HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 7 NOVEMBER 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS

1. Apologies	verbal	Chair – Terry Moran
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda **2 MINS**	verbal	Chair – Terry Moran
3. Minutes of the Meeting of the 5 September 2017 • To review, amend and approve the minutes of the last meeting	attached	Chair – Terry Moran
4. Matters Arising		
4.1 Action Tracker	attached	Director of Corporate Affairs - Carla Ramsay
4.2 Any other matters arising from the minutes	verbal	Chair – Terry Moran
4.3 Board Reporting Framework and Board Development Framework 2017-19 • To review the current Board Reporting Framework and Board Development Framework and determine if any updates are required **5 MINS**	attached	Director of Corporate Affairs – Carla Ramsay
5. Chair's Opening Remarks **2 MINS**	verbal	Chair – Terry Moran
6. Chief Executive's Briefing • To receive the Chief Executive's briefing to the Board **5 MINS**	attached	Chief Executive Officer – Chris Long

QUALITY

7. Patient Story • To focus the Trust Board on quality of patient care	verbal	Chief Medical Officer – Kevin Phillips
8. Quality Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required	attached	Chief Nurse – Mike Wright
9. Nursing and Midwifery Staffing Report The Trust Board is requested to: • Receive and accept this report • Decide if any if any further actions and/or information are required	attached	Chief Nurse – Mike Wright

10. Fundamental Standards (Ward Audits) • Receive and accept this report • Decide if any if any further actions and/or information are required	attached	Chief Nurse – Mike Wright
11. Quality Committee September 2017 minutes and summary update October 2017 • Short briefing to the Board on key issues discussed at the most recent Quality Committee and to raise any points of escalation to the Board • Receive the final minutes from the previous meeting	attached	Quality Chair – Trevor Sheldon
12. Quality Accounts – Progress Update • To summarise the progress being made to date against the Trust's quality and safety priorities identified through the Quality Accounts; receive assurance that sufficient progress is being made and that there is a robust process in place to monitor these priorities during the year •	attached	Chief Medical Officer – Kevin Phillips
35 MINS		
PERFORMANCE		
13. Performance and Finance Report • To highlight the Trust's performance against the required standards	attached	Chief Operating Officer – Ellen Ryabov, Chief Financial Officer – Lee Bond
14. Performance & Finance minutes September 2017 verbal update October 2017 • Short briefing to the Board on key issues discussed at the most recent P&F Committee and to raise any points of escalation to the Board • Receive the final minutes from the previous meeting	attached	Performance & Finance Chair – Stuart Hall
20 MINS		
STRATEGY & DEVELOPMENT		
15. Estates Strategy including Backlog Maintenance and Sustainability 2017 - 2022 • The Trust Board to approve the Estates Strategy 2017-2022	attached	Director of Estates – Duncan Taylor
16. Outline Business Case - Paper Energy Innovation Upgrade • The Trust Board to approve the OBC. • Approve the release of the OBC to NHSI for consideration/approval to progress and develop the detail to the Full Business Case stage. • Support the recommendation from the P&F Committee on the option to progress this business case through a £13.7m loan application, once notification has been received from NHSI, that the OBC has been approved.	attached	Chief Financial Officer – Lee Bond
15 MINS		
ASSURANCE & GOVERNANCE		
17. Cultural Transformation Report • Receive and accept this report • Decide if any if any further actions and/or information are required	attached	Director of Workforce – Simon Nearney

18. Guardian of Safe Working Update Report The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required	attached attached	Chief Medical Officer – Kevin Phillips Director of Corporate Affairs – Carla Ramsay
19. Standing Orders • The Board to approve the use of the Trust seal		
20. Corporate Social Responsibility	verbal	Director of Corporate Affairs – Carla Ramsay
21. Audit Committee 26 October 2017 – Summary Report • Short briefing to the Board on key issues discussed at the most recent Audit Committee and to raise any points of escalation to the Board	attached verbal	Chair of Committee – Martin Gore Chair – Terry Moran
22. Any Other Business	verbal	Chair – Terry Moran
23. Questions from members of the public	verbal	Chair – Terry Moran

35 MIN

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

Attendance 2017/18

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

Attendance 2016/17

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 3 OCTOBER 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr T Moran CB	Chairman
	Mr A Snowden	Vice Chair/Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr K Phillips	Chief Medical Officer
	Mr M Wright	Chief Nurse
	Mrs E Ryabov	Chief Operating Officer
	Mrs V Walker	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms C Ramsay	Director of Corporate Affairs
	Prof. M Veysey	Associate Non-Executive Director
	Mrs R Thompson	Corporate Affairs Officer

No.	ITEM	ACTION
1.	**APOLOGIES:** Mr S Hall, Non Executive Director, Mrs T Christmas, Non Executive Director and Ms J Myers, Director of Strategy and Planning	
2.	**DECLARATIONS OF INTEREST** **2.1 CHANGES TO DIRECTORS' INTERESTS SINCE THE LAST MEETING** There were no declarations made. **2.2 TO CONSIDER ANY CONFLICTS OF INTERST ARISING FROM THIS AGENDA** There were no declarations made.	
3.	**MINUTES OF THE MEETING OF THE 5 SEPTEMBER 2017** **Item 5 Chief Executive's Briefing – paragraph 4** – states that Mr Snowden noted the Chief Executive's blog but it was actually Mr Gore. Bonnie Grey – the correct spelling is Bonnie Gray **Item 9 Nursing and Midwifery Staffing report** – "the safety brief continues to be held 4 times a day". **Item 17 Cultural Transformation Progress Report** – Mr Nearney to re-write paragraph 6 with Ms Ramsay Following the above changes the minutes were approved as an accurate reflection of the meeting.	
4.	**MATTERS ARISING** Item 18 – Health and Safety Annual Report – Mr Phillips had checked the RIDDOR incidents and advised that no particular themes had emerged.	

4.1 ACTION TRACKER
Mr Bond agreed to circulate the national benchmarking figures linked to the Trust's STF position. **LB**

The items relating to Workforce Race Equality Standard and Cultural Transformation to be removed from the tracker as these would be discussed at a Board Development session.

4.2 ANY OTHER MATTERS ARISING FROM THE MINUTES
Mr Bond to review the delay in fixing broken and unusable hoists on the wards. **LB**

4.3 BOARD REPORTING FRAMEWORK
The Board received the Board Reporting Framework and no new requirements were raised.

5. CHAIR OPENING REMARKS
Mr Moran advised that the Board would discuss performance issues and concerns in the relevant sections of the agenda.

6. CHIEF EXECUTIVE'S BRIEFING
Mr Long presented the report to the Board. There was discussion around the good news stories and the Moments of Magic nominations.

Mr Gore expressed his concern regarding the increasing waiting list size captured in the Balanced Scorecard.

Resolved:
The Board received and accepted the report.

7. PATIENT STORY
Mr Phillips reported on a negative complaint which involved an interpreter being requested when the patient did not want to communicate in this way and had not requested this service. This issue had been raised with patient administration and the Clinical Commissioning Groups as this was sometimes requested in advance. The Trust had apologised to the patient. Mr Wright added that an interpreter budget working group had been set up to ensure appropriate requests were made, iPads utilised and costs kept to a minimum.

Another story was regarding a patient that wanted to thank all of the hospital staff who had contributed to their care, which included ambulance staff. The patient particularly wanted to thank Ward 5 and stated that the treatment received could not have been better.

8. QUALITY REPORT
Mr Wright reported that the Trust had declared 3 never events during August and September 2017. The investigations had begun and the outcomes and any learning would be shared with the Board when completed.

Mr Wright raised an issue around e-coli bacteraemia performance which was currently at 43 cases. Due to most patients having the infection before coming into the hospital, it was difficult to manage. Mr

Wright was working with the Clinical Commissioning Groups and Primary Care to develop a joint action plan to address the issues.

Mr Wright reported that there had been a case of Whooping Cough on the Paediatric High Dependency unit. The baby had been isolated and no other cases had been reported. Another premature baby had died due to extreme prematurity and Pseudomonas Aeruginosa Bacteraemia infection. The water systems had been examined but no source of infection was found. No further cases had been reported.

Mr Wright reported that the Hospital Standardised Mortality Rates was now showing a downward trend.

Mr Gore congratulated the teams on closing down complaints in a more timely way. Mr Bond asked how long the Parliamentary Health Service Ombudsman investigations took and Mr Wright reported that they could take up to 2 years.

Resolved:
The Committee received and accepted the report.

9. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that 133 student nurses had started at the Trust and were currently completing their inductions. A number of nurses would be joining the Trust from the Philippines and were waiting for their NMC clearance.

Nationally Trusts were finding it extremely difficult to recruit nurses and the Trust was reviewing its nurse associate and apprentice roles to go some way to address the issues.

Mr Wright reported that the safety briefing had increased to 6 times per day to ensure patient safety due to the additional pressures in the system.

Prof. Veysey asked what models were utilised to retain staff and did the Trust review their transitional progress. Mr Wright advised that the new students had a 2 week induction, a preceptorship programme and promotion opportunities available.

Mrs Walker was pleased to see support for staff who moved wards and asked how that was working from a cultural point of view. Mr Wright advised that it was a variable picture but feedback suggested that nurses did not like to be moved out of their ward to go and work elsewhere.

Mr Moran asked for clarity around the HEY Safer Staffing report and the quality rated as zero and whether these were tracked over different wards to highlight any issues. Mr Wright agreed to review this and add the results to the report.

Resolved:
The Committee received and accepted the report.

10. AVOIDABLE MORTALITY – STRUCTURED CASE NOTE REVIEW

Mr Phillips presented the report and advised that a number of case note reviews were currently underway and the outcomes and learning would be recorded. The three main areas of concern had been pneumonia, COPD and heart disease as there had been a spike in the Hospital Standardised Mortality Rates.

Mr Phillips suggested a Board development session to take members through the case note review process to give better understanding. It was agreed that this would be added to the Board Development Programme.

Any learning from the case note reviews would be reported at the Quality Committee.

Resolved:
The Board received the report and agreed to a Board Development session relating to Structured Case Note Reviews.

11. QUALITY COMMITTEE 29 AUGUST 2017 MINUTES AND VERBAL UPDATE 25 SEPTEMBER 2017

Mr Snowden presented the item and highlighted the monthly Serious Incident report not showing any linked themes and therefore a 6 monthly report would be presented to review themes and learning (February 2018).

Mr Gore asked about Junior Doctor distribution of employment and Mr Phillips advised that he would be meeting with the Dean at the University to discuss this issue further.

A meeting had been set up to enable both the Quality and Performance and Finance Committees to review the actions taken following the Outpatient Tracking issues identified in August 2017. All members of the Board had been invited to attend.

Resolved:
The Board received and accepted the update.

12. PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted the issues around diagnostic waiting times and the non achievement of the 1% standard. The main challenges were around the cardiac CT workload. This had now stabilised as additional sessions had been agreed and a new cardiologist appointed.

There had been an increase in diagnostic breaches in endoscopy and Mrs Ryabov had met with the team to review the issues. Performance was in excess of the planned level of activity with 500 more cases presented than last year. One of the reasons for the increase in workload was an increase in urgent referrals had displaced routine work causing breaches to occur. Mrs Ryabov advised that analysis of where the emergency referrals where coming from was ongoing. A consultant had been off ill and another retired in the service which had also had an impact on the service.

There had been 2 x 52 week waits, one due to multiple dates being declined by the patient and the other due to an incorrect clock stop. A validation exercise reviewing all clock stops had been carried out.

The cancer 2 week wait standard had failed in July due to a doctor that had been recruited not turning up to clinic and subsequently resulting in a clinic cancellation. The Trust had failed the 31 day cancer standard, however this involved very small numbers of patients.

The Trust had failed the 62 day cancer standard due to long waiters through the pathway and more complex patients and processes. However the cancer standard was improving slightly and 400 patients had been taken off the waiting list since July 2017.

The 104 day cancer standard had reduced with 26 patients on the list currently, 9 of the 26 being late referrals. Work was ongoing to reduce the list further but included patients with very complex conditions.

There was a discussion around clock stops and how accurately they were being executed. Mr Gore advised that the Performance and Finance and Quality Committees would be reviewing the validation work that had been carried out. Mrs Ryabov added that a standard operating procedure had been developed and that it would become a mandatory requirement to validate all clock stops going forward.

Referral to treatment times was meeting trajectory.

A&E performance had delivered above 90%, except in September, when performance had dipped. The Trust had still achieved the 90% for the quarter. Work was ongoing with the senior clinicians to ensure the Trust was ready for the winter pressures and would deliver safe services. There were issues around new inexperienced nurses, high levels of medical vacancies, sickness and low fill rates. Mrs Ryabov also expressed her concern relating to filling medical vacancies at premium rates which would further challenge the Trust's financial position.

Mr Wright assured the Board that the Nurse Directors were scrutinising staff fill rates, any spikes in attendances and how to use fewer staff. They were also reviewing the type of conditions patients were presenting and how these could be managed efficiently. Mr Nearney added that the HR managers were reviewing the pressure points in the system, managing the attendance policy and working with managers. The new flu vaccination campaign had been started for all staff.

Resolved:
The Board received and accepted the report.

Finance
Mr Bond presented the report and advised that at month 5 the Trust had a £9.1m deficit which was £7.1m above plan. This meant that the Trust had not received its allocation of STF funding. The Trust had a £1.4m shortfall in income and increasing run rate issues with the

Health Groups. The run rate issues included the cost of staffing AMU and gaps in middle grade rotas on the ground floor, non pay issues in the Surgery Health Group, pathology vacancies and a range of medical staffing issues. Mrs Ryabov added that a key issue for the Trust was failing to recruit to key areas adding to the financial pressures.

The Trust had a CRES shortfall at month 5 of £2.2m and reserves had been released to reduce this to a deficit of £1.6m.

Mr Bond suggested that the Financial Plan be revisited following publication of the month 6 figures. **LB**

Resolved:
The Committee received and accepted the report.

13. BORROWING REQUIREMENTS 2017/18

Mr Bond presented the report which requested approval from the Board to make an application for a uncommitted loan. The amount requested was to recover the gap relating to the non-receipt of STF funding for the first 2 quarters of the financial year.

Resolved:
The Board received the report and approved the request to apply for the uncommitted loan.

14. PERFORMANCE AND FINANCE MINTES 29 AUGUST 2017

Mr Gore reported that the Performance and Finance Committee had discussed the Winter plan in detail at its meeting in September 2017.

There had been representation from each of the Health Groups to review the Deloitte programme FIP2. The Health Groups had been generally disappointed that Deloitte had not developed any new schemes but they had brought excellent analytical skills and rigour to the processes to complete schemes.

The Estates Strategy had been discussed and would be brought back to the Board in November 2017 for further scrutiny.

Resolved:
The Board received the update.

15. ESTATES STRATEGY INCLUDING BACKLOG MAINTENANCE AND SUSTAINABILITY

Mr Bond advised that the 3 year strategy had been included in the Board papers and not the 5 year document which should have been presented.

Resolved:
The Board agreed to defer the item to the October 2017 meeting.

16. DIGITAL EXEMPLAR - LORENZO

Mr Smith attended the Board and presented the report which highlighted a new strategic directions for Lorenzo and a platform to transform the Trust digitally. The Trust wanted to express its interest

and had prepared an investment case for presentation. The Trusts selected would receive £2-4m in support of the programme. Mr Smith added that the work already done within the Trust around Lorenzo (in particular with Mr Simpson in ED) would make the Trust an attractive proposition.

Mr Snowden asked what the patient benefits would be as it was unclear to extract this from the report. Mr Smith advised that it would mean better traceability which would improve clinical quality. Mr Wright added that e-Observations provided more accurate data and better escalation routes which would reduce harm. Mr Phillips added that records could be brought together from primary care to secondary care reducing the temporary record requirements. Prof. Veysey also added that as a clinician if was better to have all patient information in front of you giving you a fuller picture of the patients care requirements.

Mr Smith reported that Wi-Fi roll out would happen across sites from March 2018 and a hardware refresh would be required to support this. A model service workshop was being established with the breast surgeons to become paperless, but this would not be possible without the internal technology to support it. Mrs Ryabov supportive of the programme asked that the investment requirements as well as additional staff requirements were clear.

Mr Moran summarised the item and stated that his personal view was one of excitement and the programme was the right direction to be moving in. He asked on behalf of the Board that more emphasis was placed on improvements for patients to enhance the bid.

Resolved:
The Board received and supported the programme. Any comments relating to the report should be presented to Mr Martyn Smith.

17. SCAN4SAFETY – TRUST BOARD CHARTER

Mr Bond presented the report and advised that in January 2016 the Department of Health introduced the Scan4Safety procurement strategy. The Trust had not been part of the first wave of demonstrator sites but had an opportunity to be in the 2nd wave which was linked to funding.

Board level support was required and a Board Charter had been produced by Mrs Rachael Ellis who was the appointed director of the project.

There was a discussion around some of the wording in the document and it was agreed that more emphasis should be put onto reducing patient harm. The Board agreed to support the Charter in principle and would sign the document at the Board meeting in November 2017.

Resolved:
The Board agreed to support the principle and requested changes to the Charter before signing the document at the next meeting in November 2017. Mr Bond agreed to receive any comments. **LB**

18. OPERATING PLAN

A verbal update from Ms Myers had been agreed but due to apologies the item was withdrawn.

19. WINTER PLAN

Mrs Ryabov presented the plan which highlighted the planning process and the plans already in place.

The Trust was in the process of reviewing last year's plan and the learning from it to ascertain the number of beds required to run a safe service. The Frailty Intervention Team were key to assessing elderly patients and the number of beds following analysis had been agreed at 40. The winter ward would be opened again but help was required from the Clinical Commissioning Groups and the primary care system. City Health Care Partnership were working with the Trust as the community provider of beds.

There was a concern that healthcare partners were late as plans had start dates of January and this would mean difficulties in securing and funding beds at this late stage.

Mrs Ryabov added that the Trust was short on funding with a £127k shortall, however potential additional funding might be available.

ED pressure was a significant cost and the Trust was spending more funds than were available due to staffing issues.
Prof. Veysey asked about ambulatory care or patients being reviewed at home using the primary care system. Mrs Ryabov assured him that the ground floor model included the FIT, a clinical suite, outpatient clinics and expanded ambulatory care.

Mrs Walker asked if any charitable initiatives were being reviewed in light of the pressures, such as the homeless centre ran by volunteers a few years ago. Mr Bond agreed that this was a good initiative and would review this.

Mr Gore commended the Medical Health Group for reducing their length of stay by ¼ day.

Resolved:
The Board received and approved the winter plan.

20. SAFEGUARDING ANNUAL REPORT

Mr Wright presented the Safeguarding Adults and Children's Annual Reports. He reported that the service was much improved despite the challenging nature of the work involved.

The reports highlighted care for people with learning difficulties, vulnerable people, children and families at risk. Mr Wright complimented Ms Rudston (Safeguarding Lead) and her team for their hard work in this area.

Mrs Walker extended her congratulations to Ms Rudston and the team and added that she was now the Safeguarding Champion for the Non

Executive Directors.

Mr Bond raised concern around the Anlaby Suite where the service was operating from and its fitness for purpose. Mr Wright agreed but advised that it needed to be close to the A&E department and care should be taken if it was to be relocated.

There was a discussion around staffing the service and Mr Wright reported that safeguarding doctors were difficult to recruit but there were no immediate risks to the service.

Mr Moran thanked the team on behalf of the board and expressed his gratitude to the work ongoing in difficult circumstances.

Resolved:
The Board received and accepted the Safeguarding Adult and Children's annual report.

21. EMERGENCY PREPARDNESS RESLILIENCE AND RESPONSE – ANNUAL ASSESSMENT

Ms Ramsay presented the report which highlighted the National requirements relating to Emergency Preparedness Resilience and Response. Ms Ramsay advised that the report had been approved at the Executive Management Committee and had been given significant assurance by internal audit.

A major incident practice session had been carried out and a debrief would take place in October 2017 reviewing response times and any issues raised.

Mr Moran added that he was the champion for this Trust requirement and had met with Mr Harper (Trust lead for Emergency Preparedness) and received assurances that the Trust was in a good position.

Resolved:
The Board received and accepted the report.

22. RESPONSIBLE OFFICER REPORT

Mr Phillips presented the report which had been updated since the last Board meeting and signed off by Mr Moran on behalf of the Board.

There was a discussion around doctor appraisal rates and what happened if a doctor had not received a timely appraisal. Mr Phillips advised that all doctors without appraisals would meet with himself and Mr Long to discuss the reasons why.

Mr Snowden asked about the quality of the appraisals being carried out. Mr Phillips advised that the process involved a prescribed format around performance and development. Mr Bond added that there was a league table by consultant under the business intelligence section of the Intranet. Mr Phillips also advised that the appraisal process did link to the revalidation process.

Mr Moran suggested a Board time out session which would give a deeper understanding of consultants and performance, their training,

fundamental standards and the support they needed.

Resolved:
The Board received and accepted the report.

23. STANDING ORDERS

Ms Ramsay presented the report which highlighted instances where the Company Seal had been used.

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

23.1 LAND ACQUISITION – GLADSTONE

Mr Bond presented the report which highlighted that the Trust requested approval from the Trust Board to make an application to the Council to adopt the street dividing Trust land.

Resolved:
The Board received the report and approved the application to the Council.

23.2 DEVELOPMENT OF A MOLECULAR IMAGING CENTRE INCLUDING RADIOPHARMACY

Mr Bond presented the report to the Board which requested its approval to use land on the Castle Hill site to facilitate the development of a Molecular Imaging Resource Centre, including radio pharmacy by the Daisy charity.

There was a discussion around what this would mean for the Trust and Mr Phillips advised that improved reputation and marketable possibilities would be received.

Resolved:
The Board received the report and approved the use of land at Castle Hill.

24. BOARD ASSURANCE FRAMEWORK

Ms Ramsay updated the Board regarding the quarter 2 position Board Assurance Framework (BAF) risk areas, adding that the non clinical risks had been added to give more context to the Trust's long term strategy. Mr Bond requested a meeting with Ms Ramsay to discuss the non clinical risks and their ratings further.

The quarter 2 risk ratings had not gone up or down but there was a growing level of risk relating to the financial plan and asked the Board to consider escalating the risk if appropriate.

Ms Ramsay also advised that there would be a Board development session on risk appetite which would explore the level of risk the Board would like to hold.

There was a detailed discussion around BAF 7.2 and whether the risk should be higher. Mr Moran suggested that the discussion be held in the next Performance and Finance Committee.

Resolved:
The report was received and the discussion regarding BAF 7.2 and its risk rating was delegated to the Performance and Finance Committee. **CR**

25. CHARITABLE FUNDS MINUTES 5 SEPTEMBER 2017
The minutes were received by the Board. Mr Snowden advised that there was nothing of concern to raise to the Board.

26. DECLARATION OF INTEREST – FIT AND PROPER PERSONS
The Board received assurance that the relevant documents had been received to ensure Prof. Veysey had complied with the Fit and Proper Persons Test.

Resolved:
The Board received and accepted the report.

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

28. QUESTIONS FROM MEMBERS OF THE PUBLIC
There were no questions received.

29. DATE AND TIME OF THE NEXT MEETING:
Tuesday 7 November 2017, 2-5pm, The Boardroom, Hull Royal Infirmary

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
October 2017						
01.10	Performance Report	Financial Plan to be reviewed and presented to the Board following publication of month 6 figures	LB	Dec 2017		
September 2017						
01.09	Performance Report	STF position – How does the Trust compare nationally – Mr Bond to circulate	LB	Oct 2017		
03.09	Workforce Race Equality Standard	To be included in the Board development programme to allow more discussion	CR	30.01.18		
05.09	Health and Safety	Feed back to be received regarding issues relating to hoists on wards	LB	Oct 2017		
August 2017						
02.08	Guardian of Safe Working Report	Non-Executive briefing to be set up	RT	Nov 2017		
03.08		Review of other Trust's medical safe staffing reports/Development of a Trust report	CR/KP	Dec 2017		
May 2017						
01.05	Patient Story	Digital Communication Strategy to be received	LB	TBC		To be included in the IM&T Strategy
COMPLETED						
Sept 2017	Young Health Champions	Trust to review how it captures its corporate social responsibility	CR	Nov 2017		On Agenda
	CEO Report	Service Resilience Report to be received at NED meeting	JM	Nov 2017		Next NED meeting
	Cultural Transformation	To be included in the Board development programme	CR	Oct 2017		Discussed at Board Development Session

Actions referred to other Committees

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

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

Overarching aims:

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

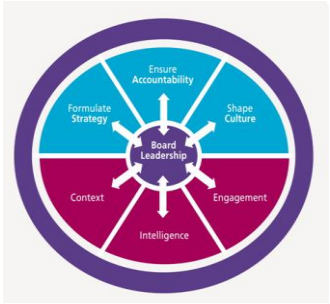
Board Development Dates 2017-18	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17					Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation		
04 July 2017		Area 1: Trust Board - updated Insights profile	Area 2 and BAF 3: Trust Strategy Refresh and appraoch to Quality Improvement				
10 October 2017		Area 1 and BAF 1: Cultural Transformation and organisational values				Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation	
28 November 2017		Area 2 and BAF 2 - Nursing staffing risks and strategic approach to solutions	Area 1: High Performing Board and BAF 3 - CQC self-assessment and characteristics of 'outstanding'	Area 4 and BAF 4 - Trust position on diagnostic capacity - short-term impact and long-term issues			
			Area 1: Risk Appetitie - Trust Board to set the Trust's risk appetite against key risk areas				
30 January 2018	Area 2 and BAF 1: Equalities within the Trust	Area 2 and BAF 2 - Staffing - short-term and long-term issues with specific focus on medical staffing. What does an adequate and sufficiently skilled workforce look like?	Area 4 and BAF 3 - Trust approach to Mortality and detailed understanding of new mortality reviews, linked with CQC requirements Area 1 and BAF 3: Quality and safety reporting at Trust Board				Area 2 and BAF 7.1 - 7.3 - Financial plan and delivery 2017-18 and financial planning 2018-19
	Area 1 and BAF 1: Completion of Insights exercises - what does a high-performing Board team look like?						
27 March 2018							
24 May 2018							

31 July 2018							
25 September 2018							
27 November 2018							
29 January 2019							
26 March 2019							

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

Principles for the Board Development Framework 2017 onwards

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



Overarching aim:

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

Area 1 – High Performing Board

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

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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

OCTOBER 2017

Emergency Care on the up

A national survey of patients using emergency care services has shown Hull Royal Infirmary to be outperforming many other hospital Trusts across the country.

The Care Quality Commission published the results of the national Emergency Department (ED) Survey 2016 in October. A sample of 342 patients who used the Emergency Department at Hull Royal Infirmary in September 2016 rated care, staff and waiting times significantly better in many areas than those of its national counterparts. This compares favourably to the patient satisfaction performance since when the last national ED Patient Survey was carried out at Hull Royal Infirmary in 2014, with significant improvements seen in 20 out of 35 question areas. The Trust cannot afford to be complacent, however, as the Trust's performance on the ED Friends and Family test shows room for improvement.

BBC online performance tracker

The NHS will continue to receive significant national and regional BBC coverage throughout winter, in particular following the publication of the BBC's new on-line 'Tracker' which will track A&E, RTT and 62-Day cancer performance of each Trust in England. For 2017/18 it appears the BBC are giving the tracker a higher profile with regional and national filming to support news programmes.

The tracker went live during October and the Trust has already responded to media enquiries. Our performance will show an improvement when it is updated for October, with ED performance expected to be within in the better performing organisations.

Hull Daily Mail Health Awards

Congratulations to Mary Share, Staff Nurse in Endoscopy, who was awarded the 'Lifetime Achievement Award' at the Hull Daily Mail's Health and Social Care awards ceremony last night. Mary was chosen to receive the honour after a NHS career spanning almost 50 years. Also taking home the award for 'Innovation in Health and Social Care' was the Perfusion Team. The team was recognised for their work to develop a new bypass system which dramatically reduces the need for donor blood, and the roll-out of this innovative technique to colleagues from across the UK and beyond.

3,000 flu jabs in two weeks

Thousands of staff have received flu jabs within two weeks of the launch of special vaccination clinics to protect patients this winter. About 3,000 people have answered the call so far to get vaccinated, with more drop-in clinics scheduled for the coming weeks, plus access to a team of volunteer vaccinators and Occupational Health nurses. In receiving their flu jab staff are eligible for an extra annual leave day between April and September 2018 (pro rata). The flu jab is also one of the eligibility criteria for the 2017 Discretionary Staff Reward Scheme.

Health Expo 2017

Over 1000 people attended the second Health Expo at the City Hall on 19th October 2017. Our Trust was one of five partners, along with NHS Hull Clinical Commissioning Group, NHS East Riding of Yorkshire Clinical Commissioning Group, City Health Care Partnership CIC and Humber NHS Foundation NHS Trust, which funded and organised the event. The Expo aims to showcase innovations within healthcare and attract local people to careers in Hull and East Yorkshire. The careers fair itself attracted almost 400 local schoolchildren and

college students. Among the many attractions were a dementia awareness zone, a cancer screening zone and a health and wellbeing area.

All five sponsor organisations nominated one individual or team for a special recognition award at the close of the event. David Haire was our worthy recipient, acknowledging 49 years of service to our local hospitals.

Have you inherited a life-threatening condition?
At the Expo our staff helped to raise awareness of a potentially life-threatening condition which affects one in 250 people, often without their knowledge.

Supported by the Lord Mayor of Hull, John Hewitt, the Trust team explained to visitors how familial hypercholesterolaemia (FH) can increase the risk of developing heart disease and how people can minimise the risk of suffering an early heart attack.

Accompanied by the Lady Mayoress Betty Hewitt, the Mayor attended the Expo to watch an animation explaining the condition linked to high cholesterol levels and he spoke to staff spearheading the awareness campaign.

"Pimp My Zimmer" at Hull's Health Expo
Also at the Expo, hospital consultants and nursing staff ran a "pimp my zimmer" workshop for elderly patients and their carers, with the aim of reducing the risk of falling among older people.

The team set up a stand at the City Hall to encourage people to decorate zimmer frames and walking aids.

Dr Katie Athorn, Dr Dan Harman and Dr Anna Folwell, Consultants in the Department of Medical Elderly at Hull Royal Infirmary, are spearheading the project after a similar scheme in Essex saw a 60 per cent reduction in falls.

Free Wi-Fi for cancer patients
Thanks to the campaigning efforts of one local man free Wi-Fi is now available to all patients and the public at the Queen's Centre for Oncology and Haematology in Cottingham.

Terry Garnett tragically lost his wife, Beverley, to pancreatic cancer in February after she was diagnosed with the disease last August. Beverley's dying wish was to enable people in receipt of cancer treatment to keep in touch with family and friends whilst in hospital.

Terry took it upon himself to begin to raise money in Beverley's name, and through the efforts of his friends and family, and with the generous support of the local community touched by his campaign, Terry raised well over £10,000 to support the project. Funds raised by Terry are being used to purchase portable devices and equipment, such as iPads and tablets, for use by patients while in hospital.

Our IT team is continuing to roll out Wi-Fi to all areas of the Trust with the Castle Hill site expected to be complete by April 2018.

£1.7m machine unveiled to help in the fight against cancer
The latest piece of equipment to support our staff and patients in the fight against cancer was unveiled at Castle Hill Hospital on 24th October 2017.

Some months ago, the Chief Executive of NHS England, Simon Stevens, announced a special fund to modernise radiotherapy equipment across the country. Our Trust was

selected to receive a share of the funding, and the Queen's Centre took delivery of a new £1.7m Varian Truebeam Linear Accelerator (Linac) in the summer.

Women and Children's Hospital Recognises Babyloss Awareness Week
As part of a national campaign to raise awareness of miscarriage and baby loss buildings across the UK were illuminated with pink and blue lights. Amongst those which participated was our Women and Children's Hospital at Hull Royal Infirmary.

The campaign coincided with Babyloss Awareness Week: Monday 9 October - Sunday 15 October 2017. This gives parents and maternity staff the opportunity to mark the lives of babies lost in pregnancy, after birth or in infancy.

The campaign was very well received, including social media.

Song For Hull
The Song For Hull City of Culture event, which was supported by the Trust saw well over 1000 parents and guests attend the City Hall in Hull to enjoy an evening of entertainment. Local schoolchildren performed alongside local rap star NB, Jonathan Ansell from G4, the Garnett family, and the HEY choir. The highlight of the evening was the debut live performance of Culture Clash, the song written by NB using lyrics provided by the children.

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

In September we received 45 Moments of Magic nominations:

Andrew Websdale	Andrew always has a smile on his face and is so helpful and friendly to anyone he comes across. He makes time for everyone and should be very proud of the care and support he gives to his oncology patients. You make a difference to people in times when it is most needed.	29/09/2017
Mick Hunt	We would like to give a big shout out to Mick Hunt. He is always friendly and approachable despite his very stressful role! He is always happy to help and always remembers people's names and asks how people are. Thanks for doing such a good job!	29/09/2017
Judy Gedney and Janine Smith	On the completion of the care certificate , great job guys !!!	28/09/2017
Ben Stevenson	Ben had noticed an abnormal result on the screen of the blood gas analyser for a patient in another department and followed it up by discussing with the team and escalating to more senior help	27/09/2017

Georgina Kirk	Gina never fails! As a long-standing play specialist on the children's' unit she ensures that every child and their siblings are always occupied or entertained. Fabulous at distraction during procedures and interventions and is never too busy to help out the team through her amazing way with children doing her upmost to ensure that that their distress is reduced. Gina organised a mass bingo game last weekend involving young patients and their siblings whilst their parents could spend time with their hospitalised children ensuring each child received a winning prize.	27/09/2017
Susan Johnson	Sue saw a set of notes which I had requested on a special on a desk not been posted to my department. She took it upon herself to get them to a department at CHH for me to pick the notes up on Monday morning as the patient was having surgery; she always goes the extra mile in her job.	26/09/2017
Sam Gent	Superb – patient-focused, conscientious work ethic	26/09/2017
Zoe Fletcher	Fantastic working under immense pressure	26/09/2017
Sarah Walker	Recently, on an extremely challenging shift for Staff Nurse Sarah Walker and the whole team that day. Several non-compliant patients were on the ward with Sarah as the qualified nurse responsible for them on the shift. There were several incidents throughout the day. Sarah coped amazingly well, all day, in extremely challenging circumstances. I absolutely think Sarah and the whole team that day deserve commendation for their consistent patient-centred approach, caring, fairness and non-judgemental attitude on a shift with significant security and safety issues to manage.	25/09/2017
Sheila Jenson	Sheila is approachable in any kind of situation, even when she is not at work! She is a credit to the team, it's a shame when this goes un-noticed! She is incredibly supportive and professional to both staff and patients!	24/09/2017
Mel Nelson	Mel on ward 11 is one of the most hardworking nurses I have ever come across. She is always happy to help and often goes above and beyond her role. She pretty much holds the ward together! You know you will have a great shift when Mel in on!	23/09/2017
Sandra Dent	Sandra the caterer on ward 11 is always so cheerful and goes above and beyond to ensure patients have meals they enjoy.	23/09/2017

Sam Bell	I would like to nominate Ward 11 manager Sam Bell to say thank you for being so supportive and helpful during my pregnancy!	23/09/2017
Debbie Jackson	Debbie volunteered to come into work on her day off, in order to allow a clinic that would have needed cancelling to continue. This must have been fate as coming from a nursing background, Debbie was here to help a patient who became ill before her appointment could go ahead. Debbie was the ultimate professional, sitting with the patient and reassuring her until she could be transferred to A & E. Well done and thank you Debbie!	22/09/2017
Stephen Kalladayil	I have nominated Stephen for a moment of magic on this occasion, although since I have worked with him he has produced many moments of magic together with his team. Stephen is the band 6 in DSU 3 and leads his team expertly making it the most efficient theatre that I have worked whilst in the trust. He regularly facilitates the accommodation of trauma cases to the DSU list at short notice, ensuring timely surgery with no complications and of direct benefit to the patients and trauma service. I feel he is an unsung hero of the trust, and in my opinion his skill and experience are invaluable. On a separate note, to highlight his non-clinical and personal skills, and a real moment of magic occurred last week when I was operating on a highly anxious lady who was a refugee, under local anaesthetic. She spoke no English and had mentioned prior to the surgery that she had passed out with anxiety at a prior surgery. Stephen having previously worked in the Middle East reassured and conversed with the patient in Arabic and took her mind off the surgery by talking with her about her children. This helped the surgery go very well and the patient stated that it had even been a pleasant experience. I could mention numerous other occasions where Stephen has made a difference to the trust, patients as well as colleagues and staff. As a Consultant in the trust for nearly 4 years embarrassingly this is my first nomination for a moment of magic, but I strongly feel Stephen requires some form of recognition for regularly going above and beyond his job description for the benefit of others.	22/09/2017
Michelle Scott	A patient was awaiting transport home after attending a diabetic retinal screening appointment. There was an unfortunate delay with the transport service and the patient decided to wait outside for some fresh air. Michelle, who does not work for retinal screening, saw the patient and upon hearing of the situation took time	21/09/2017

	out of her day to arrange a sandwich and a cup of tea for the very grateful gentleman. Michelle also offered to arrange a wheelchair taxi in order to take the patient home. This goes well beyond her duties and deserves a thank you!	
All staff ward 26 CHH	I went to Ward 26 CHH to provide some teaching sessions. I arrived at the ward and was greeted in a friendly and very professional staff. The staff checked I was who I claimed to be and listened while I explained the reason for my visit. The ward sister and staff who attended the teaching sessions where having a very busy day on the ward however they remained engaged and positive as the teaching session includes introducing new products. The ward has a lovely welcoming feel and I observed staff assisting patients with a smile on their faces. Working on the ward areas is not always an easy task with staffing, work duties and ever changing patient needs however the staff on C26 ALL deserve a huge well done for what I observed to be excellent team work.	21/09/2017
Julie Reed	Julie is the superstar of the technical team in the EOPD. She always has a bright smile on her face, and is always willing to help any of her colleagues and patients. She lifts everybody's spirits up, we definitely know when she is not around. Keep up the amazing attitude to work and to helping our patients get the best possible care.	21/09/2017
Michael Collins	Another cog in the NHS wheel of excellence, one colleague supporting another, yet he does not even know me! Thank you Mike for going the extra mile to make my job easier. Stressing out trying to find the link on "Pattie" for statistics, I emailed you for help. Not only did you find the link, you sent me step by step instructions on how to find the information I needed to find the figures I need monthly. Cheers Mike, you are a star!	21/09/2017
Fiona Wilmot	Today a volunteer who works in the NHS Shop at CHH had a fall outside the building. Two Dr's did help her but she insisted she was fine, I am on the reception at CHH when she came into the reception I looked at her arm and it was bruised, swollen, cut and bleeding I went into the Surgical Admission Lounge for someone to help and Fiona Wilmot came straight away. She was lovely with the volunteer; she made her feel at ease and took her onto Surgical Admission Lounge to see a doctor, then she dressed her wound and made her an appointment at her GP. Thank you for your help.	20/09/2017

Sarah Harrison	Sarah Harrison Auxiliary Nurse, who just left ward C20 highly deserves recognition. Sarah is an amazing AN who does her job above and beyond what is expected. Sarah never goes for the easier option, working extremely hard. Sarah is very kind and caring towards patients. It was for me a great privilege to work with Sarah. Ward C20 has lost a real diamond but Interventional Radiology HRI gained a new star. Sarah you will be always missed by myself and the patients. Thank you for all your help. I hope you will be highly appreciated in your new job (you are worth it).YOU ARE THE BEST OF THE BEST!!!!!!!. Good luck to you!!!!!!!.	20/09/2017
Jacqui Holmes	Always very helpful and welcoming. Have received great quality care and support. Really listened to my problems and was kind and caring. Wonderful staff and so friendly. Department at Hull Royal Physio is wonderful.	20/09/2017
Alysha Curtis	Alysha is a lovely girl - her time and effort are unreal. I was nervous coming on to the ward to work, Alysha showed me round the ward explained the daily routines where everything is and also offered a helping hand when ever i needed it. Alysha brightens up the ward and I wish her all the luck in the world	19/09/2017
Karly Manion	For been a top nurse, When the going gets tough she pulled through with a smile on her face.	18/09/2017
Jackie & Sandy	A very sick baby was born without a heart rate, needing extensive resuscitation. Sandy and Jackie were fantastic, finding everything the neonatal team needed and doing some extremely effective cardiac compressions. Textbook NLS resus - thank you.	16/09/2017
Martin Fisher and Dave Pedge	I would like to nominate 2 guys form estates department for always been helpful and kind on the renovations that have been going on, on ward 9. They are there to help us really quickly and efficiently under a small time scale. Thank you.	15/09/2017
Clare Drury, Trevor Parker, Rachel Wilson, Karen Zgoda	A big thank you to the MSK sonographers in Ultrasound who have supporting the successful training of shoulder ultrasound and injection therapy for staff from York NHS Trust. They did this over and above delivering the HEY MSK ultrasound service and training our own in house staff. You have done HEY proud!	15/09/2017

Rachel Horner & Steven Rose	I was attending the Eye Hospital with my six year old daughter, I expected to be seen by an Orthoptist, and then by the Optometrist as we were due a new glasses prescription and we desperately needed it because my daughter is currently wearing taped together glasses! When we saw the Orthoptist Rachel Horner, she told us that unfortunately, because of Megan's age, she had been discharged from the Optometrist as it was thought she should have her eyes tested at an Opticians, however this is inappropriate for my daughter as she has some health issues and is non verbal. She apologised but said we would have to come back another day. I explained that I would really not be happy to do this - we spend enough time at hospital appointments and I didn't want my daughter to miss more school. She asked us to wait whilst she hunted for an Optometrist who may be willing to see us that day. It was gone 4pm by this time and we were the last people there. Steven Rose came to the rescue - he had not been in clinic that day and therefore had not prepared to see a patient but he left an assessment and came to the clinic to see us, assess my daughter's eyes and provide us with our much needed new prescription. These guys went out of their way to help a patient, my daughter and me and I wanted to let them know that we really appreciate what they did.	15/09/2017
Lee, Lucy, Debbie, Dr Allen and Sandy the Receptionist	I visited ACU on two occasions now and both times my experience has been lovely but on Thursday I visited again with my mum; the reception lady welcomed us with a lovely smile as she had previously. We saw 2 lovely nurses who where very helpful, then we went to X-ray and in return my mum had a discussion with me that she was cold, before I could say anything the young lady on reception had fetched her a blanket, the rest of the day was a pleasant experience the nurses and doctors where all exceptional in their attention to giving my mum the best care possible truly all deserve a heart of gold - thank you all	15/09/2017
Sandra Buttery	Sandra is always smiling and extremely helpful, even when she is ill and going through personal issues she still manages to help everyone on ACU and AAU and always has a smile on her face	15/09/2017
Vicky	My mum was very worried about going in for surgery on her eye at Day Case Unit in Opthalmology but, leaving her in the waiting room to return to work felt a lot better knowing I was leaving her in the hands of Vicky, the housekeeper. She joked and laughed with every single patient in the waiting room and it was actually a really friendly atmosphere. When I returned	14/09/2017

	to collect her and drive her home, she was sat talking to the other patients in the waiting room as if they were old friends. She told me this was because Vicky had got them all talking. Having recently had surgery myself and sat in a quiet waiting room feeling very tense, I can only imagine how much better this must have felt for my mum! Thank you Vicky for going above and beyond to make my mum feel comfortable. You are wonderful :)	
Vicky	From the minute I walked in to the Opthalmology Day Case waiting area at 8am on a Thursday morning, Vicky, the housekeeper made not only me, but every other patient in the room, feel at ease. She was happy, friendly and really helpful. She encouraged everyone to get talking, making the atmosphere in the waiting room feel very relaxed, with patients joking and laughing together. This made a stressful and worrying situation feel a lot better. Great sense of humour, nothing was too much trouble and she made a wonderful cup of tea! Thank you so much Vicky, you are a credit to the organisation, keep doing what you are doing!	14/09/2017
Anish Mani	Anish went above and beyond during a busy clinic setting. He recognized an unusual area during an OCT scan and proceeded to scan through this area. Anish then reported to this a senior optometrist resulting in the patient been referred to Sheffield for possible treatment for cancer located within the eye. Well done and keep up the good work and thinking outside the box.	13/09/2017
Natalie Hunt	Natalie went above and beyond her role during a busy virtual clinic within the EOPD. Natalie recognised that a patient’s results did not follow the norm for a particular condition and sought out medical advice. The patient is now under the care of the doctors and having additional tests to rule out other conditions. Just wanted to say a massive well done to you for go going above and beyond please keep up the good work.	13/09/2017
Anonymous	A member of staff (who may wish to remain anonymous), giving support to a young chap living on the street, through him falling on hard times. This member of staff had and is still providing warm, clean and waterproof clothing to him (someone recently stole what had been given to him - including a thermal cup), hot food and drink, and also has sorted out his banking issues (no mean feat considering the red tape that we all endure from banks). She has also set up an appointment to try and get him some accommodation. I	13/09/2017

	was truly humbled to hear of the kindness you were showing this chap (you were not shouting about what you were doing - I actually asked what you had in a massive bag you were lugging about - which was in fact a new set of clothes for his appointment for accommodation) - well done, and you deserve more than a 'Moment of Magic'!	
Pauline Manaa and Linda Marsden	Well done to Pauline Manaa for completing your care certificate and Thank you to Linda Marsden for supporting you with it!!	12/09/2017
Vicky Proudlove	Unrelenting happiness and helpfulness in the face of adversity Vicky can always be relied upo!!	10/09/2017
Mikaela and Miss Rostron	I was a patient at the eye clinic as an emergency and required treatment for a bleed in my eye, it was a very difficult and upsetting time, the nurse and Dr were very understanding and reassuring they were able to answer any questions and give excellent advice which made the experience less distressing than it could have been. I received my treatment on the same day and I feel these individuals went above the call of duty to assist in my care	06/09/2017
Nicola Hall	I went to the surgical handover at CHH on one particular night shift to find out that the SHO who I was meant to be working with was not coming to the site to cover the surgical corridor. This meant that I was now on my own with no doctor to cover the site with me. I informed Nicola who was on a twilight shift at HRI. She made sure that I was not left on my own, agreed to finish her shift slightly early and she drove to CHH to help me cover the surgical wards until a doctor arrived at 1am. She did not have to do this and I feel she is a credit to the profession and the team as a whole. Definitely worthy of a Moment of Magic!	04/09/2017
Donna Wilkinson	Donna is always so caring with her patients and supportive to the staff with whom she works, nothing is too much trouble for her despite having a lot on gives the best of cares.	04/09/2017

Patrick Martin	While working here at C.H.H, this gentleman will and has gone out of his way to help and assist in my Clinics. He is hardworking and makes all visitors feel at ease and welcome when attending the clinics here at C.H.H, he forever has a smile on his face and brightens up my days whenever working alongside him	04/09/2017

Debbie Saville	Caring, helpful and always goes the extra mile to help	03/09/2017
Madison Carter	At the beginning of the HEY baby carousel event in the Women and Children's Hospital, a pregnant woman entered the reception area to access the delivery suite. She was clearly in advanced labour, having painful strong contractions, which caused the woman to vomit all over the floor and wall. The woman was escorted to the labour ward by midwives. Madison was passing by after finishing her shift in the eye hospital, and without hesitation began to access equipment to clean up the vomit to avoid other patients and visitors seeing the vomit or slipping on it! Madison's caring, helpful attitude deserves recognition as she went above and beyond her role in a department that she normally does not work in and after her own shift had ended.	01/09/2017
Helen Hotham, Emily Hardy, Ian Fletcher	Exceptional team working under significant pressures ensuring patient safety	01/09/2017

HEY LONG TERM GOALS - September 2017 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance September	Trend v Previous Month
R	Never Events	0	1	↓
R	Complaints (QIP - closed within 40 working days)	90%	71.80%	↓
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	53	24	↑
G	Safety Thermometer - Harm Free Care	95%	95.19%	↑
R	Venous Thromboembolism (VTE) Risk Assessment (Q1 v Q4 1617)	95%	92.13%	↑
G	Mortality - HSMR (July 17)	<100	82.1	↑
G	Friends & Family Test - Inpatients (August 17 - Trust v National %)	95.90%	98.71%	↑
R	Friends & Family Test - Emergency Department (August 17 - Trust v National %)	85.90%	84.78%	↓

Category	No. of Risks Rated 15 and above
Corporate Clinical Risks	1
Corporate Non-Clinical Risks	2

Workforce

RAG	Indicator	Target	Performance September	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.90%	↓
G	Staff Sickness	<3.9%	3.75%	→
R	Staff Vacancies	<5.0%	6.12%	↓
R	Staff WTE in post (<0.5% from Plan)	7250	7145	↑
R	Staff Appraisals - AFC Staff	85%	83.20%	↑
G	Staff Appraisals - Consultant and SAS Doctors	90%	91.00%	↑
G	Statutory/Mandatory Training	85%	90.00%	↑
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£1.9m	£3.4m	↑
R	Staff: Friends & Family Test - Place of Work (Q4 1617 v Q1 1718)	66%	64%	↓
G	Staff: Friends & Family Test - Place of Care (Q4 1617 v Q1 1718)	80%	81%	↑

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance September	Trend v Previous Month
R	18 Weeks Referral To Treatment (92%)	92%	86.50%	83.63%	↓
R	52 Week Referral To Treatment Breaches (zero)	0	0	22	↑
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	2.40%	9.30%	↑
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	90%	86.50%	↓
R	Cancer: 62 Days Referral To Treatment (85%) (August Data)	85%	83.80%	82.70%	↑
G	Length of Stay (<5.2)	<5.2	-	4.8	↑
R	Clearance Times	12 weeks	-	13	→
R	Waiting List Size	51,236	-	53,727	↓
R	Clinic Utilisation	80%	-	64.10%	↑
R	Theatre Utilisation	90%	-	79.10%	↓
G	E-Referrals (Q2 target v current performance)	80%	-	86.9%	↑
G	Appointment Slot Issues	35% (TBC)	-	33.30%	↑

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

Finance

RAG	Indicator	Target	Performance September	Trend v Previous Month
G	Capital Expenditure	3.7	7.2	↑
R	Statement of Comprehensive Income Plan - Year to Date	-2.8	-2.5	↑
R	CRES Achievement Against Plan	6.6	4.1	↑
R	Invoices paid within target - Non NHS	95%	47%	↑
R	Invoices paid within target - NHS	95%	28%	↓
G	Risk Rating	3	3	↓

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY REPORT SEPTEMBER 2017

Trust Board date	7 November 2017	**Reference Number**	2017 – 11 - 8
Director	Mike Wright, Chief Nurse	**Authors**	Mike Wright, Chief Nurse Kevin Phillips, Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	Y	Delegation	

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

4	**LINKED TO:**			
	CQC Regulation(s): All			
	Assurance Framework BAF 3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board receives this report monthly on the quality aspects of its services (Patient safety, service effectiveness and patient experience).			

QUALITY REPORT
SEPTEMBER 2017

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Caesarean Sections
- ReSPECT
- Blood and Blood Products Tracking

The Trust Board is requested to receive this report and:

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

TRUST BOARD QUALITY REPORT
SEPTEMBER 2017

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Caesarean Sections
- ReSPECT
- Blood Tracking

The Trust Board is requested to receive this report and:

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

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

2. PATIENT SAFETY

2.1 Never Events

The three Never Events declared in August and September are under investigation currently; two are due for completion in November 2017 and one in December 2017.

A Quality and Safety Bulletin briefing for the Trust of these events has been circulated during October. The Theatres audit afternoon in October 2017 was dedicated to briefing sessions at both HRI and CHH to inform all staff more fully on the events and for them to consider any associated measures to help prevent a recurrence. This session was very well attended and staff contributed to a rigorous debate on the subject area. Staff were keen to understand the conclusions of the specific investigations in order to improve their learning and practice and provide a safer service for patients.

The findings of the respective Never event investigations will be reported to the Trust Board in due course.

2.1.1 Serious Incidents declared in September 2017

The Trust declared nine Serious Incidents in September 2017. All of these are in the process of being investigated fully. Although the number of SI's declared by the Trust over the last few months has increased, these still remain lower than the 2016/17 figures. Nonetheless, this remains under review with the Health Groups.

Ref Number	Type of SI	Health Group
2017/22506 2017/22512 2017/22514	**Treatment delay, potential lost to follow up** Three patients have not received a timely follow up within Plastic Surgery.	Family and Women's
2017/22899	**Never Event – Wrong Site Surgery** Wrong site operation undertaken on a patient's rib (The Trust Board was advised of this last month)	Surgery
2017/23447	**Obstetric Incident** Unexpected admission of baby to NICU	Family and Women's

2017/23571 2017/23575 2017/23576	**Paediatric Surgery** Surgical Invasive procedures undertaken on three patients.	Family and Women's
2017/23678	**Obstetric Incident** Unexpected admission of baby to NICU	Family and Women's

3. SAFETY THERMOMETER – HARM FREE CARE

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

The NHS Safety Thermometer point prevalence audit results for October 2017 are attached as **Appendix One**.

From the 886 in-patients surveyed on Friday 13th October 2017, the results are as follows:

- **93.9%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.7% [n=15]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98.73%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 886 patients, 56 did not require a VTE risk assessment. Of the remainder, 786/830 had a VTE risk assessment undertaken. This is **94.6%** compliance on the day. VTE incidence on the day of audit was **6** patients; **4** of which were with pulmonary embolisms and **2** were deep vein thrombosis.
- New pressure ulcers were low on audit day at 2, both of which were grade 2. However, 33 patients had pre-hospital admission pressure ulcers. These are now being fed back to commissioners to manage. In addition, a health-economy wide group is being established to look at the significant number of patients that come into hospital with pre-existing pressure damage. The Trust will be a member of this group.
- There were 1**6** patient falls recorded within three days of the audit day, which is a higher than reported normally. Of these, 13 resulted in no harm to the patient and 3 with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection were moderate at **11/168** patients with a catheter **(6.5%)**. Of the **11** patients with infections, **4** were infections that occurred whilst the patient was in hospital **(2%)**. This continues to be a focused area and seems to be an area of improvement in the Trust.

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

Each ward receives its own results and feedback and ward sisters/charge nurses develop actions to address these.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2017/18 as at 30th September 2017

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

Organism	2017/18 Threshold	2017/18 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**24 (45% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0**
MSSA bacteraemia	**44**	**20 (45% of threshold)**
Gram Negative Bacteraemias		
E.coli bacteraemia	**73**	**52 (71% of threshold)**
Klebsiella (new this year)	**12**	**Baseline monitoring period**
Pseudomonas aeruginosa (new this year)	**10**	**Baseline monitoring period**

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

4.1.1. *Clostridium difficile*

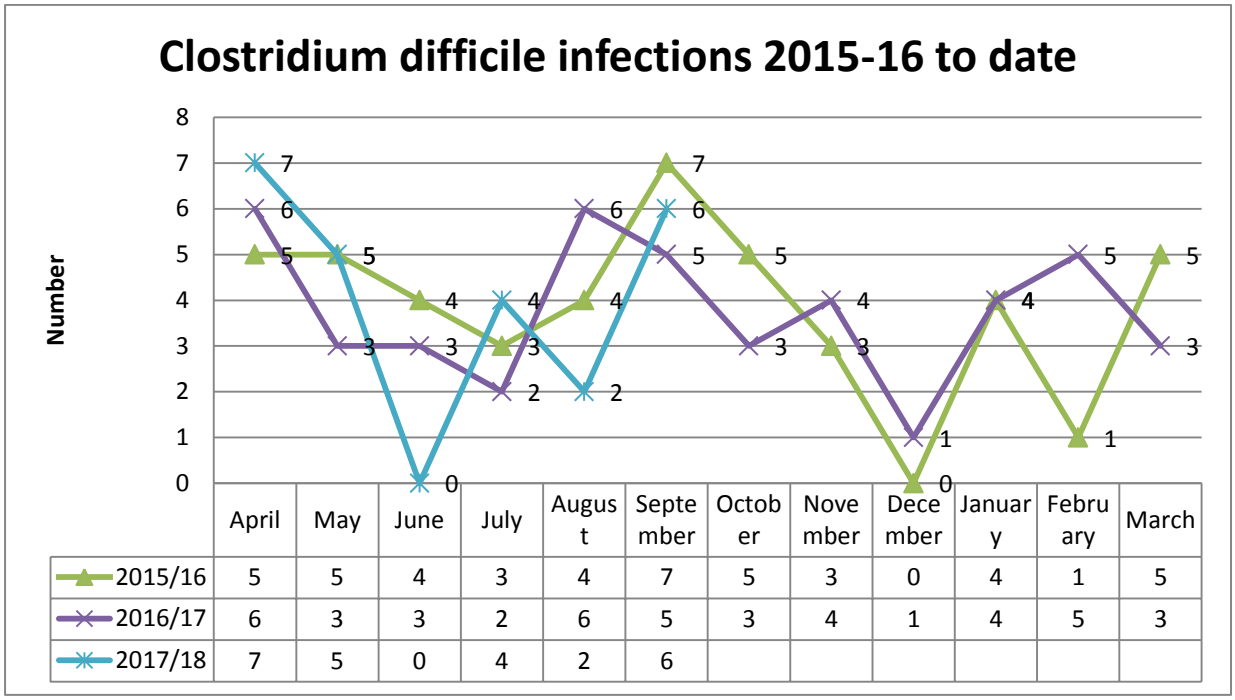
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and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

To date this financial year, at Month 6, the Trust is reporting 20 infections against an upper threshold of 53 (45% of threshold). Six Trust apportioned *C. difficile* cases were reported during September; one case in the Medical Health Group, one case in the Surgical Health Group, two cases in Clinical Support and the latter two cases in the Family and Women's Health Group.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	**53**	**24** (45% of threshold)	6 cases reported during September 2017. To date 1 case remains under investigation via RCA process. 5 RCA investigations completed. 2 of the 6 cases determined as no lapses in practice with the remaining 4 awaiting commissioner review

Lapses in practice/ Evidence of suboptimal practice	Reason for lapses in practice/ suboptimal practice	Lessons learned/ Identified learning	Actions
Cases to date x 1 (plus one linked case on same ward) This is termed a Period of Increased Incidence (PII) when more than one patient develops the same infection in the same area	Patient developed *C.difficile* associated diarrhoea secondary to a previous case identified on the ward. Both cases shared the same ribotype suggesting ward transmission and, therefore, a period of increased incidence	Breakdown in communication noted regarding history of diarrhoea with the first patient, so there was a subsequent delay in sampling and managing the patient appropriately.	Ward meeting held, enhanced *C.difficile* ward audits completed. Outcomes of RCA investigations and subsequent actions shared with ward team including medical and nursing staff. Importance of prudent communication and management emphasised. Ward deep cleaned.

