HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD
TUESDAY 11 SEPTEMBER 2018, THE BOARDROOM, HULL ROYAL INFIRMARY
9.00AM

AGENDA: MEETING TO BE HELD IN PUBLIC

	Opening Matters		
1	Apologies	verbal	Chair – Terry Moran
2	Declarations of interests 2.1 Changes to Directors' interests since the last meeting	verbal	Chair – Terry Moran
	2.2 To consider any conflicts of interest arising from this agenda		
3	Minutes of the meeting of 10 July 2018	attached	Chair – Terry Moran
4	Matters Arising	verbal	Chair – Terry Moran
	4.1 Action Tracker 4.2 Board Reporting Framework 2018/19 4.2 Board Development Framework 2018/19	attached	Corporate Affairs Manager – Rebecca Thompson
	4.3 Any other matters arising from the minutes	verbal	Chair – Terry Moran
5	Chairs Opening Remarks	verbal	Chair – Terry Moran
6	Chief Executive's Briefing	attached	Chief Executive Officer – Chris Long
7	Patient Story	verbal	Interim Chief Medical Officer – Makani Purva
8	**Top Risk Areas**		
8.1	BAF 1: There is a risk that staff engagement does not continue to improve	RR12	Director of Workforce and OD – Simon Nearney
8.2	BAF 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	RR9	Chief Nurse – Mike Wright/Interim Chief Medical Officer – Makani Purva

	Compliance and Board decision required		
9	Standing Orders 9.1 Remuneration Terms of Reference	attached	Corporate Affairs Manager – Rebecca Thompson
10	Emergency Preparedness	attached	Director of Strategy and Planning – Jacqueline Myers
11	Workforce Race Equality Standards	attached	Director of Workforce and OD – Simon Nearney
12	Responsible Officer Report	attached	Interim Chief Medical Officer – Makani Purva
13	Risk Policy – Board Approval	attached	Chief Nurse – Mike Wright
14	Energy Business Case	attached	Deputy Director of Estates - Chris Norman
	Director Reports		
15	People Strategy Update	attached	Director of Workforce and OD – Simon Nearney
16	Quality Report	attached	Chief Nurse – Mike Wright
17	Nursing and Midwifery Report	attached	Chief Nurse – Mike Wright
18	Fundamental Standards	attached	Chief Nurse – Mike Wright
19	Quality Minutes July/August 2018	attached	Chair of Committee – Martin Veysey/Andy Snowden
20	Performance and Finance Report 20.1 Update on Elective Care Performance	attached	Chief Operating Officer-Ellen Ryabov/Teresa Cope/Deputy Director of Finance – Steve Evans
21	Performance and Finance Minutes July/August 2018	attached	Chair of Committee – Stuart Hall
22	Any Other Business	verbal	Chair
23	Questions from members of the public	verbal	Chair

24 Date and time of the next meeting:
Tuesday 13 November 2018, 9am – 12pm, The Boardroom, Hull Royal Infirmary

Attendance

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

Hull and East Yorkshire Hospitals NHS Trust
Trust Board Minutes
10 July 2018

Private Session of the Board

Present:	Mr T Moran CB	Chairman (Chair)
	Mr A Snowden	Vice Chair, Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Prof. M Veysey	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Mr K Phillips	Chief Medical Officer
	Mrs J Ledger	Deputy Chief Nurse (For Mr M Wright)
In Attendance:	Mr S Nearney	Director of Workforce and OD
	Ms J Myers	Director of Strategy and Planning
	Mrs R Thompson	Corporate Affairs Manager

No **Item** **Action**

1 Apologies

Apologies were received from Prof. J Jomeen, Non-Executive Director.

Mr Moran stated that it was Mr K Phillips last meeting as Chief Medical Officer as he was going on to do other things. He thanked Mr Phillips for his commitment, passion and care for both patients and staff during his time as the Chief Medical Officer. He was not leaving the Trust entirely as he would still continue with his clinical duties.

Mr Moran also reported that the Trust Board agenda had changed so that discussion could focus on key areas, including risks, so that we did not simply duplicate discussions already had in other governance discussions at relevant committees.

Mr Moran also mentioned the NHS 70 celebrations and thanked all the staff who had been involved in arranging the Health Expo held on 7th July 2018. He thought the whole event was a great showcase for the work of the trust and others.

2 Declarations of interests

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda

There were no declarations made.

3 Minutes of the meeting of 15 May 2018 and 24 May 2018

Item 8, 15 May 2018 – Quality Report – paragraph 8 – Mrs Walker stated that she did not use the word 'easily' in the sentence.

Item 3.1, 24 May 2018 – Audit Findings Report – paragraph 4 – "Mr Moran added that to get an unqualified opinion was a very high standard to achieve and welcomed the benchmarking against other Trusts".

Item 4 – Letter of Representation – Mr Bond clarified that the letter of representation was written by the Trust Board to the Auditors.

Following these changes both sets of minutes were approved as accurate records of the meetings held 15 May and 24 May 2018.

4 Matters Arising

There were no matters arising.

4.1 Action Tracker
Quality Report –
Balanced Scorecard – Mr Snowden advised that a meeting had been scheduled to discuss this further

4.2 Board Reporting Framework 2018/19
Mrs Thompson to align the timings of the items with the new Board dates. **RT**

4.2 Board Development Framework 2018/19
Mrs Thompson agreed to clarify the July and August sessions. **RT**

4.3 Any Other Matters Arising
There were no other matters arising.

5 Chairs Opening Remarks

Mr Moran had nothing else to add to his earlier remarks.

6 Chief Executive's Briefing

Mr Long presented the report and highlighted the new Linear Accelerator that was now in place at Castle Hill Hospital.

He also spoke about the international recruitment campaign and how Mr Nearney was establishing links with hospitals in Pakistan. He added that Prof. Jomeen was working with China to look at similar opportunities.

Mr Long congratulated all staff involved with the Health Expo for their commitment and hard work.

Mr Long thanked Mr Phillips for all the work he had done at the Trust. Mr Phillips had joined the Trust at a difficult time and had stabilised the medical element thanks to his efforts.

The Board reviewed the Balanced Scorecard. Mr Snowden advised that there was more work to be done and would be meeting with Ms Myers to discuss the metrics.

7 Patient Stories

Mr Phillips gave an account of a patient whose medical notes had gone missing which had resulted in a wasted appointment. The notes had

since been found and checked to ensure all information was correct. Mr Phillips stated that the Trust was in transition from paper to digitalisation and would be fully electronic by 2021.

Mr Phillips also relayed a sad story of a young patient that had died due to a deep seated tumour. The patient's parents wanted to acknowledge and thank the wonderful doctors and nurses who had cared for him and had made his end of life as compassionate and comfortable as possible.

Mrs Walker talked about a book that had been written by a consultant regarding end of life care which she recommended to the Board. The Book was called "With the end in mind" by Katherine Manics.

8.1 BAF 2 – Workforce Challenges

Mr Nearney presented the report which highlighted the Trust's workforce challenges. He reported that the Trust was now taking greater responsibility for recruitment due to Health Education England reducing their input. Mr Nearney reported that 'Brexit' had impacted on international recruitment putting further pressure on the NHS as a whole.

He spoke about the People Strategy which was a 3 year plan looking at all aspects of recruitment and retention of staff. Mr Nearney also stated that the Remarkable People branding campaign had been successful in increasing the Trusts visibility to potential staff.

He reported that there were currently 42 consultant vacancies with 32 of these roles being covered by locums. There were a number of concerns such as the increase of patients from the South Bank, staff sickness and a small number of paternity and maternity issues.

The areas most difficult to recruit to are critical care, radiology, oncology, ED and elderly medicine. The Trust was looking to recruit a specialist recruitment manager and head hunters were being used for some roles. Mr Nearney was also discussing opportunities with the University of Pakistan to recruit more doctors. Work was also ongoing with the University of Hull and the Trust was still awaiting confirmation of its name change to promote the teaching element further.

Mr Snowden stated that a balance must be brought regarding recruiting international doctors that could be needed in their own country and developing home grown resources.

The Trust had recently agreed to develop a medical bank which would be run by Liaison in a similar way to the nurse bank.

The Trust was reporting an 82% fill rate for Junior Doctors and work was ongoing to ensure that patients and services were safe. Mrs Ledger was working with the nursing teams to recruit more overseas nurses and was overseeing the Nurse Associate programme. A number of ODPs had been recruited which would bring that vacancy gap down to 3%. Mr Gore had attended a Junior Doctor forum recently and wondered if more marketing and recruitment could be done on social media.

Mr Long added that the general practice workforce was also struggling and were being increasingly overwhelmed caring for patients with long term conditions.

Prof. Veysey asked about the longer term strategy and working with schools and colleges to get the younger generation in on work experience and training local people. He also asked to what extent the Trust and STP were looking at a full workforce redesign. Mr Nearney advised that all the points raised would be reviewed as part of the People Strategy refresh. Mr Moran added that there was a Board Development session arranged for January where this could be explored in more detail and suggested that we bring forward the discussion rather than wait until then.

Mrs Cope felt that the risk rating should be increased to 20. She stated that services were under pressure and needed to be reviewed. There were questions around the rota sustainability, increased waiting lists and patient flow difficulties. She added that the Trust was doing everything it could possibly do but the system was being pushed hard with finite resources. Mrs Cope felt that a service redesign and resetting patient expectations were key. Using Allied Health Services to establish new roles and getting the most out of the STP for a clinical redesign would be required going forward.

The Board commended the work that was ongoing and Mr Moran suggested that we take the Guardian of Safe working Report and then consider the overall risk rating and whether any further mitigation was necessary,

The agenda was taken out of order at this point.

20 Guardian of Safe Working – Annual Report

Mr Muthu presented the annual report to the Board which highlighted the work of the Guardian to ensure safe working for doctors. He was grateful to hear the previous discussion about the workforce issues and action being taken. He advised that in Trauma and Orthopaedics there were 8 vacancies out of 13 roles. He reported that there was a plan in place which included locums, a business team and alternative medical posts. He reported that Advanced Clinical Practitioners have been a valuable part of the team. Work was ongoing to attract more doctors but was proving to be a challenge.

Prof. Veysey reported that the University allocation was slightly better this year but Mr Phillips advised that the Trust was still 20% down in the major acute areas. Mr Muthu added that in the largest areas of shortfalls some consultants were covering Junior Doctor shifts.

Resolved:

The Board received and accepted the annual report.

The Board reviewed BAF Risk 2 and agreed to increase the risk rating to 20. They recognised the work already in place and ongoing and Mr Moran stated that this would be reviewed again in September 2018 to understand the impact of mitigating actions.

Resolved:
The Trust Board received the report and agreed to increase the risk rating to 20.

The agenda returned to order at this point

8.2 BAF 4: Operational Planning

Mrs Cope presented the report which highlighted the key operational risks of the organisation. She reported that Mrs Ryabov and herself chaired weekly performance meetings with the Health Groups and any issues were escalated to the Performance and Finance Committee and the Board.

There were challenges in the Emergency Department to achieve the national standard of 95% for the 4 hour wait. The Trust was still seeing record attendances with 460 patients in the department yesterday (9/7/2018). STF funding was still achievable due to the Trust being measured on the whole system performance and not just individually. She advised that there was little resilience in the wider healthcare system. The conversion rate of the 200 patients who had attended emergency care was between 6 and 8%.

Mrs Cope reported that the Trust was reviewing the processes regarding RTT and were meeting the STF trajectory. Performance had been impacted by non-elective levels increasing and work was ongoing to reach a sustainable list size. Work was also being carried out in the community to manage planned care and maximise capacity.

The Cancer 62 day standard performance was still a challenge for the Trust and was impacted by late transfers and diagnostic issues. Mrs Cope advised that Cancer Alliance support was required.

The Trust was starting to see an improved picture regarding Diagnostics as workforce issues were being addressed and new equipment put in place.

The Board had a detailed discussion around duplication of referrals and Mrs Cope advised that a large amount of validation work was ongoing to clarify the list size. Mrs Cope agreed to inform the Non-Executive Directors of the validation work and give assurance of the list size. Ms Myers added that the Clinical Admin Review would ensure that robust processes were in place. **TC**

Mr Hall reported that he attended the Performance meetings which had assured him that the risks were being managed and added that last month's RTT performance was the Trust's best performance to date. He also reassured the Board that the Performance and Finance Committee received regular updates from the Non Clinical Quality Committee and the Capital Resource Allocation Committee where capital expenditure and equipment renewal was discussed. Mr Bond added that an emergency capital bid of £3m had been requested from the regulators and asked the Chairman and Non-Executive Directors to help influence decision makers through their formal and informal networks.

Resolved:
The Board received the report and agreed that the risk rating should remain at 16.

8.3 BAF 6: Humber, Coast and Vale STP

Ms Myers presented the paper and highlighted the key aims as system wide leadership, acute provider sustainability and developing enhanced services.

She reported that the Trust was a key player within the STP programme, building leadership roles and supporting the changing atmosphere to deliver the changes. The Non-Executive Directors were also playing their part in attending events to strengthen the partner relationships.

Ms Myers spoke about the Place Based programme and how the Trust was providing leadership and provider collaborations to deliver plans and also working with community providers for out of hospital care.

She advised that Dr Patmore was building relationships with the GPs and the Trust had secured a management trainee to help with this programme.

Ms Myers spoke about the Acute Provider Review which was ongoing as was the development of the clinical strategy. The Hospital Partnership Board meetings had good engagement with further discussions being had regarding integrated care systems.

Ms Myers recommended that the risk rating should stay at 16 as it was still too early to review the impact and suggested a review in 3 months.

There was a discussion around the Trust's leadership alongside our partners and how effective it was and Mrs Walker stated that there was more networking to do as relationships in her view were still immature. Prof. Veysey added that education and research was missing from the strategy and felt that the links to the University of Hull should be strengthened.

Mr Bond asked about the timing of the Place Based plans and the effectiveness of the Integrated Care Centre. He expressed his concern that there had been little impact on the Trust since the Centre had opened and there were no tangible outcomes being presented.

Mr Moran stated that he was aware of overall progress but that it was very slow. The Board agreed to keep the risk rating at 16 and review it in 3 months time.

Resolved:
The Trust Board accepted the report and agreed to keep the risk rating at 16 for review in 3 months time.

8.4 BAF 7.1: Finance

Mr Bond presented the report and highlighted the key risk areas: medical staffing, nurse staffing, demand and capacity and capital expenditure.

He spoke about the Emergency Department and the Trust's ability to manage the surges and spikes due to poor planning and resilience. Mr Bond also mentioned that theatre productivity was not being maximised and was at 76%.

The Trust had to make savings of £17m and Mr Bond stated that weekly meetings with the Health Groups was taking place to address financial pressures, medical staffing and CRES..

Mr Bond recommended that the risk rating should remain at 20.

The Board agreed to leave the risk rating at 20 but Mr Moran expressed his concern around the end of year loading to deliver the greatest proportion of CRES. He asked that the Performance and Finance Committee develop lead indicators to assist our understanding of progress and deliverability so that we avoided learning of success or shortfalls in the last 3 months of the financial year.

Resolved:

The Trust Board received the report and agreed to keep the risk rating at 20.

9 Research and Innovation Strategy

Mr Phillips presented the final version of the strategy which had been discussed previously at a Board Development session and at the Quality Committee.

Resolved:

The Trust Board received and approved the strategy.

10 Standing Orders

Mrs Thompson presented the paper which detailed one use of the Trust seal.

Resolved:

The Trust Board received the report and approved the use of the Trust sea.

11 Charitable Funds Committee – Terms of Reference

Mr Snowden presented the changes to the Terms of Reference that had been discussed at the last Charitable Funds Committee. He Highlighted that the Committee would be reviewing the Trust's Corporate Social Responsibility and gave an example of the health of homeless people during the winter.

Resolved:

The Trust Board received and approved the Terms of Reference.

11.1 Wishh Report

Mr Snowden presented the report and highlighted the business case requesting 3 members of staff to establish and manage the brand in line with the Trust's strategic priorities and increase fundraising efforts. The Charity was hoping to have everything in place by 1st August 2018.

From August 2018 all funds, both general and legacy, but excluding funds donated for research purposes, would be directed to the WISHH charity.

The WISHH charity will also take responsibility for establishing a proactive approach to fundraising. WISHH currently has an inadequate admin support to discharge this role effectively, so the attached associated business case proposes the provision of resources by the Trust, for a time-limited period.

Mr Gore asked if the staff required had been budgeted for and Mr Bond advised that they would be paid out of the Charitable Funds budget.

Resolved:
The Trust Board approved the Wishh Charity business case.

11.2 Charitable Funds Minutes – 7 June 2018
Mr Snowden presented the minutes and spoke about the Trust Arts and Health Strategy. A booklet was circulated to Board members for information. This strategy would be a responsibility of the Charity.

Mrs Walker added that many staff within the Trust where already working hard to fundraise for the Charity.

Resolved:
The Board received and accepted the minutes and the Arts and Health Strategy booklet.

12 Freedom to speak up guardian
Mrs Thompson presented the paper which highlighted the self-assessment requirement relating to the Trust's approach to the Freedom to speak up guardian role.

Ms Ramsay had included evidence to underpin the work she had done so far and Mrs Walker stated that there could be more evidence added due to all the good work happening in the Trust. Mrs Thompson added that Mr Nearney was assuming the role of Guardian whilst Ms Ramsay was on leave and Mrs Walker agreed to have a conversation with him to ensure the evidence was as robust as it could be.

Resolved:
The Trust Board approved the self-assessment subject to any changes made by Mrs Walker and Mr Nearney.

13 Operational Plan Update
Mr Bond presented the update and highlighted the key areas. He advised that the Trust's performance trajectories were now more realistic and a piece of work was being carried out to minimise the amount of 'super stranded' patients.

Mr Phillips reported that more work needed to be undertaken outside of the hospital regarding patients with chronic conditions and staff who need to care for them as the hospital did not have the facilities to care for them.

Resolved:
The Board received and accepted the report.

14 Quality Report

Mr Phillips spoke about his visit to the East Lancashire NHS Trust and how the Trust would be sharing the learning from this regarding Never Events. He reported that East Lancashire had reported 6 Never Events in year and they had shared their processes and investigation outcomes with the Trust. Mr Phillips advised that this would be incorporated into a Board Development session at the end of July 2018.

Mrs Ledger reported that the Trust had closed 2 wards due to Norovirus. She added that there was still a risk in the community but the wards were controlling the infection well.

Mr Hall advised that he had observed an audit of the WHO checklist and was reassured to know appropriate procedures were followed
Mr Gore asked about the spike in the reporting of serious incidents and what the issues were. Mrs Ledger advised that the incidents were being investigated and the results would be scrutinised at the Quality Committee. The spike itself should not at this stage be regarded as a concern.

Mr Snowden asked how staff had taken the CQC report and Mr Long reported that there was disappointment but were pleased with the improvements shown. Mr Moran stated that the graphic at appendix 2 was really helpful and demonstrated that the number of areas previously recorded as 'requires improvement' at both hospitals had more than halved showing good underlying progress

Resolved:
The Board received and accepted the report.

15 **Nursing and Midwifery Report**

Mrs Ledger presented the report which showed the Nursing and Midwifery staffing levels which were risk managed robustly every day.

Mrs Ledger reported that the report would be changing format for the next meeting in line with NHS Improvement National requirements.

Mr Gore expressed his concern regarding the metrics changing and therefore losing the ability to follow trends. Mrs Ledger stated that the metrics would be more extensive and robust.

Resolved:
The Trust Board received and accepted the report.

16 Quality Minutes -25 June 2018

Prof. Veysey presented the minutes and advised that the Committee had approved the Quality Accounts on behalf of the Board.

He reported that VTE assessment performance had been established as a Quality Improvement Project to measure progress.

Never Event training was being disseminated at induction and members

of staff are required to sign to say they have received it.

Prof. Veysey reported that he had been on the Non-Executive Director induction programme and had received a presentation regarding statistical process control which measured performance in control windows rather than rag ratings. He agreed to share the presentation with the rest of the Board.

Resolved:
The Board received and accepted the minutes.

17 Performance and Finance Report

Mrs Cope reported that the ED standard was rated green due to performance being against the revised trajectory.

Finance

Mr Bond reported that Month 3 figures were in a balanced position, which was in line with plan. Income was £200k lower than it should have been, which was an improved position on last month.

The Health Group expenditure was also improving but Mr Bond stated that more could be done.

The Trust had released £560k of reserves in month, some of this was to cover the Clinical Support outsourcing costs.

Mr Gore expressed his concern regarding a number of children on the 52 week wait in the ENT speciality. Mrs Cope assured the Board that this backlog was due to maternity leave within the service and that the issue had now been resolved.

Resolved:
The Trust Board received and accepted the report.

18 Performance and Finance Minutes – 25 June 2018

Mr Hall presented the minutes highlighting ED issues, RTT improved performance, the breast symptomatic standard and outpatient cancellations. Mrs Cope advised that the Health Groups were reviewing outpatient cancellations weekly and there was good governance processes in place.

Mr Hall mentioned that a presentation had been received around the patient admin/secretarial review and was particularly impressed with the behaviours and staff letting go of the current processes to allow for new ways of working to be established.

There were concerns around CRES and the levels of savings that were recurrent. This was monitored at every meeting.

Resolved:
The Trust Board received and accepted the minutes.

19 Q1 Friends and Family Test – Staff Survey Report

Mr Nearney presented the report and advised that the Trust was now in the top 20% of Trusts due to a score of 3.90 out of 5. He gave credit to

Trust managers who had driven this change.

There was a discussion around maintaining the score with more work to be done.

Resolved:
The Board received and accepted the report.

21 Any Other Business

Mr Gore asked how the Trust stood regarding the fire improvement works following the Grenfell incident. Mr Bond assured the Board that works had been carried out which had resulted in the fire services removing the improvement notice that had been placed on the Trust. He advised that there was more work to be done and an application for emergency capital money had been requested.

22 Questions from members of the public

Mrs Stern (Chair of the Patient Council) stated that she appreciated that patients were now able to raise concerns through a number of routes.

Mr Snowden thanked Mrs Stern and informed the Board that she had joined the Quality Committee membership and was making a very valuable contribution.

23 Date and Time of the next meeting:

Tuesday 11 September 2018, 9am – 12pm, The Boardroom, Hull Royal Infirmary

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2018						
01.09	BAF 4: Operational Planning	Confirmation of the validation work and current list size to be agreed	TC		Sept 2018	Update
March 2018						
02.03	CEO Briefing	Balanced scorecard to be reviewed	CL/AS/ JM		Sept 2018	Update
COMPLETED						
01.05	Quality Report	Percentage of patients that received their correct medication on discharge to be clarified	MW	July 2018		Completed July 2018

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT

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

Overarching aims:

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

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

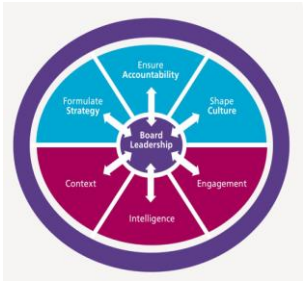
Board Development Dates 2017-19	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great local services	Great specialist services	Partnership and integrated services	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation		
04 July 2017			Area 1: Trust Board - updated Insights profile	Area 2 and BAF 3: Trust Strategy Refresh and appraoch to Quality Improvement				
10 October 2017			Area 1 and BAF 1: Cultural Transformation and organisational values				Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation	
28 November 2017			Area 2 and BAF 2 - Nursing staffing risks and strategic approach to solutions		Area 4 and BAF 4 - Trust position on diagnostic capacity - short-term impact and long-term issues; 62 day cancer			
				Area 1: Risk Appetitie - Trust Board to set the Trust's risk appetite against key risk areas				
05 December 2017				Area 1: High Performing Board and BAF 3 - CQC self-assessment and characteristics of 'outstanding'				
16 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - overview, process to review, key considerations		Area 4 and BAF 2 - People Strategy update		Area 4 and BAF 4 - Tracking Access			
30 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - key considerations and strategy delivery		Area 2 and BAF 2 - People Strategy update					Area 2 and BAF 7.1 - 7.3 - Financial plan and delivery 2017-18 and financial planning 2018-19
20 February 2018	Area 2 and BAF 4, 5, 6 : Key strategies to achieve our vision and goals and vision for the STP							
Extra meeting	Areas 2 and BAF 4 & 5: Strategy refresh -STP deliberations and direction of travel							

27 March 2018	Areas 2 and BAF 4 & 5: Strategy refresh - key strategic issues (partnerships, infrastructure)							
17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy				
		Area 1 and BAF 1: Draft 2018-19 BAF						
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents						Area 2 and BAF 7.1: Financial Strategy and Tower Block strategy
31 July 2018	Area 2 and BAF 6 & 7.2: Strategy refresh - clincial strategy		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?					
25 September 2018		Area 1 and BAF 1: What does the Board spend its time on?						
27 November 2018								Area 2 and BAF 7.1: Financial recovery plan
29 January 2019								
26 March 2019								

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

Principles for the Board Development Framework 2017 onwards

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



Overarching aim:

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

Area 1 – High Performing Board

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

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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

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

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

11 AUGUST 2018

Title:	CHIEF EXECUTIVE REPORT
Responsible Director:	CHIEF EXECUTIVE – Chris Long
Author:	CHIEF EXECUTIVE – Chris Long

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:		
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	
Key Summary of Issues:	A decade of the Queen's Centre, TAVI service to be commissioned, Hull CCG outstanding rating	

Recommendation:	That the board note significant news items for the Trust and media performance.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

AUGUST 2018 TRUST BOARD

1. KEY NEWS ITEMS

A decade of outstanding care at the Queen's Centre

In August 2008, the Queen's Centre opened its doors, heralding a new dawn in health care for more than one million patients.

A centre providing oncology and haematology services for more than one million people was announced by the Government in July 2002. The Queen's Centre for Oncology and Haematology was part of the Government's Private Finance Initiative (PFI), hailed as the largest building programme in the history of the NHS.

Our Trust was one of 13 trusts to be given approval by then Health Minister John Hutton to issue tenders for companies to build 100 new hospitals by 2010. The plan was to replace isolated radiotherapy facilities and oncology wards at Princess Royal, where inpatient services were already being withdrawn.

Services for cancer and haematology patients were to be shifted to the new centre, with beds increasing from 1,495 to 1,533 while 118 extra clinical staff were to be recruited. Along with oncology and haematology, the centre also offers neurological rehabilitation, immunology and allergy, haemophilia and lymphedema

The Queen's Centre cost £67.2m and had to fit the brief to create a "healing environment". Covering 20,000 square metres, the three-storey building was to support inpatient and outpatient facilities in calm and peaceful surroundings for patients and their families. Nine courtyards with intimate walled gardens were incorporated in the design along with a high-level glazed walkway known as the "walk in the woods".

The Cottingham countryside influenced the design, with the sloping site used as a natural way of reducing the thickness of the concrete protection required from radiation equipment.

The centre was officially opened by the Queen and the Duke of Edinburgh on March 5, 2009.

Specialised Cardiology: Transcatheter Aortic Valve Implantation (TAVI)

Following a review of TAVI services across Yorkshire and the Humber undertaken by NHS England and Public Health England, the North of England Specialised Commissioning Regional Leadership Group has recommended that a third regional TAVI service be set up for patients living across the Humber, Coast and Vale STP area.

The centre will be located at our Trust, after some inequity of access was noted during the review and the current lack of local service provision was found to be causing delays in treatment times compared to patients living in West and South Yorkshire.

Based on experience from the introduction of the TAVI service in Sheffield, it is expected that our service will become operational in quarter 4 of the 2018/19 financial year (January 2019) and will run slightly below capacity for the early part of 2019/20 as clinical practices become fully embedded. We are currently in the process of producing a detailed implementation plan to support the establishment of the new service.

Outstanding rating for Hull CCG
Congratulations to all of the staff at NHS Hull Clinical Commissioning Group which received its annual assessment score from NHS England and is one of only 20 CCGs in the country to be rated as 'outstanding'. This is the second year running Hull CCG has received the highest possible rating.

All 195 CCGs in England are evaluated every year for leadership, their financial performance, delegated functions and planning. NHS England was particularly impressed that NHS Hull CCG has maintained the highest possible rating for 2017/18, against strengthened assessment criteria and in a challenging year for the NHS.

A strong team approach and developing strong partnerships were highlighted within the annual review, and Hull CCG was particularly commended for the work it has done in supporting general practice redesign and its continued close working relationship with Hull City Council.

New £80,000 canopy to protect patients arriving by ambulance
Seriously ill patients will be protected from bad weather following completion of a new £80,000 canopy built over the entrance to Hull Royal Infirmary's Emergency Department.

Our Trust has commissioned the bespoke Perspex and steel structure to shelter patients from wind, rain and snow as they arrive in ambulances.

Crews from Yorkshire Ambulance Service will be able to drive right up to the back entrance of the Emergency Department, with patients sheltered from the elements from the moment the back doors of the vehicles are opened.

Parents-to-be use virtual reality headsets to 'experience' labour and birth
Our Women and Children's Hospital is set to become the first in the world to use virtual reality (VR) to give parents-to-be an immersive experience of labour and birth.

Pregnant women and their partners are road-testing VR headsets to "enter" the Fatima Allam Birth Centre where a woman is using one of the birthing pools in labour, supported by the baby's father.

Women can also "enter" the operating theatre where a mother is undergoing a caesarean section so they can see what happens and learn the roles of people there.

The midwifery team worked with the Hull Institute of Learning and Simulation (HILS) team, based in the Clinical Skills building at Hull Royal Infirmary, to record 360-degree footage for the VR headsets. The teams are also looking at how VR can be used in staff training and to provide other virtual experiences for women and their partners.

Young people help to transform hospital grounds
Young people from Hull aged 15 to 17 have been helping improve the surroundings for patients, staff and visitors at Castle Hill Hospital.

Forty five teenagers taking part in the National Citizen Service (NCS) with Hymers College have redeveloped previously unused green space at Castle Hill and tidied other areas in need of attention.

The group has spent a week clearing an area near to 'The Folly' of weeds and debris to transform it into a beautiful wildlife garden retreat. They will also be sprucing up a special garden near to ward 9 designed for the enjoyment of patients with dementia and their relatives, giving it a welcome injection of colour, and developing a courtyard area facing on to wards 10 and 11.

Their community work is part of a three-week National Citizen Service (NCS) programme, which sees young people taking part in outdoor activities, developing skills such as budgeting and cooking, visiting the fire service, and undertaking fundraising and projects to help their local community.

Many thanks to all of the volunteers for their hard work.

Woman thanks nurses who sent her an anniversary card from her dying husband
A woman has thanked two nurses for helping her husband send her a wedding anniversary card hours before he died.

Mark Murrell, 51, was rushed into the respiratory high dependency unit on Ward 5 at Hull Royal Infirmary in the final stages of idiopathic pulmonary fibrosis (IPF), an incurable, progressive condition which leads to a decline in lung function. He told staff nurses Sam Quiney and Hannah North he was about to celebrate his 29th wedding anniversary that weekend but had been too ill to buy his wife Wendy a card.

Sam and Hannah bought him a card and posted it to Wendy, arriving just hours after his death and the day before their anniversary.

Wendy has since nominated the two nurses for a Moments of Magic award.

Hospital researchers in trial to train dogs to detect signs of cancer
Researchers at our Trust are taking part in a three-year study to train dogs to diagnose colorectal cancer.

Dogs are renowned for their acute sense of smell and it has been known for centuries that some conditions and diseases emit characteristic odours. Cancer cells release small amounts of volatile organic compounds (VOCs) and the trust is working with the Medical Detection Dogs charity to train dogs to detect these compounds in urine and faecal samples.

If the specific smells relating to bowel cancer can be identified, an “electronic nose” could be developed in the future, allowing for faster identification and treatment for cancer patients.

Around 2,000 patients are being recruited for the study over the next three years and samples will be taken from patients aged 18 and over who have been referred to the trust’s colorectal colonoscopy clinics to see if they have cancer.

Samples will be frozen before being transported from Castle Hill Hospital to the charity’s lab in Milton Keynes where they will be used to train the dogs.

Bruno the Staffie has ‘time of his life’ as owner recovers in hospital
A man rushed into hospital with a lung condition spoke of his gratitude after a health care assistant stepped in to look after his dog.

Jenny Wilson, who works at Hull Royal Infirmary, offered to look after Nigel Sutcliffe’s Staffordshire Bull Terrier Bruno after hearing how the dog would be distressed going into kennels.

Jenny was on a 13-hour shift on Ward 5 when Nigel was brought in with a pneumothorax, also known as a collapsed lung when air builds up between the outside of the lungs and the inside of the rib cage. Grateful of Jenny’s offer, Nigel arranged for his friend to meet Jenny at his home at the end of her shift to introduce her to Bruno and she took him back to her own

home to meet her 15-year-old daughter Alysha, twin sons Owen and Declan, both 12, and her partner Amy.

After four days, Bruno was reunited with his owner. However, they all still keep in touch.

2. MEDIA COVERAGE

The Communications team issued 29 news releases this month.

72 articles out of 76 generated were positive (95%).

The most read article on our website were as follows:
1 August - Hundreds of junior doctors join Hull Royal Infirmary and Castle Hill – Junior doctors rotation / induction
6 August - Bruno the Staffie has 'time of his life' as owner recovers in hospital – Nurse offers to care for patient's dog while he's in hospital
8 August - A&E porter thanks security officer and staff for saving his life
13 August - Cook frozen sweetcorn before adding to salads, advises head of midwifery – risk of listeriosis
20 August - 'If I'd have gone to university that day, I wouldn't be alive' – Patient contracts life threatening sepsis
23 August 'Our patients are a very special group of people' – 10 years of the Queen's Centre– Tribute to Queen's Centre's 10th anniversary
23 August - 'It might sound stupid but it's like going back to a family'– Tribute to Queen's Centre's 10th anniversary
28 August - Woman thanks nurses who sent her an anniversary card from her dying husband
29 August - Work begins on refurbishment of children's wards at Hull Royal Infirmary

Facebook
Total "reach" for all posts on trust Facebook pages in August: 547,131 (July 567,668)
- Hull Women and Children's Hospital 157,130 (July 115,388)
- Hull and East Yorkshire Hospitals Trust – 37,742 (July 102,017)
- Castle Hill Hospital – 134,246 (July 139,751)
- HEY Jobs page – 20,577 (July 11,662)
- Hull Royal Infirmary – 197,436 (July 198,850)

Total followers:
- Hull Royal Infirmary: 6,922 (July 6,865)
- Hull Women and Children's Hospital: 7,254 (July 7,121)
- Castle Hill Hospital: 3,345 (July 3,289)
- Hull and East Yorkshire Hospitals NHS Trust: 3,619 (July 3,599)
- HEY Jobs: 3,795 (July 3,741)

Twitter
@HEYNHS
Followers: 5,744 (July 5,687)
Impressions: 105,200 (July 203,000)

Instagram Followers 831 (July 727)

3. MOMENTS OF MAGIC

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

In August 2018 we received 77 Moments of Magic nominations. This is the highest number of nominations we have received since launching the scheme in 2011.

Please visit the intranet to read the most recent nominations.

HEY LONG TERM GOALS - July 2018 data

Great Staff | Great Care | Great Future

Quality

RAG	Indicator	Target	Performance July	Trend v Previous Month
G	Never Events	0	0	→
R	Complaints (QIP - closed within 40 working days)	90%	84.10%	↑
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	52	13	-
G	Safety Thermometer - Harm Free Care	95%	95.14%	↑
R	Venous Thromboembolism (VTE) Risk Assessment (Q1 1819)	95%	91.31%	↑
G	Mortality - HSMR (May 2018)	<100	94.6	↓
G	Friends & Family Test - Inpatients (June 18 - Trust v National %)	95.70%	98.40%	↓
R	Friends & Family Test - Emergency Department (June 18 - Trust v National %)	87.40%	81.90%	↓

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

Workforce

RAG	Indicator	Target	Performance July	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	10.00%	→
G	Staff Sickness	<3.9%	3.58%	↓
R	Staff Vacancies	<5.0%	8.84%	↑
R	Staff WTE in post (<0.5% from Plan)	7293	7195	↓
G	Staff Appraisals - AFC Staff	85%	85.00%	↓
G	Staff Appraisals - Consultant and SAS Doctors	90%	89.00%	↓
G	Statutory/Mandatory Training	85%	91.50%	→
R	Temporary Staff/Bank/Overtime costs (Medical YTD)	£4.0m	£5.2m	-
G	Staff: Friends & Family Test - Place of Work (Q1 1819 v National)	66%	69%	↑
G	Staff: Friends & Family Test - Place of Care (Q1 1819 v National)	81%	82%	↑

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

Performance

RAG	Indicator	Target	STF Trajectory	Performance July	Trend v Previous Month
G	18 Weeks Referral To Treatment	92%	80.00%	81.32%	↓
R	52 Week Referral To Treatment Breaches	0	6	12	↑
R	Diagnostic Waits: 6+ Week Breaches (<1%)	<1%	-	8.52%	↓
R	Emergency Department: 4 Hour Wait Standard (95%)	95%	93.4%	79.76%	↓
R	Cancer: ADJUSTED 62 Days Referral To Treatment (April Data)	85%	76.00%	71.60%	↓
G	Length of Stay	<5.2	-	4.9	↑
R	Clearance Times	12 weeks	-	15.2	↓
R	Waiting List Size	52,932	-	57,718	↑
G	Available Clinic Slot Utilisation	80%	-	90.20%	↑
R	Theatre Utilisation	90%	-	82.27%	↓
G	E-Referrals - GP Engagement	100% by October 2018	-	94.4%	↑
R	Appointment Slot Issues	35% (TBC)	-	44.21%	↓

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

Finance

RAG	Indicator	Target	Performance July	Trend v Previous Month
G	Capital Expenditure	2.6	2.3	↑
R	Statement of Comprehensive Income Plan - Year to Date	-0.825	-1.239	-
R	CRES Achievement Against Plan	£3.68m	£3.65m	-
R	Invoices paid within target - Non NHS	95%	90%	↑
R	Invoices paid within target - NHS	95%	59%	↑
R	Risk Rating	3	3	→

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

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

Tuesday 11 September 2018

Title:	Board Assurance Framework
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	The purpose of this report is to present the 2018-19 Board Assurance Framework, for the Board to highlight any positive assurance or areas requiring further assurance linked to the Board's agenda.	
BAF Risk:	All	
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	✓
Summary of Key Issues:	BAF 2: Staffing – this risk was increased following discussion at the July 2018 Board meeting from 16 to 20. All other risk ratings remained the same. The level of corporate risk in some BAF areas has changed in the last 12 months.	

Recommendation:	The Board is asked to review the current risk areas on the Board Assurance Framework and determine whether: • There are any particular gaps in assurance requiring future discussion or decision-making by the Trust Board • There is positive assurance from the Board's discussions to add to the BAF • To discuss the current status of BAF 2 (staffing) and BAF 6 (partnership and STP) following the July 2018 Trust Board and agreement to review these areas in 3 months' time

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

1. Purpose of this report

The purpose of this report is to present the 2018-19 Board Assurance Framework, for the Board to highlight any positive assurance or areas requiring further assurance linked to the Board's agenda.

2. Background

The Trust Board is responsible for setting its assurance framework, to capture the key risks to achieving the Trust's strategic goals, and detail the level, or lack, of assurance during the year as to what extent the level of risk is being managed. The Board Assurance Framework (BAF) also determines what an acceptable level of risk would be. The BAF is a key governance mechanism to measure and monitor the level of strategic risk in the organisation.

The Trust has put in place a 'ward to board' process for risk management, for the BAF to include reference to relevant risks form the Corporate Risk Register, which is reviewed and agreed by the Executive Management Committee. This provides the opportunity to link corporate-level risks where they impact on the strategy and achievement of the Trust's over-arching goals.

The Board spent time at its development session in May 2018 on the use of the Board Assurance Framework and determined that Board discussions should be framed more around the Trust's strategic objectives and risks to their achievement. These are then captured on the Board Assurance Framework.

Page 1 of the Board Assurance Framework now consists of a visual to group the strategic risks in to 5 domains. This can help as an aide-memoire as to where a discussion 'fits' in terms of strategic discussion. The BAF can be populated through discussions framed around risks and assurance to the strategic objectives.

3. Board Assurance Framework (BAF) 2018-19

3.1 Board Assurance Framework in Quarter 1

At the Trust Board in July 2018, the Board discussed four of the BAF risks with the highest risk ratings in Q1:
BAF 2 – staffing. Q1 risk rating = 15
BAF 4 – performance. Q1 risk rating = 16
BAF 6 – STP and partnership working = 16
BAF 7.1 – achievement of financial plan = 20

3.2 Board Assurance Framework in Quarter 2

Through these detailed discussions at the July 2018 Trust Board, the Board increased the risk rating of BAF 2 – staffing. The Board agreed that The Board reviewed BAF Risk 2 and agreed to increase the risk rating to 20. Other BAF ratings remained the same.

These form the Q2 ratings for each BAF risk included overleaf and show the movement of the risk rating of BAF 2.

At its July 2018 meeting, the Trust Board recognised the work already in place and ongoing around BAF 2 staffing and agreed that this would be reviewed in September 2018 with a view of reducing it providing the Board were assured that actions in place mitigated the risk satisfactorily. Likewise, the Board asked to discuss the position on at BAF 6 (partnership and STP) in September 2018.

The other risk ratings were unchanged for Q2. In respect of BAF 7.1, the Board agreed to leave the risk rating at 20 but there was concern around the end-of-year loading to achieve the CRES. The Performance and Finance Committee maintains oversight of this area and to and escalate any emerging issues.

The Trust Board at its meeting today is focussing on other risk areas on the BAF to ensure these receive adequate strategic discussion as key issues facing the Trust. The Chief Financial Officer has asked for a discussion at the November 2018 Board on BAF 7.2 (infrastructure) as one of the highest areas of risk, by which time some outcomes of national capital funding streams should be known.

The Board has met twice and the Performance and Finance and Quality Committees five times this financial year. There are no other particular areas of risk or assurance that have been escalated during this time. There are some particular pressure points that will need active monitoring by Board Committees, particularly capital and infrastructure, and making quality improvements and a safety culture, as well as a long-term staffing plan. These will form Board and Committee discussions during the year.

3.3 Corporate Risk Register

The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 21 risks on the corporate risk register. Of these 21 risks, all map to risk areas on the BAF, as follows:

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 7 corporate risks
BAF 3 quality of care = 5 corporate risks
BAF 4 performance = 4 corporate risks
BAF 5 specialist services = 0 corporate risks
BAF 6 partnership working = = corporate risks
BAF 7.1 financial plan= 0 corporate risks (reduction of 2 risks)
BAF 7.2 infrastructure = 5 corporate risks

Mapping corporate risks helps to show the link between operational and strategic risk; if the number of corporate risks in a particular BAF area increases, it could indicate that strategic issues are starting to have an operational effect on patients and staff; like, the number of corporate risks in a BAF area suggests that there are already operational effects from a strategic issue and increases can be indicative of a risk escalating.

The number of corporate risks relating to the financial plan achievement has reduced by 2, following a review by the two HG raising risks before on achievement of the financial plan for this financial year (both risks related to achievement of last year's plan).

The number of infrastructure risks (BAF 7.2) has risen from 1 to 5 in the last 12 months.

The number of staffing risks if the highest level corporate risk and is also the highest-rated BAF risk. The number of staff corporate risks has increased by 3 since the start of 2017.

4. RECOMMENDATIONS

The Committee is asked to review the current risk areas on the Board Assurance Framework and determine whether:

- There are any particular gaps in assurance requiring further work by the Trust Board
- There is positive assurance from the Committee's discussions to add to the BAF

Carla Ramsay
Director of Corporate Affairs

Rebecca Thompson
Corporate Affairs Manager

August 2018

PEOPLE
Honest, caring and accountable culture
Valued, skilled and sufficient staff

Strategic risks:
Staff do not come on the journey of improvement – seen in staff engagement and staff FFT scores

Work on medical engagement and leadership fails to increase staff engagement and satisfaction

Lack of affordable five-year plan for 'sufficient' and 'skilled' staff

FINANCE
Financial sustainability

Strategic risks:
Failure to deliver 2018-19 financial plan and associated increase in regulatory attention

That the Trust is not able to formulate and implement a three-year financial recovery plan to leads to financial sustainability, and that this failure impacts negatively on patient care

PATIENTS
High quality care
Great local services
Great specialist services

Strategic risks:
Failure to continuously improve quality
Failure to embed a safety culture
Failure to address waiting time standards and deliver required trajectories – increased risk of patient harm and poorer patient and staff experience

INFRASTRUCTURE
High quality care
Financial sustainability

Strategic risks:
Growing risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment

Linked to three-year financial recovery plan – risk that capital requirements cannot be met and pose an increased risk to financial recovery

PARTNERS
Partnership and integrated services

Strategic risks:
Risks posed by changes in population base for services
Lack of pace in acute service/pathway reviews and agreement on partnership working
Risk of lack of credible and effective STP plans to improve services in the local area within the resources available, and a lack of influence by the Trust in these plans
STP rated in lowest quartile by regulator

BOARD ASSURANCE FRAMEWORK 2018-19 AS PRESENTED TO THE MAY 2018 TRUST BOARD

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	*Principal Risk*: There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to 3.88 by the 2018 staff survey There is a risk that the Trust fails to embed a safety culture *What could prevent the Trust from achieving this goal?* Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues	None	**4 (impact)** **3 (likelihood)** **= 12**	Staff Survey Working Group overseeing staff survey action plan Focus on enablers to improve staff culture (appraisals, errors and incident reporting, etc), Equality and Diversity, Job satisfaction and health and well-being, Medical engagement and accountability, and specific staffing groups less engaged than others Staff Survey action plan linked to key aims of People Strategy – annual reporting to Trust Board on progress Engagement of Unions via JNCC and LNC on staff survey action plan Chief Executive cultural briefings in 2018 on management behaviours and 'stop the line' Board Development Plan includes development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores Continuous examples and feed back to staff as to how speaking up makes a difference	**12**	**12**			**4 x 1 = 4**	**<u>Positive assurance</u>** Positive receipt by clinicians of the Never Event session – to follow up **<u>Further assurance required</u>** Recent staff engagement score shows some slowing of progress

		Risk that some staff or putting patient safety first			Integrated approach to Quality Improvement Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the People Strategy						

Risk Appetite

The Trust has been managing and mitigating the level of risk posed by staff culture since 2014, and has been on a journey of improvement on staff engagement. There needs to be a renewed focus on staff culture to bring about a new level of improvement. The appetite for risk is high, insofar as the Trust has worked in a high-risk environment regarding staff culture, which has been mitigated over time as a result of acknowledging the poor staff culture in 2014 and putting a robust plan in place to engage with staff ever since. The Trust wants to mitigate this to a lower-level risk in respect of the impact that poor engagement and poor behaviours have; the Trust is not prepared to take risks with staff culture where this jeopardises patient care or staff welfare.

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	*Principal risk:* Staff do not come on the journey of improvement – seen in staff engagement and staff FFT scores Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff *What could prevent the Trust from achieving this goal*? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse, OPD vacancies Cancer and Clinical Support HG: junior doctor levels in Queen's Centre Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists	**5 (impact)** **3 (likelihood)** **= 15**	People Strategy 2016-18 in place Workforce Transformation Committee – introduction of new roles to support the workforce and reduce risk of recurrent gaps in recruitment, including Associate Nurses, apprentices (including nursing); Advanced Clinical Practitioners and Physicians Associates being deployed and recruited to cover Junior Doctor and nursing roles, in addition the Trust has introduced new roles such as Recreational Assistances and Progress Chasers, to help manage workload and improve patient flow and experience Increased resources in to recruitment: Overseas recruitment and University recruitment plans in 18-19; Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place to account at monthly performance	Need clarity as to what 'skilled' staffing looks like and how this is measured: 1) measured in terms of having capacity to deliver a safe service per contracted levels 2) measured in terms of skills across a safe and high quality service 3) measured in terms of staff permanently employed with an associated reduction in agency spend and variable pay costs	**15**	**20**			5 x 2 = 10	**Positive assurance** New roles being put in place and supported by the Trust in 18-19 including Physicians Associates, further ACPs, nursing apprenticeships **Further assurance required** Variable pay spend predicted to continue during 18-19; some HGs already under some pressure even with re-set budgets Reviewed in detail at July 2018 Trust Board – risk rating increased, to be reviewed in September 2018 with a view to the risk rating coming back down after mitigating actions

					management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of choice during and following completion of training Nursing safety brief several times daily to ensure safe staffing numbers on each day Employment of additional junior doctor staff to fill junior doctor gaps Regular reports to the Trust Board from the Guardian of Safe Working						

Risk Appetite

There is a link between patient safety and finances; the Trust draws a 'red line' as compromising quality of care and has part of the overspent position in 2017-18 was to maintain safety of services due to staffing shortfalls. The Trust needs to reduce the risk to its financial sustainability posed by quality and patient safety but without compromising the Trust's position on patient safety. The Trust is putting a plan in place to encompass new clinical training roles and build these in to workforce plans, so is demonstrating a good appetite to adapt and change to further mitigate this risk. The Trust will need to show some agility and willingness to invest as part of this risk appetite.

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	*Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care *What could prevent the Trust from achieving this goal?* That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what good or outstanding looks like That the Trust does not increase its public, patient and stakeholder engagement, detailed in a	Corporate risk: management of consent policy and patient records MHG: Hyper Acute Stroke Unit capacity CCSHG: lack of compliance with blood transfusion competency assessments Corporate risk: risk of harm from tracking access issues CCSHG: Risk to patient safety involving discharge medicines	**3 (impact)** **3 (likelihood)** **= 9**	Setting expectations on a safety culture in the Trust – Never Event session to be followed up by Chief Executive briefings sessions and the 'Stop The Line' campaign Quality Improvement Plan (QIP) was updated in light of latest CQC report and will be further updated when new CQC report is published in Summer 2018 Trust has an integrated approach to quality improvement The Trust has put in place all requirements to date on Learning from Deaths The Trust regularly monitors quality and safety data to understand quality of care and where further response is required – Fundamental standards in nursing care on wards are being out to outpatients and theatres; will be monitored at the Trust Board and Quality Committee	Needs organisational ownership of the underlying issues within each team of the Trust; the CQC commented in Feb 17 that Trust has the right systems and processes in place but does not consistently comply or record compliance Always a feeling that more can be done to develop a learning and pro-active culture around safety and quality - to factor in to organisational development (links to BAF1)	**9**	**9**			3 x 2 = 6	**<u>Positive assurance</u>** **<u>Further assurance required</u>** CQC rating of 'requires improvement' – shows a lot of progress since last report but still work to do to progress to 'good' overall

		strategy									

Risk Appetite

The Trust remains focussed on delivery of high quality services for its patients; the Trust does not want to compromise patient care and does not have an appetite to take risks with quality of care. The Trust acknowledges that the risk environment is increasing in relation to the Trust's financial position and ability to invest in services, and that the Trust has an underlying run-rate issue to address.

GOAL 4 – GREAT LOCAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	*Principal risk:* There is a risk that the Trust does not meet operational planning guidance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 18-19, with an associated risk of distress caused to patients and the ability of the Trust to secure STF monies. *What could prevent the Trust from achieving this goal?* For 18 weeks, the Trust needs to reduce its list size compared to the position at 31 March 2018; this will require targeted work by each specialty ED performance did improve following a period of intensive support and improvement focus but performance is affected by small differences/ issues each day that need further work In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG Capacity of intra-vitreal injection service MHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target	**4 (impact)** **4 (likelihood)** **= 16**	Trajectories set against sustainable waiting lists for each service, to move the Trust closer to 18-weeks incrementally Further improvement and embedding in ED as well as with wards and other services to improve patient flow and ownership of issues Capacity and demand work in cancer pathways	Management of individual waiting lists to make maximum impact – i.e. identified work to decreasing waiting times at front-end of non-admitted pathways for 18-week trajectories	**16**	**16**			4 x 2 = 8	**Positive assurance** **Further assurance required** Performance targets not met in first two months of the year Reviewed in detail at July 2018 Trust Board; detailed understanding of current actions and underlying issues

		maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to make further gains										

Risk Appetite

A range of plans are being put in place to further manage these issues in to 2018-19. This will need further focus in 2018-19, including the completion of the work and investigation relating to the tracking access issue. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. The Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope of the Aligned Incentives Contract where the activity comes under the local commissioners' contracts, and fit within the funding from NHS England for specialised commissioning services. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes.

GOAL 5 – GREAT SPECIALIST SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	*Principal risk:* There is a risk that reductions in the Trust's patient population for (some) of its specialist services may present sustainability challenges. *What could prevent the Trust from achieving this goal?* Actions relating to this risk may be taken by other organisations than the Trust and the Trust may struggle to influence these decisions, particularly in relation to patient populations beyond the Humber geography.	None	**3 (impact)** **4 (likelihood)** **= 12**	The Trust chairs the HCAV STP Hospital partnership Board The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is a member of the Yorkshire and Humber Oversight Group for Specialised Commissioning	Ongoing discussions and evolution of the STP and also its links to local health economy programmes of work	**12**	**12**			4 x 2 = 8	**Positive assurance** **Further assurance required**

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

GOAL 6 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Director of Strategy and Planning	Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	None	**4 (impact)** **4 (likelihood)** **= 16**	The Trust has taken up key leadership roles in the reformed STP governance structure, so has 3 seats on the Executive group; digital lead (CEO), finance lead(CFO) and local maternity system lead (CMO) The Trust is playing a key role in the Humber Acute Review (CEO and DOSP) The Trust is playing a key role in the STP workforce workstream (DOWOD) The Trust has a seat on the Hull Place Board (CEO) The Trust is participating in the East Riding Place Based initiatives The Trust has a partnership meeting with CHCP		**16**	**16**			4 x 2 = 8	**Positive assurance** **Further assurance required** Reviewed in detail at July 2018 Trust Board; detailed understanding of current position and actions being taken

Risk Appetite

The Trust may need to take some risks in order to secure the correct strategic positioning; however, this would not be to compromise the Trust's strategy or delivery to patients; this area if an emerging picture and the Trust is positioned to play a key role in STP developments and the way in which this delivers better quality care across the local health economy

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	*Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2018-19 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit Failure of local health economy to stem demand for services	None	**5 (impact)** **4 (likelihood)** **= 20**	Health Group budgets revisited for 2018-19 and right-sized, depending on activity requirements and underlying recurrent pressures. Theoretically, the risk is now centred on CRES. Weekly Productivity and Efficiency Board (PEB) in place; outputs monitored by Performance and Finance Committee HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Year 2 of Aligned Incentives Contract with local commissioners; consistent approach to income Investment in staffing shortfalls and recruitment to drive reductions in variable pay	Continued assurance from local health economy on demand management Assurance over grip and control of cost base; underlying run-rates increasing pressures Managing concerns around senior doctor availability and the limited ability of the Trust to control this national position	**20**	**20**			5 x 3 = 15	**Positive assurance** **Further assurance required** Reviewed in detail at July 2018 Trust Board; detailed understanding of current position and actions being taken

Risk Appetite

The Trust is willing to review any CRES proposal and has a robust Quality Impact Assessment in place to understand any change posed to quality and safety as a result of a new CRES scheme. The Trust will not put in significant CRES schemes that would compromise patient safety. The aim of any CRES scheme is to maintain or ideally improve quality.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2017/18 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment	Corporate risk: Telephony resilience Corporate risk: IM&T infrastructure resilience Corporate risk: switchboard resilience Corporate risk: risk of Fire Safety Prohibition Notice Corporate risk: cyber-security	**5 (impact)** **4 (likelihood)** **= 20**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Recourse Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Remedial fire works undertaken in the short-term	Insufficient funds to manage the totality of risk at the current time Programme enables the Trust to run on a day-to-day basis but is not addressing the root causes sufficiently, such as fire safety – the level of risk increases as the Trust manages 'as is'	**20**				5 x 2 = 10	**Positive assurance** Trust applied for emergency loan funding from the centre to seek solutions to risk in-year **Further assurance required**

Risk Appetite

The Trust is balancing a number of risks in relation to capital; the amount of capital available to the Trust is very limited compared with the calls on capital that the Trust has quantified –i.e. backlog maintenance, equipment replacement, capital development requirements for safe patient environments, quality of sanitary accommodation; the longer the Trust manages its estates as it is, the increase of non-compliance risks with regulatory requirements

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

11th SEPTEMBER 2018

Title:	Board Assurance Framework Goal 1 – Honest, Caring and Accountable Culture
Responsible Director:	Simon Nearney Director of Workforce and OD
Author:	Simon Nearney Director of Workforce and OD

Purpose:	The purpose of the report is to update the Board on the BAF risk – Honest, Caring and Accountable Culture and to seek the Board's approval to maintain the current risk level.	
BAF Risk:	Board Assurance Framework Goal 1	
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	✓
Key Summary of Issues:	The Trust's National Staff Survey results demonstrate staff engagement has improved from 3.54 (Nov, 2014) to 3.77 (Nov, 2017). The Barrett cultural survey also shows improvement during the past 3 years, as does the quarterly Friends and Family staff survey results that have an average score of 3.81 and has peaked at 3.92. The primary aim of the Trust's People Strategy 2016-18 has been to develop and sustain an effective organisational culture and whilst more work is required; the Trust has re-launched a further programme of work that will enable HEY to break into the top 20% of organisations nationally for staff engagement.	

Recommendation:	The Trust Board is requested to note the content of the report and to approve maintaining the current risk level of 12

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

11th SEPTEMBER 2018

Board Assurance Framework Goal 1

Honest, Caring and Accountable Culture

1. PURPOSE

The purpose of the report is to update the Board on the BAF goal – honest, caring and accountable culture and to seek the Board's approval to maintain the current level of risk.

2. BACKGROUND

Positive staff engagement is associated with high performing organisations. Research by the King's Fund has provided strong evidence that NHS organisations where staff report high levels of engagement perform better in terms of productivity, performance measures and financial performance.

The Trust's staff engagement score improved significantly between 2014 and 2017; from 3.54 out of 5 in November 2014 to 3.77 in November 2017. In quarterly Friends and Family surveys that score has peaked at 3.92 and averaged at 3.81 since the Trust began measuring it in May 2015. The national average score for staff engagement is 3.79.

The challenge for the Trust now is to move into the top 20% of organisations nationally, which will require a consistent performance of >3.88.

The staff survey results continue to correlate with the Barrett cultural survey, which has also shown improvement over the past three years. An initial survey in 2014 returned a negative response against all values indicators in the 'current culture' domain. The 2017 repeat survey saw 6/10 indicators are now positive with staff reporting that the Trust's values of 'care' and 'accountability' were now present in the current culture. However, staff continued to report that the organisation remains overly bureaucratic and hierarchical with a focus on the short-term.

The Trust has staff engagement / organisational culture at the heart of its People Strategy 2016-18. Delivering the 7 workforce themes below will enable the organisation to develop and sustain high staff engagement results and be an organisation where staff want to work, be developed and remain for many years to come.

