

11.6 Option 5

This option is deliverable but represents a poor patient experience and has a knock on effect to the other services on the acute site.

11.7 Recommendation

It is recommended that the plan is at this stage approved as it stands, with Option 1 being further pursued further via the A&E delivery Board with a view to agreeing the plan by the end of September.

12 FINANCIAL IMPLICATIONS

The Trust has identified £800k to fund the proposed Winter Plan. Separate funding will be made available for patient transport.
The table below summarises the actions and costs that will be incurred, assuming a start date of 27 November 2017.

Action	**Cost (£000)**
Ward H10 - additional winter ward	500
(including £76k for medical cover)	
Clinical Support Services – enhanced provision	198
Additional Patient Transport	*0
Non-clinical support services:	
Support to the winter ward	81
Winter ward set up costs	35
Portering support to ED	42
Additional cover for bank holiday weekends	71
Total	927

*Last year we funded £95k of additional patient transport but this year this is being supported by the CCGs

These costs related to the 1 December (27 November for the ward) 2017 – 31 March 2018 period. In addition there will be £231k cost pressure in 2018/19 if provision is continued as usual through April.

Clearly these costs exceed the available budget by £127k. Initial discussions on

priorities took place at the Executive Management Committee, however, there has been a suggestion by our regulator NHS Improvement that potentially some additional funding may be made available so this is being pursued prior to any further reduction to the scope of the elements of the Winter Plan that require additional funding. This position will be reviewed at the end of October.

13 COMMUNICATION

As in previous years, a communication plan will be implemented to ensure all relevant members of staff are properly briefed regarding the service arrangements set out in the Winter Plan.

14 RISKS

A risk assessment has been undertaken to identify risks associated with the t Winter Plan and is attached as appendix 1.

Jacqueline Myers
Director of Strategy and Planning
25 September 2017

WINTER PLAN RISK REGISTER

Risk	***Pre Mitigation***			***Mitigating Action***	***Lead***	***Post Mitigation***		
	L	***I***	***Tot***			***L***	***I***	***Tot***
It will not be possible to deploy all of the additional staffing resources identified in the plan	4	4	16	All options (planned redeployments, substantive appointments, interim appointments, bank, overtime and agency) will be used to ensure that clinical staffing is deployed to the required levels. Additional capacity will only be deployed as safe staffing levels allow.	Medicine HG	2	4	8
There is failure to finalise senior medical staffing rotas	3	4	12	EMC has agreed that no major changes should be made to the acute medical rota over the winter period	Medicine HG	1	4	4
There will be insufficient acute medical beds for the numbers of patients requiring admission	3	4	12	This is less likely than in previous years as the gap between predicted demand and capacity is smaller. Enhanced site management arrangements will deploy escalation plan responses and help from system partners will be called in should this occur.	Medicine HG Surgery HG	2	3	6
Service capacity in the community and support to discharge and transfer of care processes will be adversely affected by planned changes to service models.	4	4	16	Plans for the provision of adequate levels of health and social care services through the winter period will be reviewed and endorsed by the A&E Delivery Board	CEO/COO	3	4	12
Emergency service capacity will be adversely affected by severe weather	3	4	12	Remedial actions will be taken in accordance with the Trust's agreed	Medicine HG	3	3	9

or by an outbreak of flu				severe weather and flu outbreak plans	Surgery HG			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN AND YOUNG PEOPLE ANNUAL REPORTS 2016/17

Trust Board date	3 October 2017		**Reference Number**		2017 – 10 - 20	
Director	Mike Wright – Chief Nurse		**Author**		Kate Rudston – Assistant Chief Nurse	
Reason for the report	The Board is asked to receive the annual reports for Safeguarding Adults and Safeguarding Children and Young People 2016/17 attached.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board is asked to receive the reports.					
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** The reports have been received at the Quality Committee 29.08.17					

Hull and East Yorkshire Hospitals
NHS Trust

SAFEGUARDING ADULTS

ANNUAL REPORT

2016 - 2017

INDEX	PAGE NUMBER

ANNUAL REPORT FOR SAFEGUARDING ADULTS – 2016/17

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Adults. The report will identify Safeguarding Adults activity within the Trust over 2016/17, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2017/18.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities to safeguard adults at risk of harm, abuse and neglect that access it services and premises. The challenges facing vulnerable adults remain significant in this health economy and, in particular, the increase in people that have complex needs, such as Mental Health, Dementia and Learning Disabilities.

The reduction in social care provision and allocation of personal budgets have also impacted on vulnerable adults and their families. This can cause the Trust difficulties when there are delays in social care assessments due to limited resources, provision of suitable rehabilitation services and provision of commissioned advocacy services.

Referral levels to the safeguarding adults service within the Trust continue to increase year on year along with an increase in Deprivation of Liberty Safeguard applications.

The Trust continues to meet its regulatory and contract obligations in relation to Safeguarding Adults and is a proactive member of both Local Authority Safeguarding Adult Boards.

In terms of highlights during 2016/17:

- The Trust was rated 'Good' by NHS Hull Clinical Commissioning Group in relation to Safeguarding Adults.
- Positive feedback from Serious Incident Panel (Clinical Commissioning Group) about the consistent reference to Safeguarding in each report.
- The success of the Mental Health and Learning Disability Awareness Day held in June 2016.
- The improvements in governance and processes for Deprivation of Liberty Safeguards and Independent Mental Capacity Advocates.
- The implementation of the Safeguarding Adult Care Plan.
- A positive CQC inspection with regards to Safeguarding Adults, Mental Capacity, Learning Disabilities and Deprivation of Liberty Safeguards.
- The transfer and centralising of Safeguarding Adults and Children Services under one management structure.
- The consistent training compliance of over 80% for Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards.
- Steady improvements in Mental Capacity and Best Interests assessments and documentation demonstrated in audits.
- Positive feedback from Hull and East Riding Safeguarding Adult Board Managers and Chairs regarding the Trust arrangements for Safeguarding Adults.
- 'Significant Assurance' rating by Mersey Internal Audit Agency.

There have been a number of challenges during 2016/17 for safeguarding but overall the Trust is in a strong position for 2017/18. The Trust understands the areas which require focus and strengthening and these are fully sighted on moving forward. There have been many positive aspects to comment on over the past year and in particular; good partnership working with the local authority safeguarding boards, internal governance or safeguarding, staff knowledge and training and an experienced and credible safeguarding team. All of these positive aspects will continue into 2017/18 and support the safeguarding work planned.

Key areas for focus in 2017/18 are:

- Compliance with Prevent Training and processes.
- Focus on Mental Health training and governance of persons detained under the Mental Health Act.
- Review of Domestic Abuse training, processes, policies and risk assessment.
- Implementation of electronic flagging for patients with complex needs such as learning disabilities and severe autism.
- Implementation of the Learning Disability Mortality Reviews and processes.

3. BACKGROUND

Since the last annual report for Safeguarding Adults was submitted, two years ago, new legislation has been implemented. The Care Act 2014* came into force in 2015 and replaces all previous guidance such as 'No Secrets 2001'**.

What has changed under the new legislation of the Care Act?

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect (hereafter referred to as "adults"). It is an important part of what many public services do, but the key responsibility is with local authorities in partnership with the police and the NHS. The Care Act 2014 puts adult safeguarding on a legal footing and from April 2015 each local authority must:

- make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom

- set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Group/s) and the power to include other relevant bodies

- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them

- cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

*The Care Act 2014, Department of Health, 2014

** No Secrets Guidance on developing and implementing, Department of Health, 2000

It also updates the scope of adult safeguarding:

- Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) –

  (a) has needs for care and support (whether or not the authority is meeting any of those needs),
  (b) is experiencing, or is at risk of, abuse or neglect, and
  (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In effect this means that regardless of whether they are providing any services, councils must follow up any concerns about either actual or suspected adult abuse. Safeguarding Adult Boards have been strengthened and have more powers than the current arrangements set up by "No Secrets*" but they are also have to be more transparent and subject to greater scrutiny. All organisations who are involved in adult safeguarding need to reflect the statutory guidance, good practice guidance and ancillary products that have been developed when devising their training and implementation plans for staff. Policies and procedures should be based on the processes laid out in the statutory guidance.

Key messages of the Care Act 2014

The statutory guidance enshrines the six principles of safeguarding:

1. **empowerment** - presumption of person led decisions and informed consent
2. **prevention** - it is better to take action before harm occurs
3. **proportionality** - proportionate and least intrusive response appropriate to the risk presented
4. **protection** - support and representation for those in greatest need
5. **partnerships** - local solutions through services working with their communities
6. **accountability** - accountability and transparency in delivering safeguarding.

It signalled a major change in practice - a move away from the process-led, tick box culture to a person-centered social work approach which achieves the outcomes that people want. Practitioners must take a flexible approach and work with the adult all the way through the enquiry and beyond where necessary. Practice must focus on what the adult wants, which accounts for the possibility that individuals can change their mind on what outcomes they want through the course of the intervention.

The NHS is a key component of safeguarding and the local Clinical Commissioning Groups are one of the three statutory core partners of the Safeguarding Adults Boards.

The CCG is in the best position to ensure that NHS providers meet their responsibilities through its commissioning arrangements with them. However Safeguarding Adult Boards are free to invite additional partners to sit on the Board. For example, many SABs also have local NHS Provider Trusts on their Boards. Many Boards have also found it extremely helpful to have a representative GP on their Board who can communicate directly with their colleagues to emphasise the importance of their role in protecting adults at risk of abuse and neglect.

*No Secrets Guidance on developing and implementing, Department of Health, 2000

There have been a number of high profile hospital scandals that have highlighted the need for vigilance and action among staff and managers. The NHS has particular duties for patients less able to protect themselves from harm, neglect or abuse. All commissioners and contractors have a responsibility to ensure that service specifications, invitations to tender, service contracts and service level agreements promote dignity in care and adhere to local multi-agency safeguarding policies and procedures. Commissioners must also assure themselves that care providers know about and adhere to relevant CQC Standards. Contract monitoring must have a clear focus on safeguarding and robustly follow up any shortfalls in standards or other concerns about patient safety.

NHS managers, commissioners and regulators will want assurance that when abuse or neglect occurs, responses are in line with local multi-agency safeguarding procedures, national frameworks for Clinical Governance and investigating patient safety incidents. Therefore these services must produce clear guidance to managers and staff that sets out the processes for initiating action and who is responsible for any decision making. To prevent cases falling through the net, the NHS and the local authority should have an agreement on what constitutes a 'serious incident' and what is a safeguarding concern and appropriate responses to both.

With regards to Safeguarding Adults, the Hull and East Yorkshire Hospitals NHS Trust works in close partnership with local health providers such as City Health Care Partnership, Humber NHS Foundation Trust and the Hull and East Riding Clinical Commissioning Groups as well as the Police, Local Authorities, the Probation and the Prison Service.

The Trust is a member of the two local Safeguarding Adults Boards in Hull and in East Riding. During 2016/2017, attendance of the Trust representatives at both was excellent.

The CQC undertook a full inspection of the fundamental standards in June 2016 and the Trust's Safeguarding Lead was interviewed with regards to Safeguarding Adults and Children, Learning Disabilities, Restraint, Mental Capacity and Deprivation of Liberty Safeguards. There were no compliance concerns raised with regards to Safeguarding Adults, Mental Capacity, Best Interests, Learning Disabilities, Deprivation of Liberty and detainment of patients using the correct legal frameworks. This is a significantly improved position for the Trust as the previous inspection in 2013 had identified that this area was rated as non-compliant.

The Trust's commissioners have also seen a significant improvement in the Trust's safeguarding arrangements and governance. This resulted in their rating for the Trust Safeguarding Services increasing to 'Good' following an assessment end of March 2017 at the Hull Clinical Commissioning Group Board. The Trust received the following statement to confirm the position on 7th April 2017:

"Hull CCG has currently reviewed levels of confidence for HEY in respect of safeguarding adults. It is pleasing to note that on the evidence provided through the commissioning safeguarding self-assessment tool, recent CQC report and various other information gathering processes that NHS Hull CCG currently rates HEY as providing a high level of confidence in this area. Acknowledgement must also be directed towards the Assistant Chief Nurse and safeguarding adults' team who have demonstrated leadership and progress in the essential area of patient safety."

The Trust is required to submit quarterly reports on Safeguarding to the Trust's Commissioners as part of the locally set Key Performance Indicators. These are presented to the Contract Monitoring Board and then discussed at the Clinical Quality Forum which is a

sub group of the Contract Monitoring Board and whose membership consists of local and specialist commissioners with Trust representatives. The Trust's Chief Nurse and Safeguarding Lead attend this meeting and have received positive feedback regarding the progression of safeguarding during 2016/17.

4. LOCAL CONTEXT

Hull and East Yorkshire Hospitals NHS Trust (HEYHT) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs in excess of 7000 whole time equivalent staff and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the 3rd most deprived local authority in England in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average.

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull. Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are either South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

From a Safeguarding Adult perspective, the local landscape and population is an increasing challenge and in particular with rates of abuse, neglect and harm which are closely linked with deprived areas. The increase in the ethnic minority population is also a challenge for Safeguarding Adults due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Violence and Prevent (the Governments agenda on anti-terrorism and preventing vulnerable people from being radicalised). Financial abuse has seen a significant increase in its reporting in this area and this has resulted in the Safeguarding Adult Board in Hull working with financial institutions to raise awareness and help prevent this type of abuse. The increase in people who self neglect and are hoarders is also a concern locally and numerous services use a significant amount of resources working with these individuals. Fire risks attached to these individuals is significant and the Humberside Fire and Rescue

work proactively with individuals and the housing associations to try and minimise the risk. The increase in the population requiring mental health services is also a concern locally. The Trust works closely with Humber Foundation NHS Trust regarding mental health and is a member of the Mental Health Crisis Care Concordat and recently established Mental Health Partnership Board.

It should not be underestimated that the resource limitations from the public spending cuts are having an impact locally and this in turn is proving challenging for the Safeguarding of Adults. Increase in referrals, advocacy requirements, deprivation of liberty applications, social work resources are just some of the local challenges that the Safeguarding Adult Partnership are facing and in individual organisations. The importance of good working relationships and communication between agencies cannot be overstated and the Trust has continued in a strong position in these elements for Safeguarding Adults.

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

The Executive Trust Lead for Safeguarding Adults and Children is the Chief Nurse, Mr Michael Wright.

The Trust's Lead for Safeguarding Adults and Children is Assistant Chief Nurse, Miss Kate Rudston.

There are two Safeguarding Adults Specialist nurses (1.4 WTE), Ms Janet Page and Mrs Christine Davidson, who work under the management of the Assistant Chief Nurse.

The Assistant Chief Nurse manages the operational function and governance of Safeguarding in the Trust including; Mental Capacity, Restraint, Deprivation of Liberty Safeguards, Consent, Prevent, Mental Health and managing safeguarding allegations against staff.

This structure is supported by the Trust's Executive Board and Health Group Directors.

The Assistant Chief Nurse has open access to the Executive Directors and Chief Executive Officer on matters to pertaining to Safeguarding and meets with the Chief Nurse regularly to discuss safeguarding issues.

Safeguarding is included in the Trust Quality Improvement Plan and this is submitted to the Trust Commissioners and the Trust NHS Improvement Authority on a regular basis.

Safeguarding continues to be embedded in all aspects of governance in the Trust and work continues with patient experience, risk and governance to ensure that information is triangulated and acted upon with regards to protecting vulnerable children, young people and adults at risk.

Learning Disabilities is also covered under the portfolio of Safeguarding and the Trust hosts a Learning Disabilities Liaison Nurse, Michaela Marr, who is employed by Humber Foundation NHS Trust. The Learning Disabilities Nurse meets monthly with the Safeguarding Adults Team and also with the Assistant Chief Nurse to ensure that any patient issues are identified quickly and escalated to rectify satisfactorily.

The Trust holds a monthly safeguarding committee which covers both adults and children and is supported by commissioned task and finish groups as well as subgroups for training, compliance and lessons learnt (case reviews) and Mental Health and Learning Disabilities.

The Trust Safeguarding Committee reports to the Operational Quality Committee and submitted three escalation reports during 2016/17. The Safeguarding Committee met 9 times out of possible 12 during 2016/17 with three meetings cancelled due to number of apologies received and not quorate due to operational pressures and/or annual leave.

In June 2016, the Safeguarding Childrens service was transferred under the Chief Nurse structure and the direct line management of the Assistant Chief Nurse. The centralising of the safeguarding services provides a central corporate team for safeguarding adults and children and enables a more streamlined management of safeguarding in the Trust. Since this transfer took place, there have been a number of improvements in information sharing and governance between Adults and Childrens safeguarding services. It has enabled a more joined up approach to projects such as Domestic Abuse, Human Trafficking/Modern Slavery, Mental Health and Female Genital Mutilation. The teams are not co-located together and this is something that will require further review in the future.

The Safeguarding Adult's team is relatively small compared to other similar sized acute Trusts and manages a wide range of items as well as the operational work. This has proved to be challenging in 2016/17 and is an item for review as the workload associated with Mental Health, Deprivation of Liberty, Making Safeguarding Personal, Safeguarding Adult Reviews and Domestic Abuse is significant. The requirements with Multi Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC) is also becoming increasingly significant as partnership working with the Police, Prisons and Probation has strengthened during 2016/17 in these areas.

The Safeguarding Adults Team consists of the following:

- Safeguarding Lead/Assistant Chief Nurse (1 x WTE B8C)
- Safeguarding Adult Specialist Nurses (1.4 WTE B7)

The Compliance team within the Trust Governance department provides the administration and governance processes for Safeguarding Adults and this support has been invaluable in the excellent improvements that Safeguarding Adults has made.

All data received and sent from the Trust with regards to Safeguarding Adults is captured by the Compliance Team and intelligence gathered to provide not only an internal view but also a local picture. This information can help inform areas of concern not just within the Trust with regards to high levels of safeguarding reporting but also externally. For example if a local care provider is causing a high level of referrals to be placed by Trust staff then this is not only detected quickly but also sent to the relevant Designated Professional for Safeguarding Adults in the Clinical Commissioning Group.

5.1 ROLES & RESPONSIBILITIES

The Safeguarding Adults Team provides specialist advice, support and supervision pertaining to the safeguarding of adults at risk or suffering from harm, abuse or neglect to all Trust staff and volunteers.

A dedicated Safeguarding Adults Telephone is in operation Monday to Friday 9am to 5pm (excluding bank holidays). Outside of these hours, the Site Matron team provide advice and support.

Safeguarding Adult referrals are all submitted electronically.

The Safeguarding Adults team's responsibilities are as follows:

1. Provide specialist advice on safeguarding adult's issues, mental capacity, consent, Prevent, mental health, best interests, deprivation of liberty safeguards, human trafficking, domestic abuse and learning disabilities.
2. Support and supervision to staff in relation to incidents that have occurred or are disclosed as part of safeguarding adults reviews/referrals.
3. Bespoke training to staff and ensure the safeguarding adults training is updated as required and in line with any lessons learnt locally or nationally.
4. Compliance with regulatory and contract standards in relation to Safeguarding Adults.
5. Compliance with Safeguarding Adult Boards policies and procedures including information sharing and good partnership working across agencies.
6. Undertake Safeguarding Adult Investigations (section 42 under the Care Act) and Reviews and advise on Serious Incidents, ensuring actions from learning lessons are implemented and embedded.
7. Review and triage all safeguarding adult referrals and Deprivation of Liberty applications.
8. Reporting on all activity and items for escalation to the Trust Safeguarding Committee.
9. Develop and undertake audits as required.
10. Providing leadership and visibility on Safeguarding Adults.
11. Advise on potential areas of concern to the Assistant Chief Nurse and Chief Nurse.

The list above is not exclusive but demonstrates the key areas of work.

5.2 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Adults Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP277). The Trust has Mental Capacity Act, Deprivation of Liberty Safeguards, Consent and Physical Restraint Policy (CP354). Since this policy was completely revised and implemented in July 2015, it has had five updates and amendments, two in 2016/17. Most of the updates were due to changes in legislation and national policy.

A new policy was developed and implemented in October 2015 and this has had one update since implementation. The Policy For The Care And Transfer Of Prisoners Or Offenders In Custody And Registered Offenders Not In Custody (CP356) has been extremely helpful in the management of these individuals and due to the collaboration of local prisons and probation services has strengthened communication between agencies. It has also provided structure and guidance to staff and in particular in undertaking risk assessments, transfers of care and improvements in communication and general security. The Safeguarding Adult's Specialist Nurse established a regular meeting structure with the local prison representatives and Trust security and this provides a forum for discussion areas pertinent to this high risk area of safeguarding. The meeting has proved to be successful in improving partnership working, professional debate and improvements in the transition of care for prisoners.

Safeguarding Polices are supported by procedures, protocols and guidelines. All of the documents are underpinned by the Safeguarding Adult Board Policies and Procedures as well as Department of Health guidance. All are available on the Trust intranet.

All Safeguarding Adult's activity is recorded in a monthly report and presented to the Safeguarding Committee.

All Safeguarding Adult's Investigation Reports and Reviews are reviewed, quality checked and approved by the Assistant Chief Nurse before they leave the organisation.

The Safeguarding Adult's team review all complaints that may have a safeguarding element within them. An opinion is offered on the complaint with regards to Safeguarding and this is sent to the lead patient experience officer.

All Serious Incidents when they are declared are sent to the Assistant Chief Nurse for review and opinion on Safeguarding. During 2016/17, the Serious Incident panel commented on the significant improvement in the Serious Incident reports with regards to reference to Safeguarding in each report. Further work has been undertaken with regards to inclusion of mental capacity reference in each serious incident report and this will continue to be a priority in 2017/18.

The Trust participated in a Domestic Homicide Review which was commissioned in 2015 by the Hull Community Safety Partnership and which had occurred in Hull in February 2015. The Home Office authorised the report for publishing in June 2017.

The review was undertaken to explore the role of the agencies involved with adult A and adult B, with a view to learning lessons from the case and to reflect on practice where needed in order to improve future responses to domestic abuse in the city. It is carried out in accordance with the Home Office Guidance December 2016 and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

The Trust had four actions attached to their Independent Management Review and these included:

- Using the case study in training once published
- Improving documentation and names of members attending with victims of domestic abuse where it is known to be present or disclosed
- Ensure staff know about information sharing in these cases of Domestic Abuse and where mental capacity is present
- Ensure staff know about who to contact for advice on Domestic Abuse

Progress has been made in these areas with further work required due to the delays in publication and ability to enact fully.

Mental Health and Learning Disabilities

During 2016/17, the Trust developed a draft Learning Disability and Mental Health Strategy. A committee and sub group of the Safeguarding Committee has been established to specifically focus on Learning Disabilities and Mental Health and its membership includes external representatives and health partners. The strategy is intended to be completed in 2017/18 and has been delayed due to various changes in the mental health agenda locally and nationally, and in particular the work that Humber NHS Foundation Trust is leading on.

The Trust was represented at the national launch of the 'Confidential Enquiry into Patient Outcome and Death – January 2017 – Treat as One – Mental health in General Hospitals' in January 2017. Following review of the report, a gap analysis was undertaken and in partnership with the Mental Health Service at Humber Foundation NHS Trust. This was completed and presented to the Safeguarding Committee. An action plan has been developed and submitted to the Trust's Clinical Effectiveness and Audit Committee which was approved.