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



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

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

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

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

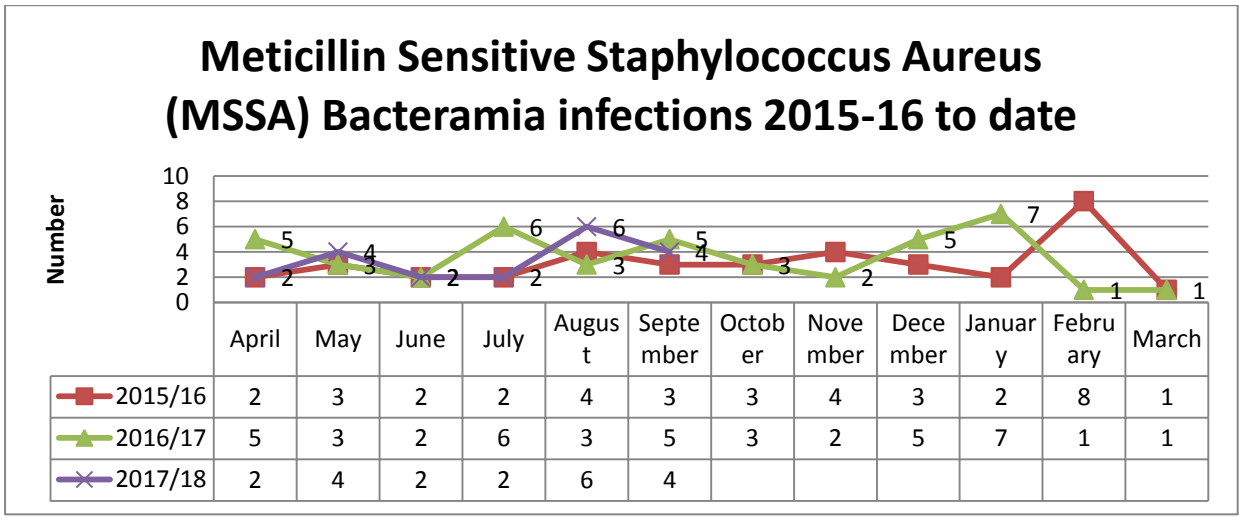
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

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

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

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	**44**	**20** (45% of threshold)	9 unavoidable 6 possibly avoidable 2 avoidable 3 awaiting outcome of RCA investigation/ meeting
Lapses in practice/ Evidence of suboptimal practice	**Reason for lapses in practice/ suboptimal practice**	**Lessons learned/ Identified learning**	**Actions**
Nil to report this month	Nil to report this month	Nil to report this month	Nil to report this month

MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection. The need for continued and sustained improvements regarding this infection remains a priority. Actions on vascular access devices/line management continue and are considered key in reducing rates of this infection both locally and nationally. The following graph highlights the Trust's performance from 2015-16 to date:



4.1.4 *Escherichia-coli* Bacteraemia

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

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

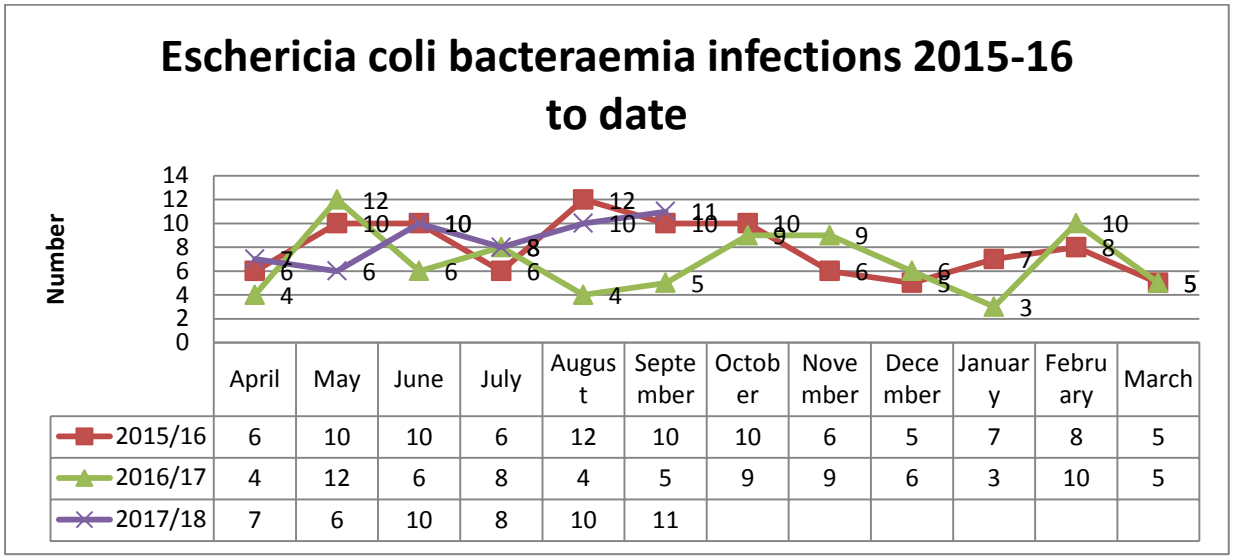
During 2017/18, Trusts will be required by NHS Improvement to achieve a 10% reduction in E. *coli* bacteraemia cases. Achievement of reductions will be collaborative with joint working with commissioners and joint action plans as required by NHS Improvement. A Trust improvement plan for E.*coli* and gram negative bacteraemia for 2017/18 has been drafted and shared with commissioners. A subsequent joint improvement plan has been drafted to capture issues, trends and learning from E.coli and gram negative bacteraemia experienced across healthcare.

On the 20th September 2017, NHS Improvement published data regarding E.*coli* bacteraemia rates for both Acute Trusts and Clinical Commissioning Groups (CCG's). The publication highlighted Acute Trusts and CCG's with the highest rates and the lowest rates; Hull and East Yorkshire Hospitals NHS Trust sits in the median of these two groups.

NHS Improvement also published a tool that aims to assist in understanding the scale and impact of E. *coli* bacteraemia at Acute Trusts and CCG's, providing an approximation of the number of patient deaths associated with E.coli Blood Stream Infections (BSIs) and the costs associated with infections from patients having extended stays in hospital and increases in ED attends/admissions. These are being considered at the joint working group that exists between commissioners and the Trust.

Organism	2017/18 Threshold	2017/18 Performance (Trust apportioned)	No. of cases investigated clinically	Outcome of Clinical Investigation (avoidable/ unavoidable)
E. coli bacteraemia	**73 (after 10% reduction)**	**52 (71% of threshold)**	52	2 x avoidable 4 x possibly avoidable 46 x unavoidable

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



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

A significant number of apportioned cases both Trust and Community that account for the increase in cases are detected because of compliance with sepsis screening, both in the Emergency Department and for inpatients. Although increases are noted and the Trust is already at 71% of threshold at Month 6 for this infection, patients are receiving improved quality of care because of targeted identification, treatment and appropriate management.

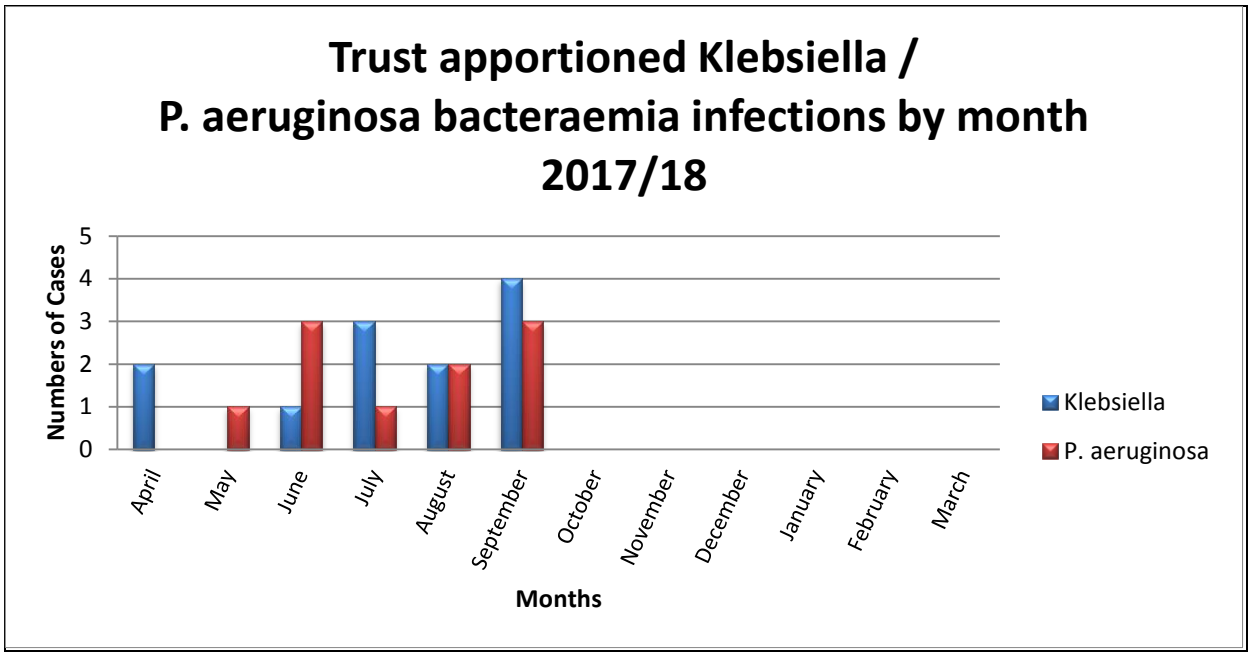
Trust apportioned *E. coli* bacteraemia cases from October 2017 will also benefit from an additional Infectious Diseases Consultant review, in conjunction with the Infection Prevention & Control Team. This is an evolving area of understanding, identification and management.

4.1.5 Gram negative bacteraemia – reporting for 2017/18

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

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

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



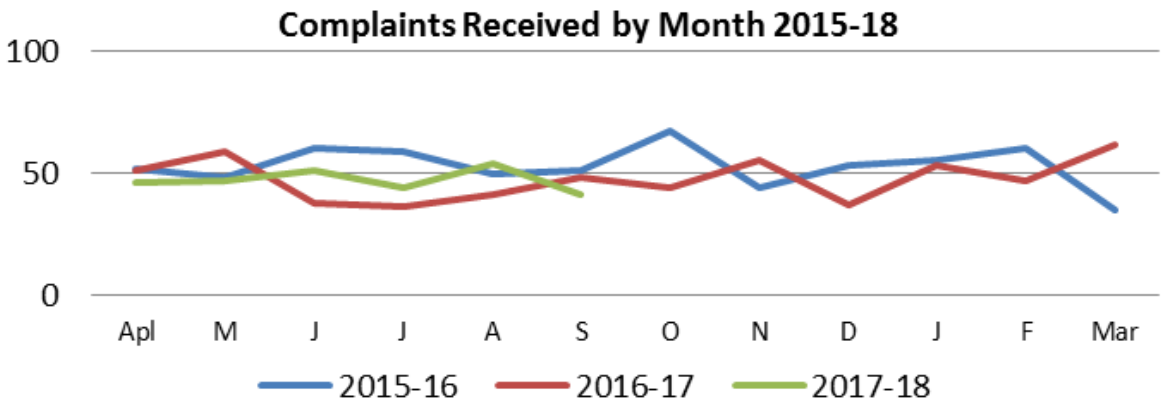
4.2 Infection Outbreaks
An outbreak is defined by two or more patients with the same infection in the same ward/area.

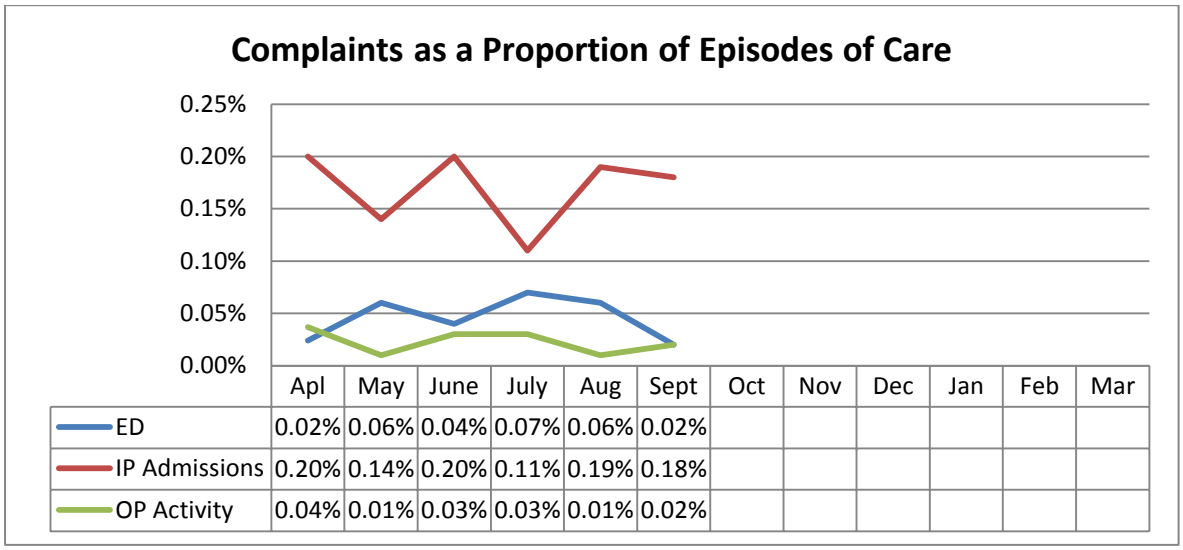
During September 2017, there were no reported infection outbreaks.

4.2.2 Invasive Group A Streptococcus
During September 2017, a number of patients were admitted with IGAS and managed as inpatients. Public Health England investigated a previous cluster of IGAS cases reported in February/March 2017 amongst people who inject drugs in the local community and across Yorkshire. This recent cluster was epidemiology linked to the previous cluster occurring amongst the same patient group – an incident meeting was held to coordinate both secondary and primary care responses and actions.

4.2.3 Influenza trends
There is mothing to report for September 2017. However, the Trust's 'flu' vaccination programme commenced on the 2nd October 2017 in earnest with over 4,000 staff being vaccinated in the first month.

5. PATIENT EXPERIENCE
5.1 Complaints
The following graph sets out comparative complaints data from 2015 to date. There were 41 new complaints logged in September 2017, lower than for the same period in the previous two years and the lowest monthly total since December 2016. The lower figures in September are possibly due to the holiday period but there is no obvious reason for this trend. Year to date, the rate of complaints received per month has been relatively stable.





	Apl	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ED	0.02%	0.06%	0.04%	0.07%	0.06%	0.02%						
IP Admissions	0.20%	0.14%	0.20%	0.11%	0.19%	0.18%						
OP Activity	0.04%	0.01%	0.03%	0.03%	0.01%	0.02%						

Although there has been a slight increase in complaints regarding inpatient care in the last two months, there is no obvious theme. Complaints regarding outpatients remain at a steady rate and complaints relating to emergency care have reduced over the last two months.

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

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delays, Waiting times & cancel	Discharge	Treatment	Total
Corporate Functions	0	0	0	0	0	0	0
Clinical Support	0	0	0	0	0	2	2
Family and Women's	0	0	0	0	0	11	11
Medicine	0	1	0	1	1	7	10
Surgery	1	0	1	2	0	14	18
Totals:	1	1	1	3	1	34	41

5.1.2 Examples of outcomes from complaints closed this month:

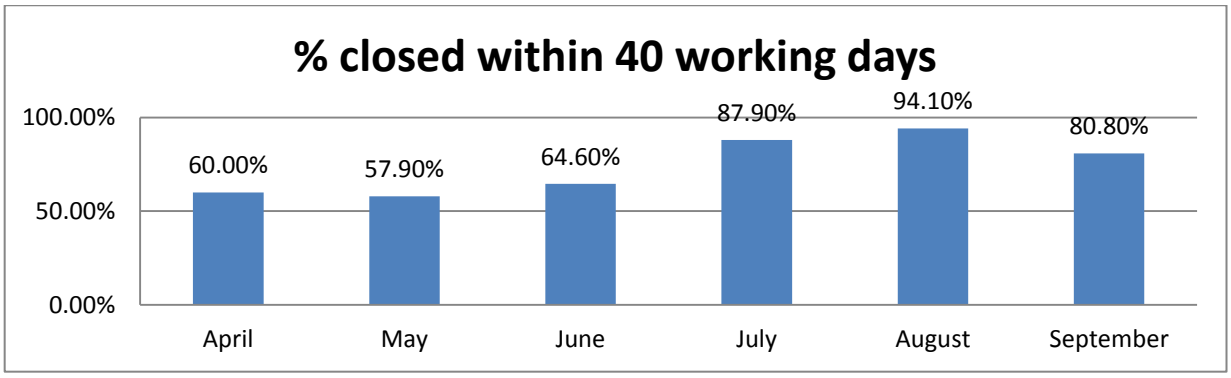
- Immediately following a difficult birth, before the woman had been given the opportunity to hold her baby, she was asked questions by a student to support his research project. Also, the baby was transferred to NICU and, during her stay, the woman was asked to walk to the unit to visit her baby. Unfortunately, the woman was unable to continue the walk to the unit as she felt unwell and was sent back to the ward unaccompanied.
  Action: The Clinical Tutor is to highlight to all students the need for sensitivity and compassion and that, immediately following a birth is not an appropriate time to be asking questions for research projects. The ward sister has informed all nursing staff that women must be supported when visiting their babies on the Neonatal Unit.
- The patient felt there was a delay in addressing her thrombosis issues by staff in ED and the stroke team, which had resulted in a stroke. Concern was also raised regarding the attitude of the nursing staff caring for her whilst in the ED, as they had implied to the patient that she was a lower priority than other patients.

Action: Following a review of the treatment plan, it was concluded that the care and treatment provided by the ED team to this patient was appropriate. However, the Senior Matron will discuss this patient's experience with all staff at the next ED staff meeting. She will also discuss the concerns with the Stroke Co-ordinator and with the Sister on the Stroke Ward to identify any learning opportunities.

- A patient was unhappy with the treatment for removal of a dressing, which caused pain and discomfort to her. The patient believed that a subsequent infection would have been avoided had appropriate measures been adopted following the removal of the dressing.
  Action: The complaint will be discussed at the specialty Governance Meeting and the issues raised will be reviewed with the individual nurse concerned.
- A patient was very unhappy with the Consultant's attitude and treatment provided. The patient has requested a second opinion.
  Action: An appointment was arranged for the patient to be reviewed by a different consultant.

5.1.3 Performance against the 40-day complaint response standard

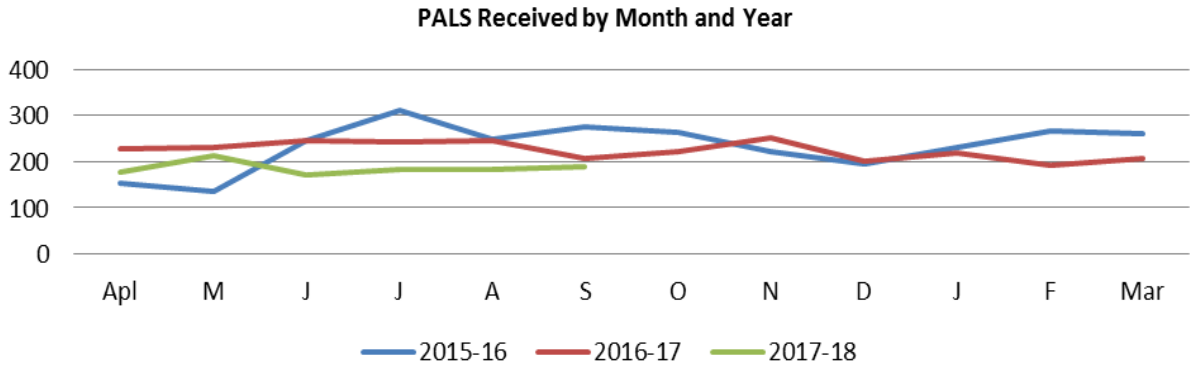
The following graph indicates the percentage of complaints closed within 40-working days of receipt. The Trust's target is for 90% of complaints to be closed within this timeframe. As can be seen, performance against this indicator fell below the required standard to 80.80% in September 2017. However, at the time of writing this report, 94.8% of open complaints have been closed within 40-working days. Whilst the number closed in September is slightly lower than the previous month, this is most likely due to the number of staff on leave during the holiday period.



5.2 Patient Advice and Liaison Service (PALS)

In September 2017, PALS received 188 concerns, 24 compliments 2 comments and suggestions and 34 general advice issues, with an overall reduction when compared to the same period for the previous two years. The majority of concerns continue to be waiting times/cancellations, not satisfied with the treatment plan, cancellation of clinic appointments and delay in notification of results.

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



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

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Treatment	Total
Corporate Functions	12	1	0	2	0	0	2	3	0	0	20
Clinical Support - Health Group	0	0	0	1	9	0	0	0	0	3	13
Family & Women's Health Group	1	3	0	2	24	1	0	0	0	9	40
Medicine - Health Group	8	7	2	2	22	4	0	0	1	9	55
Surgery - Health Group	2	4	1	3	32	2	0	0	0	16	60
Totals:	23	15	3	10	87	7	2	3	1	37	188

Of the 188 PALS concerns, 139 (77%) were closed within 7 working days during the month of September. Of these, 83 PALS were closed within 1 working day (46%) and 12 closed within 2 working days (6.6%). The Trust policy is for all PALS cases to be closed within 7 working days. The team sends weekly reports to the Health Groups to advise of cases that are open and to offer support. Cases that take longer than 7 working days are mostly due to awaiting information from staff that is not readily available. On some occasions, the difficulty is not being able to contact the patient to provide feedback and the case remains open until this is achieved.

5.3 Compliments

The following are excerpts of some of the compliments received from patients or their relatives during the month of September:

- 'I had to attend A&E and was admitted to HRI for surgery. I would like to take this opportunity to comment on how impressed I was by the whole experience from the A&E receptionist and surgical team, the Ultrasound department, PACU and especially the entire team on Ward 6. They could not have been more professional, helpful, friendly and courteous. I often think that bad press is all the NHS staff hear and I think credit should be given where credit is due. All the staff I came into contact with were a credit to the trust'.

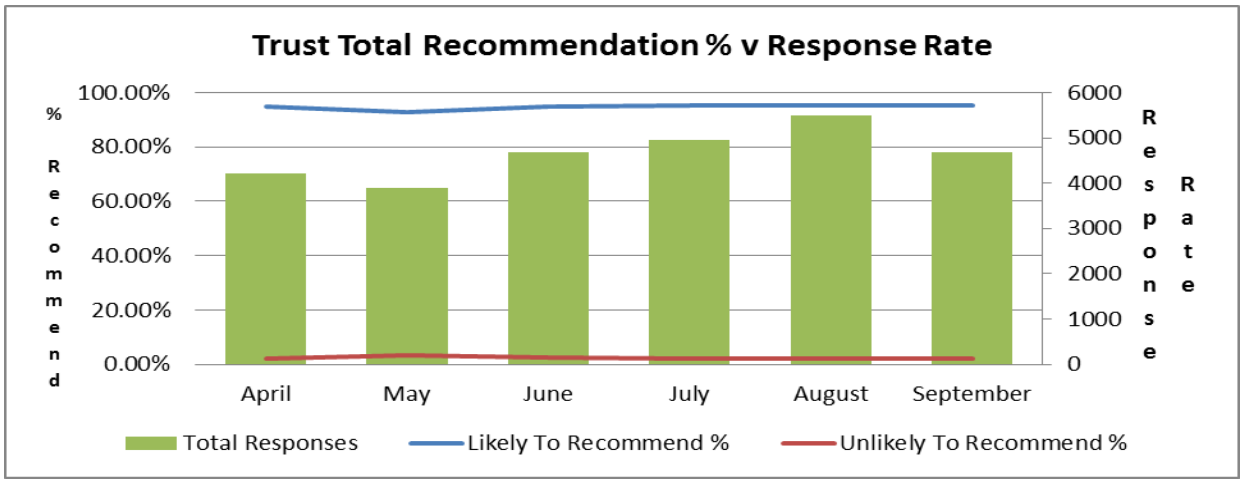
- 'Thanks for the advice and kindness given to us both regarding my husband's treatment. Since we spoke we have received an urgent appointment to talk to his Consultant so hopefully we can solve this ongoing problem. We cannot thank you enough; you were so kind and caring'.

- 'I have just returned home after an operation in Castle Hill Hospital. From my first visit before my surgery, I found from walking in the door, everyone was so helpful and told me everything there was to know. They took time to explain anything that I didn't understand. When the time came for my operation, once again everything was explained clearly. To cut it short, I just want to thank everyone, cleaners, nurses and doctors who were all fantastic before my operation, in between and up to me coming home. Nothing was too much trouble for any of the staff. A team to be very proud of'.

5.3 Friends and Family Test (FFT) – September 2017

The Trust's Friends and Family results for all areas, including the Emergency Department, indicate that there was a decrease in the number of responses for the month of September 2017 with 4,682 responding, compared to August 2017 when 5,506 responses were received. Nonetheless, this sample size is still significant and the results indicate that **95.30%** of respondents were extremely likely/likely to recommend the Trust to friends and family.

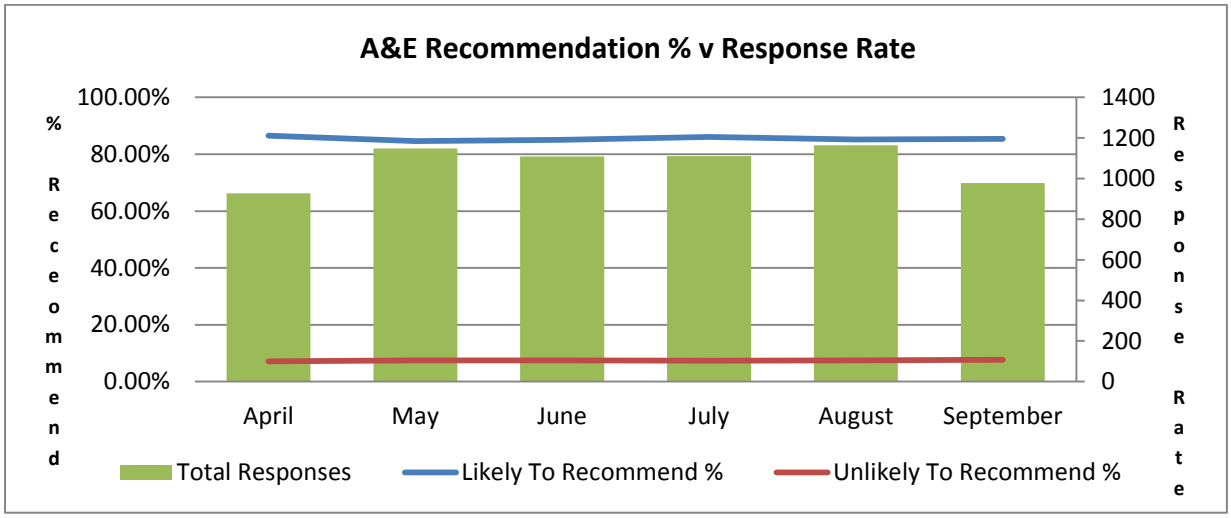
5.3.1 Trust Summary



5.3.2 Friends and Family Emergency Department (ED)

978 patients that attended the Emergency department in September 2017 responded to the Friends and Family Test with **85.38%** of patients giving positive feedback and **7.67%** negative feedback.

5.3.2.1 Emergency Department Responses



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

The Corporate Performance Report shows deterioration in performance with this indicator between March and June 2017. These data do not include the SMS text messaging F&F results, so this will be corrected in the Performance Report.

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has 12 cases currently under review by the PHSO. During the month of September there have been two new cases opened and two cases closed, both of which were not upheld. There is no theme occurring.

5.5 Adult Volunteers

The Trust continues to recruit volunteers steadily. This month has seen a rise in compliments for the volunteers supporting at the Hull Royal Infirmary site; in particular the volunteers that

signpost the public who need reassurance when entering the hospital for whatever reason and are not sure on where they should go.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 12 cases under review currently by the PHSO. During September, there have been two new cases opened and two cases closed. Of the two closed cases, neither was upheld. No emerging themes have been identified.

5.5 Adult Volunteers
The Trust continues to recruit volunteers steadily. This month, the Trust has seen a rise in compliments for the volunteers supporting at the Hull Royal Infirmary site. In particular, the volunteers that signpost patients and the public that need help and reassurance when entering the hospital have received particular praise.

6. OTHER QUALITY UPDATES
6.1 Hull and East Yorkshire Hospitals NHS Trust response to CQC maternity outlier alert for Elective Caesarean Section (ref C224/AS)
The Trust has seen an increased rate of elective Caesarean sections, which is at 14% currently compared to a national average of 12%. It is acknowledged that this is higher in comparison to some other Trusts across the Yorkshire and Humber region. In addition, the Care Quality Commission contacted the Trust recently regarding it being an outlier in this area during the July 2016 to March 2017 period. During this time period the following rates are noted:

Birth Method	Trust Percentage	National Average	Trust position compared to National Average
Elective Caesarean Sections	14%	12%	**Adverse**
Emergency Caesarean Sections	14.4%	15.4%	**Favourable**
Normal Birth	61%	59%	**Favourable**
Instrumental Birth	8.8%	12.9%	**Favourable**

As can be seen from the table above, it is possible that, by having more elective caesarean sections, this could be contributing to fewer instrumental deliveries and fewer emergencies.

However, in trying to understand what factors impact on the elective caesarean section rate, the Trust has reviewed records and available data, with the following conclusions:

1. The commonest reason was found to be - '**Previous Caesarean Section' - 43%**
2. The second most common reason was **Breech presentation – 10%**
3. The third most common reason was a **difficult previous vaginal birth including 3rd and 4th degree tears/shoulder dystocia and traumatic delivery – 3%**
4. It was identified from this data that there was some possible **overlap of coding** for 'Poor/No progress in labour' **- 4%**

There have been a number of initiatives introduced to address the elective Caesarean rate, including the development of a Birth After Caesarean Section (BACS) clinic, and there is an action plan arising from the review of Grade 3 & 4 Caesarean sections, where levels 1 and 2 are emergency situations and levels 3 and 4 are not emergencies.

Other factors that are being looked into that affect women's choices and their clinical presentations include:

- The level of deprivation in the local economy, which is one of the highest in the country

- The number of women with a Body Mass Index over 30 and indeed over 35, which are at adverse variance from the national average
- Other clinical risk factors, such as the level of smoking amongst pregnant women. For example, 1:5 women (20% of all women) are still smoking at delivery, which is again at significant adverse variance from the national average (circa 8%).

Other possible factors include issues with the accuracy of clinical coding of each pregnancy and birth.

A lot of attention is given to the maternity performance data. The Family and Women's Health Group now consider all Caesarean section data at its Health Group Board on a monthly basis. Data is submitted to the Yorkshire and Humber Dashboard on a quarterly basis and indicates that the range for Caesarean section in the Y&H region is between 5.9% - 16.9%, currently.

The clinical network supports a quarterly meeting of the Maternity Clinical Expert group, where indicators from the dashboard are discussed and good practice is shared across the region to support individual areas for improvements. In addition, the Humber Coast and Vale Strategic Partnership Group includes a Local Maternity System work-stream that will consider these data.

Currently, women who have had a previous caesarean section and book for a subsequent pregnancy are referred to the consultant clinic for an appointment at, usually, around 36 weeks or earlier gestation to discuss birth options.

The midwife-led Birth after Caesarean Section (BAC) clinic has now been agreed and the Standard Operating Policy is to be approved at the Obstetrics & Gynaecology Clinical Governance meeting in October 2017.

The proposal is for a senior midwife to see women to facilitate an opportunity to debrief their experience from their previous Caesarean section birth. This will also be offered to women who have had a traumatic birth. These early discussions are beneficial for women and are an opportunity to start the discussions about birth options much earlier in their pregnancy.

- Women will be referred to the BAC clinic by the community midwife at the booking appointment
- There is a specified inclusion criteria for women to access the midwife led appointments, as well as an exclusion criteria for those who require referral to a consultant obstetrician
- Women will be seen at 24 weeks gestation, 32 weeks gestation and at Term or as required, by exception

If women choose to have a repeat Caesarean, remain undecided or have any contraindications to a vaginal birth then a referral is made to the consultant obstetric clinic at 36 weeks gestation. Each consultant obstetrician is aligned to a community midwifery team facilitating a smooth referral process for women.

Conclusion

A number of factors may be contributing to the Trust's status as an outlier for elective Caesarean section, although this rate must be considered alongside lower than national average rates for instrumental births and emergency Caesarean section. Normal birth rates are above the national average.

Increasing awareness of Caesarean sections and implications for future pregnancies for all staff in the Women & Children's Hospital will improve knowledge and encourage professional discussions when booking elective Caesarean section.

It continues to be important that staff awareness of the rates of Caesarean section remains at high levels within the Women & Children's Hospital and the development of the 'Guideline for the perinatal mental health support pathway' will support decision making in the BAC clinics

Nonetheless, the senior obstetric and midwifery team in the Women & Children's Hospital accept that the elective Caesarean Section rates are high. However, the service wishes to assure the Trust Board that a significant amount of improvement activity has already taken place, and is on-going. This includes further audits to ensure quality improvements are being embedded in practice.

The Trust has responded to the Care Quality Commission's enquiry and awaits its response.

6.2 RECOMMENDED SUMMARY PLAN FOR EMERCENCY CARE AND TREATMENT (ReSPECT)

The Trust is part of a national project that will see its current Do Not Attempt Resuscitation (DNACPR) Policy be replaced by the ReSPECT policy. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. HEY will be part of an implementation group, which includes Hull CCG, East Riding CCG, City Health Care Partnership, Dove House Hospice and Humber NHS Foundation Trust and will launch the ReSPECT process on the 8th January 2018.

6.3 BLOOD TRANSFUSION TRACKING SYSTEM

The Trust is introducing a new blood tracking system (Bloodhound) to enhance patient safety with regards to blood and blood products. This is, in effect a traceability system that will use barcode and pass-code technology to make the whole process of ordering, collecting, checking and administering blood and blood products safer for patients and staff.

The system will be introduced incrementally, but will commence with improved processes for when blood and blood products are taken from a blood fridge and then taken en-route to the patient. The software tracks the opening of the fridge and will show who has opened the fridge through the use of a unique password assigned to individually trained staff. The blood can then be tracked through the system via the use of bar codes. Staff are in the process of being trained to use the system, which has commenced already

Overall, the system improves safety, compliance, and is better for the patient as they will get the right blood from fully trained staff. This also ensures we are compliant with all MHRA regulations in the handling of blood products.

7. RECOMMENDATION

The Trust Board is requested to receive this report and:

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

Mike Wright
Chief Nurse

Kevin Phillips
Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

October 2017
Appendix One – Safety Thermometer October 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	7TH November 2017	**Reference Number**	2017 – 11 - 9
Director	Mike Wright – Chief Nurse	**Author**	Mike Wright – Chief Nurse
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission		

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

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

2. BACKGROUND

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

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

This report presents the 'safer staffing' position as at 30th September 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3].

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual staffing levels

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

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

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

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

Fig 1: Hull Royal Infirmary

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

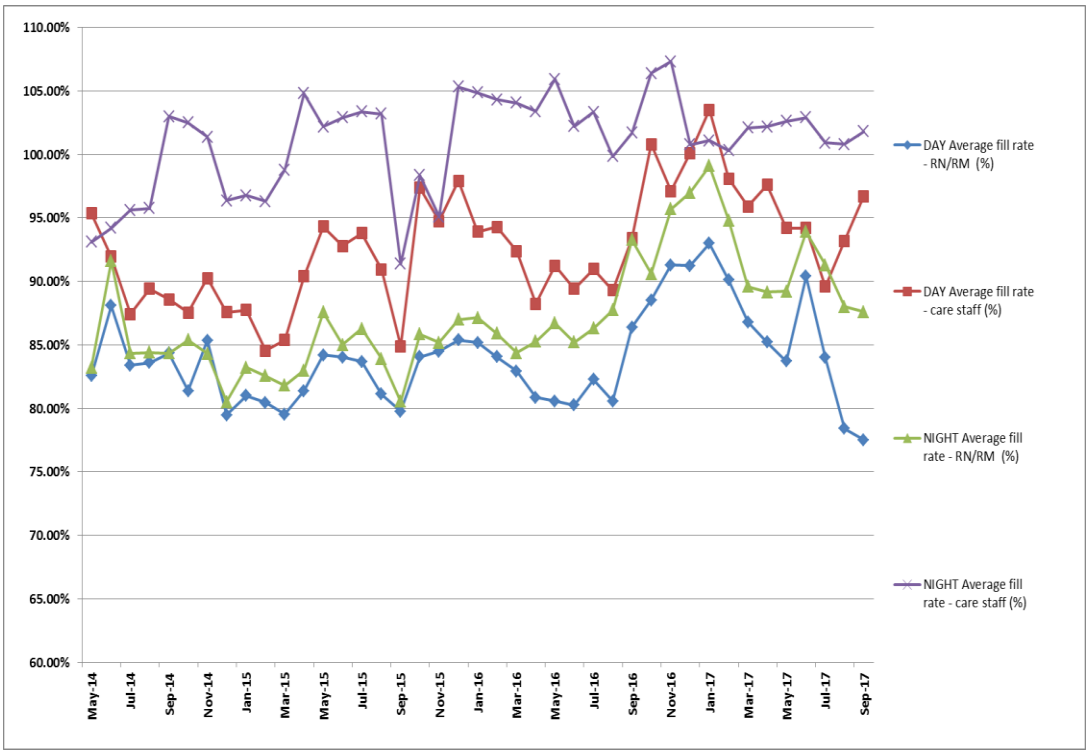
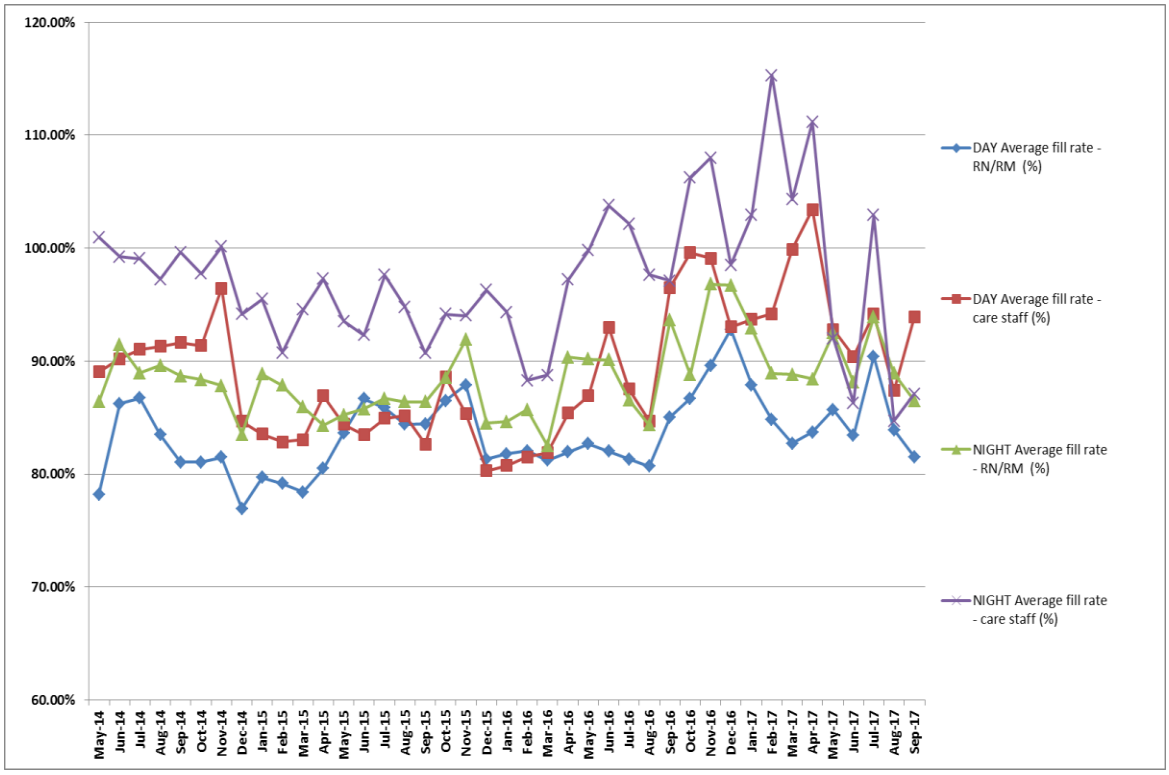


Fig 2: Castle Hill Hospital

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



As forecasted in the previous Trust Board paper (October 2017), the fill rates for registered nurses reduced throughout the month of September for both HRI and CHH. This is when the Trust hits its lowest point for nursing staffing in the year. Since the last report, 130 newly qualified registered nurses have commenced employment at the Trust from the University of Hull. As such, this position will begin

to improve as the new registrants obtain their NMC PIN numbers and complete their supervisory programmes. Although this has been a difficult period for the Trust, it has still managed to maintain minimum staffing levels of two registered nurses across all ward areas at all times.

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

- The closure of 20 beds within Surgery at CHH and the consolidation of beds and wards teams.
- The redeployment of staff from CHH to support HRI.
- Reduction in the number of Ward Sister/Charge Nurse supervisory shifts within all of the Health Groups on a temporary basis to support the areas where there are significant vacancies. (Additional managerial support is being provided by the Senior Matron for the clinical area).
- The placement of Senior Matrons into clinical shifts across all Health Groups to help boost direct care-giving hours
- Support being given to wards by specialist nurses
- Utilisation of some agency shifts, albeit on a controlled basis.

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns. In addition the Chief Nurse has commissioned the development of a Nursing Workforce Committee focused on the delivery of the following:

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

With regards to the recruitment of nurses from the Philippines, in conjunction with the Trusts recruitment partner, Resource Finder, 130 nurses from the Philippines have been interviewed, of which 110 are currently being pursued by the Trust. In terms of process, nurses must have completed their International English Language Testing System (IELTS) successfully, undertake Computer-Based Training (CBT) and apply to the NMC for a decision letter. Once all of these have been completed, the Trust can apply for a certificate of sponsorship to the United Kingdom Visas and Immigration Service (UKVI) and, if approved, the nurses are issued with a visa that allows them to travel to the UK. Once in the UK, the nurses must pass their

Objective Structured Clinical Examination (OSCE) before being issued with an NMC PIN number. Preparation for the OSCE normally takes around two months. Out of the 110 nurses offered posts, 51 have already completed their IELTS successfully, 22 are scheduled to undertake the CBT and 21 are waiting for their NMC Decision letter.

Currently, the Trust has received 5 recruits from the Philippines who, apart from one, are all now preparing for the OSCE. One of the recruits is registered with the NMC already and is working on Ward 27 CHH. A further three nurses are joining the Trust on the 13 November and plans are being finalised for their induction and OSCE preparation. The Trust is also expecting at least four nurses to join in December subject to visas being issued in timely manner.

The newly recruited nurses cannot declare themselves as registered nurses until they have received their NMC PIN Numbers. As such, they will only begin to feature in registered nursing numbers once this has happened. Until then, they will feature on the unregistered staffing lines and numbers. Therefore, fill rates will improve gradually over the coming months. Nonetheless, they have commenced working in their wards and departments and are starting their preceptorship programmes already.

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

The Chief Nurse for the North of England is holding a Nursing workforce summit/think tank on 13th December to consider the solutions to the registered nursing shortfalls. This will provide an opportunity to discuss and debate the structure of the future care-giving workforce, the future role of the registered nurse, possible solutions and the likely costs/funding options. The Chief Nurse and Deputy Chief Nurse are part of the working group that is setting up this summit.

4. ENSURING SAFE STAFFING

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

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

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

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

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

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

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

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

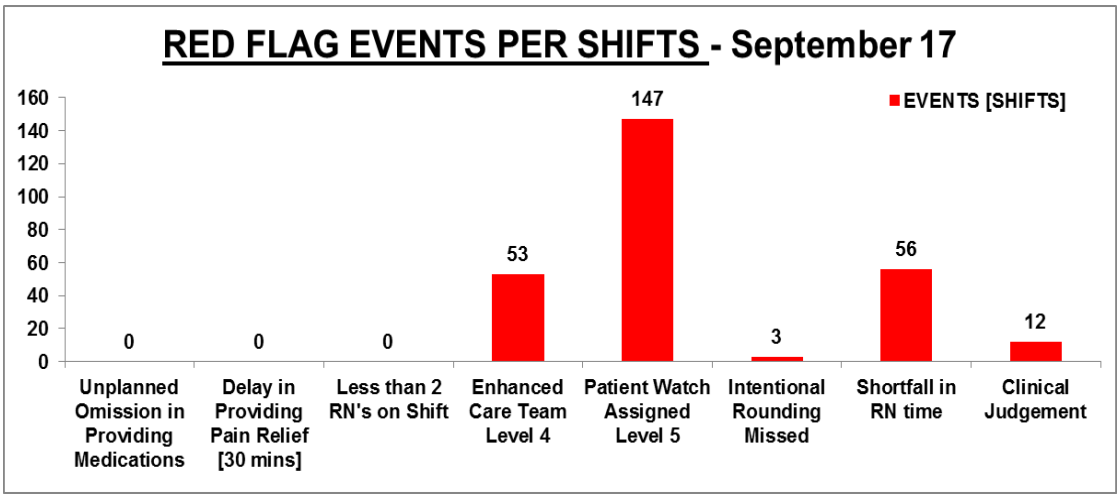
The 'red flags' suggested by NICE, are:

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

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

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

Sep-17	RED FLAG TYPE	EVENTS [SHIFTS]	%
	Unplanned Omission in Providing Medications	0	0%
	Delay in Providing Pain Relief [30 mins]	0	0%
	Less than 2 RN's on Shift	0	0%
	Enhanced Care Team Level 4	53	20%
	Patient Watch Assigned Level 5	147	54%
	Intentional Rounding Missed	3	1%
	Shortfall in RN time	56	21%
	Clinical Judgement	12	4%
	TOTAL:	**271**	**100%**



As illustrated above, the most frequently reported red flag is related to the requirement for 1:1 supervision for patients. As indicated in the previous Board Report, this will be addressed through the implementation of the Enhanced Care Team, which has now commenced as a three-month pilot that will report on its impact January 2018.

5. AREAS OF CONCERN WITH REGARDS TO SAFE STAFFING:

Despite the recruitment of 130 new registrants, there are a number of key areas that remain particularly tight in terms of meeting their full establishments. These are:

- **H70 (Diabetes and Endocrine)** has 7.96 wte RN vacancies. This ward continues to be supported in the interim by moving staff in the Medical Health Group. Additional support has been provided from the Surgical Health Group and nurse bank, therefore reducing the current net vacancies to 2.67 wte in real terms.

- **Emergency Department** has successfully recruited 15.00 wte RN's this will impact on the skill mix in the department, the senior nursing team and teacher will continue to support to develop the newly recruited workforce skills. This leaves a remaining RN vacancy gap of 0.22 wte and is a much improved position.

- **Elderly Medicine [x5 wards]** has 18.3 wte RN vacancies. The specialty has over recruited by 10.0 wte auxiliary nurses to support the RNs in the ward areas to

deliver nursing care with supervision. These are all within budget. The Senior Matrons are supporting the ward in the interim by moving staff in the Medical Health Group.

- **H5, RSU and H500 (Respiratory Services)** has 6.85 wte RN vacancies between them. However, the unit is working closely with the critical care team during this transition period until the respiratory skills are improved. The nurse bank is supporting the service with 3.00 wte RN.

- **H11** have 5.77 wte RN vacancies. The impact of this shortfall is supported by part time staff working extra hours, bank shifts and over filling of auxiliary shifts. There are also newly appointed RNs that will join the ward in October. The Senior Matron is reviewing the position continuously with the ward sister.

- **Ward H4 -** Neurosurgery has 2.8 wte RN and 2.03 wte non-registered nurse vacancies, **H40** has 1.35 wte RN vacancies. The band 7's work closely together to minimise the impact of the vacancies.

- **Ward H7 -** Vascular Surgery has 4.52 wte RN vacancies. This group of patients often require specialist dressings. A competency based teaching package is being developed to enable band 3 staff to undertake this role. There is a plan to temporarily transfer some nursing resource from within the Health Group until substantive posts are filled.

- **Ward H12 & H120 –** Trauma Orthopaedics have 7.55 wte RN vacancies across the floor. It is likely that when Maxillofacial services moved to CHH, there may need to be the closure of 6 beds due to the number of RN vacancies. This will remain under review.

- **Ward C9 -** Elective Orthopaedic Surgery has 2.91 wte RN and 2.03 wte non-registered nurse vacancies. There are currently 3 orthopaedic beds closed on C9 to support the number of nursing vacancies. These beds are flexed to minimise the impact on elective activity.

- **Ward C10 -** Elective Colorectal Surgery has 5.21 wte RN registered nurse vacancies. The nursing staff are flexed between C10 and C11.

In summary, when all of the current new recruits are accounted for, this leaves an outstanding RN vacancy rate on the Trust's wards, ED and ICU of 98.09 wte against an establishment of 1,813.72 wte (5.4%). The non-registered workforce vacancy rate is 13.71 wte, which brings the cumulative total ward, ED and ICU vacancy rate to 6.2%. This is really positive.

As indicated in the narrative, support will be provided to wards that have staffing shortfalls through the redeployment of registered nurses from elsewhere within the Trust. This will be completed in a planned and coordinated manner, in order to try and minimise the continual movement of staff on a daily basis, which at present is reported as a major concern by a number of nursing teams across the organisation. However, it is important to advise the Trust Board that, even though this will help, some significant shortfalls remain in the above wards thereafter. This poses an even greater challenge as winter approaches, given that the Senior Nursing Team have been requested to review the potential for commissioning a 27-bedded winter ward.

In the last Nursing and Midwifery Staffing paper to the Trust Board in October, the Chief Nurse advised of the possibility of the need to close further bed capacity in order to consolidate the remaining nursing workforce and keep patients safe. This has not needed to happen. Wards H12 and H120 may need to reduce bedded capacity by 6 beds in the future. However, this remains under review. In addition, it is unlikely at this stage that there will be sufficient registered nurses to be able to commission a winter ward. It is essential that the nursing workforce is not diluted to such an extent as to become inefficient and present a risk to both patients and staff. Nonetheless, this will remain under review in the coming weeks as staffing levels settle more.

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

6. SUMMARY

Nursing and midwifery establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. This is all managed very carefully and in a way that balances the risks across the organisation and will continue to be so. The challenges remain around recruitment and risks remain in terms of the available supply of registered nurses.

7. RECOMMENDATION

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
November 2017

Appendix 1: HEY Safer Staffing Report – September 2017

HEY SAFER STAFFING REPORT SEPTEMBER-17

NURSE STAFFING

FILL RATES

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	RED FLAG EVENTS [N]	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)
MEDICINE	ED	ACUTE MEDICINE	NA	1				
	AMU	ACUTE MEDICINE	45	1	100%	63%	92%	93%
	H1	ACUTE MEDICINE	22	24	75%	99%	98%	107%
	EAU	ELDERLY MEDICINE	21	10	77%	116%	66%	95%
	H5 / RHOB	RESPIRATORY	26	1	68%	97%	94%	100%
	H50	RENAL MEDICINE	19	1	74%	99%	101%	101%
	H500	RESPIRATORY	24	3	63%	88%	102%	95%
	H70	ENDOCRINOLOGY	30	19	62%	127%	59%	102%
	H8	ELDERLY MEDICINE	27	12	62%	131%	101%	107%
	H80	ELDERLY MEDICINE	27	1	57%	124%	100%	103%
	H9	ELDERLY MEDICINE	31	1	63%	117%	100%	96%
	H90	ELDERLY MEDICINE	29	3	61%	122%	100%	100%
	H11	STROKE / NEUROLOGY	28	29	55%	177%	68%	98%
	H110	STROKE / NEUROLOGY	24	3	55%	133%	103%	99%
	CDU	CARDIOLOGY	9	0	84%	37%	100%	
	C26	CARDIOLOGY	26	7	77%	87%	76%	93%
	C28 /CMU	CARDIOLOGY	27	26	75%	84%	83%	48%
SURGERY	H4	NEURO SURGERY	30	1	67%	100%	75%	109%
	H40	NEURO HOB / TRAUMA	15	24	77%	93%	109%	100%
	H6	ACUTE SURGERY	28	0	95%	81%	82%	184%
	H60	ACUTE SURGERY	28	4	90%	85%	83%	169%
	H7	VASCULAR SURGERY	30	0	75%	92%	85%	103%
	H100	GASTROENTEROLOGY	24	17	74%	110%	79%	114%
	H12	ORTHOPAEDIC	28	0	67%	99%	76%	149%
	H120	ORTHO / MAXFAX	22	0	81%	112%	84%	112%
	HICU	CRITICAL CARE	22	0	85%	104%	85%	43%
	C8	ORTHOPAEDIC	18	0	103%	102%	106%	101%
	C9	ORTHOPAEDIC	29	0	77%	90%	89%	100%
	C10	COLORECTAL	21	0	96%	88%	98%	128%
	C11	COLORECTAL	22	5	96%	88%	74%	124%
	C14	UPPER GI	27	1	75%	68%	79%	93%
	C15	UROLOGY	26	9	94%	89%	79%	100%
	C27	CARDIOTHORACIC	26	0	91%	80%	92%	103%
	CICU	CRITICAL CARE	22	0	77%	101%	80%	10%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0	68%	127%	107%	66%
	H130	PAEDS	20	0	79%	32%	80%	77%
	H30 CEDAR	GYNAECOLOGY	9	0	96%	56%	107%	
	H31 MAPLE	MATERNITY	20	0	95%	94%	124%	105%
	H33 ROWAN	MATERNITY	38	0	83%	85%	85%	94%
	H34 ACORN	PAEDS SURGERY	20	0	86%	61%	98%	92%
	H35	OPHTHALMOLOGY	12	1	72%	41%	101%	
	LABOUR	MATERNITY	16	0	85%	75%	89%	71%
	NEONATES	CRITICAL CARE	26	0	81%	80%	81%	83%
	PAU	PAEDS	10	0	87%		94%	
	PHDU	CRITICAL CARE	4	0	110%	59%	105%	
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	1	99%	71%	102%	87%
	C29	REHABILITATION	15	58	82%	101%	100%	68%
	C30	ONCOLOGY	22	2	78%	111%	99%	108%
	C31	ONCOLOGY	27	1	81%	98%	102%	101%
	C32	ONCOLOGY	22	0	93%	98%	101%	104%
	C33	HAEMATOLOGY	28	5	78%	156%	81%	126%
		TOTAL:	271		AVERAGE:			

CARE HOURS PER PATIENT DAY [CHPPD] [hrs]

HEALTH GROUP	WARD	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL
MEDICINE	ED				
	AMU	1204	4.3	2.4	6.7
	H1	616	2.6	1.8	4.4
	EAU	581	3.2	3.6	6.8
	H5 / RHOB	716	2.1	1.5	3.6
	H50	564	3.0	2.0	4.9
	H500	691	2.3	2.2	4.5
	H70	880	2.1	2.3	4.4
	H8	795	2.1	2.7	4.8
	H80	794	2.0	2.6	4.6
	H9	922	1.9	2.1	4.0
	H90	859	1.9	2.4	4.3
	H11	824	2.1	2.4	4.4
	H110	528	3.5	3.1	6.6
	CDU	108	8.9	1.0	9.9
	C26	666	3.9	1.6	5.5
	C28 /CMU	668	6.0	1.4	7.5
SURGERY	H4	739	2.8	2.0	4.8
	H40	360	6.2	3.7	9.9
	H6	695	3.1	2.1	5.3
	H60	745	2.9	2.0	4.8
	H7	840	2.8	2.2	5.0
	H100	781	2.3	2.2	4.5
	H12	769	2.6	2.9	5.4
	H120	613	3.1	2.8	5.9
	HICU	491	24.2	1.1	25.3
	C8	235	3.7	2.1	5.8
	C9	604	3.5	2.4	5.9
	C10	462	3.8	2.4	6.2
	C11	487	3.8	2.3	6.1
	C14	727	2.9	1.3	4.2
	C15	701	3.5	2.0	5.5
	C27	670	4.1	1.5	5.6
	CICU	408	21.4	1.7	23.2
FAMILY & WOMEN'S	C16	263	7.0	4.5	11.5
	H130	305	7.7	1.3	9.0
	H30 CEDAR	185	8.0	2.1	10.1
	H31 MAPLE	372	6.1	3.7	9.8
	H33 ROWAN	1089	2.7	1.5	4.2
	H34 ACORN	268	9.0	1.9	10.9
	H35	254	6.8	1.1	7.9
	LABOUR	325	15.4	4.8	20.2
	NEONATES	560	12.5	1.0	13.5
	PAU	54	24.6	0.0	24.6
	PHDU	52	29.6	2.6	32.2
CLINICAL SUPPORT	C20	405	3.4	2.0	5.4
	C29	436	3.2	4.1	7.3
	C30	617	2.7	2.2	4.8
	C31	728	2.3	2.1	4.4
	C32	601	2.8	1.8	4.7
	C33	650	3.9	2.3	6.2
	AVERAGE:	578	5.9	2.2	8.1

ROTA EFFICIENCY [04-08-17 to 01-10-17]

HEALTH GROUP	WARD	ANNUAL LEAVE [11-17%]	SICK RN & AN [3.9%]	MAT LEAVE [%]
MEDICINE	ED	15.0%	1.6%	3.7%
	AMU	16.1%	3.5%	3.9%
	H1	17.2%	6.6%	0.0%
	EAU	16.0%	4.3%	5.6%
	H5 / RHOB	15.8%	8.4%	0.0%
	H50	12.9%	2.2%	0.0%
	H500	15.3%	6.6%	3.9%
	H70	14.1%	10.3%	0.1%
	H8	12.0%	3.0%	3.2%
	H80	14.7%	12.3%	0.0%
	H9	15.3%	2.8%	2.6%
	H90	18.4%	3.6%	3.2%
	H11	15.8%	2.7%	0.0%
	H110	19.5%	4.5%	7.2%
	CDU	15.8%	16.8%	0.0%
	C26	14.6%	2.2%	15.3%
	C28 /CMU	14.8%	7.8%	1.7%
SURGERY	H4	14.9%	4.7%	4.3%
	H40	15.6%	9.3%	0.0%
	H6	15.8%	4.3%	2.7%
	H60	18.0%	1.6%	2.1%
	H7	13.5%	3.1%	0.0%
	H100	18.3%	3.9%	2.8%
	H12	18.6%	5.9%	4.4%
	H120	14.0%	4.6%	0.0%
	HICU	15.5%	5.9%	3.2%
	C8	17.1%	19.9%	0.0%
	C9	15.5%	7.0%	0.0%
	C10	17.6%	8.4%	0.0%
	C11	15.0%	3.6%	0.0%
	C14	14.7%	5.1%	4.2%
	C15	17.2%	3.6%	4.9%
	C27	17.2%	3.5%	6.0%
	CICU	15.6%	7.0%	3.3%
FAMILY & WOMEN'S	C16	20.3%	8.6%	4.8%
	H130	16.3%	1.3%	6.0%
	H30 CEDAR	11.8%	12.3%	0.0%
	H31 MAPLE	12.7%	7.9%	0.0%
	H33 ROWAN	18.8%	1.9%	2.6%
	H34 ACORN	16.8%	10.7%	0.0%
	H35	16.2%	5.6%	3.5%
	LABOUR	16.5%	0.9%	4.1%
	NEONATES	12.6%	3.0%	5.5%
	PAU	15.0%	2.8%	6.9%
	PHDU	15.6%	0.0%	0.0%
CLINICAL SUPPORT	C20	9.3%	17.9%	5.2%
	C29	16.5%	2.2%	0.4%
	C30	12.0%	12.1%	0.0%
	C31	17.5%	4.4%	0.0%
	C32	16.6%	5.5%	0.0%
	C33	16.4%	2.2%	2.2%
	AVERAGE:	15.7%	5.9%	2.5%
	TOTALS:			

NURSING VACANCIES [FINANCE LEDGER M6]