- Recruitment and retention of staff
- Leadership capacity and capability
- Innovation, learning and development
- Equality and Diversity
- Health and wellbeing
- Employee engagement, communication and recognition
- Modernising the way we work

3. STAFF SURVEY SUMMARY FEEDBACK

Key findings

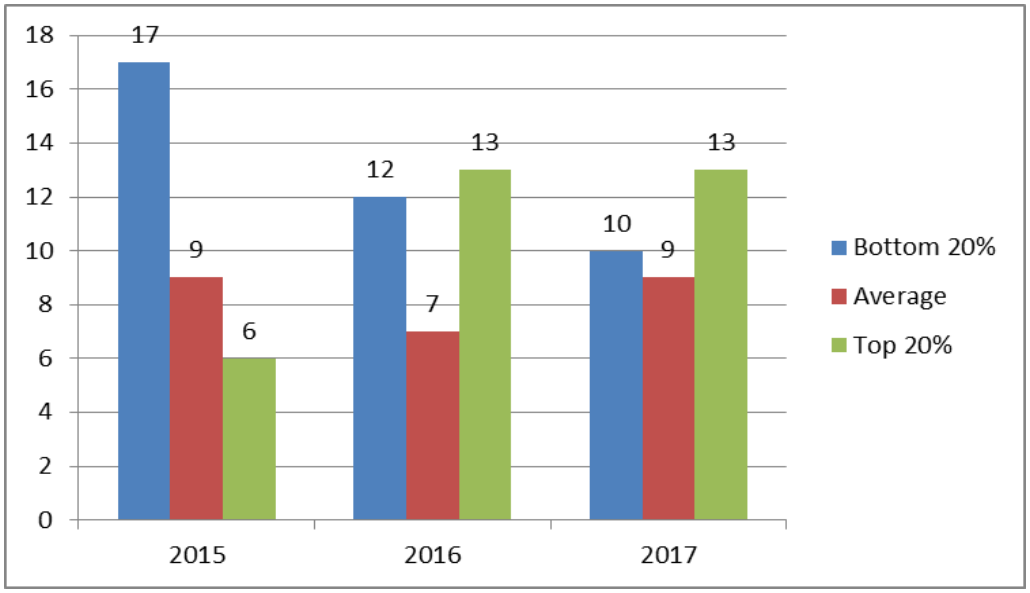
Overall performance in the staff survey has improved year on year since 2014. Significant improvements have been made in key areas, specifically those around bullying and harassment and the key indicators: recommendation of the Trust as a place to work/receive care:

	2014	2017
Staff experiencing bullying and harassment	38%	28%
Recommendation of Trust as a place to work	44%	59%
Recommendation of Trust as a place to receive care or treatment	51%	67%

The National Staff Survey comprises 32 key findings. Performance against these key findings has improved over the past three years. Trusts can benchmark themselves against other organisations and whether their scores are in the worst 20% of organisations, average or in the top 20% of organisations.

HEY's performance in 2018 shows that fewer of our key findings feature in the bottom 20% of organisations while those in the top 20% have remained the same.

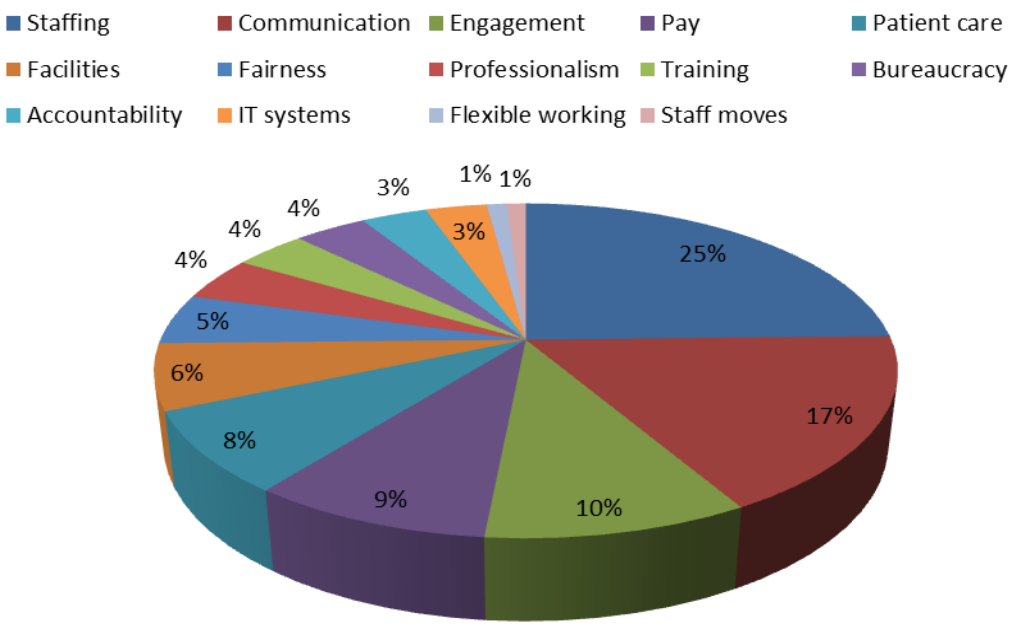
Performance against the 32 key findings over the past three years is as follows:



The Trust is in the bottom 20% of trusts for the following key findings:

- Quality of appraisals
- Management interest in health and wellbeing
- Staff recommendation of the Trust as a place to work or receive treatment
- Staff able to contribute towards improvements at work
- Effective team working
- Agreeing that their role makes a difference to patients
- Effective use of patient feedback
- Staff reporting the most recent experience of violence from patients
- Experiencing bullying or harassment from a colleague in the last 12 months
- Reporting the most recent incident of bullying or harassment from a colleague

The Trust received 2070 verbatim comments in the 2017 staff survey, in response to the question: Name one thing that could be improved about your organisation.



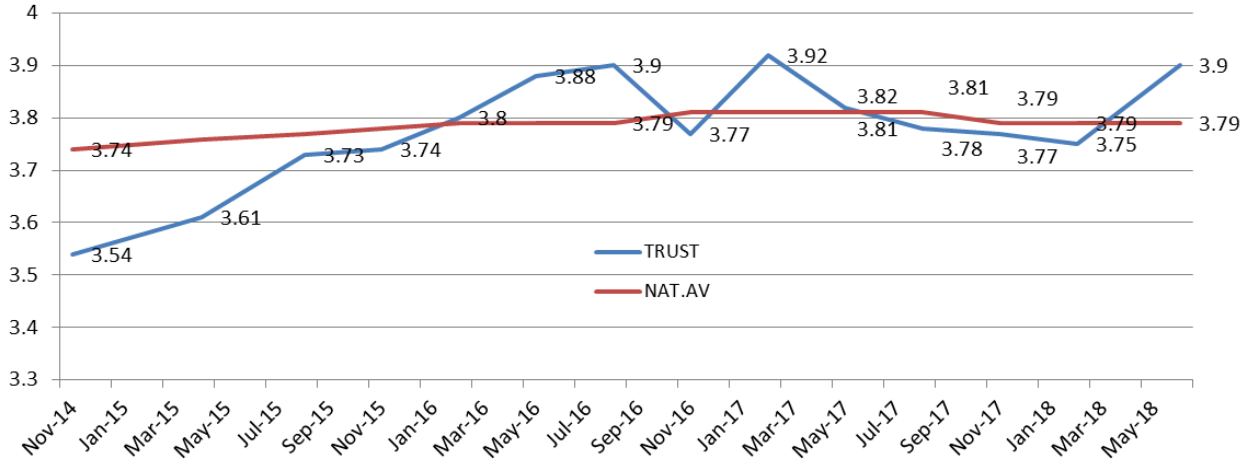
Over half of the verbatim responses we received referred to concerns around staffing levels and poor communication and engagement, specifically at management level.

Staff referred to:

- general poor communication between managers and their teams (lack of team meetings)
- managers not understanding what teams do
- lack of manager visibility
- poor team-working between wards/departments/divisions and Health Groups
- a lack of willingness to listen to staff at all levels
- poor management support for staff
- staff not feeling valued by their management (lack of acknowledgment for their work)
- staff not involved in decisions that affect them and their services

4. STAFF ENGAGEMENT AT HEY

The staff engagement score in the National Staff survey has improved since 2014. The Trust's overall score for engagement in the National Staff Survey 2017 (3.77) has remained the same as in 2016 and is just below the national average for trusts, 3.79. For the Q1 staff Friends and Family Test, the score rose to 3.9, its highest point for a year. The Q2 survey was ran in August and results will be available mid September, 2018.



The pathway to good engagement at HEY is complex however a large amount of work is currently underway, building upon the good work of staff, clinicians, managers, senior leaders and the Board.

The current work programme falls neatly under 5 key areas with assurance provided by quarterly staff surveys, CQC inspectors, NHSI and staff feedback from exit interviews and trade unions (Appendix 1 – map of 5 key areas). New actions have been agreed to address the key issues around poor management communication, leadership issues and staff-led improvement. These are indicated as follows:

1. Education and development
    i. Leadership development (see section 5)
    ii. Medical leadership programme
    iii. Talent management programme
2. Communication
    i. Strengthening Team Brief arrangements into policy
    ii. Back to the floor initiative for managers (piloted in Family and Women's)
3. Reward and recognition
    i. Staff benefits fairs (quarterly on site events)
    ii. Honours committee
4. Quality improvement
    i. Pioneer teams
    ii. Improvement development training for staff (HiP team)
5. Health and wellbeing
    i. Stress management
    ii. Mental health awareness programme

5. LEADERSHIP DEVELOPMENT

In a report from February 2015 the King's Fund identifies six building blocks for harnessing the creativity and enthusiasm of NHS staff.

1. Develop a compelling, shared strategic direction
2. Build collective and distributed leadership
3. Adopt supportive and inclusive leadership styles
4. Give staff the tools to lead service transformation
5. Establish a culture based on integrity and trust
6. Place staff engagement firmly on the board agenda

Work undertaken by the Trust since 2015 has seen us progress against the delivery of these building blocks with clear vison, values and goals in place, an improving values-based culture, engagement visible at board level, a service transformation team working to impart skills to staff at all levels and a focus on leadership development.

It is the latter area where the Trust is focussing its efforts, with the development of a bespoke People Management programme, designed to ensure all managers working at the Trust are developed to be a HEY Leader. This is being piloted in the Autumn/Spring of 2018/2019 with a view to full implementation by April 2019. All HEY managers will undertake a behavioural-based programme designed to ensure they have the skill set and tools to engage, empower and inspire their teams to deliver great care. The Trust needs to its managers to be transformational leaders, who are effective communicators, actively listen to their staff and encourage their teams to continually learn and improve. The programme will be robustly measured using 16 core competencies against which all managers will be reviewed giving them clear areas for development to be discussed in their appraisal.

This work is being undertaken by the Trust's Organisational Development team with support from Communications and Engagement and Education and Development.

Supporting the People management programme will be the ongoing and successful Great Leaders Bitesize courses offering leadership and personal development in a range of areas from financial management to managing people as a coach.

6. MONITORING AND REPORTING

In order to monitor actions being undertaken to further improve our staff engagement levels a Culture and Wellbeing Committee, chaired by the Chief Executive has been established. This group is furthering the work initiated by the PaCT Committee in 2015. Membership of the group includes representation from Health Groups, medical, AHP's and nursing.

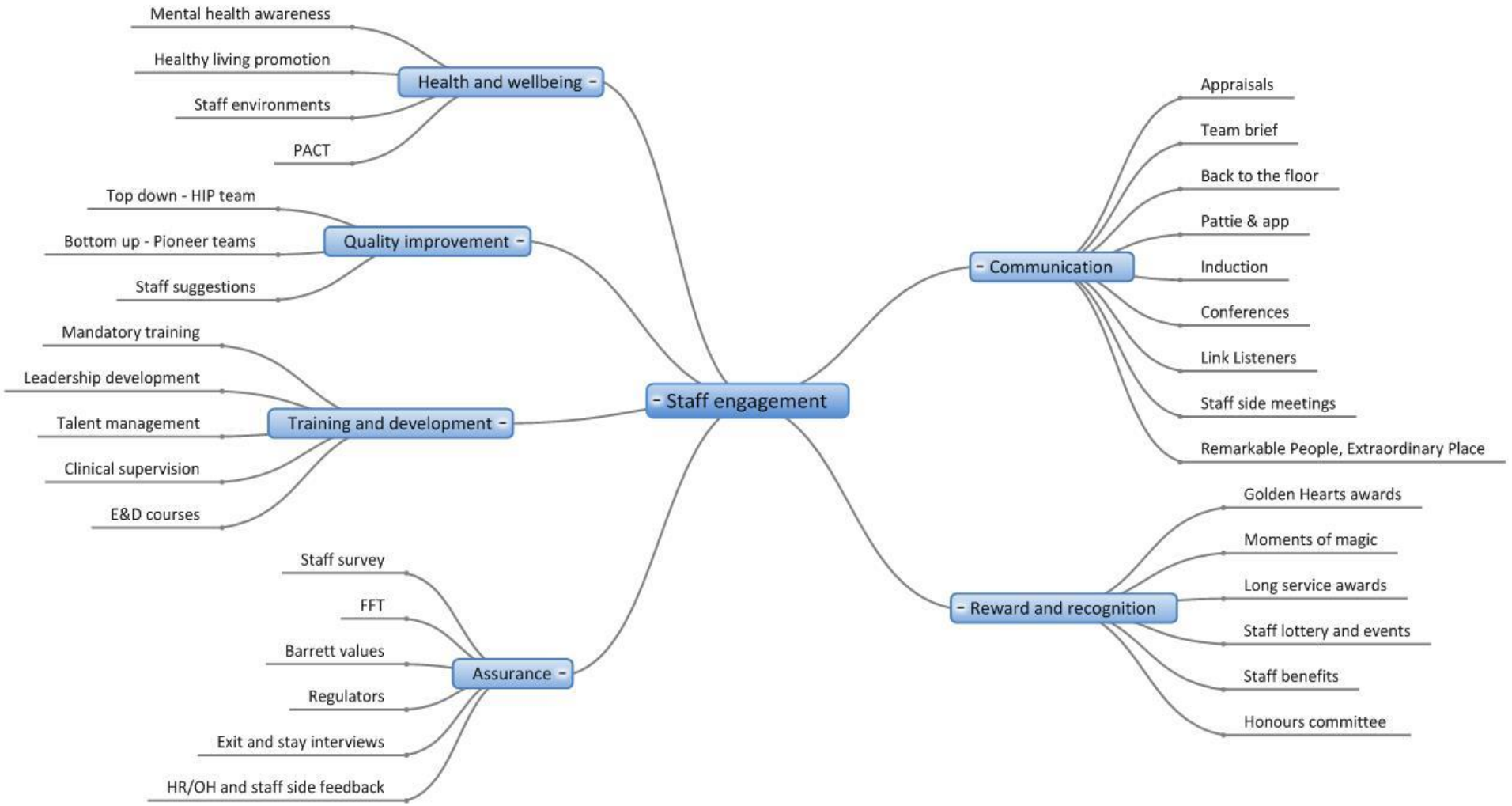
The Committee reports into the Workforce Transformation Committee.

7. RECOMMENDATIONS

The Trust Board is requested to note the content of the report and to note the actions being taken to improve staff engagement. The Board is requested to maintain the risk for Honest, Caring and Accountable Culture at its current risk level of 12.

Officer to contact
Simon Nearney
Director of Workforce and OD
Tel: 01482 676439

Appendix 1


Staff engagement
Health and wellbeing
Mental health awareness
Healthy living promotion
Staff environments
PACT
Quality improvement
Top down - HIP team
Bottom up - Pioneer teams
Staff suggestions
Training and development
Mandatory training
Leadership development
Talent management
Clinical supervision
E&D courses
Assurance
Staff survey
FFT
Barrett values
Regulators
Exit and stay interviews
HR/OH and staff side feedback
Communication
Appraisals
Team brief
Back to the floor
Pattie & app
Induction
Conferences
Link Listeners
Staff side meetings
Remarkable People, Extraordinary Place
Reward and recognition
Golden Hearts awards
Moments of magic
Long service awards
Staff lottery and events
Staff benefits
Honours committee

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

11 September 2018

Title:	Standing Orders
Responsible Director:	Director of Corporate Affairs
Author:	Corporate Affairs Manager – Rebecca Thompson Director of Corporate Affairs – Carla Ramsay

Purpose:	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.	
BAF Risk:	N/A	
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	✓
Summary of Key Issues:	The Trust Board approved some additions to the Terms of Reference of the Trust's Charitable Funds Committee in July 2018; the Trust Board is asked that these amendments also form amendments to Trust Standing Orders, which is a power reserved to the Trust Board. The Remuneration Committee also request an amendment to its Terms of Reference, for Trust Board approval, also requiring amendment to Standing Orders. The Trust's seal has been used for review by the Trust Board.	

Recommendation:	The Trust Board is requested to: • Approve amendments to Trust Standing Orders for the Charitable Funds Committee • Approve amendments to the Terms of Reference and Trust Standing Orders for the Remuneration Committee • Authorise the use of the Trust's seal.

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

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 Charitable Funds and Standing Orders

At The Trust Board meeting in July 2018, the following additions to the Charitable Funds Committee Terms of Reference were approved:

- To oversee the relationship and governance arrangements between the Trust's Charitable Funds and the Working Independently to Support Hull Hospitals (WISHH) Charity (registered charity no. 1162414 Hull and East Yorkshire Hospitals Health Charity).

- To oversee the Trust's hospital arts strategy, specifically the use of charitable funds in the delivery of this strategy.

- To oversee the Trust's broader Corporate Social Responsibility role, in particular the Trust's role to support the well-being of the local community, which may be supported through charitable funds.

The Terms of Reference for the Charitable Funds Committee are part of the Trust's Standing Orders and as such, the Trust Board is asked to also approve that these additions form an amendment to Trust Standing Orders, a matter reserved to the Trust Board.

3 Remuneration Committee and Standing Orders

The Remuneration Committee agreed an amendment to its Terms of Reference at its meeting in August 2018, for which Trust Board approval is requested. The amendment below shows the proposed replacement wording that was agreed at the Committee in August 2018.

2.1.2 The Chief Executive is responsible for putting in place effective and fair appraisal arrangements for his/her direct reports and for reporting his/her decisions formally by a paper to the Committee at least annually. In making his/her decision on the level of overall performance, Committee Members will have had the opportunity to provide feedback on individuals to inform the Chief Executive's overall assessment.

On approval of this amendment, the Trust Board is also asked to approve this point in the Remuneration Committee Terms of Reference forms an amendment to Trust Standing Orders.

4 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2018/10	Hull and East Yorkshire Hospitals NHS Trust and Persimmon Homes Ltd – Transfer of part of register titles and transfer plan	10 July 2018	Lee Bond – Chief Medical Officer and Carla Ramsay – Director of Corporate Affairs
2018/11	Hull and East Yorkshire Hospitals NHS Trust and Hull City Council – Licence agreement relating to Marfleet Childrens centre	16 August 2018	Lee Bond – Chief Medical Officer and Carla Ramsay – Director of Corporate Affairs
2018/12	Hull and East Yorkshire Hospitals NHS Trust and Hewitson Fabrications, MS Electrical Contractors Ltd, Teman Roofing Construction Ltd, West Riding Aluminium – Warranty documents relating to the Infectious Diseases unit sub-contractors	16 August 2018	Lee Bond – Chief Medical Officer and Carla Ramsay – Director of Corporate Affairs

5 Recommendations

The Trust Board is requested to:

- Approve amendments to Trust Standing Orders for the Charitable Funds Committee
- Authorise the use of the Trust's seal

Carla Ramsay
Director of Corporate Affairs

Rebecca Thompson
Corporate Affairs Manager

September 2018

Hull and East Yorkshire Hospitals NHS Trust

Remuneration Committee Terms of Reference
Tuesday 11 September 2018

Title:	Amendment to Remuneration Committee Terms of Reference
Responsible Director:	Terry Moran CB Chairman
Author:	Carla Ramsay Director of Corporate Affairs

Purpose:	The purpose of the report is to present an amendment to the Terms of Reference of the Remuneration Committee, which has been circulated to Non-Executive Directors for consideration, to be recommended to the Trust Board for approval	
Board Assurance Framework Risk:	N/A	
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	
Summary of Key Issues:	There is currently a paragraph in the Committee Terms of Reference which is does not usefully detail the role of the Committee in the Chief Executive's appraisal process for his direct reports and is open to interpretation. The proposed amendment aims to clarity the Committee's role in this respect. The current Terms of Reference are attached to this covering sheet in full. The proposed amendment is highlighted in red for clarity.	

Recommendation:	The Trust Board is asked to approve the amendment proposed, as reviewed and agreed by the Remunerations Committee in August 2018 , as an amendment to Trust Standing Orders.

Hull and East Yorkshire Hospitals NHS Trust

Remuneration Committee
Amendment to Committee Terms of Reference
(proposed amendment in tracked red below)

1. Formation of this committee

The Board has established the Remuneration Committee, in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee shall have terms of reference and powers and be subject to conditions that the Board decides, and shall act in accordance with any legislation, regulation or direction issued by the regulator.

The Remuneration Committee is a committee of the Board and has executive powers delegated specifically in these terms of reference.

2. Role

The role of the Remuneration Committee is set out below, subject to amendments at future Board meetings.

2.1 Remuneration

2.1.1 To approve the terms and conditions of the Chief Executive, Chief posts and Directors that report directly to the Chief Executive in accordance with Trust policies and following consultation with the Chief Executive, including;

- Salary, including any performance related pay or bonus
- Provision for other benefits, including pensions
- Allowances

2.1.2 To receive benchmarking information on the salaries of the posts in section 2.1.1 in order to determine the overall market positioning of the remuneration package

2.1.3 The Chief Executive is responsible for putting in place effective and fair appraisal arrangements for his/her direct reports and for reporting his/her decisions formally by a paper to the Committee at least annually. In making his/her decision on the level of overall performance, Committee Members will have had the opportunity to provide feedback on individuals to inform the Chief Executive's overall assessment.

2.1.4 To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Chief/Directors (2.1.1) whilst remaining cost effective.

2.1.5 To approve any changes to the standard contract of employment for Chiefs/Directors in section 2.1.1

2.1.6 To agree and review the extent to which a full time Board Director takes on a Non-Executive Director or Chairman role of another organisation.

2.1.7 To approve any payments to staff which are outside of Trust policy.

2.1.8 To monitor the level and structure of remuneration for Very Senior Managers and note annually the remuneration trends across the Trust

2.1.9 To approve severance payments in line with NHS Improvement (NHSI) guidance

2.1.10 To approve MAR schemes and ensure that NHSI guidance is followed for individual staff applications.

2.1.11 To receive information on:

- Any Trust post where there is a termination clause of more than 6 months
- Highest paid employees in the Trust (20 individuals) - annually
- Staff earning over £100,000 - annually
- Any special pension arrangements for any employee
- All bonus schemes (i.e. Trust earnings not paid in to salary) in operation in the Trust

2.2 Nomination

2.2.1 To review the structure, size and composition of the Board and make recommendations for changes as appropriate

2.2.2 Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board and its diversity and on the basis of the evaluation prepare a description of the role and capabilities required for appointment of Executive Directors.

2.2.3 To give full consideration to and make plans for succession planning for the Chief Executive and other Board Directors (Chiefs) taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

2.2.4 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

2.2.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise

2.2.6 Consider any matter relating to the continuation in office of any Executive Director (Chief Executive, Chief Financial Officer, Chief Nurse, Chief Medical Officer, and Chief Operating Officer) including the suspension and termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

2.2.7 To receive assurance on the succession plans for Vey Senior Managers.

3. Membership of the Committee

The Committee shall comprise:

- Trust Chairman

- All Non Executive Directors

Meetings of the Remuneration Committee may be attended by the invitation of the committee:

- The Chief Executive
- Director of Workforce and Organisational Development and any other Executive at the invitation of the Committee Chair
- Director of Corporate Affairs (Trust Secretary) (minutes)

The Chief Executive and Director of Workforce and Organisational Development shall leave the meeting when their own terms and conditions or performance is discussed

4. Chairman of the committee

The Chairman of the Committee will be the Trust Chairman

5. Quorum

The quorum shall be three, one of whom must be the Trust Chair (or in their absence the Vice Chair)

6. Meetings

The Committee shall meet at least four times a year. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7. Notice of meetings

Meetings of the Committee shall be set at the start of the calendar year by the Corporate Affairs Manager, in liaison with the Committee Chair. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

8. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced in the standard agreed format of the Trust and kept by the Trust Secretary's Office.

9. Reporting arrangements

The proceedings of each meeting of the Committee shall be reported to the next meeting of the Board. The Chair of the meeting shall draw the attention of the Board to any issues that require disclosure or require executive action. The Chair is required to inform the Board on any exceptions to the annual work plan.

To receive minutes for information from the Trust Pay, Terms and Conditions Group after each meeting

10. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

10.1 Produce an annual work plan in the agreed Trust format, in line with the objectives set, for approval by the Trust Board.

10.2 Give due consideration to the Public Sector Equality Duty and the NHS Constitution in undertaking its duties.

10.3 Identify and assess any risks that may prevent the achievement of the work plan.

10.4 Produce an annual report in the required format for the Trust's Annual report

10.5 Monitor, review and recommend any changes to the terms of reference annually to the Trust Board.

11. Authority

The Remuneration Committee is authorised by the Board to instruct professional advisors and request attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers it necessary for or expedient to the exercise of its functions.

The Committee is authorised to obtain such internal information from any employee as is necessary and expedient to the fulfilment of its functions.

Date previously ratified by Trust Board:	December 2017
Date revised by the Committee:	August 2018
Date presented to the Trust Board	September 2018
Review date:	March 2019

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

11 September 2018

Title:	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)**
Responsible Director:	Jacqueline Myers – Director of Strategy and Planning
Author:	Alan Harper – Assistant Director of Planning

Purpose:	To advise Trust Board regarding the outcome of the 2018 / 19 EPRR assessment against core standards.	
BAF Risk:		
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	✓
Summary Key of Issues:	Key points: As the Trust does not fully comply with 5 of the 105 lines of inquiry, within the 2018 / 19 Core Standards, the assurance rating is viewed as 'Substantially Compliant', rather than Full, Partial or Non-Compliant. The results of the Trust assessment and Board report will be shared with Hull CCG and East Riding of Yorkshire CCG prior to submission to NHS England on 31October. An Action Plan to address areas where attention is required, as noted in section 4 above, has been prepared. This will be monitored by the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.	

Recommendation:	Trust Board is asked to: • note the Trust's assurance rating • note the Trust's ongoing monitoring arrangements • publish results of the Trust's 2018 /19 assurance rating in the Trust Annual Report

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD – 11 SEPTEMBER 2018

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

2018 / 19 ANNUAL ASSURANCE

1. PURPOSE OF PAPER

The purpose of this paper is to advise Trust Board regarding the outcome of the Trust assessment against the 2018 / 19 NHS England Core Standards for EPRR.

2. BACKGROUND

The NHS England EPRR Framework states providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England Core Standards for EPRR set out the minimum requirements that are expected to be met.

NHS England has a statutory requirement to formally assure itself regarding NHS EPRR readiness. This is provided through the EPRR annual assurance process and assurance report which NHS England submits to the Department of Health and Social Care, and the Secretary of State for Health and Social Care.

As the Core Standards provide a common reference point for all organisations, they provide the basis of the EPRR annual assurance process.

Providers of NHS funded services complete an assurance self-assessment based on these core standards.

3. 2018 / 19 EPRR ASSURANCE

Details of the 2018 /19 EPRR annual assessment were received in July and contained 105 lines of inquiry split into ten domains: governance, duty to risk assess, duty to maintain plans, command and control, training and exercising, response, warning and informing, cooperation, business continuity and Chemical / Biological / Radiological / Nuclear, including a decontamination equipment checklist.

The subject of this year's "Deep Dive" focused on command and control.

4. ACTION ARISING FROM 2018 / 19 ASSESSMENT

Issues from this year's assessment are noted below.

4.1 Duty to maintain plans: Evacuation (Amber Risk)

EPRR Core Standard 20 states organisations should have effective evacuation plans in place, including whole site evacuation.
All wards and departments have effective evacuation plans; these are contained within their individual Fire Information Manual. The Trust Fire Safety Team works collaboratively with ward and departmental managers when preparing these plans. Clinical staff receive annual fire training and evacuation training every three years. The last large scale evacuation took place in June 2018 (Women and Children's Hospital).

Although evacuation plans are in place and tested, there is not a whole hospital site evacuation plan. Discussion has commenced within the Trust, NHS England, Humber Emergency Planning Service and neighbouring acute Trusts.

4.2 Response: Incident Coordination Centre (Amber Risk)
EPRR Core Standard 30 states the organisation must have an Incident Coordination Centre (ICC) and alternative fall-back location.
The Trust has an ICC; staffed on a 24/7 basis by the Operations Support and Site Management teams. A fall-back location has been identified (Trust IT Services Department / office suite) - a Table Top exercise is planned to test the location and facilities available.

4.3 Response: 'Clinical Guidance for Major Incidents' (Red Risk)
EPRR Core Standard 35 states Emergency Department staff should have access to the NHS England 'Clinical Guidance for Major Incidents' handbook. NHS England has not issued this publication.

4.4 Cooperation: Local Health Resilience Partnership (Red Risk)
EPRR Core Standard 40 states the Accountable Emergency Officer should attend no less than 75% of Local Health Resilience Partnership meetings per annum.
The Assistant Director of Planning and Trust Lead for EPRR deputises and attends these meetings.

4.5 Chemical Biological Radiological Nuclear: Trainers (Amber Risk)
EPRR Core Standard 67 states the organisation must have sufficient trained decontamination trainers to fully support its staff training programme.
The Trust CBRN Lead is currently the only Trainer. Two ED staff have been identified for training and will attend next NHS England organised CBRN Trainer session.

5. TRUST ASSURANCE RATING: 2018 / 19

As the Trust does not fully comply with 5 of the 105 lines of inquiry, within the 2018 / 19 Core Standards, the assurance rating is viewed as 'Substantially Compliant', rather than Full, Partial or Non-Compliant.

The results of the Trust assessment and Board report will be shared with Hull CCG and East Riding of Yorkshire CCG prior to submission to NHS England on 31October.

6. ONGOING MONITORING ARRANGEMENTS

An Action Plan to address areas where attention is required, as noted in section 4 above, has been prepared. This will be monitored by the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.

7. RECOMMENDATION

Trust Board is asked to:

- note the Trust's assurance rating – 'Substantially Compliant'
- note the Trust's ongoing monitoring arrangements
- publish the Trust's 2018 /19 EPRR assurance rating in the Trust Annual Report

Alan Harper
Assistant Director of Planning
4 September 2018

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

11 September 2018

Title:	**WORKFORCE RACE EQUALITY STANDARD (WRES)**
Responsible Director:	Simon Nearney Director of Workforce and OD
Author:	Sarah Dolby, HR Advisor, Employment Policy and Resourcing

Purpose:	The purpose of this paper is to present for consideration by the Executive Management Committee the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2018 and proposed action plan.	
BAF Risk:	BAF 1	
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	✓
Summary Key of Issues:	Key points: Whilst the data shows progress across many of the indicators, there are still improvements to be made, including: • Increasing the representation of BME staff in roles 8b and above, including the Board • Reducing bullying and harassment across the Trust for all staff • Ensuring that BME staff do not feel that they have less equality of opportunity for career progression and promotion than White staff.	

Recommendation:	The Trust Board is asked to note the content of this report and its appendices and approve the WRES return and action plan

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

WORKFORCE RACE EQUALITY STANDARD (WRES)
TRUST SUBMISSION 2018

1 PURPOSE

The purpose of this paper is to share the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2018 and proposed action plan.

2 BACKGROUND

The NHS Workforce Race Equality Standard (WRES) was commissioned in 2015 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WRES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;
- To produce action plans to close the gaps in workplace experience between White and Black and Minority Ethnic (BME) staff; and
- To improve BME representation at the Board level of the organisation.

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

3 WRES SUBMISSION 2018

The Trust is required to submit and publish a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2017 and 2018. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 10 August 2018.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WRES Action Plan which is based on the outcomes from the technical data results and is intended to address any disparities in the experiences of BME staff compared to White staff. The Action Plan builds on the 2017/18 Action Plan.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 28 September 2018.

4 ACHIEVEMENTS THROUGHOUT 2017/2018

Achievements and developments during 2017/18 have included:

- Development of a workspace for BME staff on the Trust Intranet to encourage discussion and sharing of information, which includes links to NHS Leadership Academy work on Equality and Inclusion and information on the Stepping Up and Ready Now Programmes for BME staff.
- 2 BME staff currently participating in the Trust's "New Leaders" programme.
- A review of exit data from 1 November 2016 to 31 October 2017 which showed a number of similarities in the feedback received for both BME and White staff. BME staff were also more positive in some areas e.g. morale.

- Recruitment and Selection Training content has been reviewed and updated to include a greater emphasis on awareness of unconscious bias.
- Presentation to the BME Network on the role of the Freedom to Speak Up Guardian and the SALS service.
- The OD Team has developed a Coaching and Mentoring Plan Programme to support career development for staff. The programme has been promoted to BME staff via the BME Network Meetings.

5 KEY FINDINGS FOR 2018

The key findings from the technical data for 2018 are:

- The Trust employed 8,887 staff at 31 March 2018, which is an increase of 71 compared to data from the 31 March 2017 WRES submission.
- Of the 8,887 staff, 1.6% (144) had not declared their ethnicity which is similar to the 31 March 2017 data which reported 1.7% (148) staff had not declared their ethnicity.
- Of the 8,887 staff, 988 self-define as being from a Black or Minority Ethnic (BME) background, which represents 11.1% of the total staff employed by the Trust.

Whilst the data shows progress across many of the indicators, there are still improvements to be made, including:

- Increasing the representation of BME staff in roles 8b and above, including the Board
- Reducing bullying and harassment across the Trust for all staff
- Ensuring that BME staff do not feel that they have less equality of opportunity for career progression and promotion than White staff.

6 WRES ACTION PLAN

The draft WRES Action Plan for 2018/19 is available in Appendix 3.

7 RECOMMENDATION

The Executive Management Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WRES return and action plan for submission to the Trust Board for approval.

Simon Nearney
Director of Workforce and Organisational Development

August 2018

WORKFORCE RACE EQUALITY STANDARD REPORTING TEMPLATE

Workforce Race Equality Standard

Name of organisation:	Hull and East Yorkshire Hospitals NHS Trust
Date of report:	March 2018
Name and title of Board lead for the Workforce Race Equality Standard:	Ellen Ryabov/Theresa Cope, Chief Operating Officer
Name of lead compiling this report:	Sarah Dolby, HR Advisor
Names of commissioners this report has been sent to:	Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group
Name of co-ordinating commissioner this report has been sent to:	Hull Clinical Commissioning Group
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however the ethnic status of 144 staff is not stated, which represents 1.6% of the total workforce.

Any matters relating to reliability of comparisons with previous years: The Workforce Planning Team discovered an issue regarding how ESR categorises the new CT payscales as Consultants. This was rectified manually for the purposes of reporting the technical data for the Data Template and the issue was raised with the ESR National Reporting Group.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 8,887

Proportion of BME staff employed within the Trust at the date of the report: 11.1% of the total staff employed

3. Self-Reporting

The proportion of total staff who have self-reported their ethnicity: 98.4%

Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity? All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity? To improve the quality of data stored within ESR, the Workforce Planning Team will be re-launching ESR Self Service, highlighting to staff that they can update their personal information, including ethnicity, marital/partnership status and disability status.

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2018 and activity during the financial year 2017/18.

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year 2017/18		Data for previous year 2016/17		Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
For each of these four workforce indicators, compare the data for White and BME staff							
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Appendix 2 for breakdown by pay banding. Where ethnicity is known for 31 March 2018:		See Appendix 2 for breakdown by pay banding. Where ethnicity is known for 31 March 2017:		BME representation has increased within the non-clinical and clinical (non-medical) groupings; however they are still under-represented in the higher pay bandings in comparison to White staff. The number of BME consultants increased by 23 in 2017/18, however there continues to be an under-representation of BME staff in senior medical management posts. There has been an increase in the number of clinical (non-medical) BME staff which may be attributable to the International Nurse Recruitment campaign.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
		Non-clinical workforce (White) =	23.84%	Non-clinical workforce (White) =	20.26%		
		Non-clinical workforce (BME) =	0.59%	Non-clinical workforce (BME) =	0.55%		
		Clinical workforce (non-medical White) =	57.41%	Clinical workforce (non-medical White) =	60.96%		
		Clinical workforce (non-medical BME) =	4.10%	Clinical workforce (non-medical BME) =	3.68%		
		Clinical workforce (medical and dental White) =	6.01%	Clinical workforce (medical and dental White) =	6.09%		
		Clinical workforce (medical and dental BME) =	6.44%	Clinical workforce (medical and dental BME) =	6.78%		
2	Relative likelihood of staff being appointed from shortlisting across all posts.	White: 0.22 BME: 0.16 Relative likelihood: 1.38		White: 0.20 BME: 0.14 Relative likelihood: 1.39		The Trust has seen improvement in the likelihood metrics as follows: 2014/15: 1.98 2015/16: 1.67	Please see action plan. Actions link to EDS2 goals and the Trust

	Indicator	Data for reporting year 2017/18	Data for previous year 2016/17	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
				2016/17: 1.39 2017/18: 1.38 The 2017/2018 data shows that White staff are still more likely than BME to be appointed from shortlisting.	Equality Objectives.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	White: 0.01 BME: 0.01 Relative likelihood: 0.94	White: 0.001 BME: 0.002 Relative likelihood: 1.59	There has been continuing improvement in the relative likelihood of BME staff entering a formal disciplinary process compared to White staff. In 2015/16 BME staff were twice as likely to enter the process (2.13), where as in 2017/18, BME staff were less likely than White staff. Whilst it is acknowledged that the data could be easily impacted (either negatively or positively) due to the low number of staff entering into the formal disciplinary process, the improvement may be due to the positive changes the Trust has made to organisational culture, and to the fact that managers are addressing issues rather than escalating them through the formal disciplinary process.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4	Relative likelihood of staff accessing non-mandatory	White: 0.73 BME: 0.74	White: 0.75 BME: 0.71	The data shows a shift during the year from a position where	Please see action plan.

	Indicator	Data for reporting year 2017/18	Data for previous year 2016/17	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	training and CPD.	Relative likelihood: 0.99	Relative likelihood: 1.07	White staff were more likely to access non-mandatory training and CPD than BME staff, to one where White staff are now marginally less likely to access these opportunities. Currently the Trust only captures training/CPD that is available through HEY247 with no mechanism to record other means of training/CPD. The Trust will explore whether this can be recorded in the future.	Actions link to EDS2 goals and the Trust Equality Objectives.
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.					
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 25.02% BME: 20.95%	White: 25.60% BME: 21.00%	The percentage of White and BME staff experiencing bullying and abuse from patients, relatives and the public remains high.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 27.59% BME: 27.12%	White: 30.56% BME: 29.77%	The number of staff experiencing bullying from other staff has improved compared to 2016/17, but overall the number remains higher than the average for acute Trusts in England.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White: 89.60% BME: 80.60%	White: 88.30% BME: 87.32%	The percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2017/18	Data for previous year 2016/17	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White: 5.32% BME: 11.04%	White: 6.02% BME: 12.84%	The number of staff reporting that they had experienced discrimination at work from their manager/team leader or colleagues in the last 12 months has improved for both White and BME staff. However, it remains the case that a higher proportion of BME staff still experience discrimination at work compared to White staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
Board representation indicator For this indicator, compare the difference for White and BME staff.					
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	White: 12.7% BME: -11.1%	White: 12.7% BME: -11.0%	The voting membership of the Board at 31 March 2018 was 12, all of whom self-define as White. The Trust acknowledges that, in respect of ethnicity, the Board is not representative of the population it serves or its workforce. BME groups make up 5.9% of the population of Hull and 1.9% of the population of the East Riding of Yorkshire. BME groups within the Trust make up 11.1% of the workforce which is significantly higher than the local population served by the Trust.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

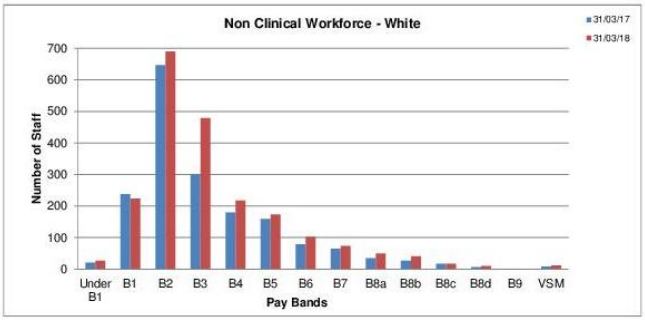
None

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

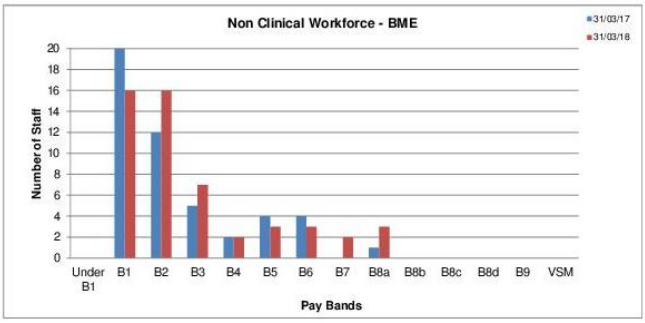
The Draft WRES Action plan is attached.

BREAKDOWN OF STAFF EMPLOYED ACROSS AFC PAYBANDS

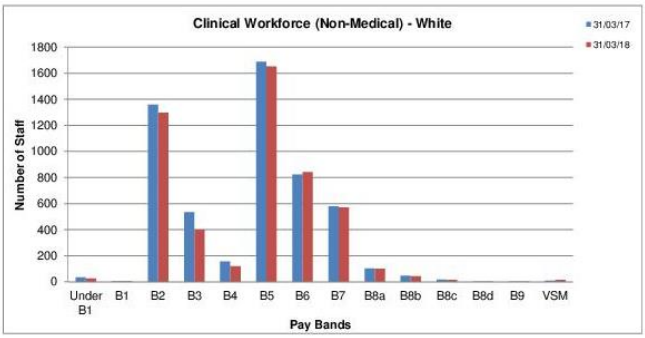
Non Clinical Workforce - White	31/03/17	31/03/18	Variance
Under B1	21	27	6
B1	238	224	-14
B2	647	690	43
B3	301	479	178
B4	180	218	38
B5	160	174	14
B6	79	103	24
B7	65	74	9
B8a	35	50	15
B8b	27	41	14
B8c	17	17	0
B8d	7	10	3
B9	0	0	0
VSM	9	12	3
Total	**1786**	**2119**	**333**



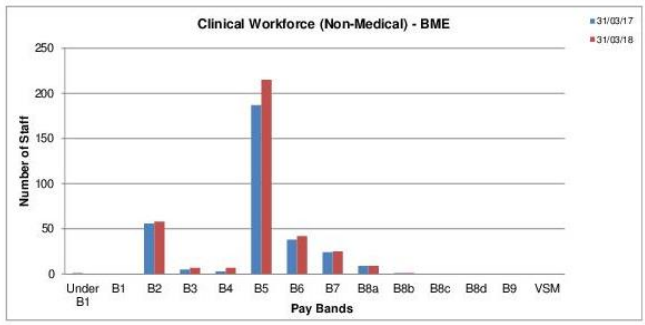
Non Clinical Workforce - BME	31/03/17	31/03/18	Variance
Under B1	0	0	0
B1	20	16	-4
B2	12	16	4
B3	5	7	2
B4	2	2	0
B5	4	3	-1
B6	4	3	-1
B7	0	2	2
B8a	1	3	2
B8b	0	0	0
B8c	0	0	0
B8d	0	0	0
B9	0	0	0
VSM	0	0	0
Total	**48**	**52**	**4**



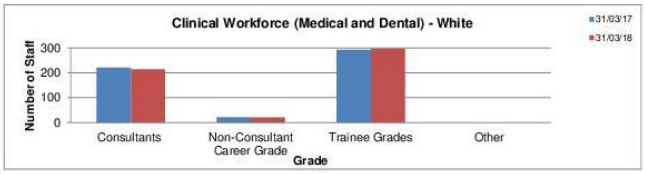
Clinical Workforce (Non-Medical) - White	31/03/17	31/03/18	Variance
Under B1	36	26	-10
B1	6	6	0
B2	1360	1299	-61
B3	535	400	-135
B4	158	121	-37
B5	1688	1652	-36
B6	824	842	18
B7	581	571	-10
B8a	103	102	-1
B8b	48	43	-5
B8c	18	17	-1
B8d	4	4	0
B9	4	3	-1
VSM	10	16	6
Total	**5375**	**5102**	**-273**



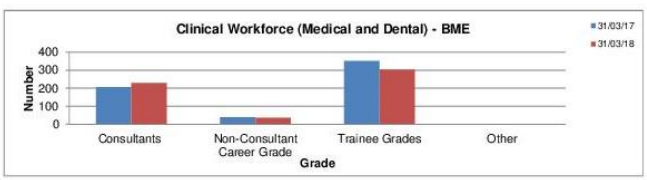
Clinical Workforce (Non-Medical) - BME	31/03/17	31/03/18	Variance
Under B1	1	0	-1
B1	0	0	0
B2	56	58	2
B3	5	7	2
B4	3	7	4
B5	187	215	28
B6	38	42	4
B7	24	25	1
B8a	9	9	0
B8b	1	1	0
B8c	0	0	0
B8d	0	0	0
B9	0	0	0
VSM	0	0	0
Total	**324**	**364**	**40**



Clinical Workforce (Medical and Dental) - White	31/03/17	31/03/18	Variance
Consultants	222	215	-7
Non-Consultant Career Grade	22	21	-1
Trainee Grades	293	298	5
Other	0	0	0
Total	**537**	**534**	**-3**



Clinical Workforce (Medical and Dental) - BME	31/03/17	31/03/18	Variance
Consultants	207	230	23
Non-Consultant Career Grade	39	37	-2
Trainee Grades	352	305	-47
Other	0	0	0
Total	**598**	**572**	**-26**



Self Declared - White	7698	7755	57
Self Declared - BME	970	988	18
Not Stated	148	144	-4
Grand Total	**8816**	**8887**	**71**

WORKFORCE RACE EQUALITY STANDARD ACTION PLAN 2018/2019

Action Plan to be tabled at Diversity and Inclusion Steering Group, Workforce and OD, Workforce Transformation Committee and BME Network.

No.	WRES Indicator	Metric	Actions	Delivery Timescale	Lead Responsibility
1.	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Staff by Pay Banding Comparison (see Appendix 2)	Continue to engage with BME staff network and encourage participation in Coaching and Mentoring Programme to support the development of BME staff.	Ongoing	Director of Workforce and OD
			Explore opportunities to increase the number of BME staff who complete exit interviews.	December 2018	
2.	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	White: 0.22 BME: 0.16 Relative likelihood: 1.38	Review how the Trust can promote unconscious bias training to existing recruiting managers.	December 2018	Head of OD / Head of HR Services
			Explore with the BME Network the opportunity for providing coaching and informal support to BME staff during the preparation stage for an interview.	December 2018	
3.	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	White: 0.01 BME: 0.01 Relative likelihood: 0.94	Continue to monitor and support all staff as required.	Ongoing	Head of HR Advisory Service
4.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	White: 0.73 BME: 0.74 Relative likelihood: 0.99	Explore options to enable staff to upload their own training and CPD undertaken outside of HEY247 to be captured on the HEY247 system.	December 2018	Head of Education and Development
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 25.02% BME: 20.95%	Consider a renewed campaign to promote the Trust's zero tolerance approach to incidents of bullying, harassment or abuse of its staff.	December 2018	Director of Communications / Head of Security
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in	White: 27.59% BME: 27.12%	Ensure the Culture and Wellbeing Committee explore the reasons for staff experiencing harassment, bullying or abuse	Ongoing	Chief Executive / Director of Workforce and OD

Appendix 3

No.	WRES Indicator	Metric	Actions	Delivery Timescale	Lead Responsibility
	last 12 months		from staff and develop appropriate action plans.		
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	White: 89.6% BME: 80.6%	Continue to develop coaching strategies to support staff	Ongoing	Head of OD
			Reinforce with recruiting managers the principles of VBR.	Ongoing	
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White: 5.32% BME: 11.04%	Continue to examine qualitative and quantitative data collected by SALS to determine trends and identify departments, roles or pay bandings where review and action is required.	Ongoing	Deputy Director Governance, Quality and Safety / Head of OD
			Consider integrating equality, diversity and inclusion in cultural briefings.	December 2018	
9.	Percentage difference between the organisations' Board voting membership and its overall workforce	White: 12.7% BME: -11.1%	Continue to ensure that the process for appointment of Executive and Non-Executive Director posts encourages applications from as diverse a pool of talent as possible and demonstrates the Trust's commitment to diversity and inclusion.	Ongoing	Chairman / Chief Executive

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
			1a) Non Clinical workforce		**Prepopulated figures**	**Verified figures**	**Prepopulated figures**	**Verified figures**	**Prepopulated figures**	**Verified figures**	**Prepopulated figures**	**Verified figures**	**Prepopulated figures**	**Verified figures**	**Prepopulated figures**	**Verified figures**	
		1	Under Band 1	Headcount	21	21	0	0	0	0	27	27	0	0	0	0	This includes Apprenctices and non AFC payscales
		2	Band 1	Headcount	238	238	20	20	7	7	214	224	14	16	4	5	
		3	Band 2	Headcount	647	647	12	12	5	5	657	690	12	16	5	5	
		4	Band 3	Headcount	301	301	5	5	5	5	472	479	7	7	5	5	
		5	Band 4	Headcount	180	180	2	2	2	2	216	218	2	2	2	2	
		6	Band 5	Headcount	160	160	4	4	0	0	170	174	2	3	2	2	
		7	Band 6	Headcount	79	79	4	4	0	0	105	103	3	3	0	0	
		8	Band 7	Headcount	65	65	0	0	4	4	72	74	2	2	4	4	
		9	Band 8A	Headcount	35	35	1	1	2	2	50	50	3	3	2	2	
		10	Band 8B	Headcount	35	27	0	0	0	0	41	41	0	0	0	0	
		11	Band 8C	Headcount	17	17	0	0	0	0	17	17	0	0	0	0	
		12	Band 8D	Headcount	7	7	0	0	1	1	14	10	0	0	1	1	
		13	Band 9	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		14	VSM	Headcount	9	9	0	0	0	0	7	12	0	0	0	0	
1	**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**		**1b) Clinical workforce** of which Non Medical														
		15	Under Band 1	Headcount	36	36	1	1	0	0	13	26	0	0	0	0	This includes Apprenctices and non AFC payscales
		16	Band 1	Headcount	6	6	0	0	0	0	6	6	0	0	0	0	
		17	Band 2	Headcount	1360	1360	56	56	15	15	1,139	1299	35	58	13	14	
		18	Band 3	Headcount	535	535	5	5	6	6	375	400	6	7	7	7	
		19	Band 4	Headcount	158	158	3	3	1	1	111	121	7	7	0	0	
		20	Band 5	Headcount	1688	1688	187	187	28	28	1,559	1652	211	215	22	25	
		21	Band 6	Headcount	824	824	38	38	17	17	817	842	41	42	13	14	
		22	Band 7	Headcount	581	581	24	24	13	13	562	571	25	25	15	15	
		23	Band 8A	Headcount	103	103	9	9	1	1	102	102	9	9	1	1	
		24	Band 8B	Headcount	48	48	1	1	0	0	43	43	1	1	0	0	
		25	Band 8C	Headcount	18	18	0	0	0	0	17	17	0	0	0	0	
		26	Band 8D	Headcount	4	4	0	0	0	0	8	4	0	0	0	0	
		27	Band 9	Headcount	4	4	0	0	0	0	3	3	0	0	0	0	
		28	VSM	Headcount	10	10	0	0	0	0	3	16	0	0	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	222	222	207	207	8	8	244	215	254	230	9	7	
		30	*of which Senior medical manager*	Headcount		6		0		0		6					
		31	Non-consultant career grade	Headcount	22	22	39	39	8	2	15	21	30	37	1	3	
		32	Trainee grades	Headcount	293	293	352	352	0	31	68	298	85	305	7	32	
		33	Other	Headcount	0	0	0	0	31	0	128	0	110	0	8	0	
2	**Relative likelihood of staff being appointed from shortlisting across all posts**	34	Number of shortlisted applicants	Headcount								3661		520		68	
		35	Number appointed from shortlisting	Headcount								794		82		20	
		36	Relative likelihood of shortlisting/appointed	Auto calculated		0.1950299534		0.1407867495				0.2168806337		0.1576923077		0.2941176471	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated		1.39						1.38					
3	**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation** **Note: This indicator will be based on data from a two year rolling average of the current year and the previous year**	38	Number of staff in workforce	Auto calculated							7275	7755	859	988	121	144	
		39	Number of staff entering the formal disciplinary process	Headcount								75		9		3	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated		0.0012990387		0.0020618557				0.0096711799		0.0091093117		0.0208333333	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated				1.59						0.94			
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce (White)	Auto calculated								7755		988		144	
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								5679		734		129	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated		0.7525331255		0.7061855670				0.7323017408		0.7429149798		0.8958333333	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated		1.07						0.99					
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage	25.60%		21.00%				25.02%		20.95%				
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage	30.56%		29.77%				27.59%		27.12%				
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage	88.30%		87.32%				89.60%		80.60%				
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?** **b) Manager/team leader or other colleagues**	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage	6.02%		12.84%				5.32%		11.04%				
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	50	Total Board members	Headcount		16		0		0		16		0		0	
		51	*of which: Voting Board members*	Headcount		5		0		0		12		0		0	
		52	*: Non Voting Board members*	Auto calculated		11		0		0		4		0		0	
		53	Total Board members	Auto calculated		16		0		0		16		0		0	
		54	*of which: Exec Board members*	Headcount		9		0		0		5		0		0	
		55	*: Non Executive Board members*	Auto calculated		7		0		0		8		0		0	
		56	Number of staff in overall workforce	Auto calculated		7698		970		148		7755		988		144	
		57	Total Board members - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		58	Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		59	Non Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		60	Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		61	Non Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		62	Overall workforce - % by Ethnicity	Auto calculated	0.00%	87.3%	0.00%	11.0%	0.00%	1.7%	0.00%	87.3%		11.1%		1.6%	
		63	Difference (Total Board -Overall workforce)	Auto calculated		12.7%		-11.0%		-1.7%		12.7%		-11.1%		-1.6%	

Hull and East Yorkshire Hospitals NHS Trust

Trust Board
11 September 2018

Title:	Responsible Officer Report
Responsible Director:	Dr Makani Purva – Interim Chief Medical Officer/Responsible Officer
Author:	Dr Makani Purva – Interim Chief Medical Officer/Responsible Officer

Purpose:	The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS Improvement (NHSI), formally the Trust Development Authority.	
BAF Risk:	BAF 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	
Summary Key of Issues:	Key points: • The Trust has an appointed Responsible Officer, who is trained and supported to perform the role • The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on Revalidation • The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice • There is a good appraisal system in place, which is developmental and formative in nature • The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC) • Uptake of appraisal in the Trust continues to surpass the NHS England target of 90%. Maintaining this high level of appraisal rate is reliant on the continued implementation of an electronic platform, and continuing administrative support for this is essential • The current percentage of Doctors having appraisal in 2017/18 is 94.3% which surpasses the NHSE target of 90%. Communication from the Regional Revalidation Lead for NHSE dated 27/07/2018 found everything to be satisfactory and the Trust was thanked for providing assurance to the higher level RO and NHSE on its processes	

Recommendation:	The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by 28th September 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2018

1. Purpose of the Paper

The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and now NHS Improvement (NHSI), formally the Trust Development Authority. The Framework for Quality Assurance, in defining the purpose of the annual report, states that: "The Trust Board should understand its responsibilities under the Responsible Officer Regulations. It should also understand the appraisal and Revalidation process within the organisation, and be aware of progress in establishing and maintaining a successful Revalidation programme for medical staff. NHS England requires that the Trust Board demonstrates fulfilment of these requirements by formally acknowledging receipt of this paper, and returning a statement of compliance signed by the Chairman."

2. Background

Following public and professional concern about the regulation of the medical profession a new system of assurance was introduced from the end of 2012. A Statutory Instrument passed in 2010 mandates the appointment of a 'Responsible Officer' for each organisation employing Doctors. The Responsible Officer has a duty to confirm that the Doctors for whom they are responsible are fit to practise, and comply with General Medical Council guidance on Good Medical Practice. This Statutory Instrument is the legislation underpinning the General Medical Council process of Revalidation, which applies to all Doctors in the United Kingdom who require a licence to practise. A licence is required by all Doctors working at Hull and East Yorkshire Hospitals NHS Trust. Revalidation is the process by which Doctors have to demonstrate to the General Medical Council that they are fit to practise. The purpose of Revalidation is to assure patients and the public, employers, and other healthcare professionals that licensed Doctors are up to date and working appropriately. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking that there are effective systems in place for monitoring the conduct and performance of their Doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and Revalidation process for their Doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Previous reports outlining progress in implementing appraisal and Revalidation have been submitted to the Trust Board (2012, 2013, 2014 2015, (with an interim update in February 2015), 2016 and 2017), and to the Quality Committee.

The Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

Recommendation to the General Medical Council for Revalidation of individual Doctors is the responsibility of the Responsible Officer. The Responsible Officer is supported in discharging this duty by a Revalidation Panel consisting of representation from senior clinical management, the Appraisal Lead, a representative from the Local Negotiating Committee, and the Head of HR Services. The Panel meets on a monthly basis. Appraisal and Revalidation processes are overseen by the Appraisal and Revalidation Committee, chaired by the Responsible Officer. This committee reviews progress against appraisal and Revalidation targets, and determines actions to address failures to meet these targets. The Appraisal and Revalidation Committee meets monthly, and reports by exception to the Operational Quality Committee.

The Trust is required to maintain an accurate record of Doctors with a prescribed connection to the organisation (as a Designated Body). This is done using the GMC Connect system, and is kept up-to-date by the HR Advisor (Medical Workforce). Doctors transferring between Designated Bodies are required to provide their new RO with details of their previous Designated Body, so that information can be exchanged between the two ROs. The Trust has developed a standard form to respond to requests for information from other Designated Bodies.

The Trust is required to complete an annual report (with quarterly updates) to NHS England describing the extent of compliance with its obligations as a Designated Body. This report is called the Annual Organisational Audit (AOA).

Policy and Guidance

Appraisal and Revalidation is conducted in accordance with the Revalidation and Appraisal for Medical Staff policy. This policy underwent a full review in 2017. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull and East Yorkshire Hospitals NHS Trust) does not undertake an appraisal within the 12 month period required is also in place.

In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), the Trust has put in place the Maintaining High Professional Standards Policy for Medical and Dental Staff and supporting procedures. The policy and supporting procedures are also based on the National Clinical Assessment Service (NCAS) document 'Back on Track' and is in line with the Department of Health document 'Tackling Concerns Locally'. The Maintaining High Professional Standards Policy for Medical and Dental Staff replaces the Disciplinary and Capability for Medical and Dental Staff and Remediation and Capability for Medical and Dental Staff policies.

4. Restrictions, Remediation, and Investigations

The Trust was the Designated Body for 559 Doctors in 2017/18: this included 439 Consultants, 41 Specialty and Associate Specialist (SAS) Doctors and 79 other Doctors (mainly short term Trust Grade Doctors).

For the 2017/18 reporting period 1 SAS Doctor was in a formal remediation process.

Table 1 shows the number of Doctors for whom the Trust is the Designated Body who were either under active investigation by the General Medical Council, or who had current notices on their licence to practise as a result of previous GMC investigations. In addition to these Doctors, there were also a number of trainees working at the Trust who were either under investigation by the GMC or who had warnings on their licence: the Designated Body for these Doctors is the Health Education England (Yorkshire and the Humber).

Table 1. Number of Doctors for whom the Trust is Designated Body who during the reporting period had GMC notices or were under investigation:

Type of sanction	Consultant	Non-Consultant
Licence warning	1	1
Undertakings	1	0
Conditions	0	0
Under investigation	1	1

During 2017/18, 7 Doctors with a prescribed connection to the Trust were under investigation. 5 of these cases are complete and 2 are ongoing.

The outcomes of the investigations are summarised in Table 2. In general, concerns about Doctors in training were referred to Health Education England (Yorkshire and the Humber), unless there had been breach of specific Trust policies.

