HULL AND EAST YORKSHIRE HOSPITALS TRUST

Meeting of the Trust Board

To be held in Public

Thursday 26 January 2017, The Boardroom, Hull Royal Infirmary at 2:00pm

AGENDA: Part 1

Opening Matters

1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 22 December 2016	attached	Chair
4. Action Tracker	attached	Director of Governance
5. Matters Arising	verbal	Chair
6. Chair Opening Remarks	verbal	Chair
7. Chief Executive Briefing	attached	Chief Executive Officer

Quality

8. Patient Story	verbal	Chief Nurse
9. Quality Report	attached	Chief Nurse/Chief Medical Officer
10. Nursing and Midwifery Staffing Report	attached	Chief Nurse
11. Fundamental Standards Report	attached	Chief Nurse

Performance

12. Performance Report	attached	Executive Team

Strategy & Development

13. Hospital Pharmacy Transformation Plan – Lord Carter	attached	Chief Financial Officer
14. Procurement Plan – Lord Carter	to follow	Chief Financial Officer
15. Organ Donation Report	attached	Chief Medical Officer

Assurance & Governance

16. Board Assurance Framework – Q3 2016/17	attached	Director of Corporate Affairs

17. Standing Orders	attached	Director of Corporate Affairs
18. Guardian of Safe Working – Quarterly Update	attached	Chief Medical Officer
19. Unadopted Minutes from Board Standing Committees	attached	Chair of Committee
19.1 – Performance & Finance 19.12.16	attached	
19.2 – Charitable Funds 17.11.16	attached	
19.3 – Quality 15.12.16	attached	
19.4 – Audit 15.12.16		

20. Any Other Business

21. Questions from members of the public

22. Date & Time of the next meeting:
Tuesday 7th March 2017, 2:00pm, The Boardroom, Hull Royal Infirmary

Attendance 2016/17

	28/1	25/2	31/3	28/4	26/5	28/7	29/9	27/10	24/11	22/12	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	9/10
L Bond	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Gore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Wright	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
T Sheldon	✓	x	✓	✓	✓	✓	x	✓	✓	✓	8/10
V Walker	✓	✓	✓	x	✓	✓	✓	✓	✓	x	8/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
E Ryabov	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Attendance											
J Myers	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	9/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Nearney	✓	✓	x	✓	✓	x	✓	✓	✓	✓	8/10
C Ramsay	-	-	-	-	-	-	-	-	✓	✓	2/2

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 22 DECEMBER 2016
THE BOARDROOM, HULL ROYAL INFIRMARY

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

1. APOLOGIES

Apologies were received from Mrs V Walker, Non-Executive Director

2. DECLARATION OF INTERESTS

2.1 – Changes to directors' interests since the last meeting

Mr Gore declared that he was a Non-Executive Director for Together Housing.

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

There were no declarations made.

3. MINUTES OF THE MEETING OF THE 24 NOVEMBER 2016

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

4. ACTION TRACKER

The action tracker was reviewed by the Board.

5. MATTERS ARISING

There were no matters arising from the minutes.

6. CHAIR OPENING REMARKS

Mr Ramsden had no opening remarks other than informing the Board that the Operating Plan was on the agenda for Board approval.

7. CHIEF EXECUTIVE BREIFING

Mr Long presented his report to the Board for information.

8. OPERATIONAL PLAN 2017/18, 2018/19

Ms Myers presented the Trust plan, which had a prescribed format and content. It linked with the Sustainability Transformation Plan and included Health Group and divisional plans. A draft of the plan had been submitted on 23 November 2016 and NHS Improvement had fed back their response to enable the Trust to finalise the plan. Ms Myers advised that the Quality section had been enhanced from the version circulated with Trust Board papers by Mr Wright to ensure that the governance structures were

robustly outlined in the plan. Prof. Sheldon added that the Quality Committee was reviewing the governance structure with the idea to bring together approved approaches to improvement models in all areas.

Prof. Sheldon also stated that the Sustainability Transformation Plan was very ambitious and it would take time to impact on activity levels with the actions recommended. Ms Myers agreed with Prof. Sheldon but stated that the plan was in good faith and aimed to reduce admissions to hospitals by providing more care in the primary care and community setting. There was a discussion around risks and Mr Bond advised that the demand risk would be with the Clinical Commissioning Groups and covered by the Payment by Results framework.

There was a discussion around potential changes to referral thresholds by Commissioners. This requires support from smoking cessation and weight management programmes in the community. There is a risk that changes to the eligibility criteria would lead to a spike in activity in the latter part of the year. Mr Long stated that patients would eventually end up on the hospital waiting lists or as acute patients and was concerned that the referral to treatment trajectories would be affected. He reported that close working with the Commissioners regarding demand planning and application of fines was required.

Resolved:
The Board approved the Operational Plan 2017/18-2018/19 with further discussion on the financial plan to follow.

9. FINANCIAL PLAN 2017/18

Mr Ramsden wanted to acknowledge the work that had gone on behind the scenes within the Trust and wanted to reiterate that whatever happened with the financial plan, patient safety was the Trust's priority.

Mr Bond reported that the control totals set by the Department of Health assumed a cost improvement of £25m, which would result a year end surplus of £5.6m. He advised that the financial position of the Trust had deteriorated in year and there were more cost pressures such as the imminent Junior Doctor contract to be taken into account. He reported that the Cash Releasing Efficiency Savings (CRES) required to achieve the £25m would be just over 5% of the Trust's turnover.

Mr Bond expressed his concern that the Trust had not been able to agree the contract income levels with the local Commissioners and the discrepancy in the level of growth activity accepted by them for 2016/17. Mr Bond was reluctant to recommend sign off of the Financial Plan until the income had been agreed with the Commissioners.

Mr Hall referenced the tabled summary from the Performance and Finance Committee held on 19 December 2016, wherein the committee debated the financial plan options and risks in detail and supported the recommended position to not yet sign off the control total and Cres Releasing Efficiency Savings target.

Mr Ramsden asked if the Trust's regulators were aware of the situation and Mr Bond confirmed that they were. Mr Ramsden asked the Board members if they agreed that the Financial Plan should not be approved until an income position was in place to which the Board can agree.

Resolved:
The Board agreed not to sign the financial plan for 2017/18 until a more achievable CRES target and income level could be agreed with local Commissioners. It was agreed

that if necessary an earlier Board meeting from 26 January 2017 could be called to accommodate this.

10. FORMAL RECEIPT OF THE SUSTAINABILITY TRANSFORMATION PLAN (STP)

Ms Myers presented the report to the Board for it to formally acknowledge receipt of the plan. She advised that the plan had been released to the public and was the overall document, with more detailed plans being developed underneath it. The general themes to enhance primary care in the community to ease pressure on secondary care and ensure patients had the best possible care in the most appropriate setting.

Mr Snowden asked what was expected in terms of public consultation and Ms Myers advised that the more detailed emerging plans within the overarching STP would be discussed in public forums.

The Board agreed that the plan was ambitious and aspirational and would take time to implement. Ms Myers stated that there were good plans emerging locally and went some way to meeting demand in a primary care setting. She reported that this was the opportunity to radically improve health systems in the wider health and social care economy.

Resolved:

The Board agreed to support the general direction of the plan and would review more detailed plans when they were presented.

11. ANY OTHER BUSINESS

Mr Phillips thanked Mrs Coggin (Hull Daily Mail) for the work she had carried out in the Emergency Department and her campaign to ensure patients were being cared for in the right setting.

Mr Gore wanted to thank the Executive team and all Trust staff for the work and effort they had put into a difficult year. He reflected that Non Executive Directors were in post to challenge but recognised the difficulties faced by the staff.

Mr Ramsden acknowledged the improvements in performance that were beginning to show and wished everyone a Merry Christmas.

12. QUESTIONS FROM MEMBERS OF THE PUBLIC

Questions were asked around the Board Assurance Framework risk scoring system and who was authorised to sign off the Financial Plan.

13. DATE AND TIME OF THE NEXT MEETING:

Thursday 26 January 2017, 2:00pm, The Boardroom, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (January 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
November 2016						
01.11	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	Mar 2017		
October 2016						
01.10	Action Tracker	Guardian for Safe Working report to be presented	HC	Mar 2017		
Actions Completed and to be removed from the Tracker						
Oct 2016	Fundamental Standards	Quarterly Fundamental Standards report to be received at the Board	MW	Jan 2017		On Agenda
Jul 2016	Workforce race equality standard 2016 return	A 6 monthly progress report to be received	SN	Jan 2017		On Agenda

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

JANUARY 2017

Help Our A&E Campaign

The Hull Daily Mail 'Help our A&E' campaign has been very well received by the public and staff. Attendances to the department have fluctuated but they reduced significantly with the campaign in its second week:

w/c 12th December – average of 363 per day (HRI only)
w/c 19th December – average of 309 per day (HRI only)
w/c 26th December – average of 351 per day (HRI only)
w/c 2nd January – average of 378 per day (HRI only)

The campaign is running until the end of January and there will be a 30-page supplement about alternatives, issued in the paper later this month. Many thanks to Allison Coggan and the Mail for their support. Winter pressures have been headline news nationally for the last month; in terms of the Trust's performance, winter has had a significant impact on patient flow, particularly over the New Year weekend and in January 2017. I would like to echo my recent message to all staff: that they have the Trust Board's heartfelt thanks for working so hard to keep patients safe and maintain standards of care.

Armed Forces Covenant

I am very pleased to report to the Board that the organisation has signed the Armed Forces Covenant. This is a formal pledge to support the Armed Forces community and to recognise the value that serving personnel, both regular and reservist, and their families, contribute to our local community. We commit to fair treatment to those who have served, or are active, in the country's armed forces, and understand that special consideration is appropriate in some cases. We also commit to support employment of veterans and their families, support employees and their families who are members of reserve forces through our employment policies, and support the role of cadets and Armed Forces Day in our community. The Covenant has been supported by a range of organisations: NHS, voluntary sector, local groups and others, to provide a community response to members of the armed forces.

Care Quality Commission and NHS Improvement – consultations

The CQC and NHSI have launched a joint consultation on the Use of Resources and well-led assessments, which are key domains of the regulatory frameworks of both organisations. The CQC has also launched a separate consultation on developing its inspection regime. The results of both proposed consultations will take effect from 1 April 2017 and will see changes to the way in which the CQC inspects the Trust, including an annual well-led assessment. The Use of Resources score and assessment requires a joint approach by the CQC and NHSI – NHSI will take the lead on assessing each Trust and providing a recommendation to the CQC, who retain the statutory responsibility to assess this domain. The Trust is responding to both consultations, as is NHS Providers as the representative body for NHS Trusts, by the deadline of 14 February 2017.

The Care Quality Commission has also published a report on the quality of investigations in the NHS, and common failures across NHS providers to adequately learn lessons from incidents, or to provide outcomes that patients and families are looking for. The Trust is reviewing the key findings and recommendations of this report as part of the review and refresh of the Trust's Quality Strategy, which will be part of the Trust Board's agenda in the coming months.

Remarkable People
The Remarkable People campaign continues to make a significant contribution to nurse recruitment. In 2015 the Trust recruited just 48 nurse graduates from the University of Hull, from a cohort of over 160. Last year, following the launch of the campaign, this number rose to 120 adult branch nurses, which equates to a cost of around £400 per nurse recruited.

Remarkable People has also recruited from other parts of the UK and in addition to adult branch has helped recruit child branch and midwives.

Remarkable People adverts were sent to student nurses before Christmas inviting them to select a preferred specialty and book an interview slot with the Trust. To date over 80 have already done so, two weeks ahead of the University's main recruitment event on 24th January. Chief Nurse, Mike Wright will attend this event where the Trust hopes that the campaign will encourage another 60 students to choose Hull as their destination.

78% of staff take up the flu jab
Our Trust was one of just 29 nationally to have achieved 75% flu vaccination uptake or more, out of a possible 265 Trusts. Reaching this level means we've afforded patients and colleagues a good level of protection against the most common strain of the virus. It also means we have reached our CQUIN target with more than £700,000 released to the Trust.

Approval granted for helipad
Plans have been approved for the construction of a new helipad to the rear of the HRI site. The Simpson Building, Haughton Building and OT Building will be demolished to make way for the new landing pad, which is used by numerous ambulance services and will further improve our offer as a major trauma centre for the region.

The works will also enable additional car parking to be provided for staff on Argyle Street.

Baby steps for year-long City of Culture arts project
A special project designed to celebrate every baby born during Hull's City of Culture year has launched.

'Born into a City of Culture' is a project which involves taking a footprint of every baby born in the city during 2017 and using those prints to make an artwork. The project will last for 12 months, building up pictures of different trees through the seasons, with footprints forming the leaves and local midwives' handprints acting as the supporting tree trunks.

The artwork is the brainchild of Sallie Ward, Community Midwifery Sister for Hull and East Yorkshire Hospitals NHS Trust, and will involve both hospital and community midwives and midwifery assistants for the duration of the year.

Hospitals' history lesson as East Yorkshire's most festive ward 2016 is crowned
The Dr Hermon Cup was originally awarded back in 1938 to the 'Best Decorated Ward' at the old Anlaby Road Hospital. After the 78-year-old silver trophy was recently uncovered in the Trust Archive, a small team of staff decided to stage a new competition to crown the hospitals' most festive ward or patient-facing department of 2016.

Angela Chapman, a Personal Assistant working in the Estates, Facilities and Development Team was intrigued by the spelling of the doctor's surname. After consulting her mum, whose maiden name was Hermon, the origins of the cup were traced to Dr Richard Hermon, an Honorary Radiologist working in the city in the 20s, 30s and 40s, and the cousin of Angela's maternal grandfather.

A judging panel of five chose Ward 11 at Castle Hill Hospital, which provides colorectal care, as their overall winner. Staff on Ward 11 were presented with the Dr Hermon Cup and a luxury hamper to share between staff and patients.

Chris Long
Chief Executive

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY REPORT

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 – 9
Director	Mike Wright - Chief Nurse	**Author**	Mike Wright - Chief Nurse Kevin Phillips - Chief Medical Officer Sarah Bates, Interim Deputy Director Quality, Governance and Assurance
Reason for the report	To purpose of the report is to inform the Trust Board of the current position in relation to patient safety and quality of care within the Trust		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Determine if this report provides sufficient information and assurance • Determine if any further actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): All Safe domains; E1 (evidence-based); E2 (outcomes); E3 (staff skills); E4 (team working); C1 (care, respect and dignity); R4 (concerns and complaints); W2 (governance); W4 (public and patient involvement)					
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** Y	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board receives this monthly report on patient safety and quality. In addition, the Trust Board's Quality Committee is tasked with gaining assurance in respect of quality of care across the organisation					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD REPORT – 2017 –01 - 9	
Meeting date:	Thursday 26th January 2017
Title:	Quality Report
Presented by:	Mike Wright, Executive Chief Nurse
Author:	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Quality, Governance and Assurance
Purpose:	**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 • Patient Experience Matters • Other Quality Updates • The Trust's Response to Patient Safety Alert: NHS/PSA/RE/2016/006 – Nasogastric Tube Misplacement: Continuing Risk Of Death Or Severe Harm
Recommendation(s):	The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT

JANUARY 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
- Patient Experience Matters
- Other Quality Updates
- The Trust's Response to Patient Safety Alert: NHS/PSA/RE/2016/006 – Nasogastric Tube Misplacement: Continuing Risk Of Death Or Severe Harm

The Trust Board is requested to receive this report and:

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT
JANUARY 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
- Patient Experience Matters
- Other Quality Updates
- The Trust's Response to Patient Safety Alert: NHS/PSA/RE/2016/006 – Nasogastric Tube Misplacement: Continuing Risk Of Death Or Severe Harm

The Trust Board is requested to receive this report and:

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

2. PATIENT SAFETY

2.1 Never Events

The investigation into the Never Event declared in September 2016 (misplaced naso-gastric tube) was completed in December 2016.

The panel identified that the following lessons were to be learned from this incident:

- The process for checking x-rays is not straightforward, particularly in patients with complex anatomy/pathology and where X-ray quality may be a possible factor.
- The level of expertise of doctors asking to check X-rays varies and there was not a procedure for all placements of nasogastric tubes for feeding to be confirmed by radiologists.
- The competency-based training packages available in the Trust are not well utilised and need to be reviewed and re-launched.
- A completed copy of the final report will be shared at all speciality governance meetings within the Family and Women's Health Group and all open actions will be monitored via the Family and Women's Health Group Governance meeting. In addition, the panel agreed that the learning from this incident needs to be Trust-wide. Therefore, the report has been shared with all Health Groups and, also, the Trust's Nutritional Steering Group.

Recommendations

In concluding of the investigation, the panel made the following recommendations:

- The process for the checking of X-rays needs to be tightened further. If a check Chest X-ray is required to confirm nasogastric tube placement (only after pH testing has been attempted and failed), this should only be confirmed by a competent Radiologist, who should produce a confirmation report of this, prior to feeding of the patient commencing. Measures to address this are underway already.
- The Trust's Policy and care bundle for the siting and checking of nasogastric tubes must be reviewed. This is to include an additional step whereby, when no aspirate is obtained and before feeding is commenced, this triggers a 'stop point' where

everything is checked a further time between the medical and nursing staff. Providing all checks are in place and the position of the tube is confirmed as being in the correct place by a Radiologist, feeding can commence.

- The competency-based training tool for the care and management of patients with nasogastric tubes must be reviewed along with a training needs analysis to determine who needs to undertake such training. Performance trajectories can then be set and compliance with this can be monitored. This can then be reported on regularly through the Performance and Accountability meetings with Health Groups.
- Utilise the findings of this investigation to support the Trust's response to the National Patient Safety Alert NHS/PSA/RE/2016/006 – Nasogastric Tube misplacement: continuing risk of death and severe harm (issued on 22 July 2016; response due by 21st April 2017)**.

**** The Trust's response to this Safety Alert is attached as Appendix 1**

A Quality and Safety Bulletin on the mis-placement of nasogastric tubes was published in December 2016, and was presented by the Chief Nurse (and investigation Panel Chair), at the December 2016 Chief Executive's Team Brief. The January 2017 Lessons Learned Bulletin will share the lessons learned from this investigation, also.

The Trust's Commissioners undertake a Root Cause Analysis review of all SI reports in order to determine if they provide them with sufficient assurance. The report into this Never Event was reviewed by the Commissioners and considered to be *''a well written and structured report which should be shared with all staff who have the responsibility of undertaking investigations. Extremely robust and honest''*.

No other Never Events have been reported since September 2016.

2.2 Serious Incidents

The rate of reporting of Serious Incidents in 2016/17 continues to be below the level reported in the same period last year. 57 Serious Incidents have been declared since the start of this financial year compared with 120 for the whole of 2015/16 year.

There were six serious incidents declared in November 2016, and four declared in December. The categories of these are set out in the tables below.

2.2.1 Serious Incidents declared in November

Type of SI	Health Group
Un-expected death. This relates to a patient who was being cared for within the Elderly Medicine speciality, and deteriorated while within our care	Medicine
Surgical Incident. This relates to a patient who underwent an unnecessary laparoscopic procedure	Clinical Support
MRSA outbreak in NICU (discussed in Section 4 of this report.	FWH
Treatment delay (patient did not receive timely plastic surgery follow up for melanomas)	FWH
Hospital Acquired Pressure Ulcer (Ward 70)	Medicine
Unexpected death (VTE incident) . This relates to a possible missed diagnosis and missed medications	Medicine

2.2.2. Serious Incidents declared in December

Type of SI	Health Group
Unexpected admission to NICU relating to issues with the management of the baby's birth	FWH
Treatment delay (outpatients) – failure to follow up a patient with sarcoma in a timely manner	Surgery
Pressure Ulcer Ward 70	Medicine
Treatment delay (cardiology/renal) – delays in following up a patient with a kidney lesion	Medicine

All of the SI's declared in November and December are still under investigation.

2.3 Serious Incident actions

At each month end the serious incidents are summarised and sent to all Health Groups along with all the full reports for their dissemination. The summary includes the actions to be taken.

Examples of two actions taken following Serious Incidents investigations completed in December 2016 are:

- An investigation was concluded into an SI when a patient was not provided with compression stockings during surgery despite close family history of deep vein thrombosis (DVT) and additional risk factors. A number of actions were identified for the Thrombosis Committee, including amending the pre-assessment form to include specific questions on Venous Thrombo-embolism (VTE), a review of practice on VTE Root Cause Analyses, and a review of policies in relation to VTE.
- An investigation into a severe extravasation injury caused to a baby (where a cannula ruptured through a blood vessel wall) highlighted the requirement for a Trust-wide review of the facilitation of nursing and medical staff training requirements on Cannulation, Venepuncture and the administration of Intravenous fluids and medication. The Trust's Policy for this is to be reviewed and updated. Also, a guide to the Administration of Intravenous Clarithromycin is to be developed by Pharmacy to include administration advice and nursing notes as well as interactions with other drugs.

3. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer (ST) is a series of point prevalence audits that were established to measure the four most commonly reported harms to patients in hospital. Each month, all inpatients are assessed for the existence of any of the four harms that have occurred either before they came into hospital or whilst in hospital. Each month, all inpatients on that day are assessed for the existence of any of the four harms.

The original intention behind the ST was for it to be a tool for local improvement. The reporting of ST results is a contractual requirement for the Trust and, also, they are used by the Care Quality Commission and NHS Improvement in their assessments of the Trust's performance. Originally, it was never intended for the ST data to be used as a performance management tool or a benchmarking tool with other trusts. This is because not all trusts collect necessarily the same data, in the same way and to the same scale. Nonetheless, they are used in this way.

As such, it is important to put any comparators into context. Despite this, the benchmarking tables prepared by the Y&H Academic Health Sciences Network Improvement Academy are still useful reference points for comparison against the Yorkshire and Humber and England averages.

The key to these is as follows:

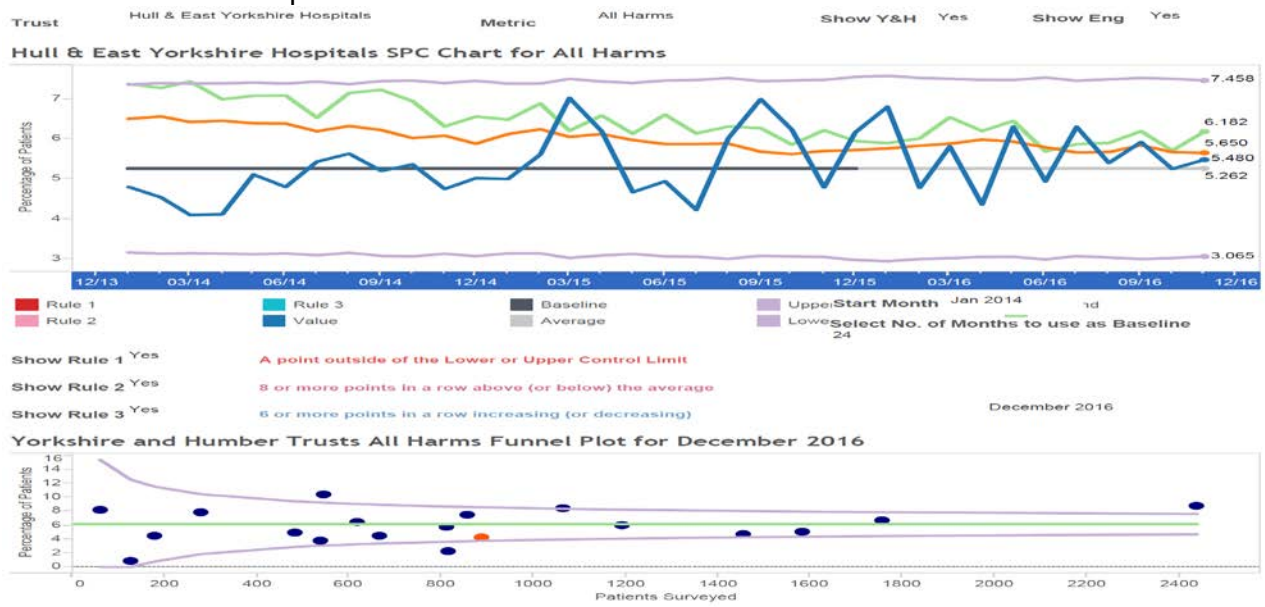
- **Navy Blue line** = Hull and East Yorkshire Hospitals NHs Trust
- **Orange line** = England average
- **Green line** = Yorkshire and the Humber Average

In terms of assuring the Trust Board, all appropriate inpatients at HEY are surveyed on Safety Thermometer day and this ranges between 800-900 patients on average. Only those patients that are in places such as operating theatres or radiology are not counted on the day. As such, the Trust's results/proportions are significant in this respect.

The data up to December 2016 are now presented on the following pages.

3.1 All Harms

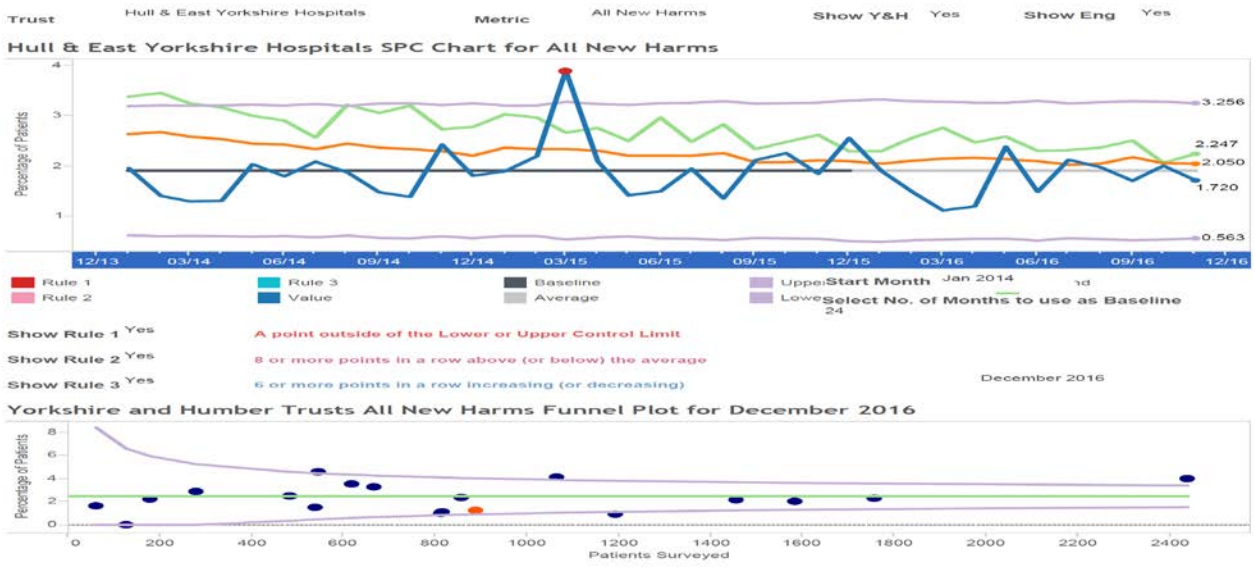
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



As can be seen, this performance sits within the control limits for this indicator and with a positive position overall when compared to the England and Yorkshire and Humber averages. In terms of the Trust's performance, it is more appropriate to consider the proportion of patients that acquire any of the four harms whilst in hospital. These are termed 'New Harms'.

3.1.1 New Harms

This measure shows the proportion of patients that sustain any of the four ST harms whilst in hospital.

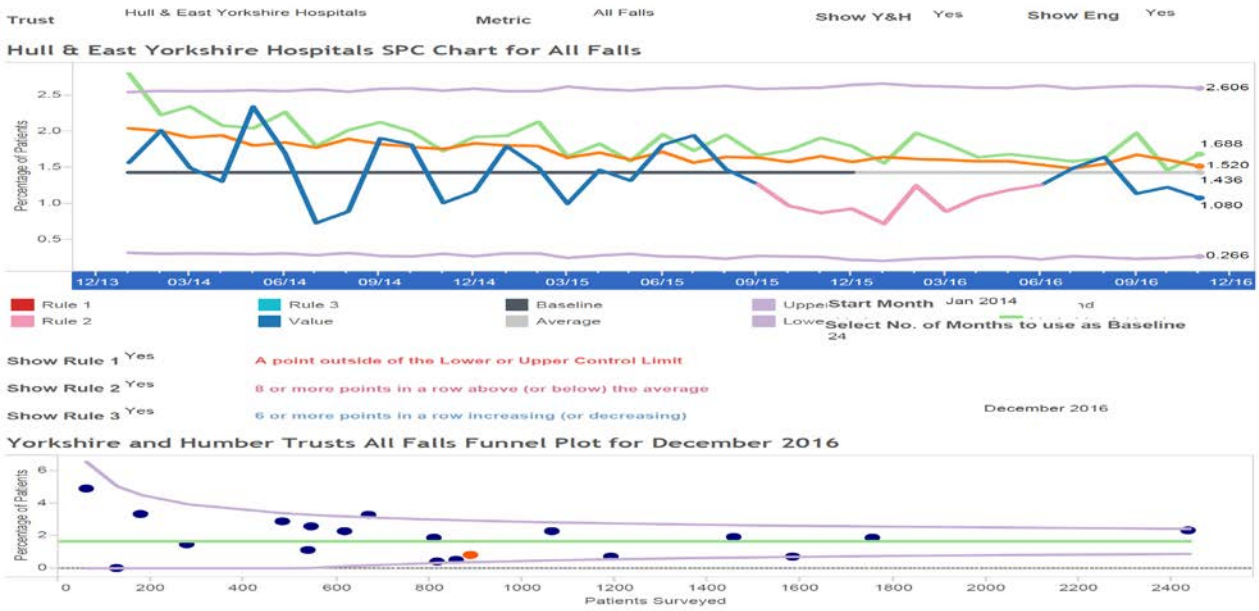


Again, and overall, the Trust performs realtively well against this indicator but there is always room for improvement, psrticularly where any harm is deemed avoidable. These data continues to be reviewed monthly. Each ward received its individual feedback and results and is required to take action accordingly. To take each of the four harms in turn:

3.2 FALLS

3.2.1 Falls (all)

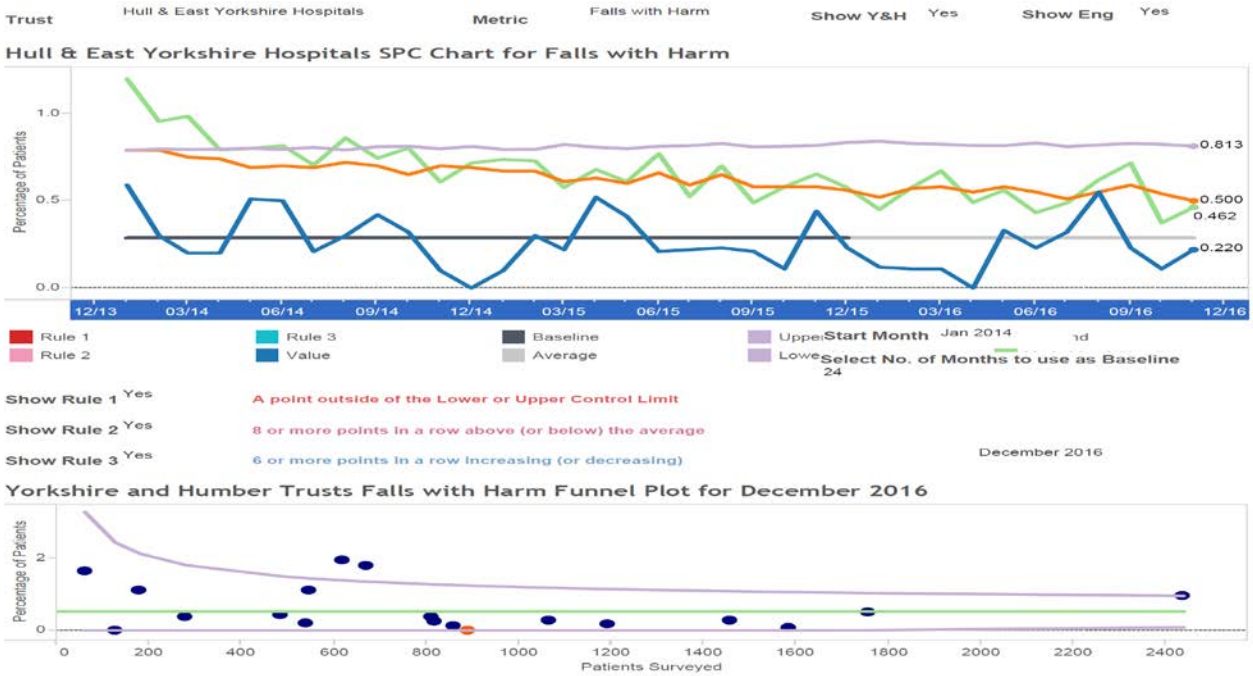
The following tables shows the percentages of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



Improvement work to help reduce patient falls continues to be rolled-out across wards as part of the Trust's transformation work to help to try and address this.

3.2.2 Falls with harm

This chart differentiates those patients that fell and sustained harm from those that fell and where there was no harm.

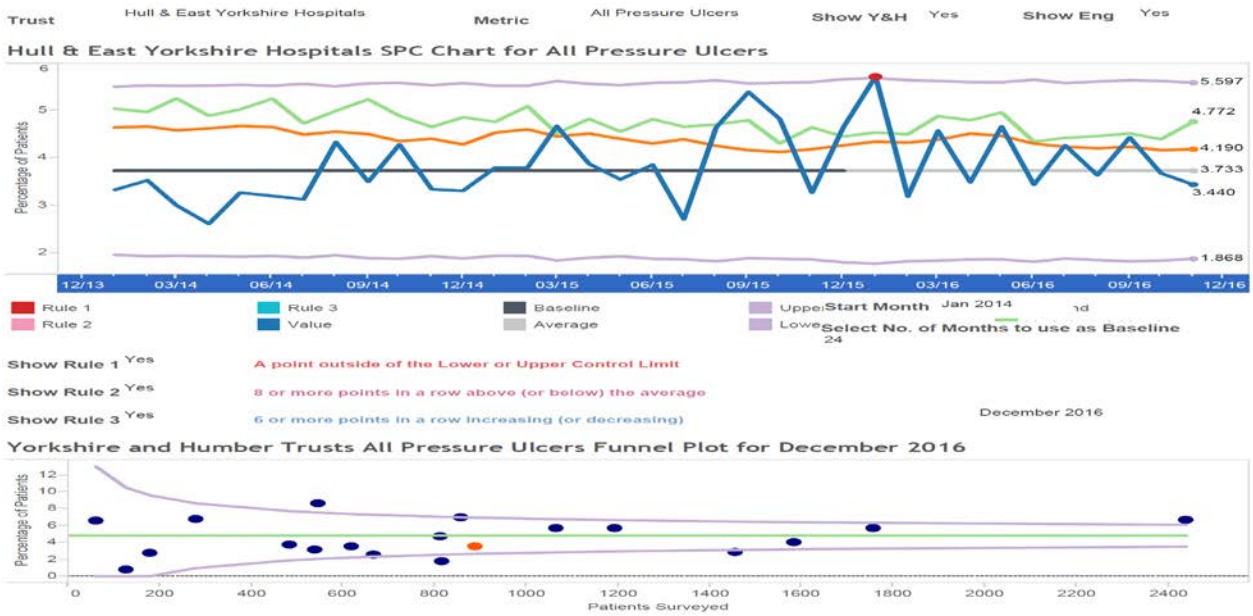


Following a recent increase in the number of patients falling resulting in harm in August 2016, this has reduced again in September 2016. Overall though, this remains very positivie performance when compared to peers.

3.3 PRESSURE ULCERS

3.3.1 Pressure Ulcers (All)

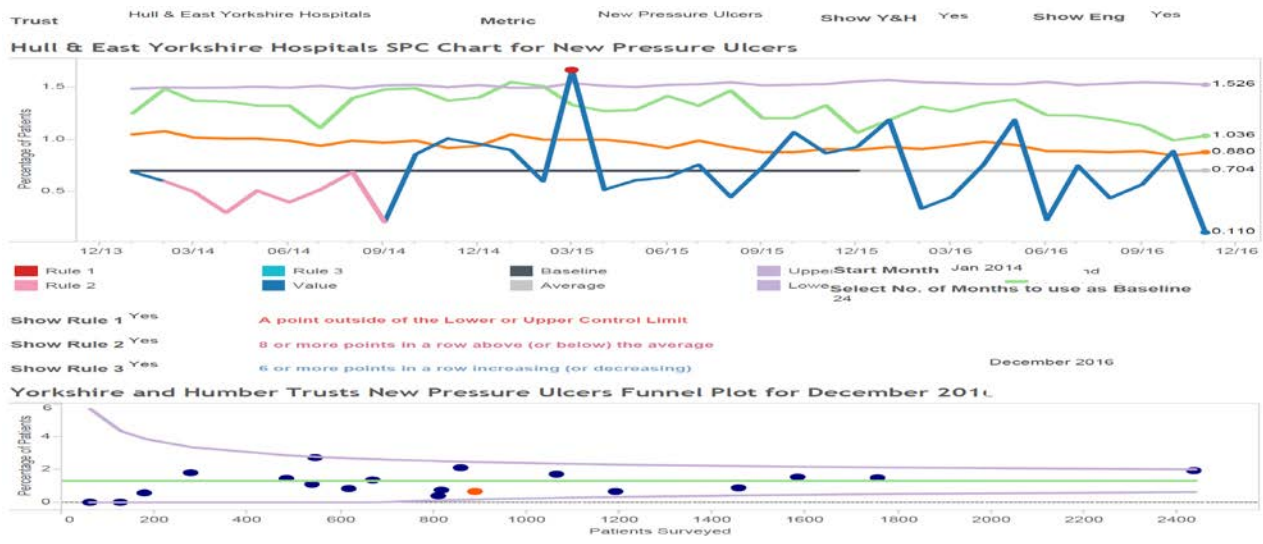
The following graph and funnel plot show variable statistics on this measure. An important factor is the proportion of patients that come into the Trust with exisiting pressure ulcer damage, which is significant, particularly in patients that are admitted via the emergency department and admissions areas (AAU and EAU).



Those patients that suffer pressure damage whilst in hospital (all grades) are now described:

3.3.1 Pressure Ulcers (new)

When the data for pressure ulcer harm that is acquired whilst in hospital is considered, this is a very different picture.



The performance for this indicator is positive overall, although the Trust is not complacent and futher work is underway to ensure further improvements in this area. Improvements in practice and care are being witnessed but the education and training programmes continue in earnest.

3.4 CATHETERS AND URINARY TRACT INFECTIONS (CAUTI)

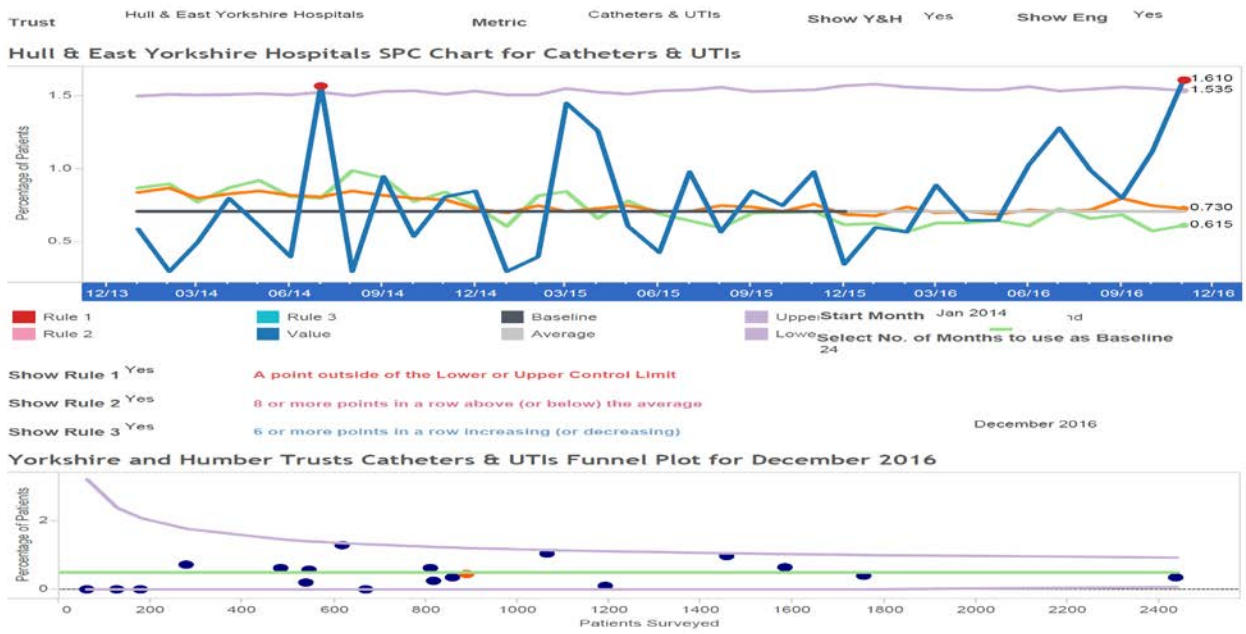
3.4.1 Catheters and UTI (All)

It is important to set some further context around this particular measure. Often, a patient can be admitted to hospital with signs and symptoms that may then manifest to be a CAUTI. However, if this is then diagnosed in the Trust and if treatment starts in the Trust, it is deemed to be hospital attributable; such are the limitations of this measure.

Another important distinction is the actual number of infections to which these charts and percentages refer. The following chart shows the actual number of patients from the ST audits that have catheters and 'New' Urinary Tract Infections over the last three months. As can be seen, the actual numbers are small. There is further work to do around the care of patients with urnary catheters and, also skills in cathertising people. However, the senior matrons and infection prevention and control nurses are working on this.