HEALTH GROUP	WARD	RN [WTE]	AN [WTE]	TOTAL [WTE]	% [<10%]
MEDICINE	ED	16.04	1.87	17.91	14.2%
	AMU	9.17	-0.16	9.01	11.2%
	H1	2.84	2.13	4.97	20.3%
	EAU	5.42	-4.95	0.47	1.5%
	H5 / RHOB	3.49	1.20	4.69	12.1%
	H50	1.51	1.87	3.38	17.8%
	H500	4.36	0.59	4.95	16.5%
	H70	9.96	1.76	11.72	34.8%
	H8	4.06	-3.88	0.18	0.6%
	H80	5.19	-3.80	1.39	4.5%
	H9	1.82	-2.36	-0.54	-1.8%
	H90	5.65	-3.63	2.02	6.6%
	H11	7.77	1.76	9.53	27.7%
	H110	6.28	0.01	6.29	18.2%
	CDU	0.86	0.48	1.34	8.5%
	C26	1.51	-0.23	1.28	3.7%
	C28 /CMU	5.23	-0.11	5.12	10.5%
SURGERY	H4	5.88	2.03	7.91	24.5%
	H40	3.99	0.61	4.60	14.9%
	H6	3.91	-1.53	2.38	8.0%
	H60	1.56	1.38	2.94	9.6%
	H7	4.52	-0.15	4.37	12.5%
	H100	3.95	0.82	4.77	15.6%
	H12	7.55	-1.03	6.52	18.6%
	H120	1.20	1.55	2.75	9.6%
	HICU	12.30	0.80	13.10	11.7%
	C8	0.72	-0.83	-0.11	-0.8%
	C9	4.29	2.03	6.32	20.5%
	C10	7.21	0.71	7.92	30.4%
	C11	1.50	1.79	3.29	12.6%
	C14	4.52	0.52	5.04	17.1%
	C15	-0.80	-0.28	-1.08	-3.8%
	C27	1.87	-0.66	1.21	3.8%
	CICU	5.65	1.66	7.31	7.3%
FAMILY & WOMEN'S	C16	5.04	-0.05	4.99	16.8%
	H130	0.21	2.02	2.23	7.9%
	H30 CEDAR	-0.92	0.12	-0.80	-3.6%
	H31 MAPLE	2.94	2.71	5.65	7.9%
	H33 ROWAN				
	H34 ACORN	0.02	-0.46	-0.44	-1.5%
	H35	0.46	1.53	1.99	9.7%
	LABOUR	-0.83	-1.93	-2.76	-4.3%
	NEONATES	5.32	0.76	6.08	8.5%
	PAU	0.76	0.00	0.76	7.3%
	PHDU	-0.84	0.00	-0.84	-6.7%
CLINICAL SUPPORT	C20	2.28	1.44	3.72	18.4%
	C29	1.53	1.11	2.64	9.1%
	C30	2.47	0.03	2.50	11.4%
	C31	0.67	1.33	2.00	7.8%
	C32	0.25	1.72	1.97	8.4%
	C33	5.17	-1.98	3.19	9.0%
	TOTALS:	185.51	10.32	195.83	10.5%

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

HIGH LEVEL

HEALTH GROUP	WARD	SAFETY THERMOMETER HARM FREE CARE [%]	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]
MEDICINE	ED				2
	AMU	91%			2
	H1	100%			
	EAU	100%		1	
	H5 / RHOB	100%			
	H50	94%			
	H500	100%	1		1
	H70	100%	4	1	2
	H8	81%		1	
	H80	100%		1	
	H9	100%		1	
	H90	100%			
	H11	100%	2	1	
	H110	100%	4		1
	CDU	100%			
	C26	100%			1
	C28 /CMU	100%			
SURGERY	H4	100%	1	2	1
	H40	90%			
	H6	100%	1	4	1
	H60	100%	5	1	1
	H7	100%	4	1	
	H100	100%			
	H12	100%	1		
	H120	100%		1	
	HICU	100%	2	1	1
	C8	100%			
	C9	100%	1		1
	C10	100%			
	C11	100%	1		
	C14	100%	2	1	
	C15	100%	1		2
	C27	100%			
	CICU	100%			2
FAMILY & WOMEN'S	C16	100%	1	1	
	H130	100%		1	
	H30 CEDAR	100%			
	H31 MAPLE	100%	1		
	H33 ROWAN	100%	1		
	H34 ACORN	100%			
	H35	100%			
	LABOUR	100%	3	3	
	NEONATES	100%			5
	PAU	100%			
	PHDU	100%			
CLINICAL SUPPORT	C20	100%			
	C29	100%			
	C30	100%			
	C31	96%			
	C32	100%		1	
	C33	100%			
	TOTALS:	50	36	23	23

FALLS

HEALTH GROUP	WARD	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL
MEDICINE	ED	1			1
	AMU	1			1
	H1				0
	EAU	3	1		4
	H5 / RHOB				0
	H50				0
	H500				0
	H70				0
	H8				0
	H80				0
	H9	2	1		3
	H90	1			1
	H11	3			3
	H110	1			1
	CDU				0
	C26	1			1
	C28 /CMU	1			1
SURGERY	H4	1			1
	H40	1			1
	H6	1			1
	H60				0
	H7				0
	H100	3			3
	H12				0
	H120	1			1
	HICU				0
	C8				0
	C9	1			1
	C10				0
	C11	1			1
	C14				0
	C15				0
	C27				0
	CICU				0
FAMILY & WOMEN'S	C16				0
	H130				0
	H30 CEDAR				0
	H31 MAPLE				0
	H33 ROWAN				0
	H34 ACORN				0
	H35	2			2
	LABOUR				0
	NEONATES				0
	PAU				0
	PHDU				0
CLINICAL SUPPORT	C20	2			2
	C29	2			2
	C30				0
	C31	1			1
	C32	1			1
	C33				0
	TOTALS:	31	2	0	33

HOSPITAL ACQUIRED PRESSURE DAMAGE [GRADE]

HEALTH GROUP	WARD	1	2	3	DTI	UNSTAG.	PRESSURE SORE TOTAL
MEDICINE	ED						0
	AMU		1		1		2
	H1						0
	EAU				1		1
	H5 / RHOB						0
	H50						0
	H500						0
	H70						0
	H8						0
	H80						0
	H9						0
	H90						0
	H11	1					1
	H110		1				1
	CDU						0
	C26		1				1
	C28 /CMU						0
SURGERY	H4				1		1
	H40	1					1
	H6						0
	H60						0
	H7						0
	H100						0
	H12						0
	H120					1	1
	HICU				1		1
	C8						0
	C9						0
	C10		1				1
	C11						0
	C14						0
	C15						0
	C27						0
	CICU						0
FAMILY & WOMEN'S	C16						0
	H130						0
	H30 CEDAR						0
	H31 MAPLE						0
	H33 ROWAN						0
	H34 ACORN						0
	H35						0
	LABOUR						0
	NEONATES						0
	PAU						0
	PHDU						0
CLINICAL SUPPORT	C20						0
	C29						0
	C30						0
	C31				1		1
	C32						0
	C33						0
	TOTALS:	2	4	0	5	1	12

QUALITY INDICATOR TOTAL

HEALTH GROUP	WARD	QUALITY INDICATOR TOTAL
MEDICINE	ED	3
	AMU	5
	H1	0
	EAU	6
	H5 / RHOB	0
	H50	0
	H500	2
	H70	7
	H8	1
	H80	1
	H9	4
	H90	1
	H11	7
	H110	7
	CDU	0
	C26	3
	C28 /CMU	1
SURGERY	H4	6
	H40	2
	H6	7
	H60	7
	H7	5
	H100	3
	H12	1
	H120	3
	HICU	5
	C8	0
	C9	3
	C10	1
	C11	2
	C14	3
	C15	3
	C27	0
	CICU	2
FAMILY & WOMEN'S	C16	2
	H130	1
	H30 CEDAR	0
	H31 MAPLE	1
	H33 ROWAN	1
	H34 ACORN	0
	H35	2
	LABOUR	6
	NEONATES	5
	PAU	0
	PHDU	0
CLINICAL SUPPORT	C20	2
	C29	2
	C30	0
	C31	2
	C32	2
	C33	0
	TOTALS:	127

Sep-17 SAFER STAFFING OVERALL PERFORMANCE

	DAY: Average fill rate - RN/RM (%)	DAY: Average fill rate - care staff (%)	NIGHT: Average fill rate - RN/RM (%)	NIGHT: Average fill rate - care staff (%)	CARE HOURS PER PATIENT PER DAY [CHPPPD]: Cumulative Count	RN / RM	CARE STAFF	OVERALL
HRI SITE	77.5%	96.7%	87.6%	101.8%	19486	4.2	2.3	6.5
CHH SITE	81.5%	93.9%	86.5%	87.1%	9436	4.5	2.1	6.6

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

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

Trust Board date	November 7th 2017	**Reference Number**	2017 -11 -10
Director	Mike Wright - Chief Nurse	**Author**	Mike Wright, Chief Nurse Jo Ledger, Deputy Chief Nurse Caroline Grantham, Practice Development Matron
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to the Nursing and Midwifery Fundamental Standards Audits		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Determine if this report provides sufficient information and assurance • Determine if any further actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	

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

4	**LINKED TO:**			
	CQC Regulation(s): All Safe domains; E1 (evidence-based); E2 (outcomes); E3 (staff skills); E4 (team working); C1 (care, respect and dignity)			
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N
5	**BOARD/BOARD COMMITTEE REVIEW** The Board receives this report on a quarterly basis, to provide an overview of fundamental standards of care, positive assurance on progress and any risk issues arising.			

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

EXECUTIVE SUMMARY

The Nursing and Midwifery Fundamental Standards audits have been developed to monitor patient care across a number of core elements of nursing and midwifery practice. These were last presented to the Trust Board in July 2017. Good progress is being made and this report presents the position as of September 2017.

Areas of achievement are summarised alongside the next areas for focused attention. Audit results are publicised in wards and departments as part of ongoing transparency and accountability to patients and the public for the care provided.

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

1. INTRODUCTION

Delivering safe, effective and high quality care to patients is of paramount importance, and is one of the Trust's most important and key strategic objectives. The Trust must account for the quality of care it delivers to patients and ensure that care is both evidence-based, where possible, 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 the Trust's nursing and midwifery teams. The last report on this topic was presented to the Trust Board in July 2017. This provides a progress report up to the end of September 2017.

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

TABLE 1 - 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

2. ASSESSMENT PROCESS

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

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

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

Score	less than 80%	80% to 89.9%	90 to 94.9%	95% or above
Frequency of Review	3 month review	6 month review	9 month review	12 month review

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

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

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

Following the review, the Ward Sister/Charge Nurse is required to formulate an action plan, within a two-week time period. A copy of each review and action plan is then sent to the Senior Matron and Nurse Director responsible for that area to approve and endorse. Performance against each action plan is monitored through the Health Groups' Governance Structures. In addition, it is a requirement that each action plan is discussed and progress reported and documented at monthly ward/unit meetings. Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard, then the Ward Sister/Charge Nurse will have an appraisal completed by the Senior Matron, with clear objectives set. If the ward gets a second consecutive Red, then the Senior Sister/Charge Nurse will have an appraisal completed by the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse in order to determine what additional help/support and/or performance action may be required.

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

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

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

Ward 40's "How are we doing?" board

Figure 1

3. CURRENT POSITION

The results are now shown for fifty two clinical areas not fifty four as reported previously. This is due to the closure of Ward 8 at Castle Hill Hospital (CHH) and the amalgamation of the assessment process for the Intensive Care Units at Hull Royal Infirmary (HRI). Table 2 below illustrates the overall Trust position in relation to all of the fundamental standards as at the 30th September 2017.

Appendix One provides an overview of individual ratings by clinical area, where applicable. Please note that a number of the fundamental standards are not applicable within all clinical areas, for example the nutritional fundamental standard is not completed on the Labour ward, this relates to the duration of time the patients spend within this clinical setting.

Current Trust Position for all Fundamental Standards: September 2017								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
23 wards	18 wards	4 wards	43 wards	18 wards	9 wards	11 wards	9 wards	21 wards
26 wards	28 wards	13 wards	8 wards	20 wards	7 wards	24 wards	19 wards	27 wards
3 wards	5 wards	34 wards	1 wards	14 wards	31 wards	16 wards	14 wards	3 wards
0 wards	0 wards	1 wards	0 wards	0 wards	2 wards	0 wards	5 wards	1 wards

Table 2

The remainder of the paper presents the progress made in relation to each fundamental standard over the last 15 months, since the first fundamental standards paper was presented to the Trust Board in July 2016.

Narrative has been provided to outline the key elements reviewed as part of each fundamental standard's assessment process. An overview of the Trust`s current position in relation to each standard is provided in conjunction with actions being undertaken to address any shortcomings.

4. STAFF EXPERIENCE

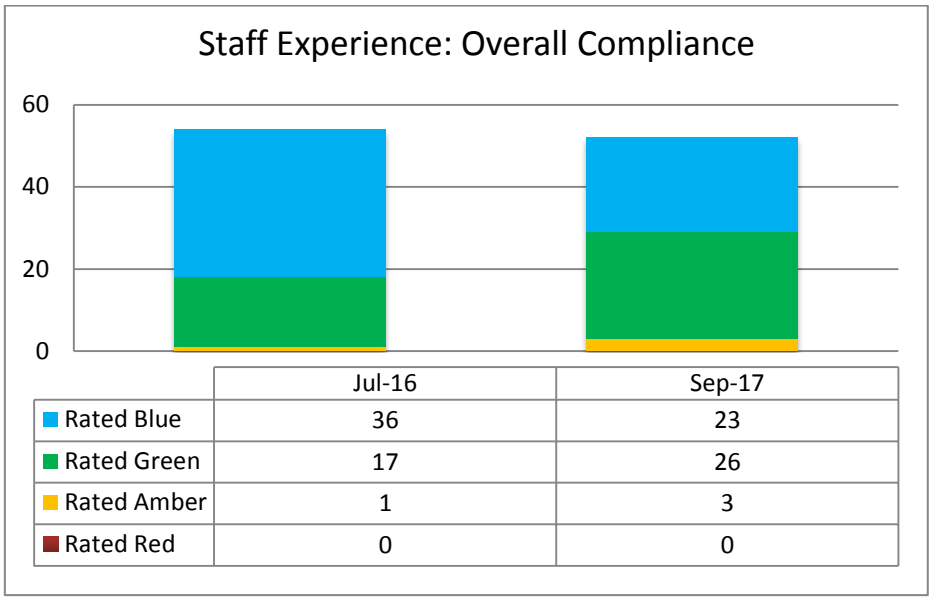
This standard focuses predominantly on the leadership capability within the area. It requires the Charge Nurse/Sister to demonstrate that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of the patients being cared for in that clinical area. It requires the Charge Nurse/Sister 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.

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. The majority of clinical areas are rated Blue or Green for this standard. The content of this standard has been revised in-year, to incorporate staffs views on whether there is sufficient staff working in that area and, also, whether staff are able to demonstrate knowledge of the escalation processes if they are concerned. The resulting impact has seen a shift from Blue to Green and Green to Amber rated scores in some areas. However, this standard still scores relatively high overall. In order to address a number of concerns raised by staff out of hours, particularly on a weekend, the site team has been enhanced by the addition of a band 7 sister/charge nurse. The purpose of which is as follows:

- Support the site team in ensuring the safe redeployment of nursing staff across the organisation.

- A point of contact for clinical issues escalated by ward/departmental staff.
- Support junior staff in prioritising clinical workloads

There are no Red rated areas for this standard.

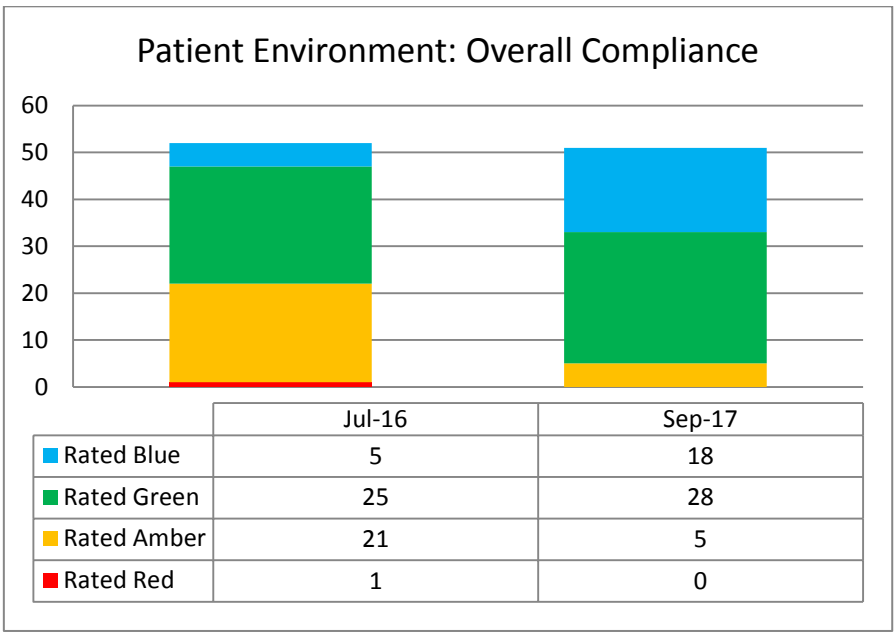


	Jul-16	Sep-17
Rated Blue	36	23
Rated Green	17	26
Rated Amber	1	3
Rated Red	0	0

5. PATIENT ENVIRONMENT

This standard assesses whether clinical environments are clean and safe for patients and that they are cared for with dignity & respect.

Overall progress made for this standard since July 16 to September 2017, is illustrated in the following chart. There has been an increase in Blue rated areas across Medicine, Surgery and Family & Women's Health Groups. Clinical Support is predominantly rated as Green with no areas rated as Blue; this relates to equipment cleaning. Clinical Support is considering introducing ward hygienist roles to pick up this workload, similar to other wards/departments.

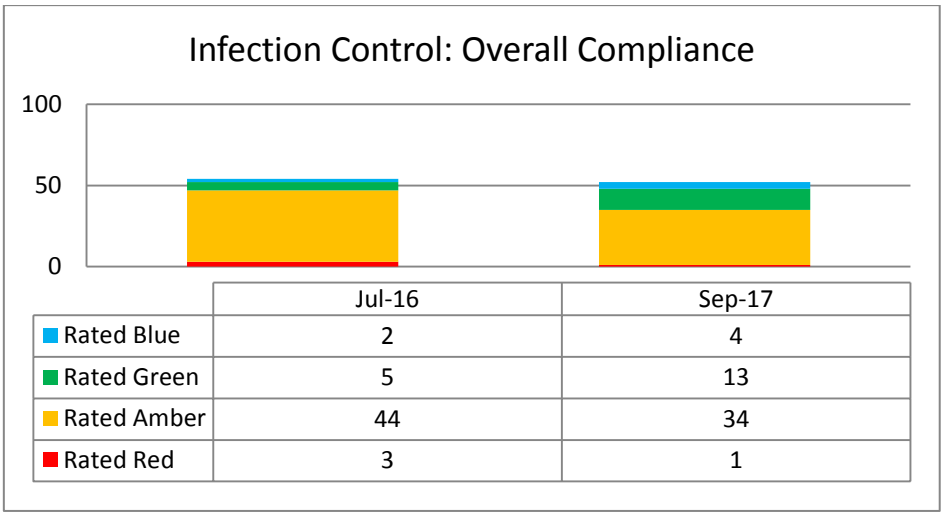


	Jul-16	Sep-17
Rated Blue	5	18
Rated Green	25	28
Rated Amber	21	5
Rated Red	1	0

6. INFECTION CONTROL

This standard assesses the adherence of the clinical area to the Trust's Infection and Control policies.

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. Across all the Health groups there has been an increase in Blue and Green rated clinical areas, although the predominant rating remains Amber. This relates to the failure to clean equipment consistently at weekends, although some areas have addressed this issue by pooling their hygienists so that wards have some cover over a weekend.

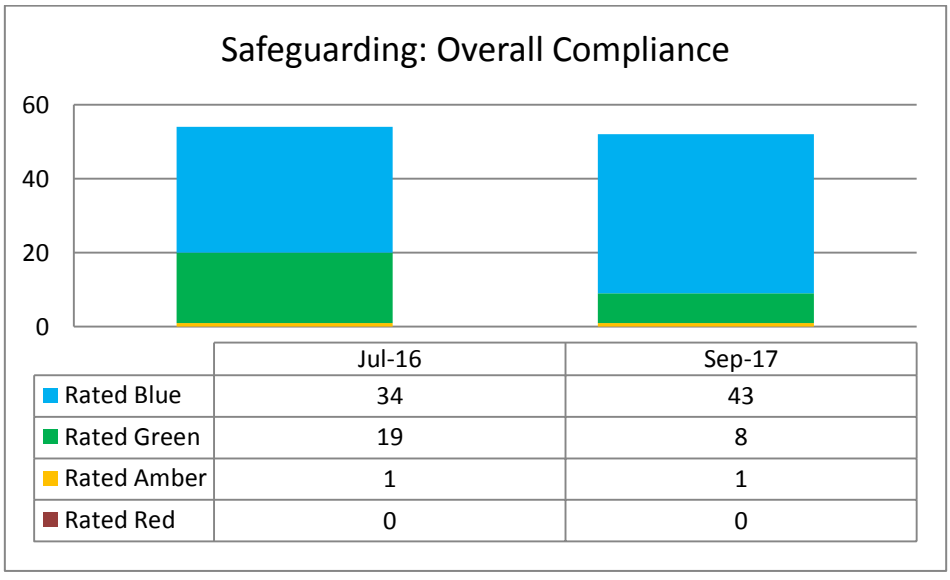


	Jul-16	Sep-17
Rated Blue	2	4
Rated Green	5	13
Rated Amber	44	34
Rated Red	3	1

7. SAFEGUARDING

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

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. Across of all the Health Groups there has been an increase in Blue rated clinical areas. There are no Red rated areas for this standard.

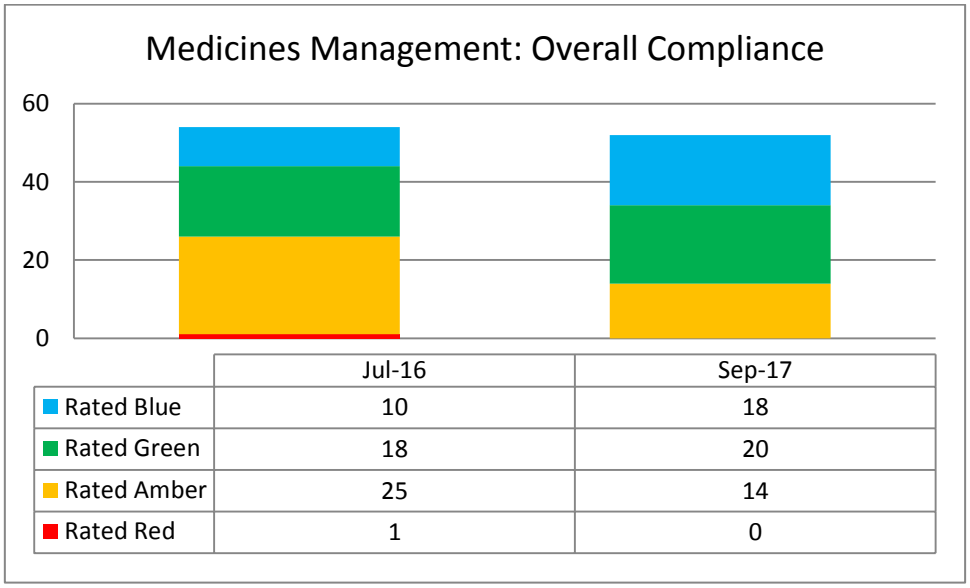


	Jul-16	Sep-17
Rated Blue	34	43
Rated Green	19	8
Rated Amber	1	1
Rated Red	0	0

8. MEDICINES MANAGEMENT

This standard assesses whether staff within the clinical area handle medicines safely, securely and appropriately in accordance with the Trust's Policy and Procedures and that medicines are prescribed and administered to patients safely.

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following. Across all of the Health Groups there has been an increase in Blue and Green rated clinical areas. There are no Red rated areas for this standard.

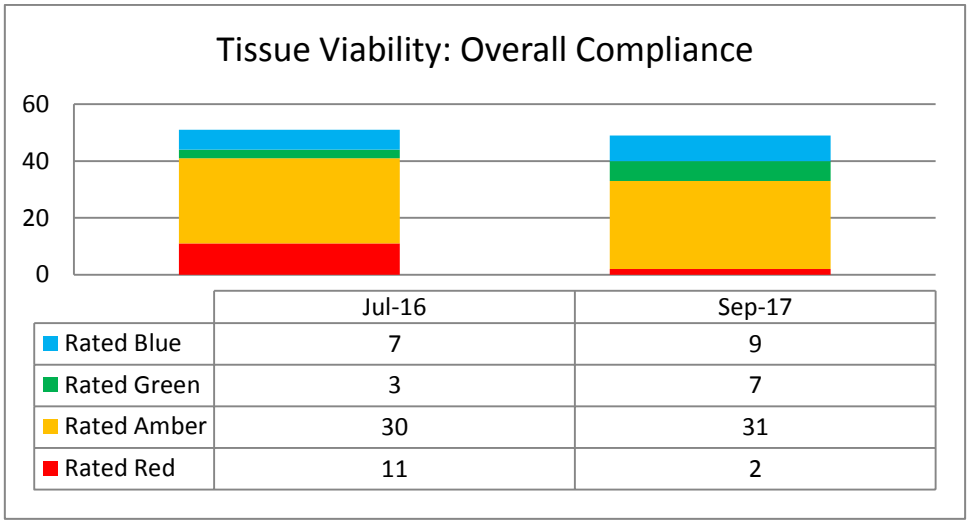


	Jul-16	Sep-17
Rated Blue	10	18
Rated Green	18	20
Rated Amber	25	14
Rated Red	1	0

9. TISSUE VIABILITY

This standard assesses clinical staffs, knowledge and delivery of safe and effective skin care and pressure ulcer prevention.

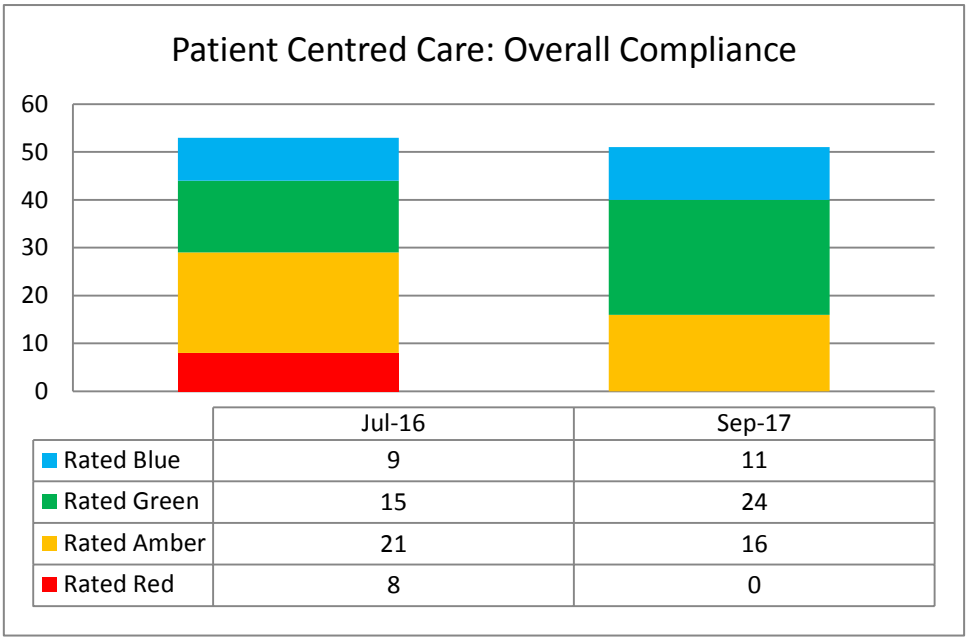
Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. Across all of the Health Groups there has been a decrease in Red rated clinical areas and an increase in clinical areas rated Blue and Green. Although there has been a significant reduction in the number of Red rated areas, this standard remains a key priority for the senior nursing team.



	Jul-16	Sep-17
Rated Blue	7	9
Rated Green	3	7
Rated Amber	30	31
Rated Red	11	2

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

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. Across all of the Health Groups there has been an increase in Blue and Green rated clinical areas. There are no Red rated areas for this standard.



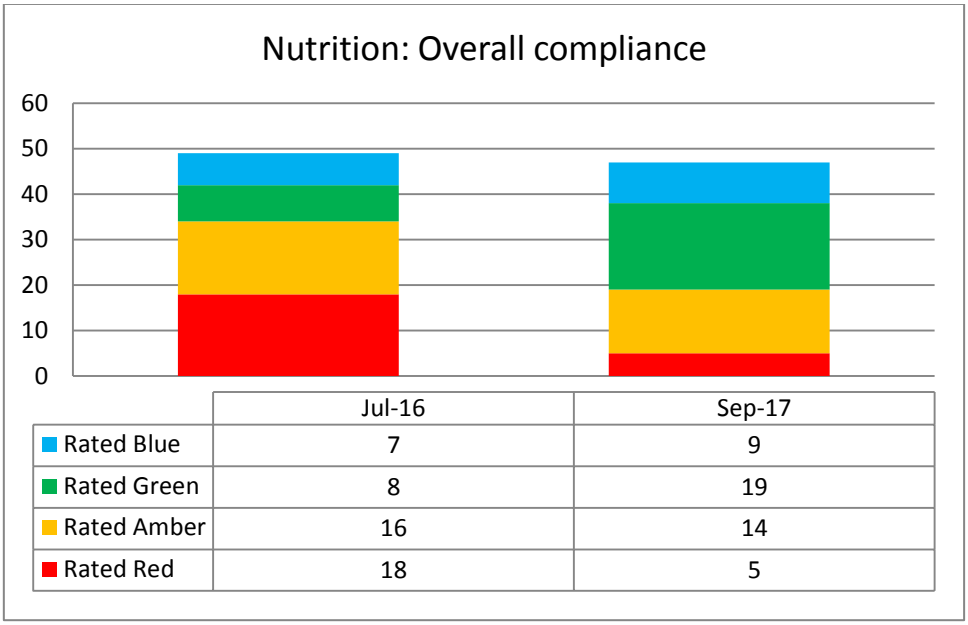
	Jul-16	Sep-17
Rated Blue	9	11
Rated Green	15	24
Rated Amber	21	16
Rated Red	8	0

11. NUTRITION
This standard assesses compliance with the Trust`s Nutrition and Hydration policy. It requires staff to demonstrate how they reduce the risk of poor patient nutrition and dehydration through comprehensive assessments, individualised care planning and implementation of care to ensure that patients are receiving adequate nutrition and hydration. This standard has been the most challenging to address, however, steady progress is now being now made.

Overall progress made for this standard since July 16 to September 2017 is illustrated in the following chart. Across all of the Health Groups there has been a decrease in Red rated clinical areas for this standard and an increase in areas rated Green. However, 5 clinical areas still have a Red rating for this fundamental standard.

There are two predominant reasons for the Red-rated scores within this standard. Firstly, poor compliance in relation to the completion of the Food and Hydration charts. Although staff members are entering what the patients are eating on a daily basis, the current food chart requires the staff to calculate a score, which is not always completed consistently.

Secondly, although the nursing staff are activating an appropriate plan of care based on a comprehensive risk assessment, they are not always documenting specific patient needs consistently/reliably. There is no evidence to suggest that this is resulting in patient harm or that patients are not receiving appropriate nutrition and hydration. The revised Nursing Care Bundle and Food Chart will be in use within all clinical areas from November 2017 and is available for review on request, should any Board members wish to look at this more closely.

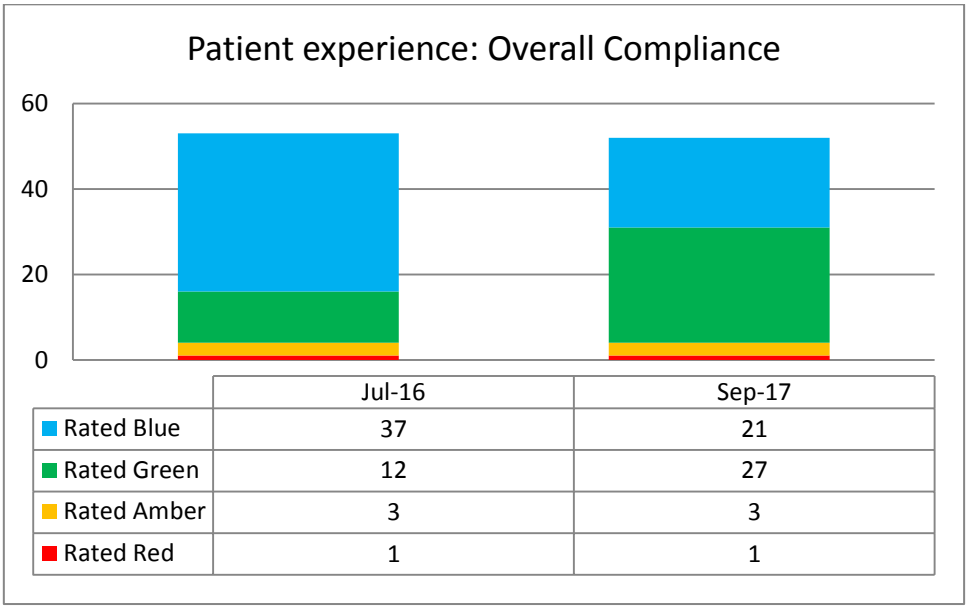


	Jul-16	Sep-17
Rated Blue	7	9
Rated Green	8	19
Rated Amber	16	14
Rated Red	18	5

12. PATIENT EXPERIENCE

This standard assesses whether the clinical area has an active process of obtaining feedback from patients and tests whether there is demonstrable evidence that practice is reviewed and changed where appropriate on the basis of patient feedback.

Overall progress made for this standard since July 16 to September 2017 is illustrated in the chart below. Across all of the Health Groups there has been a slight decrease in Blue rated clinical areas and an increase in Green rated areas. The reasons for this are multifactorial but include being unable to secure sufficient numbers of patients that are able to respond. There are no major concerns with this standard.



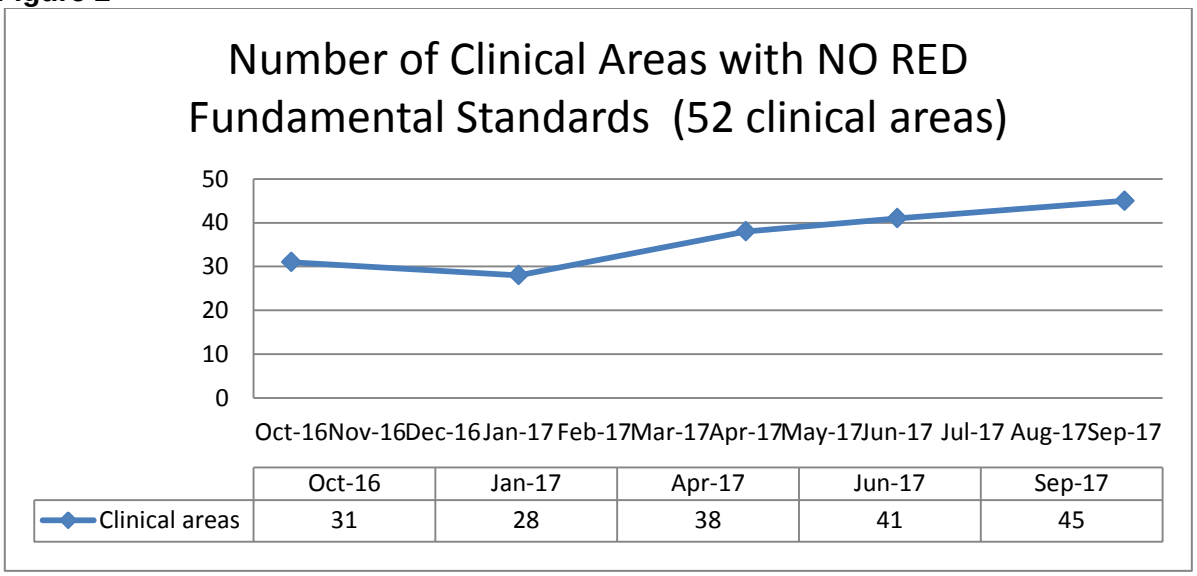
	Jul-16	Sep-17
Rated Blue	37	21
Rated Green	12	27
Rated Amber	3	3
Rated Red	1	1

13. OVERALL POSITION:
Good progress has been made against all of the fundamental standards over the fifteen months that this review process has been in place. 43 of the 52 clinical areas reviewed now have no Red Standards. Figures 2 & 3 illustrate the progress that has been made from an overall Trust perspective during this period in relation to red and blue-rated standards. This is really positive progress.

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

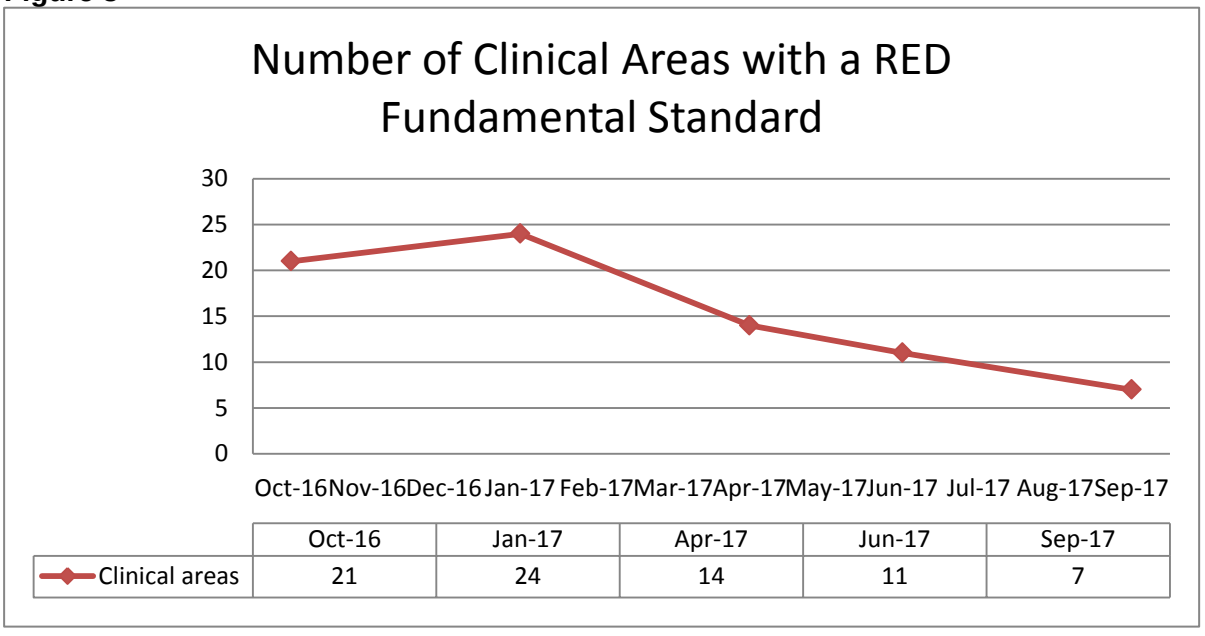
- 6 clinical areas have one red standard (Cedar Ward HRI, C15, H8, H90, H11 and AMU)
- 1 clinical area has three red standards (H70). Despite this, this ward continues to make significant progress under its new leadership.

Figure 2



	Oct-16	Jan-17	Apr-17	Jun-17	Sep-17
Clinical areas	31	28	38	41	45

Figure 3



	Oct-16	Jan-17	Apr-17	Jun-17	Sep-17
Clinical areas	21	24	14	11	7

Table 3 illustrates the specific issues which require further intervention in order to eliminate the remaining Red rated fundamental standards.

Patient Experience	Infection Control	Tissue Viability	Nutrition
Not made aware of visiting times	Gaps in cleaning lists	Body maps not completed on transfer	Weights not plotted on weight graphs only drug chart
Feel staff don't respond in a timely manner to buzzers	Equipment not stored correctly	Care plan does not state individualised risk factors	Care plan does not state individualised care
Care & treatment plans not explained	Care plan does not state individualised risk factors	Risk assessment not performed daily	Food charts not fully completed. Main meals included but not snacks.
	Sharps policy not followed. Bins not always labelled.		Patients not offered "shakes" or "Eating better to feel better" booklet.

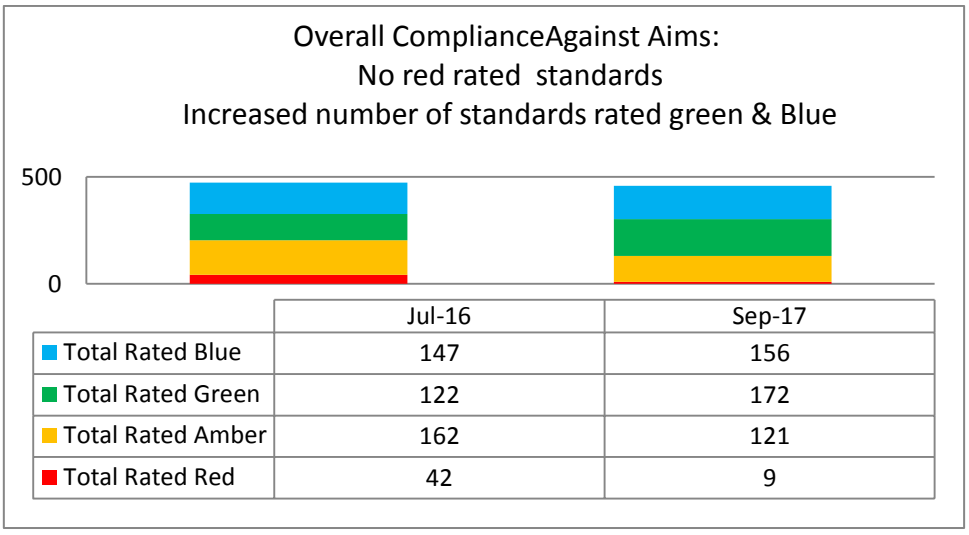
Table 3

14. AREAS FOR IMPROVEMENT

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

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

Although elimination of all Red rated fundamental standards has not been achieved fully, significant improvement has been made over the last 15 months, as demonstrated in the following chart. The target of 'No Red Standards' has not been reached but the number has reduced by approximately 75%. The number of fundamental standards rated as Blue and Green have both increased to approximately 69% of the total. A concentrated effort will now be focused on addressing the issues highlighted in Table 3, led by the Deputy Chief Nurse, with the aim of eliminating all Red rated fundamental standards by March 2018.



	Jul-16	Sep-17
Total Rated Blue	147	156
Total Rated Green	122	172
Total Rated Amber	162	121
Total Rated Red	42	9

15. SUMMARY
Although there are still 9 fundamental standards that are rated as red, significant progress has been made over the last 14 months to improve this position. A concentrated effort on improving the core standards that review Nutrition and Tissue Viability will remain a key priority of the Senior Nursing Teams. The Deputy Chief Nurse continues to meet with each of the Ward Sisters/Charge Nurses to ensure progress is been made against each of the above trajectories.

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
October 2017

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

FUNDAMENTAL STANDARDS September 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	99%	April 18	86%	Jan 18	90%	Sept 17	100%	Mar 18	94%	Nov 17	80%*	Dec 17	86%	April 18	90%	Mar 18	97%	Mar 18
C29	91%	Jan 18	91%	Jan 18	86%	Oct 17	97%	Feb 18	92%	Nov 17	**80%***	Mar 18	**93%**	April 18	100%	June 18	96%	Feb 18
C30	96%	April 18	93%	Feb 18	**80%***	Oct 17	97%	Dec 17	90%	April 18	85%	April 18	81%	Mar 18	**94%**	Mar 18	94%	Dec 17
C31	96%	Mar 18	89%	Feb 18	80%*	Dec 17	100%	Mar 18	84%	Jan 18	84%	Feb 18	91%	July 18	81%	Dec 17	95%	Mar 18
C32	96%	Mar 18	89%	Jan 18	91%	Dec 17	100%	Mar 18	89%	April 18	85%	Feb 18	**89%**	Dec 17	81%	Dec 17	94%	Dec 17
C33	89%	Jan 18	91%	Jan 18	**94%**	July 18	97%	Sept 18	85%	Jan 18	87%	April 18	89%	Mar 18	83%	Dec 17	92%	Dec 17

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	90%	Mar 18	95%	April 18	86%	April 18	90%	Nov 17	94%	April 18	83%	Mar 18	98%	Jan 18	92%	June 18	94%	Dec 17
Cedar H30	89%	May 18	91%	April 18	80%	Oct 17	97%	Dec 17	95%	Feb 18	93%	Oct 18	91%	Mar 18	74%	Dec 17	96%	June 18
H31	96%	April 18	93%	Dec 17	**85%**	April 18	100%	Oct 18	86%	Oct 17	89%	Jan 18	99%	Jan 18	NA		93%	Nov 17
H33	94%	Jan 18	89%	April 18	84%	April 18	98%	Nov 17	95%	Jan 18	100%	April 18	99%	Jan 18	NA		96	Jan 18
ACORN	95%	April 18	91%	Oct 17	90%	May 18	100%	Feb 18	100%	Mar 18	100%	June 18	93%	Feb 18	**89%**	Dec 17	96%	Mar 18
H35	89%	Dec 17	97%	June 18	93%	June 18	100%	Oct 17	94%	Mar 18	88%	April 18	96%	Feb 18	86%	April 18	92%	Dec 18
H130	95%	Jan 18	95%	Mar 18	**81%**	April 18	100%	Feb 18	97%	Mar 18	100%	April 18	90%	Nov 17	**80%**	Dec 17	94%	June 18
Labour	95%	Jan 18	NA		**80%***	**Jan 18**	100%	Nov 17	96%	Dec 17	80%*	Mar 18	99%	Jan 18	NA		98%	Jan 18
NICU	**90%**	Jan 18	95%	June 18	**88%**	Dec 17	97%	Mar 18	100%	Mar 18	100%	Mar 18			100%	June 18	98%	Mar 18
PHDU	97%	Mar 18	93%	Oct 17	**86%**	Jan 18	94%	Nov 17	100%	Oct 17	100%	June 18	92%	June 18	**96%**	Mar 18	93%	Dec 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C9	90%	Dec 17	85%	Oct 17	**91%**	April 18	96%	Jan 18	94%	April 18	**89%**	April 18	92%	Feb 18	**82%**	Dec 17	89%	Jan 18
C10	94%	Jan 18	95%	June 18	94%	June 18	94%	Oct 17	91%	Nov 17	**80%**	Mar 18	80%	Mar 18	92%	Mar 18	96%	Mar 18
C11	96%	Oct 17	91%	Jan 18	83%	April 18	95%	Dec 17	97%	June 18	**87%**	Mar 18	83%	Feb 18	93%	Mar 18	89%	Dec 17
C14	91%	Jan 18	93%	Jan 18	80%*	Jan 18	96%	July 18	88%	Feb 18	**80%***	Mar 18	82%	Feb 18	80%	Dec 17	95%	Mar 18
C15	95%	July 18	93%	Mar 18	82%	Jan 18	97%	July 18	94%	April 18	**71%**	Dec 17	92%	April 18	93%	Mar 18	94%	Dec 17
C27	99%	Mar 18	93%	Mar 18	88%	April 18	100%	Mar 18	96%	July 18	**89%**	Jan 18	93%	Nov 17	**80%**	Dec 17	91%	Dec 17
CICU1	98%	April 18	100%	April 18	97%	April 18	100%	May 18	99%	Oct 17	93%	Mar 18	96%	June 18	96%	May 18	97%	Mar 18
CICU2	90%	April 18	100%	May 18	91%	July 18	100%	May 18	100%	Oct 17	**96%**	April 18	95%	April 18	100%	May 18	92%	Dec 17

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	95%	Mar 18	95%	Mar 18	**81%**	Oct 17	100%	Dec 17	87%	Feb 18	**80%***	Nov 17	80%	Jan 18	**99%**	**Dec 17**	92%	Dec 17
H40	94%	June 18	92%	June 18	86%	Oct 17	100%	Dec 17	89%	May 18	**80%***	Dec 17	93%	Apr 18	**97%**	Dec 17	94%	Dec 17
H6	95%	Mar 18	90%	July 18	**80%***	Nov 17	97%	June 18	90%	Nov 17	**80%***	Jan 18	94%	Dec 17	**84%**	Jan 18	90%	Dec 17

H60	95%	Mar 18	97%	June 18	**89%**	April 18	97%	Jan 18	96%	Oct 17	**80%***	Jan 18	96%	Mar 18	**91%**	Mar 18	95%	Mar 18
H7	89%	Dec 17	97%	Mar 18	**82%**	April 18	97%	Mar 18	87%	Jan 18	**90%**	Oct 17	**96%**	Mar 18	**95%**	June 18	92%	Dec 17
H12	87%	Mar 18	93%	Mar 18	80%*	Oct 17	97%	Dec 17	83%	Jan 18	83%	Jan 18	90%	Oct 17	**89%**	Mar 18	96%	Mar 18
H120	95%	Mar 18	93%	Mar 18	**87%**	May 18	96%	Dec 17	93%	April 18	**80%**	Dec 17	80%	Oct 17	**90%**	Mar 18	95%	Mar 18
H100	89%	Jan 18	88%	Jan 18	**80%***	Dec 17	100%	Dec 17	83%	Dec 17	**80%***	Nov 17	82%	Jan 18	85%	Dec 17	90%	Dec 17
HICU1 & 2	89%	Jan 18	94%	June 18	100%	Oct 18	100%	April 18	95%	Nov 17	94%	April 18	92%	Jan 18	**92%**	Mar 18	95%	Dec 17

MEDICINE CHH

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

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
MAU	94%	June 18	89%	April 18	86%	April 18	100%	Oct 17	89%	Mar 18	**80%**	Oct 17	**85%**	April 18	**68%**	Dec 17	94%	Mar 18
H1	93%	Oct 17	91%	April 18	**83%**	April 18	97%	Oct 18	83%	Feb 18	80%*	Nov 17	**92%**	April 18	**89%**	Jan 18	93%	Mar 18
H200/EAU	96%	Mar 18	95%	Mar 18	**83%**	Jan 18	100%	Jan 18	80%	Jan 18	**80%***	Dec 17	86%	Oct 17	**93%**	Mar 18	89%	Dec 17
H5	84%	Jan 18	89%	April 18	**80%***	Nov 17	100%	Feb 18	89%	April 18	84%	Jan 18	**87%**	Sept 17	**93%**	Mar 18	92%	Dec 17
H50	95%	May 18	89%	July 18	**80%***	Jan 18	100%	Mar 18	96%	Mar 18	**96%**	Jan 18	**86%**	Oct 17	**93%**	Mar 18	96%	Mar 18
H500	94%	Jan 18	95%	June 18	**80%***	Dec 17	92%	Dec 17	90%	Mar 18	**80%***	Jan 18	89%	Jan 18	**93%**	Mar 18	93%	Dec 17
H70	95%	Mar 18	95%	June 18	**47%**	Dec 17	100%	Oct 17	87%	Jan 18	**80%***	Oct 17	**82%**	Nov 17	**55%**	Dec 17	**72%**	Dec 17
H8	93%	Dec 17	97%	Mar 18	80%*	Oct 17	**84%**	Dec 17	94%	Dec 17	95%	Oct 18	95%	Mar 18	78%	Dec 17	81%	Mar 18
H80	95%	Mar 18	94%	July 18	80%*	Jan 18	95%	May 18	90%	Dec 17	80%	Jan 18	94%	June 18	**83%**	Dec 17	85%	Mar 18
H9	91%	June 18	91%	Dec 17	80%*	Dec 17	100%	Mar 18	85%	Feb 18	80%	Mar 18	93%	Jan 18	83%	April 18	89%	June 18
H90	92%	June 18	91%	Oct 17	82%	April 18	90%	Dec 17	89%	Nov 17	**80%**	Mar 18	87%	Oct 17	76%	Dec 17	83%	Mar 18
H11	92%	June 18	**86%**	Jan 18	80%*	Dec 17	97%	Mar 18	84%	Dec 17	**77%**	Nov 17	**91%**	July 18	93%	Mar 18	90%	Dec 17
H110	94%	Dec 17	**88%**	Jan 18	80%*	Oct 17	100%	Oct 17	86%	Dec 17	**80%***	Mar 18	94%	Mar 18	86%	Jan 18	93%	Nov 17

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management				Patient Centred Care (inc TV)		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
Majors ED	93%	Jan 18	**96%**	Dec 17	91%	April 18	95%	Dec 17	98%	Oct 17			86%	Mar 18	92%	Oct 17	96%	Jan 18
Paeds ED	95%	April 18	**96%**	Dec 17	94%	April 18	96%	Aug 18	95%	Feb 18			94%	Oct 17			95%	Jan 18
Emergency Care	80%	Oct 17	**96%**	Dec 17	93%	April 18	89%	July 18	100%	Oct 17			94%	Nov 17			96%	Jan 18

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY COMMITTEE HELD ON 25 SEPTEMBER 2017
THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon	(Chair) – Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mr M Wright	Chief Nurse
	Dr M Purva	Deputy Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Dr A Green	Lead Clinical Research Therapist
	Mrs A Daniel	Risk Manager (for Deputy Director of Quality Governance and Assurance)
IN ATTENDANCE:	Mrs C Bowker	Head of Contracting
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

1. APOLOGIES

Apologies were received from Mr K Phillips, Chief Medical Officer, Mr A Snowden, Non Executive Director, Mr M Veysey, Associate Non Executive Director, Mrs S Bates, Deputy Director of Quality Governance and Assurance and Ms Ramsay, Director of Corporate Affairs

2. DECLARATIONS OF INTEREST

There were no declarations of interest made.

3. MINUTES OF THE MEETING HELD 29 AUGUST 2017

Item 7.2 – Integrated Performance report – paragraph 1.."it was noted that the SHMI rate had increased over the winter. There was no cause for concern regarding the weekend rates."

Item 7.2 paragraph 2 - ..."the team were reviewing three areas where there may be higher than expected number of deaths over the winter months (6 months ago)".

3.1 – MATTERS ARISING

Board development session to be arranged relating to 104 day wait standard. **CR**

Emergency caesarean rates – date to be advised when report will be received by the committee **KP**

Following the Fresenius issues following the CQC inspection it was requested that a discussion take place regarding any providers and how governance is assured. **CR**

Mr Phillips to clarify whether the Trust is required to have a medical examiner. **KP**

Mortality Policy to be presented at the Quality Committee in October 2017. **KP**

3.2 – ACTION TRACKER

It had been agreed that Mrs Walker would be the NED safeguarding champion and would also have mental health issues in her remit.

Safeguarding quarterly report to include joint working with the local economy. **KR**

DRAFT

3.2 – ANY OTHER MATTERS ARISING
There were no other matters arising.

3.4 – WORKPLAN 2017/18
There were no issues arising from the workplan.

4. RESEARCH AND DEVELOPMENT STRATEGY
This agenda items was deferred to the October 2017 meeting.

5. REDUCE AVOIDABLE HARM
5.1 – Themes and trends arising from Serious Incidents
Mrs Daniel presented the report and advised that there had been 2 Never Events declared in August 2017 and 1 declared in September 2017. The Chief Nurse and Chief Medical Officer were leading on the investigations.

There had been a number of patients found on the waiting list that had no action against them and were being reviewed by their host consultant to see if any further action needed to be taken. The Chief Medical Officer and Chief Operating Officer were leading on this issue and would report back to the committee when completed. Mrs Walker expressed her concern as to whether any of the patients would come to harm and Mrs Bowker advised that the majority of the patients would probably be discharged with only a few to follow up.

Resolved:
The Committee received the report and agreed to receive an update regarding the patients with no actions in October 2017. **ER**

5.2 – Quality Improvement Programme
Mrs Daniel presented the report and the committee discussed the issues around having the correct outcomes and ratings on the report.

The committee held a detailed discussion around medicines reconciliation and whether the target shown was unachievable and should be more realistic. Mr Corral advised that the system was working well and daily live data were being reported, but that the Trust was not hitting its target. Prof. Sheldon advised that adverse impact of medication errors was a high national priority and Mr Wright added that the Commissioners also monitored the Trust's progress.

Pressure ulcer management was discussed and Mr Wright advised that he regularly met with ward sisters to ensure they were clear of the expectations of the Trust and that training for all staff was in place. He also advised that any capability issues were being performance managed. Links to gaps in nutrition would be identified in the Root Cause Analysis investigations. Any learning relating to nutrition to be highlighted to the Committee. **AD**

There was a discussion around e-Coli bacteraemia and Mrs Walker expressed concern regarding the increase in the number of cases reported. Mr Wright advised that it was difficult to manage as most patients already had the infection on arrival at the hospital but the Trust would be penalised for this. A joint plan was being developed with the Commissioners to address this.

Resolved:
The Committee received and accepted the report.

The agenda was taken out of order at this point

6.3 – HEY Improvement Programme Report
Dr Purva presented the report which highlighted the work to improve WHO checklist compliance. Two theatres had been identified to carry out the project with resources identified and a steering group set up. A policy had been written and checklists adapted to ensure maximum efficiency when carrying out interventional procedures.

There would be training sessions rolled out in December to complement the policy and Plan Do Study Act (PDSA) reviews carried out. Checks would be carried out from ward to theatre and back to the ward again to ensure handovers run smoothly.

Mr Wright advised that a statement had been written into the policy to 'stop the line' to enable any member of staff to challenge at any point of the procedure.

The importance of linking up with others doing similar worked was stressed. Dr Purva advised that the Trust was working with Sheffield and Bristol and a visit to Bristol had been arranged as it was a centre of excellence in this area.

Resolved:
The Committee received the report.

5.4 – Emergency Readmissions
Mrs Bowker updated the Committee regarding the emergency readmissions audit that had taken place in February 2017. A snapshot of a week had been reviewed and 6 patients had been identified as having linked conditions. Further work was ongoing to review the 6 patients to look at the evidence and determine whether any of the readmissions could have been preventable.

Resolved:
The Committee received the report and requested more frequent updates and highlight any themes and trends emerging.

5.3 – Duty of Candour
Mrs Daniel updated the Committee and advised of the work ongoing with the Health Groups to increase compliance and embed the processes. The staff survey and complaints were good indicators of duty of candour compliance and there was still work to do. Mrs Daniel also advised that the team were reviewing the quality of the letters sent to patients and their families.

Prof. Sheldon asked what triggered the duty of candour process and Mrs Daniel advised that it was moderate or above harm incidents, although the Trust was encouraging all staff to adopt the process into all conversations following an incident.

Resolved:
The Committee received the report.

The agenda reverted back to order at this point

6. RECEIVED FOR ASSURANCE

6.1 – Integrated Performance Report
The Committee reviewed the report and Prof. Sheldon raised diagnostic performance and 62 day cancer screening as areas of concern. Mrs Walker also

expressed her concern regarding both issues and asked that it be raised at the Board.

Mrs Daniel advised that the NRLS reporting of incidents was not showing the Trust to be an outlier when reporting harm.

6.2 – Operational Quality Report
The Operational Quality Report was presented. Never Events and blood handling training were highlighted.

Resolved:
The Committee received the report.

6.3. – HEY Improvement Programme Report
This item was taken earlier on the agenda.

6.4 – NICE Guidance Report
The Committee deferred the item to the October 2017 meeting and requested that Mrs Shaw (Clinical Audit Manager) attend the meeting to discuss the report in more detail.

Resolved:
The item was deferred to October 2017. Mrs Shaw to be invited to the meeting. **RT**

7. BOARD ASSURANCE FRAMEWORK
The Committee reviewed the report and asked for the following areas to be considered:

- NICE Guidance – Is Trust compliance robustly covered in the BAF
- The 3 Never Events in Surgery
- Diagnostic pressures

Resolved:
The Committee received the report and highlighted the three areas above to be considered in the updates. **CR**

8. ANY OTHER BUSINESS
Mrs Walker spoke about the work of the palliative care team and wanted to invite them to future committee.