Table 2. Medical disciplinary investigations 2017-18 for medical staff for whom the Trust is the Designated Body:

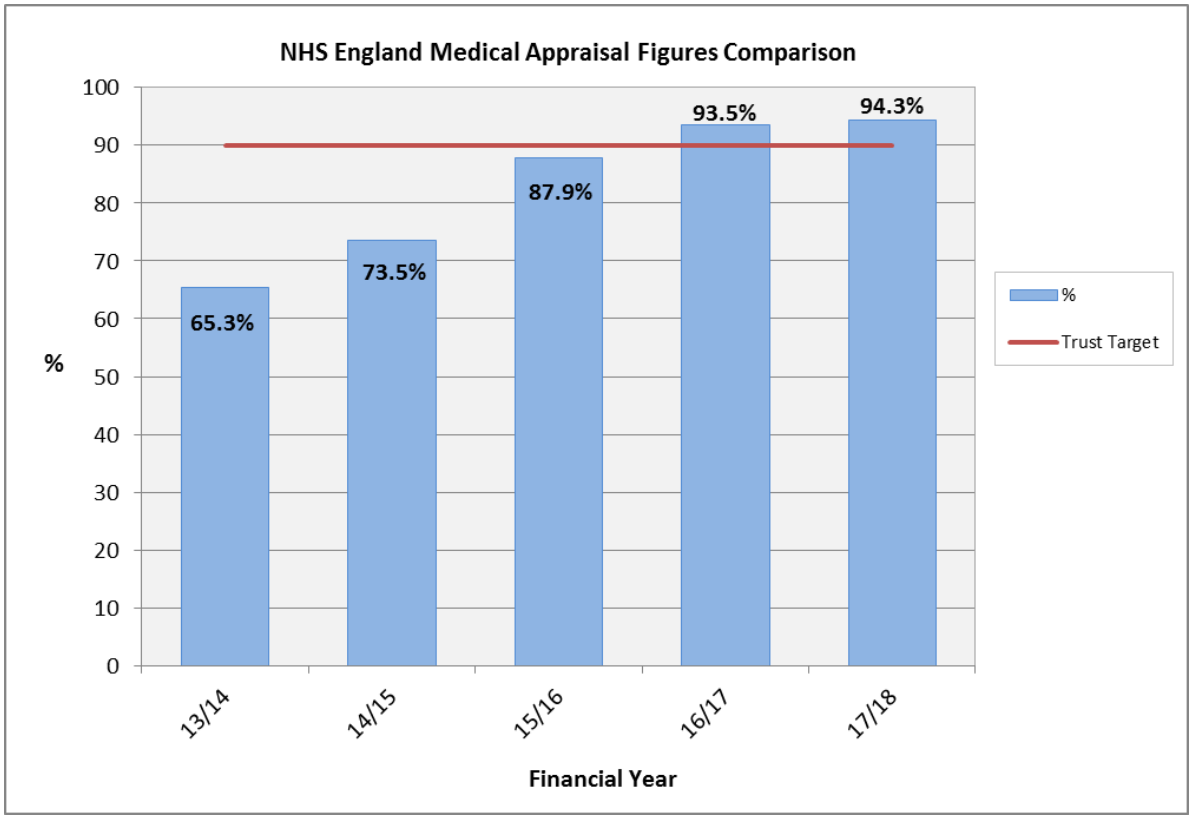
Grade	Type of Investigation	Investigation Outcome
Consultant	Disciplinary	Ongoing
Consultant	Disciplinary	Reflective learning
Consultant	Disciplinary	Formal written warning
Consultant	Disciplinary	Informal resolution, self-reflection & apology
Consultant	Bullying & Harassment	No further action
SAS Doctor	Disciplinary	Ongoing
Registrar	Disciplinary	Informal resolution, self-reflection & apology

5. Medical Appraisal

Appraisal rates
The 2017/18 NHS England Annual Organisational Audit (AOA) shows that Hull and East Yorkshire Hospitals NHS Trust's appraisal rate is 94.3% compared with the 2016/17 AOA which was 93.5%. This represents an increase of 0.8%

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer.

The graph below shows the NHS England medical appraisal figures for the Trust for the reporting periods 2013/14, 2014/15, 2015/16 2016/17 and 2017/18 against the Trust 90% performance target:



Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity/Adoption leave during appraisal period	7
Career break/Sabbatical during appraisal period	2
Sickness absence during appraisal period	4
Time constraints	12
Organisational factors	**Number**
Administration or management factors including new starters who had not had a timely appraisal with previous Designated Body	7
Total number of Doctors	**32**

Appraisers

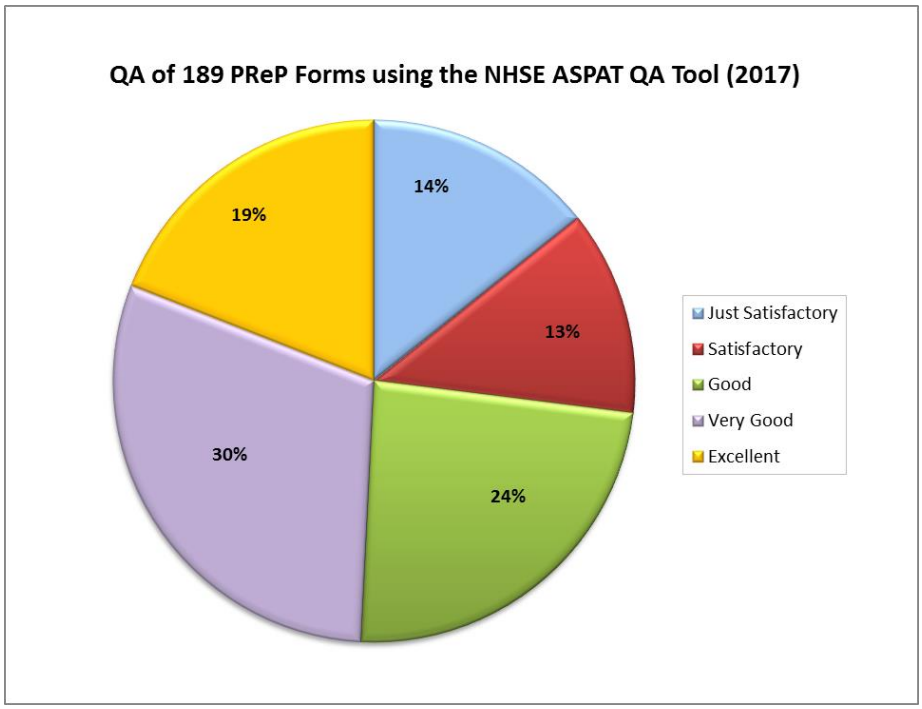
The Trust currently has 69 'active' trained Appraisers, including 2 'Senior Appraisers' and 1 Lead Appraiser. The Senior Appraisers and Lead Appraiser are responsible for ensuring that the training of the Appraiser team is up-to-date, delivering training to new Appraisers and the quality assurance of appraisals. Each Appraiser is responsible for carrying out up to 10 appraisals per year. There is an annual Appraiser Network Meeting which provides the opportunity for the Trust's medical Appraisers to share best practice and receive updates on local and national process surrounding Revalidation and appraisal.

Quality Assurance
Every Doctor being appraised completes an anonymous feedback form on the appraisal process and their Appraiser. To complete the appraisal process, every Doctor must complete this feedback questionnaire otherwise their appraisal will remain incomplete. This means that 94.3% of Doctors completed anonymous feedback in the 2017/18 appraisal year. This feedback is then provided to the Appraisers after they have appraised 5 Doctors and this is included in their own appraisal as supporting information for appropriate discussion and reflection.

There is a bi-annual Revalidation Bulletin which is circulated to all Doctors with a prescribed connection to Hull and East Yorkshire Hospitals NHS Trust. This bulletin provides updates from the Responsible Officer, Lead Appraiser and HR Advisor (Medical Workforce) and provides Doctors with the opportunity to raise any queries they may have in relation to the Revalidation and appraisal process.

The Responsible Officer and HR Advisor (Medical Workforce) attend quarterly NHS England regional RO Network and Lead Appraisal Networks, which provide updates from NHS England and the GMC on matters surrounding Revalidation and appraisal.

All appraisal inputs and outputs of those Doctors due for Revalidation are reviewed at the Revalidation Panel, of which the Appraisal Lead is a member. Reflections on good or bad practice in completing these outputs are then used in the ongoing Appraiser training programme. In addition, a random sample of output forms are regularly reviewed against set criteria by the Appraisal Lead/Senior Appraisers. The chart below shows the results of the Quality Assurance of 189 PReP appraisal forms (the Trust's electronic appraisal system for Medical staff) conducted by one of the Trust's Senior Appraisers. This was conducted using the NHS England Appraisal Summary and PDP Audit Tool (ASPAT). Certificates were provided to those Appraisers who scored "Excellent" using the ASPAT scoring criteria following review of these Output Forms.



Clinical Governance
The Trust is continuing to develop systems to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. Doctors are sent information

specific to them in relation to claims, complaints and Serious Incidents (SI's) by the HR Assistant (Medical Workforce) in the months leading up-to their annual appraisal. Doctors are also able to request a report (at any time) to support appraisal. Work is ongoing with the Clinical Governance team to improve the quality of information received.

Following discussion and agreement by the Responsible Officer at the Revalidation and Appraisal Committee in December 2017, the HR Assistant (Medical Workforce) has commenced producing a report (with effect from January 2018) which provides individual Consultants with a summary of their acknowledgement performance on the Radiology Harvard alert system. This report, which links into improved patient safety, has been produced in conjunction with the Trust's Clinical Information Officer for the Clinical Support Services Health Group and can be used as supporting information in a Consultant's annual appraisal.

6. Monitoring Performance

All Doctors being considered for Revalidation must demonstrate participation in regular appraisal. However appraisal in itself is neither an objective assessment of a Doctor's performance, nor of their compliance with trust policies and procedures. The Revalidation Panel therefore also requires confirmation from each Doctor's clinical managers that there are no concerns about performance or conduct. At present, this takes the form of a signed statement from the relevant Health Group Medical Director, based on personal knowledge and information from line managers. In any case the Revalidation process (occurring as it does once every 5 years) should not be the point at which concerns first come to light.

7. Revalidation Recommendations

The Trust made 40 recommendations on Revalidation to the GMC between 1st April 2017 and 31st March 2018. The Responsible Officer has three options in making a recommendation: recommendation for Revalidation, deferral, or failure to engage. It is not possible to recommend 'non-Revalidation'. The Trust has not made any notifications of failure to engage. The breakdown of recommendations is shown in Table 3.

Table 3. GMC recommendations April 2017– March 2018

Recommendation		Number of Doctors
Revalidate		36
Defer	Sickness, maternity, etc	1
	Appraisal/MSF not complete	3

In total 90% of recommendations this year were for a positive recommendation, which is an increase of 22.4% when compared with last year's figure of 67.6%. The 2nd cycle of Revalidation commenced in March 2018 and it is important to note that there will be a significantly higher number of recommendations submitted to the GMC in next year's annual report.

8. Recruitment and engagement background checks

The Trust Human Resources department has in place a system for checking identity, current and previous GMC Conditions or Undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance. The Responsible Officer continues to use an 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes Revalidation date, date of last appraisal and

any concerns arising from appraisal, details of ongoing or previous GMC/NCAS investigations, local conditions or undertakings, and any unresolved performance concerns. In March 2018 the Trust introduced the Engaging Temporary Workers – Bank and Agency Policy. This policy sets out the process that must be adhered to for authorising, sourcing and booking temporary workers including the booking of agency staff through approved national procurement frameworks. This policy is subject to annual review.

9. Responding to Concerns and Remediation

Revalidation should not be the expected route for identifying concerns about an individual Doctor's conduct or capability, occurring as Revalidation is only every 5 years. Appraisal may sometimes identify areas for improvement, but again it is unlikely that serious concerns will come to light purely through appraisal, which is principally a formative and developmental process. More commonly problems will be identified either through investigation of a specific incident, or following expression of concern by staff or patients.

Where there is concern about a Doctor's conduct or capability they are investigated under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NCAS. If misconduct is proved a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NCAS will be put in place. In the majority of capability cases the first option is to consider remediation and support.

In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Sometimes this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on Revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice
- There is a good appraisal system in place, which is developmental and formative in nature
- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC)
- Uptake of appraisal in the Trust continues to surpass the NHS England target of 90%. Maintaining this high level of appraisal rate is reliant on the continued implementation of an electronic platform, and continuing administrative support for this is essential
- The current percentage of Doctors having appraisal in 2017/18 is 94.3% which surpasses the NHSE target of 90%. Communication from the Regional Revalidation

Lead for NHSE dated 27/07/2018 found everything to be satisfactory and the Trust was thanked for providing assurance to the higher level RO and NHSE on its processes

11. Recommendations

The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by 28th September 2018.

Appendix 1 - Annex E – Designated Body Statement of Compliance

The Board of Hull and East Yorkshire Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Mr Kevin Phillips was the Trust's appropriately trained and appointed Responsible Officer for Hull and East Yorkshire Hospitals NHS Trust and Dove House Hospice for 2017/18. Dr Makani Purva has now taken over this role with effect from 1st August 2018.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   This record is maintained and kept up-to-date by the Trust's HR Advisor (Medical Workforce)

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   There are 69 appraisers, conducting between 6 and 10 appraisals each annually

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   There are routine appraiser network meetings, as well as formal and informal review of appraisal inputs, outputs and user experience.

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   The 2017/18 NHSE AOA Comparator Report dated 27/07/2018 shows that Hull and East Yorkshire Hospitals NHS Trust's appraisal rate is 94.3% and Dove House Hospice is 100% for 2017/18

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for Doctors to include at their appraisal;

   The systems are in place

[1] http://www.england.nhs.uk/Revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

The Trust requests information on all new licensed practitioners using a standard RO Transfer Form. The Trust RO responds to similar requests for information from other organisations.

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

There is a monthly Revalidation & Appraisal Committee whose responsibility is to ensure continual improvement and address any identified weaknesses or gaps in compliance. The key members of this committee are; The RO, a Health Group Medical Director (or delegate), The Lead Appraiser, LNC Chair, Head of HR Services and the HR Advisor (Medical Workforce).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Hull and East Yorkshire Hospitals NHS Trust

Name:

Role:

Date:

Signed:

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
September 2018

Title:	C362 Risk Policy
Responsible Director:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	April Daniel, Quality Governance Lead

Purpose:	The purpose of this report is to approve the Trust Risk Policy The policy has been reviewed at the Executive Management Board. The Audit Committee have ratified the document as a key control and governance mechanism within the organisation, and recommend approval by the Trust Board. In accordance with Standing Orders, the Trust Board approves the organisation's risk policy.	
BAF Risk:	N/A	
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	
Key Summary of Issues:	To present the Trust's updated Risk Policy for approval. The Risk Policy sets out the Trust's overall approach to risk and the policy through which the Trust manages risk. It is a key system of internal control. The policy has been updated to include a statement on risk appetite, and addition of Risk V Issues approach to risk registers.	

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

CP362 – RISK POLICY AND PROCEDURES

Broad Recommendations / Summary
Effective risk management is the foundation on which the Trust delivers its objectives. It is the key system through which all risks; clinical, organisational and financial risks, are managed to ensure benefits to patients, staff, visitors and other stakeholders. This policy describes how staff will fulfil their role in risk assessment and the production of risk registers. All risks regardless of nature or origin will be managed via this process. Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate risk control mechanism and most importantly, ensures that the agreed action is taken. The Trust has a legal requirement to give assurance that risks in the organisation are identified and appropriately managed.

CP362 – RISK POLICY AND PROCEDURES

1 PURPOSE / LEGAL REQUIREMENTS / BACKGROUND

This document sets out the arrangements in place to ensure that risk is managed in a systematic and co-ordinated way in order to:

- Demonstrate the way in which the Trust Board discharges its duty to have in place a policy of risk management
- Proactively identify, assess, prioritise, treat and monitor all risks;
- Provide a safe environment for patients, staff and visitors;
- Ensure that staff make an effective contribution to managing risks in their designated areas;
- Reduce risk to the lowest practicable levels within available resources;
- Achieve greater transparency in decision making enabling strategic investment decisions to be targeted to key risks;
- Ensure that risk management processes are adopted in the development of business plans;
- Ensure robust methods of reporting, monitoring and escalating Emergency Preparedness, Resilience and Response risks

The risk management systems and processes set out in this document will apply to risk in any context. The document applies to:

- All staff who are employed by the Trust, contractors, volunteers and individuals providing services on Trust property e.g. staff from other NHS organisations.
- Line managers who also have responsibility for co-ordinating risk management activities within their areas and for identifying any matters that might impact on other areas or the organisation as a whole
- Directors who have a specific responsibility for designated areas of risk management.

2 POLICY / PROCEDURE / GUIDELINE DETAILS

2.1.1 Risks and Issues

It is important to define the difference between a risk and an issue. The following definitions apply in this policy:

- Risk: the potential of an event occurring at some point in the future which requires management to reduce the likelihood of happening and the severity of the potential impact to the Trust's objectives or strategic goals.

- Issue: an event which has already occurred or is still occurring which will affect the achievement of the Trust's objectives or strategic goals which need to be actively dealt with to be resolved.

Risks, should they occur, become issues.

All risks and issues will be recorded on DATIX and will be categorised within the risk register as such (risk or issue). The monitoring and grading within DATIX will be the same for either a risk or an issue.

2.1.2 Risk Management Approach

Hull and East Yorkshire Hospitals NHS Trust has three levels of risk registers. The process for the three levels of risk is detailed below.

Strategic risks (Board Assurance Framework)
The risks that, if realised, would fundamentally affect the way in which the organisation exists or conducts its business. These risks may have a detrimental effect on delivery of the organisation's strategies and thus achievement of its key business objectives. This risk realisation could lead to material failure, loss or lost opportunity. Strategic risks are detailed in the Trust's Board Assurance Framework (BAF), managed by the Trust Board and mapped against the Trust's strategic objectives. The Board Assurance Framework also includes the Board's risk appetite for each risk on the Board Assurance Framework, to determine what level of risk the Board is prepared to accept in each area, which risks are priorities to mitigate and the plans that are required to make further mitigation.

Corporate Risks (Corporate Risk Register)
These risks are risks which sit between the operational risk register and the BAF. They are significant risks which may impact on the delivery of the BAF.

A rating of 15 or above is the trigger for the risk to be considered for acceptance onto the Corporate Risk Register (CRR). These risks are reviewed by the Operational Quality Committee or Non-Clinical Quality Committee and if added to the CRR through review by Executive Management Team if they are determined to be significant enough to require additional overview and challenge at a Trust-wide committee as they pose a risk across the Trust or to more than one part of the organisation..

The risk would still be managed and updated by the area it sits under, but it would appear on the corporate risk reports to these committees. These are recorded on DATIX.

It is important to remember that adding a risk to the corporate risk register is not transferring the responsibility of the management of the risk from the area it sits within. Acceptance onto the corporate risk register demonstrates that the operational 'risk appetite' has been reached, and the overseeing committee has decided that the risk requires a higher level of oversight and scrutiny within the Trust. Entry onto the corporate risk register also provides 'ward to board' escalation, as the corporate risk register will be reviewed alongside the Board Assurance Framework.

Not all high risks have to be accepted onto the corporate risk register.

Operational risks
The risks associated with the key business processes at speciality/divisional/Health Group (HG) level or within corporate functions. These are recorded on DATIX and managed at a local level by HGs or corporate departments.

Risk Assessment Forms for local risk assessments
Risk assessment forms and advice are available from the Trust's intranet site in the 'Safety' section for when areas want to undertake a risk assessment of a particular hazard, or for assessments such as for pregnant staff members at work. The Safety Team are available for help and advice on both the process or individual assessments, and are contactable either by e-mail (Ian Stanley or Dave Bovill) or phone on either 468170 / 468169 @ CHH.
If any of these risk assessments are undertaken and a risk is identified that cannot be resolved with immediate or swift action, should be escalated through for consideration onto the operational risk register (DATIX).

All risks are categorised using the same matrix and framework. This can be found at

Appendix 3.

Chart 1: Trust process for escalation from operational risk register onto corporate risk register and board assurance framework. *Can be printed for display*

Ward to Board Escalation

1. Operational Risk Register (ORR)

Formed of: ward, speciality, divisional, health group (HG) and corporate functions (CF) risks

Managed by Health Groups/Corporate Functions via DATIX

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

2. Corporate Risk Register (CRR)

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

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

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

3. Board Assurance Framework (BAF)

Managed by Trust Board. The BAF describes the key risks to achieving the Trust's strategic goals, and the positive assurance received by the Trust Board as to how these goals are being achieved , and the risk appetite for each risk area

BAF to show the ORR and CRR risks linked to each BAF as part of report. Trust Board receives regular updates on progress with BAF, which will include issues escalated by the Trust Board's Quality or Performance and Finance Committees
Deputy Director of Governance and Director of Corporate Affairs to meet regularly to review the ORR, CRR and BAF and report on significant shifts on each register.

Linked to BAF risks on DATIX

2.2 Risk Assessment Process

2.2.1 Risk Rating

Effective risk assessment is a core element in good safety management systems. Information on assessing risk can be found at Appendix 4.

The risk assessment ratings are based on the risk matrix shown at Appendix 3, which is defined as

Likelihood x Severity = Risk Rating

Each risk should be assessed using this matrix. Within DATIX the risks are assessed using this matrix at three stages,

Initial risk rating - at the time the risk is identified and added to the risk register. This is with the existing controls in place.

Current risk rating - this score is reviewed and amended each time the risk is reviewed. This score should change as actions are added, situations improve or deteriorate

Target risk rating - this is the target, set at the point when the risk is added to the risk register and reflects the level of risk that the Trust is willing to accept. The risk action plan (risk treatment plan), alongside any gaps in controls that require addressing, should be aiming to reduce the risk to this level.

2.2.2 Owning and reviewing a risk on DATIX

For the risk register to remain a dynamic tool, risks need to be reviewed and updated on a regular basis. Risks should be owned by an individual who is accountable and has overall responsibility for a risk within the area where the risk sits, and should be reviewed at an appropriate level. The timeframes depend on the type and rating of the risk. Operational risks should be reviewed as changes to the risk take place. However, minimum requirements are in place according to their rating as detailed below:

Low (≤6): A review date of no longer than 6 months must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date.

Moderate (8-12): A review date of no longer than 3 months must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date. The risk can be managed and monitored at a local level by the Line Manager.

The risk should be managed at a Divisional/Specialty/Department level by the Risk Owner.

High(≥ 15): A review date of no longer than 1 month must be recorded in the mandatory field of DATIX. This will be monitored and should be viewed as the last possible review date.

The risk should be escalated to the Health Group triumvirate/Directorate Level by the Risk Owner. The Health Group/Directorate risk registers will be reviewed by the Health Group/Directorate Governance committee to determine which risks should be escalated to the Corporate Risk Register (CRR).

2.2.3 Training & Education

For training on risk management please visit the Trust Education and Development site (HEY 24/7) or contact a member of Quality Governance and Assurance Directorate.

2.2.4 Implementation

The latest ratified version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

3 PROCESS FOR MONITORING COMPLIANCE

Report	Committee	When produced	Content
HG Escalation Reports	Operational Quality Committee (OQC)	Monthly	Items relating to governance, including escalating new high risks
Risk Report (clinical and non-clinical)	OQC	Monthly	**Risk** Incidents Serious Incidents Duty of Candour Central Alert Broadcast System
Risk Report (with a focus on non-clinical elements)	NCQC	Bi-monthly	**Risk** Incidents Serious Incidents Central Alert Broadcast System
Corporate Risk Report	OQC Non-clinical Quality Committee	Monthly Bi-monthly	Corporate Risk Register
Corporate Risk Report Linked with Board Assurance Framework	Executive Management Committee Executive Management Committee	Monthly Quarterly	Corporate Risk Register – review and agree content of CRR Review of CRR to escalate/mitigate corporate risks against BAF strategic risks
Board Assurance Framework	Trust Board	Quarterly	Board Assurance Framework including Corporate Risks

4 REFERENCES

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5 APPENDICES

Appendix 1 - Duties
Appendix 2 – Definitions
Appendix 3 - Risk Matrix and Framework for the Categorisation of Risk Issues
Appendix 4 – Additional guidance on the Risk Assessment Process

Document Control			
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Target Audience			
All staff	Clinical Staff Only	Non-Clinical Staff Only	
Managers	Nursing Staff Only	Medical Staff Only	

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January 2016	V1	Mark Green	New policy - Replaces CP213 Policy For The Management Of Clinical Negligence, Liabilities To Third Parties And Property Expenses Scheme Claims, CP309 Analysis And Improvement Following Incidents, Complaints And Claims Policy, CP350 Serious Incident/Never Event Management Policy and CP129 Incident Reporting Policy
March 2016	V1.2	Mark Green	Amendment of investigation timescale from 14 days to 28 days. Approved at Operational Quality Committee, March 2016
April 2017	V2	April Daniel	Elements relating to incident management, lessons learned and aggregation of data removed. This is now a standalone Risk Policy.
November 2017	V2.1	April Daniel	Addition of Risk v Issues approach to risks on risk registers. Addition of reference to Trust Risk Appetite statement Clarity of roles in Appendix 1

Appendix 1 – Duties and Risk and Risk Management Responsibilities

The responsibilities for risk and risk management are at the levels of the organisation to which the risks belong. As such it is the responsibility of the Board and Senior Management Team to undertake the strategic and corporate risk management activities, and for the Health Groups and Directorates to undertake the operational, and project risk management activities. These responsibilities and the Trust risk management goals will be built into individuals' objectives and personal development plans.

Trust Board
The Trust Board is charged with approving the Trust's Risk Management Policy. The Trust Board is responsible for identifying and assessing the risks to the achievement of the strategic objectives and receiving assurance that these are being controlled. This will include receiving the Corporate Risk Register and developing and maintaining the Board Assurance Framework, which underpins the Statement on Internal Control.

Chief Executive
The Chief Executive has overall accountability for all governance and risk management arrangements, both clinical and corporate, within the Trust. To ensure that the fraudulent use of resources is appropriately reported and investigated.

Chief Medical Officer
The Chief Medical Officer is responsible for: quality governance (including risk management, R&D, Clinical Audit & Effectiveness, Caldicott Guardian); for the implementation of the Trust's strategy in respect of quality across the Health Groups, in conjunction with the Chief Nurse; joint chair of Operational Quality Committee.

Chief Nurse
The Chief Nurse is responsible for the implementation of the Trust's strategy in respect of quality across the Health Groups, in conjunction with the Chief Medical Officer. Joint chair of Operational Quality Committee.

Other Directors
Responsible for facilitating, co-ordinating and monitoring risk in relation to areas of specific responsibility, including development of a risk register, and for achievement of risk pooling standards for which they have lead responsibility. The Chief Finance Officer is the Chair of the Non-Clinical Quality Committee.

Non-Executive Directors
In addition to scrutinising risk management arrangements at the Trust Board, non-executive directors have specific responsibilities via the Trust Board Quality, Audit and Performance and Finance committees.

Deputy Director of Quality Governance and Assurance
The Deputy Director of Quality Governance and Assurance is nominated with responsibility for developing and overseeing the organisation's Risk Management Policy.

Director of Corporate Affairs
Responsible for the management of the Trust Board Assurance Framework.

Audit Committee
The Audit Committee has an overarching role to oversee internal systems of control and risks management. Is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust in support of its objectives and activities. The existence of an independent committee of Non-

Executive Directors is a central means by which the Board ensures effective internal control arrangements are in place.

The Committee shall review the establishment and maintenance of an effective system of risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

Health Group Triumvirates
Lead responsibility for the implementation of the Trust's risk management policy and framework within the Health Groups and ongoing monitoring. Responsible for bringing to the attention of the Operational Quality Committee the risks and control measures identified in the Health Group's risk register.

Quality Governance and Assurance Directorate
The Quality Governance and Assurance Team Directorate responsible for the central co-ordination and management of risk management.

The Quality Governance and Assurance Directorate is also responsible for providing training and training packages, education and awareness on risk management issues relating to risk and safety, and providing advice and practical assistance to Health Groups /Directorates, Specialty Teams and departments on risk management issues. In addition, the department is responsible for the provision of information on claims and incidents to Health Groups and Trust Committees.

Risk Team
To support the Deputy Director of Quality Governance and Assurance in the implementation of the Risk Management Policy

Trust Safety Manager
To alert the Trust to any risks relating to Health and Safety. To make relevant reports to external bodies to meet the Trust's statutory obligations, such as the Health & Safety Executive

Line Managers / Departmental Heads
Line managers are responsible for the on-going identification and assessment of risk and that action plans are developed and implemented. Line managers are also responsible for ensuring that all staff are informed of and understand their responsibilities with regard to effective risk management. This will include reporting of incidents and attendance at mandatory and risk management training. This will enable risk management to become part of everyday activities so that lessons are learned from the investigation of complaints, and incidents, that changes are made as a result, and that appropriate monitoring and audit programmes are in place. Line managers are responsible for ensuring that risk is discussed at a ward (or equivalent) meeting and that any unresolved risks are reported to Specialty/Divisional/ Health Group/Directorate meetings as appropriate and are recorded on the risk register. This will include identifying risks that might impact on other areas or the organisation as a whole.

Quality and Safety Managers and Quality Facilitators
Each Health Group has a team of either/and Quality and Safety Managers and Quality Facilitators. This team is responsible for delivering cascade training in relation to risk management to the Health Groups. In addition to this, the team are responsible for ensuring that the Health Group is supported in meeting central corporate requirements.

All Staff
Risk is inherent in everything that the organisation does. Therefore, all staff have a duty to maintain a safe environment, safe systems of work and practices in order to deliver high quality services. The identification and reporting of hazards, incidents and near misses, which might

affect themselves or others is an integral component of this duty. Every member of staff will be aware of how to report hazards and incidents that exist within their area, and how these will be dealt with.

Appendix 2 – Definitions

Risk
Risk is the chance of something happening that will have an impact on day to day activities or the wider goals, objectives or strategies of the organisation. Risk is measured in terms of severity and likelihood.

Risk Management
Risk management is the process by which risks are identified, prioritised, treated and monitored. It is the process of identifying risks which could prevent successful achievement of strategic and operational objectives. It is a proactive approach which involves:

- addressing all activities of the organisation
- identifying barriers to the achievement of aims and objectives
- assessing these barriers in terms of severity and likelihood
- taking action to eliminate the risks that can be eliminated
- acting to reduce the impact of the risks that cannot be eliminated
- putting into place mechanisms to absorb the consequences of residual risks that remain e.g. insurance, pooling schemes

Risk Register
A risk register is a repository of risk information that enables the organisation to understand its risk profile. This Trust uses DATIX as its risk management system. It is a dynamic and living document which is populated through the organisation's risk assessment and evaluation process. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. The risk register contains both operational and strategic risks. This allows significant risks to be highlighted and risk treatment plans to be developed.

Risk
The potential of an event occurring at some point in the future which requires management to reduce the likelihood of happening and the severity of the potential impact to the Trust's objectives or strategic goals.

Issue
An event which has already occurred or is still occurring which will affect the achievement of the Trust's objectives or strategic goals which need to be actively dealt with to be resolved.

Hazard
A hazard is something that has the potential to cause harm, damage or loss. A hazard can develop over time and can often lie dormant before combining with other factors to result in an incident or near miss.

Strategic Risk
Those risks that could prevent the Trust meeting its strategic objectives. These are managed via the Board Assurance Framework; e.g.: *Failure to achieve strong, respected and impactful leadership throughout the organisation.*

Corporate Risk
These are high rated risks and the Trust feels that these risks may impact on the delivery of the Trust strategic objectives, and so requires a higher level of oversight and scrutiny through the Trust committee structures.

Operational Risk
A risk arising from execution of the Trust's business functions. It is a very broad concept which focuses on the risks arising from the people, systems and processes through which a company operates. In practice, these will be the day-to-day risks placed onto the Trust's risk register at specialty and divisional level, e.g.: *Ageing hematology analyzers threaten the necessary throughput within Pathology.*

Risk Owner
The individual who is accountable and has overall responsibility for managing the risk through its lifetime and for ensuring appropriate risk controls are put in place.

Risk Action Lead
This may or may not be the Risk Owner. Action leads are responsible for the delivery of the actions identified to reduce or manage the risk. Risks will be owned by one person but there may be many action leads for each individual risk.

DATIX
DATIX is the Trust's risk management database. It is where the operational and corporate risk registers are held.

Initial Risk Score
Inherent risk before controls have been applied.

Residual Risk Score
Current risk, taking into consideration the existing control measures

Gaps in Controls
Where are we failing to put controls in place? Where are we failing to make them effective?

Target Risk Score
Projected, realistic and anticipated level of risk to be achieved by the end of the current financial year.

Risk Appetite
Every organisation will have a different perception of the level of risk it is comfortable with and needs to be clear about what is and is not acceptable. An organisation's risk appetite is defined as 'the amount and type of risk that an organisation is prepared to seek, accept or tolerate.'

Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but may have more appetite for opportunity such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation.

Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board.

The Trust Risk Appetite Statement is set by the Trust Board.

Control Measures
An action undertaken to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

Gaps in Control
Where there are gaps in the existing controls in place to manage the risk.

Assurances
The information we have to know and understand that the controls in place are being implemented and are effective, e.g monitoring reports to committees, or confirmation of work being completed

Gaps in Assurance
Where there are gaps in assurance, i.e. we do not have the evidence to support that the controls are in place and effective.

Risk Control
A score of 1 to 5 to determine

1 – Risk is fully under control
2 – Risk is adequately controlled
3 – Action to control risk adequately has started
4 – Action to control risk is agreed but no action started
5 – No actions to control risk identified.

Appendix 3 - TRUST'S APPROVED RISK MATRIX / FRAMEWORK FOR THE CATEGORISATION OF RISK ISSUES

Risk Rating Matrix:

To determine the overall **risk** rating, the **severity** should be multiplied by the **likelihood**

		LIKELIHOOD				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
SEVERITY	1 Negligible	1 Very low risk	2 Very low risk	3 Very low risk	4 Low risk	5 Low risk
	2 Minor	2 Very low risk	4 Low risk	6 Low risk	8 Moderate risk	10 Moderate risk
	3 Moderate	3 Very low risk	6 Low risk	9 Moderate risk	12 Moderate risk	15 High risk
	4 Major	4 Low risk	8 Moderate risk	12 Moderate risk	16 High risk	20 High risk
	5 Catastrophic	5 Low risk	10 Moderate risk	15 High risk	20 High risk	25 High risk

Example:

If a severity of 2 is multiplied with a Likelihood of 3 then you would have an overall risk rating of 6 - Yellow with a review date of 6 months i.e.

S		L		
2	x	3	=	6 Yellow - Review in 6 months

Guidance on Severity	Staff	Patient
Negligible	No / negligible injury or adverse outcome	No / negligible injury or adverse outcome
Minor	Lost time up to 3 days	Minor cuts / sprain / strain requiring first aid, short-term distress or change in condition requiring medical review, but no follow up treatment
Moderate	Lost time up to 4 weeks	Fracture / injury likely to cause impairment, distress lasting for a number of days, change in condition requiring continuing treatment, or increased length of stay
Major	Long term sickness over 4 weeks	Injury likely to cause permanent incapacity involving one or more individuals e.g. major nerve lesion, or injury involving major internal organs
Catastrophic	Death of one or more individuals	Death of one or more individuals

Guidance on Likelihood		Probability
Rare	Cannot believe that this will ever happen	Less than 5%
Unlikely	Do not expect will happen, but small chance	6% to 20%
Possible	May occur occasionally	21% to 50%
Likely	Likely to occur on many occasions	51% to 80%
Almost Certain	Expected to occur in most circumstances and is a persistent issue	More than 80%

Risk rating	Risk scenario	Guidance
1 – 3	Very low risk	• No further action needed.
4 – 7	Low risk	• Yellow risks are generally easily resolved locally at ward or departmental level. • Report unresolved risks at specialty or equivalent meeting. • If risk unresolved at specialty meeting, report to Divisional/Directorate meeting. Identify trends.
8 – 12	Medium risk	• Management action needed to reduce risk, as soon as reasonably practical. Amber risk issues should be investigated by the manager responsible for the service. • Report unresolved risks to Divisional/Directorate meeting. Identify trends.
15 – 25	High-risk	• High-risk scenario. Immediate action needed. High risks need to be escalated to senior management in order that they are considered for inclusion onto a corporate risk register.

Framework for the categorisation of risk issues

Table below gives some examples that most appropriately describes the severity and frequency of the identified risk issue. Use this information to calculate the category of risk on table above.

TABLE 1: SEVERITY – Likely outcome of risk issue

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

		for patient safety if unresolved Reduced performance rating if unresolved	Major patient safety implications if findings are not acted on		
Human resources/ organisational development/staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix 4 – Additional guidance on risk assessment

Appendix 4.1 – How to assess a risk

This section describes the types of risks that may be identified and the overall Trust approach to risk assessment. The Trust follows national guidance on risk assessment processes. There are 5 steps as shown below:

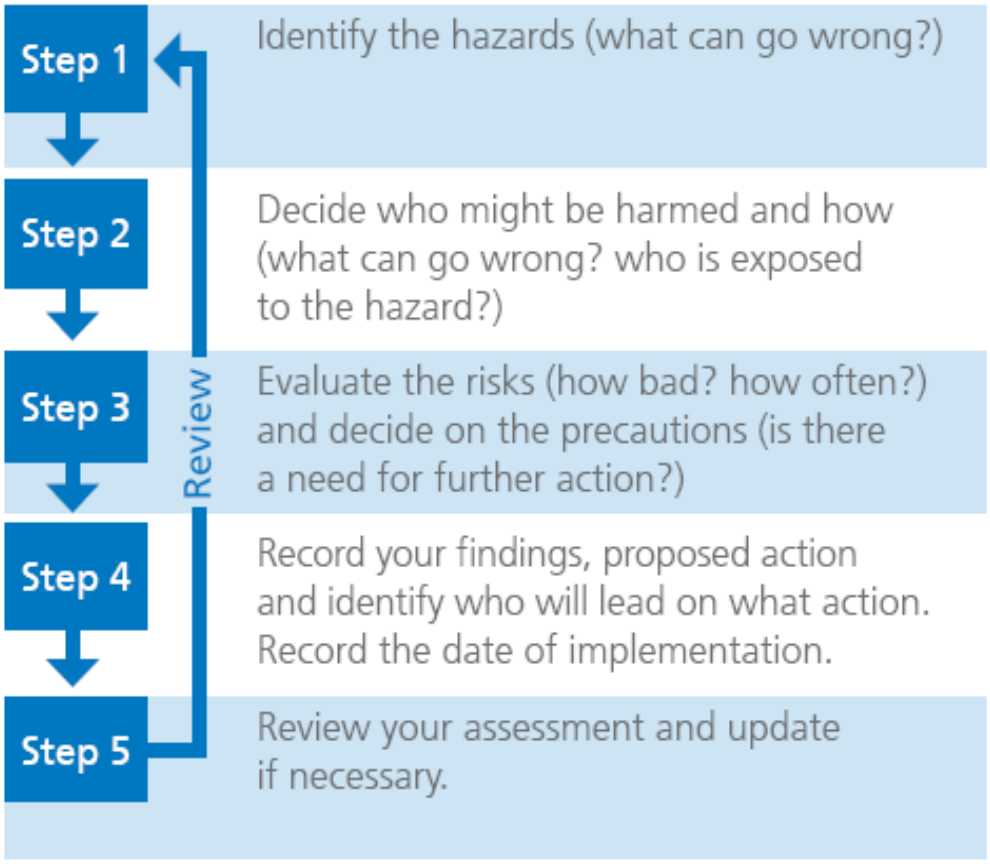


Figure 3: *Five steps to risk assessment*

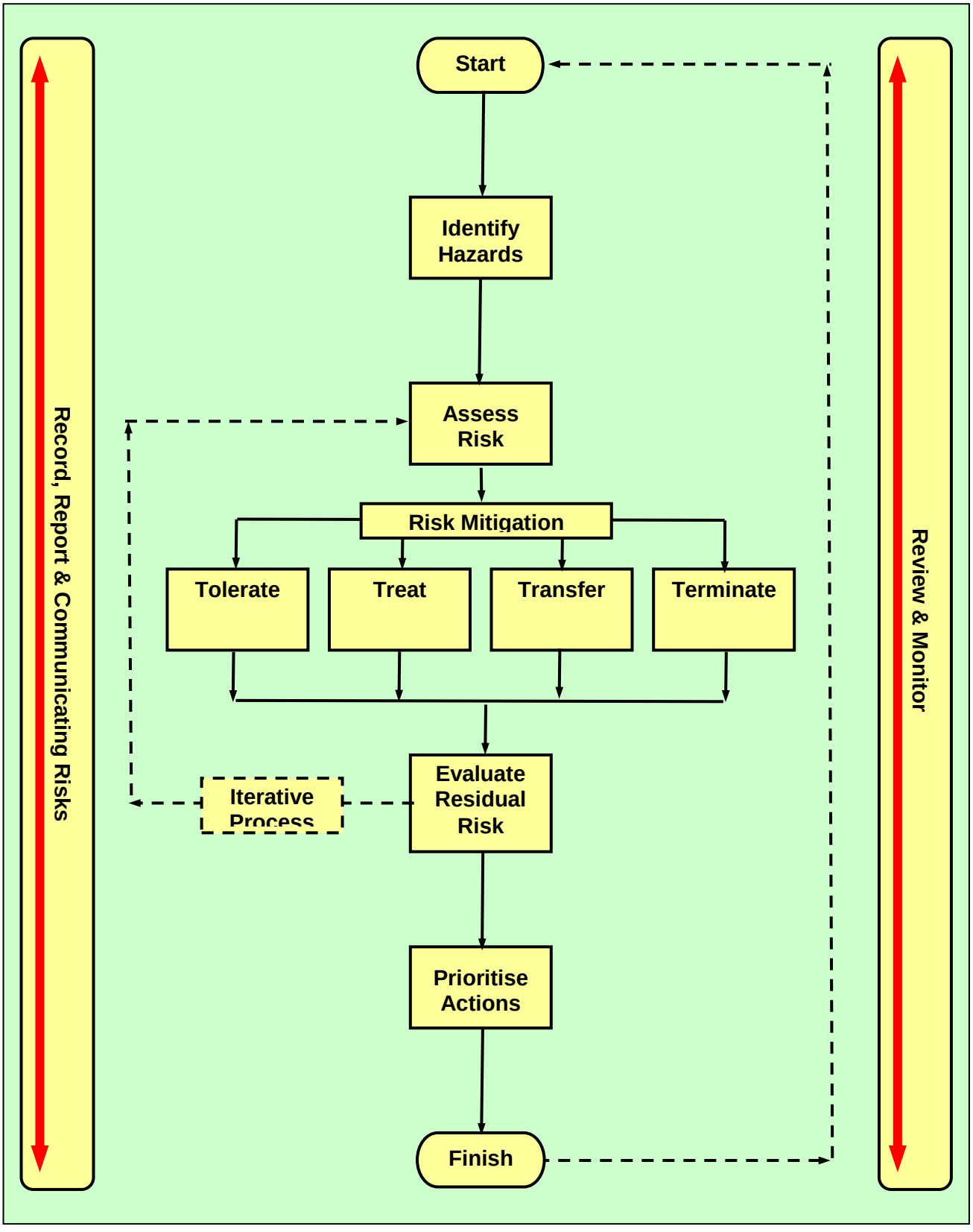
Identify the hazards (what can go wrong?)
To prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong. Consider the activity within the context of the physical environment, and the culture of the organisation and the staff who perform the activity.

Decide who might be harmed or what the impact will be on the organisation (assets, environment and reputation) and how. Take into account things that have gone wrong in the past and near-miss incidents.

Learn from the past, e.g.
1. Walk around the workplace and talk to staff.
2. Map or describe the activity to be assessed.
3. The risk assessment may require a multi-disciplinary team to ensure that all areas of the activity or task to be assessed are considered.

Evaluate the risks (how often? how bad?) and decide on the precautions (is there a need for further action?)
Consider both the likelihood (how often?) and severity (how bad?). Is there a need for additional action? The law requires everyone providing a service to do everything reasonably practical to protect patients and staff from harm.

1. Identify the **current** controls/precautions that are in place to prevent the risk from causing harm or loss.
2. Use the Risk Matrix Tool (Appendix 3) to grade the risk.
3. Decide whether further precautions need to be taken to reduce the risk and if action is required, determine what changes need to be made.
4. Re-evaluate the risks assuming the precautions (controls) have been taken (to check the expected impact of the proposed changes).



Appendix 4.2 Guidance on completing Risk Registers

4.2.1 Risk Register monitoring includes:

- Ensuring that risk descriptions convey risks clearly and concisely.
- Making sure that risk descriptions describe both the hazard and the impact of the risk.
- Ensuring that the controls described on the risk register are current and relevant to the risk.
- Identifying the source of the risk on the risk register (e.g. incident report, risk assessment, claim, complaint, internal/external audit, staff or patient feedback, gap analysis against external guidance and policy, etc).
- Training staff to use the Risk Assessment Procedure to grade risks; in particular using the severity descriptions to grade risks.
- Ensuring that action plans to address risks are appropriately described.

4.2.2 Objectives for completing risk registers

The key objectives for completing risk registers are listed below:

Ensure that risks are described succinctly and include a description of the hazard, and risk or issue in terms of impact, i.e.

- Impact on the safety of patients, staff or public (physical/ psychological harm)
- Adverse publicity/ reputation
- Business objectives/ projects
- Business/Service interruption Environmental impact
- Finance including claims
- Quality/ complaints/ audit
- Human resources/ organisational development/ staffing/ competence
- Statutory duty/ inspections, etc.

4.2.3 Recording a risk

When adding a risk to DATIX you will need to record a risk title and risk description

Risk Title

The title should accurately describe the 'risk' not the situation. Some examples of good versus poor risk titles are shown in Table 1.0 on the next page.

Risk Description

To enable a consistent approach to defining risks staff should consider using a standardised description of risk. The recommended description comprises a clear expression of the event(s) with cause and effect statements, for example:

• *There is a risk that… [an event]*
• *The risk is caused by… [specific or generic]*
• *The effect (and consequent cost/patient safety/performance impacts) will be…*

This is also known as the 3 C's – Condition, Cause & Consequence

Table 1.0: Examples of good versus poor risk title

Poor risk title	Good risk title
Surgery to incorrect site	Lack of Trust-wide safe site surgery protocol leads to increased risk of surgery to incorrect site leading to harm to patients
Recruitment and retention of staff	Failure to recruit cardiac ICU nurses leads to over-reliance on bank and agency staff resulting in increased staff costs leading to increased financial risk
Unable to meet referral wait target	Lack of available bed capacity causes the Trust to not achieve waiting target resulting in increased financial loss.
Also avoid in risk description writing an essay and combining lots of risks in one description…	
RISK OF ELECTIVE CANCELLATIONS - including short-stay patients/extended periods in recovery/A&E breaches due to delayed discharges. Reasons include TTAs not being written up in advance, lack of predicted discharge dates, outliers from other specialties and poor communication between nursing and medical teams. Other risks include Infection outbreaks reducing bed capacity available for non-elective and elective demand.	This risk description has several risks embedded within it. Describing risks in this way makes it impossible to apply the severity of risk descriptions in the Risk Assessment Procedure accurately. Consequently, the organisation does not have a clear understanding of the component parts of the risk and how urgently they need to be addressed. So it is important to avoid embedding several distinct risks in one risk description.

Source of risk
Identify the source of the risk on the risk register. Some examples of sources of risks are shown below:

- Risk assessments
- Incident reports
- SI investigations
- Staff feedback/observations
- Complaints and claims
- Gap analysis against national policy or external standards
- External/Internal/Self audit
- Walk arounds
- Business Case Analysis

NB: Identifying the source of the risk is essential to ensure that the organisation is capturing risks from a range of different sources.

Controls in place
Describe the controls **currently in place** to manage the risk. It is important to note the following two points when describing risk controls; (i) every control should be relevant to the risk you have described and actually in place at the time of writing, so ask yourself the question 'does this control materially impact on the risk? and, (ii) controls should be restricted to things that are **already in place** to mitigate or manage a given risk.

Table 2.0: Distinguishing between Controls, Assurances, and Action Plans

Key learning point
Sometimes staff confuse controls, assurances and action plans when completing the risk register. i. Controls are things that are **already in place** to manage the risk. ii. Assurances are the evidence that you use to demonstrate that the controls/systems currently in place are effective. ii. Action Plans describe how, going forward, you plan to reduce or eliminate the risk or gaps in controls and/or assurances you have described.
Consider the following illustrative example: **Risk:** Action plans to reduce clinical coding problems do not deliver expected financial gains **Controls:** (i) Redesign and restructure of clinical coding function completed (ii) Coding audit software to measure financial gains purchased (iii) Contract in place with an external software house to provide comparative analysis of coding data (iv) Clinical coders recruited and in place (v) Clear coding definitions set against tariff **Assurances:** Performance pack (depth of clinical coding report) reported to Operational Quality Committee and Trust Board. **Action plans:** Implement the clinical coding strategy, including measurement metrics so that improvements can be evidenced over time.

When describing assurances on the risk register remember that an assurance is evidence that the controls/systems that are in place to control the risk are working effectively. Assurances can be either internal or external. Internal assurance can be provided by describing the key performance indicators and monitoring arrangements that are in place evidencing that a control is working. For example, KPI's relating to coding activity, Quality Scorecard monitoring, self-audits which demonstrate policy compliance etc.

External assurance provides independent evidence that a control is effective and therefore generally provides a stronger source of assurance to the Trust Board. Examples of external assurance include Internal Audit Reviews, external audits or reviews (CQC, NHSLA, etc.), evidence of compliance with other external standards etc.

Action plans and review dates
Once the risk has been scored, produce an action plan that clearly describes what actions will be taken to reduce or manage the risk. When reviewing risks that appeared on your last risk register submission it is important to ensure previous action plans are reviewed and updated on the registers. Completed or mitigated risks will be archived.

Action plans should have a nominated 'risk action lead' for every action and a 'review date', i.e. a date upon which progress towards completing the actions will be reviewed. Hence the review dates associated with new action plans should project forwards from the date that the risk register is completed. Review dates are important because they enable the organisation to monitor progress towards reducing the risk over time.

Closing a risk
When a risk has been reduced or eliminated through the successful implementation of action plans, the following process should be applied to archive it.

The current risk rating should be amended to illustrate that the action plans have controlled the risk. That is to say, the current risk rating should be low green (1-6) prior to contemplating the archiving of a risk from the risk register. Close the risk by adding the date of closure to the ‘Date Closed’. The risk is still available for review if needed but is now archived.

Hull and East Yorkshire Hospitals NHS Trust

Trust Board
11 September 2018

Title:	THE DEVELOPMENT OF THE ENERGY INNOVATION UPGRADE SCHEMES – Full Business Case
Responsible Director:	Duncan Taylor – Director of Estates (Chris Norman – Deputy Director of Estates)
Author:	Paul O'Meara – Head of Finance - Estates

Purpose:	The purpose of this paper is to seek approval from the Trust Board for the submission of the Full Business Case for "The Development of the Energy Innovation Upgrade Schemes".	
BAF Risk:	BAF 7.2	
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	✓
Summary Key of Issues:	It is recommended that the Trust Board approves the Full Business Case for the Energy Innovation Upgrade Schemes. Support the submission of the FBC and a capital loan application of £13.9m for initial external consideration by both NHSI and the Project Appraisal Unit ("PAU") and then by the DoH/ITFF. Further detail may be required by the NHSI and DoH in answer to outstanding queries to complete their FBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI/PAU and DoH/ITFF in their requests.	

Recommendation:	Approve the submission of the Full Business Case and a capital loan application of £13.9m for external review by both NHSI and the Project Appraisal Unit for consideration.

FULL BUSINESS CASE

THE DEVELOPMENT OF
ENERGY INNOVATION UPGRADE SCHEMES

FULL 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
IASB	International Accounting Standards Board
IFRS	International Financial Reporting Standard
ITMC	Invitation to Mini Competition
ITT	Invitation to Tender
KPI	Key Performance Indicators
LTHW	Low Temperature Hot Water
MBH	Main Boiler-house
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
SoCI	Statement of Comprehensive Income
SoFP	Statement of Financial Position

1. EXECUTIVE SUMMARY

1.1 Introduction

1.1.1 The purpose of this Full Business Case ("FBC") is to update the previously approved Outline Business Case ("OBC"). This business case concerns the development of an energy innovation upgrade scheme on both the Hull Royal Infirmary ("HRI") and Castle Hill Hospital ("CHH") sites.

1.1.2 Previous discussions with NHSI have indicated an approvals process requiring a number of steps. Initial approval of a £13.9m capital loan application by NHSI would be followed by an application to the Department of Health ("DoH") and the Independent Trust Financing Facility ("ITFF") for final approval.

1.1.3 The Trust understands that there is a backlog of capital business cases currently sat in the approvals pipeline. Recent guidance from NHSI stated that all capital requests were to be prioritised as part of the local STP process. However, HEY were subsequently advised not to submit this particular business case as part of the STP process and so will therefore continue to work with NHSI on the submission of the business case to the DoH for consideration.

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

- in working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by the National Sustainable Development Strategy
- to reduce energy costs and maximise efficiency savings
- in contributing to the vision set out by Lord Carter of Coles in his report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" published in February 2016
- in following the best practice guide, as set out by Lord Carter of Coles, to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as published in October 2017
- acting on the recommendations of the Sir Robert Naylor Report of March 2017 in reducing backlog maintenance
- meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development

1.1.5 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.

1.1.6 The table below shows the total actual energy costs for HEY from financial years 2015/16 to 2017/18 and a forecast for 2018/19.

Summary of HRI & CHH site Energy Costs from 2015/16 to 2018/19

	2015/16	2016/17	2017/18	2018/19
	Actuals £000's	Actuals £000's	Actuals £000's	Forecast £000's
Electricity	2,608	2,904	3,140	3,633
Annual %age change		11%	8%	16%
Gas	1,936	1,882	1,675	1,792
Annual %age change		-3%	-11%	7%
Total	**4,544**	**4,786**	**4,815**	**5,425**

1.1.7 The table shows that the cumulative expenditure on both gas and electricity has been steadily rising since 2015/16. The marked increase in the forecasted energy spend figure, particularly electricity, for 2018/19 is due to:-

- the impact of the EU's Industrial Emissions Directive (2016) which has seen the increased closure of many UK electricity generation plants with coal fire power stations particularly targeted to help reduce emissions in energy generation. This has reduced supply and increased buyer competition resulting in the wholesale cost of purchasing energy to also rise
- the supply of alternative sources of energy, such as wind and solar power, are still not mainstream and hence still expensive
- increased costs in supplying energy to sites
- other increases have come from government policies and taxes
- further increases in energy prices are forecasted in 2019/20

1.1.8 The price rises would have been even more significant if the Trust hadn't used an energy broker to purchase and risk manage both its electricity and gas supply.

1.1.9 These figures show that by investing in new energy infrastructures there is scope for significant savings to be made. In the case of electricity some of the schemes looked at are energy self-generating with no supply to site overhead costs. Therefore, it is imperative that the Trust looks at ways of reducing its energy costs thereby contributing to improvements in the Trust's financial position and delivery of its DoH control total.

1.2 The Strategic Case

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

- working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by the National Sustainable Development Strategy
- to reduce energy costs and create efficiency savings
- contribute to the vision set out by Lord Carter in his report 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations' published in February 2016
- in following the best practice guide to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as published in October 2017
- acting on the recommendations of the Sir Robert Naylor Report of March 2017 in reducing backlog maintenance
- meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development

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

- insulation programme at the Hull Royal Infirmary and the Castle Hill Hospital, consisting of insulation improvements in the boiler house and steam distribution system. Others include lighting improvements and upgrades to the building management systems on both sites. Energy savings achieved to date of 1% to 1.5% from 2010 onwards.
- the refurbishment of an existing second hand 700kWe natural gas CHP at the Hull Royal Infirmary in 2009.

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

1.2.4 The table below shows the Trust's Annual CO_2 Performance Return figures, measured against the baseline year of 2009/10, from which the national target reduction of 34% is measured. The figures include the most recently validated return for 2017/18.

Year of Return	Total CO2 Tonnes	Change in CO2 from 2009/10	Annual %age Reduction from Baseline
2009/10	34,417	baseline	
2010/11	34,154	(263)	-1%
2011/12	31,213	(3,204)	-9%
2012/13	33,570	(847)	-2%
2013/14	32,017	(2,400)	-7%
2014/15	32,798	(1,619)	-5%
2015/16	31,469	(2,948)	-9%
2016/17	30,098	(4,319)	-13%
2017/18	27,061	**(7,093)**	-21%
Energy Project Impact:-			
Further CO2 reduction		**(7,138)**	-21%
Total CO2 Reduction		**(14,231)**	**-41%**
CO2 Reduction Target by 2020		**(11,702)**	**-34%**

1.2.5 The figures show that HEY, based on using the existing energy infrastructure and minimal investment is not on trajectory to meet the 34% CO_2 target of a reduction of 11,702 tonnes by 2020. The current reduction stands at 7,093 tonnes of CO_2 which is 4,609 tonnes short of the national target.

1.2.6 The Trust has evaluated further opportunities to drive savings through efficient, low carbon energy generation, the main one being the option to install further Combined Heat and Power ("CHP") capacity at HRI and a new CHP at CHH. A feasibility study on these options has already been completed by Ove Arup and Partners Limited (August 2012) and a high level energy survey in support of the proposed options has been completed by Sinclair Knight Merz (August 2012) ("SKM"). These reports are attached under Appendix 3a and 3b. A further feasibility study was completed by the Carbon and Energy Fund (March 2016) ("CEF") to establish the case for investment at HEY's HRI and CHH sites. The CEF feasibility report is attached as Appendix 4. A further feasibility was undertaken during April 2018, to help support the FBC, by NIFES Consulting Group, which confirmed and updated the findings of the previous reports for the CHP installations at both HRI and CHH. These are attached as Appendix 3c and 3d.

1.2.7 The impact of investment in the energy schemes has been assessed at delivering a further reduction of 7,138 tonnes of CO_2. From the table above it can be seen that when adding the CO_2 reduction from the energy investment schemes to the current baseline figures for 2017/18 HEY achieves and exceeds the national CO_2 reduction target of 34%.

1.2.8 The case for change can be summarised as the need to:-

- reduce carbon emissions in line with national policy
- replace the ageing heat and boiler plant at HRI

- use Combined Heat and Power engines that utilise a single fuel to self-generate electricity

- reduce exposure to changes in market prices by energy self-generation

- realise energy cost savings and contribute to an improved financial position for the Trust and as part of the Humber, Coast and Vale STP

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

- ensure compliance with the recommendations set out in the reports published by both Lord Carter of Coles and Sir Robert Naylor

1.3 The Economic Case

1.3.1 The feasibility studies described in Section 1.2.6 have assisted the Trust in determining the best way forward and potential optimum solutions for their two hospitals; HRI and CHH. These reports set out the current plant configuration and energy base line position and identified potential solutions for improving energy plant resilience, energy fuel supply resilience, energy performance and energy efficiency, leading to substantial reductions in carbon emissions and overall utility cost.

Hull Royal Infirmary

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

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

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

Castle Hill Hospital

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

1.3.6 A new energy centre was installed approximately ten years ago and contains 4 steam raising boilers. Other than the aspired addition of a CHP system, this leaves little or no requirement for further refurbishment

of heat raising services. While there is currently no existing CHP system at CHH, it was anticipated by the Trust that this hospital site could accommodate 1.6 – 2 MWe of CHP engine capacity.

Determining the Long List of Options

1.3.7 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.

1.3.8 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. The Nifes Consulting Group report looked at updating the best CHP installations for both sites. 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.