	October 2016	November 2016	December 2016
Number of patients surveyed	896	930	890
Number of patients with a catheter	199	191	180
Number of patient with a New UTI & Catheter	4	7	3
% of patients with a New UTI & catheter	2%	3.6%	1.6%

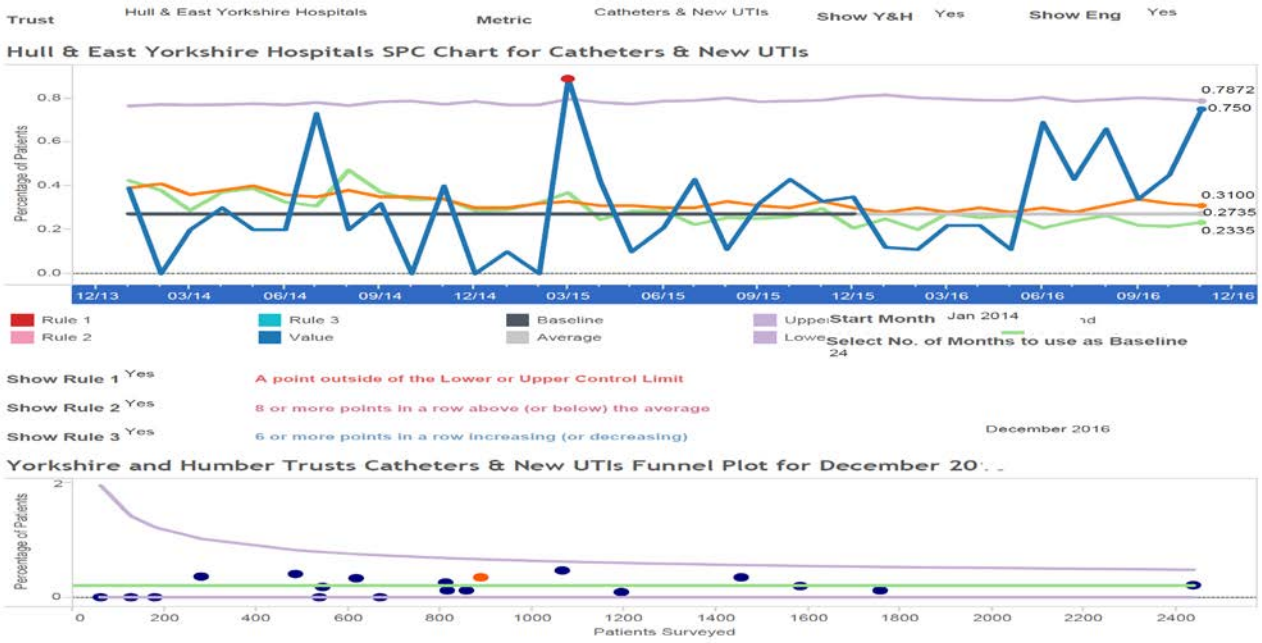
The following chart shows the percentages of patients that have a urinary catheter in place with an associated urinary tract infection from the ST prevalence audits. These charts include those patients that were both admitted with these issues and/or have either acquired them whilst in hospital or have started to receive treatment for this infection whilst in hospital.



Those patients that are deemed to have acquired this harm whilst in hospital are now described.

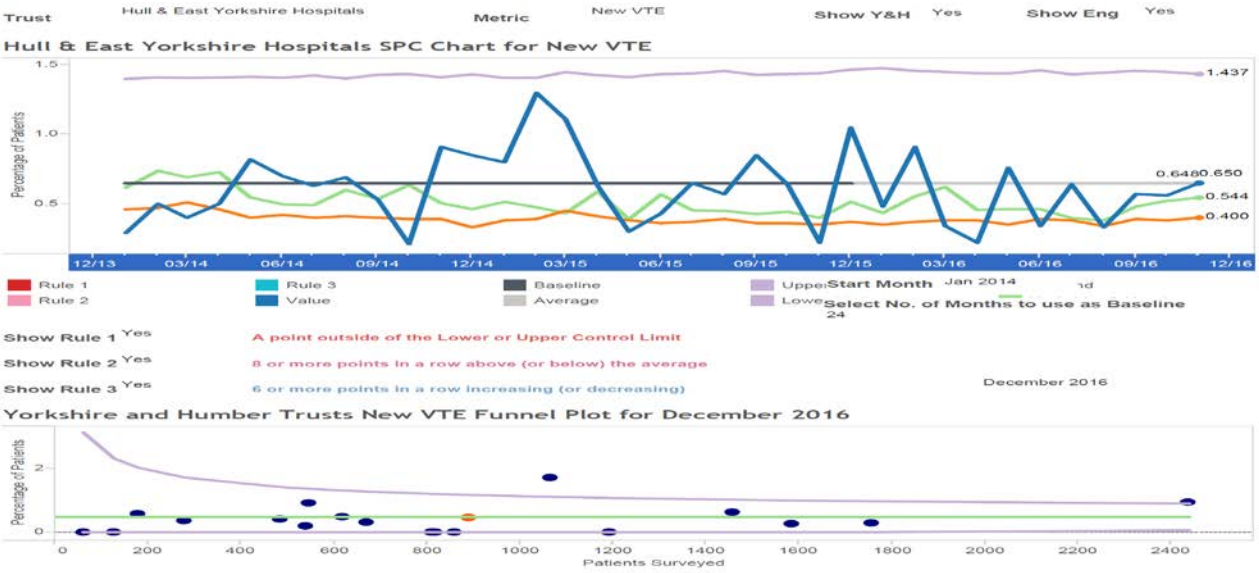
3.4.2 Catheters and UTI (new)

The following chart shows a more variable picture over time, with a spike in catheter-associated urinary tract infections infections in recent months. As has bene mentioned already, concentrated focus is being given to urinary catheter care in an effort to reduce these infections further, where possible.



3.5 NEW VENOUS THROMBO-EMBOLISM (VTE)

The following charts show those patients that acquired a venous thrombo-embolic episode whilst in hospital. Performance with this is the most erratic of the four harms, with fluctuating performance overall.



Although performance against this indicator is relatively positive overall, the Thrombosis Committee reviews all cases of perceived hospital acquired VTE episodes and provides feedback to each of the areas and team concerned. This continues to be a focused area for the Trust.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 31st December 2016

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

Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**33 (62% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1 + (1 x pending PIR) (200% of threshold)**
MSSA bacteraemia	**46**	**35 (76% of threshold)**
E.coli bacteraemia	**95**	**63 (66% of threshold)**

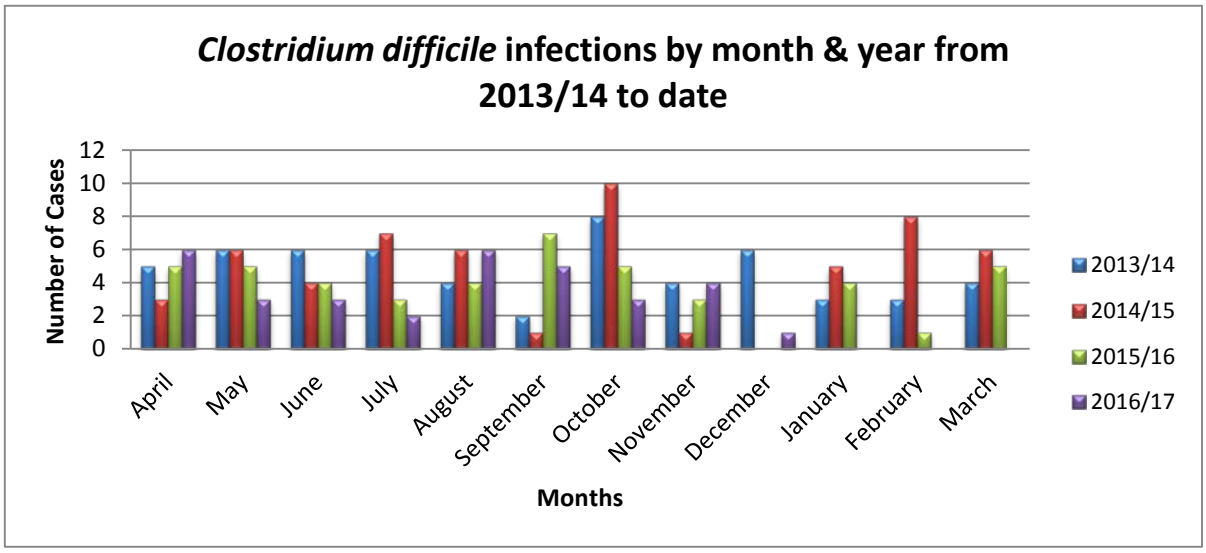
Performance against these upper thresholds is now reported in more detail, by organism.

4.1.1. Clostridium *difficile*

For rates attributable to the Trust, 4 cases were reported in November 2016 and a further case reported during December 2016. This brings the total cases reported so far this year, at month 9, to 33 against an upper threshold of 53 for the year (63%), which is positive performance so far. The Trust continues to try and reduce these cases further. Root cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

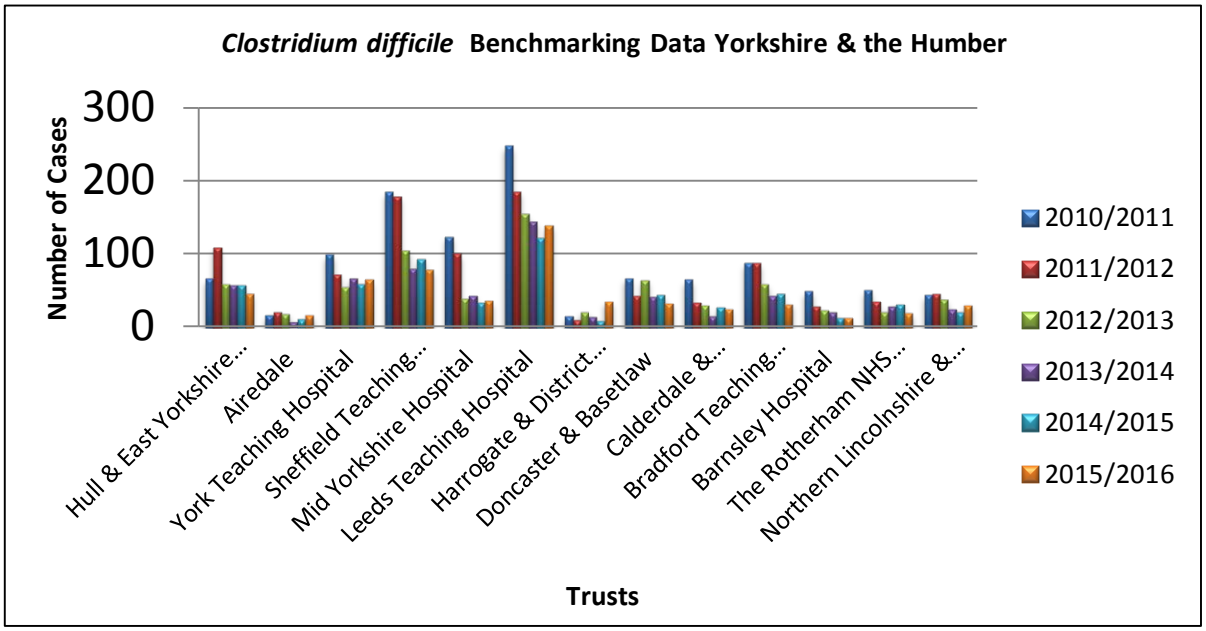
The 4 cases reported during November 2016 were identified across a number of health groups; 2 in Surgery, 1 in Medicine and the fourth in Family and Women's Health Group. The one case reported during December 2016 was identified in Medicine. In spite of an increase in diarrhoea and vomiting outbreaks during November and December 2016 and associated faecal sampling, no additional increases in Clostridium *difficile* cases have been detected.

Trends following root cause analysis investigation identify the need for continued and sustained improvements on appropriate sampling and antimicrobial stewardship.
The following graph highlights the Trust's performance from 2013/14 to date with this infection:



The following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:

Trust apportioned *Clostridium difficile* cases for Yorkshire & the Humber from 2010 onwards



As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers.

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

There have been a total of two reported MRSA Bacteraemia cases since 1st April 2016 with a case identified in Family and Women's Health Group during November 2016 and a further case reported in December 2016 in Medicine. This is against a Zero Tolerance objective for 2016/17.

- **Case One**

An MRSA bacteraemia case was detected in a neonate during November 2016 nursed on the Neonatal Intensive Care Unit (NICU) and consequently represented a NICU apportioned case. This case was detected following an increase of MRSA colonised neonates on the unit. The case was investigated utilising a Post Infection Review process and incident control meetings were held during November and December 2016. The case was identified subsequent to an increase of MRSA colonised neonates notified since the 13th September 2016, with four cases apportioned to NICU. Five MRSA positive isolates from neonates were submitted to Public Health England, Colindale which confirmed that 3 cases were linked. All three were nursed on the unit at the same time, shared the same antibiogram and phage typing identified indistinguishable strains. Two of the three cases represented twins nursed together on the unit, with the third being the MRSA bacteraemia case.

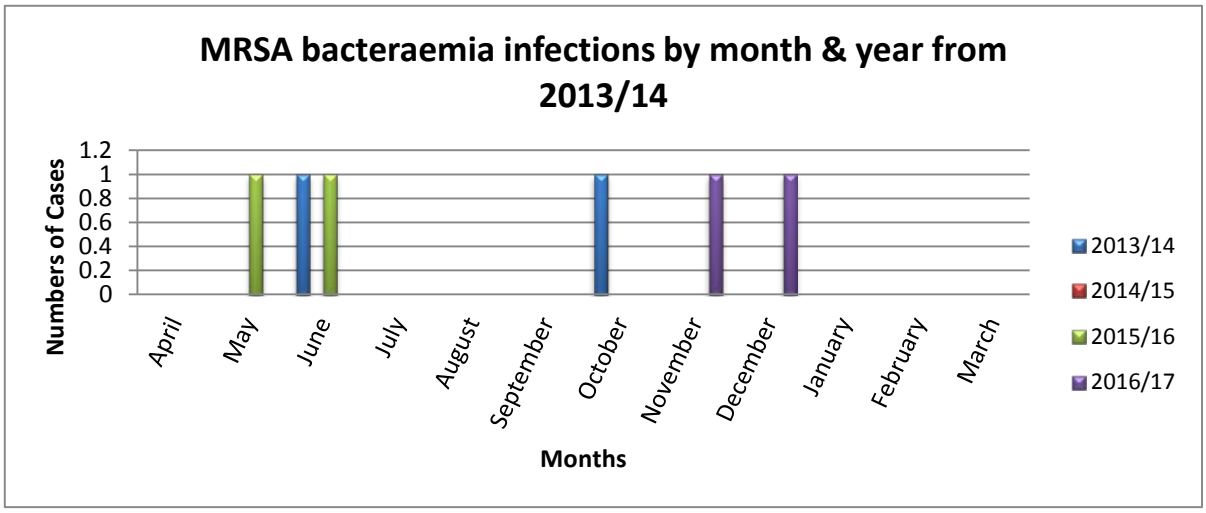
The neonate detected with an MRSA bacteraemia was treated effectively with decolonisation treatment and antibiotics and has had subsequent multiple screens/ samples which have shown clearance of MRSA. Since the detection of the bacteraemia on the unit, ongoing weekly screening has not identified further cases of MRSA colonisation and/or infection. Findings from the Post Infection Review identified transmission of infection on the unit through sub-optimal infection prevention & control practice. Actions have been put in place to address this. This was in the context of an increase in neonates admitted to the unit, with many transferred from other neonatal units coupled with an ongoing issue related to nursing staffing levels on the unit; an issue identified in many other neonatal units across the United Kingdom.

The burden of MRSA colonisation/ infection apportioned to NICU's in the Yorkshire and Humber area have increased over the last 6- 12 months with at least two neighbouring acute Trust Providers reporting outbreaks of MRSA colonisation.

- **Case Two**

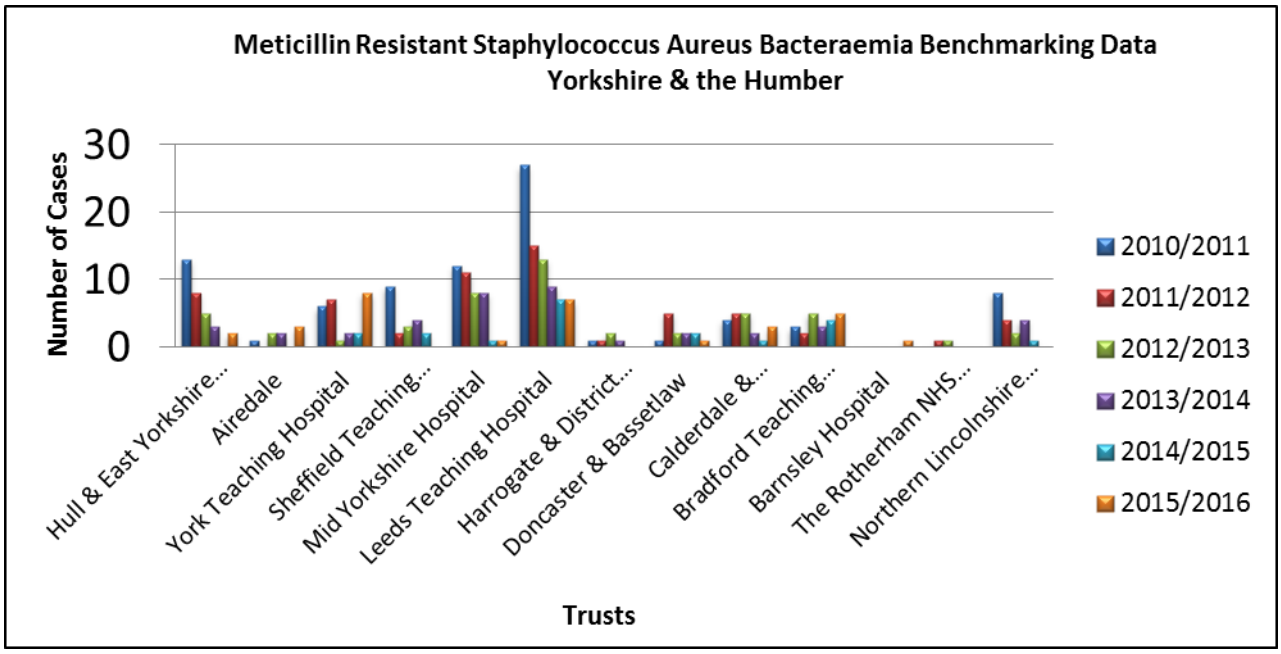
A second MRSA bacteraemia case was detected on the 6th December 2016 in a patient admitted to Hull & East Yorkshire Hospitals NHS Trust via Harrogate and District NHS Foundation Trust. The patient was transferred to the Trust on the 30th November 2016 as an emergency requiring level 3 care and was nursed on HICU2 until 2nd December 2016 whereupon the patient was transferred to CMU, CHH for ongoing cardiac management. The MRSA bacteraemia was detected on the 6th December 2016 and is initially assigned as a Hull & East Yorkshire Hospitals NHS Trust apportioned case pending Post Infection Review investigation.

This patient received treatment at Harrogate and District NHS Foundation Trust and The James Cook University Hospital (South Tees Hospitals NHS Foundation Trust) prior to admission to the Trust. The post-infection review report is being finalised. The following graph highlights that cases of this infection are now extremely rare. The performance from 2013/14 to date and demonstrates the variability in numbers year on year.



The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:

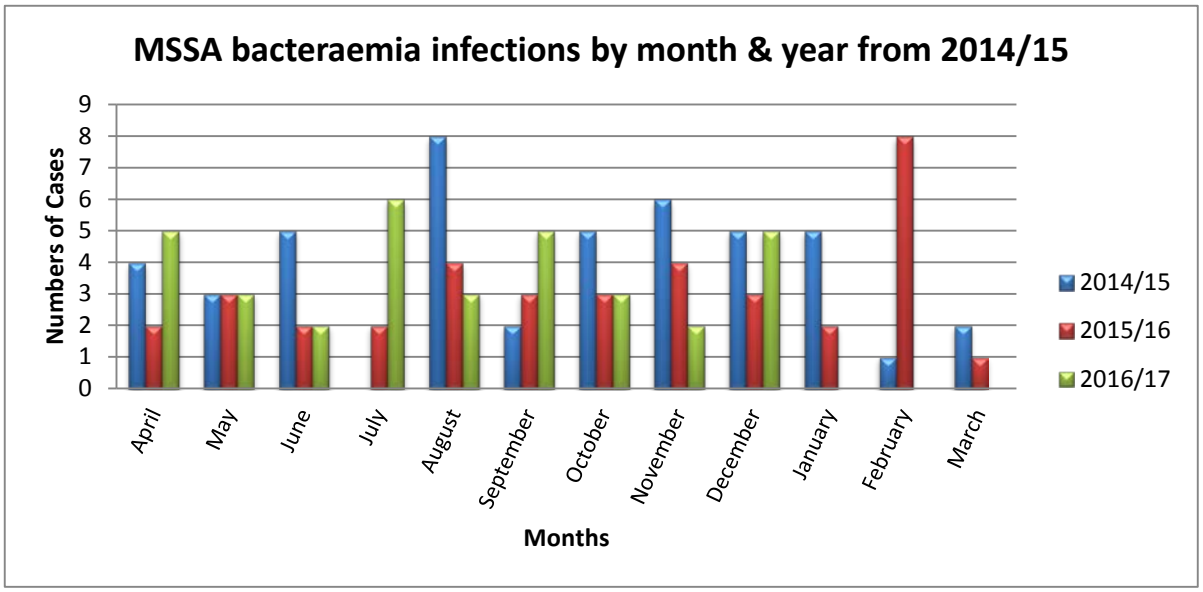
Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases for Yorkshire & the Humber from 2010 onwards



As can be seen from this, the relative improvements of this Trust over recent years are impressive when compared peers in the region.

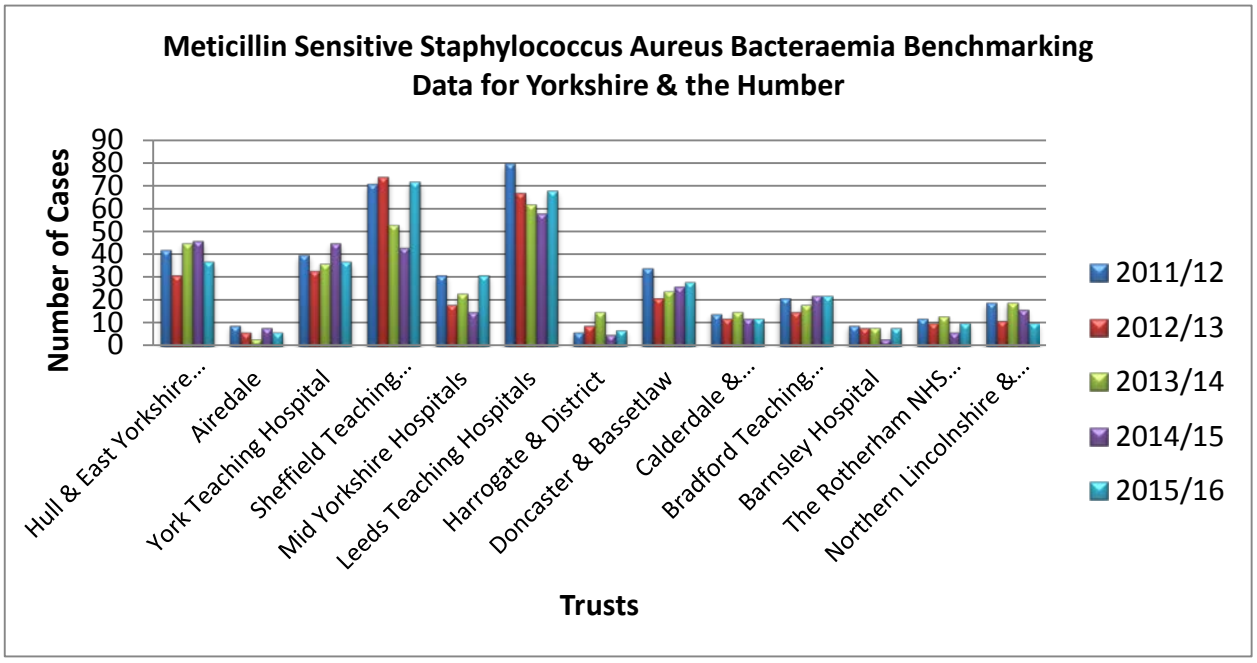
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

MSSA bacteraemia performance is provided in the following table. Cases of patients with this infection are represented across Health Groups and provide an opportunity to investigate and further analyse any trends to improve practice. The Trust continues to see improvements overall in the management and prevention of this infection but fluctuations in the number of cases reported have occurred throughout the year.



The following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:

Trust apportioned Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases for Yorkshire & the Humber from onset of surveillance 2011 onwards



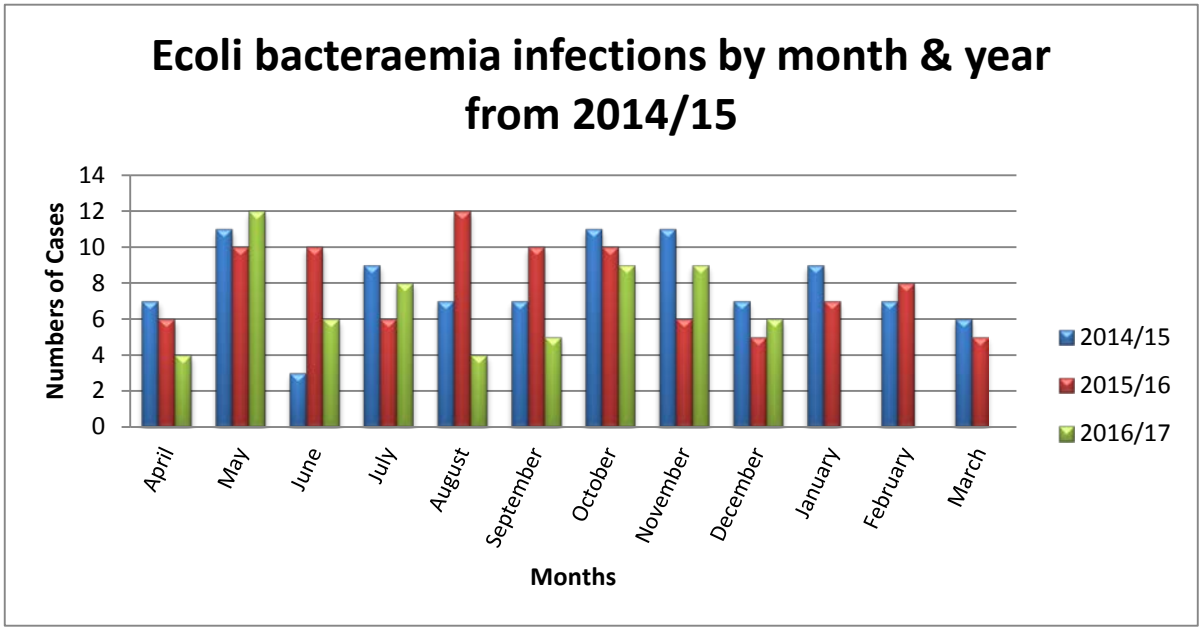
As can be seen, this is more evenly spread both across organisations and, also, recent years. The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken in the Trust.
Trends following root cause analysis investigation identify an even distribution of cases across medicine and surgery with the need for continued and sustained improvements on device/ line management.

4.1.4 Escherichia-*coli* Bacteraemia

E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Numbers are total numbers reported by the Trust onto the national Public Health England 'MESS' database. Most patients are admitted to hospital for treatment of this infection.

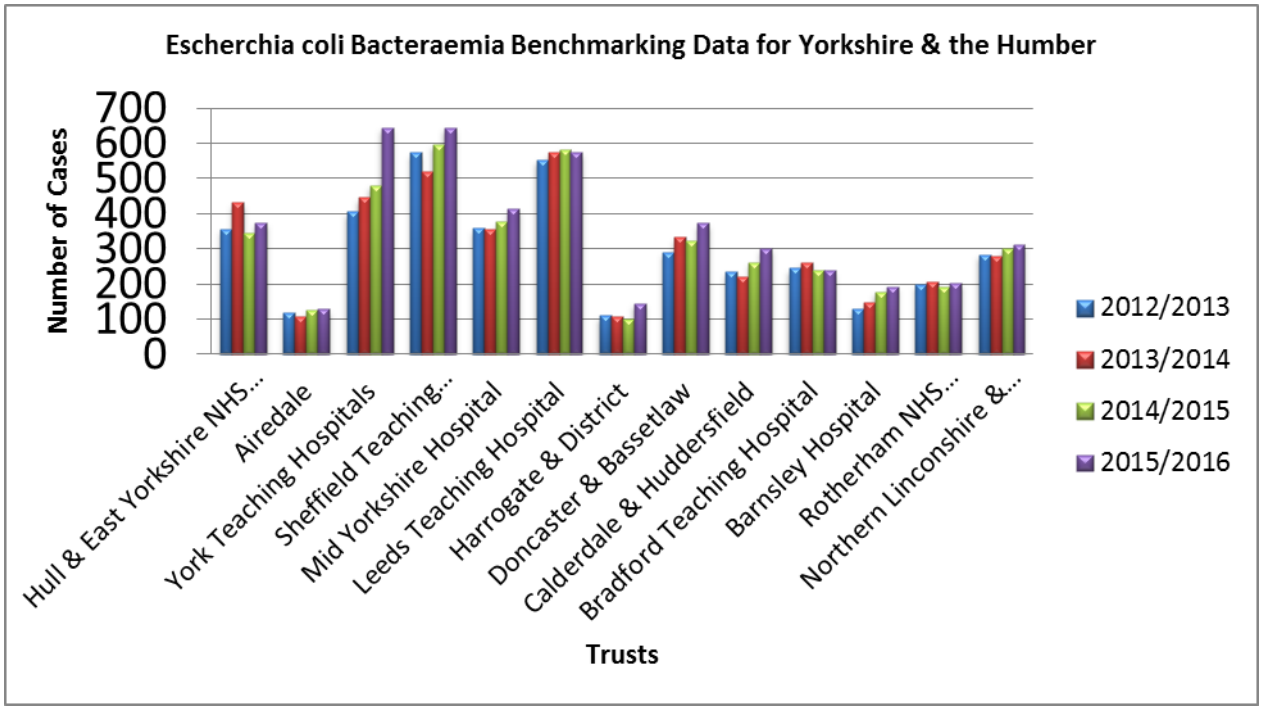
For 3 months from July – September 2016, the Trust, in collaboration with City HealthCare Partnership's Infection Prevention & Control Team collected data on E.*coli* bacteraemia cases. The purpose was to understand trends for both Trust and Community apportioned cases and develop robust systems and processes for the prevention of these infections, where possible. Cases identified during July to September 2016 for both Trust and Community apportioned infections confirmed a trend associated with urinary tract infections (UTI's), with a greater burden of infection in the community. A collaborative approach to understanding these infections will inform future improvements in the management of patients. A presentation of the findings will be provided to the Commissioners during January 2017.

In preparation for measures being introduced by NHS England/Public Health England from April 2017 to reduce the burden of gram negative bacteraemia, further surveillance of *E. coli,* Klebsiella and Proteus bacteraemia cases will commence from January 2017 until March 2017. Again, this is to understand the burden of infection and trends for both Trust and Community apportioned cases.



The following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:

Trust apportioned Escherichia-coli bacteraemia cases for Yorkshire & the Humber from 2012 onwards



Again, the patterns across all trusts are pretty consistent, which demonstrates the overall challenges with this infection.

4.2 Infection Outbreaks

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

4.2.1 Diarrhoea and vomiting episodes

During November and December 2016, the Trust had a significant number of wards affected with diarrhoea/ vomiting outbreaks some of which were confirmed as Norovirus. Public Health England noted the early increase in outbreaks across the Yorkshire & Humber region affecting both health and social care.

Wards at Hull Royal Infirmary and Castle Hill Hospital were affected, with the main burden of infection noted in the Medical Health Group, especially medical elderly wards. In the majority of cases the outbreaks were contained within bays and only 4 wards out of 12 affected resulted in the full ward being closed demonstrating robust control measures. All affected bays/wards were deep cleaned prior to reopening. In some cases staff were also affected with Occupational Health informed of incidents and reported cases.

Collaborative working with internal and external partners has provided the opportunity to review possible delays in patient pathways incurred during outbreaks of diarrhoea and vomiting. This has resulted in improved communication especially in relation to discharge planning, providing clarity on Norovirus aetiology (disease profile) and review existing documentation such as posters, leaflets and policies.

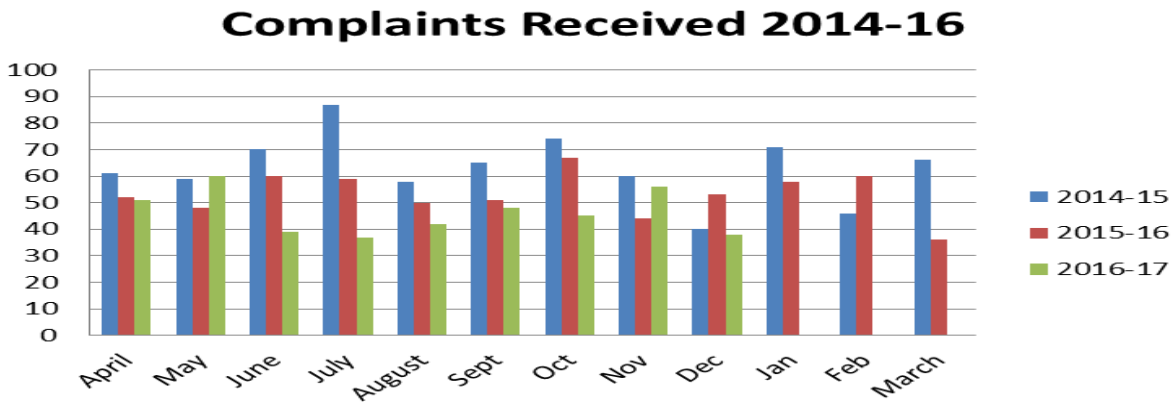
4.2.3 Influenza trends

The Occupational Health Department continues with the 2016 Influenza vaccination campaign with vaccination sessions across both sites being well attended by all groups of staff. Uptake figures continue to show a steady increase in all staff groups accessing influenza vaccination. By the end of December 2016, 78% of Trust staff had been given the influenza vaccination providing a good level of protection for both patients and staff against the most common strain of the virus. By achieving a 78% uptake, the Trust has met the national CQUIN requirement with more than £700,000 released to the organisation. The Trust was one of just 29 nationally to have achieved 75% flu vaccination uptake or more, out of a possible 265 Trusts.

5. PATIENT EXPERIENCE

5.1 Complaints

The table below sets out comparative complaints data between 2014-16.



The table below indicated the number of complaints by subject received for each Health Group during the month of October 2016.

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Comm	Delay Waiting Times and Cancellations	Discharge	Environment	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0	0
Clinical Support	0	0	0	0	0	0	1	1
Family & Women	0	0	2	0	0	0	4	6
Medicine	0	0	2	1	3	1	8	15
Surgery	1	1	0	5	0	0	7	14
Totals:	**1**	**1**	**4**	**6**	**3**	**1**	**20**	**36**

Complaints about 'Treatment' continues to receive the highest number, with Medicine and Surgery Health Groups having had 8 and 7 complaints respectively for this subject during the month of December 2016. The two key themes relate to patients who feel that their diagnoses are incorrect and, also, not being happy with the treatment plan.

5.1.2 Performance against the 40-day complaint response standard

The following table sets out performance against the Trust's standard of closing 90% of complaints within 40 days, which is improving steadily:

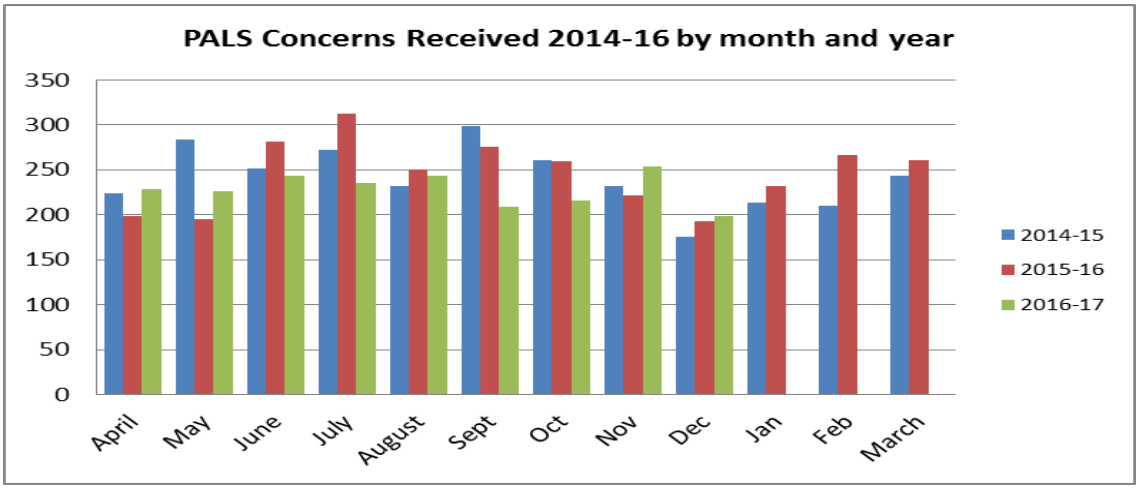
Health Group	Closed	Closed within 40 days
Clinical Support	6	3 (50%)
Family and Women's	17	5 (70%)
Medicine	22	13 (72%)
Surgery	19	10 (53%)
Total	64	38 (64%)

The Patient Experience Team is continuing to work closely with each of the Health Groups to enable timely responses to complaints whilst maintaining quality. Of the closed complaints, 32 were not upheld, 22 were partly upheld and 3 were upheld. 73 cases remained open on the 1 January and 11 complaints had been opened longer than 40 days.

A training day for the handling of complaints was arranged for the 30 November 2016 to support staff investigating and preparing responses to complainants. 12 staff attended the sessions and very positive feedback was received. These sessions have been targeted at staff that will be investigating and responding to complaints in all Health Groups.

5.2 Patient Advice and Liaison Service (PALS)

In the month of December, PALS received 199 concerns as well as 24 compliments, 42 general advice issues and 1 comment/suggestion. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of outpatient and elective treatment lists, and notification of results. As part of the Trust's Intranet upgrade, patients are now able to contact the PALS team with details of compliments, comments, concerns or complaints with one click from the front page. This has been operational since October and has received 46 contacts by this method during the month of December.



The table below indicates the number of PALS received by Health Group and primary subject in December 2016

	ADVICE	ATTITUDE	CARE	COMM	DELAY	DISCH	ENVIRO	HOTEL	SPECIAL NEEDS	TREAT	Total
Corporate Functions	7	1	0	9	2	0	0	2	0	0	21
Clinical Support	0	0	0	4	7	1	0	0	0	2	14
Family & Women's	1	2	1	8	20	0	0	0	1	10	43
Medicine	6	3	0	13	18	9	1	2	1	11	64
Surgery	1	3	1	12	40	2	0	1	0	17	77
Totals:	15	9	2	46	87	12	1	5	2	40	219

5.3 Compliments
A number of compliments have been received by the Trust. The mother of a patient praised the emergency department staff for the excellent and prompt care provided to her daughter after a very distressing accident. Westfield Primary School has sent a handful of letters to compliment and thank the doctors and nurses over the festive period, some of the letters were thanking them for saving lives of their families.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has nine cases under review by the PHSO currently. No new cases have been received during December but two cases were not upheld by the PHSO during this month.

5.5 Lessons Learned From Health Group complaints
The following are examples of action taken following the receipt and investigations of a complaint.

5.5.1 Surgery Health Group
There were a number of complaints where care and comfort was a common theme. Actions are being taken within different specialties within the Surgery Health Group to address them, which include the monitoring of the provision of drinking water, pain relief and urine bottles as well as improved patient communication and accurate information about visiting times. A new process has been introduced for the re-booking of cancelled appointments for neonatal hip screening to ensure all babies are rebooked at the next available slot.

5.5.2 Medicine Health Group
The Falls protocol will be printed and visible on a ward for all staff to be aware and competent in the use of the safer care tool. The Matron is to arrange an infection control update for a specific ward team. A complaint will be discussed at the Elderly Senior Team Meeting to reflect on the Duty of Candour letter process and the effect this had on a particular family; the outcome will be cascaded by the senior team to the ward staff. The Ward Sister will ensure that all staff are up to date with moving and handling assessments and that the assessments are part of the daily audit tool used on the ward.

5.5.3 Family and Women's Health Group

A review has been undertaken of the referral process in Plastic Surgery and the secretarial team has been made aware that they must be actioned on receipt. The Paediatric Team is to ensure that sufficient support is in place for patients with complex needs. The process of referrals for neonatal hip screening has been reviewed and a failsafe system has been introduced that will provide a monthly check that all intended referrals have been actioned and appointments have been sent out.

5.5.4 Clinical Support Health Group

The Out Patient Department Sister is to ensure that staff move any patients to a bed for comfort when required. The attitude of a staff nurse to be addressed by the Senior Matron.

5.6 Friends and Family Test

5.6.1 Inpatient areas

The Trust's Friends and Family results for December for inpatient areas indicate the following:

- Patients who would be likely to recommend the Trust (positive feedback) at **95.57%**
- Patients who would be unlikely to recommend the Trust (negative feedback) **2.17%**

5.6.2 Emergency Department (ED)

The Trust's Friends and Family results for December for the Emergency Department indicate the following:

- In December **87.79%** of patients were positive and likely to recommend ED to friends and family compared to **87.01%** in November.
- **6.10%** gave negative feedback saying that they would be unlikely to recommend the ED, compared with **7.67%** in November.
- SMS feedback has now been arranged in ED resulting in an increase in the response rate to **22.4%** Response rates in ED are normally **4%** the increase in responses is great news as this will provide more rich data. **87%** of patients gave positive feedback and **8%** negative.

5.6.3 Maternity

The Maternity are as follows:

- **97.62%** likely to recommend maternity services.
- **1.79%** unlikely to recommend.

5.7 Interpreter Services

Following a meeting at the Deaf Institute with a number of certified British Sign Language (BSL) interpreters, additional interpreters have agreed to support patients attending appointments at this Trust. The Patient Experience Team continues to work closely with the Institute for the Deaf to improve the service provided.

The provision of language interpreters is being reviewed currently and it is anticipated this will go out to tender shortly. Technological solutions as well as traditional face to face interpretation methods will be explored to ensure that patients receive quality support in a cost effective way.

5.8 Voluntary Services

The Voluntary Services continues to recruit steadily and there are now volunteers in most areas of the Trust enhancing patient experience positively. The Patient Experience Team ended the year by arranging a Christmas celebration for volunteers who give their time to the Trust. Over 50 volunteers attended. The afternoon consisted of a free raffle (prizes had been donated by staff), music and a quiz. The most special part was the attendance of Jean Bishop, Hull's Bee Lady, who spoke to the volunteers about her role in fundraising and her Pride of Britain Award.

5.9.1 Young Volunteer

The young health champions are all looking forward to the celebration event on the 31 March were the champions will be rewarded with their certificates for taking part in the programme and, also, receiving their Royal Society of Public Health Certificates. All youngsters have done extremely well on the programme and gained some significant new skills. This is now in its second phase and the new YHC are all settling in to their new areas well.

5.9.2 Hospital Radio

Studio Two is now ready to go-live on air after alterations to make it more user friendly. This lso allows disabled access and means that more people can be trained to become radio presenters in the future. Radio presenters enjoyed the voluntary services Christmas party with this year's special quest being Jean Bishop the Bee lady from Hull who has raised over £115,000 pounds for age concern as a volunteer.

5.10 Patient Leaflets

Patient Leaflets are evolving and can now be accessed from a smart phone or tablet. QR (Bar codes) codes have been added to all leaflets produced by the Trust that are available on the Internet. Posters have been displayed in patient areas advising how they can receive leaflets direct to their device by use of a QR code. This should reduce the number of leaflets being printed and make it more accessible for patients who have special requirements.

