HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 5 SEPTEMBER 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 1 August 2017 • To review, amend and approve the minutes of the last meeting	attached	Chair – Terry Moran
4. Matters Arising		
4.1 Action Tracker	attached	Director of Corporate Affairs - Carla Ramsay
4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
4.3 Board Reporting 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 Medical Officer – Kevin Phillips
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	Deputy Chief Nurse – Jo Ledger
10. Quality Improvement Programme Progress Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance	attached	Chief Medical Officer – Kevin Phillips

- Decide if any further information and/or actions are required

11. Quality Committee 31 July 2017 minutes and verbal update 29 August 2017 • Short briefing to the Board on key issues discussed at the Quality Committee and to raise any points of escalation to the Board **60 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. Performance & Finance minutes 31 July 2017 verbal update 29 August 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 **30 MINS**	attached	Performance & Finance Chair – Stuart Hall

STRATEGY & DEVELOPMENT

14. Young Health Champions 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 **15 MINS**	attached	Chief Medical Officer – Kevin Phillips

ASSURANCE & GOVERNANCE

15. Responsible Officer/Infection Control Annual Report • The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008).	to follow	Director of Infection Prevention and Control – Peter Moss
16. Workforce Race Equality Standard • The Board is asked to note the content of this report and its Appendices and approve the WRES return and Action Plan	attached	Director of Workforce & OD- Simon Nearney
	attached	Director of Workforce & OD – Simon Nearney
17. Cultural Transformation Progress Report • The Trust Board is requested to note the progress being made against the Cultural Transformation programme.	attached	Chief Financial Officer – Lee Bond
18. Health and Safety Annual Report • The Board to receive the Health and Safety Annual Report	attached	Director of Corporate Affairs – Carla Ramsay
19. Board and Committee Dates 2018/19 • The Board to receive and approve the suggested dates for Board and Committee Dates in 2018/19.	attached	Director of Corporate Affairs – Carla Ramsay
20. Standing Orders • The Board to approve the use of the Trust seal.	attached	Director of Corporate Affairs – Carla Ramsay
21. Charitable Funds Committee 31 May 2017 • Short briefing to the Board on key issues discussed at the Committee and to raise any points of escalation to the Board	attached	Charitable Funds Chair – Andy Snowden

22. Audit Committee Minutes 27 July 2017 — to be tabled — Audit Chair – Martin Gore

23. Any Other Business — verbal — Chair – Terry Moran

24. Questions from members of the public — verbal — Chair – Terry Moran

25. **Date & Time of the next meeting:**
Tuesday 3 October 2017, 2 – 5pm the Boardroom,
Hull Royal Infirmary

45 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	✓	✓					5/6
C Long	✓	✓	✓	✓	x	✓					5/6
L Bond	✓	✓	✓	✓	x	✓					5/6
A Snowden	✓	✓	✓	✓	✓	✓					6/6
M Gore	✓	✓	✓	✓	✓	✓					6/6
S Hall	✓	✓	✓	✓	✓	✓					6/6
M Wright	✓	✓	✓	✓	✓	✓					6/6
K Phillips	✓	✓	✓	✓	✓	Dr Purva					5/6
T Sheldon	x	✓	✓	x	✓	✓					4/6
V Walker	✓	✓	✓	✓	✓	✓					6/6
T Christmas	✓	✓	✓	✓	✓	✓					6/6
E Ryabov	✓	✓	✓	✓	x	✓					5/6
In Attendance											
J Myers	✓	✓	✓	✓	✓	x					5/6
S Nearney	✓	✓	x	✓	✓	✓					5/6
C Ramsay	✓	✓	✓	✓	✓	✓					6/6

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 1 AUGUST 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
	Dr M Purva	Deputy Chief Medical Officer (for Mr K Phillips)
	Mr S Hall	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr M Wright	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Prof. T Sheldon	Non-Executive Director
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms C Ramsay	Director of Corporate Affairs
	Miss H Cattermole	Guardian of Safe Working (Item 16 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

NO. ITEM **ACTION**

1. APOLOGIES
Apologies were received from Ms J Myers – Director of Strategy and Planning and Mr K Phillips – Chief Medical Officer.

2. DECLARATIONS OF INTERESTS
2.1 CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING
Mr Hall declared that his partner was a member of the Yorkshire and Humber Clinical Senate.

2.2 TO CONSIDER ANY CONFLICTS OF INTEREST ARISING FROM THIS AGENDA
There were no declarations made.

3. MINUTES OF THE MEETING OF 4 JULY 2017
The minutes were approved as an accurate record of the meeting.

4. MATTERS ARISING
There were no matters arising from the minutes.

4.1 ACTION TRACKER
The item relating to the staff survey of staff relocated to Castle Hill was presented at the July 2017 meeting and would be removed from the tracker.

4.2 ANY OTHER MATTERS ARISING FROM THE MINUTES
There were no other matters arising from the minutes.

4.3 BOARD REPORTING FRAMEWORK
Ms Ramsay advised that she would add a section on leadership to the Board Development Framework. **CR**

5. CHAIR'S OPENING REMARKS
Mr Moran advised that the agenda would be taken out of order (Item 16 – Guardian of Safe Working) to allow Miss Cattermole to return to her duties.

16. GUARDIAN OF SAFE WORKING REPORT
Miss Cattermole presented the report and advised that it was still work in progress but that improvements had been made in data collection. She reported that it was the Junior Doctor changeover on 2nd August 2017 and all new doctors would automatically go onto the e-Rostering system. This meant that any absence could be recorded in real time.

There was a discussion around the complexity of the report and Miss Cattermole advised that it was a national template and mandated to allow benchmarking to take place. Mr Hall asked if a training session or briefing for the Non Executives could take place to understand the issues and processes in place. **CR**
Mrs Walker asked about medical staffing issues and any impact this was having on patient safety. Miss Cattermole advised that there were more issues when filling the gaps on the rota with non-training posts which prompted a discussion around medical staffing as a whole.

Resolved:
The Board received the report and requested:
- A review of other trusts' safe medical staffing reports **CR/KP**
- Development of a medical safe staffing report **KP**

The agenda returned to its original order at this point

6. CHIEF EXECUTIVE'S BRIEFING
Mr Long had reflected on the NHS being the top-ranked healthcare system following a report from the Commonwealth fund and the increasing demands on services. The report also reflected that outcomes achieved by NHS services in some areas were not as strong as in other countries and reported that he would be discussing this in more detail with the Commissioners, as these reflect the poorer outcomes prevalent in our local population.

NHS England had reported that trusts nationally were still not achieving the A&E and Cancer targets.

Mr Long had added a balanced scorecard into his report and comments were invited from the Board.

Mr Gore was impressed by ward 15 at Castle Hill Hospital for their reduced their length of stay by 12 hours.

Mr Hall added that he had attended the Da Vinci Robot presentation, which he was very impressed by.

7. PATIENT STORY
Dr Purva presented two patient stories to the Board. One was regarding a patient whose appointments had been cancelled a number of times and then had been taken

out of the system completely. The issue was escalated to the patient's consultant and a new appointment was made. The patient was happy with the resolution.

The positive story was regarding a family member who had written to the Trust to thank them for the professional and compassionate care of the Cardiac team shown to the patient when they suffered a number of heart attacks.

8. QUALITY REPORT

Mr Wright presented the report and advised that there had been 6 serious incidents declared in June 2017, two of which were pressure ulcers. The Safety Thermometer audits were ongoing and the Trust was focussing onnew harms attributed to the Trust.

There had been no instances of *c. difficile* in June and the cases of e-Coli were mainly attributed elsewhere so work was ongoing with the Community partners to review what needed to be done.

Patient complaints had seen an increase but there were no emerging themes and complaints open 40 days were reviewed on a weekly basis. There had been a dip in the Friends and Family Test results in ED and Mr Wright was investigating this. SMS text messaging had been introduced. Mr Moran asked if the numbers of patients who had texted could be included in the report. **MW**

Interpreter services were being reviewed as it was proving very costly and the use of iPads and different software packages was being explored.

Mr Long requested that a report of the young volunteer activities be received at the next Board meeting. **MW**

There was a discussion around infection control and the cleaning contract and Mr Wright advised that this was out to tender but that hygienists had been appointed on a number of wards to take the cleaning responsibility of equipment away from the nurses. This seemed to be working well.

Patient and public engagement was discussed and would be followed up at a Board development session.

Resolved:
The Board received and accepted the report.

9. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that the fill rates had improved and staff sickness was being managed.

Mr Wright reported that the safety brief had been increased from twice daily to four times per day in the short term to balance any risks regarding staffing shortages. There were a number of international recruits starting with the Trust but were currently in the immigration process.

There was a discussion around red flags and occurrences when there are fewer than 2 registered nurses on a ward. Mr Wright advised that this was usually at night and was addressed at the safety briefs and nurses reallocated accordingly. He confirmed that a ward is never left with fewer than 2 registered nurses on any shift.

Prof. Sheldon asked about return to practice and whether the Trust encouraged this. Mr Wright advised that there was not a big yield from this but it was encouraged. Mr Nearney spoke about the new apprenticeships and how the Trust was planning to double its intake which was helping with staffing shortages. Mr Moran stated that he felt assured and was impressed by the processes in place.

Resolved:
The Board received and accepted the report.

10. FUNDAMENTAL STANDARDS REPORT

Mr Wright presented the report and was pleased with the progress being made around the ward audits and the improvements being seen. The Deputy Chief Nurse was meeting with all wards and there was a sense of internal competition to ensure each ward was improving against the fundamental standard requirements.

There was a discussion around nutrition and Mr Snowden asked if this was an issue with patients being fed properly. Mr Wright assured the Board that the amber ratings were largely due to record keeping issues and not that patients were not being fed properly.

Prof. Sheldon asked if the improvement approach and how nurses are supported in the areas were more work is needed, could be discussed in more detail at the Quality Committee.

Resolved:
The Board received the report and agreed that the improvement approach would be reviewed at the Quality Committee. **MW**

11. QUALITY COMMITTEE MINUTES AND SUMMARY REPORT

Prof. Sheldon informed the Board that the Quality Committee had discussed mortality and the new national case note review guidance and would be receiving a gap analysis against the guidance requirements. This includes consideration of HSMR and SHMI rates, and duty of candour.

He also reported that the learning from serious incidents and sharing values was discussed. Quality improvements included falls performance and the resuscitation trolley checks, and with clearer milestones being set out in many Quality Improvement Plan projects.

The reporting of incidents was now improved and the Trust was showing in the top 25% of reporters. Work on levels of harm was ongoing. Work on embedding the World Health Organisation check lists was also progressing.

Mr Gore added that the Audit Committee had received good assurance around clinical audit outstanding actions and how these were being closed down.

Resolved:
The Committee received and accepted the update.

12. PERFORMANCE AND FINANCE REPORT

PERFORMANCE

Mrs Ryabov presented the performance section of the report. A&E and RTT were both on track but there were concerns regarding the 62 day cancer target and diagnostic capacity.

MRI and CT performance was improving as an additional van had been hired to clear the backlog. However there were still increasing levels of patients coming through the system.

62 day cancer was a concern and very challenging. Mrs Ryabov had met with cancer leads and the Cancer Alliance Board had supplied £100k funding to help with the issues. Further capacity had been sought from the robot and home reporting had been accessed. The lung service and breast screening were of most concern.

The 104 day cancer standard was discussed and Mrs Ryabov advised that some patients are referred to the Trust after 100 days, many are already being treated and some patients want further time to consider treatment. She assured the Board that all patients were on a pathway and were reviewed weekly. Mrs Ryabov had offered the Non-Executive Directors a development session relating to the cancer standard to allow them to understand further the pressures in the system.

Mr Long advised that he wanted to establish a service resilience process and identify the hot spots in the hospital. This would be reported to the Board on a six-monthly basis. **CL**

Resolved:
The Board received and accepted the performance update.

13. PERFORMANCE AND FINANCE COMMITTEE MINUTES AND SUMMARY REPORT

Mr Hall reported that the Performance and Finance Committee had discussed the Emergency Department performance and how the Trust can go from 90% to the 95% standard.

On RTT, there was work ongoing around the waiting list size and the numbers were being validated around access plans.

A briefing was being given to the Non-Executive Team regarding the 62 day cancer standard to give further understanding of the issues; a breakdown of the categories and breaches per tumour site had been requested.

The additional scanner was helping with productivity of the diagnostic backlog and the approach to the winter planning process had been received.

Resolved:
The Board received the verbal update from the Performance and Finance Committee.

FINANCE REPORT

Mr Bond reported that the Trust's control total remained at a £11.5m deficit. The STF funding would be received providing the Trust achieved the control total and its Emergency Department target.

In month 3 the Trust had a deficit of £6.9m which was £4.1m away from plan. £1.9m of this was due to the STF funding not received.

Mr Bond reported that the Trust was working with the FIP2 team to increase the CRES position but that reserves had been released in month 3 to help ease the deficit. The Trust had also released reserves to cover other run rate issues.

Mr Bond reported that the Health Groups had a number of financial issues such as medical staffing vacancies and how they were being filled using agency spend to keep services safe.

The cash position of the Trust had improved and suppliers had been paid up to date.

Mr Snowden asked how the Health Groups were held to account and what was being done to solve the financial issues. Mr Bond advised that the Executive Team were meeting with the Health Groups on a monthly basis to discuss the issues.

Mrs Walker asked if the FIP2 team would present their findings before they left the Trust and Mr Hall confirmed that the Performance and Finance Committee had agreed to receive an exit report and how the projects would be managed at its next meeting in August 2017.

Mr Moran asked if the financial variance of month 3 was typical of most years and Mr Bond advised that it was not.

Mr Hall added that the Performance and Finance Committee had discussed the exit of Deloitte and their findings, Health Group finances, CRES and an estates benchmark report.

Mr Gore expressed his concern regarding the Trust achieving its control total and queried the Board Assurance Framework rating asking if it should be increased. It was agreed that the rating would remain the same at month 3 as the level of risk of non-achievement had not increased, but would be reviewed monthly.

14. CHANGE OF ORGANISATIONAL NAME

Mr Long presented the report which set out the proposed for the change in the Trust's name and requested approval from the Board to formally submit the request to the Department of Health.

Mr Long advised that the name had been put to staff and stakeholders for feedback and the responses received were mainly positive. There had been a number of comments supporting the HEY brand and concerns around the costings. Mr Long advised that the cost of the change would be approximately £15k and that the HEY branding would be retained with a reference also to East Yorkshire through a branding strapline.

Prof. Sheldon queried the word "teaching" and asked if "research" had been considered. Mr Long advised that the medical staff in particular felt strongly about the Trust being a "teaching" Trust as it would be more attractive to medics and other staff, and help the recruitment campaign. Prof. Sheldon noted the impact that "teaching" status brings, which is separate to the "University" part of the proposed name.

The Trust Board considered the proposed organisational name in light of the feedback received, and agreed to proceed with the proposed name change.

Resolved:

The Board approved the submission of the name change to the Department of Health.

15. FREEDOM TO SPEAK UP REPORT

Ms Ramsay presented the repor,t which set out the approach she was taking regarding fulfilling her role as 'Freedom to Speak Up' guardian. Ms Ramsay advised that she was working closely with Dr Purva in her role as 'Anti-bullying Tsar' and the Staff Advice and Liaison Service.

Ms Ramsay reported that work was ongoing with middle managers to support them and her key area of feedback is for the Trust is to support staff in a professional way using appropriate behaviours when raising difficult issues or when a line manager is dealing with a challenging situation.

Resolved:

The Board received the report and approved the approach being taken by Ms Ramsay.

16. GUARDIAN OF SAFE WORKING REPORT

This item was received at the start of the meeting.

17. BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report and advised that the BAF had been presented to all of the Board committees for their views and a number of comments had been received regarding gaps in assurance as well as some positive assurance in Quarter 1. As this report focusses on the position at the end of Quarter 1, some comments from most recent committees that have met during Quarter 2 would be incorporated and presented in due course.

The areas discussed by the Board were the financial risks around the likelihood of the Trust achieving its control total, IT and cyber security issues and payment to creditors due to financial constraints.

Mr Hall stated the CRES position should be reviewed following the Deloitte exit.

Mrs Walker asked how risks on the Corporate Risk Register were fed up to the Quality Committee and used the stroke peer review risk as an example. Ms Ramsay reported that the stroke peer review report would be received at the Quality Committee which would highlight the issues on the corporate risk register. The corporate risk register is an appendix to the BAF and risks that relate to BAF areas are incorporated to demonstrate what level of risk is being seen in the organisation. Mrs Walker asked if the top 5 risks of the organisation could be communicated in a more visual way. Ms Ramsay to consider how this might be done.

CR

Resolved:

The Board approved the Board Assurance Framework and agreed the proposed risk ratings at the end of quarter 1, which is no change to the starting position. The ratings would be next reviewed at the October 2017 meeting.

18. ANY OTHER BUSINESS

Mrs Walker asked the Board to support the WISSH charity events were possible. She advised she was attending a fashion show in August.

19. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions received from members of the public.

20. DATE AND TIME OF THE NEXT MEETING:

Tuesday 5th September 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
August 2017						
01.08	CEO Report	Service Resilience Report to be received	CR	Oct 2017		
02.08	Guardian of Safe Working Report	Non-Executive briefing to be set up	RT	Oct 2017		
03.08		Review of other Trust's medical safe staffing reports/Development of a Trust report	CR/KP	Dec 2017		
05.08	BAF	Top 5 risks to be communicated in a more visual way	CR	Oct 2017		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB			To be included in the IM&T Strategy
COMPLETED						
Aug 2017	Quality Report	Numbers of FFT responses in SMS text format to be added into the report	MW	Sept 2017		Completed
	Quality Report	Young Volunteer report to be received	KP	Sept 2017		On Agenda
	Board Reporting Framework	A section on leadership to be added to the Board Development Framework	CR	Aug 2017		Completed
July 2017	Standing Orders	The Director signing the seal to be noted in future reports	RT	Aug 2017		Completed
	Board Reporting Framework	Risk Appetite and Refresh to be added to the Board Development Framework	CR	Aug 2017		Completed
January 2017	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Sept 2017		On Agenda
	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	Jul 2017		Completed

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						
Strategy Assurance	Trust Strategy Implementation Update	annual					x											
	People Strategy inc OD	bi annual										x						x
	Estates Strategy	annual															x	
	Backlog maintenance	annual										x						
	R&D Strategy	annual										x						
	IM&T Strategy	annual										x						
Quality	Patient story	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Quality performance (CPR)	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	
	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											
	Responsible Officer Report DIPC Annual Report	annual									x							
	Guardian of Safe Working Report	quarterly	x				x			x				x			x	
	Statement of elimination of mixed sex accommodation	annual				x												
	Audit letter	annual					x											
	Mortality	quarterly										x			x			
	Workforce Race Equality Standards	bi annual									x							
	Modern Slavery	annual					x											
	Emergency Preparedness Statement of Assurance	annual										x						
	Sustainability Development Plan	annual							x									
	H&S Annual report	annual									x							
Corporate	Chairman's report	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
	Chief Executive's report	each meeting	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	
	Well-Led Self Assessment	annual					x					x	x					
	Cultural Transformation	quarterly									x				x			
	Annual Governance Self Declaration	bi annual				x											x	x
	Standing Orders	each meeting	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												
	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

AUGUST 2017

Letter from the Secretary of State

The Secretary of State for Health, Jeremy Hunt MP, wrote to the Trust this month to praise Outpatients staff for their work. The Chairman and I received a letter from Mr Hunt thanking staff for delivering a 98% patient satisfaction rate for the month of June. The achievement was delivered across Trust Outpatient Services, and measured through the Friends and Family Test. Mr Hunt described the teams involved as 'a real example to others'.

Thank you to everyone who played a part in this success.

HEY chosen to pilot the National Bereavement Care Pathway

Trust staff are taking part in a national project designed to improve the quality of care for bereaved parents.

The National Bereavement Care Pathway (NBCP), which has the support of the Department of Health, has been developed to improve the quality of bereavement care experienced by parents and families at all stages of pregnancy and baby loss up to 12 months.

HEY is one of just 11 organisations across the country to be chosen to trial the NBCP; designed to cover the whole parental journey and their contact with hospital professionals. It is set to include new materials, guidelines, and training for staff to improve the care they offer, such as training in how to talk to bereaved parents and the kind of facilities which should be available for them.

From October, staff including midwives, gynaecology nurses, paediatric nurses, obstetricians and paediatricians will begin working with the NBCP project team to understand the impact and the effectiveness of the new pathway for parents who have lost a young child.

Complementary therapy for cancer patients

A new service offering complementary therapies for people who have survived cancer is set be launched at the Queen's Centre.

Staffed entirely by volunteers, qualified therapists will donate their time and expertise to enhance the well-being of people who are undergoing or have been through cancer treatment.

The service will offer reflexology, pedicures, manicures, facials and gentle massage, and has been initiated by the Trust's Survivorship Team.

Fire Safety Review

In light of the tragedy at Grenfell Tower, we took the proactive step of reviewing arrangements around fire safety in our buildings. With the initial review now complete, we are now working to improve fire safety through a number of measures. These include: ensuring we have fire wardens at all times in every area where we have staff or patients, ensuring fire doors are shut whenever they are not in use, keeping fire exits clear of clutter and reviewing smoke alarm provision in the cavities between ceilings and floors where these exceed 800mm.

This is something we continue to treat with the utmost importance and a Director-led group has been established to oversee the necessary works.

HEY takes on first degree apprentices
Our Trust is among the first employers in the country to benefit from a new Degree Apprenticeship programme.

The Chartered Manager Degree Apprenticeship (CMDA) is aimed at building leadership and management within organisations, and is being offered at the University of Hull.

This 40-month intensive programme for aspiring or current managers combines academic study with practical 'real world' experience, and leads to a full Bachelor's Degree in Business Management. It also offers managers and aspiring managers the chance to nurture their talents whilst remaining in the workplace.

Funded through the Government's new Apprenticeship levy, the 30 apprentices on this programme are among the first in the country to benefit.

300% rise in patients recruited to clinical trials
Patients in Hull and the East Riding continue to play a leading part in advances in medical treatment, according to figures released in August.

Data published by the National Institute for Health Research (NIHR) show that Hull and East Yorkshire Hospitals NHS Trust is among the highest performing Trusts in the country for recruitment of patients into clinical trials.

The figures show that 72,931 people across the Yorkshire and Humber region have taken part in NHS clinical research during the past financial year (2016/17).

More locally, Hull and East Yorkshire Hospitals NHS Trust recorded a near-300% increase in the number of patients saying 'yes' to involvement in clinical research. Within the space of a year, the Trust has gone from recruiting 2,304 people in 2015/16 to an impressive 9,118 in 2016/17. This means the Trust now ranks 26th in the national recruitment table out of a total of 240 participating organisations.

Heart monitoring by smartphone
People experiencing unexplained blackouts are set to have their hearts monitored by doctors at Castle Hill Hospital using a new device, no bigger than three matchsticks, and their smartphone. The state-of-the-art injectable technology means Trust doctors could know there is a problem before their patients.

For some time, implantable loop recorders have been fitted in patients for cardiac monitoring, but at the size of a computer USB stick, they were visible under skin, had to be surgically implanted in a catheter lab, and patients had to return to hospital regularly for the data to be reviewed. This creates scar tissue, and the device is still very noticeable under the skin.

The new loop recorders are much smaller; about the size of three matchsticks laid side by side; which means they can be 'injected' into the skin and the opening glued shut, making the device barely noticeable once in place.

As well as benefiting patients receiving the new recorders, there are also huge benefits for the hospital. The fitting of each traditional loop recorder takes around 20 to 25 minutes in a cath labs, whereas inserting the new device can be completed in most clinic rooms in just a couple of minutes. It is less stressful for the patient and frees up the time of clinicians, theatres and follow-up clinics. Conservative estimates suggest the Trust save at least 250 clinic appointments each year by using the new devices, as well as creating considerable capacity for the cath labs.

HEY LONG TERM GOALS - July 2017 data

Great Staff	Great Care	Great Future

Quality

RAG	Indicator	Target	Performance July	Trend v Previous Month
G	Never Events	0	0	⇨
R	Complaints (QIP - closed within 40 working days)	90%	87.50%	⇧
G	Healthcare Associated Infections - MRSA	0	0	⇨
G	Healthcare Associated Infections - C.Diff (YTD target)	53	16	⇧
G	Safety Thermometer - Harm Free Care	95%	95.31%	⇧
R	Venous Thromboembolism (VTE) Risk Assessment (Q1)	95%	92.13%	⇧
R	Mortality - HSMR (March 16)	<100	101.30%	⇨
G	Friends & Family Test - Inpatients (Trust v National %)	95.90%	98.76%	⇧
R	Friends & Family Test - Emergency Department (Trust v National %)	87.50%	74.29%	⇩

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

Workforce

RAG	Indicator	Target	Performance July	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.80%	⇨
G	Staff Sickness	<3.9%	3.71%	⇩
R	Staff Vacancies	<5.0%	8.82%	⇧
R	Staff WTE in post (<0.5% from Plan)	7164	7111.15	⇩
R	Staff Appraisals - AFC Staff	85%	82.30%	⇧
R	Staff Appraisals - Consultant and SAS Doctors	90%	89.80%	⇩
G	Statutory/Mandatory Training	85%	89.30%	⇧
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£1.9m	£2.1m	⇧
R	Staff: Friends & Family Test - Place of Work (Q4 1617 v Q1 1718)	56%	64%	⇩
G	Staff: Friends & Family Test - Place of Care (Q4 1617 v Q1 1718)	72%	81%	⇧

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance June	Trend v Previous Month
G	18 Weeks Referral To Treatment (92%)	92%	85.10%	85.15%	⇧
R	52 Week Referral To Treatment Breaches (zero)	0	0	4	⇧
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	2.90%	5.56%	⇧
G	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	93.60%	⇧
R	Cancer: 62 Days Referral To Treatment (85%) (June Data)	85%	81.80%	81.60%	⇧
G	Length of Stay (<5.2)	<5.2	-	4.9	⇨
R	Clearance Times	12 weeks	-	13	⇩
R	Waiting List Size	52,449	-	54,051	⇧
R	Clinic Utilisation	80%	-	58.90%	⇩
G	Theatre Utilisation	80%	-	82.20%	⇩
G	E-Referrals (Q2 target v current performance)	80%	-	83.7%	⇧
R	Appointment Slot Issues (June)	35% (TBC)	-	46.59%	⇧

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

Finance

RAG	Indicator	Target	Performance July	Trend v Previous Month
G	Capital Expenditure	3.7	4.8	⇧
R	Statement of Comprehensive Income Plan - Year to Date	-2.8	-8.3	⇧
R	CRES Achievement Against Plan	4.3	2.6	⇧
R	Invoices paid within target - Non NHS	95%	52%	⇧
R	Invoices paid within target - NHS	95%	30%	⇩
R	Risk Rating	3	4	⇨

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

Moments of Magic

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

In July we received 50 Moments of Magic nominations:

Becky Chaplin	The staff on the endoscopy unit at CHH would like to nominate Becky Chaplin for many moments of magic! Becky is our receptionist and despite being with us only a short period of time she has shined. She is always cheerful, calm and reassuring to our patients as they arrive on the endoscopy unit which creates a very reassuring first impression and sets the tone for the rest of the patient's journey through the unit. Becky often goes above and beyond, despite being kept very busy within her role, one example was when a patient's relative needed assistance, Becky researched train, bus and taxi times and prices on behalf of the relative. This is one example of many, and the nursing team would like to let her know how much she is valued.	31/07/2017
Charlotte Fear	Charlie is a very unique Senior Sister for Cedar Ward/Gynae Day Unit; she is a very hands on ward manager helping/working on the ward, along with all the paperwork etc. that comes with a Ward Managers role. Not only that but Charlie is always there if you have problems or need someone to talk to.....or even need to take annual leave at short notice. Charlie is a very understanding young lady and is able to see things from everyone's perspective. Cedar Ward are extremely lucky to have such a lovely lady as their manager.	31/07/2017
All Staff Ward 10	I spent a total of 7 straight weeks in Ward 10 following a major Bowel operation then becoming infected with sepsis. Every single day there were numerous moments of magic from all of the staff and the visiting Doctors and Registrars. When feeling under the weather and unable to function on one's own, it is often simple gestures that help the day be one of happiness rather than dark and gloomy. I will give some examples: • One member of staff (Auxiliary) would come into the room at 06:00 and cheerfully proclaim "morning Gentlemen" with a big smile and open the curtains. Whilst to many this may sound harsh, to us in the room it was actually a good energetic way to start the day. It was delivered with humour and caring. He would then ask if we needed anything and always	30/07/2017

deliver. I'm told he gives the best shaves too. • Delivery of daily 'Fragmin' injections into the stomach were obviously not popular. However, despite the staff having, in some cases delivering 1000s of these, they were still delivered with care with a real wish to not hurt us. A couple of nurses were particularly good at distracting me as the deed was done. This showed real caring. • The Ward was spotless – absolutely – including the toilets which is very difficult at times considering we were largely colorectal patients! If you ever want to see people work flat out with humour, pleasantness, empathy and 100% diligence then visit Ward 10 and watch the Infection Control staff. Awesome. I am not saying that the others members of the staff did not work 100% - they did! • The characteristics between each of the Auxiliaries could not be any different which made life in the Ward very interesting – one tends to see the Auxiliaries slightly more than the nurses. They all performed their duties without complaint and with professionalism. I am including a special lady whom I think was the Head Housekeeper(???). If anything was needed or was broken she sorted it – she was the glue that kept the ward functioning. Over and above this were their completely different styles of humour which certainly helped the hours pass. They also each had their caring side, giving support, physical and mental, whenever it was needed. • I met almost all of the Junior Doctors on the Ward and found them to be surprisingly gentle and down-to-earth once the ice was broken i.e. taking an interest in them and their career. I really don't think the vast majority of patients felt that they could talk to them as people and therefore missed out on talking to some very interesting characters. Their support to us was, of course, second-to-none and I think they genuinely cared about us. • The nurses remained of good humour even when faced with: a private room full of projectile vomit 5 minutes into their shift; me stood in the toilet at 02:00 sporting a failed ileostomy bag and dirty legs but so tired and weak not knowing what to do next (thanks Sissy!); a rude and obnoxious patient that wants to go home but cannot due to elevated temperature and signs of infection; an old man that slept in the day and couldn't sleep at night hence kept getting out of bed and wandering around the place (being a danger to himself and disturbing others). In the case of the latter gentleman, who was very old and poorly, he was treated with utter respect by the nurses who would often sit him somewhere safe under their watch with a nice cup of tea. • Respect between members of the Ward, regardless of function or rank was complete. I saw no pulling of rank or 'that's your job' attitude – not one instance in all my time there. •

	Discipline was of course observed at all times under the keen eyes of the two wonderful and empathetic Sisters. That did NOT, however, mean it was a humourless place to be treated or work – quite the opposite. Within the walls of Ward 10 I felt safe and well cared for. It was in fact very sad to leave the Ward as the staff had become part of my family. I look forward to being there again soon for my stoma reversal!	
Sue Stephenson	I regard Sue as one of my Hospital mums – she knows I regarded her as such and once I explained it wasn't an age thing she was happy with it – I think. Sue has tried to keep me cheerful whenever she is there with her humour (often completely off-the-wall, which I love) and encouragement. She is highly efficient skilled, knowledgeable and empathetic (she feels the injections more than we do!) but I do worry she takes on too much at times in order to make as many people comfortable and happy as possible. My particular Moment of Magic began after only about 15 minutes from entering Ward 10 for the very first time and was waiting to be formally admitted. I was very unsure about having the operation. I had done seemingly 100s of hours of research into my particular cancer, its current and future treatments, and its causes such as poor diet. I had also grilled my Surgeon and Oncologist on several occasions but none of this research helped me find an acceptable clear-cut treatment that didn't lead to further problems sooner or later and would certainly cure me of the T3 tumour. Quite simply my body and mind just wanted to run from the horror of the imminent major bowel surgery. Sue must have read my body language as I awaited in the TV room. She sat down next to me, held my hand and very cleverly, with no pressure, got all my concerns out on the table and proceeded to reassure me on each of them. She didn't tell any lies or make any rash promises. What she did though was assure me that she, and the rest of the staff, would do their utmost to help and care for me throughout this awful ordeal and that the surgical staff were second-to-none. She also said I didn't need to do it if I didn't want to and the door was unlocked – I stayed and that was largely down to Sue making me see the logic. Things didn't go at all smoothly, due to Sepsis, but she and the staff did indeed make my recovery possible and it was a very sad day to leave the Ward and in particular Sue – Hospital mum!	30/07/2017
Susy Green	Much of my stay in Ward 10, following my bowel surgery, was spent with a very painful rectal drain. This is held in place with a single stitch inside the buttock.	30/07/2017

	The stich is painful anyway but on one occasion it became incredibly painful. It was diagnosed, by an on-call Dr during the night, to be a suture abscess and he would alert the duty Registrar about it the following morning. By the following morning I could not move because every time I did the pain was so intense – incredible when it is just a small abscess around a suture! The duty Registrar was Susy Green and she visited me first thing in the morning and promised to sort it out before she went home that evening. At 18:30, after a full day in theatre, Susy cheerily appeared in her surgical wear pushing a full trolley of surgical things and set up my bed with cloths and instruments and local anaesthetic. She, and the Junior Dr, then anaesthetised the stitch (ouuuuuuuuchhh!!), removed it (the abscess then drained naturally) and put in a new silk stitch. All this took about half an hour – most of the time being spent carefully setting up a sterile environment on my bed. The lack of pain in this area was such a fantastic relief and enabled me to immediately get out of bed and shower. She was a complete star – coming back as promised (one is promised so much by very busy people in hospital and sometimes it just doesn't happen) when she should really have been going home to rest. She was so pleasant throughout the procedure too and very concerned about any pain I may be feeling – she was not resenting the fact that her job was keeping her in hospital late. The straight fact is, Susy is such a bright, pleasant, open and honest person and it was always nice whenever she turned up on Rounds. Thank you so much Suzy!	
Mike Kurek	I was always pleased to see Mike appear on the night-shift as Staff Nurse as he very quickly and pleasantly gets on with his duties and we received our medications in very good time. He seems to brighten up the room when he comes in. I understand from others that he has had a great personal loss some time ago and yet this is not reflected in his demeanour – except may explain why he is a very externally calm person despite the high workload and staff shortages on the night shift. His post-drugs round cup of tea is very well earned! During my stay on Ward 10 I was mostly in pain due to a combination of my major bowel operation and Sepsis. At first, the Pain Team were not being very pro-active in helping me find the best drug combination to alleviate the pain and allow me to function normally. One day the Pain Team decided that I should halve my 3-hour break-through drug but should have something else in addition to boost the effectiveness and help reduce the pain. Unfortunately, on my Drugs Card, they had indeed halved my break-	30/07/2017

	through drug but neglected to state what the alternative was hence my pain relief was simply halved. At that point the pain was so bad that I HAD to have the break-through drug every 3 hours and spent my time, day and night, wishing time would pass quicker so that I could have more pain relief. As this particular day went on the pain was breaking through more and more as I was only getting half the previous quantity. It was about 11:00pm when I could stand the pain no more and I had had all the meds I could possibly have. Mike was the night shift Staff Nurse and I am embarrassed to say that I completely lost my temper with him when all that could be offered now was a cup of tea. He was with a female Auxiliary and a female Nurse (I do not know their names). The pain and frustration resulted in me shouting, crying, sobbing and swearing at Mike – or rather it was through Mike to my Surgeon and the Pain Team. Mike stood firm looking sympathetic but remaining silent. That was exactly the right thing to do as I burnt myself out quite quickly and was then consoled by the Auxiliary – with the cup of tea. A while later I found Mike and apologised and he smiled and said that he fully understood my frustrations and said it was ok. I saw Mike many times after that during my 7 weeks stay, and he was always very pleasant to me and clearly did not hold a grudge. A stalwart of the nursing profession. Thank you Mike!	
Sissy Vargnese	The night after my major bowel operation I was feeling so very low. I was in so much pain and probably still under the influence of the anaesthetic. In addition, I really didn't want the operation (who does?) and was now having to deal with an ileostomy too. I cried – a lot. Sissy sat next to my bed and let me sob for as long as I wanted giving me re-assuring words and letting me hold her hand. Eventually I must have fallen asleep. I would consider this act over and above her duties. She has also performed many other similar acts during my 7 weeks stay as I have had many low points due to having post-op Sepsis. Her Fragmin injections are 10 out of 10 – completely painless due to her cunning distraction techniques no doubt reserved for patients such as me. She also had to help clean me when I had an ileostomy bag failure all down my front at 02:00 in the morning in the loos! I was sorry to leave the ward partly due to her extremely kind actions and demeanour towards me. Thank you, Sissy, – one of my hospital mums!	30/07/2017
Kieran Wilson	Kieran (Head Housekeeper??) is a very quiet and unassuming lady that keeps the Ward running smoothly and yet manages to keep out of the limelight.	30/07/2017

	She is the very glue and lube that keeps the ward functioning smoothly. She is also capable of providing special things for us patients too (NHS Mars Bars!!). If anything is wrong with the Ward infrastructure, Kieran is onto it and makes sure it is corrected. If a bed doesn't work, she either knows the special move to get it to work or gets a specialist in to fix it. Nothing irregular escapes her attention. She has a lovely personality and is able to read minds and is able to conjure what is necessary to improve a patient's wellbeing seemingly out of thin air. My particular thank you to her is her expert knowledge of how to get a much better choice of food out of the system. A few days after my large bowel operation I was hit with sepsis and it completely took away my appetite. This lasted for 2 – 3 weeks resulting in a large loss of weight (almost 20% of my total body weight). The specialists gave me high energy drinks but they are very unappealing and difficult to consume. However, Kieran produced some alternative menus as well as suggesting I tried something simple. We initially agreed on tinned spaghetti on toast moving onto spaghetti with cheese and baked potato – simple food but easy to eat and digest without feeling over-faced. Voila, my appetite soon returned and she also managed to find NHS Mars Bars and cheese cake too (better than M&S!) All this helped me to put weight back on, return some of my strength and give me back some of my lost energy. Thank you so much Kieran!!	
Angie Quinn	Angie is one of the Ward's Infection Controllers and is so incredibly polite and hard working. The part of the Ward I was in was impeccable thanks to her hard work and diligence. Each day she also managed to ask how each of us were and took a genuine interest. She certainly helped keep our morale up, chatting merrily away whilst her hands skilfully wiped away all traces of dirt from every nook and cranny. Whenever there was a person change, she cleaned every part of the bed including taking off the mattress and cleaning the entire frame. A particular moment of magic from Angie was when I was struggling to return to my bed from the Ward 10 loo. Despite the close proximity of the loo to my bed I suddenly found myself completely devoid of any energy and panting heavily – this was due to Sepsis. I clung onto the doorway but was losing the battle for consciousness. I became aware of Angie asking how I was then her arms around me giving me much support and shouting for further assistance. This quickly came and I was hugely helped back to me bed. She need not have helped me at all but helping others and compassion are clearly built into her. Many thanks Angie!!	30/07/2017

Phoebe Harrison	Well done Phoebe Harrison on completing your care certificate throughout periods of ill heath; she is a credit to the auxiliary team on Ward 110.	29/07/2017
Melanie Jopling	Even when Mel is under pressure and the ward/day unit is extremely busy she is guaranteed to have a smile on her face. Mel is a pleasure to work with and her optimism and positivity can be felt with her presence, she is brilliant with the patients and staff....an asset not just to this area but to the NHS!	28/07/2017
Jackie	I attended paediatric assessment unit with my 7 month old daughter on Wednesday night. Jackie went out of her way to ensure i was comfortable and reassured. I left the unit at ~3am and was obviously a little tired as I left my daughter's changing mat there. I didn't realise this until this morning when it arrived on my desk with a note wishing my daughter well. Thank you Jackie.	28/07/2017
Lorraine Clark	For Lorraine, an auxiliary nurse on Cedar Ward who was in the right place at the right time rushing to a woman's aid and delivering her baby in the car park this morning on her way onto shift! You deserve endless credit for your quick thinking and fast acting. I'm sure the assistance you provided will never be forgotten by the parents of this precious newborn. I'm so proud of you for acting instinctively and compassionately in an area completely out of your usual realm of responsibility and comfort zone! You are amazing, WELL DONE! A moment of magic you will never forget.	28/07/2017
Alan Band 3 Auxiliary and Doctor on duty (sorry I didn't get your name)	Hull Royal A&E department - thank you for the care and patience shown to my daughter on 25th July especially to the auxiliary Alan (Band 3). My daughter came in just generally feeling rubbish, severe back pain and vomiting; we were dealt with as quickly as possible and my daughter's mind was put at ease. The department was rushed off its feet with only 2 doctors on duty but when the doctor (lady - so sorry I didn't get your name) got to my daughter you would never have known how busy they were, as she was so calm and highly professional. Luckily for us it wasn't anything serious and tests ruled out various things. Not once where we made to feel we had wasted precious time within the department. The triage nurse was also caring and compassionate - thank you so much	27/07/2017
Sister Lesley and Staff Nurse Chloe	Sister Lesley, and Staff Nurse Chloe were so calm, patient and reassuring whilst my son had a GA for his MRI. They really helped me to feel at ease despite my	27/07/2017

	son having meltdowns. Thank you both so very much.	
Steve Roberts	My son is petrified of going to sleep under GA, and he needed one for an MRI. Steve was amazing, despite my son having a meltdown, he went to sleep really quickly and Steve was not phased in the slightest! Very reassuring and comforting for me as a parent to know he's in such good hands. Thank you so much!	27/07/2017
Mike Burns and Craig Crabb	I would just like to say what a pleasure it is to walk into the grounds of HRI. The gardens are beautiful and look great, the mixture of flowers and colours are stunning. Well done to our fantastic gardeners, keep up the good work .	25/07/2017
Lovely lady heading towards Women's & Children's this morning around 07.05-07.10	I had just got to work this morning about 07.05, and as I was about to walk to my department a lovely lady approached me and asked me if I was OK and did I need any help. I thanked her very much, saying that I had been poorly but I was OK. I am sorry that I didn't get her name or where she worked, as I was really touched by her kindness. I think she may have been a nurse or midwife, heading to Women's & Children's. I am really grateful to her for her thoughtfulness and kindness, and I am hoping that the lady concerned will see this nomination.	25/07/2017
All ODP's	The life of an ODP is a difficult one, battling constant pressures, struggling with lack of equipment along with lack of staff, going without adequate breaks, lunches and occasionally teas, all the while still managing to provide high standards of patient care and skilled support alongside the medical and nursing colleagues during peri-operative care. The team of ODP's at HRI, are absolutely amazing individually and together as a unit, they are constantly pulling together to help one another. They need more recognition for the work they do and for their profession.	22/07/2017
All Ophthalmology outpatients staff	Since re-joining the trust after extended maternity leave I have nothing but praise for the staff in the Ophthalmology outpatients. They are supportive, welcoming, friendly & a fantastic team to work with. They are extremely supportive & reassuring to patients & are always happy to help. Thank you	21/07/2017

Suzanne Knaggs	Suzanne has excellent attention to detail and is passionate about the work that she does especially with referrals. It came to light that some patient	21/07/2017

	information was missing on a tracking spreadsheet that is used for patient referrals which Suzanne highlighted to management. This was then investigated and Suzanne was involved with helping to rectify this issue, ensuring that each patient had been referred to receive the relevant care and treatment that was required. The hard work that Suzanne puts in not only in this instance but on a daily basis is appreciated and doesn't go unnoticed. Well done on picking up this issue and thank you!	
Mike Burns and Craig Crabb	The gardens and grounds at HRI have never looked so beautiful. The care, attention to detail, and designs of the gardens are outstanding. I think that Mike and Craig have done a sterling job and that their efforts are award winning. Well Done!	21/07/2017
Jan Cairns	I would like to nominate Jan Cairns Head of Midwifery for a Moment of Magic. We forget sometimes that our boss has targets and huge demands within their role not only from the clinical side of the role but corporately too. Even with all the demands within her role Jan has supported me as my supervisor for many years. She has lifted me when I have had challenges at home and always inspired me. Her support continues every day her passion is our women and their families and ensuring they receive a high standard of care. I can never repay her for the support and advise she has shown towards me and I will be eternally grateful and her ongoing support to help me balance home and work.	21/07/2017
Dr Rayessa	I nominate Dr Rayessa she is always approachable and gives support and advice when needed at all times of the day and night. She is an excellent teacher and stroke consultant with her vast knowledge of stroke She has helped me develop in my role through teaching, supervision and provides the support and guidance if needed, she is very passionate about stroke and the stroke service and fights to maintain the service and acute care	21/07/2017
Lydia Parker	Lydia has had some very challenging shifts over the past few weeks. She has always stayed very professional and always keeps smiling .Lydia is a very caring nurse who always goes that extra mile to help others. We are very lucky to have her on our team.	20/07/2017
Jacqui Powell	Jacqui has provided much needed support and encouragement to a member of staff to gain confidence and grow within her role. She has played a	20/07/2017

	huge role in advising, developing and been an advocate for this member of staff. To offer such a high level of support and continue to fulfil her own role is a true reflection of the professional dedicated and supportive person she truly is.	
Marilyn Spencelayh	Maz is an extra special little lady on Cedar Ward! She never fails to give all patients nothing but 100% care which she does this with such compassion. This lady is special to us all and although going through some problems out of work Maz never complains or grumbles and you never hear her moan she cracks on with her job with a smile on her face and I want her to know that everyone....patients/staff on Cedar Ward think she is amazing! Thank you for being you Maz x	20/07/2017
Margaret Toffolo	Maggie has worked away in the background ensuring that all the pathology aspects of our new service are in place and run smoothly. The service involves genetic testing and though Maggie has a very busy workload she has ensured every sample is handled and processed with attention to detail and great care. Because of this personal touch we can be assured that samples of such great importance are in safe hands and patients are getting the very best care from our service.	20/07/2017
Katie Broadbent	Katie Broadbent (Secretary Histology) moved from her permanent role in Histology to provide temporary cover for a Consultant in our department. We are two nurses setting up a new service; Katie had an enormous amount of different work to get through in a new environment and had no obligation to help us. Every day she arrived smiling with a great attitude, asking if we needed anything and providing not just a boost to our morale but practical help that made a real difference. Katie would have been justified in getting on with just her own work; by going the extra mile Katie helped the service get up and running sooner than expected.	20/07/2017
Claire Hatfield	Claire is one of the most kind and caring midwives I have the pleasure of working with. She makes time to deliver the highest standard of care to the ladies she is looking after. She is always concerned about her colleagues and tries her best to help everyone whenever she can. Claire shows compassion in all aspects of her work. Working with Claire is a joy and she is an asset to the ward.	18/07/2017
Pete Reynolds	Pete was holding a Retinal Screening Clinic when he	18/07/2017

	was approached by the mother of one of his first time patients. This young teenager had learning difficulties and was so frightened he was refusing to get out of the car. His mum thought she would just have to take him home and forget about ever having her son screened. Pete calmed her down and asked her son to come into the clinic for nothing more than a chat about the procedure. He managed to get him into the clinic room and sat with him for some time explaining in appropriate language why we hold the clinics and exactly what we do, what will happen during the appointment and the importance of attending. He completely engaged this young patient, so much so he agreed to come the following week and have his screening done. Pete made all the necessary arrangements and put notes on the patient's records so whoever does see this patient in the future will have a clear understanding of his anxiety about the procedure and take steps to reassure him. I was so proud of Pete. It is important we look after our young patients and encourage them to attend. This is not an isolated incident. Pete constantly shows true care, compassion and concern for our patients and we will miss him dreadfully when he retires next year.	
Marie D'Arcy	Marie always does her difficult job with a smile, she never complains and always goes the extra mile. She is an amazing role model and always strives to her best every day with a sunny disposition. She is a star!	14/07/2017
All staff on Ward 29 CHH	The care my husband and our family have received whilst he is on ward 29 Castle Hill. I would like to both thank and commend all the staff most importantly the Physio and OT who have worked innovatively to help his movement and function. Our family have been through and are still a very distressing time and you all show empathy to our situation and great understanding of what we are all going through. Thank you very much	14/07/2017
Rosemary Flanagan	I was working in A&E resus and was caring for a critically ill patient who needed intensive transfusions. I was unable to leave my patient's side until he got to theatre. Rosemary could see that the patient was very poorly and that I was under pressure to complete all transfusions. Rosemary came in, even though she was only passing through the department and was not working on the shift in resus, and helped me. She helped me push the transfusions, continue fluids and administer IV medications, ensuring the best treatment and care to my patient. I felt such support from her and I cannot thank her enough for making me feel at ease and confident in what was classed as an intense	12/07/2017

	situation.	
Di Hughes	On Friday 7th July I was on call for the cardio thoracic theatres and was called in to work with the organ retrieval team who were to perform a retrieval on a lady whose family had made the amazing and brave decision to allow her organs to be donated. Di Hughes was the ICU nurse who had been caring for this lady. She had cared for her on previous shifts too, and had worked closely with the lady's family who understandably were extremely distressed. Di (and the specialist nurse for organ donation) made sure that the family's wishes were carried out for the patient and had promised the lady's husband that she wouldn't leave her. From the time the lady came to theatre, and for the entire time she was with us, almost 6 hours, Di never left the patient's side. As we performed last offices Di spoke to the lady with kind words of reassurance, explaining what we were doing and why, just as if the lady had been awake. She didn't leave her until the porters came to take her to the mortuary. I saw that night that Di was a wonderful nurse not only clinically, with years of experience behind her, but also as a kind and caring person who did everything she could for that lady and her family in a very sad and distressing time for them. I know that if my family had to go through what this lady and her family had to go through I would hope I would have a nurse like Di looking after us. She had nothing but the patient and family's best interests at heart the entire time. Although this moment of magic is mainly about Di, I do need to mention that the whole team were great, working hard and at their best in a stressful situation.	11/07/2017
Nicky Jackson/Julia Denley	A young patient tragically passed away In ED leaving a very distraught young family. This was during a day when the department was experiencing a high demand. A Play Leader from Acorn Ward came to support the ED team; in my opinion she went beyond the call of duty giving a teddy bears' picnic and being supportive under extremely difficult circumstances. She also stayed an hour after her shift ended to see the experience through to the end. Many thanks for your passionate commitment, you were exemplary and I really appreciate your support. Also my thanks to Julia Denley who was more than supportive to the ED team and family and also stayed beyond their finish time to assist me. Truly Magical people. Thanks Wendy Powell, Sister, ED	11/07/2017
Marica Shepherd	Always being prepared to do whatever it takes to ensure a positive patient journey	11/07/2017

Nathan Sheppard	Rain or shine Nathan always comes to work with a smile on his face. He always asks how everyone is and hopes they have a nice day. He even asks how your day was at the end of it. Today he has been on his own doing Diabetic Retinal Screening. We had a walk in patient who attended a week early to be screened. I knew Nathan had his hands full as everyone had attended their appointments so far but I noticed we had had a cancellation for 11:30. I asked Nathan if there was any chance he could see this patient as she was in a wheelchair and had come a long way. Without hesitation Nathan agreed to see the patient. The patient was then screened and went home very grateful we had seen her given the circumstances and thanked us. I appreciate you had to rush your lunch because of this but it is greatly appreciated. A big thank you for being so helpful, friendly and positive.	10/07/2017
Jade	I would like to thank Jade on Cedar Ward day unit who was on duty on Thursday last week. Even though she was busy she was very considerate, compassionate and helpful while I was on the unit. Well done Jade and keep up the hard work you do and thank you again for your care you gave.	10/07/2017
Andrea Cameron	Andrea has been a tower of support and strength for her ward sisters, in spite of the challenges some wards have faced! She is always there for advice and helps tackle issues with you. Andrea's guidance and support have kept the wards smiling and her staff happy! We wouldn't be without her! Thank you Andrea!!!	10/07/2017

A&E Paediatric	I brought my 8 year old daughter in the paediatric A&E after falling down the stairs in the morning. She was seen by a lovely female senior doctor who checked her over and had her discharged with 30 minutes with just cuts and bruises.	10/07/2017
Stacey Healand	Following decisions to change my career path and unfortunately been unsuccessful, I was disappointed with myself. Stacey provided me with constructive feedback which made me feel better in myself. I consulted with Stacey further and she provided me with some much needed ideas and wise words and helped me formulate some plans for my future. So thank you very much I owe you a cake and a coffee.	10/07/2017
Jenny Chapman	Jenny went above and beyond to support myself, the patient, my student nurse and the relatives in what was	08/07/2017

	a distressing time for us all. She showed so much compassion towards an acutely confused patient that required sedation prior to diagnostic procedures. She stayed with the patient throughout and gave me have the opportunity to care for my other patients. During this challenging event she had the time and patience to teach a year 1 student nurse and support the relatives and put them at ease. Jenny deserves a moment of magic because I wouldn't have survived the shift without her.	
All 120 Staff (Nicola Staff Nurse)	I was pretty new to the hospital and it was my first time as an auxiliary nurse on ward 120. They are a very welcoming bunch that made me feel very at ease and are a lovely approachable group	06/07/2017
Karen Reffin	This is not one moment but every time I see Karen she just has that smile that makes you feel instantly at ease. If it be a patient in need or a member of her team nothing is too much trouble. I witnessed her the other day helping a patient who was confused and lost. She was there, took control of the matter and made him feel at ease. She safely got him back to where he needed to be. A credit to the NHS. Keep up that smile, it brightens everyone's day.	06/07/2017
All staff on Cedar Ward H30	I would like to nominate all staff on Cedar Ward H30. All staff are always smiling and happy and are willing to help and go that extra mile. They all work extremely hard and exceptionally well together as a team ensuring patient care is priority. Advice and care delivered to patients day and night can be complex and sensitive and they all show empathy, knowledge and expertise in their speciality (gynaecology). Thank you ladies, you all do a great job.	06/07/2017
Dr Richard Oliver	My dad was referred to Cardiology with a heart problem and was very anxiously awaiting an appointment. He telephoned the department and Dr Oliver agreed to see him the same day. He answered all my dad's questions alleviating his concerns and spent extra time with him recognising how concerned my dad was. He left the appointment understanding all his options and feeling much calmer. Thank you very much to Dr Oliver for the care you gave my dad. Seemingly small gestures like this are what truly should be seen as 'moments of magic' within our organisation. Thanks very much from all our family.	04/07/2017
All staff on Ward 10 at CHH	For their continuous care of all the patients on the colorectal ward and their amazing team work. They are	03/07/2017

	always attentive to patients' needs, incredibly caring, work well as a team and support families and patients impeccably. During my time there I was particularly impressed when they arranged a patient who had been in for many months to have a birthday party and generally they always go the extra mile to make what can often be a very difficult time in a patients' life that bit more enjoyable.	
John Arnold	The first thing John did for Ward 35 was to get our Cayder Board working this Monday morning - 3rd July 2017. Later that day John responded to request regarding a longstanding problem we have had with a Ward 35 PC and the Ricoh printer/fax machine. John came to the Ward and asked us what the problem was and what we needed. He then problem solved the wiring and layout in a friendly and professional way and checked that everything was working properly in the new configuration. We are so grateful to him for his work on Ward 35 today.	03/07/2017
John Arnold	On Monday 3 July 2017, by telephone, John efficiently resolved a problem with Ward 35's Cayder Board. Later that day John responded to another Ward 35 request to sort out long standing problems we were having with a Ward PC and Ricoh Fax/Printer. He came to the Ward and asked us what we needed. Then he problem-solved the wiring and new layout before getting on with the job in a friendly and professional manner. We are so grateful to him for his work for us today.	03/07/2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT AUGUST 2017

Trust Board date	5 September 2017	**Reference Number**	2017 – 8 – 8
Director	Kevin Phillips, Chief Medical Officer	**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 BAF 3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board receives this report monthly on the quality aspects of its services (Patient safety, service effectiveness and patient experience).			

QUALITY REPORT
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
- Care Quality Commission
- The National Reporting and Learning System (NRLS)

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
- Care Quality Commission
- The National Reporting and Learning System (NRLS)

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 July 2017. Any other known matters of relevance since then will be discussed, also.

2. PATIENT SAFETY

2.1 Never Events

As of the 31st July 2017, the Trust had not declared any recent Never Events. The Trust has declared two Never Events in August and a verbal up date will be provided to Trust Board.