Prof. Sheldon asked for a rolling programme of different specialities who would like to attend the Quality Committee but wanted context behind the attendances.

9. CHAIRMAN'S SUMMARY TO THE BOARD
Prof. Sheldon to summarise the meeting at the Board 3 October 2017.

10. DATE AND TIME OF THE NEXT MEETING:
Monday 30 October 2017, 9.15am – 11.15am, The Committee Room, HRI

DRAFT

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
QUALITY SUMMARY REPORT
30 OCTOBER 2017

The Quality Committee met on 30 October 2017. The following were discussed/agreed:

1. The Committee received the Trust response to a CQC letter concerning higher than expected elective caesarean rates for briefing purposes. It was thought that the response could have: asked what specific risk factors were included in the CQC's assessment of the issue, specifically whether high obesity, morbid obesity, smoking and diabetes levels were taken into account fully in comparisons, stressed the Trust's low emergency caesarean section and instrumental delivery rates and asked for a comparison of perinatal outcomes. The CQC's feedback on the Trust's response is awaited.

2. The Committee was informed that the Trust was not required at this time to have a medical examiner linked with the national mortality guidance.

3. The Research and Innovation Strategy was presented and highlighted the established links with the University of Hull and HYMS, which will be further developed under the strategy. The Committee discussed the positive aims of the strategy, and commented on the objective of all patients being given the opportunity to be involved in clinical research and also including references to the benefits of research for improving quality of services and attracting and retaining staff. Other suggestions for revision were made; the updated strategy will come to the Trust Board for approval.

4. A summary of the Serious Incidents investigations completed in September 2017 were received; the Committee highlighted some comments on the way in which lessons are identified from investigations. A report is to be received in February 2018 showing how actions following SI investigations are followed up, how lessons are shared and how learning is evidenced.

5. The Committee reviewed the Quality Improvement Programme and discussed when actions should be closed, when they become business as usual and when an QIP should be replaced with a new project.

6. The Sign up to Safety report was received by the Committee. Incident reporting rates had increased reflecting a greater awareness of the importance of safety, but there was more work to be done on learning and integrating safety and improvement activities.

7. The Committee raised concerns regarding worsening diagnostic performance and how this was impacting on patients. A Board Development session had been put into place for November 2017 to discuss this issue further.

8. A summary report from the Operational Quality Committee was received and the new blood transfusion system highlighted as well as concerns about nurse staffing levels.

9. The Learning from Deaths Policy was deferred to the next meeting to allow for a more detailed discussion.

10. The Committee received the updated Board Assurance Framework which now linked to the Board Development Framework and fed the Board's strategic discussions.

Mr Wright advised that the CQC/NHS Improvement response to the Trust's Well Led pilot had not yet been received.

The Deanery's allocation of junior doctors was still an outstanding issue which Mr Phillips advised that he and Mr Nearney would be discussing with Health Education England.

Recommendations
The Board is asked to note the discussion held at the Quality Committee.

Trevor Sheldon
October 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY ACCOUNTS 2017-18 PROGRESS UPDATE

Trust Board	7 November 2017	**Reference Number**	2017 – 11 – 12
Director	Kevin Phillips – Chief Medical Officer	**Author**	Kate Southgate – Head of Compliance
Reason for the report	The purpose of this paper is to provide assurance to the Trust Board that progress is being monitored regarding the agreed quality and safety improvement priorities for 2017/18 as detailed in the Trust's Quality Accounts.		

Type of report	Concept Paper		Strategic Options		Business Case	
	Performance		Briefing		Review	✓

1	**RECOMMENDATION** The Trust Board is recommended to receive and accept this report					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): **W2 - Governance**					
	Assurance Framework BAF 3	**Raises Equalities Issues? N**	**Legal advice taken? N**	**Raises sustainability issues? N**		
5	**BOARD/BOARD COMMITTEE REVIEW** Progress against the Trust's Quality and Safety priorities are monitored through the Quality Improvement Plan, which is reviewed monthly by the Trust Board Quality Committee. The Trust Board is accountable for ensuring these priorities are identified and progress is made against them. The Audit Committee reviews the process by which this monitoring takes places, as well as the process for drawing up and agreeing the Quality Accounts and the Quality and Safety priorities within them.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY ACCOUNTS 2017/18 PROGRESS UPDATE

1. PURPOSE OF THE PAPER

The purpose of this paper is to provide assurance to the Trust Board that progress is being monitored regarding the agreed quality and safety improvement priorities for 2017/18 as detailed in the Trust's Quality Accounts.

2. QUALITY AND SAFETY PRIORITIES

The quality and safety priorities for 2017/18 were approved following consultation in February 2017 with patients, staff, Trust members and stakeholders. The agreed quality and safety priorities for 2017/18 are:

Safe

- Medication Safety
- Nutrition and Hydration
- Avoidable hospital acquired pressure ulcers
- VTE
- Avoidable hospital acquired infections
- Avoidable patient falls
- Deteriorating Patient

Effective

- Sepsis
- Resuscitation Equipment and Checklist Compliance
- Avoidable mortality
- Compliance with National Standards for Interventional Procedures Checklists

Experience

- Learning lessons
- Patient experience

3. QUALITY ACCOUNTS

The Quality Account action plans are managed and delivered through the Trust's Quality Improvement Programme (QIP). The QIP is managed by the Quality Governance Team and monthly assurance and escalation reports are provided to the Operational Quality Committee.

At a Trust board level, progress against each of the QIP projects, including those linked with the Quality and Safety priorities, are reviewed each month by the Quality Committee.

The Audit Committee received this update at its October 2017 to ensure there is an adequate monitoring process in place. No concerns were raised.

The Trust Board is accountable for ensuring the Trust identifies its key quality and safety priorities and makes progress against them each year. This paper confirms that there is an adequate structure in place, and that this receives regular Board level scrutiny by the Quality Committee.

Attached at Appendix 1 is the September 2017 summary provided to October 2017 Quality Committee. This appendix provides details on the QIP's current progress and was reviewed by the Committee on behalf of the Trust Board. The appendix also includes oversight of the ratings of each project over the course of the year; this provides

assurance that this is reviewed regularly and project ratings are adjusted to take account of progress or where progress is starting to slip.

There are no significant concerns or risks to report to the Trust Board at this stage, in relation to making sufficient progress against the Trust's quality and safety priorities.

4. RECOMMENDATIONS

The Trust Board is recommended to receive and accept this report.

Kate Southgate
Head of Compliance
October 2017

APPENDIX 1

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

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

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

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

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

Overview:
The overall QIP is now rated as Amber/Green. Milestones continue to impact on the aims and objectives of individual projects.

During September 2017, a 6 month review of the full project has been undertaken. This review sought to ensure that the QIP was fit for purpose in terms of delivering improvements across all projects. As such a number of business as usual milestones were identified and removed within projects and these have been noted in the individual reports. In addition, the review sought to ensure that the milestones were impacting on the overall aim of the individual projects and that projects were being given the most appropriate rating. As part of the review other sources of information were reviewed such as Serious Incidents to ensure that areas for improvement were consistently monitored within existing projects.

The style of the report has also been altered to ensure it is clear who projects have been rated throughout the year as well as areas for escalation for each project where applicable.

Following the review it was concluded that successful delivery of the overall QIP appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.

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

Current Position:

3 projects closed this period:

- 11. Maternity & Gynaecology
- 24. Children & Young People Services
- 35. Safer Standards for Invasive Procedures – moved to HEY Improvement Team as a Trust-wide improvement programme

5 projects currently rated Green (August 2017: 7 projects)

- 06. Deteriorating Patient
- 15. Sepsis
- 28. Patient Experience
- 38. Consent
- 39. Outpatients

9 projects currently rated Amber/Green (August 2017: 8 projects)

- 08. Infection Control
- 09. Falls
- 16. Resuscitation Equipment Checklist
- 22. Nutrition
- 23. Dementia
- 30. Avoidable Mortality
- 34. Critical Care
- 36. Transition from Children to Adult Services
- 37. ReSPECT

5 projects rated Amber (August 2017: 8 projects)

- 04. Safeguarding, MCA & DOLs
- 05. Medicines Management
- 10. Pressure Ulcers
- 12. Children & Young People with Mental Health Needs and CAMHS
- 14. VTE

0 project rated Amber/Red (August 2017: 8 projects)

0 projects rated Red (August 2017: 0 projects)

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

PROJECT RATINGS DURING 2017-18

PROJECT RATINGS	APRIL 2017	MAY 2017	JUNE 2017	JULY 2017	AUG 2017	SEPT 2017	OCT 2017	NOV 2017	DEC 2017	JAN 2018	FEB 2018	MAR 2018
Overall QIP Rating	G	A/G	A	A/G	A/G	A/G						
QIP02 – Learning Lessons	G	G	G	A/G	A/G	Project being revised						
QIP04 – Safeguarding, MCA and DOLs	A/G	A	A	A	A	A						
QIP05 – Medicines Management	A/G	A/G	A	A/G	A	A						
QIP06 – Deteriorating Patient	Project not opened			G	G	G						
QIP08 – Infection Control	G	A/G	A	A/G	A	A/G						
QIP09 – Falls	Project not opened		G	G	G	A/G						
QIP10 – Pressure Ulcers	G	A	A	A	A	A						
QIP11 – Maternity and Gynaecology	A/G	A/G	A/G	A/G	A/G	B	Not Applicable – Project Closed					
QIP12 – Children & Young People with Mental Health needs and CAMHS	A/G	A	A	A	A	A						
QIP14 - VTE	A/G	A/G	A/G	A/G	A/G	A						
QIP15 – Sepsis	G	G	G	G	G	G						
QIP16 – Resuscitation Equipment Checklist	Project not opened	A	A	A	A/G	A/G						
QIP22 – Nutrition	G	A	A	A	A	A/G						
QIP23 – Dementia	G	G	G	A/G	A/G	A/G						
QIP24 – Children & Young People Services	A/G	A	A	A	A	B	Not Applicable – Project Closed					

PROJECT RATINGS	APRIL 2017	MAY 2017	JUNE 2017	JULY 2017	AUG 2017	SEPT 2017	OCT 2017	NOV 2017	DEC 2017	JAN 2018	FEB 2018	MAR 2018
QIP28 – Patient Experience & Complaints	G	G	A/G	A/G	G	G						
QIP30 – Avoidable Mortality	G	A/G	A/G	A/G	A/G	A/G						
QIP34 – Critical Care	G	A	A/R	A	A/G	A/G						
QIP35 – Safer Standards for Invasive Procedures	A/G	A/G	G	A/G	A	B	Not Applicable – Project Closed and moved to HEY Improvement Team					
QIP36 – Transition from Children to Adult Services	A/G	A	A/G	A/G	A/G	A/G						
QIP37 – ReSPECT	G	G	G	G	G	A/G						
QIP38 – Consent	G	G	G	G	G	G						
QIP39 - Outpatients	G	G	G	G	G	G						
QIP40 – Compliance with National Standards for Interventional Procedures Checklist	Project not opened	G	Project closed as combined with QIP35 - Safer Standards for Invasive Procedures									
QIP41 – Getting it Right First Time	Project not opened				Project in development							

Integrated Performance Report 2017/18

October 2017

September data

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

RESPONSIVE

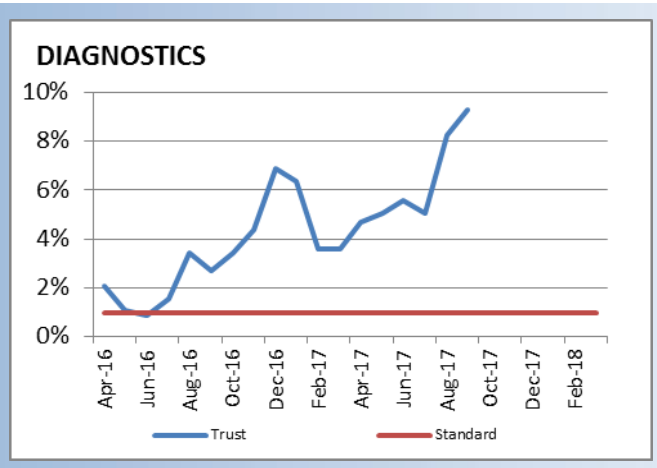
Description	Aggregate Position	Trend	Variation

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 9.30% in September

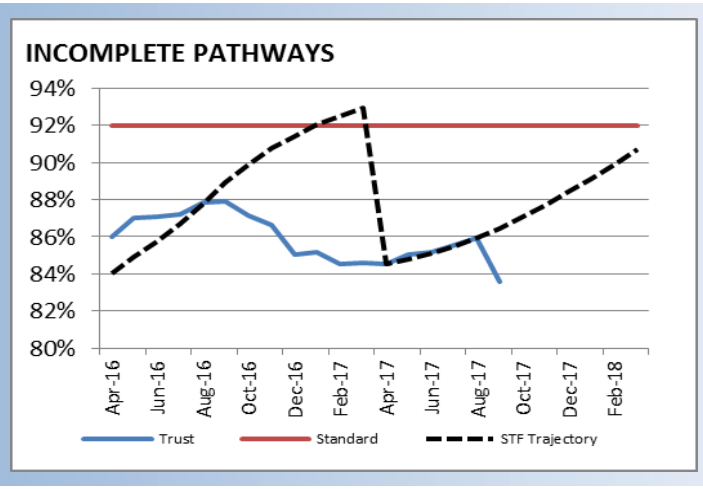


Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the September Improvement trajectory of 86.5%

September performance was 83.6%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During September there were 12 specialties that failed to meet the STF trajectory

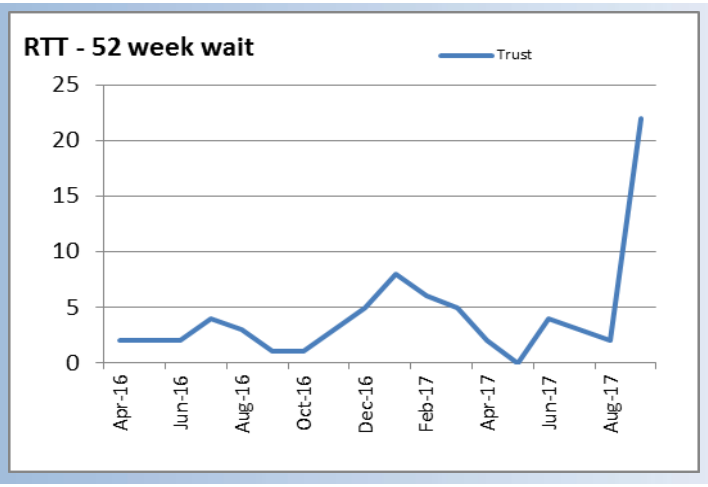
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

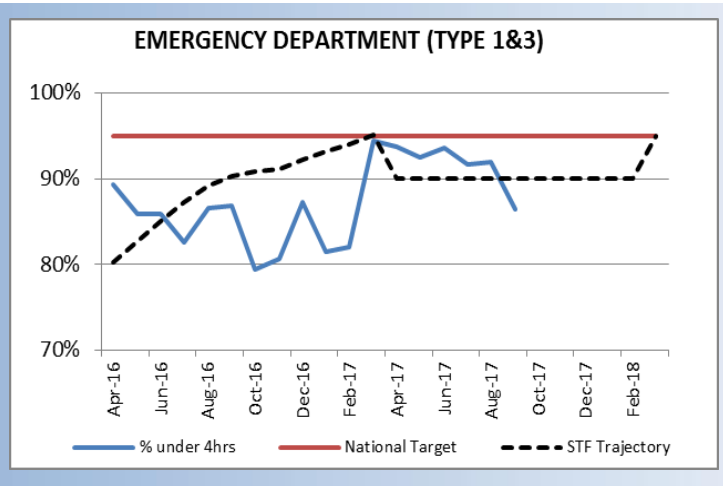
The Trust failed to achieve the national standard of zero breaches with 22 breaches during September.



A&E Waiting Times

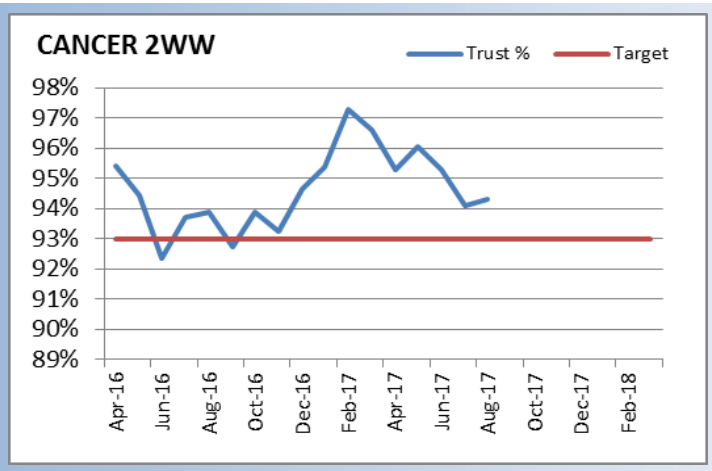
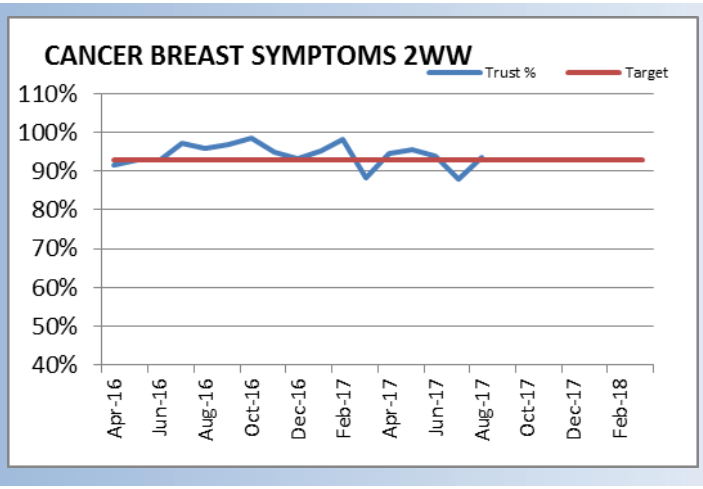
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance failed to achieve the Improvement trajectory of 90.0% with performance of 86.5% for September. This has failed to achieve the national 95% threshold.

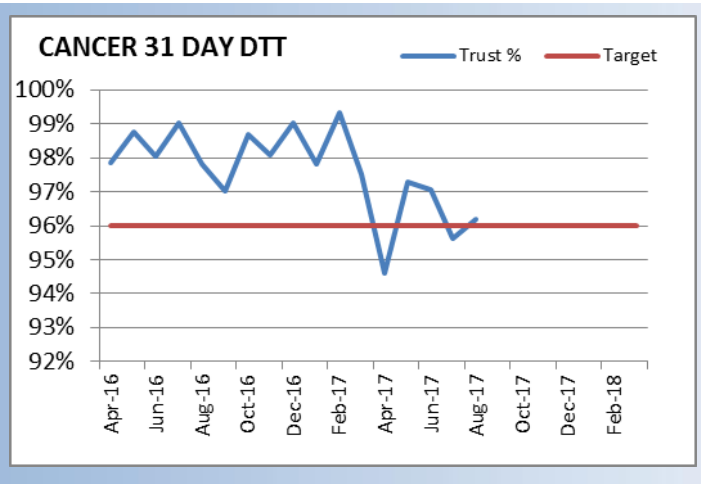
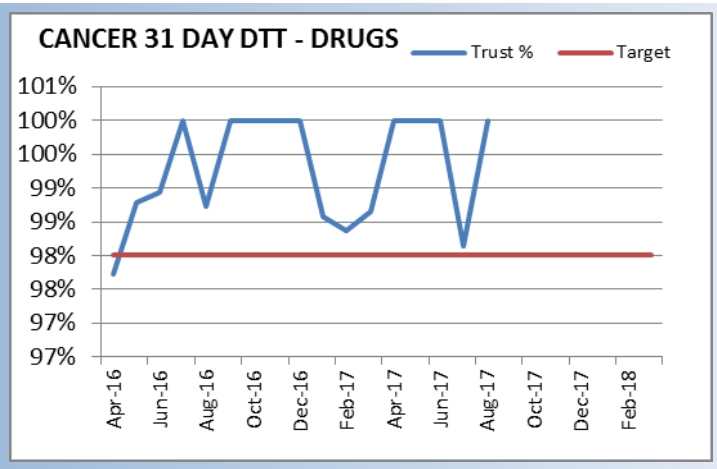


Performance has decreased by 5.5% during September compared to August performance of 92.0%.

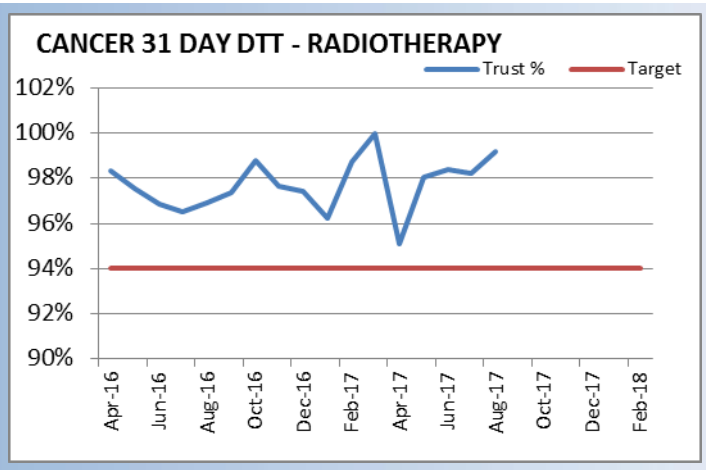
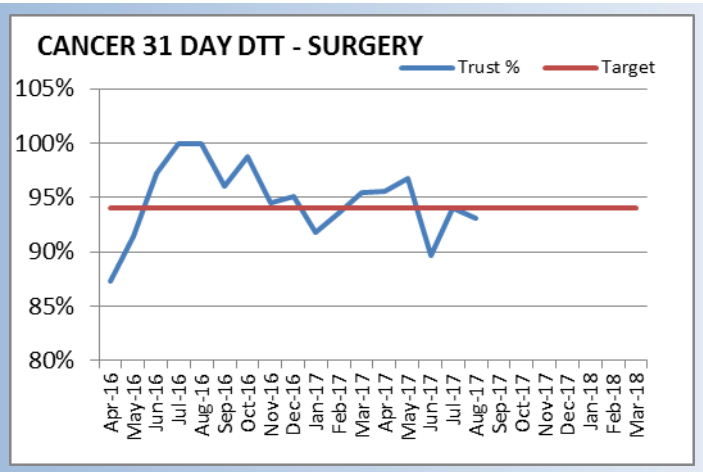
RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: Two Week Wait Standard	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.	August performance achieved the 93% standard at 94.3%		
Cancer: Breast Symptom Two Week Wait Standard	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.	August performance achieved the 93% standard at 93.6%		

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%.	August performance achieved the 96% standard at 96.2%		
Cancer: 31 Day Subsequent Drug Standard	All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 98%.	August performance achieved the 98% standard at 100%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	August performance achieved the 94% standard at 99.2%		
Cancer: 31 Day Subsequent Surgery Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	August performance failed to achieve the 94% standard at 93.2%		

RESPONSIVE

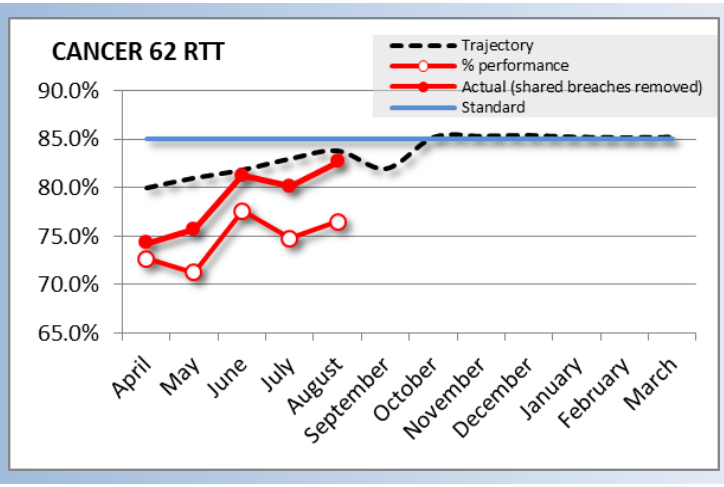
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

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

The adjusted position allows for reallocation of shared breaches

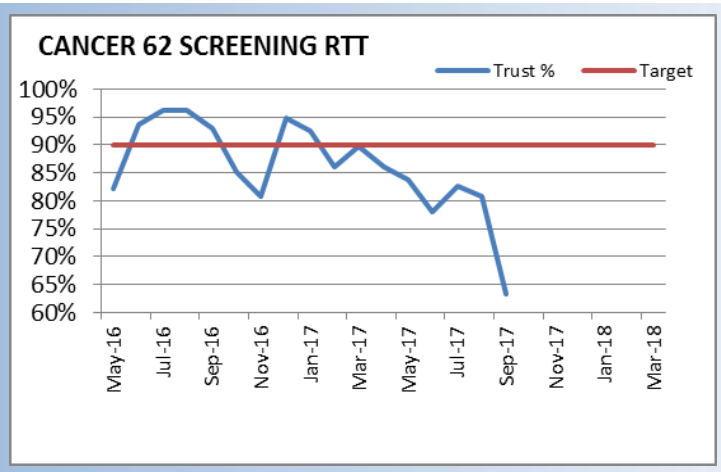
August performance failed to achieve the STF trajectory of 83.8% with performance of 82.7%



Cancer: 62 Day Screening Standard

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

August performance failed to achieve the 90% standard at 63.4%



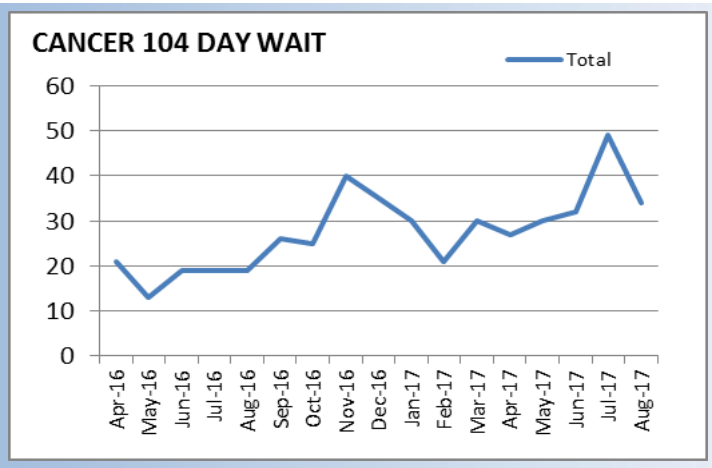
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 34 patients waiting 104 days or over at the end of August

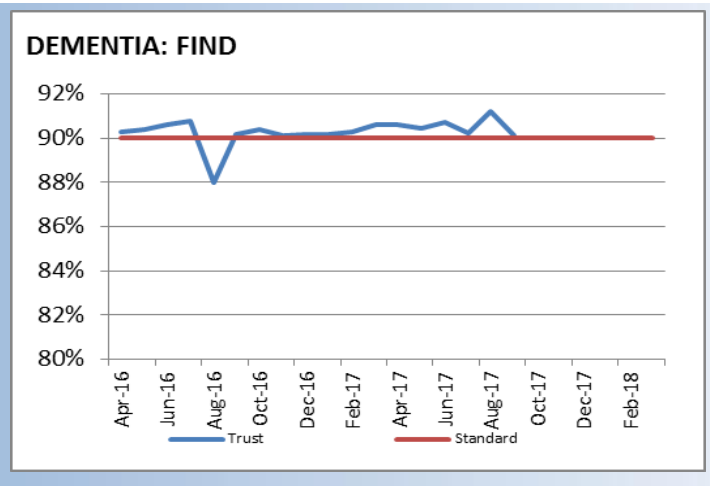


Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The standard for this indicator is to achieve 90%.

Performance for September achieved this standard at 90.1%



RESPONSIVE

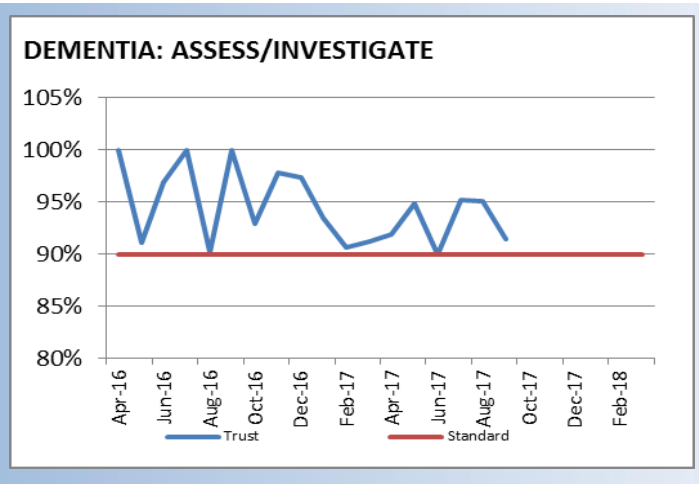
Description	Aggregate Position	Trend	Variation

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

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

The standard for this indicator is to achieve 90%.

Performance for September achieved this standard at 91.4%

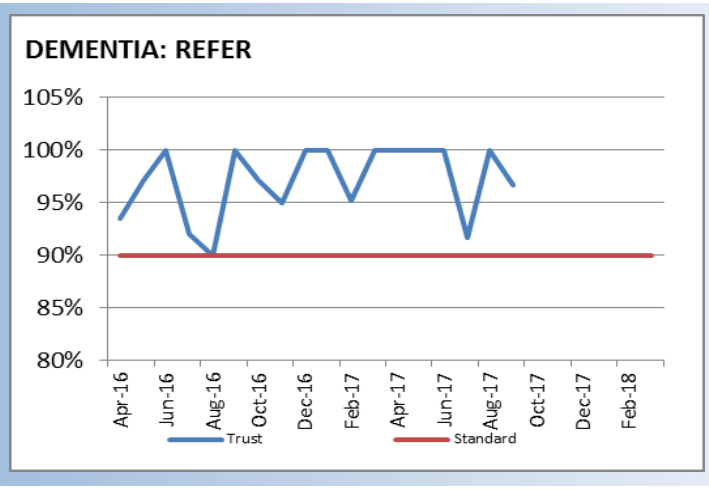


Dementia: Aged 75 and over emergency admission greater than 72 hours

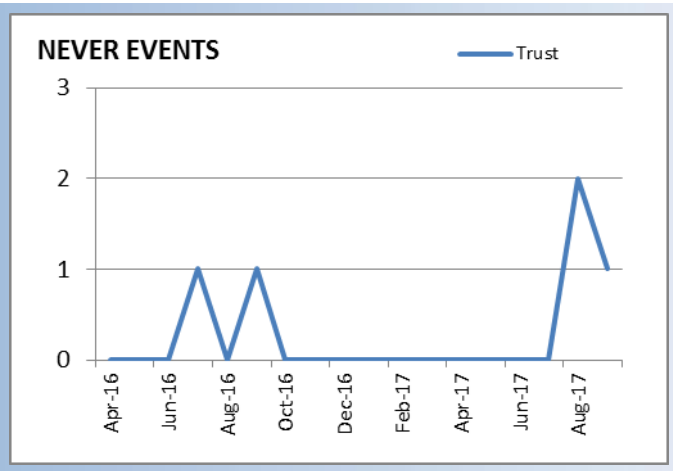
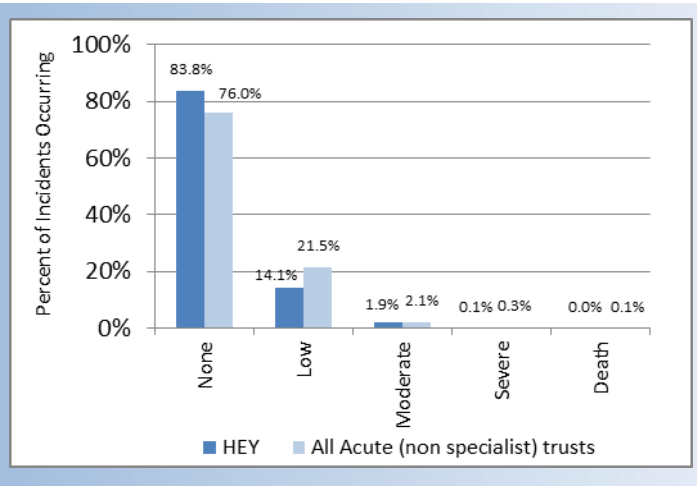
% of patients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.

The standard for this indicator is to achieve 90%.

Performance for September achieved this standard at 96.7%



SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Events	There has been 1 Never Event reported during September		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 2016 to March 2017 as reported by the National Reporting and Learning System (NRLS). The Trust reported 9,468 incidents (rate of 55.67) during this period.		

SAFE

Description	Aggregate Position	Trend	Variation

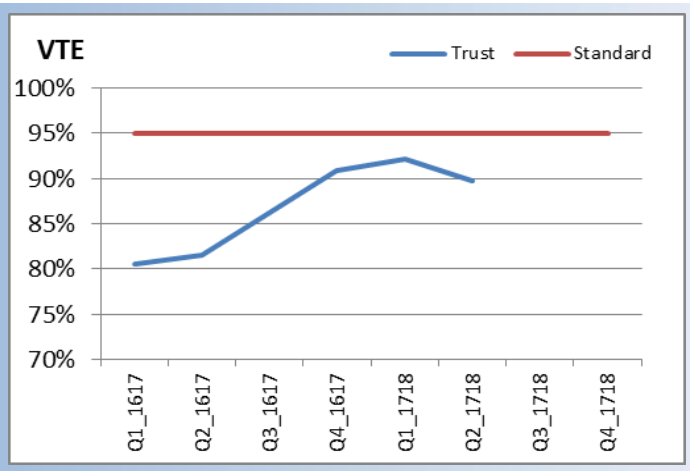
VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 89.72% for Q2 2017/18.

Q3 performance will be available 20th January 2018.

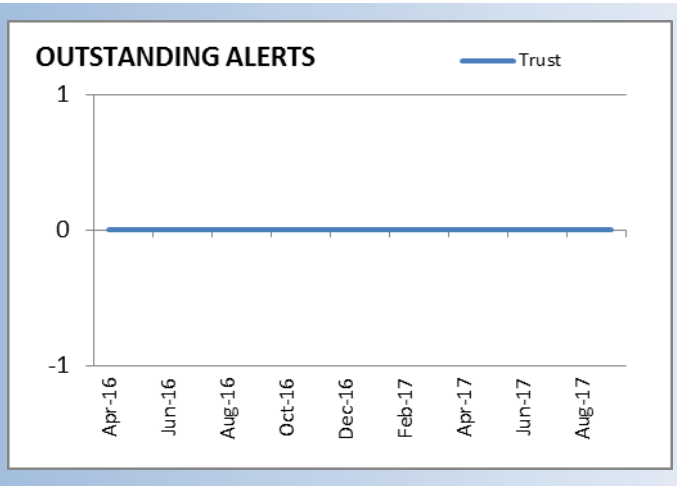


Patient Safety Alerts Outstanding

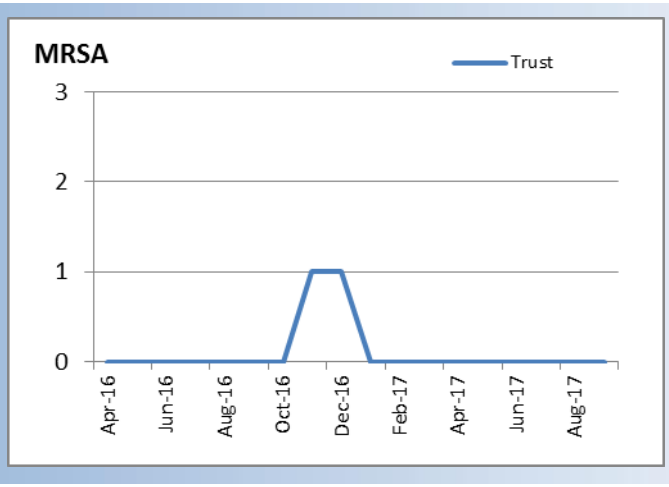
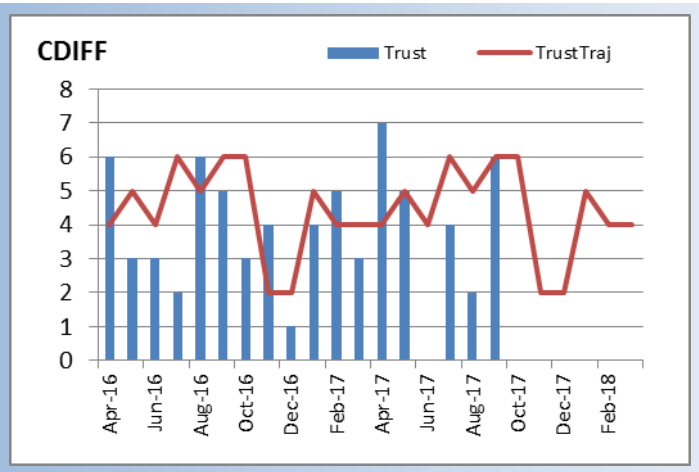
Number of alerts that are outstanding at the end of the month

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

There have been no outstanding alerts year to date.



SAFE

	Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust has reported 2 cases of acute acquired MRSA bacteraemia during 2016/17. There were no cases reported during September2017.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2017/18 is no more than 53 cases	There have been 18 cases year to date There were 6 incidents reported during September which achieved the monthly trajectory of no more than 6 cases		

SAFE

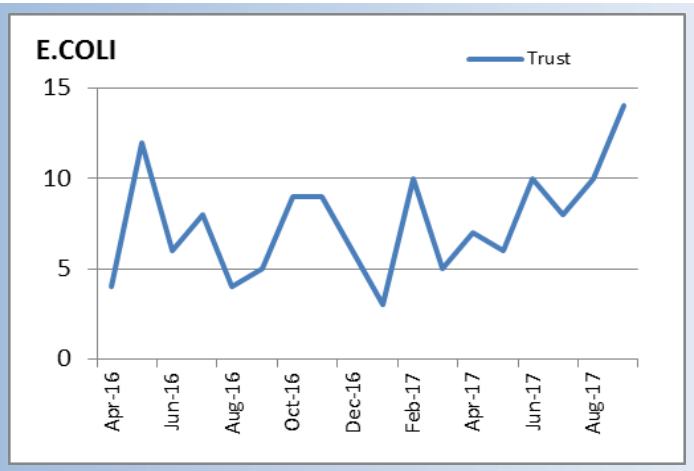
Description	Aggregate Position	Trend	Variation

Escherichia Coli

Number of incidence of E.coli bloodstream infections

There have been 55 cases year to date

There were 14 incidents reported during September.

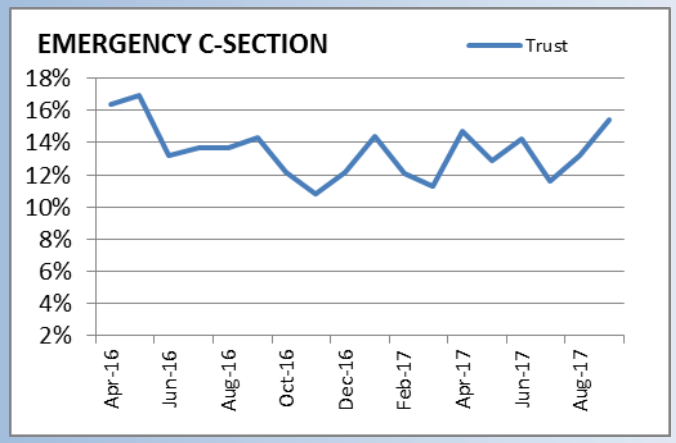


Emergency C-section rate

Maternity: Emergency C-section rate per month

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

Performance for September failed to achieved this standard at 15.4%



Further information is included in the Board Quality report

EFFECTIVE

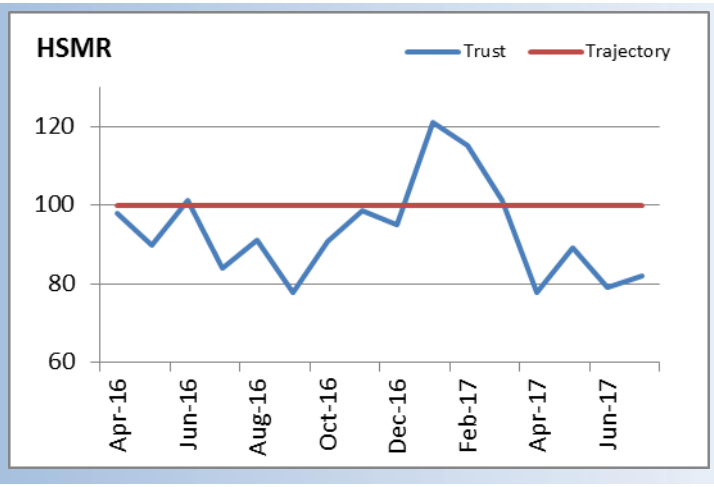
Description	Aggregate Position	Trend	Variation

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

July 2017 is the latest available performance

The standard for HSMR is to achieve less than 100 and July 2017 achieved this at 82.1

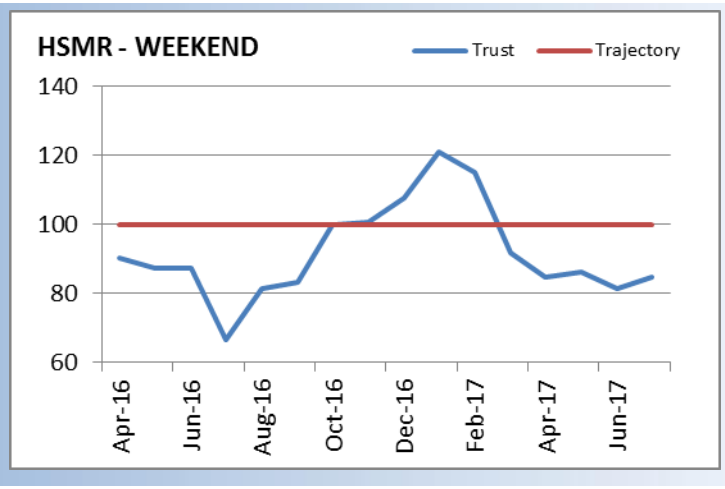


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

July 2017 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and July 2017 achieved this at 84.6



EFFECTIVE

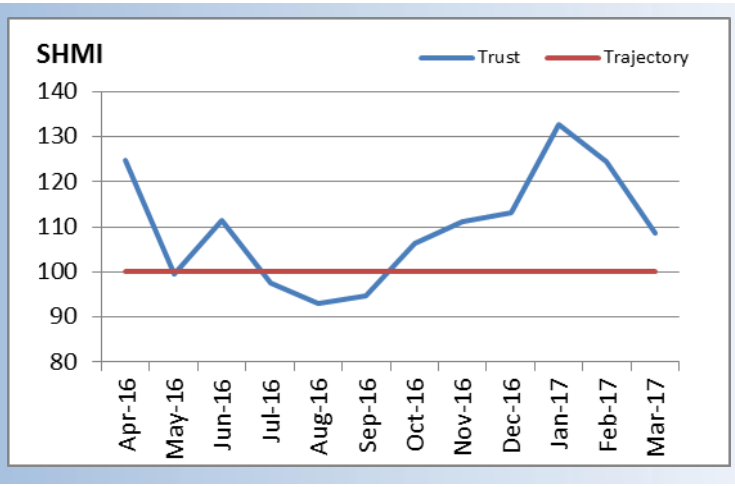
Description	Aggregate Position	Trend	Variation

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.

March 2017 is the latest published performance

The standard for SHMI is to achieve less than 100 and March 2017 failed to achieve this at 109

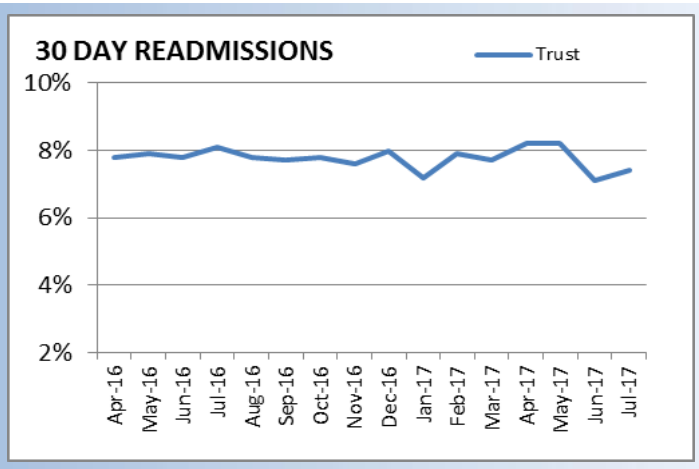


30 DAY READMISSIONS

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

The latest available performance is July 2017

The readmissions performance is measured against the peer benchmark position for 2016/17 to achieve less than or equal to 7.4%. The Trust achieved this measure with performance of 7.40%.



CARING

Description	Aggregate Position	Trend	Variation

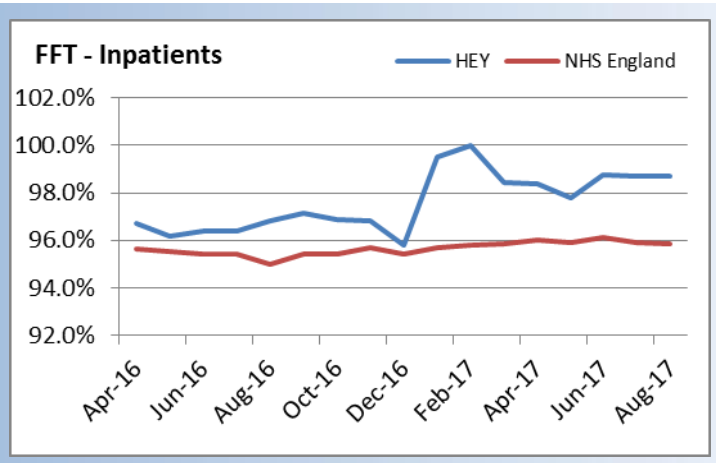
Inpatient Scores from Friends and Family Test - % positive

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

Performance for August was 98.7%

The latest published data for NHS England is August 2017.

September performance will be published on 9th November 2017.



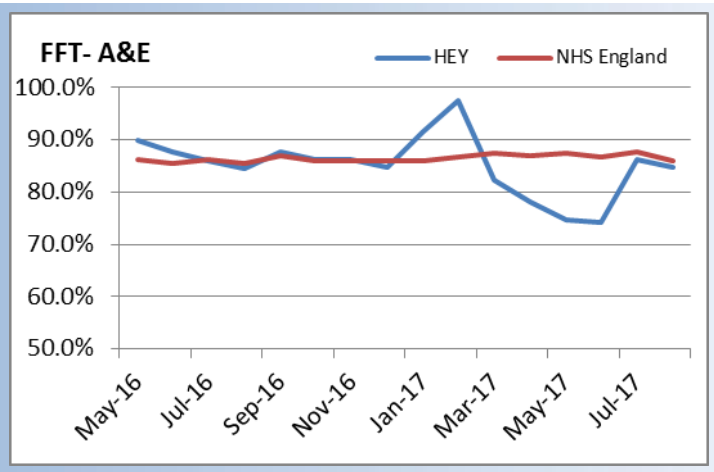
A&E Scores from Friends and Family Test - % positive

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

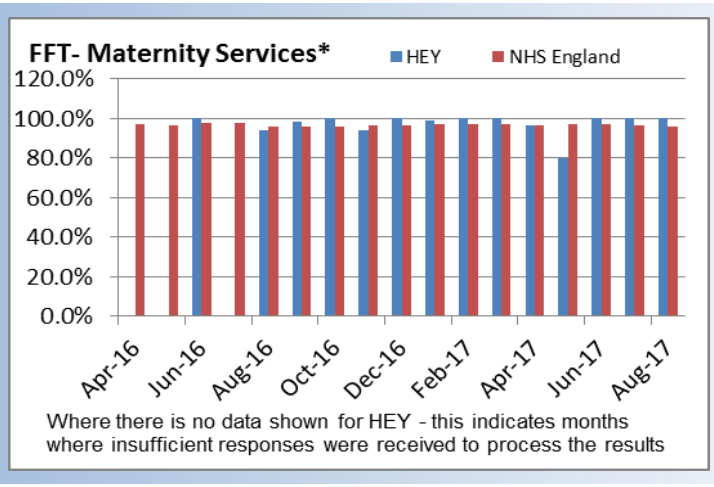
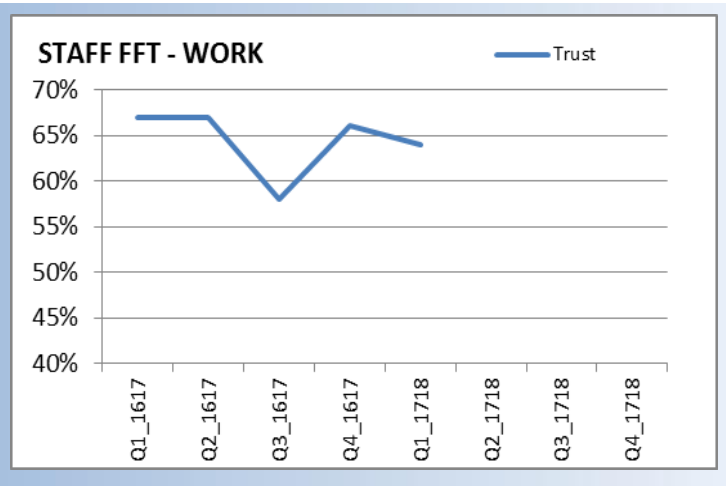
Performance for August was 84.8%

The latest published data for NHS England is August 2017.

September performance will be published on 9th November 2017.



CARING

	Description	Aggregate Position	Trend	Variation
Maternity Scores from Friends and Family Test - % Positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for August was 100% The latest published data for NHS England is August 2017. September performance will be published on 9th November 2017. Months with no data for HEY is due to insufficient responses		* Question relates to Birth Settings
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?	The latest Friends and Family Test position is quarter 1 2017/2018 shows that 64% of surveyed staff would recommend the Trust as a place to work, this has decreased from the quarter 4 position of 66%. The next release of staff FFT data will be 23rd November 2017 for Quarter 2 2017-18 data		

CARING

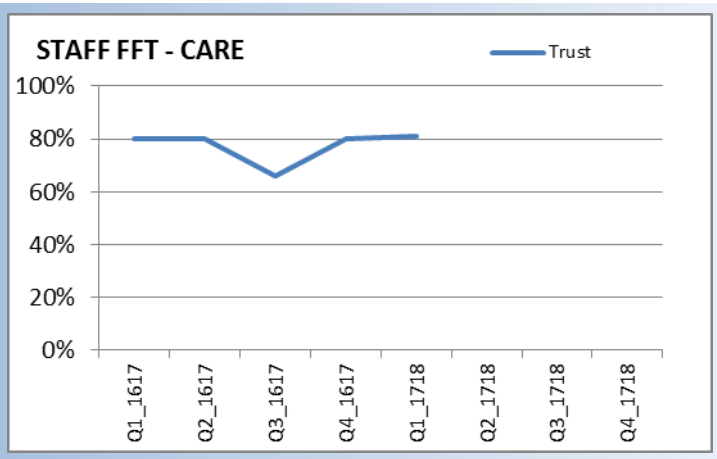
Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

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

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

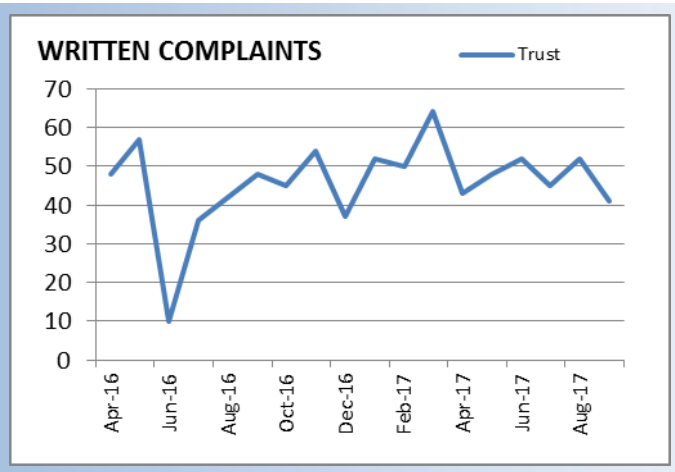
The next release of staff FFT data will be 23rd November 2017 for Quarter 2 2017-18 data



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 41 complaints during September, this is a decrease on the August position of 52 complaints

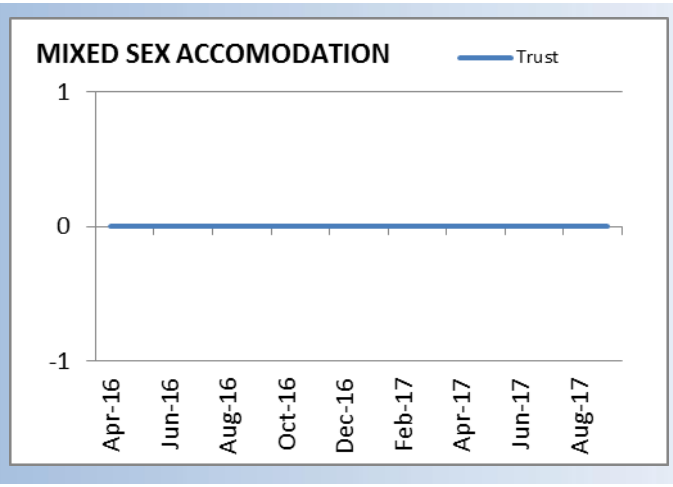


There have been 240 complaints year to date

CARING

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

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



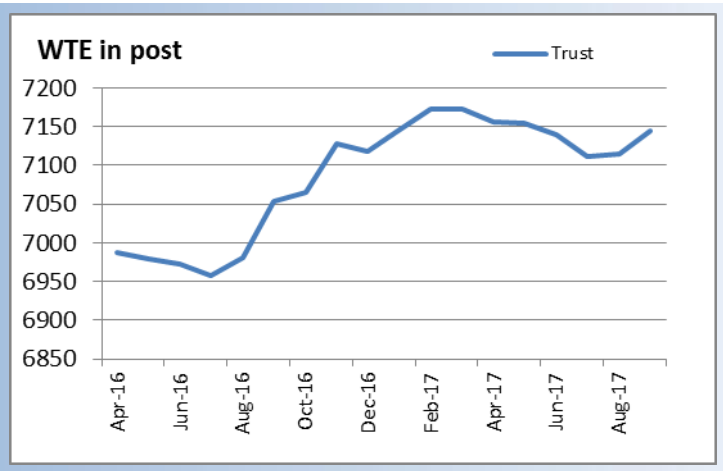
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

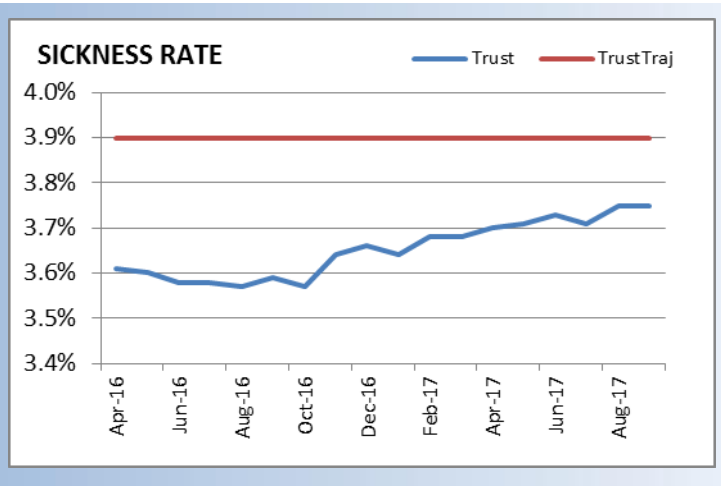
Trust level WTE position as at the end of September was 7145



Sickness Absence Rates

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

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



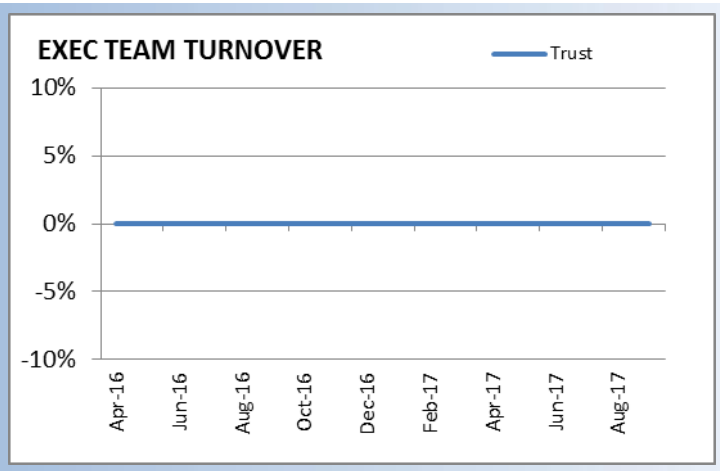
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

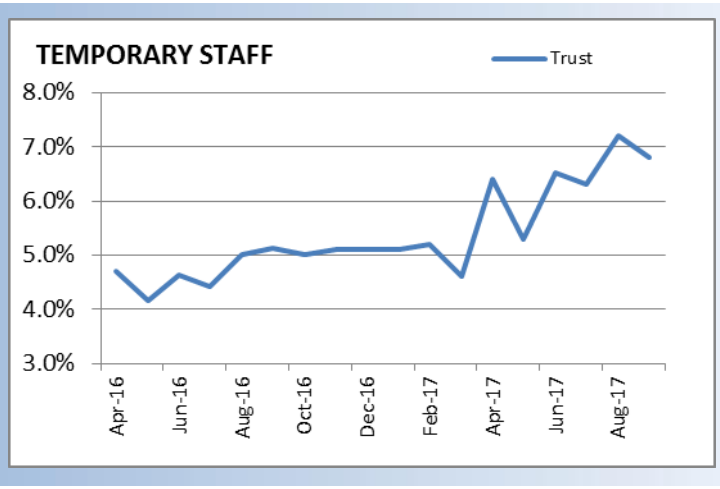


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

September performance was 6.8%



FINANCIAL SUMMARY: 6 MONTHS TO 30TH SEPTEMBER 2017

1. At the end of month 6 the Trust is reporting a deficit of £2.5m which is in line with the planned position..

2. This position is only possible following the release of 100% of the Trust's available full year reserves of £7.1m. This reported position therefore enables the Trust to assume receipt of £4.2m STF funding.

3. The Trust has a gross contract income gain of £3.6m . After adjusting for the allocation of income to HGs to reflect pass-through drugs & devices costs, there is a net shortfall of £1.8m which is an adverse movement of £0.4m in the month.

4. The Trust has a CRES shortfall at month 6 of £2.5m and would generally release 6/12ths of its CRES reserve (£0.75m) to reduce this to a deficit of £1.8m. However, as detailed in point 2, all reserves at 100% have been factored into the position to date in order to deliver the plan and therefore assume the STF funding.