1.3.9 The options considered included the following energy infrastructure upgrade works as a result of the feasibility reports:-

Summary of the Energy Capital Scoped Projects

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

1.3.10 The potential savings generated from the capital projects under 1.3.9 were calculated on the back of the Carbon and Energy Fund Feasibility Study found under Appendix 3. The table below breaks the £2.6m (incl. VAT) of savings down by project were quantified:-

Summary of the Energy Project Savings	FBC - Revised Saving Figures				
Capital Works Scheme	HRI	CHH	Net	VAT	Gross
	£000's	£000's	£000's	£000's	£000's
Combined Heat and Power Unit (CHP)	(723)	(823)	**(1,547)**	(309)	**(1,856)**
Boilers	(118)		**(118)**	(24)	**(142)**
Absorption Chiller Systems (ACS)	(65)	(66)	**(131)**	(26)	**(157)**
LED Lighting Replacement Upgrade	(124)	(88)	**(212)**	(42)	**(254)**
BMS	(88)	(50)	**(137)**	(27)	**(165)**
Total Capital Works Scheme Savings	**(1,118)**	**(1,027)**	**(2,145)**	**(429)**	**(2,574)**

1.3.11 The long list of options in the table below was generated by the ESPT with additional input from stakeholders and technical specialists.

1.3.12 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 below:-

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.
9	SALIX Loan; HRI **or** CHH sites only	Trust investment , with the support of a SALIX finance loan; operated and maintained by a mix of HEY staff and external contractors.
10	SALIX Loan; HRI **and** CHH sites **combined**	Trust investment , with the support of a SALIX finance loan; operated and maintained by a mix of HEY staff and external contractors.

Critical Success Factors

1.3.13 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:-

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%

1.3.14 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 and which are predicated upon the HM Treasury's "Five Case Model" guidance.

Short-Listing of Options

1.3.15 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 long-list options is reflected and summarised in the table below:-

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	Option 9	Option 10
Critical Success Factors		Do Nothing	Do Minimum	DH Loan HRI or CHH	DH Loan HRI & CHH	3rd Party HRI or CHH	3rd Party HRI and CHH	DH/3rd Party HRI or CHH	DH/3rd Party HRI & CHH	SALIX Loan HRI or CHH	SALIX Loan HRI & CHH
1	Strategic Fit & Business Needs	0.0	6.3	12.5	25.0	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	8.0	8.0
3	Potential Achievability	1.5	1.5	14.3	14.3	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	9.5	9.5
5	Potential Affordability	1.0	1.0	7.5	7.5	9.0	9.5	7.5	7.5	0.0	0.0
Total Weighted Score		**3.5**	**13.8**	**61.8**	**92.3**	**55.3**	**78.3**	**59.8**	**82.3**	**44.3**	**56.8**
Ranking		10	**9**	4	**1**	7	**3**	5	**2**	8	6

SALIX Finance Model

1.3.16 Included in the long list of options is the additional SALIX loan finance (options 9&10) as well as the CEF third party options. SALIX finance is a not-for-profit company funded by the Department of Energy and Climate Change and the Welsh and Scottish Governments to remove the barrier of significant upfront capital cost for public sector organisations wanting to invest in energy efficient technologies. SALIX provides interest-free loans to enable projects that fall within their compliance criteria, mainly that returns on investment and carbon savings must be proven to be achievable within a stipulated time period.

Having met and discussed directly with SALIX representatives, the loan and compliance criteria was explained in detail to the Trust and consisted of the following:-

- Schemes must be new, not required by legislation and must pay for themselves from energy savings within a maximum 5 years.
- The cost of carbon dioxide equivalent must be less than £120 per tonne over the lifetime of the scheme.
- The loan is payable at the end of the project, which must be completed within 9 months from the “commitment” date.
- The loan is repaid by the Trust in instalments over 5 years, effectively reducing the Trust capital programme by this value over the repayment period.
- Used for projects that involve saving in one fuel type and be technology changing.

The Trust scheme options have been assessed by SALIX using their developed project tool application templates and populated by information supplied by the Trust, and validated by SALIX, with regards to anticipated financial and carbon savings.

The table below is a summary of the SALIX modelled options which show the results of the considered schemes:-

Salix Finance						
Scheme Options	**Total Financial Savings**	**Payback in Years**	**Total tCO_2e pa**	**Total tCO_2e LT**	**£/tCO_2e LT**	**Compliancy**
HRI and CHH sites	£2,205,580	5.51	6,288.08	84,025.42	£144.63	Non-Compliant
HRI site only	£1,132,594	5.20	3,116.75	41,615.77	£141.47	Non-Compliant
CHH site only	£1,072,985	5.84	3,171.33	42,409.64	£147.73	Non-Compliant

Note:-
The options all cover the installation of LED lighting, CHP installation and BMS as these generate the largest savings.
Excluded is the HRI boiler plant as its 10+ years payback would skew the other project scheme options.
Only HRI and CHH site related schemes have been considered.

Key:-

tCO_2e pa	Tonnes carbon dioxide equivalent saving per annum
tCO_2e LT	Tonnes carbon dioxide equivalent savings life time
£/tCO_2e LT	Cost per tonne carbon dioxide equivalent saving life time

Main Project Criteria:-
1. The project must pay for itself from energy savings within a maximum **5** year period.
2. The cost of carbon dioxide equivalent must be less than **£120** per tonne over the lifetime of the project.

Please note that the HRI boiler scheme was excluded due to its 10+ year's payback. The figures that therefore appear in the business case were an attempt to see if the scheme option appraisals could pass the tests excluding the HRI boilers, which unfortunately they cannot.

1.3.17 The minimum four short-listed options being considered for further evaluation include:-

- **Option 2: Do minimum** – must be included despite being ranked 9 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.

1.3.18 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.

1.3.19 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.

1.3.20 Options 9 and 10 – SALIX finance loan were discounted as both schemes do not deliver the strategic Trust wide energy innovation upgrade programme and neither the full loan criteria nor compliance elements mentioned under 1.3.16.

1.3.21 Options 9 and 10 - do not meet the key business driver in maximising the delivery and benefits of immediate Trust cost efficiency savings from Year 1 due to the conditional 5 year payback required on the loan.

1.3.22 Options 9 and 10 have the potential, depending on how the SALIX loan would be paid back, to impact on the Trusts already limited internal capital resource availability.

1.3.23 Standalone schemes considered by the Trust included the HRI boilers replacement and the installation of the CHP plant at CHH and HRI. Unfortunately, when both standalone projects were modelled, the schemes either failed to meet the 5 year payback period and/or carbon dioxide equivalent of £120 per tonne or required additional funding support due to the interdependencies required to maximise the energy efficiencies and savings ie the CHP and absorption chiller installation.

1.3.24 Option 4 would deliver a proposed technical solution and strategic Trust wide energy programme, financed through a DH Capital Loan Facility. This option would also meet a key business driver in **maximising** revenue cost savings in order to support the delivery of frontline patient care.

1.3.25 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. However, both the CEF options were discounted due mainly to their significantly lower NPV rate of return on the loan investment and qualitative benefits when compared to Option 4.

1.3.26 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.

1.3.27 The detailed scoring of the long-list of options to establish the short-list of options is attached as Appendix 5.

Short Listed Options Appraisal Scoring

1.3.28 The table below summarises the Short –Listed 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	(1,576)	12,078	2,120	3,243
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**		

1.3.29 Option 4, the DoH Capital Loan financed solution, is the recommended preferred option as it ranks 1st overall in the options appraisal summary.

1.3.30 The qualitative benefit of Option 4 is ranked 1st as it delivers all the energy capital scoped projects described under Section 1.3.9 with the added advantage of retaining the use of in house maintenance knowledge, expertise and training.

1.3.31 Option 4 is affordable as it delivers the largest NPV (ranked 1st) which represents the highest rate of return on the investment.

1.3.32 Option 4 scores slightly less on risk (ranked 3rd) as the overall project delivery and savings achievement predominantly lies with the Trust and not a CEF third party.

1.3.33 In reviewing the OBC to FBC the strategic drivers for the project have not changed to make any alterations to the rankings of the short-listed options. The economic appraisal made in the OBC therefore remains valid. Option 4, the DoH Capital Loan financed solution remains the preferred option.

1.4 Commercial Case

1.4.1 The commercial case describes the Trust's proposed approach to the procurement route and key legal and commercial issues in delivering the preferred option.

1.4.2 Under the OBC options, the Trust had considered the following for the procurement routes for this project:-

- Procure 22+
- YORbuild Construction Framework
- Scape Group Framework

- Traditional OJEU Tendering (if let as one package)
- Individual contractor design and build packages.

1.4.3 The proposed work tendered for under the ITT can be broken down into five stand-alone packages which when costed are under the current OJEU threshold (effective from 1st January 2018) for construction works of £4.6m before VAT. Therefore Individual Contractor Designed and Build Packages is the preferred route of procurement.

1.4.4 Whilst the procurement strategy, route and evaluation criteria set out in the OBC hasn't changed to FBC the tendering selection of the preferred bidders, due to the tight timescales of the FBC submission and the uncertainty of when the DoH is likely to provide feedback on the capital loan financing application, the "best and final offers" are still to be completed.

1.4.5 In order to meet the timescales laid out in the Project Management Plan the Trust has agreed to proceed at risk with regards to scheme designs and the tendering process despite the uncertainty around the capital loan application approval from the DoH.

1.5 The Financial Case

1.5.1 The purpose of this Section is to set out the likely financial implications of the preferred Option 4, DH Funded Capital Loan, as identified in the Economic Case and as set out in the Commercial Case.

1.5.2 A full financial assessment review of the preferred Option 4 has been carried out between the OBC and FBC stage to evaluate and determine the financial impact of the energy project schemes.

1.5.3 A summary showing the capital cost of the project and the life-cycle replacement (LCR) for the preferred Option 4 is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	**Installation Period Oct '18 to Sept '19**		**Total Capital Works**	**Total LCR**
	Oct '18 to Mar '19	**Apr'19 to Sept '19**		
	£000's	**£000's**	**£000's**	**£000's**
External Engineering Works Costs				
CHPs installation HRI and CHH sites	2,359,253	2,162,600	4,521,853	690,000
Absorption cooling and systems	242,513	565,863	808,376	231,674
Lighting retrofit	1,768,909	589,636	2,358,545	incl. in maintenance
Controls BEMS	555,520	139,380	694,900	200,000
Boiler	859,242	858,986	1,718,228	340,000
sub total External Engineering Works	**5,785,437**	**4,316,465**	**10,101,902**	**1,461,674**
Professional Fees	503,600	362,300	865,900	
sub total Capital Costs	**6,289,037**	**4,678,765**	**10,967,802**	**1,461,674**
sub total Optimism Bias (6.6%)	**290,000**	**434,600**	**724,600**	
sub total Capital Works	**6,579,037**	**5,113,365**	**11,692,402**	**1,461,674**
VAT @20% (excl. fees)	1,215,087	950,213	2,165,300	292,335
Total Capital Works (incl. VAT)	**7,794,124**	**6,063,578**	**13,857,702**	**1,754,009**

1.5.4 The preferred option is based on the assumption that the energy upgrade funding would be through a DH Capital Loan funded route. The loan term covers 25 years with the assumed interest repayments through the UK Debt Management Office of 2.71% as at 30th April 2018. The original OBC figure was 2.62%.

1.5.5 The total capital loan repayment would be £13.9m with a total loan interest payment of £4.9m. The original OBC figures were £13.7m and £4.7m respectively. The increases are due to additional CHP installation works and the increase in interest rates.

1.5.6 The technical guidance included in the HMT's Green Book has been followed in calculating the optimism bias figure for the project. This is currently 6.6% (reduced from the OBC figure of 11.05%) and has been reviewed on a scheme by scheme basis rather than a percentage risk of the capital works. This figure represents £870k (including VAT) of risk. The OBC risk figure was originally £1.4m (including VAT).

1.5.7 The risk figure will be further refined once the project schemes enter into the detailed design and tender award process. The current risk percentage of 6.6% is within the HMT's Green Book adjustment ranges for optimism bias for this particular type of project. The current risk by scheme is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	**Total Capital Works**	**Optimism Bias**
	£000's	**£000's**
External Engineering Works Costs		
CHPs installation HRI and CHH sites	4,521,853	40,000
Absorption cooling and systems	808,376	105,000
Lighting retrofit	2,358,545	180,000
Controls BEMS	694,900	40,000
Boiler	1,718,228	289,600
General		70,000
sub total External Engineering Works	**10,101,902**	**724,600**
VAT @20%	2,020,380	144,920
Total (incl.VAT)	**12,122,282**	**869,520**

1.5.8 The highest risk value is for the potential demolition and asbestos removal of the HRI boiler-house chimney.

1.5.9 A summary showing the incremental impact on the Statement of Comprehensive Net Income is shown in the table below:-

Statement of Comprehensive Income Summary							
Trust (DH Capital Loan Funded)	**Year**	**Year**	**Year**	**Year**	**Year**	**Year**	**Total**
Preferred Option 4	**1 £000's**	**2 £000's**	**3 £000's**	**4 £000's**	**5 £000's**	**6 £000's**	**26 Years £000's**
SAVINGS							
Energy Savings (incl.VAT)	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
sub total Energy Savings	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
EXPENDITURE							
Operating & Maintenance Costs	241	416	426	437	448	572	16,971
HEY In house Staffing Costs	54	93	96	98	101	103	3,145
HEY In house Non Pay Costs	33	57	59	60	62	63	1,923
Loan interest	188	364	350	335	320	306	4,882
Depreciation	272	543	543	543	543	547	14,735
Capital charges	466	446	427	407	388	369	6,200
sub total expenditure	1,254	1,920	1,901	1,880	1,861	1,960	47,856
Savings attributable to Trusts SoCI	(239)	(654)	(738)	(824)	(910)	(881)	(38,811)

1.5.10 The above table shows that the total gross savings on energy costs over the 25 year life of the project, including inflation, will be £86.7m.

1.5.11 The table also shows that the total revenue expenditure over the life of the project will be £47.9m.

1.5.12 Over the 25 years the cumulative net incremental saving (including inflation) to the Trust will be £39m.

1.6 The Management Case

1.6.1 This Section of the FBC addresses the 'achievability' of the investment in an energy infrastructure for HEY. Its purpose, therefore, is to set out the actions that would be required to ensure a successful delivery in accordance with best practice.

1.6.2 The proposed project is a core element to the success of the estate strategy for the immediate and long term vision for HEY. The proposed development programme will involve:-

- the Outline Business Case approval process
- project stakeholder engagement throughout
- potential planning applications dependent on the selected solution
- potential public consultation if necessary
- production of a loan capital financing application between OBC and FBC stages working in conjunction with NHSI
- the Full Business Case approval process
- Performance Agreement exchange
- successful scheme implementation.

1.6.3 A project management structure has been put in place with an aim to deliver this project through to operational service. The provisional timetable, dependent on capital loan approval, is:-

Activity	Key Milestones
FBC delegation of approval to Trust Performance & Finance Committee	Jul-18
Trust Board approval	Sep-18
FBC and Loan Application Submission to NHSI	Sep-18
NHSI FBC Recommendation to DoH / ITFF	end of Sep-18
DoH / ITFF Response to Loan Application	end of Oct-18
Project Design Period	May-Sep-18
Project Tender and Award Period	Jul-Oct-18
CHH & HRI Lighting Replacement	Oct-18 to May-19
CHH CHP Installation	Oct-18 to end of Sep-19
HRI CHP Replacement	Oct-18 to end of Sep-19
HRI Boiler House Replacement	Oct-18 to Sep-19
BEMS and Controls	Oct-18 to April-19
Anticipated Completion Date	end of Sep-19

1.7 Conclusions and Recommendations

Conclusions

1.7.1 The Trust believes that the existing energy infrastructure at both the HRI and CHH sites is no longer fit for purpose and is unable to adequately meet demand, that it is inefficient and will not assist the Trust in achieving key targets described in both the National and Local Strategies.

1.7.2 This FBC demonstrates that following both internal and external reviews there is an opportunity to deliver significant energy savings for HEY. By implementing the Energy Innovation Upgrade Scheme it also helps support the Trust in delivering an improved financial position.

1.7.3 The FBC proves that the preferred Option 4, DH Capital Loan funded, is both economically and financially the best investment route for the HEY Energy Innovation Upgrade Scheme.

1.7.4 The FBC clearly demonstrates that the following key investment objectives would be achieved if the capital loan was approved:-

Investment Objectives of the HEY Energy Scheme		Preferred Option 4 Delivers:
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets	Reductions in carbon emissions of 7,138 tonnes per annum
2	To reduce energy costs and create efficiency savings	Affordable and demonstrates VFM by reducing energy costs and producing cash flow net annual savings of £1m +
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.	Would reduce energy costs £/m2 by using resources in a more cost effective manner
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	Replaces ageing and outdated heat and energy plant, new and replacement CHP's and lighting upgrades. Reduces backlog maintenance by £3.5m.
5	Follows the best practice guide to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as publiished in October 2017.	Schemes support : demand reduction (lighting & boilers) / energy management (BMS) / energy generation (CHPs)
6	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	Would meet key strategic objectives of the HEY Estates Strategy 2017-2022 by providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

Recommendations

1.7.5 It is recommended that the Trust Board approves the Full Business Case for the Energy Innovation Upgrade Schemes.

1.7.6 Support the submission of the FBC and a capital loan application of £13.9m for initial external consideration by both NHSI and the Project Appraisal Unit (“PAU”) and then by the DoH/ITFF.

1.7.7 Further detail may be required by the NHSI and DoH in answer to outstanding queries to complete their FBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI/PAU and DoH/ITFF in their requests.

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.

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.

Implementing Energy Strategies in Healthcare (2017)

2.2.14 This is a best practice guide to the Model Hospital developed to assist NHS Trusts in identifying, assessing and delivering commercially viable strategic energy solutions. It is intended to provide information for Directors of Estates, Directors of Finance and their teams, as well as other senior investment decision makers with responsibility for wider Trust affairs.

2.2.15 The document stresses the importance of delivering a strategic, Trust wide energy programme with consideration given to demand reduction, energy management, energy generation, energy markets and commercial approaches.

2.2.16 Articulates the need to identify the key business drivers of the organisation. These could be to purely maximise revenue cost savings in order to support the delivery of frontline patient care. Alternatively, the Trust may wish to use the savings to leverage extra capital that can be invested in eradicating critical infrastructure and backlog maintenance risks.

2.2.17 The Guide provides a valuable source of information to assist Trusts in developing their Strategic Transformation Plans to meet the requirements set out in the NHS England Five Year Business Plan.

Carbon Reduction

2.2.18 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.

2.2.19 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.

2.2.20 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.

2.2.21 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.

2.2.22 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%).

2.2.23 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.

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:-

[3] Carbon footprint update for the NHS in England 2012, Sustainable Development Unit

- 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 67,641m^2 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.

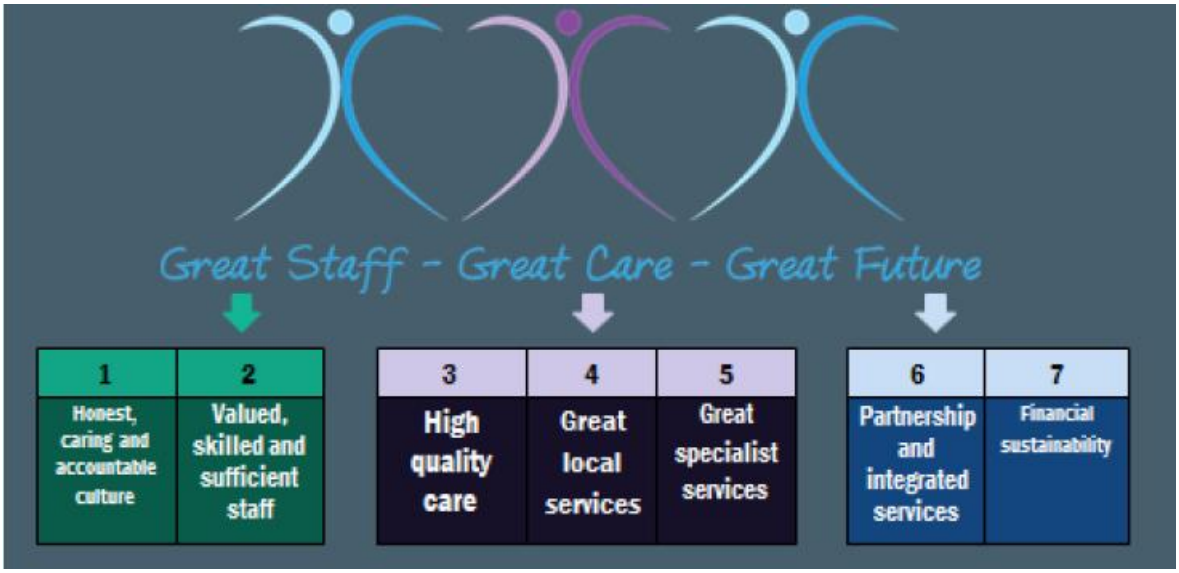
2.4.5 Hull and the East Riding are served by two separate Clinical Commissioning Groups that are largely co-terminus with their Local Authorities. The Trust provides almost all of the Hull CCG's secondary care services and around 60% of those for the East Riding of Yorkshire.

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. However, that said, this work has not been included in the financial appraisal of this business case.

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. As in the case of the Humber NHS Trust discussion this work has not been considered as part of the financial appraisal of this business case.

NLAG/ York

2.6.13 High level STP discussions are ongoing with the Directors of Estates regarding joint energy procurement and sharing sustainability resources. The energy innovation project team is also in the process of supporting the NLAG Trust with the refurbishment of the boiler-house at Goole and Scunthorpe Hospital respectively. The proposed support being provided is for Project Management duties and support with the procurement of shared similar items of plant such as CHP and boiler plant utilising the in house expertise the HEY team has. As this is still to be agreed with NLAG the proposed work has not been used as part of this business case.

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. Preliminary discussions with external leisure authorities and other Universities in the broader Yorkshire area in sharing the knowledge of the team regarding energy utilisation have started. 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. Currently it is proposed that the future of the existing clinical accommodation within the Tower Block will remain for a minimum of the next 10 years. In the meantime, the Trust will undertake a feasibility to re-provide the Tower Block wards into new purpose built clinical accommodation subject to capital funding availability. It is then proposed that once the wards eventually relocate the vacant space within the Tower Block will be re-used by the Trust for non-clinical accommodation.

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 21% from 2009/10 to 2017/18. This relates to 7,093 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 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**	**Annual %age Reduction from Baseline**
2009/10	34,417	baseline	
2010/11	34,154	(263)	-1%
2011/12	31,213	(3,204)	-9%
2012/13	33,570	(847)	-2%
2013/14	32,017	(2,400)	-7%
2014/15	32,798	(1,619)	-5%
2015/16	31,469	(2,948)	-9%
2016/17	30,098	(4,319)	-13%
2017/18	27,061	**(7,093)**	-21%
Energy Project Impact:-			
Further CO2 reduction		**(7,138)**	-21%
Total CO2 Reduction		**(14,231)**	**-41%**
CO2 Reduction Target by 2020		**(11,702)**	**-34%**

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

2.8.9 However, by investing in the energy project a further reduction of 7,138 tonnes of CO_2 can be achieved. This would put the Trust back on trajectory to deliver the nationally set targeted reduction of 11,702 tonnes of CO_2.

Trust Total Energy Consumption (kWh)

2.8.10 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)
2017/18	100	(14)

2.8.11 The figures show that whilst a reduction in consumption has been achieved from the 2009/10 baseline, with limited investment, it has remained fairly static over the last 3 years. These figures reflect the current need for HEY to seek to invest in a more efficient energy infrastructure.

Trust Total Cost of Energy

2.8.12 The table below shows the total actual energy costs for HEY from financial years 2015/16 to 2017/18 and a forecast for 2018/19.

Summary of HRI & CHH site Energy Costs from 2015/16 to 2018/19

	2015/16	2016/17	2017/18	2018/19
	Actuals £000's	Actuals £000's	Actuals £000's	Forecast £000's
Electricity	2,608	2,904	3,140	3,633
Annual %age change		11%	8%	16%
Gas	1,936	1,882	1,675	1,792
Annual %age change		-3%	-11%	7%
Total	**4,544**	**4,786**	**4,815**	**5,425**

2.8.13 The table shows that the cumulative expenditure on both gas and electricity has been steadily rising since 2015/16. The marked increase in the forecasted energy spend figure, particularly electricity, for 2018/19 is due to:-

- the impact of the EU's Industrial Emissions Directive (2016) which has seen the increased closure of many UK electricity generation plants with coal fire power stations particularly targeted to help reduce emissions in energy generation. This has reduced supply and increased buyer competition resulting in the wholesale cost of purchasing energy to also rise
- the supply of alternative sources of energy, such as wind and solar power, are still not mainstream and hence still expensive
- increased costs in supplying energy to sites
- other increases have come from government policies and taxes

2.8.14 The price rises would have been even more significant if the Trust hadn't used an energy broker to purchase and risk manage both its electricity and gas supply.

2.8.15 These figures show that by investing in new energy infrastructures there is scope for significant savings to be made. In the case of electricity some of the schemes looked at are energy self-generating with no supply to site overhead costs. Therefore, it is imperative that the Trust looks at ways of reducing its energy costs thereby contributing to improvements in the Trust's financial position and delivery of its DoH control total.

Lord Carter Benchmarking Dashboard

2.8.16 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.

2.8.17 When modelling the loan investment against the potential savings achievable under the business case the energy costs for HEY would reduce from £27.50 per m^2 to £13.46 per m^2. This represents a reduction of £14.04 per m^2.

Ageing and Obsolete Plant

2.8.18 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

2.8.19 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.

2.8.20 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 5 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) Nifes Consulting Group – updated reports (April 2018) in determining the best CHP solution for both the HRI (Appendix 3c) and CHH (Appendix 3d).

4) 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

2.10.4 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.

2.10.5 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. For example, the backlog maintenance on the HRI Boiler-house currently stands at £1.2m (excl. VAT).
- 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") and Outline Business Case ("OBC"), to proceed to Full Business Case (" FBC"), 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. The Nifes Consulting Group report looked at updating the best CHP installations for both sites. 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 Scoped Projects

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

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 £2.6m (incl. VAT) of savings down by project were quantified:-

Summary of the Energy Project Savings	FBC - Revised Saving Figures				
Capital Works Scheme	**HRI**	**CHH**	**Net**	**VAT**	**Gross**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
Combined Heat and Power Unit (CHP)	(723)	(823)	**(1,547)**	(309)	**(1,856)**
Boilers	(118)		**(118)**	(24)	**(142)**
Absorption Chiller Systems (ACS)	(65)	(66)	**(131)**	(26)	**(157)**
LED Lighting Replacement Upgrade	(124)	(88)	**(212)**	(42)	**(254)**
BMS	(88)	(50)	**(137)**	(27)	**(165)**
Total Capital Works Scheme Savings	**(1,118)**	**(1,027)**	**(2,145)**	**(429)**	**(2,574)**

3.2.5 The long list of options in the table below was generated by the ESPT with additional input from stakeholders and technical specialists.

3.2.6 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.
9	SALIX Loan; HRI **or** CHH sites only	Trust investment , with the support of a SALIX finance loan; operated and maintained by a mix of HEY staff and external contractors.
10	SALIX Loan; HRI **and** CHH sites **combined**	Trust investment , with the support of a SALIX finance loan; operated and maintained by a mix of HEY staff and external contractors.

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 and which are predicated upon the HM Treasury's "Five Case Model".

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 below:-

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	Option 9	Option 10
Critical Success Factors		Do Nothing	Do Minimum	DH Loan HRI or CHH	DH Loan HRI & CHH	3rd Party HRI or CHH	3rd Party HRI and CHH	DH/3rd Party HRI or CHH	DH/3rd Party HRI & CHH	SALIX Loan HRI or CHH	SALIX Loan HRI & CHH
1	Strategic Fit & Business Needs	0.0	6.3	12.5	25.0	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	8.0	8.0
3	Potential Achievability	1.5	1.5	14.3	14.3	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	9.5	9.5
5	Potential Affordability	1.0	1.0	7.5	7.5	9.0	9.5	7.5	7.5	0.0	0.0
Total Weighted Score		**3.5**	**13.8**	**61.8**	**92.3**	**55.3**	**78.3**	**59.8**	**82.3**	**44.3**	**56.8**
Ranking		10	**9**	4	**1**	7	**3**	5	**2**	8	6

SALIX Finance Model

3.4.2 Included in the long list of options is the additional SALIX loan finance (options 9&10) as well as the CEF third party options. SALIX finance is a not-for-profit company funded by the Department of Energy and Climate Change and the Welsh and Scottish Governments to remove the barrier of significant upfront capital cost for public sector organisations wanting to invest in energy efficient technologies. SALIX provides interest-free loans to enable projects that fall within their compliance criteria, mainly that returns on investment and carbon savings must be proven to be achievable within a stipulated time period.

Having met and discussed directly with SALIX representatives, the loan criteria and compliance was explained in detail to the Trust and consisted of the following:-

- Schemes must be new, not required by legislation and must pay for themselves from energy savings within a maximum 5 years.
- The cost of carbon dioxide equivalent must be less than £120 per tonne over the lifetime of the scheme.
- The loan is payable at the end of the project, which must be completed within 9 months from the “commitment” date.
- The loan is repaid by the Trust in instalments over 5 years, effectively reducing the Trust capital programme by this value over the repayment period.
- Used for projects that involve saving in one fuel type and technology changing.

The Trust scheme options have been assessed by SALIX using their developed project tool application templates and populated by information supplied by the Trust, and validated by SALIX, with regards to anticipated financial and carbon savings.

The table below is a summary of the SALIX modelled options which show the results of the considered schemes:-

Salix Finance						
Scheme Options	**Total Financial Savings**	**Payback in Years**	**Total tCO_2e pa**	**Total tCO_2e LT**	**£/tCO_2e LT**	**Compliancy**
HRI and CHH sites	£2,205,580	5.51	6,288.08	84,025.42	£144.63	Non-Compliant
HRI site only	£1,132,594	5.20	3,116.75	41,615.77	£141.47	Non-Compliant
CHH site only	£1,072,985	5.84	3,171.33	42,409.64	£147.73	Non-Compliant

Note:-
The options all cover the installation of LED lighting, CHP installation and BMS as these generate the largest savings.
Excluded is the HRI boiler plant as its 10+ years payback would skew the other project scheme options.
Only HRI and CHH site related schemes have been considered.

Key:-

tCO_2e pa	Tonnes carbon dioxide equivalent saving per annum
tCO_2e LT	Tonnes carbon dioxide equivalent savings life time
£/tCO_2e LT	Cost per tonne carbon dioxide equivalent saving life time

Main Project Criteria:-
1. The project must pay for itself from energy savings within a maximum **5** year period.
2. The cost of carbon dioxide equivalent must be less than **£120** per tonne over the lifetime of the project.

Please note that the HRI boiler scheme was excluded due to its 10+ year's payback. The figures that therefore appear in the business case were an attempt to see if the scheme option appraisals could pass the tests excluding the HRI boilers, which unfortunately they cannot.

3.4.3 The minimum four short-listed options being considered for further evaluation include:-

- **Option 2: Do minimum** – must be included despite being ranked 9 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.

3.4.4 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.

3.4.5 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.

3.4.6 Options 9 and 10 – SALIX finance loan were discounted as both schemes do not deliver the strategic Trust wide energy innovation upgrade programme and neither the full loan criteria nor compliance elements mentioned under 3.4.2.

3.4.7 Options 9 and 10 - do not meet the key business driver in maximising the delivery and benefits of immediate Trust cost efficiency savings from Year 1 due to the conditional 5 year payback required on the loan.

3.4.8 Options 9 and 10 have the potential, depending on how the SALIX loan would be paid back, to impact on the Trusts already limited internal capital resource availability.

3.4.9 Standalone schemes considered by the Trust included the HRI boilers replacement and the installation of the CHP plant at CHH and HRI. Unfortunately, when both standalone projects were modelled, the schemes either failed to meet the 5 year payback period and carbon dioxide equivalent of £120 per tonne or required additional funding support due to the interdependencies required to maximise the energy efficiencies and savings ie the CHP and absorption chiller installation.

3.4.10 Option 4 would deliver a proposed technical solution and strategic Trust wide energy programme, financed through a DH Capital Loan Facility. This option would also meet a key business driver in **maximising** revenue cost savings in order to support the delivery of frontline patient care.

3.4.11 Options 6 and 8 would deliver a proposed technical solution through an Energy Services Performance Agreement ("PA") with a preferred supplier and either financed with 3rd party private funding or a DH Capital Loan routed through the PA. These options include the implementation, operation and maintenance needs of the Trust's energy infrastructure.

3.4.12 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.

3.4.13 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 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 3.2.3 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

Narrative	Option 2 Do Minimum	Option 4 Trust / DH Capital Loan	Option 6 3rd Party / CEF Framework	Option 8 Trust / DH Capital Loan / CEF Managed
	£000's	£000's	£000's	£000's
Capital Works	2,043	11,692	0	12,909
Life cycle replacement	374	1,497	0	0
Revenue	1,875	15,753	0	0
Unitary payment			44,249	22,598
Total costs	**4,292**	**28,942**	**44,249**	**35,507**
Savings over 25 years	(2,950)	(53,625)	(47,520)	(47,520)
Discount Factor (time value of money)	3.50%	3.50%	3.50%	3.50%
Net present value profit (+) / loss (-)	(1,576)	12,078	2,120	3,243
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 capital loan investment will be made.

3.5.18 Option 2 delivers a negative net present value which means no return on the capital loan investment will be made.

3.5.19 Option 4 delivers the highest return on the capital loan 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	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	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. This is mainly due to the fact that the Trust would be able to retain and use the in house expertise and knowledge needed to respond to having greater resilience and the ability to influence and respond locally to any changes in consumption levels (benefit criteria 2). Also having greater flexibility when it comes to delivering strategic changes is also important without the penalties and constraints associated with a 3rd Party contract (benefit criteria 5).

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 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	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 is 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	(1,576)	12,078	2,120	3,243
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 Project breakdown:
1	The replacement of the combined CHP plant for HRI inclusive of a new absorption chiller system.
2	A new CHP plant for CHH inclusive of a new absorption chiller system.
3	Replacement of ageing and obsolete boiler plant at HRI
4	LED lighting replacement and upgrading of fittings at HRI
5	LED lighting replacement and upgrading of fittings at CHH
6	Installation and integration of a Building Management System at both HRI and CHH

3.9.4 Option 4 delivers the highest NPV which represents the highest rate of return on the capital loan investment and maximisation of savings.

3.9.5 Helps deliver the strategic, Trust wide energy programme with consideration given to demand reduction, energy management, energy generation, energy markets and commercial approaches.

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 are followed, as appropriately required.

4.3 Scope

4.3.1 **T**he Trust has decided to pursue a 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.
- Installation and integration of a building management system at both HRI and CHH.

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 project agreement.

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 for the main items of plant/boilers which will involve the following stages:-

[4] 2015 No 102 Public Procurement. The Public Contract Regulations 2015. Para 6

- 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.

- Fee bid for mechanical and electrical enabling design. Once in place it is likely that this role will supersede the technical advisor role due to the amount of shared service outputs.

- Expressions of interest and completion of approved PQQ[2] for design build Contractor for boilers and associated plant.

- Design period for mechanical and electrical enabling tasks.

- PQQ assessment and evaluation for design build contractor for boilers and associated plant.

- Invitation to Tender (ITT) for design build contractor for boilers and associated plant.

- Invitation to Tender (ITT) for mechanical and electrical enabling works package.

- Tender evaluation for design build contractor for boilers and associated plant.

- Tender evaluation for the design build contractor for mechanical and electrical enabling works package.

4.4.2 Design-Build approach gives the Trust a single point of contact for the main items of plant such as the boilers and ancillaries. 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.

4.4.3 Elements of this scheme have interdependencies between the boilers installation and the CHP installation such as the connection of gas, feed water and use of low grade waste heat. As such it is planned to take a traditional approach to this issue by conducting a traditional design package which will ensure such interdependencies are taken into account and designed for accordingly.

Combined Heat and Power (CHP) Replacement at HRI and New CHP at CHH

4.4.4 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.

- Fee bid for mechanical and electrical enabling design. Once in place it is likely that this role will supersede the technical advisor role due to the amount of shared service outputs.

- Expressions of interest and completion of approved PQQ[3] for Design Build Contractor for the CHP and associated plant.

- Design period for mechanical and electrical enabling tasks.

- PQQ Assessment and Evaluation for Design Build Contractor for the CHP and associated plant.

- Invitation to Tender (ITT) for Design Build Contractor for the CHP and associated plant.

- Invitation to Tender (ITT) for the mechanical and electrical enabling works package.

- Tender evaluation for Design Build Contractor for CHP and associated plant.

- Tender evaluation for the Design and Build for the mechanical and electrical enabling works package.

4.4.5 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

4.4.6 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 schedule of fittings and assisting Trust in development and review of tender evaluation.

- Expressions of Interest and completion of approved PQQ[5] for lighting manufacturers.

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- PQQ Assessment and Evaluation

- Invitation to Tender

- Tender Evaluation

- Appointment upon Approval of FBC

[5] PAS 2013

4.4.7 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.

4.4.8 Lighting is replaced routinely on Capital led projects and as such the interest from the local supply chain of contractors is strong.

4.4.9 BMS is replaced routinely on Capital led projects and as such the interest from the local supply chain of contractors is strong.

4.4.10 In summary the procurement strategy for each individual sub task is as follows:-

- HRI Boiler Replacement - Two stages tender Design and Build, from a restricted and Competitive procedure. Traditional single stage tender for the enabling works package.
- CHH CHP and Absorption Chiller – Two stages tender Design, Build and Maintain, from a restricted and Competitive procedure. Traditional single stage tender for the enabling works package.
- HRI CHP and Absorption Chiller – Two stages tender Design, Build and Maintain, from a restricted and Competitive procedure. Traditional single stage tender for the enabling works package.
- HRI LED Lighting replacement – Traditional two stages tender from a Competitive and Innovation Partnership procedure. Traditional single stage tender for the installation package.
- CHH LED Lighting replacement – Traditional two stages tender from a Competitive and Innovation Partnership procedure. Traditional single stage tender for the installation package.
- BMS to BEMS upgrade – traditional single stage tender for the installation package of works.

Pre-Qualifying Questionnaire ("PQQ")

4.4.11 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.

4.4.12 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

4.4.13 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.

4.4.14 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.

4.4.15 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

4.4.16 When ready, the Project Team will release its Invitation to Tender (ITT) to the bidders.

4.4.17 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)

4.4.18 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

4.4.19 The operational phase is subdivided for each project as follows:-

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- 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. It is anticipated low level maintenance such as daily checks will be carried out by the Estates Department, to allow the Trust to have a more flexible and cost effective approach to maintenance of the CHP units.

- 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. As in the case of the HRI CHP it is anticipated low level maintenance such as daily checks will be carried out by the Estates Department, to allow the Trust to have a more flexible and cost effective approach to maintenance of the CHP units.

- 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 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. All site changes must be fully compliant with current regulations and processes. A key risk identified and allowed for in the risk register is the issue around whether the HRI boiler chimney is to be retained or demolished.

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. Initially, these risks have been accounted for in the risk register.

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 FBC.

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).

4.8.2 The Business Case also gives due consideration to the introduction of IFRS 16 *Leases* from January 2019 by the International Accounting Standards Board (IASB). IFRS 16 sets out the principles for the recognition, measurement, presentation and disclosure of leases for both parties to a contract, ie the customer ('lessee') and supplier ('lessor').

4.8.3 IFRS 16 eliminates the classification of leases as either operating leases ('off balance sheet') or finance leases ('on balance sheet') for a lessee. Instead all leases are treated in a similar way to finance leases, being 'on balance sheet', applying IAS 17.

4.8.4 The CEF model used in this FBC is treated currently as an operating lease and thus 'off balance sheet'.

4.8.5 In May 2018 HM Treasury issued an Exposure Draft 18 (01) with regards to IFRS 16 *Leases* with an invitation to comment on the proposed amendments.

4.8.6 HM Treasury currently expects the new Standard to be applied in central government from 1st April 2019.

4.8.7 The introduction of IFRS 16 *Leases* applies to both new and currently existing operating leases.

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 calculated through 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 20117/18 financial year the Trust reported a deficit of £7.1m. This was supported by funding of £7.9m through the Sustainability and Transformation Fund. 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's financial plan for 2018/19 is to deliver a surplus of £2.4m which includes £12.6m of income from the Provider Sustainability Fund. The forecast outturn for the year at the end of June 2018 is that the Trust will deliver its plan, but this will require achievement of the £19.9m efficiency programme which, although currently on track, the programme is weighted towards the latter half of the year and therefore poses a significant challenge. 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 The following table provides a Summary of Key Financial Data for 2017/18 actual, 2018/19 plan and the 2018/19 forecast:-

	Actual 2017/18	Forecast 2018/19	Plan 2018/19 at Q1
Key Data			
Surplus (£m)	-7.1	2.4	2.4
Efficiencies (£m)	12.3	19.9	19.9
Capital Expenditure (£m)	19.0	36.0	36.0
Cash at End of Period (£m)	1.7	3.2	3.2
Risk Rating Year End			
Capital Service Cover	4	3	3
Liquidity	4	4	4
I&E Margin	4	2	2
Variance from Control Total	3	1	1
Agency Rating	2	1	2
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 Oct '18 to Sept '19		Total Capital Works	Total LCR
	Oct '18 to Mar '19	Apr'19 to Sept '19		
	£000's	£000's	£000's	£000's
External Engineering Works Costs				
CHPs installation HRI and CHH sites	2,359,253	2,162,600	4,521,853	690,000
Absorption cooling and systems	242,513	565,863	808,376	231,674
Lighting retrofit	1,768,909	589,636	2,358,545	incl. in maintenance
Controls BEMS	555,520	139,380	694,900	200,000
Boiler	859,242	858,986	1,718,228	340,000
sub total External Engineering Works	**5,785,437**	**4,316,465**	**10,101,902**	**1,461,674**
Professional Fees	503,600	362,300	865,900	
sub total Capital Costs	**6,289,037**	**4,678,765**	**10,967,802**	**1,461,674**
sub total Optimism Bias (6.6%)	**290,000**	**434,600**	**724,600**	
sub total Capital Works	**6,579,037**	**5,113,365**	**11,692,402**	**1,461,674**
VAT @20% (excl. fees)	1,215,087	950,213	2,165,300	292,335
Total Capital Works (incl. VAT)	**7,794,124**	**6,063,578**	**13,857,702**	**1,754,009**

5.3.2 The preferred option is based on the assumption that the energy innovation upgrade funding would be through a DH Capital Loan funded route. The loan term covers 25 years with the loan interest rate repayments calculated through the UK Debt Management Office. The loan interest rate used is 2.71% as at 30th April 2018. The original OBC figure used for the loan interest rate was 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 capital loan repayment would £13.9m with a total loan interest payment of £4.9m. The original OBC figures were £13.7m and £4.7m respectively. The increases are due to additional CHP installation works and the increase in interest rates.

5.3.5 The life cycle replacement ("LCR") of the assets is £1.8m 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 6.6% (reduced from the OBC figure of 11.05%) and has been reviewed on a scheme by scheme basis rather than a percentage risk of the capital works. This figure represents £870k (including VAT) of risk. The OBC risk figure was originally £1.4m (including VAT).

5.3.7 The risk figure will be further refined once the project schemes enter into the detailed design and tender award process. The current risk percentage of 6.6% is within the HMT's Green Book adjustment ranges for optimism bias for this particular type of project. The current risk by scheme is shown in the table below:-

Option 4 : Trust both sites with DH Capital Loan Support	**Total Capital Works**	**Optimism Bias**
	£000's	**£000's**
External Engineering Works Costs		
CHPs installation HRI and CHH sites	4,521,853	40,000
Absorption cooling and systems	808,376	105,000
Lighting retrofit	2,358,545	180,000
Controls BEMS	694,900	40,000
Boiler	1,718,228	289,600
General		70,000
sub total External Engineering Works	**10,101,902**	**724,600**
VAT @20%	2,020,380	144,920
Total (incl.VAT)	**12,122,282**	**869,520**

5.3.8 The highest risk value is for the potential demolition and asbestos removal of the HRI boiler-house chimney.

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, at the time the OBC was written it was 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.

5.4.2 The effect of energy prices in 2018/19, particularly electricity, has been referenced under 1.1.4 of this document. Whilst gas prices have steadied electricity prices have risen by 16%.

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 as well as the LED lighting replacements and repairs. 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 first full year annual revenue costs are shown in the table below:

Annual Revenue Costs (taken from Year 2 FYE SoCI)	**Full Year £000's**
Annual OP & maintenance	416
HEY Estates support - staffing	33
HEY Estates support - non pay	58
Energy Performance Contracts Manager	60
Total revenue costs per annum	**567**

5.5.2 The above revenue costs per annum of £567k have been indexed linked for future years.

5.5.3 The LED lighting life cycle replacement is factored in from year 6 at a cost of £109k per annum which is over and above the £550k figure.

5.5.4 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 £2.6m saving (incl. 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 FBC. 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 Income (SoCI)

5.8.1 A summary showing the incremental impact on the Statement of Comprehensive Income is shown in the table below:-

Statement of Comprehensive Income Summary							
Trust (DH Capital Loan Funded) **Preferred Option 4**	**Year 1 £000's**	**Year 2 £000's**	**Year 3 £000's**	**Year 4 £000's**	**Year 5 £000's**	**Year 6 £000's**	**Total 26 Years £000's**
SAVINGS							
Energy Savings (incl.VAT)	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
sub total Energy Savings	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
EXPENDITURE							
Operating & Maintenance Costs	241	416	426	437	448	572	16,971
HEY In house Staffing Costs	54	93	96	98	101	103	3,145
HEY In house Non Pay Costs	33	57	59	60	62	63	1,923
Loan interest	188	364	350	335	320	306	4,882
Depreciation	272	543	543	543	543	547	14,735
Capital charges	466	446	427	407	388	369	6,200
sub total expenditure	1,254	1,920	1,901	1,880	1,861	1,960	47,856
Savings attributable to Trusts SoCI	(239)	(654)	(738)	(824)	(910)	(881)	(38,811)

5.8.2 The table shows that the total gross savings over the life of the project will be £86.7m.

5.8.3 The table also shows that the total expenditure over the life of the project will be £47.9m.

5.8.4 Over the 25 years the net incremental saving to the Trust will be £39m.

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) **Preferred Option 4**	**Year 1 £000's**	**Year 2 £000's**	**Year 3 £000's**	**Year 4 £000's**	**Year 5 £000's**	**Year 6 £000's**	**Total 25 Years £000's**
Fixed Assets							
Opening balance	13,857	13,585	13,042	12,498	11,955	11,412	205,063
Additions (incl. VAT)	0	0	0	0	0	24	1,754
Depreciation	(272)	(543)	(543)	(543)	(543)	(547)	(14,735)
Closing balance	13,585	13,042	12,498	11,955	11,412	10,889	192,083
Current Liabilities							
Opening balance	(13,857)	(13,585)	(13,042)	(12,498)	(11,955)	(11,411)	(190,462)
Capital loan repayment	272	543	543	543	543	543	13,857
Closing balance	(13,585)	(13,042)	(12,498)	(11,955)	(11,411)	(10,868)	(176,605)
Impact on Assests / (Liabilities)	**0**	**0**	**0**	**0**	**0**	**21**	**15,478**
Cumulative cash impact							
Net cash savings benefit	239	654	738	824	910	861	37,935
Net impact on Balance Sheet	**239**	**654**	**738**	**824**	**911**	**881**	**53,413**

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 below:-

Summary Impact on the Statement of Cash Flows							
Trust (DH Capital Loan Funded) **Preferred Option 4**	**Year 1 £000's**	**Year 2 £000's**	**Year 3 £000's**	**Year 4 £000's**	**Year 5 £000's**	**Year 6 £000's**	**Total 26 Years £000's**
Capital Costs							
Total Capital Works	13,857						13,857
DH Capital Loan Funding	(13,857)						(13,857)
Life Cycle Costs	0	0	0	0	0	24	1,754
Operating & Maintenance Costs	241	416	426	437	448	572	16,327
HEY In house Staffing Costs	54	93	96	98	101	103	3,145
HEY In house Non Pay Costs	33	57	59	60	62	63	1,923
PDC Dividends	466	446	427	407	388	369	6,200
Loan Capital Repayment	272	543	543	543	543	543	13,857
Loan Interest	188	364	350	335	320	306	4,882
sub total Capital Costs	1,254	1,920	1,901	1,880	1,861	1,980	48,732
Savings							
Energy Savings	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
sub total Energy Savings	(1,493)	(2,574)	(2,638)	(2,704)	(2,772)	(2,841)	(86,667)
Cumulative Impact on Cash Flow	**(239)**	**(654)**	**(738)**	**(824)**	**(910)**	**(861)**	**(37,935)**

5.10.2 The table shows that the cumulative impact on the cash flow will be a £37.9m 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 £86.7m as per the SoCI. The costs associated with its implementation of £47.9m are more than covered by these savings.

5.11.2 The scheme is therefore affordable and the surplus saving of £39m would contribute in helping the Trust achieve its required year on year efficiency target and help stay within its control total.

5.11.3 In order to progress with the Energy Scheme a DH Capital Loan of £13.9m (incl.VAT) would need to be approved.

5.12 Commissioner Support

5.12.1 The letter of Commissioner Support is attached as Appendix 15. NHS Hull and NHS East Riding of Yorkshire CCG have jointly written to confirm support to the proposed £13.9m loan application required to fund the energy infrastructure design and upgrade for both the HRI and CHH sites.

6 MANAGEMENT CASE

6.1 Introduction

6.1.1 This Section of the FBC 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	Key Milestones
FBC delegation of approval to Trust Performance & Finance Committee	Jul-18
Trust Board approval	Sep-18
FBC and Loan Application Submission to NHSI	Sep-18
NHSI FBC Recommendation to DoH / ITFF	end of Sep-18
DoH / ITFF Response to Loan Application	end of Oct-18
Project Design Period	May-Sep-18
Project Tender and Award Period	Jul-Oct-18
CHH & HRI Lighting Replacement	Oct-18 to May-19
CHH CHP Installation	Oct-18 to end of Sep-19
HRI CHP Replacement	Oct-18 to end of Sep-19
HRI Boiler House Replacement	Oct-18 to Sep-19
BEMS and Controls	Oct-18 to April-19
Anticipated Completion Date	end of Sep-19

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 to 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 SPM would be responsible for the entire day to day liaison with third parties eg CDM Planning Co-ordinator; Technical Adviser and Independent Certifier.

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.

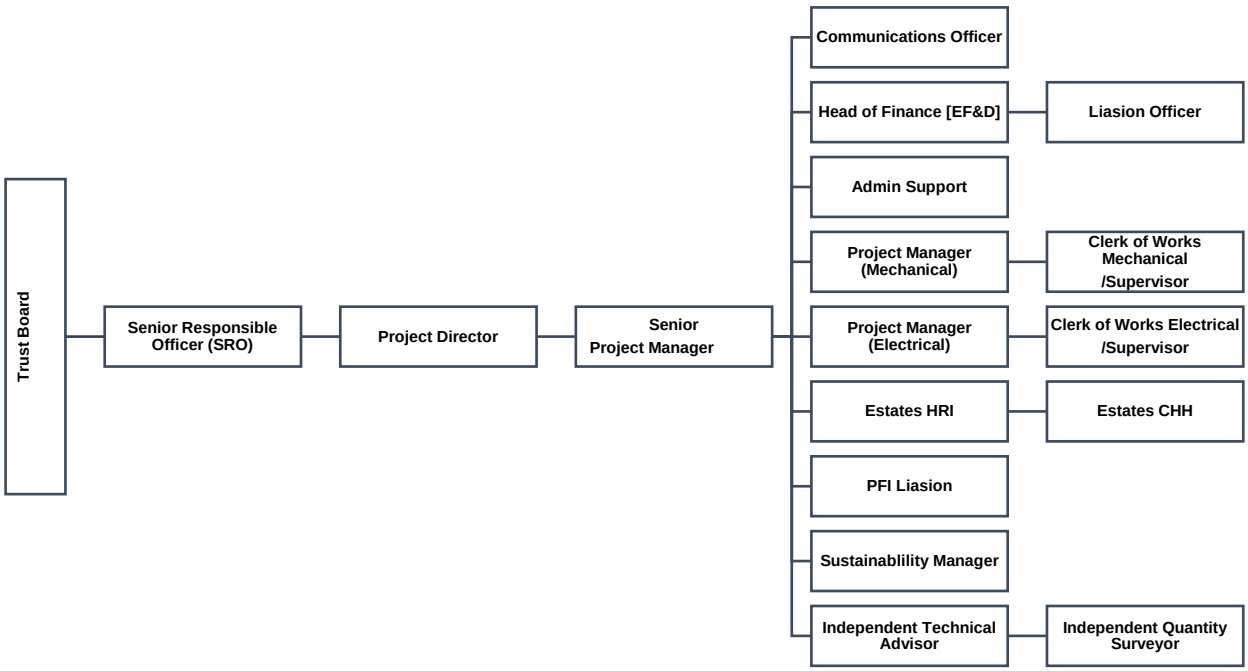
6.8.3 From the outset of a project, the preferred bidders would clearly understand the project needs, and would add maximum value to the proposed solution.

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 FBC.

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. Following the approval of the OBC and subsequent FBC now awaiting approval 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 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.

7.1.2 This FBC demonstrates that following both internal and external reviews there is an opportunity to deliver significant savings for HEY. By implementing the Energy Innovation Upgrade Scheme it also helps support the Trust in maximising efficiencies in delivering an improved financial position.

7.1.3 The FBC 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 Upgrade Scheme.

7.1.4 The FBC clearly demonstrates that the following key investment objectives would be achieved if the capital finance loan was approved:

Investment Objectives of the HEY Energy Scheme		Preferred Option 4 Delivers:
1	Working towards achieving compliance with the 2020 target carbon emissions reductions of 34% as set out by UK Government Targets	Reductions in carbon emissions of 7,138 tonnes per annum
2	To reduce energy costs and create efficiency savings	Affordable and demonstrates VFM by reducing energy costs and producing cash flow net annual savings of £1m +
3	Contribute to the vision set out by Lord Carter in his report 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' published in February 2016.	Would reduce energy costs £/m2 by using resources in a more cost effective manner
4	Acting on the recommendations of the Naylor Report of March 2017 in reducing backlog maintenance.	Replaces ageing and outdated heat and energy plant, new and replacement CHP's and lighting upgrades. Reduces backlog maintenance by £3.5m.
5	Follows the best practice guide to the Model Hospital in "Implementing Energy Strategies in Healthcare Estates" as publiished in October 2017.	Schemes support : demand reduction (lighting & boilers) / energy management (BMS) / energy generation (CHPs)
6	Meet the key strategic objectives of the HEY Estates Strategy through long term sustainable development.	Would meet key strategic objectives of the HEY Estates Strategy 2017-2022 by providing and operating fit for purpose, safe and high quality facilities at affordable costs for our local population

7.2 Recommendations

7.2.1 It is recommended that the Trust Board approves the Full Business Case for the Energy Innovation Upgrade Schemes.

7.2.2 Support the submission of the FBC and a capital loan application of £13.9m for initial external consideration by both NHSI and the Project Appraisal Unit (“PAU”) and then by the DoH/ITFF.

7.2.3 Further detail may be required by the NHSI and DoH in answer to outstanding queries to complete their FBC decision making process. We ask the Trust Board to approve continued liaison with the NHSI/PAU and DoH/ITFF in their requests.

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 (b) Sinclair Knight Merz, (c) & (d) Nifes Consulting Group 2.10.1, points 1, 2 and 3.

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, 3.4.13

8.6 **Appendix 6**, NPV Appraisals of Short Listed Options, 3.5.20

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), 5.5.4

8.12 **Appendix 12**, Statement of Comprehensive Income (SoCI), 5.8.5

8.13 **Appendix 13**, Statement of Financial Position (SoFP), 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, 5.12.1

8.16 **Appendix 16**, Management Control Plan, 6.2.2

8.17 **Appendix 17**, Project Risk Register, 6.12.1

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

11 SEPTEMBER 2018

Title:	People Strategy 2016-18 Progress Report
Responsible Director:	Simon Nearney Director of Workforce and OD
Author:	Simon Nearney Director of Workforce and OD

Purpose:	The purpose of the report is to update the Trust Board on key workforce issues and performance for the period up to 31 July 2018.	
BAF Risk:	Board Assurance Framework Goal 1 and 2	
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	✓
Key Summary of Issues:	The paper is a summary of the key workforce issues that have been developed and progressed by the Workforce Transformation Committee.	

Recommendation:	The Trust Board is requested to note the content of the report and provide any feedback.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

TUESDAY 11 SEPTEMBER 2018

PEOPLE STRATEGY 2016-18 PROGRESS REPORT

1. PURPOSE OF THE REPORT

To provide the Trust Board with an update on key workforce issues and performance for the period up to and including 31 July, 2018.

2. BACKGROUND

The Trust employs 8,898 staff and therefore it is essential that this resource is effectively recruited, managed, engaged and developed to provide great services to our patients and their families.

The Trust has a People Strategy 2016 – 18 which sets out the vision for our workforce. It outlines how Hull and East Yorkshire Hospitals NHS Trust working with partners plans to manage and develop our workforce in order to deliver the Trust's vision, values and priorities as set out in the Trust Strategy 2016-21.

The Strategy covers 7 strategic workforce themes. Underneath each theme are set actions which form part of the People Strategy programme plan for 2017-18 which is led and managed by the Workforce Transformation Committee. The 7 themes are:-

- Recruitment and retention of staff
- Leadership capacity and capability
- Innovation, learning and development
- Equality and Diversity
- Health and wellbeing
- Employee engagement, communication and recognition
- Modernising the way we work

A key focus of the strategy is cultural transformation and because of the importance of this agenda a separate report is presented at Trust Board on a quarterly basis. The People Strategy will be reviewed later in 2018 and refreshed for 2019 and beyond.

3. PROGRESS UPDATE

The Board receive a progress report on key people management issues and performance against workforce KPI's every 6 months. From January, 2018 Workforce and OD, together with the Workforce Transformation Committee have delivered and are progressing the following:-

4. RECRUITMENT AND RETENTION OF STAFF

4.1 University Nurse Recruitment

Through the Trust's Remarkable People Extraordinary Place campaign employed 133 nurses in October, 2017. A further 115 student nurses (adult branch) have been interviewed in February and March 2018 and will be commencing October 2018. Up to 9 Children nurses will also be commencing in October, 2018. The Trust has also been able to recruit additional experienced nurses through our Remarkable People campaign. The Trust has also agreed to fund a Recruitment Manager to develop HEY's brand, materials, adverts and establish contacts with agencies to fill our hard to recruit to posts.

4.2 International Nurse Recruitment

HR and nurse managers have interviewed over 100 Philippine nurses who have 2 years post qualifying experience and have a good standard of English. A total of 24 Philippine

nurses have passed their OSCE, have their PIN and are now fully registered nurses on our wards and in theatres. A further 3 are booked to take their OSCE exam on the 4th September. A further 6 Philippine nurses commenced with HEY in August, 2018 with a further 7 waiting for visas.

In addition the Trust is using Recruitment / Head Hunting firms to target specific medical posts, and whilst it is having results this is not at consultant level. However the Trust has had positive discussions with the College of Physicians and Surgeons, Pakistan (CPSP) and in summary the Trust is entering into an international partnership with CPSP to enable HEY to bring over up to 40 doctors in a range of specialities. A Memorandum of Understanding is being finalised with a view to commencing the programme early next year. A similar programme is being developed with a University Hospital in India.