2.1.1 Serious Incidents declared in July 2017

The Trust declared six Serious Incidents in July 2017. All of these are in the process of being investigated fully. These are summarised below.

Ref Number	Type of SI	Health Group
SI/2017/17188	**Treatment Delay** – This relates to a patient who was seen in December 2016 within ophthalmology and needed further treatment. The patient was added to the urgent waiting list (2-3 weeks requested by Associate Specialist). However, the patient did not receive an appointment for surgery until 21 June 2017 resulting in potential irreversible damage to the eye.	Corporate Functions - Patient Administration
SI/2017/17192	**Treatment Delay** – This relates to a lady who was 24-weeks pregnant and had collapsed at home. The ambulance crew called and spoke with the Labour & Delivery team and the patient was directed to the Emergency Department (ED). The patient presented in ED with slurred speech and a left sided weakness. The patient was reviewed by the stroke team in ED. It was thought that this was not a stroke and, therefore, the patient was transferred to Maple Ward. No scan was performed to confirm this decision. Once on Maple Ward, the obstetrics staff organised an MRI for the patient and the results showed a cerebral bleed causing a left-sided stroke. The patient was then transferred to Ward 110. The patient has since recovered.	Medicine Health Group

SI/2017/17677	**Treatment Delay** – Following the death of a patient in the Acute Medical Unit, it was discovered the patient had an abnormal arterial blood gas reading, which had not been communicated to the medical staff and not acted upon. The blood gas reading had shown a significant low glucose reading that was not treated.	Medicine Health Group
SI/2017/17680	**Surgical invasive Procedure** - A patient underwent prolonged spinal surgery and experienced low blood pressure for long periods during the procedure. Post-operatively, the patient developed an acute kidney injury and possible ischaemic bowel on CT scan.	Surgery Health Group
SI/2017/18817	**Pressure ulcer – Unstageable** - The patient was admitted with exacerbation of his Parkinson's disease, and delirium. The patient was relatively immobile and was found sat on a hard surface having been unable to move for some time. On admission to Ward 90, the patient had a grade 1 pressure ulcer to his sacrum, old blisters and his heels were red. The relevant assessments were carried out and appropriate preventative measures were put in place, including nursing the patient on an air mattress. Despite this, the patient's skin continued to deteriorate and he developed an unstageable deep tissue injury.	Medicine Health Group
SI/2017/19097	**Surgical Invasive Procedure/ Un-expected Death** – The patient was undergoing complex hip replacement at Castle Hill Hospital, as a result of a fracture. During the operation, a blood vessel was perforated inadvertently, which resulted in significant bleeding. Assistance was sought from the vascular surgery team, however, the patient's condition deteriorated rapidly and they had a cardiac arrest. The patient was transferred to the ICU but died later.	Surgery Health Group

3. SAFETY THERMOMETER – HARM FREE CARE

The July 2017 Safety Thermometer results were provided in the last Quality Report. Due to the timing of this report the August 2017 results were not available at the time of writing. These will be presented next month. However, there are a number of points to raise about the Safety Thermometer. The Trust Board is aware that the Improvement Academy at the Yorkshire and Humber Academic Health Sciences Network has been producing Safety Thermometer Benchmarking information for some time. However, this has now ceased from April 2017. The reason for this is that NHS Digital has removed the Safety Thermometer's Official Statistics Status. This means that it is no longer a mandatory data collection dataset. However, both NHS Improvement and the Care Quality Commission expect Trusts to use the dataset as a local improvement tool. Therefore, this Trust will retain the monthly point prevalence audit.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2017/18 as at 31st July 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	16 (30% of threshold)
MRSA bacteraemia infections (post 48 hours)	Zero	0
MSSA bacteraemia	44	10 (23% of threshold)
E.coli bacteraemia	73	31 (42% of threshold)

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

4.1.1. *Clostridium difficile*

Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a c.*difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and painful abdominal cramps. In extreme cases, *c. difficile* infections can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (termed toxic megacolon). In certain cases they can cause or contribute to the death of a patient. Root cause analysis (RCA) investigations are conducted for each infection and outcomes of RCA investigations for all Trust apportioned cases are shared collaboratively with commissioners. The RCA includes a review of the patient's medical care in the 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

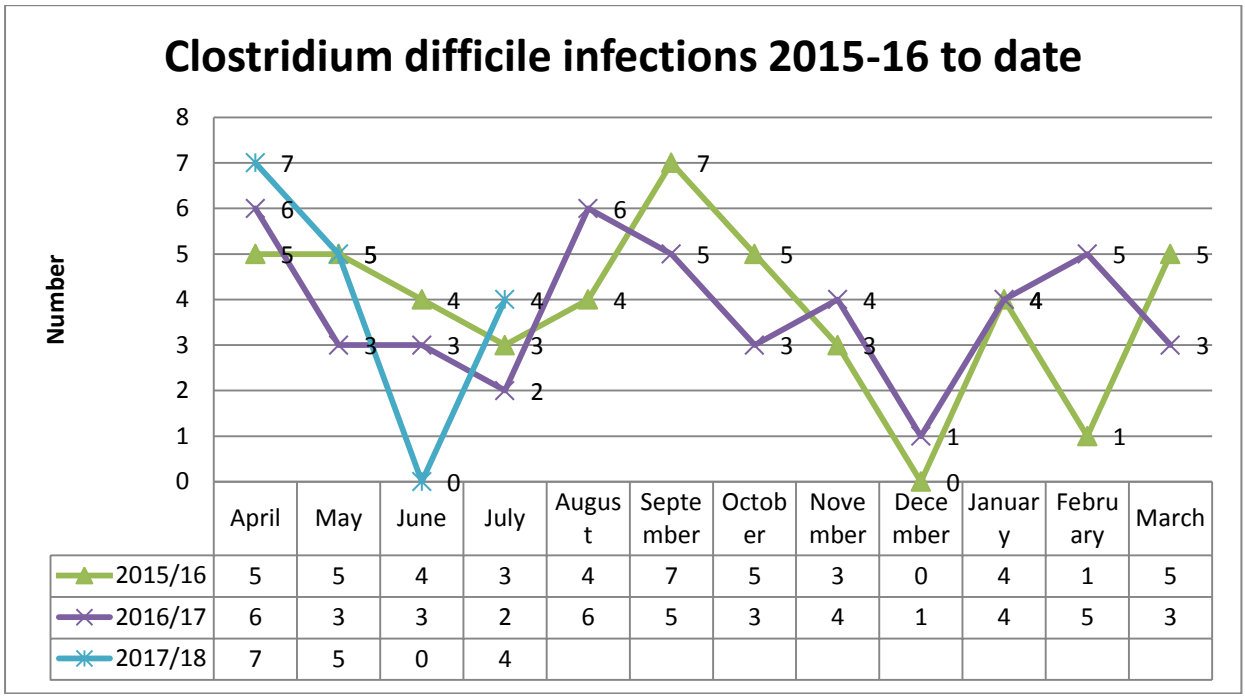
To date this financial year, at Month 4, the Trust is reporting 16 infections against an upper threshold of 53 (30% of threshold). Four Trust apportioned *c. difficile* cases were reported during July 2017; two cases in the Medical Health Group, one in Surgery and the fourth in Clinical Support.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	53	16 (30% of threshold)	The 4 cases reported during July 2017 are subject to RCA investigations, which have commenced

The Trust Board is updated on any significant findings from completed Root Cause Analysis investigations in *c. difficile* cases. Any new elements of learning are captured below:

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Nil to report	Nil to report	Nil to report	Nil to report

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



4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

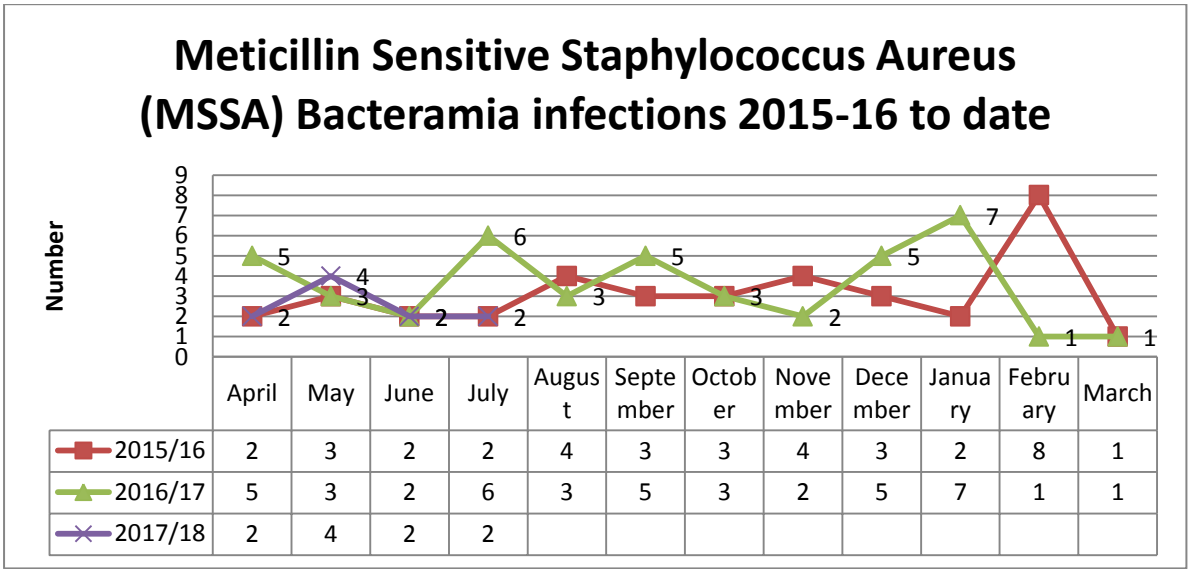
Meticillin-Sensitive *Staphylococcus aureus* is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

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	10 (23% of threshold)	8 x RCA completed 2 x pending iRCA 3 x cases to date deemed lapses in practice/ evidence of suboptimal practice (reported previously)
Lapses in practice/ Evidence of suboptimal practice	**Reason for lapses in practice/ suboptimal**	**Lessons learned/ Identified learning**	**Actions**
Nil to report	Nil to report	Nil to report	Nil to report

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:



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	2	3	2	2	4	3	3	4	3	2	8	1
2016/17	5	3	2	6	3	5	3	2	5	7	1	1
2017/18	2	4	2	2								

4.1.4 *Escherichia-coli* Bacteraemia

There are many different types of *Escherichia coli* (*E. coli*) bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals.

However, when strains of *E. coli* are outside their normal habitat of the gut, they can cause serious infections, several of which can be fatal. Potentially dangerous *E. coli* can exist temporarily and harmlessly on the skin, predominantly between the waist and knees (mainly around the groin and genitalia), but also on other parts of the body, i.e. a person's hands after using the toilet.

E. coli is now the commonest cause of bacteraemia reported to Public Health England.

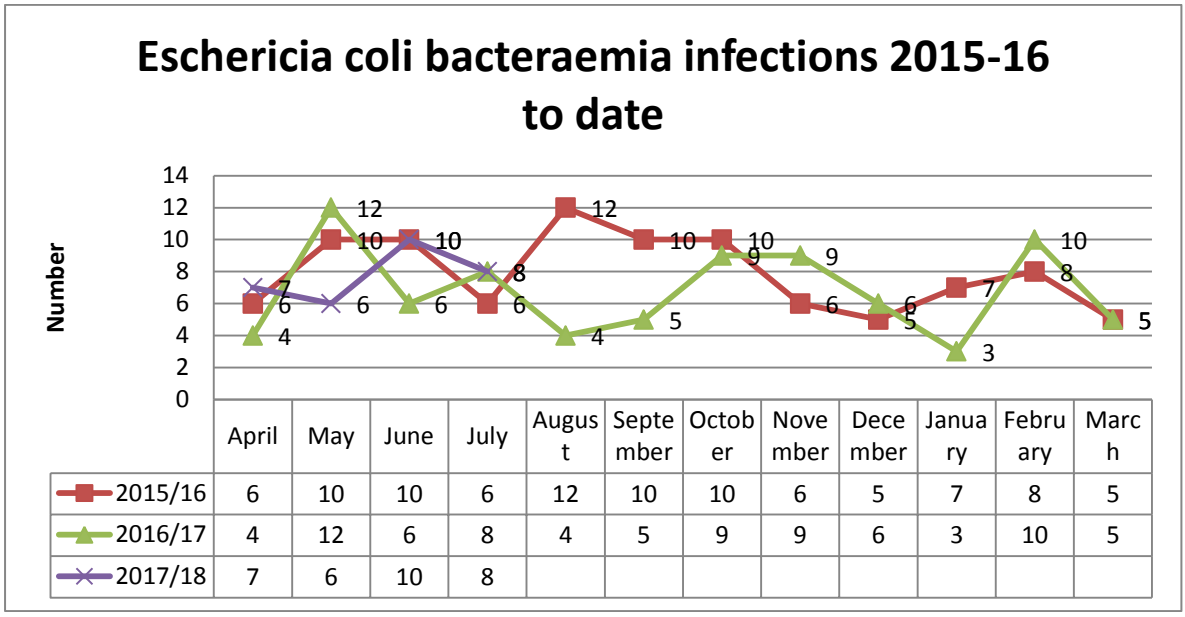
E. coli in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example.

During 2017/18, Trusts will be required by NHS Improvement to achieve a 10% reduction in E. coli bacteraemia cases. Achievement of reductions will be collaborative with joint 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.

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)	31 (42% of threshold)	31	1 x avoidable 2 x possibly avoidable 28 x unavoidable (complex, multi morbidities including bowel and biliary sepsis majority requiring ITU management)

Avoidable / Possibly avoidable *E. coli* bacteraemia cases		
Source of Infection	**Trends/ Risk Factors**	**Actions**
Nil to report	Nil to report	Nil to report

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



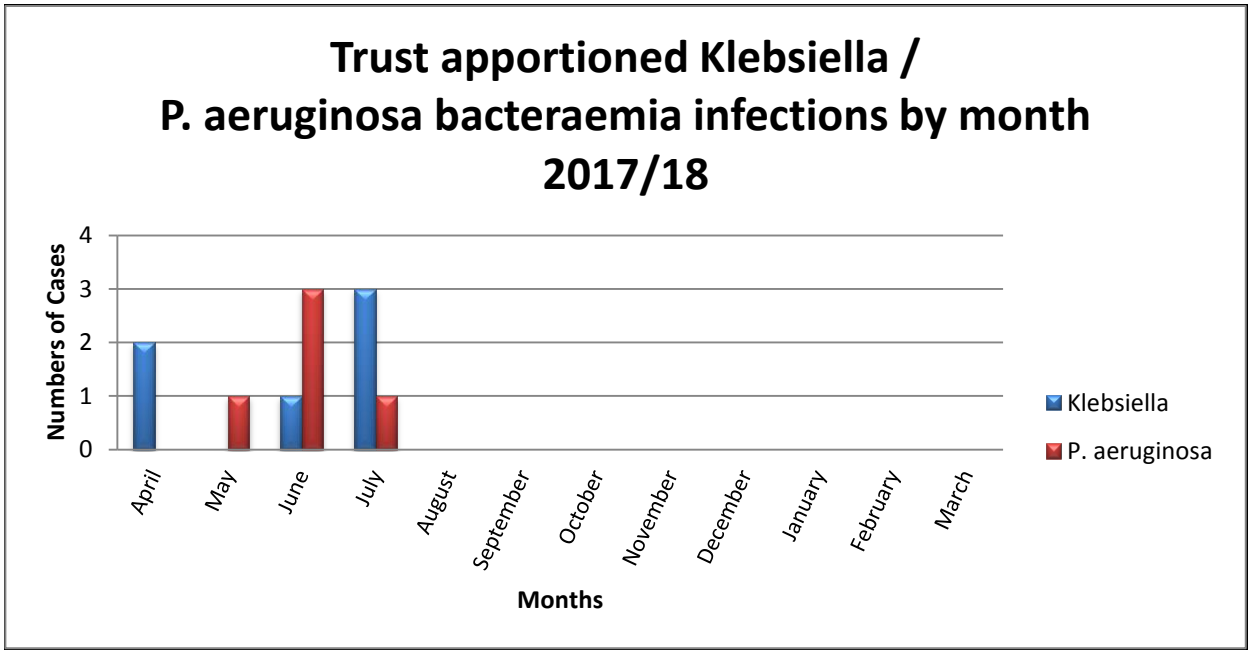
4.1.5 Gram negative bacteraemia – reporting for 2017/18

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 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 July 2017, two wards had incidents involving patients with diarrhoea and vomiting; both occurring in Medical Elderly care areas resulting in bay closures only. No causative organisms were identified. For subsequent outbreaks, the Trust will send off faecal samples to Public Health England for further testing to exclude other viral organisms, once Norovirus and Rotavirus have been excluded.

4.2.1 Incident regarding a confirmed case of Laryngeal Miliary Tuberculosis (TB)

Two incident meetings have been held to discuss the management of this case. The patient was discharged home under care of the community TB team and is responding well to treatment. A review of the patient's admission and initial management identified limited patient to patient contact that does not require screening subsequently. In total, 11 members of staff have been identified as being in contact with the patient and they will be followed up by the Occupational Health Team.

4.2.2 Influenza trends

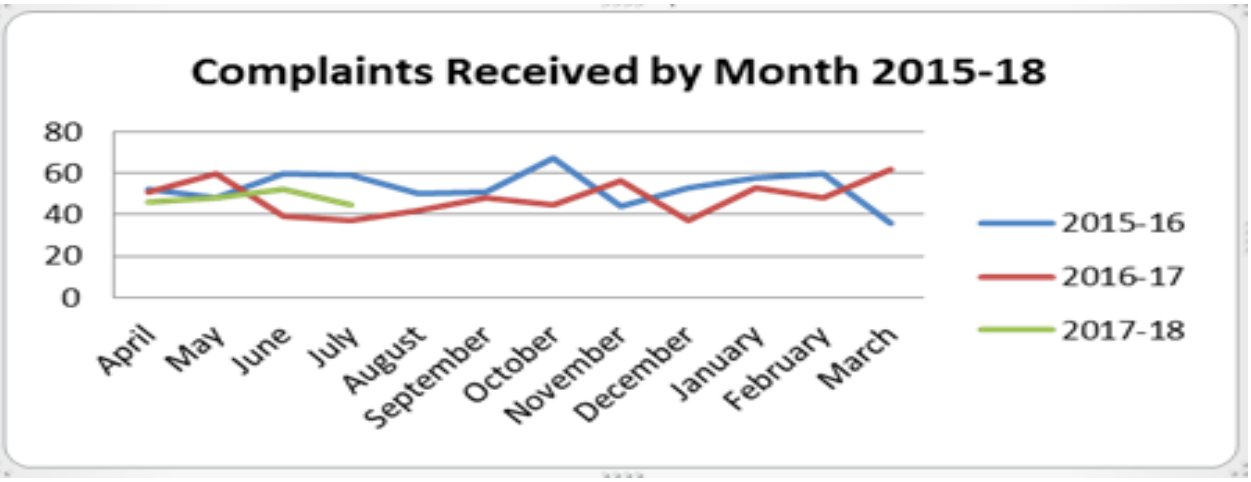
A case of Influenza A was reported in a patient admitted to the Acute Medical Unit via the ED. This patient had travelled to South East Africa and had returned to the UK two days previously with vague symptoms and was screened as a precaution. It is not unusual to detect cases of Influenza at this time of year in patients that have travelled, especially to the Southern Hemiphere. The patient was treated succesfully and discharged home.

5. PATIENT EXPERIENCE

5.1 Complaints

The following graph sets out comparative complaints data from 2014 to date. There were 45 new complaints logged in July 2017. As can be seen, complaints rates for June and July 2017 were higher than for the same period last year. However, they remain lower than the 2015/16 levels at

this stage. There is no obvious reason for this trend but it will continue to be monitored closely. Year to date, the rate of complaints received per month has been relatively stable.

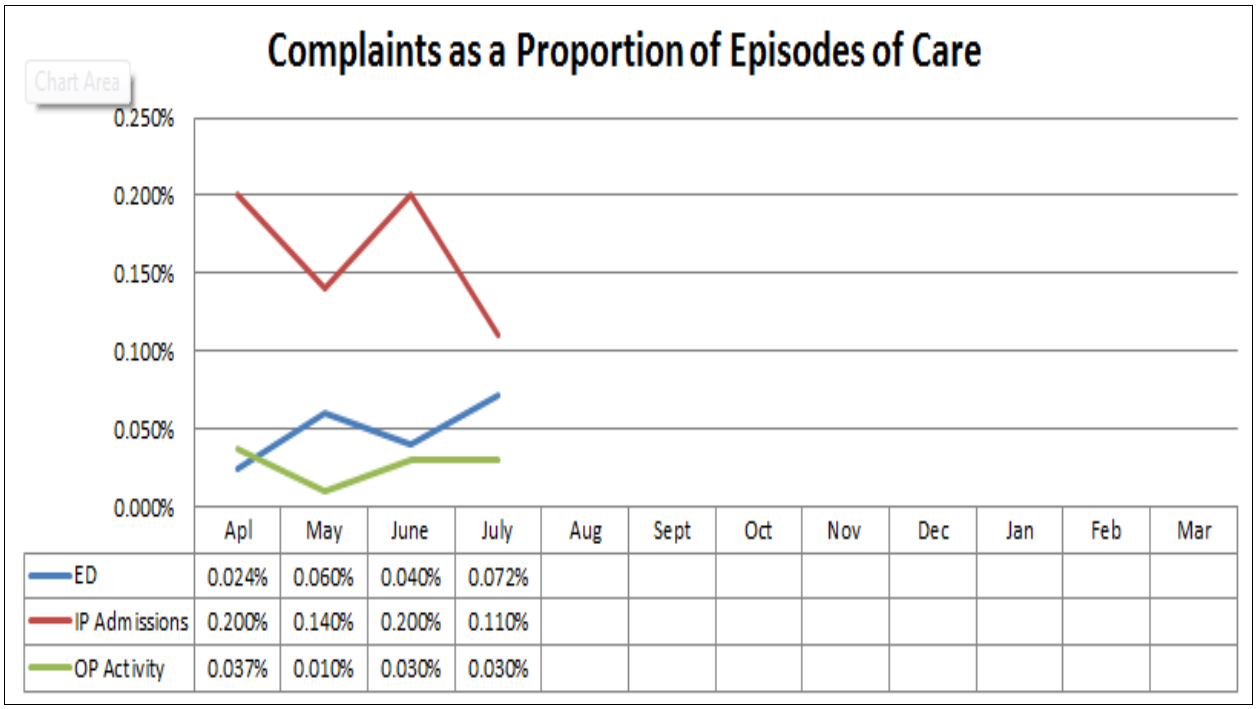


5.1.1 Complaints as a proportion of Episodes of Care

The following table shows complaints as a proportion of activity for July 2017.

July 2017	Patient Contacts	Numbers of Complaints	% (complaints as a proportion)
Emergency Department	13,286	10	0.07
Inpatient Admissions	13,050	15	0.11
Outpatient Episodes	59,615	20	0.03

The following chart shows the monthly trend of complaints against activity:



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 July 2017.

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancel	Discharge	Safe-guarding	Treatment	Total
Corporate Functions	2	0	0	0	0	1	0	3
Clinical Support	0	0	1	0	0	0	3	4
Family and Women's	0	0	1	0	0	0	9	10
Medicine	1	2	3	1	1	0	9	17
Surgery	1	0	1	1	0	0	8	11
Totals:	4	2	6	2	1	1	29	45

5.1.2 Examples of outcomes from complaints closed this month:

- A patient was admitted to the Emergency Department (ED) with a suspected foreign object lodged in her throat. This was missed during examination in ED. The patient also raised concerns that the doctor was dismissive towards her.

  Action: The Consultant investigating the complaint has spoken with the educational supervisor of the doctor involved regarding their dismissive attitude and told them this was unacceptable. The doctor has been reminded to remain polite and professional with their patients at all times in line with GMC good medical practice guidelines.

  The ED Consultant has an anonymised version of this complaint and is using this within departmental meetings to raise awareness. The associated learning point will be that patients who present with a suspected foreign body within the throat/oesophagus should be sent for an X-ray of the soft tissues of the neck and referred on appropriately. If a foreign body is not identified on the X-ray and the patient remains symptomatic then the ENT surgeons should be contacted for further advice and/or direct laryngoscopy to further investigate prior to discharge.

- A baby died soon after child birth. The parents raised concerns regarding why the placenta was not available for the post-mortem.

  Action: The normal practice is to retain the placenta for 72 hours following the birth of a child where there are concerns about the baby's health following birth and transferral to NICU. It was unclear why this did not happen on this occasion. Awareness was raised with staff by a Senior Consultant and the Labour Ward Manager issued an email with clear instructions for all staff to follow in the future.

- A patient had a fall and attended ED. They were undergoing chemotherapy treatment and following bloods being taken, they experienced a small bleed. The patient's daughter, who is also a phlebotomist, was applying pressure to the area in order to stop the bleeding. A Clinical Support Worker attempted to assist by removing the plaster resulting in the patient sustaining a skin tear.

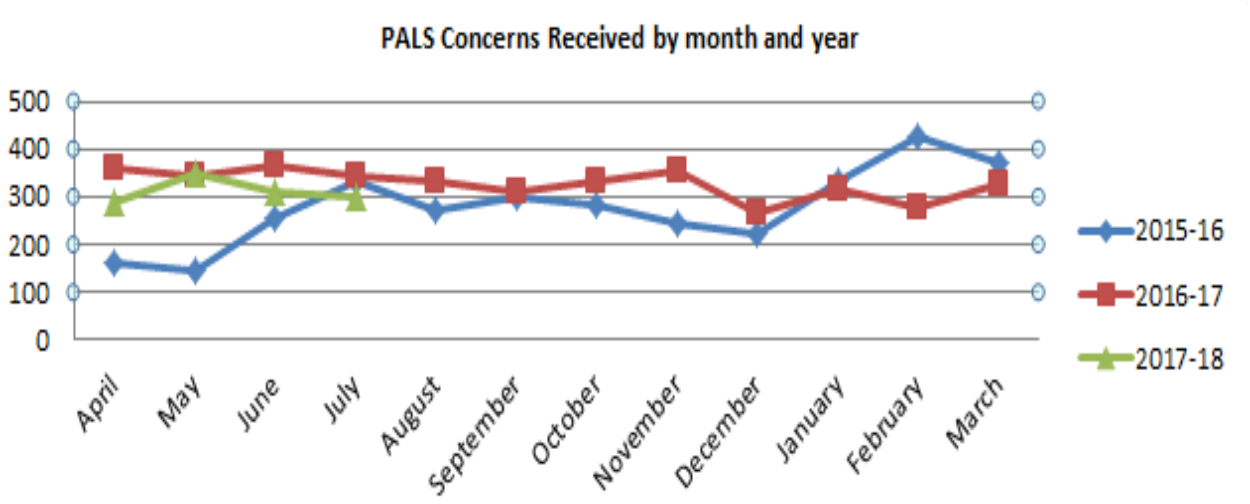
  Action: The Senior Sister has met with the Clinical Support Worker and highlighted the issue raised so that this does not happen to any other patients. The Senior Sister ensured that the Clinical Support Worker understood the effect their actions and attitude had on the patient and the patient's daughter. The Teacher Practitioner for the department will work with the Clinical Support Worker to support their learning and their progress will be monitored.

5.1.2 Performance against the 40-day complaint response standard

The Patient Experience Team has been working closely with the Health Groups to progress complaints in a timely manner and has produced guidance to assist staff in achieving the Trust's target of 90% for formal complaints to be responded to fully within 40 days of receipt. At the time of this report there are 70 complaints open, with three open over 40 days (96% compliance).

5.2 Patient Advice and Liaison Service (PALS)

In July 2017, PALS received 184 concerns, 43 compliments and 74 general advice issues, with an overall reduction when compared to June over the last two years but an increase of 11 contacts since last month. The majority of concerns continue to be waiting times/cancellations, delay in notification of results and not being satisfied with treatment plans.



This graph shows PALS contacts in 2017-18have been relatively consistent each month.

The following table indicates the number of PALS received by Health Group and primary subject in July 2017:

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times and Cancellations	Discharge	Environment	Safeguarding	Treatment	Total
Corporate Functions	10	0	0	4	6	0	0	1	0	21
Clinical Support - Health Group	1	2	0	0	5	0	1	0	1	10
Family and Women's Health Group	1	4	0	2	21	0	0	0	14	42
Medicine - Health Group	8	10	4	11	16	3	2	1	11	66
Surgery - Health Group	3	5	1	6	14	3	0	0	10	42
Totals:	23	21	5	23	62	6	3	2	36	181

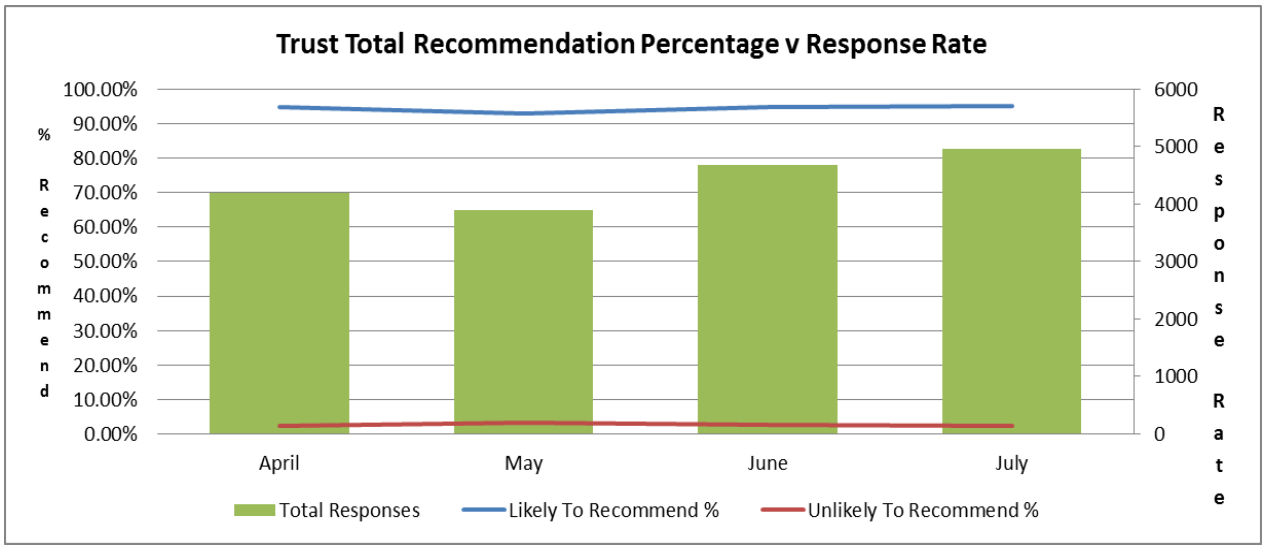
5.3 Friends and Family Test (FFT) – July 2017

The Trust's Friends and Family results for July for all areas, including the Emergency Department, indicate that there was an increase in the number of responses for July 2017 with 4,958 responses, compared to June when the Trust received 4,685 responses. From these, **95.12%** were extremely likely/likely to recommend the Trust to friends and family.

5.3.1 Trust Summary

The following table provides the Trust's overall FFT 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	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%

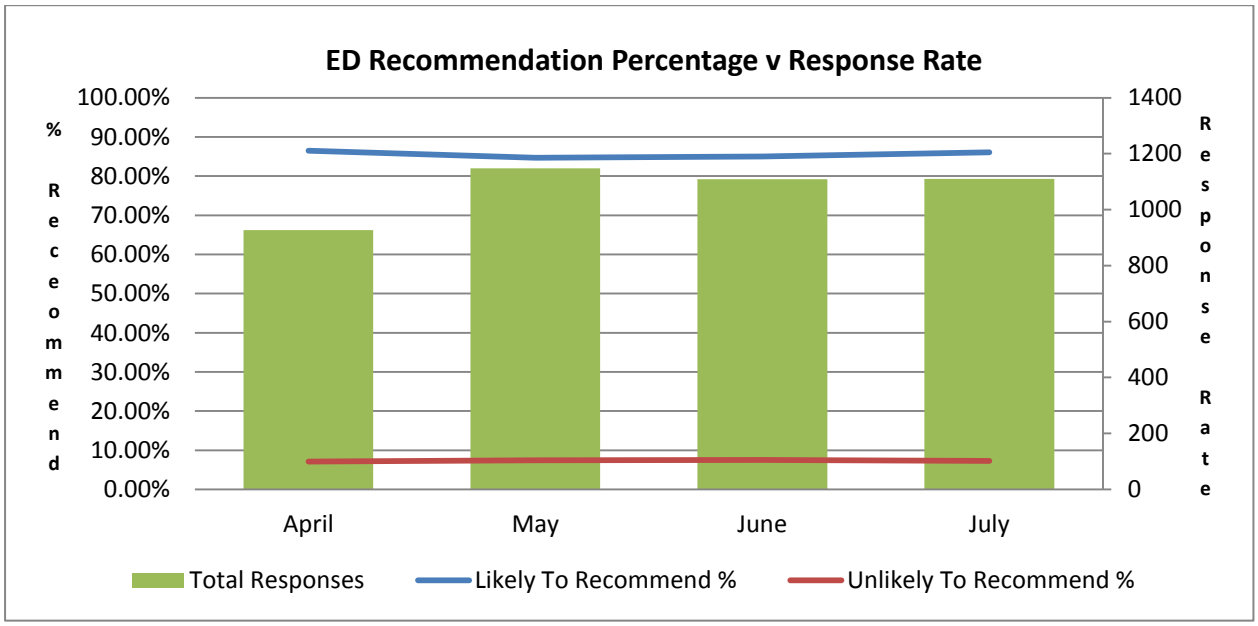


5.3.2 Friends and Family Emergency Department (ED)

In July 2017**,** 1,110 patients responded. **86.04%** of patients gave positive feedback and **7.30%** gave negative feedback. Due to the change in provider, it has now been discovered that April – June's ED's response figures were incorrect and did not include results from SMS text messaging. This has now been corrected, and accurate figures are presented, as follows:

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%



Although paper responses in ED were low in July, the SMS again had a high percentage of respondents and is proving to be a successful method of receiving feedback.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 11 cases under review by the PHSO currently. During the month of July there have been 4 new cases opened. The Trust has reviewed the four new cases and no trends have been identified.

5.5 Adult Voluntary Services
The Adult Voluntary Service continues to recruit steadily, and Voluntary Services continue to support areas in the Trust offering support and reassurance to the patients and public.
There has also been a recent increase of retired members of staff wanting to volunteer at the Trust.

5.6 Interpreters
The Patient Experience Team has seen the success of the 'iPads' pilot in several outpatient clinics to assist with interpretation requests for patients. The team is now looking at new providers for face to face interpreters and telephone interpreting services as well as other interpreting tools required for the Trust.

5.7 Compliments
A variety of compliments has been sent to the Trust for the month of July and were passed on to the Health Groups to cascade to the wider team. Examples of some compliments are as follows:

- **Neurosurgery**

"I feel compelled to tell you have made such a big difference to my life, I feel like a new man. I can wrestle with my 2 children, run after them, play, and not live with the pain I was suffering. Thank you for wanting to do the surgery and putting me forward to do so, thank you. Your team looked after me so very well, so congratulations for a job well done.

Have a safe and happy life. It is hard to fit in all I would like to say, I should have got a bigger card!!"

- **PALS**

"Thank you for that lovely email. You have been a source of great comfort and support and delightful with it. I know that your involvement has made a massive difference to getting a date for the operation. Long may your influence and talent continue in support of needy people".

- **Cardiology**

'I would like to comment regarding the excellent care that I have recently received at Castle Hill Hospital. The care I received was beyond my expectation. At the follow up appointment I received a first class service. I would like my sincere thanks and gratitude to be sent to the Team.

6. CARE QUALITY COMMISSION (CQC)

6.1 Well Led Domain pilot

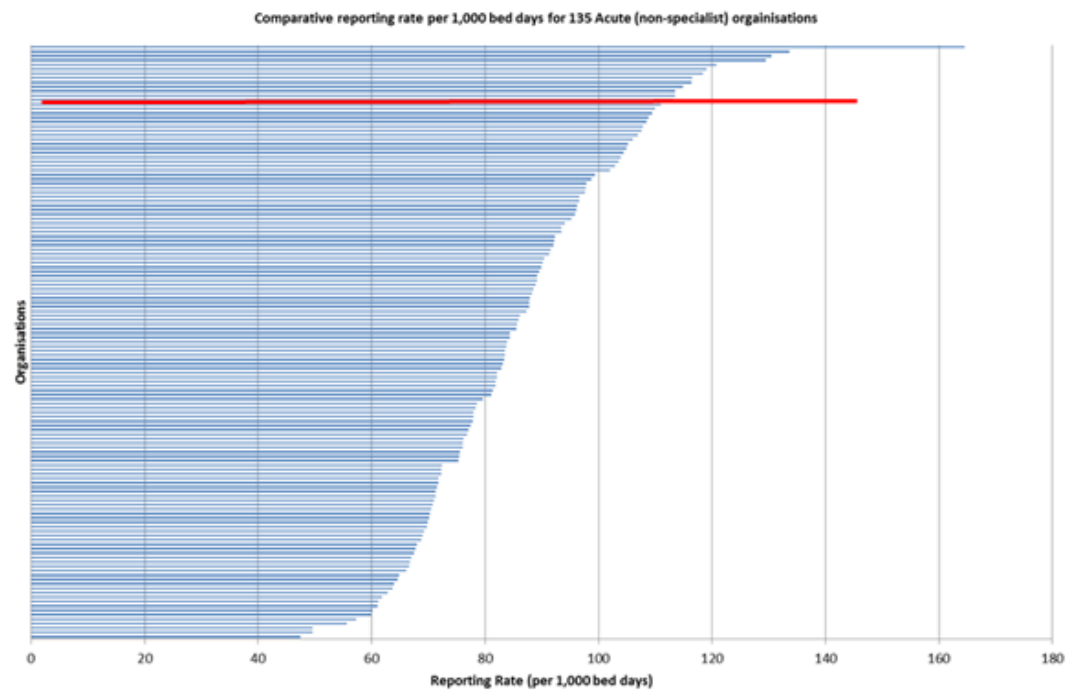
The Trust Board is aware already that the Trust took part in a joint CQC well-led and NHS Improvement (NHSI) Use of Resources pilot on the 19 and 20 June 2017. The Trust has received the draft report for factual accuracy checking and needs to respond to the CQC by 4 September 2017 with any comments. The response is in the process of being compiled. This report will not be published as it is for testing the regulators' new inspection methodology. However, the Trust found being involved in the process to be helpful and informative.

7. OTHER QUALITY UPDATES

7.1 The National Reporting and Learning System (NRLS)

The NRLS is a national database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. The reporting information used to be released to Trusts on a six-monthly basis, but this changed in July 2017 and now the figures will be released monthly.

Previous figures from 2015/16 had shown the Trust to be in the bottom third of Trusts for reporting incidents, which may have indicated a poor safety reporting culture. However, on close examination of the figures, it appears that the Trust was only reporting nationally incidents that occurred in the Trust rather than incidents that had been reported on the Trust's Datix system but had occurred elsewhere. One example is in relation to patients that present in the ED with pressure damage that has occurred in a community setting but which has been discovered on admission. The Trust has not normally counted these in its reporting statistics. However, it has been discovered that this was inconsistent with the reporting patterns of other Trusts. Now all incidents reported through the Trust's system are being uploaded to the central national database. As the following table shows, this has had a significant effect on the Trust's reporting figures and it is now in the top ten percent of Trust's, nationally. This is a really positive development, as this information is relied upon by regulators and commissioners as a proxy indicator that measures the Trust's safety culture.



8. 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	5th September 2017		**Reference Number**	2017 – 9 - 9		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

The last report on this topic was presented to the Trust Board in August 2017 (June 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 July 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

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

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

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

Fig 1: Hull Royal Infirmary

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

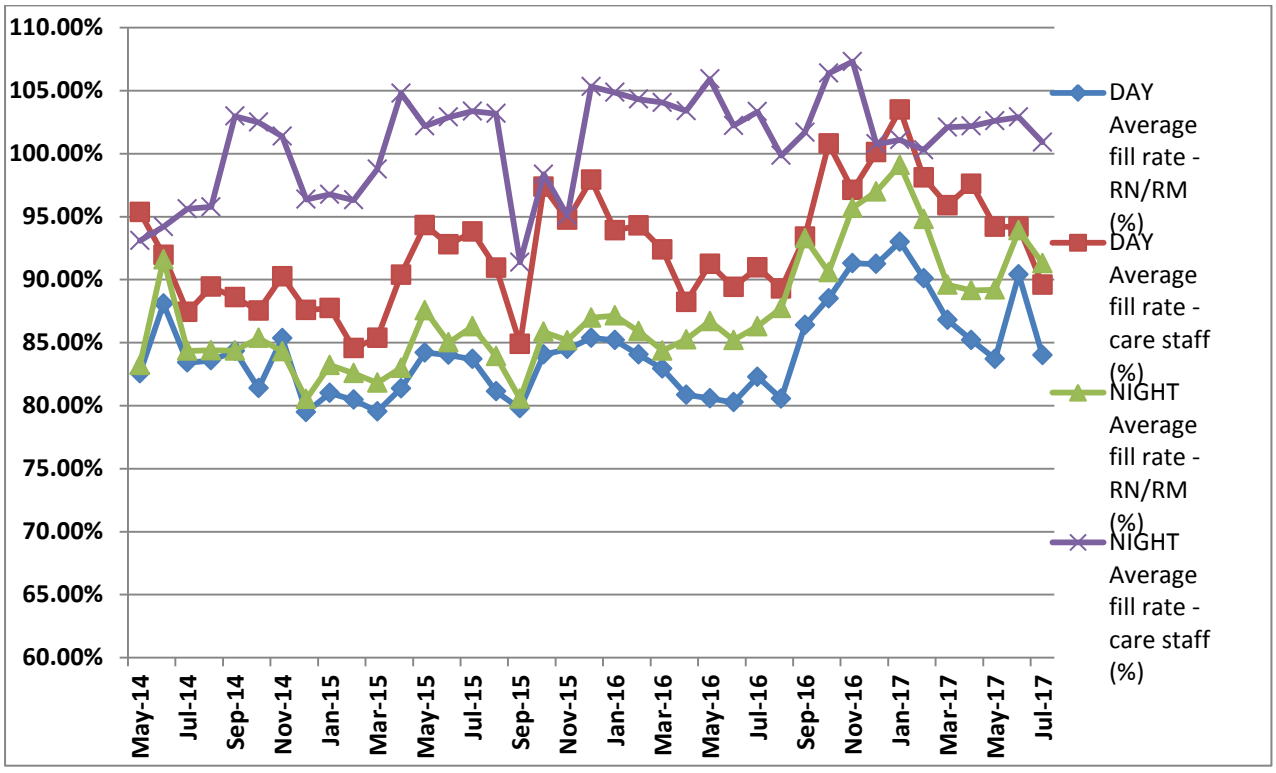
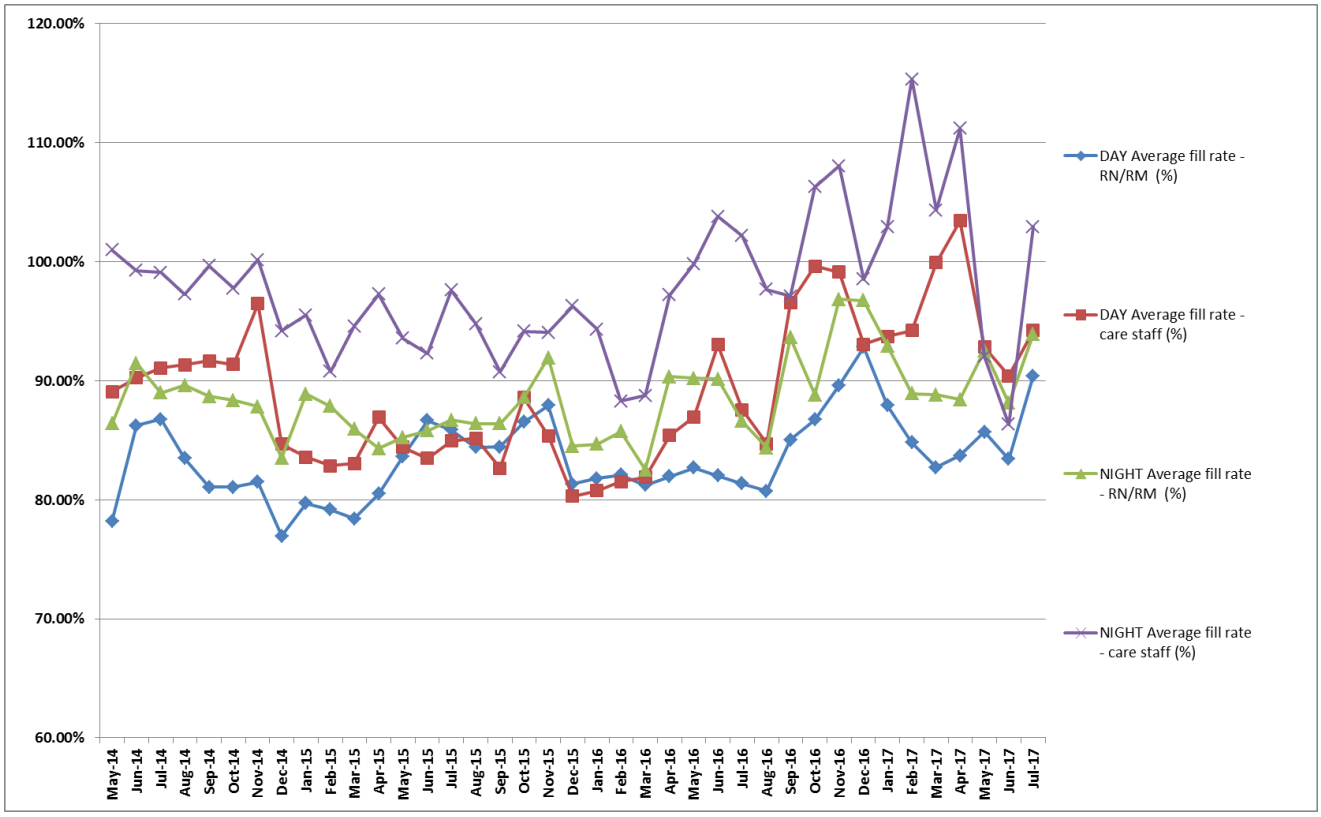


Fig 2: Castle Hill Hospital

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%



As indicated in the tables previously, the fill rates for both HRI and CHH have been variable during July. This reflects a number of factors, which include:

- The closure of 14 beds within Surgery at CHH.
- 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 Rostering of Senior Matrons into clinical shifts within Surgery to help boost direct care-giving hours.
- Inpatient vacancy rates, which are approximately 165 wte Registered Nurses (RN) - an increase of only 12 wte from the previous month
- Sickness levels on wards are within the Trust's threshold.
- The majority of clinical areas were within the 11-17% annual leave allocation, with only one area slightly in excess of this, which means that annual leave is being managed within the requirements of the Trust's Policy.

Work continues with recruitment for Registered Nurses. Circa 130 student nurses are now being pursued by the Trust from the University of Hull. These have reduced from 145 reported last month as students take alternative offers. The Trust is contacting these individuals to understand their justification for withdrawing their application and to identify if there is a possibility of them reconsidering employment with the Trust.

The Trust has received its first nurse from the Philippines who is settling in well in ICU at CHH. A further two cohorts are scheduled to arrive in September and October.

4. ENSURING SAFE STAFFING

The safety brief reviews, which are now completed four 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. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. Staffing levels are assessed directly from the live e-roster and SafeCare software.

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).

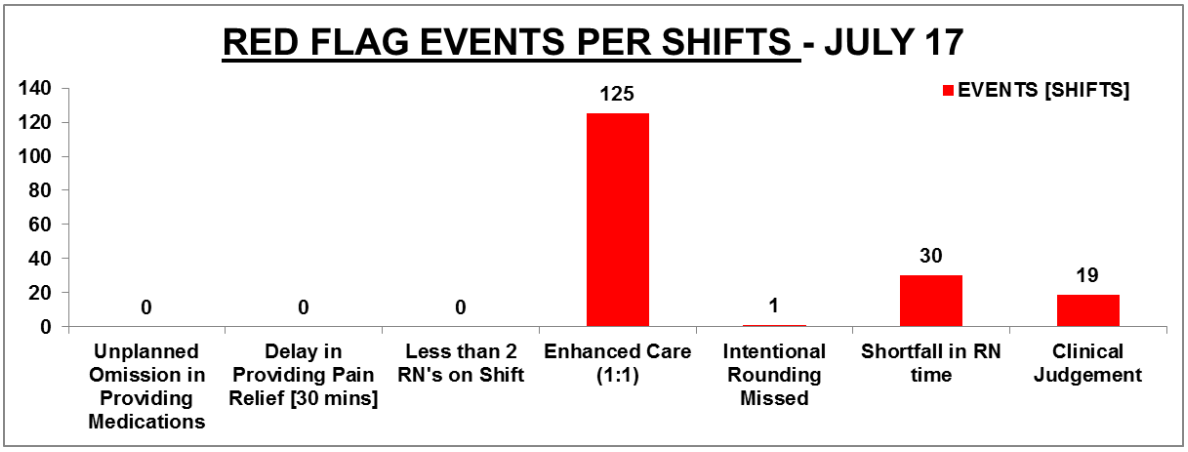
The 'red flags' suggested by NICE, are:

- 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 July 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

Jul-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 (1:1)	125	71%
	Intentional Rounding Missed	1	1%
	Shortfall in RN time	30	17%
	Clinical Judgement	19	11%
	TOTAL:	**175**	**100%**



As illustrated above, the most frequently reported red flag is related to the requirement for 1:1 supervision. As indicated in the previous Board Report, this will be addressed through the implementation of the Enhanced Care Team, which is due to commence as a pilot in September 2017.

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 7.09 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 17.36 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 7.96 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 20.87 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 4.12 wte RN vacancies and over-established for non-registered vacancies at present. The RN vacancies have all been appointed to, with the exception of 1wte. 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 5.78 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 4.60 wte RN and 1.71 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 a 7.91 wte RN vacancies across the floor. There is a plan to support with staff from C14 as this will assist in the relocation of maxilo facial patients to this ward in October 2017.

- **Ward C9 -** Elective Orthopaedic Surgery has 3.65 wte RN and 1.27 wte non-registered nurse vacancies. There are currently 6 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 5.74 wte RN registered nurse vacancies. The nursing staff are flexed between C10 and C11.