Actions include:

- Improvements in transfer of care
- Observation and supervision of patients
- Data collection and information systems on detainments under the Mental Health Act
- Discharge planning and documentation
- Training

These will be progressed during 2017/18.

The Trust arranged and hosted a Mental Health and Learning Disabilities Awareness Day in July 2016. The Trust's Project Director for Fundraising supported the event financially and the event was arranged in partnership with City Health Care Partnership and Humber Foundation NHS Trust.

The purpose of the day was to:

- Raise awareness to staff of patients who attend the Trust with mental health issues or a learning disability.
- To inform staff of the services available in the Trust and surrounding community for these groups and the referral pathways available.
- To enhance staff knowledge of the legislation around the Mental Capacity Act.
- To offer advice on how to assist an individual who comes into with our services.
- To consult with staff around what they feel they need to see in an "equality of access" strategy.

The event was attended by over 70 delegates and a broad range of professionals from all agencies.

The Trust was delighted to be supported by the following organisations who provided stalls with information and resources for staff throughout the day:

- Let's Talk – Hull Anxiety and depression services
- Renew – Hull Drug and Alcohol Services
- Age UK
- MENCAP
- MIND
- Trust Chaplaincy Service
- Humber Foundation NHS Trust
- City Health Care Partnership

The day included a presentation by a family member of a service user of their experiences of health care services and this was particularly well received by attendees.

Key areas that staff required further knowledge and training on were captured and these have been incorporated into the Mental Health and Learning Disabilities sub group for further development. The feedback from delegate evaluations was extremely positive with a request

for more days to raise awareness of these subjects. The Safeguarding Adults Team is in the process of arranging another awareness event in 2018.

5.3 EXTERNAL GOVERNANCE

During 2016/17, the Trust was represented on the Hull and East Riding Safeguarding Adults Boards by the Assistant Chief Nurse. In addition, the Trust is represented on the Safeguarding Adult Boards sub committees by the Safeguarding Adult Specialist Nurses.

The overarching purpose of a Safeguarding Adult's Board is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centered and outcome-focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

Safeguarding Adult Boards have three core duties. They must:

Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.

- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

The Hull and East Riding Safeguarding Adult's Boards are structured differently.

The East Riding Safeguarding Adult's Board incorporates a wide range of members and is supported by sub groups; Training, Audit and Assurance, Business Implementation Group and Safeguarding Adult Review Group. The East Riding Safeguarding Adult Board requests an annual self-assessment to be completed by partners and this is followed up by a challenge panel event. This was undertaken in 2016/17 and the Board Chair and Manager were extremely satisfied with the Trusts arrangements and governance of Safeguarding Adults.

The Hull Safeguarding Adult's Board consists of an Executive Board consisting of the three statutory partners stated in the Care Act 214; the Police, the Clinical Commissioning Group and the Local Authority. In addition to the core partners, the Independent Chair, the Board Manager, and the Chair of the Strategic Delivery Group are also members. The Board is supported by a Strategic Delivery Group which consists of the wider partnership. The Assistant Chief Nurse chairs the Strategic Delivery Group and this is referenced and commended in the Hull Safeguarding Adults Board Annual Reports 2015/16 and 2016/17.

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework - NHS England

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged

and in support of local accountability and assurance structures, in particular via the Local Safeguarding Adult and Childrens Boards, and in regular monitoring meetings with their commissioners (Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England, July 2015).

Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic violence, the Mental Capacity Act and Deprivation of Liberty Safeguards at a level commensurate with their role. A draft intercollegiate document by NHS England set out the specific requirements for Safeguarding Adults but this was retracted in April 2016 and is under review. It is strongly recommended that safeguarding forms part of any mandatory training in order to develop and embed a culture within their organisation that ensures safeguarding is acknowledged to be everybody's business from "the board to the floor".

The Trust is complaint with mandatory training for all staff and has consistently maintained a position of over 80% for Safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards in 2016/17.

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies including a chaperoning policy.
- Effective training of all staff commensurate with their role.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Identification of a named lead for adult safeguarding and a Mental Capacity Lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the Mental Capacity Act 2005 and the Children Act 1989/2004.

The Trust is compliant with the above arrangements and all of these elements are included in the local commissioning contract/key performance indicators to which the Trust reports quarterly to NHS Hull Clinical Commissioning Group. Further work is required with regards to Safeguarding Supervision and this is a priority for 2017/18.

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They

should work closely with their organisation's safeguarding lead, Designated Professionals and the Safeguarding Boards.

All providers are required to have a Mental Capacity Act Lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training. The named lead(s) will work closely with the Clinical Commissioning Group adult safeguarding lead.

The Trust is compliant with this requirement and undertakes bi-annual audits of Mental Capacity and Associated Documentation as well as a separate audit of Restraint. A summary of the results of the audit undertaken in February 2016 was included in April 2016 Lessons Learnt Newsletter and including in Clinical Safeguarding training and updates. Posters identifying correct practice regarding mental capacity assessment were disseminated to all clinical areas. During 2016/17 two audits were undertaken in June and October 2016. Improvements were made in many areas identified in the February 2016 audit although there were still areas of non-compliance with documentation. The results of each audit is disseminated to all Health Group Directors, the members of the Safeguarding Committee and escalated to the Trust Operational Quality Board. The audits will continue in 2017/18.

The Trust Safeguarding Adults Team have all attended external higher level training in Mental Capacity, Consent, Best Interest and Deprivation of Liberty and provide advice and expertise to colleagues as and when requested or sought. Where legal advice is required for complex cases or court of protection applications then this is referred to the Trust solicitors.

The Trust is compliant with the requirements of named leads for Safeguarding Adults, Mental Capacity Act and Managing Safeguarding Allegations against Staff. The Assistant Chief Nurse undertakes this role and is also the Prevent Lead for the organisation.

Care Quality Commission

All providers of health services are required to be registered with the Care Quality Commission. In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported

In April 2015, new fundamental standards of safety and quality were introduced, which all providers of regulated health and social care activities must meet. The standards set the benchmark below which care must not fall. One of the standards relates to safeguarding. The fundamental standard on safeguarding states that children and adults using regulated services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they become aware of them.

In addition, the standard states that care or treatment must not:

(i) discriminate on the grounds of any of the protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation)

(ii) include acts intended to control or restrain an adult or child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint

(iii) be degrading to the adult or child

(iv) significantly disregard the needs of the adult or child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority. Under the Mental Capacity Act 2005, the Care Quality Commission is responsible for monitoring how hospitals and care homes operate the Deprivation of Liberty Safeguards.

There are two Key Lines of Enquiry (KLOE) questions relating to safeguarding that the CQC inspect for NHS hospitals. These are:

- KLOE S3: Are there reliable systems, processes and practices in place to keep people safe and to safeguard them from abuse and neglect?
- Prompt – are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements?

And

- KLOE E6: Is people's consent to care and treatment always sought in line with legislation and guidance?
- Prompt – Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004?
- Prompt – Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty?

The Trust was inspected in June 2016 by the Care Quality Commission. There were no issues identified with regards to Safeguarding Adults, Mental Capacity or Deprivation of Liberty Safeguards. The published report (February 2017) provides overall assurance of staff understanding of safeguarding adults and mental capacity. There is also positive assurance of staff understanding and application of Consent, Best Interests and Deprivation of Liberty Safeguards. No issues were raised with regards to the care of patients with Learning Disabilities.

Mersey Internal Audit Agency (MIAA)

As part of the 2015/2016 audit plan, MIAA undertook a review of the arrangements that the Trust has established in relation to safeguarding children and vulnerable adults. The final approved report was received by the Trust in January 2017.

The Safeguarding review has highlighted strong partnership and integrated working arrangements. Policy documents are good and are comparable with national guidance and regulation and governance arrangements provide a clear line of reporting from ward to board.

The review has identified a number of risks which relate to roles and responsibilities, training and incident reporting.

There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their

impact would be minimal or they would be unlikely to occur. The overall rating by this audit was 'Significant Assurance'.

Some of the actions required as identified in this report have already been actioned. Work will continue to ensure the remaining actions are delivered in 2017/18.

6. TRAINING AND DEVELOPMENT

6.1 SAFEGUARDING ADULT'S TRAINING

Training and education of staff for Safeguarding Adults, Mental Capacity and Deprivation of Liberty continues to be a high priority for the Trust.

Safeguarding Adults training is updated regularly and in line with any changes in national guidance or legislation. The training is aligned to the key principles of the local Safeguarding Adult Boards Policies and Procedures.

A column for the variation since the last quarter has been added. All training has shown an increase in compliance.

Compliance (As at 31st March 2017)	Compliant	Head Count	% Compliance Target 80%
Safeguarding Adults Level 1	2431	2898	83.9%
Safeguarding Adults Level 2	5386	6132	87.8%
Mental Capacity Act	5453	6133	88.9%
Deprivation of Liberty Safeguards	5379	6139	87.6%

The Trust is required to be 80% compliant with all levels of training and this has been consistently above this target throughout 2016/17.

The main area of concern was the failure to achieve 80% compliance for the Prevent training against the training needs analysis. This was a key performance indicator set by the Trust commissioners for 2016/17. The table below states the compliance at the end of March 2017.

PREVENT HEALTH WRAP Training		
Required	**Completed**	**Compliance %**
407	**164**	**40.29**

There has been an increase in compliance since the end of March 2017 and current position as at July 2017 is 65% compliant with Health Wrap training against the Training Needs Analysis. Further targeted training is planned in August and September with an expected 75% by August and 80% compliance by September 2017. The main reason that compliance was not reached by the timeframe required was due to the difficulties in releasing staff from clinical areas to attend the training. Online training is not available for this particular training as it is set by the Home Office and Department of Health.

Work continues to ensure compliance is achieved with this indicator and is monitored at the Safeguarding Committee monthly, Operational Quality Committee and via regular communications with the Health Groups.

7. SAFEGUARDING ADULTS ACTIVITY 2016/17

All data is captured by the Trust's Compliance Team and the databases are cleansed regularly with regular meetings with the Safeguarding Adults Team. This is to ensure that all referrals are followed up as required and outstanding actions addressed in a timely manner.

All data contained in this section was correct as of 12th and 13th April 2017.

SUMMARY OF SAFEGUARDING ADULT'S REFERRALS MADE

7.1 Total Reported

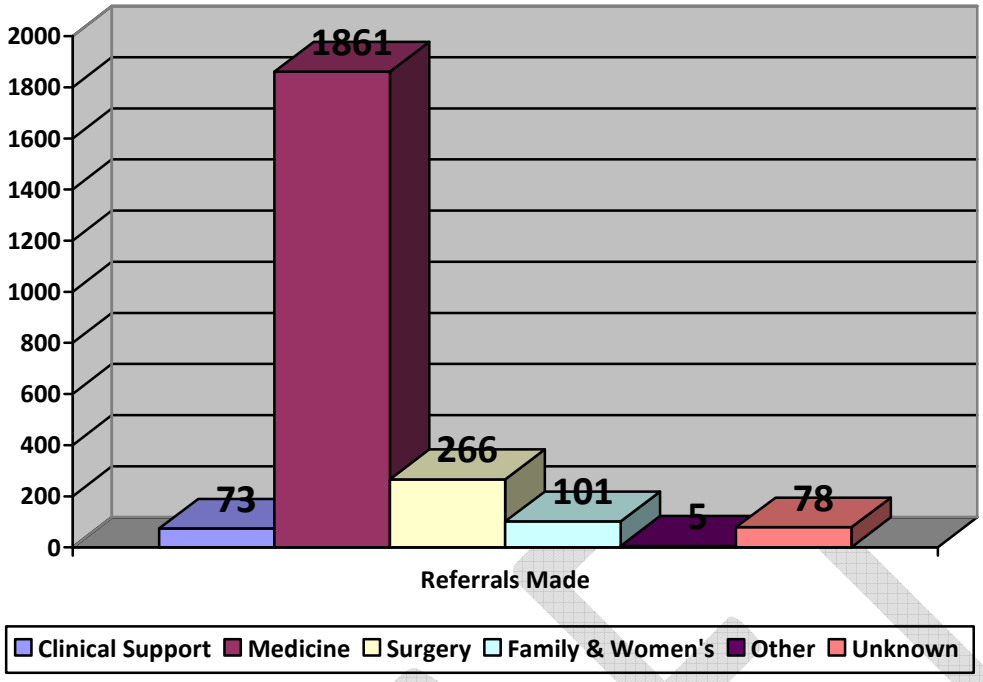
There has been a year on year increase in the number of safeguarding referrals made by Trust staff. This is due to the increased awareness, training and visibility of safeguarding adults in the Trust. The data provides assurance that staff are reporting potential safeguarding issues although further work is required with regards to appropriateness of referrals, consent and quality.

At the date of writing this report, 2263 referrals have been processed by the Safeguarding Adults Team:

Year	2013/14	2014/15	2015/16	2016/17	2017/18
Total	253*	566	679	856	32**

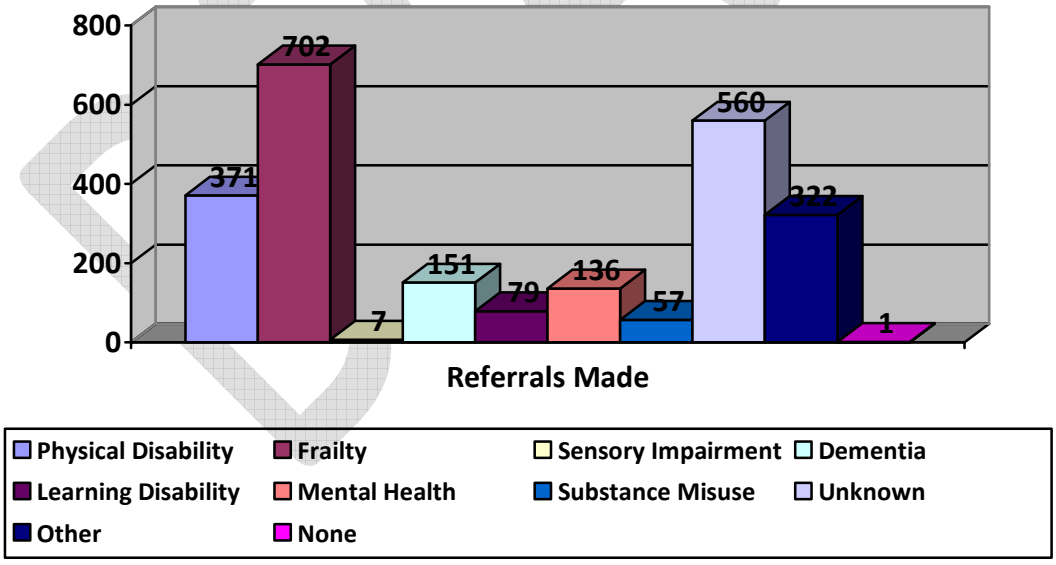
*NB 2013/14 data commenced in October 2013
**Year to date

The graph below shows the total number of referrals made by reporter per Health Group:

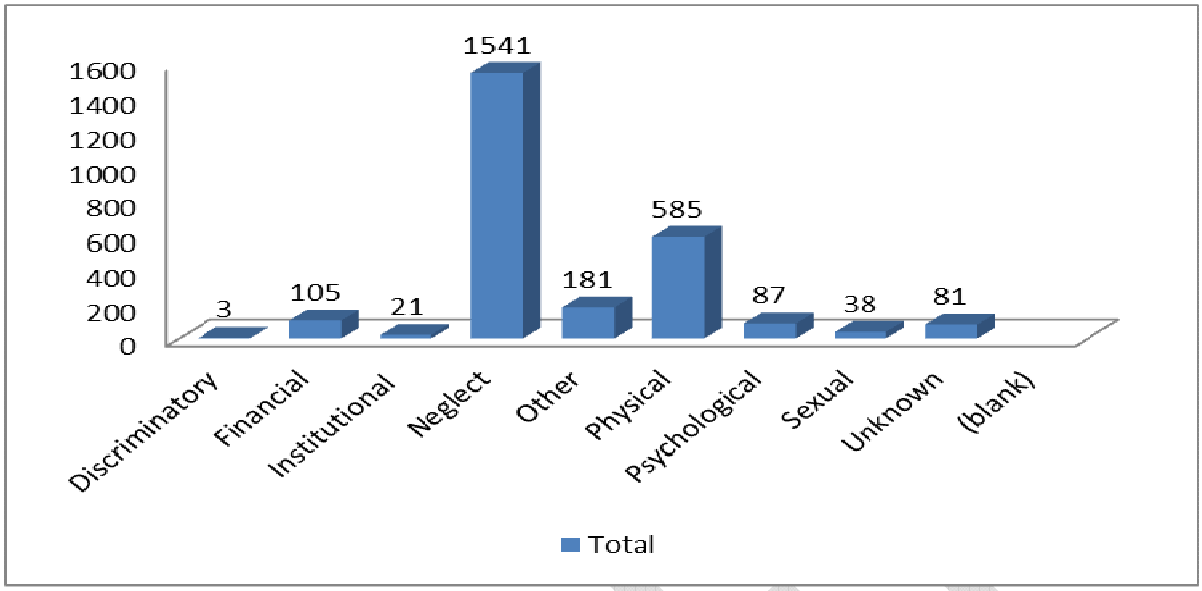


The highest reporting Health Group is Medicine with a total of 1861 referrals made.

The graph below shows the total number of referrals made by client group. The highest group is frailty at 702 referrals, followed by unknown client group of 560, and physical disability stated as 371.



The graph below shows the total number of referrals made by abuse type. Financial abuse is the highest group, followed by sexual and then physical.



7.2 Total Sent To Local Authority April 2016 – April 2017

The data recorded below demonstrates that there is further work to be undertaken with staff with regards to the criteria for safeguarding since the Care Act 2015 came into effect in 2015/16. The reasons why referrals are often not required are due to other interventions that are more appropriate and that it does not meet the Care Act criteria. Social work referrals, Tissue Viability referrals, Discharge Liaison Team, Domestic Abuse and Mental Health services are often more appropriate agencies to manage the situation and these are forwarded as necessary and considering the consent to refer. Some of the referrals are not sent as there is inadequate information or the consent to refer is declined by the individual. In these cases, feedback is provided to the referrer.

The table below shows how many of the referrals met the criteria to be sent to the local authority and how many were open within that month:

Month	Referral Not Required	Sent to Local Authority	Total	Sent to Local Authority - Open
April 2016	18	58	76	21
May 2016	22	56	78	21
June 2016	24	50	74	27
July 2016	19	44	63	21
August 2016	20	52	72	29
September 2016	18	49	67	25
October 2016	16	44	60	14
November 2016	30	50	80	20
December 2016	20	55	75	25
January 2017	17	64	81	31

February 2017	14	25	39	19
March 2017	30	49	79	37
April 2017	14	11	32	10
Total	**262**	**607**	**876**	**300**

7.3 Total Overdue for Investigation Response

The Compliance team contact the Local Authority Safeguarding Teams on a weekly basis for updates on outstanding referrals that the Trust has made. A significant amount of effort was made in 2016/17 to close down outstanding referrals particularly in Hull. This was due to escalation of concerns to the manager of the team by the Assistant Chief Nurse, the change in management of the Hull team and an increase in their resources.

The table below shows all referrals currently overdue for investigation with a local authority:

Local Authority	2013/14	2014/15	2015/16	2016/17	2017/18	Total
Hull	4	1	10	113	12	140
East Riding				20	4	24
Lincolnshire				2		2
North Lincolnshire				1		1
Coventry				1		1
North East Lincolnshire				2	1	3
Total	**4**	**1**	**20**	**139**	**17**	**171**

7.4 Total Referrals Not Appropriate For Submission to the Local Authority

Since 1st January 2017, 79 referrals received were not deemed appropriate referrals. The reasons provided following review by the Safeguarding Adults Team are shown below. Many were sent to the Discharge Liaison Team as related to social work assessment required or the Tissue Viability Team for further action.

Reason Not Sent	January 2017	February 2017	March 2017	April 2017	Total
Does not meet criteria	6	1	11	3	21
Insufficient information		1			1
No evidence of harm	6	8	4	2	20
No intent to neglect	3				3
Patient deceased	1				1
Patient has capacity to make own decisions	1				1
Unknown		4	15	9	28
Total	**17**	**14**	**30**	**14**	**75**

7.5 Referrals made against Nursing / Residential Homes

521 referrals have been made against a nursing home / residential home since October 2013.

The Compliance Team closely monitor themes of concerns reported against nursing and residential homes and identify any issues that require escalation and further investigation by the relevant safeguarding adult team as a theme against a particular nursing home. An update has been requested from local authorities on all overdue investigations.

Information collected on care homes is sent quarterly to the Designated Professionals for Safeguarding Adults in the Clinical Commissioning Groups. The information may inform further measures that may be required in obtaining assurance on the care provision within that care home. This information is presented in the monthly activity report that is presented to the Safeguarding Committee but as it has the Care Home provider names stated has been omitted from this annual report.

7.6 Referrals Made with a Possible Safeguarding Children Concern

Since April 2016, 21 referrals have been made where the referrer has indicated that a child safeguarding referral may be appropriate. From February 2016, the Compliance Team has forwarded, on a monthly basis, a list of these referrals to the Safeguarding Children's Team in order for them to cross-check against any existing child referrals and if appropriate liaise with the adult referral referrer to complete a child referral.

7.7 Referrals Made Against Trust by the Trust

These are referrals that the Trust has raised against itself. Of the 16 referrals made by Trust staff against care received by the Trust between April 2016 and March 2017, 4 of them were escalated and investigated as a Serious Incident. These were related to Avoidable Pressures Ulcers caused by poor or omissions in care.

Made by Trust Staff Against Trust	**Total**
Neglect	13
Physical	3
Total	**16**

SUMMARY OF SAFEGUARDING ADULT REFERRALS RECEIVED

7.8 Total Reported

As of the April 2017, 444 referrals have been made to the Safeguarding Adults Team. This is the number of referrals received against the Trust from Local Authorities. On receipt to the Trust the referrals are reviewed by the Assistant Chief Nurse and triaged. There are occasions when the referral does not meet the criteria for a safeguarding investigation and may be a discharge concern, serious incident or formal complaint. In these cases, a strategy discussion takes place with the local authority safeguarding team and a decision is agreed to close the safeguarding alert and convert to another avenue of investigation. If there is a safeguarding investigation required, then the referral is sent to an independent investigator, usually a Nurse Director for investigation. Following the completion of the investigation the report is sent back to the Assistant Chief Nurse for quality checking and approval before

sending to the local authority. Not all investigations proceed to a Section 42 safeguarding enquiry or are substantiated and work is ongoing with regards to the data management to capture this more thoroughly. An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

The Care Act requires local authorities to make proportionate enquiries (or to make sure that, as the lead agency, enquiries are carried out by the relevant organisation) where there is a concern about the possible abuse or neglect of an adult at risk.