4.3 Apprenticeship Programme

Over 200 members of staff are working to an apprenticeship standard in a wide range of services (Pharmacy, Nutrition, Business Administration, Physiotherapy, Estates, Pathology, Mortuary etc). 93% of our apprentices secure employment or a place within higher or further education. Since the introduction of the Apprenticeship Levy (April 2017), over 100 apprenticeships have commenced, which demonstrates a committed investment of over £1m so far. In addition to the already established Nurse Associate programme, 15 Nurse Apprenticeships will commence in September, 2018. The Trust will have a cohort of Nurse Associates and Apprentices that will start every year. HEY, with the University of Hull is one of the first Trust's in the country to develop a Nurse Apprenticeship programme. The Trust has also launched an apprentice Health Care Support Worker for young people in partnership with Hull College, who will study part-time for a Health and Social care qualification which will enable them to progress on to the nurse apprentice programme. 15 people will commence the programme in September, 2018

4.4 Workforce demand and supply

The Trust regularly analyses and debates current and future workforce requirements. It also examines turnover rates and exit interview feedback to try and reduce staff leaving; and whilst the Trust has secured nurses and midwives, doctors, radiographers pharmacists, physiotherapists and other support staff; national supply is insufficient to satisfy current demand. In an attempt to bridge the gap, the Trust has developed and implemented a range of new roles such as Nutritionist, Recreational Assistants, Discharge Assistants, Patient Trackers, increased the scope of Ward Administrators and has 36 Advanced Clinical Practitioners either completed their training or in training to cover Junior Doctor shortfalls. A further 12 ACP's will commence the programme in September, 2018. The Trust has also offered posts to employ 10 Physician Associates to commence employment from October 2018. These new roles from Hull & York Medical School will be on a two year preceptorship. The Trust does have a range of recruitment difficulties particularly in nursing and the medical workforce within Theatres, Elderly, Acute Medicine, ED, Radiology, Paediatric Surgery, Haematology, Oncology, ICU, Anaesthetics and Pathology. Through better theatre scheduling and recruitment of ODP's, the Trust will have 1.5 wte ODP vacancies in September, 2018.

5. LEADERSHIP CAPACITY AND CAPABILITY

5.1 Leadership programme

The focus for 18/19 has been on highlighting the need for great people management and the impact it can have on our staff when it is not done well. This theme has been strongly reflected in our Annual Staff Survey results (2017) alongside our quarterly staff FFT results. Three key programmes of activity are in place for 18/19:

- Chief Executive Cultural Briefings – Focus on People, Engagement and Role Modelling – All band 7's and above to attend with line management responsibilities
    - 400 senior managers attended through May, June and July
    - 1 further session scheduled for Autumn 2018 to pick up those who did not attend

- "What's it like to be managed by me" – All Band 6's and below ½ day course on people management
    - Over 100 people have attended the programme
    - A further 7 sessions are available through HEY24/7 and will be advertised regularly to ensure target participants attend
- Remarkable People Management Programme (Pilot) 9 month programme supporting leaders in some of our more challenging areas of the Trust (Begins October 2019 with a cohort of 15 participants). Engagement from Health Groups and Directorates has been excellent and critical to getting the programme off the ground.

The Trust is also introducing a specific programme for Supervisory and Team Leader level posts after receiving feedback these roles do not always associate "Leadership Programmes" as something they can access. The supervisors programme will commence this month.

The Bitesize Leadership programme which runs content that repeats every quarter based on the 9 dimensions of the NHS Leadership Model has run successfully throughout 17/18 and has seen over 700 people access leadership and personal development. Some access one-off sessions and others have used it to slowly build up their portfolio of skills across a number of sessions. The success of this programme continues and all courses are well attended and rated highly. Some of the most popular sessions are Insights Discovery Manager as Coach. The Trust is reviewing the bitesize programme in Quarter 3 18/19 to address identified gaps, cease courses that have few attendees and expand the most popular courses.

5.2 Medical Leadership

A programme for our current Clinical Leads is in consultation with our Medical Directors for sign off and will run throughout 18/19 and 19/20 to incorporate all our Clinical Leads/Directors to support them in their medical manager roles. This will be based on the five agreed areas of clinical leads responsibilities around People Management, Governance, Performance, Resource Management and Education and Research.

5.3 Coaching and Mentorship

The HEY Coaching and Mentoring Network has officially launched and currently has 15 accredited coaches, 14 more began their training March 2018 and a further 12 will begin training in Autumn 2018. A number of leadership mentors have been trained from Director level to more operational/clinical roles but we need more mentors in place to meet demand. We will be working in partnership with Hull University Business School to recruit and train mentors who will support our 12 staff currently undertaking their Chartered Management Degree Apprenticeship. We plan to have this in place by September 2018.

An extended 3 day Manager as Coach Programme has been developed into a more extensive programme beyond the current 1 day introduction. This will be launched in Autumn 2018 and is aimed at leaders who may not want to become an accredited coach but want to ensure they incorporate a coaching approach to their style of management.

5.4 Specific OD interventions

The OD team continues to use Discovery Insights with many different clinical and non-clinical teams across the Trust, improving team dynamics and enabling services to build on past successes with a clear focus on their service goals moving forward. It should be noted that there has been a significant increase in the demand for bespoke work with team with the themes emerging around team effectiveness connected to conflict and poor behaviours.

5.5 Values Based Recruitment (VBR)

The Trust has introduced VBR for posts within the Trust for all non-medical staff and ensuring they match our values. A recent review has shown that we need to ensure that all those who need to access VBR are doing so and receive the support to do so at the point of recruitment. The report will be complete with recommendation at the end of August 2018. The Consultant VBR pilot is now complete and the new process was launched on 1st April 2018 and is working well.

6. INNOVATION, LEARNING AND DEVELOPMENT

6.1 Learning and Development programmes

Education and Development design, provide and deliver a range of high quality accredited and non-accredited programmes which are influenced by the development needs of the organisation.

The Trust opened a new world class education and training centre at Castle Hill Hospital last year which provides state of the art facilities, is accessible for all staff groups and has 5 versatile training rooms, 2 training wards, a mediation room, multiple informal and demonstration areas. Later this year a surgical skills training centre will go live which will further enhance our reputation as a University Teaching Hospital.

7. EQUALITY AND DIVERSITY

7.1 The Trust continues to be committed to eliminating discrimination and encouraging diversity amongst its workforce.

To support this, over the past year the Trust has undertaken the following work:

Equality, Diversity and Inclusion Strategy 2018 – 2021
In January 2018, the Trust published its Equality, Diversity and Inclusion Strategy 2018 – 2021, which outlines the legal duties and regulatory requirements that the Trust adheres to, including the Equality Act 2010, The General Equality Duty, Human Rights Act 1998, NHS Constitution and the Care Quality Commission (CQC) Standards.

7.2 Gender Pay Gap

New regulations that took effect on 31 March 2017 (Equality Act 2010 Specific Duties and Public Authorities) Regulations 2017) required all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

The Trust published its first Gender Pay Report in March 2018, based on data for the period including the first snapshot date of 31st March 2017. The Trusts gender pay gap data, which shows the difference in average pay between men and women in the workforce, reflects that it has a majority of men in higher-paid roles, predominantly medical staff. The Trust's mean and median gender pay gap figures are higher than the average national figures, but comparable with other large Acute NHS Trusts. The Trust's bonus data, excluding long service awards, is also comparable to other large Acute Trusts with a high proportion of Medical staff. Solutions to the gender pay gap lie in culture changes in both society and organisations. The Trust is committed to addressing the gender pay gap and is using the data to help understand the underlying causes for its gender pay gap, to identify suitable steps to minimise it and will report annually on the progress it is making.

7.3 NHS Workforce Race Equality Standard (WRES)

The NHS Workforce Race Equality Standard requires NHS organisations to demonstrate progress against a number of indicators of workforce equality. The indicators focus upon Board level representation and differences between the experience and treatment of White and BME staff in the NHS. The 2017 WRES Return and Action Plan are available on the Trust's internet.

7.4 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard has been mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18. The Trust is currently reviewing the draft metrics for the WDES. These follow a similar format to the Workforce Race Equality Standard looking at numbers of disabled staff across different pay bandings, as well as drawing on results from the NHS Staff Survey.

7.5 Equality Delivery System (EDS2)

The Trust has utilised feedback from staff, patients, service users and community groups to assess progress against the goals and outcomes of the EDS2. In each case the Trust has rated itself as 'developing' as it recognises that there is further work to be done in terms of:

- demographic data collection,
- improving Trust performance in relation to access targets,
- communication with patients, service users and carers, and
- promoting equality, diversity and inclusion across the organisation.

Each of the outcomes links to the Trust's equality objectives.

7.6 Staff Networks

The Trust has a BME Staff Network that commenced in 2016. The membership has increased to 50, but attendance at network meetings could be better. The Trust has also launched an LGBT Staff Network group in January, 2018.

7.7 E,D and I Training

The Trust continues to deliver the Equality, Diversity and Inclusion training programmes and forms part of the Trust's recruitment and selection training. Equality, diversity and inclusion training now forms part of the Trust's mandatory training programme.

8. HEALTH AND WELLBEING

8.1 Health and Wellbeing

The Health and Wellbeing (H&W) programme continues to be delivered. The programme is designed largely to provide staff with information so they can "self-help" but also signposts them to various regional and national activities and information sources. The Trust provides a range of support and activities for staff including a new football team which commenced earlier this year and meditation sessions in February, 2018. The Physiotherapy service for staff has also been well received by staff and continues for the 2018/19.

8.2 Flu Vaccination

The national flu vaccination target is a minimum of 70% of staff must be vaccinated. HEY vaccinated 76% of staff in 2017/18. The Trust's flu vaccination programme for 2018/19 will commence from 1st October, 2018. The Trust offers 1 day additional annual leave to every staff member who has the flu jab.

9. EMPLOYEE ENGAGEMENT, COMMUNICATION AND RECOGNITION

9.1 Golden Hearts

We received over 240 nominations for this year's Golden Hearts Awards, the most we've ever received. There was over 350 staff at the awards ceremony which took place on 15 June 2018, which is the largest ceremony we've held in the seven years since we first launched. The evening was a fabulous celebration of the care and kindness our staff provide on a daily basis.

9.2 Link Listeners

We encourage our Link Listeners in all areas of the Trust to attend the Trust wide and local Link Listeners groups, so the senior team understand and remain connected to frontline

staff. Meetings have been held monthly during the last 6 months and were attended by at least two Executive Directors.

9.3 Staff Side

We continue to work in partnership with our trade union colleagues in managing change and the LNC and JNCC bi-monthly meetings are well regarded.

9.4 Trust reward scheme

Staff who have completed their mandatory training, had an appraisal and received a flu jab have been written to by the Chief Executive and awarded an additional days annual leave. Approximately 1500 staff received this benefit.

9.5 Culture and wellbeing

In order to enhance and improve upon the work we have started to improve our working culture, a culture and wellbeing committee has been initiated. This is chaired by the Chief Executive and will aim to drive the Trust into the top 20% nationally for our staff survey results. A work programme has been agreed and is being delivered.

9.6 Health Expo

The 2018 Health Expo celebrated 70 years of the NHS and our Trust was a key partner. As part of this, every member received an NHS70 pin badge. Staff from all professions and teams were present on the day to promote their services and careers in the NHS. The event was a great success and was held at the Hilton Hotel in Hull on the 5th July, the day of the NHS' anniversary. Over 1000 people attended the day and were made up of local NHS staff, patients and the wider community including schools and colleges. The HEY choir also performed at York Minster to celebrate NHS70.

9.7 Media performance

The Communications team targets 80% positive coverage during any given month. During July, 53 articles out of 56 generated were positive (95%), helped in part by the NHS70 celebrations that month.

16 news releases were issued from the Communications team in July 2018.
Social Media

Facebook
Total "reach" for all posts on Trust Facebook pages in July: 567,668 (June: 490,923)

- Hull Royal Infirmary – 198,850 (June: 197,256)
- Hull Women and Children's Hospital 115,388 (June: 99,763)
- Hull and East Yorkshire Hospitals Trust – 102,017 (June: 43,582)
- Castle Hill Hospital – 139,751 (June: 140,842)
- HEY Jobs page – 11,662 (June: 9,480)

Total followers:
- Hull Royal Infirmary: 6,865 (June: 6,784)
- Hull Women and Children's Hospital: 7,121 (June: 7,043)
- Hull and East Yorkshire Hospitals NHS Trust: 3,599 June: 3,364)
- Castle Hill Hospital: 3,289 (June: 3,225)
- HEY Jobs: 3,741 (June 3,710)

Twitter

Followers July: 5,687 (June: 5,629)

203,800 impressions (June: 186,900 impressions)

10. MODERNISING THE WAY WE WORK

10.1 The Temporary Workforce

Significant work has been undertaken within the back offices to improve and modernise the process associated with the management of the temporary workforce. The Trust reduced its agency spend by £3m during 2017/18 and will continue to make this a priority. The development of the staff banks is also a priority with the medical staff bank being addressed first followed by AHP and scientific staff. A business case for the further expansion of Health Roster is being prepared.

10.2 Consultant e-job planning

The Trust continues to explore the benefits of the e-job planning system. The next phase is to work towards consistency across job plans as per NHSI guidance. To support this process the Head of HR Services and the HR Advisor (Medical Workforce) are visiting Sherwood Forest Hospitals NHS Trust who are seen as a leading light in consistency across e-job plans.

10.3 Revalidation and Appraisal for Medical and Dental Staff

The Trust has just received feedback from the Medical Revalidation Annual Organisation Audit undertaken by NHS England in which it was noted that over 94% of Doctors who have a prescribed connection with the Trust had an appraisal in the last 12 months.

10.4 ESR self service

Implemented employee self-service in 2017 and implementing manager self-service in 2018, which will mean employment processes including change of hours, change of ward/department and leaver forms will be fully automated, saving time and money. Staff can remotely access their own data and the NOC paper forms will be phased out. Manager self-service has been implemented in the Clinical Support Health Group as a pilot and will be now rolled out across the Trust.

10.5 Innovative Employment Framework

The Employment framework within the Trust is continually reviewed in consultation with operational managers and staff side colleagues to enable line managers to manage and develop their people. In the last financial year, 1 April 2017 31 March 2018, the following policies have been reviewed, amended, approved and re-launched:

- Disciplinary Policy and Procedure and Guidelines for Managers
- Smoke Free Policy
- Rota Policy
- Working Time Regulations Policy
- Adverse Weather Policy
- Maintaining High Professional Standards Policy for Medical and Dental Staff
- Recruitment and Selection Policy
- Managing Organisational Change Policy
- Pre-Employment Checks Policy (incorporating Criminal Record Checking Policy)
- Revalidation and Appraisal Policy for Medical Staff
- Clinical Attachment Policy
- Employment Probation Policy
- Managing Capability Policy
- Job Planning for Medical and Dental Staff
- Personal Development Moves and Time Limited Work/Projects
- Support For Employees Experiencing Domestic Abuse Policy
- Management of Induction for New Employees Policy
- Supporting and Managing Attendance Policy
- Retirement Policy
- Communications (incorporating Social Media Policy) Policy
- Redeployment Policy

- Education and Development Policy
- Secondment to a First Level Qualification Course Policy
- Engaging Temporary Workers Policy
- Honorary Contract Policy

11. WORKFORCE PERFOMANCE DATA

The Trust measures staff attendance, retention, appraisals and statutory and mandatory training and the current performance is detailed in Appendix 1 attached.

12. RECOMMENDATIONS

The Trust Board is requested to note the content of the report. The Trust Board will receive a further progress report in March, 2019.

Officer to Contact:
Simon Nearney
Director of Workforce and OD
August 2018

Appendix 1

Workforce Performance Data

		Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
Attendance Target 96.1%	Clinical Support Services	96.97	96.94	96.88	96.86	96.99	96.86	96.86	96.94	96.95	96.98	96.90	96.90
	Family & Women's Health	96.15	96.13	96.11	96.09	96.34	96.27	96.24	96.29	96.39	96.48	96.44	96.34
	Medicine	96.21	96.22	96.27	96.23	96.41	96.20	96.18	96.18	96.17	96.26	96.22	96.24
	Surgery	95.91	95.90	95.93	95.98	96.27	96.13	96.15	96.2	96.16	96.27	96.30	96.31
	Corporate Directorates	96.44	96.47	96.44	96.51	96.78	96.69	96.67	96.60	96.63	96.73	96.74	96.82
	Estates, Facilities & Development	94.91	94.96	94.77	94.38	94.66	94.42	94.43	94.58	94.64	94.84	94.64	94.68
	Trust Total	**96.25**	**96.25**	**96.23**	**96.22**	**96.44**	**96.30**	**96.30**	**96.34**	**96.35**	**96.44**	**96.40**	**96.42**
Retention Target 90.7%	Clinical Support Services	87.7	88.2	88.4	87.9	88.4	88.1	88.3	88.5	88.2	88.2	88.9	89.0
	Family & Women's Health	91.6	91.2	90.4	90.5	91.1	91.5	91.1	91.2	90.6	91.7	91.9	92.0
	Medicine	89.1	89.8	89.8	90.4	90.5	90.5	90.3	90.0	90.1	89.4	89.3	89.1
	Surgery	90.2	90.7	90.6	90.4	91.0	91.1	90.9	90.6	90.2	90.5	91.1	91.0
	Corporate Directorates	90.5	90.5	90.5	90.4	90.4	90.1	90.1	90.1	89.3	89.5	89.4	89.4
	Estates, Facilities & Development	92.8	92.0	91.1	90.5	89.7	90.0	89.0	88.8	89.2	89.8	88.7	89.2
	Trust Total	**89.8**	**90.1**	**90.0**	**89.8**	**90.2**	**90.1**	**90.0**	**89.9**	**89.6**	**89.8**	**90.0**	**90.0**
Appraisal AFC Staff Target 85%	Clinical Support Services	83.6	84.5	85.3	88.2	87.8	87.3	86.4	86.2	88.8	89.5	90.5	89.2
	Family & Women's Health	84.5	82.5	83.2	86.9	88.0	87.6	87.3	86.4	88.3	88.4	86.3	84.9
	Medicine	81.6	83.1	83.5	81.7	82.2	81.9	80.0	82.3	83.5	82.2	80.4	82.0
	Surgery	83.4	83.9	83.7	83.1	84.1	84.8	84.8	83.2	85.2	87.1	86.3	83.3
	Corporate Directorates	76	77.6	81.6	81.0	81.4	83.7	84.1	84.0	85.0	84.9	82.9	83.1
	Estates, Facilities & Development	86	90.2	87.8	83.1	87.8	87.4	87.9	89.4	91.9	92.6	90.7	86.9
	Trust Total	**82.4**	**83.2**	**83.9**	**84.6**	**85.1**	**85.3**	**84.9**	**84.8**	**86.7**	**87.1**	**86.2**	**85.0**
Appraisal Consultants and SAS Doctors Target 90%	Clinical Support Services	91.5	90.5	90.6	91.6	95.8	92.6	93.5	92.5	92.5	87.1	90.4	85.1
	Family & Women's Health	86.5	89.3	92.3	92.5	92.5	94.4	94.3	96.2	98.1	93.2	94.2	92.4
	Medicine	90.7	90.9	90.1	93	91	90	89.6	90.9	94.8	89.6	90.8	87.8
	Surgery	90.8	91.8	87.3	87.2	89	90.6	91.1	87.1	94.8	93.1	90.2	89.0
	Corporate Directorates	100	100	100	100	100	50*	100	100	100	100	100	100
	Estates, Facilities & Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Trust Total	**90**	**91**	**89.9**	**90.5**	**91.5**	**91.7**	**92.1**	**91.2**	**95.1**	**91.4**	**91.4**	**89.0**

		Aug17	Sep17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18
Statutory and Mandatory Training Target 85%	Clinical Support Services	92.4	91.7	92.0	92.7	92.8	92.7	88.7	89.3	90.3	90.5	91.8	92.1
	Family & Women's Health	91.9	92.2	92.5	93.1	93.5	93.1	91.3	91.3	92.3	92.1	92.7	93.1
	Medicine	88.8	89.1	90.2	90.7	90.9	90.4	86.4	86.1	87.9	88.3	89.4	88.8
	Surgery	88.8	89.1	88.7	89.6	89.7	89.9	86.4	86.4	87.8	88.0	90.9	90.8
	Corporate Directorates	84.4	85.9	88.8	90.1	90.5	90.7	85.8	86.8	87.3	88.8	91.3	91.2
	Estates, Facilities & Development	95.3	95.0	95.6	95.3	96.1	95.2	92.3	93.7	95.1	94.6	95.8	95.7
	Trust Total	**89.7**	**90.0**	**90.7**	**91.4**	**91.7**	**91.6**	**87.9**	**88.2**	**89.3**	**89.7**	**91.5**	**91.5**

Attendance: Estates, Facilities and Development are not currently meeting the target for Attendance

Retention: Family and Women's Health and Surgery are meeting the Trust target

Appraisal AfC Staff: Clinical Support and Surgery are meeting the target – as a Trust we are meeting the target

Appraisal Consultants and SAS Doctors: Family and Women's Health and Corporate are meeting the Trust target

Statutory and Mandatory Training: All areas are meeting the Statutory and Mandatory Training target

Summary of Employment Cases

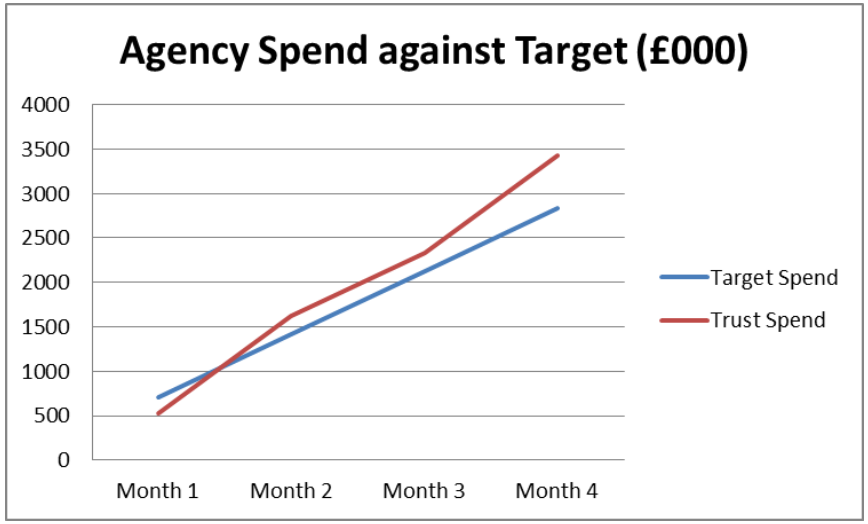
	Aug-17	Sep-17	Oct-17	Nov 17	Dec 17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul 18
Total Number of Open Cases	**50**	**34**	**28**	**19**	**27**	**22**	**13**	**17**	**26**	**30**	**28**	**22**
New Cases in Current Month	**5**	**3**	**9**	**2**	**9**	**4**	**5**	**12**	**9**	**5**	**6**	**5**
Oldest Case Start Date	**09/09/15**	**03/09/16**	**03/09/16**	**03/09/16**	**03/09/16**	**03/09/16**	**03/09/16**	**23/11/17**	**23/11/17**	**23/11/17**	**11/01/18**	**11/01/18**
Average Weeks to resolution	**14**	**15**	**16**	**15**	**16**	**16**	**16**	**12**	**12**	**12**	**12**	**12**
Trend on previous month (Weeks to resolution)	↓	↑	↑	↓	↑	-	-	↓	-	-	-	-

Agency Information

1.NHS Improvement Target: TBC

2.Internal Agency Target: 15% reduction on 17/18 spend.

	£0				
Health Groups	**Total 17/18**	**Target with a 15% reduction**	**Month 4 Target 18/19**	**Month 4 Actual 18/19**	**Month 4 Variance 18/19**
Clinical Support Services	2667	2,267	756	738	18
Family + Women's Health	487	414	138	202	-64
Medicine	3628	3,084	1028	1222	-194
Surgery	2376	2,020	673	1132	-459
Corporate Directorates	865	735	245	152	93
Grand Total	**10027**	8,523	2841	**3433**	-592



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
11 SEPTEMBER 2018

Title:	QUALITY REPORT SEPTEMBER 2018
Responsible Director:	EXECUTIVE CHIEF NURSE EXECUTIVE CHIEF MEDICAL OFFICER
Author:	Mike Wright, Executive Chief Nurse

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to service quality (patient safety, service effectiveness and patient experience)	
BAF Risk:	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
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	
Key Summary of Issues:	Information is provided in the report on the following topics: • Patient Safety Matters including Never Events and Serious Incidents • Themes and Trends from Serious Incidents • Safety Thermometer • Healthcare Associated Infections (HCAI) • Patient Experience Matters • Care Quality Commission Inspection • Learning from Deaths • Clinical Negligence Scheme for Trusts - Maternity Areas of good practice are presented alongside those that require actions and improvement.	

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

QUALITY REPORT
SEPTEMBER 2018

EXECUTIVE SUMMARY

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

- Patient Safety Matters including Never Events and Serious Incidents
- Themes and Trends from Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission Inspection
- Learning from Deaths
- Clinical Negligence Scheme for Trusts - Maternity

The Trust Board is requested to receive this report and:

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

QUALITY REPORT
SEPTEMBER 2018

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 including Never Events and Serious Incidents
- Themes and Trends from Serious Incidents
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Care Quality Commission Inspection
- Learning from Deaths
- Clinical Negligence Scheme for Trusts - Maternity

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 July 2018 and August 2018, where possible. Any other known matters of relevance since then will be described, also.

2. PATIENT SAFETY

2.1 Never Events (NE) – W178482

In September 2018 the Trust has declared a Never Event in relation to 'Overdose of insulin due to abbreviations or incorrect device'. This is the first Never Event of this category to be declared within Hull and East Yorkshire Hospitals NHS Trust and the first Never Event to be declared since March 2018.

The incident related to a diabetic patient who had high blood sugar intra-operatively. Insulin was given via a standard syringe rather than an insulin syringe. The patient should have been given 6 units of insulin IV but was given 60 units. The error was identified, corrective treatment was given and patient came to no apparent harm.

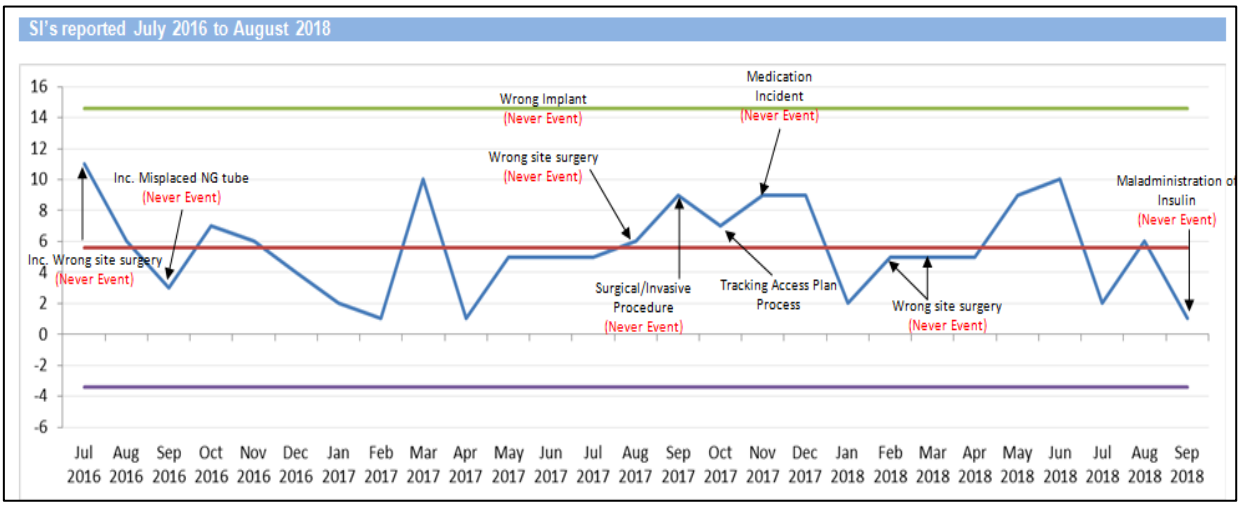
An investigation will begin, and information has been sent out Trust-wide to remind staff of the requirement that insulin needs to be administered with insulin specific syringes only.

Work continues on the actions arising from the Never Events declared in 2017/18, including the development of a corporately-branded patient safety campaign, which will include concepts akin to 'Stop the Line' and raising more awareness and empowering all staff to challenge poor practice more effectively.

2.2 Serious Incidents reporting rates

To date in 2018/19, the Trust has declared 32 Serious Incidents and one Never Event. The following graph shows the Serious Incident reporting rate, with Never Events highlighted specifically, and the Tracking Access Plan SI noted.

Graph 1: Serious Incident SPC chart



2.4 Serious Incidents declared in July and August 2018

The outcomes of all Serious Incident reports are reported to the Trust Board's Quality Committee where more detailed discussions about them takes place. A summary of the incidents declared is contained in the following tables and each of these is now under investigation. Anything of significance from them will be reported to the Quality Committee in due course and anything of undue concern will be escalated to the Trust Board as required.

The Trust declared 2 Serious Incidents in July 2018.

Table 1: Serious Incidents declared July 2018

Ref Number	Type of SI	Health Group
16572	Maternity/obstetric incident – Intrauterine Death	Family & Women's Health Group
18442	Sub-optimal care of the deteriorating patient – Patient developed left side pneumothorax	Medicine Health Group

The Trust declared 6 Serious Incidents in August 2018.

Table 2: Serious Incidents declared August 2018

Ref Number	Type of SI	Health Group
18895	Treatment Delay - Delayed follow up appointment	Family & Women's
20204	Unwitnessed fall within the hospital	Medicine
20358	Sub-Optimal Care of the Deteriorating Patient – patient did not receive treatment for bowel obstruction	Medicine
20754	Hospital Acquired Pressure Ulcer	Clinical Support
20760	Hospital Acquired Pressure Ulcer	Medicine
20990	Sub-Optimal Care of the Deteriorating Patient - patient did not receive venous thrombosis treatment	Medicine

2.5 ACTIONS COMPLETED DURING QUARTER 1 2018/19 IN RELATION TO SERIOUS INCIDENT INVESTIGATIONS

During Quarter 1 2018, there were 70 actions that related to measures taken within the Trust to prevent the type of incident occurring again. The majority of these actions related to the training of staff, how to escalate care concerns, nutritional screening and tissue viability.

The next greatest number of completed Serious Incident actions related to reviewing and improving the systems and processes in place within the hospital.

There were also a number of actions that relate to Trust policies, procedures and guidelines. This includes four Trust-wide policies that have been reviewed and updated:

- Guidance For The Admission of Vulnerable Children and Young People Who May Pose a Risk to Themselves and Others
- Clinical handover of care and transfer of patients
- Administration of Intravenous Medication and Fluids Policy
- Pre-operative marking of surgical or procedural or interventional site – new policy following a Never Event investigation

A number of actions related to how the Trust communicates with patients. These include improving patient information leaflets and letters to deliver clearer messages and advice to patients.

2.6 SERIOUS INCIDENT INVESTIGATIONS – ROOT CAUSES AND CONTRIBUTORY FACTORS

During Quarter 1 2018, there were 13 serious incident investigations completed. In August 2018, the Trust's Quality Committee received a report on the root causes and contributory factors within these events. How teams and individuals communicate effectively with one another remains the most common theme arising from the investigations.

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 July 2018 are attached as **Appendix One**.

From the 844 in-patients surveyed on Friday 8th June 2018, the results are as follows:

- **95%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **2.61% [n=22]** 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 **97.39%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day. Of the 844 patients, 48 did not require a VTE risk assessment. Of the remainder, 763/844 had a VTE risk assessment undertaken. This is **95.8%** compliance on the day. VTE incidence on the day of audit was **8** patients; **4** of which were with a pulmonary embolism and **4** were a deep vein thrombosis.
- There were 5 new pressure ulcers on the census day, all at Grade 2. However, 19 patients had pre-hospital admission pressure ulcers (16 at Grade 2, 2 at Grade 3 and 1 at Grade 4). These are now being fed back to commissioners to manage. In addition, a health-economy wide group has now been established to look at the significant number of patients that come into hospital with pre-existing pressure damage. The Trust is a member of this group.
- There were **15** patient falls recorded within three days of the audit day. Of these, 12 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 low in number at **8/165** patients with a catheter **(4.84%)**. Of the 8 patients with infections, 6 of these were infections that occurred whilst the patient was in hospital.

Overall, performance with the Safety Thermometer remains 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 2018/19 as at 31st July 2018

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

Organism	2018/19 Threshold	2018/19 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	52 (locally agreed CCG stretch target of 45)	13 (25% of threshold)
MRSA bacteraemia infections (post 48 hours)	Zero	0
MSSA bacteraemia	44	**25 (57% of threshold)**
Gram Negative Bacteraemia		
E.coli bacteraemia	73	**41 (56% of threshold)**
Klebsiella	4	Baseline monitoring period
Pseudomonas aeruginosa	1	Baseline monitoring period

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

4.1.1. *Clostridium difficile*

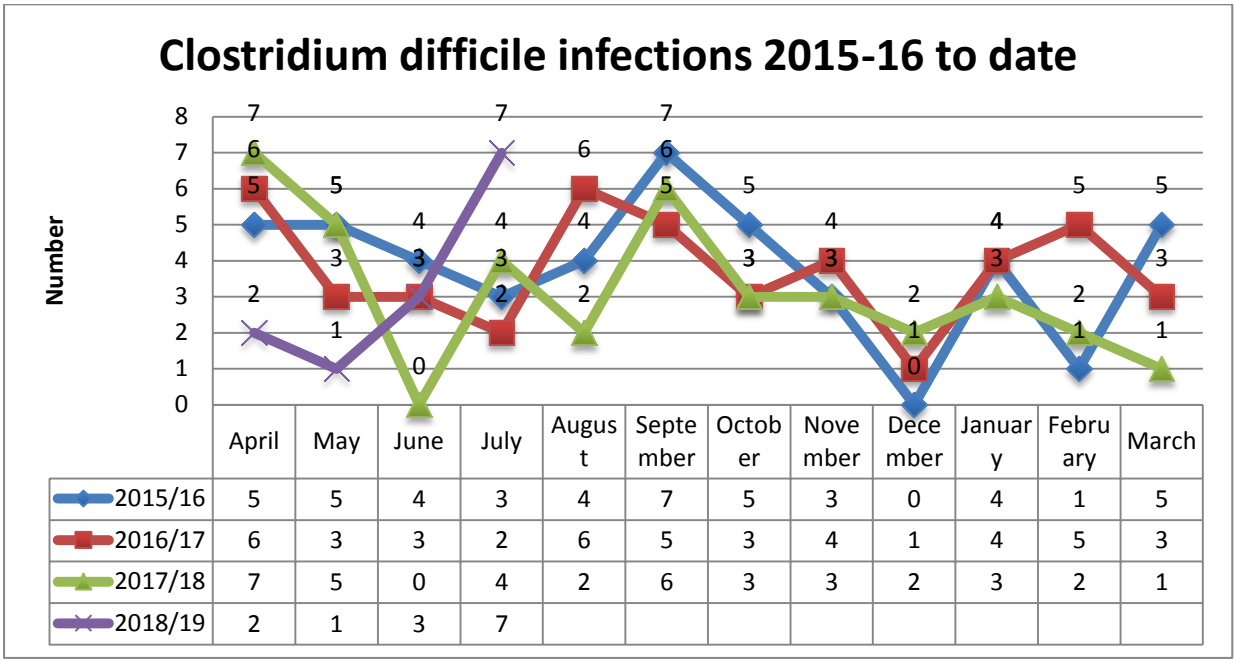
Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a *C.difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and 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 reporting requirements for 2018/19. A threshold for Trust apportioned cases has been set by NHS Improvement at 52 but a stretch target of 45 has been locally agreed with Commissioners.

NHS improvement provided guidance in March 2018 in preparation for *C.difficile* reporting during 2019/20. Changes to the *C.difficile* reporting algorithm for the financial year 2019/20 are reducing the number of days to identify hospital onset healthcare associated cases from 3 days to 2 days following admission and adding a prior healthcare exposure element for community onset cases. *Clostridium difficile* activity during 2018/19 will provide the opportunity to determine the impact the changes will have on cases apportioned to the Trust and whether any actions are required in preparation for those changes, future reports will contain information related to the measures the Trust is taking to meet these changes.

At month four, the Trust reported 13 infections against an upper threshold of 52 (25% of threshold). Three Trust apportioned *C. difficile* cases were reported during June 2018, and seven during July 2018. A total of eight cases are apportioned to the Medical Health Group, three to the Surgical Health Group and the remaining two to Clinical Support. An increase in unseasonal Norovirus activity during July 2018 has resulted in at least two cases detected during diarrhoea and vomiting outbreaks within the Medical Health Group.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Lapses in practice / suboptimal practice cases
Post 72-hour *Clostridium difficile* infections	53 (45)	13 (25% of threshold)	All thirteen cases have been subject to RCA investigation. Of the thirteen cases, three have been reviewed by Commissioners and deemed no lapses in practice. A further three are due for review by Commissioners on the 19th September 2018. The remaining seven cases are awaiting final RCA meetings with consultants responsible for their care.

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



4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

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

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of PIR Investigation / Final assignment
MRSA bacteraemia	Zero tolerance	Nil to report	Nil to report

Previously reported MRSA bacteraemia cases have been subject to a Post Infection Review (PIR) process and formally reported within a 14 working day timeframe to Public Health England. For 2018/19 the Trust will no longer be required to submit a formal PIR process because of low

rates of Trust apportioned cases – to ensure patient safety and the ongoing reduction of infection, a PIR process will continue but will be reported locally to commissioners.

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. As can be seen from the following table, at month 4, the Trust is already at 57% of its upper threshold for this infection. This is of moderate concern at this stage in the year.

Organism	2018/19 Threshold	2018/19 Performance (Trust apportioned)	Outcome of RCA Investigation (avoidable/ unavoidable)
MSSA bacteraemia	44	25 (57% of threshold)	RCA investigations ongoing for the 25 reported cases. Early indications suggest 15 cases are preventable linked to hospital acquired pneumonia, complex high risk surgery and IV device management. These 15 cases are undergoing a deeper dive by the clinicians and nursing teams responsible for their care.

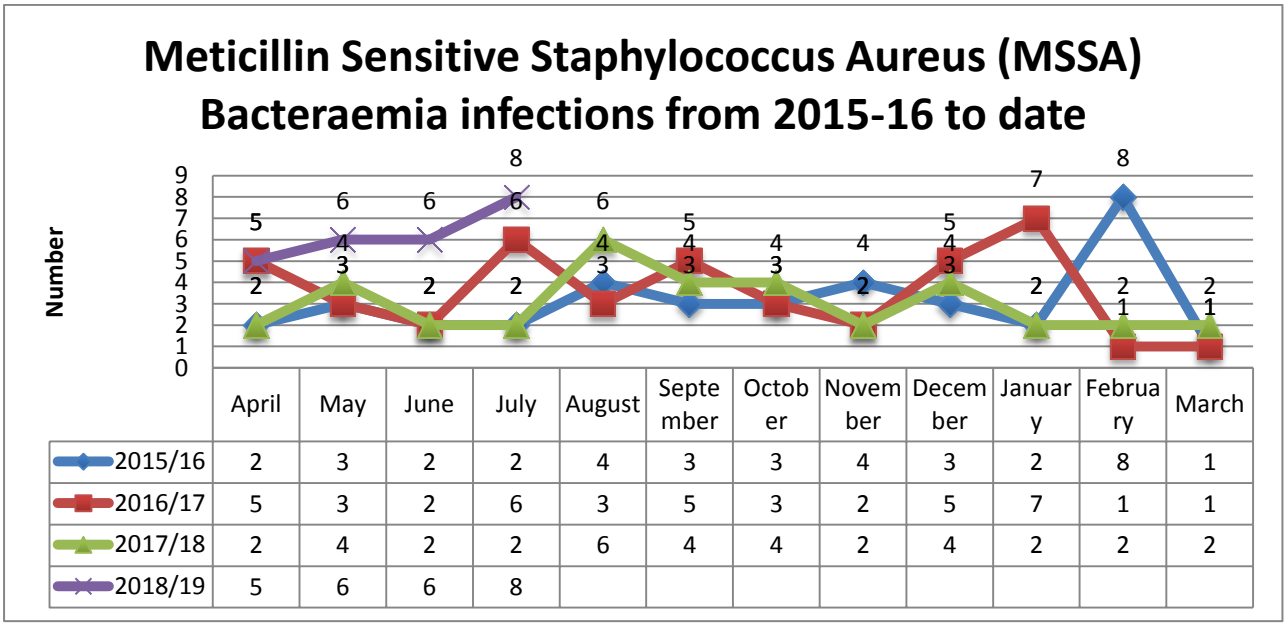
MSSA bacteraemia performance is provided in the following table. There are no national thresholds for this infection again for 2018/19 but the need for continued and sustained improvements regarding this infection remains a priority. Five cases reported since April 2018 attributed to C26 – RCA's completed. Isolates sent to Public Health England for typing all distinguishable. Incident meeting held to discuss cases – multi-factorial, two patients colonised with MSSA on admission, complex cardiothoracic surgery in 3 cases but no commonality between cases. Learning identified regarding appropriate management of patients with positive MSSA history and device management.

A further five cases reported since April 2018 were attributed to ward H50 and yet, following investigation, the source of bacteraemias were thought to be generated elsewhere within the Trust. In addition, cases are not thought to be linked as isolates sent to Public Health England are distinguishable and no commonality between cases was identified.

A 'deeper dive' into MSSA bacteraemia cases is underway by the Infection Prevention and Control Team, in collaboration with the Infectious Diseases physicians and medical and surgical

teams from the 1st September 2018. This is to try and understand what actions the Trust needs to undertake to try and prevent any avoidable infections.

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



	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	2	3	2	2	4	3	3	4	3	2	8	1
2016/17	5	3	2	6	3	5	3	2	5	7	1	1
2017/18	2	4	2	2	6	4	4	2	4	2	2	2
2018/19	5	6	6	8								

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 2018/19, Trusts will still 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, underpinned by joint action plans as required by NHS Improvement. The focus of attention is on the reduction of urinary tract infections which are responsible for the largest burden of E.coli infections. The Trust, along with system partners, are part of an NHSI UTI collaborative forum, identifying systems, processes and learning to reduce the burden associated with this infection.

From 1st November 2017 to 30th April 2018, all patients with E.coli blood stream infections were reviewed by an infectious diseases consultant, either at the bedside or via a case notes review. Data were recorded on a standardised pro forma and spread sheet. Demographic, microbiological, clinical, laboratory, treatment and outcome data were recorded. Thirty day mortality, length of stay and ninety day relapse were ascertained as well as descriptive statistics of community and Trust apportioned cases. Reasons for preventable cases were recorded for both community and acute Trust acquired cases.

Of 207 total E.coli episodes, 195 cases in 188 patients were reviewed (111 at the bedside and 84 notes reviews). Forty five cases were acute Trust attributed and 149 were community attributed, and one was attributed to a private hospital. 51% of cases were secondary to a urinary tract

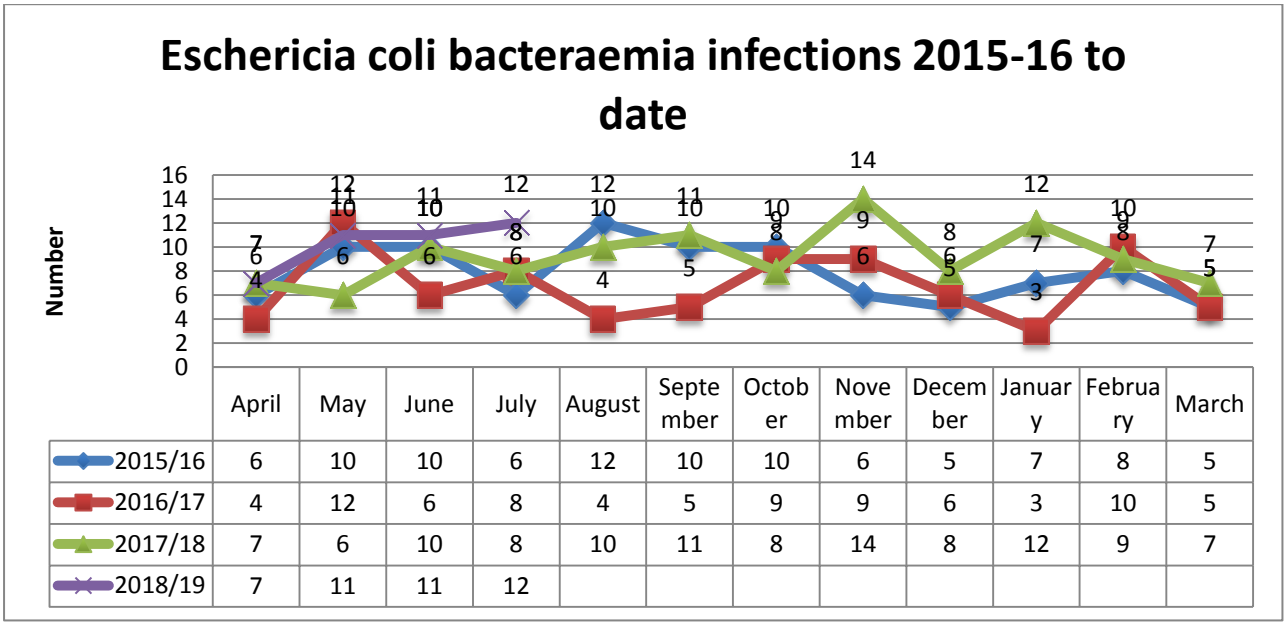
source, with 25% having a hepatobiliary source. 50% of acute trust and 17% of community acquired cases were felt to have been preventable, with nearly half of all preventable cases being related to urinary catheters. 17% had a previous urine sample positive to E.coli in last 3 months prior to the bacteraemia. Antibiotic resistance to commonly used 1st line agents (antibiotics) was high with resistance rates of 54% to Co-amoxiclav, 46% to Co-trimoxazole, 23% to Piperacillin-tazobactam and 17% to Ciprofloxacin. Co-morbidity was high, with 26% of patients having a diagnosis of cancer, 24% diabetes and 12% dementia. 7 day mortality was 13.3%, with a 30 day mortality of 23.6%. 7 (5.7%) of patients relapsed before 90 days, and the median length of stay post bacteraemia was 7 days. Source of infection, whether Trust or community attribution acquired, were not associated with any patient mortality.

A rise in the number of patients presenting with dehydration, constipation, urinary tract infections and blocked urinary catheters (both Trust and community attributed) was also recognised during the hot summer period.

Organism	**2018/19 Threshold**	**2018/19 Performance (Trust apportioned)**	**No. of cases investigated clinically**	**Outcome of Clinical Investigation (avoidable/ unavoidable)**
E. coli bacteraemia	73 (after 10% reduction)	41 (56% of threshold)	Preventable =12 Possibly preventable = 11 Not preventable = 18	Forty one Trust apportioned cases are distributed across Health Groups with the majority within the Surgical Health Group. 21 cases detected in the Surgical HG, 12 cases in the Medical HG, 3 cases detected in Families & Women's HG and the remaining 5 cases in Clinical Support HG. Review of cases suggests ongoing causes related to complex abdominal and urological surgery, biliary and urinary sepsis. A review of the 41 cases has identified 12 cases which have been deemed preventable. These are undergoing a deeper dive by the clinicians and nursing teams responsible for their care.

The main points here are the concerns over the high resistance rates to commonly-used antibiotics and, also, the learning around the care of patients with urinary catheters and indwelling devices. These matters will be discussed at the next Infection Reduction Committee, where actions will be agreed with the Health Groups.

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



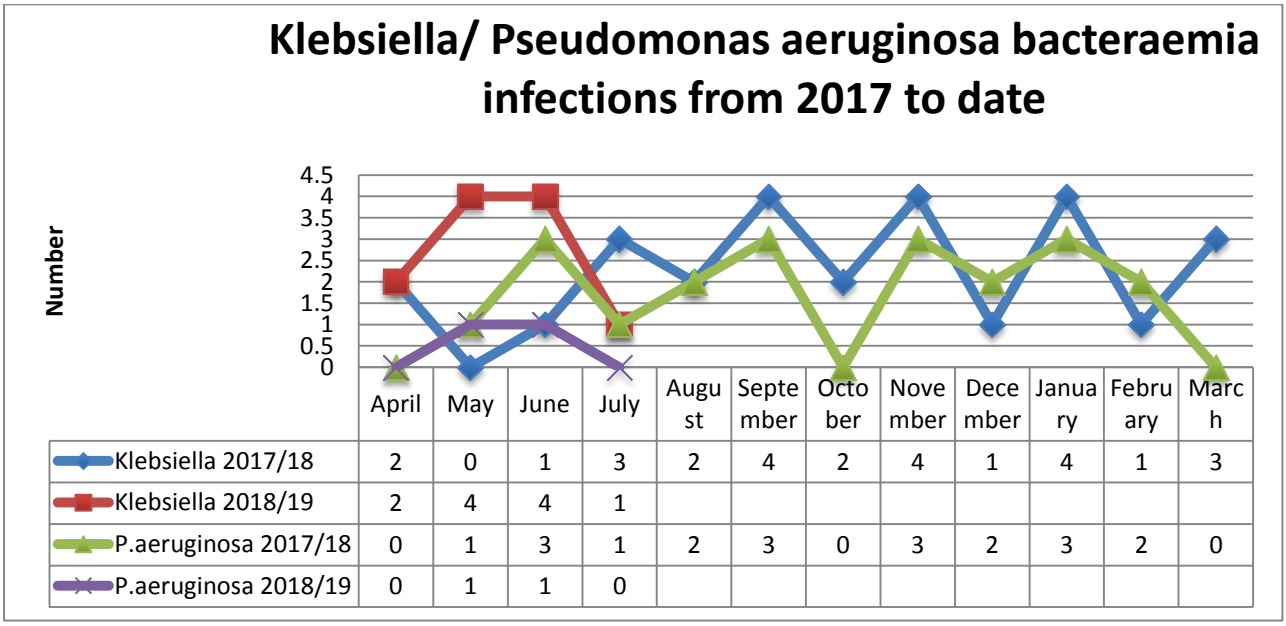
	April	May	June	July	August	September	October	November	December	January	February	March
2015/16	6	10	10	6	12	10	10	6	5	7	8	5
2016/17	4	12	6	8	4	5	9	9	6	3	10	5
2017/18	7	6	10	8	10	11	8	14	8	12	9	7
2018/19	7	11	11	12								

4.1.5 Gram negative bacteraemia – reporting for 2018/19

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 requirement across the health economy to reduce healthcare associated Gram-negative bloodstream infections (GNBSI's) by 50% by 2021. This includes the ongoing reporting of two additional organisms. Surveillance of *E. coli* bacteraemia alongside Klebsiella and Pseudomonas continues during 2018/19 although no thresholds have been published for the latter two GNBSI's.

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, in spite of low numbers reported.



	April	May	June	July	August	September	October	November	December	January	February	March
Klebsiella 2017/18	2	0	1	3	2	4	2	4	1	4	1	3
Klebsiella 2018/19	2	4	4	1								
P.aeruginosa 2017/18	0	1	3	1	2	3	0	3	2	3	2	0
P.aeruginosa 2018/19	0	1	1	0								

4.2 Infection Outbreaks

An outbreak is defined by two or more patients with the same infection in the same ward/area. The Trust experienced high levels of Norovirus during the hot summer months. This is unusual for this time of year.

On the 28th June 2018, Wards H11 and H110 reported cases of diarrhoea and vomiting, these were subsequently confirmed as Norovirus. Ward H11 had three bays closed initially, however, additional cases were detected, which resulted in the full ward being closed on the 4th July 2018.

Ward H110 was closed to admissions on Friday 29th June 2018 but patients requiring hyper acute stroke care were still admitted to the Hyper Acute Stroke Unit beds on a risk assessment basis facilitated by the stroke consultants and in conjunction with the infection prevention & control team. These were particularly protracted outbreaks, compounded by a delay in recognising that the initial increase in cases could be associated with Norovirus and patients recommencing with symptoms, which was a feature of the outbreak. Both staff and patients were affected during the outbreaks. Ward H11 was fully reopened on the 14th July 2018 and Ward H110 on the 15th July 2018.

On the 9th and 10th of July 2018, wards H9 & H90 reported cases of D&V, ward H9 was closed subsequently on the 9th July 2018 and H90 experienced bay closures on 10th July 2018 and then closed to admissions on the 11th July 2018. Both staff and patients were affected. Norovirus was confirmed on both wards. Ward H9 was cleaned with Tristel (Bleach) and steam by the Cleaning Action Team and reopened on the 16th July 2018. Ward H90 was cleaned with Tristel and steam by the Cleaning Action Team and reopened on the 18th July 2018.

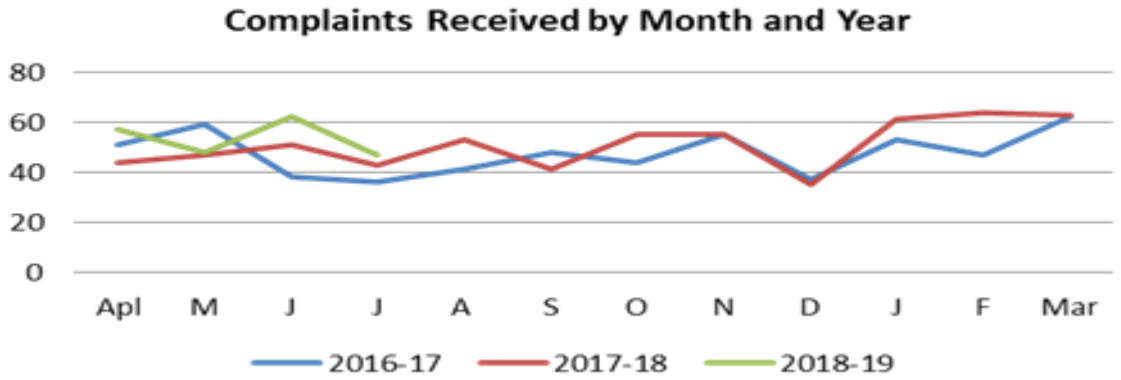
In addition, Ward H70 and C31 experienced bay closures during July 2018 due to diarrhoea and vomiting, no causative organism was detected and wards were cleaned and reopened once patients became asymptomatic.

4.2.1 Influenza trends

Nothing to report during June/July 2018. However, the influenza vaccination campaign for 2018/19 is about to start acorss the Trust.

4. PATIENT EXPERIENCE

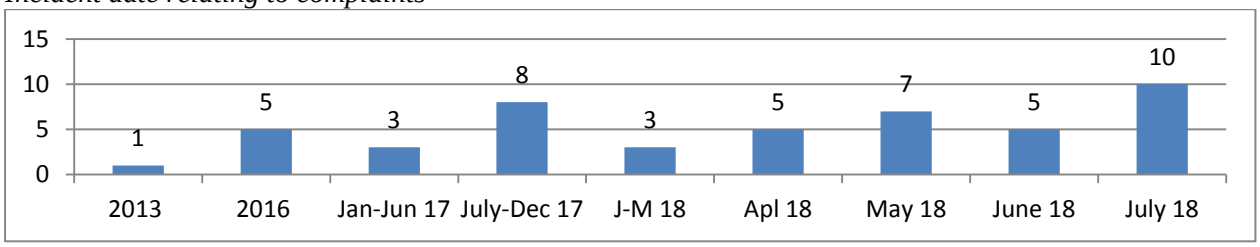
The following graph sets out comparative complaints data from 2016 to date. There were 47 new complaints recorded in July 2018. These figures show a slight increase on the number of complaints received in July 2017 but a reduction on June 2018 when 62 complaints were received. The Patient Experience Team has reviewed the complaints received to identify any themes and trends and have raised awareness with senior staff when several complaints have been received within a specific area. However, there are no particular trends from this.



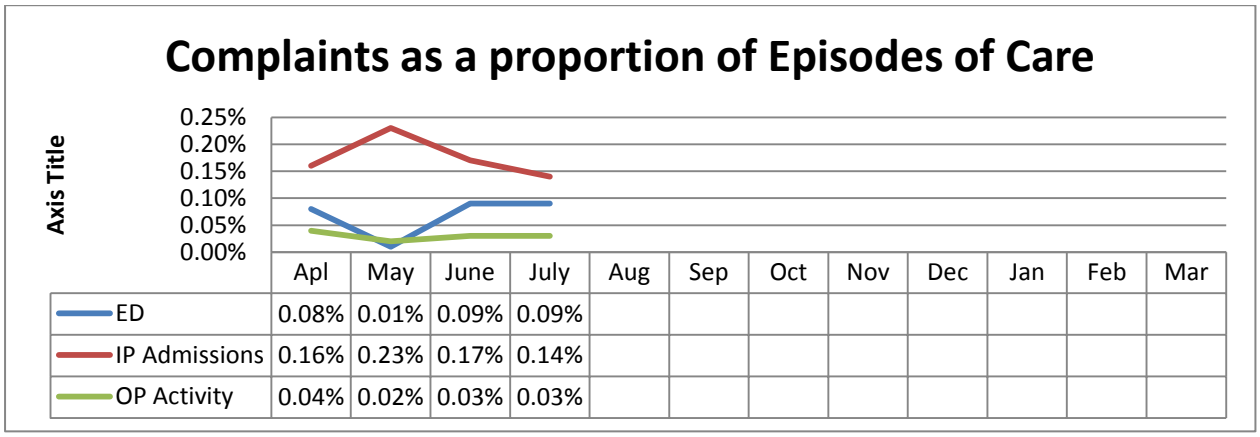
Complaints are graded on closure by a senior member of the Health Group using a rating of 1-4. 1 is low, 2 medium, 3 high and 4 a serious incident. Of the 60 complaints closed within July, 19 were level 1 and 41 level 2. There were no complaints in-month at level 3 or 4.

Complaints usually reflect activity in the previous three months. However, the Chief Nurse requested for the period that the complaint covers/refers to be reported on, also. With regards to the complaints that were received during July 2018, the following table shows the period of time that they relate to as opposed to the time the complaint was lodged with the Trust. The NHS complaints guidance suggests that trusts should only consider complaints within a 12-month time frame before being 'out of time'. However, the need to complain may not be apparent until some time after the actual event. As such, the Trust takes a pragmatic approach to these. As an example, the complaint relating to 2013 concerns a child with issues that have only started to come to light recently and the mother is challenging apparent issues that happened at the child's birth in 2013. As such, considering this complaint is appropriate and the Trust will always aim to be reasonable in this respect.

Incident date relating to complaints



The following table shows the number of complaints received in relation to patient activity at the Trust since April 2018. As can be seen, these remain relatively low.



The following table indicates the number of complaints by subject area that were received for each Health Group during the month of July 2018.

Complaints Received by Health Group and Subject – July 2018

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Safeguarding	Treatment	Total
Clinical Support	0	0	0	0	0	0	6	6
Family and Women's	1	0	0	0	0	0	8	9
Medicine	1	3	0	1	3	1	10	19
Surgery	0	0	1	1	0	1	10	13
Totals:	2	3	1	2	3	2	34	47

Complaints regarding 'treatment' remain the highest recorded category. 20 of the complaints related to outpatient issues, 1 day surgery, 5 emergency medicine and 21 ward areas. The Patient Experience Team continues to work with all Health Groups to highlight themes and trends and to ensure a timely response to complainants.

5.1.1 Examples of outcomes from complaints closed during July 2018:

- A parent raised concerns that she had to attend the clinic twice with her daughter. The eye drops to be instilled to allow examination had not been provided prior to attendance. The parent felt that these should have been posted to her in advance of the appointment. The parent was also concerned that the effects of the drops lasted longer than she had expected and questioned whether damage may have been caused. Concern was also raised that there was no record in the medical notes about the eye drops provided.

  Outcome: An apology has been given. The complainant was advised that it is not routine practice for medication to be posted to patients. The medical notes were not available at the second appointment as it was unscheduled and therefore the record of prescription could not be checked at the time. The effects of the eye drops can last for several days and this was not unusual but the Trust has been able to advise the parent that no lasting damage will be caused from this. Again, this is a learning point for the Trust. Feedback was provided to the doctor who had seen the patient initially to ensure that he provides adequately detailed information for all future patients.