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 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:

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

Mike Wright
Executive Chief Nurse
August 2017

Appendix 1: HEY Safer Staffing Report – July 2017

HEY SAFER STAFFING REPORT JULY-17

NURSE STAFFING

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	FILL RATES DAY: Average fill rate - RN/RM (%)	FILL RATES DAY: Average fill rate - care staff (%)	FILL RATES NIGHT: Average fill rate - RN/RM (%)	FILL RATES NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: Cumulative Count Over The Month of Patients at 23:59 Each Day	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: RN / RM	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: CARE STAFF	CARE HOURS PER PATIENT DAY [CHPPD] [hrs]: OVERALL	ROTA EFFICIENCY [12-06-17 to 09-07-17]: ANNUAL LEAVE [11-17%]	ROTA EFFICIENCY [12-06-17 to 09-07-17]: SICK RN & AN [3.9%]	ROTA EFFICIENCY [12-06-17 to 09-07-17]: MAT LEAVE [%]	NURSING VACANCIES [FINANCE LEDGER M4]: RN [WTE]	NURSING VACANCIES [FINANCE LEDGER M4]: AN [WTE]	NURSING VACANCIES [FINANCE LEDGER M4]: TOTAL [WTE]	NURSING VACANCIES [FINANCE LEDGER M4]: % [<10%]
MEDICINE	ED	ACUTE MEDICINE	NA	0									13.4%	1.7%	4.3%	17.36	2.06	19.42	15.4%
	AMU	ACUTE MEDICINE	45	2	98%	64%	93%	101%	1101	4.8	2.8	7.7	13.6%	0.2%	4.2%	9.17	-1.60	7.57	9.4%
	H1	ACUTE MEDICINE	22	7	81%	96%	100%	100%	628	2.5	1.7	4.2	11.4%	1.5%	0.0%	2.84	2.13	4.97	20.3%
	EAU	ELDERLY MEDICINE	21	4	83%	91%	66%	93%	594	3.5	3.6	7.1	16.6%	1.1%	4.2%	5.42	-1.55	3.87	12.0%
	H5 / RHOB	RESPIRATORY	26	17	80%	82%	103%	86%	606	2.8	1.9	4.6	18.1%	4.3%	0.2%	2.49	1.04	3.53	9.1%
	H50	RENAL MEDICINE	19	0	80%	99%	102%	107%	573	3.1	2.1	5.1	13.2%	0.8%	0.0%	1.71	1.39	3.10	16.4%
	H500	RESPIRATORY	24	10	84%	89%	100%	102%	723	2.2	2.4	4.5	15.2%	2.4%	3.8%	6.16	0.43	6.59	21.9%
	H70	ENDOCRINOLOGY	30	5	85%	124%	100%	90%	913	2.3	2.2	4.5	9.5%	1.9%	0.0%	7.96	1.76	9.72	28.9%
	H8	ELDERLY MEDICINE	27	21	77%	112%	103%	101%	824	2.1	2.4	4.5	12.3%	0.2%	3.6%	3.86	-0.44	3.42	11.1%
	H80	ELDERLY MEDICINE	27	14	77%	93%	102%	110%	819	2.2	2.3	4.4	10.2%	2.3%	0.0%	3.91	0.89	4.80	15.6%
	H9	ELDERLY MEDICINE	31	11	87%	99%	100%	103%	927	2.1	2.1	4.2	14.0%	2.0%	1.5%	1.82	-0.36	1.46	4.7%
	H90	ELDERLY MEDICINE	29	30	70%	110%	101%	123%	882	1.9	2.4	4.3	10.8%	2.8%	3.4%	4.86	-3.43	1.43	4.6%
	H11	STROKE / NEUROLOGY	28	6	74%	160%	95%	102%	835	2.1	2.3	4.4	11.9%	1.2%	0.0%	7.09	2.25	9.34	27.2%
	H110	STROKE / NEUROLOGY	24	0	73%	142%	116%	97%	513	4.0	3.3	7.3	10.3%	1.6%	9.9%	4.28	0.01	4.29	12.4%
	CDU	CARDIOLOGY	9	0	83%	100%	100%		93	11.6	1.4	13.1	10.0%	1.1%	0.0%	0.86	0.63	1.49	9.5%
	C26	CARDIOLOGY	26	0	80%	82%	83%	103%	706	4.0	1.6	5.6	17.0%	1.8%	8.7%	2.51	-0.23	2.28	6.6%
	C28 /CMU	CARDIOLOGY	27	2	77%	83%	83%	49%	709	6.0	1.4	7.4	14.2%	5.4%	3.7%	3.34	-0.11	3.23	6.6%
SURGERY	H4	NEURO SURGERY	30	6	80%	80%	94%	110%	760	3.1	1.8	4.9	12.4%	3.5%	3.8%	4.60	1.71	6.31	19.5%
	H40	NEURO HOB / TRAUMA	15	6	85%	95%	108%	102%	376	5.8	3.8	9.5	8.6%	4.1%	3.4%	4.56	1.71	6.27	20.3%
	H6	ACUTE SURGERY	28	0	92%	79%	84%	168%	691	3.2	2.1	5.3	14.5%	0.0%	6.5%	3.91	0.47	4.38	14.7%
	H60	ACUTE SURGERY	28	0	88%	88%	83%	153%	738	2.9	2.0	5.0	17.2%	0.9%	3.2%	1.56	1.38	2.94	9.6%
	H7	VASCULAR SURGERY	30	3	85%	74%	92%	102%	884	2.8	2.3	5.1	11.8%	1.8%	0.7%	4.52	0.85	5.37	15.3%
	H100	GASTROENTEROLOGY	24	1	93%	104%	98%	100%	720	2.5	2.3	4.8	15.2%	1.8%	3.3%	3.95	0.82	4.77	15.6%
	H12	ORTHOPAEDIC	28	1	85%	93%	91%	129%	787	2.6	2.7	5.3	13.3%	0.2%	5.7%	5.39	-2.19	3.20	9.1%
	H120	ORTHO / MAXFAX	22	0	87%	91%	87%	126%	609	3.4	2.7	6.1	10.8%	2.2%	0.0%	2.52	2.19	4.71	16.4%
	HICU	CRITICAL CARE	22	0	87%	104%	89%	48%	502	25.3	1.2	26.5	15.4%	1.7%	4.1%	5.47	0.98	6.45	5.8%
	C8	ORTHOPAEDIC	18	2	96%	65%	95%	67%	218	4.6	2.5	7.1	12.0%	5.4%	0.0%	2.32	-1.03	1.29	8.9%
	C9	ORTHOPAEDIC	29	0	93%	98%	100%	95%	658	3.5	2.4	5.9	14.9%	1.9%	0.0%	3.65	1.27	4.92	16.0%
	C10	COLORECTAL	21	0	90%	65%	80%	101%	462	4.2	1.8	6.0	10.7%	5.3%	0.0%	5.74	0.59	6.33	24.3%
	C11	COLORECTAL	22	0	93%	104%	98%	100%	720	2.5	2.3	4.8	14.5%	0.0%	0.0%	1.50	1.79	3.29	12.6%
	C14	UPPER GI	27	0	84%	77%	98%	122%	733	3.2	1.6	4.8	12.6%	2.3%	0.0%	3.89	0.08	3.97	13.5%
	C15	UROLOGY	26	0	87%	75%	92%	89%	554	4.3	2.5	6.8	16.1%	1.0%	1.8%	-0.30	0.75	0.45	1.1%
	C27	CARDIOTHORACIC	26	0	86%	88%	96%	107%	711	4.0	1.6	5.6	13.6%	1.5%	6.3%	1.03	-0.66	0.37	1.1%
	CICU	CRITICAL CARE	22	0	80%	61%	74%	17%	386	21.9	1.3	23.2	15.0%	0.6%	4.8%	5.47	0.98	6.45	6.5%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	100%	148%	115%	86%	284	6.8	4.1	10.9	9.1%	4.7%	0.0%	4.12	-1.06	3.06	10.3%
	H130	PAEDS	20	0	79%	39%	84%	74%	390	6.4	1.1	7.5	12.8%	0.9%	8.7%	1.21	2.02	3.23	11.5%
	H30 CEDAR	GYNAECOLOGY	9	0	92%	66%	109%		143	10.4	3.1	13.6	16.6%	0.0%	0.0%	-1.00	0.12	-0.88	-3.9%
	H31 MAPLE	MATERNITY	20	0	93%	89%	114%	100%	298	7.5	4.5	12.1	15.4%	0.8%	1.8%	4.42	1.75	6.17	8.6%
	H33 ROWAN	MATERNITY	38	0	88%	88%	86%	98%	1058	2.9	1.6	4.5	15.7%	2.4%	2.0%				
	H34 ACORN	PAEDS SURGERY	20	0	99%	47%	101%	86%	275	9.7	1.6	11.3	12.3%	1.1%	0.0%	0.02	-0.46	-0.44	-1.5%
	H35	OPHTHALMOLOGY	12	0	87%	66%	109%		240	8.4	1.7	10.1	15.9%	0.3%	3.4%	-0.54	1.53	0.99	4.8%
	LABOUR	MATERNITY	16	0	82%	76%	85%	72%	323	15.0	5.0	20.0	11.9%	4.3%	4.5%	-3.83	-1.93	-5.76	-9.1%
	NEONATES	CRITICAL CARE	26	0	78%	101%	81%	103%	643	11.0	1.1	12.1	14.3%	1.4%	6.7%	5.78	0.34	6.12	8.5%
	PAU	PAEDS	10	0	88%		92%		69	19.8	0.0	19.8	14.1%	0.0%	0.0%	0.76	0.00	0.76	7.3%
	PHDU	CRITICAL CARE	4	0	94%	107%	103%		69	21.4	1.6	23.0	8.6%	0.5%	0.0%	0.33	0.00	0.33	2.6%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	1	92%	83%	102%	84%	405	3.6	2.3	5.9	14.1%	3.3%	4.9%	2.24	0.96	3.20	15.8%
	C29	REHABILITATION	15	19	82%	104%	100%	65%	459	3.2	4.1	7.3	13.5%	1.2%	0.0%	1.37	1.22	2.59	9.0%
	C30	ONCOLOGY	22	2	83%	106%	98%	98%	633	2.8	2.1	4.8	13.6%	0.3%	2.8%	2.50	0.03	2.53	11.5%
	C31	ONCOLOGY	27	0	72%	100%	99%	105%	754	2.4	2.1	4.5	12.9%	1.4%	0.0%	0.67	1.33	2.00	7.8%
	C32	ONCOLOGY	22	3	92%	96%	102%	99%	617	3.0	1.7	4.7	12.1%	0.3%	3.1%	-0.53	1.72	1.19	5.0%
	C33	HAEMATOLOGY	28	2	76%	133%	99%	121%	660	4.2	2.1	6.3	14.2%	2.3%	2.6%	2.97	-1.99	0.98	2.8%
		TOTAL:	175		AVERAGE:				586	5.9	2.3	8.2	13.3%	1.8%	2.6%	165.91	22.14	188.05	10.7%
														TOTALS:				TOTALS:	

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

HEALTH GROUP	WARD	HIGH LEVEL: SAFETY THERMOMETER HARM FREE CARE [%]	HIGH LEVEL: REPORTED STAFFING INCIDENT [DATIX]	HIGH LEVEL: OFFICIAL COMPLAINT	HIGH LEVEL: DRUG ERROR [ADMIN]	FALLS: MINOR	FALLS: MODERATE	FALLS: SEVERE / DEATH	FALLS: FALLS TOTAL	HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]: 1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL	QUALITY INDICATOR TOTAL
MEDICINE	ED		1	10	1	2			2						0	14
	AMU	100%	2		2	1			1						0	5
	H1	100%		1	1				0						0	2
	EAU	100%			1	2			2						0	3
	H5 / RHOB	96%		1	1	2			2					1	1	5
	H50	100%							0						0	0
	H500	100%							0						0	0
	H70	100%			1	1			1		1				1	3
	H8	96%		1		2			2						0	3
	H80	100%		1	1	5	1		6						0	8
	H9	100%				2	2		4				2		2	6
	H90	96%	1	1		3			3				2		2	7
	H11	100%							0						0	0
	H110	100%	1			1			1		1		1		2	4
	CDU	100%							0						0	0
	C26	95%				1			1						0	1
	C28 /CMU	100%	1						0						0	1
SURGERY	H4	100%							0						0	0
	H40	100%							0	1					1	1
	H6	100%			2	1			1						0	3
	H60	100%							0						0	0
	H7	95%	2	1	1	2			2		2		1		3	9
	H100	100%		2	1	1			1						0	4
	H12	96%		1	2	1			1		1				1	5
	H120	100%		1		2			2						0	3
	HICU	75%			1				0		1		1		2	3
	C8	100%							0						0	0
	C9	100%							0		1				1	1
	C10	100%							0						0	0
	C11	100%							0						0	0
	C14	100%			2				0						0	2
	C15	100%							0		2				2	2
	C27	100%		1					0						0	1
	CICU	90%	1		2				0				1		1	4
FAMILY & WOMEN'S	C16	100%	1						0						0	1
	H130	100%							0						0	0
	H30 CEDAR	100%		3					0						0	3
	H31 MAPLE	100%							0						0	0
	H33 ROWAN	100%		1					0						0	1
	H34 ACORN	100%							0						0	0
	H35	100%		1	2				0						0	3
	LABOUR	100%	2	1		1			1						0	4
	NEONATES	100%			4				0						0	4
	PAU	100%							0						0	0
	PHDU	100%			1				0						0	1
CLINICAL SUPPORT	C20	100%					1		1						0	1
	C29	100%							0						0	0
	C30	100%							0						0	0
	C31	100%	1		1				0		1				1	3
	C32	100%							0						0	0
	C33	100%							0						0	0
		98.8%	49	13	27	27	30	4	0	34	1	10	0	8	1	20	121

Jul-17	DAY		NIGHT		CARE HOURS PER PATIENT PER DAY [CHPPPD]			
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Cumulative Count	RN / RM	CARE STAFF	OVERALL
HRI SITE	84.0%	89.6%	91.3%	100.9%	19696	4.5	2.3	6.8
CHH SITE	83.4%	90.4%	88.1%	86.3%	9515	4.7	2.1	6.7

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

Trust Board date	5 September 2017	**Reference Number**	2017 – 9 - 10
Director	Kevin Phillips, Chief Medical Officer	**Author**	Leah Coneyworth Compliance Team Manager Kate Southgate Head of Compliance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

1 RECOMMENDATIONS

The Trust Board is requested to receive this report and:

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

2 KEY PURPOSE:

Decision		Approval		Discussion	
Information	**Y**	Assurance	**Y**	Delegation	

3 STRATEGIC GOALS:

Honest, caring and accountable culture	**Y**
Valued, skilled and sufficient staff	**Y**
High quality care	**Y**
Great local services	**Y**
Great specialist services	
Partnership and integrated services	
Financial sustainability	

4 LINKED TO:

CQC Regulation(s): All

Assurance Framework BAF 3, 7.1	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N

5 BOARD/BOARD COMMITTEE REVIEW

As per the BAF, the QIP is key to providing assurance and action regarding the quality of patient care.

IMPROVEMENT PROGRAMME PROGRESS REPORT
AUGUST 2017

1. PURPOSE

The purpose of this report is to provide the Trust Board with the July 2017 progress update against the delivery of all the projects on the Quality Improvement Programme. The report also provides a further update against the projects that are currently rated as off-track.

2. QUALITY IMPROVEMENT PROGRAMME OVERVIEW

The Quality Improvement Programme continues to progress well during 2017/18. The full progress update report is attached at Appendix A for information. 16 of the projects are currently rated Amber/Green or above; indicating that successful completion is probable within year. 7 of the projects remain rated as Amber, which indicates that successful delivery of these projects appears to be feasible but do require constant management attention to ensure the issues are resolved. These projects are:

- QIP4 – Safeguarding, MCA and DOLs – this project was rated Amber during July 2017 due to a number of policies and guidelines being in the process of being revised. It has now been confirmed that regulatory action has closed and significant progress has been made against existing milestones, including development of policies. It is anticipated that this project will be rated as Amber/Green at the end of August 2017 with the intention that the project be closed fully and transferred to business as usual in September 2017.
- QIP10 – Pressure Ulcers – this project was rated Amber during July 2017 due to the number of in year avoidable pressure ulcers. Significant action has been taken, with the Chief Nurse seeking assurances on improvements from all leads within each Health Group.
- QIP12 - Children & Young People with Mental Health Needs and CAMHS – this project is rated Amber during July 2017 due to the delay in the development of a Service Level Agreement with external partners on the provision of mental health training for Trust staff. Discussions are due to take place between senior members of the two trusts to ensure this project moves forward as a matter of priority.
- QIP16 – Resuscitation Equipment Checklist – this project was rated Amber during July 2017 due to compliance with monthly and daily equipment checks. Since May 2017 a new checklist has been introduced and compliance has been increasing. July 2017 performance has now been confirmed and is meeting the compliance trajectory of 95%. If performance is sustained in August 2017, this project will be reviewed and receive a revised rating of Amber/Green.
- QIP22 – Nutrition – this project was rated Amber during July 2017 due to performance with Fundamental Standard reviews being below the 90% threshold (current performance is 85.7%). In addition the Nutrition and Hydration policy remains outstanding for revision and approval.
- QIP24 – Children & Young People – the project was rated Amber during July 2017 due to a number of the milestones for developing a Children's Strategy being delayed from 2016. The team continues to work with internal stakeholders and external partners to move this project forward. Whilst the strategy is outstanding the project will remain rated as Amber.

  QIP34 – Critical Care – this project was rated Amber during July 2017 due to the delay in recruiting consultants, however, the Health Group are currently reviewing ICNARC data to determine if outcome measures continue to maintain above national expectations. If outcome measures are positive this project will be reviewed with the view to change the rated in August 2017 to Amber/Green.

These projects are being closely monitored by the monthly Quality Improvement Programme meeting chaired by the Chief Nurse and the Chief Medical Officer and further actions are being taken to ensure the successful delivery of the projects within 2017/18.

3. 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

Leah Coneyworth
Compliance Team Manager

Kate Southgate
Head of Compliance
August 2017

APPENDIX A

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

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

Overall Programme Objectives:
The Objectives of the Quality Improvement Programme are to:

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

Overall delivery of programme	**Current Overall Rating**	**A/G**

Overview:
The overall QIP is now rated as Amber/Green, from a previous rating of Amber in June 2017. Performance across the projects has generally improved within the month.

Successful delivery of the overall QIP appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.

Key activity during June 2017:
All projects have reviewed with leads to ensure that the ratings given are accurate of delivery against the overall aims of the project.

Current Position:
6 projects currently rated Green (June 2017: 8 projects)

- 06. Deteriorating Patient
- 09. Falls
- 15. Sepsis
- 37. ReSPECT
- 38. Consent
- 39. Outpatients

10 projects currently rated Amber/Green (June 2017: 5 projects)

- 02. Learning Lessons
- 05. Medicines Management
- 08. Infection Control
- 11. Maternity & Gynaecology
- 14. VTE
- 23. Dementia
- 28. Patient Experience
- 30. Avoidable Mortality
- 35. Safer Standards for Invasive Procedures
- 36. Transition from Children to Adult Services

7 projects rated Amber (June 2017: 8 projects)

- 04. Safeguarding, MCA & DOLs
- 10. Pressure Ulcers
- 12. Children & Young People with Mental Health Needs and CAMHS
- 16. Resuscitation Equipment Checklist
- 22. Nutrition
- 24. Children & Young People Services
- 34. Critical Care

0 project rated Amber/Red (June 2017: 1 projects)

Information to note:
QIP06 – Deteriorating Patient adult has been revised and reopened. This project will focus on improved training compliance with clinical observations

Areas for Escalation:
None

Project Overview	Overall – RAG	Current Month - RAG	Trend from previous month	Comments
QIP02 – Learning Lessons	**A/G**	**A/G**	↓	This project is currently rated as Amber / Green. This project is influenced by all other projects contained within the Quality Improvement Programme. The majority of projects continue to progress well and the majority of milestones within this project continue to progress well. During 2017-18 the focus will be on embedding the learning across the Trust which will include taking part in phase 2 of the Improvement Academy Measuring and Monitoring of Safety Framework (MMSF). This work at times is proving difficult to gain by in from all necessary parties within the Trust. However, the project team are keen to continue to pursue this framework for improvement. (Rated Green June 2017)
QIP04 – Safeguarding, MCA and DOLs	**A**	**A**	↔	The project is rated as amber due to the delay in the delivery of a number of milestones transferred from the 2016/17 quality improvement plan. 11 milestones have had the forecast finish dates revised following an update from the lead and discussion at the QIP meeting held on 03 July 2017. The majority of these are due to be delivered in July and August 2017; however the July milestones remain overdue at the time of writing this report (28 July 2017)
QIP05 – Medicines Management	**A/G**	**A/G**	↑	The project is rated as amber/green because it has been carried forward onto the 2017/18 quality improvement plan for further improvement work to be undertaken and to further improve the medicine reconciliation rates within 24 hours of admission. (Rated Amber June 2017)
QIP06 – Deteriorating Patient	**G**	**G**	Project re-opened in July 2017	This project was re-opened in July 2017 with the focus on clinical observations and training. This project is currently rated as Green.
QIP08 – Infection Control	**A/G**	**A/G**	↑	The project is progressing well with a number of milestones being closed however two of the performance indicators are off track for year end data. These are to reduce the number of hospital acquired c.diff and to reduce the number of hospital acquired MRSA. Mitigating actions are being considered. Therefore this project is rated amber green. (Rated Amber June 2017)
QIP09 – Falls	**G**	**G**	↔	The overall RAG rating for this period is Green. Good progress is being made against the delivery of the milestones within this project and in turn the aim of the project.
QIP10 – Pressure Ulcers	**A**	**A**	↔	The project this year is progressing although there are key risks to delivery, including the return of the two specialist nurses concluding their secondments. As such the project is rated Amber/Green. At the June 2017 QIP meeting the team raised concerns regarding the number of pressure ulcers still occurring despite the progress being made last year and this year against key milestones. Despite this work it appears that the desired impact on performance has not been

				achieved. Therefore, all Health Groups will be required on an on-going basis to report to the Wound Management Committee what improvement activities and further assurances can be given to demonstrate that performance will improve. In the coming months this will be report via the QIP project to monitor these improvements.
QIP11 – Maternity and Gynaecology	**A/G**	**A/G**	↔	This project is rated as amber/green due to the inconsistent achievement with the swab count audit and the delivery of the learning lessons DVD training. The training data is currently being validated. It is suggested to keep this project open for one more month to ensure achievement of the targets and milestones. There are monitoring arrangements in place within the service, which have been in place since July 2016 and therefore well established in practice. Once this project is closed in August 2017 there is assurance that it will continually be monitored and reported on within the Family and Women's Health Group.
QIP12 – Children & Young People with Mental Health needs and CAMHS	**A**	**A**	↔	This project is rated as amber because there are delays in the partnership work with Humber and CAMHS to develop the SLA for HEYHT. The delivery of this recommendation from the CQC Comprehensive Inspection and the CQC and Ofsted Looked After Children review relies heavily on external involvement and engagement.
QIP14 - VTE	**A/G**	**A/G**	↔	This project has been rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan for further improvements to be made and for continued monitoring of the VTE assessment target. The Trust's performance in relation to the VTE risk assessments in May 2017 is overall 91.87% (95% target). This is an improving picture and the work rolling out the newly designed drug charts and Lorenzo records which will assist with VTE assessment and re-assessments.
QIP15 – Sepsis	**G**	**G**	↔	This project is currently rated Green. The project continues to progress well with all indications showing that the milestones that have been put in place are having a positive impact on sustained performance and in meeting the overall aim of the project. It should be noted that the team have been recognised for the significant work they have done and have received a golden heart due to this.
QIP16 – Resuscitation Equipment Checklist	**A**	**A**	↔	This project has been rated amber due to the current compliance with the agreed performance indicators. Additional milestones will be considered if performance does not improve within the next period.
QIP22 – Nutrition	**A**	**A**	↔	The project has continued with good progress against milestones however some slippage in forecast dates have been projected. In addition, the performance data has shown an increase which is planned to increase further. Because of

				these this project is rated as amber.
QIP23 – Dementia	**A/G**	**A/G**	↓	This project is rated as Amber / Green; good progress is being made against the delivery of the agreed milestones, however Quarter 1 performance indicators demonstrate that further work is required to achieve compliance with screening assessments and the use of the blue butterfly symbol. (Rated Green June 2017)
QIP24 – Children & Young People Services	**A**	**A**	↔	This project is rated as amber due to delays in the delivery of a number of milestones from the 2016/17 quality improvement plan. These have been transferred onto the 2017/18 plan for delivery.
QIP28 – Patient Experience & Complaints	**A/G**	**A/G**	↔	The overall rating for the project is amber/green due to delays in the delivery of the milestones and below 85% compliance with 40 day target for quarter 1.
QIP30 – Avoidable Mortality	**A/G**	**A/G**	↔	This project is currently rated as Amber/Green due to the uncertainty of resources, time and trained staff numbers which is impacting on the ability of clinicians to undertake reviews in a timely manner. However, significant progress continues to be made against key milestones, as detailed in the report.
QIP34 – Critical Care	**A**	**A**	↑	This project is currently rated Amber due to the unlikely achievement of the aim of this project, although all milestones are on track, based on the delivery of a sufficient workforce however it should be noted that the current staffing arrangements within the Critical Care teams are providing the required level of cover. (Rated Amber/Red June 2017)
QIP35 – Safer Standards for Invasive Procedures	**A/G**	**A/G**	↓	Project rated amber/green due to come slippage with baseline finish dates although these are expected to be completed within the next period. (Rated Green June 2017)
QIP36 – Transition from Children to Adult Services	**A/G**	**A/G**	↔	The project is rated amber/green due to the delay in the delivery of the milestones from 2016/17 and the transfer of them onto the 2017/18 plan for delivery. Good progress has been made against the milestones to date. All the milestones are being delivered in line with their revised timescales.
QIP37 – ReSPECT	**G**	**G**	↔	The project is rated as green because the project is new on the 2017/18 quality improvement plan. The milestones due for delivery were delivered and the target is on-track to be achieved.
QIP38 – Consent	**G**	**G**	↔	This project is rated as green because this is a new quality improvement project for 2017/18 and is on-track for delivery. CP354 – Consent, Mental Capacity, Deprivation of Liberty and Restrain Policy currently under review

QIP39 - Outpatients	**G**	**G**	↔	Project is rated green due to continuing achievement with the project target activity and good progress made against milestones.
QIP40 – Compliance with National Standards for Interventional Procedures Checklist	-	-	-	This project has been merged with QIP35 and will be managed through this. All milestones have been appropriately worded and transferred to QIP35. QIP40 will now be listed as closed.

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

QIP02 – LEARNING LESSONS

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

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

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

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

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated as Amber / Green. This project is influenced by all other projects contained within the Quality Improvement Programme. The majority of projects continue to progress well and the majority of milestones within this project continue to progress well. During 2017-18 the focus will be on embedding the learning across the Trust which will include taking part in phase 2 of the Improvement Academy Measuring and Monitoring of Safety Framework (MMSF). This work at times is proving difficult to gain by in from all necessary parties within the Trust. However, the project are keen to continue to pursue this framework for improvement.

Items for Escalation:
From September 2017 the HEY Newsletter will not be printed. The Risk Team are currently considering whether the Lessons Shared Bulletin should still be printed and sent out across the Trust.

Risks to Delivery and Mitigating Actions:
None

Performance Activity:

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

Progress – July 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:

The inhouse investigation training, 'Learning, Candour and Accountability' was launched. Delivered first to Governance and Patient Experience staff the training will be over two half day sessions running from September 2017. The training will

- Provide an understanding of duty of candour
- Provide direction on the immediate action to be taken when an incident occurs in regards to capturing and securing key information and evidence
- Provide understanding on statement writing, reflective statements, and interviewing staff when an incident occurs

- Train on Root Cause Analysis and Action Planning as a result of an investigation
- Provide guidance on report writing skills

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Behaviour and cultural surveys analysed and next steps determined	**A/G**	**A/G**	May 2017	August 2017	The survey is currently with the Improvement Academy for analysis. It has been analysed and the team is awaiting the IA coaches to present the information back to the Trust.
Quality Improvement Framework / Strategy developed	**A/G**	**A/G**	June 2017	September 2017	Draft framework has been developed.
Kitchen Table Event held (including Quality Accounts and Sign Up to Safety)	**A/G**	**A/G**	June 2017	October 2017	Packs for the kitchen table event have been ordered. Deferred to later in the year.
Quality dashboard revised and launched	**A/G**	**A/G**	August 2017	November 2017	Ongoing – deferred to November 2017
Regional learning event with Improvement Academy held	**G**	**G**	September 2017	September 2017	9th September 2017
Re-launch of Sign Up to Safety	**G**	**G**	September 2017	September 2017	
Sharing the Learning Events held	**G**	**G**	September 2017	September 2017	Deferred
Quality Improvement Framework for 2017-18 completed	**G**	**G**	March 2018	March 2018	
Project areas (wards) behaviour and cultural survey completed	**G**	**G**	March 2018	March 2018	
1st Improvement Academy workshop completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Project areas (wards) determined for MMSF	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Project areas (wards) behaviour and cultural survey completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
2nd Improvement Academy Workshop Completed	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
Quality improvement training programme defined	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
3rd Improvement Academy Workshop Completed	**B**	**B**	June 2017	June 2017	**Closed - June 2017**
CIRCLE group re-launch	**B**	**B**	May 2017	May 2017	**Closed - June 2017**
Datix amended to include contributory factors which will be sued for themes and trends analysis	**B**	**B**	May 2017	May 2017	**Closed - June 2017**
In-house investigation training package developed (RCA)	**B**	**B**	August 2017	August 2017	**Closed – July 2017**

QIP04 – SAFEGUARDING, MCA AND DOLS

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

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

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

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

Overall Delivery of the Project:

Summary of Project Delivery:
The project is rated as amber due to the delay in the delivery of a number of milestones transferred from the 2016/17 quality improvement plan. 11 milestones have had the forecast finish dates revised following an update from the lead and discussion at the QIP meeting held on 03 July 2017. The majority of these are due to be delivered in July and August 2017; however the July milestones remain overdue at the time of writing this report (28 July 2017).

Items for Escalation:
There are no items for escalation.

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

Performance Activity

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

Progress: July 2017	**RAG Status**	**A**

Progress against Key Milestones this period:
- The review all improvement work undertaken in 2016/17 to ensure they are embedded was completed. It identified that although the project wasn't fully delivered the milestones that were delivered during 2016/17 remain in place and are supported by evidence of completion. The 2017/18 project will further improve on those changes made and will aim to achieve the overall aim of this project.
- A working group has been established to ensure an effective protocol for the transfer of care of children and young people is in place. As part of this work the group is reviewing the process for children receiving medical examinations to ensure it is effective and relevant to current practice. A database to monitor the medical examinations is now in place which is monitored by the Safeguarding Children's Team and is reported on a monthly basis to the Safeguarding Committee.

Key Milestone Title	Current Month	Next Month	Baseline Finish	Actual/ Forecast	Comments

	RAG	RAG		Finish	
Allegations against Staff for adult and children and young people policy developed and approved	**A**	**A**	August 2016	July 2017	Forecast finish date revised to July 2017 due to delays during the consultation period.
Adults at risk of suicide policy developed and approved	**A**	**A**	October 2016	July 2017	Forecast finish date revised to July 2017 due to delays during the consultation period with external stakeholders.
Revised Chaperone Policy implemented	**A**	**A**	October 2016	July 2017	Forecast finish date revised to July 2017 due to delays in the consultation and approval process. Policy approved in June 2017 for implementation in July 2017.
Safe room in the Medical Assessment Unit created	**A**	**A**	October 2016	July 2017	Forecast finish date revised to July 2017. MAU safe room available required some further work. Waiting for confirmation from the service to ensure the works have been completed and the Trust has a safe room in the MAU that is fit for purpose.
End of Life Policy reviewed with a view to add a section on patients with Dementia and Learning Disabilities	**A**	**A**	November 2016	August 2017	Forecast finish date revised to August 2017 due to delays with external links to the content of the policy.
Allegations against Staff for adult and children and young people implemented	**A**	**A**	October 2016	August 2017	Forecast finish date revised to August 2017 because the policy approval has been delayed until July 2017.
Adults at risk of suicide policy implemented	**A**	**A**	December 2016	August 2017	Forecast finish date revised to August 2017 because the policy approval has been delayed until July 2017.
Implementation of the improved recording and reporting of all patients detained under the Mental Health Act monitored and further action taken where appropriate	**A/G**	**A/G**	March 2017	August 2017	
Absconding Children and Young People and Adults with lack of	**A**	**A**	October 2016	September 2017	Forecast finish date revised to September

mental capacity policy developed and approved					2017.
Revised End of Life Policy implemented	**A**	**A**	January 2017	September 2017	Forecast finish date changed to September 2017 because the policy approval has been delayed until August 2017
A protocol for transfer of care and clear process for staff to follow for delays in children receiving full medical examination following admission to Childrens wards developed and approved	**A**	**A**	October 2016	October 2017	Forecast finish date revised to October 2017. The revision of this policy is more complex than originally thought and there is now involvement from all relevant staffing groups.
ED staff to use safeguarding sheets (purple edge) for all children who have suspected NAI and safeguarding concerns	**A/G**	**A/G**	October 2016	September 2017	
Absconding Children and Young People and Adults with lack of mental capacity policy implemented	**A**	**A**	December 2016	October 2017	Forecast finish date revised to October 2017 because the policy approval has been delayed until September 2017.
A protocol for transfer of care and clear process for staff to follow for delays in children receiving full medical examination following admission to Childrens wards implemented	**A**	**A**	November 2016	November 2017	Forecast finish date revised to November 2017 because the policy approval has been delayed until September 2017.
The use of safeguarding flags on the electronic patient records considered to establish if flags can be attached to the electronic patient record to identify the healthcare practitioner of key risks that would inform their approach during consultations/appointments/inpatient admissions	**G**	**G**	September 2017	September 2017	
Action plan from the CQC looked after children review delivered	**G**	**G**	March 2018	March 2018	**New Milestone added July 2017** (added to the overall QIP)
Chaperone Policy reviewed, revised and updated	**B**	**B**	September 2016	April 2017	**Closed – April 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	July 2017	July 2017	**Closed – July 2017** Lookback exercise completed. All milestones and improvements made during 2016/17 remain in place.

QIP05 – MEDICINES MANAGEMENT

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

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

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

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

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

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

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

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

Overall Delivery of the Project

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

Items for Escalation:
There are no items for escalation.

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

staffing to the acute admissions units to improve our medicines reconciliation rate within 24 hours. We have also commissioned enhanced reporting from Cayder which will allow us to obtain more accurate medicines reconciliation data, enabling us to easily identify patients who have not been reconciled on admission and to send a daily report highlighting these patients.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs	65%	58%	52%	Being validated								
Achieve reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	77.6%	80.6%	81.8%	Being validated								
10% reduction in the average waiting times for prescriptions dispensed in the hospital pharmacy	1 hour and 40 minutes	1 hour 42 minutes	1hr 48 minutes	Being validated								
Introduction of a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled	On-track	On-track	Implemented	The target was achieved in June 2017 ahead of the original timescale of September 2017. The impact of this is monitored in the medicine reconciliation targets above.								

Progress: July 2017 | **RAG Status** | **A**

Progress against Key Milestones this period:

- 'Safety net' report from Cayder to pharmacy staff now embedded - identifying for action patients who have not had their medicines reconciled
- All medicines audits completed and signed off
- PDMs now meeting with deputy chief pharmacists each month to discuss medicines management issues & agree actions
- Electronic prescribing introduced to C29 on 3rd July 2017

- Consideration of changing process for registered nurse training from STEPS to clinicalskills.net together with competency based assessment will be discussed at the August 2017 meeting of the Nursing Board
- Monthly joint pharmacy/nursing medicines management ward checklist to be discussed at Corporate Nursing PEEQ meeting on 28.7.17
- Nurse Director leading review of Trust Discharge Policy – working group currently finalising and then will distribute for comments

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Embed, review and have a clear system of reporting and governance for: 1. The new monthly joint pharmacy/nursing medicines management ward checklist 2. The new weekly charge nurse monitoring checklist from the Chief Nurse	**R**	**A/R**	January 2017	May 2017	Awaiting confirmation from meeting with PDMs on 24.7.17
Content and monitoring systems for nurses medicines management training approved	**A**	**A/R**	July 2017	July 2017	Decision on system for registered nurse training to be discussed at August Nursing Board meeting
Trust Discharge policy reviewed and updated	**A**	**A/R**	July 2017	July 2017	Working party to meet in August & will finalise checklist and issue policy for wider comments
Medication processes at discharge reviewed	**A/G**	**A/G**	March 2017	September 2017	Meeting of pharmacy and nursing leads on 19.7.17 to discuss new discharge checklist & bundle
Improvement project on Ward 9 at HRI undertaken with pharmacy support on the morning drug round to identify any drugs not available and facilitate ordering in a timely manner, measured by a reduction in missed doses.	**G**	**G**	October 2017	October 2017	
Reconciliation of medicines on admissions to hospitals for 83% of our patients at any one time	**G**	**G**	October 2017	October 2017	
Project to increase the use of patient's own drugs be undertaken on selected wards	**G**	**G**	March 2018	March 2018	Project pharmacist to meet with Dr Purva to plan project
Reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs achieved	**A/G**	**A/G**	March 2017	March 2018	
Dispensing errors reduced – improved environment	**A/G**	**A/G**	March 2017	March 2018	
Trial of Pharmacists prescribing discharge medication completed	**A/G**	**A/G**	March 2017	March 2018	
Medicine management clinical audit plan delivered	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
'safety net' system introduced to help focus resource on those patients admitted more than 48 hours ago whose medicines have	**B**	**B**	September 2017	September 2017	**Closed – June 2017**

not been reconciled					
Electronic prescribing on ward 29 at Queens Centre introduced	**B**	**B**	September 2017	September 2017	**Closed – July 2017** 'Go live' took place 3rd July

QIP06 – DETERIORATING PATIENT - ADULT

Project title: QIP06 - Deteriorating Patient - Adult	Project Lead: Vicky Kirkby and Becky Smith

Overall project objective(s):
NICE Guidance (CG50) requires that physiological observations are carried out in all hospital settings and that the deteriorating patient is recognised and escalated in a timely and appropriate manner. A Trust audit highlighted significant shortfalls in clinical observation competencies and knowledge around undertaking clinical observations and some weakness around fluid balance recording. Furthermore, a number of Serious Incidents during 2015-16 and 2016-17 identified the deteriorating patient as an issue.

The aim of this QIP is to ensure that all Registered Nurses have undertaken both the NEW's on-line training and have been assessed as competent to complete Clinical observations on patients and can demonstrate an awareness of the importance of accurate fluid balance recording.

Regulation Breaches / Requirement Notices
None

Performance Targets:
- 95% compliance for all relevant and available staff with combined NEWs training (on-line) and Observation Competency Completion

Overall Delivery of the Project:

Summary of Project Delivery:
This project was re-opened in July 2017 with the focus on clinical observations and training. This project is currently rated as Green.

Items for Escalation:
None

Risks to Delivery and Mitigating Actions:
Possible risks to delivery of the project are staff movement, releasing staff for training, availability of Outreach to deliver training. The addition of the rotational Band 5 into the Outreach Team will free more time and support training.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
95% compliance for all relevant and available staff with combined NEWS training (on-line) and Observation Competency Completion	Data being validated for baseline											

Progress – July 2017	RAG Status	G

Progress against Key Milestones this period:

- CP326 needs final ratification but is complete in principle.
- NEWS training and observations competencies have been undertaken, competencies are completed fully for C14 but a structured approach has been identified as an ideal process.
- Incorporating fluid balance awareness has been identified and information is available but needs to be reviewed and updated then this can be facilitated alongside the observation competencies

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Ratification of Deteriorating Patient Policy (CP326)	**G**	**G**	September 2017	September 2017	The policy has been out to consultation and has been amended accordingly. This policy has been approved at the Deteriorating Patient Committee and will be submitted to the Clinical Practice Development Committee in September 2017 for ratification. Once ratification is received it will be reloaded to the intranet
Baseline figures gathered and validated for levels of training compliance with observations	**G**	**G**	October 2017	October 2017	ELearning figures will need to be correlated against signed off competencies.
NEWS eLearning and completion of observation competencies launched	**G**	**G**	March 2018	March 2018	NEWS training can be completed on line or delivered face to face to wards and areas by the Outreach team
Monthly spot check audits of the NEWS charts completed by the Outreach Team	**G**	**G**	March 2018	March 2018	Monthly spot checks have commenced and will be continually reviewed with a final report produced at financial year end.
Any lessons to learn from audit fed back to the ward for action and support from Outreach if indicated	**G**	**G**	March 2018	March 2018	This is an ongoing action each month. A final review and report will be produced at financial year end
Outreach Lead Nurse to be involved with serious incidents review panel to identify lessons learned and improvement area for focus work	**G**	**G**	March 2018	March 2018	Any SI that indicates a failing in the identification of deteriorating patients to have Outreach input for area support/ action. A final review and report will be produced at financial year end

QIP08 – INFECTION CONTROL

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

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

Performance Targets:

- To have 0 Hospital acquired MRSA bacteraemia (baseline - 2)
- To continue to reduce the number of Hospital acquired Clostridium Difficile to <=53 (baseline – 45)
- To continue to reduce the number of Hospital acquired MSSA to <=46 (baseline – 44)
  To continue to reduce the number of Hospital acquired E. Coli to <=73 (baseline – 81)

Overall Delivery of the Project:

Summary of Project Delivery:
Project is progressing well with a number of milestones being closed however two of the performance indicators are on track to not deliver to the end of the year if similar figures are reported in the following month. These are to reduce the number of hospital acquired c.diff and to reduce the number of hospital acquired MRSA. Mitigating actions are being considered. Therefore this project is rated amber green.

Items for Escalation:
None at this time.

Risks to Delivery and Mitigating Actions:
None at this time.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
To have 0 Hospital acquired MRSA bacteraemia	**0**	**0**	**0**									
To reduce the number of Hospital acquired Clostridium Difficile to <=53	**7**	**12**	**0**									
To reduce the number of Hospital acquired MSSA to <=45	**2**	**4**	**2**									

To reduce the number of Hospital acquired E. Coli to <=73	**6**	**10**	**10**									

Progress – July 2017	**RAG Status**	**AG**

Progress against Key Milestones this period:
Theatre Discipline Policy has been drafted by the lead along with Nurse Director for Surgery and the Chief Nurse. Further consultation to be sought before final draft complete. IPC Practice within the Operating Department has also been developed and this milestone closed. Review of IPC Team and trust information on the intranet is complete. This will be published on the new intranet by August 2017. Leads have commenced the update of the Infection Prevention and Control strategy. Amended Infection Prevention Control risk matrix VIP chart has been planned however some delay to rollout expected. Several milestones have been closed this month including continence management scoping which has identified training gaps which will be addressed and included onto the QIP if relevant. In addition, the surveillance data for IPC cases in the trust has been analysed and commissioners are using the Trust action plan to develop a joint action plan with the NHSi. Infection Reduction Committee will monitor the delivery of the action plan.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Infection Prevention Control risk matrix VIP chart rolled out	**A**	**A**	June 2017	August 2017	Planned however date not yet agreed for rollout
Barriers regarding compliance with sharps bin management identified e.g. physical / design / culture	**A**	**A**	June 2017	August 2017	Forecast date amended due to more time required for this milestone
Senior Matron / Site Coordinator resource folder published	**AG**	**AG**	July 2017	August 2017	Forecast date amended due to more time required for this milestone
Theatre Discipline Policy developed	**G**	**G**	August 2017	August 2017	First draft complete with Mike Wright and Steve Jessop
Infection Prevention Control intranet content updated	**G**	**G**	August 2017	August 2017	Content agreed
Catheter passport relaunched	**G**	**G**	August 2017	August 2017	On track for full re-launch by August 2017 following soft launch earlier in the year.
Infection Prevention and Control strategy updated for 2017/19	**G**	**G**	August 2017	August 2017	Review commenced. On track to deliver
Review of recommendations from recent NICU Serious Incident complete and further milestones added in response to the recommendations	**G**	**G**	September 2017	September 2017	
The Infection Prevention & Control Practice in the Operating Department Policy ratified	**G**	**G**	October 2017	October 2017	
Options for amendment to existing sharps management with waste manager scoped	**G**	**G**	October 2017	October 2017	
Theatre Discipline Policy ratified	**G**	**G**	November 2017	November 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded -	**G**	**G**	December 2017	December 2017	
Fundamental Standard Audits completed in line with the Trust programme by IPC	**G**	**G**	March 2018	March 2018	

Team – frequency determined by audit result					
Annual PLACE inspections HRI/ CHH complete	**G**	**G**	March 2018	March 2018	
Infection Prevention Control ownership tool completed on a monthly basis by all wards	**G**	**G**	March 2018	March 2018	
Observational hand hygiene '5 moments' audit completed monthly	**G**	**G**	March 2018	March 2018	
Existing Infection Prevention Control education reviewed and recommendations for amendments developed	**G**	**G**	March 2018	March 2018	
Twice yearly Daniels audit completed and recommendations / actions developed	**G**	**G**	March 2018	March 2018	
Infection Prevention Control intranet content reviewed	**B**	**B**	May 2017	May 2017	**Complete – May 2017**
Health Economy Nursing Conference on E.coli bacteraemia attended and presented by Infection Prevention Control Lead Nurse	**B**	**B**	May 2017	May 2017	**Complete – May 2017**
Infection Prevention Control risk matrix VIP chart updated	**B**	**B**	June 2017	June 2017	**Complete – May 2017**
Infection Prevention Control risk matrix VIP chart piloted in oncology	**B**	**B**	June 2017	June 2017	**Complete – May 2017**
Individual 5 moments of hand hygiene posters in place on all wards	**B**	**B**	April 2017	July 2017	**Closed – July 2017** Posters placed on all wards
Continence management, catheter training and knowledge across Health Groups scoped to support reduction in catheter acquired infections	**B**	**B**	May 2017	July 2017	**Closed – July 2017** Census audit completed and results produced
Surveillance data for July-and August 2016 and Jan- March 2017 analysed and trends/ differences in trends of Trust apportioned cases identified	**B**	**B**	May 2017	July 2017	**Closed – July 2017** Data analysed. National trends as seen before, Trust below national average reduced cases by 15% in the last year.
Action plan, based on surveillance data for July-and August 2016 and Jan- March 2017 findings, developed – e.g. CAUTI/ gram negative bacteraemia/ management of patients with biliary associated conditions	**B**	**B**	June 2017	July 2017	**Closed – July 2017** Action plan developed and presented to the Infection, Prevention and Control Committee.
The Infection Prevention & Control Practice in the Operating Department Policy developed	**B**	**B**	July 2017	July 2017	**Closed – July 2017** Developed and is currently with Steve Jessop and Mike Wright

QIP09 – FALLS

Project title: QIP09 - Falls	Project Lead: Jo Ledger/ Rosie Hoyle

Overall project objective(s):
This project will aim to achieve compliance with NICE guidance which will drive through the improvement in falls prevention through the improved completion of the MFAT and completion of e-learning and other training formats. The project will be also to focus on the outcomes for the patient following a fall and to learn lessons from the root cause analysis investigations completed. This project will also aim to achieve compliance with the Multi Factorial Assessment Tool (MFAT) which will drive forward improvements in falls prevention through the completion of e-learning.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safe Care and Treatment (12.2.A and B) – assessing the risks of the health and safety of servicer users of receiving the care or treatment and doing all that is practicable to mitigate any such risks. This relates to completing the falls risk assessments for patients.

Performance Targets:
- To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above (Baseline of 0.21)
- 50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018 (Baseline 309)

Overall Delivery of the Project

Summary of Project Delivery:
The overall RAG rating for this period is Green. Good progress is being made against the delivery of the milestones within this project and in turn the aim of the project.

Items for Escalation:
There are no items for escalation.

Risks to Delivery and Mitigating Actions:
The risks to delivery at this stage is compliance with the targets below. The lead is currently reviewing the target to achieve 50% of clinical staff to have completed the falls prevention e-learning to determine whether the target of 50% is to be reduced because it appears this would be unachievable in 2017/18.

Performance Activity

Indicator	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
To further reduce the number of patient falls per 1000 bed days for patient falls rated moderate or above	0.25	0.17	0.15	Being validated								
50% of clinical staff to have completed the falls prevention e-learning	5.2% 10 People	5.3% 8 People	7% 102 People	Being validated								

Progress: July 2017	RAG Status	G

Progress against Key Milestones this period:

- The falls prevention content for the quality and safety bulletin has been agreed and shared with the risk team for inclusion in the next quality and safety bulletin.
- Meetings held with Phil Thomson to discuss the development of the non-clinical e-learning module for falls prevention. The content for the module has been approved at the Falls committee changes were requested and need to be checked by Rosie Hoyle and Bridget Wainman and then rolled out.
- Content for the falls poster has been agreed and is currently with the Communications Team for development.
- A report has been provided by Ricky Saharia, Suzy Bunton and April Daniel in regards to the review of patients medical records who have fallen with a harm moderate or above providing assurance of rationale behind decision making process for the declaration of the SI. Suzy Bunton is to draft a summary of the findings for sharing with the triumvirates ready for cascading to medical and nursing staff.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Completed review of all improvement work undertaken in 2016/17 to ensure embedded	**G**	**G**	August 2017	August 2017	
Actions from the RCP Fall and Fragility Fracture Audit reviewed and next steps identified	**G**	**G**	October 2017	October 2017	
Development of a non-clinical e-learning module for the prevention of falls	**G**	**G**	November 2017	November 2017	Content agreed
Development of 'fall prevention' poster campaign	**G**	**G**	November 2017	November 2017	Content agreed
Auditing processes for the monitoring of the checks for injury and medical examination after a fall established	**G**	**G**	December 2017	December 2017	
Re-audit undertaken using the census tool to identify compliance with the accurate completion of falls risk assessment, clinical appropriateness use of the bedrails and individualised care plans	**G**	**G**	March 2018	March 2018	First meeting arranged for 04 July 2017 to discuss this.
Full roll-out of weekend mobility plan completed including risk assessments and kit availability achieved	**G**	**G**	March 2018	March 2018	E-learning module now on HEY 24/7. Physios have provided training dates and have been asked to get a venue and roll out the training
Review undertaken of patients medical records who have fallen with a harm moderate or above to provide assurance of rationale behind decision making process for the declaration of the SI	**G**	**G**	March 2018	March 2018	As above
Trust bedside vision tool for falls prevention (using RCP as guidance) agreed	**G**	**G**	March 2018	March 2018	
Quarterly audit of compliance against RIDDOR guidance completed -	**B**	**B**	March 2017	March 2018	**Closed – May 2017**
Content of the quality and safety bulletin for falls prevention agreed	**B**	**B**	August 2017	August 2017	**Closed – June 2017**

QIP10 – PRESSURE ULCERS

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

Overall project objective(s):
The aim of this project is to prevent all patients developing avoidable hospital acquired pressure ulcers.
This project will aim to ensure that all patients receive appropriate risk assessments, a plan of care highlighting required nursing interventions and meaningful evaluations which are undertaken by knowledgeable staff.
This project will monitor the duty of candour requirements to improve the patient's experience of open and honest communication should a hospital acquired pressure ulcer occur.

Regulation Breaches / Requirement Notices
None

Performance Targets:

- To have no avoidable hospital acquired Stage 3 pressure ulcers
- To have no avoidable hospital acquired Stage 4 pressure ulcers
- To have no more than 9 avoidable hospital acquired unstageable pressure ulcers (25% reduction)
- To have no more than 26 avoidable hospital acquired SDTI (25% reduction)
- To have no more than 37 avoidable hospital acquired stage 2 pressure ulcers (25% reduction)
- Compliance with 14 day completion of the root cause analysis investigation
- 100% compliance with duty of candour - written
- 100% compliance with duty of candour - verbal

Overall Delivery of the Project:

Summary of Project Delivery:
Whilst Hull and East Yorkshire Hospitals NHS Trust demonstrated a further 45% reduction of avoidable hospital acquired pressure ulcers during 2016-17 the project did not meet all of its ambitious aims, objectives and performance targets. A review has been undertaken to ensure the aims of this project continues to meet the needs of our patients and acknowledgment by the Executive teams that the priority of reducing pressure ulcer harms remains high on the Trusts Quality Agenda.

The successful reduction in pressure ulcer harms in 16/17 are due to the improvement in skills and knowledge of our Clinical staff through a robust training package, improved support for our frontline staff through secondments into the tissue viability team (B6 and CSW) and continued engagement of all staff to provide safe care.

The project this year is progressing although there are key risks to delivery, including the return of the two specialist nurses concluding their secondments. As such the project is rated Amber/Green. At the June 2017 QIP meeting the team raised concerns regarding the number of pressure ulcers still occurring despite the progress being made last year and this year against key milestones. Despite this work it appears that the desired impact on performance has not been achieved. Therefore, all Health Groups will be required on an on-going basis to report to the Wound Management Committee what improvement activities and further assurances can be given to demonstrate that performance will improve. In the coming months this will be report via the QIP project to monitor these improvements.

Items for Escalation:
None identified

Risks to Delivery and Mitigating Action:
Main risk area is learning from previous pressure ulcer harms. This includes failure to investigate pressure ulcer harms within 14 days despite having a good pressure ulcer reporting culture. A delay in the overview of themes and trends may result in missed opportunities to understand specific improvement requirements and a delay in communicating this back to both the patient and staff involved in a timely manner.

The Tissue Viability Service will return to a team of two specialist nurses as secondment roles end resulting in reduced capacity to support wards in pressure ulcer prevention and treatment.

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17*	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
No AHA Stage 3 pressure ulcers	**0**	**0**	**3**	**0**								
No AHA Stage 4 pressure ulcers	**0**	**0**	**0**	**0**								
No more than 9 AHA unstageable pressure ulcers	**0**	**0**	**2**	**2**								
No more than 26 AHA SDTI	**2**	**3**	**6**	**4**								
25% reduction in the number of AHA stage 2 pressure ulcers	**6** u/a = 10	**6** u/a=14	**5** u/a = 6									
Compliance with 14 day completion of the root cause analysis investigation	**No (88%)**	**No (88%)**	**No (57%)**									
100% compliance with duty of candour – written												
100% compliance with duty of candour – verbal												

* July 2017 figures currently being validated for the second half of the month.

Progress – July 2017	**RAG Status**	**A**

Progress against Key Milestones this period:
A number of milestones have closed in month. Work has been ongoing to develop the programme for the July Summer School for all newly qualified. In addition, the new RCA tool has begun to be used. This will be loaded into Datix for ease of use and will require sign of by a senior nurse.

At this month's QIP meeting the team raised concerns regarding the number of pressure ulcers still occurring despite the progress being made last year and this year against key milestones. Despite this work it appears that the desired impact on performance has not been achieved. Therefore, all Health Groups will be required on an on-going basis to report to the Wound Management Committee (July 2017) what improvement activities and further assurances can be given to demonstrate that performance will improve. In the coming months this will be report via the QIP project to monitor these improvements.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Tissue Viability Service quarterly HEY! Skin matters bulletin / newsletter developed to improve learning	**A/G**	**A/G**	June 2017	August 2017	Resources have been an issue to deliver this milestone to timescale. However, it is anticipated that this will be completed by July 2017
Identified wards to pilot new care	**G**	**G**	July 2017	August	Wards are being selected to

plan				2017	pilot the new care plans
Random audit of pressure ulcer investigation outcome and Duty of Candour communication	**G**	**G**	July 2017	August 2017	
Tissue Viability service eLearning modules on pressure prevention equipment, PU / Wound healing and nutritional requirements developed	**G**	**G**	August 2017	August 2017	
Cultural survey conducted on the pilot wards	**G**	**G**	August 2017	August 2017	
Pilot commenced on new care plans	**G**	**G**	August 2017	August 2017	
Each clinical area to have a TVLN who attends the mandatory TVLN twice yearly study day (qualified & unqualified)	**G**	**G**	September 2017	September 2017	
Tissue Viability Service embedded pressure ulcer prevention cares with Hull University student nurses and midwives - intensive training provided	**G**	**G**	September 2017	September 2017	
Link nurse event regarding Stop The Pressure held	**G**	**G**	November 2017	November 2017	w/c 13th November 2017
Pilot of new care plan concluded including any required changes identified within the pilot	**G**	**G**	November 2017	November 2017	
100% completion of eLearning module by all available nursing staff providing direct patient care	**G**	**G**	March 2018	March 2018	
Each clinical area to demonstrate 100% of available staff having completed the bedside assessment	**G**	**G**	March 2018	March 2018	
NHS England – Learning from Experience. Learning Candour and Accountability workshop	**B**	**B**	March 2017	March 2017	**Closed March 2017**
1st Improvement Academy workshop completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
2nd Improvement Academy Workshop Completed	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
HEY Safer Care Bulletin – Device Related Pressure Ulcers	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
3rd Improvement Academy Workshop Completed	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Lessons Learned reviews shared at each wound management committee	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	June 2017	June 2017	**Closed – June 2017**

QIP11 – MATERNITY AND GYNAECOLOGY

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

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

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

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

Overall Delivery of the Project:

Summary of Project Delivery:
This project is rated as amber/green due to the inconsistent achievement with the swab count audit and the delivery of the learning lessons DVD training. The training data is currently being validated. It is suggested to keep this project open for one more month to ensure achievement of the targets and milestones. There are monitoring arrangements in place within the service, which have been in place since July 2016 and therefore well established in practice. Once this project is closed in August 2017 there is assurance that it will continually be monitored and reported on within the Family and Women's Health Group.

Items for Escalation:
There are no items to escalate

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

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
100% compliance with the daily swab count audit	100%	95.8%	99.5%	100%								

Progress: July 2017	RAG Status	A/G

Progress against Key Milestones this period:

- 224 out of 244 midwives have attended the learning lessons event for far. Midwives will continue to receive this training through YMET training days
- 14 doctors have attended the learning lessons event so far.
- The review all improvement work undertaken in 2016/17 to ensure they are embedded was completed. It identified that all of the milestones that were delivered in 2016/17 are still embedded in practice and have made a difference

to the compliance with the swab count audits and learning from lessons. The milestones that were delivered during 2016/17 remain in place and are supported by evidence of completion. The 2017/18 project will further improve on compliance with the swab count audits and the attendance at the learning lessons session.					
Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
All midwives and obstetric staff attended learning lessons event in relation to the retained vaginal swab Never Event and learning lessons DVD	**A/G**	**A/G**	January 2017	August 2017	Forecast finish date extended to August 2017 due to the data being validated; however assurance has been received 100% has nearly been achieved.
Continued auditing of the swab counts to ensure 100% is achieved	**A/G**	**A/G**	July 2017	August 2017	Forecast finish date extended to August 2017 to ensure 100% is achieved.
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded across the service	**B**	**B**	July 2017	July 2017	**Closed – July 2017** Lookback exercise completed. All milestones and improvements made during 2016/17 remain in place.

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

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

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

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

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

Overall Delivery of the Project

Summary of Project Delivery:
This project is rated as amber because there are delays in the partnership work with Humber and CAMHS to develop the SLA for HEYHT. The delivery of this recommendation from the CQC Comprehensive Inspection and the CQC and Ofsted Looked After Children review relies heavily on external involvement and engagement.

Items for Escalation:
There are no items to escalate.

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

Performance Activity

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

Children and Young People at risk of self-harm				

Progress: July 2017	**RAG Status**	**A**

Progress against Key Milestones this period:

- CAMHS continue to provide support to inpatients where required and continue to provide training on the Paediatric in-house study days.
- A working group has been established to ensure an effective protocol for the transfer of care of children and young people is in place. As part of this work the group is reviewing the process for access the required mental health support to ensure it is effective and relevant to current practice.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Service level agreement developed and signed off to formalise the external support from CAMHS to HEYHT	**A**	**A**	February 2017	December 2017	
Quarterly audits of the individual self-harm risk assessments completed, compliance assessed and any learning identified	**A/G**	**A/G**	March 2017	March 2018	Q1 and Q2 audits will be completed by a doctor on the new intake from August 2017. Q1 and Q2 will be reported in October 2017.
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	May 2017	May 2017	**Closed – May 2017**

QIP14 – VTE

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

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

Regulation Breaches / Requirement Notices:
None

Targets:
- Achieve 95% compliance with the VTE Risk Assessment (Baseline of 92.5% in Q4)
- Maintain 0 VTE Serious Incidents (Baseline of 2)
- To increase the number of doctors completing the VTE e-learning module (Baseline of 986)

Overall delivery of the Project

Summary of Project Delivery:
This project has been rated as amber/green because it has been carried forward from the 2016/17 quality improvement plan for further improvements to be made and for continued monitoring of the VTE assessment target. The Trust's performance in relation to the VTE risk assessments in May 2017 is overall 91.87% (95% target). This is an improving picture and the work rolling out the newly designed drug charts and Lorenzo records which will assist with VTE assessment and re-assessments.

Items for Escalation:
There are no items for escalation.