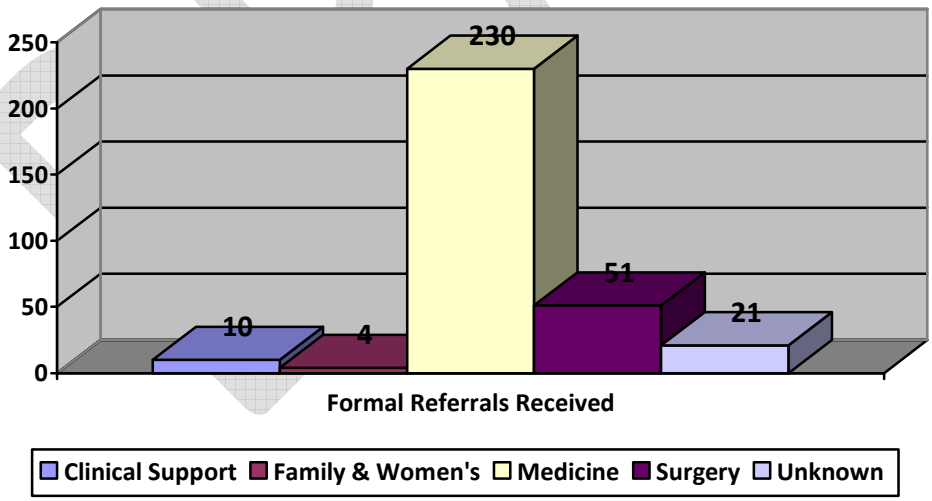
There has been a decrease in referrals received against the Trust and this is due to the criteria set in the Care Act 2014 and what constitutes a Section 42 investigation. Often the referral does not reach the criteria when reviewed by the Local Authority Safeguarding team and other interventions are more appropriate.

Below is a table which shows how the referrals are logged:

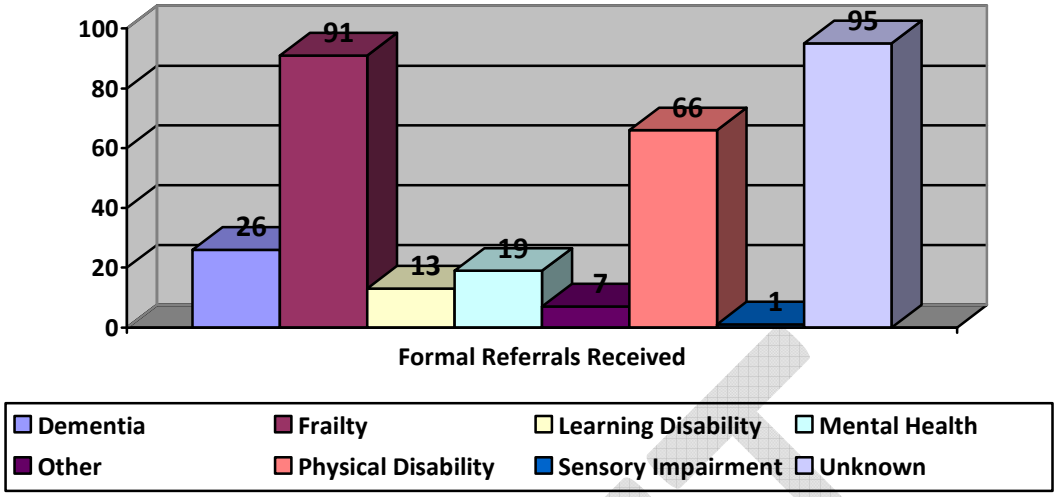
Year	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18*	Total
Formal	19	16	22	54	64	89	51	3	318
Concern		4		9	3				16
Complaint				1		36	71	1	109
Total	**19**	**19**	**23**	**64**	**67**	**125**	**122**	*	**431**

*Year to date – April 2017

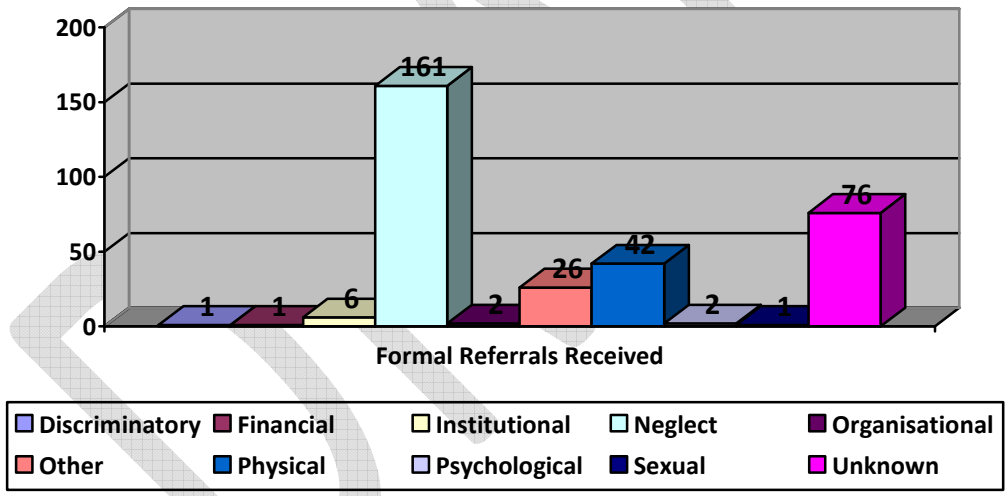
The graph below shows the total number of formal referrals made against each Health Group:



The graph below shows the total number of formal referrals made by client group

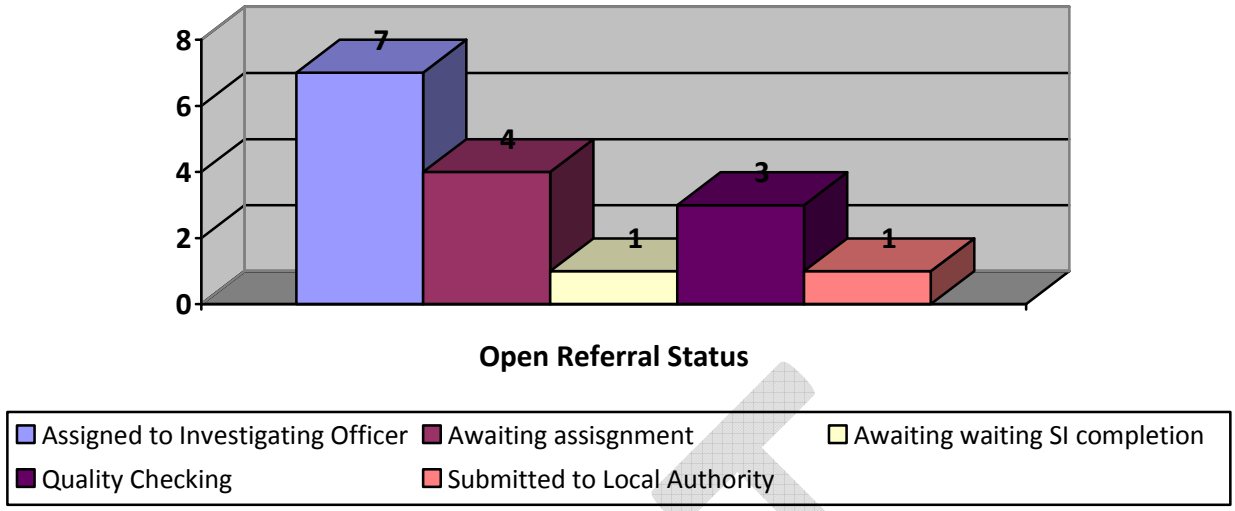


The graph below shows the total number of formal referrals made by abuse type. Neglect is the highest category and themes show that this is often placed regarding omissions in care that have resulted in a form of harm to the patient, such as pressure ulcers, falls, significant loss of weight or medication errors.



7.9 Open formal referrals

Of the 318 formal referrals made to the Trust, 16 are open currently (April 2017). The table below shows the stage within the investigation process the referrals are in:



7.10 DEPRIVATION OF LIBERTY (DOLS) APPLICATIONS

There has been a significant increase in the number of DoLS applications that the Trust is required to make following the Cheshire West Supreme Court judgement in 2014*. Prior to this judgement the Trust had made one application for a Deprivation of Liberty in the previous three years.

The Safeguarding Adults Team provides help and advice for Trust staff who may have patients that fit the criteria for a Deprivation of Liberty Safeguards. Examples of applications were circulated to ward teams in 2016/17 and training was delivered to assist staff to complete the assessment correctly. The Deprivation of Liberty application must be accompanied by a completed Mental Capacity Assessment Form and Best Interests Form. Once the forms are sent to the Local Authority, a Best Interests Assessor is appointed and then arranges a review of the patient and circumstances. This can take several days and, during that time, the patient may be transferred, discharged, have died or has regained mental capacity and no longer requires 1 to 1 supervision and legal detainment.

There is considerable work attached to the legal frameworks of this item and this is a regular agenda item on both Hull and East Riding Safeguarding Adult Boards.

Since July 2014:

- 12 DOLs applications were approved by the Local Authority
- 2 DOLs applications were not approved by the Local Authority.
- 4 DOLs are currently awaiting decision for approval from the Local Authority
- 167 DOLs applications have been cancelled

7.11 Yorkshire Ambulance Service Referrals

Since October 2016, the Trust has been recording concerns sent via the Local Authority that have been raised by members of the Yorkshire Ambulance Service. To date, the Trust has received 149 referrals.

*P v Cheshire West and Chester Council and P and Q v Surrey County Council 2014.

These are forwarded to one of the Safeguarding Adults Specialist Nurses for review a decision made whether to forward onto a relevant team for action or whether the referral can be logged and closed. Currently there are 14 referrals open. The reason why the Safeguarding Adults team made the decision to receive this additional information is that there had been occasions when information pertaining to safeguarding was not transferred to the base ward where the patient was discharged from. This was particularly the case when a referral had been made in the community by another agency and not logged formally in the patient assessment forms. By introducing this process, the Safeguarding Team can inform the relevant area of the Safeguarding alert and advice on whether there are any further actions, such as ensuring social work and discharge assessment is in place, restrictions on visitors and potential perpetrators are in place and if the Police are notified and taking further action.

7.12 Datix Incidents for Safeguarding

On a monthly basis, all Datix incidents that have been reported with safeguarding adults criteria are cross-referenced with the safeguarding adult's database and escalated for action if required to the Health Groups. The Safeguarding Adults Policy states that when a safeguarding referral is raised, an incident report (DATIX) is also completed.

During 2016/17 there have been 106 DATIX referrals made without any corresponding Safeguarding Referral received. The Assistant Chief Nurse is working with the Health Groups and the Deputy Director of Governance and Assurance to ensure there is a mechanism for following up these outstanding DATIX.

8. SAFEGUARDING ADULT REVIEWS

The Trust has undertaken one Safeguarding Adult Review in 2016/17 with the Hull Safeguarding Adult Board. The report is finalised but not released for publication due to an ongoing investigation into the events leading up to the death of the individual. The individual died in 2014 and the Trust's findings of the review found some examples of good practice with the addition of a few actions. These are mostly related to raising awareness of mental health and information sharing in best interests when patients have mental capacity.

The East Riding Safeguarding Adults Board undertakes reviews of cases where lessons can be learnt but no formal Safeguarding Adult Review was commissioned in 2016/17.

9. KEY ACHIEVEMENTS IN 2016/17

A list of key operational and strategic achievements are stated as follows:

- Revision of Independent Mental Capacity Advocate request forms and process. Development of electronic form.
- Mental health and Learning Disabilities awareness day
- Development and training of Trust Safeguarding Champions
- Review the processes of death under Deprivation of Liberty Safeguards
- Development and implementation of Safeguarding Care plan
- Compliance to regulatory standards for Safeguarding Adults - June 2016 CQC
- Reviewed and improved information sharing processes for MAPPA and MARAC and input of Safeguarding alerts on Lorenzo
- Established a Mental health and Learning Disabilities committee

- Completion of Mental Capacity Act and Restraint Audits
- Improvements in the Deprivation of Liberty Safeguards process including Restraint
- Improvements in data managements and governance with Compliance Team
- Embedded Patient Complaint and Safeguarding processes
- Embedded Restraint reporting and monitoring
- Continued good attendance and support to Hull and East Riding Safeguarding Adult Boards
- Awareness of Human Trafficking and training on Modern Slavery commenced
- Compliance with Trust Commissioners and positive feedback on Safeguarding Adults
- Sustained compliance of training above 80% for Safeguarding Adults, MCA and Deprivation of Liberty Safeguards
- Participation in the White Ribbon Campaign in collaboration with the Community Safety Partnership
- Completion of Domestic Homicide Review
- Establishment of a Managing Allegations against Staff database
- Revision of the nursing 'Fundamental Standards' for Safeguarding

10. KEY ACTIONS FOR 2017/18

The Trust has identified a number of actions required to strengthen the Safeguarding Adult's service. Actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Adult's Board activities and from the lessons learned from Case Reviews. The Trust's Quality Improvement Plan encompasses some of the key priorities for the Trust for safeguarding adults and children.

A summary of work planned in 2017/18 is as follows:

- Development and implementation of Restraint Care Plan
- Development of Enhanced Care Team (pilot commences in September 2017)
- Continued development of Safeguarding Champions
- Review and update of the Safeguarding Adults Policy
- Delivery of the Trust QIP for Safeguarding Adults
- Delivery of the Prevent key performance indicator
- Review of Safeguarding Adults Level 2 training – combining with Level 2 Childrens Safeguarding
- Review of Mental Health training requirements
- Progression of actions detailed in the NCEPOD – Mental Health in General Hospitals
- Revision of Safeguarding Concern Form
- Review of Domestic Abuse training, policies and assessment processes
- Implement information on patient detained under the Mental Health Act
- Delivery of actions from Mersey Internal Audit Agency
- Progression of electronic Safeguarding Flagging processes and applications to client groups such as Learning Disabilities
- Implement the Learning Disability Mortality Reviews (LeDR) and processes
- Commence NHS Improvement Pilot for Learning Disabilities standards and assessment of provider (December 2017)

Report Author: Kate Rudston, Assistant Chief Nurse and Safeguarding Lead
Date: August 2017

Hull and East Yorkshire Hospitals
NHS Trust

SAFEGUARDING CHILDREN & YOUNG PEOPLE

ANNUAL REPORT

2016 - 2017

INDEX	PAGE NUMBER

ANNUAL REPORT FOR SAFEGUARDING CHILDREN – 2016/17

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Children and Young People. The report will identify Safeguarding Children and Young People activity within the Trust over 2016/17, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2017/18.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities (section 11 Children Act 2004) to safeguard the best interests of children and young people that access its services and premises.

Referral levels to the safeguarding services provided by the Trust continue to increase year on year along with an increased scope of issues that the services are responsible for. These continue to be managed to a high standard with the Trust's safeguarding professional playing an active part in safeguarding children and adults at risk across the wider multiagency partnership.

The Trust continues to meet its statutory obligations in terms of having the required Named Nurse, Named Doctor(s) and Named Midwife in post. In addition, the Trust participates actively as a member of both Local Safeguarding Children Boards for Hull and the East Riding.

The Care Quality Commission (CQC) undertook a comprehensive inspection across Hull Royal Infirmary and Castle Hill Hospital in June 2016 which covered all services. The overall Trust rating is Requires Improvement. The specific actions linked to Safeguarding Children are as follows:

- Review the processes for categorising incidents, including safeguarding incidents relating to children, to ensure effective investigation and lessons learnt.
- Ensure the safeguarding children policies and procedures up to date.
- Ensure all the relevant staff are trained to the required level 3 for safeguarding children
- Improve the computerised record system to ensure it has the facility to 'flag' where there are potential safeguarding concerns

All of the actions from the June 2016 inspection were transferred into the overarching Trust Quality Improvement Plan (QIP) for Safeguarding, which is led by the Assistant Chief Nurse and Trust Safeguarding Lead Miss Kate Rudston for delivery and monitoring. An additional milestone was entered into the QIP which will monitor the delivery of the action plan from the January 2017 inspection of services for looked after children and safeguarding in Kingston upon Hull. Recommendations from these inspections have been included in key actions that were completed in 2016/2017 and some have carried over into work planned for 2017/2018.

Key actions that were completed during 2016/2017:

- The Safeguarding Children team transferred to Corporate Nursing Team management structure on 1st June 2016. This is now under the leadership of the Assistant Chief Nurse who is the Trust Lead for Safeguarding Adults and Learning Disabilities.
- Compliance with intercollegiate level 3 safeguarding children training is now compliant at above 80%.

- Safeguarding policies and procedures were reviewed, updated and ratified by the Safeguarding Committee and safeguarding concerns were given high priority and investigated in a timely manner.
- The vulnerability pathway for women with complex social factors who access the Trust's maternity services has been implemented within the Trust.
- Female Genital Mutilation (FGM) is included within Safeguarding Children training. Trust staff have the option of face to face FGM training or an e-learning package. The safeguarding children team support the training programme of pre-registration nurses and midwives, also.
- The governance around Section 47 Child Protection Medical processes has improved with the introduction of a database. This allows robust monitoring of referrals to the Anlaby suite including data on referring agency, timescales and locality of child.
- The Safeguarding Childrens Referral electronic process has now been fully embedded within the Trust.
- A database has been set up by the Safeguarding Children Team to collate data relating to children and young people who attend the hospital via the Emergency Department with self-harm and who do not require admission to the hospital.
- Daily ward rounds by the Safeguarding Children Team are now in place for Maternity and Children's wards to support and advise staff on safeguarding concerns.
- The process for categorising incidents has been reviewed and revised. The Named Nurse for Safeguarding Children now reviews all reported incidents related to children to ensure there are no missed safeguarding issues and the risk rating is appropriate.
- The Safeguarding Team has supported the Mental Health risk assessment process and documentation for children and young people considered to be at risk.
- The Safeguarding Children Team has worked with the Safeguarding Adult Team, to establish and develop the role in the Trust of Safeguarding Champions.
- The Named Midwife has attended cascade training for Modern Day Slavery and is now facilitating training for midwives on their annual mandatory training days.
- A new policy for Managing Allegations against Staff for Safeguarding Concerns has been written and is in consultation currently.
- New policies for Children and Adults (without Mental Capacity) who Abscond commenced development.
- The Chaperone Policy has been revised, approved and implemented.

Key actions and ongoing for 2017/2018:

- Ensure safeguarding children policies and procedures are up to date.
- Improve the computerised record system to ensure it has the facility to 'flag' where there are potential safeguarding concerns
- Review transfer of care process and documentation for children in the Trust in relation to safeguarding concerns specifically related to children presenting with mental health issues.
- Review the communication processes between Child and Adolescent Mental Health services (CAMHS) and the Trust, where a young person with a mental health care plan is receiving care within the Trust.
- Audit the use of paediatric documentation and the recording of key information about children and families in attendances of children in the Emergency Department.
- Work in partnership with the local authority to ensure that staff receive meeting minutes from safeguarding children meetings they attend and that they are filed within the health record of the child.
- Improve the quality of referrals to Children's Social Care.

- Continue to strengthen the Safeguarding Supervision Process within the Trust to ensure that all Trust staff who have a safeguarding concern can access planned and/or ad-hoc safeguarding supervision. This includes a review of resource and capacity for safeguarding supervision within maternity services.
- Continue to work to raise awareness and assessment/identification of children that access Trust services and who may be at risk of Child Sexual Exploitation.
- Develop a Domestic Abuse Strategy for the Trust.
- Review of the staffing resource/capacity and safeguarding activity in the safeguarding team.
- All Serious Incidents (SI's) declared within the Trust which involve a child will also be reviewed by the Named Nurse/Named Doctor to determine if there are any safeguarding issues that need to be considered

3. BACKGROUND

Working Together to Safeguard Children 2015[1] sets out the statutory framework and the legislation relevant to safeguarding and promoting the welfare of children. While the Childrens Act 1989[2] places a duty on local authorities to take the lead role and meet this requirement in relation to children in need in their area, safeguarding children and young people and protecting them from harm is everyone's responsibility. The Children Act 1989 was amended in 2004 and sets out the statutory responsibility for local agencies under Section 11.

Section 11 of Children Act 2004[3] places duties on a range of organisations and individuals to ensure their functions and any services they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. NHS organisations are subject to Section 11 as health professionals are felt to be in a 'strong position to identify welfare concerns' and have 'a critical role to play in safeguarding and promoting the welfare of children' (Working Together 2015).

Hull and East Yorkshire Hospitals NHS Trust (HEYHT) is an NHS organisation that provides acute and specialist health care to children. It works in close partnership with local health providers such as City Health Care Partnership, Humber NH Foundation Trust and the Hull and East Riding Clinical Commissioning Groups. The Trust Safeguarding Childrens services works closely with Childrens Social Care and the Police.

The Trust is a member of the two local Safeguarding Childrens Boards in Hull and in East Riding. During 2016/17, attendance of the Trust representatives at both was satisfactory and attendance at the subgroups for both Local Safeguarding Childrens Boards (LSCB's) has improved.

The strategy of HEYHT, in line with the two LSCBs and partner agencies is to ensure Trust staff are provided with the skills, support and reporting mechanisms in order that they can fulfil their section 11 responsibilities and recognise safeguarding concerns, escalate and report these appropriately, sharing information with other agencies in a timely manner.

HEYHT contribute to all local Child Death Reviews, Serious Case Reviews and Lessons Learned. Recommendation and actions from these reviews are monitored through the Trust

[1] HM Government. Working together to safeguard children - A guide to inter-agency working to safeguard and promote the welfare of children. March 2015.
[2] The Childrens Act 1989 – Government Legislation, Parliament of the United Kingdom
[3] The Childrens Act 2004 – Government Legislation, Parliament of the United Kingdom

Quality Improvement Plan (QIP) and are reviewed monthly at the Safeguarding Committee Reviews.

The Trust for 2016/2017 was compliant with the requirements for the statutory posts of Named Doctor Michelle Cutland, Named Nurse Mrs Sandra Park and Named Midwife Mrs Zoe Dale. However, it is expected that there will be a significant change to this during 2017/2018 as the Named Doctor and Named Midwife leave their roles. Recruitment to these posts will be a high priority for the Trust. In the interim, Doctor Chris Wood, who is also the local area Designated Doctor, will undertake the role of Named Doctor and Sandra Park will cover for the role of Named Midwife, seeking specialist maternity support for this from maternity services.

The Divisional Nurse Manager for Childrens Services, Mr Amedo Craven, retired in the first quarter of 2016. From the 1st June 2016 the Safeguarding Children service transferred from Family and Women's Health Group to the Corporate Nursing Service under the leadership of Assistant Chief Nurse/Safeguarding Lead, Miss Kate Rudston. The Trust Executive Director Lead for safeguarding is Mr Michael Wright, Chief Nurse.

The Safeguarding Childrens Service continues to face ongoing challenges in the increasing agenda for Serious Case Reviews (SCR's), Joint Targeted Area Inspections (JTAI's) and CQC inspections.

The Trust participated in Care Quality Commission Review of Health Services for Children Looked after and Safeguarding in Kingston upon Hull in January 2017. There are a number of recommendations and work has begun on these already. Particular areas to strengthen include:

- Improvements in documentation for looked after children and children in need and in maternity records.
- Improvements in transfers of care and information to partners, particularly CAMHS and Childrens Social care.
- Improvements in electronic flagging for looked after children and children in need.
- Improvements in 'Think Family approach and documentation of who is with the child in ED and or who is the carer of the child.
- Improvement in quality of safeguarding referrals.
- Improvements in safeguarding supervision system.
- Ensuring that minutes of safeguarding meetings are received and filed within the child's health records.