- A patient raised concerns about treatment and care following a wound infection. This was initially thought to be as a consequence of sunburn but was actually a suture that had not dissolved from surgery 10 years earlier; however, the consultant's opinion was that the sunburn may have been an aggravating factor. More recently, the patient had undergone the removal of a breast implant that resulted in her suffering with neuropathic pain. This was not discussed as a possible outcome of surgery. The patient was also upset about the attitude of the Consultant when she attended for her procedure in the day unit and felt that her procedure should have been undertaken as an inpatient.

  Outcome: An apology has been given to the patient. A written response was provided detailing an explanation about the unlikely connection of a suture from surgery carried out 10 years previously being the cause of a wound infection. An explanation about the rare complication of neuropathic pain occurring following implant removal was provided. The patient was advised why this was not cited as a complication in the consent process, due to it being a completely unexpected outcome of the surgery. The consultant explained why the surgery was planned in the day unit and acknowledged that his communication with the patient could have been better. The consultant has since reflected on the impact this had on the patient.

- The patient attended for a knee replacement procedure that had been postponed several times, to find that swabs and tests had not been conducted during his pre-assessment appointment and his procedure was again postponed. The patient asked whether the pre-assessment team had failed in their duty to conduct sufficient pre-operative checks.

  Outcome: A local resolution meeting took place when explanations and apologies were provided to the patient regarding the cancellations of his operation. It was accepted that there had been communication errors and confusion regarding the MRSA and MSSA swabbing at pre-assessment. Actions from the complaint include ensuring that ward staff have the correct knowledge and understanding of checking appropriate information for patients ahead of surgical procedures and to devise an effective process for results to be communicated to the pre-assessment unit.

- The daughter of a patient was dissatisfied with the service received from the Queen's Centre in relation to contacting the Bleep 500 advice line several times before being advised to attend hospital.

  Outcome: A resolution meeting was held with the Senior Matron, Nurse Practitioner and the family to have an open and honest discussion. Apologies were given as, on reflection, the patient should have been asked to attend hospital earlier. As a result, all patients are now assessed using the triage guidelines. The Cancer Assessment Unit is now used in order to allow patients to attend and be assessed face to face. The Nurse Practitioners have been trained with regard to this change in practice. The impact of this experience on the patient and family has been shared with staff.

- A gentleman raised concerns regarding the acute admission of his wife and why she had been sent to ED rather than attend the Queen's Centre. There were also concerns raised regarding appropriate treatment and communication.

  Outcome: This case was reviewed fully by the clinical team and the decision to defer the admission to the ED was the correct one, in light of the patient's reported symptoms at that time and the need for an urgent surgical review. Unfortunately, despite this, the ambulance crew still bought the patient to the Queen's Centre so a further discussion and assessment of the patient occurred and the decision to still send to ED was supported. Apologies were given to the family for poor communication and poor care in not making the plan clear at the time. Assurances were given to the relative that the treatment was correct for his wife.

5.1.2 Performance against the 40-working day complaint response standard

The standard is for 85% of complaints to be closed within 40 working days. In the month of July, 90% of complaints were closed within this timescale.

Complaints closed within 40 working days 2018/19 (whole Trust):

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
80%	83%	82%	90%								

The table below indicates performance by health group and the outcome of the complaint.

	N° Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Investigated	Re-opened
Corporate Functions	0	0 (100%)	0	0	0	0	0
Clinical Support	3	3 (100%)	2	1	0	0	0
Family and Women's	11	9 (82%)	4	6	1	1	4
Medicine	25	21(84%)	6	17	1	1	3
Surgery	21	21 (100%)	7	12	0	0	0
Totals:	60	54 (90%)	19	36	2	2	7

As can be seen from the previous table, performance is variable across the Health Groups, with Surgery and Clinical Support Health Groups achieving 100% of complaints closed within 40 working days in the month of July. Family and Women's and Medicine Health Groups achieved 82% and 84% respectively. The Chief Nurse continues to review each Health Group's performance weekly and improvement trajectories have now been agreed for those that need to improve. This will continue to be managed through the monthly performance and accountability meetings with Health Groups.

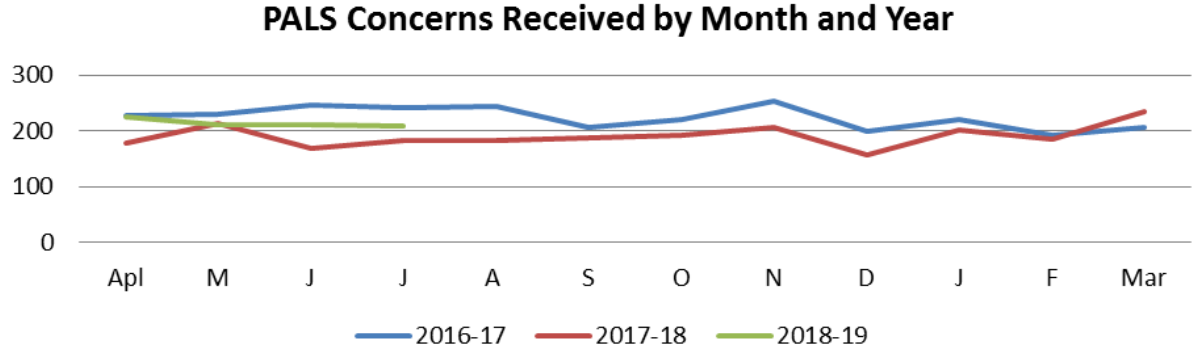
Of the two complaints not investigated in July, a patient withdrew consent on concerns raised by her father during the course of the investigation and the second complaint was forwarded to Human Resources for investigation.

The categorisation of complaints by Health Groups has been reviewed and it has been agreed that, when a complainant has raised issues that are as a result of poor communication, this will now be at least be partly upheld, even if treatment was appropriate. In the month of July, 19 complaints were upheld, 36 partly upheld and 2 were not upheld. As such, the number of not upheld complaints has reduced significantly.

5.2 Patient Advice and Liaison Service (PALS)

In the month of July 2018, PALS received 209 concerns, 21 compliments and 95 general advice issues. This information has been shared with the Health Groups in order that they can review and consider any actions that are necessary.

The following graph illustrates that the number of concerns received by PALS has been steady over the last three months at around 210; July 2018 is only slightly higher than the same period in 2017, but lower than 2016.



The following graph indicates that Delays, Waiting times and Cancellations continues to be the highest subject received by PALS, with Family and Women's and Surgery Health Groups receiving 33 and 31 concerns respectively.

PALS Received by Health Group and Subject – July 2018

PALS by HG and Subject (primary)	General Advice	Attitude	Care and Comfort	Communication	Delays, Waiting times, Cancellations	Discharge	Environment	Hotel	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	2	2	0	3	2	1	0	3	0	0	0	13
Clinical Support	1	0	0	1	7	0	0	0	0	0	2	11
Family & Women's	2	3	0	6	33	0	0	0	0	0	8	52
Medicine	6	7	5	14	24	4	1	1	0	0	10	72
Surgery	2	7	1	5	31	2	0	0	0	0	13	61
Totals	13	19	6	29	97	7	1	4	0	0	33	209

5.2.1 Examples of outcomes from PALS contacts:

- During the course of January, February and March 2018, several patients/visitors, including patients from the Surgical Admission Lounge (SAL), came to PALS to complain about the cold temperature and constant draughts in the main reception area at Castle Hill Hospital.

  Outcome Following extensive discussions with the Estates team, an air curtain will be installed over the main doors to the reception area. This work be completed in August 2018 and will be of benefit to patients and visitors in the forthcoming colder months.

- A woman who had given birth to a son in July had lost the ultrasound pictures that she had purchased during her routine scans. She wanted these to put in a memory book to give to her son when he was older. She had asked her midwife if she would be able to obtain copies but had been told that it would not be possible. She contacted PALS to see if anything could be done to help.

  Outcome: Following contact with Patient Administration, a disc that contained all of the scan pictures was forwarded to the patient for her to keep. The woman was overjoyed.

5.3 Compliments

- A relative wrote to the Chief Executive to say that her late husband was initially thought to have a lymphoma. However, following further testing he was diagnosed with metastatic cancer of unknown primary. The diagnosis was devastating for the patient and his family. His care was transferred to the oncology service in the Queen's Centre. The relative advised "I cannot thank Dr Roy enough for the treatment options given to us. This meant that my husband kept his optimism to the end and we were given time to spend together as a family; time to say everything we needed to and time to say goodbye. Michelle Tuplin (Specialist Nurse) has been a rock to me and my husband during the worst days of our lives together. She always had a hug when we needed it, been a shoulder to cry on, to talk things through and to listen. Michelle was nothing but a lifeline and her care and support will never be forgotten".

- A patient was diagnosed with a brain tumour two years ago and on the 24 June 2018 it was the second anniversary of his surgery. The patient and his wife wrote to the consultant, Mr Hussain, to say that they think of this date as his second birthday because he was given a

second chance at life. They said that they cannot thank the Trust enough and no words could express their gratitude. They said that "in addition to owing his life to the consultant and his team, they wanted to thank all the staff involved in his treatment, care and recovery".

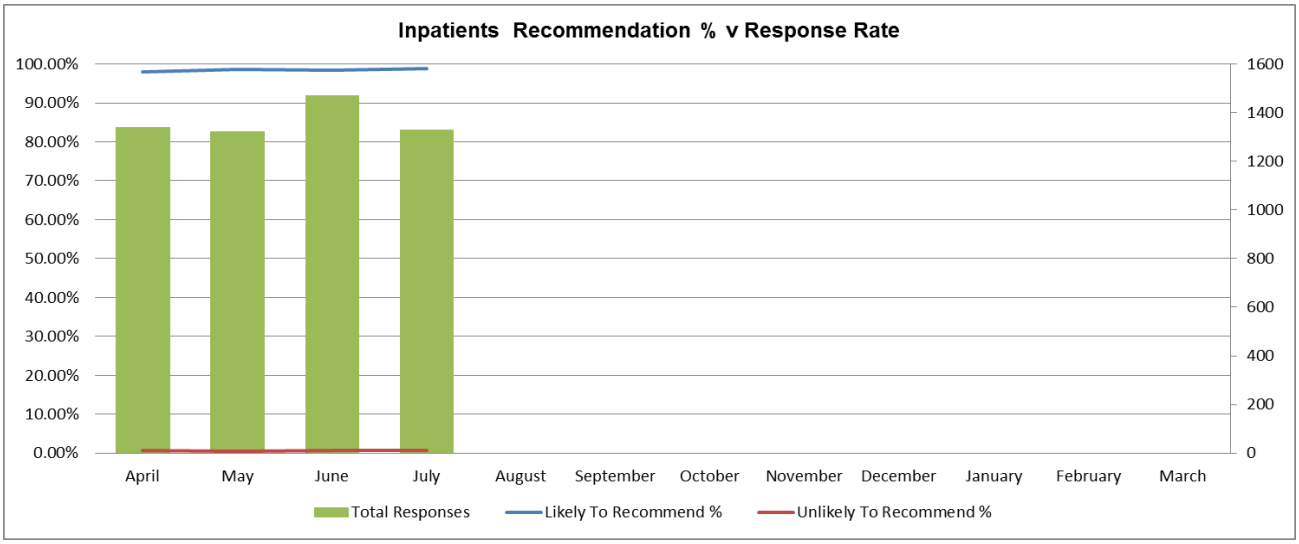
- A patient experienced a complication towards the end of her pregnancy and she had to endure two induction cycles and a caesarean section. Subsequently, she had further complications that required emergency treatment in the operating theatre. The patient wrote to the Nurse Director to express her gratitude for the outstanding care she received from the team on Maple Ward from 19 May to 27 May 2018. The patient said that every single member of staff she and her husband came into contact with during this time, were a credit to the Trust and the NHS. "Caring, professional and dedicated to the care of her and her baby". The patient had to spend several days in hospital and she said that during this time she found the staff to be very personable and friendly towards her family and her. "Words cannot express how grateful we are to the Women and Children's unit for the safe delivery of our precious baby".

- A patient attended the Emergency Care department following an accidental paracetamol overdose. The patient wanted to make it known that he received only the utmost quality of care and support in every aspect of his admittance. He wanted to convey his sincere appreciation to the doctors, nurses, caterers and everyone else who looked after him at that time.

5.3 Friends and Family Test (FFT)

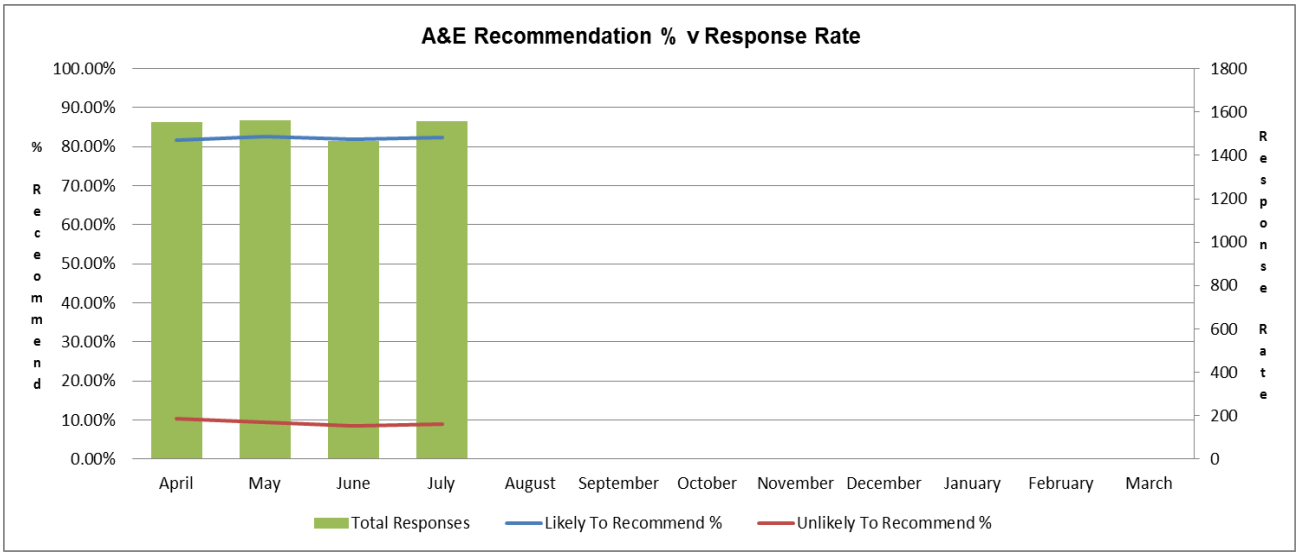
The Trust's Friends and Family test for all areas, including the Emergency Department, had a slightly lower number of responses for July 2018 with 4,908, compared to June 2018 when 4,911 were received. The July 2018 inpatient results indicate that **98.80%** were extremely likely/likely to recommend the Trust to friends and family, which is above the nationally set-target of **95%**. The Patient Experience Team is working with wards to collect patient feedback on a daily basis.

5.3.1 Inpatient Summary – all areas



5.3.2 Friends and Family Emergency Department (ED)

1,465 patients that attended the Emergency Department in June 2018 responded to the Friends and Family Test with **81.91%** of patients giving positive feedback and **8.6%** negative feedback. The remainder were neither positive nor negative. 1,559 patients who attended the Emergency Department in July 2018 responded to the Friends and Family Test with **82.30%** of patients giving positive feedback and **9.04%** negative feedback.



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

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has 9 cases with the PHSO currently. During the month of July, two cases were partly upheld and one was not upheld.

5.5 Adult Volunteers
Voluntary services are continuing to progress and a new recruitment period for August is underway. Volunteers have now been welcomed to the Radiotherapy Department and the new Assessment Area at the Queen's Centre for Oncology and Haematology.

6. OTHER QUALITY UPDATES
6.1 Care Quality Commission (CQC) - Well-Led and Core Services Inspections
Following approval of the 2018/19 Quality Improvement Plan at the July 2018 Operational Quality Committee the plan and progress to date was submitted to the CQC in line with the set deadline for receipt of a detailed action plan in response to the inspection reports.

The 2018/19 Quality Improvement Plan includes the following projects:

- QIP05 - Medicines Optimisation
- QIP06 - Deteriorating Patient
- QIP08 - Infection Control
- QIP09 - Falls
- QIP10 - Pressure Ulcers
- QIP12 - Children and Young People with Mental Health needs and CAMHS
- QIP14 - VTE
- QIP15 - Sepsis
- QIP19 - Governance
- QIP22 - Nutrition
- QIP23 - Dementia
- QIP26 - Records
- QIP28 - Patient Experience
- QIP30 - Avoidable Mortality
- QIP36 - Transition from Children's to Adult Services
- QIP37 - ReSPECT
- QIP38 - Consent
- QIP39 - Outpatients

- *QIP41 - Getting it Right First Time (GIRFT) – Paediatric Surgery (project now closed)*
- *QIP42 - Getting it Right First Time (GIRFT) – Ophthalmology (project now closed)*
- *QIP44 - Getting it Right First Time (GIRFT) – Obstetrics and Gynaecology (project now closed)*
- QIP45 - Safer Maternity Care (CNST incentive Scheme)
- *QIP46 – Handover (project now closed)*
- QIP47 - Acute Kidney Injury
- QIP48 - Mental Health
- QIP49 - Getting it Right First Time (GIRFT)

The Trust has a legal requirement (Regulation 20A) to publish its CQC ratings throughout the organisation. The CQC provides each organisation with a bespoke 'ratings' poster following an inspection. However, the posters following the latest inspection were inaccurate. Following liaison with the CQC, the Trust developed its own posters which are now available on Pattie and in place across the Trust replacing all previous ratings posters. Therefore, the Trust is compliant with Regulation 20A.

6.2 Update from Learning from Deaths reviews
The Trust continues to meet the minimum criteria for review as set by the National Quality Board for patient deaths.

During July and August 2018, there were a total of 353 deaths within the Trust. Of these deaths, 37 received a full Structured Judgement Review (10.4%). The work on disseminating the learning from these continues.

6.2.1 Focus on the Deteriorating Patient - Unplanned ICU admissions
The Structured Judgement Review process has been used to look at a cohort of patients (17) that were admitted unexpectedly to ICU. These are not deceased patients but it was felt that the structured review approach would help understand the patient's journey. This cohort of patients was chosen because the Trust has identified that further work is required around the deteriorating patient. The aim of the review was to determine if any unplanned ICU admissions within the sample were appropriate or avoidable.

The key findings were:

- Two potentially delayed ICU admissions due to delayed ICU specialist review and delay in recognition of patient deterioration.
- Two potentially unnecessary ICU admissions, relating to patients with vast co-morbidities where end of life care should have been commenced sooner and delivered in a more appropriate setting.

The review did highlight a flaw in some of the sampling processes as during the review it became evident that some of the patients received emergency (unplanned) surgery (for example laparotomy) where ICU admission is a normal part of the pathway.

To rectify this, a second review is to be undertaken, this time focussing on patients that did not receive emergency surgery but who were admitted to ICU from the ward. These patients fall under the "deteriorating patient" category and should provide a greater depth of learning. A report of findings will be circulated at the Trust's Mortality Committee in September 2018.

6.2.2 Pneumonia Hospital Standardised Mortality ratio (HSMR) Winter Spike – January and February 2018
The Trust was an 'outlier' in Pneumonia-related mortality during the winter months, most noticeably in January and February 2018. A further sample of case notes of patients who died within these months is under review currently to determine if there are any concerns in the

delivery of care and to inform of areas of further learning. A report of findings will be circulated at the Trust's Mortality Committee in October 2018.

6.2.3 E-Learning Package

The Trust's Clinical Outcomes Manager has developed an e-Learning package designed to deliver Structured Judgement Review training via the digital platform, to all trainee case-note reviewers. The package is being tested currently, with implementation planned for September 2018.

6.3 Clinical Negligence Scheme for Trusts - Maternity (CNST)

The Trust Board will recall approving the Trust's Submission to NHS Resolution to seek up to a 10% reduction in its CNST Maternity Premium to the value of circa. £500k. This required compliance with 10 predetermined standards. The Trust declared full compliance with 8/10 criteria but with plans to deliver the remaining two by October 2018. It was hoped that this would be looked upon favourably by NHS Resolution. The Trust's action plan required £16,000 funding to support additional multidisciplinary training sessions for midwives and obstetricians.

At the time of submission, it was not clear how trusts that were not declaring full compliance would be treated. However, the guidance indicated that trusts that did not meet the full requirements would be eligible for a smaller discount provided they agreed to use the funds to take action towards meeting the criteria. The Trust has since received correspondence from NHS Resolution stating that it will only receive the £16,000 reduction to fund the training requirements.

The Chief Finance Officer had written to the Chief Executive of NHS Resolution to appeal this decision and to ask for greater transparency and clarity in terms of how this has been handled and a review of the decision.

This Trust is aware that other trusts have received higher levels of premium reduction/funding support despite not meeting as many of the standards as HEY. As such, this appears to be rewarding those Trusts that haven't delivered against the standards above those Trusts that have substantially delivered, thus penalising this Trust. Not only is this disappointing but it also impacts on the £500k premium reduction that would contribute to the Trust's CRES target.

The Trust Board will be advised of the outcome of the appeal in due course.

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

Makani Purva
Chief Medical Officer

September 2018

Appendix One: Safety Thermometer – July 2018

Hull and East Yorkshire Hospitals NHS Trust

SAFETY THERMOMETER NEWSLETTER July 2018

Absence of harm from

Pressure ulcers + Falls + Urinary infections (in patients with catheters) + VTE = Harmfreecare

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 13th July on both hospital sites. 844 patients were surveyed

95% of our patients received HARM FREE CARE

Harm Free Care is defined as the number/percentage of patients who have not suffered any of the four harms measured by the safety thermometer before or since admission to hospital.

2.61% (22) of our patients suffered a New Harm

New Harm is defined as the number/ percentage of patients who have suffered or have started treatment for one of the four harms measured by the safety thermometer since admission to hospital

97.39% Of our Patients received NO NEW HARM

No New Harm is defined as the number/ percentage of patients who have not suffered any of the four harms measured by the safety thermometer since admission to hospital.

HARM FREE CARE %: How is HEY performing February 18 – July 18

	Feb 18	Mar 18	April 18	May 18	June 17	July 18
Harm Free Care %	94.1%	94%	93%	93.5%	92.5%	95%
Sample: Number of patients	885	930	870	874	864	844
Total Number of New Harm	12	18	15	16	20	22
NEW HARM FREE CARE %	98.6%	98.04%	98.28%	98.1%	97.69%	97.39%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	8	0.95%	4	4	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	48	5.69%	**% once not applicable patients removed**
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	763	90.4%	95.8%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	33	3.91%	4.2%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	24	2.84%	21	2	1
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	19	2.25%	16	2	1
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	5	0.59%	5	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	15	1.78%
Severity **No Harm**: fall occurred but with no harm to the patient	12	1.42%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	3	0.36%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number of patients surveyed	% of Total Patients Surveyed	% of patients with a urinary catheter insitu on day of survey
Total Number/Proportion of patients recorded with a Catheter	**165**	**19.55%**	
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	**8**	**0.95%**	**0.48%**
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital	**2**	**0.24%**	**0.12%**
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital	**6**	**0.71%**	**0.36%**

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 10th August 2018

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
11TH September 2018

Title:	NURSING AND MIDWIFERY (SAFE) STAFFING REPORT - JULY 2018
Responsible Director:	EXECUTIVE CHIEF NURSE
Author:	Mike Wright, Executive Chief Nurse

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board in relation to matters relating to nursing and midwifery (safe) staffing levels	
BAF Risk:	BAF Risk 2: There is a risk that a lack of skilled and sufficient staff could compromise the quality and safety of clinical services BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
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	Y
Key Summary of Issues:	The structure of this report has been revised and information is provided in the report on the following topics: • Compliance with the national reporting requirements on this topic • Nursing and Midwifery Staffing Levels for inpatient areas • The use of the new Care Hours Per Patient Day (CHPPD) Metric • An overall 'professional staffing safety risk assessment' to help contextualise and summarise this information to make it more meaningful	

Recommendation:	The Trust Board is requested to: • Receive this report • Comment on the new report format as requested in section 9 and make any suggestions for improvement • Decide if any if any further actions and/or information are required.

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], NHS Improvement[3] and the Care Quality Commission.

Since the last version of this report, NHS Improvement (NHSI) has issued revised guidance on the metrics to be used when reporting nursing and midwifery safer staffing data from July 2018. As a result, this report has been redesigned to reflect these requirements. Furthermore, as this report is now presented every two months, these changes have been applied to the June month, also.

2. BACKGROUND

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

The last report on this topic was presented to the Trust Board in July 2018 (May 2018 position).

In February 2016, Lord Carter of Coles published his report into Operational Productivity and Performance within the NHS in England[5]. In this report, Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as being due to the absence of a single means of consistently recording, reporting and monitoring staff deployment. This led to the development of benchmarks and indicators to enable comparison across peer trusts as well as wards and the development of the Care Hours per Patient Day (CHPPD) measure is in line with the second of Lord Carter's recommendations. CHPPD has since become the principal measure of nursing, midwifery and healthcare support staff deployment on inpatient wards. This replaces the 'planned versus actual' methodology used previously.

This report presents the 'safer staffing' positions for June and July 2018 using this revised approach. This report also confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

[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
[2] NHS Improvement (June 2018) Care hours Per patient Day (CHPPD) Guidance for acute and acute specialist trusts
[4] When Trust Boards meet in public
[5] An independent report for the Department of Health by Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

2.1 What is Care Hours Per Patient Day (CHPPD)?
CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level.

CHPPD is most useful at ward level where service leaders and managers can consider the workforce deployment over time, with comparable wards within a trust or at other trusts as part of a review of staff deployment and overall productivity. This measure should be used alongside clinical quality and safety outcomes measures to reduce unwarranted variation and support the delivery of high quality, efficient patient care.

2.2 How is CHPPD calculated?
The Trust is required to submit monthly returns for safe staffing as it has previously. However, these data are now submitted in a different format using the monthly aggregated average CHPPD for each ward.

CHPPD is calculated, as follows:

The total number of hours worked by both registered nurses/midwives and non-registered support staff over a 24 hour period (midnight to 23:59 hours) divided by the number of patients in beds at 23:59 hours each day.

This is then calculated and averaged across the month in question.

The guidance advises that the 23:59 census is not entirely representative of the total and fluctuating daily care activity, patient turnover or the peak bed occupancy on a given ward. However, it advises that what this does do is provide a reliable and consistent information collection point and a common basis on which productive comparisons can be made to measure, review and reduce variation at ward level within organisations and also within similar specialities across different trusts. As such, there are limitations to its use.

2.3 Which staff are included?
In addition to registered nurses, midwives and non-registered care staff, other clinical staff that provide patient care on a full shift basis under the supervision and direction of a registered nurse/midwife can now be included in the CHPPD numbers. This includes allied health professional staff providing they work the full shift on that ward, e.g. a physiotherapist working a shift on a stroke unit.

2.4 Further anticipated benefits of using CHPPD
The guidance advises further that using CHPPD provides:

- A single comparable figure that can simultaneously represent both staffing levels and patient requirements, unlike actual hours or patient requirements alone.
- Facilitates comparisons between wards within a trust and nationally, also
- As CHPPD is divided by the number of patients, the value does not increase due to the size of a ward and facilitates comparisons between wards of different sizes.
- It differentiates registered nurses and midwives from healthcare support workers to ensure skill mix is well described and that nurse to patient ratio is encompassed within staff deployment considerations.
- An opportunity to compare planned CHPPD from the roster compared to what staff are actually on duty on each given day.

2.5 The limitations of using CHPPD

There are a number of limitations/caveats with using CHPPD. These include:

- The overarching principle is that CHPPD needs to be taken into context alongside the fuller workforce and quality metrics and professional risk assessments in order to be meaningful. This is in order to be able to reach an informed conclusion as to whether nursing and care staffing levels present a quality risk or not.
- It does not account for the skill mix or experience levels of the staff on that ward. For example, a ward might not have the full number of staff it was expecting or requires but the skills and experience of the staff on duty might be able to compensate for that, at least in part.
- As the guidance itself states, 23:59 hrs is not fully representative of the patient activity that may have happened on a given ward during the day. This is particularly so in some elective wards.
- For this Trust, CHPPD does not yet include the additional roles that have been introduced on the wards from nursing establishment monies, e.g. the patient discharge assistants, ward hygienists and enhanced care team members. The aggregated hours for these staff are provided in **Appendices One and Two** at **Column H** so that they are at least declared at this stage. The Trust is making changes to the e-roster so that these staff will be included automatically in the CHPPD calculation in the future. The aim will be to try and achieve this for the next version of this report.

3. NURSING AND MIDWIFERY STAFFING AT HEY

As the Trust Board has been advised in previous editions of this report, there are many things to consider in determining whether a ward has safe staffing or not. These include, but not exclusively, the following factors:

- Establishment levels
- Vacancy rates
- Patient acuity
- Skill mix (level of experience of the nursing/midwifery staff)
- Mitigation (other roles, additional support, other professionals, variable pay)
- Level of bed occupancy
- Care hours per patient day (CHPPD)
- Leadership – quality and consistency
- Team dynamics
- Ward systems and processes

It is important that all of these are considered in context alongside an over-arching professional judgement. Also, whilst patient harms such as avoidable hospital acquired pressure ulcers, falls etc. are of serious concern, for the purposes of safe staffing analysis, an assessment needs to be undertaken to establish whether any of these harms are linked to staffing levels, either as a direct/related consequence or not.

In order to try and simplify this and set it all into context, the Chief Nurse, Deputy Chief Nurse and Nurse Directors have developed an overall ‘Professional Staffing Safety Risk Assessment (after mitigation)’. The idea behind this is to identify any areas where patient care may be compromised or potentially compromised as a consequence of staffing levels. For example, a ward may have good staffing levels and yet still be seeing high levels of patient harm. Conversely, another ward may be carrying a lot of vacancies and have a high use of temporary staff but with no care

quality concerns. As such, it is important not to make assumptions either way without considering the fuller picture for each ward.

A real example is with regards to ward H70, currently. This ward has experienced two serious available pressure ulcer harms this year. However, the two serious incident investigations demonstrated no causal link between the harms and the staffing levels. Other factors contributed to these harms, including sub-optimal ward practices. Whilst these are unacceptable issues in their own right and need to be addressed, it is important to be able to make these distinctions. The professional risk assessments are now described.

4. PROFESSIONAL STAFFING SAFETY RISK ASSESSMENTS

Appendix One provides the Nursing Staffing Key metrics for June 2018 only. **Appendix Two** is the same for July 2018. **Appendix Three** provides the Staffing Quality indicators for July 2018 (not provided for June 2018). For the purposes of this report, **Appendices Two** and **Three** refer and provide the following information by ward:

- CHPPD (peer and national comparisons)
- Nursing and midwifery vacancies
- Temporary staffing
- Rota efficiency metrics:
    - Unavailability data (excluding maternity leave)
    - Rota approval times
    - Additional duties
    - Unfilled roster
    - Hours balance
    - Staff redeployment
    - HR metrics
    - Harm rates
        - Patient falls
        - Pressure ulcers

The following tables take all of these metrics into consideration and show the current positon of each inpatient area in relation safe staffing as determined and summarised by the Chief Nurse, Deputy Chief Nurse and Nurse Directors.

The Risk Ratings have been agreed as follows:

Risk Rating	Description
LOW	No staffing related quality concerns
MEDIUM	This could mean: • Although not triggering on quality issues, nursing staff vacancies are thought to be affecting/possibly affecting the quality of care being provided. • Ward is under review/watchful observation by the nurse director and senior matron. • Potential risks as a result of high bank/agency usage
HIGH	Serious quality concerns where there are evident links to staffing levels

4.1 Nursing and Midwifery Staffing Risk Assessments – July 2018
4.1.1 Medicine Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk assessment	Comments/Mitigation
AMU	**LOW**	No staffing related quality concerns	Staff support from H1 on rotation, support from nurse bank and agency. All beds staffed as assessment care level beds.
EAU	**MEDIUM**	Although not triggering on quality issues, nursing staff vacancies are thought to be affecting continuity of care. Under review.	1 RN from another health group, bank and agency utilised.
H1	**LOW**	No staffing related quality concerns	
H5/RHoB	**LOW**	No staffing related quality concerns	
H50	**LOW**	No staffing related quality concerns	
H500	**MEDIUM**	This ward has had two SI's recently, so the quality of care is under surveillance	Support gained from nurse bank and overtime.
H70	**MEDIUM**	This is one of the better staffed wards in medicine and yet it is still having some quality concerns. Under surveillance	2 recent hospital acquired pressure ulcers rated major harm but, following SI investigation, not related to staffing levels. Actions under way looking at the overall functioning of this ward. Utilising some agency and bank. B6s and B7 staff providing weekend cover. Additional A/N's in post.
H8	**MEDIUM**	Had a recent pressure ulcer SI (under investigation); not yet clear if staffing was a factor	Additional non-registered staff in post.
H80	**MEDIUM**	3 red fundamental standards scores although not thought to be related to staffing levels.	New Senior Ward Sister in post. Senior Matron supporting the ward. 2 RNs from other health group, One RN from EAU to support the ward.
PDU H9	**LOW**	No staffing related quality concerns	
H90	**LOW**	No staffing related quality concerns	Additional A/Ns in post.
H11	**MEDIUM**	No evidence of harm but the ward needs a lot of senior support. Under review	Recruitment of additional HCA's will be in post in August. Bank and agency utilised.
H110	**MEDIUM**	Not able to open additional HASU beds due to staffing levels.	Recruitment of additional HCA's will be in post in August. Bank and agency utilised.
CDU	**LOW**	No staffing related quality concerns	
C26	**MEDIUM**	One recent patient fall, with a catastrophic outcome. Ward under review.	2.2 WTE vacancies with high unavailability (maternity leave). Additional support obtained to cover maternity leave from nurse bank and from staff within cardiology.
C28/CMU	**LOW**	No staffing related quality concerns	

4.1.2 Surgery Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
H4	**LOW**	No staffing related quality concerns	Using bank and agency plus support from H40. Recruitment plan to rotate new RN's with 12th floor
H40	**LOW**	No staffing related quality concerns	
H6	**LOW**	No staffing related quality concerns	Using bank and agency plus mutual support with H6. New starters due September 2018
H60	**LOW**	No staffing related quality concerns	
H7	**MEDIUM**	No staffing related quality concerns	New staff requiring supervision. 'Short term' agency staff in place. Plans to close 6 beds from September for 8 weeks until staffing levels stabilise more
H100	**LOW**	No staffing related quality concerns	Red fundamental standards for nutrition, although not related to staffing levels.
H12	**LOW**	No staffing related quality concerns	
H120	**LOW**	No staffing related quality concerns	
HICU	**LOW**	No staffing related quality concerns	
C9	**LOW**	No staffing related quality concerns	
C10	**LOW**	No staffing related quality concerns	
C11	**LOW**	No staffing related quality concerns	
C14	**LOW**	No staffing related quality concerns	
C15	**LOW**	No staffing related quality concerns	
C27	**LOW**	No staffing related quality concerns	
CICU	**MEDIUM**	Not triggering any quality concerns but under review	New staff requiring extended periods of supervision

4.1.3 Family and Women's Health Group

Ward	Professional Staffing Safety Risk Assessment (after mitigation)	Rationale for risk rating	Actions
C16	**LOW**	No staffing related quality concerns	Utilising bank and agency. Utilising overtime and excess hours. 1 newly qualified member of staff will need supernumerary status and support 2 new recruits have withdrawn – looking to recruit further
H130	**LOW**	No staffing related quality concerns	Staff in the childrens' wards are flexed according to patient need, so these should be considered collectively. Utilising overtime hours to cover across the 13th Floor and Acorn. Agreement for staged recruitment to vacancies for paediatric staff across these areas. Will be at establishment in September 2018
Cedar H30	**LOW**		Utilising bank and agency on occasion
Maple H31	**LOW**	No staffing related quality concerns	
Rowan H33	**LOW**	No staffing related quality concerns	
Acorn H34	**LOW**	No staffing related quality concerns	
H35	**LOW**	No staffing related quality concerns	Utilising bank and agency Hours released from H35 - 216 hours released to support other wards
NICU	**LOW**	No staffing related quality concerns	
PAU	**LOW**	No staffing related quality concerns	
PHDU	**LOW**	No staffing related quality concerns	
Labour	**LOW**	No staffing related quality concerns	Midwife to birth ratio 1:32. Undertaking Birth rate plus results due in October 2018

4.1 4 Clinical Support Health Group

Ward	Professional Risk Assessment	Rationale for risk rating	Actions
C7	**LOW**	No staffing related quality concerns	
C29	**LOW**	No staffing related quality concerns	
C30	**LOW**	No staffing related quality concerns	3.3% RN vacancies & 4.9% ML however,
C31	**MEDIUM**	No quality indicators are triggering currently; this continues to be closely monitored	This ward has 39.4% RN vacancies & 4.7% ML. Actions taken have mitigated the risk. Utilising bank and agency, support from other inpatient wards, 5 beds currently closed due to staffing
C32	**MEDIUM**	No quality indicators are triggering	This ward has 14.9% RN vacancies & 3.4% ML; Utilising bank and agency, support from other inpatient wards
C33	**MEDIUM**	the actions taken are supporting the ward and no quality indicators are triggering; this continues to be closely monitored	This ward has 15.2% RN vacancies & high ML at 10.1%. Utilising bank and agency, support from other inpatient wards and have over recruited to non-registered posts to support

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 fewer than 2 x RN`s present on a ward during any shift. They are designed to support the nurse in charge of the shift to assess systematically that the available nursing staff for each shift, or at least each 24-hour period, is adequate to meet the actual nursing needs of patients on that ward.

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

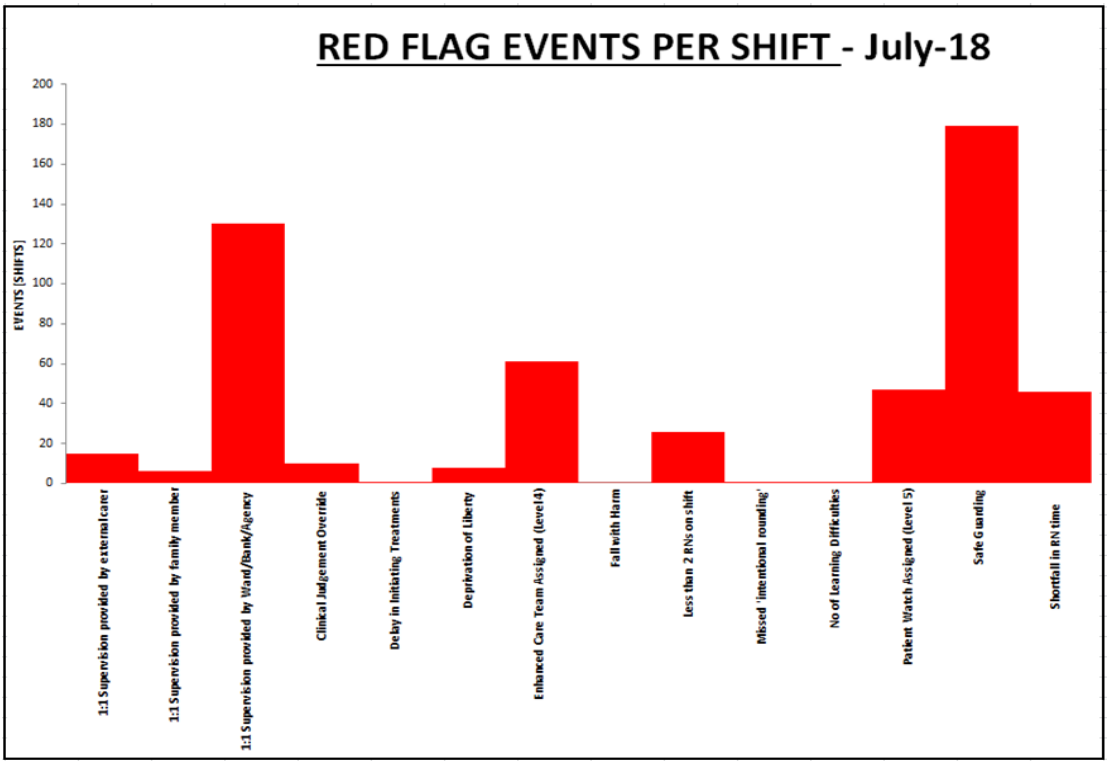
In addition, it is important to keep records of the on-the-day assessments of actual nursing staffing requirements and reported red flag events so that they can be used to inform future planning of ward nursing staff establishments or any other appropriate action(s).

The 'red flags' suggested by NICE, are:

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

The following table illustrates the number of 'Red Flags' identified during July 2018. 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.

Jul-18	RED FLAG TYPE	EVENTS [SHIFTS]	%
	1:1 Supervision provided by external carer	15	3%
	1:1 Supervision provided by family member	6	1%
	1:1 Supervision provided by Ward/Bank/Agency	130	24%
	Clinical Judgement Override	10	2%
	Delay in Initiating Treatments	1	0.50%
	Deprivation of Liberty	8	1.50%
	Enhanced Care Team Assigned (Level 4)	61	11%
	Fall with Harm	1	0.50%
	Less than 2 RNs on shift	26	5%
	Missed 'intentional rounding'	1	0.50%
	No of Learning Difficulties	1	0.50%
	Patient Watch Assigned (Level 5)	47	9%
	Safeguarding	179	33%
	Shortfall in RN time	46	8.50%
	TOTAL	532	100%



As illustrated above, the most frequently reported red flag that requires extra nursing time is related to the requirement for 1:1 supervision of some sort for patients. As indicated in the previous Board Reports, this is being addressed through the implementation of the Enhanced Care Team (ECT), which has now completed its pilot phase. Additional work has been commissioned by the Chief Nurse in order to further validate the results obtained through the pilot and will be presented to the Executive Management Committee in July 2018.

6. RECRUITMENT AND RETENTION

Robust recruitment continues within a number of specialities through the development of bespoke advertising campaigns and rotational programmes. Following successful interviews, the Trust is currently pursuing 115 student nurses who are due to complete their training in September 2018. This was originally 140. However, some students have taken up opportunities elsewhere, largely as they tend to apply to multiple trusts whilst deciding where they really wish to work.

Fifteen new Trainee Nursing Associates commence their programme in September 2018. In addition fifteen nursing student nursing apprentices start their programme in September 2018.

The Trust has also developed a unique Health Care Support Worker Apprenticeship programme with Hull College and the University of Hull (Fifteen places). This is a circa. two year programme aimed at 16-18 year olds that ultimately want to become registered nurses. The programme will provide the academic and practical underpinning to allow them to ultimately step into either traditional student nurse training or registered nursing apprenticeships at 18, subject to the attainment of the required academic qualifications (BTEC equivalent). This is a way of getting these people into gainful health employment as soon as they leave school at 16.

The International Nurses from the Philippines are all now passing their OSCE's and settling in well. Health Groups are looking to expand this programme subject to financial approval.

These developments are all really positive news in terms of helping to secure the workforce of the future.

7. ENSURING SAFE STAFFING

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

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

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

8. ESTABLISHMENT LEVELS

The nursing and midwifery establishments are set and funded to good standards and are reviewed twice a year in line with national guidance. These were last reviewed in May 2018 and are next due to report in the new calendar year as part of the Trust's operational planning round.

9. SUMMARY FOR THE NEW STYLE REPORT

It is too early to determine if the use of CHPPD will have any significant impact on helping to determine whether staffing levels are safe or not. CHPPD is only a number and must be set into context alongside a lot of other data before it can be meaningful. This will be analysed over time as trends are determined and when comparisons can be made. It provides the opportunity to benchmark and the usefulness of this will to be considered over time.

Also, a lot of information is provided in this report, particularly in the Appendices, which have attempted to be summarised in the body of the report. The Trust Board is requested to consider if this new format is helpful and whether the summary professional risk assessment provides the required assurances that the Trust's wards are staffed safely or otherwise.

10. RECOMMENDATION

The Trust Board is requested to:

- Receive this report
- Comment on the new report format as requested in section 9 and make any suggestions for improvement
- Decide if any if any further actions and/or information are required.

Mike Wright
Executive Chief Nurse
September 2018

Appendix 1: Nurse Staffing Key Metrics – June 2018
Appendix 2: Nurse Staffing Key Metrics – July 2018
Appendix 3: Nurse Staffing Quality Indicators – July 2018

HEY NURSE STAFFING KEY METRICS DASHBOARD

Jun-18

KEY METRICS ROTA: 11th Jun - 8th Jul 2018

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	PROFESSIONAL RISK ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST: Other care staff not included currently in CHPPD Monthly Hours	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M3]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]	TEMPORARY STAFFING [11th Jun - 8th Jul]: TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE: TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [< 1%]	STUDY DAY [<2.3%]	WORKING DAY [1%]	MAT LEAVE [<2.5%]	ROTA APPROVALS [6 WEEKS]: FULL [WKS]	PARTIAL [WKS]	ADDITIONAL DUTIES: TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [<20%]: UNFILLED ROSTER [%]	HOURS BALANCES [4 WEEKS] [NET + /- 2%]: HOURS BALANCE [%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]: NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	7.55	8.1%	-0.13	-0.6%	7.42	115.34	7.8%	7.3%	0.5%	90.6%	28.1%	6.1%	14.4%	1.0%	2.3%	0.3%	4.0%	6.3	6.4	1.2	0.8	0.4	17.7%	-1.0%	215.5	215.5	0.0
MEDICINE	AMU	GENERAL MEDICINE	45	LOW	178.5	1090	4.9	2.5	7.4	7.55	-0.15	7.31	0.09	10.43	23.6%	1.14	4.9%	11.57	67.57	5.7%	5.4%	0.3%	76.9%	29.4%	8.9%	14.3%	0.0%	2.3%	3.2%	0.7%	5.3	5.5	0.5	0.2	0.3	9.3%	-0.7%	198.0	215.5	17.5
MEDICINE	H1	GENERAL MEDICINE	22	LOW	399.0	617	2.7	1.8	4.5	7.55	-3.05	7.31	-2.81	0.76	5.2%	1.50	18.9%	2.26	22.51	14.6%	14.6%	0.0%	66.9%	27.4%	1.8%	14.0%	0.6%	1.3%	0.4%	9.3%	3.8	5.4	0.2	0.2	0.0	8.9%	-0.9%	50.0	76.5	26.5
MEDICINE	EAU	GERIATRIC MEDICINE	21	MEDIUM	375.9	570	3.7	3.0	6.7	6.94	-0.24	7.74	-1.04	3.78	19.8%	-4.11	-31.2%	-0.33	32.27	9.3%	6.5%	2.8%	80.3%	29.9%	1.7%	14.8%	2.4%	1.6%	4.5%	4.9%	8.4	8.9	0.1	0.1	0.0	16.6%	-1.7%	26.5	26.5	0.0
MEDICINE	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	220.5	1312	2.3	1.4	3.7	6.74	-3.04	6.38	-2.68	2.29	9.3%	0.44	3.3%	2.73	37.84	7.5%	7.2%	0.3%	51.9%	29.5%	3.3%	13.5%	0.6%	1.2%	3.6%	7.3%	4.2	5.7	0.2	0.2	0.0	9.7%	-1.5%	148.0	205.0	57.0
MEDICINE	H50	NEPHROLOGY	19	LOW	283.5	555	3.0	2.2	5.2	7.23	-2.03	7.00	-1.80	2.83	18.7%	-1.57	-18.6%	1.26	23.54	1.4%	1.1%	0.3%	34.0%	31.2%	3.3%	19.9%	0.0%	2.2%	1.3%	4.5%	4.2	4.5	0.3	0.3	0.0	17.9%	0.3%	-52.3	27.5	79.8
MEDICINE	H500	RESPIRATORY MEDICINE	24	MEDIUM	157.5	696	2.2	2.5	4.7	6.74	-2.04	6.38	-1.68	4.36	25.7%	-0.11	-0.9%	4.25	29.10	8.2%	7.3%	0.9%	47.0%	24.0%	2.2%	13.0%	0.0%	2.8%	6.0%	0.0%	3.0	3.7	0.3	0.2	0.1	14.2%	-1.1%	59.5	65.0	5.5
MEDICINE	H70	GENERAL MEDICINE	30	MEDIUM	441.0	890	2.5	2.6	5.1	7.55	-2.45	7.31	-2.21	5.9	29.4%	-1.52	-12.5%	4.38	32.22	19.8%	16.2%	3.6%	71.3%	15.7%	4.9%	7.6%	0.5%	1.9%	0.8%	0.0%	2.7	2.8	3.1	1.3	1.8	12.4%	0.2%	383.8	391.3	7.5
MEDICINE	H8	GERIATRIC MEDICINE	27	MEDIUM	220.5	799	2.2	2.4	4.6	6.94	-2.34	6.74	-2.14	2.7	16.3%	-0.87	-6.6%	1.83	29.78	6.1%	5.9%	0.2%	30.6%	23.2%	4.0%	12.6%	0.6%	0.7%	0.1%	5.2%	5.3	5.9	1.7	1.6	0.1	17.2%	-0.1%	43.5	59.0	15.5
MEDICINE	H80	GERIATRIC MEDICINE	27	MEDIUM	220.5	789	2.1	2.5	4.7	6.94	-2.24	6.74	-2.04	4.63	27.9%	-0.16	-1.2%	4.47	29.78	12.4%	11.6%	0.8%	61.3%	28.8%	14.2%	9.9%	0.0%	0.2%	0.7%	3.8%	5.3	5.5	1.2	1.1	0.1	14.6%	0.8%	203.6	209.1	5.5
MEDICINE	PDU H9	GERIATRIC MEDICINE	30	LOW	913.5	869	1.7	2.5	4.2	6.94	-2.74	6.74	-2.54	0.00	0.0%	0.00	0.0%	0.00	29.78	6.5%	4.8%	1.7%	77.0%	19.1%	2.3%	12.6%	0.0%	0.6%	3.6%	0.0%	1.7	2.4	0.6	0.5	0.1	4.4%	0.6%	80.5	80.5	0.0
MEDICINE	H90	GERIATRIC MEDICINE	29	LOW	252.0	858	2.1	2.4	4.5	6.94	-2.44	6.74	-2.24	4.75	28.6%	-1.71	-13.0%	3.04	29.78	12.2%	11.1%	1.1%	75.3%	24.6%	12.6%	9.4%	0.7%	1.4%	0.5%	0.0%	2.4	2.4	1.6	1.0	0.6	11.3%	1.2%	142.0	164.5	22.5
MEDICINE	H11	STROKE / NEUROLOGY	28	MEDIUM	126.0	782	2.3	2.5	4.9	7.55	-2.65	7.41	-2.51	5.09	22.6%	2.57	24.2%	7.66	33.16	16.2%	16.0%	0.2%	60.3%	27.3%	4.0%	15.8%	0.5%	2.2%	1.1%	3.7%	2.4	2.5	0.4	0.3	0.1	16.7%	-0.2%	68.0	94.5	26.5
MEDICINE	H110	STROKE / NEUROLOGY	24	MEDIUM	252.0	533	3.7	3.7	7.4	7.55	-0.15	7.41	-0.01	7.78	34.6%	0.02	0.2%	7.80	33.64	14.3%	14.3%	0.0%	53.0%	25.4%	8.9%	8.7%	0.0%	3.3%	0.9%	3.6%	4.5	4.5	3.4	3.3	0.1	27.2%	0.2%	35.0	81.5	46.5
MEDICINE	CDU	CARDIOLOGY	9	LOW	0.0	223	4.1	0.9	5.0	7.93	-2.93	7.73	-2.73	2.64	20.6%	0.15	5.1%	2.79	15.74	1.8%	1.8%	0.0%	34.0%	33.9%	13.0%	12.8%	0.0%	0.0%	0.0%	8.1%	4.8	5.5	0.0	0.0	0.0	10.9%	0.1%	0.0	0.0	0.0
MEDICINE	C26	CARDIOLOGY / CTS	26	MEDIUM	236.5	980	2.9	1.1	4.0	8.46	-4.46	9.93	-5.93	2.2	8.5%	0.61	7.7%	2.81	33.73	0.4%	0.0%	0.4%	32.5%	30.9%	4.6%	15.0%	0.0%	2.3%	0.2%	8.8%	-0.3	3.5	0.0	0.0	0.0	18.3%	-0.9%	33.0	33.0	0.0
MEDICINE	C28 /CMU	CARDIOLOGY	27	LOW	277.2	649	6.5	1.6	8.1	7.44	0.66	7.87	0.23	3.26	8.5%	1.37	14.3%	4.63	47.78	2.6%	2.6%	0.0%	82.6%	27.5%	3.7%	17.7%	0.0%	2.6%	1.2%	2.3%	7.4	7.5	0.0	0.0	0.0	7.7%	-0.3%	0.0	0.0	0.0
SURGERY	H4	NEUROSURGERY	28	LOW	157.5	715	3.2	2.1	5.2	8.39	-3.19	8.71	-3.51	5.08	23.3%	0.45	4.3%	5.53	32.28	17.4%	16.8%	0.6%	82.5%	31.8%	5.1%	10.7%	0.0%	6.0%	2.9%	7.1%	6.3	6.3	1.3	1.0	0.3	14.4%	-0.3%	159.5	165.5	6.0
SURGERY	H40	NEUROSURGERY / TRAUMA	15	LOW	105.0	357	6.6	3.9	10.5	8.39	2.11	8.71	1.79	2.62	12.6%	0.50	4.5%	3.12	31.95	9.9%	9.6%	0.3%	70.5%	25.2%	5.3%	14.2%	0.5%	2.5%	2.7%	0.0%	7.9	8.3	1.5	1.4	0.1	9.8%	1.6%	56.5	61.5	5.0
SURGERY	H6	GENERAL SURGERY	28	LOW	283.5	697	3.2	2.4	5.6	6.99	-1.39	7.26	-1.66	2.91	15.2%	1.13	10.6%	4.04	29.74	20.7%	19.9%	0.8%	73.3%	31.6%	2.3%	16.2%	3.3%	2.4%	3.4%	4.0%	8.5	8.8	0.4	0.2	0.2	10.9%	-2.0%	97.8	143.8	46.0
SURGERY	H60	GENERAL SURGERY	28	LOW	126.0	751	3.0	2.3	5.3	6.99	-1.69	7.26	-1.96	1.56	8.2%	0.81	7.6%	2.37	29.74	5.6%	5.0%	0.6%	51.4%	20.9%	4.0%	13.9%	0.8%	1.1%	1.1%	0.0%	8.7	8.8	0.3	0.3	0.0	6.9%	0.2%	19.3	66.8	47.5
SURGERY	H7	VASCULAR SURGERY	30	MEDIUM	283.5	807	3.2	2.3	5.4	6.99	-1.59	7.26	-1.86	3.91	18.0%	1.09	8.3%	5.00	34.89	10.8%	5.5%	5.3%	66.6%	24.5%	2.3%	14.2%	0.0%	0.5%	7.5%	0.0%	8.7	8.9	0.4	0.4	0.0	8.1%	1.7%	-160.5	17.0	177.5
SURGERY	H100	GASTROENTEROLOGY	27	LOW	239.4	783	2.7	2.2	4.9	6.63	-1.73	6.29	-1.39	2.09	10.9%	1.76	14.6%	3.85	31.23	19.9%	19.3%	0.6%	82.0%	32.4%	6.2%	9.3%	0.2%	1.5%	9.5%	5.7%	7.6	7.8	1.2	0.9	0.3	9.3%	-0.5%	145.0	151.0	6.0
SURGERY	H12	ORTHOPAEDIC	28	LOW	252.0	748	3.0	2.7	5.7	7.13	-1.43	7.25	-1.55	3.67	16.8%	-2.60	-19.8%	1.07	35.00	10.3%	8.4%	1.9%	51.0%	33.8%	5.9%	12.7%	0.4%	2.3%	9.7%	2.8%	6.9	7.3	1.6	1.5	0.1	14.6%	-1.1%	97.8	105.8	8.0
SURGERY	H120	ORTHO / MAXFAX	22	LOW	283.5	575	3.6	3.1	6.7	7.13	-0.43	7.25	-0.55	1.14	6.9%	0.35	3.0%	1.49	28.42	6.8%	5.7%	1.1%	77.0%	21.7%	1.6%	14.7%	0.0%	2.2%	3.2%	0.0%	7.7	7.8	0.2	0.2	0.0	6.5%	-1.1%	11.0	11.0	0.0
SURGERY	HICU	CRITICAL CARE	22	LOW	252.0	430	26.5	2.0	28.5	27.13	1.37	26.60	1.90	6.3	6.0%	-0.40	-5.5%	5.90	112.20	0.0%	0.0%	0.0%	Nil	25.3%	4.7%	13.7%	0.5%	1.1%	1.7%	3.6%	7.8	8.6	0.8	0.8	0.0	15.1%	-0.8%	76.7	207.3	130.6
SURGERY	C9	ORTHOPAEDIC	35	LOW	252.0	715	3.8	2.3	6.1	7.13	-1.03	7.25	-1.15	1.57	7.2%	0.63	5.5%	2.20	33.39	9.5%	9.0%	0.5%	49.4%	24.8%	1.2%	15.5%	0.1%	1.2%	2.4%	4.4%	9.6	9.7	0.0	0.0	0.0	10.4%	-0.4%	-51.0	21.0	72.0
SURGERY	C10	GENERAL SURGERY	21	LOW	252.0	517	4.2	1.6	5.8	6.99	-1.19	7.26	-1.46	1.54	8.4%	1.03	13.2%	2.57	26.08	13.1%	13.1%	0.0%	59.6%	29.7%	7.0%	11.0%	1.0%	3.9%	4.2%	2.6%	7.8	7.9	0.3	0.2	0.1	11.2%	-0.6%	16.0	48.5	32.5
SURGERY	C11	GENERAL SURGERY	22	LOW	252.0	438	4.5	2.5	7.0	6.99	0.01	7.26	-0.26	1.43	7.8%	0.63	8.1%	2.06	26.08	7.2%	7.2%	0.0%	42.7%	24.4%	6.6%	16.3%	0.0%	1.5%	0.0%	0.0%	7.4	7.4	0.5	0.4	0.1	13.4%	0.6%	7.8	83.3	75.5
SURGERY	C14	GENERAL SURGERY	27	LOW	283.5	635	3.9	1.8	5.6	6.99	-1.39	7.26	-1.66	0.96	4.7%	0.27	3.0%	1.23	29.38	4.1%	3.8%	0.3%	79.6%	23.7%	3.6%	14.7%	0.7%	3.2%	1.5%	0.0%	7.5	7.9	0.2	0.1	0.1	10.3%	0.5%	-9.5	29.5	39.0
SURGERY	C15	UROLOGY	26	LOW	283.5	563	4.2	2.4	6.7	6.47	0.23	6.67	0.03	0.63	3.1%	0.09	0.7%	0.72	32.71	11.5%	11.5%	0.0%	80.7%	29.7%	3.0%	19.3%	0.4%	1.1%	1.4%	4.5%	8.8	8.9	0.2	0.2	0.0	7.0%	0.3%	37.5	65.3	27.8
SURGERY	C27	CARDIOTHORACIC	26	LOW	283.5	461	6.0	2.5	8.5	8.46	0.04	9.93	-1.43	1.1	4.7%	0.34	3.9%	1.44	32.22	2.6%	2.6%	0.0%	80.8%	23.7%	2.1%	12.3%	1.4%	2.1%	2.3%	3.5%	7.3	7.4	0.1	0.1	0.0	5.9%	0.6%	29.5	34.5	5.0
SURGERY	CICU	CRITICAL CARE	22	MEDIUM	157.5	460	19.0	1.4	20.4	27.13	-6.73	26.60	-6.20	12.64	13.6%	1.17	15.5%	13.81	100.50	0.9%	0.9%	0.0%	89.4%	25.2%	2.4%	15.6%	0.0%	1.2%	2.5%	3.5%	7.8	8.9	0.1	0.1	0.0	23.7%	1.4%	-134.0	104.8	238.8
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	457	4.3	2.5	6.8	6.58	0.22	9.03	-2.23	4.12	22.3%	0.87	7.8%	4.99	29.65	7.8%	7.3%	0.5%	66.7%	27.3%	2.3%	13.5%	0.0%	1.2%	2.0%	8.3%	6.4	6.5	1.4	1.3	0.1	4.4%	0.3%	-23.5	14.0	37.5
FAMILY & WOMEN'S	H130	PAEDIATRICS	20	LOW	205.8	306	6.8	1.9	8.7	11.44	-2.74	12.20	-3.50	1.4	6.6%	2.06	39.5%	3.46	26.59	0.2%	0.2%	0.0%	109.1%	28.2%	6.3%	15.3%	0.0%	2.2%	1.5%	2.9%	7.9	7.9	0.8	0.8	0.0	34.0%	1.8%	1.0	12.0	11.0
FAMILY & WOMEN'S	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	146	10.0	3.1	13.1	8.02	5.08	7.70	5.40	0.14	1.9%	0.12	3.1%	0.26	11.33	3.3%	3.3%	0.0%	55.7%	30.6%	0.0%	11.9%	2.0%	1.5%	3.5%	11.7%	5.9	6.9	0.0	0.0	0.0	26.9%	-0.8%	-8.0	0.0	8.0
FAMILY & WOMEN'S	H31 MAPLE	OBSTETRICS	20	LOW	0.0	413	5.3	3.0	8.4	10.11	-1.71	15.48	-7.08	-0.45	-0.97%	0.87	3.21%	0.42	73.34	0.7%	0.7%	0.0%	89.5%	32.2%	10.1%	16.7%	0.3%	1.3%	1.2%	2.6%	6.5	7.9	0.0	0.0	0.0	13.8%	0.2%	13.3	13.3	0.0
FAMILY & WOMEN'S	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1159	2.5	1.5	4.0	10.11	-6.11	15.48	-11.48							0.4%	0.4%	0.0%	85.7%	18.5%	1.0%	12.5%	0.0%	2.2%	0.6%	2.2%			0.0	0.0	0.0	8.4%	0.3%	0.0	0.0	0.0
FAMILY & WOMEN'S	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	293	8.1	1.8	10.0	9.11	0.89	11.01	-1.01	0.94	4.5%	-0.46	-8.8%	0.48	26.00	3.3%	3.3%	0.0%	80.8%	29.1%	3.2%	16.3%	0.0%	4.1%	1.9%	3.6%	3.8	6.6	0.0	0.0	0.0	13.6%	1.7%	24.5	24.5	0.0
FAMILY & WOMEN'S	H35	OPHTHALMOLOGY	12	LOW	285.6	261	5.8	1.1	6.9	11.20	-4.30	10.70	-3.80	0.18	1.6%	1.74	64.2%	1.92	13.84	7.1%	7.1%	0.0%	54.2%	40.0%	13.5%	8.9%	0.6%	0.6%	0.1%	16.3%	7.6	8.7	0.0	0.0	0.0	20.5%	-0.9%	-216.8	33.8	250.5
FAMILY & WOMEN'S	LABOUR	MATERNITY	16	LOW	369.6	307	19.0	5.1	24.2	10.11	14.09	15.48	8.72	-2.09	-4.2%	-2.84	-20.7%	-4.93	63.84	2.0%	2.0%	0.0%	92.6%	21.9%	5.8%	11.5%	0.8%	1.7%	0.3%	1.8%	6.3	6.5	6.9	0.1	6.8	5.1%	-0.5%	-13.1	24.4	37.5
FAMILY & WOMEN'S	NEONATES	NEONATOLOGY	26	LOW	157.5	686	11.8	0.9	12.7	13.26	-0.56	12.98	-0.28	3.81	5.7%	0.8	10.6%	4.61	74.51	3.7%	3.7%	0.0%	81.7%	27.6%	1.8%	15.0%	0.0%	3.9%	2.9%	4.0%	6.7	6.9	0.3	0.3	0.0	6.3%	0.5%	18.0	30.0	12.0
FAMILY & WOMEN'S	PAU	PAEDIATRICS	10	LOW	0.0	59	20.9	0.0	20.9	11.44	9.46	12.20	8.70	1.08	10.3%	0		1.08	10.44	2.9%	2.9%	0.0%	57.7%	29.2%	0.0%	18.1%	0.0%	2.6%	0.0%	8.5%	7.9	7.9	0.0	0.0	0.0	13.1%	1.2%	-23.0	0.0	23.0
FAMILY & WOMEN'S	PHDU	PAEDIATRICS	4	LOW	0.0	64	23.0	2.1	25.1	11.44	13.66	12.20	12.90	-0.68	-5.8%	0		-0.68	11.66	0.0%	0.0%	0.0%	Nil	24.4%	0.0%	18.2%	0.0%	2.8%	0.0%	3.4%	7.9	7.9	0.5	0.5	0.0	4.8%	2.0%	-8.0	0.0	8.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASES	12	LOW	157.5	302	4.9	3.7	8.6	7.76	0.84	7.91	0.69	-0.07	-0.6%	2.22	27.1%	2.15	20.22	0.0%	0.0%	0.0%	Nil	20.4%	4.6%	13.8%	0.0%	2.0%	0.0%	0.0%	6.3	6.6	0.1	0.0	0.1	3.9%	-0.6%	18.5	42.5	24.0
CLINICAL SUPPORT	C29	REHABILITATION	15	LOW	147.0	623	2.4	2.6	5.1	7.69	-2.59	6.66	-1.56	-1.12	-8.5%	2.59	16.4%	1.47	28.89	3.5%	3.5%	0.0%	75.5%	24.7%	3.3%	17.0%	0.0%	4.4%	0.0%	0.0%	6.8	6.9	0.6	0.5	0.1	10.7%	0.1%	35.5	43.0	7.5
CLINICAL SUPPORT	C30	CLINICAL ONCOLOGY	22	LOW	220.5	627	2.7	1.8	4.4	7.92	-3.52	7.14	-2.74	0.46	3.3%	1.67	20.9%	2.13	21.97	9.3%	6.9%	2.4%	85.9%	27.8%	4.9%	11.7%	0.0%	2.2%	4.1%	4.9%	6.8	6.8	0.3	0.2	0.1	3.2%	-0.7%	38.0	57.5	19.5
CLINICAL SUPPORT	C31	CLINICAL ONCOLOGY	27	MEDIUM	220.5	606	2.7	2.2	4.9	7.92	-3.02	7.14	-2.24	5.51	39.4%	0.13	1.1%	5.64	25.74	10.3%	7.9%	2.4%	58.1%	24.9%	4.4%	14.7%	0.0%	0.4%	0.7%	4.7%	6.8	7.6	1.7	1.6	0.1	14.0%	-1.4%	111.5	128.5	17.0
CLINICAL SUPPORT	C32	CLINICAL ONCOLOGY	22	MEDIUM	220.5	650	2.6	1.6	4.2	7.92	-3.72	7.14	-2.94	2.08	14.9%	0.07	0.7%	2.15	23.57	4.2%	2.0%	2.2%	41.5%	18.4%	0.8%	13.0%	0.0%	1.2%	0.0%	3.4%	6.8	6.9	0.1	0.0	0.1	7.3%	-0.1%	1.0	22.0	21.0
CLINICAL SUPPORT	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	220.5	778	3.3	1.8	5.1	8.21	-3.11	7.23	-2.13	4.16	15.2%	-2.03	-25.4%	2.13	35.44	6.1%	5.8%	0.3%	40.1%	31.5%	2.1%	16.5%	0.0%	1.6%	1.2%	10.1%	6.3	6.3	1.3	1.2	0.1	13.7%	1.3%	-77.0	99.0	176.0
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR	TOTALS:			10505.5	604	5.8	2.2	8.1	8.84	-37.46	9.25	-57.54	139.57	10.9%	12.68	2.5%	158.06	1786.40	7.2%	6.6%	0.7%	66.7%	26.8%	4.5%	13.9%	0.4%	2.0%	2.1%	3.9%	6.2	6.7	37.9	25.4	12.5	12.3%	0.0%	1925.8	3805.6	1879.8