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

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 95% compliance with the VTE Risk Assessment	Being Validated			Q2 – to be reported in the October 2017 progress report			Q1 – to be reported in the January 2018 progress report			Q1 – to be reported in the April 2018 progress report		
Maintain 0 VTE Serious Incidents	0	0	0	Being Validated								
To increase the number of doctors completing the VTE e-learning module	20 completed (1006 in total)	16 (1022)	28 (1050)	Being Validated								

Progress: July 2017	RAG Status	A/G

Progress against Key Milestones this period:
- The user access database is now live and the IT team are currently are now spec'ing the solution that will be used to send the emails for the VTE RCA process.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Lorenzo VTE 'live' database activated and implemented	**A/G**	**A/G**	May 2017	December 2017	The specification will be shared with Dr Saleh when available. The plan was to have the specification completed by the end of July 2017 but this has slipped a bit due to the user access database go live date. A further update will be provided in August 2017.
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
24 hour VTE risk assessment form developed with the associated clinical assessment attached	**B**	**B**	September 2017	September 2017	**Closed – June 2017**
24 hour VTE risk assessment and clinical assessments implemented	**B**	**B**	October 2017	October 2017	
Compliance with NICE CG92 achieved	**B**	**B**	March 2017	March 2018	**Closed – June 2017**

QIP15 – SEPSIS

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

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

Regulation Breaches / Requirement Notices
None

Performance Targets:
CQUIN Indicators:

- 2a – The percentage of patients who met the criteria for sepsis screening and were screened for sepsis (target 90%)
- 2b – The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour (target 90%).
- 2c - Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours (target 25% for Q1, 50% for Q2, 75% for Q3 and 90% for Q4)
- 2d – There are three parts to this indicator.
  1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions
  2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions
  3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Green. The project continues to progress well with all indications showing that the milestones that have been put in place are having a positive impact on sustained performance and in meeting the overall aim of the project. It should be noted that the team have been recognised for the significant work they have done and have received a golden heart due to this.

Items for Escalation:
None identified.

Risks to Delivery and Mitigating Actions:
Lack of ability to reliably identify in patients required for auditing in both 2a and 2b this will not be fully solved until electronic observations is rolled out throughout the Trust.
We have evolved ways of identifying these patients through Lorenzo and Cayder.
2nd sepsis nurse start date is not until August 17 missing Q1 and Q2, predicting impact of having her in post not seen until at least Q4.
Additional work due to 2c, in particular more medical notes will need to be pulled.
It should be noted that there is a change in the way that data will be collected for the CQUIN. It is unclear if this will impact on the performance data.

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
2a in patients	100%	96%	95%	100%								
2a ED	90%	90%	90%									
2b	Being Validated											
2c	Being Validated											
2d.1	Being Validated											

2d.2	Being Validated									
2d.3	Being Validated									

Progress – July 2017	**RAG Status**	**G**

Progress against Key Milestones this period:

The Sepsis and Observation (SOBs) training continued in month with further training also provided to Yorkshire Ambulance Service on 6th and 11th July 2017 and to F1s as part of their induction. The SOBs training has also been revised in month and now includes fluid balance and oxygen. The team have also continued with active involvement in Serious Incident investigation and Structured Case Note reviews for mortality. Plans are in the development stages to be part of the faculty of 5th year medical students to deliver a sepsis session. This has been included as a new milestone.

Regional and national work is continuing with attendance at the Sepsis Conference in Manchester on 10th July 2017. It was evident at this conference that the Trust is further advanced with the delivery of the sepsis pathway than other organisations. Further work is planned to promote the work of the organisation. In addition, the team attended the regional sepsis meeting (quarterly). At previous meetings the Trust had provided information on the barriers to undertaking the sepsis pathway. Other organisations had been tasked with investigating within their Trust if similar barriers were present. Findings were discussed at the meeting in July and all organisations were experiencing similar difficulties. A focused piece of work was undertaken in month with ward C9. This has provided strong evidence on how the pathway can be used to make significant differences to patient care.

Further development work has taken place on the paediatric pathway and preparations are underway to take part in Sepsis Day on 14th September 2017.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Second Sepsis Nurse in post	**A/G**	**G**	June 2017	August 2017	Due to commence in post on 7th August 2017
Trust taken part in national Sepsis Day	**G**	**G**	September 2017	September 2017	***New Milestone: July 2017***
Review of NEWS in the community completed	**G**	**G**	September 2017	September 2017	***New Milestone: July 2017*** Dr Adams, Dr Purva and the CCGs reviewing NEWs in the community to ensure all organisations are using the same terminology
Paediatric sepsis pathway developed	**G**	**G**	October 2017	October 2017	***New Milestone: July 2017***
Review completed of effectiveness link nurse meetings	**G**	**G**	October 2017	October 2017	***New Milestone: July 2017***
Review completed of standardisation of sepsis emergency boxes / trollies	**G**	**G**	October 2017	October 2017	***New Milestone: July 2017***
Paediatric sepsis pathway training developed	**G**	**G**	November 2017	November 2017	***New Milestone: July 2017***
Sepsis training delivered as part of the faculty of 5th year medical students.	**G**	**G**	November 2017	November 2017	***New Milestone: July 2017*** York – 3rd November Hull – 10th November Scunthorpe – 17th November
Sepsis pathway embedded in all areas of the organisation	**G**	**G**	March 2018	March 2018	Carried forward from 2017-18
Sepsis training programme completed	**G**	**G**	March 2018	March 2018	Needs to be constantly ongoing for new members of staff/updates

Awareness raised within the community with GPs, Midwives and Nurses	**G**	**G**	March 2018	March 2018	Workshops and Training to be held
Awareness raised with HEY midwives	**G**	**G**	March 2018	March 2018	Focused training to be delivered
Awareness raised with HEY medical staff	**G**	**G**	March 2018	March 2018	Focused training to be delivered
1st Improvement Academy workshop completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Second Sepsis Nurse recruited	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
2nd Improvement Academy Workshop Completed	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
3rd Improvement Academy Workshop Completed	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Sepsis Intranet site developed	**B**	**B**	September 2017	September 2017	**Closed – July 2017** The Sepsis site is live.

QIP16 – RESUSCITATION EQUIPMENT CHECKLIST

Project title: QIP16 – Resuscitation Equipment Checklist Compliance	**Project Lead: Neil Jennison**

Overall project objective(s):
The aim of this project is to improve and monitor the completion of resuscitation equipment checklist compliance on all wards.

Regulation Breaches / Requirement Notices
Linked to a regulation breach. Regulation 12 Safe Care and Treatment 12.2.G– ensuring that equipment is used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. This relates to staff following the correct procedure for checking resuscitation equipment in accordance with Trust policy.

Performance Targets:
- Achieve 95% compliance with the completion of the daily resuscitation equipment checks – baseline 90%
- Achieve 95% compliance with the completion of the monthly resuscitation equipment checks – baseline 95%

Overall Delivery of the Project:

Summary of Project Delivery:
This project has been rated amber due to the current compliance with the agreed performance indicators. Additional milestones will be considered if performance does not improve within the next period.

Items for Escalation:
None at this time.

Risks to Delivery and Mitigating Actions:
If poor performance continues this may have an effect on project aim delivery.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 95% compliance with the completion of the daily resuscitation equipment checks	95%	94%	98%									
Achieve 95% compliance with the completion of the monthly resuscitation equipment checks	92%	100%	79%									

Progress – July 2017					RAG Status	A
Progress against Key Milestones this period: The data collection period was amended in this period for the monthly resus equipment audit to enable wards and health groups to have access to their results quicker and therefore address areas of non-compliance. Audit results will also be included in the August Health Group Briefing Reports to support compliance.						
Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments	
Audit results included in the Health Group Briefing Reports	**AG**	**AG**	July 2017	August 2017	Results to be included in August reports	
Monthly audit of the completion of the daily and monthly resuscitation equipment checklist and random sample of the contents of 5 trollies completed and results fed back to the wards for improvement and/or action	**G**	**G**	March 2018	March 2018		
New template for recording the completion of the daily and monthly resuscitation equipment checks rolled out	**B**	**B**	April 2017	May 2017	**Closed – May 2017**	
Data collection period amended	**B**	**B**	July 2017	July 2017	**Closed – July 2017** Data collection completed first week of July	

QIP22 – NUTRITION

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

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

The aim of this priority is to ensure that all wards are rated amber and above using the Trust's Fundamental Standards Ward audits which will ensure that all patients have an appropriate personal nutritional needs assessment completed and receive an appropriate care plan or referral to a dietician where required.

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

Performance Targets:

- 90% of wards rated amber or above using the Trust's Fundamental Standards audits – baseline 79.6%

Overall Delivery of the Project:

Summary of Project Delivery:
The project has continued with good progress against milestones however some slippage in forecast dates have been projected. In addition, the performance data has shown an increase which is planned to increase further. Because of these this project is rated as amber.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
90% of wards rated amber or above using the Trust's Fundamental Standards audits	79.6%	83.7%	83.7%	85.7%								

Progress – July 2017	RAG Status	A

Progress against Key Milestones this period:
First review of the Nutrition and Hydration Policy has been completed and the first consultation highlighted some amendments which require further discussion and agreement with the dietician team. Planned to be ready for approval at the August Nutrition Steering Group. NG Training and plan has been approved. Communication and logistics of delivering training still to be finalised. Plan to review the role of the nutrition apprentices within outpatients rather than targeting one area of outpatients for screening to be discussed and agreed at the following NSGs. Meeting arranged to discuss the review of Fundamental Standard questions which will also require amending the questions for AAU.

Key Milestone Title	Current	Next	Baseline	Actual/	Comments

	Month RAG	Month RAG	Finish	Forecast Finish	
Nutrition and Hydration Policy reviewed	**A**	**A**	June 2017	August 2017	First draft and consultation complete, draft to return to August NSG for final approval.
Trustwide communication produced detailing plan for NG training for registered nurses on wards	**A**	**A**	June 2017	August 2017	NG training plan approved and communication drafted. Forecast date amended
One outpatient area identified for Nutrition Screening trial	**AG**	**AG**	July 2017	August 2017	NSG reviewed using the role of nutrition apprentice role within Outpatients. Discussion to be continued at August NSG. Forecast date amended to take this into account however may be closed next period if no longer appropriate.
Review of questions within the Nutrition and Hydration Fundamental standard to ensure the questions asked provide the relevant assurance that the Trust processes are being followed complete	**AG**	**AG**	July 2017	August 2017	Meeting arranged, further update to be reported at August NSG.
Commissioning Excellent Nutrition and Hydration Guidance reviewed	**G**	**G**	August 2017	August 2017	
Fluid balance training package delivered on all relevant wards by Trust Teacher Trainers	**G**	**G**	August 2017	October 2017	
Nutrition and Hydration Policy ratified	**G**	**G**	August 2017	September 2017	
Appraisal of the role of the Nutritional Apprentice impact completed and placement of apprentices' agreed	**G**	**G**	September 2017	September 2017	
Review completed on all housekeeping / ward hostess roles and standardisation of job description	**G**	**G**	October 2017	October 2017	
To develop a Task and Finish group to look at implementation of outpatient nutritional screening	**G**	**G**	October 2017	October 2017	
NG training delivered to senior nursing teams which enables cascade training	**G**	**G**	October 2017	October 2017	NG training approved
Nutrition Steering Group receive monthly updates NG feeding training programme	**G**	**G**	October 2017	October 2017	
Nutrition Census re-audit completed	**G**	**G**	November 2017	November 2017	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	November 2017	November 2017	
Nutrition and Hydration Fundamental Standards audit programme completed in line with methodology	**G**	**G**	March 2018	March 2018	Programme continues
Baseline data from monthly ward census audits established	**B**	**B**	May 2017	May 2017	**Closed May 2017**
QIP leads attended Trust Board's Quality Committee to detail QIP progress and update on Nutrition and Hydration	**B**	**B**	May 2017	May 2017	**Closed May 2017**

Monthly ward nutrition and hydration census audits completed	**B**	**B**	March 2018	March 2018	**Closed May 2017**
Additional milestones which are required based on the baseline data from the monthly ward census audits identified	**B**	**B**	June 2017	June 2017	**Closed June 2017**
All wards assessed in CQC language, based on Fundamental Standards and census audit results (good, requires improvement etc.) and disseminated	**B**	**B**	January 2018	January 2018	**Closed June 2017**

QIP23 – DEMENTIA

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

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

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

Regulation Breaches / Requirement Notices:
None

Performance Targets:
- Achieve 90% compliance with dementia/delirium screening assessments undertaken (baseline 65%)
- Achieve 75% compliance (H8/80, H9/90 and EAU) with the use of blue butterfly symbol over the bed and reach out to me (no baseline)
- Work towards 60% compliance/awareness of the John's campaign (no baseline)

Overall Delivery of the Project:

Summary of Project Delivery:
This project is rated as Amber / Green; good progress is being made against the delivery of the agreed milestones, however Quarter 1 performance indicators demonstrate that further work is required to achieve compliance with screening assessments and the use of the blue butterfly symbol.

Items for Escalation:
None

Risks to Delivery and Mitigating Actions:
None

Performance Activity

Indicator	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Achieve 90% compliance with dementia/delirium screening assessments undertaken	70.74%			Q2 – to be reported in the October 2017 progress report			Q3 – to be reported in the January 2018 progress report			Q4 – to be reported in the April 2018 progress report		
Achieve 75% compliance with the use of blue butterfly symbol over the bed and reach out to me	21%			Q2 – to be reported in the October 2017 progress report			Q3 – to be reported in the January 2018 progress report			Q4 – to be reported in the April 2018 progress report		
Work towards 60% compliance/awareness of the John's campaign	55%			Q2 – to be reported in the October 2017 progress report			Q3 – to be reported in the January 2018 progress report			Q4 – to be reported in the April 2018 progress report		

Progress – July 2017	RAG Status	A/G

Progress against Key Milestones this period:
- The Dementia Garden at Castle Hill Hospital has been completed and is now open

Key Milestone Title	Current	Next	Baseline	Actual/	Comments

	Period RAG	Period RAG	Finish	Forecast Finish	
Completed review of all improvement work undertaken in 2016/17 to ensure that they are being embedded	**G**	**G**	August 2017	August 2017	SB has completed an annual progress report that has been presented to the dementia programme board. This has also been made available to the QSM team for reference. This will be updated continually as this work stream is 2016 - 2019
Cinema area on Ward 8 and Ward 80 created	**G**	**G**	September 2017	September 2017	Due to commence in the next 2 weeks.
Established links made with Dietetic team and Dementia Lead Nurse with regards to reviewing Nutritional overview of patients with Dementia and improvements.	**A/G**	**A/G**	November 2016	November 2017	SB has already formed close working relationships with SLT team this is to be extended across the full Dietetic services.The Catering department became engaged with dementia awareness week. Staff training was delivered and Sue Mannion and Neil Woods are keen to be involved listening to any future ideas involving Nutrition and Dementia
Audit completed to review transfers of care and quality of information (admissions, transfers and discharges).	**A/G**	**A/G**	January 2017	November 2017	SB to discuss with Dan Harman and QSM to formulate an action plan.
Audit completed of the use or adherence to the Dementia and Delirium Screening Pathway, including the Butterfly Scheme and the John's Campaign principles.	**G**	**G**	March 2018	March 2018	SB has met with Andrew Ferguson and Ruth Colville who have agreed to support this project. Suzy has provided the back ground information and will meet with Andrew on a monthly basis.
Dementia awareness within Hull and East Yorkshire promoted through the media.	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Attended Dementia Carer's event at Hull City Hall to promote	**B**	**B**	April 2017	April 2017	**Closed - April 2017**
Dementia Awareness Week completed – (involvement to drive forward organisational engagement to focus on the senses and	**B**	**B**	May 2017	May 2017	**Closed – May 2017**

nutritional challenges in a person living with Dementia).					
Attended Nurses Day conference – (to show collaborative working in relation to staff education in Dementia).	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
Participated in the Dementia Awareness Event at Princes Quay, Shopping Centre, Hull	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
The Dementia Garden at Castle Hill Hospital completed.	**B**	**B**	June 2017	June 2017	**Closed – June 2017** Opened
EoL policy reviewed with regards to Dementia and best practice.	**B**	**B**	December 2016	July 2017	**Closed – July 2017.** The end of life care plan is found to be beneficial on ward 80 when piloted. It has been requested that the butterfly scheme and John's campaign is added to this document.

QIP 24 – CHILDREN & YOUNG PEOPLE SERVICES

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

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

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

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

Overall Delivery of the Project

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

Items for Escalation:
There are no items for escalation.

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

Performance Activity

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

Progress: July 2017

RAG Status **A**

Progress against Key Milestones this period:
- Procedural document for undertaking a pregnancy test prior to surgery for young people audit commenced

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Procedural document for undertaking a pregnancy test prior to surgery for young people audited and next steps agreed	**A/G**	**A/G**	December 2016	August 2017	Forecast finish date has been amended to August 2017. The audit has commenced; however it is not yet been completed and analysed for the next steps to be agreed.
Completed review of improvement work	**G**	**G**	August	August	

undertaken in 2016/17 to ensure they are embedded			2017	2017	
Children Strategy developed and approved	**A/G**	**A/G**	December 2016	December 2017	
Children Strategy implemented	**A/G**	**A/G**	January 2017	January 2018	

QIP28 – PATIENT EXPERIENCE AND COMPLAINTS

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

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

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

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

Overall Delivery of the Project:

Summary of Project Delivery:
The overall rating for the project is amber/green due to delays in the delivery of the milestones and below 85% compliance with 40 day target for quarter 1.

Items for Escalation:
None.

Risks to Delivery and Mitigating Actions:
None.

Performance Activity

Indicator	**Apr 17**	**May 17**	**Jun 17**	**July 17**	**Aug 17**	**Sept 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**
Achieve 85% of formal complaints closed within the 40 day target (Baseline 61.60%)	67.3 %	53.3 %	67.0 %	92% as of 18 Jul								

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

Progress against Key Milestones this period:
There was no progress to report this month.

Key Milestone Title	Current Period RAG	Next Period RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Interpreters Policy and supporting tools implemented	**A/G**	**A/G**	June 2017	March 2018	Currently under review and working with Procurement to engaged a new contractor. Policy will be complete on conclusion.

					iPads, introduced into clinics to provide additional translation tools in emergencies. The trust has there own ipods which are used for various things including the Say Hi app
Completed review of all improvement work undertaken in 2016/17 to ensure being embedded	**G**	**G**	August 2017	August 2017	
Development of Interpreters using telephone interpreting service and 'Browse Aloud' service for the visually impaired completed	**G**	**G**	September 2017	September 2017	Meeting arranged with potential contractor to provide telephone interpretation. Browsealoud now in place, however some issues crashing the Trust browser and this is being addressed by web services.
Quarterly monitoring and updating against the Patient Experience Strategy work plan completed	**G**	**G**	March 2018	March 2018	Areas on the work plan due to be delivered on Q1 as per work plan
Patient Experience work plan delivered	**G**	**G**	March 2018	March 2018	On target
Patient Experience Strategy presented to the Trust board approved	**B**	**B**	September 2017	July 2017	**Closed July 2017 -** This has been incorporated into the Trust strategy and Trust Board Approved.
Patient Experience work plan developed (based on the Patient Experience Strategy objectives)	**B**	**B**	July 2017	July 2017	**Closed July 2017 -** This has now been completed
Patient experience dashboard used within the Health Groups to inform service changes/improvements	**B**	**B**	March 2017	June 2017	**Closed July 2017** - Completed June 2017

QIP30 – AVOIDABLE MORTALITY

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

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

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

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

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated as Amber/Green due to the uncertainty of resources, time and trained staff numbers which is impacting on the ability of clinicians to undertake reviews in a timely manner. However, significant progress continues to be made against key milestones, as detailed in the report.

Items for Escalation:
Minimal criteria for mortality review, as set by the CQC and National Quality Board are not been met. Further work is needed to engage more Clinicians in undertaking mortality reviews. Higher visibility is needed for Mortality Review throughout the Trust.

Risks to Delivery and Mitigating Actions:
There is a need for further resources/job planning for mortality review. Reviewing of deaths associated with Sepsis require a relatively large time resource.

Performance Activity:

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
100% - where family, carers or staff have raised a concern	Data not validated		G	G 100%								
100% - patients who are identified to have a learning disability and/or severe mental illness	G	G	G	G 100%								
100% - patients subject to care interventions from which a patient's death would be wholly unexpected	Data not validated		Data not validated	Data not validated								

100% - where learning will inform the organisations planned or existing Quality Improvement work, for example deaths associated to Sepsis	Data not validated	**R**	**R 3%**								
100% - Patients who underwent Elective Procedures during their last episode.		**R**	**A 68%**								
Further sample of patient deaths	**Baseline to be established in 2017-18**										

Progress – July 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:

- First Trustwide quarterly mortality report written and to be circulated at August Mortality Committee
- Surgery Health Group has had a positive increase in trained reviewers via the Matrons/Specialist nurse teams
- The Trust Business Intelligence Analyser now allows deaths by speciality to be summarised at any given period in time. This is ideal for targeting any potential spikes in mortality at ward/speciality level in real-time.
- Access to CHSK granted for Clinical Outcomes Manager.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
First quarterly dashboard report published	**G**	**G**	June 2017	August 2017	**Update July 2017** There has been a minor delay in implementing the Trust dashboard due to staffing issues within the Information Team; however work is to be completed during August 2017, so date now deferred to August 2017.
Quality check audit completed	**G**	**G**	October 2017	October 2017 (and then Quarterly)	**Update July 2017** The audit will consist of a random sample selection of 20 reviews, which will be then checked for quality of content and value by both the Clinical Outcomes manager and Clinical lead for Mortality reduction.
Mortality Policy developed	**G**	**G**	October 2017	October 2017	As stated in CQC learning from Deaths letter.
Good practice identified through SCNR shared for lessons learnt	**G**	**G**	November 2017	November 2017	**New Milestone: July 2017** A paper is to be written to highlight the good practices that have been identified by the SCNR. It

					will be delivered to the mortality committee before disseminated throughout the proper channels.
Efficiency review conducted on making current SCNR process leaner and more efficient.	**G**	**G**	November 2017	November 2017	**New Milestone: July 2017** The current process for reviewing deaths (physical process) needs reviewing with the possibility of making the process more lean and efficient, and potentially increase engagement.
Executive Director Appointed to lead on Mortality	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
1st Improvement Academy workshop completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Quality check process in place	**B**	**B**	May 2017	May 2017	**Closed May 2017**
Review of mortality work included in Quality Accounts completed	**B**	**B**	May 2017	May 2017	**Closed May 2017**
2nd Improvement Academy Workshop Completed	**B**	**B**	May 2017	May 2017	**Closed May 2017**
Process for informing and involving next of kin confirmed	**B**	**B**	July 2017	July 2017	**Closed May 2017**
Trust Policy written for mortality review	**B**	**B**	May 2017	May 2017	**Closed May 2017**
Patients with Learning Difficulties identified	**B**	**B**	May 2017	May 2017	**Closed May 2017**
Quality Improvement Work – NOF fracture documentation – Baseline audit	**B**	**B**	June 2017	June 2017	**Closed June 2017**
Criteria for prescribed deaths via death certificates, reviews and investigations defined	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
3rd Improvement Academy Workshop Completed	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Criteria for selecting patients to undergo case record review defined	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Non-Executive Director Appointed to lead on Mortality	**B**	**B**	June 2017	June 2017	**Closed – June 2017**
Engaged with Royal College of Physicians to increase training provision	**B**	**B**	July 2017	July 2017	A national training day has been arranged by the Improvement Academy and Royal College, to take place on 1st of December. The Clinical Outcomes Manager is arranging for 2 or 3 clinical staff to attend. **Closed - July 2017**
Process for learning from reviews and investigations developed	**B**	**B**	June 2017	July 2017	The Lorenzo system currently asks the reviewer to summarise any key learning points from the case, this is asked at the end of the proforma. For

					less patient specific, overall learning points (for the speciality) plans of action are to be recorded via the Covalent system, allowing them to be monitored against a timeline delivery. All reviews with low scores will also be shared with the Quality Safety Managers, along with monthly data detailing the amount of deaths/reviews undertaken for the Health Group (including death by Ward/Speciality). This data will be presented at Speciality Governance meetings as a feedback mechanism to the Clinicians. **Closed July 2017**
Reporting structure including Board Reports reviewed	**B**	**B**	May 2017	July 2017	A quarterly Trust-wide report will be supplied to the Mortality Committee, which will cover, in detail, the quarterly mortality statistics for the Trust, the amount of completed reviews the Trust has undertaken and the outcomes from any cases escalated to the Triumvirate. A monthly summary update, per Health Group, will also be supplied to Health Group Directors which will briefly summarise the amount of deaths (by ward and Speciality) as well as the amount of completed and outstanding reviews. **Closed July 2017**

QIP34 – CRITICAL CARE

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

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

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

Performance Targets:

- Number of Critical Care Consultants – target of 16 consultants

The following performance targets will be included once auditing is embedded within the service:

- *100% of patients reviewed within 12 hours by a consultant following admission*
- *100% of days when two ward rounds completed*

Overall Delivery of the Project:

Summary of Project Delivery:
This project is currently rated Amber due to the unlikely achievement of the aim of this project, although all milestones are on track, based on the delivery of a sufficient workforce however it should be noted that the current staffing arrangements within the Critical Care teams are providing the required level of cover.

Items for Escalation:
Unlikely to achieve project aim within the projected project time period.

Risks to Delivery and Mitigating Actions:
The business case for the required number of advanced practitioner posts was not approved and deadline for application to the university has now passed therefore this milestone will not be achieved as planned. Additionally, the recruitment drive has not yet been successful in identifying the three suitable candidates for the consultant posts which would ensure the unit is staffed adequately.

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Number of Critical Care Consultants – target of 16 consultants	**13**	**13**	**13**	**13**								
100% of patients reviewed within 12 hours by a	*performance targets will be included once auditing is embedded within the service:*											

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

Progress – July 2017	**RAG Status**	**A**

Progress against Key Milestones this period:
Business case has been re-submitted however the project lead has been informed that the required funds are unlikely to be released for this plan. Deadline for university applications has also now passed which means that this milestone will not be completed within the timescale and has now been closed. Lead has completed the review of Critical Care Outreach Cover and has reorganised the outreach service with Critical Care Nursing Team to ensure cover and some development within the structure. Review has not required any additional funds from business case due to the rearrangement of existing posts. Interviews to take place in August and posts in place by September 2017 therefore this milestone has been closed.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**AG**	**AG**	August 2017	September 2017	Meeting provisionally arranged for early September
Audit of documentation for ward rounds and review of new patients within 12 hours completed	**G**	**G**	October 2017	October 2017	Audit is ongoing
Inclusion of the additional performance targets (100% of patients reviewed within 12 hours by a consultant following admission and 100% of days when two ward rounds are completed) within the QIP	**G**	**G**	November 2017	November 2017	
Review of current critical care qualifications to ascertain how nursing staff can achieve a critical care qualification	**G**	**G**	January 2018	January 2018	
Review of National Guidelines to complete gap analysis. Gap analysis to provide the focus for 2018/19 QIP	**G**	**G**	February 2018	February 2018	
Implement the training of 5 advanced practitioner posts	**G**	**G**	March 2018	March 2018	
Consultant recruitment campaign commenced	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Business case completed for 4 advanced practitioner posts	**B**	**B**	May 2017	May 2017	**Closed April 2017**
Audit of documentation for ward rounds and review of new patients within 12 hours commenced	**B**	**B**	April 2017	June 2017	**Closed June 2017**
4 advanced practitioner posts recruited to and applications to the University made	**B**	**B**	June 2017	June 2017	**Closed July 2017** Business case has been resubmitted however application deadline has passed therefore this milestone cannot be

					completed within the project timescale.
Review completed of the critical care outreach service and business case/action plan submitted to Senior Health Group Team for funding and/or reorganisation	**B**	**B**	August 2017	August 2017	**Closed July 2017** Review and reorganisation of structure complete.

QIP35 – SAFER STANDARDS FOR INVASIVE PROCEDURES

Project title: QIP35 – Safer Standards For Invasive Procedures	**Project Lead: Dr Purva, Vicky Marshall**

Overall project objective(s):
The aim of the project is to reduce mortality and morbidity, including wrong site surgery, haemorrhage and infection) through full creation and implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) in all specialities across the Trust.

Regulation Breaches / Requirement Notices:
Linked to a regulation breach. Regulation 17 Good Governance (17.2.B) – assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This relates to ensuring the effective use and auditing of best practice guidance such as the "Five steps for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.

Performance Targets:
- To be agreed once project finalised

Overall Delivery of the Project:

Summary of Project Delivery:
Project rated amber/green due to come slippage with baseline finish dates although these are expected to be completed within the next period.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

Indicator	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
TBA												

Progress – July 2017	**RAG Status**	**A/G**

Progress against Key Milestones this period:
Steering group for this project has commenced and is now held on a weekly basis. Some forecast finish dates have been amended however those milestones are expected to be complete in early August 2017.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Performance targets agreed	**AG**	**AG**	July 2017	August 2017	Due to be finalised early August 2017
Project finalised	**AG**	**AG**	July 2017	August 2017	Due to be finalised early August 2017
Governance process for ratification of NatSSIPs and LocSSIPs agreed	**AG**	**AG**	July 2017	August 2017	Due to be finalised early August 2017
Core NatSSIPs checklist ratified	**G**	**G**	August 2017	August 2017	
Pre-theatre checklist ratified	**G**	**G**	August 2017	August 2017	
Recovery handover form ratified	**G**	**G**	August 2017	August 2017	
NatSSIPs and LocSSIPs policy ratified	**G**	**G**	September 2017	September 2017	
Audit process in place for all LocSSIPs checklists developed	**G**	**G**	September 2017	September 2017	
Training needs assessment completed	**G**	**G**	December 2017	December 2017	

Scoping for any additional external training required complete	**G**	**G**	December 2017	December 2017	
Training rolled out as per needs assessment	**G**	**G**	January 2018	January 2018	
LocSSIPs checklist ratified for all specialities	**G**	**G**	March 2018	March 2018	
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**G**	**G**	March 2018	March 2018	
Steering group commenced	**B**	**B**	July 2017	July 2017	**Closed – July 2017** Steering group established

QIP36 – TRANSITION FROM CHILDREN TO ADULT SERVICES

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

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

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

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

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

Overall Delivery of the Project

Summary of Project Delivery:
The project is rated amber/green due to the delay in the delivery of the milestones from 2016/17 and the transfer of them onto the 2017/18 plan for delivery. Good progress has been made against the milestones to date. All the milestones are being delivered in line with their revised timescales.

Items for Escalation:
There are no items for escalation.

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

Performance Activity

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

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

Progress against Key Milestones this period:
- No key milestone activity recorded

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Develop a procedural document ensuring	**A/G**	**A/G**	May 2015	August	Document in draft,

there is effective transition for young people to adult services				2017	discussed the Transition Programme Steering Group on the 13.07.17 adjustments made and sent to virtual email group 19.07.17 for comments prior to formal approval. Comments received as per request by 31.07.17. Formal approval now to be sought.
Seek formal approval of the procedural document ensuring there is effective transition for young people to adult services	**A/G**	**A/G**	April 2016	August 2017	
Communication campaign promoting the procedural document ensuring there is effective transition for young people to adult services launched	**A/G**	**A/G**	February 2016	September 2017	
Implement the procedural document ensuring there is effective transition for young people to adult services	**A/G**	**A/G**	October 2016	September 2017	
Ready, Steady, Go toolkit implemented in Diabetes, Epilepsy and Cystic Fibrosis and audited in order to learn any lessons prior to implementing across the other speciality services	**A/G**	**A/G**	August 2016	September 2017	Email 11.07.17 to owner of RSG to ensure permission to use. T/C on 18.07.17 July to chase assurance given will be ok to use.
Review of the relevant recommendations from paediatric services and OP's detailed in the CQC reports from the 2015 and 2016 inspections completed to ensure all areas for improvement are captured and addressed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Baseline assessment of all transitional arrangements from children to adults within the Trust and from specialist centres completed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Ready, Steady, Go toolkit approved	**B**	**B**	June 2016	April 2017	**Closed – April 2017**
Completed review of all improvement work undertaken in 2016/17 to ensure they are embedded	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Virtual network of all adult and paediatric clinicians both nursing medical and AHP's working in the transition from children to adults developed	**B**	**B**	May 2017	May 2017	**Closed – May 2017**
Baseline assessment completed to demonstrate Trust compliance against the Transition NICE quality standards and areas of improvement	**B**	**B**	March-17	May 2017	**Closed – May 2017**

QIP37 – RESPECT

Project title: **QIP37 – ReSPECT**	**Project Lead: Neil Jennison**

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

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

Regulation Breaches / Requirement Notices
None

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

Overall Delivery of the Project:

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

Items for Escalation:
There are no items for escalation.

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

Performance Activity

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

Progress: July 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
- The second meeting of the locality meeting was held Tuesday 25 July 2017. The group is continuing to work towards a joint launch in both CCGS, HFT, HEY and CHCP, which is estimated to be in early 2018 due to the training involved.
- Received an implementation pack from the Resuscitation Council who is leading on its launch
- Finalising the policy for circulation and approval. Consultation completed with Paediatrics and Palliative Care.
- Met with the Education and Development to discuss the e-learning package.

Key Milestone Title	Current	Next	Baseline	Actual/	Comments

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

QIP38 – CONSENT

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

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

Regulation Breaches / Requirement Notices
None

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

Overall Delivery of the Project:

Summary of the Project Delivery:
This project is rated as green because this is a new quality improvement project for 2017/18 and is on-track for delivery. CP354 – Consent, Mental Capacity, Deprivation of Liberty and Restrain Policy currently under review

Items for Escalation:
The June Consent Working Group did not go ahead due to number of apologies received. The group must continue to meet on a regular basis with all agree members to ensure the delivery of this QIP.

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

Performance Activity

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

Progress: July 2017	**RAG Status**	**G**

Progress against Key Milestones this period:
- CP354 – Consent, Mental Capacity, Deprivation of Liberty and Restrain Policy currently under review

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Consent Policy reviewed and revised to incorporate the new CJD wording	**A/G**	**A/G**	July 2017	September 2017	Consent is included in CP354 – Consent, Mental Capacity, Deprivation of Liberty and Restraint. Other elements of the policy under review also,

					work ongoing and expected to take longer than the forecasted finish of July 2017.
Pilot areas identified for the Lorenzo consent forms	**G**	**G**	September 2017	September 2017	
Pilot of the Lorenzo consent forms completed	**G**	**G**	December 2017	December 2017	
Pilot of the Lorenzo consent forms analysed and next steps agreed	**G**	**G**	January 2018	January 2018	
New CJD wording added to all consent forms	**G**	**G**	March 2018	March 2018	
Lorenzo consent forms fully developed	**G**	**G**	March 2018	March 2018	
To have new printed consent forms available for patients	**G**	**G**	March 2018	March 2018	
Consent forms linked to up to date patient information leaflets and leaflets available at the time of consent	**G**	**G**	March 2018	March 2018	
Development, approval and monitoring process for the Trust consent forms developed and implemented	**G**	**G**	March 2018	March 2018	
Consent task and finish group task terms of reference and work plan agreed	**B**	**B**	April 2017	April 2017	**Closed – April 2017**
Ward rounds undertaken and all old consent forms removed from circulation	**B**	**B**	June 2017	June 2017	**Closed – June 2017**

QIP39 - OUTPATIENTS

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

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

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

Performance Targets:

- Outpatients governance committee held

Overall Delivery of the Project:

Summary of Project Delivery:
Project is rated green due to continuing achievement with the project target activity and good progress made against milestones.

Items for Escalation:
None at this time

Risks to Delivery and Mitigating Actions:
None at this time

Performance Activity

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

Progress – July 2017	RAG Status	G

Progress against Key Milestones this period:
Lead has been working with one of the Quality and Safety Managers to agree a procedure and dissemination system for learning lessons for outpatient complaints and PALs however not yet agreed as does not fully address the best way to share. All other milestones are on track.

Key Milestone Title	Current Month RAG	Next Month RAG	Baseline Finish	Actual/ Forecast Finish	Comments
Targeted information developed for outpatient staff on all outpatient complaints/PALs to provide learning	AG	AG	July 2017	August 2017	Forecast date amended due to definitive process not yet agreed
Risk register developed specific to Outpatient Services	G	G	August 2017	August 2017	
Existing asset management process for outpatient areas assessed for efficiency and assurance	G	G	September 2017	September 2017	
Skill mix review for nursing staff completed for all outpatient areas	G	G	September 2017	September 2017	
Create Learning Space for outpatient staff members on the intranet to include	G	G	November 2017	November 2017	

resource on risks, incidents and learning lessons					
Communications strategy for internal and external Outpatient Services with a focus on public and patient engagement	**G**	**G**	December 2017	December 2017	
Fundamental Standards Audit developed for Outpatient Services	**G**	**G**	December 2017	December 2017	
Head of Outpatient Services appointed	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Board level lead for Outpatient Services identified	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Audiology Outpatients clinical area deep cleaned	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Audiology Outpatients clinical area unsuitable furnishings replaced	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Programme of development in place to address all outpatient areas where the environment is not fit for purpose	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Surgical Outpatients preparation room assessed and made fit for purpose	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Plastics outpatients consultants rooms desks replaced	**B**	**B**	April 2017	April 2017	**Closed April 2017**
Terms of reference developed for a trustwide governance committee	**B**	**B**	May 2017	May 2017	**Closed May 2017**
Targeted information developed for outpatient staff on all outpatient SIs to provide learning	**B**	**B**	June 2017	June 2017	**Closed May 2017**
Targeted information developed for outpatient staff on all outpatient incidents to provide learning	**B**	**B**	July 2017	July 2017	**Closed May 2017**
A trustwide governance committee for Outpatient Services established with required regular health group attendance	**B**	**B**	June 2017	June 2017	**Closed June 2017**
Clear governance map for outpatients produced which demonstrates a ward to board process	**B**	**B**	June 2017	June 2017	**Closed June 2017**
Terms of reference approved for a trustwide governance committee	**B**	**B**	July 2017	July 2017	**Closed June 2017**
Action plan developed to address all areas of concern highlighted by the CQC in the 2015/2016 inspections that are not included within the 2017/18 QIP	**B**	**B**	July 2017	July 2017	**Closed July 2017** All areas of non-compliance highlighted by the CQC in relation to Outpatients have either been addressed or are part of this QIP.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE MINUTES
HELD ON MONDAY 31 JULY 2017, 9.15AM – 11.15PM
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	Chair
	Mrs V Walker	Non Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs J Ledger	Deputy Chief Nurse
	Mrs K Southgate	Head of Compliance
	Mr D Corral	Chief Pharmacist
	Dr M Purva	Deputy Chief Medical Officer
IN ATTENDANCE:	Mrs R Thompson	Assistant Trust Secretary (Minutes)

No. Item **Action**

1. APOLOGIES

Apologies were received from Mr A Snowden, Non Executive Director, Dr A Green, Lead Clinical Research Therapist and Mrs S Bates, Interim Deputy Director of Quality Governance and Assurance

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF THE MEETING OF 26 JUNE 2017

The minutes of the meeting of 26 June 2017 were approved as an accurate record.

3.1 Matters Arising

- The safeguarding annual report would be received at the August 2017 meeting. **MW**
- Mortality Report (to include national guidance gap analysis undertaken by the Trust, HSMR and any other areas to review) to be received at the August 2017 committee and then to the Board in September 2017. **KP**
- Mrs Ryabov to give assurance around cancer 104 day waits – Ms Ramsay to discuss this with Mrs Ryabov **ER**

3.2 Action Tracker

- The Fresenius follow up report to be added to the tracker **RT**
- The tracker to be updated and all 'not yet dues' to be removed **RT**

3.3 Any Other Matters Arising

There were no further matters arising.

3.4 Workplan

The Committee reviewed and confirmed the workplan as current.

4. REDUCE AVOIDABLE DEATHS

Prof. Sheldon asked for an update regarding how the Trust was responding to the National Guidance relating to learning from deaths and in particular how the Trust was dealing with the duty of candour element for avoidable deaths.

Mr Phillips reported that all avoidable deaths that come under the serious incident category would mean that the duty of candour process would be followed. Mrs Walker was interested to learn what happened at the moments shortly after the patient's death and how this was handled with families and carers. Mr Phillips advised that this would be varied depending on the experience of the staff member.

Ms Ramsay stated that some wards carry out bereavement surveys and ask families and carers how they thought the patient's death was handled and if anything more could have been done.

There was a discussion around weekend and weekday mortality figures and the Committee was assured that there was no significant difference between sets of figures. Mr Wright stated that the Trust should explain why and what it was doing about measuring mortality, what the measures showed and what the Trust was doing about it.

Dr Purva advised that a number of specific areas such as pneumonia and COPD were having case note reviews carried out as these had seen an upward trend in mortality.

Prof. Sheldon asked how the Trust was intending to respond to a recent report based on a confidential enquiry into deaths from non-invasive ventilation. Ms Ramsay assured him that all reports of this type were reviewed at the Clinical Effectiveness Committee and a summarised list would be received at a future committee.

Resolved:
The Committee received the update.

5. REDUCE AVOIDABLE HARM

5.1 Serious Incidents – June 2017 (incorrectly entitled April 2017 on agenda)

The serious incidents were reviewed; Mrs Walker commented that some of the lessons learned described were more like the findings of the incident than learning. She also stated that the findings were more process driven than changes in values and behaviour of staff.

Prof. Sheldon reported that it was not clear in the summary which lessons were linked with which findings. He stated that sometimes there were too many recommendations following the incident that the important issues were lost. Mrs Walker asked whether staff other than nursing staff used lessons learned as part of reflective practice. Mr Phillips advised that the medics were now following a process of a reflective appraisal system which was being used as a learning experience.

Resolved:
The Committee received the report.

5.2 Quality Improvement Programme (QIP)

Prof. Sheldon stated that the QIP had more realistic milestones after review by the Compliance Team.

Mrs Walker expressed her concern regarding external partnership

engagement and asked what the Trust was doing about improving relationships. Mr Phillips advised that the Trust's relationship with Humber NHS Foundation Trust was getting better but there had been staffing issues which had meant reduced communication. Mr Wright reported that he was working closely with the Chief Nurse at Humber to overcome these issues. Mrs Walker suggested that the Non Executive Directors from both Trusts could meet to build relationships and assist the organisations where possible.

There was a discussion around the deteriorating patient QIP. Mr Phillips reported that policies were in place but that the escalation process was key. Dr Purva added that fundamental reviews were being carried out which related to application of knowledge, time and staffing pressures and how these affected day to day working. Mrs Southgate also advised that the Health Groups were developing new projects to be added to the QIP.

Prof. Sheldon complimented the team regarding the Trust's falls figures and the improvements regarding the crash trolley compliance.

The Committee discussed the Outpatients section of the QIP and agreed that the title should read 'Outpatient Governance' to match the contents of this particular QIP.

Resolved:
The Committee received the report.

5.3 – NRLS [NPSA] Benchmarking Information
Mrs Southgate presented the report which highlighted that the Trust was now in the top 25% of reporters of incidents.

She advised that this had changed from the Trust being in the bottom 20% due to changes in the DATIX coding and a number of incidents not previously being uploaded per national guidance.

Mr Wright stated that the levels of harm of the incidents would be reviewed to assess the distribution of severity of the increased reports. The types of incidents had been included in a report which would be circulated to committee members. **KS/SB**

Resolved:
The Committee received the report and agreed to receive the report showing the themes of the incidents uploaded via the NRLS.

6. INCREASE INCIDENT REPORTING TO THE HIGHEST 25% COMPARED TO PEERS
No agenda items under this standing agenda section – received as 5.3 above

7. RECEIVED FOR ASSURANCE

7.1 Integrated Performance Report
The Committee reviewed the report and highlighted the 52 week wait breaches. The Committee was assured that the Chief Operating Officer meets with the Health Groups on a weekly basis to ensure that this is monitored and care is managed appropriately. The issues were around complex patient care, better data quality with the Lorenzo system and patient choice.

The cancer targets were also discussed and Mrs Walker was particularly concerned with the 104 day target performance and if there was any impact to the patient due to this. Ms Ramsay fed back that a similar question had been raised, from a performance perspective, at the Performance and Finance Committee and Mrs Ryabov had confirmed that patients whose care had breached the 104 day standard were all on a relevant pathway, receiving diagnostics, assessment and starting treatment; there was assurance provided that this waiting time did not represent that no actions were being taken regarding patient assessment and care.

Emergency caesarean sections were also discussed and Mr Phillips assured the Committee that he was not concerned with the level of performance. He agreed to review the whole system, both emergency and non-emergency to bring more detail back to the Committee. **KS**

Mrs Walker asked about the Financial Improvement Planning team and whether any of the schemes identified could impact on quality. It was requested that this question be asked at the Board meeting 1 August 2017 for clarification by the Chief Financial Officer.

Resolved:
The Committee received the report and agreed:

- Quality impact on patients – cancer 104 days – briefing to be arranged with Mrs Ryabov to understand the cancer 104 day target and current in more detail
- FIP2 programme – to ask the Trust Board if any of the schemes identified have an identified impact on quality.

7.2 Operational Quality Committee Minutes
Mr Phillips reported that the Harvard reporting system relating to radiology was showing further improvement in consultants acknowledging their reports.

Resolved:
The Committee received the summary report.

7.3 Healthcare Delivery Improvement Group
Dr Purva presented and advised that a number of medical staff including junior doctors had been identified to carry out projects linked to the Quality Improvement Plan or the objectives of the organisation. The first projects were linked to sepsis and elderly medicine. Prof. Sheldon suggested that undergraduate students could assist with the QIP as part of their project work.

Resolved:
The Committee received the update.

7.4 Lessons Shared Newsletter July 2017
The Committee received the newsletter.

8. BOARD ASSURANCE FRAMEWORK
Ms Ramsay presented the report which highlighted the key risks to the Trust achieving its strategic objectives.

There was a discussion around the 'day to day' risks and the strategic risks to the organisation. Mrs Walker stated that more emphasis should be put into clinical engagement and becoming a learning organisation. Mr Phillips added

that medical workforce staffing was still an issue and was reflected on the BAF. He also stated that the diagnostic capacity problem should be made more specific.

There was a discussion around the title 'Great Specialist Services' and the Committee requested that this include a reference to sustainable specialist services.

Ms Ramsay agreed incorporate the proposals in the next update to the Trust Board.

Resolved:
The Committee received the report and:

- Ms Ramsay to incorporate suggestions in the next BAF paper to the Trust Board **CR**

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

10. DATE AND TIME OF THE NEXT MEETING:
Tuesday 29 August 2017, 9.15am – 11.15am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report 2017/18

August 2017

July 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

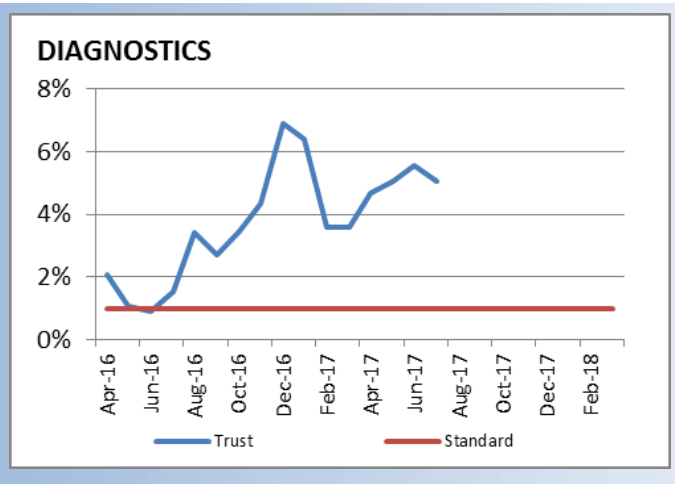
Description	Aggregate Position	Trend	Variation

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 5.03% in July

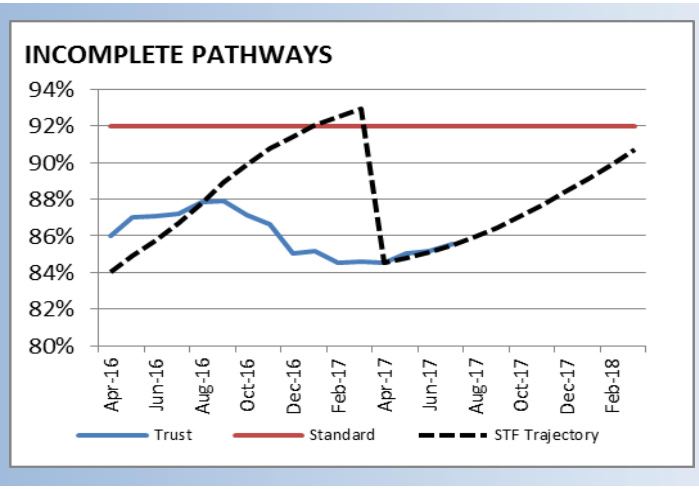


Referral to Treatment Incomplete pathway

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

The Trust achieved the July Improvement trajectory of 85.5%

July performance was 85.53%. This failed to meet the national standard of 92%.



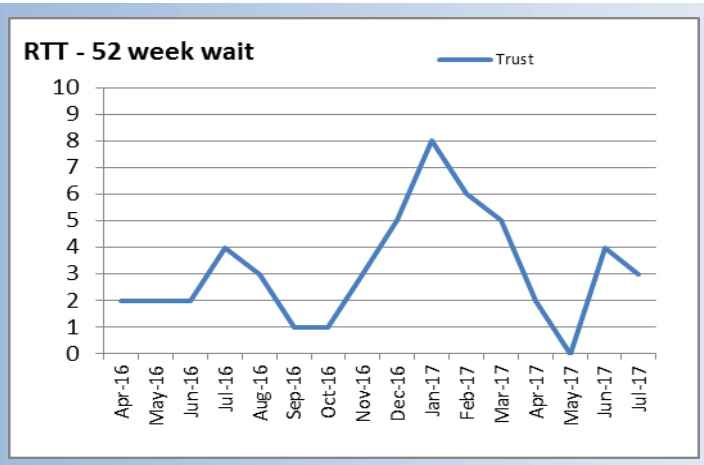
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

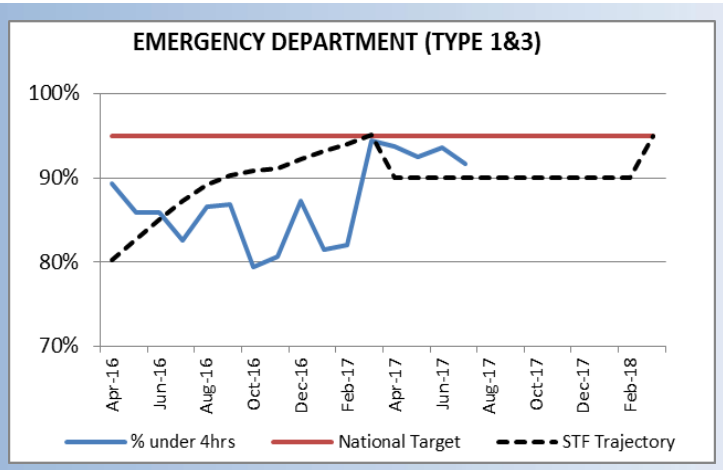
The Trust failed to achieve the national standard of zero breaches with 3 breaches during July.



A&E Waiting Times

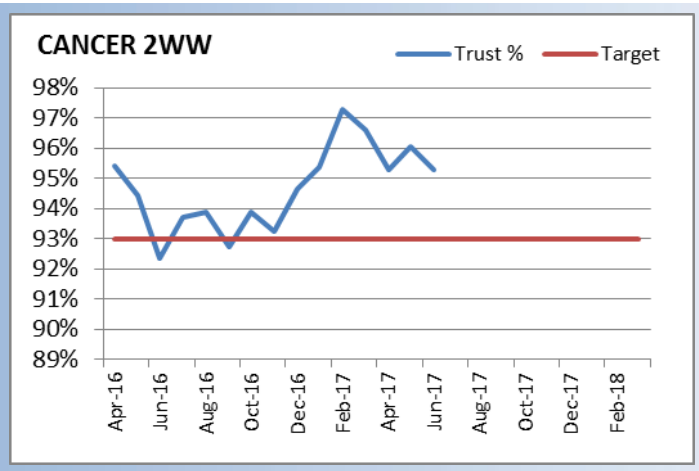
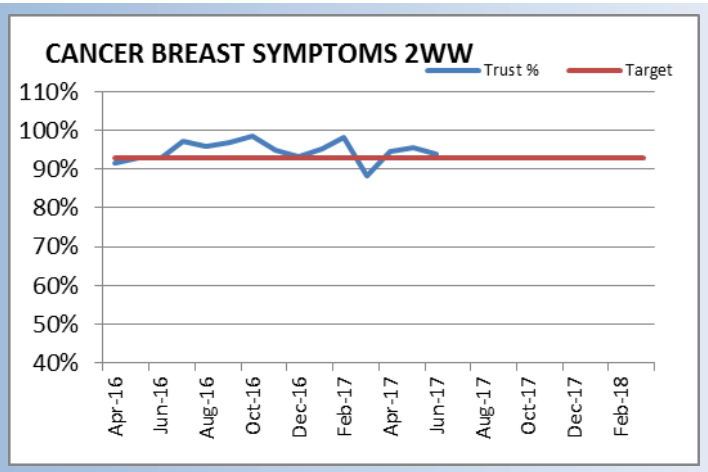
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance achieved the Improvement trajectory of 90.0% with performance of 91.7% for July. This has failed to achieve the national 95% threshold.



Performance has decreased by 1.9% during July compared to June performance of 93.6%.

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%.	June performance achieved the 93% standard at 95.3%		
Cancer: Breast Symptom Two Week Wait Standard	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.	June performance achieved the 93% standard at 93.8%		

Integrated Performance Report - August 2017

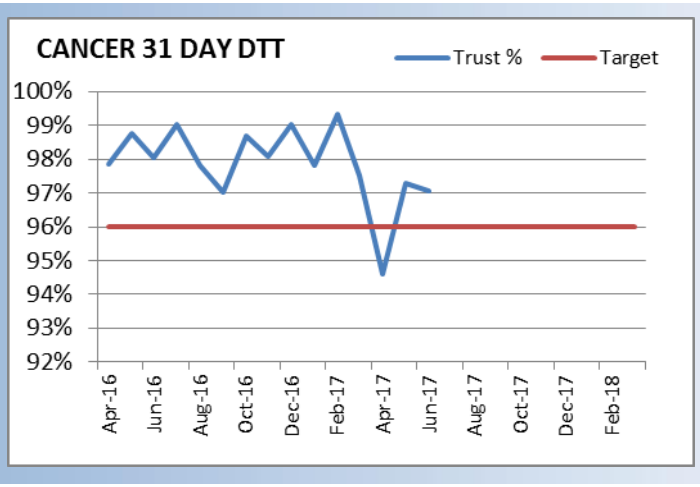
RESPONSIVE

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%.