Good practice was recognised in and this included:

- The facilities and management of the dedicated child protection medical suite.
- The role and development of the Safeguarding Champion to uplift safeguarding awareness in the Trust.
- Governance and reporting arrangements to the Trust Safeguarding Committee of Safeguarding Childrens activity.
- Positive safeguarding culture amongst health services leaders with good understanding of where challenges are and improvement plans.
- Good knowledge and understanding of Female Genital Mutilation amongst maternity staff, including training and processes.
- Interface of adult safeguarding referrals and Childrens services.
- Young people over 16 and up to 18 given the choice of whether to be seen in paediatric ED or Adult ED.

Mental Health care for children and young people featured in the report and with further improvements required as a partnership.

The Trust did not receive a rating from this inspection. The recommendations and action plan are monitored by the NHS Hull Clinical Commissioning Group (CCG) and internally through the Trust's Quality Improvement Plan and monitored by the Safeguarding Lead, the Chief Nurse and the Chair of the Quality Improvement Plan committee.

Despite the challenges faced, the Trust has continued to deliver a safe service. The LSCBs have not reported any concerns about the Safeguarding Children service or the Anlaby Suite with regards to Section 47 Child Protection Medicals. The NHS Hull Clinical Commissioning Group remains satisfied with the general Safeguarding Children service and the progress made against areas of concern such as the Level 3 Safeguarding Children training. No contract notices have been received regarding the Safeguarding Childrens service.

The term "children" within the *Working Together to Safeguarding Children* (2015) document, and the Children's Act of 1989 and 2004 respectively, define that "a child is anyone who has not yet reached their 18th birthday". Therefore the term 'children' means 'children and young people' throughout this report.

4. LOCAL CONTEXT

Hull and East Yorkshire Hospitals NHS Trust (HEYHT) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs over 8000 staff (headcount) and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the 3rd most deprived local authority in England in 2015 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average.

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull. Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are either South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East

Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

From a Safeguarding Children perspective, the local landscape and population is an increasing challenge and in particular with rates of abuse, neglect and harm which are closely linked with deprived areas. The increase in the ethnic minority population is also a challenge for Safeguarding Children due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Abuse and Prevent (the Governments agenda on anti-terrorism and preventing vulnerable people from being radicalised).

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

5.1 THE ANLABY SUITE

The Anlaby Suite provides dedicated facilities for the provision for undertaking Section 47 Child Protection medical examinations (S47 Medicals). Referrals for S47 Medicals are received from the Police and Child Social Care Services. S47 Medicals are requested when there is suspicion of, or actual harm, abuse or neglect that has occurred to the child or young person. The S47 Medicals are undertaken by a trained Consultant in the Trust and the reports are submitted to the lead agencies for review. These are used to inform the evidence for court and care proceedings and/or criminal charges against the perpetrator/s.

There is agreement with both Hull and East Riding Local Safeguarding Children Boards that the Anlaby suite and the Trust practitioners provide this service locally. The service is provided Monday to Friday (excluding bank holidays) and usually 9am to 5pm although this is flexible depending on the circumstances and urgency of the S47 Medical. Outside of these hours, there is an agreement that the Police and Childrens Social Care can request a S47 Medical via the General Paediatric Consultant although this is only in circumstances when it cannot wait and is deemed in the best interest of the child or young person and in cases of injury in non-mobile babies. The Safeguarding Childrens Team support the administrative function of the Section 47 Medicals. The governance around Section 47 Child Protection Medical processes has improved with the introduction on 1st April 2017 of a database which is auditable and with performance indicators should these be requested by regulators or contract commissioners.

The Anlaby Suite is also used as a facility by the Police as an interview area for vulnerable witnesses. Out of hours, the Suite is available as a facility for children, young people and adults who require examination and/or interviews following actual or alleged sexual assault. The Anlaby Suite is furnished with fixtures and fittings intended to meet the required forensic standards for a sexual assault referral centre (SARC), as well as maintaining a child friendly environment. The facility is located on the Hull Royal Infirmary Site and is well placed due to its ability to access urgent medical care services, and support services including, X-ray, and video recording facilities.

The Anlaby Suite is the base for the Trust's Safeguarding Childrens Team including the Named Nurse for Safeguarding Children, Named Midwife and Named Doctor for Safeguarding Children.

The Trust has an established Safeguarding Committee chaired by the Assistant Chief Nurse/Safeguarding Lead and subgroups. The Safeguarding Committee is attended by key staff from all the health groups, corporate services and external partner representatives (bi-annually) and meets monthly, reporting to the Operational Quality Committee.

5.2 SAFEGUARDING TEAM STRUCTURE

The Working Together to Safeguard Children 2015 document states that all providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. These individuals work closely with their organisation's safeguarding lead, designated professionals and the LSCBs. The requirements for statutory and lead roles are also referenced in the *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2015.*

The Trust is compliant with the requirements for the statutory posts and the team consists of the following:

- Named Doctor for Safeguarding Children (7 pa's per week)
- Named Nurse for Safeguarding Children (1 x WTE B8a)
- Named Midwife for Safeguarding Children (1 x WTE B7)
- Safeguarding Educator/Safeguarding Supervision Co-ordinator (1 x WTE B6)
- Safeguarding Children Practitioners (2 x WTE B6)
- Administrator for S47 Child Protection Medicals (1 x WTE B5)
- Management Assistant (1 x WTE B3)

5.3 ROLES & RESPONSIBILITIES

The Safeguarding Childrens team provides specialist advice, support and supervision pertaining to the safeguarding of children and young people to HEYHT staff. Additional child protection support and advice is available via the on-call consultant paediatrician so that there is 24 hours, 7 days a week cover.

The Named Nurse and Named Midwife have established robust communication processes with the Trust Adult's Safeguarding team for activity and cases that involve both teams.

It is the responsibility of the Safeguarding Childrens Team and Named Leads to provide the following key duties:

1. Medical examinations under Section 47 Children Act 1989 in partnership with the Local Authorities Children's Social Care (CSC) services and the Police.
2. Advice and support (safeguarding supervision) to staff members in relation to safeguarding children and young people matters presenting within the Trust.
3. Training of Trust staff and to contribute to the training resources across the local health partnership and to pre-registration nursing and midwifery training.
4. Administration of safeguarding children activities within the Anlaby Suite.
5. Compliance with regulatory standards in relation to Safeguarding Children and Young People.
6. Compliance with LSCB's policies and procedures including information sharing and good partnership working across agencies.
7. Compliance or working towards compliance of Commissioner contracts as per annum.
8. Participation in Serious Case Reviews and Serious Incidents, reports and ensuring the actions from learning lessons are implemented and embedded.

9. Review of all Safeguarding Childrens referrals and incidents involving children and young people occurring in the Trust.
10. Reporting on all activity and items for escalation to the Trust Safeguarding Committee.
11. Providing leadership on the Safeguarding children and young people's agenda.
12. Advising the Trust's Safeguarding Lead and Chief Nurse on any impending or likely changes that will impact on the Safeguarding Children and young people agenda and activity.

The list above is not exclusive but demonstrates the key areas of work.

In order to maximise the Named Doctor role, components of the Name Doctor duties are assigned to trained individuals and have been incorporated within their job plans. These are as follows:

Doctor	Number of Sessions
Dr M Cutland	4 Sessions
Dr M Barraclough	2 Sessions
Dr J Osman	1 Session

The local area Designated Doctor for Safeguarding Children, Dr Chris Wood, supports the service also. Further support is available and accessed from the Consultant Paediatrician particularly during out of hours.

Additional medical staff were employed in early 2016 to support the development of the Child Sexual Abuse Assessment Service (CSAAS). There is a deficit of approximately 2 sessions per week of consultant medical staff undertaking child protection medical assessments. These were not successfully appointed to in 2016 and further recruitment has been commenced in summer 2017. Cover is provided by the Named Doctor and Dr Chris Wood so that there are no delays to the children who require this service. However, there can be an impact on the administration duties if there is an increase in the requests for the service. If the service cannot accommodate the request locally then the referring service will seek review in another CSAAS unit. Recruitment to the posts are difficult nationally due to the specific skill set required and the risk attached to the service and practitioner.

The Trust is required to have a Senior Designated Officer (SDO), who manages allegations against staff for safeguarding children concerns. Since the 1st July 2016, this role has been held by the Assistant Chief Nurse/Safeguarding Lead who has implemented a number of changes to improve the governance of the role. The Trust's Draft Policy has been revised to reflect this and includes include both adults and children. In the absence of the Assistant Chief Nurse/Safeguarding Lead, the SDO role is covered by Dr Mary Barraclough who has received the specific training for the role or the Chief Nurse, Mr Michael Wright.

The role of the SDO is to ensure that safeguarding allegations that are raised against Trust staff are managed according to the LSCBs policies and procedures. The NHS England Policy for Managing Allegations against Staff Policy and Procedure 2014 sets out the overarching principles for the role and that the SDO works in partnership with the Local Area Designated Officer (LADO) when children, young people are believed to have suffered, or are likely to suffer, significant harm. Concern may also be raised if the staff member is behaving in a way which demonstrates unsuitability for working with children, young people or adults at risk, in their present position, or in any capacity. The allegation or issue may arise either in the employee's/professionals work or private life.

The number of cases managed through this process during 1st July 2016 and 31st March 2017 were 3. Other cases were reported but did not reach the threshold for LADO.

5.4 CHILD SEXUAL ABUSE ASSESSMENT SERVICE (CSAAS)

HEYHT has continued to be commissioned by NHS England during 2016/2017, to provide a Child Sexual Abuse Assessment Service (CSAAS) for the Humberside Police area i.e. East Yorkshire, Hull, North Lincolnshire and North-East Lincolnshire, for children and young people under the age under 16 years and for 16 to 17 year olds with vulnerabilities.

Quarterly reports are submitted to NHS England by the Named Doctor using the NHS England's report template and they inform the quarterly contract meeting to review service provision and activity. This meeting is attended by the Named and/or Designated Doctor and the Named Nurse. Following a review of the service, the service was reduced from a seven day service to a five day service which covers Monday to Friday (excluding bank holidays). The weekend /bank holiday service was decommissioned due to the low number of children and young people requiring assessment. From 1st April 201 the CSAAS service the weekend and bank holidays service provision was transferred to Sheffield Childrens Hospital and Mountain Health care in Dewsbury. This is pan-regional service.

The service provides medical and forensic assessment for sexual abuse at the request of the local Children's Social Care department and Humberside Police, offering holistic medical and nursing support, emergency contraception, post exposure prophylaxis for HIV and screening and treatment where necessary. Assessment also supports identification of those at risk of self-harm or Child Sexual Exploitation. Information and evidence is gathered to assist the Children's Social Care service and the Police in the investigation of possible abuse. The assessment is provided by a doctor and a nurse working in the Anlaby Suite, Hull Royal Infirmary. Professionals undertaking the assessments are trained specifically to undertake this role. Links with local sexual health services, local Children and Adolescents Mental Health Service (CAMHS) services and local Children's Independent Sexual Violence Advisers (ISVAs) via the Police and Crime Commissioner Office for Humberside provides ongoing support of child victims as necessary.

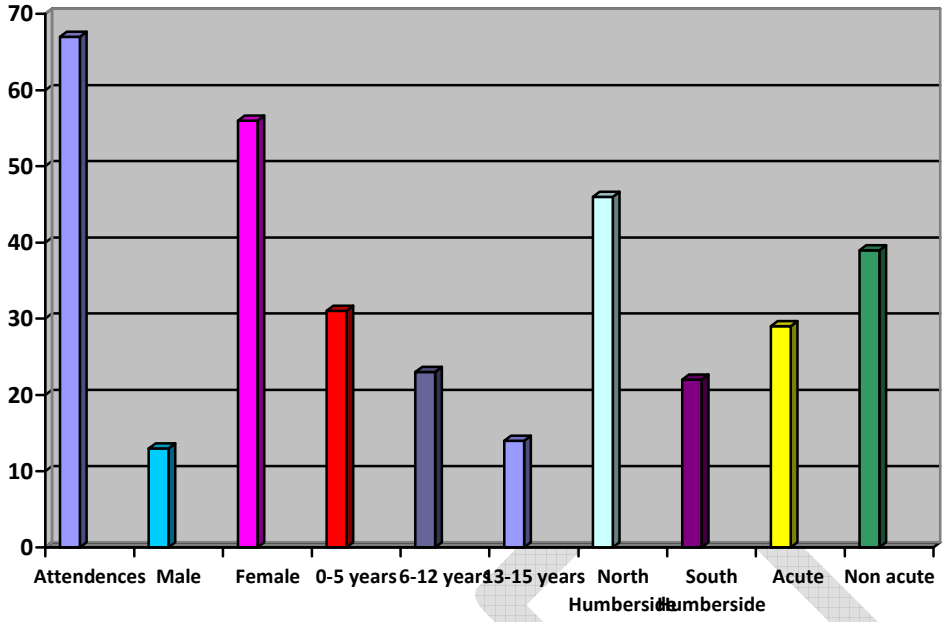


Figure 1: CSAAS activity for 2016-2017

5.5 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Children Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP 278). The Policy is supported by procedures, protocols and guidelines. All of the documents are underpinned by the LSCBs Policies and Procedures. All are available on the Trust's intranet for Safeguarding Children.

The overall accountability for Safeguarding in the Trust is the Chief Executive. The delegated Executive Director responsible for Safeguarding is the Chief Nurse with the Assistant Chief Nurse undertaking the role as Safeguarding Lead. The Named Nurse reports directly to the Safeguarding lead, but also has a direct professional line to the Chief Nurse.

Safeguarding activity is monitored within HEYHT through the Safeguarding Committee, which meets monthly. The Safeguarding Children report is presented monthly detailing activity and items for discussion and consideration. The Safeguarding Committee report to the Trust's Operational Quality Committee and escalates issues by exception when required.

The Named Nurse now reviews all reported incidents within the Trust related to children to ensure there are no missed safeguarding issue's and the risk rating for each incident is appropriate. Serious Incidents (SI's) may be declared internally to the Trust or externally by the designated safeguarding professionals. All SI's relating to children in 2016/2017 were shared with the Safeguarding Lead for a safeguarding overview. If a SI has a child or midwifery element then the SI is sent to the Named Nurse to determine if there are any safeguarding issues. This process commenced in April 2017.

All Serious Case Review's (SCR's) and SI reports are reviewed, quality checked and signed off by the Safeguarding Lead or a Senior Manager/Director before leaving the organisation.

5.6 EXTERNAL GOVERNANCE

During 2016/17, HEYHT was represented on the Hull and East Riding Safeguarding Children's Board (HSCB) by the Assistant Chief Nurse/Safeguarding Lead.

In addition, HEYHT is represented on LSCB's sub committees by the Named professionals and staff working within the Safeguarding Children Team. Attendance at the East Riding Safeguarding Children Board's sub committees has improved significantly for 2016/2017.

The LSCBs monitor HEYHTs safeguarding performance through:
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- A self-assessment of Safeguarding Children arrangements: known as a Section 11 Audit* are completed on a minimum of 3 yearly basis but usually annually as requested by the local LSCBs. The Section 11 audit was last submitted in July 2016. Submission can be accompanied by the requirement to attend a Challenge Panel event with Board members and the agency. The Hull LSCB held a Challenge Panel with the partners of the Board and HEYHT was represented by the Named Nurse and Assistant Chief Nurse. Feedback was positive by the Board Chair and Manager on the work undertaken and planned with regards to the Section 11 requirements.

**Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.*

The Trust is also monitored and/or inspected by the following agencies with regards to Safeguarding Children arrangements:

- Ofsted - Ofsted is been responsible for inspecting the Local Authorities and their Partner Agencies in relation to their Safeguarding Children and Looked after Children arrangements. HEYHT was last inspected in June 2011.

- NHS England and the Care Quality Commission (CQC) - CQC monitor and review the Safeguarding Children Standards of the Trust. The Trust was inspected in June 2016 and January 2017 (as part of the NHS Hull CCG inspection) and a number of recommendations were identified for Safeguarding Children. These were included in the Trust Quality Improvement Plan. The CQC inspection in June 2016 identified a number of areas of concern regarding Safeguarding Children and these actions have already been completed or are on track for delivery in 2017/18. All actions from this inspection were added to the Trust QIP.

- NHS Hull Commissioners – As part of the Quality Contract with the Trust Commissioners, the Trust has a number of key performance indicators for Safeguarding Children and Adults. For 2016/17, the Trust delivered the majority of the performance with agreed indicators carried forward to 2017/18. There is no financial target attached to the key performance indicators. The Assistant Chief Nurse/Safeguarding Lead attends the monthly Clinical Quality Forum meetings with the Commissioners and receives any questions regarding safeguarding from the Contract Monitoring Board to which the quarterly reports are submitted. This was established in 2013 and has proved to be a positive link with the Commissioners and enabled the Safeguarding agenda to be discussed and supported.

5.7 SERVICE USER AND STAKEHOLDER FEEDBACK/INVOLVEMENT

This has been collected from the second year of operation of CSAAS (2016/2017) and was available from Quarter 3. The feedback from the children and carers has so far been overwhelmingly positive. Each quarter the comments are shared with the safeguarding team.

> *'(staff) made my daughter feel at ease, really looked after her, thank you'*
>
> *'I am very impressed – the whole approach was excellent. Doctor and nurse made the child so relaxed and not awkward in any way. Very sensitively done'.*

A meeting took place with the Named and Designated Nurses from North Lincolnshire and Goole in February 2017. The purpose of the meeting was to clarify referral processes around the CSAAS and to discuss any issues. The outcome of this meeting was that the Named and Designated professionals from North Lincolnshire and Goole developed their own flowchart process to ensure that staff in their areas were clear about the communication/ referral pathways for accessing the services provided by the Anlaby suite/CSAAS.

6. TRAINING AND DEVELOPMENT

6.1 SAFEGUARDING CHILDREN TRAINING

Training and education of staff for Safeguarding Children continues to be a high priority for HEYHT. In the 2015/2016 compliance with level 3 safeguarding children training was reported at 64.5%. In July 2016, it was added to the Trust's Risk Register and a key action for 2016/2017 was to strengthen compliance with safeguarding children training, specifically level 3. The table below shows the training compliance rates, by level of training, as at 31st March 2017. The Trust is now compliant with this indicator.

Intercollegiate level of training	Number of HEYHT staff requiring this level of training	Current compliance (%) Target 80%
Level 1 (Basic)	2899	82.4%
Level 2 (Intermediate)	5328	81.3%
Level 3 (Advanced, multi-agency)	727	88.7%
Level 4	5	100%

Figure 2: Compliance rates at 31st March 2017 and shows above 80% compliance across all levels of safeguarding children training

The compliance has been maintained at above 80% and is monitored closely by the Training and Education department, the Named Nurse for Safeguarding Children and the Assistant Chief Nurse. Training data is submitted monthly to the Trust Safeguarding Committee where any areas of concern are reviewed and actions agreed if required.

In addition, the Hull Safeguarding Children Training Board Threshold training has been made available to Trust staff during 2017, and is available on HEY 24/7 to all those staff that are required to train at level 3.

In 2016/2017, 3 two-hour sessions with a safeguarding focus were delivered to the medical paediatric staff by the Named Doctor. Topics covered included:

- A review of paediatric FGM cases in the Trust
- Nutritional neglect

- Updates on physical abuse, including dangerous dogs and abusive head trauma
- A regional review of child protection reports

Mandatory Consultant training is also delivered 10 times a year and all Trust Consultant staff must attend every 3 years. This training in 2016/2017 included:

- Safeguarding Childrens Update on lessons learned from Serious Case Reviews
- Hot topics
- Dissemination of information, relevant guidance
- Signposting to additional training and local advice and support.

6.2 SAFEGUARDING SUPERVISION TRAINING

Safeguarding Supervision training is now available on HEY 247 for staff who want to take on the role of Safeguarding Supervisor. This area is a key area for focus for 2017/18.

6.3 FEMALE GENITAL MUTILATION (FGM)

FGM is included within Safeguarding Children training. Trust staff have the option of face to face FGM training or an e-learning package. The safeguarding children team also support the training programme of pre-registration nurses and midwives.

7. MANAGING INDIVIDUAL CASES/ ACTIVITY

7.1 REFERRALS TO SOCIAL CARE

A key action from 2016/2017 was to review improve the electronic safeguarding children referral process, which was introduced in February 2016. This review took place and it was felt that there had been an increase in the number of referrals made. Initially, staff found the change of process difficult. However, this is now embedded in practice.

Following the CQC inspection in June 2016, the safeguarding team revisited its process of ward rounds and paediatric liaison within the Trust. This resulted in a more detailed and supportive approach to their daily ward rounds extending this into paediatric outpatient areas and Neonatal Intensive Care Unit. This has also been introduced by the Named Midwife in maternity service. In 2016/2017, the number of referrals to Childrens Social Care has significantly increased. This is likely to be due to the increase in the awareness of Safeguarding Children processes since the actions of the June 2016 CQC inspection were initiated as well as the daily ward rounds identifying safeguarding concerns which trigger a referral on review. However, further work needs to be undertaken to audit the quality of referrals.

Number of referrals made to Children's Social Care Teams by staff group	2014-15	2015-16	2016-2017
HEYHT Midwives (both hospital and community)	354	490	586
HEYHT staff (not including midwives)	301	286	409
Total number of referrals made	655	776	995

Figure 3: Number of safeguarding Children referrals - 3 year comparison.

7.2 CHILD PROTECTION MEDICALS

The following table illustrates the number of S47 Child Protection Medicals carried out during office hours within the Anlaby Suite over the last 3 years. In total, there were 140 medical examinations carried out 2016-2017, which remains relatively stable.

Examination	2014-2015	2015-2016	2016-2017
Sexual Abuse	49	49	62
Physical Abuse	38	53	47
Neglect	8	21	15
Other	10	0	0
Follow up/ Outpatient	36	24	16
Total	**141**	**147**	**140**

Figure 4: Number of child protection medicals with reason for attendance

The figures in the previous table includes; follow ups and other Anlaby Suite activity, including FGM medicals and Sexual Transmitted Infection (STI) screening in under 13 year olds.

During 2016/2017 the CSAAS service provided out of hours service on weekend and Bank Holidays from 9 am to 1pm. This out of hour's rota was covered for Quarter 1 to Quarter 3 at 78-79% and was covered 100% for Quarter 4.

7.3 CHILD DEATHS

The Named Nurse and the Named Doctor act as the central point within the Trust for the notification and subsequent sharing of information with other agencies in regard to child deaths. Access to a Designated Doctor for Child Deaths is a requirement for every LSCB as part of the Child Death Review process. Dr Mary Barraclough, Consultant Paediatrician at HEYHT carries out this role.

The Child Death Overview Panel (CDOP) collates information in relation to the number of child deaths locally and their categorisation as either expected or unexpected. HEYHT provides reports to the CDOP's and as a member of Hull and the East Riding Safeguarding Children Boards. The CDOPs provide annual reports, which HEYHT receive.

8. SAFEGUARDING SUPERVISION

Safeguarding supervision remains a key priority for the 2017/2018. In May 2016, a part time Safeguarding Supervision co-ordinator role was established to support this priority. Work has progressed well and all staff have access to adhoc safeguarding supervision from the safeguarding children team and named professional. Staff who work directly with children have access to planned group supervision or one to one supervision dependant on whether they are caseload holders. However there is lack of consistency in the frequency of this supervision taking place and, also, in the number of staff who are able to attend due to clinical commitments.