Patients will need to have a QR reader app on their device, which can be downloaded free of charge from the app store. With the app open, the code can be scanned and the leaflet will be displayed on the screen. This can be translated into over 100 different languages, saved, emailed, printed and font enlarged to suit the needs of the individual. It is proposed that future developments will include the opportunity for the leaflet to have an audio option.

6. OTHER QUALITY UPDATES

6.1 Mortality

The new Structured Judgement review process is being rolled currently out across the Surgery Health Group specialties. The Clinical Outcomes Manager, along with the mortality leads, Dr Ganesh Gopalakrishnan and Dr Oliver Byass, are delivering training sessions to tier 1 and tier 2 reviewers. The Clinical Outcomes Manager is attending all Surgery Health Group morbidity and mortality meetings in order to introduce the new system to clinicians and nursing staff, as well as delivering any ad-hoc training upon request. The electronic mortality proforma has been developed within the Lorenzo system, which mirrors the suggested proforma created by the Royal College of Physicians and Improvement Academy.

The proforma asks the reviewer to give explicit judgement comments on the following:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/ procedure care
- End-of-life care
- Assessment of care overall

The reviewer will also be prompted to give a *care score* to each of the phases of care. The scores are range from 1 – Very poor care, to 5 - Excellent care.

The Trust's Business Intelligence Analyser is linked to the Lorenzo based mortality proforma, therefore allowing detailed analysis of all completed mortality reviews. This will be integral to identifying reoccurring themes and patterns in both good and bad care given to patients and will allow summary reports to be written, as well as detailed speciality/ward level reports.

The next steps are for the remaining Surgery Health Group specialties to begin reviewing mortality via the new process, immediately followed by the Medicine Health Group.

A training plan is being developed currently to allow as many clinicians/matrons/specialist nurses as possible to be tier 1 and 2 reviewers.

6.2 Venous Thromboembolism Risk Assessments (VTE)

The performance in relation to VTE risk assessments (95% target) is, as follows:

- The Medicine Health Group has improved to 72.76%.
- The Surgery Health Group had dropped to 85%; it was noted that this could be improved by addressing some recording issues within Day Surgery at HRI.
- The Women's and Childrens Health Group are at 78%.
- There were no figures available from Clinical Support for the month, however, its Medical Director was confident that a positive improvement was in place.

Failure to meet the required levels of VTE risk assessments continues to be a risk to the Trust. Further work on this is being addressed by the Chief Medical Officer and Health Group Medical Directors.

6.3 Safeguarding Children Update

The following updates are provided in relation to Safeguarding Children arrangements:

- Safeguarding Childrens Level 3 Training was 64% (against a minimum target of 80%) at the time of the last CQC inspection. A full review of the staff lists required to undertake

this training was undertaken and cleansed with the support of the Health Group Directors. This continued for several months to ensure accuracy of the data. The Education and Development department took over the management of the bookings and data input so that it was held centrally and this improved the administration as it was previously held by the Safeguarding Childrens Team. By November 2016, the Trust achieved over 80% and has held this position, with current compliance at 81.4%. This will be continued to be monitored via the Health Group Performance Meetings and the Safeguarding Committee.

- Awareness has been raised about the reporting of incidents within Childrens services and how these are risk-rated, even if the actual incident does not result in patient harm. A Serious Incident was declared retrospectively following the inspection on one incident, which related to the absconding of a 15 year old patient from the ward. No harm occurred and the child was brought back from Leeds later the same day. All incidents reported on DATIX from Childrens areas are now sent to the Safeguarding Named Nurse for Children, so that they can all be reviewed for possible safeguarding concerns.

6.4 Outpatients Backlog Follow Up Arrangements

The Trust Board has been notified previously of patients that have not had a follow-up appointment in the timescale advised by their clinician. The number of patients waiting follow up has now begun to reduce and all specialties have agreed a trajectory for eliminating all overdue appointments. Three specialties do not have a backlog; 6 specialties addressed their backlog by December 2016 and a further 13 specialties will have done so by the end of the financial year. Nearly all specialties have confirmed their elimination timescales.

A revised capacity plan has been developed for Ophthalmology, which continues to be the service facing the most significant overdue follow up backlog challenge due to the scale of the volume of appointments delivered. The ophthalmology backlog recovery plan is working and all aspects of progress with the plan are monitored closely by the Health Group senior leadership team.

The Trust-level recovery plan continues to be based on minimising any risks caused by delays through clinical validation and agreement has been reached with GPs to discharge those patients that do not require on-going hospital monitoring. This work is on-going and progress is monitored within the Health Groups and at the weekly Performance and Access meeting (PandA), which is chaired by the Chief Operating Officer.

Detailed information about this issue was presented to ERY CCG's Governing Body Board meeting in December 2016 and THE Trust presented a full summary of the recovery and management plans to ERY CCG and Hull CCGs' quality leads on 14th December 2016 to provide further assurance. Also, the NHS Improvement Elective Intensive Support Team presented feedback on HEY's Elective Care processes to the Executive Management Committee on 16th November, noting that HEY continues to demonstrate strong management and maintain clear visibility on this issue, comparing favourably to peer organisations who are managing the same issue with overdue follow up backlogs.

7. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

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

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director of Quality,
Governance and Assurance

January 2017

APPENDIX ONE - NHS IMPROVEMENT PATIENT SAFETY ALERT - Reference Number: NHS/PSA/RE/2016/006 – Nasogastric Tube Misplacement: Continuing Risk Of Death Or Severe Harm

APPENDIX ONE

NHS IMPROVEMENT PATIENT SAFETY ALERT - Reference Number: NHS/PSA/RE/2016/006 – Nasogastric Tube Misplacement: Continuing Risk Of Death Or Severe Harm

Context
NHS Improvement issued this Patient Safety Alert in July 2016, which the Trust is required to respond to by 21st April 2017. As the Trust had a never event related to this type of incident, the recommendations from the review of this incident have informed the Trust 's response to this safety alert.

Specifically, the alert requires the Trust to respond to the following action points.

- ***Identify a named executive director who will take responsibility for the delivery of the actions required in this alert***

  Kevin Philips, Chief Medical Officer, has been appointed the named executive director for this alert.

- ***Using the resources supplied with this alert, undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.***

  The Trust has had a policy and care bundle for the care and management of patients with nasogastric or orgastric tubes in place for a number of years, which was developed in line with the original National Patient Safety Alert about this same topic in 2005. These have been used successfully for some years with the last incident similar to this occurring in December 2013.

  The Policy and Care Bundle in themselves were robust and met with the 2005 guidance. However, the latest Never event has enabled a further review of the Trust's systems and process to make them even safer going forwards. These are addressed in response to the next action point.

- ***If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.***

  The key findings from the investigation and actions, which are in the process of being addressed in a timed action plan, are:

  - The process for checking x-rays is not straightforward, particularly in patients with complex anatomy/pathology and where X-ray quality may be a possible factor. This needs to be improved upon and made safer. The placement of nasogastric tubes for feeding should only be confirmed by radiologists in the future, in the absence of gastric acid aspirate to confirm placement. This has now been agreed and is in the process of being ratified and implemented. This is being accompanied by a standard operating procedure that can be communicated to all relevant staff and against which compliance can be audited periodically, also. Also, if there are any doubts about future correct placement of a nasogastric tube either at first siting or subsequently, feeding should not take place until authorised

by a Radiologist. In addition, an internal safety alert bulletin has been disseminated to all clinical teams to this effect.

- The process as stands is not as fail-safe as it can be. It only took one thing from a list of checks to be incorrect for this incident to happen. A further check is being put in place; a 'stop point' before feeding commences when no gastric acid aspirate can be obtained. The Trust's Policy and care bundle for the siting and checking of nasogastric tubes are in the process of being re-written to make this clearer and safer. Providing all checks are in place and the position of the tube is confirmed as being in the correct place by a Radiologist, feeding can commence.
- The competency-based training packages available in the Trust were not utilised and training records in this area are poor. This is being reviewed, firstly with a training needs analysis being undertaken for each Health Group, from which training delivery plans will be agreed. In addition, the training packages are being checked to ensure they are current and accessible. Performance trajectories will then be set and compliance with them will be monitored. This can then be reported on regularly through the Performance and Accountability meetings with Health Groups and Executive Directors each month
- The Family and Women's Health Group must provide feedback to individuals that provided statements to this investigation. A completed copy of the final report will be shared at all speciality governance meetings within the Family and Women's Health Group and all open actions will be monitored via the Family and Women's Health Group Governance meeting. In addition, the panel agreed that the learning needs to be Trust-wide. Therefore, the report will be shared with all Health Groups and, also, the Trust's Nutritional Steering Group.
- The lessons learned from this incident have been promoted via the Trust's Lesson Learned Bulletin January 2017 edition and via the December 2016 Quality Safety Bulletin.

- ***Share this assessment and agree any related action plan within relevant commissioner assurance meetings.***

  This report will be shared with commissioners at the January Clinical Quality Review meeting on 1st February 2017

- ***Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.***

  This is the report to the Trust Board

The specific alert form NHS Improvement is on the following two pages

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number: NHS/PSA/RE/2016/006

Alert stage: Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	26 January 2017		**Reference Number**	2017 – 1 – 10		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

The last report on this topic was presented to the Trust Board in November 2016 (October 2016 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.

The new guidance sets out specifications for the future format of these reports, which form part of Lord Carter's work in relation to developing a 'Model Hospital' Dashboard. However, there has been no further progression since last reported in the September Board report 2016. This format will be adopted as soon as it is released and available. However, the piece of work commissioned by the Chief Nurse to look at the Trusts current nursing metrics and how these metrics can be deployed and monitored at ward level continues and will be reported back to the Trust Board November in 2016.

This report presents the 'safer staffing' position as at 30TH September 2016 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3]. In addition, nursing and midwifery staffing establishments have been revised during September 2016 and the summary results of these are presented, also.

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:

---

[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

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).

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%

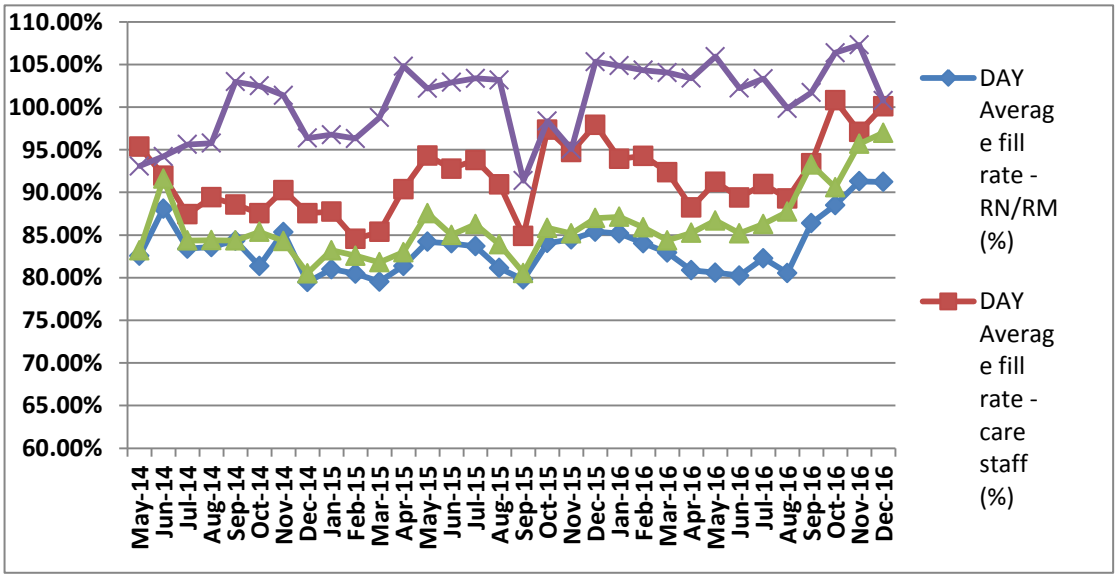
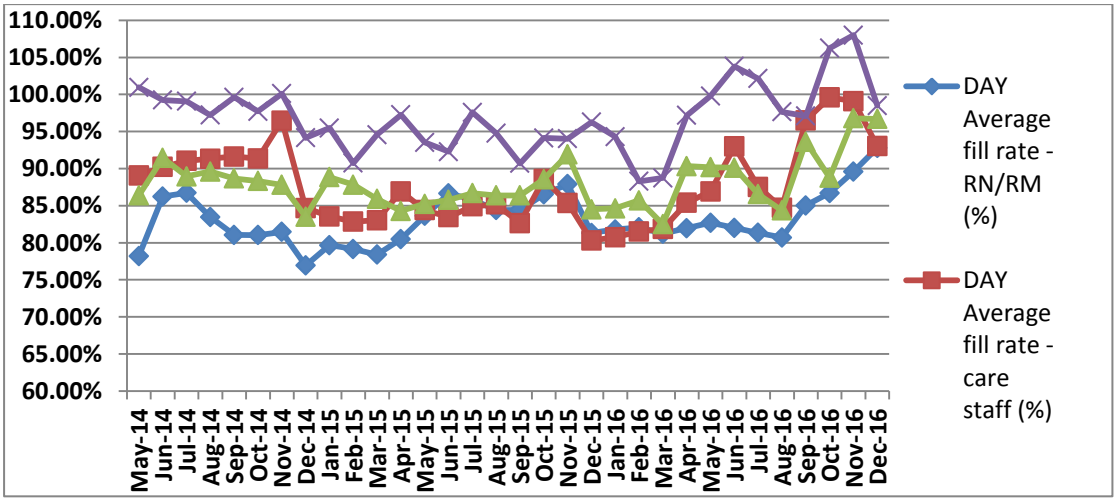


Fig 2: Castle Hill Hospital

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%



The Trust has seen significant improvements in both the registered nurse and care staff (unregistered) fills rates over recent months, especially as more of the newly registered nurses review their full registration status from the Nursing and Midwifery Council (NMC).

Some pressures remain in recruiting to optimal staffing levels in some areas and recruitment efforts continue. The Trust has already set up interviews in February 2017 for 82 of the adult nursing branch students that are due to qualify from the University of Hull in September 2017. Also, the Trust is presenting to prospective additional university candidates at the Careers Fair on 24th January 2017 to try and secure more interviewees.

With regards to international recruitment, the Trust has agreed its preferred partner, which is a locally-based company. Agreement has been reached to try and recruit 100 registered nurses from the Philippines in cohorts of 20 starting in May 2017, and every 2 months thereafter for an 8-month period. The contract allows the Trust to review the contractual arrangements after each cohort of nurses has arrived. In order to start this process and promote Hull and East Yorkshire Hospitals NHS Trust in the Philippines, two senior nurses have gone out to the Philippines to meet and develop the relationship with the company and prospective candidates.

4. ENSURING SAFE STAFFING

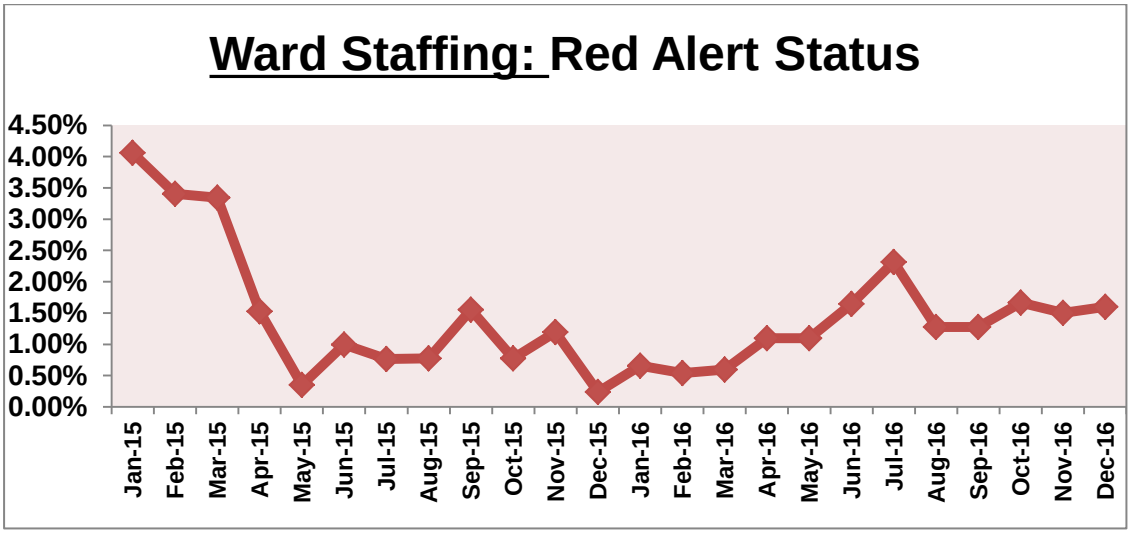
The twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. However, as the Trust is running a winter ward (H10) and supporting extra beds on C8 and H30, there are still some challenges on some shifts.

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 view on the safety and staffing levels that day
- the physical layout of the ward
- The availability of other staff – e.g. bank/pool, matron, specialist nurses, speciality co-ordinators and allied health professionals.
- The balance of risk across the organisation

The Trust will be moving to a more automated safety brief in the near future, which will be fed directly from the e-rostering system. Staff are being trained on the use of the new software (SafeCare) and it is anticipated that this will go-live during Q4.

The following table provides information on the number of occasions staff have declared their wards unsafe (Red Alert), ahead of a safety brief. These are the times over each month that this rating has been allocated represented as a percentage of the total number of assessments in that month.



The number of red alert declarations remains relatively small overall.

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

- The adult intensive care units continue to experience very high demand, which has continued across the winter. These units are established fully for nursing staff. However, as the number of level 3 (maximum intensive care level) patients is nearly double what they are established to provide, this has resulted in high

use of agency staff. The team is looking to see if there are any other viable alternatives to the use of expensive agency staff.

- Wards H70 (Diabetes and Endocrine) and H500 (Respiratory) have a number of Registered Nurse (RN) vacancies which are priority areas for recruitment currently.
- The Neonatal Unit and Paediatric High Dependency Unit (PHDU) still have a number of vacancies and high levels of maternity leave. Staffing risks are managed on a daily basis and some agency staffing is being utilised in these areas.
- C8 (Elective orthopaedics), which normally reduces staffing at the weekend has stayed open to full capacity 7 days throughout most of the winter. This has presented some staffing challenges but these are being managed.

5. NURSE ASSOCIATE – FAST FOLLOWER PILOT SITE

The Trust has been successful in securing 20 placements as part of the national nurse associate pilot programme. The Trust will be the lead employer (co-ordinator) for what is termed the Humber Partnership, which has been allocated 37 places in total, with the remaining 17 being spread across the following partner organisations:

- City Health Care Partnership
- Hull and East Riding CCGs
- Humber NHS Foundation Trust
- University of Hull
- Dove House Hospice
- Care Plus
- St Hugh's Hospital (Grimsby)
- NAVIGO
- Northern Lincolnshire and Goole NHS Foundation Trust

It is expected that the Nurse Associate role will bridge the gap between health and care support workers, who have a care certificate or equivalent, and registered nurses. The role offers opportunities for health care assistants to progress into nursing roles. It is anticipated that these roles will provide a real benefit to the nursing and care workforce across a range of settings and play a key role in the delivery of patient care with safety at its heart. It is anticipated that these roles will be regulated upon qualifying, most likely with the Nursing and Midwifery Council (NMC), although this has yet to be confirmed.

Trainee Nursing Associates will work under the direction of a Registered Nurse (RN) and will undertake duties delegated by the RN. This has the benefit of allowing the RN to spend more time on the assessment and care associated with complex patient needs and advances in treatments knowing that their patient is being supported appropriately by a well-educated and trained nursing associate.

Recruitment to these placements is now underway with their programme commencing on 28th April 2017. The Trainee Nursing Associate is a Band 3 role for existing employees who are willing and eligible to undertake a day-release programme with the University of Hull over 24 months, leading to a Foundation Degree qualification. Upon successful completion of the 2 year course programme, they will be eligible to work as a Band 4 Nursing Associate.

The Trainee Nursing Associate role will appeal to those with personal ambition to embrace this new role and advance themselves and who are committed to providing excellent patient care. Successful candidates will then be able to access fast-track

RN training programmes in the future. Further updates on how this is progressing will be provided in due course.

6. NURSING AND MIDWIFERY REVALIDATION INFORMATION APRIL 2016 - MARCH 2017

The Trust Board is aware that revalidation was introduced for registered nurses and midwives from 1st April 2016. This is a three-yearly revalidation cycle. The table below summarises the position within the Trust to date:

Quarter 1	• 101 registrants were due to revalidate in the first quarter and all revalidated successfully
Quarter 2	• 216 registrants due to revalidate in the second quarter; 209 of these have revalidated successfully. • 4 registrants have retired from their posts • 2 registrants have been granted 'exceptional circumstances' by the NMC. This means that they do not have to revalidate during this cycle but will need to when their next revalidation date is due in three years' time. • 1 registrant has chosen not to revalidate and has subsequently left the Trust. This person has been taken off the NMC register and is no longer allowed to practice as a registered nurse.

Quarter 3	• 265 registrants have revalidated successfully
	• 1 registrant is retiring
	• 2 registrants have decided not to revalidate:
	  o 1 due to ill health
	  o 1 has decided to take a career break
	• 1 registrant had been given an extension until 12 December 2016. This registrant may have requested 'exceptional circumstances', however, this is still with the NMC. This person is suspended form work currently for other reasons, so is not practising currently
	• Another registrant (midwife) had been given an extension until 31 December 2016, this registrant failed to revalidate and has now been taken off the NMC register. This registrant will need to re-apply to go back on the register; this includes obtaining three references and also submitting their revalidation. This registrant is being supported by the Trust.
	• 5 registrants have left the Trust to work elsewhere

Quarter 4	• 236 registrants due to revalidate in Q4; 82 of these have successfully submitted their revalidation applications, but this is still work in progress throughout this current quarter • 1 registrant is retiring

The NMC published its 'Revalidation Quarterly Report' (Year 1, Quarter 2 – July to September 2016). This report stated that 'the number of nurses and midwives not revalidating is in line with those not renewing in previous years (before revalidation) at around 5%'. At HEYHT for the same period, the non-revalidation rate is 2%.

Nursing and Midwifery staffing establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. The next establishment reviews are due to be completed by the end of March 2017.

However, the challenges remain around recruitment and risks remain in terms of the available supply of registered nurses, although this position has improved in the short-term.

7. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Chief Nurse
January 2017

Appendix 1: HEY Safer Staffing Report - December 2016

HEY SAFER STAFFING REPORT DECEMBER-16

NURSE STAFFING

HIGH LEVEL QUALITY INDICATORS *[which may or maynot be linked to nurse staffing]*

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	MONTHLY AVERAGE	DAY		NIGHT		PATIENT TO RN RATIO		RN & AN	ACUITY MONITORING [AVERAGE]					HIGH LEVEL			FALLS				HOSPITAL ACQUIRED PRESSURE DAMAGE						QUALITY INDICATOR TOTAL
				Nurse Staffing Red Alert Status	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	EARLY SHIFT [8:1]	LATE SHIFT [8:1]	NIGHT SHIFT [10:1]	0	1a	1b	2	3	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	GRADE 2	GRADE 3	GRADE 4	DEEP TISSUE INJURY	UNSTAGEABLE	PRESSURE SORE TOTAL	
MEDICINE	ED	ACUTE MEDICINE	NA	6%													1		5	2			2						0	8
	AMU	ACUTE MEDICINE	45	0%	84%	174%	102%	98%	7 : 1	7 : 1	6 : 1	39%	15%	45%	1%	0%		2	1	1			1	1			1		2	6
	H1	ACUTE MEDICINE	22	0%	80%	93%	100%	100%	8 : 1	10 : 1	7 : 1	41%	24%	36%	0%	0%		1	2				0						0	3
	EAU	ELDERLY MEDICINE	21	3%	90%	117%	78%	103%	6 : 1	7 : 1	7 : 1	70%	0%	30%	0%	0%	1			4			4						0	5
	H5	RESPIRATORY	20	0%	93%	93%	96%	89%	10 : 1	10 : 1	8 : 1	20%	21%	59%	0%	0%			1	3			3	1					1	5
	RHOB	RESPIRATORY	6	3%	93%	93%	96%	89%	3 : 1	3 : 1	2 : 1	0%	1%	2%	92%	6%							0						0	0
	H50	RENAL MEDICINE	19	6%	82%	102%	102%	98%	7 : 1	10 : 1	6 : 1	45%	0%	53%	0%	2%		1			1		1						0	2
	H500	RESPIRATORY	24	0%	94%	77%	104%	84%	8 : 1	9 : 1	8 : 1	41%	3%	56%	1%	0%			3			2	2				1		1	6
	H70	ENDOCRINOLOGY	30	3%	84%	101%	93%	92%	8 : 1	10 : 1	10 : 1	18%	9%	73%	0%	0%	2		1	1			1	`1			1		1	5
	H8	ELDERLY MEDICINE	27	0%	90%	106%	101%	102%	8 : 1	10 : 1	9 : 1	8%	0%	91%	0%	0%			2	1			1						0	3
	H80	ELDERLY MEDICINE	27	0%	97%	112%	101%	98%	9 : 1	10 : 1	9 : 1	13%	2%	85%	0%	0%			1	3			3						0	4
	H9	ELDERLY MEDICINE	31	3%	80%	166%	94%	108%	9 : 1	10 : 1	10 : 1	19%	1%	80%	0%	0%				2			2						0	2
	H90	ELDERLY MEDICINE	29	0%	98%	102%	100%	100%	9 : 1	10 : 1	10 : 1	24%	2%	74%	0%	0%			1	4			4						0	5
	H11	STROKE / NEUROLOGY	28	0%	84%	131%	90%	104%	8 : 1	9 : 1	9 : 1	43%	12%	45%	1%	0%		2		3			3						0	5
	H110	STROKE / NEUROLOGY	24	3%	81%	129%	102%	123%	7 : 1	7 : 1	6 : 1	25%	21%	54%	0%	0%	1	2	1	1	1		2	2					2	8
	CDU	CARDIOLOGY	9	0%	94%	43%	88%		4 : 1	6 : 1	9 : 1	25%	75%	0%	0%	0%							0						0	0
	C26	CARDIOLOGY	26	3%	98%	86%	101%	94%	6 : 1	7 : 1	7 : 1	35%	40%	23%	2%	0%				2			2						0	2
	C28	CARDIOLOGY	17	0%	82%	115%	89%	55%	6 : 1	7 : 1	6 : 1	12%	40%	48%	0%	0%				1			1						0	1
	CMU	CARDIOLOGY	10	6%	82%	115%	89%	55%	3 : 1	3 : 1	3 : 1	1%	13%	22%	62%	2%							0						0	0
	H10	WINTER WARD	27	0%	92%	94%	85%	101%	8 : 1	8 : 1	8 : 1	44%	1%	55%	0%	0%							0						0	0
SURGERY	H4	NEURO SURGERY	30	0%	84%	100%	90%	99%	8 : 1	9 : 1	9 : 1	24%	0%	75%	0%	0%		1		2			2						0	3
	H40	NEURO HOB / TRAUMA	15	0%	84%	86%	86%	84%	5 : 1	5 : 1	4 : 1	0%	47%	49%	4%	0%		1					0						0	1
	H6	ACUTE SURGERY	28	0%	95%	92%	95%	194%	8 : 1	9 : 1	8 : 1	36%	20%	44%	0%	0%	1		1				0	1					1	3
	H60	ACUTE SURGERY	28	0%	100%	88%	93%	206%	8 : 1	9 : 1	8 : 1	35%	20%	46%	0%	0%			3	1			1						0	4
	H7	VASCULALR SURGERY	30	0%	97%	73%	87%	89%	8 : 1	8 : 1	9 : 1	32%	8%	59%	0%	0%	1						0						0	1
	H100	GASTROENTEROLOGY	24	0%	91%	90%	97%	98%	7 : 1	8 : 1	8 : 1	52%	1%	47%	0%	0%				1			1						0	1
	H12	ORTHOPAEDIC	28	9%	97%	88%	99%	101%	8 : 1	9 : 1	9 : 1	11%	2%	87%	0%	0%	1						0						0	1
	H120	ORTHO / MAXFAX	22	0%	104%	109%	109%	95%	6 : 1	7 : 1	7 : 1	18%	5%	77%	0%	0%			1				0	1					1	2
	HICU	CRITICAL CARE	22	0%	97%	198%	96%	113%	2 : 1	2 : 1	2 : 1	0%	4%	1%	40%	55%							0				2		2	2
	C8	ORTHOPAEDIC	18	0%	87%	73%	64%	68%	8 : 1	8 : 1	8 : 1	63%	3%	35%	0%	0%	1						0						0	1
	C9	ORTHOPAEDIC	29	0%	114%	95%	110%	101%	8 : 1	8 : 1	8 : 1	35%	0%	64%	2%	0%		2		1			1	1			1		2	5
	C10	COLORECTAL	21	6%	95%	78%	100%	88%	6 : 1	8 : 1	6 : 1	44%	1%	55%	0%	0%					1		1						0	1
	C11	COLORECTAL	22	0%	95%	69%	101%	90%	7 : 1	8 : 1	8 : 1	43%	1%	56%	0%	0%							0						0	0
	C14	UPPER GI	27	3%	82%	80%	88%	136%	7 : 1	8 : 1	8 : 1	68%	0%	31%	1%	0%					1		1	1					1	2
	C15	UROLOGY	26	0%	91%	91%	96%	94%	6 : 1	7 : 1	7 : 1	70%	3%	27%	0%	0%							0				2		2	2
	C27	CARDIOTHORACIC	26	0%	97%	103%	99%	100%	6 : 1	7 : 1	7 : 1	42%	0%	58%	0%	0%		2					0						0	2
	CICU	CRITICAL CARE	22	3%	98%	84%	98%	63%	2 : 1	2 : 1	2 : 1	0%	0%	2%	59%	38%	1						0						0	1
FAMILY & WOMEN'S	C16	ENT / BREAST	30	3%	94%	108%	119%	86%	8 : 1	8 : 1	9 : 1	51%	30%	15%	4%	0%	1	1					0						0	2
	H130	PAEDS	20	0%	89%	37%	91%	77%	5 : 1	6 : 1	5 : 1	49%	49%	2%	0%	0%			2				0						0	2
	H30 CEDAR	GYNAEOCOLOGY	9	0%	77%	62%	109%		7 : 1	7 : 1	7 : 1	94%	0%	6%	0%	0%							0						0	0
	H31 MAPLE	MATERNITY	20	0%	86%	88%	99%	99%	5 : 1	5 : 1	6 : 1	100%	0%	0%	0%	0%	1	2					0						0	3
	H33 ROWAN	MATERNITY	38	0%	97%	95%	95%	91%	7 : 1	7 : 1	9 : 1	95%	5%	0%	0%	0%							0						0	0
	H34 ACORN	PAEDS SURGERY	20	0%	88%	68%	99%	107%	5 : 1	5 : 1	7 : 1	82%	17%	1%	0%	0%							0						0	0
	H35	OPHTHALMOLOGY	12	0%	88%	80%	109%		6 : 1	6 : 1	6 : 1	60%	7%	32%	0%	0%							0						0	0
	LABOUR	MATERNITY	16	3%	111%	70%	110%	75%	3 : 1	4 : 1	3 : 1	81%	8%	7%	4%	0%	2						0						0	2
	NEONATES	CRITICAL CARE	26	0%	93%	113%	93%	115%	3 : 1	3 : 1	3 : 1	0%	32%	5%	41%	23%	2						0						0	2
	PAU	PAEDS	10	0%	91%		99%		5 : 1	5 : 1	5 : 1	35%	60%	5%	0%	0%							0						0	0
	PHDU	CRITICAL CARE	4	0%	99%	56%	103%		2 : 1	2 : 1	2 : 1	41%	18%	7%	35%	0%			1				0	1					1	2
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0%	97%	87%	101%	97%	9 : 1	9 : 1	6 : 1	67%	0%	33%	0%	0%				1			1						0	1
	C29	REHABILITATION	15	6%	101%	109%	100%	257%	6 : 1	7 : 1	5 : 1	32%	1%	67%	0%	0%							0						0	0
	C30	ONCOLOGY	22	0%	81%	112%	89%	101%	8 : 1	9 : 1	7 : 1	24%	15%	61%	0%	0%			1	1			1						0	2
	C31	ONCOLOGY	27	0%	94%	114%	99%	99%	7 : 1	8 : 1	9 : 1	45%	6%	49%	0%	0%				1			1						0	1
	C32	ONCOLOGY	22	3%	94%	88%	93%	92%	7 : 1	8 : 1	7 : 1	26%	1%	73%	0%	0%							0						0	0
	C33	HAEMATOLOGY	28	0%	89%	128%	99%	101%	6 : 1	7 : 1	8 : 1	61%	11%	25%	3%	0%		1	1	3			3						0	5
		AVERAGE:		1.3%				AVERAGE:	6 : 1	7 : 1	7 : 1	38%	12%	40%	7%	2%														
		TOTALS:															16	18	28	39	4	2	45	9	0	0	8	0	17	124

Dec-16	DAY		NIGHT	
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
HRI SITE	91.2%	100.1%	97.0%	100.8%
CHH SITE	92.8%	93.0%	96.7%	98.5%

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

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

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 – 11
Director	Mike Wright - Chief Nurse	**Author**	Mike Wright, Chief Nurse Jo Ledger, Deputy Chief Nurse Caroline Grantham, Practice Development Matron
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits		

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

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

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

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in October 2016. Good progress is being made and this report presents the position at December 2016.

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

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

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

1. INTRODUCTION

Delivering high quality, safe and effective care to patients is of paramount importance, and is one of the Trust's key strategic objectives. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our nursing and midwifery teams. The last report on this topic was presented to the Trust Board in October 2016. This provides a progress report as at the end of December 2016.

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

Table to illustrate the Nine Fundamental Standards

1. STAFF EXPERIENCE
2. PATIENT ENVIRONMENT
3. INFECTION CONTROL
4. SAFEGUARDING
5. MEDICINES MANAGEMENT
6. TISSUE VIABILITY
7. PATIENT CENTRED CARE
8. NUTRITION & HYDRATION
9. PATIENT EXPERIENCE

Table 1

2. ASSESSMENT PROCESS

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

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

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

Score	79% or less	80% to 88%	89 to 94.9%	Above 95%
Frequency of Review	3 month review	6 month review	9 month review	12 month review

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

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

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

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

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in the **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard then the Ward Sister/Charge Nurse will have an appraisal completed by the Divisional Nurse, with clear objectives set. If the ward gets a second consecutive Red then the Senior Sister/Charge Nurse will have an appraisal completed by the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse.

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

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

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

Ward 40’s “How are we doing?” board

Figure 1

3. CURRENT POSITION

Fifty Four Clinical areas have been reviewed consisting of Ward Areas, Critical Care Units & our Emergency Department. **Appendix One** provides an overview of individual ratings by clinical area, where applicable. The following tables illustrate progress made in relation to each fundamental standard from July 2016 to January 2017, across the four Health Groups. Please note that in some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of the fundamental standard assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken currently and as a priority to address those fundamental standards rated Red**.** A number of assessments are outstanding for quarter 3, predominantly, Staff Experience, Infection Control and Patient Experience. The Chief Nurse has tasked each of the Nurse Directors to ensure that all reviews are completed and in date by the end of quarter 4.

4. STAFF EXPERIENCE

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

Staff Experience														
Trust			**Clinical Support**			**Family & Women's**			**Surgery**			**Medicine**		
July	**Oct**	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**
36	**36**	**37 Wards**	5	5	**5**	**5**	**5**	**5**	14	14	**15**	12	12	**12**
17	**17**	**15 Wards**	1	1	**1**	**4**	**4**	**4**	5	5	**4**	7	7	**6**
1	**1**	**2 Wards**	0	0	**0**	**1**	**1**	**1**	0	0	**0**	0	0	**1**
0	**0**	**0 Wards**	0	0	**0**	**0**	**0**	**0**	0	0	**0**	0	0	**0**

Progress since October: 3 reviews have been completed during this period. However there are a number which remain outstanding for this standard. The number of clinical areas rated as Blue has increased, which relates predominantly to the improvements the clinical areas have made in providing an environment conducive to learning for student nurses.

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

Patient Environment														
Trust			**Clinical Support**			**Family & Women's**			**Surgery**			**Medicine**		
July	**Oct**	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**	July	Oct	**Jan**
5	7	**8 wards**	0	0	**0**	2	3	**2**	2	3	**4**	1	1	**2**
25	28	**32 wards**	3	5	**5**	5	4	**5**	9	11	**13**	8	8	**9**
21	15	**12 wards**	3	1	**1**	2	2	**2**	7	3	**1**	9	9	**8**
1	1	**0 Ward**	0	0	**0**	0	0	**0**	0	0	**0**	1	1	**0**

Progress since October: 22 reviews completed have been completed during this period. There are two reviews outstanding as these wards were closed with norovirus when the review date had been arranged with the patient representatives. The number of clinical areas rated both Blue and Green have increased in number, in both Medicine and Surgery. There are no areas rated Red. These improvements are related predominantly to enhancements made to patient areas such as ward day rooms. In addition, a significant amount of work has been completed in relation to improving written information for patient and carers.

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

Infection Control														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
2	2	2 wards	0	0	**0**	0	0	**0**	1	1	**1**	1	1	**1**
5	6	10 wards	1	1	**1**	0	0	**1**	3	3	**5**	1	2	**3**
44	44	40 wards	5	5	**5**	10	10	**9**	14	14	**12**	15	15	**14**
3	2	2 Ward	0	0	**0**	0	0	**0**	1	1	**1**	2	1	**1**

Progress since October: 14 reviews were completed during this period. However, there are a number of overdue reviews for this standard. The infection control team is working to rectify this and expect all reviews to be in date by the end of quarter 4, which will be monitored by the Deputy Chief Nurse.

The number of Green rated clinical areas has increased within the Medical, Surgery and Family & Women's Health Groups. The two remaining red ratings within the Surgical Health Group and Medical Health Group are due predominantly to failure of the clinical areas to adhere sustainably to local equipment cleaning regimes. A review of the current cleaning requirements across a seven-day period is being completed currently in conjunction with the Infection Control Team to support improved performance in the above element. The Practice Development Matrons are working closely with the facilities department to ascertain if the domestic staff can take on any cleaning of equipment, which should support improved compliance in this area.

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

Safeguarding														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
34	35	40 wards	4	4	**5**	5	5	**9**	14	14	**15**	11	12	**11**
19	18	11 wards	2	2	**1**	5	5	**1**	4	4	**2**	8	7	**7**
1	1	3 ward	0	0	**0**	0	0	**0**	1	1	**2**	0	0	**1**
0	0	0 wards	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**

Progress since October: 18 reviews have been completed during this review. There are five outstanding reviews which were due in December 16. The number of Blue rated clinical areas has increased in the Clinical Support, Surgery and Family & Women's Health Group with no clinical areas rated Red within this standard. However, there has been a slight

increase in the number of amber ratings, which relates primarily to the lack of written information available to patients and carers with regards to safeguarding, this has since been rectified.

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

Medicines Management														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
10	9	14 wards	1	1	**1**	3	3	**5**	5	5	**6**	1	0	**2**
18	21	24 wards	3	3	**3**	6	6	**5**	4	3	**8**	5	9	**8**
25	23	16 ward	2	2	**2**	1	1	**0**	10	11	**5**	12	9	**9**
1	1	0 wards	0	0	**0**	0	0	**0**	0	0	**0**	1	1	**0**

Progress since October: 19 reviews completed have been completed during this period. There are no outstanding reviews for this standard. There has been an increase in the number of Blue and Green rated clinical areas. There are now no clinical areas rated Red for this standard. These improvements are related to improvements in security following the introduction of the joint assessments done with the ward pharmacist every month.

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

Tissue Viability														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
7	9	10 wards	0	0	**0**	5	6	**6**	1	1	**1**	1	2	**3**
3	4	6 wards	1	2	**2**	0	0	**0**	2	2	**3**	0	0	**1**
30	26	26 ward	4	4	**4**	5	4	**4**	9	9	**10**	12	9	**8**
11	12	9 wards	1	0	**0**	0	0	**0**	7	7	**5**	3	5	**4**

Progress since October: 25 reviews have been completed during this period, with no outstanding reviews for this standard. Overall results show an improvement in pressure ulcer prevention care, this is demonstrated through the increase in the number of Blue and Green rated clinical areas and the decrease of Red rated clinical areas within the Surgery and Medicine Health Groups.

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

Patient Centred Care														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
9	9	9 wards	0	0	**0**	5	5	**5**	3	3	**3**	1	1	**1**
15	14	12 wards	2	2	**2**	2	2	**1**	4	3	**2**	7	7	**7**
21	23	24 ward	4	4	**4**	2	2	**3**	10	11	**12**	5	6	**5**
8	6	7 wards	0	0	**0**	0	0	**0**	2	2	**2**	6	4	**5**

Progress since October: 10 reviews completed during this period but there are a number of overdue reviews for this standard. There has been an increase in the number of Amber rated scores within both the Family & Women's and Surgical Health Groups and an increase in Red rated Scores. The remaining Red rated scores relate predominantly to incomplete documented re assessments, when patients are transferred between clinical areas. In order to address this, the Chief Nurse has commissioned a piece of work reviewing the current nursing documentation, which is currently ongoing.

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

Nutrition														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
7	9	9 wards	0	0	**0**	1	3	**4**	3	3	**4**	3	3	**1**
8	8	8 wards	1	1	**1**	1	1	**1**	4	4	**2**	2	2	**4**
16	18	13 ward	3	3	**3**	3	3	**2**	5	4	**5**	5	8	**3**
18	14	19 wards	2	2	**2**	2	0	**0**	7	8	**8**	7	4	**9**

Progress since October: 48 reviews completed during this period. There are no outstanding reviews for this standard. There has been an increase in Red rated areas with the Medicine Health Group. The Family & Women's and Surgery Health Groups have seen an increase in the number of Blue rated areas. The clinical teams are working closely with the dieticians to improve compliance with this standard specifically around documentation of individualised care.

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

Patient Experience														
Trust			Clinical Support			Family & Women's			Surgery			Medicine		
July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan	July	Oct	Jan
37	37	39 wards	4	4	4	8	8	8	13	13	14	12	12	13
12	12	11 wards	2	2	2	1	1	1	6	6	5	3	3	3
3	3	2 ward	0	0	0	0	0	0	0	0	0	3	3	2
1	1	1 wards	0	0	0	0	0	0	0	0	0	1	1	1

Progress since October: 2 reviews completed during this period, however there are a number of outstanding reviews for this standard. There has been an increase in Blue rated clinical areas for this standard within the Surgery and Medicine Health Groups.

13. SUMMARY:
26 clinical areas have one or more fundamental standard rated as Red. Of these:

- 19 clinical areas have one red standard
- 3 clinical areas have two red standards.
- H6, MAU and H1 have 3 Red Standards
- H70 has four red fundamental standards (tissue viability, patient centred care, nutrition and patient experience). The Chief Nurse commissioned a comprehensive review of this clinical area which commenced in November 2016. The leadership of this clinical area has changed following this review and the current ward manager is implementing a detailed action plan that was produced from the issues found during the review.