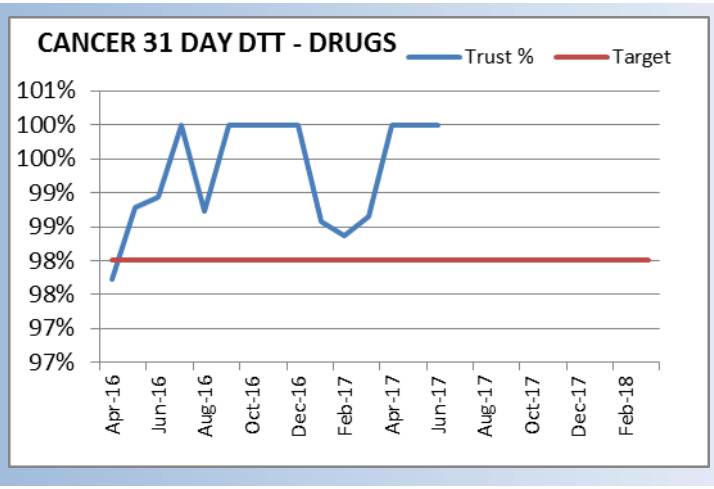
June performance achieved the 96% standard at 97.1%



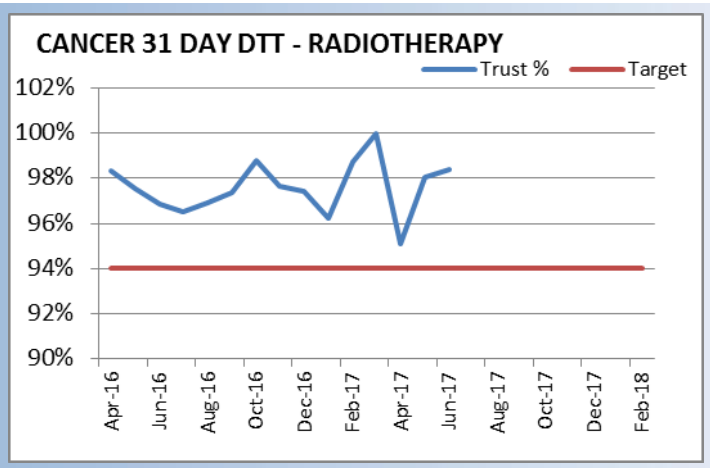
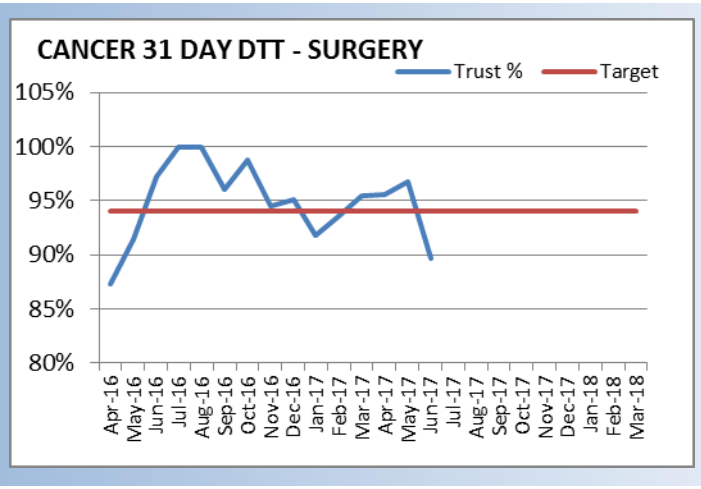
Cancer: 31 Day Subsequent Drug Standard

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

June performance achieved the 98% standard at 100%



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%.	June performance achieved the 94% standard at 98.4%		
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%.	June performance failed to achieve the 94% standard at 89.7%		

RESPONSIVE

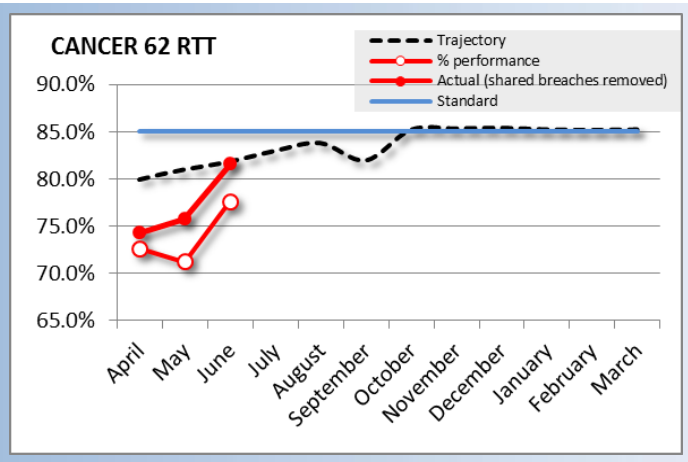
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

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

The adjusted position allows for reallocation of shared breaches

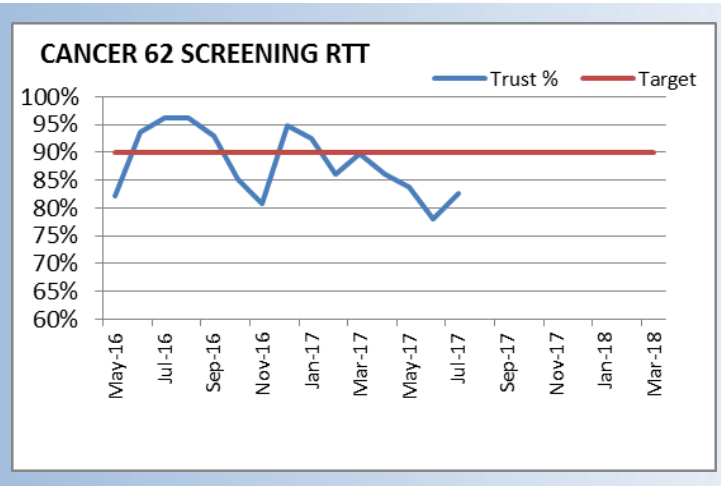
June failed to achieve the Sustainability and Transformation trajectory of 81.8% with performance of 81.6%



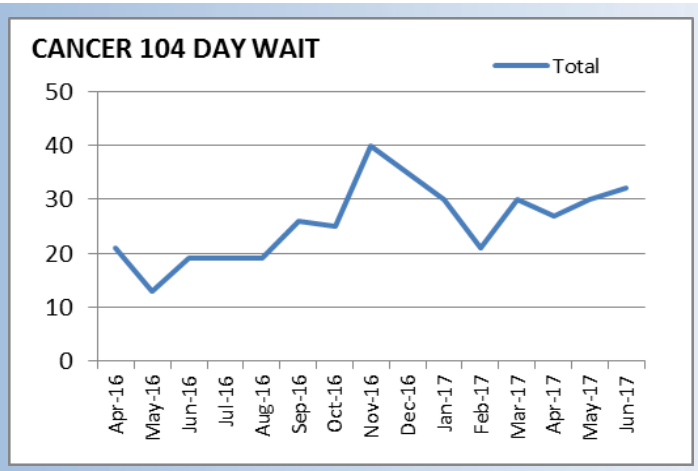
Cancer: 62 Day Screening Standard

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

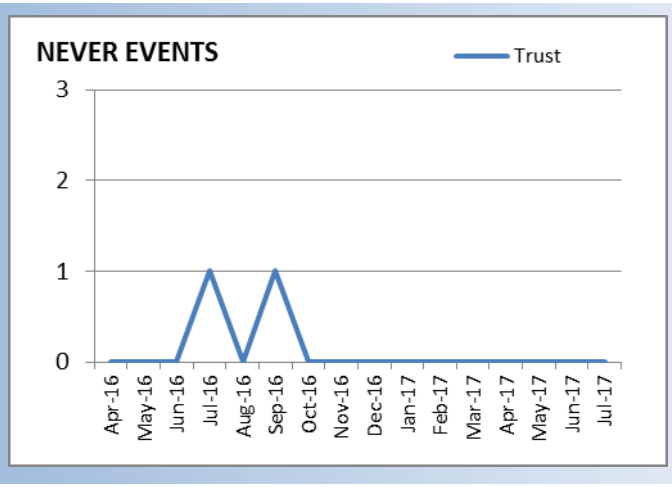
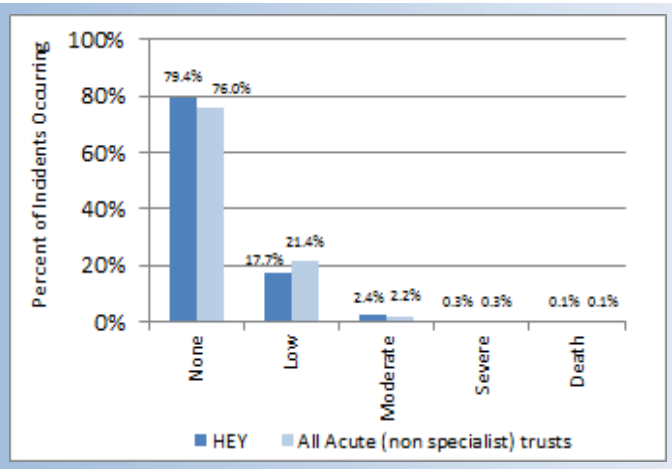
June performance failed to achieve the 90% standard at 82.7%



RESPONSIVE

Description	Aggregate Position	Trend	Variation
Cancer 104 Day Waits	There were 32 patients waiting 104 days or over during July		

SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Events	There were zero Never Events reported during July		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. The next publication date is 27th September 2017		

SAFE

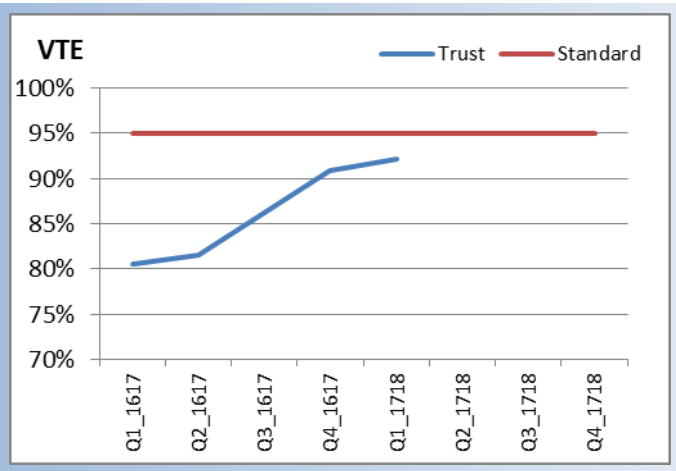
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

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

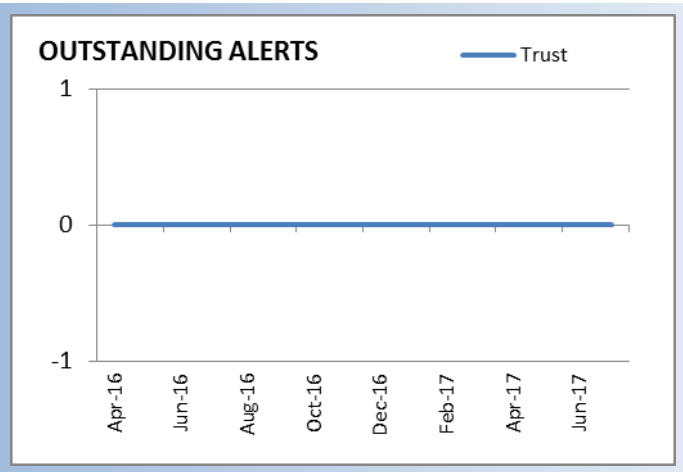


Patient Safety Alerts Outstanding

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

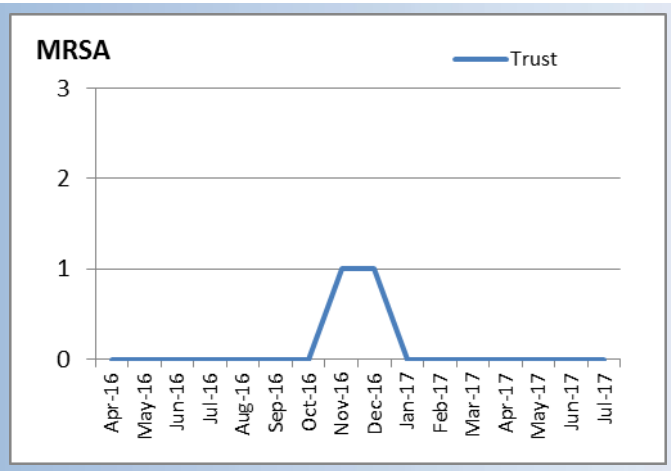
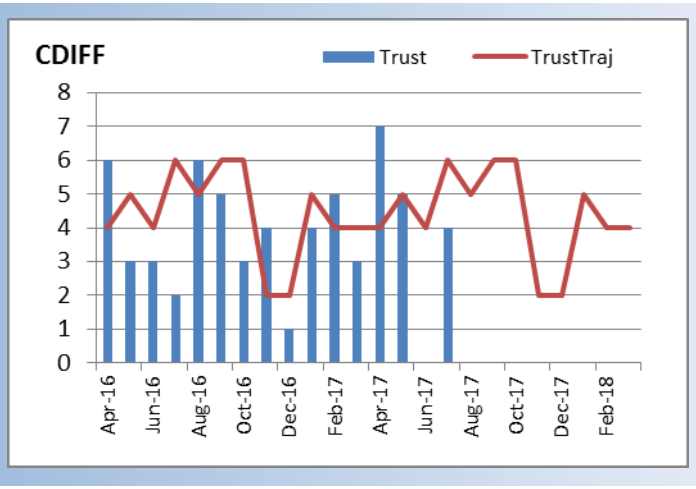
There have been zero outstanding alerts reported at month end for July 2017.

There have been no outstanding alerts year to date.

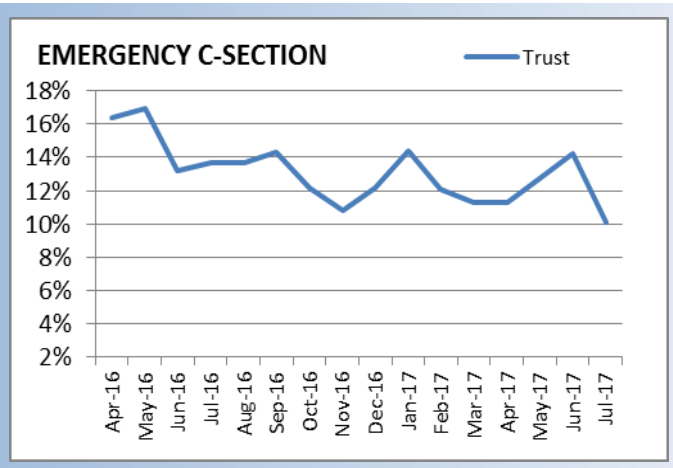


Integrated Performance Report - August 2017

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 July 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 16 cases year to date There were 4 incidents reported during July which achieved the monthly trajectory of no more than 6 cases		Further information is included in the Board Quality report

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 July achieved this standard at 10.10%		Further information is included in the Board Quality report

EFFECTIVE

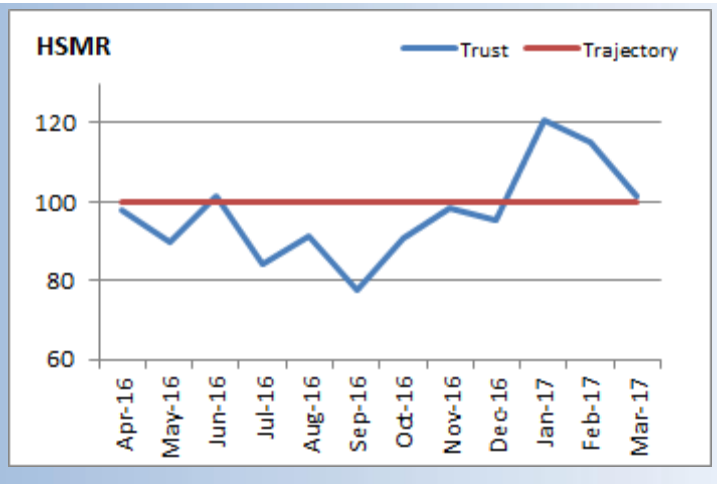
Description	Aggregate Position	Trend	Variation

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

March 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and March 2017 failed to achieve this at 101.3

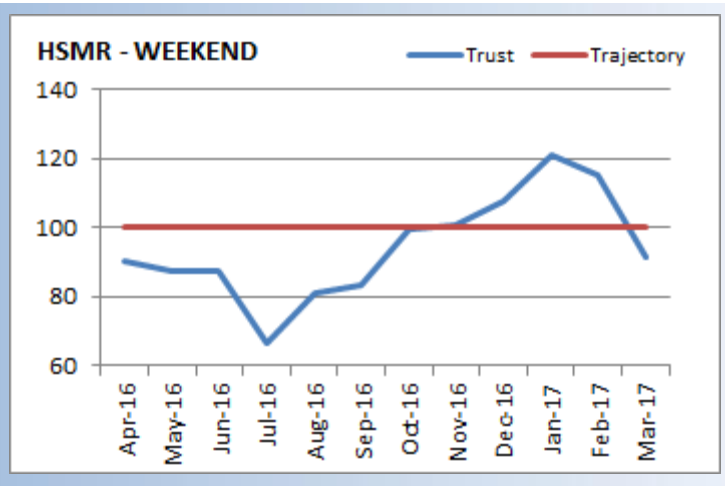


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

March 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and March 2017 achieved this at 92



EFFECTIVE

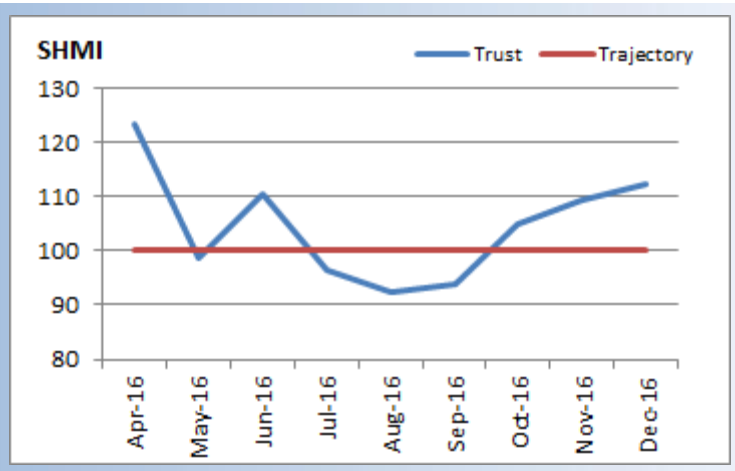
Description	Aggregate Position	Trend	Variation

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

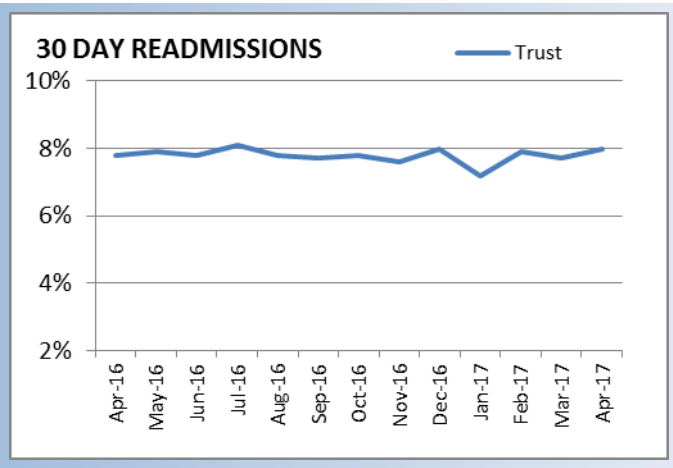


30 DAY READMISSIONS

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

The latest available performance is April 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 failed to achieve this measure with performance of 8.0%.



Integrated Performance Report - August 2017

CARING

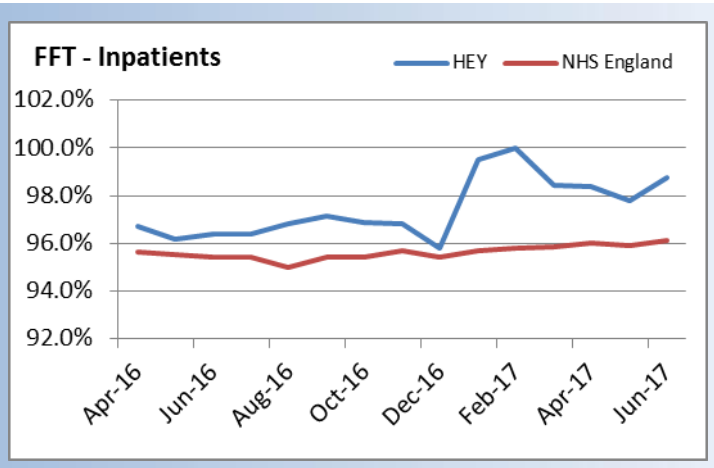
Description	Aggregate Position	Trend	Variation

Inpatient Scores from Friends and Family Test - % positive

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

Performance for June was 97.6%

The latest published data for NHS England is June 2017.

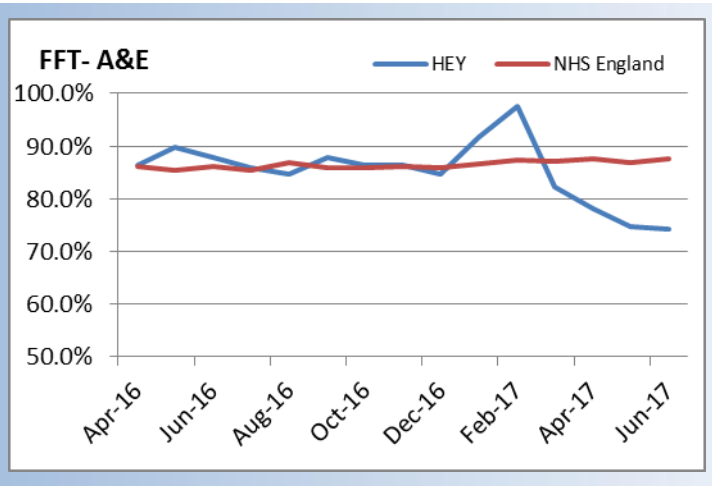


A&E Scores from Friends and Family Test - % positive

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

Performance for June was 74.29%

The latest published data for NHS England is June 2017.



CARING

Description	Aggregate Position	Trend	Variation

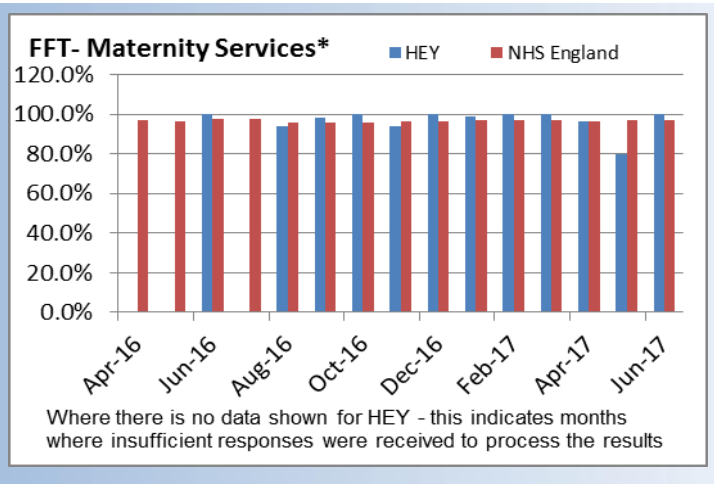
Maternity Scores from Friends and Family Test - % Positive

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

Performance for June was 100%

The latest published data for NHS England is June 2017.

Months with no data for HEY is due to insufficient responses



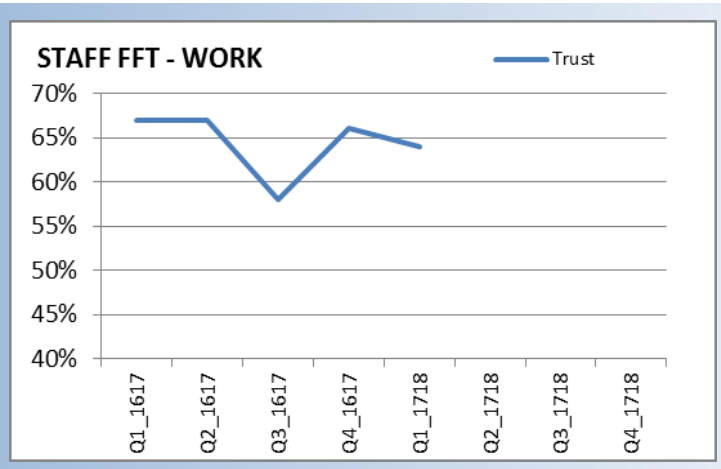
* Question relates to Birth Settings

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 slightly from the quarter 4 position of 66%.

Quarter 2 performance will be published 23 November 2017.



CARING

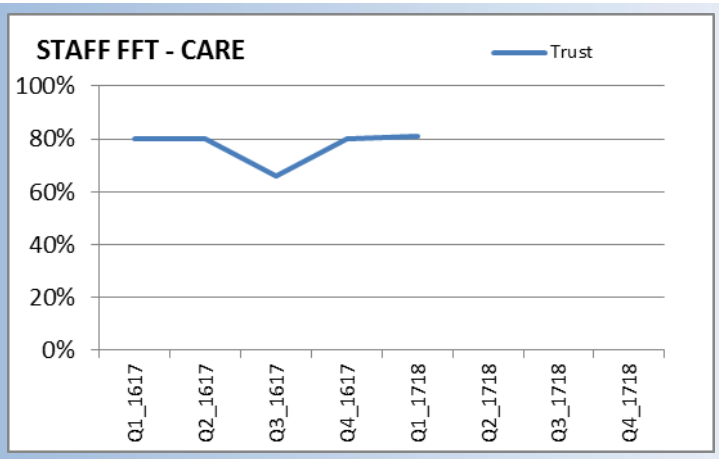
Description	Aggregate Position	Trend	Variation

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 slightly from the quarter 4 position of 80%.

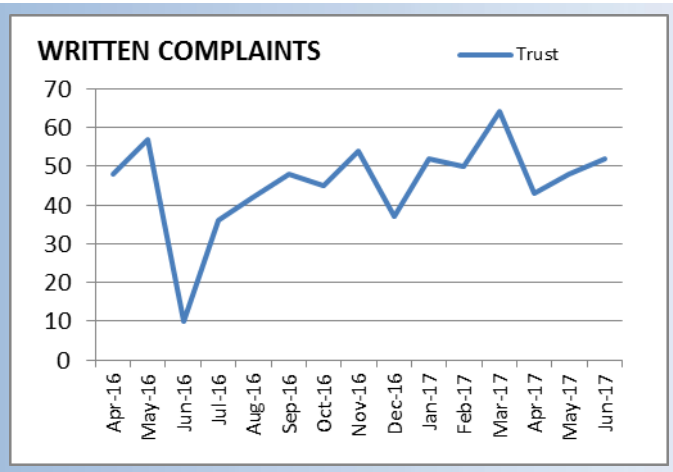
Quarter 2 performance will be published 23 November 2017.



Written Complaints Rate

The number of complaints received by the Trust

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

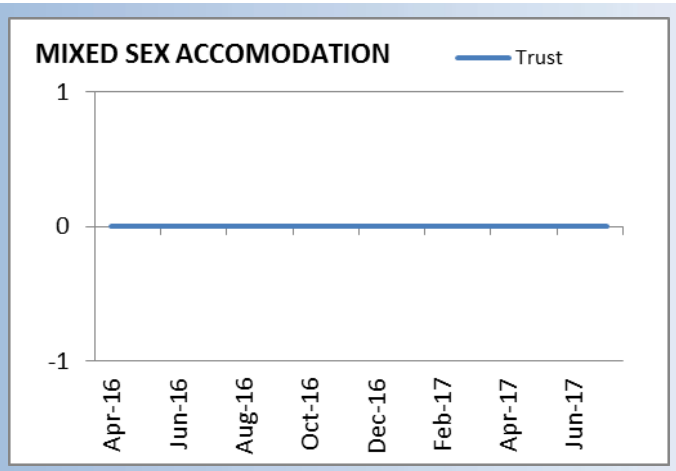


There have been 188 complaints year to date

CARING

Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches	There were no occurrences of mixed sex accommodation breaches throughout July 2017.		

Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.



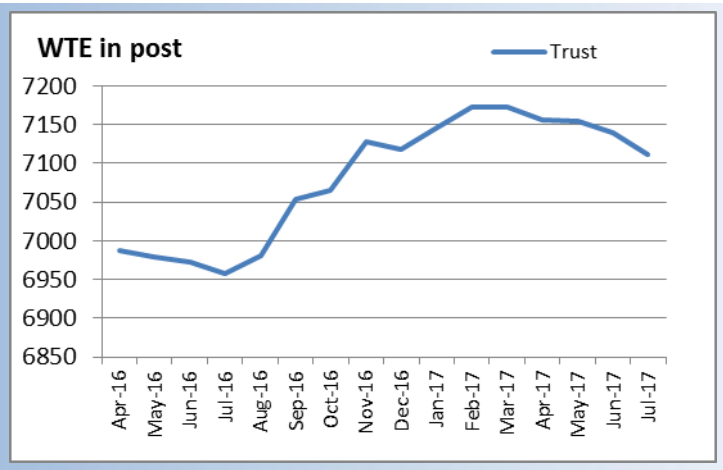
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

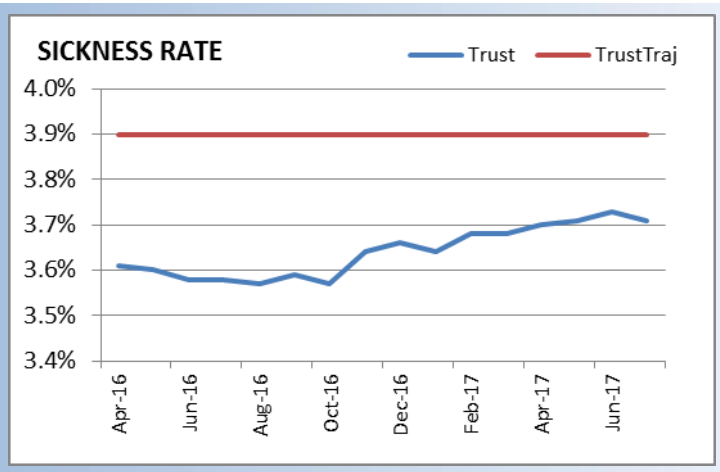
Trust level WTE position as at the end of July was 7111.25



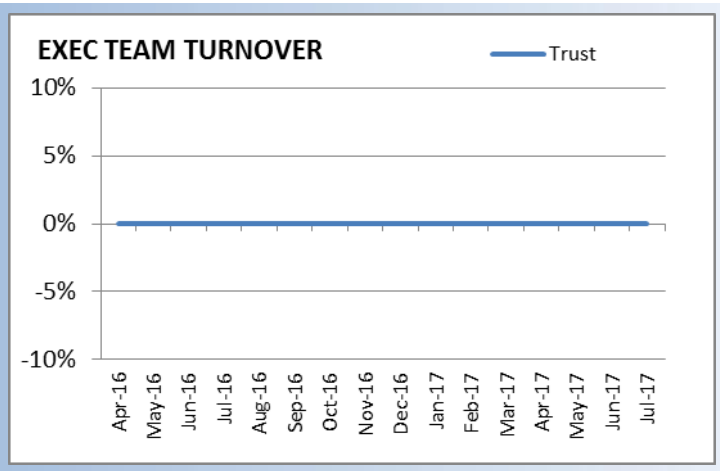
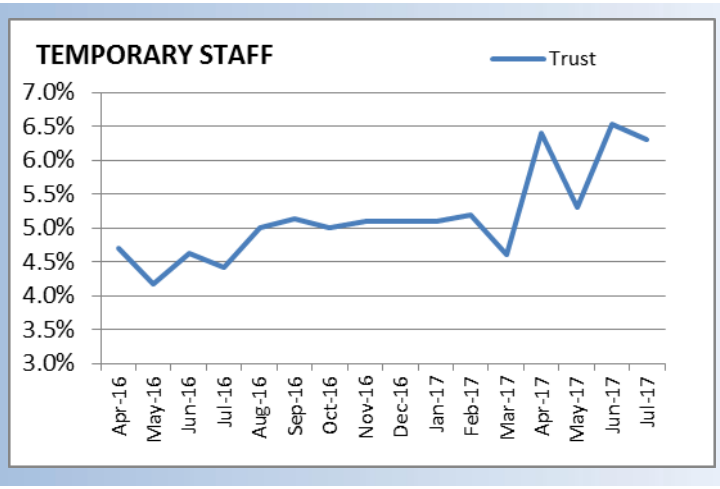
Sickness Absence Rates

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

Performance for July achieved the standard of less than 3.9% with performance of 3.71%



ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation
Executive Team Turnover	Percentage turnover of the Trust Executive Team	Turnover has been 0% for the Executive team within the last 12 month period.	
Proportion of Temporary Staff	% of the Trusts pay spend on temporary	Performance is measured on a year to date basis as at the month end July performance was 6.3%	

FINANCIAL SUMMARY: 4 MONTHS TO 31ST JULY 2017

1. At the end of month 4 the Trust is reporting a deficit of £8.3m. This is £6.0m above the planned deficit of £2.3m.

2. The deficit includes non receipt of £2.6m of STF income for non delivery of the financial plan to month 4. 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 £2.4m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs there is a net shortfall of £1.1m which is an adverse movement of £0.6m in the month.

4. The Trust has a CRES shortfall at month 4 of £1.67m. The Trust has released 4/12ths of its CRES reserve (£0.5m) to reduce this to a deficit of £1.17m.

5. Health Group run rate positions have deteriorated in month by 0.6m. Medicine's increase was in non pay associated with Bariatric equipment £0.04m and their main pressures continue to be related to the staffing of the 3 zone Acute model (£0.3m), the Fit model (£0.1m) and ED medical staffing (£0.3m) although these are partly offset by nursing vacancies (-£0.4m). Surgery's overspend deteriorated sharply in month (0.9m) driven principally by further non-pay issues of £0.4m which is unrelated to levels of activity being undertaken, £0.2m medical pay pressures , 0.1m Spire costs and £0.2m CRES. 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 similar rate of increase to last month and overall are mainly in Medical staffing (£0.2m) related to vacancies and sickness.

6. Agency spend to the end of July is £3.5m which is slightly below planned levels.

7. General reserves of £1.6m have been released to partially offset the run rate and income pressures

8. Overall forecasts have improved by £2M due to income gains of £0.7m (incl £0.3m HYMS) improved Health Group forecasts of £0.8m and £0.5m reserve assumptions. The financial information indicates a problem of £8m by year end if current trends continue. This is based on Health Groups being £11.1m overspent and £3.2m short on income, offset by the release of £6.4m of reserves. Immediate actions need to be identified to offset this potential £8m 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 Trusts cash position had improved due to the receipt of additional cash from the 2 local CCGs to reflect the movement to paying in 10ths rather than 12ths. However CCGs have been advised by NHSE to revert to payment in 12ths for the remainder of the contract term due to national pressure on cash reserves. In comparison with the August payment, this is a £9m reduction in the monthly receipt for September to January. Together with the deficit position, including non receipt of STF funding, this will place additional pressure on the Trust and loan applications will need to be made.

11. 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 earlier this month, CCGs have been advised to withhold payment if Trust's 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 £4.8m of capital at month 4 and is forecasting to spend £19.9m during the financial year in line with plan, which now includes an extra £1m for ED Primary Care Streaming.

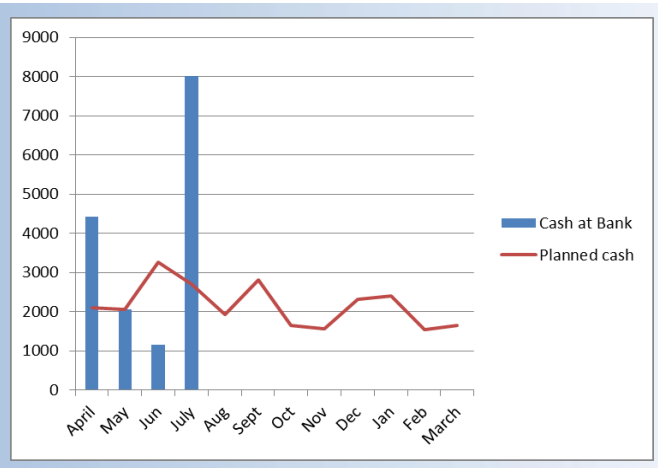
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of July was £8.016m, of which £8.001m was held in bank accounts and £15k in petty cash. During July we received an additional £20m of cash from Commissioners as a result of re-profiling contract payments. We used most of this to pay suppliers and this eased the pressure significantly. NHSE have subsequently asked Commissioners to revert back to contract terms from September which means the cashflow forecast and strategy for drawing down loans will need to be revisited and pressure on relationships with suppliers will resume.

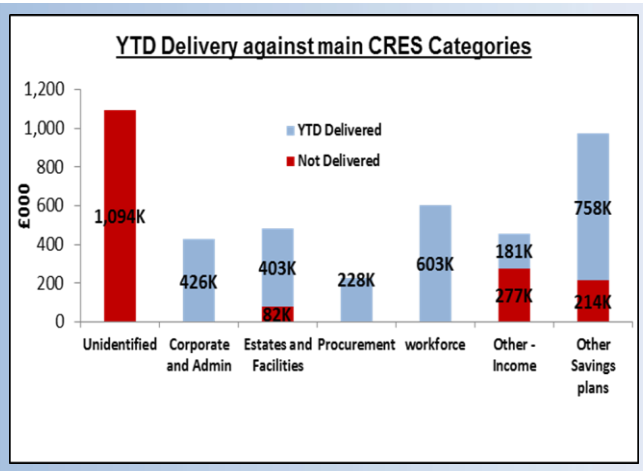


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 4 the Trust has delivered £2.6m of CRES savings against a CRES ytd plan of £4.3m (£1.7m adverse variance)

The Trust is forecasting delivery of £11.2m of savings against a plan of £15.0 (£3.8m adverse). Through working closely with Deloittes 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

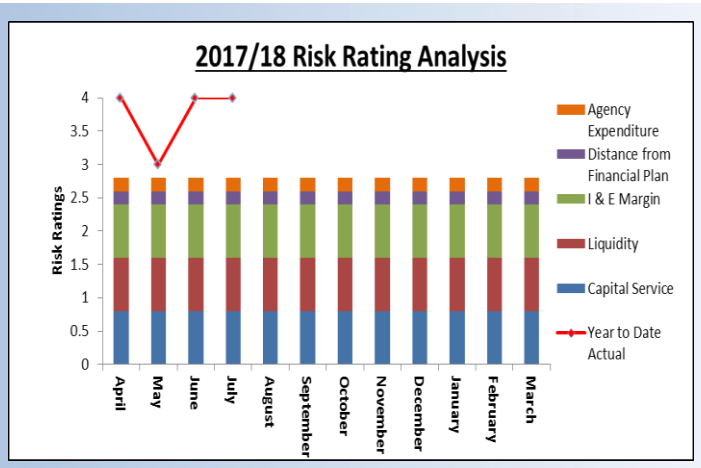
Risk Rating

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 4 the Trust is reporting a deficit of £8.3m against a planned deficit £2.3m (£6.0m 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.

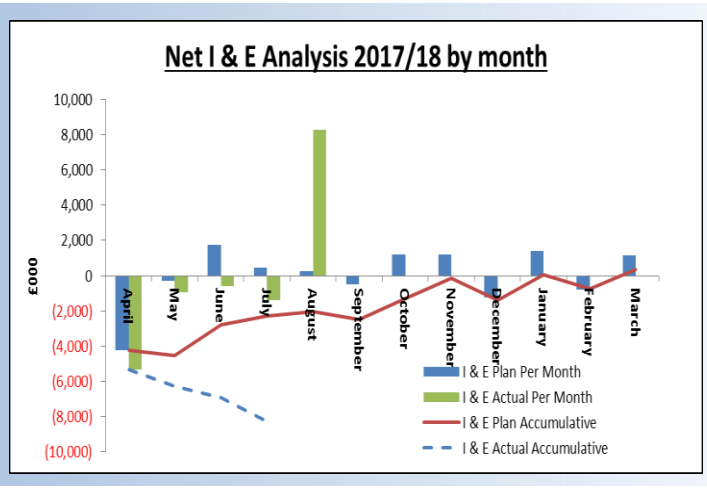


Income & Expenditure

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 4 the Trust has delivered a deficit of £8.3m against a plan of £2.3m deficit (£6.0m 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
PERFORMANCE AND FINANCE COMMITTEE MEETING MINUTES
HELD ON 31 JULY 2017

PRESENT:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD
IN ATTENDANCE:	Mr K Phillips	Chief Medical Officer (Item 5.2 only)
	Mr D Taylor	Director of Estates, Facilities and Development (Item 5.1 only)
	Mrs A Drury	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
	Ms R Thompson	Corporate Affairs Manager (minutes)

1. APOLOGIES **ACTION**

Apologies were received by Mr S Evans, Deputy Director of Finance.

The agenda was taken out of order at this point

5.2 – GIRFT REVIEW: VASCULAR AND UROLOGY

Mr Phillips gave a presentation to the Committee which reviewed the actions in place regarding the 'Getting it right first time' Lord Carter programme. The two specialities included in the presentation were orthopaedics and vascular. The Urology review is scheduled later this year.

Mr Phillips advised that there had been a number of actions put into place regarding the Orthopaedic service such as: reductions in loan kit requests, sharing of STP data, an audit had been completed by the coding team, an ACP had been advertised in elderly medicine to help achieve better outcomes and receive best practice tariff and the transformation team had completed an analysis of length of stay.

The Vascular service had reviewed theatre capacity, identified the need for a diabetic foot clinic, and reviewed staffing, including Consultant, numbers The service would be looking to introduce a surgical admissions lounge at HRI in December 2017.

There was a discussion around productivity per consultant and Mr Phillips reported that by the end of the year all consultant job plans would be in place incorporating productively requirements, and reflecting the Carter recommendations.

Resolved:

The Committee received the presentation and requested that Mr Phillips bring back a benefits realisation report to the committee when available. **KP**

2. DECLARATIONS OF INTEREST

Mr Hall declared a new interest, in that his partner was now a member of the Yorkshire and Humber Clinical Senate.

3. MINUTES OF THE MEETING HELD 26 JUNE 2017

There were two amendments to the minutes:

- Item 4.2 – Mrs Drury to be added as an attendee of the meeting
- Item 11 – A quarterly *Workforce and OD Progress report including key performance indicators* to be received.

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

4. MATTERS ARISING FROM THE MINUTES

The diagnostic MRI/CT scanner bid had not been successful, but Mr Bond advised that there would be an opportunity to submit another bid in the Autumn. This action on the tracker to be closed.

The actual activity levels have been included in the Demand Report – action closed. Mr Bond also noted that a new performance dashboard had been included in the CEO report to the Board and feedback from colleagues is welcome.

5. ACTION TRACKING LIST

E-Roster business case would be received at the Workforce Transformation Committee in August. An update to be received at the August 2017 meeting. **SN**

Mr Bond advised that a new barcoded medical records system would be introduced which would achieve savings due to a reduction in staffing. This item was to be removed from the tracker. **RT**

5.1 – ESTATES BENCHMARKING REPORT

Mr Taylor presented the annual Estates Return Information Collection (ERIC) to the Committee. He advised that comparison with other Trusts was difficult as the data requests were not consistent each year and the ways in which Trusts interpret and submit the data requirements differ.

He highlighted the environment audits PLACE as a concern as many of the Trust's ratings on PLACE areas are rated red. A number of external and internal assessors carry out the PLACE audits and include not only the domestic cleaning but the state of the buildings and also the equipment. Mr Taylor reported that as the estate became smaller it would be easier to manage. He advised that the Trust was working with North Lincolnshire and Goole Hospitals NHS Foundation Trust and York Teaching Hospital NHS Foundation Trust to compare issues and identify potential efficiencies.

Mr Gore asked about infection control and wards with lower scores, and asked what was being done. Mr Taylor advised that one of the challenges was the increased number of certain areas and the Trust was looking at different cleaning methods to work around this. He also reported that the cleaning contract was out to tender and there is an opportunity to revise the cleaning regime potentially including equipment cleaning through the updated specification.

Resolved:
The Committee received and accepted the update.

5.3 – CANCELLED OPERATIONS

Mr Bond presented the paper; a recent Yorkshire Post report had stated that the Trust had double the amount of cancelled operations than any other Trust in the Yorkshire region. However there were no other large acute teaching or major trauma centres included in the comparison. Presenting the Trust's figures, he reported that the Trust was performing much better than the national average at rebooking patients within 28 days following a cancelled operation but was just below average on the number of cancelled operations. He advised that the Trust's data on both standards were reporting and monitored on a monthly basis.

Mr Bond reported that key issues causing cancellations were consultants starting lists late, patients not being ready for theatre, kit not available or procedures becoming more complex during the operation.

Resolved:

The Committee received the update.

6. WORKPLAN

The Committee reviewed the workplan. Mr Gore requested a review of the procurement process and Mr Bond agreed to bring a 6 month review of the Procurement Strategy to the meeting. **LB**

The Committee also agreed to receive regular updates from November 2017 onwards on a monthly basis for CRES and financial planning 2018-19; this is to be a new line on the work plan. The existing CRES item on the work plan will be amended to CRES Delivery 16-17 for the avoidance of doubt. **LB/SE** **RT** **RT**

The timings for the quarterly Workforce updates will be updated to be received following the end of each quarter (to be amended to August 2017, November 2017, February 2018 and May 2018). **RT**

7. DEMAND REPORT – MONTH 3

Mrs Drury presented the report and updated the Committee regarding activity levels for elective and non elective procedures.

She advised that GP referrals were 4.2% down compared with last year. The South bank referrals were 10% lower than last year and referrals are lower from North Yorkshire also. There were however specialities that were above plan including Cardiology which was 6.5% above plan. She reported that the Trust and Commissioners were reviewing two high volume referral areas (palpitations and heart failure) with a view to streamlining the pathways and reducing referrals if possible.

The current position against the Emergency Department activity trajectory is a 4.4% increase in attendances. An average 378 patients attending on a daily basis against a plan to the end of June of 362. If the attendees continued to increase Mr Bond advised that the activity levels would have to be discussed with the Commissioners as there was no cap on activity due to the block contract in place.

Mrs Ryabov advised that the increase in patients was in the under 5 year olds and over 65 year olds. A review of these age groups was being undertaken to understand the increase in activity. There was also a review of frequent attenders to the department.

Mrs Drury advised that the Trust's overall overtrade was £3.1m in Quarter 1.

Resolved:
The Committee received and accepted the report.

8. CORPORATE FINANCE REPORT

Mr Bond advised that the Trust was reporting a £6.9m deficit in the first quarter which was £2.3m away from the plan excluding STF. The cash position had improved and agency spend was in line with plan. The capital programme was being managed against plan.

Resolved:
The Committee received the financial report.

8.1 – HEALTH GROUP MONTH 3 FINANCIAL SUMMARIES

Mr Bond presented the information which gave the month 3 financial positions of the Health Groups.

All Health Groups under-delivered against CRES requirements to Month 3. The Health Groups also incurred additional over-spends:

The Medicine Health Group's main issue was additional medical staffing costs. There was an issue with consultants acting down when Registrar-level medical staff were not available or on sick leave. There had been a number of staff across the medical grades on sick leave in the last couple of weeks. The team were interviewing soon to remove as much of the locum cost as possible.

The Surgery Health Group had non pay issues and was down on productivity, partially due to the holiday entitlement in June. Some expensive equipment loan kits had caused costs to increase so another level of authorisation had been added to the procurement process. A group was to be established to look at standardising consumables and review stock counts.

Mr Bond reported that the Family and Women's Health Group did not have large single overspends but had a number of small items that cumulated in an overspend. Gynaecology was the biggest non pay area of concern. There are additional cost pressures in the Health Group for medical staffing in junior doctors for levels of sickness and maternity leave.

The Clinical Support Health Group had overspends due to Pathology costs. There was a shortage of manpower in a number of specialties leading to the use of expensive locum doctors. In radiology the absence of locums has led to parts of the service being outsourced to a private provider.

There was a discussion around the underlying overspend and the

financial projection. It was agreed that a much greater level of rigour is required with regard to general run rate issues.

It was agreed that Deloitte should be invited to the next meeting to discuss their exit process and how the Health Groups CRES would be managed after that time.

Resolved:
The Committee received the update and agreed that Deloitte should attend the next meeting in August 2017. **LB/RT**

The Committee also requested a benchmarking report on non-pay costs in Surgery and a comparison to an appropriate Trust, to compare the relative impact/size of issue in the Trust, if possible **LB/AD**

8.2 – CRES REPORT (FIP2 PROGRESS)
Mr Bond presented the report and advised that the Health Groups had identified further CRES opportunities. Currently the Trust is forecasting delivery of £11.74m CRES against a target of £15m (74% achievement). Mr Bond reported that both corporate services and the estates department were performing well.

There was a discussion around length of stay and Mr Gore asked how much it would save to close a ward if length of stay could be brought down and Mr Bond agreed to bring a report back to the committee with further details. **LB**

Deloitte and the FIP2 process was discussed. Mr Hall asked how long Deloitte would remain at the Trust and what was the process after they left. Mr Bond advised that an exit plan was in place and the Hospital Improvement Team would take over a number of the enabling (transformational) projects when the FIP2 team had left. It was agreed that Christine Armistead from the FIP2 team would be invited to the next committee to discuss the exit plan.

9. PERFORMANCE REPORT
Mrs Ryabov presented the report and advised that the Emergency Department was still on the planned trajectory and delivering 90% consistently. It was noted that the year-end national target remains 95%.

Referral to Treatment was on plan but there had been 4 x 52 week wait breaches. These were due to a number of issues including a choose and book error and a patient with a complicated pathway. The Committee was also briefed on a significant access tracking issue that had come to light in the last week; detailed validation is taking place to understand the specific issues and this will be reported at the next meeting. **ER**

Mr Gore asked if Mrs Ryabov could include the actual list size in her report as he had two conflicting figures. **ER**

The Committee also requested that the RTT position on each speciality is shown as month-by-month data rather than just the most recent month. **ER**

There were concerns around the cancer standards in particular colorectal, lung and urology. Performance was at 78.7% which was below the national target. Mrs Ryabov advised the clinical leads and the cancer manager were meeting on a regular basis to identify and better manage avoidable issues. They are also reviewing the robot capacity and seeking the support of the Cancer Alliance Board for help in this area.

Breaches attributed to other Trusts were discussed and how this could be managed better. A new procedure had been put into place to try to avoid cancellations of procedures for patients with cancer: Cancellations would only happen with prior sign off by the Chief Nurse, Chief Medical Officer or the Chief Operating Officer.

The Committee requested further detail of avoidable breaches per tumour site, including at least one action planned per tumour site that will improve performance. **ER**

The Committee reviewed the current position in relation to diagnostic breaches; it is anticipated that future months will see a reduction in the number of breaches as capacity is reviewed and the impact of replacement equipment is seen.

Resolved:
The Committee received the report and requested some specific actions as detailed above **ER**

9.1 – CANCER 62 DAY PATHWAYS: UROLOGY AND LUNG
This item was received as part of the Performance Report in item 9.

9.2 – APPROACH TO THE WINTER PLAN
Mrs Ryabov presented the report which outlined the approach being taken to set the winter plan for 2017/18. Work was being undertaken around the bed model, staffing and partner engagement. Mrs Ryabov reported that the Trust will likely need 30+ extra beds for the winter plan.

Mrs Ryabov also advised that support services such as social services and community support were key to the plan. She noted that the Trust would not be purchasing step down/residential beds in winter this year. The draft plan would be presented to the Executive Management Committee in September 2017 and would then be presented to the Performance and Finance Committee at the end of September 2017.

Resolved:
The Committee received the approach to the winter plan.

10. AGENCY SPEND PROGRESS REPORT
Mr Nearney reported that the Agency spend was in line with plan at £2.7m. He advised that all of the Health Groups were held to account at the monthly performance meetings and appropriate controls were in place.

Mr Nearney reported that there were still a number of vacancies that

were being worked through and plans for the difficult to recruit areas but that there were no quick solutions. Mr Gore asked that patient admin agency spend be reviewed as this should not be difficult to recruit to. The Committee also noted the position with IR35 and the work on-going with specific Consultants agency positions.

Resolved:
The Committee received the report and Mr Nearney agreed to review the patient admin issues and report back to the Committee. **SN**

11. BOARD ASSURANCE FRAMEWORK

Ms Ramsay presented the report which highlighted the Trust's main risks which would prevent achievement of the organisational objectives. The Committee had reviewed at today's meeting issues that link specifically to BAF areas: the need for robust detail around diagnostic capacity, not achieving the control total, the cash flow, capital funding and backlog maintenance.

Mr Gore asked if the risk rating for BAF 7.1 on delivery of the financial plan should be increased due to the Trust's deteriorating financial position. The specific detail of the risk is that the Trust would not deliver its financial plan. It is currently rated 5 for impact and 4 as likelihood. An increased rating of certain would state that the Trust cannot and will not deliver its financial plan, and this is not the status of the Trust at the present time. Mr Gore also noted the discussion he had had with the Trust's Procurement lead this morning and whilst payments to suppliers are up to date, the Trust continues to face a reputational risk with some suppliers should cash-flow impact on payments in the future.

Resolved:
The Committee agreed to review the Board Assurance Framework at each meeting and Ms Ramsay to add in the comments made. **CR**

11.1 – APPROVAL OF CONTRACT AWARD – KCOM

Mr Bond presented the item and requested that the Committee retrospectively approve under Standing Orders the contract awarded to KCOM for the provision of telephony and IT kit for Castle Hill Hospital. The contract had been approved by the Chief Executive and the Chair of the Performance & Finance Committee. There was a timing issue to place the order at a specific point in time, which is the reason for bringing this retrospectively to the Committee.

Resolved:
The Committee approved the contract.

12. ITEMS DELEGATED FROM THE BOARD

There were no specific items delegated from the Board.

13. ANY OTHER BUSINESS

There was no other business discussed.

13.1 – NON EXECUTIVE DIRECTOR UNDERSTANDING – 62 DAY CANCER STANDARD

Mr Hall requested further training for the Non Executives regarding the cancer standards to fully understand the issues and to ensure

appropriate questioning and challenge took place. Mrs Ryabov advised that she would facilitate a development session with the Non-Executive Directors. Ms Ramsay asked that this be linked with the queries raised by the Quality Committee for the impact on patient care and patient experience. Mrs Ryabov also invited the NEDs to attend the alternative RTT and Cancer performance meetings held fortnightly at Trust. **ER/RT**

14. DATE AND TIME OF THE NEXT MEETING:

Tuesday 29 August 2017, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
YOUNG HEALTH CHAMPION REPORT AUGUST 2017

Trust Board date	5 September 2017	**Reference Number**	2017 – 9 - 14
Director	Mike Wright, Executive Chief Nurse	**Author**	Rachael Pearce, Senior Patient Experience Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the young volunteer programme running within the Trust, called 'Young Health Champions'		

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

1 RECOMMENDATIONS

The Trust Board is requested to receive this report and:

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

2 KEY PURPOSE:

Decision		Approval		Discussion	
Briefing	**Y**	Assurance	**Y**	Delegation	

3 STRATEGIC GOALS:

Honest, caring and accountable culture	**Y**
Valued, skilled and sufficient staff	**Y**
High quality care	**Y**
Great local services	**Y**
Great specialist services	
Partnership and integrated services	
Financial sustainability	

4 LINKED TO:

CQC Regulation(s): All

Assurance Framework Ref: BAF 3	**Raises Equalities Issues?** Y	**Legal advice taken?** N	**Raises sustainability issues?** N

5 BOARD/BOARD COMMITTEE REVIEW

The Chief Executive offered a more detailed briefing on the Young Health Champions at the August 2017 Board meeting.

TRUST BOARD
YOUNG HEALTH CHAMPIONS BRIEFING PAPER
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 the Young Health Champions Programme running in the Trust.

2. BACKGROUND

Around three million people volunteer for health, disability and welfare organisations in England, equating to more than 78,000 volunteering in Acute Trusts. An average Acute Trust in England has about 471 volunteers and it is estimated for every pound spent on a volunteer the Trust yields, £11 in added value (Kings Fund 2013).

Hull and East Yorkshire Hospitals NHS Trust has had a long tradition of valuing and supporting volunteers within the organisation. In April 2015 the management of this service moved to the Patient Experience Team. At that point the number of volunteers was just over 200 and when profiled the majority were ladies of retirement age (all extremely valuable). There was a preference for the volunteers to cover the Castle Hill Site, and an apparent reluctance to cover Hull Royal Infirmary.

Encouraged and supported by the Chief Executive the Patient Experience Team began looking at innovative ways to recruit new volunteers of all backgrounds and age groups. As part of the Trust's corporate social responsibility work, it was believed that the organisation could give volunteers invaluable experience of working in a health care setting and not necessarily in traditional areas such as wards. We currently now have recruited just under 600 volunteers and cover both sites undertaking a variety of roles.

One work stream which has been led by Racheal Pearce, Senior Patient Experience Officer was to look at developing younger volunteers from the age of 16. This entailed recruiting young people to undertake more traditional volunteer work and a bespoke programme that runs with a partner organisation looking at helping young people (16-24) who are considered to be long term unemployed.

3. YOUNG HEALTH CHAMPIONS (YHC) TRAINEESHIP

In December 2015 the Trust began working closely with Active Humber, a social enterprise who were using sport and mentorship to help young people (16-24) gain experiences that will lead them into employment.

The purpose of the YHC Traineeship is to recruit, develop and deploy young people across the Trust, giving them opportunities to raise awareness amongst their peers and their local community about lifestyle-related risks to health, and can provide safe signposting information about local services for health and wellbeing.

Each YHC Trainee completes the Royal Society of Public Health (RSPH) Level 2 certificate for Youth Health Champions qualification, functional skills, Maths, English, and ICT where appropriate, plus department-specific Trust in-house training. This in-house training includes Information Governance, Safeguarding, Infection Prevention and Control and Manual Handling and Safety.