The plan in 2017/18 is to continue to strengthen the safeguarding supervision process by a conducting a review of resources and capacity needed for all staff, including maternity services, to receive planned safeguarding supervision regularly commensurate with their role and workload. This is particularly relevant within maternity services. A full review of the Safeguarding Supervision Policy will be undertaken in 2017/18 alongside the operational review of this item.

9. SAFEGUARDING CHILDREN

9.1 EHASH (Early Help and Safeguarding Hub)

Both Hull and East Riding Local Authorities are now operating an EHASH team for all safeguarding children and early help referrals. The EHASH in East Riding has been in operation for several months and has had little impact on staff within the Trust as the safeguarding referral pathway/paperwork has not changed. The Hull EHASH commenced at the end of June 2017. The main change for staff is that there is a new contact /referral form. At present Trust staff do not have access to this but is expected that by September 2017 this new contact/referral will be available on the Trust Intranet. The Hull LSCB has agreed with Childrens Social Care that staff can continue to follow the existing referral pathway using the referral forms available on the intranet as an interim arrangement.

9.2 MENTAL HEALTH

Work is ongoing to review the communication processes between Child and Adolescent Mental Health services (CAMH's) and the Trust, where a young person with a mental health care plan is receiving care within the Trust. This includes a review of the transfer of care process and documentation for children in the Trust in relation to safeguarding concerns.

A database has been set up by the Safeguarding Children Team to collate data relating to children and young people who attend the hospital via the Emergency Department with Self-harm. Quarterly reports will be submitted to the Safeguarding committee for review.

9.3 CHILD SEXUAL EXPLOITATION (CSE)

Raising awareness of Child Sexual Exploitation with staff employed within the Trust is an important area of work for the safeguarding children team. Safeguarding Children Training has been written to include this as a subject area. This is key priority for the Trust in 2017/18.

The Named Nurse attends the CSE professional practice group with the Hull Safeguarding Children Board and the CSE strategic group at the East Riding Safeguarding Board. The plan for 2017/2018 is to implement a CSE assessment tool for Trust staff, to support assessment and referral of children at risk of CSE.

10. MIDWIFERY

10.1 Female Genital Mutilation / multi-agency pathway

In April 2016, staff were required to submit Notification to Health and Social Care Information Centre (HSCIC) of female babies born to mothers, who have had FGM. In addition, staff are expected to follow the safeguarding children referral a pathways for pregnant women who have had FGM and if they have female children. Children's Social care and health partners

hold 6-8 weekly meetings to discuss all FGM cases. The Named Midwife, Zoe Dale, is the Trust lead for FGM and attends the strategy meetings for cases.

An audit with Obstetric staff reviewing all FGM cases was completed in May 2016. The findings from this were excellent, 100% compliance was achieved in 4 out of 5 standards, as follows:

- 100% identified at first presentation (92% at booking and 8% at early pregnancy contact)
- 100% referred to a Consultant
- 100% were offered screening for Hepatitis B , HIV and Syphilis
- 9% had Hepatitis screening offer documented
- 100% were referred to Childrens Social Care

Further training and awareness of the low compliance of documented Hepatitis screening is underway and a further internal audit planned in 2017/18 to review this area of poor compliance.

10.2 DOMESTIC VIOLENCE

During 2016/17, as part of the work to improve communication between agencies, Humberside Police share information with the Trust for all pregnant women involved in a domestic abuse incident. This information is sent to the community midwives via the Safeguarding Children Team to ensure that they are aware of the recent issue and the level of concern regarding the domestic abuse. The Trust also provides and receives information to the Multi-Agency Risk Assessment Conference (MARAC). The MARAC is a monthly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan. Currently, the process for sharing this information is generally paper based in Maternity services but the transfer to Lorenzo will enable information to be recorded within the electronic patient record. This system is already in place for Safeguarding Adults.

The Named Midwife is leading the development of a Domestic Abuse Strategy for the Trust.

10.3 CARING FOR VULNERABLE WOMEN

Following lessons learned and recommendations from local Serious Case Reviews a Vulnerability Risk Assessment Toolkit for pregnant women was developed in 2015/16. This was implemented for use 1st March 2016. The key purpose of the tool is to ensure that women are assessed and identified for vulnerabilities and then referred into the correct pathway. This then allows the appropriate support to be available for the women and close supervision of their pregnancy and domestic circumstances.

Following the launch of the toolkit, feedback from the midwives was encouraged and some amendments were made. Key changes included:

- Capturing the use of alcohol and therefore prompting the discussion between the women and their midwife if necessary.
- Strengthening the layout of the document to allow signatures and dates in each column.
- Adding a section for the postnatal period which will prompt reassessment of the vulnerability identified in pregnancy.

A Guideline for Women who misuse drugs and alcohol was developed and implemented in February 2016. In 2017/2018, midwifery staff will receive perinatal mental training delivered by the Vulnerability Midwife as part of the Caring for Vulnerable Women training package.

Work is ongoing on the development of additional guidelines in relation to this subject and people who have complex social factors.

10.4 MODERN DAY SLAVERY

The Named Midwife is a member of the Humber Modern Slavery Group and has attended cascade training. This has resulted in her facilitating training of Midwives on their annual Mandatory training days and on Safeguarding Champions training sessions.

11. SERIOUS INCIDENTS/SERIOUS CASE REVIEWS

11.1 SERIOUS INCIDENTS

In 2016/2017, there were seven Serious Incident's (SI's) declared by the Trust in relation to Children and four were of a safeguarding nature. When the SI is declared, a copy of the incident is shared with the Assistant Chief Nurse for a safeguarding review. This process has been reviewed and from 2017/2018 a copy of the incident related to children will also be shared with the Named Nurse for Safeguarding Children. This will allow any additional information from Childrens Social Care to be triangulated.

In addition to the SI's declared within the Trust, five SI's were declared to NHS England by the Designated Nurse Safeguarding Children Hull CCG. The SI's were declared after a child had died (3 cases) or a child had suffered significant harm (2 cases). Out of the two cases where a child has suffered significant harm, one has progressed to Serious Case Review.

11.2 SERIOUS CASE REVIEWS/ LESSONS LEARNED REVIEWS

The Trust has participated in six Serious Case Reviews (SCR's) in 2016-2017 and one Lessons Learned Review (LLR) across Hull and East Riding. HEYHT contributes to the process in relation to its contacts with the child and their family. The level of involvement in the review process varies on a case by case basis ranging from a scoping exercise to the completion of an agency report with recommendations and actions for HEYHT. Updates on the progress of these reviews are reported monthly into the Safeguarding Committee

All Serious Case Review's (SCR's) and SI reports are reviewed, quality checked and signed off by the Safeguarding Lead or a Senior Manager/Director before leaving the organisation.

The Named Nurse and Named Midwife, supported by the Assistant Chief Nurse/Safeguarding Lead, take lead responsibility for recommendations, actions from SCR's and LLR's and support the implementation of changes in practice. Progress against Serious Case Review recommendations are reviewed and monitored by the LSCB's. The Trust is on track with the delivery of actions associated with these reviews.

12. KEY ACTIONS for 2017-2018

The Trust has identified a number of actions required to strengthen the Safeguarding Childrens service. Actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Childrens Board activities and from the lessons learnt from Serious Care Reviews. The Trust's Quality Improvement Plan encompasses key priorities for the Trust for safeguarding adults and children.

A summary of work planned for 2017/18 is as follows:

- Review transfer of care process and documentation for children in the Trust in relation to safeguarding concerns specifically related to children presenting with mental health issues.

- Review the communication processes between Child and adolescent Mental Health services (CAMH's) and the Trust, where a young person with a mental health care plan is receiving care within the Trust

- Audit the use of paediatric documentation and the recording of key information about children and families in attendances of children in the Emergency Department.

- Work in partnership with the local authority to ensure that staff receive meeting minutes from safeguarding children meetings they attend and that they are filed within the child's health record.

- Improve the quality of referrals to Children Social Care.

- Continue to strengthen the Safeguarding Supervision Process within the Trust, to ensure that all Trust staff who have a safeguarding concern can access planned and/or ad hoc safeguarding supervision. This includes a review of resource and capacity within the maternity service.

- Continue to work to raise awareness and assessment/identification of children who access Trust service and who may be at risk of Child Sexual Exploitation.

- Develop a Domestic Abuse Strategy for the Trust.

- Review of staffing resource/capacity in the Safeguarding team together with safeguarding activity.

- All Serious Incidents (SI's) declared within the Trust which involve a child, will also be reviewed by the Named Nurse/Named Doctor to determine if there are any safeguarding issues that need to be considered.

- Midwifery staff will receive perinatal mental training delivered by the Vulnerability Midwife as part of the Caring for Vulnerable Women training package.

Report Authors: Sandra Park, Named Nurse for Safeguarding Children
Zoe Dale, Named Midwife
Kate Rudston, Assistant Chief Nurse

Date: August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

Meeting Date	19 September 2017		**Reference**		2017 – 10 - 21	
Director	Jacqueline Myers – Director of Strategy and Planning		**Author**		Alan Harper – Assistant Director of Planning	
Reason for the report	To advise the Trust Board regarding the outcome of the 2017/18 EPRR assessment against core standards.					
Type of report	Concept paper		Strategic options		Business case	
	Performance	✓	Briefing		Review	

1	**RECOMMENDATIONS** The Trust Board is asked to: • receive the progress from 2016/17 assessment and actions from 2017/18 assessment • note the Trust's level of compliance • receive the Trust's ongoing monitoring arrangements					
2	**Key purpose**					
	Decision		Approval		Discussion	
	Briefing		Assurance	✓	Delegation	
3	**STRATEGIC OBJECTIVES**					
	• Safe, high quality effective care					✓
	• Strong, high performing FT					✓
	• Creating and sustaining purposeful partnerships					✓
	• Efficient economic use of resources – targeted and prioritised effectively					✓
	• Delivery against our priorities and objectives					✓
	• Capable, effective, valued and committed workforce					✓
	• Strong respected impactful leadership					✓
4	**LINKED TO** • Civil Contingencies Act 2004 • Health and Social Care Act 2012 • NHS England Emergency Preparedness Framework 2015					
	Assurance Framework Ref: N/A		**Legal advice:** N		**Linked to Sustainability**? N	
5	**BOARD/BOARD COMMITTEE REVIEW** This has been discussed and approved by the Executive Management Committee as the most senior management meeting of the Trust. It is received by the Trust Board for briefing, compliance and assurance purposes.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

2017/18 ASSURANCE PROCESS

1. PURPOSE OF PAPER

The purpose of this paper is to update the Trust Board regarding the 2016/17 assessment against core standards for EPRR and to provide the Trust's level of compliance following the 2017/18 assessment.

2. ACTION AND PROGRESS FROM 2016/17 ASSESSMENT

Summarised below are details of action taken following last year's assessment.

2.1 Evacuation plans

Trust Fire Safety Advisors have worked closely with ward and departmental teams to agree evacuation plans. Last year 50% of areas had plans. This has now increased to 95% and is expected to be at 100% by January 2018.

2.2 Mass fatalities

As this is a local authority responsibility, it was discussed at the Local Resilience Forum (LRF) and added to their Risk Register on 4 August 2017. A draft LRF Mass Fatalities Plan (September 2017) has been prepared.

2.3 Major Incident Live Exercise

The Trust led a multi-agency Project Group and delivered the live exercise on 24 June 2017.

2.4 Chemical, Biological, Radiological and Nuclear (CBRN) training

CBRN refresher training has taken place and 81% of ED nursing staff have attended. Additional trainers have been identified to support the Trust CBRN Lead and course dates are awaited from PHE. An eLearning module is being developed.

2.5 HAZMAT/CBRN:

Chemical Exposure Assessment Kits

PHE expectations, regarding support associated with the collection of samples, are awaited.

3. NHS EPRR ASSURANCE

The 2017/18 EPRR annual assessment commenced in July and is used by NHS England to seek assurance the NHS is prepared to respond to an emergency and has resilience in relation to the continuing provision of safe patient care.

This year there were 108 core standard questions within the assessment process which included governance, risk assessment, emergency / business continuity planning, command and control, communications, information sharing, training and exercising, hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear planning (CBRN).

The subject of the 2016/17 "deep dive" focused on EPRR organisational governance.

4. ACTION ARISING FROM 2017/18 ASSESSMENT

Issues from this year's assessment are noted below.

4.1 Evacuation Plans (Amber Risk)
As noted in 3.1, significant progress has been made over the past year. This issue will be removed once 100% is achieved

4.2 Expected Number of 'in date' PRPS suits (Amber Risk)
NHS England is co-ordinating the replacement of 'expired' PRPS suits. The Trust has x22 'in date' and x2 'expired' suits. The Trust has raised this formally with NHS England.

4.3 CBRN training (Amber Risk)
81% of ED nursing staff have attended CBRN refresher training. Additional trainers have been identified, to support the Trust CBRN Lead, and course dates are awaited from PHE. An eLearning module is being developed.

4.4 2016/17 EPRR results to be published in Annual Report (Amber Risk)
The Trust Annual Report was compiled and signed off in accordance with DoH guidance. There was no DoH requirement to publish 2016/17 EPRR results in the Annual Report; they will however be formally reported in future reports. The Trust's EPRR Results are published on the Trust's website under Corporate Information.

4.5 Local Health Resilience Partnership (Amber Risk)
Assistant Director of Planning deputises for Director of Strategy and Planning, in accordance with LHRP Terms of Reference.

5 TRUST COMPLIANCE LEVEL: 2017/18

As the Trust does not fully comply with 5 of the 2017/18 core standards the level of compliance is viewed as Substantial, rather than Full, Partial or Non-compliant.

The results of the Trust assessment and Improvement Plan have been shared and discussed, at a local health economy level, with Hull CCG, East Riding of Yorkshire CCG, Humber NHS FT, City Health Care Partnership and Northern Lincolnshire and Goole NHS Foundation Trust. The outcome of the Trust assessment will be submitted to NHS England by 6 October 2017.

A signed Statement of Compliance and Improvement Plan are attached.

6 ONGOING MONITORING ARRANGEMENTS

The Improvement Plan addresses areas where action is required, as noted in section 3 above. The plan will be monitored by the Trust Resilience Committee and reported quarterly at the Non Clinical Quality Committee.

7 RECOMMENDATION

The Trust Board is asked to:

- receive the progress from 2016/17 assessment and actions from 2017/18 assessment
- note the Trust's level of compliance
- receive the Trust's ongoing monitoring arrangements

Alan Harper
Assistant Director of Planning
6 September 2017

Yorkshire and the Humber EPRR core standards improvement plan 2017-18

Organisation: Hull and East Yorkshire Hospitals NHS Trust

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
8	Evacuation (Amber)	Increase in percentage of wards and departments with agreed evacuation plans.	Fire Safety Advisors have worked closely with ward and departmental teams to agree evacuation plans. Last year 50% of areas had plans. This has now increased to 95%.	100% by Jan 18
8	Mass Fatalities (Red)	As this is a local authority responsibility discussion has taken place within the Humber LRF.	LRF agreed to put this issue on their Risk Register. Draft LRF Mass Fatalities Plan (September 2017) prepared.	Added to LRF Risk Register 4 August 2017
35	Live exercise (Amber)	Participation in exercises. Trust to organise multi-agency Live Exercise.	Trust has participated in a number of exercises and led a multi-agency Project Group and delivered a live exercise on 24 June 2017.	Complete June 17
41 / 49	CBRN refresher training (Amber)	Increase in staff attending refresher training. Additional CBRN trainers to support Trust CBRN Lead. To develop eLearning package.	ED staff to attend CBRN refresher training (81% ED nursing staff trained). Additional CBRN trainers identified – training dates awaited from PHE. eLearning module being developed.	100% by Apr 18
E27	Chemical Exposure Assessment Kits (chEAKS) (Amber)	ED has not been provided with chEAKS by PHE.	Expectations of PHE, regarding support associated with the collection of samples, are awaited.	TBC

Yorkshire and the Humber EPRR core standards improvement plan 2017-18

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
18	Evacuation (Amber)	Increase percentage of wards and departments with agreed evacuation plans.	Fire Safety Advisors have worked closely with ward and departmental teams to agree evacuation plans. Last year 50% of areas had plans. This has now increased to 95%.	100% by Jan 18
59	Expected number of in date PRPS suits (Amber)	Trust to have x24 PRPS 'in date' suits.	Trust has x22 'in date' and 2 'expired' suits. NHS England (Vicky Lee) co-ordinating replacement programme.	Ongoing
64 / 65	CBRN training (Amber)	Increase in staff attending refresher training. Additional CBRN trainers to support Trust CBRN Lead. To develop eLearning package.	ED staff to attend CBRN refresher training (81% ED nursing staff trained). Additional CBRN trainers identified – training dates awaited from PHE. eLearning module being developed.	100% by Apr 18
DD2	16 / 17 EPRR results published in Trust Annual Report (Amber)	Results published in Annual Report and on Trust website.	16/17 Annual Report compiled and signed off in accordance with DoH guidance - therefore no reference to 2016 / 17 EPRR results. Results are published on Trust web site.	Results will be included in future Annual Reports
DD6	Attendance at Local Health Resilience Partnership (Amber)	Assistant Director deputises and is 'Nominated Representative' for Accountable Emergency Officer.	Assistant Director attends for Trust in accordance with LHRP Terms of Reference (June 2017).	Ongoing

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Hull and East Yorkshire Hospitals NHS Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	24 June 2017
A desktop exercise (required at least annually)	14 Oct 16 and 24 June 2017
A communications exercise (required at least every six months)	1 March, 24 June and 6 Sept 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incident at North Lincolnshire and Goole NHS FT and The Leeds Teaching Hospitals NHS Trust Pathology Incident. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Jacqueline Myers

Signed by the organisation's Accountable Emergency Officer

19/09/2017
Date of board / governing body meeting

04/09/2017
Date signed

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT

Trust Board date	3 October 2017	**Reference Number**	2017 -10 - 22
Director	Kevin Phillips – Chief Medical Officer	**Author**	Kevin Phillips – Chief Medical Officer
Reason for the report	The Board is asked to receive the signed report.		

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

1	**RECOMMENDATIONS** The Board is asked to receive the signed 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):					
	Assurance Framework	**Raises Equalities Issues?**	**Legal advice taken?**	**Raises sustainability issues?**		
5	**BOARD/BOARD COMMITTEE REVIEW**					

TRUST BOARD REPORT 2017	
Meeting date:	5th September 2017
Title:	Responsible Officer Report
Presented by:	Mr Kevin Phillips – Chief Medical Officer/Responsible Officer
Author:	Mr Kevin Phillips – Chief Medical Officer/Responsible Officer
Purpose:	The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS Improvement (NHSI), formally the Trust Development Authority. The Framework for Quality Assurance, in defining the purpose of the annual report, states that:
Recommendation(s):	The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by the end of September.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2017

1. Purpose of the Paper

The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and now NHS Improvement (NHSI), formally the Trust Development Authority. The Framework for Quality Assurance, in defining the purpose of the annual report, states that: "The Trust Board should understand its responsibilities under the Responsible Officer Regulations. It should also understand the appraisal and revalidation process within the organisation, and be aware of progress in establishing and maintaining a successful revalidation programme for medical staff. NHS England requires that the Trust Board demonstrates fulfilment of these requirements by formally acknowledging receipt of this paper, and returning a statement of compliance signed by the Chairman."

2. Background

Following public and professional concern about the regulation of the medical profession a new system of assurance was introduced from the end of 2012. A Statutory Instrument passed in 2010 mandates the appointment of a 'Responsible Officer' for each organisation employing doctors. The Responsible Officer has a duty to confirm that the doctors for whom they are responsible are fit to practise, and comply with General Medical Council guidance on Good Medical Practice. This Statutory Instrument is the legislation underpinning the new General Medical Council process of revalidation, which applies to all Doctors in the United Kingdom who require a licence to practise. A licence is required by all Doctors working at Hull and East Yorkshire Hospitals NHS Trust. Revalidation is the process by which doctors have to demonstrate to the General Medical Council that they are fit to practise. The purpose of revalidation is to assure patients and the public, employers, and other healthcare professionals that licensed doctors are up to date and working appropriately. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking that there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Previous reports outlining progress in implementing appraisal and revalidation have been submitted to the Trust Board (2012, 2013, 2014 2015, with an interim update in February 2015, 2016), and to the Quality Committee.

The Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

Recommendation to the General Medical Council for revalidation of individual Doctors is the responsibility of the Responsible Officer. He is supported in discharging this duty by a Revalidation Panel consisting of representation from senior clinical management, the Appraisal Lead, a representative from the Local Negotiating Committee, and the Head of HR Services. The Panel meets on a monthly basis. Appraisal and revalidation processes are overseen by the Appraisal and Revalidation Committee, chaired by the Responsible Officer. This committee reviews progress against appraisal and revalidation targets, and determines actions to address failures to meet these targets. The Appraisal and Revalidation Committee meets monthly, and reports by exception to the Operational Quality Committee.

The Trust is required to maintain an accurate record of Doctors with a prescribed connection to the organisation (as a Designated Body). This is done using the GMC Connect system, and is kept up-to-date by the HR Advisor (Medical Workforce). Doctors transferring between Designated Bodies are required to provide their new RO with details of their previous Designated Body, so that information can be exchanged between the two ROs. The Trust has developed a standard form to respond to requests for information from other Designated Bodies.

The Trust is required to complete an annual report (with quarterly updates) to NHS England describing the extent of compliance with its obligations as a Designated Body. This report is called the Annual Organisational Audit (AOA).

Policy and Guidance
Appraisal and revalidation are conducted in accordance with the Appraisal and Revalidation for Medical Staff policy. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull and East Yorkshire Hospitals NHS Trust) does not undertake an appraisal within the 12 month period required.

In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), the Trust has put in place the Maintaining High Professional Standards Policy for Medical and Dental Staff and supporting procedures. The policy and supporting procedures are also based on the National Clinical Assessment Service (NCAS) document 'Back on Track' and is in line with the Department of Health document 'Tackling Concerns Locally'. The Maintaining High Professional Standards Policy for Medical and Dental Staff replaces the Disciplinary and Capability for Medical and Dental Staff and Remediation and Capability for Medical and Dental Staff policies.

4. Restrictions, Remediation, and Investigations

The Trust was the Designated Body for 554 Doctors in 2016/17: this included 419 Consultants, 51 Specialty and Associate Specialist (SAS) Doctors and 84 other Doctors (mainly short term Trust Grade Doctors).

There is 1 SAS Doctor currently in a formal remediation process.

Table 1 shows the number of Doctors for whom the Trust is the Designated Body who are either under active investigation by the General Medical Council, or who have current notices on their licence to practise as a result of previous GMC investigations. In addition to these Doctors, there are also a number of trainees working at the Trust who are either under investigation by the GMC or who have warnings on their licence: the Designated Body for these Doctors is the Deanery.

Table 1. Number of Doctors for whom the Trust is Designated Body who have current GMC notices or investigation:

Type of sanction	Consultant	Non-Consultant
Licence warning	1	1
Undertakings	0	0
Conditions	0	0
Under investigation	0	0

During 2016/17, 6 Doctors with a prescribed connection to the Trust were under investigation. 3 of these cases are now complete and 3 are outstanding.

The outcomes of the investigations are summarised in Table 2. In general, concerns about doctors in training were referred to the Deanery, unless there had been breach of specific Trust policies.