In general, scores are improving overall. However, specific focused attention is now being given to the nutrition standard. Primarily, the problems here relate to record keeping.

14. AREAS FOR IMPROVEMENT
To ensure continual improvement, the following trajectories have been endorsed by the Chief Nurse indicating that by September 2017:

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

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

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

16. ACTION REQUESTED OF THE TRUST BOARD
The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
January 2017

Appendix One – Nursing and Midwifery Fundamental Standards Audits Scores as at 20th January 2017

NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS January 2017 – APPENDIX ONE

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C20	100%	Mar 17	90%	July 17	90%	Sept 17	100%	Mar 17	99%	Feb 17	94%	June 17	82%	July 17	90%	Sept 17	100%	Mar 17
C29	94%	Mar 17	90%	May 17	88%	April 17	100%	Jan 17	89%	Feb 17	**94%**	Mar 17	**84%**	Mar 17	86%	June 17	90%	Mar 17
C30	98%	Mar 17	90%	May 17	**86%**	May 17	100%	Jan 17	93%	Feb 17	88%	Jan 17	82%	Aug 17	**82%**	May 17	90%	Mar 17
C31	98%	Feb 17	91%	Mar 17	86%	Mar 17	95%	Oct 17	94%	April 17	80%*	April 17	92%	Mar 17	67%	Mar 17	100%	Mar 17
C32	100%	Mar 17	80%	April 17	80%	Feb 17	100%	Feb 17	87%	July 17	89%	Jan 17	**85%**	Mar 17	81%	June 17	100%	Mar 17
C33	100%	Jan 17	90%	May 17	**87%**	May 17	92%	Jan 17	86%	May 17	84%	April 17	90%	Mar 17	55%	Mar 17	100%	Mar 17

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	100%	June 17	100%	Oct 17	85%	Mar 17	92%	Jan 17	92%	Aug 17	87%	Jan 17	98%	Jan 18	81%	June 17	100%	Mar 17
Cedar H30	89%	Sept 17	93%	Mar 17	80%*	Mar 17	97%	Dec 17	94%	Feb 17	80%*	Jan17	88%	June 17	83%	June 17	100%	Mar 17
H31	91%	Mar 17	90%	May 17	**80%***	Mar 17	100%	Feb 17	95%	Mar 17	96%	April 17	100%	Mar 17	NA		98%	Mar 17
H33	88%	Mar 17	90%	May 17	80%*	Mar 17	98%	Nov 17	95%	Jan 17	100%	April 17	94%	Mar 17	NA		98%	Mar 17
ACORN	92%	Mar 17	90%	Oct 17	80%*	Mar 17	100%	Feb 17	91%	Mar17	80%*	Mar 17	96%	Mar 17	**97%**	Dec 17	100%	Mar 17
H35	95%	Mar 17	95%	May 17	89%	Sept 17	100%	Oct 17	93%	April 17	86%	April 17	97%	Mar 17	92%	Sept 17	100%	Mar 17
H130	100%	Mar 17	88%	April 17	**80%**	May 17	100%	Feb 17	94%	Mar 17	97%	April 17	88%	Mar 17	**97%**	Nov 17	96%	April 17
Labour	100%	June 17	NA		**80%***	Mar 17	100%	Nov 17	96%	Dec 17	100%	Sept 17	83%	Mar 17	NA		NA	
NICU	**92%**	Mar 17	88%	April 17	**80%***	Mar 17	100%	Feb 17	98%	Mar 17	100%	Mar 17			100%	Dec 17	90%	Mar 17
PHDU	95%	June 17	92%	Oct 17	**84%**	Mar 17	100%	Feb 17	100%	Oct 17	100%	Mar 17	97%	Feb 17	**94%**	Sept 17	100%	Mar 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C8	92%	Jan 17	91%	Mar 17	**89%**	Feb 17	89%	Jun 17	95%	Nov 17	**77%**	Feb 17	85%	July 17	**65%**	Mar 17	100%	April 17
C9	96%	Mar 17	90%	Feb 17	**86%**	Mar 17	84%	Mar 17	88%	April 17	**80%***	Feb 17	86%	Mar 17	**76%**	Mar 17	100%	June 17
C10	89%	Mar 17	95%	May 17	80%	Mar 17	100%	Jan 17	91%	Feb 17	**79%**	Feb 17	83%	Aug 17	96%	Nov 17	100%	Mar 17
C11	96%	Oct 17	95%	Oct 17	86%	Mar 17	100%	Jan 17	87%	May 17	**80%***	Feb 17	82%	July 17	95%	Nov 17	100%	Mar 17
C14	97%	Mar 17	93%	July 17	80%*	Feb 17	100%	Aug 17	89%	Aug 17	**86%**	June 17	81%	July 17	82%	May 17	93%	Mar 17
C15	100%	April 17	93%	Mar 17	80%*	Mar 17	87%	May 17	88%	April 17	**80%***	Feb 17	82%	Aug 17	72%	Mar 17	97%	Mar 17
C27	98%	Mar 17	93%	Mar 17	89%	Sept 17	100%	Mar 17	94%	Aug 17	**76%**	Feb 17	84%	Feb 17	**86%**	June 17	100%	Mar 17
CICU1	100%	Mar 17	94%	May 17	100%	April 17	100%	April 17	99%	Oct 17	82%	May 17	96%	June 17	100%	Oct 17	96%	Mar 17
CICU2	100%	Mar 17	95%	Sept 17	89%	Feb 17	100%	April 17	100%	Oct 17	**92%**	Mar 17	99%	Mar 17	100%	Oct 17	96%	Mar 17

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	100%	Mar 17	91%	April 17	**80%***	Feb 17	100%	Jan 17	92%	Aug 17	**78%**	April 17	92%	Mar 17	**66%**	**Mar 17**	97%	Mar 17
H40	100%	Mar 17	93%	Oct 17	84%	Mar 17	100%	Jan 17	89%	Aug 17	**80%***	Jan 17	89%	Mar 17	**64%**	Mar 17	100%	Mar 17

H6	96%	Mar 17	89%	July 17	**80%***	Feb 17	95%	May 17	83%	Jan 17	**76%**	April 17	70%	Mar 17	**70%**	Mar 17	95%	Mar 17
H60	94%	Mar 17	95%	April 17	**84%**	Mar 17	97%	Feb 17	96%	Oct 17	**93%**	Mar 17	87%	Mar 17	**86%**	June 17	90%	Mar 17
H7	100%	Mar 17	93%	April 17	**80%***	June 17	100%	Mar 17	91%	Aug 17	**80%***	April 17	**77%**	Mar 17	**93%**	Sept 17	100%	June 17
H12	92%	July 17	90%	Feb 17	80%*	June 17	97%	Dec 17	91%	Aug 17	90%	July 17	85%	Mar 17	**90%**	Sept 17	91%	Jan 17
H120	100%	Mar 17	90%	Feb 17	**71%**	Mar 17	96%	Dec 17	91%	Aug 17	**80%***	Mar 17	85%	Mar 17	**87%**	June 17	92%	Mar 17
H100	100%	April 17	84%	April 17	**80%***	Mar 17	94%	Mar 17	82%	April 17	**80%***	April 17	84%	Mar 17	85%	June 17	90%	Jan 17
HICU1	100%	Mar 17	94%	July 17	92%	Sept 17	97%	April 17	95%	Nov 17	96%	Feb 17	88%	Mar 17	**74%**	Mar 17	96%	June17
HICU2	100%	Mar 17	NA		92%	Sept 17	97%	April 17	97%	June 17	80%*	April 17	97%	June 17	**76%**	Mar 17	96%	June 17

MEDICINE CHH

Clinical Area	**Staff Experience**		**Patient Environment**		**Infection Control**		**Safeguarding**		**Medicines Management**		**Tissue Viability**		**Patient Centred Care**		**Nutrition**		**Patient Experience**	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	100%	Mar 17	**91%**	July 17	92%	May 17	100%	June 17	89%	July 17	94%	Aug 17	**92%**	Mar 17	79%	Feb 17	95%	Mar 17
C26	100%	Mar 17	93%	Mar 17	89%	Mar 17	93%	Mar 17	91%	Aug 17	80%*	Jan 17	81%	July 17	92%	Sept 17	100%	Mar 17
C5DU	94%	Mar 17	95%	Oct 17	97%	Oct 17	100%	June 17	94%	Feb 17	100%	April 17	95%	Mar 17	100%	April 17	100%	Mar 17

MEDICINE HRI

Clinical Area	**Staff Experience**		**Patient Environment**		**Infection Control**		**Safeguarding**		**Medicines Management**		**Tissue Viability**		**Patient Centred Care**		**Nutrition**		**Patient Experience**	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
MAU	85%	July 17	80%	May 17	80%*	Jan17	100%	Oct 17	82%	May 17	**79%**	April 17	**69%**	Mar 17	**63%**	Mar 17	83%	Mar 17
H1	100%	Mar 17	95%	June 17	**75%**	Mar 17	91%	Aug 17	87%	July 17	87%	April 17	**75%**	Mar 17	**71%**	Mar 17	100%	May 17
H200/EAU	98%	Feb 17	84%	May 17	**84%**	Mar 17	95%	Feb 17	92%	May 17	**80%***	June 17	84%	Mar 17	**73%**	Mar 17	96%	Feb 17
H5	95%	May 17	84%	May 17	**84%**	Jan 17	92%	Mar 17	89%	July 17	84%	June 17	**81%**	Mar 17	**68%**	Mar 17	91%	Jan 17
H50	97%	May 17	91%	Aug 17	**84%**	Mar 17	100%	Mar 17	94%	Mar 17	**80%***	Feb 17	**71%**	Mar 17	**92%**	Sept 17	96%	May 17
H500	93%	Mar 17	82%	May 17	**83%**	April 17	92%	Feb 17	88%	May 17	**80%***	April 17		Mar 17	**82%**	June 17	96%	June 17
H70	94%	Mar 17	80%	May 17	**80%***	Mar 17	100%	Oct 17	81%	May 17	**67%**	Feb 17	**74%**	Feb 17	**71%**	Feb 17	**77%**	Feb 17
H8	96%	Feb 17	95%	Sept 17	81%	Feb 17	**96%**	May 17	90%	Mar 17	80%*	Jan 17	89%	Mar 17	67%	Mar 17	100%	Mar 17
H80	98%	Feb 17	94%	Sept 17	82%	Mar 17	100%	Mar 17	82%	Feb 17	80%*	Jan 17	90%	Mar 17	**85%**	June 17	100%	April 17
H9	100%	Mar 17	86%	Mar 17	84%	Mar 17	95%	Mar 17	94%	Aug 17	97%	Sept 17	94%	Mar 17	69%	Mar 17	100%	June 17
H90	100%	Mar 17	82%	Mar 17	80%*	Mar 17	89%	Mar 17	86%	Jan 17	**86%**	April 17	91%	Mar 17	76%	Mar 17	96%	Mar 17
H11	100%	Feb 17	**81%**	May 17	80%*	Jan 17	97%	Mar 17	83%	April 17	**67%**	April 17	85%	Mar 17	91%	Sept 17	96%	Mar 17
H110	100%	Mar 17	**89%**	Mar 17	80%*	Mar 17	100%	Oct 17	85%	May 17	**67%**	Feb 17	77%	Mar 17	86%	May 17	100%	Mar 17

EMERGENCY MEDICINE HRI

Clinical Area	**Staff Experience**		**Patient Environment**		**Infection Control**		**Safeguarding**		**Medicines Management**				**Patient Centred Care (inc TV)**		**Nutrition**		**Patient Experience**	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
Majors ED	94%	Mar 17	**92%**	Aug 17	80%*	Mar 17	95%	Dec 17	98%	Oct 17			83%	Mar 17	95%	Oct 16	83%	Mar 17
Paeds ED	94%	Mar 17	**91%**	Aug 17	93%	May 17	88%	July 17	89%	Feb 17			90%	Mar 17			90	Mar 17
Emergency Care	94%	Mar 17	**94%**	Aug 17	80%*	Mar 17	93%	Sept 17	100%	Oct 17			89%	Mar 17			93	Mar 17

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

Integrated Performance Report 2016/17

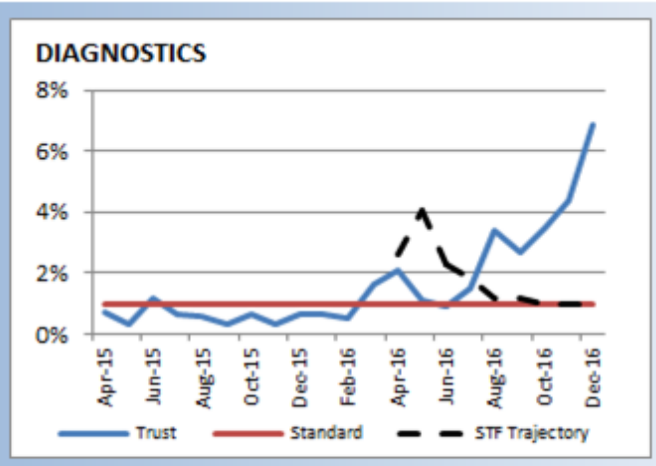
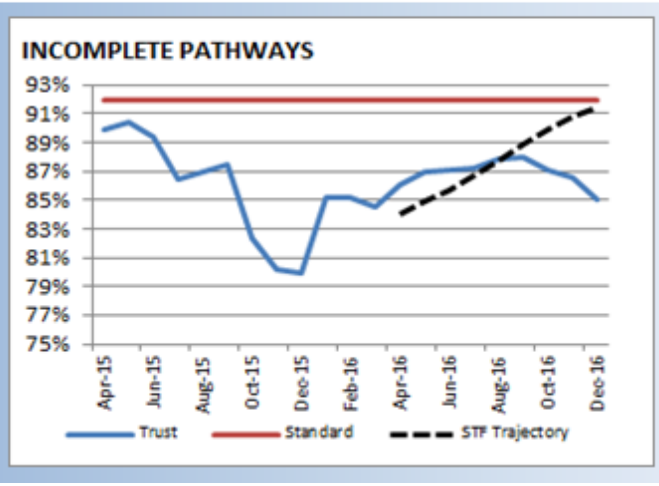
January 2017

December data

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

Integrated Performance Report - January 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times: 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made The target is less than 1% over 6 weeks	Diagnostic waiting times has failed to achieve target with performance of 6.88% in December Sustainability and Transformation trajectory is 1.0% the Trust also failed to meet this trajectory		>6 Week Breaches: MRI = 223 CT = 147 Non-obs U/sound = 2 Cardiology - echo = 1 Urodynamics = 2 Colonoscopy = 79 Flexi sigmoidoscopy = 21 Cystoscopy = 95 Gastroscopy = 13 TOTAL 583
Referral to Treatment Incomplete pathway	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%	The Trust failed to achieve the December Sustainability and Transformation trajectory of 91.4% December performance was 85.0%		The RTT return is grouped in to 19 main specialties. During December there were 16 specialties that failed to meet the STF trajectory

RESPONSIVE

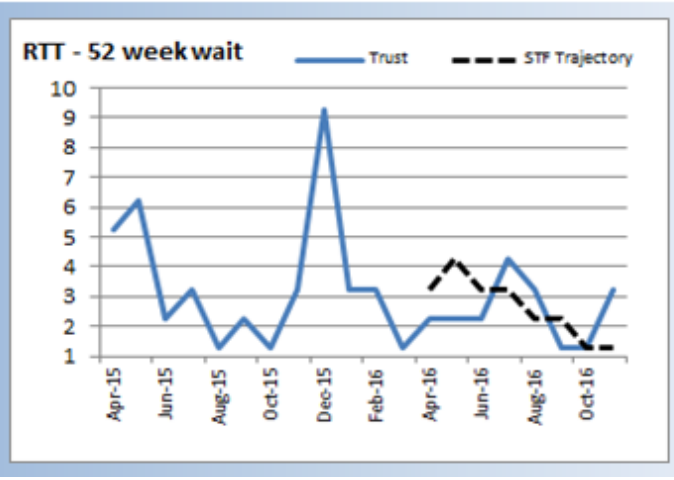
Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The Trust failed to deliver the national standard of zero breaches with 5 breaches for December

The Trust also failed to achieve the STF trajectory of zero breach during December



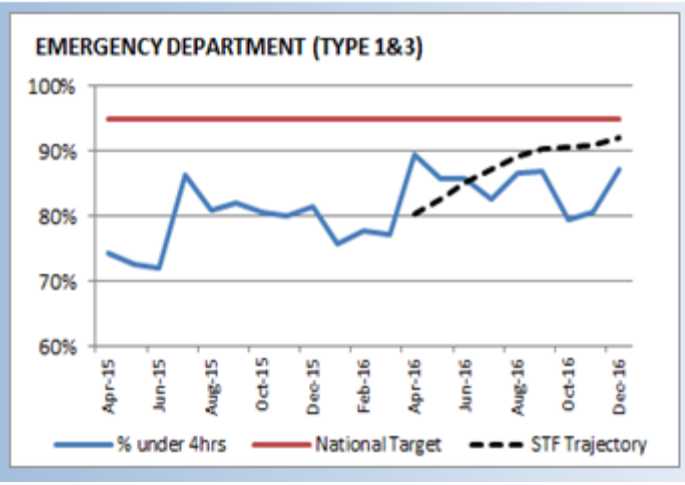
The reported breach specialties were:

Cardiology x1
Cardio- thoracic Surgery x2
Orthpaedics x1
Paediatric - Gastroenterology x1

A&E Waiting Times

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

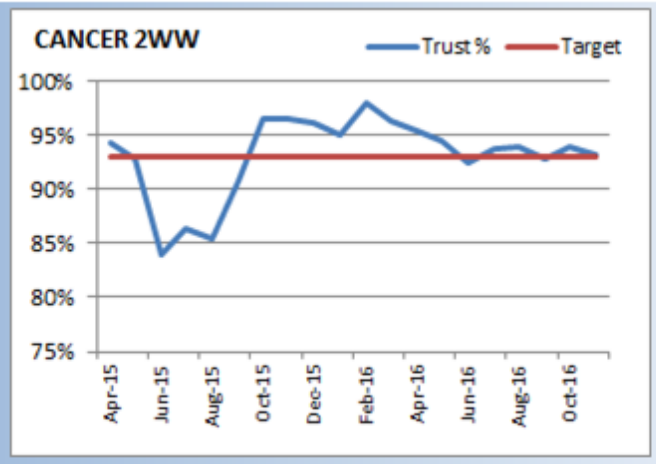
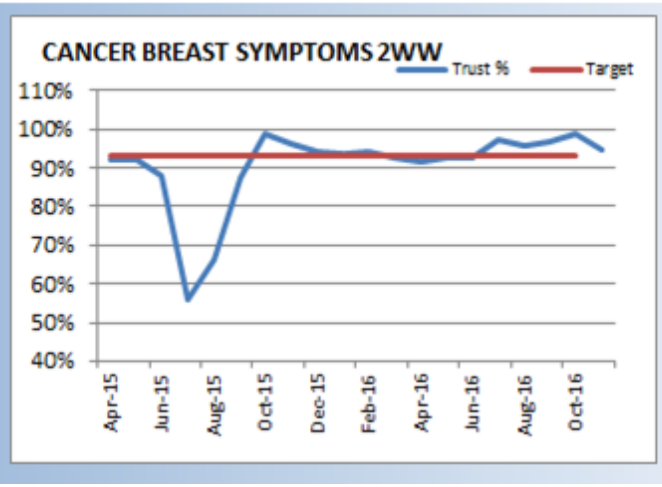
A&E performance has remained below the national 95% threshold with performance of 87.3% for December which was also below the agreed Sustainability and Transformation trajectory of 92.1%



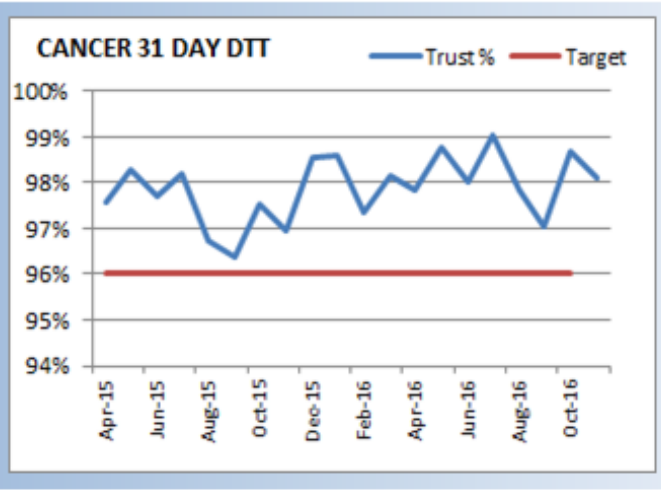
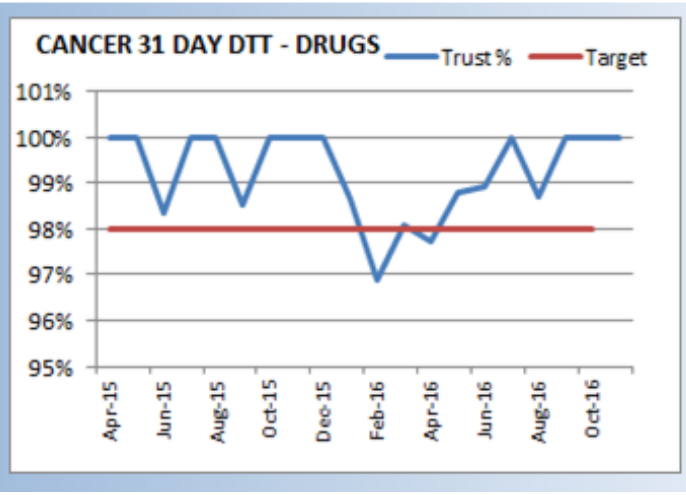
Performance has improved by 6.6% during December compared to November performance of 80.7%.

Integrated Performance Report - January 2017

RESPONSIVE

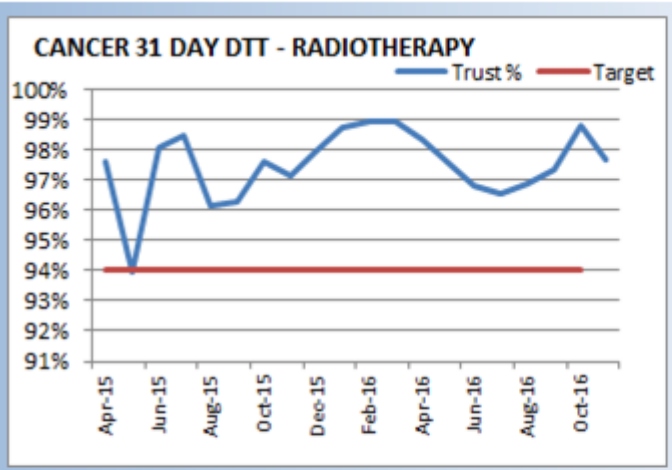
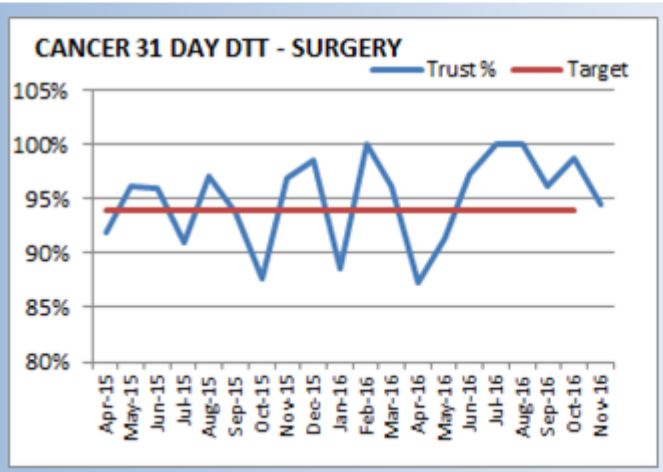
Description	Aggregate Position	Trend	Variation
Cancer: Two Week Wait Standard	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.	November performance achieved the 93% standard at 93.3%		Tumour Sites failing to meet the 93% standard: Haematological 90.0% Lower GI 88.7% Lung 91.7% Skin 90.6% Upper GI 90.6%
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.	November performance achieved the 93% standard at 94.8%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	November performance achieved the 96% standard at 98.1%		Tumour Sites failing to meet the 96% standard: Gynaecological 94.4% Head & Neck 93.3% Skin 95.9%
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 94%.	November performance achieved standard at 100%		There were no tumour sites failing to meet the 94% standard

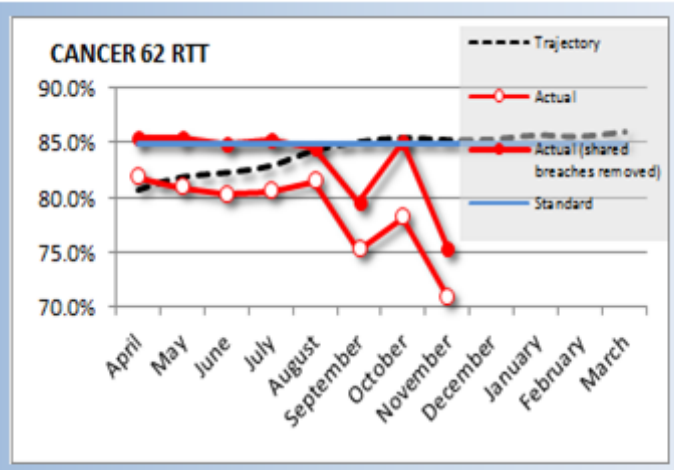
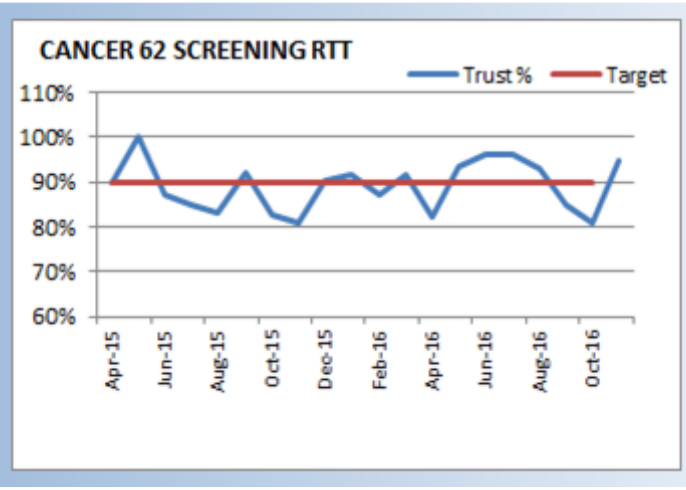
Integrated Performance Report - January 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	November performance achieved standard at 97.7%		Tumour Sites failing to meet the 94% standard: Head & Neck 83.3%
Cancer: 31 Day Subsequent Surgery Standard	All patients to receive first treatment for cancer subsequent surgery within 31 days days of decision to treat. Threshold of 94%.	November performance achieved standard at 94.5%		Tumour Sites failing to meet the 94% standard: Haematological 50.0% Lung 0% (1 Patient) Lower GI 66.7% Urological 93.8%

Integrated Performance Report - January 2017

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: ADJUSTED - 62 Day Standard	All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85% Sustainability and Transformation trajectory is 85.4%	The adjusted position allows for reallocation of shared breaches November failed to achieve the STF trajectory of 85.4% with performance of 75.3%		Tumour Sites failing to meet the 90% standard: Breast 66.7% Gynaecological 83.3% Haematology 50.0% Lower GI 46.5% Lung 65.8% Upper GI 64.7% Urological 78.6%
Cancer: 62 Day Screening Standard	62 Day Screening	November performance achieved standard at 94.7%		There were no tumour sites failing to meet the 90% standard

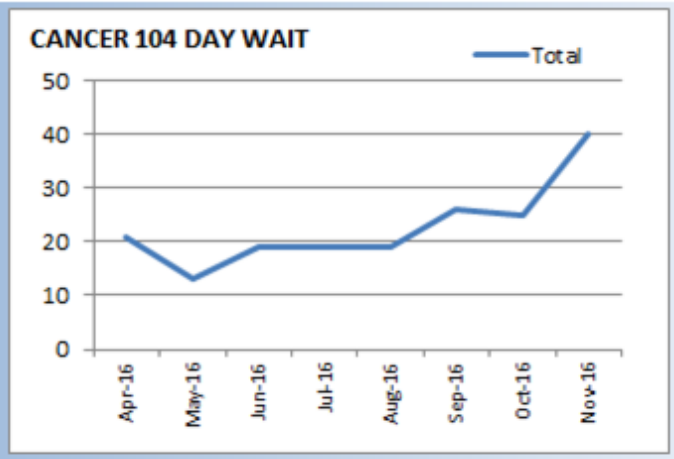
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

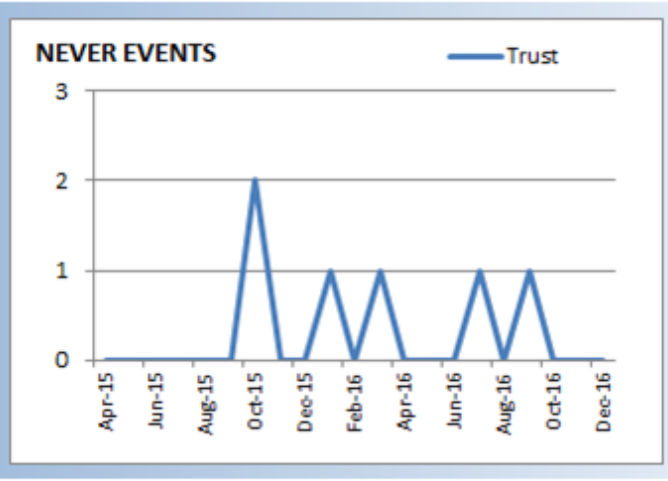
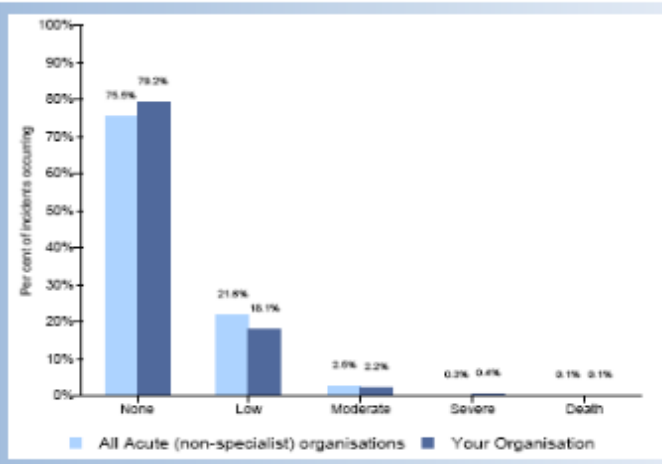
There were 40 patients waiting 104 days or over during November



October by Tumour Site:

Breast x3
Colorectal x11
Gynaecology x2
Haematology x1
Head and Neck x4
Lung x7
Skin x4
Upper GI x3
Urology x5

SAFE

Description	Aggregate Position	Trend	Variation
Occurence of any Never Events	There were zero Never Events reported during December		Further information is included in the Board Quality report
Number of incidents reported per 1000 bed days	The latest data available for this indicator is October 2015 to March 2016 as reported by the National Reporting and Learning System (NRLS). The Trust reported 5,896 incidents (rate of 34.44) during this period. The Median rate for reporting in this period was 39.91		Degree of Harm: None 4672 Low 1057 Moderate 129 Death 5 The Trust has now moved in to the middle 50% of reporters, previously the Trust was in the lowest 25% of reporters

Potential under-reporting of patient safety incidents

SAFE

Description	Aggregate Position	Trend	Variation

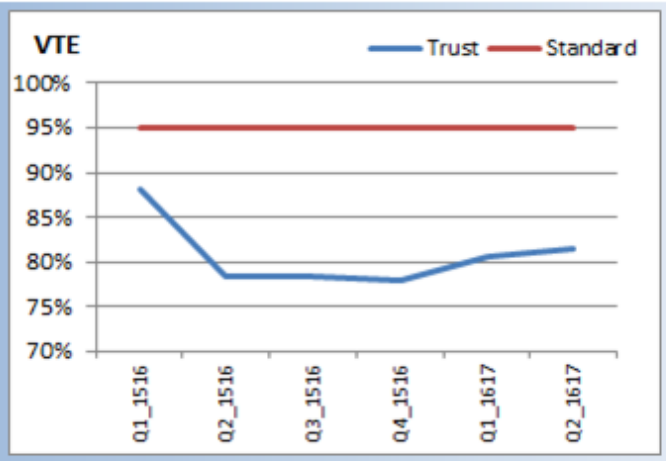
VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 81.59% Q2 2016/17.

Quarter 3 performance will be available in February 2017.



Health Group Performance:

Clinical 93.51%
Family &Women 90.34%
Medicine 59.74%
Surgery 88.92%

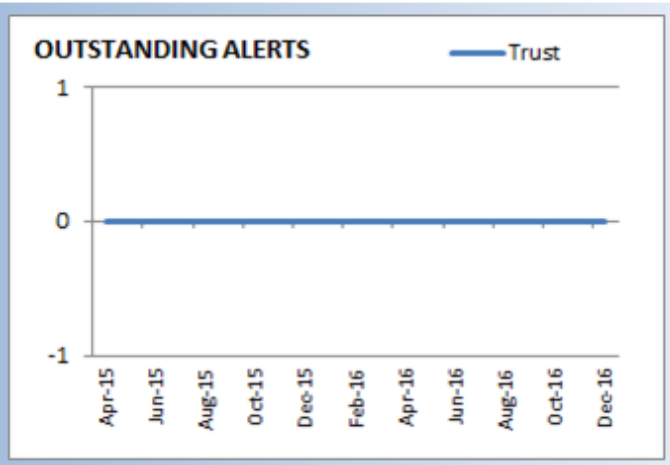
Further information is included in the Board Quality report

Patient Safety Alerts Outstanding

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

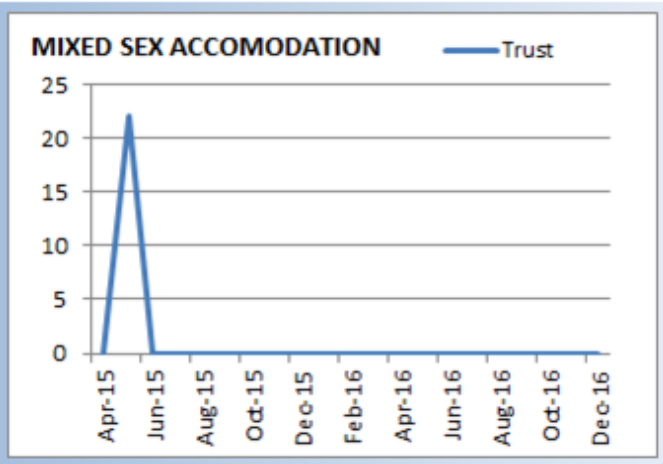
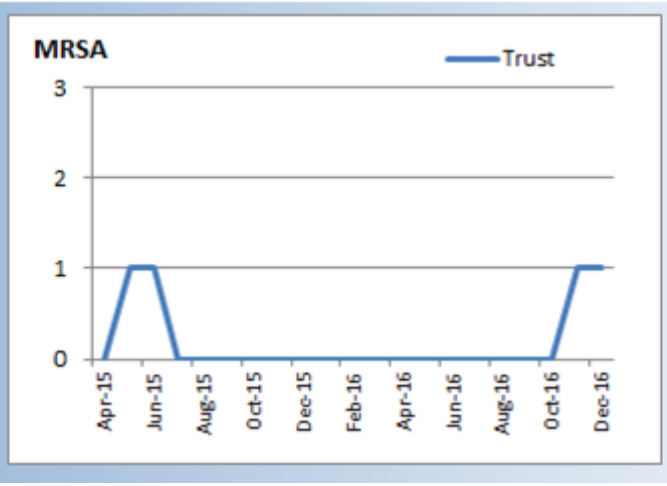
There have been zero outstanding alerts reported at month end for December 2016.

There have been no outstanding alerts year to date.



Integrated Performance Report - January 2017

SAFE

	Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches	Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.	There were no occurrences of mixed sex accommodation breaches throughout December 2016.		
MRSA Bacteraemias	National objective is zero tolerance of avoidable MRSA bacteraemias	The Trust reported 1 case of acute aquired MRSA bacteremia during December		Further information is included in the Board Quality report

SAFE

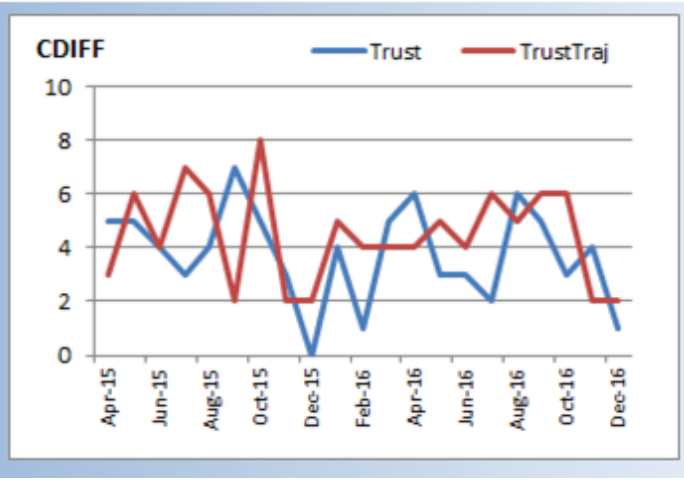
Description	Aggregate Position	Trend	Variation

Clostridium Difficile

The Clostridium difficile target for 2016/17 is no more than 53 cases

There have been 32 cases year to date

There was 1 incident reported during December which achieved the monthly trajectory of no more than 2 cases



Health Group Performance:

Clinical - 0
Family&Women - 0
Medicine - 1
Surgery - 0

Further information is included in the Board Quality report

EFFECTIVE

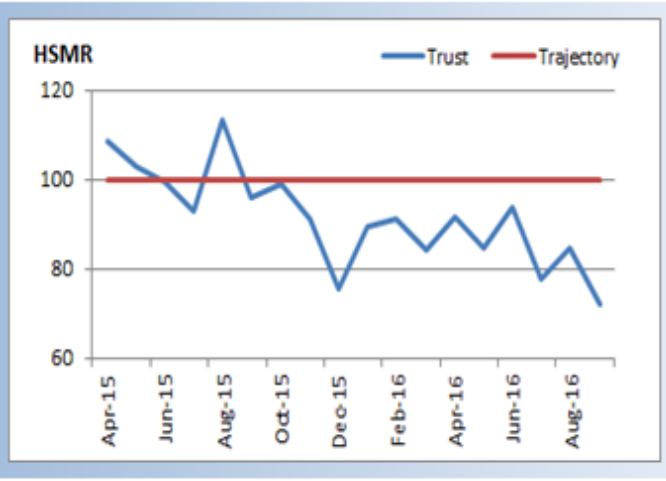
Description	Aggregate Position	Trend	Variation

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

September 2016 is the latest available performance

The standard for HSMR is to achieve less than 100 and September 2016 achieved this at 72.2

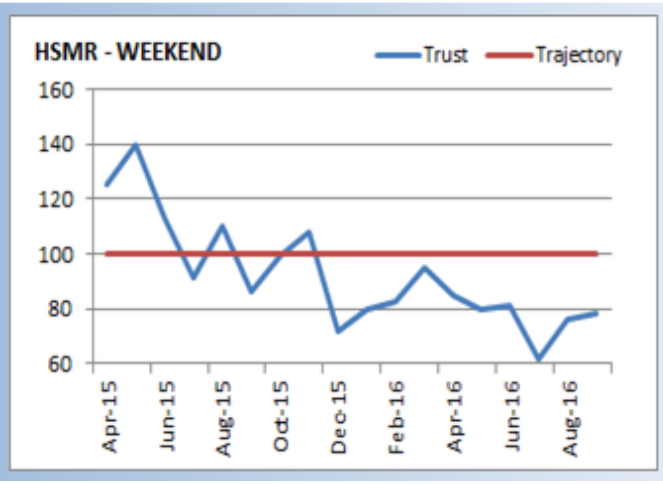


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

September 2016 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and September 2016 achieved this at 78.0



Integrated Performance Report - January 2017

EFFECTIVE

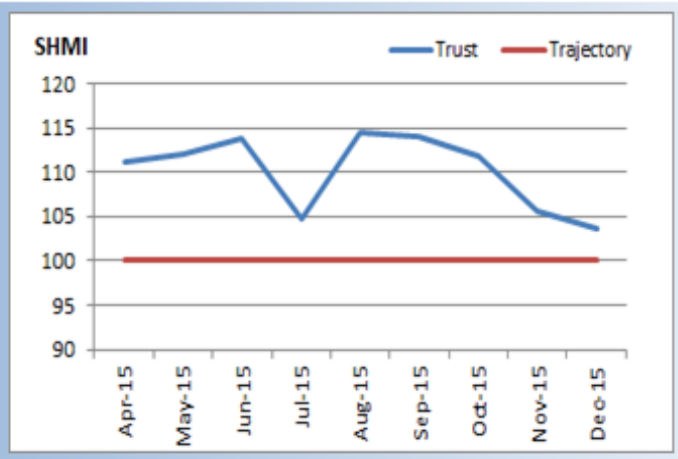
Description	Aggregate Position	Trend	Variation

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 2015 is the latest published performance

The standard for SHMI is to achieve less than 100 and December 2015 failed to achieve this at 103.6