One unique element of the YHC programme is that each young person is allocated a departmental mentor, providing ongoing support and information, advice and guidance throughout their Traineeship. Mentors have been identified across the Trust and have undertaken internal training. Active Humber also provide a mentor to all Young Health

Champions working with them for any additional needs that they may have as some of the Young Health Champions suffer from Social Anxiety and Depression, Active Humber mentors work with them and deliver an Activating Confidence course to work on their social skills and confidence building.

Two years in to the programme, the Trust and Active Humber have engaged and developed over 30 young people with some moving into Apprenticeships and paid employment in their chosen departments. The intention has been has been to place Trainee's into suitable positions, working with them so that they are recruitment ready. This support has included completing job applications and interview techniques, enabling the young people to be work ready when positions internally or externally become available. Individual hospital departments such as Catering, Gardening and Linen Services devised opportunities by creating specific traineeship programmes to equip these young people with some of the skills needed to adapt to a working environment.

Success story

Elliott is a 20 year old from Hull and became a Trainee on the Young Health Champions traineeship programme. Elliott has mild Asperger's and struggled with low confidence, and found it difficult to be independent; using public transport to get around was a significant challenge for him. Finding a job and putting himself in front of employers was something he did not feel he could do.

After spending time in hospital, he realised that he wanted to work in a hospital environment, and be on the other side of the hospital bed, helping and caring for people in need. Active Humber and the Trust helped Elliott with his confidence issues and supported him with getting around, teaching him how the public transport system works. They would meet him at the bus station and support him for his first few journey's until he felt comfortable on his own. Once Elliott had built up his confidence and we understood his aspirations we invited him along to a Young Health Champions information day at Hull Royal Infirmary.

Elliott has now completed his Traineeship volunteering two days a week within the Facilities department at Castle Hill hospital and Hull Royal Infirmary. Before he started his Traineeship a situation like this wouldn't have been possible for him; meeting new people and being in unfamiliar surroundings was a big challenge but now he is facing new situations every day and loving it.

Elliott said, "I feel much more confident since starting my traineeship, and I am really enjoying meeting new people. I now feel comfortable getting on the bus on my own and I no longer worry about what people think. Each week I feel increasingly comfortable facing different situations and I gain more confidence as the traineeship goes on. I have confidence in myself to do things independently and be more confident in speaking to people and not hiding away. I feel that I have grown as a person and my self-esteem has grown immensely too."

Elliott has now moved on from the Trust but all those people who worked hard with Elliott are very proud of this young man for overcoming his fears and gaining such confidence that he has now obtained a full-time job.

Elliott's story is just one of the successes of the Young Health Champions traineeship programme. Further work is underway to help many other young adults by offering them such opportunities. The Trust highlights to the young people the sheer variety of NHS careers available including those which do not require a university education as well as to inspire young people's career choices and offer some practical hands on experience.

4. YOUNG HEALTH CHAMPIONS

Running alongside the Young Health Champions Traineeship, the Trust supports one hundred and twenty young volunteers within the Trust. Established in November 2015 the Trust visited local schools, colleges and university talking to young adults between the ages of 16 – 24 years old, encouraging them to volunteer at the Trust. Not only does it the individuals an opportunity to do something good in their spare time, it also enables them to use their experiences for such things as university and job applications.

The Trust now has a well embedded network of external partners who we work alongside monthly including: -

- St Mary's College
- Bishop Burton College
- Hull FC Academy
- The Boulevard Centre for young mums
- Hymers College
- The Tiger Trust
- NCS Programme
- Wyke College
- Wilberforce College
- Mencap
- Mathews Hub
- All secondary schools in the Hull and East Riding area have also been sent information.

The Trust young volunteers are assigned to a specific placement. The Young Health Champions are invaluable to the organisation. Some of these roles include befriending, talking and reading to patients and helping with serving beverages and meals. The Trust offers many opportunities to volunteers; some are training to be Radio Disc Jockeys others are volunteering in the Pathology Labs. Three young volunteers help in the Trusts gardens, designing new flower beds weeding and general maintenance work. All three of these volunteers are enjoying volunteering and have created some amazing areas around our Castle Hill site.

Success stories

Maisie – Maisie came to volunteer for us after leaving school. She started on the Neurophysiology department and after eight weeks successfully achieved a Trust apprenticeship in Endoscopy. After completing her apprenticeship she now has a full-time job with the Pharmacy Department.

Katie – Katie was a young lady who attended the Boulevard centre for young mums her lifelong dream was to become a Nutritionist after volunteering and gaining experience Katie put herself forward for a Trust Apprenticeship as a Nutritionist and was successfully selected and starts at the Trust in September.

Bethany – Bethany was a volunteer in the Trust volunteering on the wards. She now has an apprenticeship on Ward 8 and 80 as event's organiser.

Jessica - Jessica has volunteered for us at the Women's and Children's hospital. She gained lots of different experiences and has since left us and obtained a full-time job in a GP's practice on Kingswood.

Nathan – Nathan volunteered for us wanting to be part of the Pathology team after volunteering for six weeks the Pathology team a position became vacant and he successfully was appointed to this post.

5. SUMMARY

The last two years has seen the success of developing the Young Health Champions programme in the Trust. Not only are we seeing young people who are dedicated to giving up their time to help others, we are also seeing the development of our future workforce which is invaluable.

6. RECOMMENDATIOS

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

Rachel Pearce
Senior Patient Experience Officer

Sarah Bates
Deputy Director Quality, Governance and Experience
August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)

ANNUAL REPORT 2016-17

1 PURPOSE OF THE REPORT

This report provides an overview of the work done in accordance with the Infection Prevention and Control Strategy 2015-17. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and also describes areas where improvement is needed.

2 BACKGROUND

This report is required by the Code of Practice for the Prevention and Control of Healthcare Associated Infection contained in the Health and Social Care Act 2008.

3 INFECTION CONTROL ARRANGEMENTS

Dr Peter Moss, as **Director of Infection Prevention and Control**, is responsible for leading and managing the Trust's Infection Prevention and Control (IPC) strategy. Kevin Phillips, **Chief Medical Officer**, has executive responsibility for infection Prevention and Control. The **Lead Nurse for the Department of Infection** is responsible for the IPC team.

The **Infection Reduction Committee (IRC**) meets monthly, under the chairmanship of the DIPC. The IRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate.

The **Infection Prevention and Control Committee (IPCC)** meet bimonthly under the chairmanship of the Infection Control Doctor (ICD), although the post of ICD is currently under review. The IPCC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, from the Department of Infection, from Occupational Health, from the Facilities Directorate, from the Sterilisation and Decontamination Unit, and from Pharmacy. It reports to the Infection Reduction Committee. The IPCC has responsibility for guiding Infection Prevention and Control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment.

The **clinical IPC team** is composed of the Infection Prevention and Control Doctor, specialist Infection Prevention and Control nurses, and supporting secretarial and

administrative staff. The nursing team is managed by the Lead Nurse for the Department of Infection and for the period covered by this report consisted of 3.5 WTE band 7 and 2 WTE band 5 IPC Nurses, supported by a secretary and a part-time administrative assistant. The national recommendation is for 1 nurse per 250 acute beds (as part of a fully supported team); 83% of English NHS Trusts achieve this figure. The vision, strategy and structure of the nursing IPC team is currently being reviewed, under the leadership of the Chief Nurse.

Shortage of medical microbiology staff has caused problems in the past year, in particular with post infection reviews, root cause analyses, and other clinical review processes. Microbiology is a national shortage specialty, with numerous unfilled consultant vacancies around the country, and HEY is no exception to this pattern. For much of the period covered by this report the Trust had no substantive consultant in microbiology in post. A single locum was employed where possible, and some limited assistance was provided by the York Trust, but most of the work of the former microbiology department was picked up by the Infectious Diseases physicians. A substantive microbiology post is currently out to advert, with reasonable likelihood of a single appointment being made (the department previously had 5.5 WTE consultants). The problem has been most acutely felt in the role of the **Infection Control Doctor**. Although this is not a statutory post, and a significant part of the work previously done by the ICD has been taken on by the Lead Nurse, the lack of a doctor trained in infection control has caused difficulties. None of the ID physicians are appropriately trained, and the Trust is currently in negotiation with York about support for this role.

The **Infection Control Strategy 2015-17** can be found at
http://intranet/corporate/trustStrategies.asp

4 OTHER RELEVANT COMMITTEES

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the IPCC, and report to IRC. There have been concerns about poor attendance at some meetings over the past year, and consultant microbiology vacancies have made it difficult to provide adequate clinical support for these functions. The chair of the Water Safety Committee, which is a mandatory institution, continued to be poorly supported by Health Groups, despite the nomination of specific attendees by the HGs. The first quorate meeting was finally held in 2016.

The Trust's designated Board level Decontamination Lead (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development.

5 THE WIDER INFECTION PREVENTION TEAM

In addition to the core clinical IPC team (DIPC, Infection Control Doctor, IPC nurses, etc.) an increasing number of other clinicians are being recruited to support the Trust's efforts.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention & control practice within their clinical areas. Study days, which are facilitated by the Infection Prevention and Control Team, and extremely well attended, demonstrating a

committed Link Practitioner work force, are held twice each year to disseminate new information and guidance. The Link Practitioners are then supported by the Infection Prevention and Control Team to be proactive in implementing this guidance within their workplace.

Access to infection prevention and control information can also be obtained from the Trust intranet site and via a dedicated email address Ask Infection. Queries to Ask Infection are dealt with by ID physicians in the first instance, with support available from the IPC team as required.

6 SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

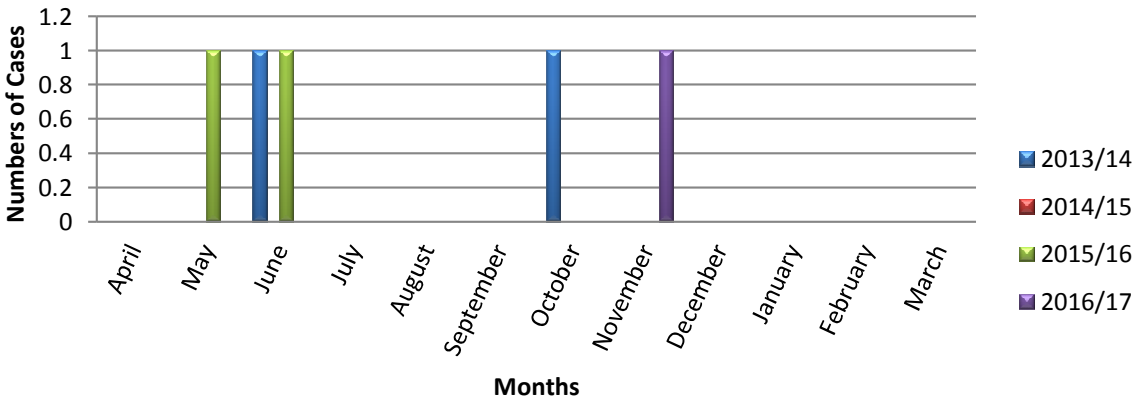
Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

The Trust has achieved a year on year reduction in cases of MRSA bacteraemia since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA bacteraemia by the Department of Health, and the Trust met its target for 2011-12 (8 cases against a threshold of 9), and 2012-13 (6 cases against a threshold of 7). The significant reduction in cases of MRSA bacteraemia has been achieved mainly by improved practice during insertion and care of intravenous devices.

For 2013-14 the Department of Health moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. During 2016-17 there was 1 case of Trust-attributed MRSA bacteraemia: the numbers for 2014-15 and 2015-16 were zero and two respectively (Figure 1).

The single Trust-attributed MRSA bacteraemia case reported during 2016/17 was detected on Neonatal Intensive Care Unit (NICU) and was an outcome of an increased burden of MRSA colonisation on the unit.

Figure 1. MRSA bacteraemia infections 2013-17



Clostridium difficile Associated Diarrhoea (CDAD)

The Trust has participated in the mandatory surveillance of *Clostridium difficile* since 2004. In 2011-12 the Trust performed particularly poorly in preventing hospital attributed *C difficile* infection. In this period there were 105 cases of CDAD attributed to the Trust, against a maximum threshold of 60 set by the Department of Health. Following a number of interventions the number of cases in 2012-13 fell to 58, and the Trust has maintained a steady improvement in performance since then (*Figure2*). In 2016-17 there were 45 cases reported, against a threshold of 53. From 2015-16 there was an opportunity for cases of *C difficile* for which the commissioners agreed that there had been no lapses of care (and the infection was therefore unavoidable) would be highlighted and removed from any financial penalty, although still included in the total. The Trust agreed a very strict definition with the commissioners, whereby any deviation from Trust or national guidance (even if not necessarily contributory to the development of infection) was classed as a lapse of care. Despite that over 20% of the reported cases in 2015-16 and 2016-17 were agreed to have been unavoidable, through a robust consultation process with the IPC representatives of the Clinical Commissioning Groups (CCG's).

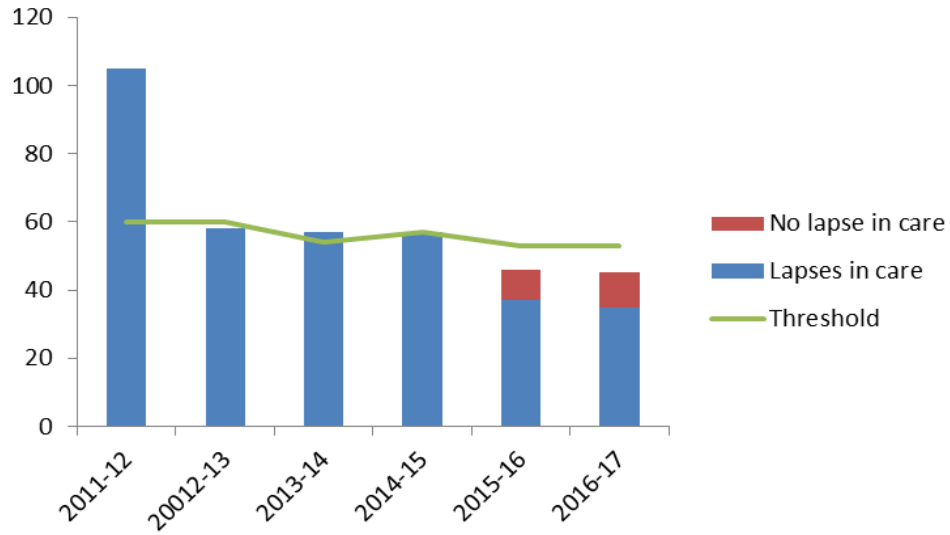


Figure 2. Annual reported number of Trust-attributed C difficile infections 2011 - 2017

One of the most important factors in reducing the number of cases of hospital acquired *C difficile* diarrhoea during 2011-12 and 2012-13 was the establishment of a dedicated *C difficile* cohort ward on the Castle Hill Hospital. This led to a dramatic fall in the number of secondary cases. However it was only ever intended as a temporary facility, and was never fully equipped or resourced. A decision was made to gradually run down the cohort area: in 2015-16 only about 50% of patients with the infection in the Trust were moved there, and in July 2016 it was closed completely. The fact that there has been no increase in the number of Trust-attributed cases since then reflects improved infection control processes on the general wards, and dramatically improved antibiotic prescribing practices across the Trust.

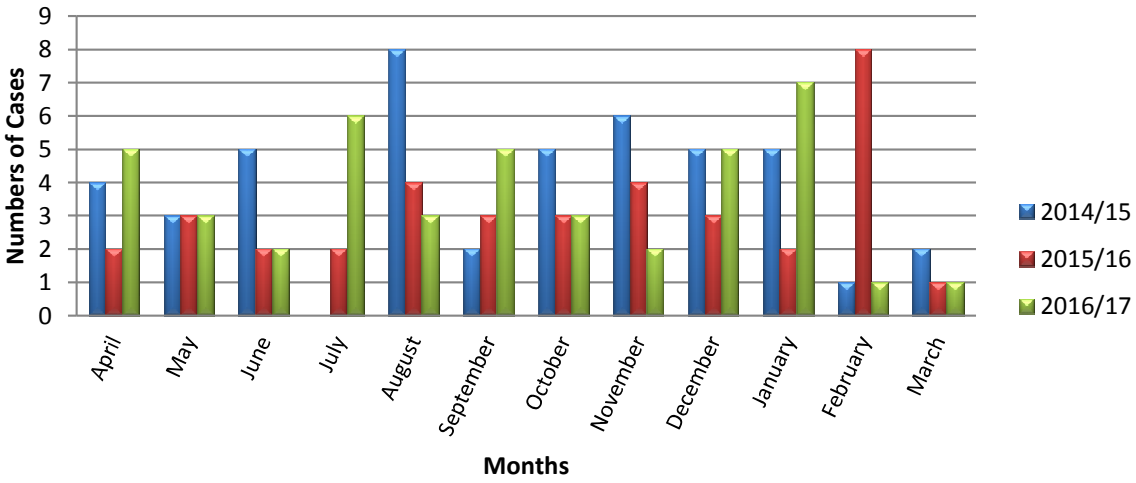
All cases of *C difficile* infection are subject to a Root Cause Analysis (RCA). The RCA process is led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPC team. Summary outcomes are presented to the IRC. Engagement from senior clinicians and timeliness of investigations along with completion of the process has improved over the last couple of years (although as discussed above lack of microbiology support has been a problem). In most cases there were no significant failures of care apparent that had led to the development of CDAD. The main areas that were identified for improvement were timely isolation of patients with diarrhoea, delay in submitting a faecal sample, and completion of bowel charts.

Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia

National data show that the general reduction in MRSA bacteraemia has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. During 2015/16 root cause analysis of MSSA bacteraemia cases across the Health Groups were completed and reported via the Infection Reduction Committee. Since 2013/14 a year on year reduction in cases has been demonstrated (Figure 3), but we are still seeing cases of hospital-acquired MSSA bacteraemia associated with poor intravascular line insertion and care. These are less frequent than in the past, but should be completely avoidable. Other cases associated with intravenous drug use and chronic ulcers are more difficult to address.

Figure 3. MSSA bacteraemia infections by month & year from 2014/15



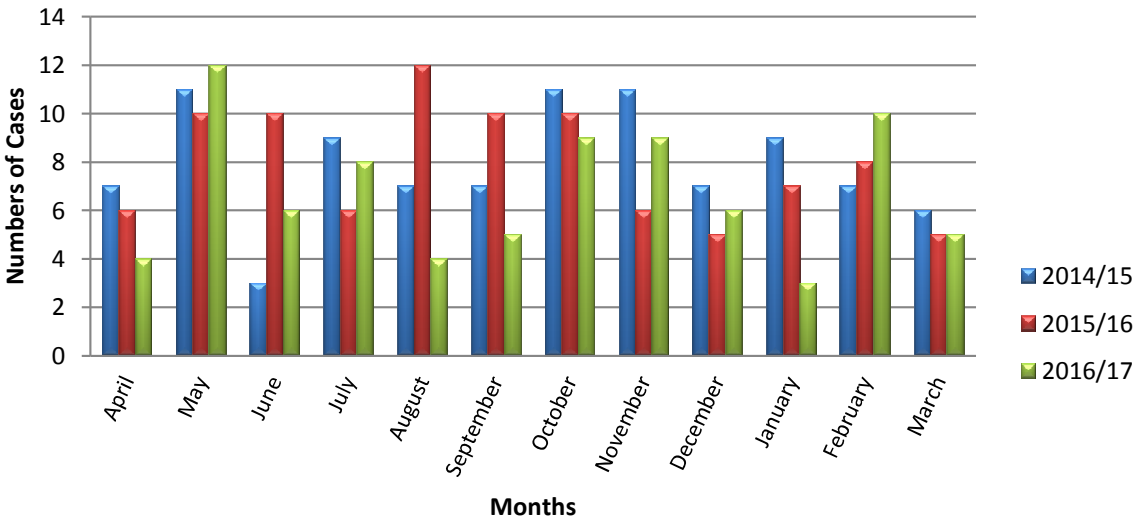
Escherichia coli bacteraemia

Mandatory surveillance of *E coli* bacteraemia was introduced in 2011. This organism is the commonest cause of bacteraemia in hospital (38 000 cases, and 8 000 attributable deaths in 20116), and numbers are increasing year on year. There is a steady increase in the proportion of these organisms which produce Extended Spectrum Beta Lactamase (ESBL), an enzyme which makes them highly antibiotic-resistant. These facts have led PHE, NHSI, and ARHAI to focus on reducing the rate of Gram negative bacteraemia, and especially blood stream infection due to *E coli*. In 2016 the Prime Minister announced an intention to reduce the incidence of *E coli* bacteraemia by 50% by 2020, and the Trust has been working towards the introduction of this new 'ambition' for some time. During 2016/17 the Trust achieved a 15% reduction in Trust apportioned *E.coli* bacteraemia cases.

The majority of *E coli* bacteraemia diagnosed in HEY are the cause of admission rather than being hospital-acquired (usually related to urine or gall bladder infections), and are therefore considered as 'non-attributable' to the Trust. However a proportion of *E coli* bloodstream infections are acquired in the hospitals, associated with urinary catheters, wound infections, vascular devices, and ventilator-associated pneumonia. Even for the 'community-attributable' bacteraemia the situation is not as straightforward as it may seem, as infections developing in the community may be related to a previous admission to hospital. Although surveillance of cases is reported, it is difficult to determine which infections were potentially avoidable without robust investigation (which is difficult given the large number of cases). During 2016-17 the IPC team conducted simple reviews of E coli cases to try to identify the likely source: this process will need to be refined in order to identify areas for improvement.

The number of Trust-attributed *E coli* bacteraemia from 2014/15 is shown in Figure 4.

Figure 4. Ecoli bacteraemia infections by month & year from 2014/15



Screening for MRSA colonisation

In August 2014 the Department of Health changed the requirement for universal MRSA screening to a more focussed strategy. The new guidance is that only patients admitted to specific high risk specialties, and those known to have been previously colonised, should be screened on admission. It is accepted that this shift in policy might result in occasional avoidable MRSA infection, but continuing universal screening is not cost effective. However, only about 50% of acute trusts in England have so far adopted the 2014 guidance. The Trust has so far not changed its policy (on the advice of the ICD), although this is under active review by IPCC.

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2016-17 this included colorectal surgery surveillance and orthopaedic surveillance (hip replacements).

Surveillance figures for colorectal and orthopaedic specialities and subsequent infection rates remain below the national average as reported by Public Health England.

Caesarean section surveillance was also undertaken during 2016/17. Previous surveillance had been completed in 2014 with higher than expected infection rates. A number of measures were introduced, changes in antibiotic prophylaxis, changes in skin preparation and wound dressings. The surveillance was completed during 2016 and again identified higher than expected infection rates. These are often multi-factorial – emergency versus elective section, obesity, and management of the wound on discharge. Due to the voluntary nature of this type of surveillance it is very difficult to provide national comparisons as not all Trusts participate with the type of surgical site surveillance. Trust obstetricians, midwifes, the IPC team and Public Health England surgical site surveillance team continue to scope measures and actions to improve outcomes.

Non-mandatory Surveillance

Although it is important for the Trust to address the targets set against specified organisms such as MRSA and C difficile there are a number of other serious HCAI which cause significant morbidity and mortality. In the past the Trust has collected clinical information on all bloodstream infections, in order to understand the causes of these infections and reduce future infection rates. As previous DIPC reports have stated this work has not been maintained due to lack of specialist medical staff, but with new appointment made this year it is hoped that it can be reinstated.

7 OUTBREAKS

The Trust's policy on outbreaks and incidents of infection has been followed by the IPC team. Incident and Outbreak Control Group meetings have been held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patients are cared for, and seeking to prevent further cases.

Norovirus

The majority of Incident/Outbreak Control meetings were called because of norovirus. The overall number of norovirus cases locally and nationally over the year was below nationally expected numbers and the local situation was in line with national epidemiology.

During 2016/17, outbreaks of diarrhoea & vomiting, mainly affecting medical elderly wards were reported. The majority of these were identified as being caused by norovirus. In accordance with national guidance hospital outbreaks of norovirus were managed with partial restrictions but some complete ward closures were necessary, although markedly fewer than 2015/16. Overall the impact on patient flow was not as great as in 2015/16.

All areas affected by norovirus were closed and cleaned in full accordance with IPC guidance. Opportunities to review existing policies, procedures and communication strategies with internal and external partners continued throughout 2016/17.

Crusted Scabies

During August/ September 2016 an outbreak of scabies was identified on a surgical ward. A patient admitted with abdominal pain also had a history of extensive psoriasis, for which they received treatment for by the dermatology team. Unfortunately crusted scabies and psoriasis can appear similar. Three weeks following the patient's admission, a number of healthcare workers who had had skin to skin contact with the patient developed rashes. This is in line with the incubation period for scabies. On investigation it was determined that the patient had had a previous skin biopsy completed by a private provider who identified the presence of scabies mites, with a delay in the patient being notified during their admission to HEY. It was determined the patient had crusted scabies, which can be highly infectious in healthcare settings, and the ward had an outbreak of subsequent scabies. Outbreak meetings were held with representation from Public Health England to discuss management and treatment.

Contact tracing of patients (188 in total) who had been on the ward during the affected patient's admission was undertaken with all being offered advice & treatment, either during admission and/or via their General Practitioner (GP). All staff were traced, followed up by occupational health, and provided with treatment. In total 32 staff were affected and treated. No further issues were identified once the patient had received appropriate treatment.

Vancomycin Resistant Enterococci (VRE)

No further incidents of VRE have been identified on Neonatal Intensive Care Unit (NICU) following the outbreak in 2015/16. During 2016/17 screening of neonates continued with no cases identified.

Meticillin-resistant Staphylococcus aureus

From September/ October 2016 an increase in Trust attributed MRSA colonisation in neonates on NICU was noted. Although no notable links initially between cases were identified, a Trust attributed MRSA bacteraemia prompted a further investigation. A serious untoward incident (SUI) investigation was completed which identified previous cases of MRSA colonisation and the MRSA bacteraemia case were microbiologically indistinguishable, suggesting patient to patient transmission, possibly via the hands of healthcare workers on the unit. Screening of the unit did not identify subsequent cases and all previously positive cases were treated effectively and discharged home.

The SUI identified a number of issues which mirrored those from the previous VRE outbreak and subsequent peer review. Although actions following that outbreak are being addressed, including enhanced cleaning, and replacing storage facilities, there remain wider concerns. These include lack of isolation facilities for neonates with level 3 intensive care needs, and inadequate space between cots (according to national guidance). These are currently being scoped and addressed.

Influenza

During February 2017 a cluster of Influenza A cases were diagnosed on H10, HRI. Microbiology advice was obtained and prophylactic antiviral drugs were prescribed for those patients who had been in contact with the infected patients. Due to the number of patients affected the ward was closed to admissions in accordance with PHE advice. PHE Guidelines were followed in the use of personal protective equipment and the appropriate management of patients. The ward was reviewed daily by the Infection Prevention and Control Team and all patients monitored closely for any flu-like symptoms. In total eight patients were confirmed as having Influenza A by laboratory testing. The ward remained closed until five days after the last new confirmed case. No staff were reportedly affected during the incident reinforcing the importance of the seasonal influenza vaccination campaign.

Invasive Group A Streptococcus (IGAS)

During March 2017, a number of patients were admitted with IGAS and managed as inpatients. Public Health England were investigating an increase in infections amongst people who inject drugs in the local community and across Yorkshire, with a number of incident meetings held to coordinate both secondary and primary care responses and actions. The incident provided the opportunity to address possible inequalities experienced by this group of often difficult to reach patients.

Carbapenemase producing Enterobacteriaceae (CPE)

Infections with multi-drug resistant Gram negative bacteria are becoming increasingly common in Britain, and there have been a number of healthcare associated outbreaks (including some in other acute trusts in Yorkshire). As yet Hull and East Yorkshire Hospitals NHS Trust has had only a handful of infected or colonized patients, all of whom have brought the organism in from elsewhere. There have been no cases of local transmission. The Trust Board in 2014 agreed to fully implement the national toolkit on prevention and management of CPE and during 2016-17 met the requirements of the toolkit e.g. identifying, screening and managing at risk patients.

8 ISOLATION FACILITIES

There are a number of concerns about the Trust's isolation facilities. Like many other NHS Trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution. However more pressing concern surrounds the specialist Infectious Diseases ward at Castle Hill Hospital. This ward has now been left itself isolated by the move of other departments to HRI, and is the only clinical area left in the southern part of the CHH site. The ward has one room which meets national standards for isolating patients with MDR TB; this is also the only room suitable for assessing patients with potentially highly infectious conditions such as viral haemorrhagic fever.

To resolve the problem, funding has been approved to convert C7 (previously a cardiothoracic ward and now vacant) into a new isolation and infectious disease ward. The new facility will have 6 rooms with full isolation capability (negative pressure room, positive pressure anteroom), including one room with separate entrance/exit routes and additional filters allowing the safe assessment of patients with potentially highly contagious imported pathogens. There will also be 6 standard single rooms. The operating policy for the unit will ensure that the beds are used for patients requiring isolation, or highly specialised infection management. Most patients with more straightforward infections will be managed on base wards with input from the ID team. A new national specification for commissioning four regional isolation centres is currently being developed by NHSE and DoH; the new unit will potentially put the Trust in a position to bid for this if is thought appropriate to so do.

9 ANTIMICROBIAL STEWARDSHIP

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control strategy. This is useful in reducing the development of *C difficile* infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship. In 2016-17 CQUIN targets for reduction in the use of the broad spectrum antibiotics meropenem and piperacillin/tazobactam were achieved, even though we started from low baseline usage compared to national average. The Trust did not achieve the overall antibiotic usage reduction target required by the CQUIN.

The Antibiotic Control Advisory Team (ACAT), under the leadership of Dr Gavin Barlow, continues to work on improving antibiotic usage within the Trust. Advice on the use of antibiotics is included in consultants' mandatory training day. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, prescribing in patients at high risk of *C difficile*, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on the intranet. ACAT meets regularly to review antibiotic usage, and reports to IRC. Regular audits of the quality of antimicrobial prescribing are carried out by Pharmacy staff; these are presented at IRC and any areas requiring improvement are highlighted to Health Groups. This process is supported by the dedicated antimicrobial prescribing section of the drug chart, which makes it more difficult to inadvertently

overprescribe antibiotics. These (and other) measures have led to an objectively measured improvement in the quality of prescribing, and an increased diversity of antibiotics used. RCA for CDAD have also shown a considerable reduction in cases which could be attributed to poor antibiotic prescribing.

10 TRAINING AND EDUCATION

Education and training are essential to the strategy to limit healthcare associated infections (HCAI) in the Trust. They form part of every staff job description, and an integral part of the appraisal process.

Infection prevention & control education forms part of the mandatory induction programme for all staff. Infection prevention & control is included in junior doctor orientation and as part of the consultants' mandatory training programme. Staff attendance at mandatory infection prevention & control updates is recorded centrally.

In addition to mandatory training, the infection prevention & control team conduct ad hoc education sessions to staff groups and most recently have tailored a programme for Mitie staff.

11 OTHER ACHIEVEMENTS IN 2016-17

The Trust has always worked in collaboration with commissioners and other partners in reducing avoidable infections. Although some national targets and CQUINs divide healthcare associated infections into 'acute-attributed' and 'community-attributed' these are artificial distinctions. Many infections diagnosed in the community have their origins in hospital, and vice versa. It is therefore essential that a 'whole system' approach is taken to tackling healthcare associated infections. The Trust continues to meet regularly with partners in a number of forums, and it has been agreed that the current successful collaborative review process for *C difficile* will be extended to other HCAIs.

The loss of consultant microbiologists, although it has caused problems in some areas, has allowed a change in the way clinical infection advice is provided. Significant laboratory results (such as positive blood cultures) are now often followed up by a bedside visit from an ID physician, rather than being phoned to the ward: this has resulted in very positive feedback from some clinical teams. Regular infection in reach is now provided in a number of areas (e.g. orthopaedics, vascular surgery, diabetes, neurosurgery, cardiology/ cardiothoracic), in addition to the specific visits requested through 'Ask Infection'.

12 OTHER RISKS IN 2016-17

In June 2015 the Trust were made aware of a Medical Device Alert related to heater-cooler devices used during cardiac surgery: risk of infection with *Mycobacterium chimaera*. A number of the Swiss-made units were contaminated in the factory with this organism, which

can then be transmitted to patients during surgery. Although it has been established clearly that the fault lies with the manufacturer, and that Trusts could have neither foreseen nor avoided the problem, NHSE has made it clear that individual Trusts are responsible for managing any consequences (and has suggested that Trusts can try separately to seek redress from the manufacturers should they so wish). Guidance has been issued by PHE: the Trust has been fully compliant with the requirements of the guidance, and continues to monitor and mitigate risks associated with these devices. Dedicated clinics have been set up by the ID department to review patients who might be at risk of infection. To date, although machines used in the Trust have been found to be contaminated, no infections have been attributed to HEYHT. One patient with *M chimaera* endocarditis has been treated by the ID department, but their infection was acquired elsewhere.

The Neonatal Intensive Care Unit has had two outbreaks of serious HCAI (with VRE in 2015/16, and then with MRSA in 2016/17). The physical facilities on the unit are not ideal, and although improvements have been made there remain times when there is inadequate space for the number of babies being managed there. This problem is recognised by the Health Group, and options for a solution are to be reported to IRC. Isolation facilities are also inadequate in the general paediatric admissions unit, and there have been cases of hospital transmission of respiratory viruses including influenza. Again there is no simple solution, and it can only be resolved as part of wider changes within the Health Group.

13 EXTERNAL INSPECTIONS

During 2016/17 the Care Quality Commission (CQC) inspected the Trust. Infection prevention & control was assessed as part of the inspection process, with no concerns raised in relation to IPC management, systems and processes. This represented an improvement on the previous inspection undertaken in May 2015 which highlighted a number of concerns especially in relation to IPC in the Emergency Department and Theatres.

14 KEY POINTS AND RECOMMENDATIONS

- Internal and external reviews have confirmed that in the Trust has appropriate systems and processes in place for the prevention and control of healthcare associated infection.
- Performance against mandatory local and national targets has been satisfactory.
- The Trust has a strong antimicrobial stewardship programme, and there has been documented improvement in antimicrobial prescribing.
- There have been significant improvements in some specific aspects of infection prevention and control (e.g. management of *C difficile*, clinical engagement in root cause analysis, and increased partnership working).
- There are weaknesses in the Trust estate and facilities for managing patients with infections:
    - limited number of single rooms
    - inadequate facilities to isolate highly infectious adult patients
    - inadequate isolation facilities in paediatrics

  Solutions to these estate issues are being considered as part of a wider Trust strategy
- There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections.
- There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.

The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

Peter Moss
Director of Infection Prevention and Control
August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

WORKFORCE RACE EQUALITY STANDARD (WRES)
TRUST SUBMISSION 2017

Meeting date	5 September 2017		**Reference Number**			
Director	Simon Nearney Director of Workforce and OD		**Author**	Jackie Railton Head of Strategic Planning		
Reason for the report	The purpose of this paper is to present for consideration by the Trust Board the findings of the Trust's Workforce Race Equality Standard submission for 2017 and proposed action plan.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board is asked to note the content of this report and its appendices and approve the WRES return and Action Plan.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): Regulation 18 – Staffing					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** This paper was considered at the Diversity and Inclusion Steering Group and the Executive Management Committee in August 2017					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

WORKFORCE RACE EQUALITY STANDARD (WRES)
TRUST SUBMISSION 2017

1. PURPOSE

The purpose of this paper is to present for consideration by the Trust Board the findings of the Trust's Workforce Race Equality Standard submission for 2017 and proposed action plan.

2. BACKGROUND

The NHS Workforce Race Equality Standard (WRES) was commissioned and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WRES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;

- To produce action plans to close the gaps in workplace experience between white and Black and Minority Ethnic (BME) staff; and

- To improve BME representation at the Board level of the organisation.

By using the WRES, NHS England expects that all NHS organisations will, year on year, improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

3. WRES SUBMISSION 2017

The Trust is required to submit two returns and an action plan:

- Data Template – The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2016 and 2017. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations and is uploaded via the Unify2 system.

- Reporting Template (Appendix 1) – This is a pdf form which the Trust is required to publish on its website. The data contained within this document and the accompanying data report for Indicator 1 (Appendix 2) is based on the Unify2 submission.

- WRES Action Plan 2017/18 (Appendix 3) – The action plan is based on the WRES data and is intended to address the disparities in the experiences of BME staff compared to White staff.

  The action plan attached builds on the 2016/17 action plan. Achievements during the year included:

  - Established a BME Staff Network
  - Staff network support and resourcing protocol in place

- Coaching and mentoring identified as a key area for support – OD Department is developing proposals for discussion with the BME network in September 2017.
- Promotion of leadership development opportunities, both in-house and through the NHS Leadership Academy BME programme.
- Implementation of Values-based Recruitment (VBR) as part of the relaunch of the Trust's recruitment and selection process.
- Promotion of the Trust's Extraordinary People, Extraordinary Place recruitment campaign.
- Introduction of VBR online and face-to-face training programme for recruiting managers.
- Updating of the Trust's Employee Relations Case Tracker to include equality monitoring data.
- Review and updating of key employment policies.

4. KEY FINDINGS FOR 2017

The key findings from the data analysis for 2017 are:

- 8,816 staff were employed within the Trust at 31 March 2017 (increase of 264 when compared to 31 March 2016)

- Of the 8,816 staff, 1.7% (148) had not declared their ethnicity.

- The Trust employs 970 staff who self-define as being from a Black or Minority Ethnic background. This represents 11% of the total staff employed in the Trust.

- The analysis of data for Indicator 1 (Percentage of staff in each pay banding compared to the percentage of staff in the overall workforce) shows that BME staff are under-represented in the higher pay bandings for clinical and non-clinical posts when compared to White staff. Whilst the percentage of White and BME medical and dental staff is broadly similar, there is an absence of BME representation in the senior medical managerial posts, ie Health Group Medical Director and Chief Medical Officer levels.

- Indicator 2 – Relative likelihood of staff being appointed from shortlisting – Whilst the gap between the 2016 and 2017 returns has decreased, it is still the case that BME applicants are less likely to be appointed from shortlisting than White applicants.

- Indicator 3 – Relative likelihood of staff entering the formal disciplinary process – The return shows improvement from 2.13 (2016) to 1.59 (2017), however BME staff continue to be more likely to enter formal disciplinary proceedings than White staff.

- Indicator 4 – Relative likelihood of staff accessing non-mandatory training and CPD – The gap between White and BME staff remains small at 1.07.

- Indicators 5, 6, 7 and 8 relate to specific key findings within the NHS Staff Survey. The table below provides a comparison of the Trust's scores in the 2015 and 2016 surveys and demonstrates improvement in the experiences of White and BME staff. However, a higher percentage of Trust staff continue to experience harassment, bullying or abuse from staff when compared with other acute Trusts.

Key Finding	Ethnicity	Trust Score 2015	Trust Score 2016	Change compared to 2015	National average 2016
KF25: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	26%	26%	0%	27%
	BME	27%	21%	**-6%**	26%
KF26: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	35%	31%	**-4%**	24%
	BME	57%	30%	**-27%**	27%
KF 21: % of staff believing that the organisation provides equal opportunities for career progression or promotion	White	85%	88%	**3%**	88%
	BME	73%	87%	**14%**	76%
Q17b: In the last 12 months have you personally experienced discrimination at work from your manager/team leader or other colleagues?	White	8%	6%	**-2%**	6%
	BME	16%	13%	**-3%**	14%

- Indicator 9 – Percentage difference between the Board's voting membership and its overall workforce. The Trust is reporting a negative value: -11% as none of the Trust Board's membership is from a BME background. The Board is therefore not representative of its workforce or the population it serves.

5. WRES ACTION PLAN

Attached at Appendix 3 is the draft WRES Action Plan for 2017/18 which identifies a series of actions aimed at addressing the issues identified in the WRES.

6. RECOMMENDATION

The Board is asked to note the content of this report and its appendices and approve the WRES return and Action Plan.

Jackie Railton
Chair – Diversity and Inclusion Steering Group

17 August 2017

Appendix 1

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Hull and East Yorkshire Hospitals NHS Trust

Date of report: month/year

March 2017

Name and title of Board lead for the Workforce Race Equality Standard

Ellen Ryabov, Chief Operating Officer

Name and contact details of lead manager compiling this report

Jackie Railton, Head of Strategic Planning

Names of commissioners this report has been sent to (complete as applicable)

Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Hull Clinical Commissioning Group

Unique URL link on which this Report and associated Action Plan will be found

www.hey.nhs.uk

This report has been signed off by on behalf of the Board on (insert name and date)

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

The data has been collected from the Trust's Electronic Staff Record, however the ethnic status of 148 staff is not stated. This represents 1.68% of the total workforce.

b. Any matters relating to reliability of comparisons with previous years

None

2. Total numbers of staff

a. Employed within this organisation at the date of the report

8,816

b. Proportion of BME staff employed within this organisation at the date of the report

11% of total staff employed.

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

98.3%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

The Trust has reviewed the standard entries within its Electronic Staff Record (ESR) system to determine whether information against each of the protected characteristics can be collected and reported on. At the present time information on gender reassignment and pregnancy is not collected, although maternity leave is recorded.

All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on the ESR. However, the Trust had noted that the level of data completeness for existing staff was variable. In order to improve the quality of workforce data by

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

Staff will continue to be encouraged to self-report at key stages in their career path, such as when they apply for new posts. In addition, staff will be reminded to periodically check their personal details held on the ESR and to inform the Human Resources Department of any gaps in personal information.

4. Workforce data

a. What period does the organisation's workforce data refer to?

Staff in post as at 31 March 2017 and activity during the financial year 2016-17.

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See attached for breakdown by pay banding. Where ethnicity is known for 31 March 2017: * Non-clinical workforce (White)	See attached for breakdown by pay banding. Where ethnicity is known for 31 March 2016: * Non-clinical workforce (White)	The data shows that BME staff are under-represented in the higher bandings (Bands 8-9 and VSM) for clinical and non-clinical posts compared to White staff. Whilst the percentage of White and BME medical and dental staff is broadly similar, there is an absence of BME representation in the senior	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Relative likelihood = 1.39	Relative likelihood was 1.67	The Trust has seen improvement in the likelihood metrics as follows: 2014/15 - 1.98 2015/16 - 1.67 2016/17 - 1.39. Whilst it is still the case that BME staff are less likely to be appointed from shortlisting, the gap	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Relative likelihood = 1.59	Relative likelihood = 2.13	There has been improvement in this indicator over the year, however BME staff are still more likely to be entering the formal disciplinary process.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	Relative likelihood = 1.07	Relative likelihood = 1.06	White staff are marginally more likely to access non-mandatory training and CPD more than BME staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 25.60 BME 21.00	White 25.60 BME 26.67	Whilst the percentage of White staff experiencing bullying and abuse from patients, relatives and the public remained static, the percentage of BME staff experiencing this behaviour had declined.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 30.56 BME 29.77	White 34.92 BME 56.67	The number of staff experiencing bullying from other staff has declined since 2016, with BME staff seeing the greatest improvement. However, the number of White and BME staff experiencing bullying remains high when compared to other	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 88.30 BME 87.32	White 85.49 BME 72.73	A higher percentage of White and BME staff reported believing that there was equality of opportunity for career progression or promotion than in the previous year, with the gap between White and BME staff closing significantly in 2016.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 6.02 BME 12.84	White 7.60 BME 16.13	The percentage of staff experiencing discrimination at work has decreased over the reporting period. However the percentage of BME staff experiencing discrimination was twice as high as for White staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	-11%	-9.9%	The voting membership of the Board is 12, all of whom are White. The Trust acknowledges that, in respect of ethnicity, the Board is not representative of the population it serves or its workforce.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

None

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

The Draft WRES Action plan is attached.

Click to lock all form fields and prevent future editing

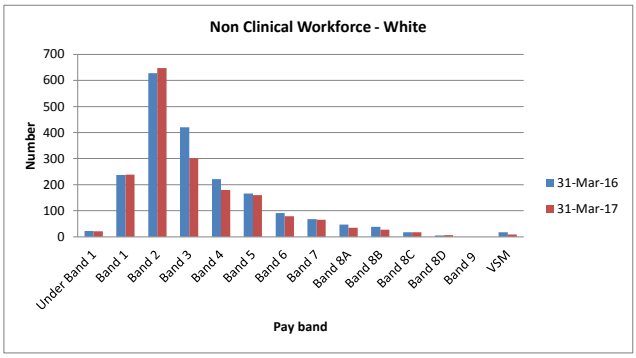
Produced by NHS England, April 2016

Indicator 1: Percentage of Staff in AfC Bands 1-9 and VSM

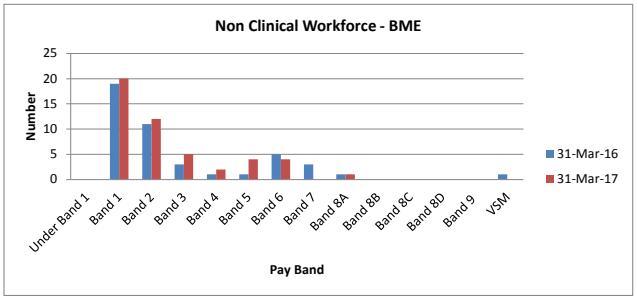
Appendix 2

WRES Comparison 2016 - 2017

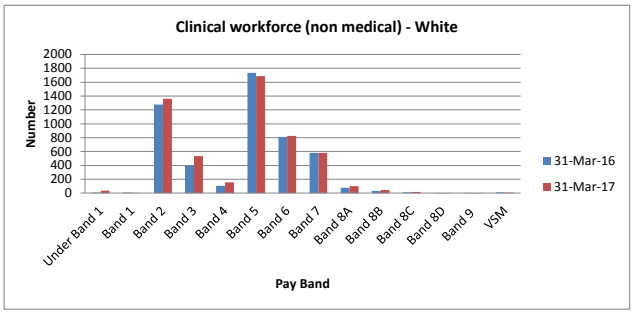
Non Clinical Workforce - White	31-Mar-16	31-Mar-17	Variance
Under Band 1	22	21	-1
Band 1	237	238	1
Band 2	628	647	19
Band 3	420	301	-119
Band 4	222	180	-42
Band 5	166	160	-6
Band 6	91	79	-12
Band 7	68	65	-3
Band 8A	47	35	-12
Band 8B	38	27	-11
Band 8C	17	17	0
Band 8D	5	7	2
Band 9	0	0	0
VSM	17	9	-8
Total	**1978**	**1786**	**-192**



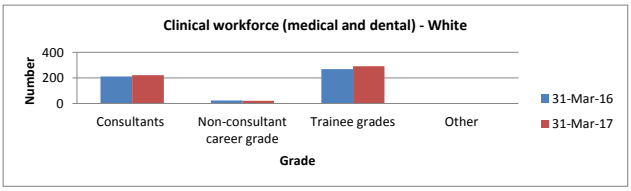
Non Clinical Workforce - BME	31-Mar-16	31-Mar-17	Variance
Under Band 1	0	0	0
Band 1	19	20	1
Band 2	11	12	1
Band 3	3	5	2
Band 4	1	2	1
Band 5	1	4	3
Band 6	5	4	-1
Band 7	3	0	-3
Band 8A	1	1	0
Band 8B	0	0	0
Band 8C	0	0	0
Band 8D	0	0	0
Band 9	0	0	0
VSM	1	0	-1
Total	**45**	**48**	**3**



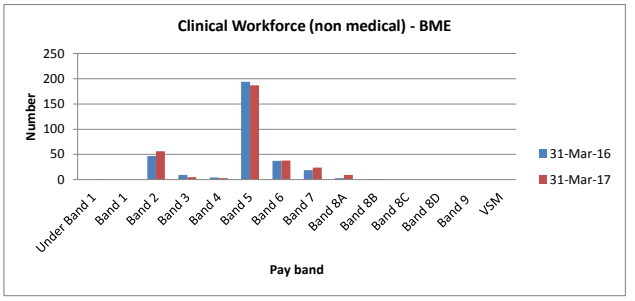
Clinical Workforce (non medical) - White	31-Mar-16	31-Mar-17	Variance
Under Band 1	9	36	27
Band 1	8	6	-2
Band 2	1279	1360	81
Band 3	395	535	140
Band 4	105	158	53
Band 5	1733	1688	-45
Band 6	814	824	10
Band 7	583	581	-2
Band 8A	80	103	23
Band 8B	34	48	14
Band 8C	14	18	4
Band 8D	4	4	0
Band 9	4	4	0
VSM	14	10	-4
Total	**5076**	**5375**	**299**



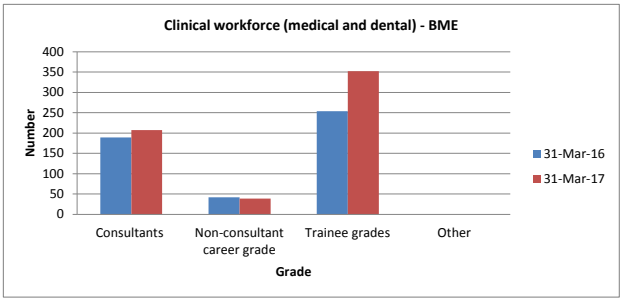
Clinical workforce (Medical and Dental) - White	31-Mar-16	31-Mar-17	Variance
Consultants	213	222	9
Non-consultant career grade	23	22	-1
Trainee grades	269	293	24
Other	0	0	0
Total	**505**	**537**	**32**



Clinical Workforce (non medical) - BME	31-Mar-16	31-Mar-17	Variance
Under Band 1	0	1	1
Band 1	0	0	0
Band 2	47	56	9
Band 3	9	5	-4
Band 4	4	3	-1
Band 5	194	187	-7
Band 6	37	38	1
Band 7	19	24	5
Band 8A	3	9	6
Band 8B	1	1	0
Band 8C	0	0	0
Band 8D	0	0	0
Band 9	0	0	0
VSM	0	0	0
Total	**314**	**324**	**10**



Clinical workforce (Medical and Dental) - BME	31-Mar-16	31-Mar-17	Variance
Consultants	189	207	18
Non-consultant career grade	42	39	-3
Trainee grades	254	352	98
Other	0	0	0
Total	**485**	**598**	**113**



Self declared - white	**7559**	**7698**	**139**
Self declared - BME	**844**	**970**	**126**
Grand Total (declared)	**8403**	**8668**	**265**
Not stated	149	148	-1
Declared and non-delared total	8552	8816	264

Hull and East Yorkshire Hospitals NHS Trust

WORKFORCE RACE EQUALITY STANDARD (WRES)
DRAFT ACTION PLAN 2017/18

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.	Staff by pay banding, by clinical, non-clinical groupings, and by White/BME (see Indicator 1 data sheet)	• Continue to engage with BME staff network to identify potential barriers to the progression of BME staff past Band 7 and to identify appropriate mechanisms by which the Trust can identify and develop BME staff with potential for career progression.	Ongoing	Director of Workforce and OD
			• Continue to encourage participation of BME staff in leadership development programmes with a view to preparing BME staff for roles in Bands 8-9 and VSM.	Ongoing	Director of Workforce and OD
			• Improve collection and analysis of exit interview data to better understand people's reasons for leaving and to identify and implement actions to improve staff retention.	December 2017	Head of HR Services
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White = 0.195 BME = 0.140 Relative likelihood = 1.39	• Review and consider the introduction of unconscious bias as a component of recruitment and selection training.	December 2017	Head of HR Services
			• Seek to make better use of technology and social media to reach and attract potential candidates from all protected characteristic communities.	December 2017	Director of Communications and Engagement / Head of HR Services
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	White = 0.001 BME = 0.002 Relative likelihood = 1.59	• Improve the quality of disciplinary data held and put in place better systems for monitoring and review of disciplinary cases.	Ongoing	Director of Workforce and OD / Head of HR Advisory Service
			• Undertake an annual in-depth analysis of the qualitative and quantitative data from the disciplinary process to identify any issues and trends by department/health group/directorate, by profession and pay banding.	Ongoing	Head of HR Advisory Service

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
			• Review induction and training given to staff to ensure that staff who trained overseas are given sufficient training and information about the NHS, UK culture and behavioural expectations.	December 2017	Head of HR Services
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White = 0.75 BME = 0.70 Relative likelihood = 1.07	• Utilise data to understand where there may be pockets of under-representation (either by BME or White staff) in terms of accessing mandatory and non-mandatory training and identify departments, roles or pay bandings where review and action is required.	Ongoing	Head of Education and Development
			• Explore ways in which the Trust can increase participation by BME staff in the available programmes/training events.	Ongoing	Head of Education and Development
			• Review and update relevant training policies and procedures.	Ongoing	Head of Education and Development
5.	KF25 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White = 26% BME = 21%	• Undertake a refreshed communications campaign to all service users and visitors to the Trust regarding the Trust's zero tolerance approach to bullying, harassment, abuse and violence.	December 2017	Director of Communications and Engagement / Head of Security
6.	KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White = 31% BME = 30%	• In areas where bullying is identified as an issue, undertake a programme of organisational development, re-emphasising the Trust's values and expectations of behaviour.	Ongoing	Health Group HR Business Partners
			• Deliver Staff Survey action plan	December 2017	Director of Communications and Engagement / Head of OD

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
7.	KF21 – Percentage believing that Trust provides equal opportunities for career progression or promotion.	White = 88% BME = 87%	• Detailed annual review of staff responses to survey question relating to whether the Trust acts fairly in relation to career progression and promotion to establish what changes take place over time.	Ongoing	Head of OD
			• Develop Coaching strategy specifically for BME staff connected to senior managers.	November 2017	Head of OD
8.	Q17 – In the last 12 months have you personally experienced discrimination at work from any of the following: b) Manager/team leaders or other colleagues?	White = 6% BME = 13%	• Review of the role of the Staff Advice and Liaison Service (SALS).		Deputy Director Governance Quality and Safety
			• Examine qualitative and quantitative data collected by the SALS to determine trends and identify departments, roles or pay bandings where review and action is required.	December 2017	Deputy Director Governance Quality and Safety
			• Manage and address allegations of discrimination thoroughly and swiftly.	Ongoing	Head of HR Advisory Service
9.	Percentage difference between the organisation's Board membership and its overall workforce	-11%	• Ensure that the process for appointment of Executive and Non-Executive Director posts encourages applications from as diverse a pool of talent as possible and demonstrates the Trust's commitment to diversity and inclusion.	Ongoing	Chairman Chief Executive

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CULTURAL TRANSFORMATION PROGRAMME

Meeting date	Tuesday 5 September	**Reference Number**	2017 – 9 - 17
Director	Simon Nearney – Director of Workforce and Organisational Development	**Author**	Myles Howell, Director of Communications Simon Nearney – Director of Workforce and Organisational Development
Reason for the report	To inform the Trust Board of progress made against the Cultural Transformation programme, initiated in March, 2015, and to outline next steps.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive and accept this report for the progress being made in the Cultural Transformation programme.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): W3 – Culture and leadership					
	Assurance Framework Ref: BAF 2	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**TRUST BOARD/BOARD COMMITTEE REVIEW** (if applicable) The Trust Board receives periodic updates on the Trust's work on cultural transformation. The Performance and Finance Committee now receives a quarterly update on workforce.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD AUGUST 2017

CULTURAL TRANSFORMATION PROGRAMME

1. PURPOSE OF THE REPORT

The purpose of this report is to inform the Trust Board of progress made in the Cultural Transformation programme, initiated in March, 2015, and to outline next steps.

2. KEY ISSUES

- The Trust has seen performance in national staff surveys improve significantly since 2014. The challenge now is to move into the top 20% of organisations nationally.
- Medical Engagement remains a key area for improvement, together with addressing issues affecting staff with a disability or health condition.
- There will need to be a strong focus on enabling managers and leaders to shift from good performance to outstanding performance and a culture of excellence.
- Some staff still feel that the organisation remains overly bureaucratic and hierarchical. They describe us as short-term in our focus and they have described a culture of working long hours.

3. BACKGROUND

At the March 2015 Trust Board meeting an approach to Transforming the Culture of the Trust was agreed. This included a plan to address key areas that staff had raised as either a concern or area for development.

Since then the Trust's staff engagement score, which is the key measure for cultural performance, has improved from the worst in the country to rank among the middle 60% of organisations.

The CQC, which had previously identified cultural issues, including bullying, has specifically noted improvements to the working culture at the organisation. The most recent feedback described the organisation as being on the cusp of 'good'.