Table 2. Medical disciplinary investigations 2016-17

Grade	Type of Investigation	Investigation Outcome
Consultant	Disciplinary	Reflective learning
Consultant	Disciplinary	Ongoing
SAS Doctor	Grievance	Informal resolution
Consultant	Bullying & Harassment	Ongoing
Consultant	Disciplinary	Informal resolution
Consultant	Disciplinary	Ongoing

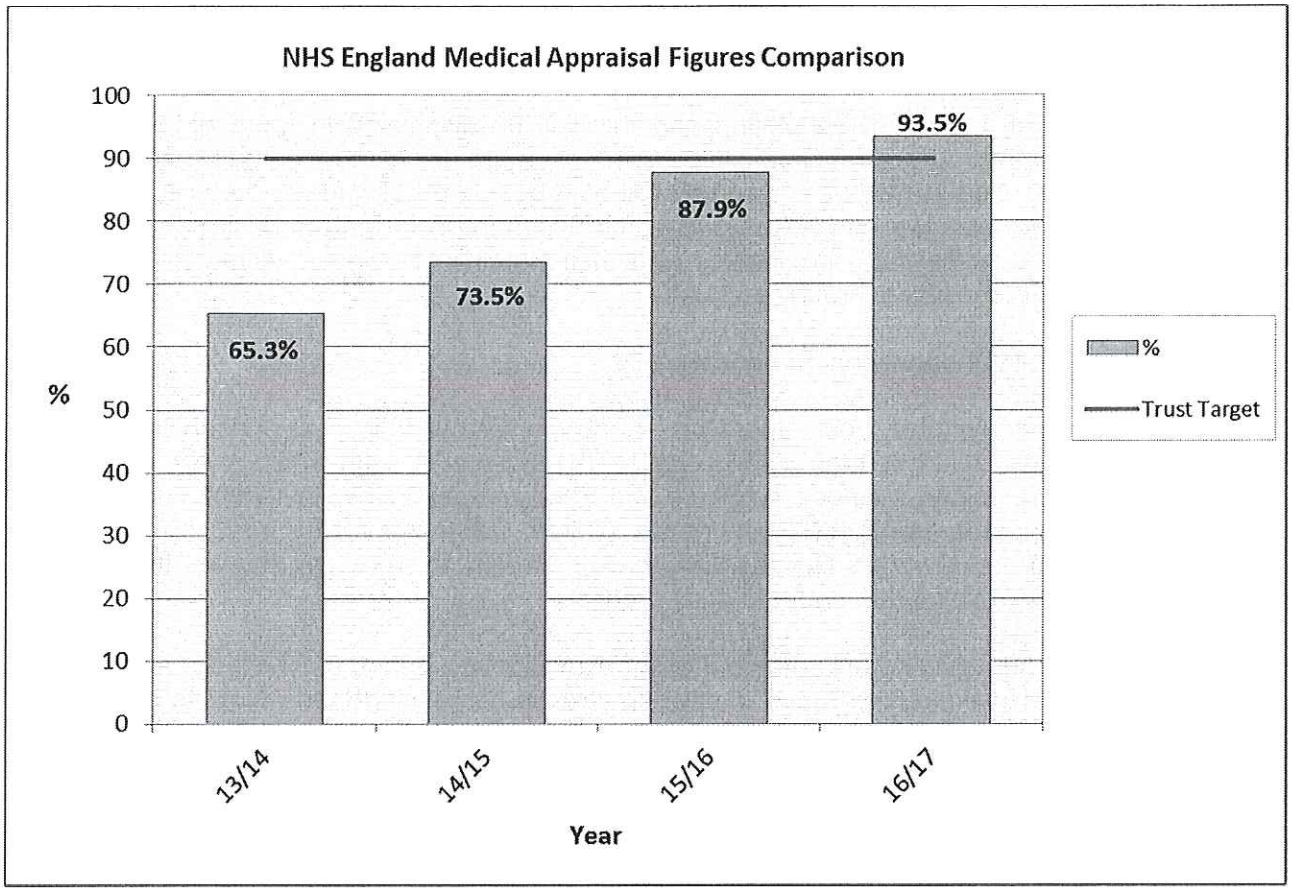
5. Medical Appraisal

Appraisal rates

The 2016/17 NHS England Annual Organisational Audit (AOA) shows that Hull and East Yorkshire Hospitals NHS Trust's appraisal rate is 93.5% compared with the 2015/16 AOA which was 87.9%. This represents an increase of 5.6%

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer.

The graph below shows the NHS England medical appraisal figures for 2013/14, 2014/15, 2015/16 and 2016/17:



Appraisers
The Trust currently has 73 'active' trained Appraisers, including 2 'Senior Appraisers' and 1 Lead Appraiser. The Senior Appraisers and Lead Appraiser are responsible for ensuring that the training of the Appraiser team is up-to-date, delivering training to new appraisers and the quality assurance of appraisals. Each Appraiser is responsible for carrying out up to 10 appraisals per year. The Trust is going through a process of ensuring that time given to carry out this role is in line with a Doctor's individual job plan.

Quality Assurance
Every Doctor being appraised completes an anonymous feedback form on the appraisal process and their Appraiser. To complete the appraisal process, every Doctor must complete this feedback questionnaire otherwise their appraisal will remain incomplete. This means that 93.5% of Doctors completed anonymous feedback in the 2016/17 appraisal year. This feedback is then provided to the Appraisers after they have appraised 5 Doctors and this is included in their own appraisal for appropriate discussion and reflection.

In addition to anonymous feedback form, the Trust commissioned a medical appraisal feedback questionnaire (using Survey Monkey) to gather further feedback on the revalidation and appraisal process. The response rate of this survey was 14%. The key findings were:

100% of Doctors who completed the survey understood the revalidation and appraisal process

75% of Doctors who completed the survey felt they benefited from this year's appraisal process

61% of Doctors who completed the survey felt the appraisal process benefited patients

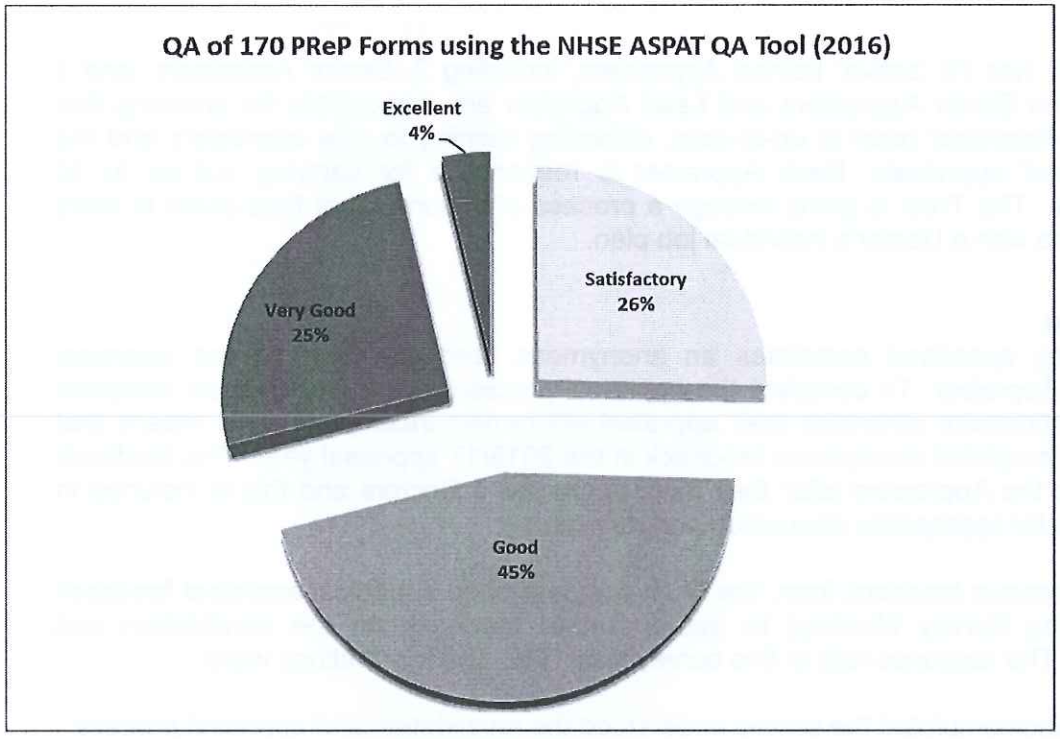
93.4% of Doctors who completed the survey rated the Revalidation/System Admin Team as excellent or good

The response rate of 14% is disappointing and this will be discussed in more detail at the monthly Revalidation and Appraisal Committee as to how a greater response can be achieved. The questions to be used in next year's survey will also be looked at and updated, as well as further discussions on how we can adjust processes accordingly so that more of our Doctors feel their appraisal benefits both themselves and their patients. However, ultimately we are governed by national processes through the GMC.

It is planned to repeat the survey on an annual basis.

As well as the anonymous post appraisal feedback and medical appraisal feedback questionnaire (Survey Monkey), there is a quarterly Revalidation Bulletin which is circulated to all Doctors with a prescribed connection to Hull and East Yorkshire Hospitals NHS Trust. This bulletin provides updates from the Responsible Officer, Lead Appraiser and HR Advisor (Medical Workforce) and provides Doctors with the opportunity to raise any queries they may have in relation to the revalidation and appraisal process.

All appraisal inputs and outputs are reviewed at the Revalidation Panel, of which the Appraisal Lead is a member. Reflections on good or bad practice in completing these outputs are then used in the ongoing Appraiser training programme. In addition, a random sample of output forms are regularly reviewed against set criteria by the Appraisal Lead. The chart below shows the results of the Quality Assurance of 170 PReP appraisal forms (the Trust's electronic appraisal system for Medical staff) conducted by the Appraisal Lead throughout 2016. This was conducted using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT).



Clinical Governance

The Trust is continuing to develop systems to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. Doctors are sent information specific to them in relation to claims, complaints and Serious Incidents (SI's) by the HR

Assistant (Medical Workforce) in the months leading up-to their annual appraisal. Doctors are also able to request a report (at any time) to support appraisal. Work is ongoing with the Clinical Governance team to improve the quality of information received.

6. Monitoring Performance

All Doctors being considered for revalidation must demonstrate participation in regular appraisal. However appraisal in itself is neither an objective assessment of a Doctor's performance, nor of their compliance with trust policies and procedures. The Revalidation Panel therefore also requires confirmation from each person's clinical managers that there are no concerns about performance or conduct. At present, this takes the form of a signed statement from the relevant Health Group Medical Director, based on personal knowledge and information from line managers. In any case the revalidation process (occurring as it does once every 5 years) should not be the point at which concerns first come to light.

7. Revalidation Recommendations

The Trust made 37 recommendations on revalidation to the GMC between 1st April 2016 and 31st March 2017. No recommendations were missed or delayed. The Responsible Officer has three options in making a recommendation: recommendation for revalidation, deferral, or failure to engage. It is not possible to recommend 'non-revalidation'. The Trust has not made any notifications of failure to engage. The breakdown of recommendations is shown in Table 3.

Table 3. GMC recommendations April 2016– March 2017

Recommendation		Number of Doctors
Revalidate		25
Defer	Sickness, maternity, etc	2
	Under investigation/Subject to an ongoing process	3
	Appraisal/MSF not complete	4
	Recent starter	3

In total 32.4% of recommendations this year were for deferral, which is an increase of 16.2% when compared with last year's figure of 16.2%. However, it is important to note that there were significantly less recommendations submitted this year (total of 37) when compared with last year (204). This is due to the first cycle of revalidation nearing completion.

8. Recruitment and engagement background checks

The Trust Human Resources department has in place a system for checking identity, current and previous GMC Conditions or Undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance. The Responsible Officer has now approved a 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NCAS investigations, local conditions or undertakings, and any unresolved performance concerns. At present agency locums are not subject to the same checks, and work is in progress to establish a process to check on these doctors (accepting that they are sometimes brought in at very short notice, and

should in any case have had all appropriate checks done by their own Designated Body – usually the locum agency).

9. Responding to Concerns and Remediation

Revalidation should not be the expected route for identifying concerns about an individual Doctor's conduct or capability, occurring as it does only every 5 years. Appraisal may sometimes identify areas for improvement, but again it is unlikely that serious concerns will come to light purely through appraisal, which is principally a formative and developmental process. More commonly problems will be identified either through investigation of a specific incident, or following expression of concern by staff or patients.

Where there is concern about a Doctor's performance or behaviour they are investigated under Trust policies relating to conduct, capability, or both. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NCAS. If misconduct is proved a range of disciplinary sanctions, including dismissal, is available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NCAS will be put in place.

In addition to local Trust investigations doctors may also be subject to investigation by the GMC. Sometimes this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice
- There is a good appraisal system in place, which is developmental and formative in nature
- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC)
- Uptake of appraisal in the Trust has improved significantly. Maintaining this high level of appraisal rate is reliant on the continued implementation of an electronic platform, and continuing administrative support for this is essential
- The current percentage of Doctors having appraisal in 2016/17 is 93.5% which surpasses the NHSE target of 90%. Communication from the Regional Revalidation Lead for NHSE dated 21/07/2017 found everything to be satisfactory and the Trust was thanked for providing assurance to the higher level RO and NHSE on it's processes

11. Recommendations

The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in

compliance with the regulations. This must be signed and returned to NHS England by the end of September 2017.

Appendix 1 - Annex E – Designated Body Statement of Compliance

The board of Hull and East Yorkshire Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Mr Kevin Phillips is the Trust's appropriately trained and appointed Responsible Officer for Hull and East Yorkshire Hospitals NHS Trust and Dove House Hospice

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   This record is maintained and kept up-to-date by the Trust's HR Advisor (Medical Workforce)

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   There are 73 appraisers, conducting between 6 and 10 appraisals each annually

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   There are routine appraiser network meetings, as well as formal and informal review of appraisal inputs, outputs and user experience. The Appraisal Lead has developed an e-learning module for Appraiser Training which has been in place since September 2016

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   The 2016/17 NHSE AOA Comparator Report dated 21/07/2017 shows that Hull and East Yorkshire Hospitals NHS Trust's appraisal rate is 93.5% and Dove House Hospice is 100% for 2016/17

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   The systems are in place

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

The Trust requests information on all new licensed practitioners using a standard RO Transfer Form. The Trust RO responds to similar requests for information from other organisations.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

There is a monthly Revalidation & Appraisal Committee whose responsibility is to ensure continual improvement and address any identified weaknesses or gaps in compliance. The key members of this committee are; The RO, a Health Group Medical Director (or delegate), The Lead Appraiser, LNC Chair, Head of HR Services and the HR Advisor (Medical Workforce).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Hull and East Yorkshire Hospitals NHS Trust

Name: TERRY MORAN
Role: CHAIRMAN
Date: 27/9/17

Signed:

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 – 23
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

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

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2017/16	Hull and East Yorkshire Hospitals NHS Trust and University of Hull – Lease relating to part of the MRI Centre at Hull Royal Infirmary, Anlaby Road Hull, HU3 2JZ	08.09.17	Lee Bond and Carla Ramsay

3 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Corporate Affairs Manager
October 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

LAND ACQUISITION - GLADSTONE STREET

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 – 23.1
Director	Lee Bond – Chief Financial Officer	**Author**	Jayne Tatterson – Trust Property Manager
Reason for the report	To provide information on the stopping of the public highway known as Gladstone Street in the City of Hull and the freehold Title of the land passing to Hull and East Yorkshire Hospitals NHS Trust.		

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

1	**RECOMMENDATIONS** It is recommended that approval is given for Hull and East Yorkshire Hospitals NHS Trust to stop up the Public Highway known as Gladstone Street together with the associated costs.					
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**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

LAND ACQUISITION - GLADSTONE STREET

1. PURPOSE OF THE PAPER

To provide information on the stopping of the public highway known as Gladstone Street in the City of Hull and the freehold Title of the land passing to Hull and East Yorkshire Hospitals NHS Trust.

2. INTRODUCTION

Hull and East Yorkshire Hospitals NHS Trust own the freehold of parcels of land adjoining three sides of the public highway known as Gladstone Street shaded pink on the plan attached at Appendix 1 [for indicative purposes only]

In order to give Hull and East Yorkshire Hospitals NHS Trust direct responsibility for traffic management and condition of the road, and to square off our freehold ownership the City Council was approached to ask if the highway could be 'stopped up'.

3. CURRENT POSITION

The City Council agreed to the request to stop up the highway, and to transfer ownership and maintenance of it to the Trust. In order to satisfy other interested parties with services within the highway Wayleaves need to be entered into with Yorkshire and Northern Gas allowing them undisrupted access to their services. Further Hull and East Yorkshire Hospitals NHS Trust have to purchase the existing street lighting and maintain the same whilst ever the road is within our ownership.

Hull City Council has confirmed that no change of use consent is required from a Planning perspective, as the road will remain as is only the ownership will change.

The adoption of the highway will give the Trust more control over any future redevelopment of Argyle Street car park and the current heli-pad.

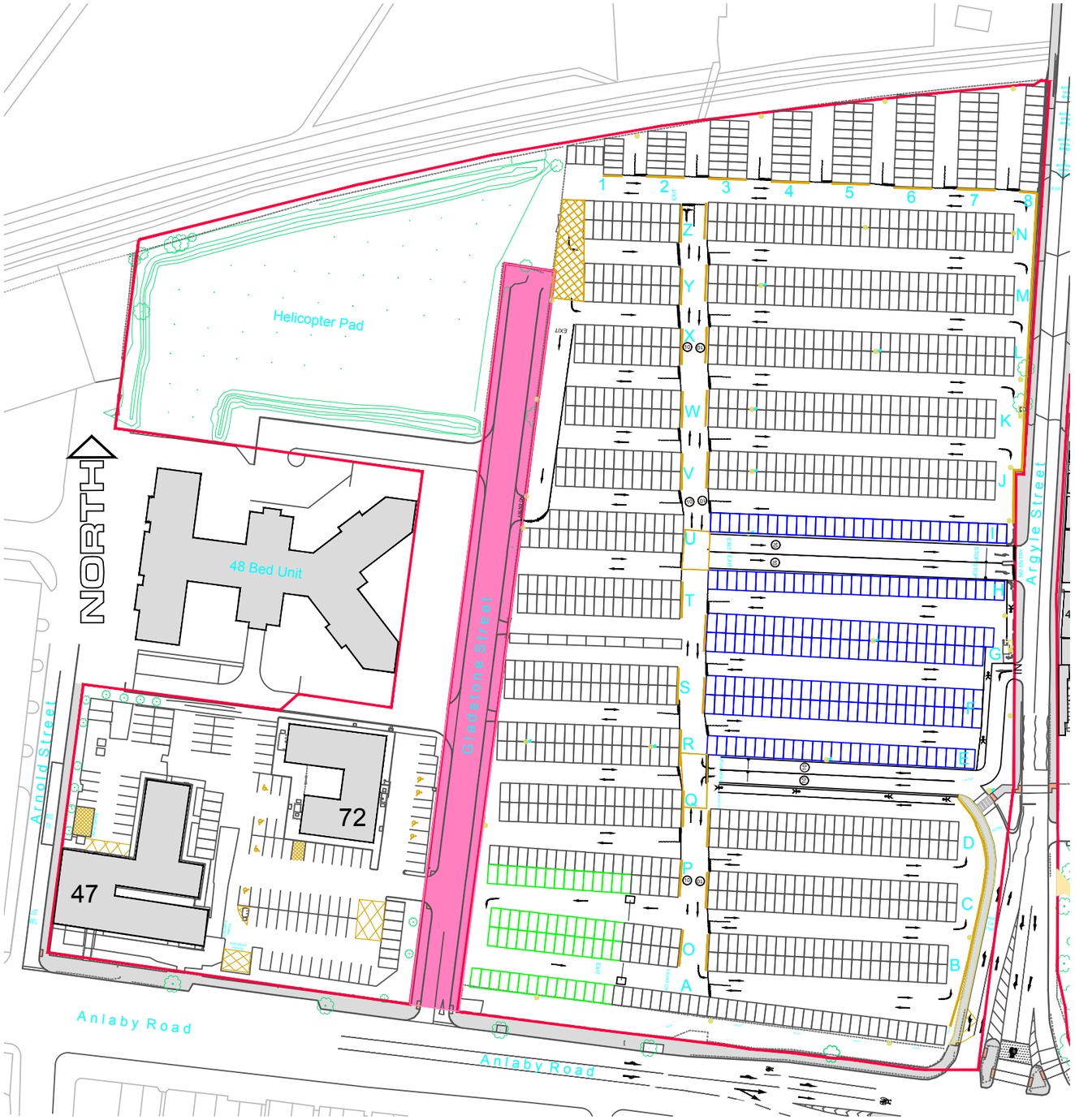
4. FINANCIAL IMPLICATIONS

Hull and East Yorkshire Hospitals NHS Trust will need to meet the Councils legal costs of £2,000 + VAT; the cost of entering into the Wayleave with Northern Gas Network of £1,280 and the purchase of the street lighting from Hull City Council £1,151.15 – source of funding to be advised.

5. RECOMMENDATIONS

It is recommended that approval is given for Hull and East Yorkshire Hospitals NHS Trust to stop up the Public Highway known as Gladstone Street together with the associated costs.

Jayne Tatterson
Trust Property Manager
September 2017



Rev	Date	Revision	By	Appd
B				
A				

Hull and East Yorkshire Hospitals

NHS Trust

Castle Hill Hospital
Castle Road
Cottingham
HU16 5JQ

www.hey.nhs.uk

Site

Hull Royal Infirmary

Building

Part Site Plan

Drawing Title

Detail of Freehold Area at Argyle Street and Gladstone Street

Status

-

Drg No.	-	Revision
Block No.	-	*

Drawn	CJ	Checked	-	Approved	-

Scale	To Fit A3	Date	25/05/17

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PROPERTY MATTERS - CASTLE HILL HOSPITAL
DEVELOPMENT OF A MOLECULER IMAGING CENTRE INCLUDING RADIOPHARMACY

Trust Board date	2nd October 2017	**Reference Number**	2017 -10 – 23.2
Director	Lee Bond – Chief Financial Officer	**Author**	David Haire – Project Director – Fundraising
Reason for the report	To seek, in accordance with Standing Orders, the formal approval of the Trust Board to the use of land on the Castle Hill Hospital site to facilitate the development of a Molecular Imaging Research Centre, including radiopharmacy by the Daisy Charity,		

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

1	**RECOMMENDATIONS** The Trust Board is recommended to:- • Approve the use of the land identified in Appendix A (shaded red) for the purposes outlined in this report • Approve entering into the various property agreements, as set out in section 6 in relation to the proposed Molecular Imaging Research Building					
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): Not applicable			
	Assurance Framework	**Raises Equalities Issues?** None	**Legal advice taken?** Yes	**Raises sustainability issues?** No
5	**BOARD/BOARD COMMITTEE REVIEW** Key stages of the planning and development of this project have been reported to and supported by the Capital Resources Allocation Committee.			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PROPERTY MATTERS – CASTLE HILL HOSPITAL
DEVELOPMENT OF A MOLECULER IMAGING CENTRE INCLUDING RADIOPHARMACY

1. PURPOSE OF PAPER

The purpose of this paper is to seek the approval of the Trust Board to the property implications of permitting the Daisy Charity to create a Molecular Imaging Research Centre, including Hospital Radiopharmacy (MIRC), on land on the Castle Hill Hospital site.