5. Health Group run rate positions have deteriorated in month by £0.3m. Medicine's reported position shows an improvement of £0.03m on last month related to the release of a provision for medical pay arrears . Without this the position would have deteriorated by £0.13 in line with the previous month. Surgery's overspend reduced by £0.3m in month through a budget re-phase. Without this the position would have deteriorated by £0.3m. Both Clinical Support and Family & Women's HG reported adverse in-month movements. Lower activity income , particularly daycases, resulted in the Family & Women's HG variance being worse than trend, at £0.3m. Clinical Support HG's position moved £0.6m in month , which is £0.4m above previous trends and is mainly in non-pay expenditure, particularly Radiology devices.

6. Agency spend to the end of September is £5.4m which is slightly above planned levels (£34k).

7. Overall forecasts have remained similar to last month, with a slight improvement of £0.1m. There were minimal movements overall in Health Group forecasts, although an improved Medicine forecast offset a deterioration in Clinical Support. The financial information indicates a problem of £6.6m by year end if current trends continue. This is based on Health Groups being £10.7m overspent and £3m short on income, offset by the release of £7.1m of reserves. Immediate actions need to be identified to offset this potential £6.6m risk.

8. In line with published NHSI guidance the Trust is still reporting that it will achieve its year end financial plan however this is extremely challenging and requires the delivery of planned levels of expenditure or additional income in order for this to be realised. Discussions have commenced with local commissioners regarding the risk share approach in order to deliver the most favourable position for the system.

9. As previously reported, now that the contract payments have reverted back to equal instalment as opposed to tenths, the Trust's cash position is gradually worsening. This, coupled with the delayed receipt of STF income, results in additional pressure on the Trust and a loan application has been submitted in lieu of the £4.2m STF funding.

10. As previously reported, there is still the additional risk to the Trust forecast position relating to 0.5% of the CQUIN payment from CCGs (£1.6m) . Given the block nature of our main contract it is not clear whether this is a risk to the Trust. National debate is still ongoing between NHSI & NHSE over the treatment of these monies across the Acute sector.

11. The Trust has spent £7.2m of capital at month 6 and is forecasting to spend £19.9m during the financial year in line with plan, which includes the agreed extra £1m for ED Primary Care Streaming.

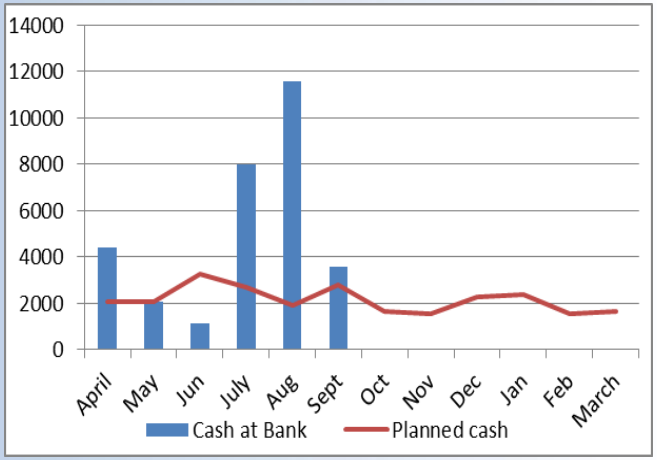
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of September was £3.567m, of which £3.55m was held in bank accounts, £0.017m in petty cash. We have managed to pay a large number of suppliers on time during September and this is reflected in our performance against the better payment practice code (BPPC), which has significantly improved. The outlook for cash from October to March is one of challenge as Commissioners realign contract payments resulting in £9m less cash in each of the last 6 months of the year. This will place significant pressure on relationships with suppliers and careful management will be needed to ensure the operational impact is minimised. We have requested a loan of £4.2m in lieu of quarter one strategic transformation funding (STF). The loan will be repaid once the STF is received but will help relieve some of the pressure on cash in the meantime.

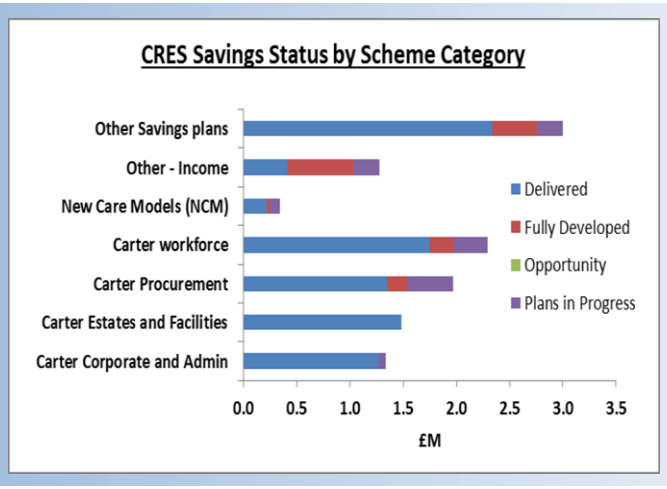


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 6 the Trust has delivered £4.1m of CRES savings against a CRES ytd plan of £6.6m (£2.5m adverse variance)

The Trust is currently forecasting delivery of £11.9m of savings against the plan but is still working to identify new schemes and revise its forecast to a more favourable one in coming months.



The target for the year is to save £15m.

The chart shows an analysis of year to date CRES in terms of fairly broad categories.

Description	Aggregate Position	Trend	Variation

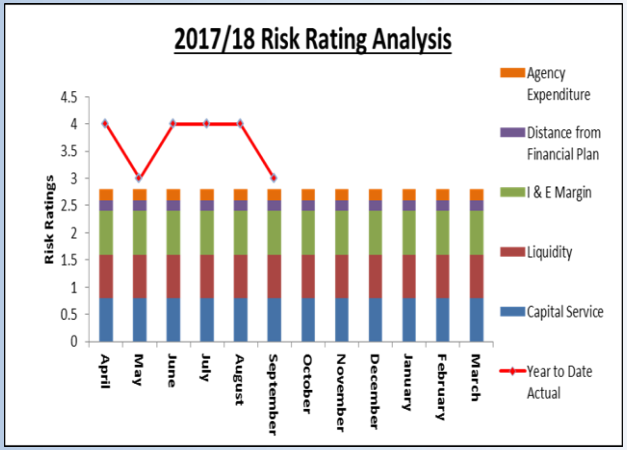
Risk Rating

Financial Sustainability Risk Rating

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

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

As at month 6 the Trust is reporting a deficit of £2.5m against a planned deficit £2.5m. This has resulted in liquidity and Capital servicing being rated as a 4, an I&E Margin rating of 3, distance from plan rating of 1 and agency rating of 2. This culminates in an overall risk rating of 3 which is the best risk rating score for the Trust since May.

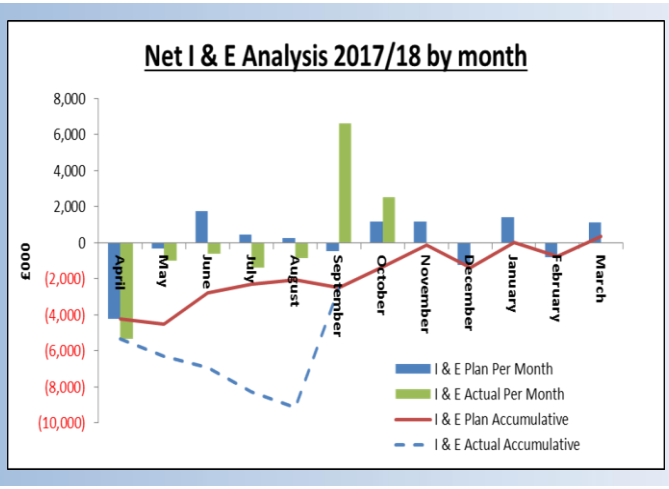


Income & Expenditure

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 a cumulative position of plan and actual.

At month 6 the Trust has delivered a deficit of £2.5m against a plan of £2.5m The plan for 17/18 is to deliver a surplus of £0.4m, this includes STP funding.



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE AND FINANCE COMMITTEE MEETING MINUTES
HELD ON 25 SEPTEMBER 2017

PRESENT:	Mr S Hall	Chair – Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD
IN ATTENDANCE:	Mr S Evans	Deputy Director of Finance
	Ms J Myers	Director of Strategy and Planning (Item 10 only)
	Mrs W Page	Nurse Director – Clinical Support (Item 8.2 only)
	Mr J Wood	Operations Director –Clinical Support(Item 8.2 only)
	Mrs R Wrightson	Head of Finance – Clinical Support (Item 8.2 only)
	Mr M Lowry	Head of Finance – Surgery (Item 8.2 only)
	Mrs D McLean	Nurse Director – Medicine (Item 8.2 only)
	Mrs M Kemp	Operations Director–Family and Women's(Item 8.2 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No. Item **Action**

1. APOLOGIES

Apologies were received from Ms C Ramsay, Director of Corporate Affairs and Mrs Drury, Deputy Director of Finance

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

The agenda was taken out of order at this point.

10. WINTER PLAN

Ms Myers attended the meeting to present the draft winter plan to the committee.

She advised that the key focus would be on optimising patient flow using models such as the frailty model. Discussions were ongoing with the Commissioners to identify the level of extra capacity required in the community. She advised that the Trust had a level of reserves set aside for the winter plan, but would not cover all the associated costs.

Ms Myers reported that there may be an extra allocation of winter funding available but this had not been confirmed. Action plans were being developed for the Christmas and New Year annual leave periods to ensure staff were available when required. The main concern was the staffing of the winter ward.

There was a discussion around staffing issues and reductions in length of stay and what impact this would have. Mr Bond advised that a minimum agreed level of doctors was being agreed by the Chief Medical Officer.

Resolved:

The Committee received the draft winter plan.

- The Committee requested a further update when details of Hull CCG's

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capacity planning known.

- Mr Hall referred to the existence of a minimum staffing plan, i.e. what are the minimum staffing levels needed in each clinical capacity to allow the Trust to function.

Ms Myers left the meeting.

8.2 – FIP2
Representatives from each Health Group were in attendance at the meeting to discuss the FIP process and how they found it.

There was a detailed discussion around how the FIP2 team had brought drive and focus to the teams but had not added any new CRES schemes to the projects. The Deloitte team had encouraged regular meetings, had given resource where required, pushed projects through more quickly and had strengthened governance arrangements. The Health Groups were keen to keep the momentum going and complete the CRES plans already in place.

A discussion took place around lack of ambition and the Trust being short term focussed and Mrs Kemp stated that staff were cautious but with the right guidance were advancing further. Mr Wood added that Deloitte had brought good analytical staff which brought focus and momentum. The Health Groups agreed this provided a catalyst for cross health group initiatives.

Resolved:
The Committee and the Health Groups discussed the next steps and agreed:

- The Health Groups would continue working on their CRES schemes to achieve the maximum amount possible for 2017/18
- Show ambition with new schemes
- Identify any resources needed to achieve their goals
- A "Close-out report" on FIP2 was being finalised and would be presented at the next Committee meeting.

The Health Group representatives left the meeting
The agenda reverted back to order at this point

3. MINUTES OF THE MEETING HELD 29 AUGUST 2017
Item 8.3 – FIP2 – Para 3 .."Dr Armistead advised that 95% of the project documentation…."
Para 5 - "Mr Bond assured the committee that the team would include financial improvements made as a result of improvement measurements and KPIs in place…"

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

4. MATTERS ARISING FROM THE MINUTES
Item 7 – Demand Report - Orthopaedic case mix review to be added to the action tracker **ML**

Item 9 – Ambulance Turnaround Times – Mrs Ryabov clarified that the meetings would be reinstated with YAS.

Item 11 – Workforce Transformation Committee – Mr Bond asked for clarity

around the number of nurses that had started working for the Trust. Mr Nearney to confirm. **SN**

Mr Nearney to forward exit interview information to the Committee members. **SN**

5. ACTION TRACKING LIST

Mr Evans agreed to circulate the list of CRES schemes with FIP2 input and add to the next CRES report. **SE**

GIRFT – Mr Hall to discuss with Mr Phillips the next steps regarding the strategy and reports to the Performance and Finance Committee **SH**

RTT Validation – Mrs Thompson to arrange an extra ordinary meeting at the end of October to include Quality and Performance and Finance members to discuss RTT validation and the patients with no actions against them.

6. WORKPLAN 2017/18

The workplan was reviewed by the committee. Mrs Christmas stated that because the winter plan had holiday (.i.e. Christmas and New Year) plans included in it this should be reflected on the workplan.

7. DEMAND REPORT

Mr Bond presented the report and advised that referrals were lower than last year's figures. Spire referrals had increased and NLAG referrals were again lower than last year. Activity in a small number of areas was also down on last year. Emergency Department attendances were still high at 360+ and non-elective admissions were below plan.

Resolved:
The Committee received the report.

8. CORPORATE FINANCE REPORT

Mr Bond presented the report and advised that the Trust's deficit was £7.1m, or £3.7m excluding STF. The underlying trading position had deteriorated by £0.7m in the month to £6.2m which consisted of £1.3m due to the block contract, £2.2m CRES shortfall and £2.7m of run rate issues.

Mr Bond reported that the rate of deterioration had slowed in month but that there was still work to do to achieve the year end targets.

Resolved:
The Committee received the report and Mr Hall agreed to write to each Health Group regarding their revised plans for 2017/18 delivery and initial plans for 2018/19.

8.1 – CRES Report

Mr Evans advised that progress was slow and more effort was required relating to new schemes. The Trust had delivered £3.2m of efficiency savings in month 5 and this was £2.2m short of the plan, equating to 60%. The Trust was still working towards the delivery of £15m by year end but the current forecast is delivery of £11.5m.

Resolved:
The Committee received the report.

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8.3 – Forecast Outturn
Mr Lowry presented the report which highlighted that the Surgery Health Group would achieve 81% of their CRES plan at the end of the year but had run rate issues of £3m.

Mr Lowry highlighted a number of issues such as the Health Group being down on non elective work, being behind plan on excess bed days, having non pay pressures and light activity occurring in August. These issues would be reviewed in the budgeting setting process for 2018/19.

Resolved:
The committee received the update.

8.4 – Financial Plan
Mr Bond presented the outline financial plan for 2018/19. The Trust is expected to achieve a £5.6m surplus next year which would mean delivering £23m in CRES schemes.

A number of concerns were raised such as the proposed increase in pay awards next year and CCG engagement with a flat cash contract rather than a block contract. CCG engagement and delivery of CRES schemes would be key in 2018/19.

The agenda was taken out of order at this point

13. CAPITAL RESOURCE ALLOCATION COMMITTEE
13.1 – CAPITAL PLAN 2018/19 – 2020/21
A brief discussion around capital requirements took place. The Committee was updated on the shortfall to be addressed over the next 3 years which was approximately £40m. A more detailed view of this would be presented to the next committee in October 2017.

Resolved:
The Committee received the report and Mr Hall agreed to highlight the capital issues to the Board.

9. PERFORMANCE REPORT
Mrs Ryabov presented the report and advised that A&E performance was on trajectory as was RTT. There had been issues around cancer performance and a number of cancellations due to significant levels of emergency patients displacing planned operations. Diagnostic performance was poor with endoscopy being highlighted due to above planned levels of activity. Endoscopy activity had increased by 20%.

Mr Gore asked why there had been an increase in 31 day treatment urgent cancellations and Mrs Ryabov advised that this was due to an increased number of fracture neck of femurs over a period of 3 days.

There was a discussion around the validation work ongoing to review patients found to be on the list with no action against them. Mrs Ryabov would be reporting to both the Quality and Performance Committees in October the results from this work.

Resolved:
The Committee received the report.

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10. WINTER PLAN

This item was taken out of order.

11. AGENCY SPEND PROGRESS REPORT

Mr Nearney presented the report and advised that the current spend was £4.4m with the highest costs in the Medical Health Group. Other issues were in Surgery (theatre staff) and recruiting medical staff. The Trust was working with the University to ensure that the number of student placements could be maximised going forward.

There was a discussion around the retention of staff and Mr Nearney advised that the Apprenticeship scheme was working well and would be rolled out further. This was helping with staff retention.

Resolved:

The Committee received the report.

12. E-ROSTERING REPORT

Mr Nearney advised that 132 rotas had been added to the system and were now linked to the payroll system. Mr Nearney advised that 2000 staff would need to be added to the system. As part of the Lord Carter initiative a business case was being developed in line with the new employee self service system. Once developed Mr Nearney would present it to the committee.

Resolved:

The committee received the update and agreed to receive the e-Rostering business case when available. **SN**

13. ***This item was discussed at 8.4***

14. PROCUREMENT STRATEGY

Mr Bond presented the procurement strategy and advised that work was ongoing to review purchase costs and benchmark against other Trusts. Mr Bond spoke about aggregated volume purchasing and stock reduction as key areas to drive costs down.

There was a discussion around purchasing hubs and Mrs Christmas asked if there was a hub for the Hull area and Mr Bond said that this would be reviewed as part of the strategy.

Resolved:

The Committee received the strategy and supported the programme.

15. BOARD ASSURANCE FRAMEWORK

Mr Hall presented the paper and asked the committee members to submit any comments to Ms Ramsay for inclusion in the next report.

Resolved:

The Committee received the report.

16. ITEMS DELEGATED BY THE BOARD

There were no specific items delegated by the Board.

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17. ANY OTHER BUSINESS

17.1 – SCAN FOR SAFETY PROGRAMME

The Scan for Safety report was presented to the committee for information.

17.2 – SUPPLY OF VASCULAR RADIOLOGY CONSUMABLES

The Committee was asked to approve the extension of the contract for a further 12 months until 30 June 2018.

Resolved:

The Committee approved the extension to the contract.

17.3 – SUPPLY OF A LINEAR ACCELERATOR

The Committee was asked to approve the awarding of the contract to Varian Medical Systems Ltd utilising the NHS Supply Chain framework.

Resolved:

The committee approved the awarding of the contract to Varian Medical Systems Ltd.

18. DATE AND TIME OF THE NEXT MEETING:

Monday 30 October 2017, 2.00pm – 5.00pm, The Committee Room, Hull Royal Infirmary

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE SUMMARY REPORT

30 OCTOBER 2017

The Performance & Finance Committee met on 30 October 2017. The following points were discussed/agreed at the meeting:

1. The month 6 Demand Report was presented and was showing a 4.3% reduction on referrals. Electronic referrals had seen a dip in June but since then were increasing. Contract performance was below plan with elective inpatient and day case activity being 5.5% lower than this time last year. This is mainly in Colorectal Surgery, Plastic Surgery, Interventional Radiology and Clinical Haematology. The Committee asked for further information on this at the next meeting. Outpatients is 4% below plan and more follow ups should have been done due to the drop in activity seen.

2. The Trust was reporting a deficit of £2.5m at the end of month 6, in line with plan. The Trust had released its full year reserve of £7.1m to achieve this. There was a net shortfall of £1.8m on income, a CRES shortfall of £2.5m and £3.5m Health Group cost pressures from run rates; the income position and run-rates deteriorated in-month and were driven by higher agency spend (£34k over budget) and non-pay expenditure.

3. As the Trust had achieved the plan at month 6 it had received £4.2m STF funding. Mr Bond highlighted the £6.6m gap to year-end as a risk and at present there was no plan in place to manage this. A recovery plan is being developedMr Bond had met with other Financial Directors to discuss the financial risks as a patch.

4. The Trust had a CRES shortfall at month 6 of £2.5m, which was a 38% shortfall. Progress on cost savings and efficiencies is being monitored including fortnightly meetings with Health Groups to assess performance. Particular concerns were raised regarding £3.1m of unidentified CRES for this financial year and £1.4m relating to plans in progress, yet to be fully developed. At month 6, the Trust released the entirety of its £1.5m delivery reserve.

5. The Carter Steering Group minutes were presented; Integrated Better Care Funds are being discussed in the health economy along with other initiatives being explored. Mrs Vietch advised that a task and finish group had been established to review discharge, Immediate Discharge Letters and pharmacy issues.

6. Mr Bond presented the close-out report on FIP 2 prepared by Deloitte. There was discussion around capacity to implement schemes and the transformational nature of a proportion of them, which would take additional capacity and resource to implement. Ms Myers advised that the HEY Improvement Team would be picking up the priority programmes and working with the Health Group Triumvirates to deliver them; Mr Bond confirmed that he and Ms Myers are putting in place the required PMO resource to continue to drive CRES and efficiency savings. An overview on progress for the 2018/19 financial planning process was requested and will be received at the next meeting.

7. ED performance was at 84.9% against the 90% improvement target in September 2017, with the main issues affecting performance around patient flow, maintaining the three consultant model and weekend consultant cover, and difficulties operating

the frailty model. There has been an increase in A&E attendances throughout the year compared with plan.

8. RTT was behind trajectory at 83.65% with the deterioration linked to the tracking access issues recently faced by the Trust. The Health Group Operations Directors were developing recovery plans. There had been 22 x 52 week waits reported in September 2017, with 20 of these being tracking access issues.

9. There were still performance issues with the cancer standards. 62-day screening stood at 60.7% (12 breaches within the month), which represents the worst performance for 12 months. Mrs Vietch reported that a £300k bid had been received and the funding was being used to improve the services' performance.

10. Diagnostic waits was discussed with endoscopy breaches highlighted. The Trust's performance is 9.3% against the 1% standard, and is the worst performance reported this year. This area was being discussed with the Health Groups and a Board Development session set for November 2017 to understand the impact in more detail.

11. Ms Myers attended the committee to discuss the 3 priority programmes the HEY Improvement Team were working on with the Health Groups. These were theatre utilisation, ward configurations and the outpatient programme.

12. The Board Assurance Framework was reviewed by the Committee.

13. An Outline Business Case Paper on an Energy Innovation Upgrade was presented to the Committee for them to recommend the case to the Board for approval. Mr Taylor set out the scheme which looked at six main energy saving schemes that could be put in place, replacing the Trust's boiler plant with new, energy efficient boilers. The energy efficiency measures would save the Trust £39m over 25 years. The Committee recommended that the scheme be presented to the Board, with the preferred option of applying for a loan to finance the efficiency schemes.

14. Mr Bond presented the outline Capital Programme 2018/19 – 2020/21 to the Committee which included equipment replacement, IT system upgrades and the backlog maintenance programme. The cost of funding the three-year programme would be £32m but access to such levels of capital are not fully determined.

Recommendations

The Board is asked to note the discussion held at the Performance and Finance and to consider the following items specifically.

- The gap in the CRES programme and the overspends at Health Group level, as well as release of full-year reserves
- To approve the Outline Business Case Paper - Energy Innovation Upgrade
- The emerging risk associated with a significant shortfall in capital funding for the next 3 years
- Growing performance pressures in cancer and diagnostics

Actions
The Board is asked to consider what further actions if any, are required to support the Trust's financial and performance position.

Stuart Hall
October 2017

NHS
Hull and East Yorkshire Hospitals
NHS Trust

Estate Strategy 2017 – 2022

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

Estates, Facilities and Development

Contents

Foreword

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

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

This strategy sets out to articulate the direction of travel over the next 5 years acknowledging that further work will be undertaken to develop the detailed delivery plans.

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

Duncan Taylor
Director of Estates, Facilities & Development

Chris Norman
Deputy Director of Estates, Facilities & Development

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

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

The directorate will seek to expand and provide its high quality, specialist services to public and commercial partners.

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

Our key strategic objectives are:

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

Trust Profile

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

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

Terry Moran CB
Chairman

Chris Long
Chief Executive

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

Backlog Maintenance to condition B +5 years
£64.4 million

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

We are also:

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

Land area of
53.5 Hectares
(132 acres)

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

Trust planned income 2017/18
£555 million

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

Directorate Profile

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

The Trust Strategy

The Trust Vision is:

"Great Staff, Great Care, Great Future"

The Vision is supported by:

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

The Trust Long Term Goals

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

Our Contribution

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

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

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

Estates, Facilities and Development

External Factors Influencing the Strategy

Sustainability and Transformation Plans STP's

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

The Humber Coast and Vale areas of focus are:

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

Humber Coast & Vale STP geographical footprint

Lord Carter Efficiency Review

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

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

reduce **non-clinical space to a maximum of 35%** of the overall Trust footprint.

April 2017: **33.28%**

ensure that **empty / underused areas would not exceed 2.5%** of the overall Trust footprint.

April 2017: **1.99%**

reduce energy consumption by investing in energy efficiency schemes.

2015/16: Upper Quartile

achieve median benchmark in **Soft FM costs** such as cleaning and patient food services.

2015/16: Upper Quartile

achieve the median benchmark for **Estates & Facilities** running costs.

2015/16: Upper Quartile

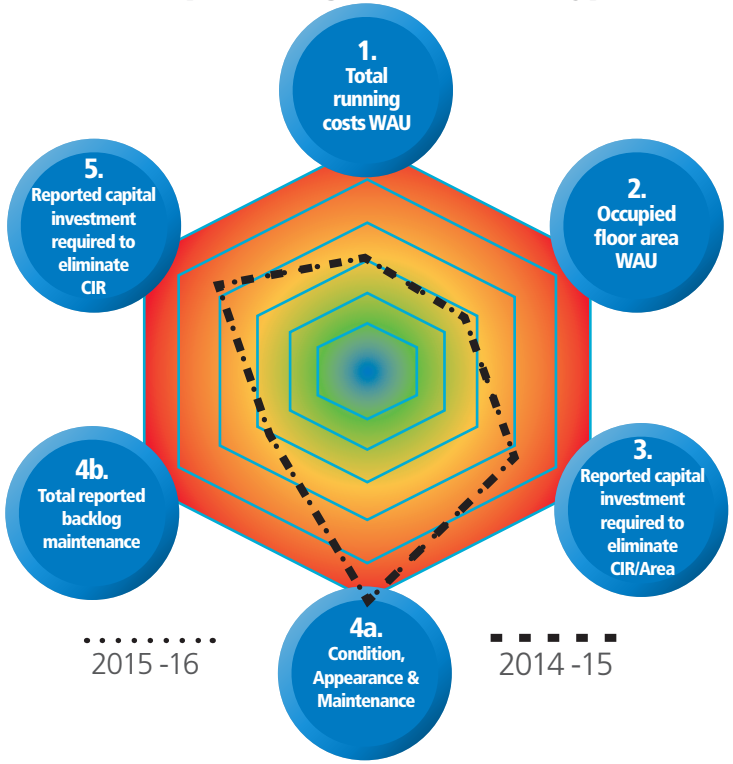
secure delivery of the plan by **April 2020**

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

Operational productivity and performance in English NHS acute hospitals.

An independent review by Lord Carter of Coles

Trust metrics plotted against the trust type median

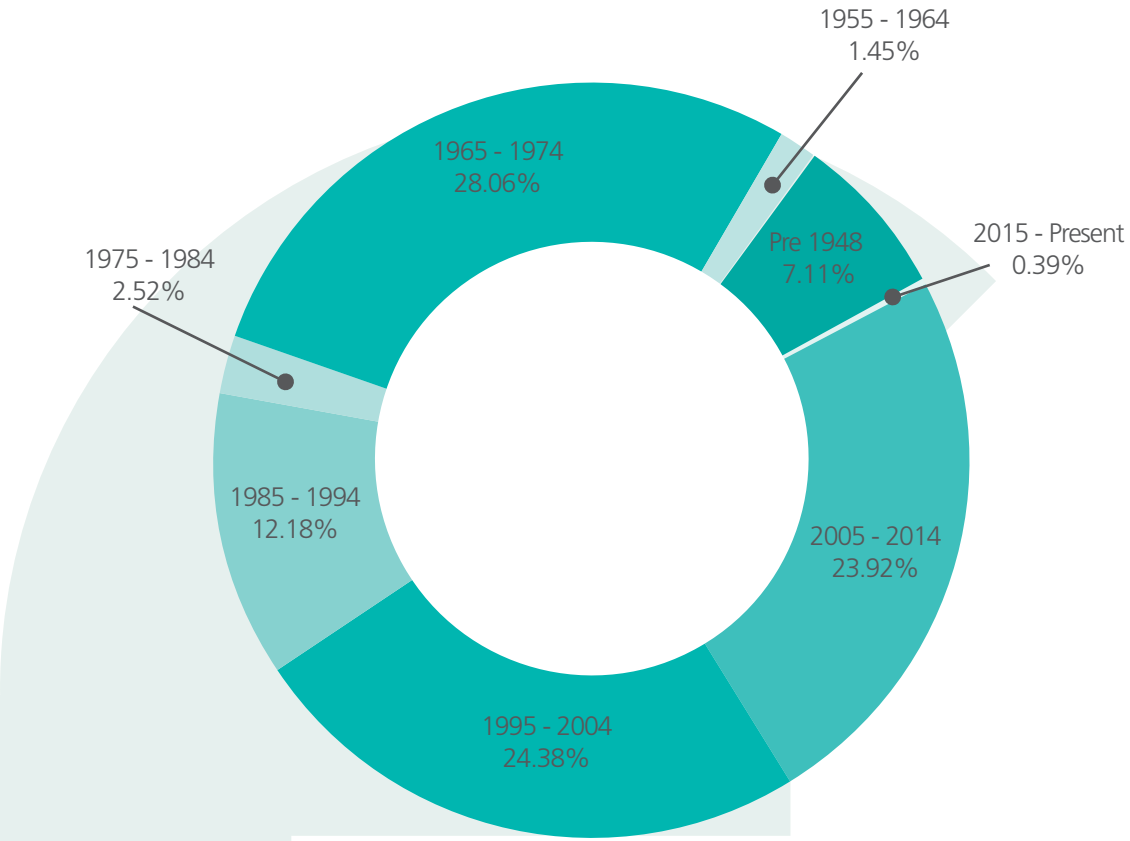


Estate Condition

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

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

Trust Building Age Profile by GIA (M2)



Please note: All costs associated to backlog include the recommended 40% uplift to allow for preliminaries and are the current Cost to B plus 5 years. PFI's and buildings not maintained by the Trust are excluded from these figures.

Total Trust Backlog
£64.4M

Physical Condition
£60.5M

High and Significant Risk
£30.3M

Statutory Compliance
£1.3M

High and Significant Risk
£0.7M

DDA
£2.6M

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

Hull Royal Infirmary, Tower Block

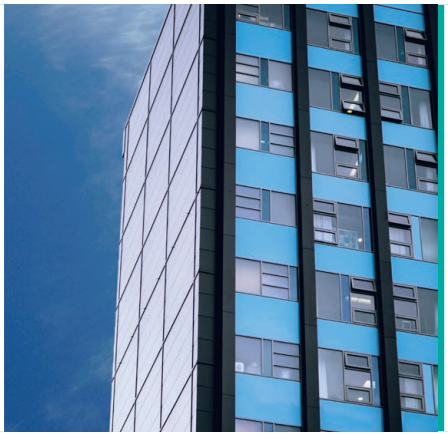
The Hull Royal Infirmary Tower Block opened in June 1967, and has played a significant part in the provision of healthcare to the local economy for the last 50 years. It can be seen from the information below that it is a considerable problem with regards to the Trust backlog maintenance in both risk and cost. However, clinically, it is the nucleus for all emergency admissions including operating theatres, critical care facilities, wards and clinical support services (e.g. Radiology and Pharmacy). Recently there has been significant investment into the Tower Block which means that it will most likely remain for the foreseeable future. This building is responsible for 80% of the Trust high and significant backlog and therefore the Trust needs to develop and approve an effective backlog maintenance reduction programme.

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

Total Backlog bill of **£35.1m** (54.4% of Trust)

23 wards

87% is clinical space



16 floors and **2,258** rooms

9 operating theatres

2 Adult Intensive Care Units

Emergency Department and Acute Admissions Units

Prioritised Backlog Maintenance Investment Profile

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

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

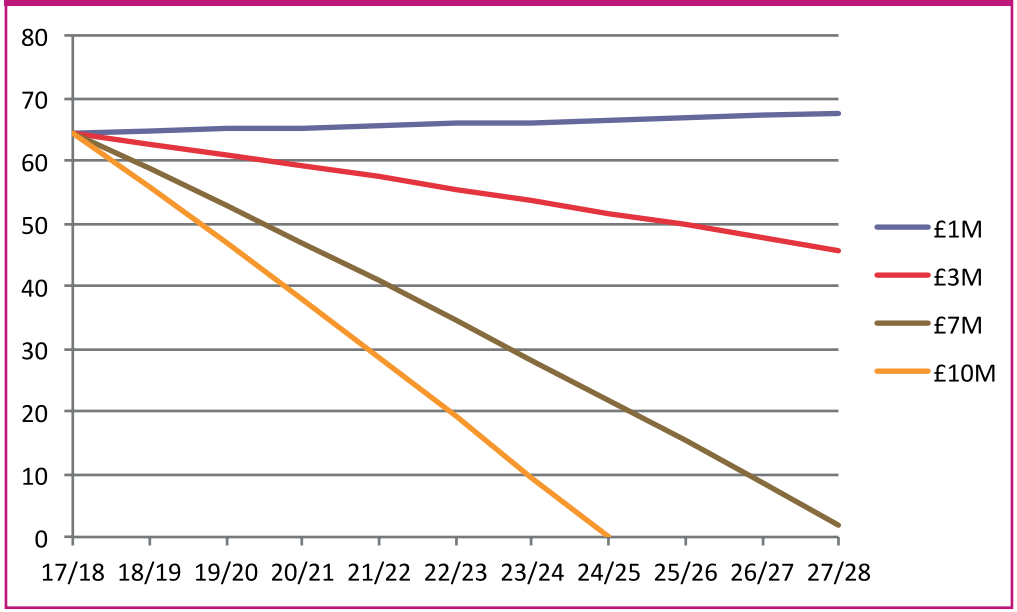
In order to ensure the Trust is best positioned to take advantage of any land disposal proceeds, an external review was commissioned to undertake a thorough review of the Trust's backlog position. The management consultants had undertaken a similar commission in 2009.

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

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

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

Backlog investment profiles



Programme Content

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

Estate Rationalisation

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

Haughton Building (West): to be demolished mid 2017

Finance Building: demolished mid 2017

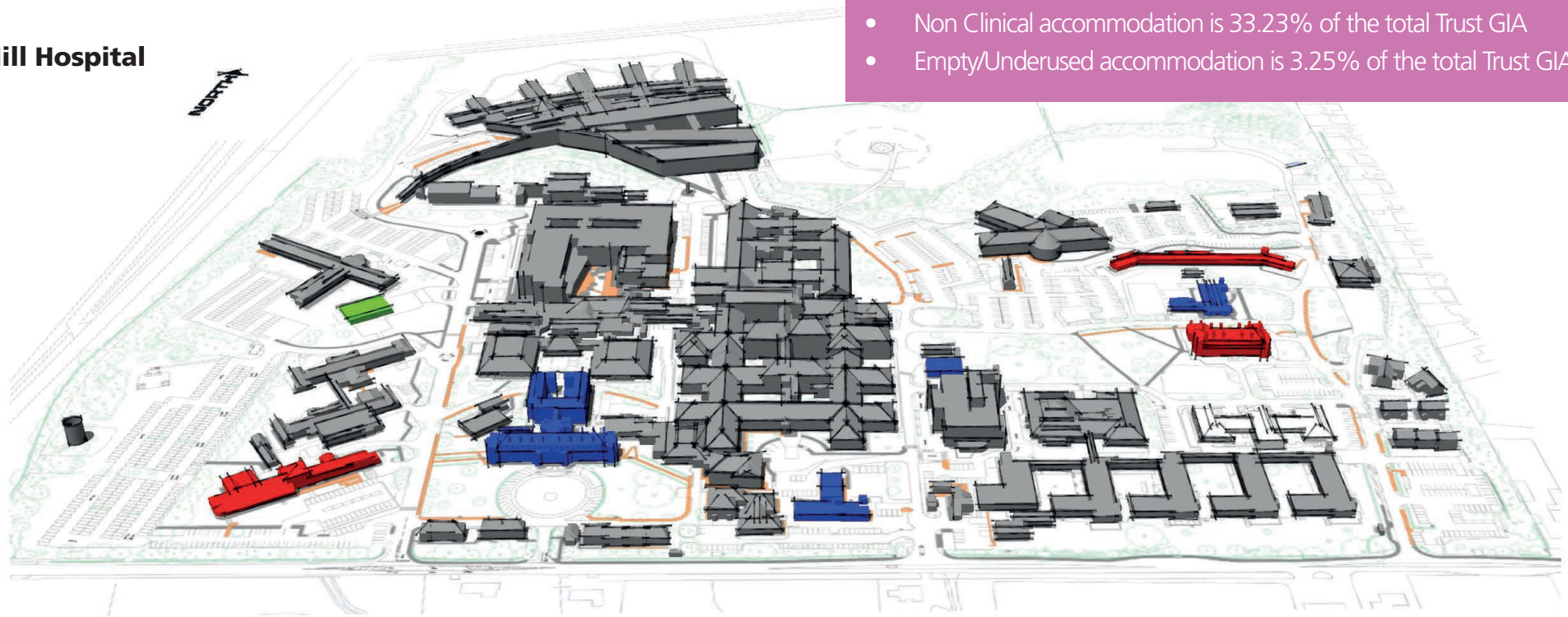
Estate Rationalisation Programme

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

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

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

Castle Hill Hospital



Please note: All costs associated to backlog exclude the recommended 40% uplift to allow for preliminaries and are the current Cost to B plus 5 years. PFI's and buildings not maintained by the Trust are excluded from these figures.

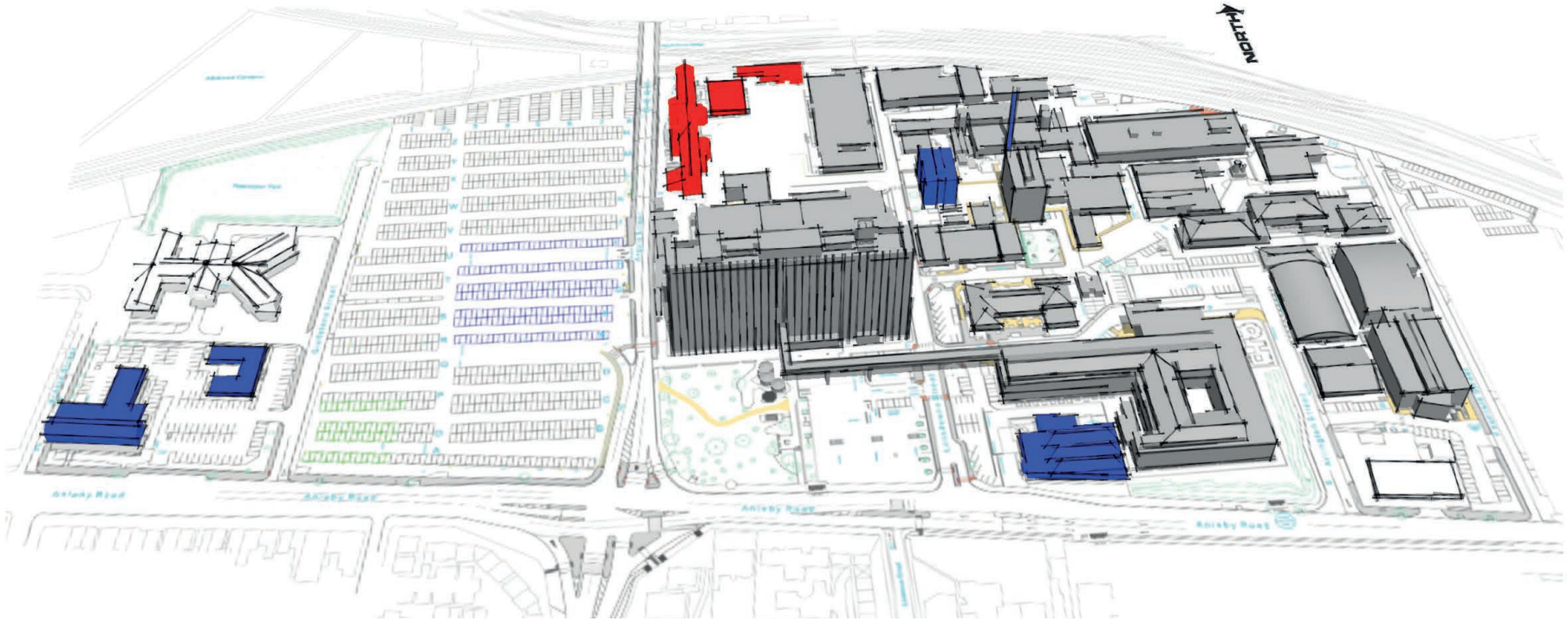
Completion of Phase 2 it will deliver the following:

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

Key

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

Hull Royal Infirmary



Capital Development

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

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

Capital Programme 2017 – 2019

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

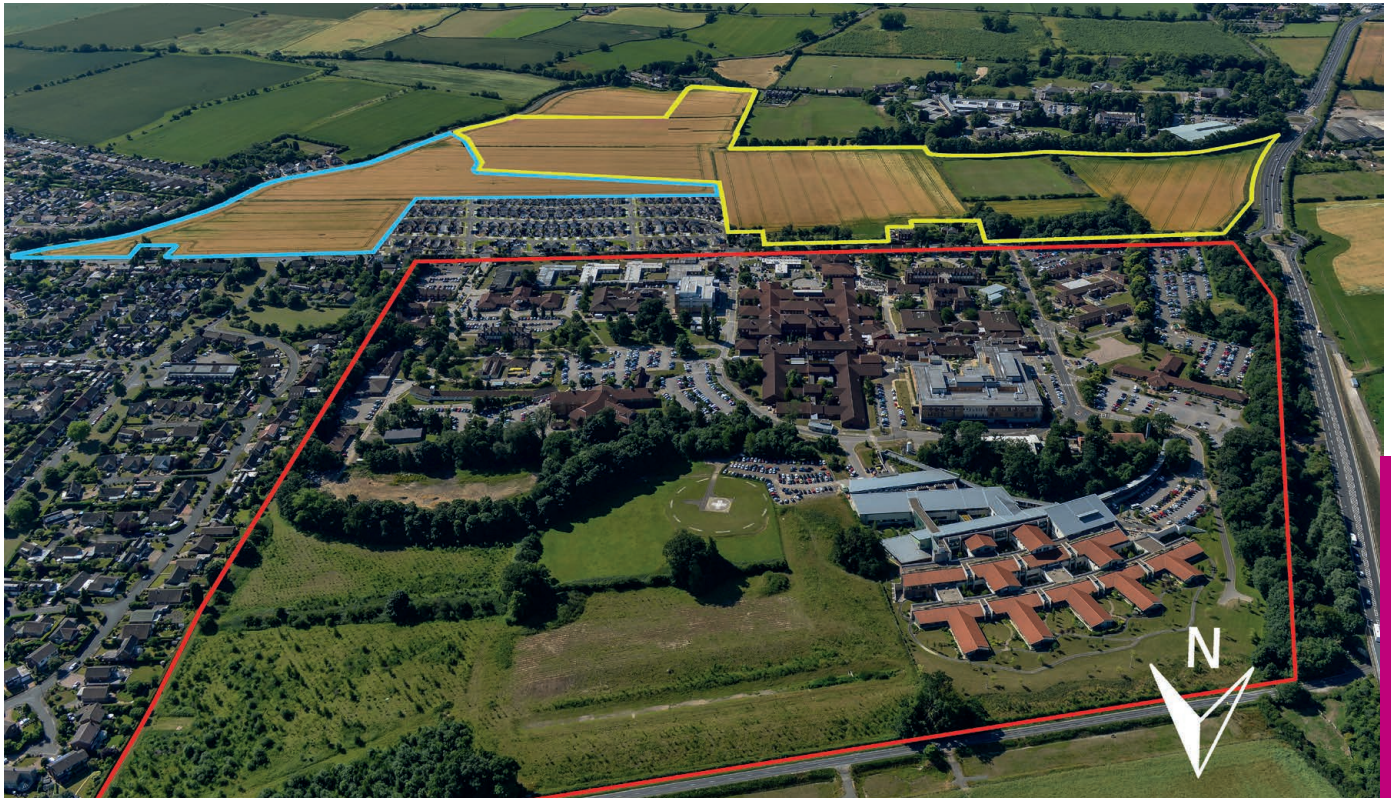
The programme is also funding the continuing works associated with the improvements and resilience of the IM&T infrastructure. Additional information is available in the IM&T Strategy.

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

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

Property Services

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



Key

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

Castle Hill Hospital

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

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

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

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

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

Castle Hill Hospital
17.4 hecatres of surplus land

Hull Royal Infirmary
4.3 Hecatres of surplus land

Hull Royal Infirmary

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

Future Development Zones

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

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

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

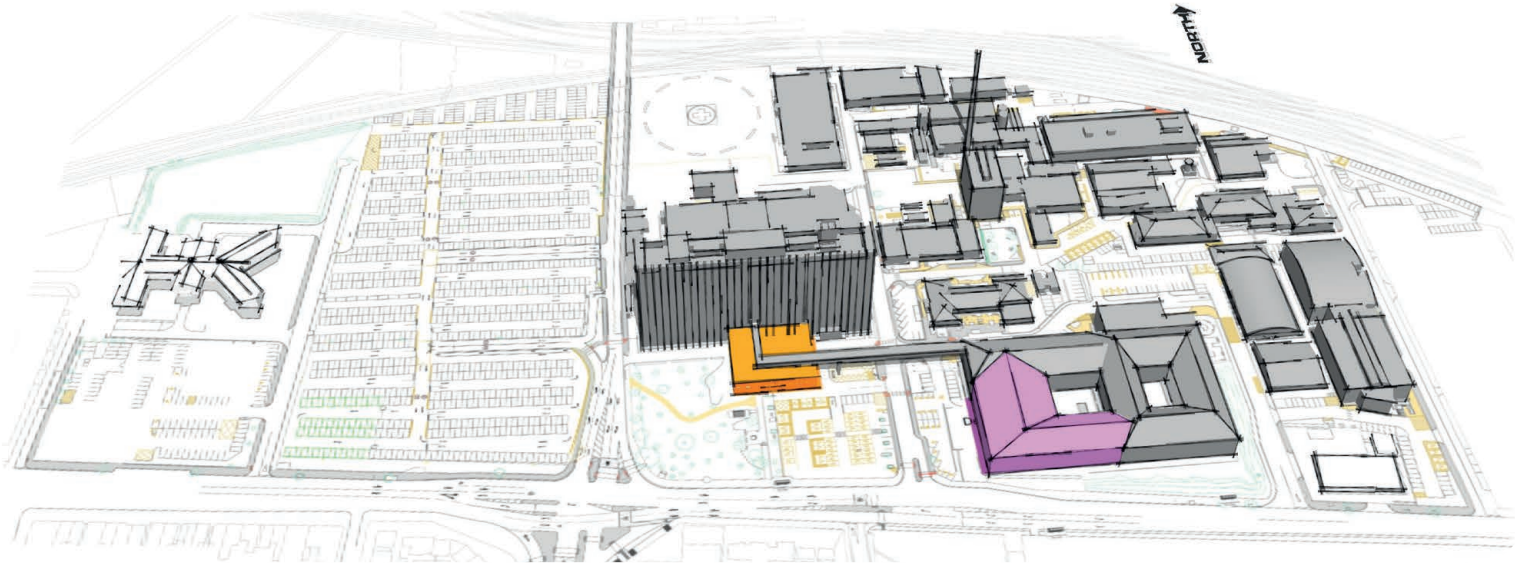
Opportunities for the development of new state of the art clinical accommodation with links to current facilities via existing hospital streets, which will improve the overall patient experience

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

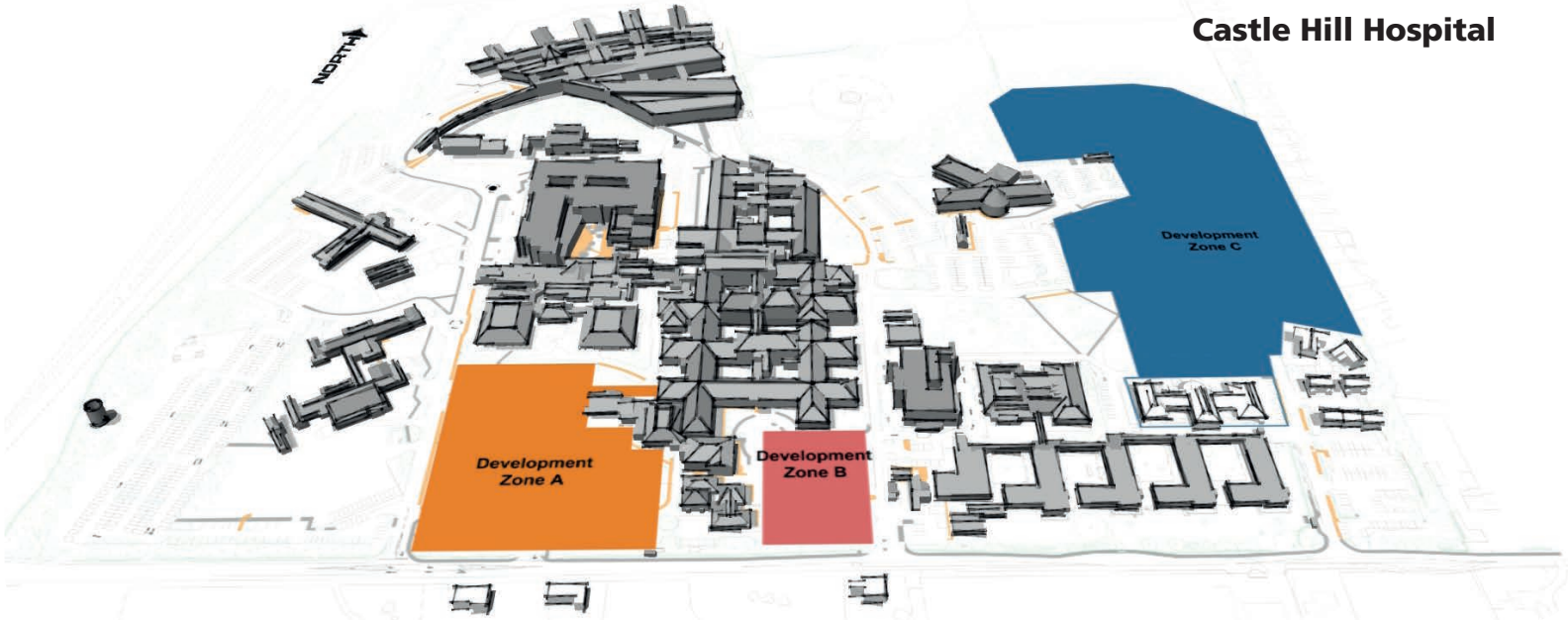
Enabling the Trust to respond to decisions based on clinical strategies and developments as determined by the STP.

In conjunction with the demolition works scheduled for the Hull Royal Infirmary and Castle Hill Hospital sites and any land disposal at the respective sites it is important that future development zones are identified. At the Hull Royal Infirmary there is a potential development zone adjacent to the Women and Children's Hospital. There is also the provision of a development site for the front retail development when plans progress to delivery and construction. Whilst no developments have been identified for the Castle Hill Hospital site, areas that have development potential have been illustrated along with direct connections to hospital streets for two of the three development zones.

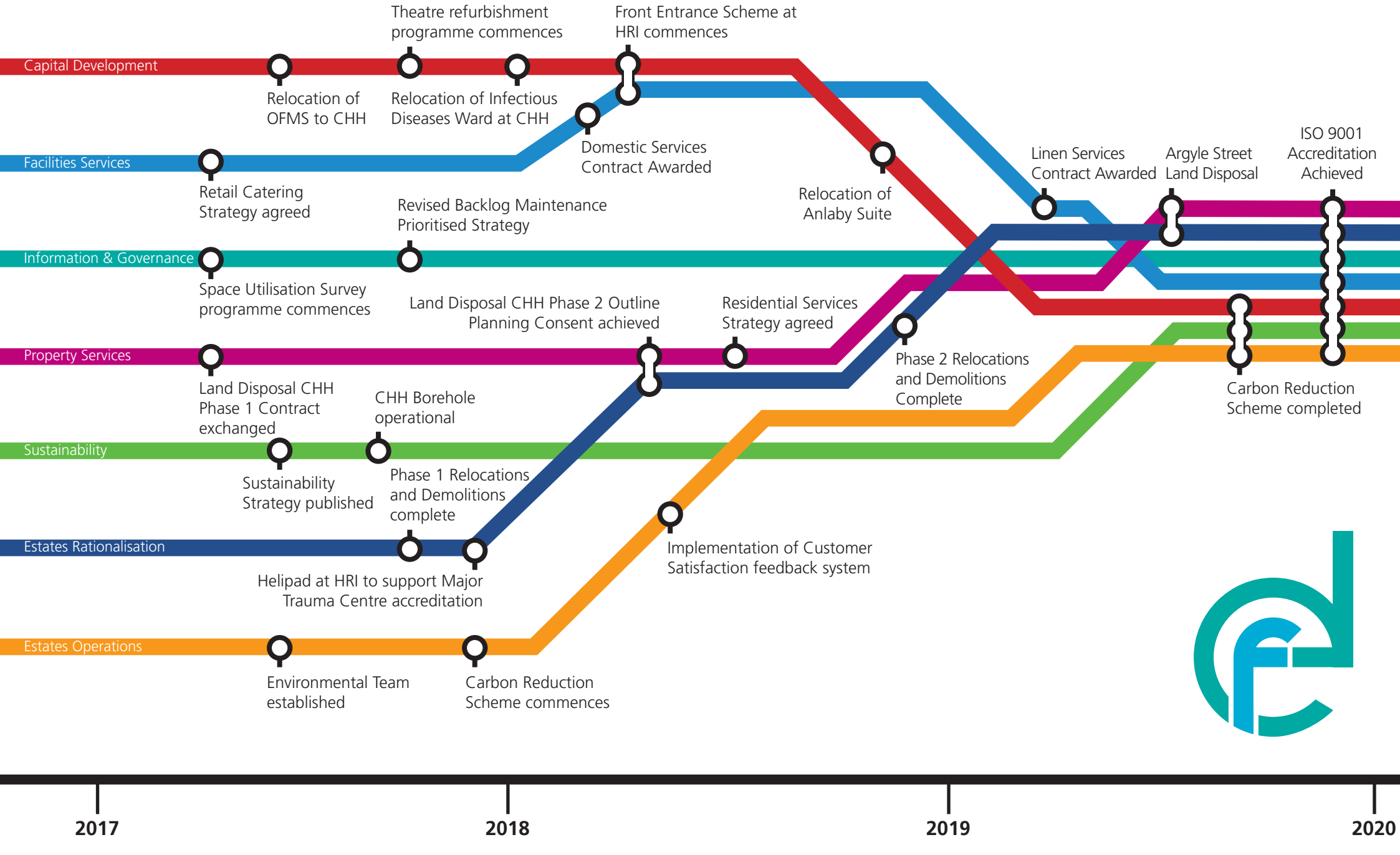
Hull Royal Infirmary



Castle Hill Hospital



Estate Strategy Timeline



Customer Satisfaction

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

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

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

How do you rate our service?

Good

Average

Poor

Estates Operations

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

Facilities Services

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

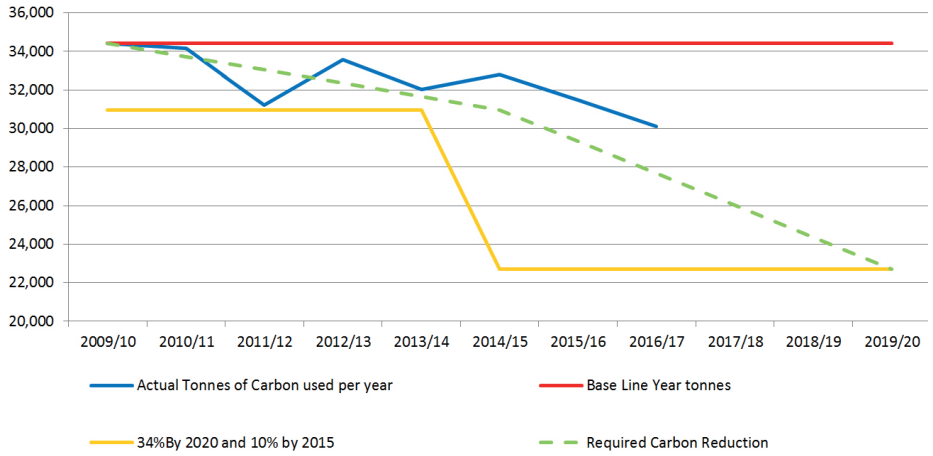
Sustainability *(further detail available in Sustainability Strategy)*

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

UK Government Carbon Reduction Targets

34%
by 2020
80%
by 2050

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



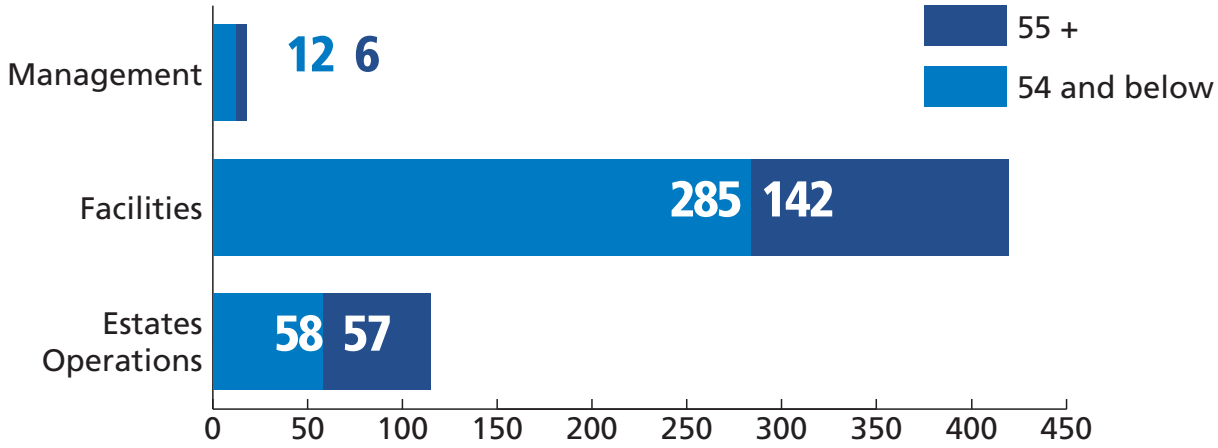
Workforce

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

42.6%

of the directorate workforce are aged 55+ years of age

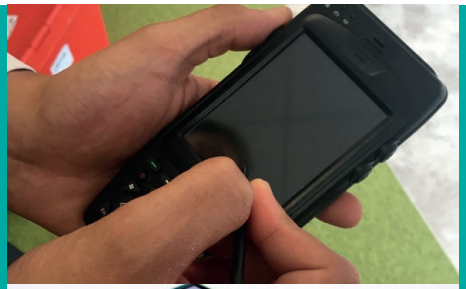
Age profile for Estates, Facilities & Development Personnel 55 years of age and above



Information & Governance

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

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



Electronic Sensors used to provide evidence based Space Utilisation data.