Furthermore, a cultural assessment tool, the Barrett Values Indicator has described the cultural improvement at the Trust as twice that which they would have expected to see in the 30 months since we last ran the Barrett survey.

With improved performance in ED and waiting times showing strong signs of recovery and the QiP programme progressing positively, the Trust is now facing the challenge of creating a culture of high performance and excellence defined by some of the values which staff have said they wish to see in the latest Barrett report (January, 2017).

4. CURRENT POSITION - METRICS

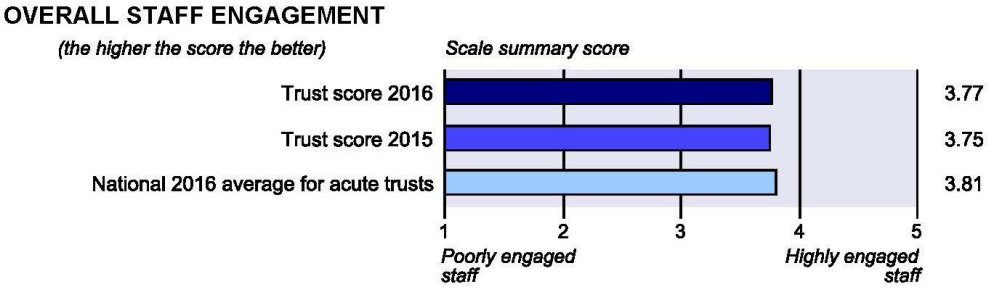
National Staff Survey

The Trust undertook the NHS National Staff Survey 2016 between October and December for a full census of its staff.

The response rate for the Trust was 44% (3,508 staff), against a national average of 43%. Of these completed survey questionnaires, 0.23% were paper questionnaires and 99.77% were online. This is the largest number of staff to respond to the staff survey in the past ten years with staff groups represented proportionately.

In the 2016 report there were 32 key findings and a measure of staff engagement. Each key finding is comprised of a cluster of questions, which can be found in the full version of the Trust's report, published on 7th March 2017.

The Trust's engagement score improved from 3.75 in 2015 to 3.77 in 2016. Despite this it remains below the national average when compared with trusts of a similar type. In 2014 the Trust's engagement score was 3.54.



The medical and dental workforce is the most disengaged in the Trust. This was affirmed by a Medical Engagement Scale survey which also noted significant disparity between medical staff with management responsibility (highly engaged) and those without management responsibility (disengaged).

Staff who report having a disability or health condition report low engagement. They also report higher incidences of bullying and harassment.

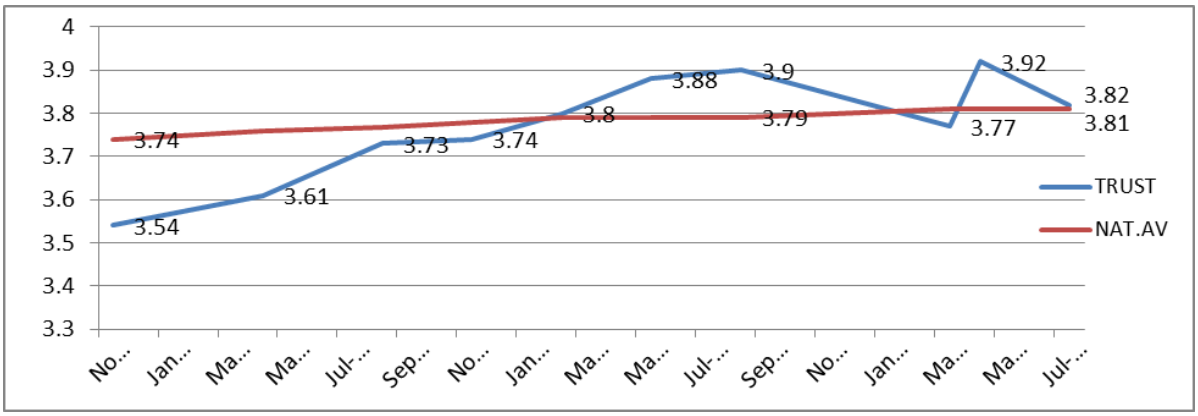
Staff Friends and Family Test
The Trust is required by NHS England to survey staff quarterly with the following two questions:

1. How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family as a place to work?

As part of the organisation's ongoing work to improve the culture of the Trust, the decision was taken at the start of 2015 to extend the survey to reflect the questions in the national staff survey which make up the score for 'overall engagement':

The Trust Staff FFT for Quarter One 2017/2018 ran from 24th May 2017 until 30th June 2017. 8,800 staff were invited to participate, with 1,553 staff responding, equivalent to an 18% response rate.

The overall score for engagement was 3.82. This is higher than the national average but represents a drop from the high point of 3.92 in Q4 2016/2017. The graph below demonstrates the trend in engagement score since November 2014. An overall positive improvement is seen.



Health Group Performance
All overall scores for engagement in the Health Groups and Directorates have shown a decline compared with Q4 2016, with Clinical Support Services being the only exception. Corporate, Family and Women's, Surgery and Estates, Facilities and Development have seen the biggest declines, with the latter three all scoring worse than the national average (3.81) for overall engagement (highlighted).

		Q4 16	Q1 17
Trust	**Hull and East Yorkshire NHS Trust**	**3.92**	**3.82**
Health Group	Clinical Support Services	**3.88**	**3.90**
Health Group	Corporate	**3.94**	**3.84**
Health Group	Family & Women's Health	**3.95**	**3.79**
Health Group	Estates, Facilities and Development	**3.95**	**3.67**
Health Group	Medicine	**3.95**	**3.90**
Health Group	Surgery	**3.92**	**3.67**

CQC
In its 2016 report the Care Quality Commission stated the following about the culture at Hull and East Yorkshire Hospitals NHS Trust:

"Leadership had improved. There was a clear vision and strategy for the trust with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork."

This was a significant endorsement for the cultural transformation programme after the CQC first raised concerns about the working culture in 2014.

Barrett survey
Barrett is a globally recognised measure of organisational culture, based on the personal values of staff, set against the values staff believe characterise their organisation and the values they would like to see in the future.

The Barrett values cultural survey which ran in late 2014 indicated a workforce which felt undervalued and disenchanted with the organisation and the quality of work they were able to deliver. The staff survey results and the CQC report earlier that year reflected the same.

The current culture was described by the following ten (limiting) values, selected by over 800 staff:

COST REDUCTION
BUREAUCRACY
TARGET-ORIENTATED
BLAME
CHAOS
HIERARCHY
SHORT-TERM FOCUS
ARROGANCE
LONG HOURS
CONTROL

The repeat of this survey in 2017 showed a significant improvement, with only four (highlighted) limiting values in the current culture:

HIERARCHY
ACCOUNTABILITY
CARE
BUREAUCRACY
PATIENT SAFETY
LONG HOURS
TEAMWORK
CONTINUOUS IMPROVEMENT
SHORT-TERM FOCUS
RESULTS ORIENTATION

Staff are also requesting some new values in their 'desired culture': PROFESSIONALISM and TEAMWORK.

Barrett has interpreted this as a positive shift towards a culture of pride and excellence. Staff now feel they offer good and safe care to patients and are keen to develop closer and better team-working and a keener sense of professionalism. They still believe, two and a half years later, that the Trust is overly bureaucratic and hierarchical and they describe a culture which is fixed on the short-term, indicating a reactive organisation. They continue to describe a culture of working long hours.

It is noteworthy that when the Trust ran a series of 'Big Conversations' in 2012, asking staff what was getting the way of delivering 'Great Care' the most frequent response was 'bureaucratic systems and processes'. This referred specifically to: paper-based systems, procurement issues, IT issues and staff believing they did not have permission to act when seeking service improvements.

5. WORK UNDERWAY

A staff survey group has been established to oversee all actions being undertaken to address the issues identified by the metrics above. Three key areas of work at present are as follows:

Develop leadership and managerial skills to address issues of bullying and harassment, staff feeling undervalued, and cultural issues of bureaucracy and hierarchy

- Annual Development Programme – April 2017
- New Leaders programme - April 2017
- Talent Development Course - April 2017
- Management skills programme - April 2018
- Manager briefing sessions – May-September 2017

Address medical engagement issues

- Establish engagement group with medical membership – Feb 2017
- Identify engagement issues – March 2017
- Review roles and responsibilities of medical staff – July 2017
- Develop and launch medical leadership programme – October 2017

Recruitment and retention

- Remarkable People recruitment and retention campaign - ongoing
- Communications focussed on areas of success and excellence

6. CULTURAL SHIFTS

Initial work to address cultural shifts required to move the organisation from 'good' to 'great' have seen some key barriers emerging for staff. These are identified as having an impact on the bureaucratic nature of the organisation as well as the frustrations staff experience on a routine basis:

- There is significant discord around the need to log into multiple systems when carrying out clinical activity. One consultant has identified 27 systems she uses on a daily basis, all of which have separate log ins. This has been discussed at the Trust Executive team meeting.
- Staff have raised frustrations around the systems for procurement and payment of goods – the length of time it takes to order services and goods and the complex sign off system currently in use. This also requires a separate log-in.
- Car parking continues to be an issue for many staff. There is a sense of unfairness around the requirement to pay for a pass and not be able to park.

7. SUMMARY

Progress continues to be made against the Trust's Cultural Transformation programme. Making the next step from 'good' to 'great' is a difficult challenge however key areas for improvement have been identified. While performance remains above the national average in many areas it is vital that the Trust does not become complacent and we have seen the overall score for engagement dip from the 2016/2017 Q4 high point, albeit this was a very high score.

Corporately the organisation is continuing to grapple with a perception that it is reactive and bureaucratic. It is vital that Trust managers are encouraged to empower and enable their staff to continue the good to work to create a positive working culture for all of our workforce.

8. RECOMMENDATIONS

The Trust Board is requested to receive and accept this report and the progress being made in the Cultural Transformation programme.

Simon Nearney
Director of Workforce
August 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

SAFETY DEPARTMENT ANNUAL REPORT 2016 / 2017

Meeting date	5th September 2017	**Reference Number**	2017 – 9 - 18
Director	Lee Bond – Chief Financial Officer	**Author**	Dave Bovill – Trust Safety Manager
Reason for the report	To update the Board on the work carried out by the Trust's Safety Team in 2016/17		

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

1	**RECOMMENDATIONS** The Trust Board is requested to: • Receive the 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): **S1 –** Safety performance					
	Assurance Framework Ref: 7.2	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is also received at the Non Clinical Quality Committee.					

Safety Department Annual Report, 2016 / 2017.

Contents:

1. KPI's / Executive Summary

Key Performance Indicators (KPI's) – Monitored quarterly - and covering the following topics:

General Safety KPI's:

- **Number (and rate – No. / 8319 employees x 100) of RIDDOR reportable incidents.** This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses. The target for RIDDOR reportable incidents should always be as few as possible, though an organisation as large and complex as HEYT would certainly alert the regulator (HSE) if no such incidents were reported. Recent years have seen an average of around 10 RIDDOR reportable incidents per quarter.
- **Total staff slips, trips and falls incident rate (not just RIDDOR).** The justification for this choice of KPI is that it is the single biggest cause of staff injury. The target improvement here would be a steady decrease.
- **Employer's Liability Claims** ('non-clinical') – that is new claims opened in the year. Ideally this number would be zero, though a trend of reduction would be a more realistic ambition, especially set against a national / industry sector pattern of a continual increase in claims, (based on insurance premiums). More information would be available from the Trust's Claims and Legal Services Department.
- **Numbers of hazards identified by site quarterly inspections** by the Safety Team; a pro-active measure. We would want to see a reduction in the number of hazards identified in any given area upon subsequent inspections if the corrective actions have been taken. This will clearly take some time to give a more meaningful picture.
- **Number of Departmental Quarterly Inspections** – another pro-active indicator with numbers large enough to give meaningful comparisons at quarterly frequency. NB: Due to ongoing amendments to the system of recording on the Trust's intranet site, the departmental quarterly audit Inspection's will not be reported on until further notice.
- **Staff accidents reported by severity (new KPI)**. Numbers of those classed as either severe or catastrophic. A good reporting culture in the organisation would have staff recording high numbers of near misses, no harm or minor harm incidents. For this reason, an increase in overall staff incidents should not necessarily be seen as a negative outcome. However, we would want to see low numbers of those incidents classed as major or catastrophic, as such incidents are unlikely to go unreported.

Moving and Handling KPI's:

- **Manual Handling RIDDOR Reportable Incident Rates**. This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses.
- **Coverage of Manual Handling Link Trainers**
- **Patient Handling Assessments Performed** Patient handling assessments are seen to be a key proactive control measure for the reduction of both the likelihood and severity of harm arising from clinical moving and handling. They are a planning tool to identify the necessary equipment and staffing levels etc. during the patient's stay.

A random sample of 50 ward based inpatient notes will be audited each quarter to identify if patient handling assessments have been completed satisfactorily).

Executive Summary:

General RIDDOR Reportable Incidents:

- RIDDOR reportable incidents have shown a decrease, with 31 (0.35 per 100 staff) incidents reported to the Health and Safety Executive for this year against 33 (0.39) incidents reported for the previous year. The year prior to that (2014/15) had 40.
- The commonest causes of RIDDOR incidents were Slips, trips and falls (10); needle-sticks (9) and Moving and Handling related injuries (8).

Annual RIDDOR incidents by Health Group:

- Shows that Medicine was the Health Group with the most reported incidents for the past 12 months with a total of 11 (giving a rate of 0.75). This was an increase of 3 when compared to the previous year (8). Clinical support had the lowest rate of RIDDORs, with just 0.05 per 100 staff. The overall Trust rate was 0.37.

RIDDOR Reportable slip trip falls:

- No change from the previous year (10).

Staff non – RIDDOR reportable slip, trips and falls:

- The past twelve months has witnessed an increase from the previous year from 82 incidents to 96 incidents.

Occupational Health RIDDOR reportable Incidents:

- When compared to the previous twelve months, there has been a decrease in dermatitis incidents (0 from 2) but an increase in needle-stick injuries (9 from 5) and blood born virus exposures, (7 from 6). This is an overall increase for the past 12 months of three incidents.

Moving and Handling RIDDORs:

- We have seen eight in 2016/17 (mean over the last five years is 7.6).

Timeliness of Reporting of incidents to the HSE:

- The reporting of incidents in accordance the RIDDOR Regulations 2013 is **within 15 days.** When compared to the previous year, we have seen an improvement in the timeliness of reporting of incidents to the HSE: the proportion of those reported late has reduced from 42% to 23%. (NB**:** This information does *not* include Occupational Health reportable incidents).

Quarterly Site Inspections:

- During 2016/17 there were eight quarterly inspections carried out across HRI and CHH: four inspections on each site. These inspections identified 67 defects at the HRI site and 32 at CHH site. At the time of writing, we have witnessed 18 (27%) of the defects at HRI acted upon and 22 (69%) of the defects at CHH acted upon. We anticipate that we will see further reductions in the number of defects found due to the ongoing remedial work.

Safety Focal Persons:

- As a result of the infrequency of available training for new Safety Focal Persons (SFP's) the Safety Department have taken charge of the training. May 2017 saw 15 new SFP's trained; two more dates have been booked for September (30 places).

Overall Moving and Handling incidents

- Whilst a reduction of approximately 3% of all incidents reported on Datix occurred between 15/16 and 16/17, there was a **31% reduction in M&H incidents**. This could be seen as very encouraging.

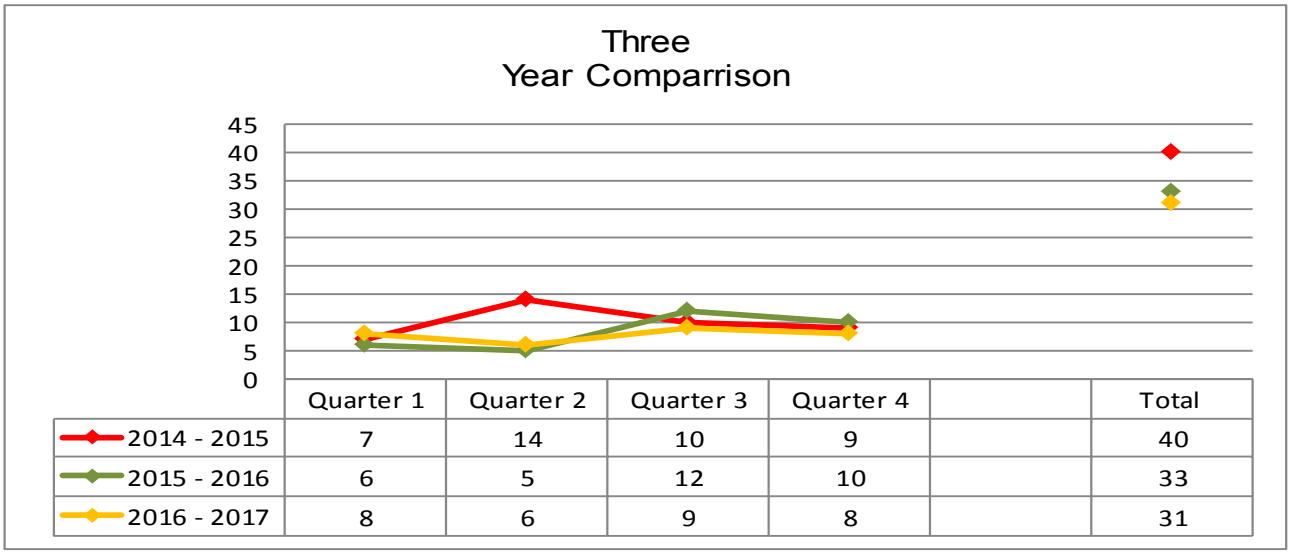
2. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013

Table 1: General RIDDOR Reportable Incidents: totals and rates (per headcount x 100):

Incident Category	Headcount	Total	Rate
Slip, trip or fall	8319	**10**	0.12
Moving and handling		**8**	0.09
Struck by or against something		**4**	0.04
Contact with hot/cold object/liquid, machinery or electricity		**1**	0.01
Contact with sharp material or object, non-medical		**1**	0.01
Other Personal Accident		**6**	0.07
Contact with other medical sharps		**-**	-
Exposure to harmful agent e.g. radiation, substance, bio agent,		**1**	0.01
Total		**31**	**0.35**

We have thus witnessed a **decrease of 2 incidents** when compared to the previous year. The overall pattern over the last three years is showing a downturn in reportable incidents.

Figure 1: RIDDOR reportable incidents over a three year period, by quarters:



	Quarter 1	Quarter 2	Quarter 3	Quarter 4		Total
2014 - 2015	7	14	10	9		40
2015 - 2016	6	5	12	10		33
2016 - 2017	8	6	9	8		31

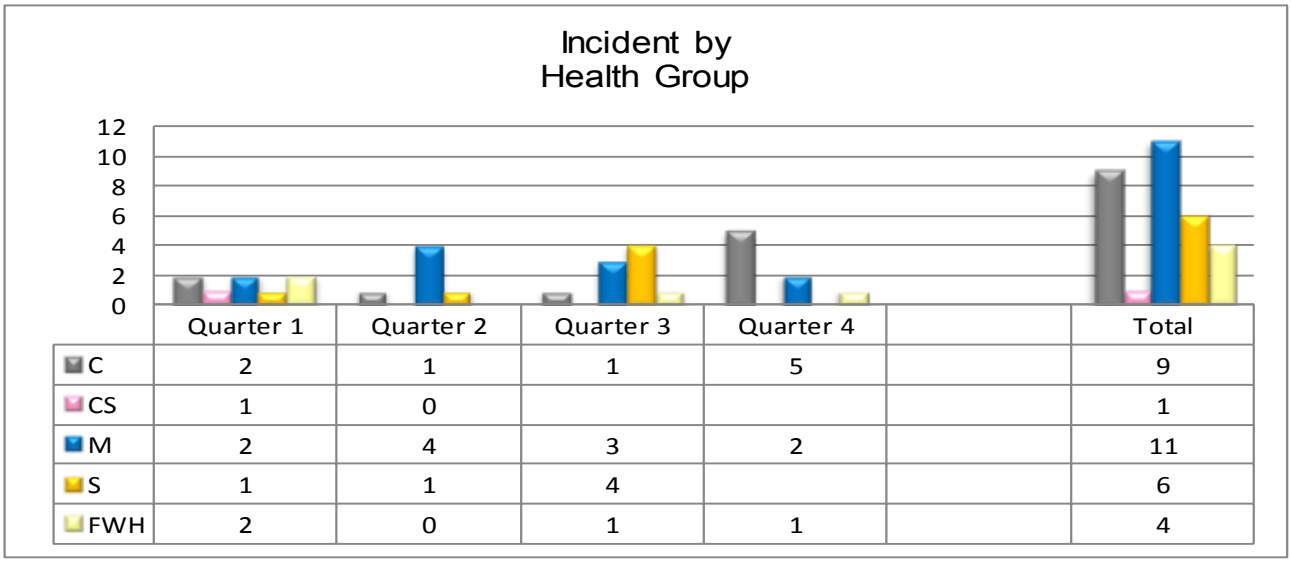
3. Annual RIDDOR incidents by Health Group:

Table 2: RIDDOR incidents by HG:

Health Group	Headcount	RIDDOR Incidents	RIDDOR Rate
Clinical Support	1918	1	0.05
Family and Women's Health	1285	4	0.31
Surgery	2125	6	0.28
Corporate Directorates	1527	9	0.58
Medicine	1464	11	0.75
Total:	**8319**	**31**	**0.37**

Medicine has the most reportable incidents with an increase of 3 when compared to last year (8) with Clinical Support showing the largest decrease - 5 - when compared to last year (6).

Figure 2: RIDDOR incidents by HG:



	Quarter 1	Quarter 2	Quarter 3	Quarter 4		Total
C	2	1	1	5		9
CS	1	0				1
M	2	4	3	2		11
S	1	1	4			6
FWH	2	0	1	1		4

4. RIDDOR Reportable slip trip falls:

Table 3: 2016/17 RIDDOR Reportable slip trip falls:

Headcount: 8319	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Incidents:	2	2	2	4	**10**
Rate:	0.02	0.02	0.02	0.04	**0.12**

When compared to the previous 12 months there has been no increase or decrease for slip trip falls (10 - 10).

5. Non-reportable slip trip falls:

Table 4: Non-reportable staff slip trip falls by HG:

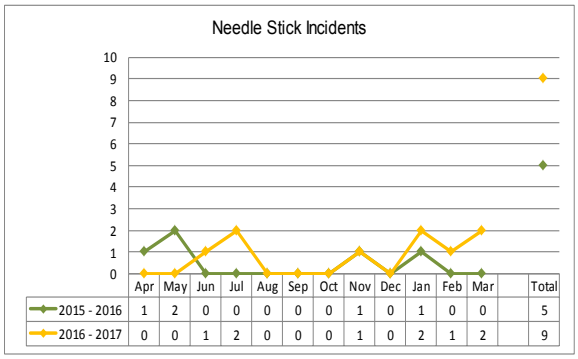
Health Group	Q1	Q2	Q3	Q4	Total	Rate
Clinical Support	1	4	4	3	**12**	0.14
Corporate Directorates	6	10	11	5	**32**	0.38
Family and Women's Health	9	5	4	2	**20**	0.24
Medicine	5	2	3	5	**15**	0.18
Surgery	1	4	7	5	**17**	0.20
Total	**22**	**25**	**29**	**20**	**96**	**1.15**

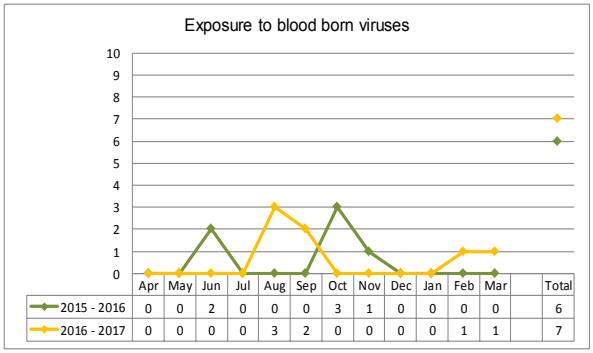
We have witnessed an increase on the previous year from 82 to 96 for the past 12 months with quarter 3 shows the highest quarter for incidents being reported with Corporate Directorate showing the overall highest group with 32 incidents equating to 33% of all non-reportable incidents.

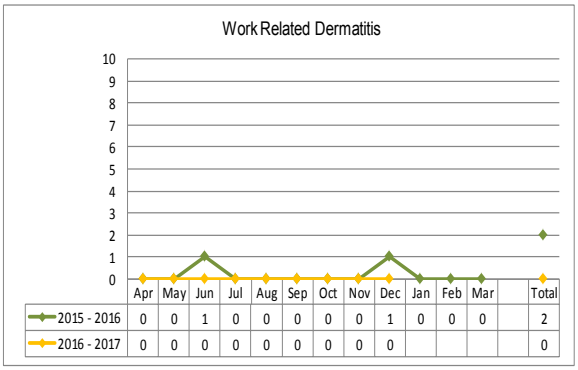
6. RIDDOR – reported by the Occupational Health Department:

Table 5: RIDDOR – reported by Occupational Health – by category:

Incident by Category	Q1	Q2	Q3	Q4	Headcount	Total	Rate
Needle Stick Injuries	1	2 ▲	1 ▼	5	8319	**9**	**0.10**
Exposure To Blood Born Viruses	-	5 ▲	- ▼	2		**7**	**0.08**
Work Related Dermatitis	-	-	-	-		**-**	**-**
Total	**1**	**7**	**1**	**7**		**16**	**0.18**







We have witnessed an increase in needle stick injuries when compared to last year (9 from 5).

We have witnessed a small increase in Exposure to BBV when compared to last year (7 - 6).

We have witnessed no reportable dermatitis incidents over the past 12 months; this is a reduction of 2 when compared to the previous 12 months.

7. Timeliness of Reporting of incidents to the HSE:

The reporting of incidents in accordance to regulation 4.2 of the RIDDOR Regulations 2013 - **within 15 days.** (**NB:** The following information does *not* include Occupational Health reportable incidents).

Table 6: Timeliness of Reporting of incidents to the HSE in 2016/17:

Reported (16/17)	Reported on time	Reported late
Quarter 1	6	2
Quarter 2	5	1
Quarter 3	8	1
Quarter 4	5	3
Total	**24**	**7 (23%)**

2015 – 2016	**19**	**14 (42%)**

When compared to the previous year, we have seen an improvement in the timeliness of reporting of incidents to the HSE: the proportion of those reported late has reduced from 42% to 23%.

8. Quarterly Site Inspections:

Table 7: Defects found at the HRI Estate, by quarter and severity:

Hull Royal Infirmary:

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	11	15	20	13	**59**
Low	3	1	2	2	**8**
Very low	-	-	-	-	**-**
Overal total	**14**	**16**	**22**	**15**	**67**

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	-	7	6	4	**17**
Low	-	-	1	-	**1**
Very low	-	-	-	-	**-**
					18

Deficit	**14**	**9**	**15**	**11**	**49**

Table 8: Defects found at the CHH Estate, by quarter and severity:

Castle Hill Hospital:

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	10	7	9	5	**31**
Low	-	-	-	1	**1**
Very low	-	-	-	-	**-**
Overal total	**10**	**7**	**9**	**6**	**32**

Defects acted upon					
Risk Rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	9	2	9	2	**22**
Low	-	-	-	-	**-**
Very low	-	-	-	-	**-**
					22

Deficit	**1**	**5**	**0**	**4**	**10**

When compared to the previous year, we have seen an increase of defects identified at HRI (67 from 58) however, we have witnessed a decrease in defects identified at CHH (32 from 55).

Going forward, the number of defects will be compared of each section of the site against the previous number for that particular section. This will be reported at the Trust's Health, Safety and Security Committee.

9. Staff incidents reported by severity (New KPI):

Table 9: Staff incident severity:

Risk Rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Rate
No harm	75	82 ▲	74 ▼	45 ▼	**3.31**
Minor	88	91 ▲	96 ▲	87 ▼	**4.35**
Moderate	3	7 ▲	14 ▲	6 ▼	**0.36**
Major	-	-	1 ▲	-	**0.01**
Catastrophic	-	-	-	-	**-**
Total	**166**	**180**	**185**	**138**	

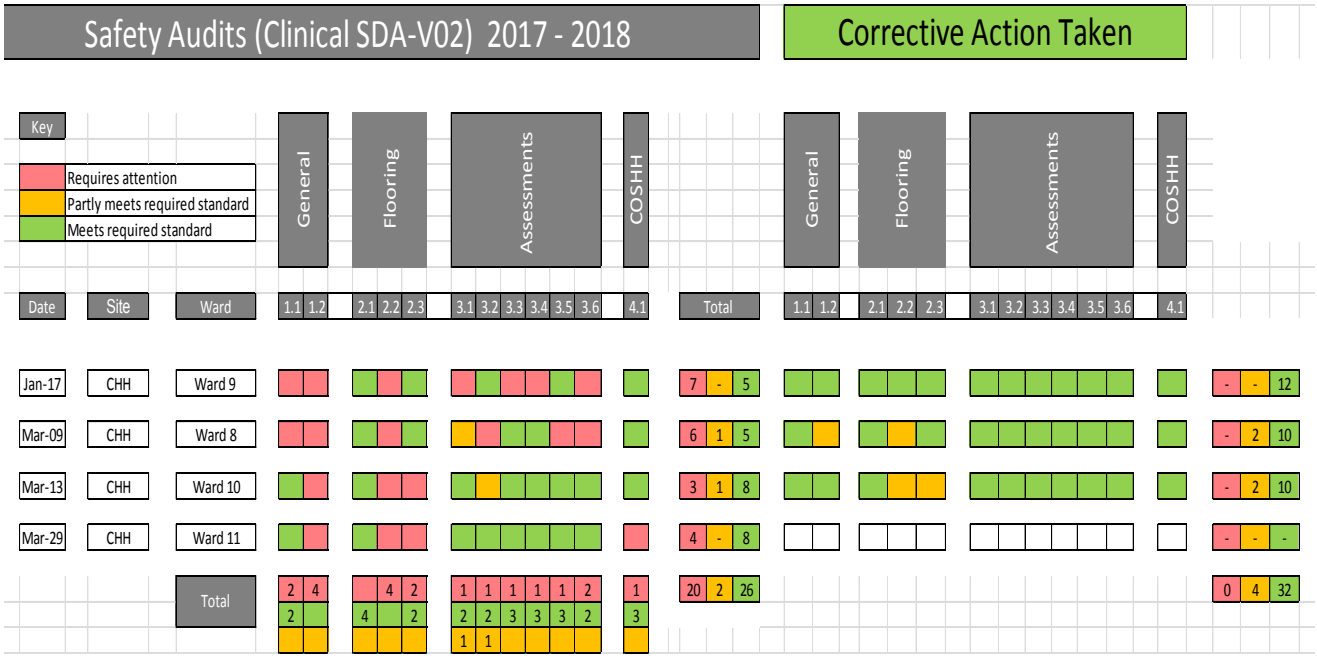
As this is a newly added KPI, a comparison with the previous year has not been made. This will be undertaken in future quarterly and annual reports.

10. Departmental Safety Audits:

Using the new Safety audit which looks at the environment and risk assessments undertaken in each area, the Safety department have so far carried out 4 audits and have identified a number of issues which when based on the 12 points of each audit, equated to a combined total of 61% of non-compliance.

With further assistance and guidance from the Safety team, this non-compliance has been reduced to 13% with further ongoing remedial action to be completed at the time of writing.

Table 10: Safety Audits – four CHH wards:



11. Safety Focal Persons:

The Safety department identified a gap in the training of new Safety Focal Persons (SFP) and as a result have taken charge of providing the necessary training needed for staff to become an SFP.

The new revised training course has been reduce from its original 3 days to just 1 day thus reducing the time staff spend away from the workplace while still managing to maintain and keep all of the key elements and cores skills needed for a staff member to become an SFP.

Since advertising the new revised course there has been a keen interest from staff across the Trust with initial 32 staff members names added to the waiting list with others showing an interest. 15 staff undertook the training course, delivered by the Safety Manager and Asst Safety Manager, on the 25th May 2017, with excellent feedback received by the delegates.

12. Employer's Liability Claims:

Whilst Claims are out-with the remit of the Safety Team, it was felt worthwhile to include this simple illustration of the recent activity in this area.

Table 11: New EL claims received by the Trust:

Year	Staff claims[1]
2012/13	25
2013/14	31
2014/15	36
2015/16	17
2016/17	14

Comment: This reduction in the last two years seems at first glance to be potentially highly significant and is certainly in contradiction of the trend over the previous 3 years. One possible causal factor may be a renewed desire within the Safety and Claims Teams for scrutiny of claim validity, including use of CCTV footage and publicity in the Trust Newsletter when claims have been proved to be dishonest.

13. Moving and Handling

Key Activity – Annual Summary

The Moving and Handling Lead has been in post for just over 12 months and regularly liaises with the Yorkshire Back Exchange, Critical Care and Surgery Clinical Nurse Educators, PDN's from various divisions and with the University. This has been achieved by attending study meetings, supporting and assisting the Teacher-Trainers with their training and attending University Moving and Handling sessions to assist and share knowledge. This has also ensured parity between theoretical and practical sessions, despite delivery by different teams.
As a result of further training, Link Training staff are now more engaged in the risk assessment process within their areas. This has resulted in more detailed and individualised risk assessments being produced in specific areas and a more positive and proactive approach to recognising and managing risk.

[1] New claims received.

The equipment procurement plan is to be discussed in July 2017. The Moving and Handling Lead will once again visit all wards and departments to assess the need for new/replacement equipment. The assessment will take into account:

- Age of existing equipment
- Condition of current equipment
- Storage facilities
- Staff engagement in moving and handling training

During the past 12 months, the Moving and Handling Lead has also delivered equipment to several areas which previously had none. In most cases this has been for the following reasons:

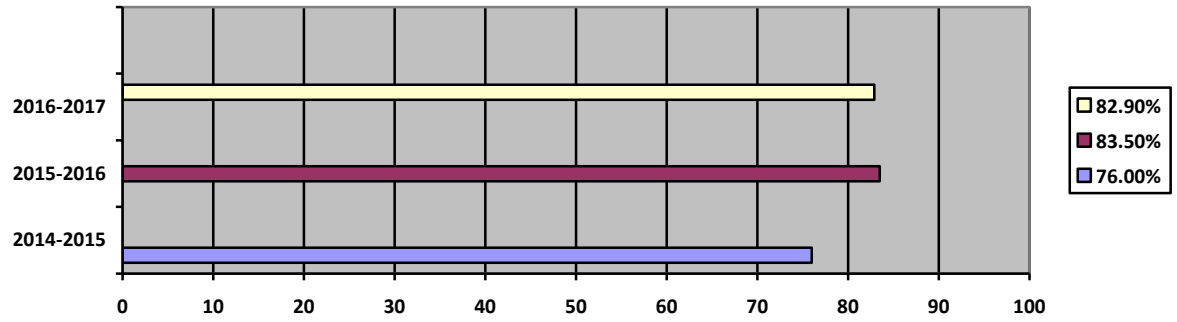
1. Awareness of new equipment following equipment training
2. Changes to patient acuity
3. More elderly patients
4. Higher dependency of patients
5. Heavier patients

Several wards have also reported severe delays between reporting breakdowns of equipment and repairs being performed. Some wards are completely without hoists due to this and this can continue for many months (ward 8,Ward 12/120 and Ward 60) Other areas are using items of equipment which are below acceptable standard but they are unwilling to replace due to budgetary constraints (e.g. Emergency Department patient trolleys).
The Moving and Handling Lead diarised ten half-day sessions in which to meet and update the existing link staff. This was well-attended however, approximately one-third of Link Trainers did not attend for a number of reasons: off-duty changes, child-care issues, non-reading of emails, retired from or left the trust, etc. Non-attendees were contacted personally and assurances were received that they will attend future training.
Two three-day 'Train the Trainer' courses were held this year. This resulted in 36 new Link Trainers being inducted from many different areas. It is envisaged that a one-day update and conference will take place in autumn 2017 for all Link Trainers, location permitting. Arranging training has been challenging this year; The Haughton Building is currently used by the Moving and Handling Lead for training. The Moving and Handling Lead was unable to plan future training events, as the date of closure and demolition of the Haughton Building was regularly deferred (sometimes with one weeks' notice) and there was no suitable alternative location available for Moving and Handling training and storage. Original closure of the building was earmarked for the end of June 2016 but this was extended numerous times to Mid-June 2017. Most wards and departments using 'E-Roster' plan off-duty for the ensuing three month period, which is then sanctioned and 'locked.' Despite the reduction of training from five to three days, Managers were unable to release staff without a three-month notice period which the Moving and Handling Lead was unable to provide.

Forward Planning:
The three KPI's identified for reporting against in 2015-2016 continue to be significant for the period 2016-17. It is recognised that the KPI's detailed below will provide an indication on which areas to build future business plans, asset procurement and training needs.

Training Analysis:

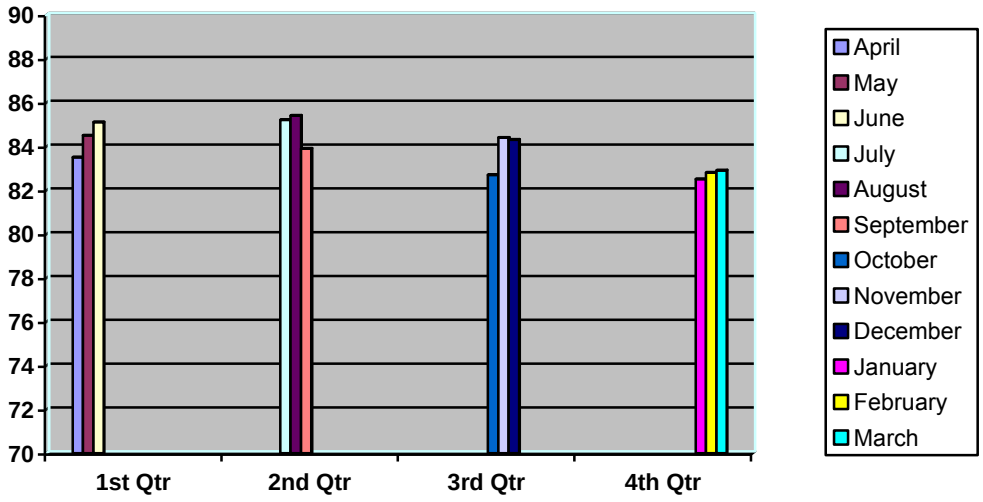
2016-2017 Annual Manual Handling Training Compliance (Percentage.)
Three-Year Comparison



Training Compliance has fallen overall by 0.6% throughout this year. This is thought to be for several reasons:

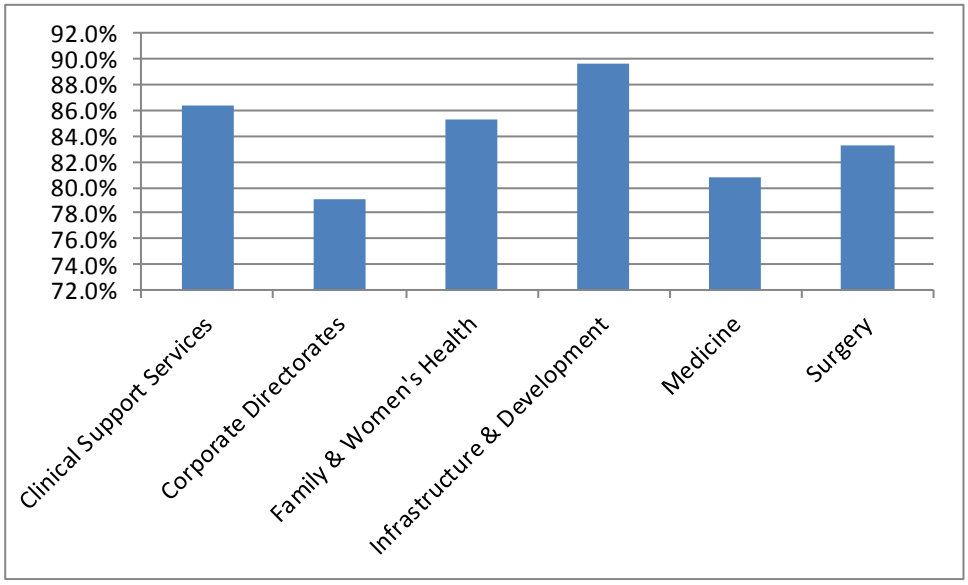
i. Unprecedented winter pressures leading to increase in clinical activity and reduction in available training time
ii. Reduction in number of Link Trainers due to existing staff leaving Trust, relinquishing role or moving to other areas.
iii. Reduction in number of Link Trainer induction courses and subsequent staff training due to ongoing plan to close Haughton Building

2016-2017 Manual Handling Training Compliance (Percentage) by Quarter



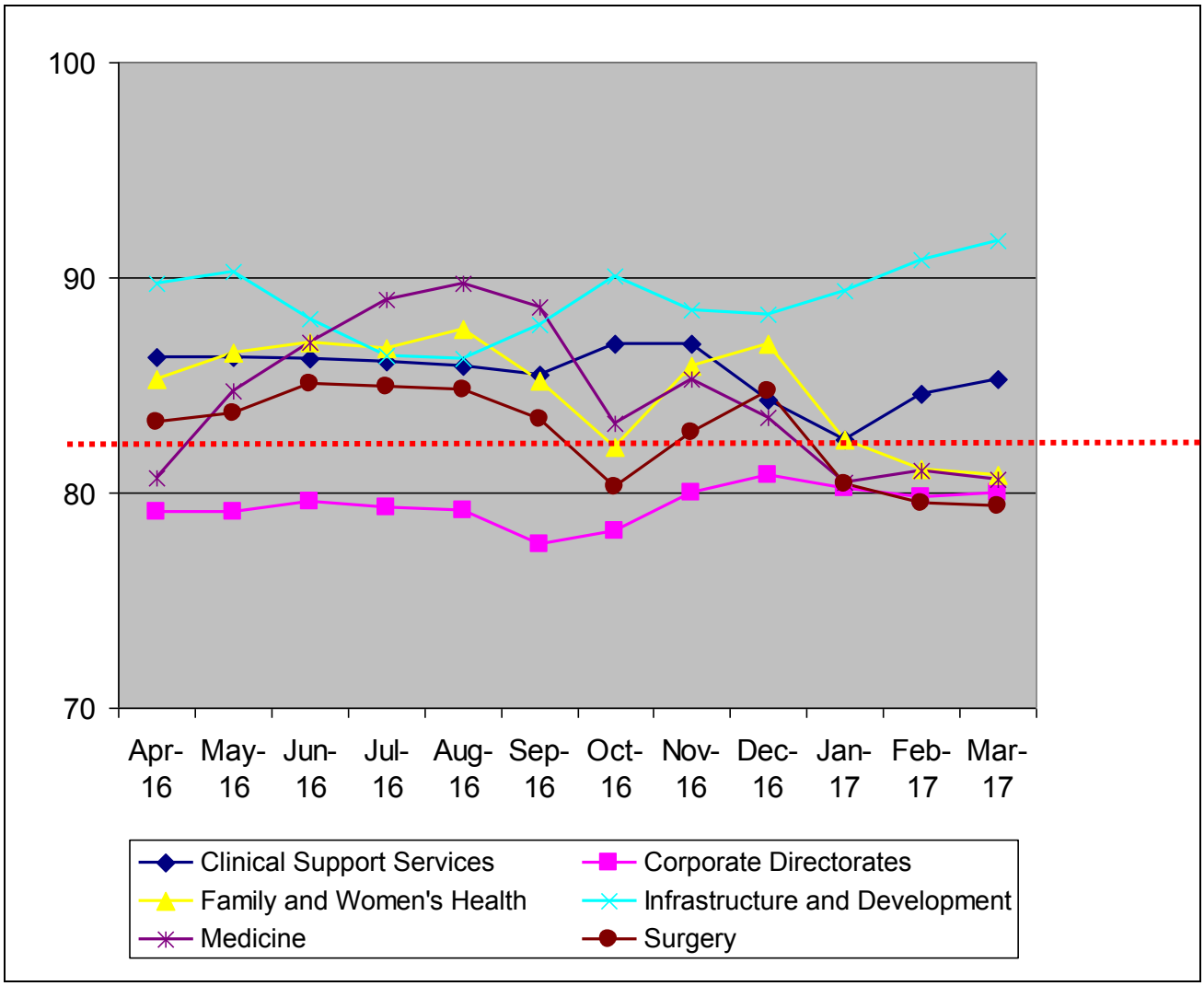
The 4th Quarter is seen to have the largest reduction in compliance.

2016-2017 Yearly Manual Handling Training Compliance[2] by Individual Health Group



[2] The Trust compliance target is 85%.

2016-2017 Yearly Manual Handling Training Compliance[3]: (Trend) by Individual Health Group (---------- = Trust Compliance)



Reduction in compliance is most evident across the Surgery, Family and Women's Health and Medicine Health Groups. Reduction occurs more noticeably during late third quarter to mid fourth quarter. This is possibly symptomatic of an increase in patient activity during this time.

[3] The Trust compliance target is 85%.

Manual Handling Incidents (all) – Quarterly Comparison

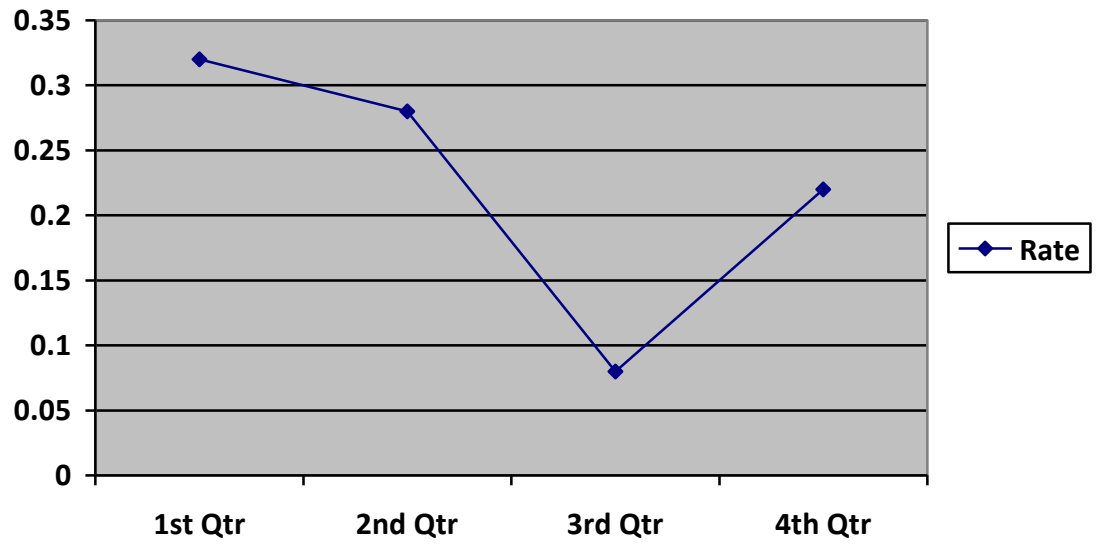
	2015/ 16	Q1 16-17	Q2 16/17	Q3 16/17	Q4 16/17	Total	Fin Yr Var	Qtr Var
Clinical Support Health Group	**9**	**3**	**3**	**0**	**3**	**9**	**0.0%**	**100.0%**
Imaging Division		1	2	0	0	3		100.0%
Specialist Services Division		0	1	0	1	2		100.0%
Therapy & Therapeutics Division		2	0	0	2	4		100.0%
Corporate Functions	**22**	**7**	**1**	**2**	**5**	**15**	**-31.8**	**150.0%**
Estates, Facilities & Development		0	0	1	5	6		400.0%
Finance & Business (inc patient admin)		1	1	1	0	3		-100.0%
Infrastructure & Development		6	0	0	0	6		0.0%
Family & Women's Health – Health Group	**7**	**3**	**4**	**1**	**3**	**11**	**57.1 %**	**200.0%**
Children, Opthalmology and Dermatology Division		2	3	0	0	5		0.0%
Division 2 Women and Children's Division		0	0	1	3	4		200%
Women's Services Division		1	1	0	0	2		0.0%
Medicine Health Group	**20**	**8**	**6**	**2**	**5**	**21**	**5.0%**	**150%**
Elderly Medicine		1	2	0	1	4		100.0%
Emergency Medicine Division		3	1	1	2	7		100.0%
General Medical Division		0	1	0	2	3		100.0%
Specialist Medical Division		4	0	1	0	5		-100.0%
Surgery Health Group	**38**	**6**	**10**	**2**	**3**	**21**	**-44.7%**	**50.0%**
Cardiovascular and Critical Care		1	4	0	0	5		0.0%
Digestive Diseases		1	0	1	1	3		0.0%
Specialist Surgery		1	0	0	0	1		0.0%
Theatres		3	4	1	2	10		100.0%
Trauma		0	2	0	0	2		0.0%
Grand Total	**96**	**27**	**24**	**7**	**19**	**77**	**-19.8%**	**171.4%**

There has been an increase in all Moving and Handling incidents reported on DATIX within the Medicine and Family and Women's Health Groups. The increase of reported incidents and decrease in training compliance may be significant. However, the Surgical health group experienced a reduction in compliance but reported a decrease in manual handling incidents of 44.7%. Monitoring will continue.

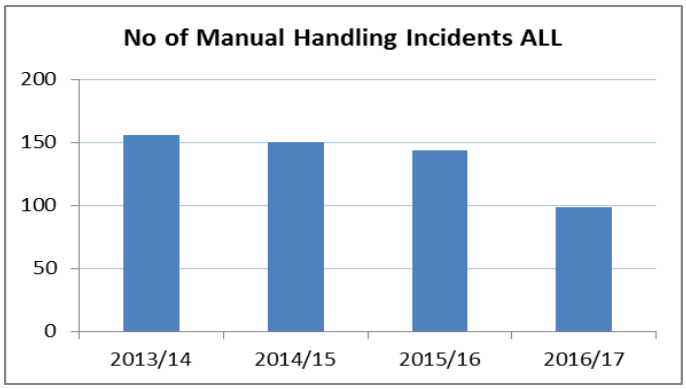
Manual Handling Incidents (all) – Quarterly Comparison with Staffing Figures:

Quarter	Number of Incidents	Number of Staff	Rate (incidents per 100 staff).
Q1 16/17	27	8537	0.32%
Q2 16/17	24	8629	0.28%
Q3 16/17	07	8717	0.08%
Q4. 16/17	19	8823	0.22%

Manual Handling Incidents (all) – Quarterly Rates shown as percentage of Staffing Figures

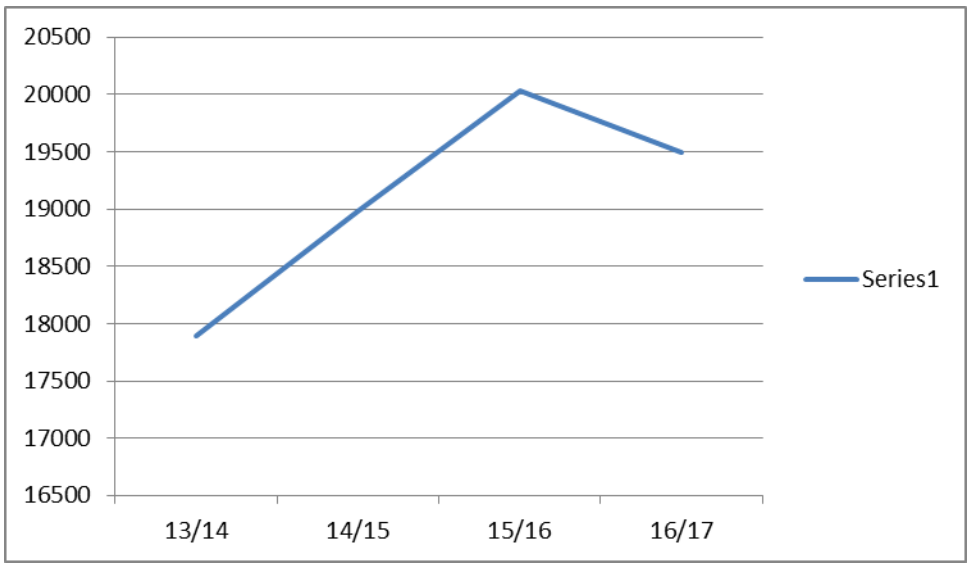


Number of Manual Handling Incidents – ALL (Last 4 years)



There has been a 31.3% reduction on the number of moving and handling incidents reported over the last 12 months in comparison to the previous three years. The figure below shows the overall reporting numbers for ALL incidents reported on Datix for the same period. The overall reduction in the M&H incidents is thus all the more encouraging.

All reported incidents on Datix:



Incident Reporting: ALL Moving and Handling - Related Incidents Recorded on Datix:

Year	No of Incidents	Change from previous year
2014/15	150	-3.8%
2015/16	144	-4.0%
2016/17	99	-31.3%

Incident Reporting: STAFF Moving and Handling - Related Incidents Recorded on Datix:

Year	No of Incidents	Change from previous year
2014/15	122	Nil
2015/16	96	-14.3%
2016/17	77	-19.8%

Incident Reporting: PUBLIC Moving and Handling - Related Incidents Recorded on Datix:

Year	No of Incidents	Change from previous year
2015/16	48	Unknown
2016/17	21	-43.75%

Comment:
Overall, there appears to have been a significant reduction in all moving and handling incidents reported throughout the Trust in 2016/17. Now the obvious question that follows relates to the significance of these numbers: in other words, is this pattern reflected in the overall reporting numbers in the Trust? Recourse to the data from the last 4 years was performed:

All reported incidents on Datix:

13/14	17894
14/15	18975
15/16	20034
16/17	19491

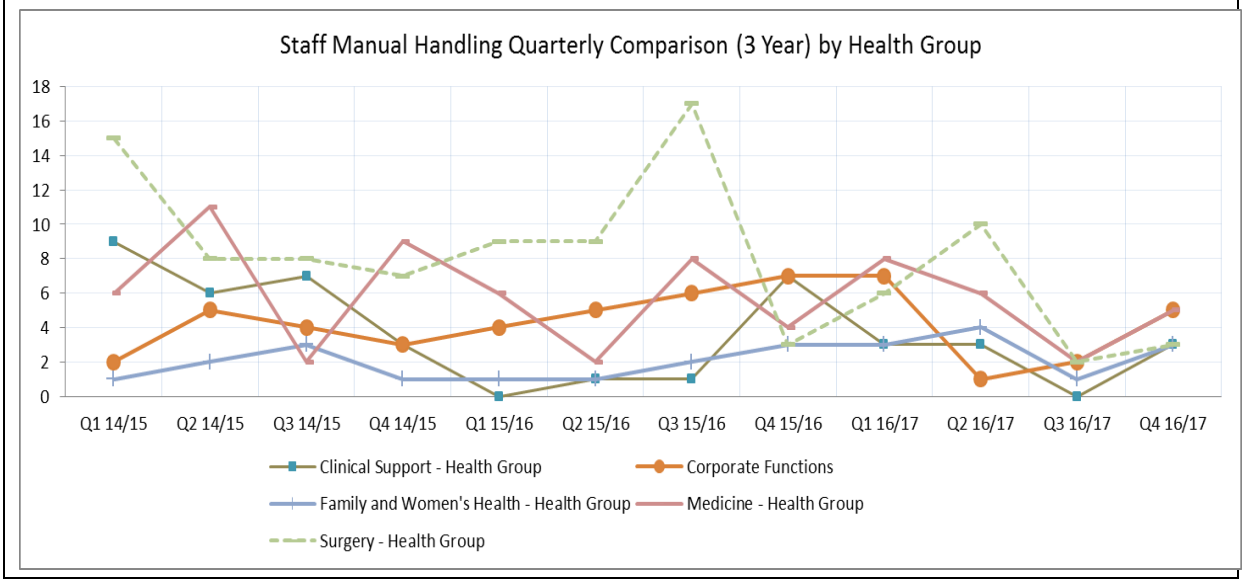
Whilst a reduction of approximately 3% occurred between 15/16 and 16/17, there was a 31% reduction in M&H incidents. This could be seen as very encouraging.