HEY NURSE STAFFING KEY METRICS DASHBOARD

Jul-18

KEY METRICS ROTA: 9th Jul - 5th Aug 2018

HEALTH GROUP	WARD	SPECIALITY CODE	BEDS	PROFESSIONAL RISK ASSESSMENT	CARE HOURS PER PATIENT DAY [CHPPD] [hrs] PEER HOSPITALS - CHKS LIST: Other care staff not currently included in CHPPD HPW	Cumulative Count Over The Month of Patients at 23:59 Each Day	RN / RM	CARE STAFF	OVERALL	MODEL HOSPITAL PEER	VARIANCE AGAINST PEER	MODEL HOSPITAL NATIONAL	VARIANCE AGAINST NATIONAL	NURSING & MIDWIFERY VACANCIES [FINANCE LEDGER M4]: RN [WTE]	RN % [<10%]	NON -RN- [WTE]	NON - RN-% [<10%]	TOTAL VACANCY [WTE]	RN & NON-RN-Est. [WTE]	TEMPORARY STAFFING [9th Jul - 5th Aug-18]: TOTAL [10%]	BANK [%]	AGENCY [%]	BANK & AGENCY FILL RATE [80%]	UNAVAILABILITY HEADROOM 21.6% EXCLUDES MATERNITY LEAVE: TOTAL [21.6%]	SICK RN & AN [3.9%]	ANNUAL LEAVE [11-17%]	OTHER [< 1%]	STUDY DAY [<2.3%]	WORKING DAY [1%]	MAT LEAVE [<2.5%]	ROTA APPROVALS [6 WEEKS]: FULL [WKS]	PARTIAL [WKS]	ADDITIONAL DUTIES: TOTAL [WTE]	LEGITIMATE [WTE]	AVOIDABLE [WTE]	UNFILLED ROSTER [<20%]: UNFILLED ROSTER [%]	HOURS BALANCES [4 WEEKS] [NET + /- 2%]: HOURS BALANCE [%]	STAFF REDEPLOYMENT [INBOUND INC. 208 & ECT]: NET VARIANCE [HRS]	INBOUND [HRS]	OUTBOUND [HRS]
MEDICINE	ED	GENERAL MEDICINE	NA	LOW	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.48	4.8%	-0.13	-0.6%	4.35	115.34	6.2%	5.4%	0.8%	78.6%	27.7%	5.9%	16.5%	0.1%	1.7%	0.2%	3.3%	7.3	8.5	1.1	0.4	0.7	18.4%	-1.0%	215.5	215.5	0.0
	AMU	GENERAL MEDICINE	45	MEDIUM	187.0	1212	4.4	2.4	6.9	7.55	-0.65	7.31	-0.41	11.23	25.4%	3.53	15.1%	14.76	67.57	8.0%	7.6%	0.4%	72.4%	28.7%	10.1%	13.2%	0.4%	1.7%	3.2%	0.1%	6.3	6.3	0.6	0.3	0.3	7.9%	-0.7%	199.5	215.5	16.0
	H1	GENERAL MEDICINE	22	LOW	418.0	653	2.6	1.9	4.5	7.55	-3.05	7.31	-2.81	0.76	5.2%	1.50	18.9%	2.26	22.51	15.7%	15.4%	0.3%	62.6%	27.4%	2.1%	14.8%	0.0%	1.0%	0.3%	9.2%	4.6	5.5	0.7	0.4	0.3	12.2%	-0.9%	69.0	76.5	7.5
	EAU	GERIATRIC MEDICINE	21	MEDIUM	393.8	619	3.4	3.0	6.3	6.94	-0.64	7.74	-1.44	4.78	25.0%	-4.00	-30.4%	0.78	32.27	4.2%	2.8%	1.4%	40.4%	28.4%	1.9%	15.7%	3.2%	0.8%	3.5%	3.3%	6.8	7.5	0.4	0.3	0.1	20.3%	-1.7%	-4.0	26.5	30.5
	H5 / RHOB	RESPIRATORY MEDICINE	26	LOW	231.0	1376	2.2	1.3	3.5	6.74	-3.24	6.38	-2.88	3.29	13.3%	0.44	3.3%	3.73	37.84	6.9%	6.1%	0.8%	37.3%	33.5%	2.9%	16.9%	0.0%	2.1%	4.2%	7.4%	5.5	7.5	0.2	0.2	0.0	16.3%	-1.5%	185.0	205.0	20.0
	H50	NEPHROLOGY	19	LOW	297.0	581	3.0	2.3	5.3	7.23	-1.93	7.00	-1.70	2.83	18.7%	-1.57	-18.6%	1.26	23.54	1.2%	1.2%	0.0%	73.9%	23.3%	0.4%	14.6%	0.0%	1.7%	2.0%	4.6%	4.6	7.4	0.0	0.0	0.0	13.8%	0.3%	-29.4	27.5	56.9
	H500	RESPIRATORY MEDICINE	24	MEDIUM	165.0	735	2.2	2.4	4.6	6.74	-2.14	6.38	-1.78	5.36	31.6%	-0.11	-0.9%	5.25	29.10	15.6%	14.7%	0.9%	64.9%	26.0%	3.5%	16.6%	0.0%	3.0%	2.9%	0.0%	-1.7	0.0	0.2	0.2	0.0	14.3%	-1.1%	41.5	65.0	23.5
	H70	GENERAL MEDICINE	30	MEDIUM	462.0	919	2.3	2.5	4.8	7.55	-2.75	7.31	-2.51	6.42	32.0%	-1.52	-12.5%	4.90	32.22	25.5%	21.1%	4.4%	70.0%	28.2%	10.4%	12.0%	0.5%	1.7%	3.6%	0.0%	2.3	3.5	2.0	1.3	0.7	16.2%	0.2%	383.3	391.3	8.0
	H8	GERIATRIC MEDICINE	27	MEDIUM	231.0	824	2.1	2.4	4.6	6.94	-2.34	6.74	-2.14	3.7	22.3%	0.13	1.0%	3.83	29.78	12.4%	11.8%	0.6%	68.7%	28.6%	4.0%	16.5%	1.2%	0.7%	0.1%	6.1%	6.6	7.6	0.6	0.4	0.2	19.3%	-0.1%	59.0	59.0	0.0
	H80	GERIATRIC MEDICINE	27	MEDIUM	231.0	814	2.1	2.5	4.6	6.94	-2.34	6.74	-2.14	5.63	33.9%	0.04	0.3%	5.67	29.78	10.8%	9.6%	1.2%	46.0%	30.8%	10.4%	13.7%	0.3%	1.1%	1.5%	3.8%	4.3	7.5	0.5	0.4	0.1	16.2%	0.8%	198.6	209.1	10.5
	PDU H9	GERIATRIC MEDICINE	30	LOW	957.0	868	1.8	2.6	4.3	6.94	-2.64	6.74	-2.44	6.5	39.1%	-5.24	-39.8%	1.26	29.78	8.5%	4.5%	4.0%	68.3%	24.5%	7.7%	16.3%	0.2%	0.3%	0.0%	0.0%	2.3	2.3	1.0	0.8	0.2	14.5%	0.6%	54.5	80.5	26.0
	H90	GERIATRIC MEDICINE	29	LOW	264.0	851	2.1	2.3	4.4	6.94	-2.54	6.74	-2.34	4.75	28.6%	0.29	2.2%	5.04	29.78	8.7%	8.1%	0.6%	69.2%	25.0%	11.8%	12.0%	0.2%	0.6%	0.4%	0.0%	2.9	2.9	0.5	0.3	0.2	17.9%	1.2%	128.5	164.5	36.0
	H11	STROKE / NEUROLOGY	28	MEDIUM	132.0	831	2.2	2.4	4.6	7.55	-2.95	7.41	-2.81	5.09	22.6%	2.57	24.2%	7.66	33.16	15.6%	15.3%	0.3%	49.1%	25.9%	1.4%	15.5%	1.9%	0.9%	0.3%	5.9%	2.9	3.3	0.4	0.3	0.1	20.1%	-0.2%	48.5	94.5	46.0
	H110	STROKE / NEUROLOGY	24	MEDIUM	264.0	520	3.6	3.7	7.3	7.55	-0.25	7.41	-0.11	7.78	34.6%	0.02	0.2%	7.80	33.64	11.5%	11.3%	0.2%	42.3%	24.6%	1.5%	12.0%	0.2%	3.3%	3.7%	3.9%	2.9	3.8	1.2	1.0	0.2	21.0%	0.2%	81.5	81.5	0.0
	CDU	CARDIOLOGY	9	LOW	0.0	125	9.1	2.6	11.7	7.93	3.77	7.73	3.97	3	23.4%	0.15	5.1%	3.15	15.74	2.4%	2.4%	0.0%	50.4%	29.4%	9.1%	11.3%	0.0%	0.0%	0.0%	9.0%	-1.1	-1.1	0.0	0.0	0.0	11.2%	0.1%	0.0	0.0	0.0
	C26	CARDIOLOGY / CTS	26	MEDIUM	247.7	980	2.9	1.1	4.0	8.46	-4.46	9.93	-5.93	2.51	9.7%	0.61	7.7%	3.12	33.73	4.0%	4.0%	0.0%	43.8%	32.3%	5.1%	14.2%	0.6%	0.3%	3.2%	8.9%	4.9	6.3	0.1	0.1	0.0	17.2%	-0.9%	33.0	33.0	0.0
	C28 /CMU	CARDIOLOGY	27	LOW	290.4	724	6.0	1.5	7.5	7.44	0.06	7.87	-0.37	3.26	8.5%	1.37	14.3%	4.63	47.78	2.3%	2.0%	0.3%	78.2%	27.4%	6.4%	14.8%	0.0%	2.2%	1.7%	2.3%	6.9	7.6	0.1	0.1	0.0	22.0%	-0.3%	-14.0	0.0	14.0
SURGERY	H4	NEUROSURGERY	28	LOW	165.0	815	2.7	2.2	5.0	8.39	-3.39	8.71	-3.71	5.08	23.3%	0.45	4.3%	5.53	32.28	13.9%	13.7%	0.2%	80.2%	31.8%	5.1%	15.1%	0.4%	3.9%	0.0%	7.3%	6.9	8.5	1.4	1.2	0.2	16.8%	-0.3%	153.5	165.5	12.0
	H40	NEUROSURGERY / TRAUMA	15	LOW	132.0	433	6.3	3.8	10.1	8.39	1.71	8.71	1.39	2.62	12.6%	-1.14	-10.3%	1.48	31.95	11.0%	7.2%	3.8%	65.5%	29.1%	7.7%	14.1%	0.0%	1.8%	5.5%	0.0%	4.8	4.9	1.5	1.3	0.2	9.3%	1.6%	50.0	61.5	11.5
	H6	GENERAL SURGERY	28	LOW	297.0	713	3.3	2.2	5.5	6.99	-1.49	7.26	-1.76	2.91	15.2%	1.13	10.6%	4.04	29.74	12.6%	12.3%	0.3%	70.5%	24.4%	4.5%	12.5%	0.3%	1.8%	1.7%	3.6%	8.5	8.5	0.3	0.3	0.0	10.1%	-2.0%	98.1	143.1	45.0
	H60	GENERAL SURGERY	28	LOW	132.0	771	3.0	2.3	5.3	6.99	-1.69	7.26	-1.96	1.56	8.2%	0.81	7.6%	2.37	29.74	7.8%	7.7%	0.1%	55.0%	26.8%	5.5%	18.5%	0.6%	0.8%	0.6%	0.8%	8.6	8.8	0.2	0.1	0.1	8.9%	0.2%	50.8	66.8	16.0
	H7	VASCULAR SURGERY	30	MEDIUM	297.0	807	3.2	2.3	5.4	6.99	-1.59	7.26	-1.86	5.16	23.7%	1.09	8.3%	6.25	34.89	14.7%	7.8%	6.9%	62.5%	25.0%	5.0%	15.3%	0.0%	1.1%	3.6%	0.0%	8.6	9.3	0.1	0.1	0.0	13.5%	1.7%	-23.0	17.0	40.0
	H100	GASTROENTEROLOGY	27	LOW	250.8	804	2.8	2.1	5.0	6.63	-1.63	6.29	-1.29	2.09	10.9%	0.52	4.3%	2.61	31.23	15.1%	13.9%	1.2%	67.6%	25.9%	3.3%	16.6%	0.2%	0.8%	2.9%	2.1%	6.7	6.7	0.0	0.0	0.0	10.4%	-0.5%	102.5	151.0	48.5
	H12	ORTHOPAEDIC	28	LOW	264.0	808	2.9	2.5	5.3	7.13	-1.83	7.25	-1.95	3.67	16.8%	-2.60	-19.8%	1.07	35.00	12.1%	9.8%	2.3%	53.5%	34.5%	7.0%	16.0%	0.0%	1.7%	7.0%	2.8%	6.3	7.5	1.0	0.9	0.1	14.4%	-1.1%	58.3	105.8	47.5
	H120	ORTHO / MAXFAX	22	LOW	297.0	598	3.5	3.2	6.7	7.13	-0.43	7.25	-0.55	1.74	10.5%	0.35	3.0%	2.09	28.42	8.6%	6.1%	2.5%	87.4%	22.4%	7.6%	11.4%	1.2%	0.6%	1.6%	0.0%	4.8	6.3	0.6	0.5	0.1	5.5%	-1.1%	-35.0	11.0	46.0
	HICU	CRITICAL CARE	22	LOW	264.0	496	25.1	2.0	27.1	27.13	-0.03	26.60	0.50	4.66	4.4%	-0.40	-5.5%	4.26	112.20	0.0%	0.0%	0.0%	Nil	28.5%	7.9%	14.0%	0.3%	0.7%	1.7%	3.9%	7.9	9.3	0.0	0.0	0.0	17.6%	-0.8%	50.8	207.3	156.5
	C9	ORTHOPAEDIC	35	LOW	264.0	715	3.8	2.3	6.1	7.13	-1.03	7.25	-1.15	1.57	7.2%	0.79	6.8%	2.36	33.39	6.0%	6.0%	0.0%	38.0%	22.7%	1.7%	14.8%	0.0%	0.7%	1.1%	4.4%	9.3	9.3	0.4	0.4	0.0	14.6%	-0.4%	-121.0	21.0	142.0
	C10	GENERAL SURGERY	21	LOW	264.0	539	4.0	1.8	5.8	6.99	-1.19	7.26	-1.46	2.54	13.9%	1.03	13.2%	3.57	26.08	17.0%	14.9%	2.1%	59.6%	30.6%	4.9%	16.2%	0.0%	2.8%	4.1%	2.6%	7.3	7.3	0.5	0.5	0.0	12.9%	-0.6%	-4.8	48.5	53.3
	C11	GENERAL SURGERY	22	LOW	264.0	578	3.8	2.0	5.8	6.99	-1.19	7.26	-1.46	2.43	13.3%	0.20	2.6%	2.63	26.08	13.4%	12.2%	1.2%	64.3%	26.4%	7.3%	16.6%	0.0%	2.4%	0.1%	0.0%	7.9	8.5	0.5	0.4	0.1	11.0%	0.6%	29.3	83.3	54.0
	C14	GENERAL SURGERY	27	LOW	297.0	688	3.5	1.6	5.2	6.99	-1.79	7.26	-2.06	1.56	7.7%	0.27	3.0%	1.83	29.38	6.6%	6.3%	0.3%	62.2%	23.8%	3.9%	15.3%	0.0%	1.6%	3.0%	0.0%	7.5	7.7	0.4	0.4	0.0	14.7%	0.5%	-17.0	29.5	46.5
	C15	UROLOGY	26	LOW	297.0	592	4.1	2.4	6.5	6.47	0.03	6.67	-0.17	2.22	10.8%	0.09	0.7%	2.31	32.71	6.6%	6.3%	0.3%	76.6%	24.5%	1.3%	15.6%	0.1%	0.6%	0.6%	6.3%	8.3	8.8	0.0	0.0	0.0	8.4%	0.3%	18.3	65.3	47.0
	C27	CARDIOTHORACIC	26	LOW	297.0	733	3.8	1.5	5.4	8.46	-3.06	9.93	-4.53	1.14	4.8%	0.34	3.9%	1.48	32.22	1.1%	1.1%	0.0%	60.3%	21.9%	1.6%	13.6%	0.0%	1.0%	2.4%	3.3%	7.5	7.5	0.0	0.0	0.0	9.1%	0.6%	15.8	34.5	18.8
	CICU	CRITICAL CARE	22	MEDIUM	165.0	452	21.8	2.0	23.8	27.13	-3.33	26.60	-2.80	15.44	16.6%	1.17	15.5%	16.61	100.50	2.6%	2.6%	0.0%	72.3%	30.2%	4.4%	15.7%	1.2%	1.1%	2.0%	5.8%	7.9	8.6	0.4	0.4	0.0	15.1%	1.4%	-97.3	104.8	202.0
FAMILY & WOMEN'S	C16	BREAST / ENT / PLASTIC	30	LOW	0.0	433	4.4	2.8	7.2	6.58	0.62	9.03	-1.83	5.12	27.7%	0.87	7.8%	5.99	29.65	8.5%	6.2%	2.3%	69.6%	27.9%	4.0%	14.1%	0.2%	0.8%	0.3%	8.5%	1.8	1.8	0.2	0.1	0.1	8.8%	0.3%	-78.8	14.0	92.8
	H130	PAEDIATRICS	20	LOW	215.6	358	5.9	1.9	7.8	11.44	-3.64	12.20	-4.40	0.64	3.0%	2.11	40.4%	2.75	26.59	0.0%	0.0%	0.0%	Nil	30.1%	6.1%	14.2%	1.0%	3.8%	2.2%	2.8%	7.8	7.9	0.0	0.0	0.0	30.9%	1.8%	6.0	12.0	6.0
	H30 CEDAR	GYNAECOLOGY	9	LOW	0.0	168	9.6	2.9	12.5	8.02	4.48	7.70	4.80	0.14	1.9%	0.12	3.1%	0.26	11.33	4.1%	3.5%	0.6%	26.7%	29.4%	1.0%	16.4%	0.0%	0.3%	0.0%	11.7%	5.5	5.8	0.7	0.6	0.1	23.4%	-0.8%	-48.3	0.0	48.3
	H31 MAPLE	OBSTETRICS	20	LOW	0.0	366	5.8	3.7	9.5	10.11	-0.61	15.48	-5.98	0.55	1.19%	1.00	3.69%	1.55	73.34	1.3%	1.3%	0.0%	82.9%	33.2%	11.8%	13.5%	0.7%	1.8%	2.8%	2.6%	6.3	6.3	0.0	0.0	0.0	15.6%	0.2%	13.3	13.3	0.0
	H33 ROWAN	OBSTETRICS	38	LOW	0.0	1102	2.7	1.4	4.1	10.11	-6.01	15.48	-11.38							0.6%	0.6%	0.0%	40.6%	22.9%	2.2%	16.8%	0.0%	1.6%	0.1%	2.2%			0.1	0.1	0.0	13.8%	0.3%	0.0	0.0	0.0
	H34 ACORN	PAEDIATRIC SURGERY	20	LOW	0.0	315	7.6	1.8	9.4	9.11	0.29	11.01	-1.61	0.94	4.5%	-0.46	-8.8%	0.48	26.00	0.7%	0.7%	0.0%	71.7%	28.9%	2.5%	16.2%	1.0%	2.5%	3.1%	3.6%	3.5	4.8	0.0	0.0	0.0	18.6%	1.7%	-17.0	24.5	41.5
	H35	OPHTHALMOLOGY	12	LOW	264.0	268	5.7	1.2	6.9	11.20	-4.30	10.70	-3.80	0.18	6.6%	1.74	64.2%	1.92	13.84	6.7%	6.7%	0.0%	78.6%	40.2%	12.2%	9.7%	0.7%	0.5%	0.8%	16.3%	6.4	6.5	0.0	0.0	0.0	14.7%	-0.9%	-132.3	33.8	166.0
	LABOUR	MATERNITY	16	LOW	387.2	314	18.6	4.7	23.3	10.11	13.19	15.48	7.82	-1.18	-8.6%	-2.11	-15.4%	-3.29	63.84	1.4%	1.4%	0.0%	91.0%	25.2%	4.3%	14.8%	0.7%	3.4%	0.2%	1.8%	4.5	4.5	5.3	0.5	4.8	10.2%	-0.5%	11.5	24.4	12.9
	NEONATES	NEONATOLOGY	26	LOW	165.0	717	11.0	0.9	11.9	13.26	-1.36	12.98	-1.08	3.62	48.0%	0.8	10.6%	4.42	74.51	1.3%	1.3%	0.0%	79.8%	25.5%	4.1%	13.5%	0.0%	1.9%	1.9%	4.1%	5.8	6.4	0.1	0.1	0.0	10.7%	0.5%	30.0	30.0	0.0
	PAU	PAEDIATRICS	10	LOW	0.0	70	16.9	0.0	16.9	11.44	5.46	12.20	4.70	1.08	10.3%	0	0.0%	1.08	10.44	0.9%	0.9%	0.0%	29.8%	24.5%	0.0%	14.1%	0.9%	1.0%	0.0%	8.5%	7.8	7.9	0.0	0.0	0.0	14.3%	1.2%	-22.0	0.0	22.0
	PHDU	PAEDIATRICS	4	LOW	0.0	72	21.1	1.9	23.0	11.44	11.56	12.20	10.80	-0.95	-8.2%	0	0.0%	-0.95	11.66	1.9%	1.9%	0.0%	90.7%	24.3%	0.6%	15.0%	0.0%	1.3%	0.1%	7.3%	7.8	7.9	0.3	0.3	0.0	9.1%	2.0%	0.0	0.0	0.0
CLINICAL SUPPORT	C7	INFECTIOUS DISEASE	12	LOW	165.0	357	4.3	2.7	6.9	7.76	-0.86	7.91	-1.01	-0.07	-0.9%	2.22	27.1%	2.15	20.22	12.7%	12.7%	0.0%	86.8%	24.5%	0.4%	22.4%	0.0%	1.7%	0.0%	0.0%	7.8	8.0	0.1	0.0	0.1	12.1%	-0.6%	13.5	42.5	29.0
	C29	REHABILITATION	15	LOW	154.0	464	3.5	4.0	7.5	7.69	-0.19	6.66	0.84	-1.12	-7.1%	2.59	16.4%	1.47	28.89	6.3%	6.3%	0.0%	75.5%	21.9%	2.8%	15.6%	0.6%	2.8%	0.0%	0.1%	7.5	8.8	1.4	1.4	0.0	8.3%	0.1%	32.0	43.0	11.0
	C30	CLINICAL ONCOLOGY	22	LOW	231.0	668	2.7	1.8	4.4	7.92	-3.52	7.14	-2.74	0.46	5.8%	0.31	3.9%	0.77	21.97	6.8%	6.4%	0.4%	52.7%	31.9%	4.7%	16.8%	0.0%	1.6%	4.3%	4.5%	7.8	7.8	0.3	0.3	0.0	8.1%	-0.7%	22.0	57.5	35.5
	C31	CLINICAL ONCOLOGY	27	MEDIUM	231.0	678	2.5	2.3	4.9	7.92	-3.02	7.14	-2.24	4.51	38.4%	0.13	1.1%	4.64	25.74	12.2%	9.9%	2.3%	97.9%	21.5%	3.7%	11.9%	0.0%	0.3%	1.0%	4.6%	5.8	6.9	2.8	2.8	0.0	13.2%	-1.4%	96.5	128.5	32.0
	C32	CLINICAL ONCOLOGY	22	MEDIUM	231.0	640	2.6	1.8	4.4	7.92	-3.52	7.14	-2.74	2.08	21.7%	0.07	0.7%	2.15	23.57	9.9%	8.2%	1.7%	62.2%	23.2%	1.2%	17.1%	0.0%	1.4%	0.1%	3.4%	8.4	8.8	0.6	0.5	0.1	7.5%	-0.1%	0.0	22.0	22.0
	C33	CLINICAL HAEMATOLOGY	28	MEDIUM	231.0	700	3.7	1.9	5.6	8.21	-2.61	7.23	-1.63	3.55	44.4%	-2.03	-25.4%	1.52	35.44	3.4%	3.2%	0.2%	39.0%	35.9%	2.6%	19.7%	0.0%	1.2%	2.7%	9.7%	5.8	6.7	1.6	1.5	0.1	18.3%	1.3%	-10.5	99.0	109.5
WARD	WARD IN WHICH THERE IS NO MODEL HOSPITAL PEER OR NATIONAL COMPARATOR			TOTALS:	10992.5	630	5.7	2.3	7.9	8.84	-44.06	9.25	-64.14	157.31	12.3%	12.68	2.5%	158.06	1786.40	7.7%	6.8%	0.9%	63.9%	27.4%	4.8%	15.0%	0.4%	1.5%	1.8%	4.0%	5.9	6.5	30.4	21.2	9.2	14.2%	0.0%	1895.0	3804.9	1909.9

HEY NURSE STAFFING QUALITY INDICATORS

Jul-18

HR METRICS

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	STAFF APPRAISAL [85%]	STAFF RETENTION [90.7%]	OVERALL MAND. TRAINING [85%]	LG. TRAINING [95%]	BLOOD TRANS. [85%]	FIRE TRAINING [85%]	RESUS TRAINING [85%]	TISSUE VIABILITY TRAINING [85%]
MEDICINE	ED	ACUTE MEDICINE	NA	85.4%	86.6%	89.0%	84.0%	96.0%	83.0%	72.0%	81.0%
	AMU	ACUTE MEDICINE	45	75.0%	93.7%	96.0%	95.0%	100.0%	96.0%	89.0%	100.0%
	H1	ACUTE MEDICINE	22	95.5%	96.9%	95.0%	92.0%	96.0%	92.0%	83.0%	92.0%
	EAU	ELDERLY MEDICINE	21	100.0%	85.2%	96.0%	97.0%	94.0%	97.0%	94.0%	89.0%
	H5 / RHOB	RESPIRATORY	26	94.1%	93.5%	88.0%	89.0%	84.0%	78.0%	78.0%	92.0%
	H50	RENAL MEDICINE	19	100.0%	82.8%	93.0%	100.0%	89.0%	95.0%	79.0%	95.0%
	H500	RESPIRATORY	24	72.7%	69.1%	87.0%	84.0%	76.0%	84.0%	80.0%	88.0%
	H70	ENDOCRINOLOGY	30	82.6%	100.0%	86.0%	84.0%	66.0%	84.0%	78.0%	94.0%
	H8	ELDERLY MEDICINE	27	89.3%	89.4%	83.0%	68.0%	90.0%	65.0%	74.0%	84.0%
	H80	ELDERLY MEDICINE	27	92.3%	93.2%	79.0%	67.0%	90.0%	73.0%	57.0%	83.0%
	H9	PDU	30	100.0%	72.5%	88.0%	75.0%	50.0%	50.0%	75.0%	100.0%
	H90	ELDERLY MEDICINE	29	87.0%	95.9%	93.0%	90.0%	86.0%	86.0%	83.0%	90.0%
	H11	STROKE / NEURO	28	96.0%	87.9%	92.0%	97.0%	48.0%	90.0%	90.0%	86.0%
	H110	STROKE / NEURO	24	66.7%	82.6%	88.0%	87.0%	77.0%	97.0%	65.0%	87.0%
	CDU	CARDIOLOGY	9	64.3%	71.3%	90.0%	86.0%	93.0%	86.0%	50.0%	86.0%
	C26	CARDIOLOGY	26	83.3%	93.8%	82.0%	70.0%	97.0%	73.0%	62.0%	84.0%
	C28 /CMU	CARDIOLOGY	27	100.0%	86.6%	92.0%	84.0%	90.0%	86.0%	84.0%	88.0%
SURGERY	H4	NEURO SURGERY	28	75.0%	92.2%	82.0%	94.0%	84.0%	69.0%	69.0%	78.0%
	H40	NEURO / TRAUMA	15	89.3%	88.0%	85.0%	97.0%	75.0%	75.0%	72.0%	78.0%
	H6	ACUTE SURGERY	28	85.2%	93.7%	87.0%	93.0%	87.0%	77.0%	83.0%	87.0%
	H60	ACUTE SURGERY	28	83.3%	97.7%	90.0%	97.0%	94.0%	90.0%	77.0%	81.0%
	H7	VASCULAR SURGERY	30	74.2%	85.6%	87.0%	94.0%	76.0%	76.0%	61.0%	85.0%
	H100	GASTRO	24	77.8%	94.6%	79.0%	88.0%	82.0%	70.0%	85.0%	52.0%
	H12	ORTHOPAEDIC	28	93.9%	96.9%	95.0%	95.0%	100.0%	93.0%	95.0%	95.0%
	H120	ORTHO / MAXFAX	22	84.0%	96.0%	96.0%	90.0%	97.0%	87.0%	97.0%	97.0%
	HICU	CRITICAL CARE	22	85.0%	91.9%	89.0%	89.0%	92.0%	70.0%	83.0%	96.0%
	C9	ORTHOPAEDIC	35	94.4%	96.6%	90.0%	93.0%	90.0%	93.0%	76.0%	83.0%
	C10	COLORECTAL	21	66.7%	83.1%	84.0%	96.0%	83.0%	88.0%	79.0%	92.0%
	C11	COLORECTAL	22	91.7%	88.9%	89.0%	97.0%	97.0%	90.0%	83.0%	79.0%
	C14	UPPER GI	27	92.6%	87.6%	85.0%	94.0%	79.0%	82.0%	79.0%	70.0%
	C15	UROLOGY	26	92.6%	83.6%	85.0%	85.0%	76.0%	82.0%	79.0%	82.0%
	C27	CARDIOTHORACIC	26	70.6%	93.5%	92.0%	89.0%	83.0%	86.0%	69.0%	89.0%
	CICU	CRITICAL CARE	22	82.9%	86.7%	95.0%	94.0%	97.0%	89.0%	91.0%	92.0%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	91.7%	80.2%	91.0%	88.0%	65.0%	88.0%	85.0%	85.0%
	H130	PAEDS	20	92.6%	88.5%	94.0%	93.0%	79.0%	90.0%	70.0%	71.0%
	H30 CEDAR	GYNAECOLOGY	9	92.3%	95.8%	92.0%	92.0%	100.0%	83.0%	83.0%	92.0%
	H31 MAPLE	MATERNITY	20	83.3%	93.6%	92.0%	98.0%	85.0%	87.0%	74.0%	88.0%
	H33 ROWAN	MATERNITY	38								
	H34 ACORN	PAEDS SURGERY	20	90.3%	90.3%	97.0%	94.0%	90.0%	97.0%	100.0%	57.0%
	H35	OPHTHALMOLOGY	12	100.0%	86.3%	90.0%	90.0%	80.0%	80.0%	65.0%	85.0%
	LABOUR	MATERNITY	16	70.0%	91.8%	89.0%	92.0%	91.0%	87.0%	79.0%	88.0%
	NEONATES	CRITICAL CARE	26	87.5%	84.7%	95.0%	96.0%	85.0%	89.0%	93.0%	95.0%
	PAU	PAEDS	10	84.6%	95.0%	93.0%	92.0%	100.0%	92.0%	85.0%	54.0%
	PHDU	CRITICAL CARE	4	100.0%	87.2%	96.0%	93.0%	92.0%	100.0%	100.0%	77.0%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	94.7%	91.2%	94.0%	84.0%	100.0%	95.0%	89.0%	84.0%
	C29	REHABILITATION	15	92.6%	93.6%	91.0%	89.0%	89.0%	86.0%	86.0%	96.0%
	C30	ONCOLOGY	22	100.0%	71.1%	89.0%	84.0%	72.0%	88.0%	72.0%	84.0%
	C31	ONCOLOGY	27	73.9%	83.1%	86.0%	88.0%	96.0%	80.0%	84.0%	92.0%
	C32	ONCOLOGY	22	79.2%	95.4%	86.0%	96.0%	96.0%	83.0%	79.0%	83.0%
	C33	HAEMATOLOGY	28	88.2%	92.3%	86.0%	89.0%	95.0%	76.0%	71.0%	82.0%
TOTALS :				86.6%	88.9%	89.6%	89.6%	86.3%	84.3%	79.3%	85.1%

IN PATIENT FALLS WITH HARM

	MODERATE		SEVERE / DEATH		TOTALS	
	MONTH	YTD	MONTH	YTD	MONTH	YDT
ED					0	0
AMU					0	0
H1					0	0
EAU		1	1	4	1	5
H5 / RHOB					0	0
H50					0	0
H500					0	0
H70					0	0
H8		1			0	1
H80	1			2	1	2
H9		1		1	0	2
H90	1			2	1	2
H11		1			0	1
H110					0	0
CDU					0	0
C26		1			0	1
C28 /CMU					0	0
H4					0	0
H40					0	0
H6		1			0	1
H60					0	0
H7					0	0
H100					0	0
H12					0	0
H120					0	0
HICU					0	0
C9					0	0
C10					0	0
C11					0	0
C14					0	0
C15		1			0	1
C27					0	0
CICU					0	0
C16					0	0
H130					0	0
H30 CEDAR					0	0
H31 MAPLE					0	0
H33 ROWAN						
H34 ACORN					0	0
H35					0	0
LABOUR					0	0
NEONATES					0	0
PAU					0	0
PHDU					0	0
C20					0	0
C29		1			0	1
C30					0	0
C31					0	0
C32					0	0
C33					0	0
TOTALS :	2	8	1	9	3	17

ADMITTED WITH & HOSPITAL ACQUIRED PRESSURE ULCERS [AVOIDABLE AND UNAVOIDABLE]

	MASD				GRADE 2				GRADE 3				GRADE 4			
	ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED	
	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YDT
ED					118	456		1	5	45			4	13		
AMU					9	36				1				1		
H1					4	6										
EAU					12	34			1	2			1	1		
H5 / RHOB					1	4	1	3	1	1						
H50						3		1								
H500					1	5	2	2								
H70					1	9										
H8							1	1								
H80							1	3								
H9						3										
H90						2							2	2		
H11								3								
H110						3	1	1	3	3		1				
CDU																
C26						1										
C28 /CMU						2		1								
H4					1	3	1	2		1						
H40						1										
H6					1	2										
H60					1	1								1		
H7					3	18	2	3		1						
H100						1		4								
H12						1		1								
H120						1	1	4								
HICU						1		1								
C9					1	2										
C10					1	2										
C11						1			2	2						
C14								1								
C15						5										
C27																
CICU							1	1								
C16																
H130																
H30 CEDAR																
H31 MAPLE																
H33 ROWAN																
H34 ACORN																
H35					1	4	1	1						1		
LABOUR																
NEONATES																
PAU																
PHDU																
C20																
C29							1	1								
C30					3	11	2	3								
C31					3	12										
C32					5	9								1		
C33					3	7		2								
TOTALS :	0	0	0	0	169	646	15	40	12	56	0	1	7	20	0	0

	DEEP TISSUE INJURY				UNSTAGEABLE				DEVICE RELATED [TOTAL]		TOTALS							
	ADMITTED WITH		HOSPITAL ACQUIRED		ADMITTED WITH		HOSPITAL ACQUIRED				ADMITTED WITH		HOSPITAL ACQUIRED		AVOIDABLE / REQUIRE RCA			
	MONTH	YTD	MONTH	YTD	MONTH	YTD	MONTH	YDT	MONTH	YTD	MONTH	YTD	MONTH	YDT	MONTH	YDT	RCA Outstanding
ED	21	130	1	1	27	107				1	175	751	1	2	1	2		
AMU	3	8			2	10					14	56	0	0				
H1						1					4	7	0	0				
EAU	4	14			3	11					21	62	0	0				
H5 / RHOB				1					1	1	2	5	1	4	1	4		
H50	1	1	1	1		1					1	5	1	2		1		
H500	3	4			1	1					5	10	2	2			1	
H70		1	1	1			1	2			1	10	2	3			3	
H8	1	1		1				1			1	1	1	3	1	1	1	
H80			1	1			1	2		2	0	0	3	6	1	2		
H9											0	3	0	0				
H90		2									2	6	0	0				
H11										1	0	0	0	3		1		
H110		1		2			1	2	1	2	3	7	2	6			3	
CDU											0	0	0	0				
C26	1	1		1			1	1	1	1	1	2	1	2	1	1		
C28 /CMU											0	2	0	1				
H4											1	4	1	2		1	1	
H40				1		1					0	2	0	1		1		
H6	1	1									2	3	0	0				
H60											1	2	0	0				
H7	2	3	1	5		7			1	3	5	29	3	8		3	2	
H100				2						1	0	1	0	6		6		
H12	1	2	1	1					1	1	1	3	1	2	1	1		
H120							1	1		1	0	1	1	5				
HICU		1	1	3	1	1	1	4	1	4	1	3	1	5	1	1		
C9	1	1									2	3	0	0				
C10											1	2	0	0				
C11											2	3	0	0				
C14				1							0	0	0	2				
C15		1				2					0	8	0	0				
C27											0	0	0	0				
CICU			2	3			1	1	1	2	0	0	4	5				
C16											0	0	0	0				
H130											0	0	0	0				
H30 CEDAR											0	0	0	0				
H31 MAPLE											0	0	0	0				
H33 ROWAN																		
H34 ACORN											0	0	0	0				
H35											1	5	1	1				
LABOUR											0	0	0	0				
NEONATES											0	0	0	0				
PAU											0	0	0	0				
PHDU											0	0	0	0				
C20											0	0	0	0				
C29									1	1	0	0	1	1	1	1		
C30	2	2		1	1	3			1	1	6	16	2	4		1		
C31	2	5	2	3		3					5	20	2	3				
C32				2							5	10	0	2		1		
C33		3				2					3	12	0	2		2		
TOTALS :	43	182	11	31	35	150	5	11	9	22	266	1054	31	83	8	30	11	

Hull and East Yorkshire Hospitals NHS Trust

Trust Board

11 September 2018

Title:	Nursing and Midwifery Fundamental Standards Report
Responsible Director:	Mike Wright – Chief Nurse
Author:	Mike Wright, Chief Nurse Jo Ledger, Deputy Chief Nurse Caroline Grantham, Practice Development Matron

Purpose:	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	
BAF Risk:	BAF1, BAF2, BAF3	
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	
Summary Key of Issues:	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.	

Recommendation:	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

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 March 2018. Good progress is being made and this report presents the position as of June 2018.

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

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

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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. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our nursing and midwifery teams. The last report on this topic was presented to the Trust Board in March 2018. This provides a progress report up to the end of June 2018.

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 within.

Table to illustrate the Nine Fundamental Standards

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

Table 1

The following fundamental standards have been agreed for the Outpatient Departments (Table 2). Work has commenced on assessing every Outpatient Department against these seven fundamental standards. The results from these reviews will be reported in Quarter Three's Trust Board report.

Table to illustrate the Seven Outpatient Fundamental Standards

1. **STAFF EXPERIENCE**
2. **PATIENT ENVIRONMENT**
3. **INFECTION CONTROL**
4. **SAFEGUARDING**
5. **MEDICINES MANAGEMENT**
6. **PATIENT CENTRED CARE**
7. **PATIENT EXPERIENCE**

Table 2

2. ASSESSMENT PROCESS

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

- Observations of care given and patients' documentation
- Discussion with patients and staff members
- Discussion with the Ward/Department's 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 88%	89 to 94.9%	Above 95%
Frequency of Review	3 month review	6 month review	9 month review	12 month review

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

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

- 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 Group's Governance Structures. In addition, it is a requirement that each action plan is discussed and progress reported and documented at monthly ward/unit meetings.

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in the **Appendix One**. If the ward achieves a 'Red' rating for any fundamental standard then the Ward Sister/Charge Nurse will have an appraisal completed by the 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 Senior Charge Nurse/Sister every six months. This purpose of this is threefold, essentially:

1. To ensure that good practice is disseminated and areas of concern are reviewed and addressed from a corporate perspective.
2. Identification of themes across the clinical services which require an organisational approach to resolve, for example issues relating to the nursing documentation.
3. Provide the Chief Nurse with assurance in relation to the level of 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/departments now displays their individual results on a "How are we doing?" board (as illustrated below in Figure 1), for patients and relatives to view and as part of our drive to be more 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 60's "How are we doing?" board

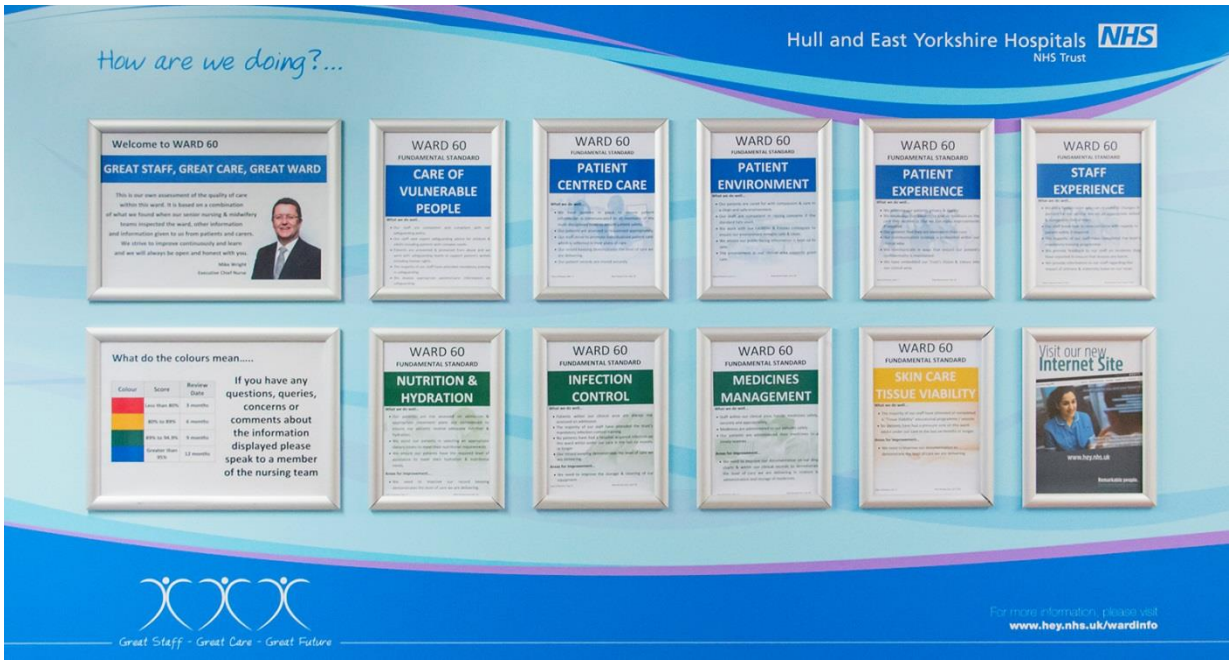


Figure 1

3. CURRENT POSITION

The results are shown for fifty two clinical areas. Firstly, Table 2 below illustrates the overall Trust position in relation to all of the ward fundamental standards as at the 30th June 2018 and the number of wards that are performing at each level.

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 women spend within this clinical setting.

Current Trust Position for all Ward Fundamental Standards: June 2018								
Staff Experience	Patient Environment	Infection Control	Safeguarding	Medicines Management	Tissue Viability	Patient centred Care	Nutrition	Patient experience
15 wards	30 wards	9 wards	47 wards	16 Wards	11 wards	10 wards	11 wards	26 wards
33 wards	16 wards	18 wards	5 wards	30 Wards	9 wards	30 wards	14 wards	17 wards
4 wards	6 wards	25 wards	0 wards	6 Wards	28 wards	11 wards	14 wards	9 wards
0 wards	0 wards	0 wards	0 wards	0 Wards	1 wards	1 wards	7 wards	0 wards

Table 3

The following tables illustrate progress made in relation to each fundamental standard from February 2018 to June 2018, across the four Health Groups. In some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results. Narrative has been provided to outline the key elements reviewed as part of the fundamental standard assessment process. An overview of the Trust`s current position in relation to each

standard is provided in conjunction with actions being undertaken currently and, as a priority, to address those fundamental standards rated Red**.**

3. 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 the clinical area. It requires the leader to demonstrate that they are promoting a `Learning Environment` where staff improve continually the care they provide by learning from patient and carer feedback, incidents, adverse events, errors, and near misses.

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	**June 18**	Jun 17	Sep 17	Feb 18	**June 18**	Jun 17	Sep 17	Feb 18	**June 18**	Jun 17	Sep 17	Feb 18	**June 18**
4	4	2	**2**	6	5	4	**3**	9	9	9	**5**	5	5	5	**5**
2	2	2	**3**	3	5	6	**7**	10	7	5	**11**	8	12	12	**12**
0	0	2	**1**	1	0	0	**0**	0	1	3	**1**	6	2	2	**2**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Progress since February: 28 reviews have been completed during this period. There are no outstanding reviews or Red-rated areas for this standard. The predominant rating for this standard is Green with 33 areas overall rated as Green.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
0	0	0	**1**	4	4	7	**8**	6	6	8	**10**	8	8	8	**11**
6	5	5	**4**	5	5	2	**2**	10	9	8	**6**	9	9	9	**4**
0	1	1	**1**	0	0	0	**0**	2	2	1	**1**	2	2	2	**4**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Progress since February: 19 reviews have been completed during this period. There are no areas rated Red. There has been an increase in Blue rated areas across all the Health Groups. There is a slight increase in Amber rated areas in Medicine, which relate to failure to complete the required nurse cleaning at a weekend. Plans to address this issue are discussed under the infection control standard.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
0	0	0	**0**	0	0	0	**0**	1	2	2	**5**	2	2	2	**4**
3	3	2	**3**	1	8	2	**3**	3	4	4	**5**	2	4	4	**7**
3	3	4	**3**	9	2	8	**7**	15	11	11	**7**	15	12	13	**8**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**0**

Progress since February: 40 reviews have been completed during this period with 6 outstanding reviews for this standard this quarter. There are no areas rated Red. There has been an increase in Blue rated areas within Medicine and Surgery Health Groups and an increase in Green rated areas across all of the Health Groups. Across all the Health groups the predominant rating remains Amber, although the numbers at this rating have reduced as the number of Green and Blue rated areas have increased. The main issue remains the failure to clean equipment consistently at weekends, although some areas have addressed

this issue by pooling their ward hygienists so that wards have some cover over a weekend. The introduction of the new cleaning contract will allow the re-alinement of the hygienists' role to potentially allow greater seven-day cover across the Health Groups.

6. **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 their human rights are respected and upheld.

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
5	6	6	**6**	7	8	10	**10**	16	18	17	**16**	12	13	17	**15**
1	0	0	**0**	2	2	0	**0**	2	1	0	**1**	6	5	2	**4**
0	0	0	**0**	1	0	0	**0**	1	0	0	**0**	1	1	0	**0**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Progress since February: 24 reviews have been completed during this review. There are no outstanding reviews for this standard. The majority of ward areas are rated as Blue for this fundamental standard. There are no Red rated areas for this standard. The 5 Green rated areas within Surgery and Medicine relate to the ward areas not displaying the relevant patient information leaflets. These results have been sent to the Nurse Directors for their action to ensure future compliance.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
0	0	0	**2**	7	7	7	**5**	7	6	3	**4**	5	5	5	**5**
2	4	5	**3**	2	2	3	**5**	11	6	10	**13**	8	8	5	**8**
4	2	1	**1**	1	1	0	**0**	1	5	4	**0**	6	6	9	**6**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**

Progress since February: 40 audits have been completed during this period. There are no outstanding reviews for this standard. There has been an increase in the number of Blue-rated ward areas within Clinical Support and Surgery. Medicine, Surgery and Family & Women's Health Groups have seen an increase in Green-rated areas. There are no clinical areas rated Red for this standard. The improvements are related to sustained compliance in 24 hour monitoring of medication fridges and controlled drugs checks.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
0	0	0	**0**	6	5	5	**6**	1	1	1	**3**	3	3	4	**2**
2	0	1	**2**	2	2	2	**1**	4	5	4	**4**	1	0	1	**2**
5	6	5	**4**	3	3	3	**3**	11	10	12	**10**	10	12	11	**11**
0	0	0	**0**	0	0	0	**0**	3	1	0	**0**	2	1	0	**1**

Progress since February: 33 reviews have been completed during this period, with 8 outstanding reviews for this standard. There has been an increase in the number of Blue and Green-rated clinical areas within all the Health Groups. There is one Red-rated area for this standard within Medicine. Given the current number of category 3 and 4 pressure ulcers being declared over the last quarter. The Chief Nurse has commissioned a robust review of the fundamental standard related to tissue viability to ensure it incorporates all themes identified following the recent SI's investigations.

9. **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.

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
0	0	0	**0**	5	5	4	**4**	5	4	5	**4**	2	2	3	**2**
2	4	4	**6**	3	4	5	**4**	6	7	8	**9**	5	9	11	**10**
4	2	2	**0**	1	0	0	**1**	8	6	4	**4**	9	8	5	**6**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	0	0	**1**

Progress since February: 20 reviews have been completed during this period. There has been an increase in Green-rated scores within Clinical Support & Surgery. There is one Red rated area for this standard within Medicine. There are no major concerns with this standard. Please note that this standard does not assess the documentation associated with, Nutrition, Infection Control and Tissue Viability this is completed as part of the individual standard reviews.

10. **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.

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
1	1	1	**2**	2	2	3	**4**	5	5	3	**3**	1	1	3	**2**
2	2	4	**4**	2	2	2	**1**	7	7	8	**5**	5	8	7	**4**
3	3	1	**0**	1	2	2	**1**	5	5	5	**7**	6	4	3	**6**
0	0	0	**0**	2	1	0	**1**	2	0	1	**2**	3	4	3	**4**

Progress since February: 36 reviews completed during this period. There has been an increase in Blue-rated scores within Clinical Support & Family Women's Health Group. Overall there has been a slight decrease in this standard over the last quarter with a slight decrease in Green-rated areas and a subsequent increase in Amber-rated areas across, Medicine and Surgery. There has been a slight increase in the number of clinical areas rated as Red for this fundamental standard. These areas need to improve their 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.

The Deputy Chief Nurse is meeting with the Charge Nurses and Senior Matrons of these areas to address the issues raised within their audits to ensure future compliance with this fundamental standard. In addition the Nutritional Team has devised a robust educational package which they are disseminating to all ward areas.

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

Clinical Support				Family & Women's				Surgery				Medicine			
Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18	Jun 17	Sep 17	Feb 18	June 18
3	3	2	**2**	5	5	7	**6**	8	7	11	**9**	6	6	7	**9**
3	3	3	**3**	4	5	3	**4**	11	10	5	**5**	8	9	6	**5**
0	0	1	**1**	1	0	0	**0**	0	0	1	**3**	5	3	6	**5**
0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**0**

Progress since February: 17 reviews completed during this period. There are no Red-rated areas for this standard. There has been a decrease in Blue-rated clinical areas for this standard within Family & Women's and Surgery Health Groups and an increase in Medicine. 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.

12. OVERALL POSITION:
45 of the 52 clinical areas reviewed have no Red Standards. Figures 2 illustrates the progress that has been made from a Trust perspective over the last quarter in relation to the number of Fundamental Standards rated Red. Figure 2 illustrates progress since July 2016 in the reduction of red fundamentals.