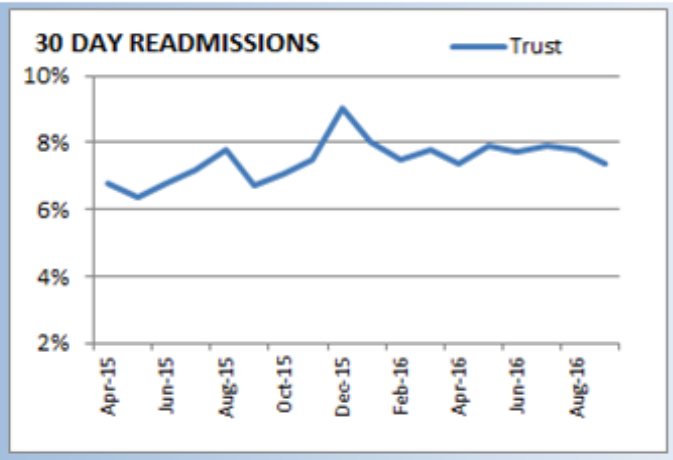


30 DAY READMISSIONS

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

The latest available performance is September 2016

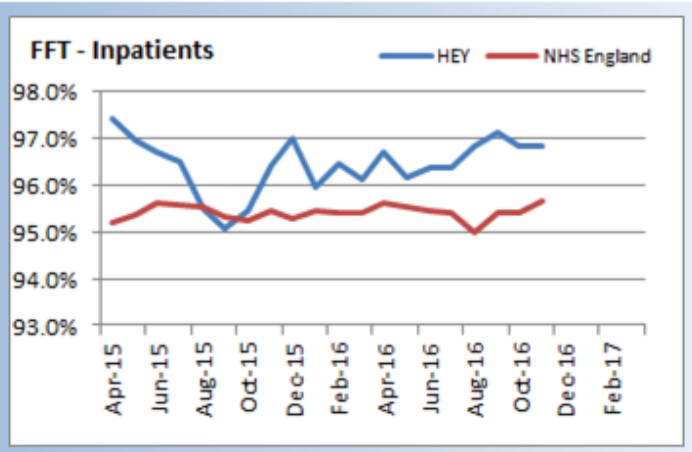
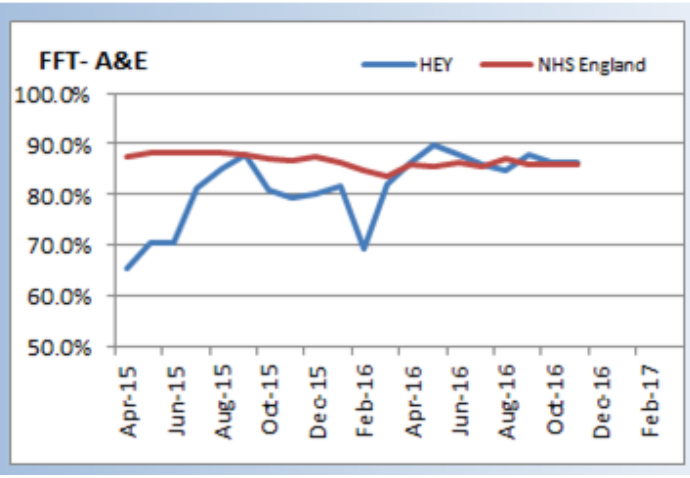
The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than 7.8%. The Trust achieved this measure with performance of 7.4%



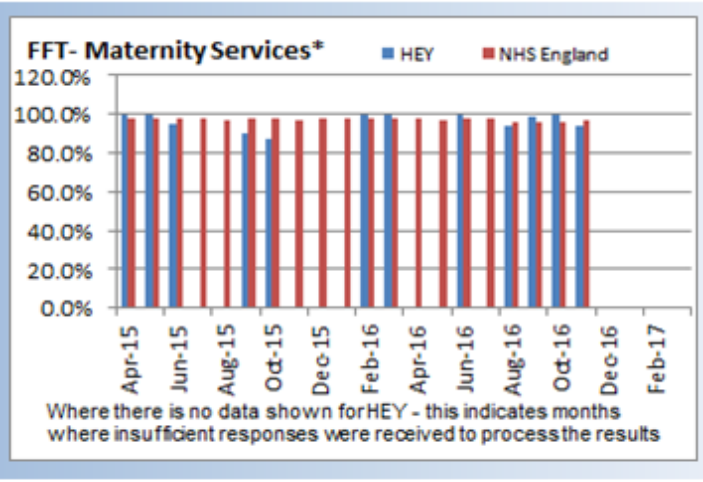
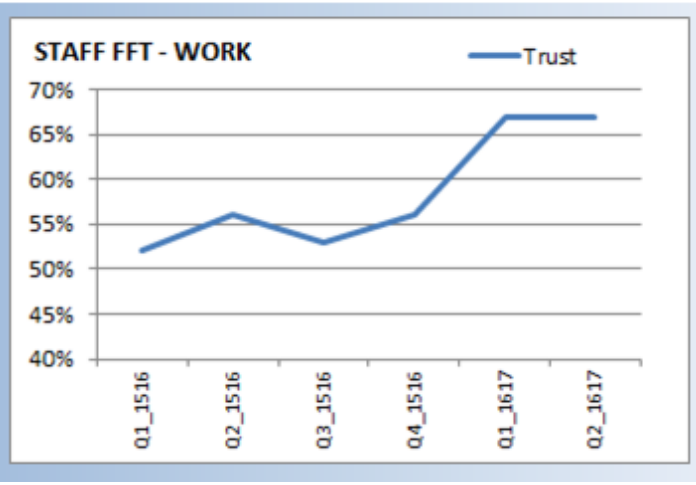
Health Group Performance:

Clinical Support	7.8%
F&WH	4.9%
Medicine	14.1%
Surgery	4.5%

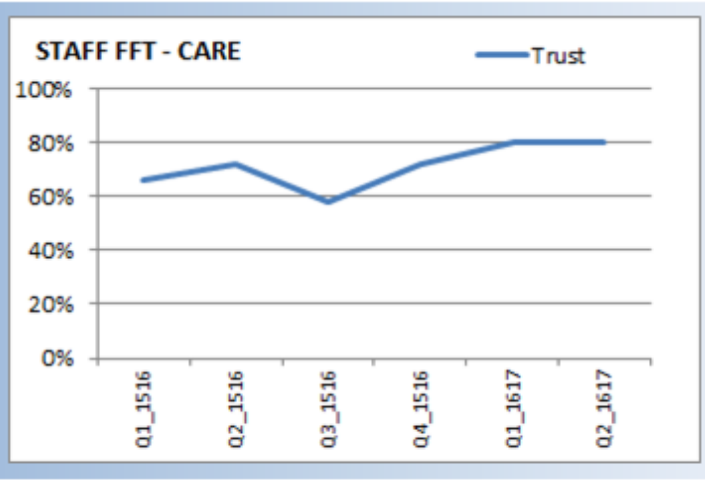
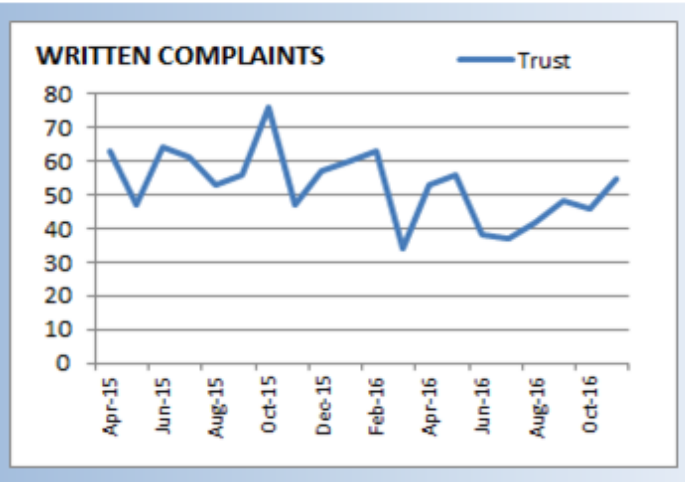
CARING

	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 November was 96.82% The latest published data for NHS England is November 2016		
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for November was 86.28% The latest published data for NHS England is November 2016		

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 November was 94.2% The latest published data for NHS England is November 2016 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 2 2016/2017 shows that 67% of surveyed staff would recommend the Trust as a place to work, this remains consistent with 67% for Quarter 1.	 The overall response rate for Quarter 2 was 20.3%

CARING

	Description	Aggregate Position	Trend	Variation
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?	The latest Friends and Family Test position is Quarter 2 2016/2017 shows that 80% of surveyed staff would recommend the Trust as a place to receive care/treatment, this remains consistent with 80% for Quarter 1.		The overall response rate for Quarter 2 was 20.3%
Written Complaints Rate	The number of complaints received by the Trust	The Trust received 55 complaints during November, this is an increase on the October position of 46 complaints		There have been 375 complaints year to date

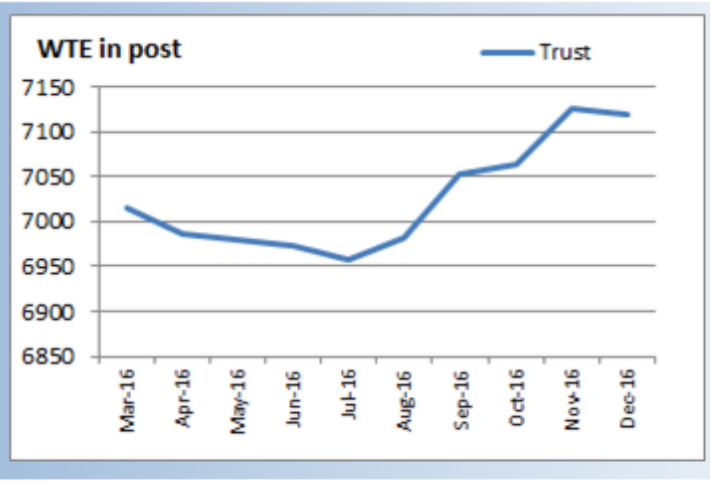
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

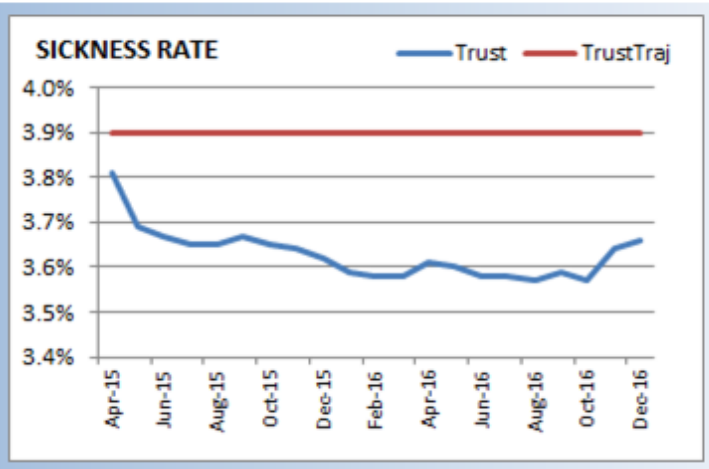
Trust level WTE position as at the end of December was 7118.5



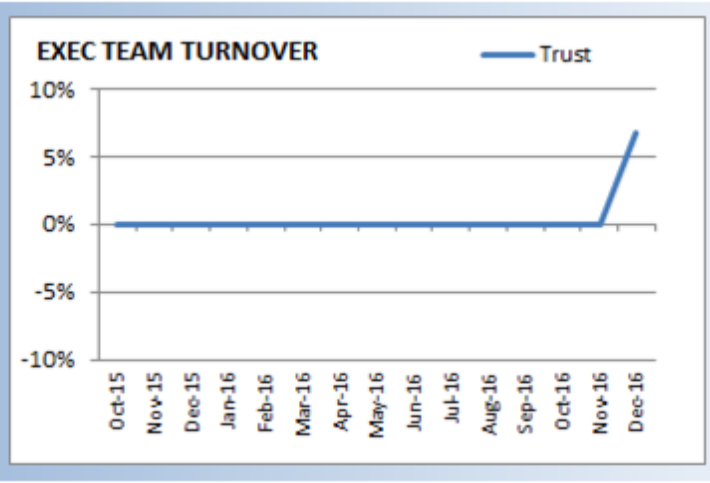
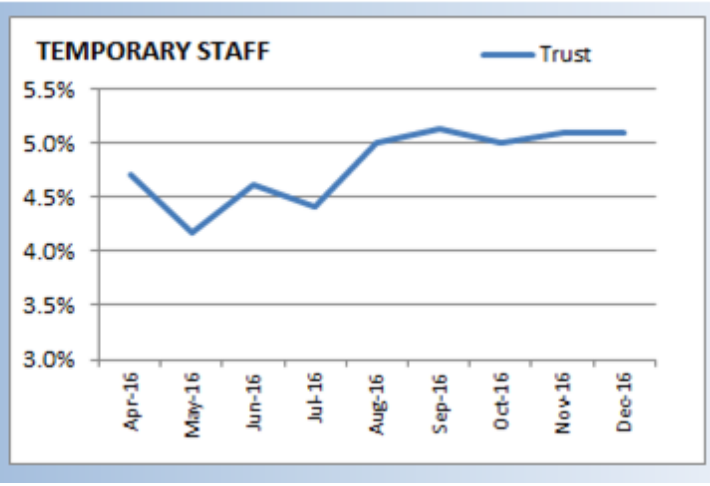
Sickness Absence Rates

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

Performance for December achieved the standard of 3.9% with performance of 3.66%



ORGANISATIONAL HEALTH

	Description	Aggregate Position	Trend	Variation
Executive Team Turnover	Percentage turnover of the Trust Executive Team	Turnover has been 6.7% 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 December performance was 5.1%		

ORGANISATIONAL HEALTH

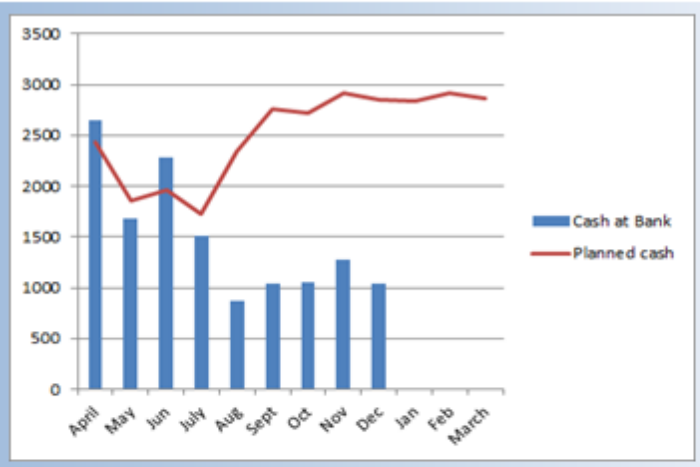
Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of December was £1.039m.

The level of cash is not permitted to fall below £1m or exceed on average £13.4m whilst the Trust is drawing against its revolving working capital loan facility. There is still intense pressure on cash and the Trust is not able to meet obligations to suppliers as they fall due.

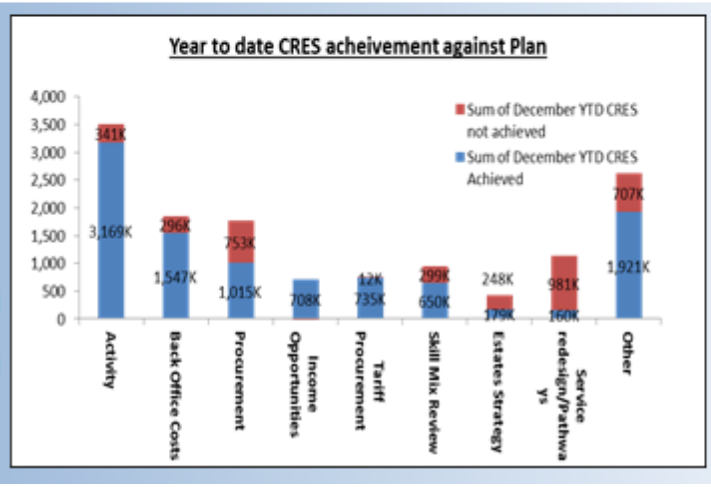


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 9 the Trust has achieved £10.1m of CRES savings against a plan of £13.7m, an adverse variance of £3.6m.

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



The Health groups have been tasked with finding additional schemes to cover their CRES shortfall.

ORGANISATIONAL HEALTH

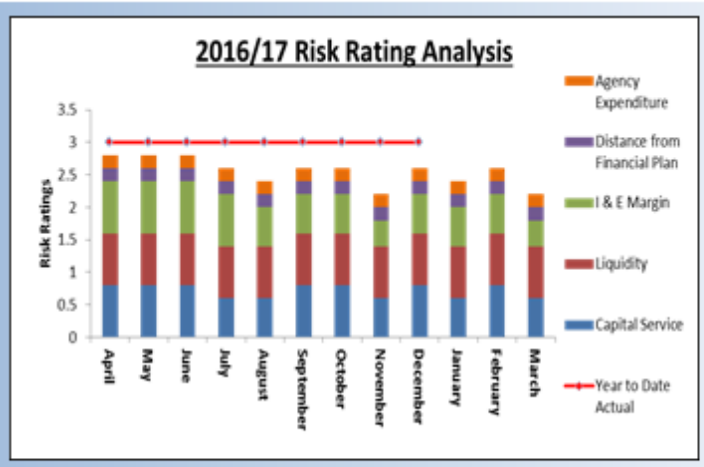
Description	Aggregate Position	Trend	Variation

Risk Rating

Financial Sustain-ability Risk Rating

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

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst. The Trusts risk rating is currently 3.
The Trust is £1.1m short of its I & E Plan as at month 9, the Trust has not achieved the required level of performance in quarter 3 to receive the STP funding which would have put the Trusts financial performance in line with plan

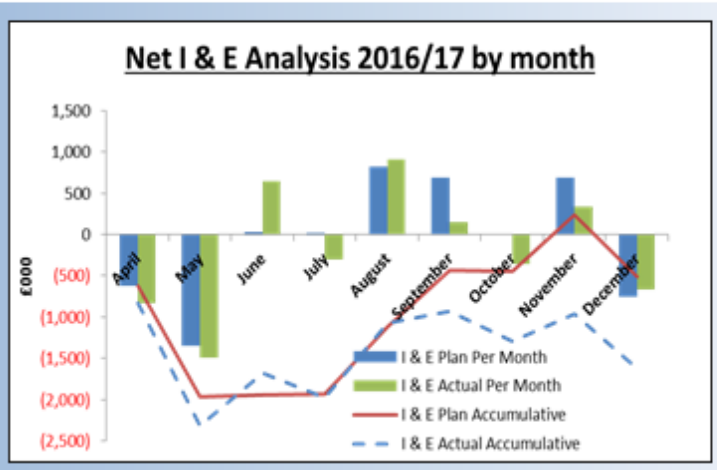


Income & Expenditure

Net income and Expenditure

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

At month 8 the Trust is £1.2m below plan this is a deterioration of £0.4m in month



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

HOSPITAL PHARMACY TRANSFORMATION PROGRAMME (HPTP) PLAN REPORT

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 - 13
Director	Chief Financial Officer – Lee Bond	**Author**	David Corral – Chief Pharmacist
Reason for the report	The purpose of this paper is to inform the board of the Hull and East Yorkshire Hospitals NHS Trust Hospital Pharmacy Transformation Programme (HPTP) Plan.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to review and approve the HPTP (Hospital Pharmacy Transformation Programme 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): **W1 –** A clear vision and a credible strategy to deliver good quality			
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** Y
5	**BOARD/BOARD COMMITTEE REVIEW** The plan has been reviewed at operational management level through the Carter Group.			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

HOSPITAL PHARMACY TRANSFORMATION PROGRAMME PLAN

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the Hospital Pharmacy Transformation Plan (HPTP) for approval

2. BACKGROUND

In June 2014, Lord Carter of Coles was appointed to the position of Chair of a new NHS Procurement & Efficiency Board to direct the NHS Procurement & Efficiency Programme and its portfolio of projects.

In accepting this new role Lord Carter stated his intent to include a review of hospital pharmacy and medicines optimisation in the work of the Board. Accordingly, in September 2014, Dr Keith Ridge, Chief Pharmaceutical Officer was invited to join the NHS Procurement & Efficiency Board and to chair the Hospital Pharmacy and Medicines Optimisation Project (HoPMOp).

On 5th February 2016, Lord Carter published his final report to the Secretary of State for Health identifying unwarranted variation across all of the main resource areas worth an estimated £5billion in terms of efficiency opportunity.

Of this, the report stated that the NHS could save at least £800million through transforming hospital pharmacy services and medicines optimisation. It made eight recommendations at acute Trust, regional and national levels. All of the recommendations were accepted.

Lord Carter's final report contained 15 recommendations. Whilst some of the other recommendations touch upon the Hospital Pharmacy Transformation programme, the key recommendation for the HPTP is Recommendation 3.

Recommendation 3: Trusts should, through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities.

a) developing HPTP plans at a local level with each Trust board nominating a Director to work with their Chief Pharmacist to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally; with the Chief Pharmacist Officer for England signing off each region's HPTP plans (brigaded at a regional level) as submitted by NHS Improvement;
b) ensuring that more than 80% of Trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits and reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another Trust or through a third party provider;
c) each Trust's Chief Clinical Information Officer moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA);
d) each Trust's Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, is accurately recorded within NHS Reference Costs;

e) NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for Trusts to pursue;
f) the Commercial Medicines Unit (CMU) in the Department of Health undertaking regular benchmarking with the rest of the UK and on a wider international scale to ensure NHS prices continue to be competitive, and updating its processes in line with the Department of Health's NHS Procurement Transformation Programme as well as giving consideration as to whether the capacity and capability of the CMU is best located in the Department of Health or in the NHS, working alongside NHS England's Specialist Pharmacy Services and Specialised Commissioning functions;
g) consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically

As part of the Carter work (Recommendation 12) NHS Improvement has produced a 'Model Hospital' with underlying metrics across a range of areas. One of the areas active is 'Pharmacy & Medicines' and this has and will be used to support the work-streams in the HPTP (Appendix 1 – Trust data from dashboard January 2017).

3. TRUST POSITION

The Trust has identified Lee Bond, Chief Finance Officer, as the Executive lead for 'Carter' implementation. He chairs the Carter steering group which includes the Hospital Pharmacy and medicines optimisation workstream and that of the HPTP plan. Operational lead for co-ordination will be through David Corral, Chief Pharmacist.

Draft HPTP plans had to be submitted to NHS Improvement by 31st October 2016. Feedback was arranged through two national study days as well as some direct Trust feedback. The feedback nationally as well as to Hull and East Yorkshire Hospitals NHS Trust was largely positive and plans have been further developed in light of this feedback with a focus on collaborative working.

The Department of Pharmacy at Hull and East Yorkshire Hospitals NHS Trust has a long history of working collaboratively with others especially the regional Yorkshire Chief Pharmacist YCP) network. This has delivered on range of projects where collaboration has proved to be beneficial and cost effective:

- Joint funded posts by YCP e.g. regional quality control post, regional purchasing
- Regional specialist groups for information sharing, benchmarking and task and finish projects
- Regional education & training collaboration to maximise funding opportunities
- Annual conference showcasing best practise
- Innovative Regional purchasing with an overall return on investment of 12 to 1 (laterally involving commissioning input)
- Back up support e.g. use of aseptic facilities in a shut down
- Peer support for Chief Pharmacists

As well as regional collaboration, the Department of Pharmacy has long standing good relationships with other local providers and Clinical Commissioning Groups (CCGs). Some of the benefits of this joint working include:

- Joint posts with Humber NHS Foundation Trust
- Joint working with City Health Care Partnership on pharmaceutical services to patients in care homes
- Cost saving initiatives with CCGs (and their support units)
- Patient safety initiatives with CCGs and community Pharmacies

The HPTP will utilise these existing networks as well as the local Strategic Transformation Programme (STP) Humber Coast and Vale network. The initial Pharmacy focus will be working with the the acute Trusts at Northern Lincolnshire and Goole and York.

The plan will also support the Hull and East Yorkshire NHS medicines optimisation framework which will be updated in 2017 supporting the strategic direction of the Pharmacy and the Trust.

4. HPTP PLAN

A summary of the plan is attached (Appendix 2) with more detail on each project and time-scales (Appendix 3). The plan has been developed to be realistic and deliverable and takes account of issues and risks detailed.

5. GOVERNANCE

Overall implementation and progress of the plan will be monitored by the Trust Carter steering group. Each project within the HPTP will have a nominated lead, though the project management structures will vary related to the complexity of the work.

The projects will also link in with existing governance structures (e.g. health group governance and evolving structures around STP development) as appropriate.

6. WORKFORCE

A motivated and skilled workforce will be key to successful delivery of the projects. The Pharmacy department employs approximately 200 members of staff with a mix of Pharmacists, technicians and other staff.

Roles have and will continue to change for successful delivery of the plan. Pharmacy and medicines optimisation will be part of the multidisciplinary healthcare workforce transformation required at all levels in the Trust.

6. FINANCE

Any savings associated with the projects will be managed and reported through existing Trust structures.

Projects requiring pump priming will also use existing Trust processes to access funding required. Other networks will also be used to access and bid for funding where available.

7. RISKS AND ISSUES

A risks and issues log is attached (Appendix 4)

8. ACTIONS REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and approve the HPTP (Hospital Pharmacy Transformation Programme Plan).

David Corral
Chief Pharmacist and Clinical Director
Therapy and Therapeutics

16th January 2017

Pharmacy & Medicines, Trust Level

Money & Resources	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Pharmacy Staff & Medicines Cost per WAU	2015/16	£423	£383	£350			No trendline available
Medicines Cost per WAU	2015/16	£386	£344	£312			No trendline available
High Cost Medicines per WAU	2015/16	£122	£152	£112			No trendline available
Non High Cost Medicines per WAU	2015/16	£264	£210	£196			No trendline available
Choice of Paracetamol Formulations [% IV Paracetamol vs Total Spend] *NEW*	2015/16	56%	53%	56%			No trendline available
Use of Generic Immunosuppressants [% Generic vs Total Spend (Selected Drugs)] *NEW*	-	NOT AVAILABLE	-	-			
Use of Inhalation Anaesthetics - % Spend on Sevoflurane *NEW*	2015/16	65%	65%	66%			No trendline available

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Total Antibiotic Consumption in DDD*/1,000 Admissions	2015/16	3,925	4,534	4,549			
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Jun 2016	20.66%	3.36%	8.85%			
% ePrescribing Chemotherapy	2014/15	80%	100%	50%			No trendline available
% ePrescribing IP	2015/16	0%	10%	50%			No trendline available
% ePrescribing OP	2014/15	20%	-	50%			No trendline available
% ePrescribing Discharge	2014/15	20%	90%	60%			No trendline available

Pharmacy & Medicines, Trust Level

Effective	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities] *NEW*	2015/16	73%	53%	66%			No trendline available
% Pharmacists Actively Prescribing	2015/16	10%	12%	20%			No trendline available
% Medicines Reconciliation Within 24 Hours of Admission	2015/16	85%	76%	73%			No trendline available
% Use of Summary Care Record (or Local System) per Month	Aug 2016	197.0%	65.1%	52.1%			
% Soluble Prednisolone of Total Prednisolone Uptake	Sep 2016	5.6%	1.6%	3.4%			
% Biosimilar Infliximab Uptake (Monthly)	Sep 2016	14.4%	43.8%	68.3%			
% Biosimilar Etanercept Uptake (Monthly)	Aug 2016	6.7%	-	17.0%			
Total Spend on Etanercept in 201516	2015/16	£1.0m	£1.7m	£1.1m			No trendline available
Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands] *NEW*	2015/16	60%	30%	42%			No trendline available
Number of Medication Incidents Reported to NRLS per 100,000 FCEs of Hospital Care *NEW*	Mar 2016	178.2	264.7	285.6			
% Medication Incidents Reported as Causing Harm or Death/All Medication Errors *NEW*	Mar 2016	6.6%	8.5%	9.7%			No trendline available
Number of Days Stockholding	2015/16	19.0	25.0	18.8			No trendline available
Pharmacy Deliveries per Day [Average Number of Deliveries]	2015/16	16	15	15			No trendline available
e-Commerce - Ordering (Alliance) *NEW*	2015/16	0.0%	84.7%	90.4%			No trendline available
e-Commerce - Ordering (AAH) *NEW*	2015/16	23.0%	75.4%	82.0%			No trendline available

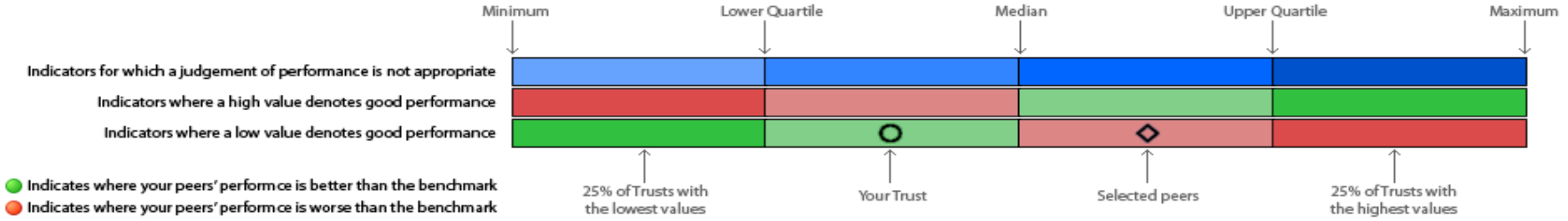
Pharmacy & Medicines, Trust Level

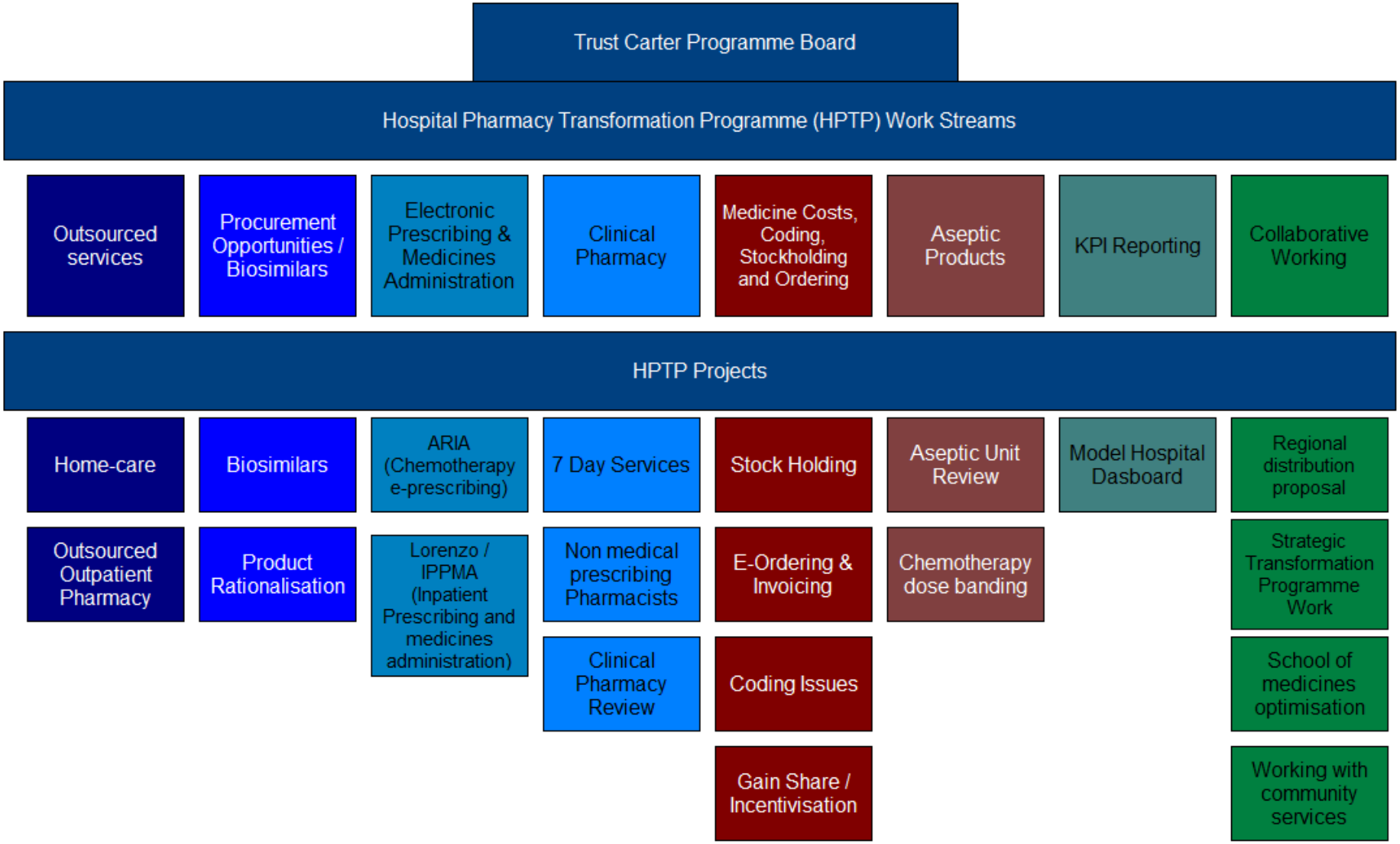
Effective	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Data Quality of NHS England Monthly Data Set Submissions From Providers *NEW*	Sep 2016	24	19	20			No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
National Inpatients Survey - Medicines Related Questions	2015/16	69.5%	74.3%	73.1%			

Responsive	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Sunday ON WARD Clinical Pharmacy Hours of Service (MAU/Equivalent)	2015/16	4.0	10.0	7.0			No trendline available

People, Management & Culture: Well-led	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
% Sickness Absence Rate	2015/16	2.7%	3.6%	3.1%			No trendline available
% Staff with Appraisals Completed	2015/16	91%	100%	85%			No trendline available
% Staff with Statutory and Mandatory Training	2015/16	91%	98%	91%			No trendline available
% Staff Turnover Rate	2015/16	10%	10%	14%			No trendline available
% Staff Vacancy Rate *NEW*	2015/16	9%	11%	6%			No trendline available




Trust Carter Programme Board
Hospital Pharmacy Transformation Programme (HPTP) Work Streams
Outsourced services
Procurement Opportunities / Biosimilars
Electronic Prescribing & Medicines Administration
Clinical Pharmacy
Medicine Costs, Coding, Stockholding and Ordering
Aseptic Products
KPI Reporting
Collaborative Working
HPTP Projects
Home-care
Biosimilars
ARIA (Chemotherapy e-prescribing)
7 Day Services
Stock Holding
Aseptic Unit Review
Model Hospital Dasboard
Regional distribution proposal
Outsourced Outpatient Pharmacy
Product Rationalisation
Lorenzo / IPPMA (Inpatient Prescribing and medicines administration)
Non medical prescribing Pharmacists
E-Ordering & Invoicing
Chemotherapy dose banding
Strategic Transformation Programme Work
Clinical Pharmacy Review
Coding Issues
School of medicines optimisation
Gain Share / Incentivisation
Working with community services

Appendix 4 Issues and Risks Associated with the HPTP

Issues	Mitigation
Issues around 'gain-share' may disincentive trusts and make outsourced models non-viable	We have worked closely with NHS England to support their work plans and for them to understand Trust issues.
Lack of funding to pump prime major projects	Work closely with key colleagues e.g. chief exec/ finance officers to fully brief on projects and benefits
Capacity to deliver projects	Estimate resource required for projects and ensure time allocated or funding sought and agreed.
Difficulties to recruit and retain suitable workforce	Grow our own approach and increase in training posts. Work closely with trust recruitment campaign.

Risk	Mitigation
Future funding arrangements to support training and education including that of non-medical prescribers	Work closely with the school of medicines optimisation. Chief Pharmacist at HEY is on steering board.
Partners unwilling to work together	Be proactive and open with plans with all key partners
Further workforce issues and inability to recruit and retain suitable staff e.g. loss to GP practices	Look at more innovative ways to recruit and retain, including potential rotational posts in GP practices

Appendix 3

Trust Carter Programme Board
Hospital Pharmacy Transformation Programme (HPTP) Work Streams

1.Outsourced Services

a) Home Care - The department oversees the safe and cost effective use of direct to home delivered medication. This is traditionally used for long term chronic conditions treated with high cost medicines e.g. rheumatoid arthritis treated with cytokine agents. Patients typically receive a medication delivery from a third party provider every 2-3 months from a prescription/ order generated by the Trust. The focus of this work is to ensure compliance with the Hackett report ensuring clinical and financial governance are in place for each clinical area. Approximately £12m/yr is spent on home-care so this project saves the health communities approximately £1.5m net per year. Working with the regional medicines optimisation and procurement group, new and existing therapies will be reviewed for the most cost effective supply process (Carter 3b, 3d –reference to Carter report recommendations or MH model hospital metrics)

   Action 1a – Three year rolling audit plan produced for each therapy area against best practice - April 17.

b) Outsourced Out Patients – Boots UK Ltd commenced a 5year (+ 2) contract to provide out-patient services to Hull Royal Infirmary & Queens Centre in May 2016. The contract as well as dispensing required out-patient medicines also includes for the home delivery of medicines, as well as TTO (To Take Out) dispensing, and is supported by robust governance arrangements. Going forward the trust will work with Boots to maximise efficiencies in both terms of new services that they can provide and how we deliver existing services. These need to be patient focussed and cost effective and some of this work will link with the review of home-care services. The pilot realised net savings of £1.2m /yr to the health community. (Carter 3b, 3d)

   Action 1b(i) – Ensure gain share / incentivisation arrangements keep project viable for the trust - Feb17 (then annually).

   Action 1b (ii) – Maximise use of provider for dispensing of TTO's within contract specification - June 17

2.Procurement Opportunities / Biosimilars

a) Biosimilars – (Biosimilar medicines are chemical entities similar to the original biological medicine which exert a similar clinical affect.) HEY has largely delivered successfully on the change to biosimilars (or managed the market with the opportunities created from biosimilars introduction) e.g. for filgrastim, pegfilgrastim, growth hormone and epoetins. This has saved the health community approximately £100K per annum. Biosimilar Infliximab infusion has been introduced and HEY is working through a plan for the safe switching, including patient involvement, with an estimated health community saving of £800,000. (Carter 3b 3d MH)

Action 2a(i) – Complete the change of existing patients, where appropriate to biosimilar Infliximab using lessons learned to support future projects- June17

Action 2a(ii)- Deliver on upcoming biosimilar opportunities and ensure switches managed in a safe and efficient manner eg Rituximab, Adalimumab and Etanercept (predicted Etanercept savings £600K to the health community)- March 19

Action 2a (iii)- Ensure gain share / incentivisation arrangements keep project viable for the trust by Mar17 (then annually).

b) Product Rationalisation – This project is headed by our Deputy Chief Pharmacist who is a member of the regional medicines optimisation and purchasing committee. Opportunities are identified in a number of ways and changes managed in a structured fashion involving other partners eg CCGs when required. Existing Trust governance structures eg drugs & therapeutics committee, safe medication committee and quality impact assessment process are utilised to ensure the impact upon safety and patient experience are assessed. Recent projects include change from weekly pegfilgrastim to daily biosimilar filgrastim (£20K saving), switch to 'branded generic' oxycodone (£25K) and a reduced usage of soluble prednisolone (£12K). (Carter 3d 3e MH)

Action 2b(i) This workstream will systematically work through those drugs identified by NHS improvement as the top 10 with savings opportunities- April 17.

Action 2b(ii) Opportunities for savings will be shared across the STP patch on a quarterly basis - Feb 17.

3. EPMA (Electronic Prescribing and Medicines Administration)

a) ARIA – Aria is the e-prescribing system used by the Trust for chemotherapy. It is used (January 17) for 80% of regimens and the project will aim to increase this number of regimens as well as support a NHS paperless environment This will greatly improve information available eg SACT data (Systemic anti-cancer therapies) which will be an enabler to identifying further opportunities to drive efficiencies in the system by being able to compare clinical outcomes and prescribing practices. (Carter 3c MH)

Action 3a(i)To have 95% of regimens built (excluding trials)-Mar17

Action 3a(ii) Project reviewed and management structure put in place to support –Sep 17

b) Lorenzo IPPMA (In-patient prescribing and medicines administration) – This is live on 5 Cardiology wards for TTO prescribing and in the Emergency Department for Out-patient prescribing. The business case has been approved by the trust board and the first in-patient ward is due to go live in April 2017. This major 3 year project plan will be subject to project management using Prince 2 methodology. (Carter 3c MH)

Action 3b Fully support the implementation and delivery of first go-live ward - April 17 (Further timelines will be determined by the success of the pilot)

4 Clinical Pharmacy

a) 7 Day Services – The departments are open 365 days a year on both sites and provides a targeted clinical service at weekends following previous working hour reviews and consultation. The department supports flexible working which as well as helping individual work life balance is key for 7 day working patterns. This project will ensure services are reviewed to be focussed when required for patient need. It will also match other clinical service reviews provided by the trust e.g. weekend chemotherapy clinics, out-patient clinic moves. It will review opening hours, work/shift patterns, use of e-rostering as well as a review of on-call arrangements.(Carter 3b,MH)

   Action 4a(i) Working hours review will be formalised to a staff consultation with a view to increase staffing and opening hours at bank holidays, weekends –Aug17

   Action 4a(ii)E-rostering will be assessed for suitability for Pharmacy and introduced if appropriate –Mar18

b) NMP Pharmacists – The Trust has 9 active prescribers including a Cardiology pharmacist running a lipid clinic with follow up phone review This project will support maximising the use of Pharmacist prescribers (currently 7 in training) and ensure the governance arrangements are in place to support patient safety and experience. The project will also ensure there is a robust business model around the use of Pharmacist prescribers.(Carter 3b,MH)

   Action 4b(i) Review of pharmacy pilot of Pharmacist prescribing discharge prescriptions and business case developed if appropriate- Apr17 /Sep 17

   Action 4b(ii) Pilot transcribing policy on acute admissions areas to support early medicines reconciliation to support patient safety – Mar18

   Action 4b (iii) Assess the method (in conjunction with school of medicines optimisation) and numbers undertaking non-medical prescribing – Mar18

c) Clinical Pharmacy Review – Our current measure of Pharmacists clinical activity has been measured at 73%. This may appear high compared to others in the region but is on the back of the successful skill mix reviews and introduction of technician led dispensary, procurement, and IT services. The project will focus on increasing the percentage of time spent clinically by linking in with other infrastructure projects as well as review of job plans of all Pharmacists. The project will also monitor delivery of medicines reconciliation targets.(Carter 3b,MH)

   Action 4c(i) Undertake a workforce review of assistants and technician work at ward level including the success of medicines management assistants and use of technicians in drug administration rounds and support for controlled drug management –Mar 18

   Action 4c(ii) Review of support systems to the clinical services including dispensing trollies , pre-packs and ward based automation – Sep 18

   Action 4c(iii) Review of how clinical Pharmacy services are delivered including review of a pilot of increased resource into admission units. The review will also include how e-prescribing influences delivery of the clinical Pharmacy service- Sep 18

5.Medicine Costs, Coding, Stockholding and Ordering

a) Stock Holding – The pharmacy department current position on stock-holding is 19 days (down from 23 days in 2015) against the Carter target of 15 days. A task and finish group has been set up to maximise efficiencies in this area. It is important stock reductions are achieved without affecting patient care or introducing additional financial risk. It is expected this work will result in a reduction of a few days stock holding. Any further major reduction will only be achieved via a larger project- see 7(a) Collaborative Working regional distribution work under (Carter 3d 3g MH)

   Action 5a Evaluate task and finish group and decide if embedded in normal business processes – Jun 17

b) E-Ordering & Invoicing –The department (Oct 16) orders approximately 60% of all lines by e-ordering but 0 % undergoes e-invoicing. A task and finish group has been set up to improve performance in this area. Discussions are taking place with other manufacturers to switch to e-ordering. A pilot is underway on e-invoicing, with a target of 60% by March 2018. The Department of Pharmacy work closely with Finance Department on maximising the opportunity for e-commerce. (Carter 3d 3g MH)

   Action 5b- Group to produce a report on success of initiatives – Dec 17.

c) Coding Issues – The Assistant Director of Finance is leading a piece of work to identify any issues in this area for the Trust. Issues identified will be managed in conjunction with the Trust's information and coding team.