Directorate Compliance Framework

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

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

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

Estates, Facilities and Development

Version 2017 / v 4

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

OUTLINE BUSINESS CASE

THE DEVELOPMENT OF THE ENERGY INNOVATION UPGRADE SCHEMES

Trust Board	7 November 2017		**Reference Number**	2017 – 11 - 16		
Director	Lee Bond – Chief Financial Officer		**Author**	Duncan Taylor Director of Estates, Facilities & Development Paul O'Meara Head of Finance Estates, Facilities & Development		
Reason for the report	The purpose of this OBC paper is to seek approval from the Trust Board and NHS Improvement ("NHSI") to proceed with the development of a preferred solution for an energy infrastructure design and upgrade for both the Hull Royal and Castle Hill sites.					
Type of report	Concept Paper		Strategic Options		Business Case	✓
	Performance		Information		Review	

1	**RECOMMENDATION** 1) The Trust Board to approve the OBC. 2) Approve the release of the OBC to NHSI for consideration/approval to progress and develop the detail to the Full Business Case stage. 3) Support the £13.7m loan application, once notification has been received from NHSI, that the OBC has been approved.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					✓
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework	**Raises Equalities Issues?**		**Legal advice taken?**		**Raises sustainability issues?**
5	**BOARD/BOARD COMMITTEE REVIEW**					

OUTLINE BUSINESS CASE

THE DEVELOPMENT OF
ENERGY INNOVATION UPGRADE SCHEMES

OUTLINE BUSINESS CASE

THE DEVELOPMENT OF ENERGY INNOVATION UPGRADE SCHEMES

CONTENTS

GLOSSARY

AHU	Air Handling Unit
BIS	Business Innovation and Skills
BMS	Building Management System
CEF	Carbon and Energy Fund
CHP	Combined Heat and Power
CIP	Cost Improvement Programme
CPM	Construction Project Manager
DHW	Domestic Hot Water
DNO	Distribution Network Operator
ECA	Enhanced Capital Allowances
ESPT	Energy Saving Project Team
FBC	Full Business Case
FC	Financial Close
GIA	Gross Internal Area
HEY	Hull and East Yorkshire Hospitals NHS Trust
ITMC	Invitation to Mini Competition
ITT	Invitation to Tender
KPI	Key Performance Indicators
LTHW	Low Temperature Hot Water
MBH	Main Boilerhouse
MCR	Maximum Continuous Rating
MRI	Magnetic Resonance Imaging
NHSI	NHS Improvement
NPC	Net Present Costs
OBC	Outline Business Case
OPD	Outpatients Department

GLOSSARY (cont'd)

PPE	Post Project Evaluation
PUBSEC	Public Sector Building Non Housing
QIPP	Quality, Innovation, Productivity and Prevention
RHI	Renewable Heat Incentive

1. EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The purpose of this Outline Business Case ("OBC") is to seek approval from the Hull and East Yorkshire Hospitals ("HEY") NHS Trust Board and NHS Improvement ("NHSI"), for a £13.7m loan application, to proceed with the development of a preferred solution for an energy infrastructure design and upgrade on the Hull Royal Infirmary and Castle Hill Hospital sites. The existing provision requires enhancement and replacement as the current energy facilities have exceeded the end of their useful life and are no longer fit for purpose.

1.1.2 The energy solutions to be considered will utilise the latest energy efficient technology and provide the sustainable infrastructure to deliver the Trust's obligations to reduce carbon emissions and to meet its energy conservation targets. The preferred scheme should assist the Trust:-

- in achieving compliance with the 2020 target carbon reductions set out by the National Sustainable Development Strategy
- in producing carbon energy and financial savings
- in contributing to the vision set out by Lord Carter in his report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" published in February 2016
- in reducing backlog maintenance
- in meeting the infrastructural needs of the Trust in the most cost effective way through long term sustainable development.

1.1.3 Energy consumption by the Trust has been increasing as a result of new and extended development on the Hospital sites, and new medical technologies being introduced which are increasingly energy reliant. Such energy usage is consuming an increasing proportion of Trust resources and it is proposed that improving the energy infrastructure will go some way to readdress the balance.

1.1.4 The table overleaf shows the total energy costs for HEY in financial years 2016/17 and 2015/16:-

HEY Energy Costs Over Previous 2 Financial Years

	2016/17		2015/16	
Energy	**HRI £000's**	**CHH £000's**	**HRI £000's**	**CHH £000's**
Gas	1,002	880	1,126	810
Electricity	1,283	1,621	1,115	1,493
Total by Site	**2,285**	**2,501**	**2,241**	**2,303**
Total by Year		**4,786**		**4,544**

1.1.5 The expenditure on both gas and electricity totalled between £4.6m and £4.8m over this period. These figures show that by investing in new energy infrastructures there is scope for significant savings to be made. Therefore, it is imperative that the Trust looks at ways of reducing its energy costs thereby contributing to improvements in the Trust's financial position and delivery of its control total.

1.2 The Strategic Case

1.2.1 This Section of the OBC addresses the strategic reasons for the business case in working towards achieving the following:

- working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets
- to reduce energy costs and create efficiency savings
- contribute to the vision set out by Lord Carter in his report 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations' published in February 2016
- acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance
- meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development

1.2.2 The Trust is committed to reducing its energy costs and carbon emissions and has already taken some steps to improve energy performance and save carbon through:-

- insulation programme at the Hull Royal Infirmary and the Castle Hill Hospital, consisting of insulation improvements in the boiler house and steam distribution system. Others include lighting improvements and upgrades to the building management systems on both sites. Energy savings achieved to date of 1% to 1.5% from 2010 onwards.

- the refurbishment of an existing second hand 700kWe natural gas CHP at the Hull Royal Infirmary in 2009.

1.2.3 The Climate Change Act 2008 sets out the UK's legally binding targets for CO_2 emission reductions. The Committee for Climate Change is an expert, independent statutory public body created by the Climate Change Act 2008 to assess how the UK can best achieve its emissions reductions target for 2020 and beyond.

1.2.4 The table below shows the Trust's Annual CO_2 Performance Return figures, measured against the baseline year of 2009/10, from which the national target reduction of 34% is measured:-

Year of Return	Total CO2 Tonnes	Change in CO2 from 2009/10
2009/10	34,417	baseline
2010/11	34,154	(263)
2011/12	31,213	(3,204)
2012/13	33,570	(847)
2013/14	32,017	(2,400)
2014/15	32,798	(1,619)
2015/16	31,469	(2,948)
2016/17	30,098	(4,319)

CO2 Reduction Target by 2020	**(11,702)**

1.2.5 The figures show that HEY, based on using the existing energy infrastructure and minimal investment is not on trajectory to meet the 34% CO_2 target of a reduction of 11,702 tonnes by 2020.

1.2.6 The Trust has evaluated further opportunities to drive savings through efficient, low carbon energy generation, the main one being the option to install further Combined Heat and Power ("CHP") capacity at Hull Royal Infirmary ("HRI") and a new CHP at Castle Hill Hospital ("CHH"). A feasibility study on these options has already been completed by Ove Arup and Partners Limited and a high level energy survey in support of the proposed options has been completed by Sinclair Knight Merz ("SKM"). These reports are attached under Appendix 3a and 3b. A further feasibility study was completed by the Carbon and Energy Fund ("CEF") to establish the case for investment at HEY's HRI and CHH sites. The CEF feasibility report is attached as Appendix 4.

1.2.7 The case for change can be summarised as:-

- to realise energy cost and carbon savings
- to comply with the recommendations set out by Lord Carter in generating energy efficiency savings
- there is a need to enhance and install CHP support for both hospital sites as the majority of the existing heat and energy plant

at HRI is aged and not fit for purpose in places. The CHH site needs to better manage demand capacity constraints

- the Trust is required to deliver at least a 34% reduction in its carbon emissions by the year 2020. This target would be impossible to meet with the existing plant and infrastructure, and will require investment in innovation equipment

- savings in Estates costs are needed to offset increased demand and require a step change in efficiency of energy generation

- the Trust needs to secure heat, hot water and steam generation in the long term for both sites to support future development.

1.3 The Economic Case

1.3.1 The feasibility studies described in Section 1.2.5 have assisted the Trust in determining the best way forward and potential optimum solutions for their two hospitals; HRI and CHH. These reports set out the current plant configuration and energy base line position and identified potential solutions for improving energy plant resilience, energy fuel supply resilience, energy performance and energy efficiency, leading to substantial reductions in carbon emissions and overall utility cost.

Hull Royal Infirmary

1.3.2 The HRI is located in Hull centre and is comprised of buildings of a mixture in age surrounding the dominant building; a 50 year old fifteen storey tower block.

1.3.3 The site requires heat only for space heating and hot water. Due to the history of the site (in the past there were sterilisation activities and laundry activities on site) most of the heat is generated through steam raised in a central energy plant. The boiler house contains 50 year old steam raising boilers converted from coal firing to natural gas and oil dual fuel burners alongside an ageing 700 kWe CHP.

1.3.4 Analysis indicates that the site can accommodate a new larger 1.562MWe CHP engine and benefit from the renewal of the ageing boiler plant.

Castle Hill Hospital

1.3.5 CHH is a former isolation hospital set in a rural landscape of over 41 hectares and is located approximately six miles to the east of HRI. The buildings are a mix of ages with some modern buildings forming core clinical service areas. CHH has seen significant expansion in the last 20 years with new Cardiology and Oncology blocks, and is now a similarly sized hospital from an energy usage point of view to HRI.

1.3.6 A new energy centre was installed approximately ten years ago and contains 4 steam raising boilers. Other than the aspired addition of a CHP system, this leaves little or no requirement for further refurbishment of heat raising services. While there is currently no existing CHP system at CHH, it was anticipated by the Trust that this hospital site could accommodate 1.6 – 2 MWe of CHP engine capacity.

Options

1.3.7 The scope of the proposed capital works based on the findings of the feasibility studies by Arup, SKM and the CEF considered the following projects under each of the short-listed options:-

Summary of the Energy Capital Scoped Projects

Project	Capital Project breakdown:
1	The replacement of the combined CHP plant for HRI inclusive of a new absorption chiller system.
2	A new CHP plant for CHH inclusive of a new absorption chiller system.
3	Replacement of ageing and obsolete boiler plant at HRI
4	LED lighting replacement and upgrading of fittings at HRI
5	LED lighting replacement and upgrading of fittings at CHH
6	Installation and integration of a Buildding Management System at both HRI and CHH

Following a review of available options the minimum four short-listed options that were considered for further evaluation included:-

- **Option 2:** Do minimum – included despite being ranked 7 as this provides a benchmark for value for money ("VFM") throughout the appraisal process. This "do minimum" of Option 2, which provides a benchmark for VFM, was agreed by the Energy Saving Project Team as being the replacement of ageing and obsolete boiler plant at the HRI site ONLY.

- **Option 4:** Trust investment, via a DH Capital Loan, in the energy solution for HRI and CHH combined; operated and maintained by a mix of HEY staff and external contractors. This option would deliver a proposed technical solution, financed through a DH Capital Loan Facility.

- **Option 6:** Third Party, investment by means of a contractor through open competition and through the Carbon Energy Fund ("CEF") framework for HRI and CHH combined; financed, implemented, operated and maintained through the CEF performance agreement by an external contractor.

- **Option 8:** Trust investment, with the support of a DH Capital Loan for HRI and CHH combined; managed through the CEF framework; implemented, operated and maintained through the CEF performance agreement by an external contractor.

1.3.8 The "do nothing" option was discounted at an early stage as it was not considered a feasible solution as this will not assist the Trust in improving its energy resilience nor will it contribute to energy savings or carbon reductions. There is a real risk in doing nothing that the Trust will fail to meet its national obligation in the reduction of carbon emission targets and it lacks compliance with the recommendations within Lord Carter's report.

1.3.9 Options 6 and 8 would deliver a proposed technical solution through an Energy Services Performance Agreement (PA") with a preferred supplier and either financed with 3rd party private funding or a DH Capital Loan routed through the PA. These options include the implementation, operation and maintenance needs of the Trust's energy infrastructure.

1.3.10 For Options 4, 6 and 8 - the energy solution is created through a combination of the base recommendations from the Arup and SKM reports and tailored by the suppliers' innovative suggestions.

1.3.11 The table below summarises the Option Appraisal results:-

Options Appraisal Summary of the Short-Listed Options

Heading	**Option 2**	**Option 4**	**Option 6**	**Option 8**
	"Do Minimum" Trust/ DH Capital Loan	**Trust / DH Capital Loan**	**3rd Party / CEF Framework**	**Trust / DH Capital Loan / CEF Managed**
Qualitative benefits score	22.1	86.5	77	77
Rank	**4**	**1**	**2**	**2**
NPV	(2,071)	9,157	1,086	4,012
Rank	**4**	**1**	**3**	**2**
Affordability	No	Yes	Yes	Yes
Rank	**4**	**1**	**3**	**2**
Risk score	26.5	53	61	61
Rank	**4**	**3**	**1**	**1**
Overall ranking	**4**	**1**	**3**	**2**

Preferred option		**Yes**		

1.3.12 Option 4, the DH Capital Loan Financed solution, is the recommended preferred option as it ranks 1st overall in the options appraisal summary.

1.3.13 Option 4 delivers all the energy capital scoped projects described under Section 1.3.7.

1.3.14 Option 4 delivers the highest NPV which represents the highest return on the investment.

1.4 Commercial Case

1.4.1 The commercial case describes the Trust's proposed approach to the procurement route and key legal and commercial issues.

1.4.2 Under the options, the Trust has considered the following for the procurement routes for this project:-

- Procure 22+
- YORbuild Construction Framework
- Scape Group Framework
- Traditional OJEU Tendering (if let as one package)
- Individual contractor design and build packages.

1.4.3 The proposed work tendered for under the ITT can be broken down into five stand-alone packages which when costed are under the current OJEU threshold for construction works (£4.1m before VAT). Therefore Individual Contractor Designed and Build Packages is the preferred route of procurement.

1.5 The Financial Case

1.5.1 The purpose of this Section is to set out the likely financial implications of the preferred Option 4, DH Funded Capital Loan, as identified in the Economic Case and as set out in the Commercial Case.

1.5.2 A full financial assessment of the preferred Option 4 has been carried out to evaluate and determine the financial impact of the energy project schemes.

1.5.3 A summary showing the capital cost of the project and the life-cycle replacement (LCR) for the preferred Option 4 is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	Installation Period Aug '18 to Aug '19		Total Capital Works	Total LCR	Total
	£000's	£000's	£000's	£000's	£000's
Capital					
Indirect on-costs (legals, insurances etc.)	60	20	80		**80**
External Engineering Works	7,583	1,526	9,109	3,644	**12,753**
Fees	805	395	1,200		**1,200**
Other Costs	72	0	72		**72**
sub total Capital Costs Only	**8,520**	**1,941**	**10,461**		
sub total Optimism Bias (11.05%)	**941**	**215**	**1,156**		
sub total Capital Works & LCR			**11,617**	**3,644**	**15,261**
VAT @20% (excl. fees)			2,069	729	2,798
Total Capital Works & LCR (incl. VAT)			**13,686**	**4,372**	**18,058**

1.5.4 The preferred option is based on the assumption that the energy upgrade funding would be through a DH Capital Loan funded route. The loan term covers 25 years with the assumed interest repayments through the UK Debt Management Office of 2.62%.

1.5.5 The total capital loan repayment would be £13.7m with a total loan interest payment of £4.7m.

1.5.6 The technical guidance included in the HMT's Green Book has been followed in calculating the optimism bias figure for the project. This is currently 11.05% and is calculated based on the value of the capital works. This figure represents £1.4m (including VAT) of risk. This figure will be refined once the OBC is approved and the project is able to enter into the detailed design, contract and procurement process.

1.5.7 A summary showing the incremental impact on the Statement of Comprehensive Net Income is shown in the table below:-

Statement of Comprehensive Income Summary							
Trust (DH Capital Loan Funded) Preferred Option 4	Year 0 £000's	Year 1 £000's	Year 2 £000's	Year 3 £000's	Year 4 £000's	Year 5 £000's	Total 25 Years £000's
SAVINGS							
Energy Savings (incl.VAT)	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
sub total Energy Savings	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
EXPENDITURE							
Operating & Maintenance Costs	233	400	410	420	430	441	13,884
HEY In house Staffing Costs	54	93	96	98	101	103	3,244
HEY In house Non Pay Costs	33	57	59	60	62	63	1,987
Loan interest	179	348	334	320	306	292	4,661
Depreciation	268	537	537	537	537	537	16,711
Capital charges	0	0	0	0	0	1	592
sub total expenditure	769	1,435	1,435	1,435	1,435	1,437	41,079
Savings attributable to Trusts SoCI	(585)	(886)	(944)	(1,004)	(1,064)	(1,125)	(39,548)

1.5.8 The table shows that the total gross savings on energy costs over the life of the project will be £80.6m.

1.5.9 The table also shows that the total expenditure over the life of the project will be £41.1m.

1.5.10 Over the 25 years the net incremental saving to the Trust will be £39.6m.

1.6 The Management Case

1.6.1 This Section of the OBC addresses the 'achievability' of the investment in an energy infrastructure for HEY. Its purpose, therefore, is to set out the actions that would be required to ensure a successful delivery in accordance with best practice. This Section includes the following elements.

1.6.2 The proposed project is a core element to the success of the estate strategy for the immediate and long term vision for HEY. The proposed development programme will involve:-

- the Outline Business Case approval process
- project stakeholder engagement throughout
- potential planning applications dependent on the selected solution
- potential public consultation if necessary
- production of a loan capital financing application between OBC and FBC stages working in conjunction with NHSI
- the Full Business Case approval process
- Performance Agreement exchange
- successful scheme implementation.

1.6.3 A project management structure has been put in place with an aim to deliver this project through to operational service. The provisional timetable is:-

Activity	Completion Dates/Milestones
OBC to HEY Trust Board	7th November 2017
Submission of OBC to NHSI	8th November (period of 12 weeks to complete)
NHSI Resource Committee meeting	End of January 2018 - NHSI decision on OBC
Tender Period	From February 2018
Loan application	From February 2018 to complete April 2018
Submission of FBC – Trust Board	May Trust Board
Submission of FBC - NHSI	Approval of FBC by August 2018 (max 12 weeks)
Project Design & Agreement Finalisation	From February 2018
Project Implementation	During August 2018
Contract Signature	End of August 2018
Site Mobilisation	August 2018 Onwards
HRI LED lighting upgrade and fittings	October 2018 – March 2019
CHH LED lighting upgrade and fittings	October 2018 – March 2019
HRI Boiler replacement	September 2018 – July 2019
CHH CHP Installation	September 2018 – June 2019
HRI CHP Installation	September 2018 – June 2019
Anticipated Completion date	End of August 2019

1.7 Conclusions and Recommendations

1.7.1 The Trust believes that the existing energy infrastructure at both the HRI and CHH sites is no longer fit for purpose and is unable to adequately meet demand, that it is inefficient and will not assist the Trust in achieving key targets described in both the National and Local Strategies.

1.7.2 This OBC demonstrates that following both internal and external reviews there is an opportunity to deliver significant savings for HEY. By implementing this scheme it also helps support the Trust in delivering its financial position.

1.7.3 The OBC also proves that the preferred Option 4, DH Capital Loan funded, is both economically and financially the best investment route for the HEY Energy Innovation Scheme.

1.7.4 The OBC clearly demonstrates that the following key investment objectives would be achieved if the capital loan was approved:-

Investment Objectives of the HEY Energy Scheme		Preferred Option 4 Delivers:
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets	Reductions in carbon emissions of 7,138 tonnes per annum
2	To reduce energy costs and create efficiency savings	Affordable and demonstrates VFM by reducing energy costs and producing cash flow net annual savings of £1m
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.	Would reduce energy costs £/m2 by using resources in a more cost effective manner
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	Replaces ageing and outdated heat and energy plant, new and replacement CHP's and lighting upgrades
5	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	Would meet key strategic objectives of the HEY Estates Strategy 2017-2022 by providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

Recommendations

1.7.5 It is recommended that the Board approves the OBC for the energy upgrade, subject to the Trust Board Approval, to NHSI for consideration / approval to progress and, subject to approval by NHSI, move to the next stage of the process and develop the further detail required to produce an FBC.

1.7.6 Further detail may be required by the NHSI in answer to outstanding queries to complete their OBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI in their requests.

1.7.7 Subject to the OBC being approved, agree to work on the production of a capital financing application between OBC and FBC stages. This work will be done alongside NHSI's regional team who will help to assist in the development of the capital loan application required of £13.7m should it be approved at OBC.

2. STRATEGIC CASE

2.1 Introduction

This section introduces the strategic context within which the proposal has been developed. It provides:-

- an overview of the Hull and East Yorkshire Hospitals NHS Trust and the key business strategies so far as they relate to the proposed investment
- the case for change
- the proposed investment objectives , scope, constraints and benefit criteria
- an outline of the strategic risks associated with the proposal

STRATEGIC CONTEXT

2.2 National Context

NHS Five Year Forward View (2014)

2.2.1 The Five Year Forward View (FYFV) noted that changes in demand for care was being driven by the aging population, increasing demand and the potential impact of new technologies. Three areas were identified where fundamental changes were needed:-

- **Health and Well Being**
- **Care and Quality** – including developing more efficient and cost effective ways of delivering care and making good use of NHS resources
- **Finance and Efficiency** – including sharing innovative ways of working.

2.2.2 The Five Year Forward View acknowledged the growing consensus within the NHS that more integrated models of care were required to meet these challenges and that the growing financial problems in different parts of the NHS could not be addressed in isolation.

Providers and commissioners were asked to come together as Sustainability and Transformation Partnerships (STPs) to manage the collective resources available for NHS services for their local populations. In addition, STPs were required to ensure their five year plans included key areas for change which had been identified nationally, these included: Mental Health, Urgent and Emergency Care, Maternity Services and General Practice.

Local sustainability and transformation plans were identified as the vehicles for making the most of each pound of public spending, for example, by sharing buildings or back office functions.

NHS Shared Planning Guidance 2017-19 (2016)

2.2.3 The Shared Planning Guidance described the shared tasks of the NHS – to implement the Five Year Forward View to drive improvements in health and care; to restore and maintain financial balance; and to deliver core access and quality standards.

2.2.4 The Planning Guidance outlined nine 'must do' priorities which included:-

- **Sustainability and Transformation Plans** – implementation and delivery
- **Primary Care** – including implementation of the General Practice Forward View
- **Urgent and Emergency Care Delivery**
- **Elective Care** – delivery of waiting time targets, review of elective care pathways, implementing the Maternity Services review
- **Cancer** – including delivery of key access targets and improvements in survivorship
- **Mental Health** – improvements in access and quality and implementation of the Mental Health FYFV
- **Learning Disabilities** – improving access, reducing premature mortality and delivering Transforming Care Partnership plans
- **Improving Quality in Organisations** - including quality of care
- **Finance** – including implementing provider efficiency measures such as back office rationalisation and estates transformation.

2.2.5 Providers and commissioners were expected to have a relentless focus on efficiency in 2017/18 and 2018/19 which would enable the provider sector to return to aggregate balance in 2017/18.

2.2.6 It was noted that the capital environment remained challenged with capital resources being severely constrained. The Planning Guidance stated that provider capital plans needed to be consistent with clinical strategy and should clearly provide for the delivery of safe, productive services. Providers were urged to continue to procure capital assets more efficiently, to maximise and accelerate disposals and to extend asset lives.

Next Steps for the NHS Five Year Forward View (2017)

2.2.7 This document set out the main service improvement requirements for the NHS for the next two years within the constraints of what is necessary to achieve financial balance across the health service. Actions included reducing the number of delayed transfers of care to free up hospital beds, reduction in temporary staffing costs, improvements in procurement and achieving best value in medicines and pharmacy, reductions in avoidable demand and reductions in unwarranted variation in clinical quality and efficiency.

2.2.8 It was noted that Facilities Management has a direct bearing on patient experience, for instance, by ensuring that premises are a safe, warm and clean environment for staff and patients. The NHS spends over £6.5billion maintaining and running its estate and facilities and it was acknowledged that there are opportunities to achieve efficiency savings, for example, through reducing unwarranted variation in energy costs.

Lord Carter of Coles Report (2016)

2.2.9 In his independent report to the Department of Health[1], Lord Carter noted that the NHS is expected to deliver efficiencies of 2-3% per year, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021. The review looked at productivity and efficiency in English non-specialist acute hospitals using a series of metrics and benchmarks to enable comparison. The review concluded that there is significant unwarranted variation across all of the main resource areas, worth £5billion in terms of efficiency opportunity. The report made 15 recommendations designed to tackle this variation and help Trusts to improve their performance to match the best. The benchmark for total estates and facilities running costs per area (£/m^2) was £320. According to the last dashboard issued by the Estates and Facilities Management Efficiency Project Team, Department of Health, 2015/16 data, the Trust cost was £360m^2. The 2016/17 data is due to be issued in November 2017.

NHS Estate Strategy

2.2.10 Sir Robert Naylor's review[2] set out to develop a new NHS Estate Strategy which would support the delivery of specific Department of Health targets to release £2billion of assets for reinvestment and to deliver land for 26,000 new homes.

2.2.11 The report was predicated on widely accepted assumptions that the NHS estate was not configured to maximise benefits for patients or taxpayers. It considered:-

- the size of the opportunity – building on the Carter Report on efficiency;
- the mix of incentives and sanctions required for delivery; and
- how to strengthen capacity and capability across the system.

2.2.12 It was noted that historic under-investment had left the NHS with an aged estate, with more than 43% being more than 30 years old. Backlog maintenance of at least £5billion was needed.

[1] *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variation: An Independent Report for the Department of Health by Lord Carter of Coles. (February 2016)*

[2] *NHS Property and Estates: Why the Estate Matters for Patients – An Independent Review by Sir Robert Naylor for the Secretary of State for Health. (March 2017)*

2.2.13 The report called on the NHS, through the Sustainability and Transformation Partnerships process, to rapidly develop robust capital plans which were aligned with clinical strategies, but which would reduce running costs and waste through better utilisation and regulation of the NHS estate, sustainability and energy programmes, estates rationalisation and addressing backlog maintenance, resulting in an estate that is fit for purpose and efficient.

Carbon Reduction

2.2.14 Carbon management is an increasingly important issue for all organisations. Taking sustainability and carbon emissions seriously is an integral part of a high quality health service. With an annual energy bill of over £600m, total carbon emissions from the NHS represent 3% of the UK total. By effectively managing their emissions, NHS Trusts can successfully prepare for regulation like the Carbon Reduction Commitment Energy Efficiency Scheme and the Energy Performance in Buildings Directive.

2.2.15 The UK Government has committed to take action and has introduced the Climate Change Act with a target to cut carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020 across the UK.

2.2.16 As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet these targets and began its commitment through reducing its carbon footprint by 10% to 2015. It aims to achieve its legal obligations and reduce emissions by 34% by 2020.

2.2.17 The Department of Health's Sustainable Development Strategy published in October 2008 was designed to complement and support this government directive. Since 2008 the move towards a more sustainable health system has been supported by the development of a carbon footprint for the NHS in England. A series of footprints have been published relating to NHS data.

2.2.18 A report by the Sustainable Development Unit[3] published in December 2013 with 2012 data showed that the carbon footprint of the NHS in England for 2012 is 25 million tonnes CO_2 per year. This is composed of energy (18%), travel (13%), procurement of goods and services (60%) and health services commissioned outside the NHS (9%).

2.2.19 The report showed that between 2007 and 2012 there has been a 5.5% reduction in five years. However, the building energy use carbon footprint has increased by 0.9% since 2007 and will need concerted effort to reduce as patient activity is increasing. For direct emissions in the NHS to be in line with the Climate Change Act, building energy use emissions needed to decrease by over 10% between 2012 and 2015.

[3] Carbon footprint update for the NHS in England 2012, Sustainable Development Unit

2.3 Local Strategic Context

Humber, Coast and Vale Sustainability and Transformation Partnership

2.3.1 The Trust is a partner in the Humber, Coast and Vale STP footprint which covers communities in Hull, the East Riding of Yorkshire, Vale of York, Scarborough and Ryedale, North Lincolnshire and North East Lincolnshire.

2.3.2 The Humber, Coast and Vale footprint faces some major challenges:-

- 23% of its 1.4million population live in the most deprived areas of England
- An ageing population, of which 8.9% are over the age of 75 years which will lead to an increasing strain on health and care services
- The variation in life expectancy for men is 20 years, and for women is 17 years across the best and worst areas of the footprint
- If no action is taken, the STP will be in a deficit positon of £420million by 2020/21.

2.3.3 It is recognised that, in order to address these challenges, health and social care organisations will need to come together to deliver service transformation at scale and secure financial sustainability.

2.3.4 The vision for the Humber, Coast and Vale STP is to be seen as a health and care system that has the will and the ability to help patients start well, live well and age well. To achieve this vision, it is the aim of the STP to move the local health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves.

2.3.5 The STP has identified five key priorities:-

- Helping people stay well
- Place-based care
- Creating the best hospital care
- Supporting people through Mental Health
- Strategic commissioning.

2.3.6 One of the key enablers supporting delivery of these priorities is ‘Making the Best Use of our Estate’. The STP acknowledges that, in order for patients to be able to access care in the right place, it will need to rethink its estate strategy. Currently the STP estate covers 67,641 sqm and has a total running cost of £208million each year. The STP estate strategy is in the process of being developed. A key part of the strategy includes the identification of opportunities to reduce the estate and land that is held, and to explore opportunities for reducing running costs.

Hull City Plan (2013-23)

2.3.7 The priorities of the City Plan are to make Hull:-

- **a UK Energy City** – a UK hub for new and emerging industries with a focus on renewable energy
- **a World Class Visitor Destination** – as UK City of Culture 2017 and through the wider Destination, Hull capital programme of major cultural and transport infrastructure project, Hull is seeking to create a thriving visitor economy, building on its rich heritage, culture and diversity
- **a place of community and opportunity** – including ensuring that people get the services they need as early as possible through prevention and early intervention, so helping to build strong, resilient and productive communities.

2.3.8 In line with the ambitions within the City Plan and the transformation of the City, the Trust is developing plans to redesign the front entrance to the Tower Block at Hull Royal Infirmary.

2.4 Hull and East Yorkshire Hospitals NHS Trust

2.4.1 Hull and East Yorkshire Hospitals NHS Trust is a large acute Trust providing a comprehensive range of secondary care services to the local population of Hull and the East Riding of Yorkshire (population c. 600,000), and specialist services to a wider catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only services not provided locally are transplant surgery, major burns and some specialist paediatric services.

2.4.2 The Trust is a recognised:-

- Cancer Centre
- Cardiac Centre
- Vascular Centre
- Major Trauma Centre, and
- Regional Specialist Centre for hyper-acute stroke, renal medicine and dialysis, neonatology, paediatric orthopaedics, plastic surgery, neurosciences and infectious diseases.

2.4.3 The Trust is a University Teaching Hospital and a major partner in the Hull York Medical School.

2.4.4 The Trust employs 8,816 people and has a turnover over £555million (2017/18). It operates from two main hospital sites – Hull Royal Infirmary which is situated in the city of Kingston Upon Hull, and Castle Hill Hospital which is situated in the East Riding of Yorkshire.

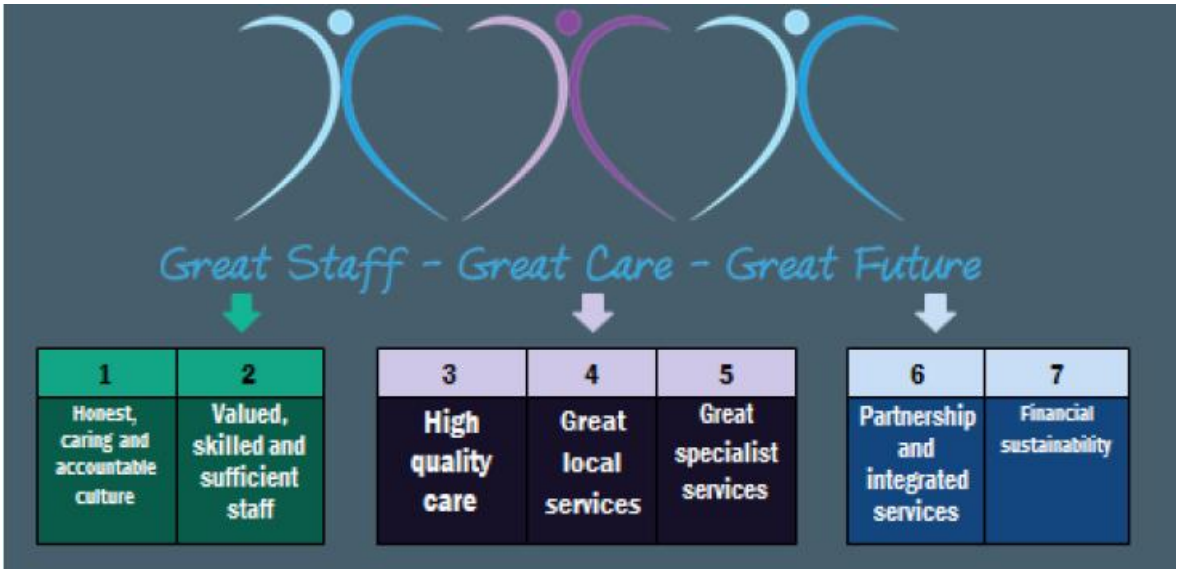
2.4.5 Hull and the East Riding are served by two separate Clinical Commissioning Groups that are largely co-terminus with their Local Authorities. The Trust provides almost all of the Hull CCG's secondary care services and around 60% of those for the East Riding of Yorkshire.

2.4.6 For 2017/18 the Trust is planning a small surplus of £0.4m which includes £11.9m of income from the Sustainability and Transformation Fund. The forecast outturn for the year at the end of September 2017 is that the Trust will deliver its plan, but this will require achievement of the £16.5m efficiency programme. The Trust's risk rating remains at a 3 with the liquidity rating of 4 reflecting the Trust's ongoing cash issues.

2.5 Trust Strategy (2016-2021)

2.5.1 The Board approved the current Trust Strategy at their meeting in April 2016.

2.5.2 The Trust's vision is *'Great Staff, Great Care, Great Future'*, as we believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community.



2.5.3 The vision is underpinned by seven organisational goals which focus on achieving high quality care, delivered by a skilled workforce and in partnership with local and regional health and social care providers.

- **Strategic Goal 1 – Honest, Caring and Accountable Culture**
  - Great staff engagement and satisfaction
  - Strong accountability, professionalism and pride
  - Communication
  - Staff led innovation and improvement

- **Strategic Goal 2 – Valued, Skilled and Sufficient Workforce**
  - Increased recruitment and retention
  - Enhanced training and development
  - New roles and ways of working
  - Promotion of improved health and wellbeing

- **Strategic Goal 3 – High Quality Care**

- Reduced avoidable harm
- Learning and sharing good practice
- Great patient satisfaction
- Reliability and responsiveness
- Supporting prevention of ill health

- **Strategic Goal 4 – Great Local Services**
  - Delivery of the key waiting times standards
  - Integrated services across Hull and East Riding for older people and those with long term conditions
  - Improvements to outpatient services
  - Excellent elective services

- **Strategic Goal 5 – Great Specialist Services**
  - Centres of Excellence for major trauma, cancer and cardiac
  - Development of clinical networks and partnerships
  - Formal teaching hospital status

- **Strategic Goal 6 – Partnership and Integrated Services**
  - Culture of collaboration and cooperation with partner providers
  - Development of integrated care pathways and services across primary, community and secondary care
  - Joint working on IT, workforce and estate

- **Strategic Goal 7 – Financial Sustainability**
  - Improved productivity and value in use of beds, theatres and outpatients
  - Reduced supplier costs
  - Development of technology
  - Smaller, better quality estate
  - Modernised back office functions

2.5.4 The Strategy forms the framework within which corporate and clinical services have developed their own detailed long term and annual plans.

2.6 Trust Enabling Strategies

2.6.1 Delivery of the Trust Strategy is underpinned by three enabling strategies:-

People Strategy (2016-18)

2.6.2 The People Strategy sets out the key challenges facing the Trust, the impacts upon its workforce and how the Trust intends to respond to those challenges in the short to medium term.

2.6.3 A key focus of the People Strategy is on creating the right organisational culture to enable the workforce to work as one team, with a clear set of values and objectives, where individuals and teams are held to account in a positive and supportive way. Current leadership styles will need to change to inspire, engage and empower a more flexible workforce.

2.6.4 Seven strategic workforce themes are identified within the People Strategy:-

- Recruitment and Retention
- Leadership Capacity and Capability
- Innovation, Learning and Development
- Equality and Diversity
- Health and Well Being
- Employee Engagement, Communication and Recognition
- Modernising the Way We Work.

Information Management and Technology Strategy

2.6.5 Over the last 3 years national policy has set out a number of expectations and challenges regarding how better use of information technology will drive innovation and efficiency and will contribute to transforming health and social care. In summary, these expectations are that:

- Care professionals and organisations will use data and technology to transform outcomes.

- There will be greater interoperability with more joined-up systems and greater sharing of information with care partners and service users.

- Systems will support 'paper free at the point of care' wherever that may be.

- Access to information will enable care to be more integrated across sectors and be provided closer to home.

2.6.6 The Trust's Information Management and Technology Strategy is currently under review and is being refreshed to take account of evolving national requirements, patch-wide IM&T intentions in support of the Sustainability and Transformation Plans (STPs) and progress with internal Trust technological priorities.

Estates Strategy (2017-20)

2.6.7 The Trust's Estates Strategy has been refreshed in light of national and local challenges and will be discussed by the Trust Board in November 2017. The strategy seeks to support delivery of the Trust's strategic goals by:-

- Improving key areas to assist in the delivery of high quality care, including:-

  - Creation of a new helipad adjacent to the Emergency Department
  - Dementia-friendly facilities
  - Centralisation of children's services
  - Provision of a new Infectious Diseases ward
  - Relocation of services from our oldest buildings to improved facilities
  - Reducing the size of the overall estate

- Reducing backlog maintenance
- Benchmarked in the Top 20% of Trusts in the annual PLACE scores

- Modernising services to reduce costs and improve performance, including:-

  - Maximising space utilisation
  - Targeted investment in plant and equipment
  - Reviewing working practices and skill mix
  - Investment in energy efficiency schemes
  - Utilisation of technology and improved data analysis.

A copy of the Estates Strategy (2017-20) is attached as Appendix 1.

Sustainable Healthcare Strategy

2.6.8 The Trust's Sustainable Healthcare Strategy has been refreshed in light of national Government targets and will also be discussed by the Trust Board in November 2017. The relevant sections of this strategy that help support the Energy Scheme OBC as well as supporting delivery of these national targets, amongst others, are:-

- Reducing its carbon emissions and greenhouse gases in line with the Carbon Reduction Strategy 'Saving Carbon, Improving Health'.

- Having regard to its 'Corporate Social Responsibility' in being aware of the impact work has on people and the environment they work in, and taking steps to reduce negative effects.

A copy of the HEY Sustainable Healthcare Strategy is attached as Appendix 2.

Energy Sharing Schemes with other Public Sector Bodies

2.6.9 The Trust has been working, over the last 18 months, with a number of local public sector organisations relating to future joint working arrangements either in the supply of energy or the management of shared energy contracts. The following is a summary update on the position of those discussions with each organisation:

Hull University

2.6.10 Discussions have taken place regarding the potential sharing of some services along with early discussions regarding Energy procurement and potential network supply.

Humber NHS Trust

2.6.11 Detailed discussions are taking place due to the close proximity of a number of Humber FT buildings regarding the potential to supply energy to a large part of their estate. This would allow us to maximise the use of waste heat and the optimal use of the existing boiler plant.

Hull City Council

2.6.12 A feasibility review is underway to look at options of supplying spare / waste heat to the Blocks of Flats opposite the HRI and a small Council Office Development of Linnaeus Street. In the future this would form part of the Council's plans for a District Heating System of which the Trust would form part of the future network.

NLAG/ York

2.6.13 High level STP discussions are ongoing with the Directors of Estates regarding joint energy procurement and sharing sustainability resources.

Private Sector

2.6.14 The Trust has just entered into early discussions with a Hull Schools Academy regarding energy management, advice and general estates maintenance support. The feasibility of such an undertaking is still to be agreed and is not being considered as part of this business case.

Summary of Progress

2.6.15 Given the point at which the discussions have reached, with regards to the sharing of energy schemes, none of the Public Sector Bodies engaged, mentioned above, alongside progress made so far, will have any impact on the current Trust strategy with regards to energy and CO_2 savings reductions at this point in time. Whilst not considered as part of this business case, investment in the Energy Innovation Scheme could be seen as a wider enabler for these discussions going forward.

2.7 The Trust Estate

2.7.1 The Trust's Estate consists primarily of two main hospitals sites – Hull Royal Infirmary and Castle Hill Hospital.

Hull Royal Infirmary

2.7.2 The Hull Royal Infirmary is located within the City of Kingston upon Hull on one of the main arterial roads leading into the City Centre. It is the Trust's Emergency Trauma Centre, with a large Emergency Department supported by a full range of diagnostic and treatment facilities. In addition, the site provides a comprehensive range of medical and surgical services, including Women's and Children's services.

2.7.3 The site comprises a number of buildings of a mix of ages with the dominant building being a 50-year old, fifteen-storey Tower Block podium, surrounded by a mix of high-rise structures, single and two storey blocks.

Castle Hill Hospital

2.7.4 Castle Hill Hospital is a former isolation hospital set in a rural landscape over 41 hectares and is located approximately six miles to the east of Hull Royal Infirmary. The hospital focuses primarily on elective care for a range of medical and surgical specialties. The site also accommodates the Queen's Centre for Oncology and Haematology, and the Centre for Cardiology and Cardiothoracic Surgery.

2.7.5 The buildings at Castle Hill Hospital are a mix of ages with some modern buildings forming core clinical service areas. The site has expanded over recent years with new Cardiology and Oncology blocks and is now a similarly sized hospital from an energy usage point of view to the Hull Royal Infirmary.

Combined Estate

2.7.6 The Trust is committed to reducing its energy costs and carbon emissions and has already taken some steps to improve energy performance and save carbon through:-

- insulation programme at Hull Royal Infirmary and the Castle Hill Hospital, consisting of insulation improvements in the boiler house and steam distribution system. Others include lighting improvements and upgrades to the building management systems on both sites. Energy savings achieved of 1% to 1.5%

- installation of a 700kWe natural gas CHP at Hull Royal Infirmary.

2.7.7 These initiatives contributed to the Trust making a reduction in CO_2 emissions from energy activities of 14% from 2009/10 to 2016/17. This relates to 4,319 tonnes of CO_2.

2.8 Case for Change

2.8.1 A robust case for change requires a thorough understanding of what Hull and East Yorkshire Hospitals is seeking to achieve; what is currently happening; and the present problems and future service gaps.

2.8.2 The investment objectives for the scheme can be summarised in the table below:-

Investment Objectives of the HEY Energy Scheme	
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets
2	To reduce energy costs and create efficiency savings
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.
5	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.

2.8.3 The investment objectives for the energy project clearly relate to the underlying policies, strategies and business plans of the organisation. They have also been made SMART – specific, measurable, achievable, relevant and time-constrained.

2.8.4 By establishing the SMART investment objectives this has helped to facilitate the subsequent generation of options and provide the foundation for post-implementation review and evaluation. The SMART objectives are summarised in the table below:

	SMART Investment Objectives				
Objective	**S**pecific	**M**easurable	**A**chievable	**R**ealistic	**T**imescaled
1	Contribution towards achieving 34% target	Reduction in carbon emission levels	Yes	Yes	2020
2	Achieve savings target identified in business case	Carbon emission and energy spend reductions	Yes	Yes	2020
3	Lord Carter targets	Against model hospital benchmark figures	Yes	Yes	2020
4	Naylor Report targets	Reduction in HEY backlog maintenance	Yes	Yes	2020
5	HEY Estates Strategy	Achievement against key HEY strategic objectives	Yes	Yes	2020

Trust Carbon Reduction Requirements

2.8.5 The Trust is required to deliver at least a 34% reduction in its carbon emissions by the year 2020 and believes this target would be impossible to meet with the existing energy infrastructure.

2.8.6 The Trust's performance in terms of carbon emissions over the last number of years, as detailed in the national returns, shows little change despite measures outlined in section 2.7.6 above. This suggests that the opportunity to meet emission reduction targets is very limited without a radical change and investment in new and upgraded energy infrastructure.

2.8.7 The table overleaf shows the Trust's annual CO_2 performance return figures, measured against the baseline year of 2009/10, from which the national target reduction of 34% is measured:-

Year of Return	Total CO2 Tonnes	Change in CO2 from 2009/10
2009/10	34,417	baseline
2010/11	34,154	(263)
2011/12	31,213	(3,204)
2012/13	33,570	(847)
2013/14	32,017	(2,400)
2014/15	32,798	(1,619)
2015/16	31,469	(2,948)
2016/17	30,098	(4,319)

CO2 Reduction Target by 2020	**(11,702)**

2.8.8 The figures show that HEY, based on using the existing energy infrastructure is not on trajectory to meet the 34% CO2 target of a reduction of 11,702 tonnes by 2020.

Trust Total Energy Consumption (kWh)

2.8.9 The table below shows the Trusts annual energy (gas and electricity) consumption figures since 2009/10:-

Year of Return	Total kWh	Change in kWh from 2009/10
	millions	millions
2009/10	114	baseline
2010/11	116	2
2011/12	106	(8)
2012/13	116	1
2013/14	107	(8)
2014/15	104	(11)
2015/16	103	(11)
2016/17	103	(11)

2.8.10 The figures show that whilst a reduction in consumption has been achieved from the 2009/10 baseline, with limited investment, it has remained static over the last 3 years. These figures reflect the current need for HEY to seek to invest in a more energy efficient infrastructure.

Trust Total Cost of Energy

2.8.11 The table overleaf shows the total energy costs for HEY in financial years 2016/17 and 2015/16:-

HEY Energy Costs Over Previous 2 Financial Years

	2016/17		2015/16	
Energy	**HRI £000's**	**CHH £000's**	**HRI £000's**	**CHH £000's**
Gas	1,002	880	1,126	810
Electricity	1,283	1,621	1,115	1,493
Total by Site	**2,285**	**2,501**	**2,241**	**2,303**
Total by Year		**4,786**		**4,544**

2.8.12 The expenditure on both gas and electricity totalled between £4.6m and £4.8m over this 2 year period. These figures show that by investing in new energy infrastructure there is an opportunity to reduce its energy costs well below current levels. Therefore, it is imperative that the Trust looks at ways of reducing its energy costs thereby contributing to improvements in the Trust's financial position and delivery of its control total.

Lord Carter Benchmarking Dashboard

2.8.13 The recent publication of the ERIC Return for 2016/17 has shown HEY to be currently in the upper quartile for energy costs at £27.50 per m^2 for the Teaching Hospitals cluster peer group. The median for this peer group is £22.13 per m^2. This means that HEY is £5.13 per m^2 more expensive than the median value for a Teaching Hospital Trust.

Ageing and Obsolete Plant

2.8.14 The Trust's main sites contain a mix of buildings of varying ages. In respect of heat and power requirements:-

Hull Royal Infirmary
The site requires heat only for space heating and hot water. Due to the history of the site (in the past there were sterilisation activities and laundry activities on site) most of the heat is generated through steam raised in a central energy plant. The boiler house contains 50 year-old steam raising boilers converted from coal firing to natural gas and oil dual fuel burners alongside a refurbished 700 kWe CHP. It is anticipated that the site could potentially accommodate a larger Combined Heat and Power system and benefit from the renewal of the ageing boiler plant.

Castle Hill Hospital
A new energy centre was installed at the site approximately ten years ago and contains four steam raising boilers. The main aspiration for the CHH site would be the installation of a new Combined Heat and Power (CHP) system.

Summary

2.8.15 The case for change can be summarised as the need to:-

- reduce carbon emissions in line with national policy
- replace the ageing heat and energy plant at Hull Royal Infirmary and to better manage demand
- secure heat, hot water and steam generation in the long term for the site to support future development
- realise energy cost savings and contribute to an improved financial position for the Trust and as part of the Humber, Coast and Vale STP; and
- ensure compliance with the recommendations set out by Lord Carter.

2.8.16 It is the view of the Trust that replacement of outdated heat and energy plant at the Hull Royal Infirmary and a new Combined Heat and Power plant at both Castle Hill Hospital and Hull Royal Infirmary, as well as LED lighting improvements on both sites, will enable the Trust to address the challenges outlined above and achieve the reduction in costs and emissions required, whilst ensuring sufficient capacity to meet future service needs.

2.9 Investment Objectives

2.9.1 The intention of the Trust is to achieve significant revenue savings by investing in new heat and plant infrastructure. The main objectives of this invest to save and how they map to the investment objective summary under the case for change under section 2.8.2 are:-

- assist in delivering a minimum 34% reduction in carbon emissions by the year 2020 (investment objective 1)
- reduce operating costs (investment objective 2 &3)
- improve resilience and business continuity (investment object 5)
- reduce the Trust's carbon footprint (investment objective 1&5)
- reduce the Trust's site running costs (investment objective 2&3)
- improve the Trust's energy infrastructure (investment object 4&5)
- achieve recognition of the Trust as an exemplar for energy efficiency and carbon reduction (investment object 1,3&5)
- support the continued delivery of clinical services (investment object 5)
- improve resilience of the existing time expired infrastructure such as the HRI boilers (investment object 4&5)

- manage the risk of introducing leading-edge technologies by entering into a design, build and operate contract with selected industry experts depending on which element of the five individual projects is awarded (investment object 5)

2.10 Scope

2.10.1 The initial potential scope of the Energy Innovation Upgrade Scheme was based on the commissioning and report findings of 3 feasibility studies, these being:

1) Ove Arup & Partners Limited ("Arup") – this report was the HRI and CHH CHP feasibility study and is attached as Appendix 3a.

2) Sinclair Knight Merz ("SKM") – this report reviewed the energy saving. Options for Carbon and Energy Fund support and is attached as Appendix 3b.

3) The Carbon and Energy Fund – this feasibility study was completed to establish the case for investment at HEY with regards to the energy infrastructure upgrade. This is attached as Appendix 4.

2.10.2 The scope of these feasibility studies was to identify a core scheme case scenario and additional options for investment, subject to the whole scheme generating a positive NPV investment return, at the Trust's sites. The following potential core areas for investment were identified:-

- Upgrade and/or replacement of the Combined Heat and Power Unit at Hull Royal Infirmary – core scheme.
- Installation of a new Combined Heat and Power Unit at Castle Hill Hospital – core scheme.
- Boilers HRI - replacement/upgrade/maintenance of the Low Temperature Hot Water (LTHW) unit and/or steam distribution from the energy centres on both sites to remote plant rooms – priority back log maintenance core scheme.

2.10.3 Additional schemes for investment include:-

- Lighting replacement – additional option
- Replacements of inefficient chilled water plant – additional option.
- Replacement of Air Handling Units on the third floor plant room at Hull Royal Infirmary – additional option

2.10.3 All three feasibility reports concluded that significant indicative savings could be made with investment made in HEY's energy infrastructure with the minimum of the core schemes and improved with the additional schemes for investment added.

2.10.4 At this moment in time, as referenced in 2.6.15, energy sharing schemes with other public sector bodies is not considered as part of the scope for this business case.

2.11 Benefits Criteria

2.11.1 Based on the strategic case outlined detailed below are the main benefit criteria against which each option for investment in the Energy Innovation Upgrade Scheme will be assessed:-

Criterion 1 – Delivers Organisational Benefits

- Supports delivery of the Trust's Estates Strategy
- Supports delivery of the Trust's Strategy and organisational goals
- Supports delivery of the Humber Coast and Vale Sustainability and Transformation Plan
- Supports compliance with NHS Estate Strategy
- Contributes to increased efficiency and productivity
- Contributes to reduction in carbon emissions
- Contributes to reduction in Trust costs
- Supports future clinical service developments
- Compliance with Carter Report recommendations

Criterion 2 – Organisational Fit

- Timeliness of the solution deployment
- Affordability/contribution

Criterion 3 – Delivers Service and Operational Benefits

- Improved resilience and business continuity
- Trust compliance with 2020 carbon emissions reduction deadline
- Reduction in level of backlog maintenance

Criterion 4 – Delivers patient and staff benefits

- Improved environment (heating, lighting and hot water)
- Improved patient experience
- Improved staff experience

2.12 Strategic Risks

The main strategic risks of not investing in the replacement/upgrading of out-dated and under-performing facilities are:-

- Not having a mechanical and electrical infrastructure to support the Trust's Strategy and delivery of clinical services.
- Risk of catastrophic failure, resulting in potential harm to the patient and the reputation of the Trust.
- Potential for breakdowns of the energy and heating systems impacting on the delivery of clinical services.
- Non-compliance with the Carter Report recommendations.
- Non-compliance with national policy, guidelines and targets.

2.13 Constraints and Dependencies

2.13.1 The main constraints and dependencies are:-

- availability of Trust technical and project management resource
- availability of sufficient financial investment to deliver the required solution
- ability of external suppliers to deliver the scheme to time and specification
- requirement for minimum disruption to clinical services during decommissioning, build and commissioning phases.
- must demonstrate support for the target reduction in carbon emissions by 2020
- needs to be affordable and be able to demonstrate value for money (“VFM”)
- act in accordance with Government policy and directives
- demonstrate it meets the infrastructural needs of the Trust and is aligned with its Estates Strategy

2.14 Summary

2.14.1 The Trust believes that the existing energy infrastructure at the Trust is no longer fit for purpose and is unable to adequately meet demand, that it is inefficient and will not assist the Trust in achieving key targets described in both the National and Local Strategies.

3 ECONOMIC CASE

3.1 Introduction

3.1.1 This section sets out the basis for the selection of the preferred solution for the Energy Innovation Upgrade Scheme.

3.1.2 This follows approval by the NHS Improvement ("NHSI") Resource Committee, of the previously submitted Strategic Outline Case ("SOC"), to proceed to the Outline Business Case ("OBC"), the next compliance stage of Her Majesty's Treasury ("HMT") Green Book 5 Case Model.

3.1.3 The Trust can give assurance of full compliance with all elements of the HMT Green Book 5 Case Model. The process of establishing the preferred option for investment has ensured a full quantitative and qualitative appraisal has been undertaken.

3.2 Determining the Long List of Options

3.2.1 The purpose of determining the long list of options is to identify as wide a range of options as possible that meet the spending objectives, potential scope and benefits criteria as identified in the strategic case. The associated strengths, weaknesses opportunities and threats of each option were considered by the ESPT.

3.2.2 As referenced in Section 2.10, a feasibility study was undertaken by Arup. The Trust also commissioned a high level energy survey in support of the proposed options with SKM. They identified potential solutions for improving energy plant resilience, energy fuel supply resilience, energy performance and energy efficiency, leading to substantial reductions in carbon emissions and overall utility cost.

3.2.3 The options considered included the following energy infrastructure upgrade works as a result of the feasibility reports:-

Summary of the Energy Capital Projects

Project	Capital Project breakdown:
1	The replacement of the combined CHP plant for HRI inclusive of a new absorption chiller system.
2	A new CHP plant for CHH inclusive of a new absorption chiller system.
3	Replacement of ageing and obsolete boiler plant at HRI
4	LED lighting replacement and upgrading of fittings at HRI
5	LED lighting replacement and upgrading of fittings at CHH
6	Installation and integration of a Buildding Management System at both HRI and CHH

3.2.4 The potential savings generated from the capital projects under 3.2.3 were calculated on the back of the Carbon and Energy Fund Feasibility Study found under Appendix 3. The table below breaks the £1.9M of savings down by project were quantified:-

Summary of the Energy Capital Project Savings

Capital Works Scheme	HRI £000's	CHH £000's	Total £000's
Combined Heat and Power Unit (CHP)	(828)	(806)	**(1,634)**
Boilers	(61)	0	**(61)**
Absorption Chiller Systems (ACS)	(65)	(66)	**(131)**
LED Lighting Replacement Upgrade	(62)	(45)	**(107)**
Total Capital Works Scheme Savings	**(1,017)**	**(917)**	**(1,934)**

3.2.4 The long list of options in the table below was generated by the ESPT with additional input from stakeholders and technical specialists.

3.2.5 The 'do nothing' and 'do minimum' options have been included in the long list of options as a baseline for value for money purposes ("VFM"). Whilst included, it is considered by the ESPT that the 'do nothing' option is not a feasible long term option. The long-list of options, as complied and agreed by the ESPT, is detailed in the table overleaf:-

Summary of the Long List of Options

Option	Name	Description
1	Do nothing	Maintain the existing ageing plant and machinery
2	Do minimum	Replacement of HRI boilers only; operated and maintained by a mix of HEY staff and external contractors.
3	PSC; HRI **or** CHH site **only**	Trust investment , with the support of a DH capital loan; operated and maintained by a mix of HEY staff and external contractors.
4	PSC; HRI **and** CHH sites **combined**	Trust investment , with the support of a DH capital loan; operated and maintained by a mix of HEY staff and external contractors.
5	Third party; HRI **or** CHH site **only**	Third party, investment by means of a contractor through open competition and through the CEF framework; financed, implemented, operated and maintained through an external contractor.
6	Third party; HRI **and** CHH sites **combined**	Third party, investment by means of a contractor through open competition and through the CEF framework; financed, implemented, operated and maintained through an external contractor.
7	DH/Third party; HRI **or** CHH sites only	Trust investment, with the support of a DH loan managed through the CEF framework; implemented, operated and maintained through an external contractor.
8	DH/Third party; HRI **and** CHH sites **combined**	Trust investment, with the support of a DH loan managed through the CEF framework; implemented, operated and maintained through an external contractor.

3.3 Critical Success Factors

3.3.1 By definition, the critical success factors ("CSFs") are the attributes essential to the successful delivery of the Energy Innovation Scheme, against which the available long list options are assessed. Alongside the assessment against CSFs is the assessment of how well the options meet the scheme's objectives and benefits criteria. The key point for this scheme is that the options considered are crucial (not desirable) and have been set at a level which doesn't exclude important options. The weightings represent the considered relative importance of each CSF with the reasons set out alongside. Table below shows what CSFs the ESPT have considered which are predicated on the "Five Case Model".

CSF	Critical Success Factors (CSF)	Weighting %age
1	**Strategic Fit and Business Needs**	25%
	How well the option:	
	Meets agreed spending objectives, related business needs and service requirements	
	Provides holistic fit and synergy with other strategies, programmes and projects	
2	**Potential VFM**	40%
	How well the option:	
	Maximises the return on the required spend (benefits optimisation) in terms of economy, efficiency and effectiveness from both the perspective of the organisation and wider society.	
	Minimises any associated risks.	
3	**Potential achievability**	15%
	How well the option:	
	Is likely to be delivered in view of the organisation's ability to assimilate, adapt and respond to the required level of change	
	Matches the level of available skills which are required for successful delivery	
4	**Supply-side capacity and capability**	10%
	How well the option:	
	Matches the ability of the service providers to deliver the required level of services and business functionality	
	The option is deliverable within the strategic timescales	
5	**Potential affordability**	10%
	How well the option:	
	Meets the sourcing policy of the organisation and likely availability of funding	
	Matches other funding constraints	
	Total	100%

3.3.2 All the CSF criteria have been derived from the SMART (specific, measurable, achievable, realistic and time bound) objectives as set out in the Strategic Case.