All moving and handling training now includes information on 'how and when' to record information on DATIX and the Moving and Handling Lead has asked that Link Trainers report ALL incidents and issues, irrespective of whether they are perceived as being

innocuous initially. Culturally, staff had admitted that they did not report certain incidents due to the possibility of reprisal. The Moving and Handling Lead has re-assured staff that reporting of risk or incident is encouraged and welcomed by the Trust.

When coming into post, the Moving and Handling Lead was asked to visit areas with 'historic' problems (high incidence of injury and sickness, significant risk from environmental factors or system requirements, etc.) however, no incident reporting or risk assessments were made in support of these reports and all staff are now actively encouraged to report ALL incidents. This ensures that issues are recognised earlier than previously and that suspected trends can be more readily monitored.

Three-Yearly Rates of Staff Manual Handling reporting by Health Group



This three-year comparison of manual handling reporting illustrates that health groups act independently of each other and that parity across these groups is rare. Significant perhaps, is that all health groups experienced a rise in reporting during the third/fourth quarter (Oct-Jan 2016) when patient acuity and activity was at a previously unseen level.
No sub-category figures are available for the year, due to changes in coding. These changes skewed the Fourth Quarterly Figures, thereby negating comparison to previous quarters/years.

Moving and Handling KPI's (see section 9 for more detail):

- MANUAL HANDLING RIDDOR REPORTABLE INCIDENTS. This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses

- MANUAL HANDLING LINK TRAINERS

- PATIENT HANDLING ASSESSMENTS (Patient handling assessments are seen to be a key proactive control measure for the reduction of both the likelihood and severity of harm arising from clinical moving and handling. They are also used as a planning tool to identify whether the necessary equipment is available and provided during the patient's stay. A random sample of 50 ward based inpatient notes are audited each quarter to identify if patient handling assessments have been completed satisfactorily).

10.4 Progress against Moving and Handling KPI's:

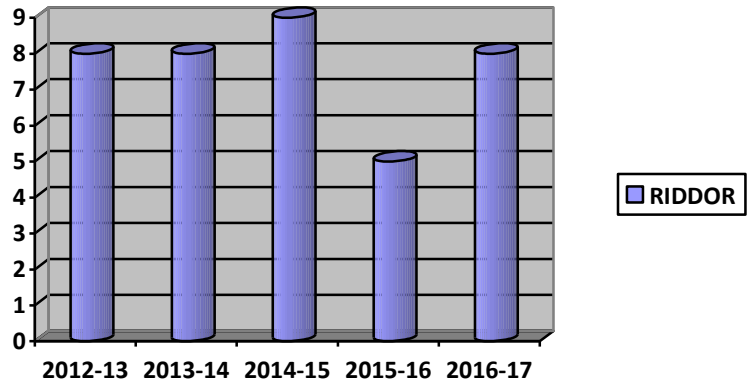
KPI 1 – Manual Handling RIDDOR Reportable Incidents.

Target – 0

Actual - 8

RIDDOR reports are usually associated with incidents of a more serious nature, which impact directly on the health and well-being of the individual. However, these reports are quantifiable and comprehensive. They provide necessary material for detailed investigation and reflective practice. Despite the fact that RIDDOR reportable incidents are *reactive* (rather than proactive), these incidents are more likely to be reported; as such, they are a more reliable measure and indicator of risk and performance across all Health Groups, wards, departments and individual staff members.

Number of Yearly RIDDOR Reports Made by Trust in Last Five Years



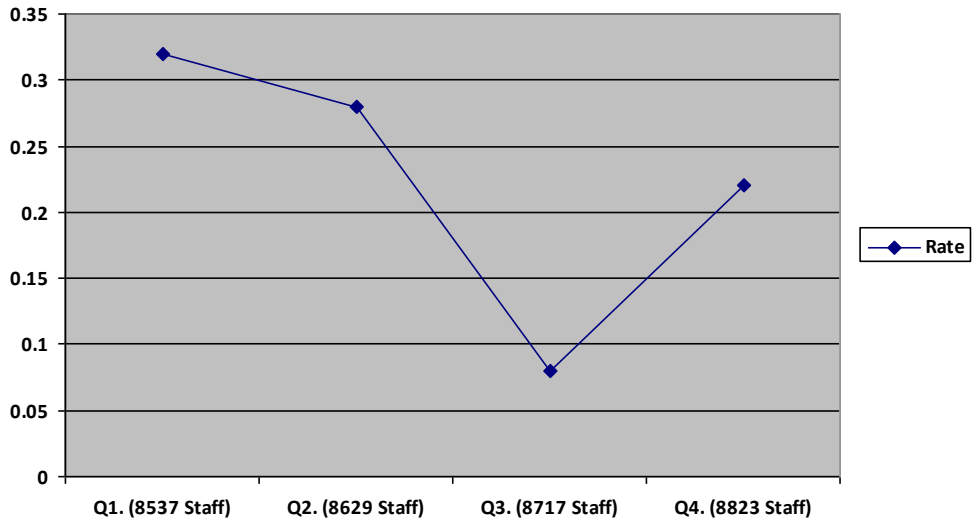
Despite a significant reduction in reporting of incidents related to Moving and Handling, the period 2016-2017 has seen an increase in Moving and Handling RIDDOR reportable incidents. The mean average for the last 5 years is 7.6. It is hoped that an increase in the number of Link Trainers will help to reduce this rate. However, several factors may influence this:

- Increasingly ageing workforce (many NHS workers are now required to work up to the age of 67 before reaching pensionable age and the NHS Employers website states that one in three workers will be experiencing chronic ill-health by 2020[4].)
- Increasingly ageing population (with higher dependency and increasing comorbidity). The King's Fund states that from 2012 to 2032 the populations of 65-84 year olds and the over 85s are set to increase by 39 and 106 per cent respectively.[5]
- Higher hospital admission rates (rising by an average of 3% every year)[6]
- Increase in very heavy/bariatric patients. 25% of British adults are now classed as clinically obese (Royal College of Physicians, 2013) and this number is growing.

[4] http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/working-longer-group-tools-and-resources/the-ageing-workforce-a-resource-for-managers/managing-an-ageing-workforce-the-key-issues
[5] https://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[6] https://www.gov.uk/government/statistics/hospital-admitted-patient-care-activity-2015-to-2016

- Budgetary constraints on equipment purchase (The Moving and Handling Lead is currently trialling a hoist from an alternative provider which if successful, will be more cost-effective).

Rate of RIDDOR Reportable Incidents per 100 staff:



NB. Previous yearly staffing rates were not available. Monitoring of this rate will be compared annually from hereon in.

KPI 2 – Manual Handling Link Trainers

Target – 100% coverage in Key Areas

All clinical areas are expected to have access to a manual handling link trainer in order to provide ongoing advice to staff and provide practical training updates. The Clinical Nurse Educators and PDN's have proven to be invaluable in fulfilling this role. Although there are numerous sub-divided areas across the Trust, Appendix 1 shows the key areas that have been identified as requiring a manual handling link trainer and is the list that will be measured against. The assessment criteria will be broken down to show the following information;

a) A named link trainer is working within the department or one has been identified from a related area to provide support and training.

b) The nominated link trainer has attended the internal training course to give them the skills and knowledge to fulfil the role.

c) The nominated link trainer has attended an update within the last 12 months.

d) The nominated link trainer is active in their role and has provided support and training within the department as identified in the departments TNA.

Appendix 1: Areas with a Nominated Moving and Handling Link Trainer

HRI			
A&E	AAU	X-Ray	Ward 34
AMU	MRI	Day Surgery	Ward 35
Ward 1	Ward 500	Recovery	Acorn Ward
Endoscopy	Physiotherapy	Ward 12	Ward 30 Cedar
ICU	GHDU	General Theatres	Ward 31
Recovery	Ward 4	Ward 40	Ward 32
Ward 5	Ward 50	Ward 6	Ward 33
Ward 60	Ward 7	Ward 70	Gynae Theatres
Ward 8	Ward 80	Ward 9	Gynae Recovery
Ward 90	AMU	Ward 100	Labour/Delivery
Ward 11	Ward 110	OT	Ward 130E
Ward 130W	# Clinic	Estates	Porters
Cath Lab	Combined procedures	CT Dept	Radiology
Cardiac Physiology	Mortuary Services	Neurophysiology	Nuclear Medicine
Ultrasound	General X Ray	Community Midwives	Gynae OPD
IVF W&C	ANC & ADU W&C	L&D W&C	Ophthalmic Pre-assess
Opthalmic Theatres	Opthalmic OPD	Paediatric OPD	Ward 200
EPAU/EGU Clinic	Medical OPD	Elderly OPD	SSMU
CHH			
ENT/Breast Theatres	ENT/Breast Recovery	Plastics Theatres	Ward 6/7
Ward 16	Ward 8	Ward 9	Ward 10
Ward 11	Ward 32	Ward 14	Ward 15
Gen/Ortho theatres	Gen/Ortho recovery	ICU 2	GU Recovery
ICU 1	Ward 26	Ward 27	Ward 28
Cardio theatres	Cardio recovery	G/U Theatres	Ward 16
Ward 19	Ward 20	Ward 21	Ward 22
Ward 33	Ward 29	Ward 30	Ward 31
Ward 12	Cardiac Day Ward	Diabetes Centre	Cardiology OPD
Breast care Unit	Dermatology	Interventional Card	BWH/ERCH
DSU	Teacher Trainer Team	Pain Management	Transfusion
Oncology/Haem OPD	Bowel Screening		

KPI 3 – Patient Handling Assessments

Target - 100% / Actual 100%
Trust policy states that all in-patients should be assessed for moving and handling need upon admission. Random samples of 50 ward-based in-patient notes are to be audited each quarter. This will identify whether patient handling assessments have been completed satisfactorily. 10 wards were visited in the past financial year, and 200 patients were randomly selected (50 per quarter).

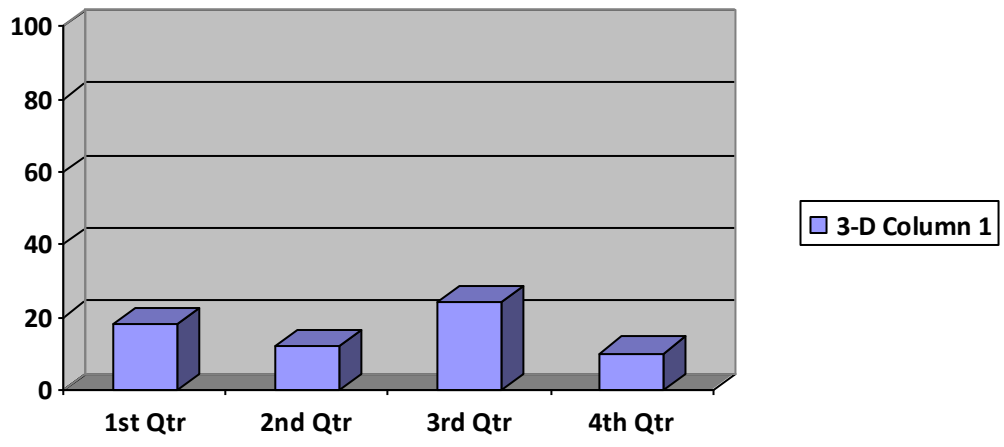
Appendix 2: Areas of Audit

HRI			
A&E	AAU	Ward 12	Antenatal Day Unit
AMU	MRI	Day Surgery	Ward 500
Ward 1	MOPD	Ortho OPD	Acorn Ward
Endoscopy	Ultrasound	Ward 31	Ward 30 Cedar
GHDU	Ward 4	Ward 40	Ward 32
Ward 5	Ward 50	Ward 6	Ward 33
Ward 60	Ward 7	Ward 70	ICU
Ward 8	Ward 80	Ward 9	Ward 11
Ward 90	AMU	Ward 100	Ward 110
Labour/Delivery	Ward 130E	Ward 130W	Ward 34
Ward 35	Ophthalmic Day	Ophthalmic OPD	Ward 120
CHH			
Ward 32	Recovery	ICU 2	Ward 6/7
Ward 16	Ward 8	Ward 9	Ward 10
Ward 11	Endoscopy	Ward 14	Ward 15
Breast Care Unit	Ward 16	Ward 33	Radiotherapy
ICU 1	Ward 26	Ward 27	Ward 28
Ward 19	Ward 20	Ward 21	Ward 22
Pre-Assessment	Ward 29	Ward 30	Ward 31

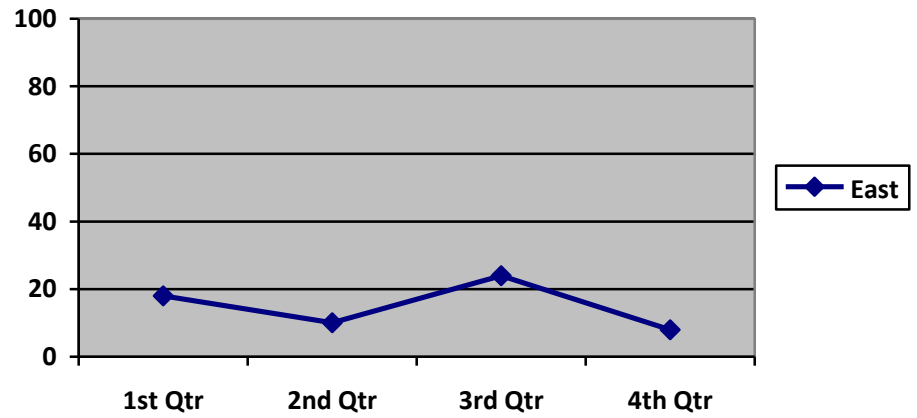
It was decided to reduce the areas suitable for audits by removing the areas with transitory patients (such as XRay, Theatres, etc.) There is a risk that a single patient could be audited twice; both on wards and in departments they are visiting temporarily for procedures.

General rates were as follows (non-ward specific)

Percentage of Patients Who Were Not Assessed for Mobility as Per Policy

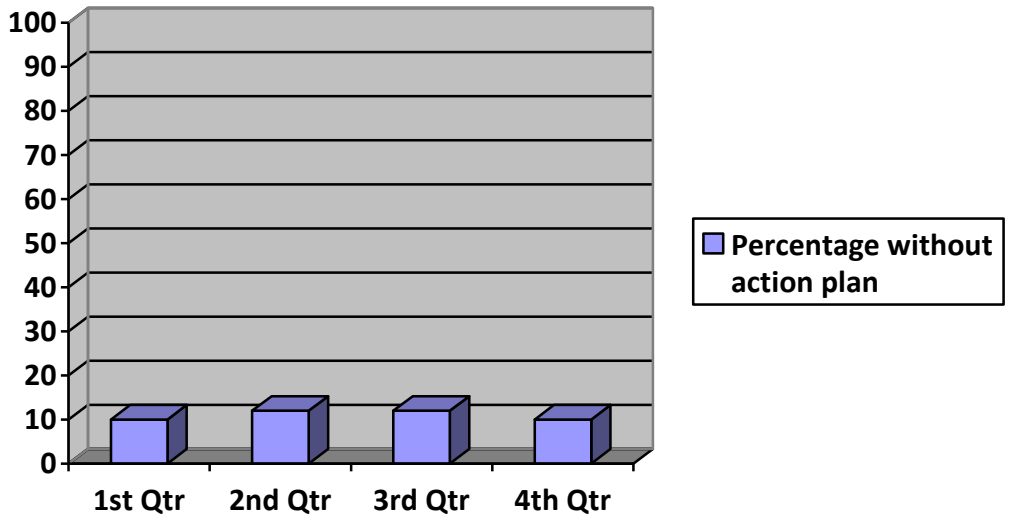


Percentage of In-Patients Not Assessed for Mobility as Per Policy (Expressed as Trend-Line)

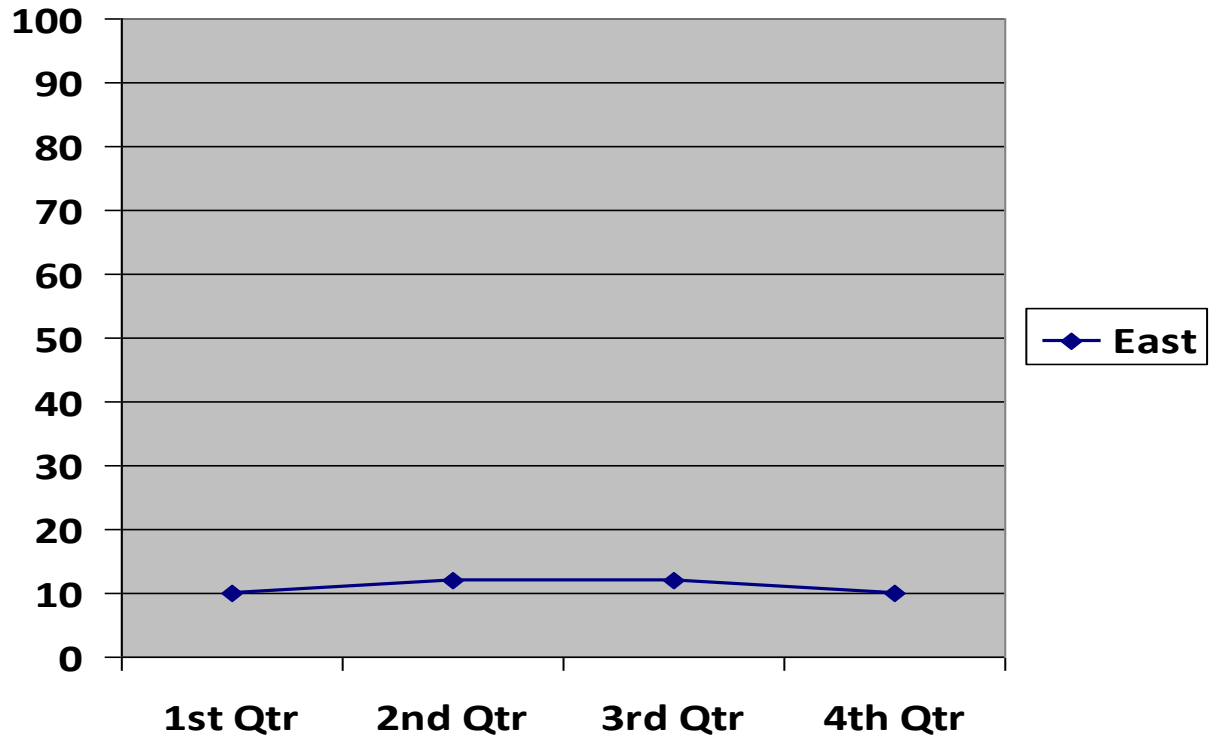


There is a visible increase in rates between 3rd and 4th Quarter. This could be as a result of increased admission rates. It was also noted that some patients do not undergo assessment during the weekend, when physiotherapists are at reduced numbers.

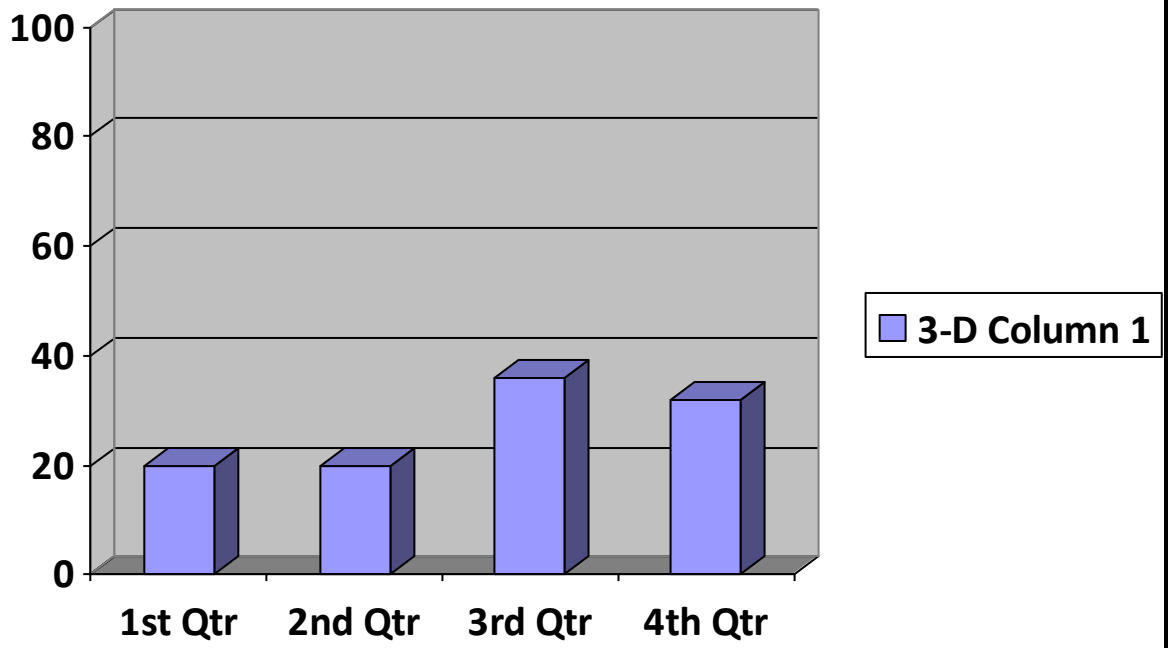
Percentage of Dependent Patients without Moving and handling Action Plan Performed on Admission



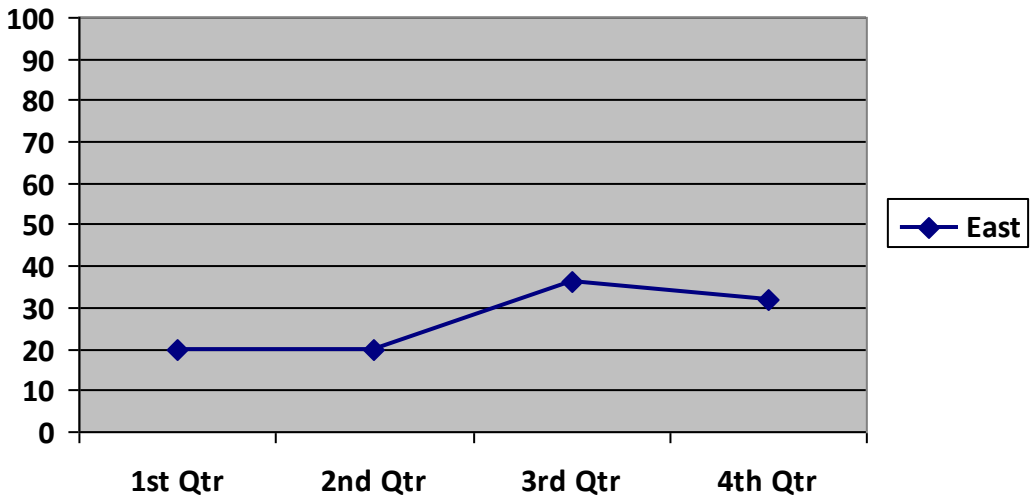
Percentage of Dependent Patients without Moving and Handling Action Plan Performed on Admission Expressed as a Trend



Percentage of Patients not Undergoing DAILY Moving and Handling Action Plans



Percentage of Patients not Undergoing DAILY Moving and Handling Action Plans Expressed as Trend



There was a definite decrease in the number of daily mobility assessments completed in Nursing Care-plans between second and third quarter. However, this appears to be reversing, as more assessments are now being carried out. The Moving and Handling Lead is to ask all Link Trainers to monitor this during their 'time-out' and to reiterate the importance of completing these daily.
Despite publication Trust-wide, the Audits carried out throughout the year have highlighted that many departments and wards are using substandard Lateral Transfer boards. An audit was performed and information for ordering new lateral transfer boards was sent to every department and ward. The preferred suppliers have informed me that uptake has been poor. Further communication with wards and Departments has not encouraged ordering. A further Audit will take place in 2017-18.
The ward audits have also once again highlighted a distinct lack of commitment towards using slide-sheets by several wards and departments. Reasons for this are mostly financial. The preferred supplier has stated that figures of use which were forecast have fallen very short of actual use. The Trust historically orders 100x100cm slide-sheets from Banana/GB UK. Two sheets are to be used per patient. A snap-shot audit completed by myself at training sessions has provided 4 reasons as to why use is limited:

1. There are none available
2. They are too expensive
3. They are too time-consuming to find, fit and remove.

The Moving and Handling Lead is to provide bespoke training with the preferred supplier in departments and areas where use is low. Alternatives to the use of two 100x100cm slide sheets are also to be considered.

14. Objectives / Priorities for 2017/18

- Increase the number of properly trained Safety Focal Persons and Moving and Handling Link Trainers within the organisation.
- Reduce the likelihood and / or severity of 'major' incidents which could have the potential to cause multiple casualties and damage to the Trust. This will involve working with colleagues from related teams to audit current arrangements and (a) seek assurance where it exists and (b) suggest preventive measures where assurance is inadequate.
- Build upon the successes seen in the reduction of Employer's Liability Claims made against the Trust: this can be achieved by (a) preventive, pro-active measures generally, and (b) investigations that enable realistic defence for the Trust along with lesson learning to reduce the likelihood and quantum of future claims.
- Increase involvement in Capital Schemes / Projects.
- Increase activity in the prevention of slip hazards, including close working with cleaning services, (Safety are already involved in the steering group for the cleaning services tender).
- Review the adequacy of the Trust's management arrangements in the area of work-related stress: this hazard is a stated priority for the HSE in the coming year.
- Ensure adequate or improved quality of training for M&H Link Trainers through the utilization of training facilities and equipment. Following the closure of the training facilities at the Haughton Building and the imminent opening of the new facility at CHH, we need to ensure that hands-on training with equipment is maintained. This need was illustrated in July 2017 with the £1m fine handed to North Linc's Trust following a fatality caused by inadequate knowledge of the safe use of a standing hoist.
- Continued efforts to maintain and improve performance towards the KPI targets described at the beginning of this report.

David Bovill, Trust Safety Manager, July 2017.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD AND COMMITTEE DATES

Trust Board date	5th September 2017	**Reference Number**	2017 – 9 - 19
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson
Reason for the report	To approve the attached Trust Board and Committee dates for 2018/19		

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

1	**RECOMMENDATIONS** The Trust Board is requested to approved the Trust Board and Committee dates for 2018/19					
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 Board and Committee dates is reserved to the Trust Board.					

BOARD AND COMMITTEE DATES
2018/19

DATE	TIME	MEETING	LOCATION	PAPERS DUE
Thursday 25th January 2018	9.00am – 12.00pm	Audit	The Committee Room, HRI	18th January 2018
Monday 29th January 2018	9.15am –11.15am	Quality	The Committee Room, HRI	23rd January 2018
	11.30am – 1.00pm	NED	The Committee Room, HRI	23rd January 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	23rd January 2018
Tuesday 30th January	9.00am – 1.00pm	Trust Board/Board Development	The Boardroom, HRI	23rd January 2018
Monday 26th February 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	20th February 2018
	11.30am – 1.00pm	Remuneration	The Committee Room, HRI	20th February 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	20th February 2018
Wednesday 28th February 2018	10am – 12pm	NED	The Committee Room, HRI	19th February 2018
Tuesday 13th March 2018	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	6th March 2018
Monday 26th March 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	19th March 2018
	11.30am – 1.00pm	NED	The Committee Room, HRI	19th March 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	19th March 2018
Tuesday 27th March 2018	9.00am – 12.00pm	Board Development	The Boardroom, HRI	20th March 2018
Wednesday 25th April 2018	10.00am – 12.00pm	NED	The Committee Room, HRI	20th April 2018
Thursday 26th April 2018	9.00am – 12.00pm	Audit	The Committee Room, HRI	20th April 2018
Monday 30th April 2018	9.15am – 11.15pm	Quality	The Committee Room, HRI	23rd April 2018
	11.30am – 1.00pm	Charitable Funds	The Committee Room, HRI	23rd April 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	23rd April 2018
Tuesday 15th May 2018	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	8th May 2018
Thursday 24th May 2018	11.00am – 12.00pm	Extraordinary Audit meeting to approve the accounts	The Boardroom, HRI	17th May 2018
	12.00pm – 1.00pm	Extraordinary Trust Board meeting to approve the accounts	The Boardroom, HRI	17th May 2018
	2.00pm – 4.30pm	Board Development	The Boardroom, HRI	17th May 2018
Tuesday 29th May 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	22nd May 2018
	11.30am – 1.00pm	Remuneration	The Committee Room, HRI	22nd May 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	22nd May 2018
Wednesday 30th May 2018	10.00am – 12.00pm	NED	The Committee Room, HRI	22nd May 2018

DATE	TIME	MEETING	LOCATION	PAPERS DUE
Monday 25th June	9.15am – 11.15am	Quality	The Committee Room, HRI	18th June 2018
	11.30am – 1.00pm	NED	The Committee Room, HRI	18th June 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	18th June 2018
Tuesday 10th July 2018	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	3rd July 2018
Thursday 26th July 2018	9.00am – 12.00pm	Audit	The Committee Room, HRI	19th July 2018
	12.30pm – 2.30pm	NED	The Committee Room, HRI	19th July 2018
Monday 30th July 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	23rd July 2018
	11.30am – 1.00pm	Charitable Funds	The Committee Room, HRI	23rd July 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	23rd July 2018
Tuesday 31st July 2018	9.00am – 12.00pm	Board Development	The Boardroom, HRI	24th July 2018
Tuesday 28th August 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	21st August 2018
	11.30am – 1.00pm	Remuneration	The Committee Room, HRI	21st August 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	21st August 2018
Wednesday 29th August 2018	10.00am – 12.00pm	NED	The Committee Room, HRI	21st August 2018
Tuesday 11th September 2018	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	4th September 2018
Monday 24th September 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	17th September 2018
	11.30am – 1.00pm	NED	The Committee Room, HRI	17th September 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	17th September 2018
Tuesday 25th September 2018	9.00am – 12.00pm	Board Development	The Boardroom, HRI	18th September 2018
Thursday 25th October 2018	9.00am – 12.00pm	Audit	The Committee Room, HRI	18th October 2018
	12.30pm – 2.30pm	NED	The Committee Room, HRI	18th October 2018
Monday 29th October 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	22nd October 2018
	11.30am – 1.00pm	Charitable Funds	The Committee Room, HRI	22nd October 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	22nd October 2018
Tuesday 13th November 2018	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	6th November 2018
Monday 26th November 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	19th November 2018
	11.30am – 1.00pm	Remuneration	The Committee Room, HRI	19th November 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	19th November 2018
Tuesday 27th November 2018	9.00am – 12.00pm	Board Development	The Boardroom, HRI	20th November 2018
	1.00pm – 3.00pm	NED	The Committee Room, HRI	20th November 2018

DATE	TIME	MEETING	LOCATION	PAPERS DUE
Monday 17th December 2018	9.15am – 11.15am	Quality	The Committee Room, HRI	10th December 2018
	11.30am – 1.00pm	NED	The Committee Room, HRI	10th December 2018
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	10th December 2018
Thursday 24th January 2019	9.00am – 12.00pm	Audit	The Committee Room, HRI	17th January 2019
Monday 28th January 2019	9.15am – 11.15am	Quality	The Committee Room, HRI	21st January 2019
	11.30am – 1.00pm	NED	The Committee Room, HRI	21st January 2019
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	21st January 2019
Tuesday 29th January 2019	9.00am – 1.00pm	Trust Board/Board Development	The Boardroom, HRI	22nd January 2019
Monday 25th February 2019	9.15am – 11.15am	Quality	The Committee Room, HRI	18th February 2019
	11.30am – 1.00pm	Charitable Funds	The Committee Room, HRI	18th February 2019
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	18th February 2019
Wednesday 27th February 2019	10.00am – 12.00pm	NED	The Committee Room, HRI	19th February 2019
Tuesday 12th March 2019	9.00am – 12.00pm	Trust Board	The Boardroom, HRI	5th March 2019
Monday 25th March 2019	9.15am – 11.15am	Quality	The Committee Room, HRI	18th March 2019
	11.30 – 1.00pm	Remuneration	The Committee Room, HRI	18th March 2019
	2.00pm – 5.00pm	Performance and Finance	The Committee Room, HRI	18th March 2019
Tuesday 26th March 2019	9.00am – 12.00pm	Board Development	The Boardroom, HRI	19th March 2019
	1.00pm – 3.00pm	NED	The Boardroom, HRI	19th March 2019

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	5th September 2017	**Reference Number**	2017 – 9 – 20
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
2017/09	Hull and East Yorkshire Hospitals NHS Trust and Cardronics UK Ltd – ATM agreement at Castle Hill Hospital	04.08.17	Lee Bond and Carla Ramsay
2017/10	Hull and East Yorkshire Hospitals NHS Trust and Cardtronics UK Ltd – ATM agreemement at Hull Royal Infirmary	04.08.17	Lee Bond and Carla Ramsay
2017/11	Hull and East Yorkshire Hospitals NHS Trust and Clear Channel UK Advertising Hoardings – Lease relating to land fronting Anlaby Road and on the corner of Argyle Street situated at Hull Royal Infirmary	08.08.17	Lee Bond and Carla Ramsay
2017/12	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction Limited – Replacement of Signa MRI facility, Hull Royal Infirmary	09.08.17	Lee Bond and Carla Ramsay
2017/13	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction Ltd – Interventional Radiology Theatre (IRT) Room 2 upgrade, Hull Royal Infirmary	09.08.17	Lee Bond and Carla Ramsay
2017/14	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction Ltd – CT2 Scanner refurbishment, Castle Hill Hospital	09.08.17	Lee Bond and Carla Ramsay
2017/15	Hull and East Yorkshire Hospitals NHS Trust and Hobson and Porter Ltd – Formation of 3rd floor theatre reception, Hull Royal Infirmary	09.08.7	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
September 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	31 May 2017	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- Midwifery led unit – overspend, VAT costings to be checked
- Consolidating fund investments – two investors currently, a paper to be received at the July meeting
- Da Vinci Robot – Benefactor agreed to fund a second robot. Timings to be reviewed. Post implementation review to be presented to the Quality Committee in July 2017.
- Dementia ward – using funds appropriately. Dr Harman to attend the next meeting.
- Ms Lockwood presented current projects regarding the WISHH charity. £10k run, WISHH ball and fashion show. Press and PR strategy to be developed.
- Fund balance management was reviewed.
- The Legacy procedures were discussed and how Health Groups allocate the money.
- The financial report was presented and at month 12 donations were £737k.
- A review of effectiveness was carried out with results showing an efficiently chaired and run meeting.

Decisions made by the Committee:

- Bid for the Trust fun day was approved by the Committee.
- The Admin charge for 2017/18 was approved
- The Committee agreed the signatories authorised to undertake transactions on the account
- Dr Harman to be invited to the next meeting to discuss the Dementia ward

Key Information Points to the Board:

- Nothing to escalate, key issues discussed captured above

Matters escalated to the Board for action:

- Nothing to escalate, key issues discussed captured above

CHARITABLE FUNDS COMMITTEE
HELD ON TUESDAY 31 MAY 2017
THE COMMITTEE 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 Mr D Haire, Project Director, Fundraising
IN ATTENDANCE:	Mrs D Roberts, Deputy Director of Finance Ms S Lockwood, Chair, WISHH Charity Mrs R Thompson, Assistant Trust Secretary (Minutes)

ACTION

1 APOLOGIES FOR ABSENCE

Apologies were received from Ms C Ramsay, Director of Corporate Affairs.

2 DECLARATIONS OF INTEREST

Mr Haire declared that he was a Trustee of the Osprey Charity and Chairman of the Vertual Company. The Vertual Company in partnership with Hull University provided 3D training packages for radiographers.

3 MINUTES OF THE MEETING 17 NOVEMBER 2016

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

4 MATTERS ARISING

Mr Bond raised whether the Trust should hold two investment funds with two different investors or whether these funds should be consolidated. Mr Bond agreed to bring a proposal to the July 2017 meeting to allow the Committee to review this further. **LB**

There was a discussion around the Charitable Funds policies and it was agreed that the updated policies would be approved (following a final check from Mr Bond) with a review at the end of the year. **DR**

5 ACTION TRACKER

The Committee discussed issues associated with the creation of a dementia friendly environment on Wards 8 and 80 and in particular issues associated with the staffing of the newly created reception and the perceived underutilisation of the memory cafe. This was a concern as monies had been allocated by the committee for this specific purpose. It was agreed that Dr Harman (Dementia Consultant) could attend the next meeting to discuss this further. Mrs L Roberts to invite Dr Harman to the next meeting. **LR**

The policy regarding memorials to be reviewed and discussed at the next meeting. **CR**

Mr Haire reported that a post implementation review of the robot would be presented to the Trust's Quality Committee in July 2017. **DH**

6 DRAFT WORKPLAN 2017/18

The workplan was reviewed and approved by the Committee.

7 PROJECT DIRECTOR'S REPORT

Mr Haire presented the report and reported that a cinema facility was to be created on both wards 8 and 80 for the benefit of patients, particularly, but not exclusively those that were prone to wander.

Mr Haire also reported that he was undertaking work on the strategic development of robotic-assisted surgery within the Trust and the need or otherwise for a second system. Mr Snowden asked if the existing robot was being fully utilised and Mr Haire advised that its use had now been extended to four procedures and activity was in excess of three hundred cases per year. In addition, a dialogue was ongpoing with other specialties which wished to have access to the system. He reported that the post implementation review would show the benefits, quantify the financial implications and how it was helping the organisation overall.

Mr Haire also reported that current financial reports indicated that there was an overspend on the midwifery led unit project by £6k but this was being reviewed and it was expected that this would reduce. There was a discussion about the VAT assessment and Mr Haire agreed to clarify this at the next meeting in July 2017. **DH**

There was a discussion around the Gait Trainer which was being trialled in the Queens Centre. This equipment would help with physical rehabilitation and would be reviewed by the Head of Therapies after the 3 month trial had finished. Mr Bond expressed his concern regarding the governance around the equipment and Mr Haire agreed to remind Health Groups to launch fundraising appeals appropriately and through the correct channels. **DH**

Mr Haire spoke of a family that had raised £10k for the Queens Centre, following the loss of a family member and their daughter's links to the Hull York Medical School..

Resolved:
The Committee received the updated and agreed:

- Mr Haire would clarify the VAT assessment relating to the MLU **DH**
- Mr Haire to remind the Health Groups of the fundraising procedures **DH**

8 WORKING INDEPENDENTLY TO SUPPORT HEY HOSPITALS CHARITY UPDATE

Ms Lockwood thanked Mr Haire for his ongoing support and advised that the appropriate governance and finance arrangements were in place.

The Charity was launched in November 2016 with fundraising to support the dementia strategy. Ms Lockwood advised that there was more work to be done with the website but that this was now live and offered a place to donate money and comments. Ms Lockwood and Mr Haire had visited Sheffield Children's hospital to review their fundraising facility and would supply a report to the Trustees. She reported that Sheffield had a fund raising team and suggested that the work load of the HEY charity was such that this might need to be considered in the future.

Ms Lockwood thanked Mrs Hadfield for her help with the charity 10k run being organised by WISHH. Ms Lockwood also mentioned a charity fashion show and a WISHH ball being held in November 2017. There was an idea to place wishing wells around the hospital as these were seen to be a good fundraising initiative.

There was a discussion around press coverage and PR relating to the charity and Ms Lockwood advised that there was much more to do in this area. Mr Haire added that he was looking at the PR strategy and would be proactively joining nursing team meetings to promote the charity, in due course

Resolved:
The Committee received the report and thanked Ms Lockwood for all her hard work.

9 FUND BALANCES AND SPENDING PLANS

Mrs Roberts presented the paper and advised that at 30 April 2017 there was £1m available to spend. The finance team were currently working through the commitments. Mrs Roberts advised that Mr Haire was continuing to work with the Health Groups to ensure funds were moving and it was agreed that Mr Haire would bring a paper to the next meeting showing projects that are being implemented and timelines.

There was a discussion around over commitments and how they are funded and Mr Bond advised that other gains would cover the shortfall.

There was a bid for charitable funds relating to the Trust's family fun day. The Committee were supportive of the event and approved the bid.

Mrs Roberts advised that the annual accounts for the charity were now in draft and would be presented to the next meeting in July 2017 following review by the external auditors.

Resolved:
The Committee received the report and approved the bid for charitable funds relating to the family fun day.

10 LEGACY UPDATE

Mr Haire presented the paper which gave a list of the legacies received. There was a discussion around the strategy of utilising legacies and Mrs Walker asked if these could be held centrally and manged on behalf of the Health Groups for funds over £10k. Mrs Roberts agreed to check this. **DR**

Resolved:
The Committee received the report.

11 FINANCIAL REPORT AS AT 31 MARCH 2017

Mrs Roberts presented the report and reported that at month 12 the donations to the Trust were £737k. This figure included a boost from a local benefactor and Mrs Roberts reported that donations were lower than last year.

Assets and liabilities were £1.5m and cash was at £482k. Bayer healthcare owed the Trust £30k and Mrs Roberts was reviewing these arrangements.

Resolved:
The Committee received the report.

12 ANNUAL COMMITTEE PERFORMANCE REVIEW

Mrs Thompson presented the report and advised that each agenda for 2016/17 had been reviewed to ensure that the Committee was reviewing appropriate issues. There were no issues raised regarding the surveys completed by the members and all reported that the meeting was efficiently chaired and run appropriately.

Resolved:
The Committee received the report.

13 ADMINISTRATION CHARGE 2016/17

Mrs Roberts presented the report and advised that the fee had increased by £12k to £58,114. The fee had changed based on activity at 2016/17 levels and was in line with 2015/16 and the revised 2016/17 charges.

Resolved:
The Committee received the report and agreed the administration charges for 2017/18.

14 CHAIRS SUMMARY OF THE MEETING

Mr Snowden agreed to summarise the meeting to the Board.

15 ANY OTHER BUSINESS

Mrs Roberts explained that the authorised signatory details for the CCLA COIF account were out of date. The Committee agreed that the following were authorised to undertake transactions on the account.

- Lee Bond , Chief Financial Officer - Hull and East Yorkshire Hospitals NHS Trust
- Dianne Roberts, Deputy Director of Finance – Accounting & Audit Hull and East Yorkshire Hospitals NHS Trust
- Stephen Evans, Deputy Director of Finance – Hull and East Yorkshire Hospitals NHS Trust
- Alison Drury, Deputy Director of Finance – Hull and East Yorkshire Hospitals NHS Trust

The Committee thanked Ms Lockwood for her attendance and contribution to the meeting.

16 DATE AND TIME OF THE NEXT MEETING:

Tuesday 5 September 2017, 9:30am – 11:30am, The MRI Meeting Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AUDIT COMMITTEE

Meeting Date:	27 July 2017	**Chair:**	Mr M Gore	**Quorate (Y/N)**	Y

Key issues discussed:

- Performance & Finance minutes – it was noted that the capital bid for MRI/CT Scanners had not been supported by NHS England
- Quality minutes – briefing on new mortality case reviews process and gap analysis against national requirements to be received by the Board
- Gareth Kelly introduced himself and Grant Thornton and their approach to be taken as the Trust's new external auditors
- The Annual Audit letter 2016-17 (KPMG) was formally received by the committee – this will be published on the Trust's website
- MIAA (internal audit) presented their follow up report with progress made to close down old actions – further progress required by October 2017 to close oldest actions
- Reference costs – Mr Bond updated the committee regarding the data collection being undertaken at present and provided assurance that the Trust would meet requirements to feed in to this national data collection process
- IT Disaster Recovery Plan – Mr Bond gave assurance to the Committee on IT resilience issues and the strengthened perimeter security for cyber-security
- Neurosurgery Report – Mr Bond updated the committee regarding a specific issue in this team
- Board Expenses for Q1 were received
- Credit Card expenditure for Q1 was received
- Debtors greater than £50k were received
- The Clinical Audit Annual Report was received (presented by Vicki Shaw) – the committee commented on how comprehensive it was and the good progress made
- Mrs Newlove presented the Clinical Negligence report and highlighted the work ongoing to reduce costs and challenge claims
- The Trust's Gifts and Hospitality register was received
- Ms Ramsay presented the Whistleblowing and Freedom to Speak Up Report – assurance was provided that the Trust had relevant whistleblowing arrangements in place
- The Financial Governance update was received and the financial MOT was closed

Decisions made by the Committee:

- A report to be received at the October 2017 committee regarding Job Plans and consultant staffing levels relating to an internal audit from 2014/15– KP
- Martyn Smith to attend in October 2017 to update the Committee regarding IT security and Wifi controls

Key Information Points to the Board:

- The Trust's new external audit provider (Grant Thornton) has started with the Trust
- MIAA presented their progress report – significant assurance had been given for budget setting but the CRES elements tested within this internal audit demonstrated that the Trust needs to do more work on CRES ownership and accountability
- The Board Assurance Framework was discussed – the elements around Clinical Negligence costs and IT infrastructure discussed today to be added to BAF 3 and BAF 7.3 respectively as areas requiring more assurance

Matters escalated to the Board for action: • None
Matters referred to other Committees:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE MINUTES
HELD ON THURSDAY 27 JULY 2017
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr M Gore (Chair)	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
IN ATTENDANCE:	Mrs D Roberts	Deputy Director of Finance
	Mr G Kelly	Grant Thornton (external audit)
	Mr G Baines	MIAA (internal audit)
	Ms C Ramsay	Director of Corporate Affairs
	Mrs V Shaw	Clinical Audit Manager (Item 15 only)
	Mrs A Newlove	Claims Manager (item 18 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

Action

1. APOLOGIES
Apologies were received by Mrs S Bates, Interim Deputy Director of Quality, Governance and Assurance.

2. DECLARATIONS OF INTEREST
Mr Hall declared that his partner was now a lay member of the Hull Clinical Senate and Mrs Christmas declared that her cousin worked for KPMG.

3. MINUTES OF THE MEETING 27 APRIL 2017
Mr Moran, Chairman to be added to the minutes as he was in attendance.

Item 8 – Accounts Policies should read Accounting policies.

Item 10 – Draft Annual Governance Statement to be moved to be after item 2 in the minutes, as this item was taken out of agenda order.

Following the above changes the minutes were accepted as an accurate record.

3.1 – MINUTES OF THE MEETING 25 MAY 2017
Mr Bond's apologies to be removed as he was in attendance at the meeting.

Following this alteration the minutes were approved as an accurate record of the meeting.

4. MATTERS ARISING
Mrs Roberts advised that item 7.1 ESR Audit and Recommendations – work was ongoing with 7 of the recommendations completed. Mr Nearney would attend the meeting in October 2017 to assure the Committee that all the recommendations had been completed.

The Committee discussed the work ongoing regarding IR35 to ensure the Trust was compliant with regulations. The timescale for completion was September 2017.

Mrs Christmas queried the IT expenditure as an outstanding action from April 2017 to provide a Q4 breakdown; Ms Ramsay has this information and will forward this.

4.1 – ACTION TRACKER

The Committee reviewed the action tracker and agreed to remove the following items from the Tracker as they were completed: **CR**

- Pathology IT concern
- Clinical Audit Effectiveness Review
- Serious Incidents Requiring Investigation – On workplan

Audit Planning would be received at the December 2017 meeting.

4.2 – WORKPLAN

The Workplan was reviewed by the Committee and no changes were made.

5. COMMITTEE MATTERS

5.1 - Performance and Finance 26.06.17 – The capital bid for MRI/CT scanning equipment had not been supported by NHS England, but Mr Bond advised that further funding would likely be available in the Autumn.

Mr Bond reported that the issue regarding the Tower Block cladding had been closed as it had been confirmed compliant with fire regulations. Mr Gore requested that mandatory fire training have a focus as part of the locality review audits carried out by MIAA when checking mandatory training compliance.

5.2 – Quality 26.06.17

Mortality and the new case note review system was noted; assurance on the process and an understanding of the independence of the reviewers would be received at the September 2017 Board.

5.3 – Charitable Funds 31.05.17

The Committee received the minutes of the meeting.

6. EXTERNAL AUDITORS

6.1 – Introduction

Mr Kelly introduced himself and Grant Thornton and explained that the Committee would receive a technical update report at each future meeting.

6.2 – HEY Benchmark Report

Mr Kelly presented a benchmark report which compared 150 NHS Annual Reports from 2015/16. Hull and East Yorkshire Hospitals NHS Trust's report had compared favourably, with some areas to work on. Mr Kelly and Ms Ramsay to review the next report when published.

6.3 – Annual Audit Letter (KPMG)

The Annual Audit Letter was formally received by the Committee. The letter set out the audit programme undertaken by external audit in 2016/17 and associated costs. There were no significant issues to highlight.

7. INTERNAL AUDITORS

7.1 – Internal Audit Progress Report

Mr Baines presented the report and advised that the budget setting audit had

been given significant assurance. There was a discussion around ownership and accountability of the budget sign off and Mr Bond expressed his concern around the middle management accountability of their CRES. Mr Bond confirmed that budget holders are required to sign off their budgets and these signature sheets are held electronically. Mr Gore added that robust job planning and the FIP2 programme would help with the issues raised. Mr Bond agreed and also stated that cultural issues would need to be addressed around ownership and accountability for signing off expenditure against budget, robust budget management and CRES delivery.

Resolved:
The Committee received the report.

7.2 – Follow up Audit Actions
Mr Baines presented the follow up report and advised that there were 27 outstanding actions with 7 high risk areas. The high risk areas were not jeopardising patient safety. There was a discussion around consultant staffing levels and the procedures for taking annual leave and this would be discussed in more detail at the October 2017 meeting. Mr Phillips would be invited to the meeting to report on the plans in place. Mr Baines and Ms Ramsay would meet to review all outstanding actions and seek timely updates from management leads to close off follow up to these audits as soon as possible. **KP**

Resolved:
The Committee received the report and agreed to receive an update at the October 2017 meeting. Mr Phillips to be invited to the Committee to discuss medical staffing and management of staffing levels.

8. REVIEW OF REFERENCE COSTS
Mr Bond presented the report which highlighted that the required processes were in place for data collection but that more clinical engagement would always be of benefit when looking at reference costs.

Mr Hall suggested that it would be useful to have data figures from highly pressurised areas such as diagnostic testing and radiotherapy and Mr Bond assured him that data was being collected.

9. IT DISASTER RECOVERY
Mr Bond reported that the Chief Executive and the Chairman had asked, following the recent international cyber-attack, for the internal auditors to check the Trust's perimeter security and ensure that as much as possible or practical was being done to avoid a major incident. Mr Bond advised that this had been done and the Trust's IT security was robust and restoration time was good and in line with national standards. Password control was good and there had been no major failures in the Trust relating to this.

One of the key areas of concern was staff opening infected , but this risk was communicated regularly and any emails not thought to be safe reported to the IT department. Mr Bond noted that further communications are always of benefit and more will be done. Mr Bond also reassured the Committee that contingency plans were in place should the systems go down. Ms Ramsay added that the IG Toolkit would be reviewing the robustness of the Trust's business continuity plans and risk assessment on key IT systems. **RT**

There was a discussion around systems that did not belong to the Trust (such as the ones that run with the linear accelerators) and security of the patient Wifi once in place and any risk to Trust Wifi. It was requested that Mr Smith attend the October 2017 meeting to discuss these issues.

Resolved:
The Committee received the update and agreed that Mr Smith attend the October 2017 Committee to discuss third party systems and patient Wifi security.

10. PAYMENTS MADE TO NEUROSURGICAL REGISTRARS

Mr Bond presented the report which gave details regarding a decision to settle a dispute between Speciality Trainees, a Trust Research Fellow in Neurosurgery and the Trust regarding a non-compliant rota. The decision has significant financial implications on the Trust.

The Committee discussed the issue and agreed that the learning taken from the investigation was key. Mr Bond has asked Mr Nearney for assurance that any other similar issues are being sought out and addressed.

Resolved:
The Committee received the report.

11. DIRECTOR'S EXPENSES Q1 2017/18

The Director's expenses Q1 2017/18 was received by the Committee. No issues were raised.

Resolved:
The Committee received the report.

12. CREDIT CARD EXPENDITURE Q1 2017/18

The credit card expenditure Q1 2017/18 was received by the Committee. No issues were raised.

Resolved:
The Committee received the report.

13. REVIEW OF DEBTS>£50K AND OVER 3 MONTHS OLD

The report was received by the Committee. No issues were raised.

Resolved:
The Committee received the report.

14. LEGAL FEES – Q1 2017/18

The report was received by the Committee. No issues were raised.

Resolved:
The Committee received the report.

At 11.25am Mrs Vicki Shaw – Clinical Audit Manager and Mrs Alyson Newlove – Claims Manager joined the meeting.

15. CLINICAL AUDIT ANNUAL REPORT 2016/17 / PLAN 2017/18

Mrs Shaw presented the paper and reported that the number of outstanding clinical audit actions had reduced and their processes had been given

significant assurance by the internal auditors.

Mr Bond asked how many PAs were given to doctors to complete clinical audits and Mrs Shaw advised him that time was included in their non-patient contact PAs and review of their clinical audit work was built into their revalidation assessment. **RT**

There was a discussion around 7 day working and the Trust's compliance rate and this would be monitored through the Clinical Audit team, which provides robust assessment of the Trust's compliance with these growing requirements.

Mr Gore congratulated Mrs Shaw on a comprehensive and informative report and agreed to visit the team to understand further their roles and responsibilities.

Resolved:
The Committee received the report and it was agreed that Mr Gore would meet with the Clinical Audit team.

The agenda was taken out of order at this point.

16. CLINICAL NEGLIGENCE CLAIMS – ANNUAL REPORT

Mrs Newlove presented the report and advised that there had been a downturn in the number of clinical negligence claims.

She reported that the team were working closely with NHS Resolution (the new name for the NHS Litigation Authority) to minimise the impact on premiums. Where claims were confirmed, reserves were forecasted and the claims were processed in a timely manner as possible to avoid further legal costs. Mrs Newlove advised that a lot of the preparation of the claims was carried out in-house to avoid extra costs.

Mrs Newlove advised that there had been no Regulation 28 notices against the Trust by the Coroner in the last year and fraudulent claim cases were highlighted to staff to make them aware of the consequences. Mr Gore asked which committee reviewed claims and Mrs Newlove advised that it was the Operational Quality Committee.

There was a discussion around the learning from claims and how this was communicated to the members of staff involved and how others were informed of the outcomes. Mr Bond suggested that any avoidable claims could be raised at the Health Group performance meetings. This was agreed.

Resolved:
The Committee received the report.

Mrs Shaw and Mrs Newlove left the meeting at 11.45pm

17. REVIEW OF GIFTS AND HOPSITALITY REGISTER

Ms Ramsay presented the report which showed 15 months of gifts and hospitality received. She advised that the new national policy had now been applied to ensure staff were more open and accountable.

Ms Ramsay also advised that a Freedom of Information request had been

received by the Trust asking for the last five years of the register, which the Corporate Affairs Team had complied with.

Resolved:
The Committee received the report.

18. WHISTLEBLOWING/FREEDOM TO SPEAK UP REPORT

Ms Ramsay presented the report which set out the process and gave assurance that all staff where able to and do blow the whistle with appropriate support from the Trust. She provided assurance that she was not aware of any case where a member of staff had reported a detriment in their employment as a result of blowing the whistle.

Ms Ramsay had also included her role as 'Freedom to Speak Up Guardian' and the work that she had undertaken so far.

Resolved:
The Committee received the report.

19. FINANCIAL GOVERNANCE

Mrs Roberts presented the report which showed the updated position of the finance governance arrangements. Mr Gore thanked Mrs Roberts and the finance team for auditing the processes and stated that the Committee were now assured that the Trust could now close this item.

Resolved:
The Committee received the report and agreed to close the item.

20. BOARD ASSURANCE FRAMEWORK

The Committee reviewed the Board Assurance Framework. Mr Hall stated that following the earlier conversations he wanted to see further assurance relating to CRES ownership.

There was a discussion around how the CQC ratings could be improved and what would be required for the Trust to be 'outstanding'. Ms Ramsay advised that the CQC would review how the Trust was learning from errors, which related to today's discussion on claims and clinical negligence.

Mr Bond suggested that the BAF risk around critical infrastructure failure should include the IT infrastructure risk and this should be rated with a high impact but low likelihood.

Mr Hall noted the issue captured in the BAF regarding the STP partnership concerns, which should be considered by the Board further as there were few tangible outcomes at present from NED engagement in the STP.

Resolved:
The Committee received the report and Ms Ramsay agreed to add in the comments made regarding the BAF.

21. DATE AND TIME OF THE NEXT MEETING:

Thursday 26 October 2017,
9am – 12pm
The Committee Room
Hull Royal Infirmary