   Action 5c(i)- The Trust will support the national implementation of prescribing by DM+D based software systems and pharmacy systems which support improved coding. –Jun17 (or when upgrade available)

   Action 5c(ii) - Report produced to identify any issues for the Trust- Jun 17

d) Gain Share/Incentivisation – A gain share arrangement is in place with NHS England to March 2017. (need to check… Steve has offered gain share to end of March 2018). They have indicated a wish to terminate this style of arrangement from April 2017 and move to a cost per item basis. New commissioning circulars are indicating costs to be passed through VAT exempt with no share of benefits. This position will be challenged by HEY commissioning team. A gain share is in place on a case by case basis with the CCG for opportunities e.g. for Infliximab and Etanercept. These are reviewed in a collaborative approach as opportunities arise.

   Action 5d- Trust to agree annual gain share /incentivisation schemes with commissioners – Feb 17 (NHS England) Mar17 (CCG's) annually thereafter.

6 Aseptic Products

a) Aseptic Unit Review –An internal review of aseptic services is currently being undertaken. This has resulted in working with a third party provider (under the auspices of the Yorkshire &Humber regional contract) resulting in 65% of lines being procured externally (Oct 16). This

supports delivery of the aseptic unit capacity plan. The pharmacy aseptic team focus on medication within clinical trials, unstable items and supporting patients requiring urgent change in their therapy. Use of third party provider, coupled with dose banding of products has saved approx £50K/annum. (Carter

Action 6a- Report on further review of process and opportunities for additional dose banding. This will include any potential regional/ STP work on aseptic services – Nov17

b) Chemotherapy dose banding –The department has agreed a QIPP plan with NHS England to deliver 20 chemotherapy medications via standard dose bands. This reduces waste, improves patient experience and allows national market testing to drive efficiencies and bring prices down. It also supports the use of licensed products which are now entering the market. (Carter 3d)

Action 6b(i)- The Aria e-prescribing system to be updated to support this new way of prescribing.-Mar 17

Action 6b(ii) –Introduction of dose banded products (identified in the NHS England MO CQUINN, including paclitaxel, carboplation, vincristine etc.) –Jul17

7.KPI (Key Performance Indicator) Reporting

a) Model hospital dashboard – This will be used to support and inform the HPTP and associated projects. It may also result in new projects being added. However the Carter Dashboard is somewhat limited so the department will supplement this information with existing and new KPIs to drive efficiency and innovation. (Appendix 1 Jan 17 data attached) (Carter 3b,3c,3d,3e3g)

Action 7a(i) Decide if Trust to undertake national medicines optimisation bench marking exercise - Jun17

Action 7a(ii) Formal system to review model hospital data to be introduced - March 17

8. Collaborative Working

a) Regional distribution – This project involves the proposal of a regional store to provide direct to ward deliveries. The Trust is engaged in the work and supportive of taking to a further scoping level. This major piece of work will require significant project management funding and a bid has been put together involving 8 trusts to take the project to the next scoping level.

Action 8a(i) Trust to nominate lead to work with regional project - Jan 17

Action 8a(ii) Trust to decide if to take forward project once full business case produced - May 17

b) STP Work - The Humber Coast and Vale STP has 3 main acute Trusts - Hull and East Yorkshire Hospitals NHS Trust, North Lincolnshire and Goole NHS Trust and York Foundation Trust. The 3 Chief Pharmacists are now meeting every 3 months to assess any potential joint initiatives and projects. This will supplement the well-established Yorkshire Chief Pharmacist

network. Working with other organisations e.g. mental health, community services etc. will be considered in due course as the network is established. (Carter 3b 3e)

Action 8b(i)- Identify Pharmacy projects and workstreams to be added to STP development plans - Feb 17

Action 8b(ii) Seek funding to support project management of STP work - April 17

c) School of Medicines Optimisation – This new 'regional' school supported by Health Education England is being launched in late October and is expected to support the region on all training and education issues including e.g. a review of pre-registration provision. Hull and East Yorkshire Hospitals NHS Trust's Chief Pharmacist is on the school's project board as the representative of Yorkshire Chief Pharmacists.(Carter 3b)

Action 8c(i) Chief Pharmacist to join the board of the School of Medicines Optimisation- Feb 17

d) Working with Community Services – The Trust has a history of working with community services supported by the monthly interface group and area prescribing committee linking in with Community Pharmacy, GP's, community services and mental health providers. Much has been achieved e.g joint working with CHCP (City healthcare Partnership) where care home patients have a full medication review if admitted to hospital with a follow up on discharge in the care home. A 'Refer to Pharmacy ' scheme is currently being trialled where patients prescribed new medication can be directed to a named pharmacy for a follow up review in a community Pharmacy. (Carter 3 b)

Action 8d(i) – Assess success of "Refer to Pharmacy" scheme and extend if appropriate - July17

Action 8d (ii) - Scope the viability of joint working between HEY Pharmacists and local GP practice - June 17

Action 8d (iii) - Scope the potential of joint community working eg STP formulary being extended to STP level by March 18

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PROCUREMENT TRANSFORMATION PROGRAMME

Trust Board date	26th January	**Reference Number**	2017 – 1 - 14
Director	Lee Bond	**Author**	Lee Bond, Julie Lumb
Reason for the report	This document builds on the initial DH/NHSI template issued at the end of July 2016 and has been designed to assist trusts in achieving recommendation 5a of the Lord Carter review.		

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

1	**RECOMMENDATIONS** The Board are asked to approve the Procurement Transformation Programme (PTP) as part of the Carter procurement work stream and as part of the DH Better Care Better Value programme.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework Ref:	**Raises Equalities Issues?** No	**Legal advice taken?** No	**Raises sustainability issues?** No		
5	**BOARD/BOARD COMMITTEE REVIEW**					

Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

An independent report for the Department of Health by **Lord Carter of Coles** (Feb 2016)

Recommendation 5a:

"developing PTP plans at a local level with each trust board nominating a Director to work with their procurement lead to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally".

Procurement Transformation Programme (PTP)

Hull & East Yorkshire NHS Trust

Julie Lumb– Head of Procurement

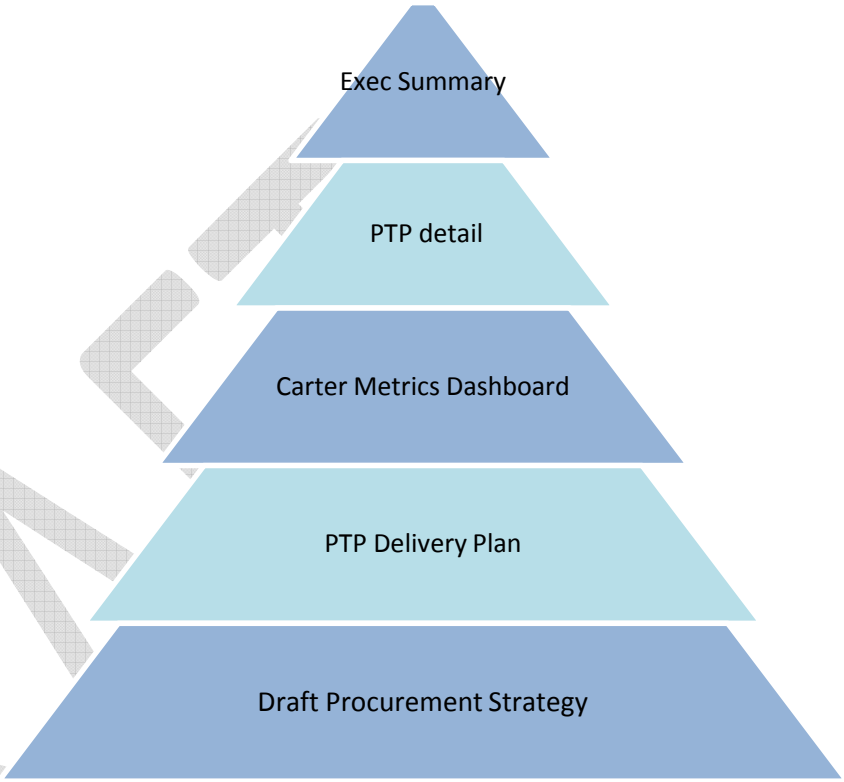
Lee Bond – Chief Finance Officer

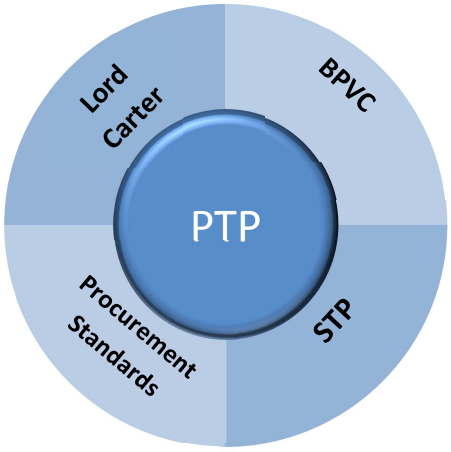
Version control	
23Jan	Draft 1.0

Contents:

This document builds on the initial DH/NHSI template issued at the end of July 2016 and has been designed to assist trusts in achieving recommendation 5a of the Lord Carter review

Recommendation 5a requires all acute Trust Boards to have a board approved PTP in place by autumn 2016.





The Trust has developed a PTP, making reference to four key policy areas:

1) The recommendations from the Lord Carter review
2) *Better Procurement, Better Care, Better Value* (BPVC)
3) Local Sustainability and Transformation Plan (STP) for 'back office' efficiency/rationalisation
4) The self-assessment score and any development needs/actions identified from this process.

This report sets out the current position, the recommendations made in the report, the progress towards those recommendations and the action plan for meeting and sustaining those recommendations.

1. EXECUTIVE SUMMARY

- This PTP delivery plan details the current activity to support the Carter metrics, with the aim of achieving the required targets. Trust management, via the Carter steering group, receive regular progress reports concerning the Trusts performance gains the Carter metrics.

- The Procurement team are actively working with the 'Working Together Group' which consists of 7 other Trusts across the South Yorkshire region. This gives the opportunity for aggregated spend and further savings benefits. The work programme for the Working Together Trusts is also aligned to the Shelford Group of Trusts collaborative procurement programme

- The national price benchmarking tool has now been released. An on line tutorial has been made available for Trusts to understand the data and the benefits the Trust can achieve. This includes benchmarking prices and products against other Trusts. The database contains information on spend totalling £8.2bn and is intended to be used as a vehicle for challenging purchasing decisions going forward.

- The Trust is working closely with NHS Supply Chain to identify areas of savings opportunities. Their 'Compare and Save' initiative is being actioned and wherever possible implemented. Progress against these initiatives is reported back to the Trust via the Supply Chain Customer Board (Northern)

- Adoption of GS1 based practice forms a significant part of the agenda. The Trust has recently approved a business case to introduce GS1 compliant inventory management system into its operating theatres. The plan would be to do this and then extend it beyond the traditional inventory management arena to support the identification of inefficient processes in other areas. Due to its complexity this project will require a dedicated team to ensure full compliance across all aspects of the project. This is not a purely procurement led exercise. This is being considered as part of the business case rollout.

- The Procurement team has previously been audited against the Standards of Procurement. This Audit demonstrated that the Procurement function is a high performing service department. A revised version of the standards has been issued in July 2016 and a further Audit of compliance is required in 2016 to confirm our position against these standards. The aim would be to meet level 3 standards by the end of 2017.

.

2. PROCUREMENT TRANSFORMATION PLAN (PTP)

2.1 Background

An independent report for the Department of Health was conducted by Lord Carter of Coles in relation to Operational Productivity and Performance in English NHS Acute Hospitals. The report was commissioned to understand what could be done in hospitals to address the widely varying issue of resource utilisation across the NHS.

It estimated that if we reduced unwarranted variance at least £5bn could be saved, representing 9% of the £55.6bn currently spent. The report makes 15 recommendations to address these variations. The timescales for achieving these are between now and 2020. Initial engagement has been with a cohort of 32 Trusts to discuss performance data and indicators to enable the creation of a consistent set of comparable metrics. It is recognised that realising the full productivity and efficiency opportunities set out in the review will be challenging and NHS Improvement will be responsible for managing the delivery of these savings.

Recommendation five of fifteen relates to procurement activity and requires all Trusts to report their procurement information monthly to NHS Improvement to create a NHS Purchasing Price Index commencing in April 2016. Trusts are also required to commit to the Department of Health's NHS Procurement Transformation Plan (PTP) so there is an increase in transparency and a reduction of at least 10% in non-pay cost delivered across the NHS by April 2018.

The PTP plan joins together a number of activities to improve procurement within the healthcare system, aiming to save £750m per annum from the total NHS spend on goods and services. There is a drive for Trusts to aim to work in collaboration with other Trusts to maximise savings wherever possible.

There are three main components to achieving this.

1. A high quality national catalogue of goods where Trusts can have confidence in both the range and price of goods they procure.
2. The re-modelling of NHS Supply Chain using the opportunity created by the end of the existing contract in October 2018.
3. Delivery of the e-procurement agenda to drive the adoption to the global GS1 coding and PEPPOL standards (bar coding)

The report identified a set of benchmarks as part of the "Model Hospital" which will enable Trusts to understand their maturity and performance across a number of different dimensions. For procurement there are 6 specific metrics:

Metric 1	Spend per Weighted Activity Unit
Metric 2	Percentage of transactions on an e-catalogue
Metric 3	Requisition to electronic purchase order (composing of 4 elements)
Metric 4	Spend on contract
Metric 5	Inventory management
Metric 6	Standards of Procurement (non mandatory)

Trusts are expected to embrace the adoption and promotion of the NHS Standards of Procurement. Although this is not a mandatory requirement it is strongly advised that Trusts carry out this exercise.

2.2 Current Capability - People & Organisation

To deliver all the initiatives and expectations of the review there will be a requirement for significant data analysis, which needs to be consistent and meaningful. This analysis will require resource not only to analyse data but to implement the findings. To enable achievement of the metrics and fulfil all aspects of the report it has been identified that the Procurement team is currently under-resourced, and expertise is required at a senior level to support the Head of Procurement to deliver the requirements outlined in the Carter report.

Reorganisation of the procurement budget and existing vacancies at lower levels has enabled two posts to be created to support the Head of Procurement with the implementation of the Carter metrics and the PTP

The draft Procurement Strategy identified a number of key elements mentioned in the Carter review, and some of the essential metrics, which include the requirement for all areas of the Trust to be underpinned by modern procurement practices with transparent reporting of KPI's based on spend on contracts.

The procurement team will work with healthgroups to address excess stock holding and to embrace available technology. This will include external support to analyse areas of high stock holding with a view to reconfiguring procurement practice.

The Materials Management team will aim to maintain optimum levels of stock held through continuous review. Stock reduction will be reflected in the yearly stock, with the aim to reduce year on year by 10%

The Trust recognises the benefits of electronic trading and has invested and will continue to invest as appropriate in systems to maximise efficiency.

It is a requirement of the organisation, and it's clinicians to support collaborative working, taking its lead from senior Medical Directors who have bought into the concept of standardisation and savings. This is in place nationally with commitment from our own Chief medical Officer.

The following metrics form part of the Carter review and details how they will be achieved

Metric 1

Monthly cost of clinical supplies and general supplies per weighted activity unit (WAU): The concept of a weighted activity unit was introduced by Carter and whilst it is still in its relative infancy, the notion of being able to produce unit cost information in a standard form is one which the Trust will look to actively pursue.

Metric 2

Percentage of transactions on an e-catalogue: Work is currently being actioned in several areas of the Trust to ensure compliance with this metric. There are currently 65,000 active catalogue lines that allow end-users to purchase items on line at contracted prices.

The roll-out of ordering on line direct from Supply Chain is now complete

Non-pay spend for the trust is currently in excess of £230m. Detailed analysis of this spend has also been completed.

The Procurement team currently influences £109m, covering supplies, services, service maintenance contracts, and spend with Supply Chain. The £109m is the figure being used for completing metric 2 to 4 inclusive.

The remaining is influenced by other departments which include

Pharmacy -	£48m
Capital (buildings) -	£15m
NHS Bodies	£24m
Agency Staff	£10m
Miscellaneous spend	£34m

To achieve the requirements of the Carter review the Procurement team are analysing all data for the last 6 months, from 1.4.2016. The purpose of this exercise is to establish which products departments are ordering. This will enable the team to identify products that can be added to a current contract which were not part of the original contract which will address Metrics 2 & 4. It will increase contract coverage and confirm fixed prices for the remainder of the existing contract.

The report also highlights items that have been purchased using a paper requisition. There are currently 2200 individual items that are in the process of being uploaded for end-users to purchase on line, therefore reducing the requirement for end users to complete a paper requisitions. Due to the diversity and infrequent use of these products there is no formal contract in place, although by uploading these items we will address Metrics 2 and 3. These transactions will continue to be assessed and will be added to the catalogues retrospectively.

Current figures for on line ordering via a catalogue is currently 96% including Supply Chain transactions, this currently exceeds the required Carter metric (metric 2)

Metric 3

Expenditure previously not part of an electronic purchase order is now being analysed, with a view to prioritising areas that currently do not use an electronic order. This includes Capital, Catering, NHS Bodies and miscellaneous spend

Catering has now been completed with an interface downloaded from their current catering system. This complies with the requirement for the full end to end process (P2P)

NHS Bodies will have its own product catalogue and its own order type to enable ordering via an electronic catalogue. The catalogue is being prepared for upload into the system. The intention is to have this live by the end of November. Although they will have their own order type they will still form part of the required Metric 2 and 3.

Pharmacy currently uses its own purchasing system (Ascribe) to order drugs. Invoices are posted to the new ABS financial system for payment. This partially addresses elements of metric 3.

Agency spend is dealt with through alternative methods in line with Monitor guidance.

Work is currently on-going with the Capital team to establish an efficient way of moving their current procedures to the new ABS system. There will be a requirement for a new order type and further analyse of their procedures, policies and complexities require fine tuning to enable completion.

Metric 4

The Procurement team actively analyse spend on an on-going basis. A recent analysis highlighted opportunities for movement from coverage on formal quotations to contract.

£1.3m will be tendered to support full contract coverage

£235k of spend will transferred to NHS Supply Chain – the changes will realise further savings for the organisation, comply with Metric 1 and 4 and increase percentages for these metrics.

£730k will be renewed on formal quotations and address Metrics 1-4.

As the Trust currently has a wide range of goods and services on a formal contract. By means of increasing the coverage, the above will be actioned and will achieve the required 90% coverage required to meet this metric.

Metric 5

Inventory stock turnaround - a reduction of stock is currently being reviewed on a 6 monthly basis

Metric 6

Standards of Procurement, The Trust has previously been audited against the NHS Standards and achieved the following:
9 standards excelling
6 standards achieving
3 standards building
1 standard not achieving

The NHS has subsequently revised these Standards and a further review is now required to ensure that the high level of performance previously achieved has not slipped. The ambition of the Trust would be to achieve level 3 standards by the end of 2017.

2.3 Price Benchmarking data

The Trust is actively providing information on a monthly basis and is currently up to date with supplying this data to the national Carter procurement team. With specific regard to the national price benchmarking database (PPIB), further on line training sessions are being undertaken in order to enable the Trust to analyse the data in a more structured and meaningful way.

2.4 Strategic & Operational Partnerships

The Trust is currently working closely with NHS Supply Chain and the Working Together Group (WTG). The national agenda requires Trusts to commit to working together either nationally, regionally or both. Where possible the Trust is working primarily with the WTG to agree commitment to their initiatives. Aggregating spend with 7 other Trust regionally is securing lower unit cost per item due to volume commitment. The WTG is also taking its lead from the Shelford Group and commitment from Medical Directors across the membership of these groups has strengthened its position. One or possibly two Trusts will be assigned to trial products with the understanding the clinicians across the whole membership change. There is an expectation that these changes will not be challenged to ensure cost savings are swiftly recognised for each Trust.

It needs to be noted that although commitment from the Medical Directors across the NHS has been voiced, approved and documented, individual opinions within the organisation relating to clinical practice mean that decisions taken outside the organisation sometimes struggle to gain traction within the Trust. For this change in working to be truly effective we require a change in mind set and culture otherwise we will not take advantage of these regionally driven initiatives.

NHS Supply Chain has been tasked by the Business Service Authority (BSA) to make savings on behalf of Trusts. Meetings regularly take place with NHS Supply Chain at each individual Trust and a comprehensive ‘Compare and Save’ strategy is now in place. The Trust is working closely with Supply Chain to embrace the changes and realise benefits.

At this point, STP discussions around the aggregation of back office services such as procurement haven’t touched the prospect of formal joint working arrangements between the Trusts located within the STP footprint. This is something which will need to be addressed by the Chief Finance Officers as part of the STP delivery discussions,

3.Carter Metrics Dashboard

MEASURES		PERFORMANCE			COMMENTARY
		CURRENT DEC 2016	TARGET SEPT 17	TARGET SEPT 18	
1	Monthly cost of clinical and general supplier per 'WAU'	£6.8m	£6.46M	£6.14M	The target is to reduce by 10% by Sept 18
2	Total % purchase order lines through a catalogue (target 80%)	96%	96%	96%	Metric achieved
3a	Total % of expenditure through an electronic purchase order (target 80%)	100%	100%	100%	Excluding Supply Chain – all expenditure influenced by procurement has an electronic PO (£110m)
3b	Total % of transactions through an electronic purchase order (target 80%)	100%	100%	100%	As above
4	% of spend on a contract (target 90%)	74%	80%	90%	Will vary each quarter due to product mix, although sufficient new spend is currently being tendered to deliver the 90%.
5	Inventory Stock Turns	10 days	tba	tba	Monitored 6 monthly to reduce stock where possible
5	NHS Standards Self-Assessment Score (average total score out of max 3)	2.21	3.0	3.0	Previously assessed against the original NHS Standards of Procurement (recently revised) Achieved against the old standards – although may need reassessing
6	Purchase Price Benchmarking Tool Performance	tba	tba	tba	Currently be reviewed
7	CIP savings delivery	£0.4m	£1.0	£1.5	Reported savings are cash releasing.

4. PTP Delivery Plan

Carter Recommendation	Link to NHS Standards of Procurement	Objective	Current Position	Actions Required	Milestone/ Review Dates
5a. Every trust should have a local PTP in place	Strategy & Organisation 1.2	PTP should cover plans to meet the model hospital benchmarks, collaborate with other trusts and the national solutions such as NHS Supply Chain.	The PTP highlights areas identified in the Carter review. Current activities taking place to support all the requirements and milestones.	Delivery of PTP milestones	
		Lord Carter recommends a board director should be nominated to work with the trust procurement department to ensure PTPs are fully embedded in the trust performance improvement plans.	Lee Bond (Chief Financial Officer) will be working with the Trust Procurement Department to ensure the PTP is fully embedded.	Ensure delivery against actions within PTP	Quarterly review
5b. Spend analysis and benchmarking solution	Strategic Procurement 3.1	Lord Carter makes it clear that addressing the variety of products and manufacturers supplying the NHS is a key strand of the national PTP. At a local level trusts must begin to address the proliferation of suppliers and products used within their organisations aiding reduction in spend and clinical variation.	Utilising the PPIB Tool for benchmarking against other Trusts. PPIB information is being utilised to challenge NHS Supply Chain to understand variance in cost. Supply Chain data has been loaded in its totality, therefore the challenge to Supply Chain is valid. More work and clarity is required to use other data available in the PPIB and this is being addressed. Workings closely with NHS	We have supplier catalogues to support restricting end-user choices. The next stage is to continue to restrict access to products where contractual negotiation has taken place, and end-users continue to purchase outside of the contract. This is currently on-going but does require further work.	Ongoing

			Supply Chain to deliver opportunities for aggregation of spend. Committed to the Working Together Group (WTG), ensuring standardisation across Trusts coupled with aggregation of spend to reduce costs, and attract further commitment discounts. This address variation in supplier base. . Materials Management currently in 138 wards and departments. At a local level we have a standardisation programme in place resulting in reducing clinical choice, reducing the supplier base, masking all other products. To continue to realise the benefits of the standardisation programme we are working closely with relevant areas within the Trust including Infection Control, Health and Safety and Occupational to ensure when decisions relating to product change are made they are sufficiently robust to support the changes. Currently purchasing consumables to the value (£27m per annum) from NHS Supply Chain. Collaboration with a further group	Continue to work with NHS Supply Chain to standardise products wherever appropriate and acceptable. Working with Supply Chain to implement the core list where appropriate.	

			of Trusts is currently being explored, covering a different geographical area to the WTG.		
	Data, Systems and Performance Management 5.2, 5.5		The PPIB tool is being populated by other Trusts although in its infancy, information is not complete and aspects of the information are misleading. Certain aspects of Trust activity is not accounted for, therefore could result in giving inaccurate results	Establish an in depth comprehension of the differing types of data uploaded. Analyse data and highlight areas where there are issues relating to information not being consistent.	Dec 17
	Strategic Procurement 3.6	Lord Carter identified the need for a national price benchmarking service. This has culminated in the launch of the national PPIB in August 2016 from AdviseInc. All trusts are expected to submit their data monthly for upload into the tool, allowing continuous benchmarking and highlighting areas for non-pay cost reduction.	The Trust continues to review data and report findings to Adviselnc requesting confirmation data/analysis All data for the Trust has been uploaded from 1.4.2016 – 31.12.2016 (9 months) NHS Supply Chain upload their data on behalf of all other Trusts for benchmarking against other Trusts, and identifying savings opportunities where possible Detailed PO and NHSSC data is submitted monthly.	Continue to supply information on a monthly basis as requested as required. Longer term – utilise tool to identify realistic savings opportunities.	Confirm monthly figures submitted Ongoing Ongoing
5c. Prioritise the	Data, Systems and	The Lord Carter review identified big variation in	The Trust has currently implemented the new purchase to	Continue to implement and improve information	Ongoing

role of procurement - ensuring effective system control and compliance, building supply chain capability in terms of both inventory management systems and people	Performance Management 5.4	Purchase to Pay (P2P) system maturity and compliance. Enhancing P2P systems must be seen as a priority for trusts that do not have well developed systems and compliance. Trusts are also encouraged to work in partnership with organisations within local health economies and with partner organisations as well as the national PTP to ensure opportunities to adopt common systems are maximised.	pay system (Advanced Business Solutions) incorporating a catalogue solution to support electronic ordering for end-users. The current system will be upgraded with further enhancements to the e-procurement functionality Enabling end-users to have access to detailed information for the whole end-to end P2P process. The Trust is currently looking at options for the implementation of GS1 coding to support transparency in relation to an automated stock replenishment system, reduce waste and more transparency with patient costing.	and access to the information to end-users.	Ongoing
	Supply Chain 4.1	Lord Carter identified a general under investment in inventory control. Building on the DH eProcurement Strategy the Lord Carter report urges trust procurement departments to build supply chain capability on inventory management systems.	The Trust is currently looking at a solution for the GS1 coding that also addresses the lack of an inventory system A project manager will be assigned to support the project with involvement from all relevant parties including the procurement team. Implementation plans and	It is likely that an inventory management system for Trust will be implemented at a later, when the analysis of the best option and most appropriate option has been agreed	Dec 17
	Data,	Building on the DH			

	Systems and Performance Management 5.7	eProcurement Strategy the Lord Carter report urges trust procurement departments to align themselves to the GS1/PEPPOL DH work stream and develop and execute plans as part of trust wide approach to GS1/PEPPOL adoption.	strategy are currently in place. .		
	People & Skills 2.1 & 2.3	Lord Carter urges trusts to prioritise on capability through better recruitment, enhanced skill sets and appropriate remuneration to attract the right people.	2 member of the team are MCIIPS qualified Staff within the team attend regular updates, where relevant. Skills Development Network programme is circulated to all staff, and currently a number of staff have attend one day events.2 others have committed to a full of study days Staff have varied qualifications including NVQ level 2 – 4. Plus ad hoc day events covering all aspects of procurement. Appraisals are also a mechanism of identifying other training requirements.	Continue to invest in training and development and to encourage attendance at relevant training courses	Ongoing
5d. Procurement Metrics	Data, Systems and Performance Management	Lord Carter suggests progress against key metrics should be made by Sept-17.	The Procurement Strategy details the requirements and actions required to achieve the metrics in the Carter Review	The Procurement team continue to develop the catalogue and roll out access to the e-	Sep 17

	5.3, 5.4 Policies & Procedures 6.2	The main metrics being: • 80% Catalogue Usage • 90% PO Coverage • 90% Contract Coverage		procurement system.	
5e. Collaboration - with other trusts and NHS Supply Chain with immediate effect	Strategy & Organisation 1.5	As a guideline Lord Carter recommends that trusts collaborate with at least five other trusts to share data and resources to modernise their procurement function. Lord Carter also challenges trusts to improve their relationships with procurement partner organisations.	The Trust continues to collaborate with 7 regional Trusts, and sharing of data There is on-going work with Supply Chain to maximise savings and efficiencies	Continue to support collaborative working with all partners	Ongoing Ongoing
	Strategic Procurement 3.5 & 3.7	Lord Carter requests trusts take the following actions on national sourcing initiatives: 1) Aggregate sourcing by working with NHSSC in particular 2) Accept and adopt clinically driven product testing wherever possible, in particular with reference the NHS Clinical Reference Board and Clinical	Spend with NHS Supply Chain is in excess of £27m. Standardisation attracts financial savings and further commitment discounts, aggregating spend with WTG is realising further benefits. Our rigorous standardisation work plan supports the evaluating of products, with the involvement of clinical staff and other areas of the organisation. Clinical trials of products take place to ascertain	Continue to work alongside national solutions, implementing where appropriate. .	Ongoing

		Evaluation Team and any work streams with the BSA/NHSSC 3) Collaborate to take committed volume to market 4) Reduce variation and proliferation of choice 5) Lord Carter states: "We do not expect to see hubs competing with or undermining the national solutions, so we recommend trusts take this into account in developing their PTP plans".	the most cost effective and value for money solution. The Trust has confirmed they will adopt the 12 nationally procured products.		When available.
5f. Adoption and promotion of the NHS Standards of Procurement	All Policies & Procedures 6.2, 6.5 Strategic Procurement 3.3	Lord Carter requests that trusts embrace the adoption and promotion of the NHS Standards of Procurement with the support of the new Skills Development Networks. Those who have already achieved Level 1 achieving Level 2 of the standards by October 2018; and those trusts that are yet to attain Level 1 achieving that level by October 2017. All trusts to produce a self-improvement plan to meet their target standard by March 2017.	The Trust has been previously assessed against the original 19 standards. This will need to be done again to be compliant with the revised standards An initial meeting is to take place to conduct a further self – assessment in June With a final audit planned for August.	Level 1 Standards of Procurement to be achieved – although level 2 and 3 will be achievable in some areas	Sep 17

DRAFT PROCUREMENT STRATEGY 2015/16

Procurement Department
Infrastructure & Development
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2 JZ

1. PURPOSE

The purpose of this paper is to present the Trust's Procurement strategy and to provide an outline work plan for Procurement for the current financial year.

2. BACKGROUND

In August 2013 the Department of Health issued a Procurement Development Programme for the NHS 'Better Procurement, Better Value, Better Care'. The programme aims to improve Procurement capability, raising it to world-class standards, in doing so we will reduce costs and improve patient outcomes. The National Audit Office identified the potential for £500million savings by embracing Procurement, and by the end of 2015/2016 Trusts need to identify over £1.5billlion of procurement efficiencies to be delivered over the next 3 years. There are key areas in the strategy that all Trusts need to embrace, for example, the avoidance of inflationary pressures on non-pay spend, greater transparency of spend and the sharing of information. A price benchmarking exercise will be on-going to give visibility of individual Trusts' performance, and to challenge performance within each organisation. There is a significant drive to engage clinicians to combine clinical outcome data with commercial data and to identify ways to help the NHS reduce variation and cost, and subsequently deliver better outcomes for patients.

Procurement is the process of acquiring goods, services and works from the initial identification of a potential requirement through to purchasing, having regard for whole life costings, and process around the end of useful life. It also includes option appraisal around whether to "make or buy", ie whether what may be best done in-house and what may be best outsourced.

The Trust recognises that the proper management of supply is essential to the efficiency and effectiveness of clinical and support services. Patient care depends on the assured availability of high quality equipment, materials and services.

This strategy incorporates the whole spectrum of procurement activities which involves a very complex set of networks of manufacturers, suppliers and a range of other stakeholders.

The main benefits will be delivered by the Trust itself, however, contributions are expected from NHS Supply Chain for stock products and a range of national contracts negotiated on behalf of the NHS and wider public sector by organisations including Crown Commercial Services (CCS) and NHS Shared Business Services amongst others, as well as locally negotiated Trust contracts.

The Procurement Department continues to ensure the Trust's current spend is covered by cost effective contracts that demonstrate value for money, and are compliant with Trust Standing Orders, Standing Financial Instructions and EU Regulations.

The Chief Finance Officer has Board level Executive responsibility for the Procurement function within the Trust. The Chair of the Audit Committee is the nominated Non Executive lead for Procurement.

Currently non-pay spend is £213m – this represents invoices paid in 2013/2014 of which £101m is influenced by the Procurement Department

Total Trust spend breakdown 2013/14 - £213m

Source	Value
Influence by the Procurement team	**£m**
NHS Supply Chain	£16
Local/National	£58
Capital Equipment	£2.5
Service Maintenance	£7.5
Various spend	£17
Total	**£101**
Spend not influenced by the procurement team	
Pharmacy	£47
NHS Bodies	£18
Capital works	£15
Other spend	£32
Total	**£112**

3. STRATEGIC AIMS

Strategy Statement: To support the delivery of safe, innovative, cost effective and high quality patient centred services the Procurement Department has the following aims:

1. **Regulation:** Ensure that procurement practices operate within Trust Standing Orders, Standing Financial Instructions and EU procurement law and ensure that the Procurement function meets all department of Health best practice guidelines
2. **Internal Business Partner:** Ensure that the Procurement function is seen as a key business partner by the Health Groups & other Hospital directorates
3. **External Business Partner:** Participate in, and further develop procurement collaborations with other public bodies and partnering arrangements with suppliers.
4. **Technology:** Ensure that high quality procurement practices are delivered in the most effective manner taking account of the latest technologies.
5. **Cost Effective:** Ensure that procurement delivers year on year cash releasing savings and efficiencies.
6. **Staff:** Continue to develop skills, knowledge, support and experience for procurement staff.

3.1 Regulation

- **Transparency**
  The Prime Minister has set-out three specific transparency commitments in procurement and contracting. As part of government policy there is a need for information on departmental tendering and contracting activities to be made publicly available. All government tender documents for contracts over £10k are to be published on a single website which is to be made available to the public free of charge.

- **GS1 Coding & Peppol**
  No standard coding exists within the NHS. As such, the basic building block required to enable aggregation of demand is not in place. Therefore, organizing collaboration between Trusts for aggregating orders is complex and problematic.

GS1 standards make it easy to do business globally using a unique set of identification numbers for products, companies, locations, services, assets, logistics units or customers at any point in the supply chain.

No matter where in the world a business is based or what language you use, trading partners can always understand one another using GS1 standards.

The Department of Health has mandated the use of GS1 standards throughout the NHS. This means the Trust and all our suppliers must become GS1 compliant.

Adoption of both GS1 coding and PEPPOL standards are mandated in the recently published 'NHS eProcurement Strategy, also included in the 2014/2015 NHS Standard Contract, and the August 2013 NHS Terms and Conditions of Contract.

There is a requirement that all Trusts have a strategic plan for the adoption of these standards approved at Board level. The lead needs to be at Board level and have Trust wide influence, and someone who can integrate the strategy across both clinical and non-clinical areas.

The Department of Health estimates that adoption of GS1 standards will take approximately 2 years to implement.

- **New Terms & Conditions**
  New standard NHS terms and conditions have been published by the Department of Health. The latest version (August 2014) are being used by the Trust. These will be detailed in all tenders to support changes made to safeguard the Trust.

Going forward:
We will continue to ensure all opportunities are compliant with the guidance issued by the Government.

The Trust will develop its own GS1 & PEPPOL implementation plans as they encompass much more than just procurement. Specifically relating to Procurement we will:

- Ensure all requests for GS1/PEPPOL information in all documentation, including tendering, upload of contract information, catalogue information.
- We will monitor any amendments to NHS standard terms & conditions and update with the current version as and when necessary to do so
- We will ensure that all changes in legislation are updated and communicated to all staff where appropriate. This will include on-going reviews of all documentation to ensure compliance with legislation which will reduce any potential legal challenges.
- We will develop a business case to introduce automated, seamless supply chain processes and inventory management starting with our operating theatres.

3.2 <u>Internal Business Partner</u>

Context:
The Procurement Department provides each Health Group with a quarterly report including information on expenditure, procurement trends, tender progress, contracts held and those that are due to expire.

KPI's are reported monthly by Health Group on specific areas that include non-contract v contract spend, savings and contracts in place.

Regular meetings with the Health Groups are held where specific savings and product standardisation opportunities are discussed and worked on in a collaborative way

To underpin Procurement performance the following indicators are used and available for scrutiny by Health Groups, the Trust procurement lead and the Trust Performance and Finance Committee. As procurement activity, service and structures develop further these will be amended and/or added to:

No	Indicator	Frequency
1.	% of spend via formal contracts/agreements, whether local or national	Quarterly by Healthcare Group
2.	Total non-stock transactional spend	Quarterly by Healthcare Group
3.	Spend via NHS Supply Chain (part of contracted spend)	Quarterly by Healthcare Group
4.	Contracts by expiry date (including service/maintenance	Quarterly by Healthcare Group
5.	Register of Department with Oracle non-stock on-line ordering	Quarterly by Healthcare Group
6.	Register of stock bar-coding	Quarterly by Healthcare Group
7.	Tenders in progress	Quarterly by Healthcare Group

Stock Management
The Procurement Department has worked historically with various departments, notably Theatres to develop centralised stores, which involve reducing stock levels and standardisation, as well as discussing all aspects of the procurement systems and procedures.

The centralisation of 12 theatres at Castle Hill Hospitals has reduced waste, led to more efficient daily deliveries from the central store, reduced stock holding in the theatres, and realised savings.
Work is currently on going to centralise all 9 Theatres at Hull Royal Infirmary, this will be completed by July 2015 realising the same benefits as Castle Hill.

Going forward:
- Expand the numbers and levels of Procurement staff involved in each Healthcare Group to ensure greater penetration of procurement practice and greater delivery of efficiencies.
- Work is ongoing to support electronic ordering, to date 60% of non-stock orders are done on line.
- Stock orders - 95% of stock ordering is done electronically by end-users complete with electronic capturing of goods with pre-defined levels.
- Working with external support to analyse areas of high stock holding with a view to reconfiguring procurement practices and reducing stock holding.

3.3 External Business Partner

Context:

3rd Party Procurement Organisations

- The Procurement Department continues to explore options for using national frameworks for goods and services, which ensures contract coverage and compliance with relevant legislation, often at short notice. These contracts allow requirements to be tested via mini-competitions to demonstrate best value, or be called-off directly without further competition where there is a robust and justifiable reason for doing this.

- Examples of 3rd party framework providers used and with whom there will continue to be discussions, include NHS Supply Chain. Meetings take place with Supply Chain on a regular basis to discuss opportunities for savings, product standardisation or other initiatives. To ensure value for money the Procurement Department regularly select product ranges to market test against Supply Chain contracts and framework agreements. Supply Chain continue to offer the benefits of commitment discounts of which the Trust is signed into all currently on offer. The Trust has recently worked in conjunction with Supply Chain for them to run a number of high value mini competitions on behalf of the Trust. This has taken advantage of their specialist product and market knowledge and has delivered significant savings to the Trust

Capital funding – NHS Supply Chain (£300m)

In response to the recommendations from the Public Accounts Committee in 2011, which highlighted the need to find ways in which the NHS could offer collective commitment to suppliers of high value medical equipment in return for lower prices, the Department of Health created a 'Capital Equipment Fund' of £300m in NHS Supply Chain.

Hull and East Yorkshire NHS Trust has utilised this agreement and to date spent £711k through Supply Chain taking advantage of this agreement, resulting in a 19% saving.

Going forward

- We will continue to utilise external frameworks to benefit from competitive pricing,
  this will negate the need to tender locally.
  - Continue to work with organisations such as NHS Supply Chain and Crown Commercial Services to ensure that the Trust obtains VFM through all of its contract placements
  - Explore membership of the South Yorkshire "Working Together" collaborative
  - Carter of Coles resource utilisation cohort
  - Explore collaboration locally in Hull with other public sector organisations (including Hull University and across wider local health economy (Doncaster,N Lincs, NLAG, York)

3.4 Technology

Context:

To maximise the human and financial resources available for the delivery of patient care it is imperative that the management and process costs associated with purchasing goods and services are at the minimum level commensurate with maintaining a high quality and effective supply service. In this context the Trust

recognises the benefits of electronic trading and has invested, and will continue to invest as appropriate, in systems to maximise efficiency.

The Trust has a fully automated system for items purchased from Supply Chain. There are approximately 140 wards and departments that have their stock ordered via Supply Chain with a significant amount of items masked in the system, which is in line with our standardisation programme.

As at the end of June 2015 there are 102 departments/cost centres using this facility. This is supported by an electronic tendering system which provides fully automated formal competitive tendering.

Going Forward:

- Use e-auctions as a standard way to drive price efficiency
- Implement on-line ordering for the majority of wards and departments to purchase from e-catalogues with negotiated prices.
- Promote the adoption of electronic Catalogue management in order to reduce choice, promote consistency of approach, and maximise value for money
- Continue to push product standardisation across all areas of the Trust.
- Ensure that the NHS Core List is exploited to ensure that the Trust is getting Value for money from its core consumables
- Ensure on-line access to order all stationery items not currently on the bar-code top-up system by the end of August 2015
- Introduce a procure to pay (P2P) service between the existing finance and procurement departments

3.5 <u>Cost Effective</u>

Context:

<u>Savings and CRES</u>

82% of the Trusts influenceable non-pay spend is covered by local contracts or national agreement.

Savings targets are set annually by the Procurement Department based on anticipated opportunities and agreement with Health Groups.

The Head of Procurement meets with Health Groups to discuss realistic savings targets including cash releasing and cost avoidance savings. This is identified in three ways, whether they have been achieved through local tender, via NHS Supply Chain or standardisation and product substitution work.

Inflation Avoidance – Zero inflated contracts

- 70% of the Trusts existing contracts are fixed for the term of the contract, therefore there will be no inflationary uplifts to these contracts including any extension periods thereafter.

Standardisation

- Over the past 7 year we have standardised a total of 104 different product lines, with savings for the organisation of £1.1m. These included the following:

Examination Gloves	£136,370.00
Hand Washing	£ 12,000.00
Syringes	£ 31,896.00
Needle Free Devices	£145,502.00

Going forward

- Establishment of annual savings plans, agreed with the Health Groups which build on reducing unit price through increased product standardisation and collaboration through external partnerships such as the South Yorkshire "Working Together" initiative, or through more local forums such as the Hull "2020" program.