2. BACKGROUND

When the Daisy Charity proposed to the Trust in 2012 the development of the Jack Brignall PET/CT Centre it was also recognised that there would be a second phase to the development with the provision of a molecular imaging research centre. This new building was to be adjacent to the proposed PET/CT Centre and directly linked to enable the efficient movement of radioactive isotopes from the MIRC to the PET/CT Centre.

This second phase of development was planned to provide facilities to house a cyclotron and supporting facilities to enable the local development and production of a range of radioactive isotopes, which are administered to patients who are having PET/CT scans. Whilst the facility will be capable of producing the routinely used FDG isotope, currently delivered daily from Preston, the prime focus of the new cyclotron will be research focused.

This research focus will build on the work already undertaken by the University of Hull's Chemistry Department which has had use of a developmental cyclotron, previously provided by the Daisy Charity. It will also involve partnership working with the Trust and Alliance Medical Ltd, the national contract provider of PET/CT scanning services, which includes the services provided within the Jack Brignall Centre.

The focus of the research activity will be to expand the range of fluorine 18 and Carbon 11 based radiotracers available for clinical application. All of these radioactive isotopes will have a relatively short half-life and therefore need to be produced close to the PET/CT Scanner. Working with colleagues at the University, who already have expertise in microfluidics and radiochemistry, the facility will also enable the development of "dose-on-demand" technologies. This will ultimately enhance the speed with which customised radiotracers can be produced for specific clinical needs.

The charity's overall aim, with this combined development, is to capitalise on existing local strengths in clinical imaging and related scientific expertise in the field to establish an internationally renowned Molecular Imaging Research Centre. The research strategy of the centre will be overseen by a Board with senior representation from the Charity, University, and Trust and with input from a recognised expert in the field.

3. CURRENT POSITION

The planning and fundraising for this development has been ongoing for a number of years and whilst the charity still has some funds to raise it has committed to both the equipment and construction costs at an overall cost of some £7.4m.

It has ordered a state-of-the-art" GENtrace 600 small cyclotron from GE Healthcare and it is expected this will be the first site in the world to have this model installed. It is also expected that this will be designated by GE Healthcare as a "demonstration" site.

All of the detailed planning and related matters have been reported to the Trust's Capital Resource Allocation Committee and through this dialogue it has also been possible to include a replacement radiopharmacy for the Trust in the proposed building.

4. FINANCIAL AND OPERATIONAL IMPLICATIONS

Due to the nature of the activities being undertaken in the proposed centre and for operational efficiency it is planned that the day-to-day management and staffing of the centre will be undertaken by the Trust. An appropriate service level agreement will be put in place to cover both the practicalities of this arrangement and the related financial responsibilities. The performance of the facility will be overseen by a joint management team.

All of the costs associated with the operation of the MIRC are the responsibility of the Daisy charity and will be primarily funded from research and commercial income sources. The related research financial model has been jointly developed by the Daisy charity and the University.

Costs associated with the operation of the replacement hospital radiopharmacy will continue to be the Trust's responsibility and have been dealt with in a separately approved business case.

5. TIMESCALES

It is currently envisaged that the new building will take some 14 months to construct and equip and that it will be brought into use in the first quarter of 2019.

6. PROPERTY MATTERS

The siting of this new building is as shown in Appendix A attached. The red building is the existing Jack Brignall PET/CT Centre and the area highlighted in blue is the proposed Molecular Imaging Research Centre.

The Charity and the Trust have appointed Legal Advisors and finalisation of the relevant property documents is well advanced, advised by the Trust's Property Manager. The property documents that will be put in place include:

Development Lease Agreement

- Main lease agreement between the Trust and the Daisy Charity to allow the charity to develop the facility for a peppercorn rent

Lease

- Between the Daisy Charity and the Trust covering the use of the building

Underlease

- Between the Trust and the Daisy Charity to cover the rental and use of the radiopharmacy by the Trust.

All the legal documents will be signed off prior to work on the new building being commenced.

7. RECOMMENDATION

The Trust Board is recommended to:-

7.1 Approve the use of the land identified in Appendix A (shaded red) for the purposes outlined in this report

7.2 Approve entering into the various property agreements, as set out in section 6 in relation to the proposed Molecular Imaging Research Building.

Lee Bond
Chief Financial Officer
September 2017

Appendix A

mlj
morgan lloyd jones
chartered architects

THE OASIS APPEAL

PROPOSED CYCLOTRON & RADIO-PHARMACY FACILITIES
CASTLE HILL HOSPITAL
COTTINGHAM, HULL

LOCATION PLAN

161851-100-002-C1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

Meeting date	3 October 2017		**Reference Number**	2017 – 10 - 24		
Director	Carla Ramsay - Director of Corporate Affairs		**Author**	Carla Ramsay - Director of Corporate Affairs		
Reason for the report	The purpose of this report is to present the updated Board Assurance Framework (BAF) for 2017-18 from the September 2017 Committee discussions, to determine if there are any risk areas where this Committee can provide positive assurance and to give scrutiny to areas where there are gaps or a lack of assurance					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Briefing		Review	✓

1	**RECOMMENDATION** The Trust Board is asked to review the current Board Assurance Framework and: • Determine whether there is positive assurance from the Board meeting discussions to add to the BAF • Review gaps in control and assurance to determine whether an issue is being managed or whether it should be escalated for further Board scrutiny/discussion attention • Review and confirm/change the proposed Q2 risk ratings based on the assurance received by the Trust Board and its committees to date					
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 is monitored regularly for positive assurance received, as well as maintaining and oversight and requesting action on gaps on control or assurance					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

1. PURPOSE OF THIS REPORT

The purpose of this report is to present the updated Board Assurance Framework (BAF) for 2017-18 from the September 2017 Trust Board Committee discussions, to determine if there are any risk areas where this Committee can provide positive assurance and to give scrutiny to areas where there are gaps or a lack of assurance.

2. BACKGROUND

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

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

3. BOARD ASSURANCE FRAMEWORK (BAF) 2017-18

3.1 Focus on Non-Clinical Risk

The Chief Executive identified that further exploration of non-clinical risk in the organisation would be worthwhile, in relation to understating the link between these and the risk areas on the Board Assurance Framework. This is to take a view as to what extent the current corporate risks impact on the risks associated with delivering the Trust's long term objectives, per the Board Assurance Framework.

In relation to the Corporate Risk Register at Appendix B, which captures the greatest operational and organisational risks at the present time, these can be summarised as:

Corporate Clinical Risks	**Corporate Non-Clinical Risks**	**Corporate Staffing Risks**
2675 – capacity in ophthalmology 3096 – HASU capacity 2789 – intravitreal service 2665 – chronic eye disease 82817 – dietetics for paediatrics 2979 - Risk to the continuity of drug supplies	2984 – equipment in Breast screening 3109 – surgery CRES 3092 – IT infrastructure 3090 – Consent forms 3089 – open injectable systems 2888 – phone system resilience 3011 - Medicine CRES 3085 – IR35 compliance 3091 – Live Major Exercise and Resilience	3038 – junior doctor rota CSS 2982 – anaesthetic cover under 2 year olds 2916 – trained staff in blood sciences 3044 – shortage of breast pathologist 2799 – nurse vacancies in MHG 2949 – RN and ODP vacancies in SHG 2956 – Neonatal staffing
6 in total	9 in total	7 in total
Grand total: 23		

The detail of all these corporate risks is attached at Appendix B. For additional transparency and linked with operational performance, those corporate risks with a rating of 15 and above as high-rated risks (19 of these 23 risks) are captured in the balanced scorecard as part of the Chief

Executive's report, to show where the operational burden of corporate risk lies across the organisation.

At the Non Clinical Quality Committee held on 13 September 2017, a confirm and challenge was put in to the Committee to confirm if the non-clinical risks on the Corporate Risk Register represent the correct risks in the organisation at present. There was broad agreement that these represent the right areas and levels of risk, from a non-clinical perspective: the risks cover buildings infrastructure, resilience, fire safety, equipment, financial compliance and governance.

The risk burden within the organisation is quite balanced between non-clinical and clinical risk. Whilst the clinical risks are smaller in number, all of these have a risk rating of 15 or above (high), whereas 3 non-clinical risks have a moderate rather than high risk-rating. Arguably, the corporate staffing risks all present elements of clinical risk as well, tipping the balance to the clinical side of risk.

The next steps will be to ask the Clinical Quality Committee to put in the same confirm and challenge to the clinical risks on the corporate risk register as the Non Clinical Quality Committee has done. It is also asked that all risks (clinical and non-clinical) dated more than two years ago are reviewed again to ensure they remain current, or for these to be closed as old risks and a new risk for the current situation opened. Furthermore, there will be a session arranged between the two operational risk committee to do a 'read-across- of risks; to determine if the risk rating of 16 of a clinical risks represents the same level of risk as a non-clinical risks rated 16, in terms of risk to the organisation.

In respect of the Board Assurance Framework, these current non-clinical risks link with some of the areas on the BAF. Where there is a link, this is noted in the specific column in the Board Assurance Framework, and this provides a view as to where the burden of risk lies to the long-term achievement of the organisation's objectives – these particularly lie in the BAF areas of staffing and finance (including infrastructure). The Trust Board receives a quarterly update on the Cultural Transformation Programme and will be receiving the Estates Strategy (including backlog maintenance), the IM&T strategy and the annual Emergency Preparedness statement over the next two months to provide opportunities to discuss and receive assurance as to how these risks can be mitigated in the long term. Risk appetite will be a topic at the October 2017 Board Development session, and financial planning for 2018/19 will be subject to scrutiny at the Performance and Finance Committee from Q3 onwards, and will be subject of a Board Development session prior to Christmas.

3.2 Assurance

From the April – September 2017 Trust Board meetings and Board Committee meetings, there are some areas of positive assurance that have been received. A quarter 2 risk rating for each BAF area is proposed. These are included in the BAF appended to this paper, for the Trust Board's review.

The Performance and Finance Committee and the Quality Committee provided further input in to assurance and risks in the BAF at their September 2017 meetings as follows:

- Positive assurance provided by the gap analysis against new national requirements on mortality reviews, and an understanding of the work still in progress towards compliance by the May 2018 deadline
- Reference to CQC well-led pilot draft report – positive assurance as well as some further assurance required
- Deloitte exit plan – further assurance required
- Infrastructure risks (fire safety) – further assurance required
- Potential need to access loans for cash flow – further assurance required

The Performance and Finance Committee also received positive assurance received on the continued delivery of the People Strategy from the first quarterly update from the Workforce

Transformation Committee, which also confirmed the BAF risk area on retention of staff and managing agency costs. The Committee also commented on the risk associated with any failure to gain full benefits from e-rostering and electronic job planning and to have a forward view on workforce risks in future quarterly papers.

These points have also been incorporated in the updated BAF at Appendix A.

3.3 Corporate Risk Register – September 2017

The BAF has been populated with corporate risks and updated in line with the Corporate Risk Register, for the flow of corporate risks up to the BAF as part of the agreed 'ward to board' risk escalation process

The Executive Management Committee reviewed the Corporate Risk Register in September 2017 and reviewed a recommendation from the Non Clinical Quality Committee to add a new corporate risk in relation from the Medicine Health Group, which is a new risk on the potential non-achievement of CRES in 2017/18.

The current Corporate Risk Register is retained as a source of information for the current BAF at Appendix B, explored in more detail in section 3.1, above.

3.4 Further Risk Management Developments linked with the Trust Board

A session on Risk Appetite is being developed, for the Trust Board to determine what level of risk the organisation is prepared to manage with, or tolerate, in each part of the Trust's business. This will start a refreshed process of Board to Ward risk management, with the Board defining what level of risk the organisation is prepared to manage, and cascade that within the organisation to manage to this level.

4. RECOMMENDATIONS

The Trust Board is asked to review the current Board Assurance Framework and:

- Determine whether there is positive assurance from the Board meeting discussions to add to the BAF
- Review gaps in control and assurance to determine whether an issue is being managed or whether it should be escalated for further Board scrutiny/discussion attention
- Review and confirm/change the proposed Q2 risk ratings based on the assurance received by the Trust Board and its committees to date

Carla Ramsay
Director of Corporate Affairs

September 2017

APPENDIX A

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

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey The staff engagement score is used as a proxy measure to understand whether staff culture on honest, caring and accountable services continues to improve *What could prevent the Trust from achieving this goal?* Failure to develop and deliver an effective staff survey action plan would risk achievement of this goal Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement	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 positive enforcement of behaviours and organisational culture Leadership Development Programme commenced April 2017 to develop managers to become leaders able to	Clarity as to full set of accountabilities, deliverables and acceptable standards given the progress made in the last two years is still required and an understanding of cascade/ communication and acceptance of the same; this needs to be at Health Group leads and cascaded down, as well as support service leads	**12**	**12**			**4 x 1 = 4**	**Positive assurance** Receipt of detailed staff survey report and action plan – analysis of where work is needed to make further impact on staff engagement; positive messages from most recent results; best results for the Trust in a long time for the number of questions in the top 20 percent of Trusts Approach agreed in April 2017 regarding the Freedom to Speak Up Guardian role, and how this will feed back issues on staff culture and behaviour to the Trust Board Verbal update May 2017 that Barratt (cultural work) had told the Trust that the pace of cultural improvements made were twice that as would normally be seen in a two-year timeframe 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 **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

		Risk of adverse national media coverage that impacts on patient, staff and stakeholder confidence			engage, develop and inspire staff Integrated approach to Quality Improvement						

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

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

			staffing Corporate Risk: The Trust may not be fully compliant with IR35		choice during and following completion of training						Assurance on implementation of e-rostering and electronic job plans from a benefits realisation/service capacity optimisation point of view

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 and stakeholder engagement, detailed in a strategy	Corporate risk: management of consent policy and patient records Corporate risk: Restricted use of open systems for injectable medication	**4 (impact)** **3 (likelihood)** **= 12**	Quality Improvement Plan (QIP) being updated in light of latest CQC report QIP being reviewed ton ensure actions are correct and include sufficient stretch to reach good and outstanding Trust taking part in CQC well-lead pilot – will give an opportunity for the Trust to test out part of new inspection methodology and also have further insight in to part of what 'good' and 'outstanding' look like	Needs organisational engagement – CQC commented that Trust has the right systems and processes in place but does not consistently comply or record compliance Need to build in feedback from CQC around greater involvement of patients in pathway review/development Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1) New CQC regime being introduced – impact of this and how quickly the Trust will be able to move up the ratings is unknown at present	**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 **<u>Further assurance required</u>** Some QIP areas have a greater impact on organisational development and are the ones needing more progress such as Lessons Learned QIP

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: ophthalmology service issues x 2 F&WHG: breast screening equipment and breast pathology issues MHG: Hyper Acute Stroke Unit capacity	**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**			4 x 2 = 8	**Positive assurance** 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 **Further assurance required** Effectiveness of accountability framework and improved consistency of delivery Role of external agencies in supporting ED in particular (links to BAF6) – these may change during 17-18 as new service developments come on line external to the Trust and as the STP and placed-based plans look at service configurations Sufficient diagnostic capacity available now to meet demand and to receive onward investment to meet future demand alongside equipment replacement requirements and staffing issues, as well as manage in-year impact of diagnostic capacity on cancer pathways and waiting times; to understand any risks relating to patient care or patient hard

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

GOAL 5 – GREAT SPECIALIST SERVICES

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

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: that the Trust's relationship with the STP does not deliver the changes needed to the local health economy to support high-quality local services delivered efficiently and in partnership; that the STP and the Trust cannot articulate the outcomes required from secondary and tertiary care in the STP footprint and a lack of clarity on the Trust's role What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	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**			4 x 2 = 8	**Positive assurance** **Further assurance required** STP NED event held – start of engagement process but few tangible outcomes at present Issue of clarity of strategy between STP, STP workstreams and place-based plans and Trust positioning within these

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2017-18 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	SHG risk: risk to delivering sufficient CRES SHG risk: risk to income from critical care CQUIN, which continues in 17-18 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 Strengthen governance around CRES planning and delivery, including a new escalation process up to the Trust Board Committee level (linked with BAF1) HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meeitngs FIP2 diagnostic to understand Trust-wide potential for additional savings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities – may link to FIP2 diagnostic New governance structure with local system partners to try	Embedding CRES delivery and financial management requirements in Health Groups, rather than await escalation of issues Assurance from local health economy on demand management Assurance over grip and control of cost base	**20**	**20**			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 **<u>Further assurance required</u>** August 17 - gap in CRES identification in 17-18 August 17 - gaps in CRES delivery to date Introduction of service line reporting planned during 17-18 – assurance would be to see positive impact of SLR on understanding and reducing cost base Exit plan and continued pace on CRES following FIP2 team departure

					to manage demand						

GOAL7 – FINANCIAL SUSTAINABILITY

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

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		**20**	**20**			4 x 1 = 4	**Positive assurance** **Further assurance required** Need to sell land and/or explore issue with the Department of Health as to how the Trust can inject cash Two local CCGs no longer able to pay Trust across tenths in 2017-18 – need to update cashflow projections Anticipate the need for relief funding in 17-18 to meet payment obligations

APPENDIX B – CORPORATE RISK REGISTER (AS PRESENTED TO EXECUTIVE MANAGEMENT COMMITTEE ON 19 SEPTEMBER 2017)

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2675	Clinical Support - Health Group	Patients may experience delays in treatment due to insufficient capacity to accommodate the increase in demand	22/01/2014	Condition - Demand continues to increase (to greater than current capacity / faster than capacity growth) Cause - Increasing numbers of referrals to all speciality areas within Radiology (highest demand growth is in MRI) Consequence - Waiting times increased, breaches experienced, additional sessions & expenditure incurred	Waiting lists / times monitored (Capacity & demand) & managed on a day by day basis Additional capacity requirements identified and created (additional scanning sessions arranged, temporary extension of working hours, additional reporting sessions, reporting outsourcing, alternative providers utilised)	Goal 2 - Valued, skilled and sufficient workforce, Goal 4 - Great local services, Goal 7 - Financial sustainability	20
2984	Family and Women's Health - Health Group	Equipment Issues Within Breast Screening Service	08/09/2016	The risk is that the equipment is unreliable and breakdowns causing excessive down time and has resulted in 1500 ladies needing to be rebooked. This, if left, will directly impact on the 36 month round length, causing breaches.	Maintenance contracts, staff awareness, extra clinics being booked.	Goal 4 - Great local services	16
3011	Medicine - Health Group	Failure to deliver the CRES programme for 2017/18	16/04/2017	1. Regular individual financial performance meetings at budget holder level 2. Performance reviews at Divisional and Health Group level 3. Dedicated focus at Health Group Business meeting 4. Finance committee and Transformation committee focuses on CRES delivery 5. Productivity and Efficiency Board meetings at Trust level	1. Regular individual financial performance meetings at budget holder level 2. Performance reviews at Divisional and Health Group level 3. Dedicated focus at Health Group Business meeting 4. Finance committee and Transformation committee focuses on CRES delivery 5. Productivity and Efficiency Board meetings at Trust level		16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3096	Medicine - Health Group	HASU capacity no longer meets needs of the service	08/05/2017	The risk identified during the Stroke Peer Review was that an increase in HASU capacity of up to 12 beds was recommended to safeguard current and future demand. The cause of this is that the HASU currently operates with 4 beds, the Peer Review recommends that there should be between 8 and 12 HASU beds to meet current and future demand. The consequence of not increasing HASU capacity is that patients are moved out of HASU onto the Stroke ward before the HASU phase of care is completed, leading to patient's care and recovery being potentially delayed.	Patients are reviewed by a consultant in order to prioritise them for use of available HASU beds.		16
3109	Surgery - Health Group	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2017-18.	15/06/2017	Inability to deliver required level of cash releasing efficiency savings and achieve financial balance in 2017-18. Failure to deliver key financial targets could result in withdrawal of non-recurrent support funding. Delays in authorising expenditure due to additional controls presents clinical risk. The 2017/18 CRES value is £4,232k.	Devolved CRES targets/accountability. Challenge through monthly divisional performance meetings. Created CRES efficiency matrix tool to enable divisions to focus on key areas of opportunity. Introduction of regular operational and efficiency meetings. Commencing specialty level reviews and benchmarking process. Re-aligning financial/business support in the Health Group to support delivery.	Goal 7 - Financial sustainability	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3038	Clinical Support - Health Group	Inability to fill junior doctors rota in the oncology wards at Queen's Centre, CHH	11/01/2017	Condition: Inability to fill the junior doctor rota; this is especially in haematology service. Cause: There is a national shortage of junior doctors to recruit into the posts Consequence: Inability to safely cover the rotas within the Queen's Centre ward base. This will impact on patient care.	1. Attempting to cover via specialty doctors and / or locums	Goal 2 - Valued, skilled and sufficient workforce	16
2982	Family and Women's Health - Health Group	Lack of Anaesthetic cover for Under 2's out of hours	19/08/2016	The risk is delay in treating a child for their surgery. The consequence is children and neonates may have to be transferred to another hospital for treatment. The cause is the lack of paediatric anaesthetist emergency cover for children under the age of 2. (This is due to vacancy and sickness)	Children are managed conservatively until it is safe to operate and transfer to an alternative hospital will be arranged.	Goal 4 - Great local services	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2789	Family and Women's Health - Health Group	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	16/12/2014	Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. This capacity risk has increased recently as a result of the time to treatment for patients requiring injections increasing to 10 weeks, rather than the recommended 48 hours. Additional causes to this risk are: 1. The significant expansion in the numbers of retinal diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely affect their vision.	On a weekly basis the service meet to discuss capacity and plans are made to create additional capacity where needed. The service are currently trying to recruite to a number of medical staffing posts. The posts are currently out to advert. A nurse practitioner was recently appointed to provide support to the nurse injection service. Injection service has begun at CHH (November 2015).	Goal 4 - Great local services	16
2665	Family and Women's Health - Health Group	Patients treatment may be delayed resulting in potential loss of eyesight due to lack of capacity (chronic eye disease service)	20/11/2013	The risk is Ophthalmology is currently experiencing a significant delay in meeting outpatient appointments, particulary in relation to the management of chronic disease pathways including glaucoma and medical retina disease. The cause is insufficient capacity. The consequence is patients are not been reviewed in a timely fashion which may have adverse implications for their vision.	Review the position on a weekly basis with the consultant team and re-deploy capacity were possible. Urgent self referrals/GP referrals seen as a priority. Newly introduced glaucoma virtual reivew sessions.	Goal 4 - Great local services	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2916	Clinical Support - Health Group	Reduction in trained staff in the Blood Transfusion Laboratories (Compliance Risk).	10/12/2015	There have been a number of vacancies in the Blood Transfusion Laboratories which are being currently addressed. Though this is required to maintain future service delivery there is the short to medium term problem that the one to one training which is required to meet compliance with the Blood Safety and Quality Regulations means that both trainee and trainer are not available for service delivery. This is having a knock on effect on the maintenance of the quality system as more senior staff resources are being diverted to service delivery and training.	1. Service delivery is being maintained by distribution of trained senior staff into key areas. The situation is improving as staff training continues and new staff become competent at more tasks.	Goal 2 - Valued, skilled and sufficient workforce	16
3092	Corporate Functions	Resilience of Critical Infrastructure	25/04/2017	The resilience of critical IT infrastructure is being routinely affected, particularly by mandatory generator testing.	IM&T and Estates functions are working together to minimise the future impact of these operations and to consider systems resilience in general Audit being undertaken on critical systems and systems checks following power changes	Goal 7 - Financial sustainability	16