3.4 Short-Listing of Options

3.4.1 This stage recommends a way forward based on the appraisal and scoring of the long list of options. Each option is given a score out of 100 and then multiplied by the CSF weighting to calculate the final score. The scoring and ranking of the options is reflected and summarised in the table overleaf:-

Summary of the Long-List Options Appraisal and Scoring

		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Critical Success Factors		Do Nothing	Do Minimum	DH Loan HRI or CHH	DH Loan HRI and CHH	3rd Party HRI or CHH	3rd Party HRI and CHH	DH/3rd Party HRI or CHH	DH/3rd Party HRI and CHH
1	Strategic Fit and Business Needs	0.0	6.3	12.5	25.0	12.5	25.0	12.5	25.0
2	Potential VFM	0.0	4.0	18.0	36.0	10.0	20.0	16.0	26.0
3	Potential Achievability	1.5	1.5	14.3	14.3	14.3	14.3	14.3	14.3
4	Supply-side Capacity and Capability	1.0	1.0	9.5	9.5	9.5	9.5	9.5	9.5
5	Potential Affordability	1.0	1.0	7.5	7.5	9.0	9.5	7.5	7.5
	Total Weighted Score	**3.5**	**13.8**	**61.8**	**92.3**	**55.3**	**78.3**	**59.8**	**82.3**
	Ranking	8	7	4	1	6	3	5	2

3.4.2 The minimum four short-listed options being considered for further evaluation include:-

- **Option 2: Do minimum** – must be included despite being ranked 7 as this provides a benchmark for value for money ("VFM") throughout the appraisal process.
- **Option 4: Ranked 1st** - Trust investment, via a DH Capital Loan, in the energy solution for HRI and CHH combined; operated and maintained by a mix of HEY staff and external contractors.
- **Option 8: Ranked 2nd** – Trust investment, with the support of a DH Capital Loan for HRI and CHH combined; managed through the CEF framework; implemented, operated and maintained through the CEF performance agreement by an external contractor.
- **Option 6: Ranked 3rd** – Third Party, investment by means of a contractor through open competition and through the Carbon Energy Fund ("CEF") framework for HRI and CHH combined; financed, implemented, operated and maintained through the CEF performance agreement by an external contractor.

3.4.3 The “do nothing” of Option 1 is not considered a feasible solution as this will not assist the Trust in improving its energy resilience nor will it contribute to energy savings or carbon reductions. There is a real risk in doing nothing that the Trust will fail to meet its national obligation in the reduction of carbon emission targets and it lacks compliance with the recommendations within Lord Carter’s report. The “do minimum” of Option 2, which provides a benchmark for VFM, was agreed by the ESPT as being the replacement of ageing and obsolete boiler plant at the HRI site.

3.4.4 Options 3, 5 and 7 – either the HRI or CHH site options were discounted as they are unlikely to deliver sufficient benefits bearing in mind that the intention is ‘invest to save’ and to deliver a maximum positive net present value (“NPV”). Also they would fail to deliver against both the investment objectives and CSFs of the project. Option 4 would deliver a proposed technical solution, financed through a DH Capital Loan Facility.

3.4.5 Option 4 would deliver a proposed technical solution, financed through a DH Capital Loan Facility.

3.4.6 Options 6 and 8 would deliver a proposed technical solution through an Energy Services Performance Agreement (“PA”) with a preferred supplier and either financed with 3rd party private funding or a DH Capital Loan routed through the PA. These options include the implementation, operation and maintenance needs of the Trust’s energy infrastructure.

3.4.7 For Options 4, 6 and 8 - the energy solution is created through a combination of the base recommendations from the Arup and SKM reports and tailored by the suppliers’ innovative suggestions.

3.4.8 The detailed scoring of the long-list of options to establish the short-list of options is attached as Appendix 5.

3.5 Economic Appraisal

Assumptions and Methodology

3.5.1 The economic appraisal focusses on the value for money offered by each short- listed option, expressed as Net Present Value (NPV). The appraisal includes all quantifiable costs, benefits and risks to both the organisation and wider society over the estimated life of the assets.

3.5.2 Included, as part of the economic appraisal, is the whole-life costing of the short-listed options. The whole-life costing takes into account both the total capital and revenue (operating, maintaining and managing) costs of owning the assets. The energy scheme has been evaluated over a life cycle duration period of 25 years.

3.5.3 Also included in the whole-life costs is a provision for optimism bias. This is the risk allowance attached to the difference between what’s expected and the potential outcome of the project costs. The technical guidance in the HMT’s Green Book for the calculation of optimism bias for each of the short-listed options has been followed. In calculating the capital cost of each of the short-listed options, inclusive of general risks, the amount

by which optimism bias would increase the options capital costs has been estimated and reflected in the figures.

3.5.4 The whole-life costing calculation of Options 2, 4, 6 and 8 are included in the Appendices. The whole life cost is not discounted and does not include capital charges or depreciation and cash releasing benefits. Also not included is VAT, whether recoverable or non-recoverable.

3.5.5 The NPV costs of the options have been calculated against base year pricing and include the following:-

- All quantifiable costs, benefits and risks
- Life cycle costs.

3.5.6 Based on the current bids a discounted cash flow analysis has been undertaken using the Net Present Costs (NPC) method to ensure that the investment in an energy infrastructure makes economic sense. Discounting is undertaken to reflect that £1 in one year's time is worth less than £1 today.

3.5.7 The evaluation was carried out in accordance with the Department of Health Capital Investment Manual (CIM) and the HM Treasury Green Book. In accordance with the guidelines the cash flow excludes:-

- Capital charges as the full cost of capital investment is included in the first year
- VAT, as this represents a flow of money from one part of government to another
- Financing costs (capital repayment and loan interest) relating to DH loans as this also represents a flow of money from one part of Government to another
- General inflation.

Costs of Capital Investment

3.5.8 The initial capital costs for the energy innovation upgrade scheme, for both sites, are based on the summary of energy capital projects as summarised under paragraph 3.2.3

3.5.9 Options 2, 4 and 8 are modelled on the initial capital investment being funded via a DH Capital Loan facility.

3.5.10 Option 6 is modelled on the 3rd party investment route (unitary payment) via the CEF framework.

3.5.11 The capital cost for each option has been calculated in accordance with the best practice contained in the CIM Business Case Guide.

3.5.12 For each short-listed option the capital costs include, in accordance with the CIM guidance, an allowance for:-

- Works costs – including building and engineering
- Professional fees – for example legal fees, design costs, quantity surveyors
- Non-works costs – including enabling works.

Revenue Costs

3.5.13 As with the capital costs, the revenue costs included are based on the project breakdown as summarised under Section 3.4.5 and comprise the following elements:-

- annual operating, maintenance and lifecycle costs. These are based on the plant and equipment proposed in each option
- an annual service charge for the private funded option and using a current funding rate (from a CEF approved funder) - which includes an element of capital repayment, interest and profit - of £72.50/£1000 over a 25 year funding term
- gross annual energy savings as assessed by the Trust based on the information provided by the Carbon Energy Fund.

Net Present Values (NPV)

3.5.14 The NPV is the difference between the present value of the future cash flows from an investment and the amount of investment. The table below shows the outcome of the NPV appraisal for each of the short-listed options:-

Net Present Value (NPV) Summary of the Short-Listed Options

	Option 2	Option 4	Option 6	Option 8
Narrative	Do Minimum	Trust / DH Capital Loan	3rd Party / CEF Framework	Trust / DH Capital Loan / CEF Managed
	£000's	£000's	£000's	£000's
Capital Works	2,213	11,617	0	12,909
Life cycle replacement	374	3,644	0	0
Revenue	2,615	18,053	0	0
Unitary payment			46,617	27,499
Total costs	**5,202**	**33,314**	**46,617**	**40,408**
Savings over 25 years	(2,394)	(48,346)	(48,265)	(48,265)
Discount Factor (time value of money)	3.50%	3.50%	3.50%	3.50%
Net present value profit (+) / loss (-)	(2,071)	9,157	1,086	4,012
Rank	4	**1**	3	2

3.5.15 The present value of the expected cash flows has been discounted at the required rate of return, as per the HMT Green Book guidance, of 3.50%.

3.5.16 Under the NPV decision making process rule a positive return is regarded as an investment worth undertaking whilst a negative return on an investment is one that should be avoided.

3.5.17 Options 4, 6 and 8 deliver a positive NPV which means a rate of return on the investment will be made.

3.5.18 Option 2 delivers a negative net present value which means a no return on the investment.

3.5.19 Option 4 delivers the highest return on the investment and is therefore ranked 1st.

3.5.20 The detailed NPV appraisals for each short-listed option are attached as Appendix 6.

3.6 Non Financial Benefits Appraisal

3.6.1 The shortlisted options have been appraised against a set of non-financial benefit criteria derived from the project objectives as set out in the table below. Only non-financial objectives were included here (in line with the HMT Green Book guidance) as financial benefits are measured in the economic appraisal.

The Weighted Non Financial Benefits Appraisal

Benefit	Benefits of investment objectives	Weighted %age
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets.	15%
2	Create energy resilience and reduce consumption levels.	30%
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranteed variations' published in February 2016.	15%
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	30%
5	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	10%

3.6.2 The table above includes the weightings allocated out of 100 to each benefit to reflect their relative importance. These were agreed by the Energy Scheme Project Team.

3.6.3 The options have then been scored against each benefit to generate weighted scores. Each option is given a score out of 100 and then multiplied by the benefit weighting to calculate the final score. The outcome has then been ranked according to that option which generates the highest score. The table below summarises the scoring outcome for each option against the investment benefits:

Summary of the Benefits Appraisal Scoring

	Benefit Criteria	Option 2 Do Minimum Weighted Score	Option 4 Trust / DH Capital Loan Weighted Score	Option 6 3rd Party / CEF Framework Weighted Score	Option 8 DH Capital Loan / CEF Managed Weighted Score
1	Assist compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets.	3.3	12.0	12.0	12.0
2	Create energy resilience and reduce consumption levels.	6.9	30.0	21.0	21.0
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranteed variations' published in February 2016.	3.0	12.0	12.0	12.0
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	6.9	24.0	24.0	24.0
5	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	2.0	8.5	8.0	8.0
	Total Weighted Score	**22.1**	**86.5**	**77.0**	**77.0**
	Ranking	4	**1**	2	2

3.6.4 The benefits are consistent with the SMART objectives identified in the Strategic Case.

3.6.5 The outcome of the benefits appraisal shows Option 4, the DH Capital Loan Funded, having the highest weighted score and therefore ranked 1st.

3.6.6 The Do Minimum, Option 2 (replacement of ageing and obsolete boiler plant), does provide, albeit limited additional qualitative benefit, in assisting the Trust achieve all of the investment objectives.

3.6.7 Options 6 and 8 scored the same as essentially the only difference would be the source of the Capital funding. The impact of this is reflected in the net present value calculations.

3.6.8 The detailed benefit scoring for the short-listed options is attached as Appendix 7.

3.7 Non-Financial Risk Appraisal

3.7.1 The weighting and scoring of risk is similar to the approach for evaluating the non-financial benefits. In assessing the risk the following has been undertaken:-

- All risks that can be measured financially, including optimism bias, have been excluded.
- The weighting and scoring of the risks was undertaken by the ESPT
- The impact of each of the risks has been given a weighted percentage
- The likelihood of the risk occurring has been scored out of 100
- The calculation of each risk score has been the impact multiplied by the likelihood
- The options have been ranked in terms of their risk with the preferred option identified on the basis of the highest score.
- The table below shows what the risks have been assessed against and their weightings:-

Key Risk Assessments and Weightings

Risk	Risk assessment	Weighting %age /100
1	Not having a mechanical and electrical infrastructure to support the Trust's future strategy.	5%
2	Catastrophic failure resulting in potential harm to the clinical service provision and the reputation of the Trust as a result of faulty infrastructure and obsolete technology.	20%
3	Possible breakdowns in energy and heating systems which can result in an unpredictable return on investment.	30%
4	Non-compliance with the Lord Carter recommendations and, for example, in not addressing a significant maintenance backlog.	15%
5	Non-compliance with other national guidelines and targets in not reducing carbon emissions and energy consumption levels.	10%
6	The reduction in resilience, for both sites, to meet the Trusts future needs.	20%

3.7.2 Each option is given a score out of 100 and then multiplied by the risk weighting to calculate the final score. Under NHSI guidance the higher the risk score calculated the lower the risk is for that option. A summary of the short-listed options risk assessment scoring and ranking are shown in the table below:-

Summary of the Risk Assessment Scoring

	Risk Factor	Option 2	Option 4	Option 6	Option 8
		Do Minimum	Trust / DH Capital Loan	3rd Party / CEF Framework	DH Capital Loan / CEF Managed
		Weighted Score	Weighted Score	Weighted Score	Weighted Score
1	Not having a mechanical and electrical infrastructure to support the Trust's future strategy.	0.5	1	1	1
2	Catastrophic failure resulting in potential harm to the clinical service provision and the reputation of the Trust as a result of faulty infrastructure and obsolete technology.	4	8	8	8
3	Possible breakdowns in energy and heating systems which can result in an unpredictable return on investment.	9	18	24	24
4	Non-compliance with the Lord Carter recommendations and, for example, in not addressing a significant maintenance backlog.	1.5	3	3	3
5	Non-compliance with other national guidelines and targets in not reducing carbon emissions and energy consumption levels.	3.5	7	9	9
6	The reduction in resilience, for both sites, to meet the Trusts future needs.	8	16	16	16
	Total Weighted Score	**26.5**	**53**	**61**	**61**
	Ranking	4	3	**1**	**1**

3.7.3 Options 6 and 8 are both ranked 1st in having the highest weighted score and hence the lowest risk.

3.7.4 Option 2 has a higher risk of not delivering against all of the risk assessment criteria and hence scores the lowest.

3.7.5 In carrying out the scheme itself under Option 4, the Trust loses the guaranteed reduction in carbon emissions and carries the risk of under-achievement which are protected against under a CEF contract.

3.7.6 The detailed scoring for the risk scoring is attached as Appendix 8.

3.8 Sensitivity Analysis

3.8.1 Sensitivity analysis is used to test the vulnerability of the options to unavoidable future uncertainties and to test the robustness of the ranking of the options. It involves testing the ranking of the benefit options by changing some of the key assumptions.

3.8.2 The table below shows the impact of reversing the order of the weightings against the benefits to recalculate the weighted score. Please note the original scores out of 100 remain unchanged as it is this scoring assessment that is being tested. The revised scoring shows no impact on the original ranking of the options.

Scoring Summary by Reversing the Weightings for the Short-Listed Options

Reversal of the Original Weightings	Option 2	Option 4	Option 6	Option 8
Benefit Criteria	Do Minimum	Trust / DH Capital Loan	3rd Party / CEF Framework	DH Capital Loan / CEF Managed
	Weighted Score	Weighted Score	Weighted Score	Weighted Score
Assist compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets.	3.3	12.0	12.0	12.0
Create energy resilience and reduce consumption levels.	2.3	10.0	7.0	7.0
Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranteed variations' published in February 2016.	3.0	12.0	12.0	12.0
Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	2.3	8.0	8.0	8.0
Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	6.0	25.5	24.0	24.0
Total Weighted Score	**16.9**	**67.5**	**63.0**	**63.0**
Ranking	4	1	2	2

3.8.3 The table overleaf shows the impact of recalculating the weighted score of each benefit by changing the weighting so that all are equal. Again the original scores out of 100 remain unchanged.

Scoring Summary by Evening the Weightings for the Short-Listed Options

Applying Even Weightings	Option 2	Option 4	Option 6	Option 8
Benefit Criteria	**Do Minimum**	**Trust / DH Capital Loan**	**3rd Party / CEF Framework**	**DH Capital Loan / CEF Managed**
	Weighted Score	Weighted Score	Weighted Score	Weighted Score
Assist compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets.	4.4	16.0	16.0	16.0
Create energy resilience and reduce consumption levels.	4.6	20.0	14.0	14.0
Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranteed variations' published in February 2016.	4.0	16.0	16.0	16.0
Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	4.6	16.0	16.0	16.0
Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	4.0	17.0	16.0	16.0
Total Weighted Score	**21.6**	**85.0**	**78.0**	**78.0**
Ranking	4	1	2	2

3.8.4 The impact of both methods of sensitivity analysis in reversing and applying equal weightings to the original scoring, under 3.6.3, confirms the robustness of the ranking to the options.

3.8.5 To conclude Option 4 is still ranked 1st under both methods of sensitivity analysis, with Option 6 and 8 both still ranked equal 2nd and Option 2 still ranked 4th.

3.8.6 The detailed scoring for both the sensitivity analysis methods is attached as Appendix 9.

3.9 Recommendation for a Preferred Option

3.9.1 This section sets out a summary of the appraisal results, by the Energy Saving Project Team, in calculating and evaluating the following areas for the Economic Case:-

- Options appraisal for establishing the long list and then short-list of options
- The basis of the costs and assumptions
- The benefits
- The risks
- The NPV, optimism bias and sensitivity analysis.

3.9.2 The table below summarises the option appraisal results:-

Options Appraisal Summary of the Short-Listed Options

Heading	Option 2	Option 4	Option 6	Option 8
	"Do Minimum" Trust/ DH Capital Loan	Trust / DH Capital Loan	3rd Party / CEF Framework	Trust / DH Capital Loan / CEF Managed
Qualitative benefits score	22.1	86.5	77	77
Rank	**4**	**1**	**2**	**2**
NPV	(2,071)	9,157	1,086	4,012
Rank	**4**	**1**	**3**	**2**
Affordability	No	Yes	Yes	Yes
Rank	**4**	**1**	**3**	**2**
Risk score	26.5	53	61	61
Rank	**4**	**3**	**1**	**1**
Overall ranking	**4**	**1**	**3**	**2**

Preferred option		**Yes**		

3.9.3 Option 4, DH Capital Loan, which includes the capital works detailed below, is the recommended preferred option as it ranks 1st overall in the options appraisal summary.

Summary of the Energy Capital Works Under Preferred Option 4

Project	Capital Works Included:-
1	The replacement of the combined CHP plant for HRI inclusive of a new absorption chiller system.
2	A new CHP plant for CHH inclusive of a new absorption chiller system.
3	Replacement of ageing and obsolete boiler plant at HRI
4	LED lighting replacement and upgrading of fittings at HRI
5	LED lighting replacement and upgrading of fittings at CHH
6	Installation and integration of a Buildding Management System at both HRI and CHH

3.9.4 Option 4 delivers the highest NPV which represents the highest return on the investment.

4 COMMERCIAL CASE

4.1 Introduction

4.1.1 The commercial case describes the Trust's proposed approach to the type of commercial contract award procedure, procurement process and key legal issues.

4.1.2 Should the Board approve this OBC, the Trust will engage (to be confirmed) as the Trust's legal advisors to review frameworks and proposed contract conditions. Approval will also enable the Trust to conduct the required survey works and review potential planning obligations or requirements.

4.2 The Public Contracts Regulations 2015

4.2.1 There are five types of Contract Award procedure under the Public Contracts Regulations ("PCR") 2015 Regulations. The five types of contract award are:-

- open procedures with no restrictions in legislation on the use
- restricted procedures with no restrictions in legislation on the use
- competitive dialogue procedures can only be used in certain circumstances
- competitive with negotiation procedures can only be used in certain circumstances
- innovation partnership procedures can only be used in certain circumstances

4.2.2 The Trust has given due consideration to the PCR 2015 Award Procedure. The PCR 2015 also has a number of provisions that are relevant in these situations which the Trust is aware of and must be compliant with. The main points are covered below:-

- The choice of the method of calculating the estimated value of procurement cannot be made with the intention of bringing it below the relevant service/works threshold (Reg 6 (5)).
- Where a proposed work may result in contracts being broken down into separate lots then account needs to be taken of the value of all of the lots when assessing the value of a contract (Reg 8 (11)].
- The design of a procurement process should not be made with the intention of excluding it from the scope of the rules or artificially narrowing competition (Reg 18 (2)

4.2.3 The ESPT has given due consideration to the commercial feasibility and compliance for the project, in relation to the PCR 2015 sections, and would ensure the procedures, as appropriately required.

4.3 Scope

4.3.1 **T**he Trust has decided to pursue the Bespoke Project Team approach and the Team proposes to sub divide the master programme into the following distinct projects:-

- The replacement of the combined heat and power (CHP) plant for HRI inclusive of a new absorption cooling system
- The installation of a new combined heat and power (CHP) plant for CHH inclusive of a new absorption cooling system
- Replacement of ageing and obsolete boiler plant at HRI.
- LED lighting controls and upgrading of fittings at CHH.
- LED lighting controls and upgrading of fittings at HRI.

Resulting in:-

- a reduction in operating costs and carbon footprint
- an improvement in resilience and business continuity
- a reduction in risk through improved infrastructure and risk transfer to contractor.

4.3.2 Should a separate solution be considered for the individual sites of HRI and CHH, these could potentially be included under one PA.

4.3.3 A Master project timetable for the energy innovation upgrade schemes has been produced detailing the timescales for each individual project. Whilst the overall value of the works is £13.7m (incl.VAT) individual works contracts will be considerably less and therefore will be within the OJEU limits given that OJEU limits are net of VAT[4].

4.3.4 An overview of the procurement process is detailed below.

4.4 Procurement Process

HRI Boiler Replacements

4.4.1 In the case of the HRI Boiler replacement the Hull and East Yorkshire Hospitals NHS Trust will be operating from a restricted and Competitive procedure. These projects are intended to be Design and Build Contracts, which will involve the following stages:-

- Fee bid for Independent Technical Advisor and Quantity Surveyor who will be responsible for developing performance specification and assisting Trust in development and review of Design and Build tender evaluation.

[4] 2015 No 102 Public Procurement. The Public Contract Regulations 2015. Para 6

- Expressions of interest and completion of approved PQQ[5] for Design Build Contractor.
- PQQ Assessment and Evaluation for Design Build Contractor.
- Invitation to Tender (ITT) for Design Build Contractor.
- Tender Evaluation for Design Build Contractor.

4.4.2 Design-Build approach gives the Trust a single point of contact. However, the client commits to the cost of construction, as well as the cost of design, much earlier than with the traditional approach. Whilst risk is shifted to the contractor, it is important that design liability insurance is maintained to cover that risk. Changes made by the client during design can be expensive, because they affect the whole of the Design-Build contract, rather than just the design team costs.

Combined Heat and Power (CHP) Replacement at HRI and New CHP at CHH

4.4.3 In the case of the CHP replacement at HRI and new installation at CHH the Hull and East Yorkshire Hospitals NHS Trust will be operating from a restricted and Competitive procedure. These projects are intended to be Design and Build Contracts, which will involve the following stages:-

- Fee bid for Independent Technical Advisor and Quantity Surveyor who will be responsible for developing performance specification and assisting Trust in development and review of Design and Build tender evaluation.
- Expressions of interest and completion of approved PQQ[6] for Design Build Contractor.
- PQQ Assessment and Evaluation for Design Build Contractor.
- Invitation to Tender (ITT) for Design Build Contractor.
- Tender Evaluation for Design Build Contractor.

4.4.4 Design-Build approach gives the Trust a single point of contact. However, the client commits to the cost of construction, as well as the cost of design, much earlier than with the traditional approach. Whilst risk is shifted to the contractor, it is important that design liability insurance is maintained to cover that risk. Changes made by the client during design can be expensive, because they affect the whole of the Design-Build contract, rather than just the design team costs.

LED Lighting Controls and Upgrading of Fittings at CHH and HRI

4.4.5 For the LED Lighting Replacement, the Hull and East Yorkshire Hospitals NHS Trust will be operating from a Competitive and Innovation Partnership procedure, which will involve the following stages:-

- Fee bid for Independent Technical Advisor and Quantity Surveyor who will be responsible for developing performance specification

[5] PAS 2013
[6] PAS 2013

schedule of fittings and assisting Trust in development and review of tender evaluation.

- Expressions of Interest and completion of approved PQQ[7] for lighting manufacturers.

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- PQQ Assessment and Evaluation
- Invitation to Tender
- Tender Evaluation
- Appointment upon Approval of FBC
- Expressions of Interest and Completion of Approved PQQ[8] for Electrical Contractors
- PQQ Assessment and Evaluation
- Invitation to Tender
- Tender Evaluation
- Appointment upon approval of FBC

4.4.6 The chosen procurement strategies for each sub task with the overall carbon Energy reduction schemes have been chosen as they provide the best value for money to the Trust. In the case of boiler replacements and CHP installation and replacement, these are considered specialist tasks with a smaller field of suppliers, in addition in previous years the Trust has installed the CHH boiler house on a design and build contract based upon a performance specification. Previous attempts to replace the HRI boilers from a traditional route have identified a skill shortage in the market place for competency and relevant experience of such schemes.

4.4.7 Lighting is replaced routinely on Capital led projects and as such the interest from the local supply chain of contractors is strong.

4.4.8 The procurement strategy for each individual sub task is as follows:-

- HRI Boiler Replacement - Design and Build, from a restricted and Competitive procedure
- CHH CHP and Absorption Chiller – Design, Build and Maintain, from a restricted and Competitive procedure
- HRI CHP and Absorption Chiller – Design, Build and Maintain, from a restricted and Competitive procedure

[7] PAS 2013
[8] PAS 2013

- HRI LED Lighting replacement – Traditional Two stage tender from a Competitive and Innovation Partnership procedure

- CHH LED Lighting replacement – Traditional Two stage tender from a Competitive and Innovation Partnership procedure.

Pre-Qualifying Questionnaire ("PQQ")

4.4.9 Market place interest has been gauged on previous attempts to use the CEF route. On each occasion the marketplace interest from major suppliers such as Veolia, Doosan, and Imtech has been high. It is expected given the large infrastructure tasks such as Boilers and CHP will attract significant interest.

4.4.10 Each individual project will be commencing with a PQQ based upon current HM Government guidelines. This will only be required should the contractor/consultant be 'new' to the Trust and not already on the Trusts approved list. Given that the majority of the schemes with the exception of the lighting remain outside of the normal construction activities that the Trust undertakes, it is likely that PQQ will be necessary, notably PAS2013.

Output Specification

4.4.11 The Trust will issue an output based specification at the tender stage of the procurement process to the contractors. It requires bidders to provide a robust energy service solution for both the HRI and CHH.

4.4.12 The specification requires bidders to provide proposals for investment in an energy infrastructure that would enable the Trust to meet the NHS requirement and reduce the Trust's carbon footprint.

4.4.13 The project team with the responsibility of evaluating the bidding process during this feasibility phase is made up of the following members:

- the Executive Director and Chief Financial Officer as Project Sponsor and member accountable at board level for this project

- the Director of Estates ,Facilities and Development as Project Director

- the Senior Project Manager as the Trust's Project Lead

- Senior Technical Operations Manager Trust side

- Trust Finance representative

- Trust Procurement Lead.

Invitation to Tender

4.4.14 When ready, the Project Team will release its Invitation to Tender (ITT) to the bidders.

4.4.15 Each bidder will produce its best bid for the Trust based on the information and advice given, and present this to the Trust in the form of

a business case. The project team will evaluate the bids, choose the project that offers the best value for money, add a recommendation sheet and send it through the Trust's Governance process, including the Board, for approval. Should the Board withhold approval for the project, then it will cease.

Construction (Project Dependent)

4.4.16 The installation phase starts with contract award and typically lasts a year. The project team will chair monthly technical and project board meetings to manage the installation and the project team will work closely with the Trust to oversee the tests for practical completion. Only when the installation is proven to meet standards and to perform properly technically and financially will practical completion be approved. The project enters the operational phase.

Operational Phase

4.4.17 The operational phase is subdivided for each project as follows:-

- Replacement of HRI boilers will be operated and maintained by the Estates Department
- Replacement of current HRI CHP will be let with maintenance contract based upon performance and availability due to lack of current specialised skill sets with Estates Department.
- Installation of new CHP at CHH will be let with maintenance contract based upon performance and availability due to lack of current specialised skill sets with Estates Department.
- Lighting upgrade maintenance will be carried out by the Estates Department.

4.5 Key Contractual Issues

4.5.1 All contracts will be let under the NEC3 Option A and B Suite of Contracts. Lighting Replacement Contracts to be let under NEC Engineering Contract Option A, based upon a schedule of rates for common light fittings/design services. The contract process will be managed using web based collaborative software package SYPRO.

4.5.2 Boiler and CHP contracts will be Option A based upon an activity schedule detailing milestone payments once activity such as the installation, delivery mechanical first fix etc have been completed. All professional services contracts for works such as design surveys will be let under the NEC3 Professional services contract. The contract process will be managed using web based collaborative software package SYPRO

Town and Country Planning & Building Regulations

4.5.3 Planning and building obligations will become more certain once the preferred technical solution is identified and a full update will be provided as part of the FBC. All site changes must be fully compliant with current regulations and processes.

4.6 Contractual Risk

4.6.1 This Section provides an assessment of how the project risks might be apportioned between the Trust and the preferred bidders as corporate entities engaged to assist in the delivery of the energy upgrade scheme. As the bidders are expected to design and implement the solution, all associated risk would sit with them. The allocation of risk for the energy project scheme is shown in the table below:-

Risk Category		Potential Allocation		
Applies to all 5 Capital Projects		Trust	Contractor	Shared
1	Design	25%	75%	
2	Construction & development	10%	90%	
3	Transition and implementation			100%
4	Availability and performance	20%	80%	
5	Operational	100%		
6	Variability of revenue	100%		
7	Termination			100%
8	Technology & obsolesence	100%		
9	Control	100%		
10	Residual value	100%		
11	Financing	100%		
12	Legislative	25%	75%	
13	Energy prices / savings guarantee	100%		

4.6.2 A full provisional risk appraisal has been undertaken although some risks remain dependent upon the final design solution and would depend on the solution being proposed. This is explored further in the Management Case section of the OBC.

4.7 Personnel

4.7.1 It is not anticipated that the new boiler plant will have any detrimental effect to staffing levels with the HEY Operational Estates Team. Although the CHP maintenance is intended to be carried out by a specialist as part of the installation contract, it is anticipated that in the future that this will be covered by the HEY Estates Operational Team. It is likely that the reduced time spent on replacing light fittings/changing lamps will be used to keep up with increasing backlog maintenance activities.

4.7.2 The Hull and East Yorkshire Trust has also opened dialogue with other local NHS trusts such as York and NLAG with a view to either sharing or providing Estates services. The new specialist equipment will broaden

the knowledge base of the in-house Estates department and bring in line with modern heating, CHP and lighting systems, further increasing the possibility of the Trust providing external services in the future. However, this is not being considered as part of this OBC.

4.8 Accountancy Treatment

4.8.1 The intended accountancy treatment of the Energy Innovation Upgrade Scheme capital works assets will be on balance sheet as they will be purchased by HEY as defined under the Commercial Case. This is in agreement with the International Reporting Financial Standards (IFRS). These are the set of standards developed by the International Accounting Standards Board (IASB).

5 FINANCIAL CASE

5.1 Introduction

5.1.1 The purpose of this Section is to set out the likely financial implications of the preferred Option 4, DH Funded Capital Loan, as identified in the Economic Case and as set out in the Commercial Case.

5.1.2 A full financial assessment of the preferred option 4 has been carried out to evaluate and determine the financial impact of the energy project schemes.

5.1.3 The preferred option is based on the assumption that the energy upgrade funding would be through a DH Capital Loan funded route. The loan term covers 25 years with the capital and interest repayments through calculated the UK Debt Management Office.

5.2 Financial Position of the Trust

5.2.1 HEY is a financially challenged Trust, within a financially challenged health economy and has recognised that internal efficiencies savings alone will not be sufficient to secure the infrastructure to support the clinical, operational and financial sustainability of the Trust. This proposed scheme is an unavoidable investment in infrastructure to support a modern hospital and deliver energy efficiency.

5.2.2 At the end of the 2016/17 financial year the Trust reported a surplus of 2.6m. This was supported by funding of £15.1m through the Sustainability and Transformation Fund and £1.5m of non-recurrent income from the Department of Health. The Trust had an overall risk rating of 3 with the liquidity position (rated 4) continuing to be a major concern for the Trust.

5.2.3 The Trust has produced a two year financial plan for the financial years 2017/18 and 2018/19. For 2017/18, the Trust is planning a small surplus of £0.4m which includes £11.9m of income from the Sustainability and Transformation Fund. The forecast outturn for the year at the end of September 2017 is that the Trust will deliver its plan, but this will require achievement of the £16.5m efficiency programme. The Trust's risk rating remains at a 3 with the liquidity rating of 4 reflecting the Trust's ongoing cash issues.

5.2.4 For 2018/19 the Trust's plan indicates a surplus of £5.6m, including income of £11.9m from the Sustainability and Transformation Fund. This requires the delivery of a further £15m of efficiency savings.

Despite the improvement in the surplus achieved the Trust risk rating remains at a 3 with liquidity at a 4.

5.2.5 The following table provides a Summary of Key Financial Data for 2016/17 actual, 2017/18 forecast and 2018/19 plan:-

	Actual 2016/17	Forecast 2017/18	Plan 2018/19
Key Data			
Surplus (£m)	2.6	0.4	5.6
Efficiencies (£m)	15.0	16.5	15.0
Capital Expenditure (£m)	17.8	19.0	13.1
Cash at End of Period (£m)	2.9	1.8	3.1
Risk Rating Year End			
Capital Service Cover	4	3	4
Liquidity	4	4	4
I&E Margin	3	2	1
Variance from Control Total	2	1	1
Agency Rating	3	2	1
Overall Risk Rating	**3**	**3**	**3**

5.3 Capital Expenditure

5.3.1 A summary showing the capital cost of the project and the life-cycle replacement (LCR) is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	Installation Period Aug '18 to Aug '19		Total Capital Works	Total LCR	Total
	£000's	£000's	£000's	£000's	£000's
Capital					
Indirect on-costs (legals, insurances etc.)	60	20	80		**80**
External Engineering Works	7,583	1,526	9,109	3,644	**12,753**
Fees	805	395	1,200		**1,200**
Other Costs	72	0	72		**72**
sub total Capital Costs Only	**8,520**	**1,941**	**10,461**		
sub total Optimism Bias (11.05%)	**941**	**215**	**1,156**		
sub total Capital Works & LCR			**11,617**	**3,644**	**15,261**
VAT @20% (excl. fees)			2,069	729	2,798
Total Capital Works & LCR (incl. VAT)			**13,686**	**4,372**	**18,058**

5.3.2 The assumed rate of interest based on the 25 year loan rates from the UK Debt Management Office, as at the 22nd October 2017, is 2.62%.

5.3.3 The calculation of the scheme's capital cost has been completed on form OB1 according to CIM guidance. This is attached as Appendix 10.

5.3.4 The total initial capital works cost of the project, including the risk adjustment (optimism bias) and VAT, is £13.7m. This figure has been split to reflect how the work will be phased according to the management control plan. The Trust will require the DH loan funding to match this profile.

5.3.5 The life cycle replacement ("LCR") of the assets is £4.4m over the 25 year duration of the loan repayment. This funding is not included in the DH Capital Loan request and will be the responsibility of the Trust to fund over the life of the assets.

5.3.6 The technical guidance included in the HMT's Green Book has been followed in calculating the optimism bias figure for the project. This is currently 11.05% and is calculated based on the value of the capital works. This figure represents £1.4m (including VAT) of risk. This figure will be refined once the OBC is approved and the project is able to enter into the detailed design, contract and procurement process.

5.4 Net Effect on Prices

5.4.1 All the primary financial statements include inflation for the duration of the Energy Scheme. A standard inflation rate of 2.5% has been applied on all expenditure and savings for consistency. However, it should be noted that historically energy prices have been known to rise faster than the rate of inflation. Whilst this could be viewed as a perceived risk the Trust has had in place, for several years now, an energy brokerage contract. This contract has a proven track record in helping the Trust to mitigate energy price rises. The expertise in knowing when and when not to buy, by following the market, has assisted the Trust in containing its current energy contract purchase costs.

5.5 Revenue Costs

5.5.1 The revenue running costs of the scheme make provision for the annual operating and maintenance of the upgraded and new engineering plant and equipment. The majority of this work will be undertaken as a contracted out service and hence VAT reclaimable. Also included are costs for additional in house support and an energy performance contracts manager. The full year annual revenue costs are shown in the table below:

Annual Revenue Costs (from SoCI)	**Full Year £000's**
Annual OP & Maintenance	400
HEY Estates support - staffing	33
HEY Estates support - non pay	57
Energy Performance Contracts Manager	60
Total revenue costs per annum	**550**

5.5.2 The revenue costs per annum of £550k have been indexed linked for future years.

5.5.3 The loan interest will also be a revenue cost and this has been factored into the calculations. The whole life cost of the project is attached as Appendix 11. The whole life cost is not discounted and does not include capital charges, depreciation, cash releasing benefits and VAT.

5.6 Savings

5.6.1 The annual savings from the energy upgrade scheme, for each project, are detailed under 3.2.4 of the Economic Case. The impact on the first full year will be a £1.9m saving (excl. VAT) on energy costs.

5.7 Assumptions on Other Costs and Savings

5.7.1 Advice on the treatment of VAT for the project has been taken from the Trust advisors KPMG. From a VAT perspective, the treatment would be undertaken on a traditional NHS capital build project basis whereby VAT recovery would be limited to components of the scheme eligible for VAT recovery on a 'line by line' basis. At this stage of the business case no VAT recovery on the capital project , other than fees, has been assumed until the work can be progressed onto the detailed designs, contract and procurement process which are subject to approval of the OBC. KPMG have confirmed VAT recovery would apply to the operating and maintenance costs providing they were not undertaken by the Trust.

5.7.2 The ownership of the assets is confirmed and would appear on the asset register for HEY. These assets would be treated as on balance sheet for HEY and therefore subject to the relevant accounting standards under IFRS regulations.

5.7.3 The split of costs between revenue and capital is confirmed as being in line with the current capitalisation policy.

5.7.4 The depreciation costs have been calculated based on a 25 year asset life.

5.8 Impact on the Statement of Comprehensive Net Income (SoCI)

5.8.1 A summary showing the incremental impact on the Statement of Comprehensive Net Income is shown in the table below:-

Statement of Comprehensive Income Summary							
Trust (DH Capital Loan Funded)	**Year**	**Year**	**Year**	**Year**	**Year**	**Year**	**Total**
Preferred Option 4	**0**	**1**	**2**	**3**	**4**	**5**	**25 Years**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
SAVINGS							
Energy Savings (incl.VAT)	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
sub total Energy Savings	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
EXPENDITURE							
Operating & Maintenance Costs	233	400	410	420	430	441	13,884
HEY In house Staffing Costs	54	93	96	98	101	103	3,244
HEY In house Non Pay Costs	33	57	59	60	62	63	1,987
Loan interest	179	348	334	320	306	292	4,661
Depreciation	268	537	537	537	537	537	16,711
PDC Dividends	0	0	0	0	0	1	592
sub total expenditure	769	1,435	1,435	1,435	1,435	1,437	41,079
Savings attributable to Trusts SoCI	(585)	(886)	(944)	(1,004)	(1,064)	(1,125)	(39,548)

5.8.2 The table shows that the total gross savings over the life of the project will be £80.6m.

5.8.3 The table also shows that the total expenditure over the life of the project will be £41.1m.

5.8.4 Over the 25 years the net incremental saving to the Trust will be £39.6m.

5.8.5 The detailed SoCI over the 25 years is attached as Appendix 12.

5.9 Impact on the Statement of Financial Position (SoFP)

5.9.1 A summary showing the incremental impact on the Statement of Financial Position is shown below in the table below:-

Statement of Financial Position Summary							
Trust (DH Capital Loan Funded)	**Year**	**Year**	**Year**	**Year**	**Year**	**Year**	**Total**
Preferred Option 4	**0**	**1**	**2**	**3**	**4**	**5**	**25 Years**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Fixed Assets							
Opening balance	13,686	13,418	12,881	12,345	11,808	11,271	210,453
Additions (incl. VAT)	0	0	0	0	0	24	4,339
Depreciation	(268)	(537)	(537)	(537)	(537)	(537)	(16,710)
Closing balance	13,418	12,881	12,345	11,808	11,271	10,758	198,082
Current Liabilities							
Opening balance	(13,686)	(13,418)	(12,881)	(12,344)	(11,807)	(11,270)	(188,036)
Capital loan repayment	268	537	537	537	537	537	13,693
Closing balance	(13,418)	(12,881)	(12,344)	(11,807)	(11,270)	(10,733)	(174,343)
Impact on Assests / (Liabilities)	**0**	**0**	**1**	**1**	**1**	**25**	**23,739**
Cumulative cash impact							
Net cash savings benefit	585	886	944	1,004	1,064	1,101	38,200
Net impact on Balance Sheet	**585**	**886**	**945**	**1,005**	**1,065**	**1,126**	**61,939**

5.9.2 The detailed SoFP over the 25 years is attached as Appendix 13.

5.10 Statement of Cash Flows

5.10.1 A summary showing the incremental impact on the Statement of Cash Flows is shown in the table overleaf:-

Summary Impact on the Statement of Cash Flows							
Trust (DH Capital Loan Funded) **Preferred Option 4**	**Year 0 £000's**	**Year 1 £000's**	**Year 2 £000's**	**Year 3 £000's**	**Year 4 £000's**	**Year 5 £000's**	**Total 25 Years £000's**
Capital Costs							
Total Capital Works	13,686						13,686
DH Capital Loan Funding	(13,686)						(13,686)
Life Cycle Costs	0	0	0	0	0	24	4,373
Operating & Maintenance Costs	233	400	410	420	430	441	13,884
HEY In house Staffing Costs	54	93	96	98	101	103	3,244
HEY In house Non Pay Costs	33	57	59	60	62	63	1,987
PDC Dividends	0	0	0	0	0	1	592
Loan Capital Repayment	268	537	537	537	537	537	13,686
Loan Interest	179	348	334	320	306	292	4,661
sub total Capital Costs	769	1,435	1,435	1,435	1,435	1,461	42,427
Savings							
Energy Savings	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
sub total Energy Savings	(1,354)	(2,321)	(2,379)	(2,438)	(2,499)	(2,562)	(80,627)
Cumulative Impact on Cash Flow	**(585)**	**(886)**	**(944)**	**(1,004)**	**(1,064)**	**(1,101)**	**(38,200)**

5.10.2 The table shows that the cumulative impact on the cash flow will be a £38.2m improvement.

5.10.3 The detailed Cash Flow over the 25 years is attached as Appendix 14.

5.11 Overall Funding and Affordability

5.11.1 The Energy Upgrade Scheme, if implemented, would generate a total energy saving of £80.6m as per the SoCI. The costs associated with its implementation of £41.1m are more than covered by these savings. The scheme is therefore affordable and the surplus saving of £39.6m would contribute to HEY's CRES targets.

5.11.2 In order to progress with the Energy Scheme a DH Capital Loan of £13.7m (incl.VAT) would need to be approved.

5.11.3 The loan interest rate applied has been 2.62%. The RPI rate used for indexation has been 2.50%.

5.12 Commissioner Support

5.12.1 Letter confirmation of Commissioner Support is to follow. This will be Appendix 15 and is a requirement for the submission of the OBC to NHSI.

6 MANAGEMENT CASE

6.1 Introduction

6.1.1 This Section of the OBC addresses the 'achievability' of investment in an energy infrastructure for HEY. Its purpose, therefore, is to set out the actions that would be required to ensure a successful delivery in accordance with best practice.

6.1.2 The proposed project is a core element to the success of the estate strategy for the immediate and long term vision for HEY. The proposed development programme includes:-

- the Outline Business Case approval process
- project stakeholder engagement throughout
- potential planning applications dependent on the selected solution
- potential public consultation if necessary
- production of a loan capital financing application between OBC and FBC stages working in conjunction with NHSI
- the Full Business Case approval process
- Performance Agreement exchange
- successful scheme implementation.

6.2 Programme Plan

6.2.1 The indicative timetable – which is dependent on the timing of the Business Case approvals – is as follows:-

Activity	Completion Dates/Milestones
OBC to HEY Trust Board	7th November 2017
Submission of OBC to NHSI	8th November (period of 12 weeks to complete)
NHSI Resource Committee meeting	End of January 2018 - NHSI decision on OBC
Tender Period	From February 2018
Loan application	From February 2018 to complete April 2018
Submission of FBC – Trust Board	May Trust Board
Submission of FBC - NHSI	Approval of FBC by August 2018 (max 12 weeks)
Project Design & Agreement Finalisation	From February 2018
Project Implementation	During August 2018
Contract Signature	End of August 2018
Site Mobilisation	August 2018 Onwards
HRI LED lighting upgrade and fittings	October 2018 – March 2019
CHH LED lighting upgrade and fittings	October 2018 – March 2019
HRI Boiler replacement	September 2018 – July 2019
CHH CHP Installation	September 2018 – June 2019
HRI CHP Installation	September 2018 – June 2019
Anticipated Completion date	End of August 2019

6.2.2 A full Management Control Plan (MCP) can be found at Appendix 16 to this document.

6.2.3 An Office of Government ("OGC") gateway risk assessment has been completed and can be provided if required, although recent HMT guidance has suggested that this may not be necessary. The overall consequential impact assessment came out "low" on the scoring for the project.

6.2.4 A full record of all matters relating to the project to date is being kept on file with shared/easy access for the members of the Project Team. These include technical and quality data, commissioned reports, meeting minutes and action points and a log of any work in progress or outstanding matters.

6.3 Project Management

6.3.1 A suitably qualified Project Team has been established for the feasibility of the proposed scheme and is comprised of key members from the Trust's Corporate and Estates divisions, key personnel from Procurement as well as being supported by external advisors including the Trust's legal, VAT and audit support. Should the Board approve the development of a preferred bid; the Team will invite the successful bidders to join the Team. This ensures that there is total conformity and understanding of the design, proforma, risks and programme for the desired solution.

6.3.2 The project team with the responsibility of evaluating the bidding process during this feasibility phase is made up of the following members:-

- the Executive Director and Chief Financial Officer as Project Sponsor and Senior Responsible Officer ("SRO") at Board Level for this project
- the Director of Estates, Facilities and Development as Project Director
- the Head of Sustainability as the Trust's Energy Lead
- the Senior Project Manager as Project Lead
- Senior Technical Operations Manager Trust side
- Trust Head of Finance for E,F&D
- Trust Procurement Lead.

6.3.3 The members of the Project Team are the senior stakeholders responsible for the strategic planning and operational delivery of the Project. Key responsibilities of the Team include:-

- review and discuss the quality and effectiveness of the existing energy provision against national guidelines

- recommend and discuss the strategic development for any proposed scheme, for example business case development, business planning etc. prior to presentation to the various stakeholders

- to decide on an approach for funding in the delivery of the scheme which most benefits the Trust

- to decide on a planning approach and programme should this be necessary

- agree and assist in the management of the project programme

- receive monthly updates on the project progress from the lead Senior Project Manager

- to act as a forum for the discussion of any problem identified by team members and institute appropriate investigation

- monitor targets and environmental requirements e.g. CSF's, stakeholder engagement, planning submission dates

- review and agree the final scheme's inclusions and costs in the delivery of the project

- ensure progress against the agreed project plan and update the plan as the project develops

- manage the Business Case approval process through NHSI

- ensure that risks involved in the project are identified and appropriately dealt with and recorded to identify and assess any risks that may prevent the delivery of the project and enter risks onto the Trust's Risk Register;

- to report any exceptions to the agreed plan to the Capital Resource and Allocation Committee;

- to monitor strategic and operational systems and processes which ensure competent delivery of the scheme;

- to establish overall methodology, processes and change control process that govern the delivery of the project, including criteria for assessing and categorising investment risk for capital and revenue funds, taking into account relevant best practice;

- to ensure communication and consultation with other health groups, directorates and external organisations in achieving the objectives;

- to ensure each lead manager submits monthly updates on progress, expenditure, communication and risk;

- to ensure due consideration is given to all aspects of sustainability seeking advice if needed;

- to support on-going staff, patient and visitor communications;

6.4 Project Reporting and Monitoring

6.4.1 The Project Team has agreed terms of reference and formally report to the Capital Resource and Allocation Committee ("CRAC").

6.4.2 The Project Team will maintain their knowledge and control of the project through routine meetings. A meeting schedule is aligned to the timeline for key project milestones. The Project Director chairs Project Team meetings. In the absence of the Project Director, a nominated deputy will chair the meeting.

6.5 Project Delivery

6.5.1 The selected Preferred Bidders would be selected following a compliant procurement process managed by the Trust. The following conditions would be in place alongside a Contract Management Plan:

- All Contractors will have provided contractors/sub-contractors risk assessments, and method statements would be vetted prior to work commencing
- where contractors/sub-contractors are exposed to common/shared risk factors, the preferred bidders would co-ordinate control measures common to all sub-contractors concerned where necessary
- each sub-contractor's work package would be programmed and co-ordinated to eliminate safety risks arising to other parties where possible
- where an interaction problem occurs, the preferred bidders would take a positive role in ensuring all general principles of control that were agreed are effectively put into place including the exchange of health and safety information between sub-contractors.
- regular site co-ordination meetings would be held with clients, CDM Principle Designers, contractors and sub-contractors during which health and safety issues, progress, quality and any other concerns will be discussed for appropriate address.

6.6 Management to Completion

6.6.1 During the period to Financial Close, the Trust's main point of contact will be the Head of Sustainability and Senior Project Manager as Project Lead.

6.6.2 During this time, the Senior Project Manager ("SPM") who would commence the process and preparations for the detailed design, build, and install and commissioning phases.

6.6.3 The SPM would lead the management and co-ordinate the bid delivery programme and would be the main point of contact for the Trust during this period.

6.6.4 The SPM would ensure all statutory conditions and other compliances are met.

6.6.5 Monthly reports would be issued and a site meeting with the project team and the Trust staff would occur as when the Trust see fit, circa every 2 weeks.

6.6.6 Once the project is at a mobilisation and operational stage, these key staff, are also be supported by the Trust's Help Desk arrangements, and energy bureau for monitoring and verification.

6.7 Works and Commissioning Period

6.7.1 The SPM would work with the Trust through to financial close and prepare for the construction works and commissioning phases and would assume the central role of coordinating the relevant work streams. The CPM would also be the main point of contact for the Trust.

6.7.2 During this period, the SPM would chair weekly work stream meetings and attend monthly Project Board meetings and regular meetings with the Trust. The SPM would have responsibility to the Project Board for the accurate and timely reporting of Progress and Quality. The CPM would be responsible for all day to day liaison with third parties eg CDM Planning Co-ordinator; Technical Adviser and Independent Certifier etc.

6.8 Operational Service

6.8.1 During the Operational phase the organisational structure would be almost identical to that used during the construction and mobilisation phase. The continuity of this organisational structure would help to affect a seamless transfer from construction to operations.

6.8.2 The preferred bidders for each individual project would be responsible for remote monitoring of the systems, analysing usage trends and providing an early alert service should any issue occur with the equipment. The information gathered by the preferred bidders would be used in a number of ways, including:-

- informing strategic decisions regarding energy usage and management
- reducing the need for onsite presence allowing better operational continuity for the Trust
- ensuring optimisation of the plant against the load profile - this monitoring information would also allow the Trust to monitor performance in managing energy usage across the estate and hence operate the contract payment mechanisms.

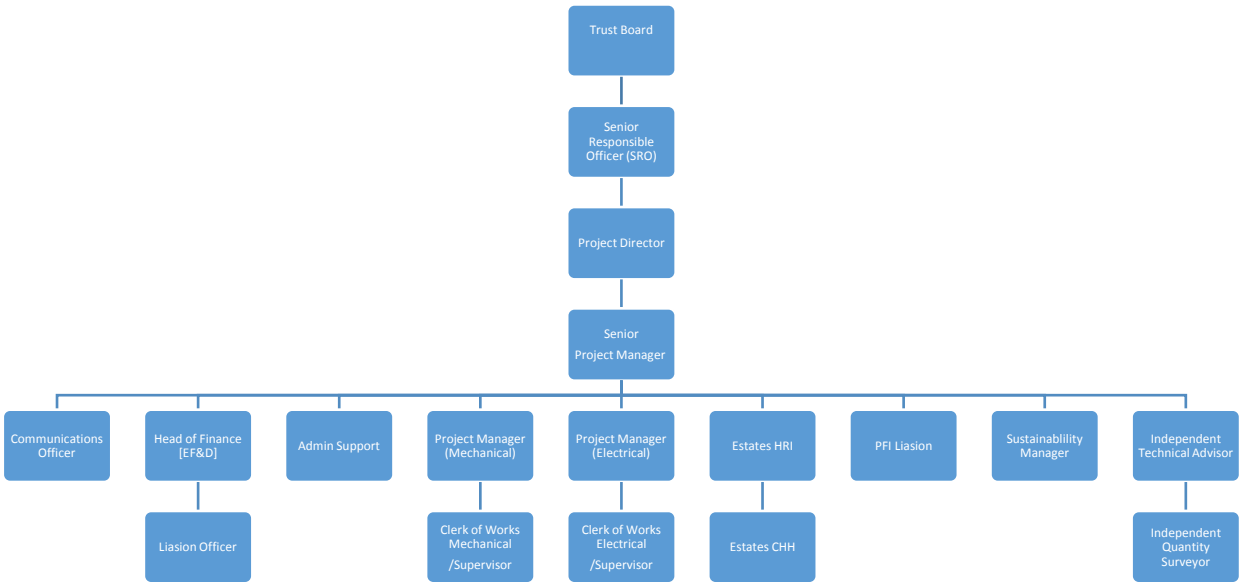
6.8.3 From the outset of a project, the preferred bidders would clearly understand the project needs, and would add maximum value to the proposed solution.

6.8.4 On-going performance measurement would be undertaken both at strategic and operational level. Systems would enable the service provider to pro-actively and closely manage supply-partner performance against pre-determined objectives and therefore identify and jointly

address any issues or problems, at the earliest possible stage, by empowered teams at project level. It is only in the unlikely event that a project team is unable to satisfactorily and rapidly address an issue, that this will be escalated to more senior staff to resolve in strict accordance with the terms of the partnering charter.

6.8.5 The CHP contracts are intended to include a performance and availability contract related and designed to ensure all plant is operated and maintained at optimum efficiency to achieve the savings guarantee and this includes best use of fuel and is monitored through the contract KPIs and from performance verification auditing throughout the entire contract term.

6.9 Energy Project Team Structure



6.10 Benefits Management

6.10.1 The benefits to be realised would be both clinical and non-clinical and would deliver financial and non-financial value to the Trust. These benefits have been described in detail under section 3 of The Economic Case of this OBC.

6.10.2 The Benefits Realisation Table is as follows overleaf:-

Ref	Benefit Area (refer to options appraisal)	Source/Scheme	Specific Benefit/Quantitative (Qn) or Qualitative (Ql)	Key Performance Indicator (Target value)	Baseline Measurement	Measurement /Source of Evidence	Benefit Owner (Monitoring/ Management Assurance)	Target Realisation Date(s)
B1	Energy and financial reduction	Boilers	Supports the Trust CRES program. Supports Trust Sustainable Healthcare Strategy. Reduced gas consumption. Financial Saving/Cost avoidance.	Less gas burnt	Baseline measurement is from previous gas consumption.	Supplier invoices. In house meter reads. normalized against degree days to remove effect of ambient temperature	Head of Sustainability	12 months from implementation date
B2	Carbon Reduction	Whole Scheme	Support Trust in achieving national carbon reduction targets.	Less carbon dioxide emitted	Previous emissions data	Supplier invoices and in house meter reads.	Head of Sustainability	12 months from implementation date
B3	Load Matching	Boilers	Improved efficiency over a range of load profiles.	Less gas burnt/per tonne steam raised	Current HEY data	Boiler daily log sheet.	Estates Operations Manager	12 months from implementation date
B4	Maintenance revenue savings	Boilers	Revenue saving from reduced visits. Increased parts availability combined with lower cost.	Less than current costs	Current Budget	Budget reports.	Estates Operations Manager	12 months from implementation date
B5	Security of steam supply	Boilers	Greater opportunity for remote diagnosis and rectification of faults	Reduced call out	Current Reports	Monthly boiler reports.	Estates Operations Manager	As each project is completed per the MCP
B6	Energy and financial reduction	CHP	Supports the Trust CRES program. Supports Trust Sustainable Healthcare Strategy. Reduced Electricity Import. Financial Saving/Cost avoidance.	Less Electricity Import.	Baseline measurement is from previous electricity consumption.	Supplier invoices. In house meter reads.	Head of Sustainability	12 months from implementation date
B7	Maintenance revenue savings	CHP	Reduced cost per kWh Increased parts availability combined with lower cost.	Less than current costs	Current Budget	Budget reports.	Estates Operations Manager	As each project is completed per the MCP
B8	Security of supply	CHP	Greater security against grid faults.	Reduced interruption to site.	Current Reports	Number of outage and time to re-instate supply.	Estates Operations Manager	As each project is completed per the MCP
B9	Energy and financial reduction	Lighting, BMS	Supports the Trust CRES program. Supports Trust Sustainable Healthcare Strategy. Reduced Electricity Import. Financial Saving/Cost avoidance.	Less Electricity Import.	Baseline measurement is from previous electricity consumption.	Supplier invoices. In house meter reads.	Head of Sustainability	As each project is completed per the MCP
B10	Maintenance revenue savings	Lighting, BMS	Reduced life cycle cost	Less than current costs	Current Budget	Budget reports.	Estates Operations Manager	As each project is completed per the MCP
B11	Patient Environment	Lighting, BMS	Improve lighting quality and levels Improved infection control.	Place inspections	Place Scores	Place inspections	Estates Operations Manager	In line with MCP
B12	Reduction in backlog	Lighting, BMS, Boilers	Reduced backlog costs	Backlog Schedule	Backlog Schedule	Backlog Schedule	Estates Operations Manager	In line with MCP

6.11 Change Management

6.11.1 Potential changes resulting from this proposed energy infrastructure upgrade would be managed by the relevant members of the Project Team and would be overseen by the Project Board. The process for managing change requests is as follows:-

- User/stakeholder submits formal request on change request form.
- Change requests are then reviewed by project board, namely Senior Project Manager and Project Director.
- Final approval/decline of change requests is actioned by Project Director
- Senior Project Manager will then action change request and notify the requester of the completion/status in written format.

6.11.2 All change requests will be recorded upon the scheme change request register.

6.12 Risk Management

6.12.1 A project risk register will be kept and updated, for the duration of the project and is detailed in the Appendix 17. A service interruption risk appraisal will be implemented and would be based on the preferred option of works. A separate construction risk and designers risk register would be developed by the preferred bidders to be shared with the Trust.

6.12.2 This assessment would consider the risks associated with the potential to interrupt Trust services during implementation. Risks considered would relate to:-

- mobilisation and site establishment
- removal of old plant and installation of new plant
- continuation of supplies to all stakeholders
- commissioning of new plant.

6.12.3 Although no longer a pre requisite, the Trust has completed a Gateway Risk Potential Assessment (RPA) review of the project which would demonstrate the project's risk profile. This process has now been withdrawn by the DH as a formal requirement; the Trust intends to use this as part of its own assurance arrangements.

6.13 Project Evaluation

6.13.1 Only when the installation has passed Practical Completion, the Trust would commence its post project evaluation in line with the Hull and East Yorkshire NHS Trust Post Implementation Reviews.

6.13.2 The Trust has recently reviewed its arrangement for post project evaluation and new guidance has been developed. The elements involved in Post Project Evaluation are as follows:-

- Measuring the success of the project in achieving its planned objectives;

- Monitoring the progress of benefits realisation;
- Identifying the reasons for any problems which arose;
- Assessing the management of risk;
- Identifying any necessary remedial action;
- Recording the lessons learned in order to improve the performance of subsequent projects;
- Disseminating the lessons learned from the project.

6.13.3 This will be a multi-disciplinary process, and will be contributed to by many levels within the Trust. The key responsibilities and reporting mechanisms will be as follows:-

- The Project Director will co-ordinate the process and be responsible for overall delivery of the plan. The Estates, Facilities and Development team will take the lead in the formal evaluation processes and will undertake the detailed consultation necessary with staff and users of services;
- The Capital Resources and Allocation Committee will receive the final full report.

6.13.4 There will be four main stages of review:-

- **Stage 1:** Planning and costing the scope of the post-project evaluation work. Produce an evaluation plan in the FBC.
- **Stage 2:** Evaluation of project outputs on completion of the development.
- **Stage 3:** Initial post-project evaluation of the service outcomes six to twelve months after the service has been commissioned.
- **Stage 4:** Follow-up post-project evaluation to assess longer-term service outcomes two years after the service has been commissioned.