- Work to ensure that 90% of influencable non-pay spend is covered by local or national agreements, including low value spend.

- Ensure that all tendering and contracting information is recorded electronically on a database using GS1 coding standards.

- Aim to maximise the number of contracts with fixed prices for the duration of the contract and any further extensions

- Working with Health Groups we will agree an annual program of standardisation, which also ties to contract renewal timescales.

3.6 <u>Staff</u>

Context:

The Procurement Department provides training and development opportunities for staff to help them develop personally and professionally.

All Procurement Department staff have annual appraisals which are aligned to Trust objectives.

Going forward

Activity around contracting and tendering is seen as a particularly increasing and fast changing area with developments in legislation and best practice. This is an area where some specific training needs have been identified and will continue to be taken.

We will review our staffing structure to ensure fitness for purpose and to ensure that our analytical capabilities and business partnering expertise are aligned with the Health Groups, and also allow for succession planning where possible.

Julie Lumb
Head of Procurement

Lee Bond
Chief Finance Officer

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

HULL ORGAN DONATION SUMMARY

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 - 15
Director	Kevin Phillips – Chief Medical Officer	**Author**	NHS Blood and Transplant Specialist Team
Reason for the report	To update the Trust Board regarding the work of the Hull Organ Donation team		

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

1	**RECOMMENDATIONS** The Trust Board is asked to receive the report as an update position.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	✓	Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): E1 – Evidence based guidance E4 – Staff, teams and services work together C2 – Patients and family involvement W2 - Governance					
	Assurance Framework Ref:	**Raises Equalities Issues?** Y/N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board received an update in this area in August 2014. It is good practice for the Trust Board to receive updates periodically.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

HULL ORGAN DONATION SUMMARY

1. HULL ORGAN DONATION SUMMARY

The Executive Summary provided below by NHS Blood and Transplant (NHSBT) for April to September 2016 was complied when there was a lack of Specialist Nurses for Organ Donation within the Trust.

This meant that the potential audit data (PDA) was not completely submitted before the deadline and that the figures are not fully accurate. Since then the team have caught up on PDA: the current organ donation figures as seen below can be found in full on the attached spreadsheet and is a true reflection of the numbers.

The next Executive Summary will be a true reflection of the PDA.

2. NHSBT EXECUTIVE SUMMARY

Donation After Brain-Stem Death (DBD)
DBD referral rate has increased from 88% (2015) to 100% (2016)
However there is reduced performance in some other measured outcomes.
Consent rate for DBD reduced from 100% (2015) to 60% (2016). National average is 66%.

Donation After Circulatory Death (DCD)
DCD referral has increased from 73% (2015) to 87% (2016).
Although there has been a reduction in family approaches from 75% (2015) to 67% (2016), this is still above the UK average of 43%. Similar reduction has been seen in SNOD involvement, however we still remain above the national average of 78%.

DCD consent rate rose from 50% (2015) to 63%(2016). National average rate is 58% for DCD.

Organ Donation and Transplantation Outcomes April 2016 to September 2016 Actual Figures
10 Donors (DBD – 5, DCD - 5)
Resulting in 19 organs retrieved for transplantation.

Specialist Nurse – Organ Donation (SNOD and Clinical Lead – Organ Donation (CLOD) Presence

No embedded SNOD between April 2015 to November 2016
No CLOD in post between June 2016 to September 2016
This situation has now been rectified with the appointment of 2.5 WTE SNOD's and a full time CLOD.

The implementation of the Nurse Led Referral has been successful as reflected in the increase in referrals from both CHH and HRI. However the lack of embedded SNOD's have resulted in a decrease in collaborative approaches made.

3. FUTURE ACTIONS BY THE ORGAN DONATION TEAM

1. Continuing with nurse led referral
2. SNOD presence during some morning handovers. Phone calls to the nurse-in-charge in ICU HRI are carried out when the SNODs are unavailable.
3. Increased educational activities for nurses and medical staff in ICU, ED, and Theatres
4. More robust scrutiny and analysis of missed opportunities
5. Increased public awareness campaigns
6. Improve quality of donated organs by facilitating withdrawal in theaters. We are the first Trust to produce an SOP for this process and we are one of the centres within the Yorkshire region piloting DCD heart donation
7. Implementation of the Specialist Requester Role to improve consent rates. One of the 5 specialist requesters covering the Yorkshire region will be based in Hull

4. SUPPORT REQUESTED FROM THE TRUST

1. Facilitate admission of potential organ donors from ED by improving patient throughput in ICU and exploring other options when no ICU bed is available.
2. A streamlined process to book a theatre to facilitate organ donation. As CHH is an elective site, it does not have emergency theatre capacity that can be accessed in a streamlined way for organ donation requirements. This means potential impact on elective scheduling.
3. Support for the purchase and installation of a donor memorial in a prominent place. The majority of trusts have a physical memorial to celebrate the Gift of Life given by our donors and their families, and also to celebrate the work and contribution of our staff and Trust to Organ Donation.

5. RECOMMENDATION

The Trust Board is asked to receive the report as an update position.

Executive Summary
Actual and Potential Organ Donors
1 April 2016 - 30 September 2016

NHS Blood and Transplant

Hull and East Yorkshire Hospitals NHS Trust

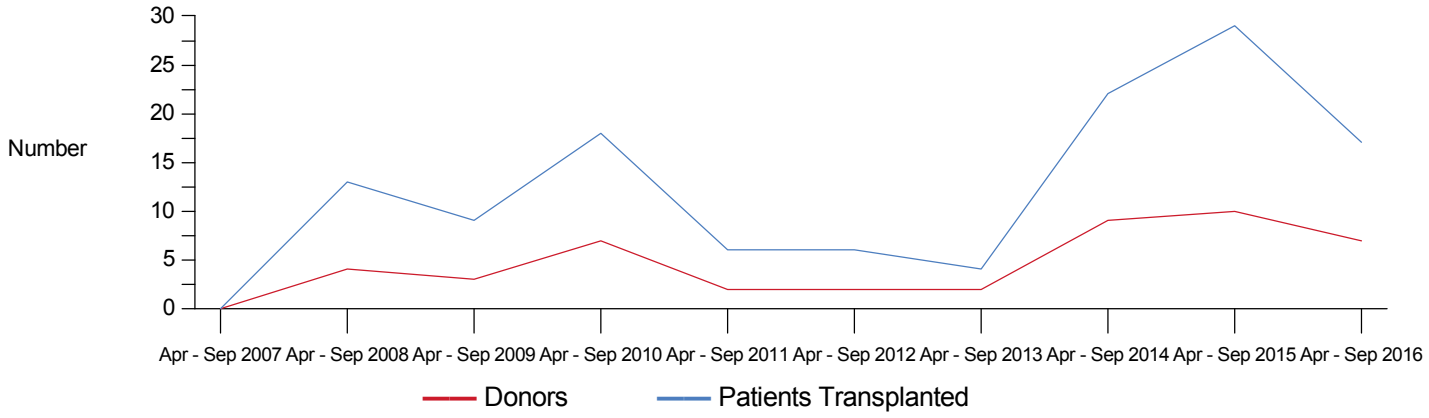
Donor outcomes

Between 1 April 2016 and 30 September 2016, your Trust had 7 deceased solid organ donors, resulting in 17 patients receiving a transplant. Further details are provided in the table and chart below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

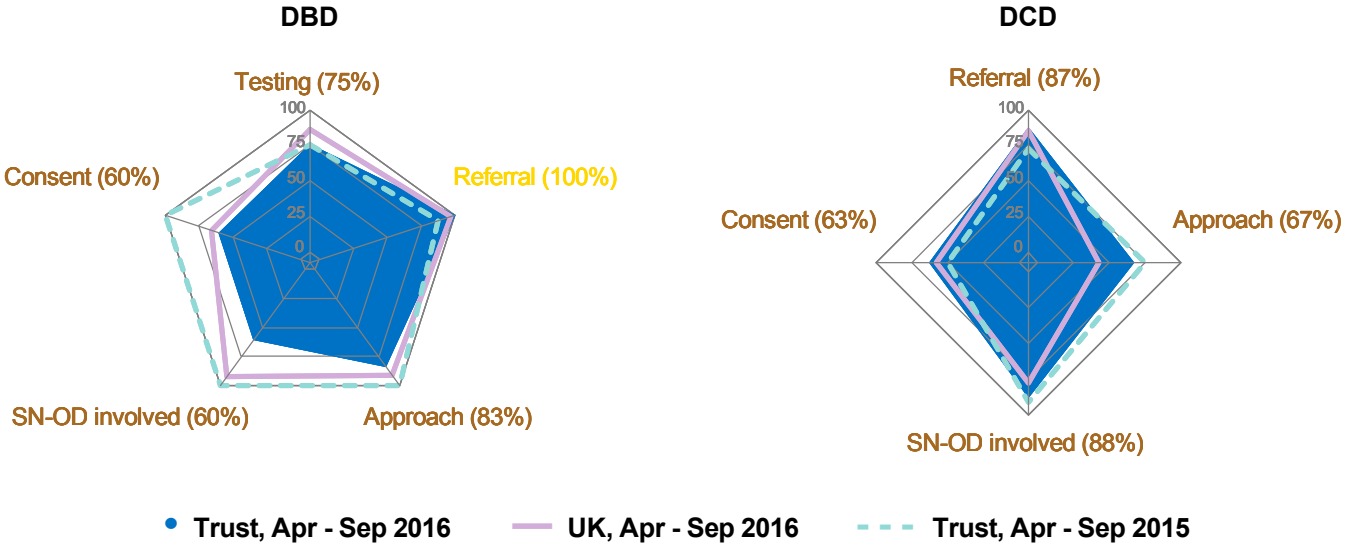
Donors, patients transplanted and organs per donor, 1 April 2016 - 30 September 2016 (1 April 2015 - 30 September 2015 for comparison)

	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
Deceased donors	7	(10)	17	(29)	3.1	(3.3)	3.4	(3.4)

Number of donors and patients transplanted between April and September each year



Radar charts of key rates, 1 April 2016 to 30 September 2016



The blue shaded area represents your Trust's rates for the first six months of 2016/17. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. The colour of the rate label on each of the radar charts indicates the Trust performance as shown in the appropriate funnel plot (included in the detailed report) using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

Key numbers and rates

There are nine measures on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. Funnel plots can be found in the detailed report. Between 1 April 2016 and 30 September 2016, your Trust met a statistically acceptable level in all of these measures. Of the 8 potential DBD donors with suspected neurological death, 3 proceeded to donation and 5 did not proceed. Of the 12 eligible DCD donors, 3 proceeded to donation and 9 did not proceed. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD					DCD				
		Apr - Sep 2016		Apr - Sep 2015			Apr - Sep 2016		Apr - Sep 2015	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		8	855	8	847		23	3,004	26	3,073
Referred to SN-OD		8	830	7	816		20	2,571	19	2,525
Referral rate %		G *100%*	*97%*	*88%*	*96%*		B *87%*	*86%*	*73%*	*82%*
Neurological death tested		6	741	6	726					
Testing rate %		B *75%*	*87%*	*75%*	*86%*					
Eligible donors[2]		6	698	6	689		12	2,046	16	1,970
Family approached		5	636	6	639		8	873	12	930
Approach rate %		B *83%*	*91%*	*100%*	*93%*		B *67%*	*43%*	*75%*	*47%*
Family approached and SN-OD involved		3	587	6	573		7	685	11	700
% of approaches where SN-OD involved		B *60%*	*92%*	*100%*	*90%*		B *88%*	*78%*	*92%*	*75%*
Consent ascertained		3	418	6	438		5	506	6	501
Consent rate %	*72%*	B *60%*	*66%*	*100%*	*69%*	*68%*	B *63%*	*58%*	*50%*	*54%*
Expected consents based on ethnic mix		4		4			4		6	
Expected consent rate based on ethnic mix %		*73%*		*74%*			*60%*		*55%*	
Actual donors from each pathway		3	381	5	383		3	267	5	248
% of consented donors that became actual donors		*100%*	*91%*	*83%*	*87%*		*60%*	*53%*	*83%*	*50%*
Colour key - comparison with funnel plot confidence limits		G *Gold* A *Amber*		S *Silver* R *Red*			B *Bronze*			

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued November 2016 based on data reported at 7 November 2016.

	National Target	NHSBT Executive Summary 2015 April to September 2015	NHSBT Executive Summary 2016 April to September 2016	True Data Following Completion of PDA April to September 2016
DBD referral	100%	88%(7/8)	100% (8/8)	100% (8/8)
BST testing	95-100%	75%(6/8)	75% (6/8)	75% (6/8)
Eligible donors		6	6	6
Families approached		100%(6/6)	83%(5/6)	83% (5/6)
DBD SNOD app	98-100%	100%(6/6)	60%(3/5)	60% (3/5)
DBD consent	80%	100%(6/6)	60%(3/5)	60% (3/5)
Abdominal organs retrieved from DBD				11
Cardiothoracic organs retrieved from DBD				2
DCD referral	88-90%	73% (19/26)	87%(20/23)	86% (19/22)
Eligible donors		16	12	8
Families approach		75%(12/16)	67%(8/12)	100% (8/8)
DCD SNOD app	60-65%	92%(11/12)	88%(7/8)	87% (7/8)
DCD consent	65%	50%(6/12)	63%(5/8)	62% (5/8)
Abdominal organs retrieved from DCD				6

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 3 2016/17

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 - 16
Director	Chairman – Mike Ramsden	**Author**	Director of Corporate Affairs – Carla Ramsay
Reason for the report	The purpose of this report is to present quarter 3 ratings for each risk on the Board Assurance Framework for the Board to review and approve.		

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

1	**RECOMMENDATIONS** The Board is asked to review the BAF and satisfy itself that the risks are being appropriately managed, and to confirm the proposed ratings for Q3, specifically the changed risk ratings for risks F1 and F3. The Board is also asked to review and approve the process mapped out at Appendix 4, to strengthen the 'ward to board' escalation of corporate risks linked to Board Assurance Framework issues.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	

3	**STRATEGIC GOALS:**	
	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	✓
	Great local services	✓
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	✓

4	**LINKED TO:**			
	CQC Regulation(s): W2 - governance			
	Assurance Framework Ref: N/A	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** This paper reflects assurance and updates received throughout Quarter 3 at the Trust Board and its committees Appendix 4 has been discussed and approved at EMC 18 January 2017 from an operational management point of view, for recommendation to the Trust Board			

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 3 2016/17

1. PURPOSE OF THIS REPORT

The purpose of the paper is for the Trust Board to review the Board Assurance Framework risks at Quarter 3 and satisfy itself that these are being managed.

2. KEY ISSUES

- Risk F1 (risk that the Trust will not resolve the financial deficit) is proposed to increase in rating to 20 (high risk)
- The next highest rated risks are rated at 16 and relate to learning lessons (Q2), workforce (Q3), and the Strategic Transformation Plan (P1)
- The risk rating for the risk relating to the capital programme (F3) is proposed to be reduced to 8

3. BOARD ASSURANCE FRAMEWORK (BAF)

There are 9 risks on the Board Assurance Framework. Six risks were reviewed and updated in quarter two with the lead Director. For quarter three, 3 risks have been updated with the lead Director. For all risks, the mitigating actions and assurance received have been reviewed and updated against papers received at Trust Board and Board Committees in Quarter 3.

The three risks reviewed with lead Directors this quarter are:

- G1 NHS Constitution standards
- F1 Financial Deficit
- F3 Capital programme

In relation to G1, as reported to the Trust Board in Quarter 3, the Trust is not meeting its agreed recovery trajectories for waiting times (RTT) and while performance in the Emergency Department showed improvement in Quarter 3, it was not at the performance trajectory. On reviewing this risk area for Q3, it is proposed that the risk rating remains the same, as the impact on patients during Q3 remained the same as in previous quarters. In addition, this risk is specifically linked to the Trust's rating under the new Single Oversight Framework (SOF), which has not changed in Q3 as a result of the Trust's performance against the key measures in the SOF. As part of discussions on the year-end position, the updates against this risk in Q4 may affect this risk rating, as the final position for the year becomes clearer.

In relation to risk F1, the Trust Board throughout Quarter 3 was apprised of the deteriorating position of the Trust's underlying financial deficit; there has been insufficient evidence that the Health Groups have full grip on cost control and productivity, and have not yet identified sufficient cash-releasing efficiency savings. The risk that the Trust will not meet its control total increased during Quarter 3, as reported to the Performance and Finance Committee and to the Trust Board. It is therefore proposed that this risk rating is escalated to 20 (likelihood 4 x impact 5).

In relation to risk F3, it is recommended that this risk rating is reduced to 8 (likelihood 2 x impact 4) due to the effect of the control measures on the likelihood of the risk materialising, and the overall reduction of the level of corporate risk reported against this risk. As detailed at the Performance and Finance Committee and the Trust Board during Q3, the risk that the capital programme is not sufficient and has an impact on clinical quality has been mitigated and managed throughout the year. The capital programme has been sufficient to meet requirements in-year. There are risks linked to the capital programme that remain on the Corporate Risk Register, but some link more to staffing in order to perform diagnostics, rather than an increasing risk about the equipment itself, which is being actively managed as the

capital programme allows. The number of high-rated corporate risks relating to F3 reduced from 6 to 4 in Q3.

The BAF is attached at appendix 1 for review.

In addition to the recommended escalation of the risk rating for F1, and the reduction of the risk rating of risk F3, the Trust Board should also review and confirm whether the proposed Q3 ratings for the other 7 risks on the risk register reflect the Trust Board's levels of assurance on each risk.

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

Attached at Appendix 4 is a updated 'ward to board' risk escalation process, as to how operational risks are identified and agreed on to the Corporate Risk Register, and the way in which Corporate Risks are reviewed where these might have an impact on BAF areas. The aim of this process is to strengthen the link between the BAF and the Corporate Risk Register. It also makes further progress, following the recommendation from internal audit as part of their 2015/16 year end assurance work, for the way in which the Performance and Finance Committee and the Quality Committee review those BAF risks that are relevant to their remit.

4. RECOMMENDATIONS

The Board is asked to review the BAF and satisfy itself that the risks are being appropriately managed, and to confirm the proposed ratings for Q3, specifically the changed risk ratings for risks F1 and F3.

The Board is also asked to review and approve the process mapped out at Appendix 4, to strengthen the 'ward to board' escalation of corporate risks linked to Board Assurance Framework issues.

Carla Ramsay
Director of Corporate Affairs
January 2017

Appendix 1

BOARD ASSURANCE FRAMEWORK Q3 – 2016/17

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Mitigating Actions Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q1	Chief Medical Officer, Chief Nurse Quality Committee	5 risks • Crowding and physical space issues (2) • Safeguard-ing training compliance (1) • Reduction in trained staff in blood transfusion labs (compliance risk) (1) • Paediatric access to dietary assessment (1)	**The Trust is non-compliant with CQC regulatory requirements** There is a risk that the Trust does not achieve the fundamental standards and that regulators and service users may have concerns about the quality and safety of our patient services.	**20** **L-4** **X** **S-5**	• QIP established • Fortnightly QIP meetings chaired by CMO to monitor achievement of milestones • QIP programme reviewed at Operational Quality Committee and deviations from plan escalated • Internal inspection programme in place during Q1 • NHSI involved in 'health check' • Governance toolkit developed to support staff to prepare for inspection • Fortnightly Charge Nurse meetings with ward sisters	Informal feedback from the CQC identified areas where further work needs to be undertaken. This includes embedding checking procedures, adherence to escalation procedures, documentation and staffing. A review has been undertaken of the QIP following informal CQC feedback and the QIP has been updated. This will be reviewed on receipt of the formal CQC report **Leads**: CN, CMO and Director of Governance **Completion**: Anticipated March 2017	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**		**4** **L1** **X** **S4**	**Positive assurance** • Informal feedback received from the CQC following the comprehensive inspection at the end of June 2016 identified a number of areas where positive improvements had been made • Review by Internal Audit that the QIP was complete and accurate – reported to the Audit Committee at May 2016 meeting • Internal reports giving significant assurance during 2015/16 – Fit and Proper persons, discharge planning, safe staffing levels, performance management arrangements and lessons learnt • Internal Audit provided positive feedback on the Duty of Candour arrangements (May 2016) • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days • QIP programme reviewed – areas with progress made that are now business as usual now removed; deteriorating patient programme provisionally closed ; overall programme rating amber/green **Further assurance required** • Internal audit reports giving limited assurance in 2015/16 – infection control, incident reporting, planned medical staff absence and responding to Francis • Recently established Heath Care Delivery Improvement Group. This group will be responsible for ensuring learning is shared and embedded throughout the Trust • 2 Never Events declared in 2016/17 • Two areas escalated from the QIP in November/December 2016 – VTE compliance and Resuscitation equipment checks audit compliance

Q – High Quality Care													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q2	Chief Medical Officer Quality Committee	0 risks	**Lessons learned** There is a risk that the Trust does not learn from adverse events and that errors continue to occur which could affect patient care and safety	**20** **L4** **X** **S5**	• Learning lessons QIP project group established • Monthly Lessons learned newsletter • Quality Bulletin • Lessons Learned Intranet site • Monthly SI summary report distributed to Health Groups • Analysis of incidents and trends • Use of videos to replicate incidents in order to improve learning • Application of Root cause analysis techniques and training • Operational Quality Committee • Health Group Governance meetings • Health Group performance reviews • Clinical Incident Review Creating a Learning Environment **(**CIRCLE) • Table top RCA's being piloted for some SI's • Trialling PDSA cycles for learning	• At the end of Q2 there was a reduction in the number of SIs reported when compared to 2015/16 .The themes and trends in incidents and Serious Incidents (SIs) are continuing from 2015/16 into 2016/17. Further review and analysis required • Revised incident reporting system launched April 2016. The national coding structure implemented at the same time is causing some concerns when analysing themes and trends and is being reviewed **Lead:** Director of Governance **Completed:** December 2016	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**		**4** **L2** **X** **S2**	**Positive assurance** • Significant Assurance – internal audit, lessons learned review, March 2016 • Positive feedback received from staff who attended the learning lessons workshops (May 2016) which included the training video of the Never Event retained vaginal swab • Positive feedback received from CQC that staff were aware of the Lessons Learned Bulletin and the safety brief and that work had been undertaken to improve learning from incidents including human factors training • Information about changes in practice now being included in the Board's Quality report related to complaints and Never Events/Serious Incidents • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days. • Training videos produced and PDSA cycle being introduced • Fewer Serious Incidents declared year-to-date • Improvements to structured case review for lessons learned with mortality and patient deaths • QIP for Lessons Learned still on track to deliver against milestones for March 2017 **Further assurance required** • New processes for dissemination of information strengthened during 2015/16. However, there is evidence that changes in practice are not always occurring across the Trust and further work needs to be put in place so that learning occurring in one part of the Trust is transferred to other areas. • 2 Never Events declared in 2016/17 • Recurrent themes in Serious Incidents – amber/green rating Lessons Learned QIP as a result

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

H – Honest, Caring and Accountable Culture												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H1	Chief Nurse Quality Committee	0 risks	**Patient Experience** There is a risk that patients receive and report a poor experience through complaints, PALS, Family and Friends Test and the National Patient Survey. The impact of this poor experience is loss of confidence and trust in the care provided for new and existing patients along with reputational damage for the Trust	**16** **L4** **X** **S4**	• Ward audit programme • FFT being used as improvement tool 'You said we did'. • Patient Council established • Complaint Policy • Inpatient survey top quartile for improvements in patient experience • Intentional Rounding in ED every 2 hours • Two hourly Board Rounds in ED, led by Emergency Physician in Charge • Monthly Health Group Performance reviews	• Response times to complaints. Further work needs to be undertaken to improve response times to complaints within 40 days **Lead** :HG Medical Directors Completed:30.11.16	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**		**8** **L2** **X** **S4**	**Positive assurance** • Quality Report to every Trust Board including lessons learned • Patient Stories presented at every Trust Board • The FFT report for September 2016 identifies • Average score of 4.75 • Trust information indicates 94.9% patients likely to recommend the Trust (2.1% unlikely to recommend) • ED information indicates 87.9% likely to return and 6.6% would not return • PHSO – Complaints about acute trusts 2014-15 identified Trust has a low conversion rate of 1.61 per 10,000 clinical episodes • 17% decrease in the number of complaints received when comparing 2015/16 to 2014/15 • No. of complaints responded to over 40 days improved in Q3 **Further assurance required** Health Groups are not meeting the Trust's standard of responding to complaints within 40 days – improvement seen in November 2016 of 78% of complaints closed within 40 days against target of 90% - need to continue improvement

H – Honest, Caring and Accountable Culture

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

G – Great Performance and Reliability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
G1	Chief Operating Officer Performance and Finance Committee	6 risks • Capacity in Radiology (2) • Ophthalmo -logy delays (3) • Medical outliers (1)	**NHS Constitution standards** There is a risk that the Trust will not improve on its current TDA Oversight Category – Single Oversight Framework rating of 3 (requires support)	**16** **L4** **X** **S4**	• Increased management support • Emergency Care Improvement Programme (ECIP) support • IST support from NHSI for RTT • Action plans for emergency care recovery including ED • Action plan for RTT recovery • Action plan for Cancer recovery • Agreed trajectories with NHSI • SAFER bundles agreed and implemented. • Urgent and Emergency Care Programme established	• RTT is not expected to deliver fully against trajectories • Trajectories are being updated with commissioners for 18 weeks - year-end position with commissioners will impact on this area • **Lead:** Chief Operating Officer **Completion**:31.03.17 It is possible that the risk rating will increase in Q4 as trajectories will not be met – need to understand if this impacts on SOF rating	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**		4 L2 X S2	**Positive assurance** • Operating plan approved at April 2016 Trust Board • Some improvement seen in Q3 ED performance due to changes in pathways and resources **Further assurance required** • Internal audit - Performance reporting/Management - April 2015 Significant assurance – corporate. Limited assurance – Health Group • Understanding impact of year-end financial agreement on trajectories • Internal Audit report identified limited assurance for medical staffing planned absence management (June 2015)

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

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

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

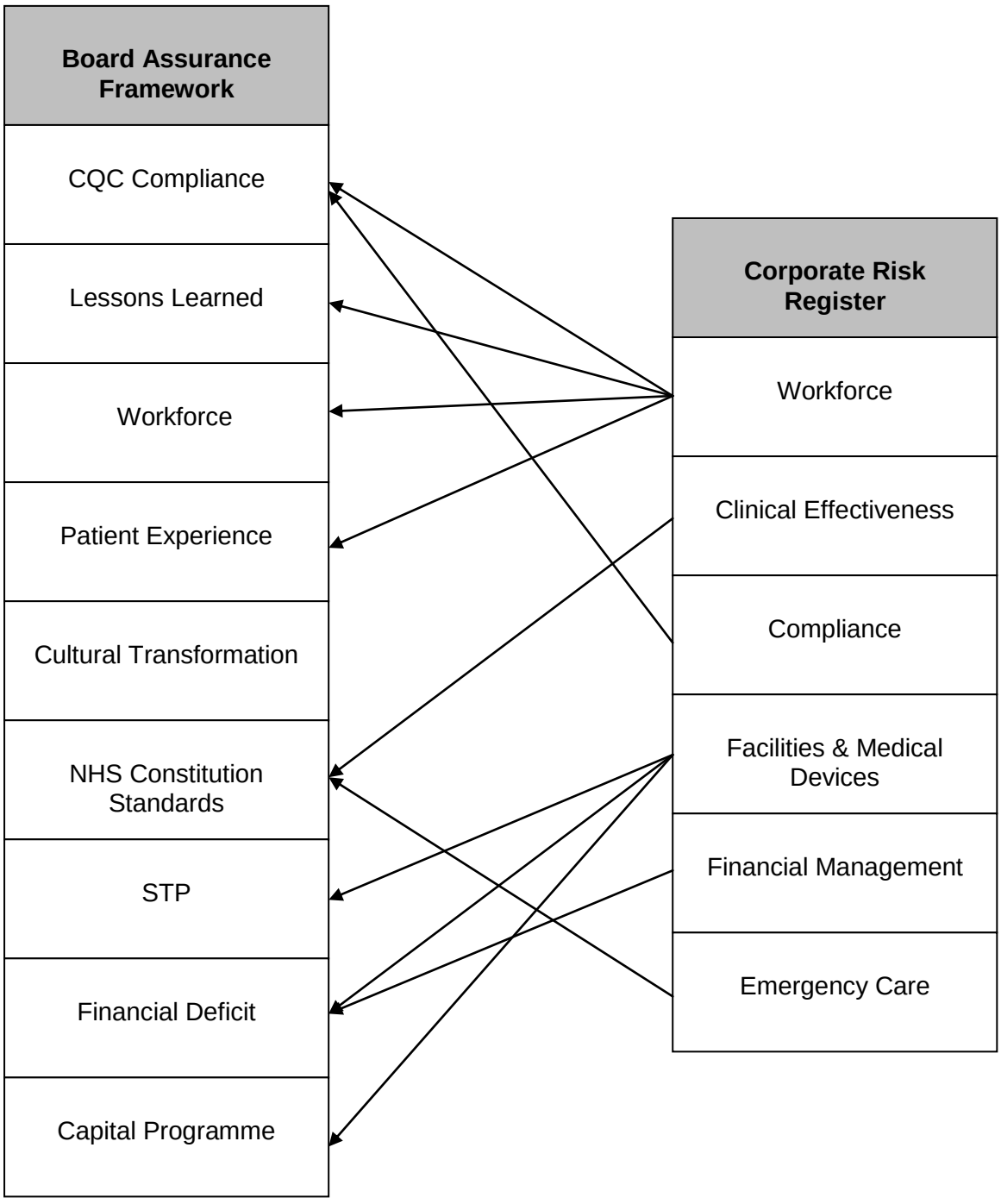
Appendix 2

Board Assurance Framework risks and Trust Board agendas

No	BAF Risk	Trust Board
Q1	CQC	Quality Report (April, May, July & September, October, November 2016) Integrated Performance Report (April, May, July & September, October, November 2016) Board Assurance Framework (April, July and October 2016) Chair Opening Remarks (April, November 2016) Portfolio Board Report (May 2016) Infection Prevention and Control Annual Report (September 2016)
Q2	Lessons Learned	Portfolio Board Report (May 2016) Quality Accounts (June 2016) Quality Report (April, May, July, September, October and November 2016)
Q3	Workforce	Nursing & Midwifery Report (April, May, July, September, October and November 2016) Equality Objectives 2016 – 20 (April 2016) Transforming HEY's Culture – Progress Report (May and November 2016) People Strategy Report (April 2016) Chief Executive's opening Remarks - Success at the Apprenticeship Awards, (April 2016) Chairman's opening remarks - Junior Doctors Strike (July 2016) Workforce Race Equality Standard 2016 Return (July 2016) Guardian of Safe Working Hours – Junior Doctors in Training (September 2016) Modern Slavery Statement (September 2016) Responsible Officer Report (October 2016) Agency spend (November 2016)
H1	Patient Experience	Patient Story (April 2016) Corporate performance report (April, May, July, September, October and November 2016) Quality Report (April, May, July, September, October and November 2016)
H2	Cultural Transformation	Cultural Transformation – Progress Report (September and November 2016)
G1	NHS Constitution	Integrated Performance Report (April, May, July, September, October and November2016) Emergency Department Report and Action Plan (April 2016) Operational and Financial Plan 2017/18, 2018/19 (December 2016) Winter Plan (November 2016)
P1	STP	Trust Strategy (April, May, July, September and November 2016) Sustainability and Transformation Plans (April, October and December 2016)
F1	Financial Deficit	Corporate Finance Report (April, May, July, September, October and November 2016) Annual Accounts 2015/16 (May 2016) Standing Orders/SFIs (September 2016) Capital Developments Update (September 2016) Charitable Funds Annual Accounts (November 2016)
F3	Capital Programme	

Appendix 3

Relationship between Board Assurance Framework and the Corporate Risk Register



Appendix B - Operational, Corporate Risk Registers and the Board Assurance Framework

Ward to Board Escalation

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

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

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

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

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

Linked to BAF risks on DATIX

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

Notes on implementation
Need to add to DATIX for ORR and CRR – approval and escalation process, action plans, control measures, assurance on controls
Ward to Board escalation is shown. Board to Ward communication achieved through HG and Corporate Function representation at OQC (clinical risks), Non-clinical Quality Committee (non-clinical risks) and EMC
HG and Corporate Functions need to share any updates back through governance structures.
Existing Corporate Risk Register of 6 themes can still be used to 'group' together the types of risks within DATIX or can group these under the Trust's 7 strategic goals

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 - 17
Director	Assistant Board Secretary – Rebecca Thompson (on behalf of Carla Ramsay)	**Author**	Director of Corporate Affairs – Carla Ramsay
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to approve the proposed changes to the Trust's Standing Financial Instructions relating to the application of OJEU thresholds.					
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** The proposed amendments to Standing Financial Instructions were reviewed by the Audit Committee on 15 December 2016, to be recommended for approval by 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

There have been no occasions of the use of the Trust seal since the last report to the Trust Board.

3 STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Attached at Appendix 1 is a proposed amendment to Standing Financial Instructions (SFIs) for approval by the Board.

Section 9 of the SFI's sets out the procedure for procuring goods and services and includes details of the threshold above which goods and services need to be procured through the Official Journal of the European Union (OJEU) process.

There are 6 OJEU thresholds relating to different areas of procurement activity. Most of these are unlikely to apply to procurement exercises undertaken in the Trust but the procurement team is aware of them and apply the rules accordingly where necessary.

Only one limit has been included in the current SFI's. The proposed amendment is to add the limit for "schemes of works" only as this will be used frequently by the Trust. An explanatory note is proposed for the foot of the table in section 9.1. Appendix one sets the proposed amendment and shows a table of the 6 OJEU thresholds.

The proposed changes were reviewed and recommended for approval by the Audit Committee on 15 December 2016. The Board is requested to consider the proposed amendments

4 RECOMMENDATIONS

The Trust Board is requested to approve the proposed changes to the Trust's Standing Financial Instructions relating to the application of OJEU thresholds.

Rebecca Thompson
Assistant Trust Secretary
January 2017

Appendix 1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PROPOSED AMENDMENTS TO STANDING FINANCIAL INSTRUCTIONS (SFIs)

The proposed changes to current SFIs are highlighted

9.1 General

Value of Goods/Services	Tender/quotation requirement
Less than £10k (including VAT)	Use NHS supply chain and established contracts where possible otherwise obtain a quotation (see guidance below)
Between £10k and up to £50k (including VAT)	Obtain a quotation (see guidance below)
£50k to £106k (including VAT)	Undertake a local tender exercise (see guidance below)
More than £106k (Including VAT) *	Tender exercise using EU procurement procedures

Programmes of "works" have an EU tender threshold of £4,104,394

*The table below shows the 6 OJEU limits

Goods and Services – central procurement including NHS Trusts	£106,047
Goods and service sub central government (including NHS foundation Trusts)	£164,176
Goods and services – utilities and defence	£328,352
Light touch regime services – public sector rules	£589,148
Light touch regime services – utilities	£785,530
Works	£4,104,394

Drafting note *(not part of the proposed amendments): the reference in the table above to (see guidance below), refers to an existing sections of the SFIs that do not require amendment. This is section 9.9, which provides the guidance on obtaining quotations for goods/services valued between £10k and up to £50k (including VAT), and section 9.5, which details the process by which to undertake a local tender exercise. These sections are not affected by these proposed amendments, but the Audit Committee asked for clarity on this point to be included when the amendments were proposed to the Trust Board*

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS: JUNIOR DOCTORS IN TRAINING

Trust Board date	26 January 2017	**Reference Number**	2017 – 1 - 18
Director	Kevin Phillips, Chief Medical Officer	**Author**	Helen Cattermole, Guardian of Safe Working Hours
Reason for the report	**PURPOSE OF THIS REPORT** The purpose of this report is to inform the Trust Board of the current position in relation to the Guardian of Safe Working Hours appointment, systems and processes		

Type of report	Concept paper		Strategic options		Business case	
	Performance		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	✓	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 –** How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?					
	Assurance Framework Ref: Q1, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Board received an update on this area at its meeting of September 2016					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS: JUNIOR DOCTORS IN TRAINING

1. PURPOSE OF THIS REPORT

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

- Guardian of Safe Working Hours appointment
- Junior doctor working hours
- Rota gaps
- Locum usage
- Exception reports, where appropriate
- System-wide junior doctor issues, where appropriate
- The Trust Board is requested to receive this report and:
- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required.

2. HIGH LEVEL DATA

Total number of doctors in training: 594 (figure includes some Trust doctors)

Number of doctors in training on 2016 TCS (new junior doctor contract): 69

Amount of job planned time for educational supervisors: 0.25 PA per trainee (variable)

3. GUARDIAN OF SAFE WORKING HOURS APPOINTMENT

Miss Helen Cattermole, Consultant Orthopaedic Surgeon, was appointed as the Trust's Guardian of Safe Working Hours and commenced these duties on 3 August 2016. She works closely with Professor Loubani, Director of Medical Education, the Medical Education Centre and Human Resources to ensure support for the new junior doctors' contract.

The agreed remuneration is 2 PAs for this role. Working hours are being monitored to ensure sufficient time has been allocated for this role.

Administrative Support has been identified for diary support and administration of the Junior Doctors' Forum. There is a need for further support in relation to administering the electronic exception reporting system and providing reports. This requirement for further support is being monitored and Medical Education and Human Resources have been asked to try and work together to find this from existing staffing.

A separate Guardian email address has been established, and a Guardian intranet page is planned with links from both Medical Education and Human Resources intranet pages.

4. JUNIOR DOCTOR WORKING HOURS

4.1 Issues raised at Junior Doctors' forum

The Guardian of Safe Working co-chairs, with the Director of Medical Education, a monthly Junior Doctors' Forum which began meeting in August 2016. Issues raised by the representatives since its establishment include:

- Provision of phlebotomy to reduce inappropriate tasks
- Management of annual leave requests
- Timescales for issuing of rotas before changing posts

4.2 Roll-out of 2016 contract

All F1 doctors transferred to the new contract (TCS) on 1 December 2016 (69 doctors). The Trust has purchased software to allow exceptions to the new TCS to be reported electronically. Training on this system was offered to the F1 doctors and to their clinical and educational supervisors prior to the transfer date.

All F1 doctors received their generic work schedule 8 weeks prior to the transfer date, in accordance with the Code of Practice. Work schedules comprise working pattern, a breakdown of pay, training opportunities and key contacts. They are personalised once doctors are in post, after discussion with the educational supervisor. The work schedule should accurately reflect the actual activities of a doctor's working time, including education, handovers, supervision, breaks and rest periods.

The next group of doctors to transfer on 1 February 2017 includes surgery and paediatric junior doctors, pathology, microbiology and infectious diseases juniors (74 doctors). All have received their work schedules 8 weeks in advance. Training is being arranged for the doctors and their supervisors on the new software before the transfer date.

4.3 Monitoring/routine exception reports

Junior doctors under the 2002 contract have their hours monitored routinely by the Trust on a twice-yearly basis.

Three rotas (out of 57) have had problems identified in the current round of monitoring, and work is underway to find solutions to prevent this recurring:

- Neurosurgery StR rota – breach of maximum duty length
- ENT StR rota – breach of maximum duty length
- Haematology / Oncology StR rota – inadequate natural breaks during duty hours

Doctors on the 2016 contract submit exception reports to inform the Trust when their day to day work varies significantly and/or regularly from the agreed work schedule. The Guardian of Safe Working Hours (GSW) receives copies of all exception reports submitted by junior doctors reporting breaches in their safe hours of work, and the Director of Medical Education (DME) receives copies of reports where the issue is educational.

The educational/clinical supervisor receiving the exception report will review the content and then discuss it with the doctor to see what action is necessary to address the issue. The supervisor will then set out the agreed outcome to the exception report, including any agreed actions, in an electronic response to the doctor, coped to the GSW and/or the DME.

It is expected that most decisions are dealt with at clinical/educational supervisor level.

Exception reports by department (as of 16-01-2017)					
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Comments**
Acute Surgery	0	3	1	2	1 educational
ICU	0	2	2	0	Duplicate, sent to wrong supervisor
Cardiology	0	2	2	0	One not covered by new TCS
Haematology	0	2	2	0	
General Surgery	0	1	0	1	

Exception reports (response time) as of 10-01-2017					
Grade	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Overdue**	**Still open**
F1	0	4	3	1	2

In certain, clearly defined circumstances where there has been a breach of working hours, the Guardian is expected to levy a fine on the department or Health Group where the breach occurred. All fines levied must be reported to the Board. The following breaches have required the Guardian to apply a fine to the department or Health Group this quarter:

- No breaches

5. EXCEPTION REPORTS FOR ESCALATION

The Guardian of Safe Working Hours is required to escalate issues in relation to safe working hours to the Chief Medical Officer where they have not been addressed at departmental level. This quarter the following issues have been escalated:

- No issues

The Guardian of Safe Working Hours is required to escalate issues to the Board which remain unresolved after the involvement of the Chief Medical Officer. This quarter the following issues require escalation to the Board:

- No issues

6. ROTA GAPS / VACANCIES

The Guardian of Safe Working Hours is required to present data to the Board on all rota gaps on all shifts.

This data is not centrally held (particularly for Trust doctors who may share rotas with doctors in training). This remains an area of work and may not be resolved until all

departments are fully utilising the electronic rota. At the moment, the Clinical Support Health Group is fully using the e-roster system. Progress is being made in getting the other Health Groups to use e-roster to its full extent in all departments, and this may be helped by a system upgrade due in late January/early February.

For F1 doctors currently on the new contract, there is one rota gap (1/70) due to failure by Health Education England (HEE) to recruit to all posts. This currently affects psychiatry in-hours and acute medicine out-of-hours. The acute medicine gap is being covered by internal locums.

7. LOCUM USAGE

The Guardian of Safe Working is required to present data to the Board on Locum Usage in all specialties and at all levels.

Different Health Groups collect the data in different ways; a unified system of data collection is being developed in conjunction with the Health Groups so that more information will be available over the next few months.

8. QUALITATIVE DATA

8.1 Good Practice

Medical Staffing and Medical Education have worked very well in ensuring that work schedules are produced in good time and in sufficient detail to allow them to be useful documents. Compared to other Trusts in the region, this organisation has, so far, met the timescales and has engaged with the junior doctors in a positive way. This was recognised by the BMA junior doctors' rep who offered unsolicited thanks to the Trust for the way they have handled the contract transition to date.

8.2 Persistent or recurrent concerns

None identified this quarter

9. SYSTEM-WIDE ISSUES

The Guardian of Safe Working Hours is required to inform the Board if posts have issues that cannot be remedied locally and require a system-wide solution. The Board will then raise the issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution.