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3044	Family and Women's Health - Health Group	Shortage of Breast Pathologist	18/01/2017	The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also. There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.	Negotiations are to be had with Nottingham to outsource some of the Pathology work. Trust grade doctors to support solitary Consultant Pathology to explore recruiting more Advanced Practitioners Pathology to explore recruiting more Consultants	Goal 4 - Great local services	16
2817	Family and Women's Health - Health Group	Inability to access dietetic reviews for Paediatric patients	01/04/2015	Condition - Lack of dietetic input to children as both inpatients and within MDTs cause - Substantive dietetic team reduced by 2/3 due to Maternity leave consequence - children do not receive a timely dietetic review	Service working with dietetic lead to look at robust future arrangements F&WHG paying for locum dieticians as available Dietetic team prioritising work		15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3090	Corporate Functions	Lack of governance around consent forms	13/04/2017	There is a risk that the consent processes within the Trust are not managed through a central governance system. The lack of one process to manage consent processes means that consent forms are inconsistent in terms of format, content and update. The cause is the lack of a central process. The consequence may be that forms are not updated appropriately, miss key content and do have version control.	Consent forms are currently managed within Health Groups and clinical teams. The Clinical Effectiveness, Policies and Practice Development committee is the Trust committee for the management of consent forms. A Task and Finish Group has been set up to put in place a central governance system for the management of forms, to co-ordinate the collation of all forms in use and to pursue a long term goal of management of consent through Lorenzo.	Goal 3 - High quality care	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2799	Medicine - Health Group	Patient care/experience may be compromised due to the inability to recruit and retain sufficient nursing staff across the MHG	31/12/2014	Increasing vacancies within the funded MHCG nursing establishments and the opening of the Winter Ward in December 2016. The cause of the risk is the inability to recruit due to a shortage of suitably qualified registered nurses. An increase in the supervision required for the newly recrutied overseas nurses. Registered nurses leaving the trust has been higher than anticipated increasing the pressure on the current establishment. The consequence is that there is an increased risk of the ability of the nursing workforce capacity to deliver timely, holistic safe care	1. Twice daily safety briefing chaired by senior nurse to address any short notice concerns re: safety and staffing 2. Senior Matron to sign off all off duty to ensure efficient use of available resources 3. Regular discussions with nurse bank/agency Senior Nurse to improve fill rates 4. International recruitment is being promoted/pursued 5. Maternity leave is now being managed through vacancy control 6. Clinical nurse specialists and teacher trainers are working clinical shifts 7. Recruitment / communications with universities to promote appointments of student hurses into HEY posts. 8. Skill mix review to attract and retain staff in areas difficult to recruit to. 9. Teacher trainers working planned clinical shifts 10. Ward Manager management shifts worked as clinical shifts when required to maintain safe staffing levels. 11.Pool RNs allocated to the Winter Ward. Additional B2s appointed to support basic care standards and also to staff Winter Ward.	Goal 2 - Valued, skilled and sufficient workforce	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2949	Surgery - Health Group	Registered Nurse and ODP vacancies	11/04/2016	Condition: Surgery Health Group has significant registered nurse and ODP vacancies across wards, theatres and critical care. Cause: Difficulties in recruitment, limited availability of bank and agency staff. University course now completed annually and ODP course now 3 year duration. 6 New Registrant ODP appointed from Oct 17 cohort. Current Registered Vacancies: 92.7 WTE. 24 ODP [HRI 18] CHH 4] New Agency Restrictions: 1st April 2017 may reduce the availability of Agency Staff under new contract. Consequence: This has an impact on the level of care that can be provided to deliver safe patient care. Reduced bed capacity (closed beds)limited ability to provide theatre access for elective surgery.	1) Twice daily safety brief 2) Block booking of agency staff. 3) Current staff working overtime. 4) Band 7s, Matron and Divisional Nurse Manager all working clinical shifts to support. 5) ODP apprentice programme is under development 6) Reduction in elective bed base to support acute bed base 7) Focused nurse / ODP recruitment, European recruitment 8) 20 nurses from the Philippines commencing May 2017 9) Associate nurse role out registered and NMC phase 2 rollout will assist with theatres and critical care. 10) Secondment of theatre staff onto the ODP course [x3 applied] 11) Option to recruit to RN and support with anaesthetic nurse module 13.04.17 First recruits, with PIN numbers, will arrive May 2017.	Goal 2 - Valued, skilled and sufficient workforce	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3089	Corporate Functions	Risk of incidents occurring from the use of open systems for injectable medication	13/04/2017	PSA 2016/008 was published September 2016. The risk is that the Trust has identified within Operational Quality Committee that it is not fully compliant with the alert as some areas still use open systems. The cause is that it is accepted working practice within the organisation to use open systems, and in some areas safe alternative systems cannot be adopted due to restrictions in available equipment. The consequence is that the trust may be at risk of incidents relating to this alert happening, as well as being non-compliant with this alert be the deadline of 7 June 2017.	Pharmacy Department and Health Groups have been working together on audits to establish what areas are using open systems, and to offer alternative working practices where available. A working group has been set up, first meeting was held in April 2017, to respond to this alert. The alert has been disseminated widely so people are aware of the risk. Gina's Story has been shown in learning events and is on the Trust intranet site.	Goal 3 - High quality care	15
2956	Family and Women's Health - Health Group	Shortfall in Neonatal staffing	29/04/2016	Condition - acute staffing shortfall and increased proportion of inexperienced staff over the summer period of 2016 Cause - Combination of retirement of experienced staff, maternity leave and the national shortage of suitably qualified nurses Consequence - potential inability to staff the full 26 cots on the neonatal unit leading to increase in in-utero transfers	The children's service have looked to mitigate by: - a) Rolling recruitment program b) Secondment of nurses from paediatric wards to NICU over summer period c) Suspension of all non-essential training d) ANPs, Neonatal Outreach and other staff undertaking additional shifts.	Goal 2 - Valued, skilled and sufficient workforce	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2888	Corporate Functions	There is a risk that the Trust phone system cannot be repaired resulting in a loss of communications and fire & CPR alerts	05/08/2015	Condition: Potential total loss of telephone system Cause: The Trust has an old telephone system which has been progressively upgraded over the years, but which is fundamentally based on traditional analogue technology. All such systems will no longer be supported by suppliers from April 2017. Moreover, spare parts are increasingly difficult to source. The Trust has embarked on a re-procurement of the telephone system alongside the data network replacement. This will see the transition to a fully digital data and voice service in due course. Work has commenced to replace the telecommunications network. Consequences: There is a risk that, if there was a total failure of major component in the telephone system, the phone service would be disrupted for a long time. This would potentially affect both internal and externally facing services. There is a risk that, if there was a total failure of major component post April 2017 there will be no technical support available and/or no spare parts. A catastrophic event of this nature would carry a serious risk of a total and permanent failure of telephone service across HEY.	Internet Protocol Telephony (IPT) systems will be upgraded as a priority. A single IPT telephone will be deployed to all key departments in order to improve resilience. The Trust fall back telephone system (red phones) is available in key locations. Exploring means of obtaining parts for the old system.	Goal 7 - Financial sustainability	15

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
2979	Clinical Support - Health Group	Risk to the continuity of drug supplies	24/08/2016	There is a risk that pharmacy will be unable to continue supply some medicines to patients. This is due to some manufacturers not fulfilling our orders due to non payment of invoices. The consequence is we may run out of certain medicines causing concerns for our patients' safety and their effective treatment	We are currently negociating with manufacturers to try and resolve the issues. We are trying to obtain supplies from alternative manufacturers.	Goal 7 - Financial sustainability	12

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3085	Corporate Functions	The Trust may not be fully compliant with IR35	05/04/2017	IR have strengthened the IR35 legislation and NHSI have implemented new policy from 6th April, 2017 which states NHS organisations must not use PSC arrangements either directly or indirectly through agencies. HEY is assessing each PSC arrangement and will be ending the majority of these assignments with immediate effect. However some PSC arrangements will continue as the IR self assessment tool confirms the arrangement is outside IR35. Having passed this test, the IR may still be of the view that some of our PSC arrangements are not IR35 compliant and therefore the IR may fine the Trust, seek the Trust to pay any outstanding tax and NI for the person(s). There is also a reputational risk. In respect of 2 medical Consultants in Acute Medicine, they have passed the IR35 test and we must continue with then for patient safety reasons, so we are continuing with their PSC arrangements, although its not through an agency, its directly with us, so reducing our spend on agency. Both Consultants have signed a declaration as well committing to paying any additional tax and NI should the IR deem the arrangement is an employee / employer one.	HR are undertaking an audit to identify all PSC arrangements and will be making an assessment whether to continue with services on an individual basis. Clear instructions have been issued re-enforcing the new IR35 rules, that in exceptional circumstances would IR35 exemptions be accepted.	Goal 2 - Valued, skilled and sufficient workforce	12

ID	HG	Title	Opened	Description	Controls in place	Strategic Goals	Rating (current)
3091	Corporate Functions	Live Major Incident Exercise - Resilience	13/04/2017	The NHS England Emergency Preparedness, Resilience and Response Framework (2015) states NHS funded organisations are required to have a "Live play exercise" every three years. This requirement is contained within the NHS Contract / Core Standards, Civil Contingencies Act and the NHS Act. Whilst HEY NHST has undertaken Table Top exercises during 2016 (June, September and October) and participated in other Live exercises (Leeds Teaching Hospitals, July 2016 and Humberside Airport, December 2016), a Trust focused exercise last took place in 2007. This was highlighted to NHS E during the 2016/17 Core Standards annual assurance exercise.	In terms of action; a multi-agency Live Exercise is now planned for 24 June 2017. A Project Group has been established which includes key Trust staff plus all emergency service partners and is co-ordinating the planning of the exercise. The exercise will test the Trusts response to a major contamination exercise and will involve 60 casualty volunteers.		9

CCSHG – Cancer and Clinical Support Health Group
FWHG – Family and Women's Health Group
MHG – Medicine Health Group
SHG – Surgery Health Group

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	05 September 2017	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- Charitable Funds investment update
- Investment funds proposal
- Received the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)
- Financial report was presented for Quarter 1, 2017/18
- Fund balances and spending plans review

Decisions made by the Committee:

- Formally approved the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)
- Agreed a funding request for visual aid cards for stroke patients
- Approved the release of charitable funds for Christmas expenditure on the hospital wards for Christmas 2017 and 2018

Key Information Points to the Board:

- The approval of the Annual Accounts for 2016/17
- The approval for the commencement of a merger programme for health group charitable funds into fewer accounts

Matters escalated to the Board for action:

Nothing to escalate, key issues discussed captured above

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHARITABLE FUNDS COMMITTEE
HELD ON TUESDAY 5 SEPTEMBER 2017
THE MRI SEMINAR ROOM, HULL ROYAL INFIRMARY

PRESENT: Mr A Snowden (Chair), Vice Chair, Non Executive Director
Mr L Bond, Chief Financial Officer
Mrs V Walker, Non Executive Director

IN ATTENDANCE: Mrs D Roberts, Deputy Director of Finance
Ms C Ramsay, Director of Corporate Affairs
Mr D Herdsman, Client Senior Manager (Brown Shipley)
Mrs L Roberts, Corporate Affairs Administrator (Minutes)

1 APOLOGIES FOR ABSENCE

Apologies were received from Mr D Haire, Project Director, Fundraising.

Mr Snowden advised the Committee that the agenda would be taken out of order.

2 DECLARATIONS OF INTEREST

There were no declarations of interest made.

7 INVESTMENT UPDATE

Mr Herdsman, Brown Shipley tabled and presented an overview summary report showing the status of the charitable fund portfolios since the last update at the September 2016 meeting.

Since the last update the Brexit vote had occurred, Donald Trump was elected as President of the United States of America, Theresa May triggered Article 50 and the European elections had taken place. These factors all had a varying effect on the stock market; however the market remained strong and continued to rise.

The value of the portfolio as at 31 August 2017 was £1.161m which had increased since the last valuation on 31 August 2016 when the value was £1.054m.

The Committee was informed of the current asset allocation which included 32.1% UK Equity, 31.1% International Equity, 14.6% Fixed Interest, 15.9% Alternative Investments, 1.95% in property and 4.3% in cash.

Mr Herdsman advised that no more than 15% of the portfolio value was invested in structured products at any one time and that investments could be withdrawn or sold if requested by the Committee.

There was a discussion around the stock market's past performance and future predictions. Concerns were expressed regarding the affect the European elections would have on the stock market. Spain and Greece were showing signs of recovery with the only concerns being around the Italian elections, which would be held by the spring of 2018.

The Charitable Funds portfolio was performing higher than the ARC Charity Balanced, which shows an average return through benchmark comparison.

Resolved
The Committee received the summary and accepted the contents.

Mr Herdsman left the meeting after this item.

12 INVESTMENT FUNDS PROPOSAL

The paper was presented by Mr Bond who advised the Committee that the charity owed the NHS Trust £0.362m; this had been incurred through spending plans which had exceeded the available income. A further £0.647m would be required for the budgeted expenditure in 2017/18. The current levels of cash reserves would not meet both of these outgoings by circa £0.5m.

The Committee were informed of the various options available relating to the Trust's charity investments. The options were discussed in detail and Mrs Walker expressed concerns regarding selecting the appropriate choice for the charitable funds.

The preferred choice was option 4. This option would entail Brown Shipley selling the portfolio content to realise previously unrealised gains. This would generate cash which would be used to settle outstanding commitments. The remaining funds would be deposited into COIF investments with CCLA.

It was agreed that Mr Bond and Mrs Roberts would meet with CCLA regarding the charity investment fund. Subject to the outcome of the meeting it was agreed by the Committee that Option 4 would be the most appropriate course of action for the investments.

Resolved
The Committee:

- received the report and accepted the contents
- agreed Mr Bond and Mrs Roberts would meet with the CCLA regarding the charity investment fund and make the appropriate decision for the investment **(LB / CR)**

Mr Bond left the meeting after this item.

4.1 MEMORIALS POLICY (MATTERS ARISING)

Ms Ramsay advised the Committee that the outdated memorials policy had been discussed at an Executive meeting. It was decided at the Executive meeting that individual situations would be discussed at and decisions made by the Trust Board. Final decisions should lay with the Trust Board with the outcomes being reported back to the Charitable Funds Committee.

It was agreed by the Committee that conversations with the relevant benefactor should take place prior to donations being made to the Trust.

Resolved
The Committee agreed that final decisions on memorials would remain with the Trust Board with the outcomes communicated to the Charitable Funds Committee.

Ms Ramsay left the meeting after this item.

3 MINUTES OF THE MEETING 31 MAY 2017

There were two amendments to the minutes of the meeting held on 31 May 2017:

- Item 4, Matters Arising – the Charitable Fund Policies would be reviewed at the November 2017 meeting

- Item 10, Legacy Update – the sentence should read “Mrs Walker asked if these could be held centrally and managed on behalf of the Health Groups for funds over £10k”

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

4 MATTERS ARISING

Matters arising from the minutes of the meeting held on 31 May 2017 were:

Project Directors Report

- the Committee asked for clarification of Mr Bond’s concern regarding the Gait Trainer
- Mrs Roberts advised that the VAT in relation to the Midwifery Led (Self Care) Unit would be recoverable as it was a PFI project

Legacy Update

- Confirmation was given that Health Group legacies over £10k could be held centrally and managed on behalf of the Health Groups

There were no other matters arising.

Resolved:

The Committee agreed to receive clarification of the concern regarding the Gait Trainer. **(LB)**

5 ACTION TRACKER

May 2017 – Matters Arising agenda item

It was agreed that the Charitable Funds Policies would be deferred until the November 2017 meeting.

6 WORKPLAN 2017/18

The Committee reviewed the workplan and as already discussed at this meeting it was agreed that the Charitable Funds Policies (May 2017 – Matters Arising agenda item) would be deferred until the November 2017 meeting.

8 PROJECT DIRECTOR’S REPORT

The Committee received the paper and discussed the projects detailed within the report.

Creating a Dementia Friendly Environment – Wards 8 and 80

The Committee asked that Mr Haire clarify the dates/timescales for the next phase of works for Creating a Dementia Friendly Environment.

Da Vinci Robotic Surgical System

Mr Haire to confirm the date for the post implementation review process of the Da Vinci Robotic Surgical System for the period ending March 2017.

Paediatric Fundraising Group

The Committee requested clarification of the information contained within paragraph one in the Paediatric Fundraising Group section of the report.

Midwifery Led (Self Care) Unit

It was agreed that Mrs L Roberts would arrange a visit to the Midwifery Led (Self Care) Unit for those committee members who had expressed an interest.

Health Group Charitable Funds
Mr Haire is continuing to liaise with the health groups in relation to the efficient management of charitable funds.

Gait Trainer
The committee asked for confirmation of timescales for the gait trainer business case.

A Garden of Positivity
There was a discussion around general fundraising for the Trust.

Mrs Roberts advised that issues can occur when fundraising to buy specific equipment and the target amounts are not met. In this situation the money should be legally given back to the donator unless it had been agreed that the money can be donated to another specified cause. Mrs Roberts agreed to prepare fundraising guidance.

The Committee were supportive of the garden of positively project and would advise the staff concerned to seek fundraising and legal advice prior to commencement.

Resolved
The Committee agreed:

- to receive timescales for the next phase on creating a Dementia Friendly Environment **(DH)**
- the date for the post implantation review process of the Da Vinci Robotic Surgical System **(DH)**
- to receive clarification of the information contained within paragraph one in the Paediatric Fundraising Group item **(DH)**
- a visit to Midwifery Led Unit to be arranged **(LR)**
- timescales for the gait trainer business case to be received **(DH)**
- fundraising guidance to be prepared **(DR)**
- supported the garden of positively project

11 YEAR-END ACCOUNTS AND ANNUAL GOVERNANCE REPORT
The external auditors, KMPG had completed their audit of Charitable Funds and issued the Annual Governance Report (ISA 260).

Mrs Roberts presented the Year-end Accounts, Annual Report and Annual Governance Report (ISA 260) to the Committee for formal approval.

The Committee were advised that after KMPG had completed their audit an amendment had been made to the table for the Statement of Financial Activities for the year ended 31 March 2017 (page 8) of the Annual Accounts. Due to this revision KMPG carried out further audit work resulting in additional costs of circa £2.5k being incurred.

Mr Snowden expressed concern at the increase in fees. It was agreed that Mrs Roberts would liaise with KPMG regarding the concerns on behalf of the Committee.

There were three minor spelling/numerical errors in the accounts which Mrs Roberts agreed to amend prior to KPMG formally completing and sign off the Annual Accounts.

Resolved
The Committee:

- received the Annual Accounts, Annual Report, Letter of Representation and Annual Governance Report (ISA 260)
- formally approved the Annual Report and Accounts
- concerns regarding the increased fees to be discussed with KPMG **(DR)**

10 FINANCIAL REPORT – QUARTER 1, 2017/18

The Financial Report was presented to the Committee by Mrs Roberts. The Committee was advised of the financial position of the charitable funds as at 30 June 2017.

For Quarter 1, 2017/18 a total of £106k in incoming resources was received, total expenditure was £168k and the investment portfolio and cash reserves were valued at £1.8m.

Resolved
The Committee received the report and accepted the contents

7 FUND BALANCES AND SPENDING PLANS REVIEW

Mrs Roberts presented the Fund Balances and Spending Plans Review paper and advised that as at 30 June 2017 the charity had circa £1.5m available for spending. It was noted that there were currently 17 funds with a balance in excess of £20k.

At the last Committee meeting it was noted that two funds appeared to be overdrawn. Mrs Roberts clarified that the funds were now within balance and that the monies from the funds committed to projects no longer required had since been released.

Mr Haire continues to work with the health groups to reduce the number of separate charitable funds, which are currently at over 230. The Committee reviewed the proposal of fund mergers for the Clinical Support Health Group and the Family and Women's Health Group. It was agreed that the amalgamations seemed feasible; however the decision would remain with Mr Haire and Mrs Roberts.

Mrs Roberts agreed to list charitable funds balances by health group rather than by fund number on future tables to the Committee.

A request for funding was received from the Speech Therapy Service to replace the visual aid cards used to assist patient recovery following a stroke. The Committee approved the request and encouraged the service to put copyright procedures into place.

Resolved
The Committee:

- agreed the final decision on the fund mergers should remain with Mr Haire and Mrs Roberts **(DR/ DH)**
- agreed the funding request for the visual aid cards for stroke patients

13 CHAIRS SUMMARY OF THE MEETING

Mr Snowden advised that he would inform the Trust Board of the following items approved at this Committee meeting:

- The approval of the annual accounts for 2016/17

- Approved a programme for health group charitable funds to be merged into fewer accounts

14 ANY OTHER BUSINESS

Christmas expenditure

Mrs Roberts sought Committee approval for the release of the appropriate charitable funds for Christmas expenditure upon the hospital wards. This would be for the use of decorations, buffet type food and presents for the patients. The Committee were advised that the expenditure allocated for Christmas in 2016 was £19k. Of this allocation £18k was spent and the remaining cash returned to charitable funds. Mrs Roberts informed the Committee that procedures where in place and that the resources would released from the appropriate funds.

Resolved:

The Committee approved the release of charitable funds for Christmas expenditure on the hospital wards for Christmas 2017 and 2018 retrospectively.

15 DATE AND TIME OF THE NEXT MEETING:

Thursday 30 November 2017 at 9:00am – 12:00pm in the Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPTIALS NHS TRUST
FIT AND PROPER PERSONS

Trust Board date	3 October 2017	**Reference Number**	2017 – 10 - 26
Director	Carla Ramsay – Director of Corporate Affairs	**Author**	Rebecca Thompson – Corporate Affairs Manager
Reason for the report	To provide assurance that Martin Veysey – Associate Non Executive Director has completed his declaration of interest and meets the requirements of Care Quality Commission (CQC) Regulation 5: Fit and Proper Persons.		

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

1	**RECOMMENDATIONS** The Trust Board to review and confirm there is assurance that: • Martin Veysey has completed a declaration of interest and meets the requirements of CQC Regulation 5: Fit and Proper Persons					
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): **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 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 Martin Veysey – Associate Non Executive Director has completed his declaration of interest and meets 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. The forms for 2016/17 were completed by Board members in March 2017. The Trust had appointed a new Chairman in April 2017 (Terry Moran), who had also completed a 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.

Appendix A details the completed declaration by Martin Veysey for review by the Trust Board for assurance. Appendix B contains the Fit and Proper Person Assessment criteria, for reference.

4. RECOMMENDATION

The Trust Board to review and confirm there is assurance that:

- Martin Veysey has completed declaration of interest and meets the requirements of CQC Regulation 5: Fit and Proper Persons.

Rebecca Thompson
Corporate Affairs Manager
September 2017

APPENDIX A

FIT AND PROPER PERSON DECLARATIONS FOR BOARD MEMBERS AND TRUST DIRECTORS COMPLETED MARCH 2017

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Prof. M Veysey	Associate Non Executive Director (From 1st September 2017)	✓	No	No

APPENDIX B

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?	