6.13.5 As well as the Trust's own internal reporting arrangements on Post Project Evaluation (PPE) there is also a requirement from NHSI to complete Annexe 7 of the Business Case Approval Guidance for NHS Trusts as issued in November 2016. This pro forma is to be completed and submitted to NHSI within six months after commissioning a new facility which has required a business case to be approved by them. Subject to the OBC and subsequent FBC being approved for the Energy Scheme the Project Team will ensure adherence to this request and be mindful of it when completing its own internal PPE.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

7.1.1 The Trust believes that the existing energy infrastructure at both the HRI and CHH sites is inefficient and will not assist the Trust in achieving key targets described in both the National and Local Strategies.

7.1.2 This OBC demonstrates that following both internal and external reviews there is an opportunity to deliver significant savings for HEY. By implementing this scheme it also helps support the Trust's challenging financial position.

7.1.4 The OBC also proves that the preferred Option 4, DH Capital Loan funded, is both economically and financially the best investment route for the HEY Energy Innovation Scheme.

7.1.5 The OBC clearly demonstrates that the following key investment objectives would be achieved if the capital loan was approved:

Investment Objectives of the HEY Energy Scheme		Preferred Option 4 Delivers:
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets	Reductions in carbon emissions of 7,138 tonnes per annum
2	To reduce energy costs and create efficiency savings	Affordable and demonstrates VFM by reducing energy costs and producing cash flow net annual savings of £1m
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.	Would reduce energy costs £/m2 by using resources in a more cost effective manner
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	Replaces ageing and outdated heat and energy plant, new and replacement CHP's and lighting upgrades
5	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	Would meet key strategic objectives of the HEY Estates Strategy 2017-2022 by providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

7.2 Recommendations

7.2.1 Approve the OBC and release to NHSI for consideration / approval to progress, subject to approval by NHSI, to the next stage of the process and develop the further detail required to produce an FBC.

7.2.2 Further detail may be required by the NHSI in answer to outstanding queries to complete their OBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI in their requests.

7.2.3 Subject to the OBC being approved, agree to work on the production of a capital financing application between OBC and FBC stages. This work will be done alongside NHSI's regional team who will help to assist in the development of the capital loan required of £13.7m.

8 APPENDICES (all sent under separate cover)

8.1 **Appendix 1**, HEY Trust Estates Strategy, 2.6.7

8.2 **Appendix 2**, HEY Sustainable Healthcare Strategy, 2.6.8

8.3 **Appendix 3**, Commissioned External Technical Reports; (a) Arup and (b) Sinclair Knight Merz, 2.10.1, points 1 and 2

8.4 **Appendix 4**, Carbon and Energy Fund Feasibility Report, 2.10.1, point 3

8.5 **Appendix 5**, Long List of Options Detailed Scoring Matrix, 3.4.9

8.6 **Appendix 6**, NPV Appraisals of Short Listed Options, 3.5.19

8.7 **Appendix 7**, Detailed Benefits Scoring for the Short-listed Options, 3.6.8

8.8 **Appendix 8**, Detailed Risk Scoring for the Short-listed Options, 3.7.6

8.9 **Appendix 9**, Detailed Scoring for Both Sensitivity Analysis Methods, 3.8.6

8.10 **Appendix 10**, Capital Cost Form OB1, 5.3.3

8.11 **Appendix 11**, Whole Life Costs (NHSI Tables 15 and 16), 5.5.3

8.12 **Appendix 12**, Statement of Comprehensive Income (SoCI), 5.8.5

8.13 **Appendix 13**, Statement of Financial Position (SoCI), 5.9.2

8.14 **Appendix 14**, Statement on the Impact of Cash Flow, 5.10.3

8.15 **Appendix 15**, Letter of Commissioner Support (to follow), 5.12.1

8.16 **Appendix 16**, Management Control Plan, 6.2.2

8.17 **Appendix 17**, Project Risk Register, 6.12.1

8.18 **Appendix 18**, NHSI Business Case Core Checklist not included (for NHSI completion requirements only to accompany OBC if approved by Trust for release)

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CULTURAL TRANSFORMATION PROGRAMME

Meeting date	7 November 2017		**Reference Number**	2017 - 11 - 17		
Director	Simon Nearney, Director of Workforce and OD		**Author**	Myles Howell, Director of Communications		
Reason for the report	The purpose of the report is to inform the Board of the results from the second quarter Staff Survey that took place during August and September 2017					
Type of report	Concept paper		Strategic options		Business case	
	Performance	✓	Briefing	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive and accept the information presented in the report and feedback any comments.					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing	✓	Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): W2 – Governance					
	Assurance Framework Ref: BAF 1, BAF 2	**Raises Equalities Issues?** Yes	**Legal advice taken?** No	**Raises sustainability issues?** No		
5	**TRUST BOARD/BOARD COMMITTEE REVIEW** (if applicable) The report has been presented and discussed at the Workforce Transformation Committee and was subject to discussion at the Board Development session in October 2017.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CULTURAL TRANSFORMATION PROGRAMME

1. PURPOSE OF THE REPORT

The purpose of this report is to inform the Trust Board of the 2nd quarter FFT Staff Survey results that took place during August and September, 2017.

2. KEY ISSUES

The Trust has seen performance in national staff surveys improve since 2014. The challenge now is to move into the top 20% of organisations nationally.

Medical Engagement remains a key area for improvement, together with addressing issues affecting staff with a disability or health condition.

There will need to be a strong focus on enabling managers and leaders to shift from good performance to outstanding performance and a culture of excellence.

Some staff still feel that the organisation remains overly bureaucratic and hierarchical. They describe us as short-term in our focus and they have described a culture of working long hours.

3. BACKGROUND

At the March 2015 Trust Board meeting an approach to Transforming the Culture of the Trust was agreed. This included a four-point plan to address key areas that staff had raised as either a concern or area for development.

Since then the Trust's staff engagement score, which is the key measure for cultural performance has improved from the worst in the country to rank among the middle 60% of organisations and on occasions broke into the top 20% of Trusts.

The CQC which had previously identified cultural issues, including bullying, has specifically noted improvements to the working culture at the organisation. The most recent report described the organisation as being on the cusp of good.

Furthermore, a cultural assessment tool, the Barrett Values Indicator has described the cultural improvement at the Trust as twice that which they would have expected to see in the 30 months since we last ran the Barrett survey.

From 1st April 2014 all organisations providing acute, community, ambulance and mental health services were required to implement the Staff Friends and Family Test (Staff FFT); giving all staff the opportunity at least once a quarter to answer two standard questions. The third quarter test is not undertaken because it coincides with the NHS National Staff Survey.

Our Trust Staff Survey for quarter two 2017/18 ran from 11th August 2017 until 8th September 2017. All 8,800 staff were invited to participate, with 464 staff Responding, equivalent to a 5% response rate. This is significantly lower than in recent FFT surveys. Routinely the FFT is completed by in excess of 1000 staff.

4. OVERALL SCORE FOR ENGAGEMENT

The overall employee engagement measure comprises of nine questions, which are displayed below alongside the positive percentages and scores.

Question	Positive %	Score
Q1 How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family if they needed care or treatment?	80%	4.02
Q2 How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family as a place to work?	63%	3.62
Q4 There are frequent opportunities to show initiative in my role	71%	3.85
Q5 I am able to make suggestions to improve the work of my team/department	75%	3.92
Q6 I am able to make improvements happen in my place of work	57%	3.53
Q7 Care of patients/service users is my organisation's top priority	70%	3.90
Q8 I look forward to going to work	54%	3.43
Q9 I am enthusiastic about my job	70%	3.81
Q10 Time passes quickly when I am at work	70%	3.90
Average:	**68%**	**3.78**

Note: Q1 and Q2 the 'Extremely Likely' and 'Likely' responses have been used excluding don't know responses. Q4 to Q10 the 'Strongly Agree' and 'Agree' responses are used.

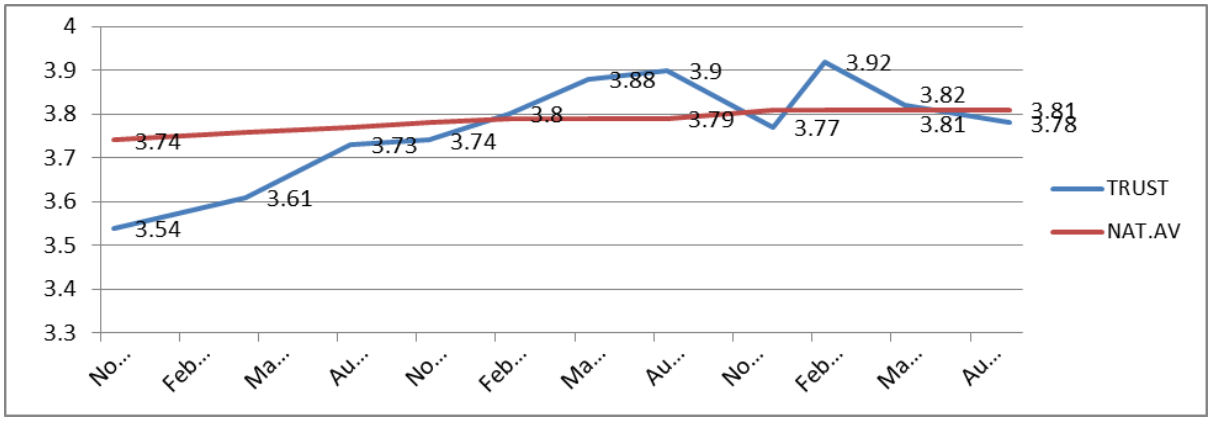
The overall Staff Engagement Score for Hull and East Yorkshire Hospitals NHS Trust in Quarter Two 2017/2018 is **3.78**.

Question 6 has regularly been challenging for the Trust. This theme was reflected in the Barrett survey which identified issues of Hierarchy and Bureacracy as limiting values and barriers to delivering improvements.

The overall score for engagement is showing a deterioration since the start of 2017/2018, albeit in Q2 only 464 staff completed the survey, which is a significantly lower return than previous quarters. All Health Groups are showing a deterioration in their engagement scores, except Clinical Support which has remained the same and Corporate which has improved.

		Q1	Q2
Trust	Hull and East Yorkshire NHS Trust	3.82	3.78
Health Group	Clinical Support Services	3.90	3.90
Health Group	Corporate	3.84	3.96
Health Group	Family & Women's Health	3.79	3.73
Health Group	Infrastructure and Development	3.67	3.54
Health Group	Medicine	3.90	3.68
Health Group	Surgery	3.67	3.60

The trend scores since 2014 are as follows, where this graph shows the Trust average compared with the national average. For the first time since the National Survey 2016, the Trust average (3.78) has slipped below the national average (3.81):



For all areas where 10 or more staff complete a survey the Trust receives an overall score for engagement. These scores are RAG rated, placed in a league table and discussed at the Workforce Transformation Committee and Health Group / Directorate management team meetings. HG's and Directorates are aware of the Trust's ambition to be an employer of choice and to have a workforce who are engaged, feel valued and enjoy working for the organisation. Services that score below 3.88 are required to formulate a plan with HR to discuss and address the concerns raised by staff.

4. WORK UNDERWAY

A staff survey group continues to meet to discuss the findings and actions required to address the issues identified above.

Two key areas of work at present are as follows:

I. Develop leadership and managerial skills to address issues of bullying and harassment, staff feeling undervalued, reduce cultural issues of bureaucracy and hierarchy

- Annual Development Programme – April 2017
- New Leaders programme - April 2017
- Talent Development Course - April 2017
- Management skills programme - April 2018
- Manager briefing sessions – May-September 2017

II. Address medical engagement issues

- Establish engagement group with medical membership – Feb 2017
- Identify engagement issues – March 2017
- Review roles and responsibilities of medical staff – July 2017
- Brief clinical leads and directors – December 2017
- Develop and launch medical leadership programme – January 2018

In addition, staff have frequently identified IT issues, and specifically frustrations about multiple log-ins to software as a frustration and barrier to efficient working. An agreement has recently been reached to invest in a single sign on solution which would remove the need for staff to log-in separately to multiple systems.

5. NATIONAL STAFF SURVEY

The 2017/2018 National Staff Survey is currently live. We are aiming to achieve a response rate of 50% for all Health Groups and Directorates and an overall response rate of 50%+ for the Trust. All staff have received a survey, sent to their @hey.nhs.uk email accounts.

6. RECOMMENDATIONS

The Trust Board is requested to receive and accept the information presented in this report and to feedback their comments and views.

Officer to Contact
Simon Nearney
Director of Workforce and OD
November, 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS: JUNIOR DOCTORS IN TRAINING

Trust Board date	7 November 2017	**Reference Number**	2017 – 11 - 18
Director	Kevin Phillips, Executive Chief Medical Officer	**Author**	Helen Cattermole, Guardian of Safe Working Hours
Reason for the report	The purpose of this report is to inform the Trust Board of the current position in relation to: • Guardian of Safe Working Hours appointment • Junior doctor working hours • Exception reports, where appropriate • Rota gaps • Locum usage • System-wide junior doctor issues, where appropriate		

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

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Briefing	✓	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): S3 - Safe					
	Assurance Framework BAF 2 - Workforce	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The Guardian of Safe Working reports directly to the Trust Board on a quarterly basis, to ensure that key issues and any emerging risks can be reported directly to the Board.					

1. PURPOSE OF THIS REPORT

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

- Junior doctor working hours
- Exception reports, where appropriate
- Rota gaps
- Locum usage
- System-wide junior doctor issues, where appropriate

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from April - June 2017 with reference to:

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. HIGH LEVEL DATA

Number of doctors / dentists in training (total):	527 (establishment) 440.5 (actual)
Number of doctors / dentists in training on 2016 TCS (total):	440.5
Amount of time available in job plan for guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the guardian (if any):	0.25 WTE
Amount of job-planned time for educational supervisors: (max; varies between HGs)	0.25 PAs per trainee

This quarter has shown a huge rise in the number of doctors starting on the 2016 terms and conditions of service (TCS). Since the beginning of October 2017, all trainees in the Trust are now on the 2016 TCS.

All doctors currently on the 2016 terms and conditions of service (TCS) have received their work schedules and most have received them in accordance with the timings set out in the HEE Code of Practice. An electronic exception reporting system is running well and all trainees and trainers have been given access and offered training on the system.

Trainees on the 2016 TCS are issued with a **work schedule**, which sets out the working pattern, rota template and pay, and also sets out the training which they can expect to receive during the placement. Health Education England has agreed a Code of Practice regarding the timescales by which trainees should receive this information.

Trainees submit an **exception report** if their work varies significantly and/or regularly from that set out in the work schedule. They can also submit an exception report if they do not get the expected training (e.g. they miss a scheduled clinic due to providing ward cover for an absent doctor).

Exception reports fall into the following four categories:

- Difference in educational opportunities or available support
- Difference in access to training due to service commitments
- Difference in the hours of work

- Difference in the pattern of work (including failure to achieve natural breaks)

Exception reports are discussed by the trainee and their educational or clinical supervisor and an outcome is agreed. This may be overtime payment or time off in lieu (for extra working hours). For educational differences or where regular hours adjustments are required, a work schedule review may be appropriate. Alternatively, both parties may agree that no action is required and the report is filed for data collection purposes.

Educational exceptions are copied to the Director of Medical Education for action if needed. Hours exceptions are copied to the Guardian of Safe Working Hours, who reviews the reports, ensures (if the data is available) that trainees are working safely, and has the power to issue fines to departments if trainees are breaching their safe working conditions.

The Guardian of Safe Working ensures that the Health Groups are kept updated about problems identified in their areas so that appropriate action can be taken by the departments to maintain patient and junior doctor safety.

The Guardian of Safe Working Hours is also responsible for producing this quarterly report to the Trust Board. The data for the report comes from the exception reports, and from systems held or created by the Trust, particularly Human Resources and payroll data.

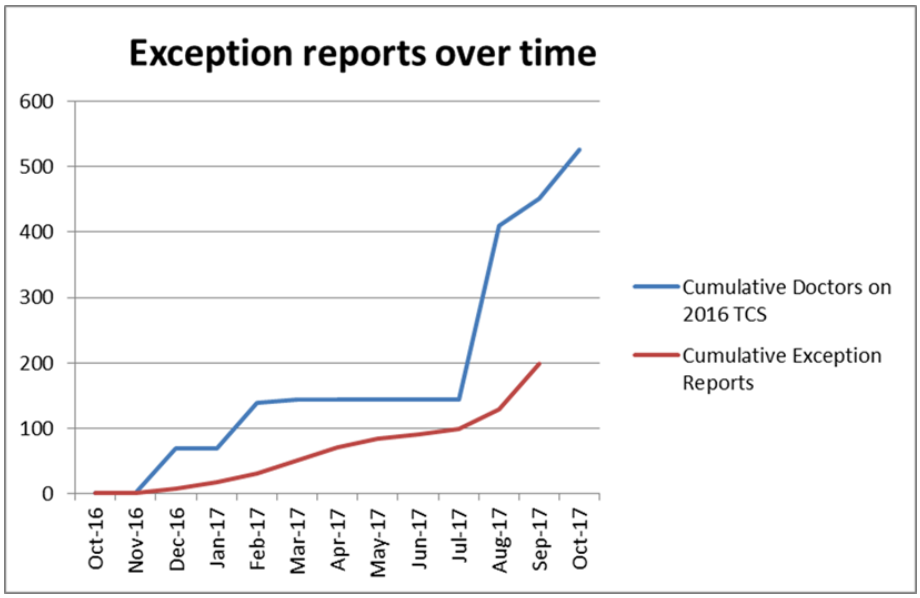
3. JUNIOR DOCTOR WORKING HOURS

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region.

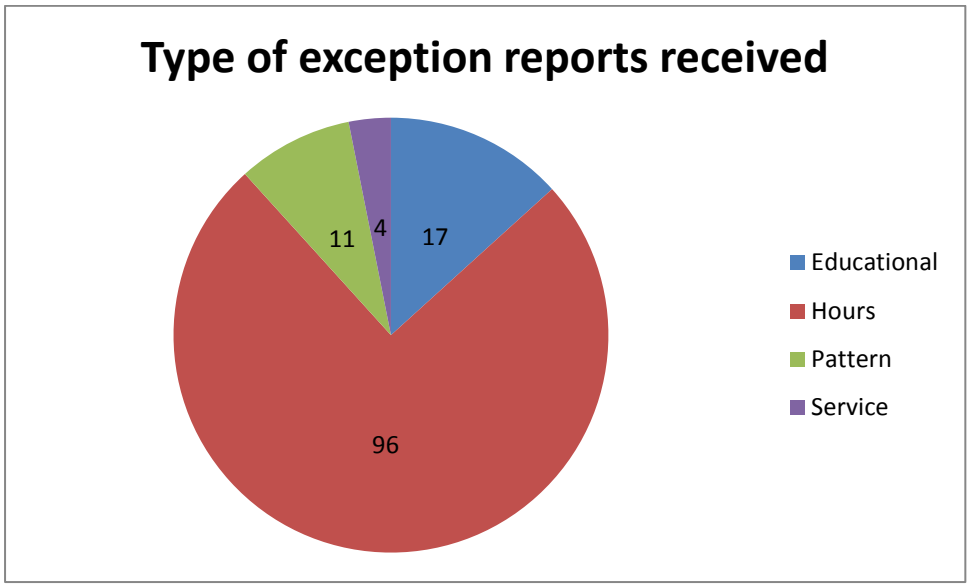
There were 121 exception report episodes submitted between 1 July and 30 September 2017 and seven carried forwards from the previous quarter. The number of reports has shown a steady rise in tandem with the number of doctors on the contract.

a) Exception reports (with regard to working hours)

Exception reports over time

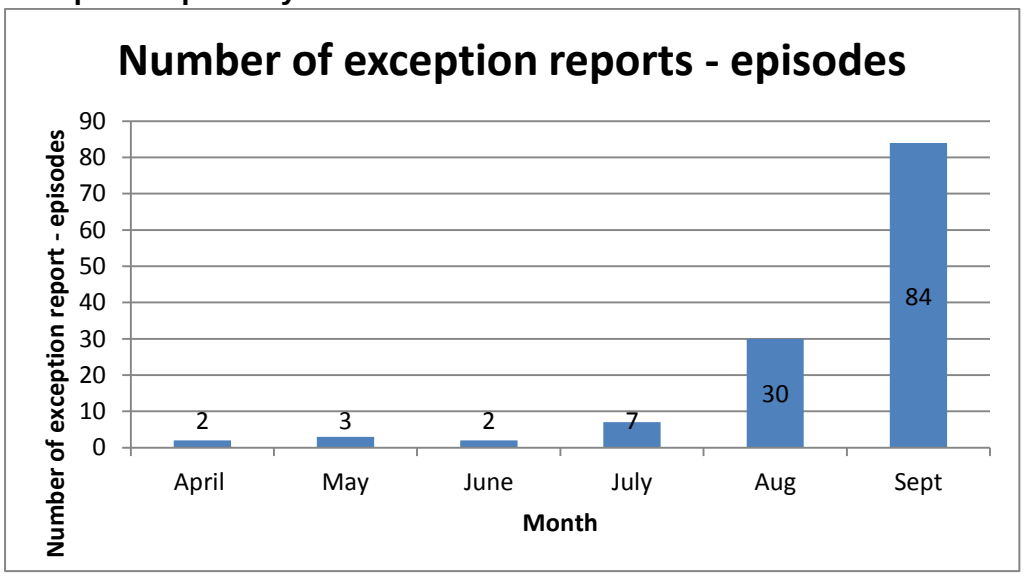


Types of exception reports received 1 July 2017-30 September 2017



While the majority of reports still relate to hours worked, there has been an increase in the proportion of reports relating to educational and training concerns. This rise was predicted and is mirrored nationally as trainees became more familiar with the system of exception reports.

Exception reports by month



The steady rise in reports is unsurprising, given the number of doctors for whom this system is now available. Once a steady state is in place, I would also expect to see a fluctuation in numbers of reports with each rotation, rising as trainees change over and settling again as they get used to their new departments.

Exception reports (episodes) by specialty 1 July 2017 – 30 Sept 2017

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by Trust but trainee feels issue unresolved	Trainee left Trust with issue unresolved	Unresolved - No response from Supervisor despite deadline	Waiting for doctor agreement
A&E		5	1	4				
AAU		3	2	1				
Acute Medicine Ward 1		8	8					
Acute Surgery HRI		24	21	3				
Breast Surgery	1						1	
DME		7	6	1				
General Medicine HRI		1	1					
General Surgery (CHH)	3		2				1	
Infectious Diseases		13	13					
Major Trauma		2	2					
Medicine Nights		1			1			
Neurology		2	2					
Obstetrics & Gynaecology		1		1				
Oncology	3	1	3					1
Orthopaedic Surgery		1		1				
Paediatrics		6	6					
Renal		4	4					
Respiratory		9	6	3				
Upper GI Surgery		4	3			1		
Urology		19	1	18				
Vascular Surgery		10	5	5				

'Hot spots' for reporting in this quarter are:

- Infectious Diseases (one trainee reporting problems, now sorted)
- Acute Surgery (workload, intensity)
- Urology (one trainee reporting problems, still to be addressed by department)
- Vascular Surgery (rota gaps, multiple trainees reporting problems)

Exception reports (episodes) by grade 1 July 2017- 30 Sept 2017

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by Trust but trainee feels issue unresolved	Trainee left Trust with issue unresolved.
F1	7	99	76	27		3
F2		13	7	5	1	
CT2	0	2	2	0		
ST2		1		1		
ST3		1	1			
STR		5	1	4		

F1 doctors are the most likely to report problems, particularly regarding working hours. They have been on the contract longer than any other group of doctors and are most familiar with the exception reporting mechanism; indeed, none of them have ever worked under any other contract. Foundation 1 doctors are the most junior of the trainees, and are learning how to work, how to manage their time, and, in many cases in this early part of the year, are learning how to do things for the first time. They are ward-based, and often feel that they cannot leave until all the jobs are done. As a group, they report reluctance to hand over routine daytime jobs to colleagues covering later in the day. The importance of appropriate and safe handover, and how to do this practically, forms part of the discussions with educational supervisors.

Exception reports (episodes) by rota 1 July 2017 – 30 Sept 2017

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding	Completed by Trust but trainee feels issue unresolved	Trainee left Trust with issue unresolved	Waiting for Doctor Agreement	No response from supervisor
Rota 124a - General Surgery (elective) SHO		1	1					
Rota 124a - General Surgery (acute) SHO		1		1				
Rota 124b General Surgery (Uro/ENT) SHO		4	1	3				
Rota 134 - Orthopaedic F2		1		1				
Rota 25 - Acute/Elective Surgery F1	3	23	23	1		1		1
Rota 23 - Vascular Surgery F1		13	7	6				
Rota 18 - Medicine F1	1	26	23	4				
Rota 18B - Medicine F1	2	1	3					
Rota 4 - Medicine F1	1	20	20					1
Rota 4B - Medicine F1 *		15		15				
Rota 6 - RMO		1	1					
Rota 9 - Medicine SHO blp 575		2		1	1			
Rota 1 - A&E F2		1	1					
Rota 2 - A&E SpR		4		4				
Rota 12 - Medical Oncology SpR		1					1	
Rota 51 - O&G ST1-2		1		1				
Rota 58 - Paediatrics SHO		6		6				

**covering urology*

This table further breaks down the general groups of doctors into their constituent rotas. This shows that the doctors submitting most reports are Foundation 1 doctors in medicine, general surgery, vascular surgery and urology. This is not the biggest group of doctors but this clearly shows that these doctors are under significant pressure.

Exception reports (episodes) - response time 1 July 2017 – 30 Sept 2017

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open	Unresolved or waiting
F1	17	28	28	27	3
F2	1	0	3	5	1
CT2	1	0	1	0	0
ST2	0	0	0	1	0
ST3	0	1	0	0	0
STR	0	0	0	4	1

The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within SEVEN days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.

This is shown in the table below:

Exception reports (episodes): response time by department 1 July 2017 – 30 Sept 2017

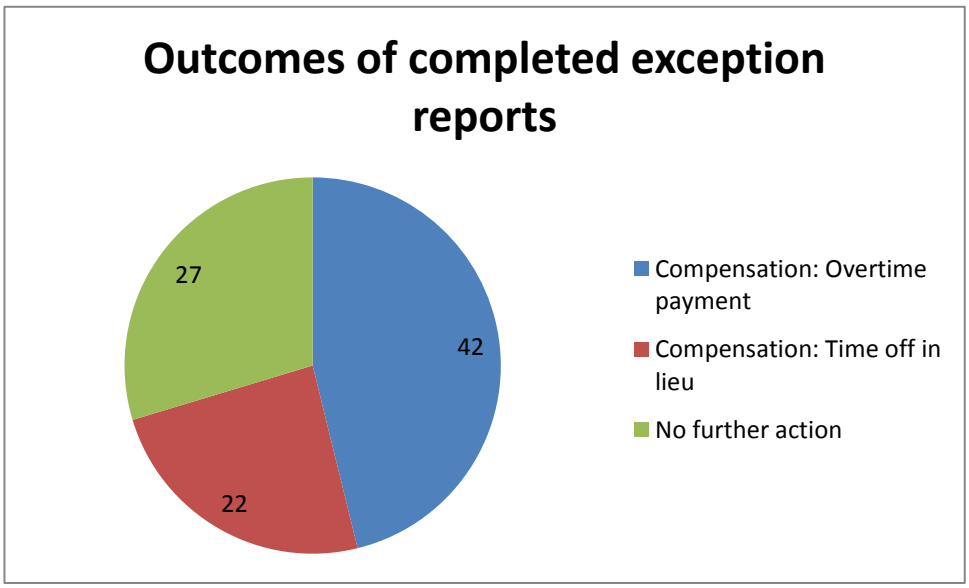
Department (base dept)	No of reports	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports	Unresolved or waiting for trainee
A&E	5			1	Meeting took place after 2 days but not recorded for 5 weeks	4	Trainer on sabbatical, no response, escalated	
Breast Surgery	4					2	No response from trainer, escalated	2
Colorectal Surgery	2	1		1	No reason given			
Critical Care F1	3		3					
Infectious Diseases	13			13	Trainer on leave			
Neurology	2		2					
Obstetrics and Gynaecology	1					1	Trainee on leave	
Oncology	5			3	Trainee missed meeting (clin commitments) then on leave. Supervisor unhappy to complete report. Escalated to CSHG x2, 1 = Supervisor unhappy to complete report. 1=meeting completed but not recorded for 4 weeks	1	No action from supervisor despite response to request	1

Department (base dept)	No of reports	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Notes for delayed reports	Still open	Notes for outstanding reports	Unresolved or waiting for trainee
Orthopaedic Surgery	1					1	No action from supervisor despite response to request	
Paediatric Neonates	2	2						
Paediatrics	4	2		2	Confusion over supervisor x2			
Renal	5		5					
Respiratory	12	5	2	1	No reason given	3	Meeting imminent	1
Rheumatology	14	4	5	5	No reasons given			
Upper GI Surgery	23	9	7	6	No reasons given			1
Urology	19	1				18	No response from supervisors	
Vascular Surgery	13	1	5	1	No reasons given	6	No action from supervisors despite response to request	

The surgical specialties seem to be the most difficult ones for trainers and trainees to meet in a timely fashion. This may be due to a number of contributory factors:

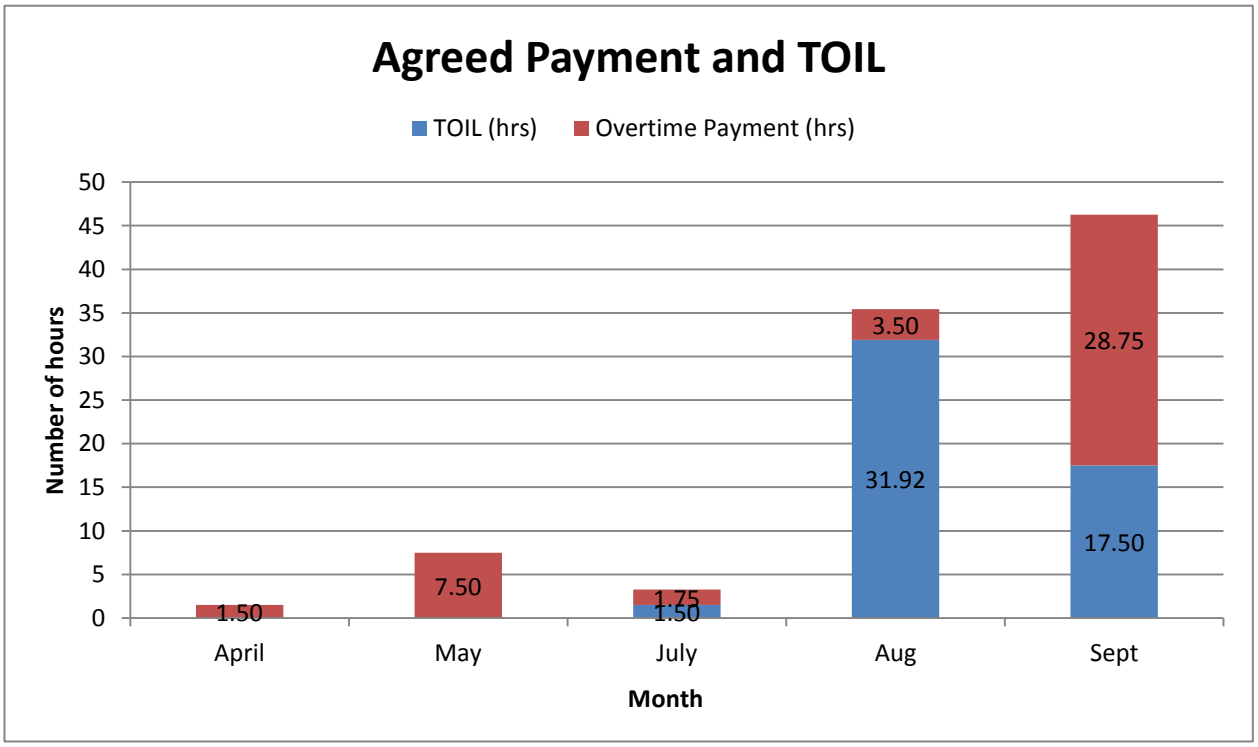
- Split site working
- Consultants working off the wards (in theatre and clinic) and having less ward-based time in which to meet trainees
- Minimal office time on consultant job plans, often split into a few small blocks rather than a bigger chunk of time where trainer and trainee can arrange to meet
- Lack of education, understanding or engagement from consultants in some departments

Outcomes of completed exception reports 1 July 2017- 30 Sept 2017



This shows broadly similar proportions of time versus payment compared to the last quarter. The decision whether to pay or give time back (or to take no action) is a joint decision between the trainee and the educational supervisor.

Payment and TOIL trends by month



Extra hours paid resulting from exception reporting 1 July 2017- 30 Sept 2017:

Specialty	Grade	Overtime worked at standard rates	Overtime worked at night rates	Overtime worked at punitive rates	Cost
Acute Surgery	F1	5hr	8hr	5hr 15	£550.38
Colorectal Surgery	F1	1hr 45			£40.90
Infectious Diseases	F1	2hr 45			£64.24
Neurology	F1	30 min			£11.69
Oncology	F1	6hr 45			£157.76
Rheumatology	F1	5hr 45			£134.32
Upper GI Surgery	F1	4hr			£93.47
Vascular Surgery	F1	4hr 30	3hr 30		£240.54

Agreed time off in lieu resulting from exception reporting 1 July 2017-30 Sept 2017:

Specialty (base dept)	Grade	TOIL
Critical Care	F1	1hr 30
Urology	CT2	1hr
Neurology	F1	1hr
Renal	F1	2hr 25
Respiratory	F1	9hr
Rheumatology	F1	1hr 30
Paediatric Neonates	F2	9hr
Paediatrics	F2	24hr
Respiratory	F2	2hr
Oncology	StR	3hr

It should be recognised that TOIL and overtime payments can only be given after the supervisor has agreed this with the trainee. Delayed responses from either party mean that the trainee cannot receive their overtime payment or take time back. The total owed to trainees from this quarter is higher than the tables would suggest due to the delayed responses.

Patterns and responses
Patterns of exception reports have been seen and dealt with as follows:

<u>Vascular Surgery</u>
Two F1 trainees on this rota failed to start their F1 placement. This has left a situation with severe rota gaps. Locums have been sought and appointed; additionally trainees on the rota have been extremely flexible in moving shifts around to maintain patient safety. The number of exception reports received is probably a significant underestimate of the problems trainees are experiencing. There are also a number of outstanding supervisor reviews in this department, as all levels of staff have had to work particularly hard to maintain patient care.

Acute General Surgery / Upper GI Surgery
F1 trainees rotate to acute general surgery from Upper GI surgery and colorectal surgery, so these reports often have to be considered together and are hard to separate out.
There are particular issues in Upper GI surgery at present, which have required trainees to work additional hours to maintain patient safety. In one case this has resulted in a breach of safe working for the trainee involved. The issue has been identified and is being appropriately addressed.

Infectious diseases
A cluster of reports was received which identified a scheduling issue. This has been addressed and the ward schedule adjusted so that trainees no longer have to report exceptions.

Respiratory
Routine heavy ward work continues to be reported intermittently by trainees. No common factors have been identified and the Medicine HG is aware of the reports.

Rheumatology
Reports from this department relate to the acute medicine part of the job rather than rheumatology itself. Again, the Medicine HG is aware of the workload issues being reported but no common factors have yet been identified.

Paediatrics
These reports relate mainly to induction days being scheduled during rest time for some trainees, which required full days to be given back in lieu.

Gastroenterology
In the last quarter, exception reports suggested there were a number of issues arising over a long period of time. The department were made aware of these concerns, and have made adjustments. No further exception reports have been received from this department in this quarter.

Trainees in psychiatry placements

The Trust has a number of Foundation trainees in psychiatry placements. These trainees are employed by this Trust, but have their placements in Humber Foundation Trust, who are responsible for the working hours, work patterns and training opportunities during the length of the placement. We have had to work collaboratively with colleagues in HFT to produce work schedules for these trainees, and will be working together to manage issues arising from any exception reports submitted. There have been no exception reports raised by our trainees related to their psychiatry placement to the end of this quarter.

Hours Monitoring Exercises

Routine bi-annual hours monitoring ceased in July 2017 as trainees migrated on to the new 2016 TCS where hours monitoring is replaced by exception reporting.

Monitoring of trainees in GP placements

Historically, and nationwide, hours monitoring of Junior Doctors working out of the Trust on placement at local GP practices has never taken place. The posts were unbanded, as there

was an expectation that trainees worked 40 hours Mon-Fri. During the previous quarter we were asked, for the first time, to monitor a rota that foundation doctors were working in a local GP practice. This exercise showed that trainees at the practice were working above the expected hours and they have been offered additional pay to reflect this work.

Foundation trainees in GP placements are now on the 2016 TCS and are able to exception report. This change has required a significant amount of negotiation to confirm individual GP practice timetables so that work schedules can be issued.

b) Work schedule reviews

There have been no formal work schedule reviews this quarter.

c) Locum bookings July - Sept 2017

i) Bank July - Sept 2017

The Trust currently has an informal medical bank in place which strives to fill as many shifts internally as it can. With the successful creation of a Nurse and Clerical Bank the Trust is looking at creation of a formal Medical Bank in line with the 2016 TCS. The work to start bringing this together has commenced on schedule with the aim of getting a formal process in place later in 2017. The work on this project will be fed through to the Guardian by the Medical Staffing Operations Group.

A summary of bank use across the Trust is now available in areas where the e-rostering system is in use. The next step in the process of continued refinement will be to capture this information across all clinical areas, and to translate this into bank and agency costs.

The information in this table only covers shifts that have been booked by the Medical Staffing Team or where this information has been shared with Medical Staffing. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

Locum Bookings (bank) by grade					
Grade	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
F1*	0	0	51	0	0
F2/CT/ST-2/GPSTR	2263	343	1920	2456.52	2456.52
ST3+	413	0	413	3803	0
TOTAL	**2676**	**343**	**2384**	**6259.52**	**2456.52**

**due to F1 doctors only possessing Provisional Registration with the GMC we cannot employ F1 doctors on bank contracts.*

Locum Bookings (bank) by department					
Specialty	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Acute Medicine	75	46	29	621.65	296.9
Cardiology	13	9	4	140.4	92.4
Chest Medicine	73	9	64	632.90	64.65
Colorectal Surgery	1	1	0	12.5	12.5
Emergency Medicine *	1148	581	546	9040	4787
Elderly Medicine	330	193	137	2179.57	951.57
ENT	22	2	20	223	25
Gastroenterology	24	0	24	282.50	0
General Surgery	100	0	100	1085.50	0
Neurology	71	39	32	607.40	326.15
Neurosurgery	47	15	32	627.25	346
Obstetrics & Gynaecology	15	1	14	181.50	24
Oncology	89	0	89	759.75	0
Oral & Maxillofacial Surgery	2	0	2	15.5	0
Orthopaedics	244	17	227	2074.42	235.6
Paediatric Surgery	21	0	21	235	0
Paediatrics	17	0	17	204	0
Paediatric Neonatal Medicine	2	0	2	24	0
Plastic Surgery	5	2	3	59	35
Radiology	2	0	2	12	0
Renal Medicine	1	0	1	12	0
Rheumatology	5	1	4	42.5	12.5
Upper GI	6	6	0	30.5	30.5
Urology	1	0	1	12	0
Vascular Surgery	22	0	22	221.50	0
TOTAL	**1021**	**276**	**750**	**8888.89**	**1986.32**

**Bank doctors are booked by the Emergency Department directly.*

Locum Bookings (bank) by reason					
Reason	Number of shifts requested	Number of shifts Worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	2382	251	2131	20468.95	2017.95
Additional Staff	145	70	75	990.41	473.92
Sick	51	0	51	545.75	0
Other Leave	127	0	127	1124	0
TOTAL	**2705**	**321**	**2384**	**23129.11**	**2491.87**

As indicated above, because of the specialised nature of the work, the Emergency Department books internal locums directly, and this information is collected by ED and passed on to Medical Staffing. In a similar fashion, and for specialised clinical reasons, the anaesthetic department also books its own internal locums. The anaesthetic department uses a specialised rota management software system, designed specifically for anaesthetic departments. Now that anaesthetic trainees are on the 2016 TCS, reports from this software system about internal locum bookings will need to be passed on to Medical Staffing for Trust-wide collation. This is not happening at the moment.

Data in these tables is still work in progress and should be interpreted with caution until the internal bank is fully operational and all shifts are logged routinely on e-roster using consistent processes. There has been an improvement in logging the reasons for bank requirements since the last quarterly report. Medical Staffing are now commencing an exercise to capture ‘the life of a vacant shift’ which will improve qualitative and quantitative information.

ii) Agency July-Sept 2017

The data in these tables is collected and presented in the standard fashion requested by NHS Employers, and this provides more information about locum requirements for junior doctor vacant posts.

Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked***
Acute Medicine	29	12	324.75	134.50
Cardiology	4	0	48	0
Care of the Elderly	137	126	1228	1098.25
Chest Medicine	64	56	568.25	481.50
Emergency Medicine*	546	302	4056.23	2272.73
ENT	20	20	198	198
Gastroenterology	24	7	282.5	82.75
General Medicine	171	120	1688.51	1155.51
General Surgery	100	82	1085.5	885.50
Neonatal Medicine	50	43	417	334.50
Neurology	32	25	281.25	200.25
Neurosurgery	27	19	305	221
Obstetrics and Gynaecology	14	12	157.5	139
Oncology	89	60	759.75	522.25
Oral and Maxillofacial Surgery	2	2	15.5	24
Orthopaedic and Trauma Surgery	227	210	2024.32	1838.82
Paediatric Surgery	21	10	235	129
Paediatrics	17	3	204	36
Paediatrics and Neonates	2	2	24	24
Plastic Surgery	3	2	35.5	24
Radiology	2	0	15.5	0
Renal Medicine	1	0	12	0

Rheumatology	4	2	30	15
Urology	1	0	12	0
Vascular Surgery	22	21	222	221.50
TOTAL	**1609**	**1136**	**14230.06**	**10038.06**

**The Emergency Department books its own agency locums through the same agency*.

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	51	21	511.50	211.50
F2/CT/ST-2/GPSTR	1920	762	16318	6756.25
ST3+	413	239	3803	2129.56
Total	2384	1022	20632.5	9097.31

Locum bookings (agency) by reason				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Extra Cover	75	70	516.49	463.99
Other Leave	127	5	1124	57.75
Sick	51	15	545.75	176
Vacancy	2131	1400	18451	12333.65
Total	2384	1490	20637.24	13031.39

It is clear from the data that there is often a shortfall between the number of shifts required, and the number of shifts covered.

All vacant shifts are offered to internal staff first. If these shifts are not filled internally, then a decision is taken by the service whether to go to agency or not. In some cases, the service decides not to request agency cover. This may be, for example, to cover a short gap in cover (e.g. three hours) where experience has shown that there will be no uptake from agency staff. In this case, the service is short-staffed, but only for a brief period, which can be managed, usually by senior doctors acting down in combination with increased nursing input.

For a longer period without internal or external cover, a number of strategies may be employed to maintain patient safety. One option is to redeploy existing doctors, for example by sending home a daytime doctor to get rest before asking them to come back and cover a vacant night shift. Other options include moving doctors from one ward or site to another, where the gap is more critical. Where the wider, non-medical, workforce can be deployed to help cover the gap, this is done. Sometimes it is possible to obtain cover at a higher level , in which case one of the senior doctors will act down to cover the gap. In the worst case scenario, senior doctors will act down but at the expense of the service; the emergency situation is covered but at the expense of the routine work.

d) Locum work carried out by trainees July-Sept 2017

This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available for all trainees. Further information is required about the trainee's rostered hours and the actual hours worked. In an ideal situation this would be entered 'live' on to e-roster. This is the next stage in the roll-out of the e-roster system, but can only be commenced once e-roster is being fully utilised as a live system. In some parts of the Trust this live usage is happening, and it is hoped that actual hours worked, overtime and TOIL will be entered as the next stage in the roll-out process.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the EWTD.

Locums Worked By Trainees				
Speciality/Rota	**Grade**	**Number of hours worked**	**Number of hours rostered per week**	**Opted out of EWTD**
Urology	CT	223	46:45	Yes
Elderly Medicine	GPSTR	159.5	46:00	Yes
Colorectal	ST	100	47:52	Yes
Neurosurgery	CT	76.5	47:00	No
ENT	CT	64	46:45	No
Plastics	ST	63	46:45	Yes
Urology	F2	61	46:45	No
Orthopaedics	F2	59.75	46:15	No
Colorectal	CT	55.5	44:45	Yes
OMFS	CT	50	46:45	No

This is the first time we have been able to pull this information from the systems, and represents an improvement in data collection. This shows that, despite opting out of the EWTD, some trainees were at risk of breaching even their increased limits due to the number of additional hours they opted to work. It should be noted that most of these extra shifts took place before August 2017. Since then, trainees who have not opted out of the EWTD limits have been unable to book extra shifts, and the Trust is now better able to monitor trainees who have opted out when they book an additional shift.

Trainees volunteering to cover large numbers of extra shifts can now be identified early and their extra hours monitored to ensure they are safe. This is in addition to their personal responsibilities to ensure they are safe to work.

The negative side of this monitoring may be that vacant shifts become harder to cover.

e) Vacancies – table showing vacancies among medical training grades on 19 October 2017

This section should list all vacancies among the medical training grades (including trust doctors) during the previous quarter.

Information on the training grade doctors in post is relatively straightforward to obtain and is detailed in the table below. However, non-training doctors are much harder to capture; there are differences in nomenclature, and in recording between different systems such as ESR, finance and payroll. Additionally, this is a very fluid group of doctors, so an accurate picture is almost impossible to achieve as it changes almost daily.

The full picture of the non-training grade establishment and vacancies is not available at present, although Medical Staffing are still working with the businesses to collect and record this information centrally, so that the Trust will always have an accurate picture of this fluctuating workforce at any one time.

	Establishment						In Post						
Department	F1	F2	CT/ST1-2	GPSTR	ST	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Filled
Academic	0	5	0	0	0	5	0	5	0	0	0	5	100.0
Acute Medicine	0	6	9	0	6	21	0	5	5	0	2.5	12.5	59.5
Anaesthetics	4	4	19	0	29	56	4	4	12.5	0	25.7	46.2	82.5
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	80.0
Cardiology	2	1	4	1	9	17	2	1	4	1	9	17	100.0
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	3	6	100.0
Chemical Pathology	0	0	0	0	2	2	0	0	0	0	1	1	50.0
Dermatology	1	0	0	1	0	2	0	0	0	1	0	1	50.0
Elderly Medicine	5	3	6	7	6	27	4	1	4	4	5.5	18.5	68.5
Emergency Medicine	0	12	8	5	13	38	0	11	12	4.5	10	37.5	98.7
Endocrinology	3	0	2	0	4	9	4	0	1	0	3	8	88.9
ENT	1	1	2	1	5	10	1	1	2	1	4	9	90.0
Gastroenterology	3	0	2	0	5	10	3	0	2	0	4	9	90.0
General Practice	0	19	0	0	0	19	0	19	0	0	0	19	100.0
General Surgery	0	1	0	0	0	1	0	0	0	0	0	0	0.0
Haematology	1	0	2	0	3	6	1	0	2	0	2	5	83.3
Histopathology	0	0	0	0	4	4	0	0	0	0	3	3	75.0
HIV/GUM	0	1	0	0	0	1	0	1	0	0	0	1	100.0
Infectious Diseases	2	0	2	0	4	8	2	0	0	0	3	5	62.5
Lower GI Surgery	7	0	2	0	3	12	7	0	2	0	3	12	100.0
Neurology	2	2	4	0	5	13	2	2	2	0	5	11	84.6
Neurosurgery	1	1	2	0	4	8	0	1	2	0	4	7	87.5
Obstetrics & Gynaecology	0	2	7	4	11	24	0	2	6	3	10	21	87.5
Oncology	3	1	3	4	6	17	3	1	3	4	4	15	88.2
Ophthalmology	1	1	3	0	4	9	0	0	3	0	3	6	66.7
Oral & Maxillofacial Surgery	0	0	10	0	3	13	0	0	7	0	2	9	69.2
Paediatric Emergency Medicine	0	0	7	0	0	7	0	0	7	0	0	7	100.0
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	4	0	7	11	78.6
Paediatric Surgery	0	0	2	0	0	2	0	0	2	0	0	2	100.0
Paediatrics	3	4	3	2	9	21	2	3	2.4	1.5	7.9	16.8	80.0
Palliative Care	0	0	0	2	0	2	0	0	0	1.5	0	1.5	75.0
Plastic Surgery	0	0	3	0	6	9	0	0	2	0	5	7	77.8
Psychiatry	5	5	0	4	0	14	5	4	0	3	0	12	85.7
Public Health Medicine	0	1	0	0	0	1	0	1	0	0	0	1	100.0
Radiology	0	0	0	0	25	25	0	0	0	0	23	23	92.0
Renal Medicine	2	1	2	0	5	10	2	1	2	0	5	10	100.0
Respiratory Medicine	6	2	2	2	8	20	3	1	0	1	6	11	55.0
Rheumatology	3	0	1	3	3	10	2	0	0	1	2.5	5.5	55.0
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	0	0	0.0
Trauma & Orthopaedics	0	5	3	1	9	18	0	4	3	1	8	16	88.9
Upper GI Surgery	7	0	2	0	3	12	6	0	2	0	3	11	91.7
Urology	1	3	2	0	3	9	1	3	2	0	3	9	100.0
Vascular Surgery	5	0	1	0	3	9	4	0	1	0	3	8	88.9
TOTAL	**70**	**84**	**123**	**37**	**213**	**527**	**60**	**74**	**97.9**	**27.5**	**181.1**	**440.5**	**83.6**

f) **Fines**

There has been one Guardian fine levied during the last quarter. This compares very favourably with Trusts across the region.

Fines by department		
Department	Number of fines levied	Value of fines levied
Acute Surgery	1	£145.37

The circumstances leading to this fine have been investigated. A trainee breached their safe working hours by doing additional, unpredictable work when they were already scheduled to work a number of long shifts in quick succession. This extra work was necessary for patient care but caused the trainee to work more than 72 hours in a seven day period.

The underlying reasons why this trainee was required to do this additional work are being addressed. There is nothing that the department could have done to predict or prevent this breach. The trainee is now aware that they are at risk of breaching if they work additional hours during this particular week of long days, and will flag up early if this pattern looks likely to recur.

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at the end of this quarter
£39.26	£145.37	£00.00	£221.26

Qualitative information

E-roster roll out

E-roster continues to be rolled out across the organization. All new starters in August 2017 have had their rotas added to e-roster and this is proving very popular among the trainees. There are still some issues regarding live updating and locking down of the roster in some areas, and the trainees are keen to see the development of a module which will allow them to swap duties without waiting for third party approval. However the majority of duties are now available for viewing and reporting which will improve the quality of data about junior doctor working available to the Trust.

Implementation of the new contract

This has been a challenge to the Medical Staffing team, Medical Education team and the Health Groups because of the tight timescales involved and the large number of doctors transitioning to the new contract at the same time (approx. 250). The Medical Staffing team has worked extremely hard in producing work schedules for the trainees starting in August, September and October. All but a few trainees received their work schedules on time, and where this was not possible (e.g. due to addressing complex pay protection issues) they received an interim letter with as much information as possible to allow them to plan while the issues were addressed.

Junior Doctor Forum

The Junior Doctor Forum is well-established. The August transition has produced an increase in the number of trainees volunteering to represent their colleagues on the Forum. One or two trainees have reported difficulties being released to attend, primarily over

concerns about missing education and training. This has been fed back to their departments but I have yet to hear of any significant concerns from trainers about allowing trainees away from the department to attend.

The minutes of the Forum are available on the newly-established junior doctor pages of Pattie.

Consultant engagement

There is an ongoing programme of training aimed at consultant supervisors, run by the Director of Medical Education and the Guardian of Safe Working. This has uncovered a number of misconceptions about the time and skills required for supervisors to deal with the issues raised by the contract, and about the culture of exception reporting. It is hoped that with more uptake of the contract among all grades of trainees that some of these anxieties can be allayed. Uptake of the training has been variable, with some departments not sending any representatives at all to date, but the Health Group management have all been active in assisting consultants to address the exception reports in a timely manner.

Rota administrative support

It is clear that data about junior doctors needs to be captured in real time at department level and entered on to the e-rostering system as it happens. This is to allow service planning, to place trainees in the correct environment for their training and service, to capture where vacancies exist and where these have been filled. There is already an investment into rota administrative support at this level, but, particularly where rotas are large and/or complex, health groups need to be sure that the administrative support is adequate for the multiple tasks required.

Issues arising

The amount of data available to provide information about the working conditions of trainees continues to improve, however streamlining of processes and information remains a challenge. Much of this information was not collected in any systematic fashion over the past decade, and therefore it would be unrealistic to expect instant answers. There is still a lot of background work required, particularly at the business level, to make the required changes.

It is clear that rota gaps, for whatever reason, are putting a significant strain on the system, particularly when shifts are put out for cover and this cannot be found. More data is required here to understand the effects a gap can have in any particular area.

Trainees are still under-reporting problems with the exception reporting system. Some have concerns that raising issues will have a negative effect on how they are perceived at work, others have remain to be convinced of the utility of making a report and the effect this will have on improving working conditions.

There are a number of areas where exception reports are not being addressed, either because the outcomes of meetings are not being recorded, or because meetings are not taking place at all. In some cases, issues have been escalated to the Health Groups for action, but because of a paucity of information coming back down, trainees have not been aware of any actions or improvements as a result of exception reporting. For many trainers, this is a new system, and the work involved in addressing an exception report has still to be completely understood and incorporated into their daily work.

Actions taken to resolve issues

All trainees are now on the 2016 TCS and all are now using e-rostering. This system is very popular among trainees, as it provides real-time rota information available on their smartphones. Further work is required among businesses and departments to make the most of this technology, so that they can realise the benefits.

There is a significant investment across all Health Groups into administrative support for e-rostering. However the next steps in making the most of this system will involve real-time input of the hours that trainees actually work, rather than just their rostered hours. Additionally, businesses and departments will need training to ensure that they can make the most of the information available, to help them plan their services and reduce the effect of rota shortages.

There is an ongoing programme of education for trainers and trainees to help them understand and make the most of e-roster, and the exception reporting system. This training is also open to all levels of clinical and non-clinical management.

Trainees are encouraged to exception report issues, and are supported if they feel vulnerable as a result. There is a network of junior doctor representatives available through the Junior Doctor Forum. Information and links are available through the Junior Doctor pages of Pattie, and a Junior Doctor Workspace is being built to provide additional support, advice and information.

Exception reports and work schedule reviews are mechanisms to identify departments and rotas that are at risk of unsafe working. There is a mechanism in place for alerting the Health Group management team to clusters of reports or areas or risk and this system seems to be working well. However, feedback on what has been done to respond to these reports is an area for improvement.

Summary

The Trust continues to make good progress in developing systems and processes that will allow the Guardian to monitor safe working hours. Exception reporting seems to be a good early-warning system to indicate where there may be issues. However this information needs triangulating with other sources to gain a complete understanding of system problems and to develop appropriate and robust solutions.

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

Trust Board date	7 November 2017	**Reference Number**	2017 – 10 – 19
Director	Director of Corporate Affairs – Carla Ramsay	**Author**	Corporate Affairs Manager – Rebecca Thompson
Reason for the report	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.		

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

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

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2017/17	Hull and East Yorkshire Hospitals NHS Trust and The University of Hull – 2 x equipment lease agreements – GE Healthcare MR750 Discovery 3. OT and associated equipment. (Agreement relates to agenda item 23.2 of the 3 October 2017 HEY Trust Board meeting)	10/10/17	Chief Financial Officer – Lee Bond and Director of Corporate Affairs – Carla Ramsay
2017/18	Hull and East Yorkshire Hospitals NHS Trust and Unico Construction Ltd – Form of Agreement x 2. Lansdowne Street Improvement works – Phase 5, Hull Royal Infirmary	10/10/17	Chief Financial Officer – Lee Bond and Director of Corporate Affairs – Carla Ramsay

3 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Corporate Affairs Manager
November 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT SUMMARY REPORT
26 OCTOBER 2017

The Audit Committee met on 26 October 2017. The following points were discussed/agreed at the meeting:

1. Mr Smith presented a report regarding cyber security and advised that the Trust had been audited by NHS Digital at the 2 main data centres at Hull Royal Infirmary and Castle Hill Hospital. A number of critical recommendations had been made which are being actioned, but the core systems had been found to be well defended from an external attack.

2. Mr Smith advised that patient WIFI had 'gone live' on 30th September 2017 at the Queen's Centre, Castle Hill Hospital and was being rolled out to other areas.

3. Mr Nearney presented the Agency Audit report which highlighted 9 recommendations following the internal audit that had given limited assurance, and presented the actions in place to address these issues. The internal audit team will be following up on progress in December 2017.

4. Mrs Bates reported that the Trust had only received a Trainee allocation of 54%, which would have clinical impact, and a meeting with the deanery is being set up to discuss further. There had been 214 Consultant electronic job plans signed off with 169 in progress. 79 had not yet started and updates were sent to Medical Directors and Operations Directors on a weekly basis. The deadline for completion across the Trust is 30 November 2017.

5. The Committee discussed the possibility of the Trust having a minimum staffing level for medics during holiday periods in order to meet elective activity plans as well as emergency/on-call cover.

6. The Committee was concerned regarding RTT validation and patients not being properly tracked. Mr Bond advised that the Executives had agreed to commission an external review of the processes to fully identify the issues.

7. Grant Thornton presented their first audit report as the Trust's new external auditors. There was a discussion around "Getting it Right First Time" and Mr Gore volunteered to be the NED champion for this initiative.

8. Internal Audit reported that two audits had been carried out and received limited assurance. One was in the procurement area with the issues being: a particular contract was signed by the Chief Financial Officer but required a second signature under Standing Orders;, a contract extension was approved after the existing contract had expired and Standing Financial Instructions Waiver Forms needed to be completed in a more timely basis prior to contract expiry dates, with more timely flagging of outstanding issues to health groups. An action plan to address the issues (3 high, 1 medium-rated) had been signed off by the Procurement Team. The Committee agreed to increase the frequency it reviews single source waivers to twice per year. The other report, which received limited assurance, was on the Trust's data warehousing arrangements, for which four high- and one medium-rated issues were raised. An action plan to address these issues has been agreed by the Trust and is being implemented.

9. The counter fraud report was received by the Committee, which noted that five fraud investigation cases had been concluded in the reporting period. It was recommended that the Trust would communicate to staff the results of recent investigations relating to

fraud and the subsequent consequences to raise awareness of the potential for severe consequences from fraud.

10. Mrs Roberts presented the register for losses, special payments and write off for the last 12 months. There had been £98k in losses and special payments. These were related to pension payments and lost patient property.

11. An update regarding the Information Governance Toolkit was received. Ms Ramsay also informed the Committee that the new General Data Protection Regulations (GDPR) would be implemented on 28 May 2018 and this would replace the Data Protection Act 1988. There are implications for the Trust in the way it reports and manages data under GDPR; an action plan to prepare for GDPR is being monitored by the Information Governance Committee.

12. Mrs Bates informed the Committee that changes to the processes around Serious Incident investigations had been added to the new incident policy and that the Trust's commissioners had given the Trust significant assurance in this area.

13. The Board Assurance Framework process was reviewed by the Committee and no concerns were raised.

14. The Quality, Performance and Finance and Charitable Funds committee minutes were received for assurance purposes.

Recommendations
The Board is asked to note the discussion held at the Audit Committee.

Martin Gore
October 2017