The following system-wide issues have been identified this month:

- No issues

10. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

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

Helen Cattermole
Guardian of Safe Working Hours

Kevin Phillips
Chief Medical Officer

January 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE

Meeting Date:	19 December 2016	**Chair:**	Mr S Hall	**Quorate (Y/N)**	Y

Key issues discussed:

- Financial Plan 2017/18 – Control totals set by the Department of Health
- Winter Plan 2016/17 – An update regarding the extra procedures put into place
- Performance - Emergency Department, Cancer and Referral to Treatment Times
- Quality Improvements in the Emergency Department
- Performance presentation from the Surgery Health Group
- Finance, cash releasing efficiency schemes – Trust position
- Agency expenditure – Discussion around the controls in place to reduce agency spend
- Lord Carter of Coles
- Capital Resource Allocation Committee

Decisions made by the Committee:

- Agreed to recommend not to sign the control totals at this time.

Key Information Points to the Board:

Matters escalated to the Board for action:

- The Committee agreed to escalate the decision not to sign the control totals at this time

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON MONDAY 19TH DECEMBER 2016
THE COMMITTEE ROOM

PRESENT:	Mr S Hall (Chair)	Non-Executive Director
	Mrs E Ryabov	Chief Operating Officer
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce & OD
IN ATTENDANCE:	Mr P Watson	Director of Operations (Surgery) item 7.2 only
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

No **Item** **Action**

1 APOLOGIES FOR ABSENCE

There were apologies for absence from Ms C Ramsay, Director of Corporate Affairs.

2 MINUTES OF THE MEETING HELD ON 21 NOVEMBER 2016

Ms Ramsay was in attendance at the meeting and would be added to the distribution list.

Following this amendment the minutes were approved as an accurate record of the meeting.

2.1 – P&F ASSURANCE DOCUMENT

Mr Hall advised that going forward the document would form part of the Trust Board papers.

3. ACTION TRACKING LIST

Cancer conversion rate – Mrs Ryabov advised that the cancer pathway was increasing and that the Trust was up 15% on all treatments. GPs were referring sooner ensuring patients got on the pathway sooner.

Outpatient Transformation Programme – It was agreed to invite a member of the team to give an update of the programme in January 2017. It was also agreed to add this to the committee workplan for quarterly updates. **ER**

Patient Administration – Mr Bond to present the recovery plan report to the January 2017 meeting. **LB**

Getting it right first time – Mrs Ryabov advised that the vascular meeting was well attended and the department had reported that they did not have sufficient capacity to manage the entire population of Hull and East Riding. It was noted that this is the 3rd such review (orthopaedics and neurosurgery being the other two). Mr Bond stated that each review should be used to develop a specific action plan focussing on the removal of clinical practice variation and resulting in increased productivity. Mrs Ryabov agreed to follow this up with each of the specialities concerned. **ER**

4. WORKPLAN 2016/17

The workplan was reviewed and it was agreed to invite Mr Vize from Women and Children's Health Group to discuss the ophthalmology back log. **RT**

5. MATTERS ARISING

Mrs Ryabov reported that information relating to the MRI/CT scan vans was now included in the Integrated Performance Report.

6. FINANCIAL PLAN 2017/18

Mr Bond presented the plan to the Committee and highlighted that the current control totals set by the Department of Health meant that the Trust had to find £25m in CRES (5% of turnover) to achieve a £6m surplus. If the Trust accepted this control total no fines would be allowed. Mr Bond and the Committee agreed that this would not be achievable and was setting the Trust up to fail.

Mr Bond and the financial team had developed a new plan which assumed £15m CRES (3%) and would result in a minimum £16m deficit which would require cash support. In addition to this the Trust would potentially be liable for fines against the constitutional standards and the capital programme would also have to be limited yet further.

The committee discussed the two options at length and what the implications were for each option. Mrs Ryabov was concerned that asking staff to find a 5% CRES and ensure performance was sustainable was too much and stated that she would be happy to reject the control total and accept option 2. The Committee agreed to reject the control total at this present time and would recommend this way forward to the Board. Mr Nearney stated that there was much to gain from accepting the control total and stretch staff but agreed that with performance as it was it was more sensible to reject it at present.

Resolved:

The Committee received the presentation and agreed to recommend rejecting the control total to the Board at this time. Option 2 was the preferred way forward. **SH**

6.1 – WINTER PLAN UPDATE

Mrs Ryabov reported that the winter plan was now on the Trust website and was being implemented although the Trust had not signed up to the wider health economy plan. She advised that Mr Long (as chair of the Area Delivery Board) would be taking support from partners to the next meeting.

7. PERFORMANCE REPORT

Mrs Ryabov presented the report and advised that ED performance was at 80.8% at the end of October 2016, key issues were the wait for beds and first clinician. New ways of working had been put into place and there was now a director of the day to support the flow through the department and 7 zones with representatives carrying bleeps and managing escalation. A number of Plan Do Study Act initiatives had been implemented and the department had seen a number of days with performance over 90% and an improved discharge position.

Ambulance turnaround times were poor in November mainly due to the lack of bed capacity.

Referral to treatment times had held at 86.6% performance and although it was not at trajectory it was above the contract level. Mrs Ryabov advised that the ISTC (who had been on site for 10 months) would prepare a report detailing the progress made in the department. Mrs Ryabov agreed to share the report with the committee when available. **ER**

There had been 2 x 52 week waiters and the patients were due to incorrect pathway interruptions.

62 day cancer continued to be a challenge, in particular the access to diagnostics and insufficient capacity in theatres due to staffing issues. There had been 29 breaches which related to diagnostics, complex cases, patient choice and late referrals.

The 62 day screening breaches were small numbers with 1 cancelled operation due to issues with equipment in diagnostics. Work was ongoing to rectify the problems.

Resolved:
The Committee received the report and noted the Trust's performance at Month 8.

7.1 – QUALITY IMPROVEMENT IN EMERGENCY DEPARTMENT
Mrs Ryabov updated the Committee regarding the quality improvements in the Emergency Department. She advised that the Emergency team had embraced having the Transformation team in the department and a workplan was in place to ensure improvements were sustainable. The work was aligned with the Unscheduled Emergency Care Board but at a more granular level.

Resolved:
The Committee received the update.

7.2 – SURGERY HEALTH GROUP
Mr Watson jointed the committee and gave a presentation which highlighted the issues within the Surgery Health Group relating to performance and finance. He spoke about the deficit and CRES being at 51% as well as the agency overspend of £900k. There was work ongoing to improve theatre productivity but there had been issues with the new robotic system and the logistics in bedding it in. Mr Bond requested clarity of the CRES figures as they did not match the current Trust finance report.

He reported that the Health Group's referral to treatment position was also having a financial impact and a number of initiatives had been put into place to address this. One of the main issues was the number of vacancies currently held particularly in the ICU due to maternity leave and agency spend increase as a consequence of this. Mr Watson advised that the Health Group was 90 posts down on where it should be. A review of wards at Castle Hill had taken place to see if anything could be done.

There was a discussion around why Surgery was still missing their plan and why the triumvirate had signed up to a plan they could not achieve. Mr Watson reported that there should have been caveats written into the plan as a number of problems had impacted on the deliverability of the plan. Mr

Gore suggested that the recruitment of nurse associates should be commenced as quickly as possible to reduce the number of nursing vacancies.

Mr Watson advised that the Health Group were looking at taking out a ward, a non pay review of theatre consumables and reviewing other services at other Trusts.

Mr Bond stated that the level of overspend in the Health Group would not be sustainable much longer and this would be discussed at the next performance meetings in December 2016. Mrs Ryabov added that a better understanding of the core capacity in the theatres was key to delivering higher levels of activity.

Resolved:
The Committee thanked Mr Watson for the update and asked that a further update was received in 3 months. **RT**

8. CORPORATE FINANCE REPORT

Mr Bond reported that the financial position of the Trust was poor and was reporting a deficit of £0.52m which was £0.76 below the planned surplus of £0.24m. The Health Groups continued to be overspent with £3.5m of reserves left for the remainder of the year.

The cash position remained weak and this was impacting on supplier relationships. There was an ongoing dispute with the Commissioners regarding the declared levels of ED patients and non elective activity.

The Trust was still overspending on agency staffing and the Trust's underlying financial position is now a £25m deficit. If the Commissioners refused to fund the outturn the deficit would be circa £35m.

Resolved:
The Committee received the update and noted the Trust's financial position.

8.1 – CASH RELEASING EFFICIENCY SCHEMES (CRES) 2016/17

Mr Bond reported that the non delivery of CRES remained an issue. There was a £3.1m shortfall against a £12m plan.

Resolved:
The committee received the updated CRES position.

8.2 - AGENCY REPORT

Mr Nearney presented the report and reassured the Committee that nursing and medical staff were managed centrally with the exception of some night and out of hours shifts. There was guidance in place to ensure only agencies on the framework were used and any staff costing over £120 per hour would have to be signed off by the Chief Executive. Any staff bypassing the system would be picked up by the new electronic invoicing procedures and the members of staff involved would be reminded of the procedures in place.

Mr Nearney reported that although there was an overspend in agency costs the Trust was still underspent on its pay budget. He advised that the recruitment of permanent staff would stabilise the position and reduce the

need for agency staff. Mrs Christmas asked if she could see in the next report whether the overspend against activity matched the payroll underspend within the Health Groups. Mr Nearney agreed to put this into the next report. Mrs Ryabov added that in the ICU there were 16 members of staff on maternity leave and this was having a major impact on agency spend as well as continuing to pay the staff in post.

Resolved:
The Committee received the report and noted the agency position of the Trust. Mr Nearney to add activity overspend against payroll underspend to his next report. **SN**

8.3 – LORD CARTER OF COLES – UPDATE
Mr Bond advised that work was ongoing and that there were 7 workstreams being completed. These included back office functions such as payroll and procurement. He reported that the Chief Pharmacist would be presenting the Pharmacy plans at the January 2017 Board meeting. Mrs Ryabov added that standardisation of implants was being reviewed.

9. CAPITAL RESOURCE ALLOCATION COMMITTEE
Mr Bond presented the summary report and highlighted the funding risk around the relocation of the OMFS and infectious diseases departments.

10. ITEMS DELEGATED BY THE BOARD
Items delegated by the Board were discussed in items 6 and 7.

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

12. DATE AND TIME OF NEXT MEETING:
Monday 30 January 2017, 2.00pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	17 November 2016	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- The progress made in relation to the launch of the Independent Health Charity - WISHH Ball on Friday 4 November 2016
- Receipt and review of the new format Financial Report– detailing income, expenditure and investment details which provided the relevant level of information and assurance
- The progress being made on various fundraising activities and charitably funded projects in which the Trust is involved or associated

Decisions made by the Committee:

- The Draft Annual Report and Accounts 2015/16 were presented to the Committee and were recommended to the Trust Board

Key Information Points to the Board:

- Nothing to escalate, key issues discussed captured above

Matters escalated to the Board for action:

- The Draft Annual Report and Accounts 2015/16 to be formally approved at the November 2016 Trust Board meeting

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

HELD ON THURSDAY 17 NOVEMBER 2016
THE COMMITTEE ROOM, HRI

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
Mrs D Roberts, Deputy Director of Finance

IN ATTENDANCE: Ms C Ramsay, Interim Planning Manager – Surgery
Mrs L Roberts, Corporate Affairs Administrator (Minutes)

ACTION

1 APOLOGIES FOR ABSENCE
No apologies were received.

2 DECLARATIONS OF INTEREST
There were no declarations made.

3 MINUTES OF THE MEETING 22 SEPTEMBER 2016
The minutes were approved as an accurate record of the meeting.

4 MATTERS ARISING
Minute 10 – Charitable Funds Policies
It was agreed to review the Charitable Funds polices along with any comments at the next meeting. **ALL**

Resolved:
The Committee would review the Charitable Funds Policies at the next meeting **ALL**

5 ACTION TRACKER
Mr Haire advised the Committee that a copy of the Mental Health Awareness event report had been forwarded to Mrs Walker.

The Committee would be kept informed of opportunities to work with the Smile Foundation charity. **DH**

It was agreed that Mrs L Roberts would liaise with Dr Harman and those wishing to visit wards 8 and 80 to view the work done to create a dementia friendly environment to arrange a suitable date. **LR**

Mr Haire advised the Committee that savings of approximately £40k - £50k had been identified in relation to the Midwifery Led Unit project. Once the details were confirmed Mr Haire would inform the Committee of the final costings. **DH**

The Committee were advised that the business case for implenting the robotics system in Gynaecology was expected to be completed before the end of November 2016.

The Health Group spending plans item on the action tracker would be covered under agenda item 11 – Fund Balances

Items marked completed were agreed and these would be removed from the tracker.

Resolved:
The Committee:

- noted a visit to wards 8 and 80 would be arranged for those who had expressed an interest **LR**
- would receive the final costings of the Midwifery Led Unit project once confirmed **DH**
- gynaecological business case for the robotic system to be presented **DH**

6 DRAFT WORK PLAN 2016/17

The Committee noted the workplan.

7 PROJECT DIRECTOR'S REPORT

Mr Haire presented the report and gave the Committee an overview of the various fundraising schemes and related activities which were currently ongoing.

Hull & East Yorkshire Hospitals Health Charity

Mr Haire informed the Committee that the official launch of the Independent Health Charity, Working Independently to Support HEY Hospitals (WISHH) took place on Friday 4 November at the Mercure Hotel, Willerby. The charity ball was well attended and positive feedback was received from all involved.

An outline PR strategy had been developed which would be finalised by the Charity's Trustees, this would be rolled out over the coming months to promote the charity. Posters would be displayed around the Trust and a staff newsletter article prepared as well as local media interaction. Mr Haire advised that he had written to the Health Group Medical Directors informing them of WISHH and had offered to attend a Health Group Board meeting to talk about the charity.

It was agreed that Mrs Lockwood, Chair of the WISHH charity would be invited to attend the Charitable Funds Committee meeting twice yearly. **DH**

Creating a Dementia Friendly Environment – Wards 8 and 80

Phase 1 of the work to create the dementia friendly environment had been completed and the details for phase 2 were been identified. Phase 2 included creating a "breakout area" on both wards for patients where they could relax and watch old films and programmes.

It was agreed that Mrs L Roberts would arrange a visit of wards 8 and 80 for those Committee members who had expressed an interest. **LR**

Da Vinci Robotic Surgical System

It was reported that the robotic system had been established within Urology. Other specialities which included thoracic and pancreatic surgery were envisaged to commence using the robot in early 2017-18.

Mr Haire advised that a new generation robotic system would be coming demonstrated in Trust in February or March 2017. For PR opportunities local GPs and other health professionals would be invited.

Integrated Cyclotron and Radiopharmacy Development
It was reported that the approval of the building contractors was in the final stages and pending a response to queries the work is expected to commence in January 2017. The Radiopharmacy was envisaged to be in operation from December 2017.

Proposed Paediatric Development
The contractor's feasibility report had been produced for the proposed Paediatric Development and would be considered by the Facilities Directorate. A paper setting out the proposed next steps had been presented for consideration by the Capital Resource Allocation Committee and would be received at the Family and Womens Health Group Board meeting.

Midwifery Led (Self Care) Unit
The work on the Midwifery Led (Self Care) Unit project had been scheduled to commence at the beginning of December 2016 with an estimated completion date of the end of February 2017. It is envisaged that the official opening ceremony will take place in early March 2107.

Health Group Charitable Funds
Mr Haire advised that the Health Group Charitable Funds would be covered in an item on this agenda.

Resolved:
The Committee:

- received the report and noted its contents
- agreed that the Chair of the WISHH charity would be invited to attend the Charitable Funds Committee meeting twice yearly **DH**

8 LEGACY UPDATE
Mr Haire presented the report which detailed the legacies donated to the Trust since the last report received by the Committee in June 2016.

The Committee were advised that a review of all existing legacies would be undertaken and a report brought back to the Committee at a later date detailing the findings. **DH**

Mr Snowden enquired about the protocol in relation to a donated legacy if a service was no longer available at the Trust. Mr Haire advised that in the first instance the next of kin would be contacted. If this was not possible after legal advice had been sought, then the funds could be transferred to the appropriate service of the organisation who had taken over. Following discussion it was confirmed that people will be encouraged to continue to donate legacies directly to the Trust and as well as to the WISHH charity.

Resolved:
The Committee:

- received the report
- agreed a review of all existing legacies would be undertaken and a report brought back to the Committee at a later date detailing the findings **DH**

9 FINANCIAL REPORT AS AT 30 SEPTEMBER 2016
Mrs Roberts presented the report which set out the income, expenditure and investment details of the Trust's Charitable Funds as at 30 September 2016.

In the six months up until 30 September 2016 a total of £147k in donations and legacies had been received, this was an unusual low level of income against the projected income of £288k. Expenditure was £186k which was also below an estimated budget of £299k. Due to new processes in place Mrs Roberts advised the Committee that these figures would be cross referenced with East Lancashire Financial Services. **DR**

The total value of the Trust's investments as at 30 September was £1.512m and cash of £369k was in the bank account. Mrs Roberts advised that investment gains were higher than expected during that period, which consisted of realised gains from the sale of shares.

Mr Bond sought clarity regarding the calculation of the figures in the top 5 income and expenditure transactions table in the Financial report. Mrs Roberts agreed to clarify the figures and cross check the other appendices of the report. **DR**

Mr Snowden requested that information to explain the transactions, rather than the coding detail be included in the transaction description column of the expenditure transactions over £100 table. **DR**

Resolved:
The Committee:

- received the report and noted its contents
- agreed to receive clarification on the income and expenditure figures and the appendices in the report **DR**
- would receive more information in the transaction description column rather than coding details in future reports **DR**

10 YEAR-END ACCOUNTS AND ANNUAL GOVERNANCE REPORT

The Charitable Funds Annual Report and Accounts 2015/16 were presented to the Committee by Mrs Roberts for approval. The Committee was advised that the feedback received at the last meeting had been incorporated into the narrative section of the Annual Report and Accounts and that no other amendments had been made.

The Annual Report and Accounts are required to be lodged with the Charities Commission by 31 December 2016

The Committee reviewed the Annual Goverence Report ISA 260 and the Letter of Representation. Mrs Roberts advised that no recommendations for improvement had been identified.

The Committee ratified the Annual Report and Accounts, the Annual Governance Report ISA 260 and the Letter of Representation. The Letter of Representation was signed by Mr Snowden.

It was agreed to recommend that the Annual Report and Accounts be approved by the Trust Board. **LR**

Resolved:
The Committee:

- ratified the Charitable Funds Annual Report and Accounts 2015/16, the Annual Goverence Report ISA 260 and the Letter of Representation
- agreed to recommend that the Annual Report and Accounts be approved by the Trust Board **LR**

11 FUND BALANCES

Mrs Roberts presented the report which informed the Committee of the fund balances of the individual health groups as well as the four Trust charities.

The report gave assurance that the balances were being monitored and that donations were spent as intended by the donator and spending plans were in place for larger sums. Slow moving funds and any impact on fund balances or expenditure were identified.

As at 30 September 2016 £1.561m was available in charitable funds. It was noted that this amount did not include allocated investment gains and losses and management charges. A commitment of £699k by fund managers was also noted. Mr Haire agreed to bring a report to the next Committee meeting with further information on the £699k of commitments. **DH**

Investments losses of £288k were identified which had accrued over several years. Investment gains were estimated at £50k per year so it was proposed that £188k of the losses be shared out between individual funds and that the remaining £100k be offset over the next 1-2 years by gains. Mr Haire had advised that the Health Groups had been informed of this proposal but has yet to receive a response. The Committee would be notified of the outcome. **DH**

Resolved:
The Committee:

- noted the contents of the report
- agreed to receive further information on the £699k of commitments and the investment losses proposal **DH**

12 HEALTH GROUP SPENDING PLANS

A paper was tabled which gave an overview of the spending plans for each of the Health Groups for individual funds valued at over £5k.

There was a discussion around slow moving health group funds and it was suggested that the smaller funds be merged together. Mr Haire advised that this was something that the Health Groups already did.

It was brought to the Committee's attention that a review of the fund balances had identified some concerns. A number of unrealised losses had created a negative impact on the individual fund balances which resulted in them been decreased by £188K. There were also a number of long standing commitments identified which upon investigation may result in some of the fund balances increasing.

Mr Haire advised that work was still ongoing and agreed to bring an updated report on the Health Group spending plans to the next Committee meeting. **DH**

Resolved:
The Committee:

- received the report and noted its contents
- agreed to receive an updated report on health group spending plans **DH**

13 REVIEW OF INVESTMENT STRATEGY

The paper detailing the outcome of the investments strategy review was presented to the Committee for consideration.

Mrs Roberts advised the Committee of the different types of funds that the Trust invested in. It was noted that the Trust's charitable funds currently had £369k of cash in the bank for investment. Following discussion it was agreed that Mr Bond and Mrs Roberts would meet with the COIF Investment Manager and advise the Committee of the outcome before any investment decisions were reached. The final consultation should remain with the Trust Board. **LB/DR**

It was agreed that charitable funds induction training for Mr Snowden and Mrs Walker would be led by Mrs Roberts. **DR/LR**

Resolved:
The Committee:

- agreed to await the outcome of the meeting with the COIF Fund Manager before a decision was taken regarding investments **LB/DR**
- charitable funds induction training to be arranged **DR/LR**

14 ADMINISTRATION CHARGE – HALF YEARLY REVIEW

A half yearly review of the administration charges was undertaken by Mrs Roberts. It was reported that the proposed administration fee of £45k had been reduced by East Lancashire Financial Services (ELFS) to £38k; this included fixed costs of circa £7k.

It was noted that the budget for the administration charge was on track for the remainder of the financial year

Resolved:
The Committee received the report and noted its contents.

15 FUNDRAISING REGISTER

The Committee was informed that there was nothing to report regarding the Fundraising register.

16 CHAIR'S SUMMARY OF THE MEETING

Mr Snowden summarised the meeting.

17 ANY OTHER BUSINESS

There was no other business discussed

18 *DATE AND TIME OF THE NEXT MEETING:*

Tuesday 7 February 2017, 12:00pm – 2:00pm, The Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	15 December 2016	**Chair:**	Prof T Sheldon	**Quorate (Y/N)**	Y

Key issues discussed:

- Fracture neck of femur operation timings
- Emergency readmissions
- Quality Impact of CRES
- Medicines management
- e-Observations
- Actions to reduce wrong site surgery
- WHO surgical checklist
- Renal Contract (Fresenius)
- Outpatient service developments
- Quality Committee ways of working
- Clinical Audit

Decisions made by the Committee:

Received more detailed information and analysis on:

- Emergency readmissions
- Impact of outpatient delays on patient outcomes
- Impact of variations in guidance/guidelines adherence on patient outcomes (revealed by clinical audits)
- Impact of e-Obs
- Progress on simplifying surgical checklists
- VTE reporting
- Surgical robot outcomes
- Bowel cancer screening programme

Key Information Points to the Board:

- e-Observation cannot be rolled out Trustwide until the Trust wifi is improved.
- There is a level of grip on CRES activities and quality impact of these.
- The Trust is improving its approach to surgical checklists by simplifying the tools used.
- Progress is being made on analysing and improving outpatient services, but feel patient outcome impact of delays needs assessing and reducing

Matters escalated to the Board for action:

- A discussion to help bring together a ‘unified model’ of service/quality improvement would be beneficial.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON THURSDAY 15 DECEMBER 2016
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon (Chair)	Non Executive Director
	Mr A Snowden	Vice Chair/Non Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs (Designate)
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
IN ATTENDANCE:	Dr M Purva	Deputy Chief Medical Director
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

ACTION

1. APOLOGIES
Apologies were received from Mrs V Walker, Non Executive Director

2. MINUTES OF THE MEETING 20 OCTOBER 2016
The minutes of the meeting were approved as an accurate record of the meeting.

3. ACTION TRACKING LIST
3.1 - Image intensifier – Ms Ramsay advised that capacity in trauma had been freed up as lists were being moved to Castle Hill Hospital. She reported that a time trend relating to the 36hr standard would be monitored and reported back to the committee in due course to see if the technology was housing the anticipated impact. **CR**

3.2 – Workplan – The workplan was received for information.

4. MATTERS ARISING
4.1 - Emergency readmissions within 30 days – Mr Philips reported that emergency readmissions were being reviewed and a snapshot audit had been carried out in April – October 2016 by the performance team. He advised that there was no evidence from the audit to suggest patients were being discharged too early.
4.2 – Quality Impact of CRES – Mr Wright advised that he had previously reported the process of the quality impact assessments and presented the table of live schemes submitted by the Health Groups. There were not many schemes coming forward and a number of schemes appeared to be ongoing with savings being made even though no executive sign off had occurred. Mr Wright advised that a further round of meetings would be held in January 2017 to discuss schemes and the savings highlighted by the Health Groups. A more detailed analysis would be forthcoming.
4.3 – Medicines Administration Incidents – Mr Corral gave a verbal update to the Committee. He advised that a review of medicines management had taken place and alterations to how the Trust worked was being implemented. Staff had attended a 2 day Human Factors training course and safety briefs were in place giving more structure to the department.
4.4 – e-Observations – Mr Wright gave the update and highlighted that the original business case had suggested a CRES of £1.3m, however £1.25m had been spent to date on the project. This comprised of £1m capital expenditure and £214k of revenue. Each ward would have to fund its own apple devices which would mean £13k from their budgets. There were currently 5 wards using e-Obs and these wards had saved £6k to date between them.

Mr Wright spoke about the wifi issues at the hospitals. The Queens Centre had its own wifi but the Trust as a whole would need an upgrade to ensure the devices worked as they should.

Dr Purva added that the wards with e-Obs had increased performance on their NEWs scores from 30 – 80% with the escalation process being more efficient. Mr Wright advised that the Trust was to go back to basics and an escalation audit was being carried out at HRI and CHH to ensure staff were aware on the impact of earlier actions and if not further training would be implemented. The results from the audits would be presented to the committee once completed. She also reported that performance had improved in non e-Obs wards due to improvement in activity.

4.5 – Wrong site surgery – Dr Purva updated the committee and advised that work was ongoing since the never event happened to ensure the checklists were followed, images were taken during and after the procedures and checklists were signed off and filed the patients case notes. Monitoring of the procedures was being carried out and so far the team had achieved 100% compliance. Prof. Sheldon asked if our reporting was more robust than other Trusts and Mr Phillips advised that there were different ways of viewing and reporting errors that had occurred across different Trusts. He advised that Hull and East Yorkshire Hospitals was transparent and a robust reporter.

4.6 – WHO Checklist – Dr Purva reported that the WHO checklist had been added to over a period of time and the Trust was simplifying it by taking it back to its original form. Mrs Bates advised that a policy was now being developed to ensure fundamental steps were carried out but would not be overcomplicated. **SB**

4.7 – Renal Contract (Fresenius) – Mr Phillips advised that Fresenius had addressed the issues raised by the Trust and that he felt assured that the processes were now in place to avoid recurrence.

4.8 – Clinical Audit Report – The committee discussed the clinical audit processes and impact of audits on the Trust. There was a discussion around NICE guidelines and Mrs Bates agreed to bring back a report outlining what the Trust 'must' do and which guidelines relate to should dos, and the extent to which variations in adherence was likely to have a significant effect on patient safety or outcomes.

5. OUTPATIENT SERVICES

Mrs Henderson gave a presentation which highlighted that the Trust delivers more than 700,000 outpatient consultations a year in over 92 different locations. She gave a general overview of the service, pointed out the issues and what actions were in place to ensure improvements were made. Mrs Henderson advised that the team was looking at follow up appointments and whether these could be carried out over the phone as well as reviewing best practice from other Trusts.

Mr Snowden asked for further information around patient journeys and what effect the outpatient backlogs were having on patient outcomes. He stated that the changing lists and rerouting of patient appointments was inappropriate and asked what the key themes were for the changes. Mrs Henderson agreed to review this in more detail and report back to the Committee.

Resolved:

The Committee received the presentation and agreed to receive further information regarding patient journeys due to delayed, changed or cancelled appointments at a future meeting. **EH**

6. CARE QUALITY COMMISSION

Mr Wright advised that the report had been received and that a factual accuracy checked response had been sent back to the CQC. Mr Wright suggested that the Non Executive Directors should receive a copy of the response that had been submitted to the CQC.

Resolved:
The Committee received the update.

7. QUALITY COMMITTEE ARRANGEMENTS

Prof. Sheldon suggested that each meeting the Committee should have an in depth discussion relating to specific issues within the Trust (e.g. pressure sores), relevant data would be collected and collated, staff would be invited and models of improvement discussed. This would aim to reassure the Board that the key issues were being addressed.

Mr Wright added that he would be reviewing the key risks to the quality agenda and map out the scope of the new Committee. He would also be reviewing the committee structure below the Quality Committee to ensure the correct escalation process was in place.

Prof. Sheldon raised the issue that the Trust needed to bring together and better coordinate improvement activities and adopt one or two agreed improvement models or approaches which could be promulgated and where expertise could be challenged. This should be raised at Board level. **TS**

Resolved:
The Committee received the update regarding the merging of the two committees.

8. SURGICAL ROBOT OUTCOMES

Ms Ramsay reported that the clinical team working with the robot was preparing a report which compared the outcomes against the original benefits set out in the business case. She advised that the main benefit was that the robot was allowing the Trust to treat more patients. Mr Phillips added that the patients treated had a reduced length of stay and Mrs Green stated that there had been a reduction in physiotherapy appointments.

Resolved:
The Committee received the update.

9. REPORTS RECEIVED FOR INFORMATION

9.1 – QUALITY IMPROVEMENT PROGRAMME

There was a discussion around the QIP report and it was requested that the first five pages which gave the summary would be received at future meetings.

9.2 – INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report was received for information.

9.3 – OPERATIONAL QUALITY COMMITTEE REPORT

Mr Wright reported that the Committee had discussed VTE recording. There was still work to be done in this area.

9.4 – EXTERNAL AGENCIES

Mr Snowden praised the report which highlighted external agency visits to the Trust. It was noted that the major trauma report had not yet been received. Prof. Sheldon asked for more information regarding the bowel screening and Mr Phillips agreed to bring this back to a future meeting. **KP**

10. ANY OTHER BUSINESS

Dr Purva agreed to prepare a summary report from the Healthcare Delivery Improvement Group. **MP**

Mrs Bates agreed to prepare a report highlighting incidents, complaints and areas of concern to a future meeting. **SB**

Mrs Bates to prepare a paper for the Committee relating to the mortality issues and the Trust's response. **SB**

11. CHAIRMANS SUMMARY TO THE BOARD

Prof. Sheldon agreed to summarise the key points to the Board.

12. DATE AND TIME OF THE NEXT MEETING:

Monday 30 January 2017, 9am – 11am, The Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AUDIT COMMITTEE

Meeting Date:	15 December 2016	**Chair:**	Mr M Gore	**Quorate (Y/N)**	Y

Key issues discussed:

- Increased premium costs with the NHS Litigation Authority for 2017-18
- The external auditors provided a technical update report of policy changes and items for awareness. These included leadership, cyber security (risk assessments), operating planning guidance and agency spending
- The internal auditors presented an update report on progress with the internal audit plan 16-17 – key points are captured below to the Board
- The external auditors outlined the key areas for audit testing for 16-17 as management override of controls, revenue, the new financial system (ELFS) and new outsourcing arrangements
- The internal auditors presented the report on the effectiveness review of the Audit Committee conducted in October 2016. The review concluded that the Audit Committee was delivering its core duties effectively. The report included a development plan, which will be picked up by the Audit Committee Chair and the Director of Corporate Affairs
- The Audit Committee received and reviewed the quarterly update on Gifts and Hospitality, credit card spend and Declarations of Interest

Decisions made by the Committee:

- Review of the internal audit plan and some changes of timings of up-coming internal audits so as to maximise the potential of the internal audit process
- To escalate outstanding internal audit actions, for completion by staff within the Trust
- Approval to retain MiAA as internal auditors for another year to ensure stability following the change in the external auditors in 2017/18.

Key Information Points to the Board:

- There were six internal audit reports received: three with significant assurance (emergency preparedness, theatres planned preventative maintenance programme and complaints management) and three with limited assurance (medicines management, bank and agency staffing, Clinical Sciences locality review). Action plans to address the key findings are in place to address the areas of limited assurance, which were reviewed by the Audit Committee

Matters escalated to the Board for action:

- Amendments to Standing Financial Instructions, as reviewed and recommended by the Audit Committee (included on the January 2017 Trust Board agenda)

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE MINUTES
HELD ON THURSDAY 15 DECEMBER 2016
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:	Mr L Bond	Chief Financial Officer
	Mr J Prentice	KPMG
	Ms L Thomas	Director of Governance
	Mr D Davies	MiAA
	Ms C Ramsay	Director of Corporate Affairs (Designate)
	Mrs S Bates	Interim Deputy Director of Quality Governance and Assurance
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

Action

1. APOLOGIES
Apologies were received from Mrs Roberts, Deputy Director of Finance.

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

3. MINUTES OF THE MEETING 23 JUNE 2016
Mr Bond asked that item 6 paragraph 4 be altered to read "…KPMG looking at the Trust's underlying financial systems…" and remove "high risk creditors".

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

4. MATTERS ARISING/ACTION TRACKER/WORKPLAN
Gifts and Hospitality – Mr Gore asked if the Executive Team would be reviewing the policy and Ms Thomas advised that there was a new overarching NHS policy that was out for consultation which would be useful to adopt. She suggested waiting for the new policy to be published before the Executive Team reviewed the Trust policy. It was agreed that the new policy would be reviewed in March 2017. **CR**

Mr Gore asked for a general response from Mr Phillips regarding the cancellation of clinics due to training courses. **KP**

Mortuary Debt – Mr Bond advised that the Council had cancelled a number of invoices to offset the debt. He had written to the Council expressing his concern at this action.

TRACKER
The Committee reviewed the tracker and agreed to remove the items marked completed.

WORKPLAN
There was a discussion around reviewing the workplan and linking it to the recent effectiveness review. Mr Gore requested the annual internal audit plan be received in January 2017 to update the committee as well as the outstanding audit actions.

4.1 – CNST CLAIMS

Ms Thomas presented the report which highlighted the increase in premiums paid by the Trust over the last 3 years. She advised that there had been a change in the way that claims were managed with the NHSLA, jointly managing cases with the claims team completing more of the preliminary work (instead of this going straight to the solicitors) to keep costs down. Mr Bond advised that the NHSLA had a provision of £131m for the Trust.

There was a discussion around a local solicitor who was proactively targeting specific areas for patients to claim and this was affecting the number of claims received by the Trust.

Resolved:

The committee received the update and requested a list of the top claims (by value) paid out. **SB**

5. BOARD COMMITTEE MINUTES

5.1 – PERFORMANCE & FINANCE 21.11.16

The minutes were received for information and assurance.

5.2 – QUALITY 20.10.16

The Committee discussed NICE guidelines and how compliant the Trust was. Mrs Bates had agreed to produce a report for the Quality Committee reviewing the 'must dos' and the 'should dos'.

Mr Gore asked for assurance around the overall effectiveness of the clinical audit process and Mrs Bates agreed to prepare a report for the next meeting. **SB**
Internal Audit to carry out a review of clinical audit effectiveness in the first quarter. **GB**

5.3 – CHARITABLE FUNDS 17.11.16

There was a discussion around levels of investment, Health Group spending plans and profiles.

6. TECHNICAL UPDATE

Mr Prentice presented the report and highlighted items relating to leadership, cyber security (risk assessments), operating planning guidance and agency spending. Mr Bond advised that the Trust had received £1.6m to be offset against the new linear accelerator as part of the NHS England cancer upgrade initiative.

There was a discussion around the new apprenticeship levy and how this would be a challenge to the organisation when planning the workforce. Mr Gore stated that he supported work based learning for local people. Mrs Bates added that the Trust would be employing Nurse Associate roles from April 2017.

Mr Bond asked Mr Prentice if he could share any learning from other Trusts who were suffering financial difficulties and Mr Prentice agreed to review this as some transformational work had been carried out in West Sussex.

There was a discussion around agency spending and the processes in place to ensure compliance with not exceeding the agency cap.

Mr Bond reported that the Pharmacy Team would be presenting their progress relating to the Lord Carter programme at the January 2017 Board meeting, which included work being carried out to reduce prescribing errors.

Resolved:
The Committee received the updated and noted its contents.

6.1 – AUDIT PLANNING 2016/17
Mr Prentice presented the report which highlighted the areas of focus as part of the audit planning process. The key areas were management override of controls, revenue, the new financial system (ELFS) and new outsourcing arrangements.

There was a discussion around accruals and their appropriateness and Mr Bond agreed to review accruals with the Heads of Finance. **LB**

7. INTERNAL AUDIT PROGRESS REPORT
Mr Baines presented the paper and reported that 6 audits had been carried out and 3 had been given limited assurance.

There had been a review of medicines management and the process around Patient Group Directions (guidelines for staff who administer medicines). Limited assurance had been given and an action plan and further training for staff was in place.

Bank and agency staffing had been reviewed and the main area of concern was no policy in place and bypassing of the system to recruit agency staff. Mrs Christmas expressed her concern that corporate processes were being by-passed. Mr Bond assured the committee that processes were in place and all agency staff were taken from an approved NHS framework. It was agreed to discuss this matter further with Mr Nearney to ensure a policy was being put into place.

There had also been issues around the Clinical Sciences audit and this had been referred to the Operational Quality Committee. There had been problems with incorrect batch numbers and stock write-offs not being recorded properly.

Emergency preparedness, theatres planned preventative maintenance programme and complaints management had all received significant assurance.

There was a discussion around mortality and the scope of the review and Ms Thomas reassured the committee that a clinical outcomes manager was now in place and this audit should be deferred to the second quarter to allow new processes to be embedded first.

Ms Ramsay would lead the well-led self-assessment in quarter 4.

7.1 – Effectiveness Review Report
Mr Baines presented the report and development plan. Mr Gore and Ms Ramsay would review this plan and take forward the actions into the new financial year. Ms Ramsay would review the process of monitoring the effectiveness of Internal and External Audit.

The review concluded that the Audit Committee was delivering its core duties effectively.

Resolved:
The Committee received the report and noted the contents of the review.

7.2 – Follow up Audit Actions
The Committee discussed the outstanding audit actions and the high risk areas. Mr Gore expressed his concern regarding the group passwords used in pathology and requested an update from Mr Phillips regarding consultant job plans.

The reviews highlighted were no response had been given would be reviewed by Mrs Bates and Mr Baines to ensure that the correct personnel had been contacted. **SB/GB**

Resolved:
The Committee received the report and agreed to review the outstanding actions at the next meeting.

7.3 – Anti Fraud Progress Report
Mr Davies presented the report and advised that the fraud plan was on track to deliver its action plan. He reported that NHS Protect would be carrying out another inspection around induction and e/learning.

Resolved:
The committee received the report and noted its contents.

7.4 – NHS Protect Final Inspection Report
Mr Davies presented the report which rated the Trust's fraud compliance as green. He advised that this would be reported formally in the MiAA annual report. Mr Gore congratulated the team on behalf of the Trust.

Resolved:
The committee received the report and congratulated Mr Davies and his team on the results of the assessment.

8. DECLARATIONS OF GIFTS AND HOSPITALITY
Ms Thomas presented the report and advised that the new NHS guidance would inform the review of the policy in due course and Ms Ramsay would lead on this. The guidance showed an uplift in the amount of money staff could receive as gifts.

A number of issues were discussed regarding the details within the report and Mr Gore asked that more information be requested of an eye consultant and an immunology consultant. The Chief Medical officer to countersign the medical director's disclosure.

Resolved:
The committee received the report and requested further information as detailed above to be in the next report to the committee.

9. INFORMATION GOVERNANCE
Ms Thomas updated the Committee and reported that the IG Toolkit evidence was being reviewed and actions being carried out to ensure level 2 was achieved. There were a number of actions outstanding relating to IT and Mr Bond agreed to speak to Mr Smith regarding these.

Ms Thomas advised that the Information Governance electronic training was being replaced with a new version in the new year.

9.1 – Serious incidents requiring investigation
Ms Thomas presented the report which highlighted that one SIRI was outstanding and the investigation was ongoing. She reported that there had been less SIRIs reported in 2016 than the previous year.
Resolved:
The committee noted the information governance update.

10. STANDING FINANCIAL INSTRUCTIONS
Mr Bond presented the report which detailed changes required to the Official Journal of the European Union (OJEU) limits.

There was a discussion around whether one or three quotations should be sought for values over £10k and up to £50K and Mr Bond agreed to review this.

Resolved:
Subject to Mr Bond reviewing the number of quotations required the committee agreed to recommend the changes to the Board. **LB**

11. LEGAL FEES
Mr Bond presented the report and highlighted the legal fees paid by the Trust. The committee requested further information relating to the accrual figure and Mr Bond agreed to bring the details back to the next meeting.

Resolved:
The Committee received the report and requested further information relating to the accruals for the next meeting. **LB**

12. REVIEW CLINICAL AUDIT ANNUAL PLAN
Ms Thomas presented the report and advised that work had been done to reduce the number of overdue actions.

Resolved:
The Committee received the report and noted its contents.

13. REVIEW OF QUALITY ACCOUNTS
Mrs Bates advised that she would prepare a report to the committee towards the end of the financial year.

14. BOARD ASSURANCE FRAMEWORK
Ms Thomas presented the Board Assurance Framework and advised that the risks to review going forward was the high quality care risk once the CQC report was published, workforce at the end of the financial year and the NHS constitutional standards due to poor performance.

Ms Ramsay agreed to discuss the financial risks further with Mr Bond.

Resolved:
The Committee received the report and noted the risks to be reviewed at the next meeting. **CR**

15. CREDIT CARD EXPENSES Q1 AND Q2
Mr Bond presented the report which highlighted the credit card expenditure from April 2016 to September 2016. The main areas of expenditure were IT hardware, food and accommodation and UK border checks for new staff. Mr Bond advised that another

credit card would be issued to the Communications Team for expenditure relating to items agreed to be purchased for, and from, the staff lottery fund.

Resolved:
The Committee received the report and noted its contents.

16. APPOINTMENT OF INTERNAL AUDITORS

Mr Bond presented the report and sought approval from the committee to retain MiAA as internal auditors for another year to ensure stability following the change in the external auditors in 2017/18.

Resolved:
The Committee received the report and approved the extension of the contract for a further 1 year term.

17. REFERENCE COSTS

Mr Bond presented the report and the outcome of the PWC audit relating to reference costs stating that the Trust was non-compliant. Mr Bond advised that actions were in place to address the issues raised in the report to ensure future compliance.

Resolved:
The Committee received the report and noted the results of the audit.

18. ANY OTHER BUSINESS

Mr Gore thanked Ms Thomas for her services to the Committee and the Trust, and that she had been the 'go to' person on a number of occasions. He wished her a long and happy retirement on behalf of himself and the committee.

19. CHAIRS SUMMARY OF THE MEETING

Mr Gore agreed to summarise the meeting to the Board.

20. DATE AND TIME OF THE NEXT MEETING:

Tuesday 7 February 2017, 2pm – 5pm, The Committee Room, HRI