There are nine standards rated as red, currently:

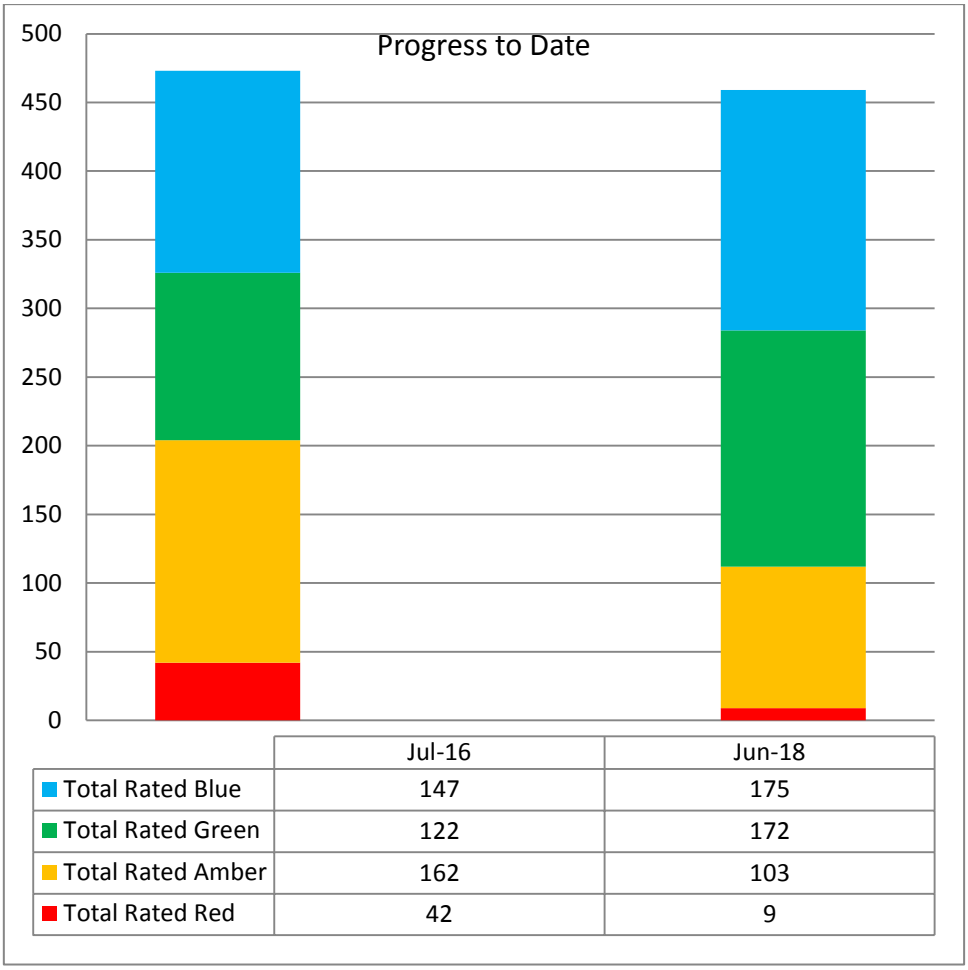
- 7 - Nutrition
- 1 - Patient centred Care
- 1 - Tissue Viability

6 clinical areas have one red rated standard. These are:

- Acorn, H60, H100, H1, H5 & H110

The issues for these areas are highlighted earlier in the report under the Nutrition standard with the relevant actions to ensure future compliance with this standard.

One clinical area, H80 has three Red rated standards. These are: Tissue Viability, Patient Centred Care and Nutrition. The leadership of this clinical area has changed recently and the current senior ward sister is implementing a detailed action plan to address the issues raised during these reviews to improve compliance against these fundamental standards.



	Jul-16	Jun-18
Total Rated Blue	147	175
Total Rated Green	122	172
Total Rated Amber	162	103
Total Rated Red	42	9

Figure 2

The reduction in the total number of standards audited between 2016 and 2018, relate to the reconfiguration of a number of services, elective Orthopaedics and Critical Care.

13. 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, as demonstrated in the charts above. The number of fundamental standards rated as Blue and Green have both increased to approximately 76% of the total.

14. SUMMARY

Currently there are three core fundamental standards with any Red ratings. Tissue Viability and Patient Centred Care have one clinical area with a Red-rated standard and Nutrition has seven areas now rated as Red. A concentrated effort on improving this position remains a key priority of the Senior Nursing Teams.

15. 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
July 2018

Appendix One – Overview Fundamental Standards June 2018

FUNDAMENTAL STANDARDS June 2018 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
C7	94%	Jan 19	86%	Jan 18	87%	April 18	100%	Mar 19	89%	Mar 19	93%	Sept 18	89%	Feb 19	90%	Dec 18	89%	Nov 18
C29	95%	July 19	90%	Sept 18	91%	Jan 19	100%	Feb 19	88%	Dec 18	**80%***	Oct 18	**93%**	April 18	97%	June 19	93%	Oct 18
C30	95%	April 19	97%	May 19	**89%**	Dec 18	100%	Feb 19	96%	May 19	89%	Jan 19	93%	Jan 19	**94%**	Dec 18	93%	Aug 18
C31	90%	Nov 18	93%	Feb 19	82%	Sept 18	100%	Mar 19	94%	Nov 18	82%	Oct 18	91%	July 18	94%	Sept 18	82%	Aug 18
C32	92%	Nov 18	91%	Feb 19	80%*	Oct 18	100%	Mar 19	100%	May 19	88%	Oct 18	**89%**	Oct 18	97%	June 19	99%	Jan 19
C33	87%	July 18	90%	Sept 18	**94%**	July 18	97%	Sept 18	91%	Nov 18	80%	Jan 19	92%	Jan 19	94.5%	Nov 18	100%	Jan 19

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	93%	Nov 18	95%	April 18	94%	Mar 19	97%	Nov 18	97%	Mar 19	86%	Sept 18	90%	Oct 18	95%	June 19	96%	Jan 19
Cedar H30	94%	Feb 19	91%	April 18	86%	Aug 18	97%	Oct 18	92%	Dec 18	93%	Oct 18	83%	Nov 18	93%	Nov 18	94%	Feb 19
H31	90%	Feb 19	96%	Jan 19	**83%**	Nov 18	100%	Oct 18	93%	Nov 18	100%	Feb 19	100%	Jan 19	NA		96%	Jan 19
H33	94%	Oct 18	89%	April 18	83%	Nov 18	100%	Nov 18	96%	Feb 19	100%	May 18	100%	Jan 19	NA		100%	Jan 19
ACORN	96%	Mar 19	100%	Jan 19	80%	Nov 18	100%	Mar 19	94%	Dec 18	100%	June 18	92%	Nov 18	**66%**	Sept 18	97%	Mar 19
H35	99%	Nov 18	97%	June 18	80%*	Dec 18	96%	Feb 19	94%	Dec 18	80%*	Sept 18	89%	Oct 18	88%	Jan 19	92%	Dec 18
H130	94%	Nov 18	95%	Mar 18	**85%**	Nov 18	100%	Mar 19	93%	Feb 19	83%	Nov 18	89%	Oct 18	**98%**	Dec 18	91%	Mar 19
Labour	93%	Oct 18	95%	May 19	**86%**	**Nov 18**	100%	Jan 19	96%	Nov 18	100%	Mar 19	100%	Jan 19	NA		98%	Jan 19
NICU	**91%**	Oct 18	95%	June 18	**94%**	Jan 19	100%	Mar 19	100%	Mar 19	96%	July 19			100%	June 19	97%	Mar 19
PHDU	97%	Mar 19	100%	Jan 19	**93%**	Dec 18	100%	Dec 18	100%	Jan 19	100%	June 18	97%	July 19	**97%**	Mar 19	97%	Dec 18

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	94%	Oct 18	97%	April 19	**84%**	Oct 18	91%	Dec 18	89%	Dec 18	**80%***	Oct 18	94%	Nov 18	**97%**	June 19	98%	Jan 19
C10	93%	Oct 18	97%	April 19	80%	Sept 18	100%	Nov 18	94%	Mar 19	**86%**	Sept 18	86%	Oct 18	92%	Dec 18	94%	Nov 18
C11	95%	Oct 18	95%	Nov 18	80%*	July 18	100%	Feb 19	94%	Mar 19	**96%**	Mar 19	83%	Sept 18	94%	Dec 18	96%	Oct 18
C14	89%	Oct 18	100%	April 19	90%	Nov 18	96%	July 18	94%	Nov 18	**81%**	Oct 18	90%	Dec 18	94%	Mar 19	86%	Aug 18
C15	89%	April 19	93%	Feb 19	80%*	Nov 18	97%	July 18	94%	Jan 19	**80%***	Aug 18	88%	Nov 18	80%	Sept 18	97%	Jan 19
C27	97%	Feb 19	93%	Feb 19	94%	Jan 19	100%	Mar 19	93%	Mar 19	**80%***	Sept 18	93%	Oct 18	**92%**	Mar 19	93%	Oct 18
CICU1	96%	May 19	100%	April 18	95%	May 19	100%	May 19	100%	June 19	94%	Jan 19	96%	June 19	96%	May 19	100%	Feb 19
CICU2	98%	April 19	100%	May 18	93%	July 19	100%	May 19	100%	June 19	**92.3%**	Feb 19	98%	April 19	100%	May 19	98%	Jan 19

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	93%	Feb 19	95%	Mar 18	**80%***	Nov 18	97%	Dec 18	96%	Mar 19	**85%**	Oct 18	88%	Aug 18	**90%**	**Nov 18**	91%	Oct 18
H40	91%	Mar 19	93%	Feb 19	97%	April 19	95%	Dec 18	90%	Mar 19	**96%**	Jun 19	89%	Jan 19	**83%**	Aug 18	96%	July 19
H6	90%	Feb 19	90%	July 18	**80%***	Aug 18	97%	July 19	89%	Oct 18	**96%**	Mar 19	96%	Dec 18	**86%**	Aug 18	96%	Jan 19

H60	94%	Dec 18	97%	May 19	**94%**	Jan 19	100%	Mar 19	93%	Mar 19	**91%**	Jan 19	97%	Mar 19	**68%**	July 18	94%	Dec 18
H7	93%	Mar 19	97%	Mar 18	**90%**	Jan 19	100%	Mar 19	91%	Jan 19	**80%***	Sept 18	**94%**	Jan 19	**83%**	Dec 18	91%	April 19
H12	89%	Dec 18	95%	May 19	100%	April 19	97%	Dec 18	89%	Jan 19	80%*	Oct 18	89%	Oct 18	**80%**	Oct 18	80%	Sept 18
H120	95%	Mar 19	93%	Feb 19	**95%**	April 19	100%	Feb 19	92%	Jan 19	**80%***	Sept 18	90%	Nov 18	**81%**	Oct 18	85%	Sept 18
H100	92%	April 19	84%	June 18	**86%**	Sept 18	100%	Jan 19	90%	Mar 19	**83%**	June 18	94%	Nov 18	63%	Aug 18	96%	Jan 19
HICU1 & 2	89%	Oct 18	94%	June 18	100%	Oct 18	97%	April 19	98%	Feb 19	92%	Feb 19	94%	Nov 18	**82%**	Oct 18	100%	Dec 18

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	92%	Oct 18	**95%**	April 18	88%	Nov 18	100%	July 19	91%	Dec 18	88%	May 18	**88%**	Aug 18	90%	Dec 18	95%	Oct 18
C26	91%	Nov 18	93%	Feb 19	89%	June 18	100%	Mar 19	89%	Dec18	86%	May 18	84%	Aug 18	92%	Mar 19	82%	Aug 18
C5DU	94%	Aug 18	97%	Feb 19	97%	Oct 17	97%	June 19	96%	Feb 19	100%	April 18	95%	Mar 18	100%	Mar 19	95%	Feb 19

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	86%	Dec 18	87%	Nov 18	80%*	July 18	97%	Feb 19	87%	Oct 18	**80%***	July 18	**81%**	Oct 18	**100%**	Aug 18	87%	Sept 18
H1	96%	July 19	95%	May 19	**91%**	Jan 19	97%	Oct 18	89%	Dec 18	80%*	Nov 18	**92%**	Jan 19	**67%**	Oct 18	85%	Sept 18
H200/EAU	95%	May 19	95%	Mar 18	**97%**	Mar 19	100%	Jan 19	95%	Jan 19	**94%**	Sept 18	90%	Sept 18	**82%**	Jan 19	96%	July 19
H5	92%	Oct 18	87%	Nov 18	**82%**	Oct 18	96%	Feb 19	89%	Decl 18	80%*	Oct 18	**91%**	Oct 18	**72%**	July 18	95%	Dec 18
H50	93%	April 19	89%	July 18	**95%**	Mar 19	93%	Dec 18	90%	Dec 18	**98%**	Feb 19	**94%**	Oct 18	**86%**	Dec 18	95%	July 19
H500	97%	Jan 19	95%	June 18	**87%**	Oct 18	100%	Dec 18	89%	Dec 18	**80%***	Oct 18	92%	Oct 18	**91%**	Jan 19	91%	Oct 18
H70	89%	Dec 18	96%	May 19	**84%**	Aug 18	100%	Nov 18	86%	Oct 18	**85%**	Aug 18	**92%**	Oct 18	**86%**	Jan 19	**91%**	Aug 18
H8	92%	Sept 18	97%	Mar 18	92%	Mar 19	**100%**	Feb 19	89%	Mar 19	80%*	Jan 19	84%	Jan 19	82%	Jan 19	86%	Sept 18
H80	90%	dec 18	94%	July 18	80%*	Sept 18	90%	Feb 19	80%	Dec 18	69%	Sept 18	56%	Oct 18	**51%**	Aug 18	89%	Dec 19
H9	98%	June 19	90%	Aug 18	87%	Aug 18	100%	June 19	85%	Oct 18	86%	Jan 19	87%	Aug 18	83%	April 18	91%	Feb 19
H90	91%	Mar 19	97%	May 19	83%	Jan 19	90%	Nov 18	86%	Dec 18	**93%**	April 19	92%	Sept 18	89%	Aug 18	86%	Sept 18
H11	88%	Jan 19	**86%**	Jan 18	94%	Nov 18	97%	May 19	86%	Dec 18	**80%***	Mar 18	**91%**	July 18	85%	Octr 18	90%	Oct 18
H110	90%	Sept 18	**88%**	Jan 18	97%	Feb 19	100%	Jan 19	89%	Mar 19	**80%***	Mar 18	94%	Mar 18	77%	Aug 18	97%	Dec 18

EMERGENCY MEDICINE HRI

Clinical Area	**Staff Experience**		**Patient Environment**		**Infection Control**		**Safeguarding**		**Medicines Management**				**Patient Centred Care (inc TV)**				**Patient Experience**	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due			Rating	Next due			Rating	Next due
Majors ED	94%	Nov 18	**97%**	May 19	91%	April 18	100%	Dec 18	96%	Oct 18			86%	Mar 18			97%	Jan 19
Paeds ED	97%	June 19	**97%**	May 19	94%	April 18	100%	Mar 19	100%	Mar 19			93%	Sept 18			97%	Jan 19
Emergency Care	91%	April 19	**96%**	Oct 18	93%	April 18	89%	July 18	96%	May 19			100%	Nov 18			100%	Jan 19

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

Meeting Date:	30 July 2018	**Chair:**	Prof M Veysey	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Serious Incidents themes and trends was received – there was a discussion around the 11 maternity related incidents
- HSMR and the spike in deaths Jan/Feb 2018 was discussed – the focus would be on any avoidable deaths
- QIP – GIRFT projects now reviewed separately but Mrs Kemp to be invited in October 2018 to present an update. VTE and the SLA with Humber Foundation Trust were the key areas of the discussion
- Structured case note reviews – Update report received. End of life care plans and patients dying in the most appropriate setting was being monitored
- Dr Purva gave a presentation relating to safer standards for invasive procedures and the WHO checklist review
- Medicines management/optimisation presentation was received. A review of discharge and missed doses improvements were included.
- Operational Quality Committee – Mr Wright updated the committee regarding the CQC report
- Board Assurance Framework – BAF risk 2 – staffing and skilled workforce had been upgraded to a risk rating of 20 by the July 2018 Trust Board meeting

Decisions made by the Committee:

Key Information Points to the Board:

- The Operational Quality Committee was changing the way it approached Serious Incidents giving each Health Group and opportunity to present their action plans and how they are managing all incidents

Matters escalated to the Board for action:

- Hull and East Riding Joint Scrutiny Committee – Mr Wright had met with the Committee to provide assurance following the CQC report and subsequent action plan

HULL AND EAST RIDING HOSPITALS NHS TRUST

Minutes of the Quality Committee
30 July 2018

Present:	Prof. M Veysey	Non-Executive Director (Chair)
	Mr A Snowden	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Wright	Chief Nurse
	Dr M Purva	Deputy Chief Medical Officer
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
In Attendance:	Mrs R Thompson	Corporate Affairs Manager

No	Item	Action
1	**Apologies:** Apologies were received from Mr K Phillips, Chief Medical Officer, Mrs V Walker, Non-Executive Director, Prof J Jomeen, Associate Non-Executive Director and Mrs M Stern, Chair of Patient Council	
2	**Declarations of Interest** There were no declarations of interest received.	
3	**Minutes of the meeting of 25 June 2018** The minutes of the meeting were approved as an accurate record.	
3.1	**Matters Arising** Clarification was requested about the process to de-escalate a Serious Incident. Mrs Bates advised that all Serious Incidents that are de-escalated must be reviewed by the Commissioners and approved before de-escalation takes place.	
3.2	**Action Tracking List** Mrs Bates reported that the spike in HSMR performance in January and February 2018 was being reviewed and discussed at the Mortality Committee. She advised that the same spike had been observed last year too. Dr Purva added that the Structured Case Note reviews would draw out any themes or trends in those areas. Mrs Bates noted that the spike was so far not showing any anomalies, but investigations were ongoing. As this item was being reviewed by the Mortality Committee it was agreed that this would be removed from the Action Tracker. Mr Wright added that although the spike in deaths was being reviewed he would be more concerned about any avoidable deaths reported. NRLS data was discussed and it was agreed to remove the item from the tracker. A review of NRLS data would be received in October 2018.	**SB**
3.3	**Any Other Matters Arising** There were no other matters arising.	

3.4 Workplan 2018/19

The Workplan was received by the Committee.

4 Reduce Avoidable Harm

4.1 Serious Incidents Themes and Trends

Mrs Bates presented the report and advised that there had been 25 Serious Incidents since April 2018 but no themes were emerging.

She reported that the team were concentrating on the 'So What?' question to close the loop when completing investigations.

There was a discussion around the Maternity service which accounted for 11 of the 25 incidents. Prof. Veysey had received feedback that there were cultural issues within the service.

Dr Purva stated that the service now incorporated a much younger generation and felt that there may be some complex cases to overcome and a lack of experience to manage the processes. Mr Wright added that there were challenges relating to the culture but that the Nurse Director of the Family and Women's Health Group was carrying out a review.

There was a discussion around human errors and Mr Wright stated that safety procedures were in place to reduce these errors and was implementing more training and reflective practice to assist staff.

Prof. Veysey asked about 'closing the loop' on incidents and Mrs Bates advised that the Commissioners heavily scrutinised all investigations to ensure the recommendations and actions were in place. Mr Snowden asked how the information following the investigations was communicated to the patients and their families and Mrs Bates reported that the team actually visited the patients to talk through what had happened and the next steps. She advised that this built relationships and in most cases left the patients and their families satisfied with the outcomes.

Resolved:

The Committee received and accepted the report.

4.2 Quality Improvement Plan

Mrs Bates presented the Quality Improvement Plan to the Committee. She advised that from June 2018 all of the 'Getting it Right First Time' projects would be reported through the Carter Group and the Operational Quality Committee and would not be part of the QIP. It was agreed that Mrs Kemp would be invited to the October 2018 Committee to discuss GIRFT in more detail. **MK/RT**

The Service Level Agreement with Humber Foundation Trust was discussed and the concerns regarding mental health support between the two Trusts. Mr Wright advised that there are not enough staff at Humber to address the issues with mental health patients that required specialist care. Mr Snowden asked if this was typical elsewhere and Mr Wright stated that it was a national issue and that the social consequences were significant.

The ratings of the QIP were discussed and Mrs Bates agreed to provide a key of the ratings in the next report. **SB**

Mr Hall asked about VTE performance and wanted to understand what a VTE assessment looked like and why certain departments were better at completing them than others. Dr Purva agreed that she was looking into this but stated that the process should be standardised across departments. Prof Veysey added that he would carry out assessments if they had not been completed and so could be undertaken by senior clinicians to ensure compliance. Mr Wright agreed and advised that the assessment performance was now specific to all areas and performance was being scrutinised at the Operational Quality Committee. Dr Purva agreed to feed back to the Committee any areas of concern.

The Committee discussed the Junior Doctor improvement handover forms programme and Dr Purva advised that this was being tested on a small scale before being rolled out as there were some complex issues to be addressed.

Resolved:
The Committee reviewed and accepted the report.

4.3 Mortality Structured Case Note Reviews

Mrs Bates presented the report which summarised the first quarter of the year's deaths. She reported that 100 Structured Judgement Reviews had been carried out in line with National Quality Board requirements.

Mrs Bates also advised that the Mortality Lead was meeting with GPs and reviewing end of life care plans and how people did not have to die in hospital but could remain in care homes if this could be supported. She advised that the Trust has an excellent palliative care team but work was ongoing with care homes and the Ambulance Service to avoid hospital admissions if appropriate.

The themes and trends coming out of the reviews would be monitored at the Mortality Steering Group. Mrs Bates advised that there was now a national requirement to include relatives when planning end of life care and this was also being picked up by the Mortality Steering Group. The Bereavement Service were also getting involved to help relatives be more informed.

Work was also ongoing with the Integrated Care Centre as to what quality improvements they could bring within the community setting.

Prof. Veysey spoke about the importance of embedding the learning and auditing the process as to how the information was being fed back to the consultant body.

Resolved:
The Committee received and accepted the report.

4.4 Safer Standards for Invasive Procedures

Dr Purva gave a presentation relating to safer standards for invasive procedures. She advised that it had come to light following the Never Events linked to wrong site surgery.

She reported that the WHO checklist had not been embedded and in some cases there was a failure to engage with the checklist. Work was ongoing in a number of areas to improve performance, team discipline, communication and efficiency.

Dr Purva concentrated on the theatre checklist improvements and presented new documents to ensure the correct checking procedures were carried out. The new checklist also included a 'stop the line' box for any member of staff to pause the procedure if they thought something was wrong.

Mr Snowden asked how the Trust safeguarded against complacency and Dr Purva advised that there were monitoring observation audits in place once the checklist training had been completed by the team.

Mr Wright advised that staff behaviours were being challenged and some areas were better than others. He added that the checklist was in place to help staff as he had witnessed consultants being significantly affected following events that could have been avoided by pausing to think.

Resolved:
The Committee received and accepted the report.

4.5 Medicines Management/Optimisation

Mr Corral gave a presentation updating the Committee around the missed doses performance. He advised that the number of distractions had been reviewed and reduced which had led to less missed doses. Ward 70 had carried out the trial and it would be rolled out to other areas following its success.

The discharge process was being assessed and pharmacists were now completing Immediate Discharge Letters on the 5th Floor. A Medicines Management Assistant had been appointed to help with the logistics of this trial. Patient experience was also being monitored in the Discharge Lounges.

Mr Corral advised that savings had been achieved by changing drug brands and that these changes were in line with NICE guidance, patient consent and quality impact assessments.

Mr Corral also reported that he was the Accountable Officer for any incidents relating to Controlled Drugs and was working closely with the Chief Nurse on any security breaches or anomalies in the system. The e-Prescribing now in place at Castle Hill Hospital meant that drug usage was now fully auditable. All incidents were reported and monitored at the Operational Quality Committee.

Mr Corral spoke of some new initiatives such as drugs being scanned at receipt to ensure they had been verified, and then scanned again at

issue. He reported that this could have savings attached but further work was being carried out and the project was in its very early stages.

Resolved:
The Committee received and accepted the presentation.

5 Received for Assurance

5.1 Integrated Performance Report

The report was received for assurance purposes. The Committee noted VTE and elective caesareans performance and Mr Wright advised that these areas were being reviewed.

Prof. Veysey stated that he was pleased to see the Trust was seen as a good reporting organisation of incidents and events.

Resolved:
The Committee received and accepted the report.

5.2 Operational Quality Committee Report

Mr Wright presented the document and advised that the Trust had met with the CQC regarding the action plan in place. The CQC had accepted the plan and were satisfied that all actions were included. Mr Wright advised that it was likely the CQC would inspect again in Summer 2019.

Resolved:
The Committee received and accepted the report.

6 Board Assurance Framework

Mrs Thompson presented the report to the Committee. She advised that the risk BAF 2: sufficient and skilled staff had been increased from 16 to 20 by the Board agreeing. The risk would be reviewed again in September 2018 at the Board meeting.

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

7 Any Other Business

7.1 – Research and Education

This item was deferred to the next meeting in August 2018.

7.2 – Feedback from the Health Expo 2018

Prof Veysey was impressed by the Health Expo 2018 and found it a good opportunity to network and meet people from the local community.

8 Chairman's Summary to the Board

The Chair agreed to summarise the meeting to the Board.

The East Riding and Hull Joint Scrutiny Committees was discussed as an excellent example of leading the way in local healthcare partnerships. Mr Wright had attended and delivered the CQC report to them, to advise and assure them of the progress the Trust had made since its last inspection. This item was to be highlighted to the Board. **MV**

The Operational Quality Committee was changing the way it approached Serious Incidents giving each Health Group and opportunity to present their action plans and how they are managing all incidents. This to be included in the information points to the Board.

9 Date and time of the next meeting:

Tuesday 28 August 2018, 9.00am – 11.00am, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	28 August 2018	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Maternity Services in relation to serious incidents and the review taking place
- Fundamental Standards – Nutrition, infection control and VTE were discussed by the committee and assurance received that work was ongoing to improve the issues raised in the report.
- Serious incident report was received – 26 incidents had been received to date
- Mr Nearney attended the Committee to discuss the quarterly Workforce report.
- Discussion around the partnership work with the University in Pakistan
- QIP – focus on pressure ulcers and leadership control
- Quality Impact of CRES – the policy is due for review. Assurance that all schemes are being managed through the process and appropriately.

Decisions made by the Committee:

Key Information Points to the Board:

- Fundamental standard report useful when Board members visit wards.

Matters escalated to the Board for action:

- Harm free care performance relating to patients who attend the hospital with harm.

Hull and East Riding Hospitals NHS Trust

Quality Committee
Held on 28 August 2018

Present:	Mr A Snowden	Vice Chair/Non-Executive Director (Chair)
	Mrs V Walker	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Wright	Chief Nurse
	Mrs S Bates	Deputy Director of Quality Governance and Assurance
	Mr D Corral	Chief Pharmacist
In Attendance:	Mr S Nearney	Director of Workforce and OD (item 5.3 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Prof. M Veysey, Non-Executive Director, Dr M Purva, Interim Chief Medical Officer, Mrs A Green, Lead Clinical Research Therapist	
2	**Declarations of interest** There were no declarations received.	
3	**Minutes of the meeting held 30 July 2018** Item 4.2 QIP – paragraph 4 – sentence 3 should read: Prof Veysey added that he would carry out assessments in his clinical practice if they had not been completed….. Following the above change the minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Mr Snowden raised the issue around staff behaviours in the labour ward as this had been linked to a number of incidents and asked what was being done to address these issues. Mrs Bates advised that the Trust was carrying out a CQC type inspection of the service to analyse relationships and pick up soft intelligence to get a sense of the problem areas. Mr Wright added that there had been a number of staff changes with experienced staff retiring and newer, younger staff being recruited so teams were still establishing their working behaviours. Retraining and reflective practice was being implemented where it was needed but there was more work to be done. Mrs Walker asked if leadership interventions and intensive organisational development could be undertaken with support from the Organisational Development team. Mr Wight advised that this was taking place and suggested that Miss Hingorani and Ms Cairns, the midwifery leads be invited to a Quality Committee meeting to discuss the work ongoing and give assurance around the governance within the service.	**RT**
	The Committee were informed that Mr Vize was now the lead regarding the SLA with Humber Foundation Trust. Mrs Bates advised that the mental health assessments were improving but the service was very stretched especially concerning young people and mental health support.	

3.2 Action Tracking List
The Committee reviewed the action tracking list.

3.4 Workplan
The Committee reviewed the Workplan.

The Agenda was taken out of order at this point

4.3 Fundamental Standards
Mr Wright presented the report which detailed the fundamental standard audits carried out on the wards and the outcomes. Mr Wright advised that the red rated standards highlighted the wards with development needs and further assessment. Each of the ward sisters were responsible for their wards and the Deputy Chief Nurse met with them on a regular basis to review the specific standards and their scores.

Mr Wright reported that the process was paper based at the moment but electronic systems were being reviewed.

Mr Corral asked if the results were triangulated with complaints, serious incidents etc. and Mr Wright advised that Mrs Grantham reviewed each audit closely looking at the ward's history and asking relevant questions.

Nutrition was still an issue but was due to recording nutrition rather than patients not being fed. Mr Wright advised that the audits were highlighting the issues and ward sisters were now aware of the areas needed to improve.

Mrs Walker asked how the staff felt about being asked the questions and Mr Wright advised that the Compliance Team spent time on the wards and did not get resistance.

Mr Snowden commended the work that Mr Wright's team were carrying out and the clear report showing progress being made. Mr Wright suggested that Board members could use the report when visiting wards and Mr Snowden proposed this as a key information point to the Board.

Resolved:
The Committee received and accepted the report.

4.1 Serious Incidents Themes and Trends
Mrs Bates presented the report which highlighted 26 serious incidents that had been reported to date. There had been 2 incidents de-escalated by the Commissioners, these were due to the investigations finding the management of care to be appropriate. There had been 9 investigations closed to date.

There was a discussion around the Lorenzo system and other electronic systems and staff not using them, preferring traditional paper based systems. There was work ongoing within radiology to ensure failsafe processes were in place. Mr Snowden added that more work looking at culture and behaviours would be necessary to ensure staff used the more efficient and failsafe electronic systems.

Mrs Bates highlighted incidents in obstetrics and maternity and the recommendations in place to avoid recurrence. She added that the service had received a 'Good' rating by the CQC and this was to be taken into account when

reviewing the incidents.

There was a discussion around the human aspects of providing care and ensuring robust accountability is in place with the consequences clear for any staff not following clear procedures.

Resolved:
The Committee received and accepted the report.

5.3 Workforce Transformation Report – Quarterly Update

Mr Nearney presented the report which was a quarterly update reviewing the 3 year People Strategy and its progress.

He reported that a recruitment manager would be commencing with the Trust in February 2019 to target potential staff to work at the Trust. The post would be time limited.

Mr Nearney reported that the international partnership working was ongoing and that he had forged a partnership with a Pakistan college with a view to trainee doctors working for the Trust in return for NHS experience and training. Birmingham Hospital Trust had also engaged with Pakistan and the doctors would be working at cheaper rates than UK doctors.

Mr Wright was concerned around the ethics of paying the doctors less and it was suggested that a further discussion would take place in the Executive meeting being held later that day.

Mrs Walker highlighted the leadership initiatives and asked what the impact has been on the Trust following their programme and Mr Nearney advised that he would prepare a report reviewing that would capture outcomes and improvements in leadership and staff experiences.

Mr Corral asked if there had been any impact on international recruitment relating to Brexit and Mr Nearney advised that there had been a large reduction in LMC registrations in Europe.

Resolved:
The Committee received and accepted the report.

4.2 Quality Improvement Programme

Mr Wright introduced the item and reported that he was working towards eradiating avoidable pressure ulcers with the nursing teams. He was frustrated that pressure ulcers were continuing to occur after training and other initiatives had been introduced. He had met with the nursing leads to ensure that they were taking full responsibility for their areas as they would be held to account for any avoidable pressure ulcers due to poor quality of care. Mr Wright advised that he had spoken to a patient and family regarding a pressure ulcer acquired whilst in the care of the Trust and wanted them to attend the Nursing Conference later in the year, using their experience as a real example of poor care.

The Committee discussed nutrition and the need to streamline the process to ensure good quality recordings of what patients were eating, their weight and fluid balances were achieved. Mrs Walker asked if nutrition was a direct link to tissue viability and Mr Wright stated that it was. He reported that the Nutrition Steering Group was reviewing all incidents relating to nutrition and had produced

an annual report which would be shared with the members of the meeting.

Mrs Bates advised that work around the infection control QIP was ongoing and VTE was improving but still not achieving the standard.

Resolved:
The Committee received and accepted the report. Mrs Bates agreed to circulate the Nutrition Annual Report to the Committee members. **SB**

4.4 Quality Impact of CRES
Mr Wright presented the item and advised that the Policy was being reviewed but did not anticipate any changes to the process.

He advised that there was a CRES tracker in place for each Health group and that he met with the Chief Operating Officer to review all schemes and highlight any issues to the Health Group responsible. A Quality Impact Assessment was required for any scheme over £100k and Mr Wright assured the Committee that there were currently no concerns.

Resolved:
The Committee received and accepted the update.

The agenda returned to order at this point

5.1 Integrated Performance Report
The report was received by the Committee.

5.2 Operational Quality Committee
The report was received by the Committee.

6 Board Assurance Framework
The Board Assurance Framework was received by the Committee.

7 Any Other Business
Mr Hall advised that the % of patient receiving harm free care was showing a decline in the integrated performance report. Mr Wright advised that this statistic related to patients attending the hospital with harm and not harm caused whilst in the hospital. It was suggested that this item would be raised at the Board meeting for further discussion during Mr Wright's Quality Report which detailed the Harm Free Care outcomes as part of the Safety Thermometer audits.

8 Chairman's Summary to the Board
Mr Snowden agreed to summarise the meeting to the Board in September 2018.

9 DATE AND TIME OF THE NEXT MEETING:
Monday 24 September 2018, 9.00am -11.00am, The Committee Room, Hull Royal Infirmary

Integrated Performance Report

2018/19

August 2018

July data

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

Integrated Performance Report - August 2018

RESPONSIVE

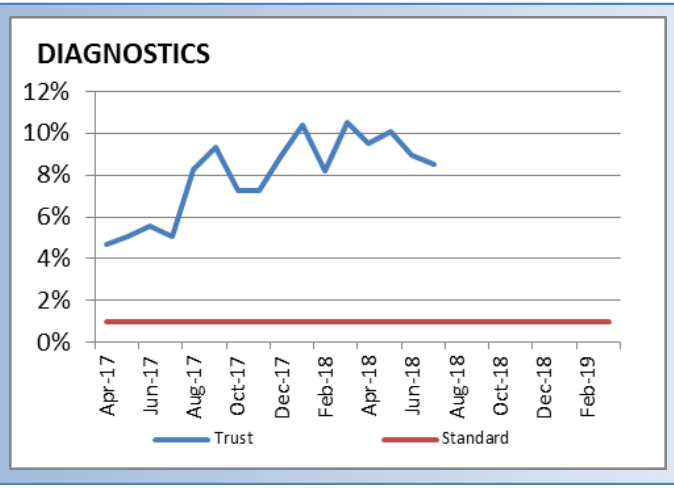
Description	Aggregate Position	Trend	Variation

Diagnostic Waiting Times: 6 Weeks

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

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target during July with performance of 8.52%

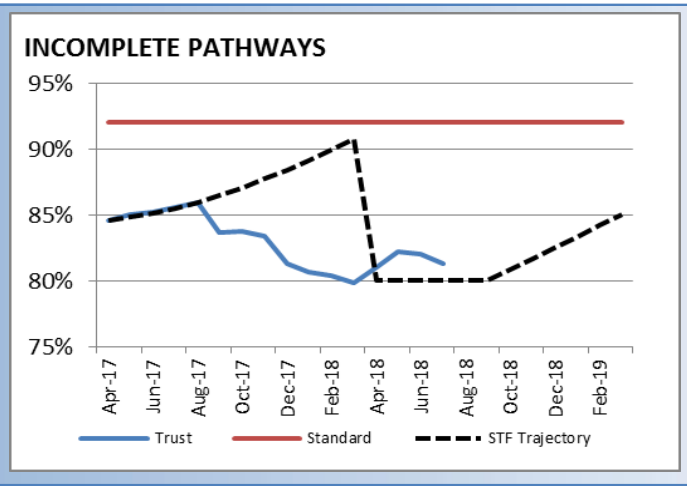


Referral to Treatment Incomplete pathway

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

The Trust achieved the July improvement trajectory of 80%

July performance was 81.32%. This failed to meet the national standard of 92%.



The RTT return is grouped in to 19 main specialties.

During the month there were 5 specialties that failed to meet the STF trajectory

Integrated Performance Report - August 2018

RESPONSIVE

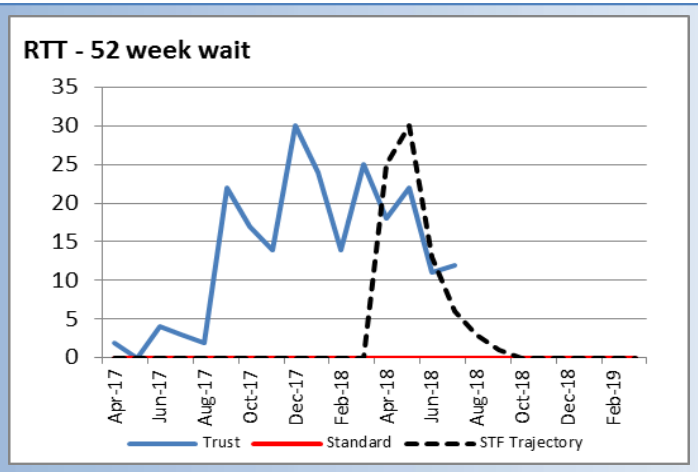
Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The Trust failed to achieve the July improvement trajecotory of 6 breaches with 12 breaches during July

The Trust failed to achieve the national standard of zero breaches.

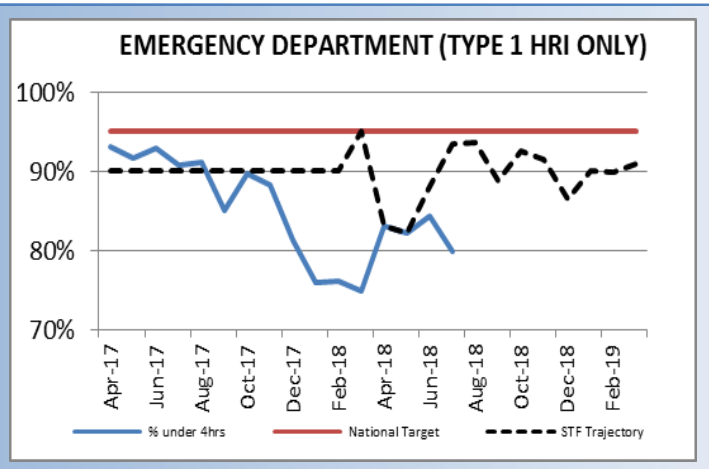


ED Waiting Times (HRI only)

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

The ED STF Improvement trajectory was revised 20th July 2018. Performance failed to meet the revised trajectory of 93.4% with performance of 79.8% for July.

This has failed to achieve the national 95% threshold.



Performance has decreased 4.6% during July from the June position of 84.3%.

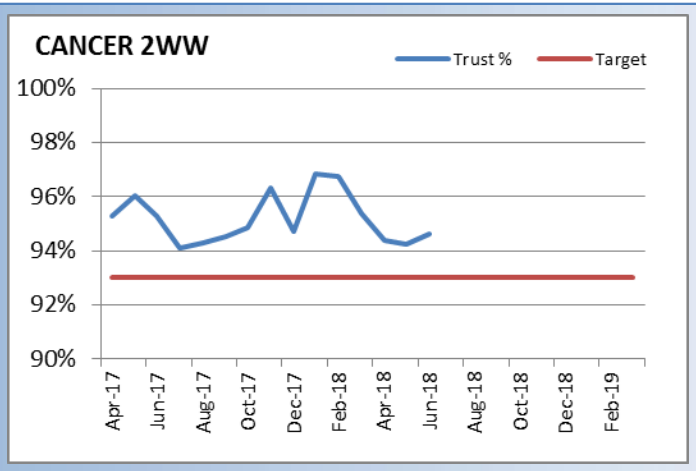
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: Two Week Wait Standard

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

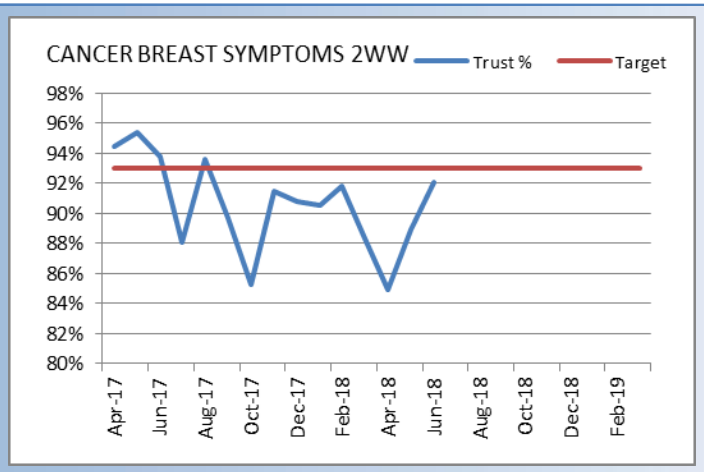
June performance achieved the 93% standard at 94.6%



Cancer: Breast Symptom Two Week Wait Standard

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

June performance failed to achieve the 93% standard at 92.1%



Integrated Performance Report - August 2018

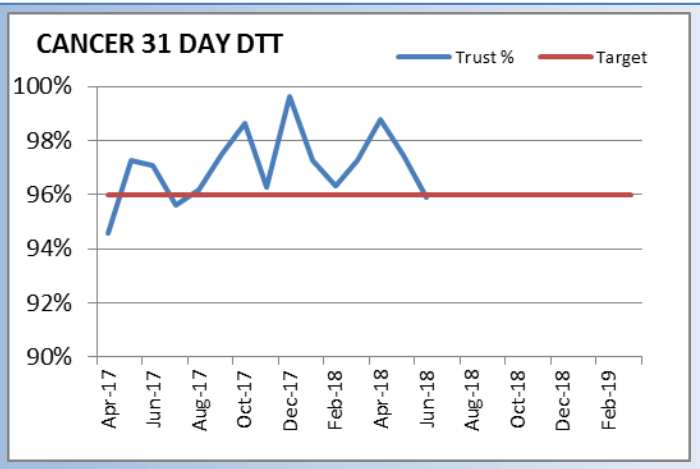
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Standard

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

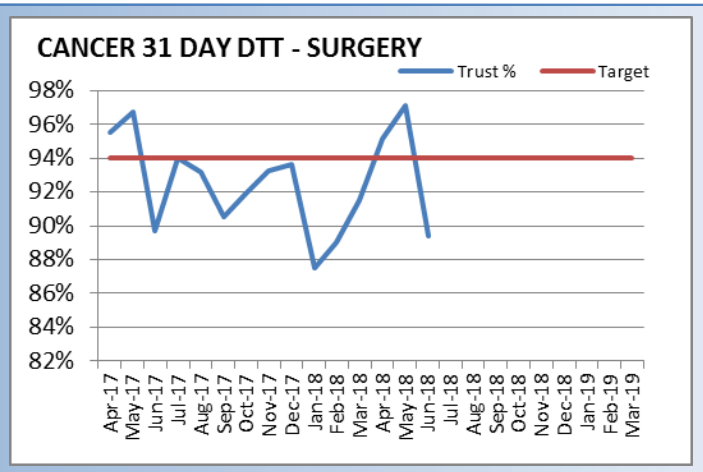
June performance failed to achieve the 96% standard at 95.9%



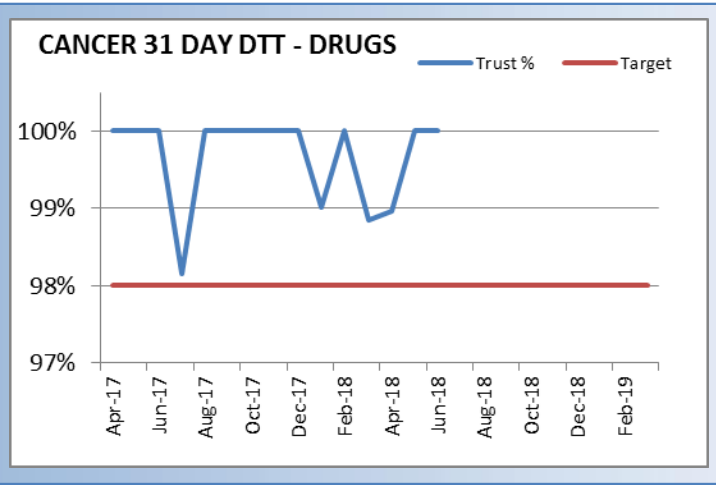
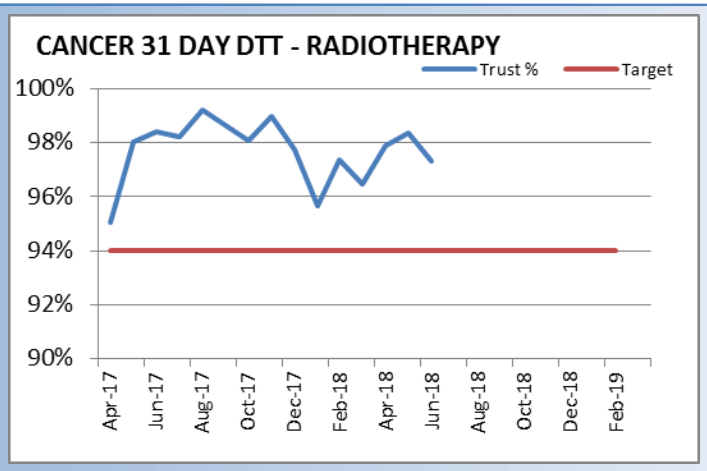
Cancer: 31 Day Subsequent Surgery Standard

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

June performance failed to achieve the 94% standard at 89.4%



RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Drug Standard	All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 98%.	June performance achieved the 98% standard at 100%		
Cancer: 31 Day Subsequent Radiotherapy Standard	All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.	June performance achieved the 94% standard at 97.3%		

Integrated Performance Report - August 2018

RESPONSIVE

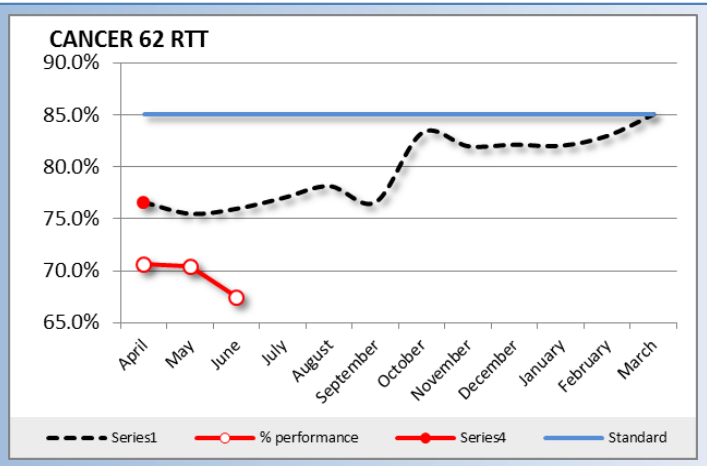
Description	Aggregate Position	Trend	Variation

Cancer: ADJUSTED - 62 Day Standard

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

The adjusted position allows for reallocation of shared breaches

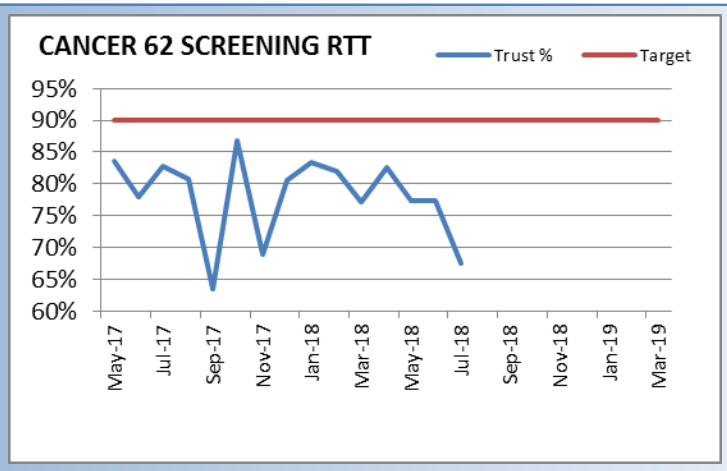
June performance failed to achieve the STF trajectory of 76.0% with performance of 71.6%



Cancer: 62 Day Screening Standard

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

June performance failed to achieve the 90% standard at 67.4%



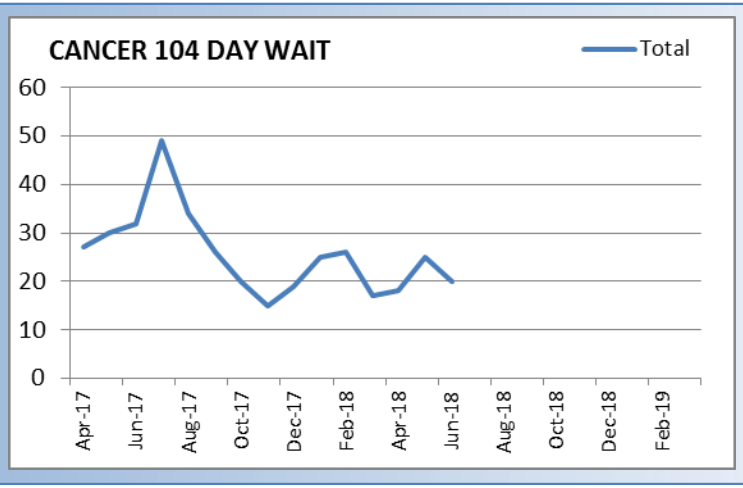
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 20 patients waiting 104 days or over at the end of June



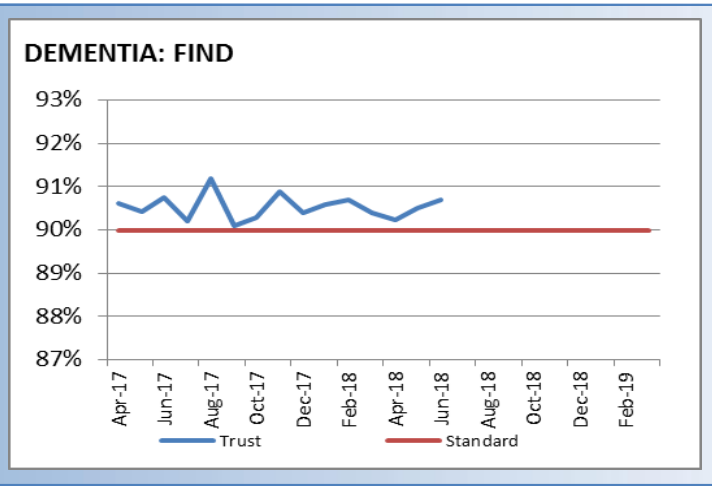
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

The latest performance available is June 2018.

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard at 90.7%



RESPONSIVE

Description	Aggregate Position	Trend	Variation

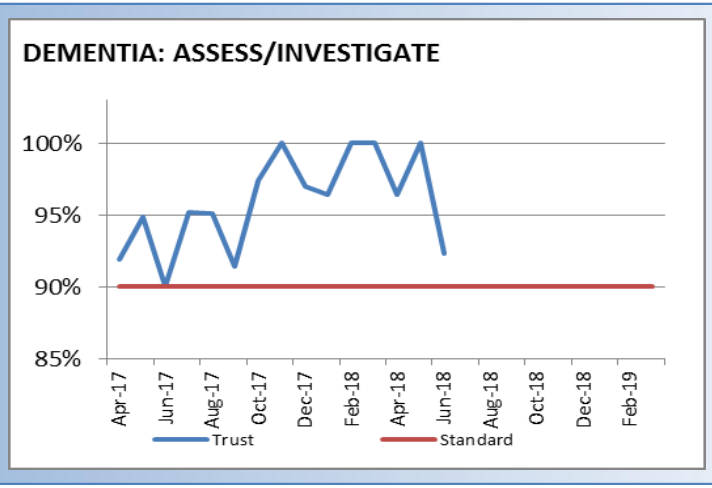
Dementia: Aged 75 and over emergency admission greater than 72 hours

% 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 latest performance available is June 2018

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard at 92.3%



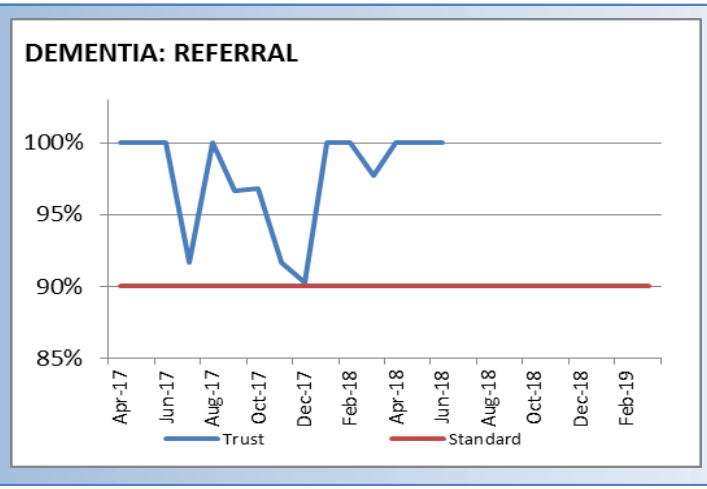
Dementia: Aged 75 and over emergency admission greater than 72 hours

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

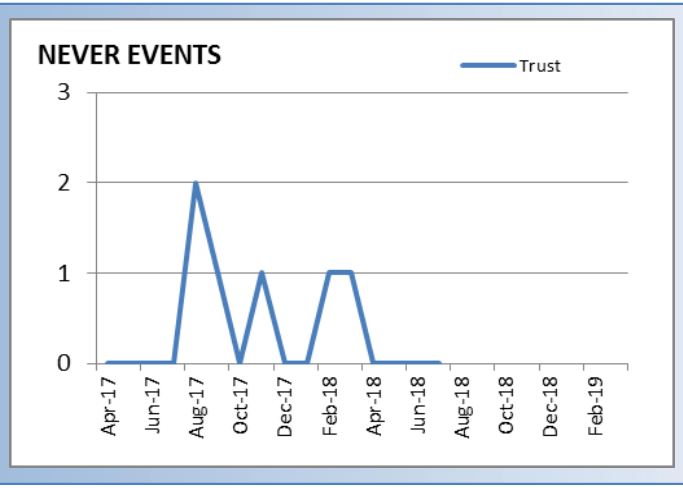
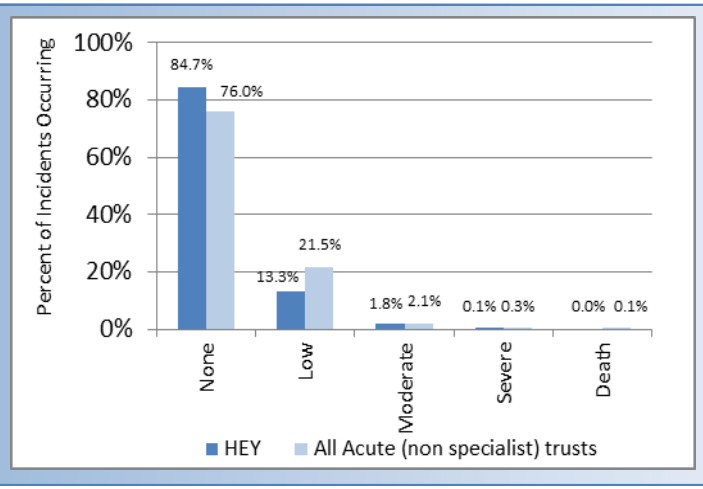
The latest performance available is June 2018.

The standard for this indicator is to achieve 90%.

Performance for June achieved this standard



SAFE

Description	Aggregate Position	Trend	Variation
Occurrence of any Never Events	The latest available performance is July 2018 The Trust reported 6 Never Events in 2017-18 There were no cases reported during July 2018.		Further information is included in the Board Quality report
Potential under-reporting of patient safety incidents	Number of incidents reported per 1000 bed days	The latest data available for this indicator is April 2017 to September 2017 as reported by the National Reporting and Learning System (NRLS). The Trust reported 9,677 incidents (rate of 58.55) during this period. This rates the Trust in the highest 25% of reporters October to December 2017 position will be available at the end of September 2018		

SAFE

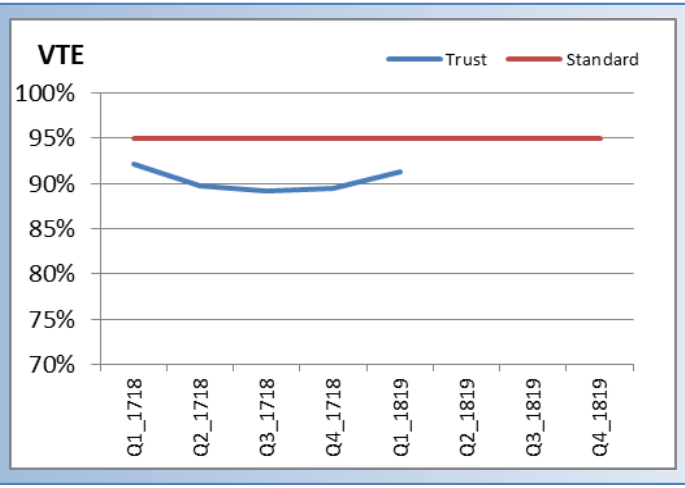
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 91.31% for Q1 2018/19.

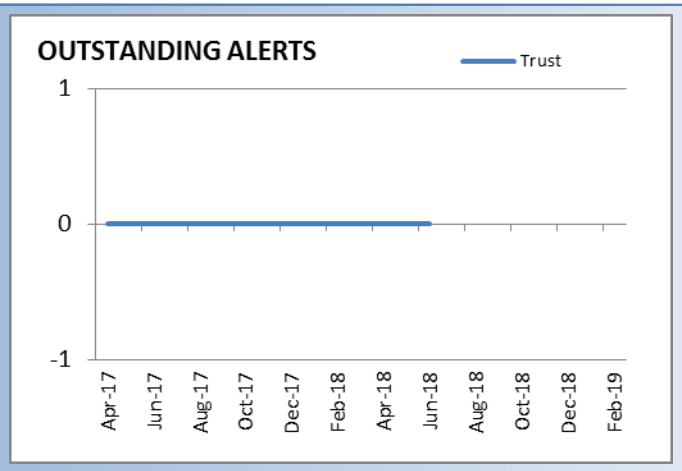


Patient Safety Alerts Outstanding

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

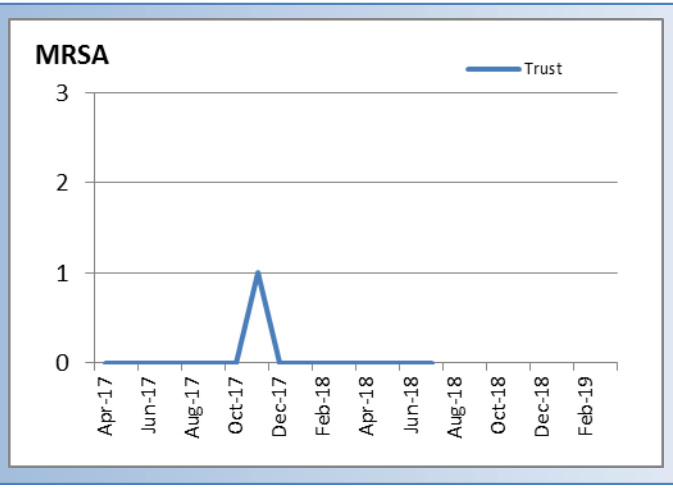
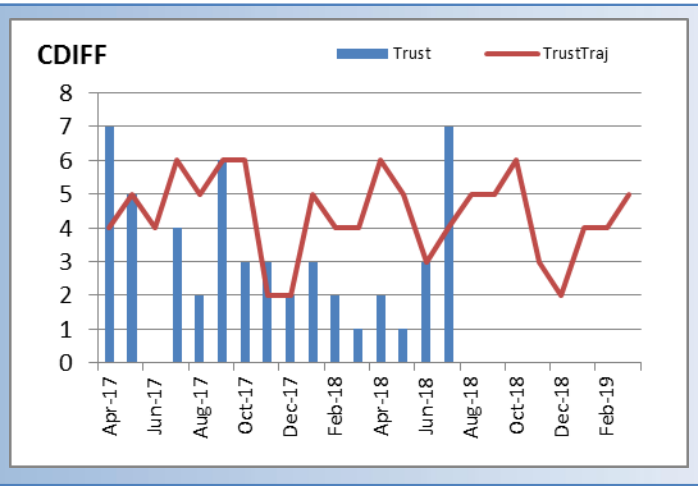
There have been zero outstanding alerts reported at month end for July 2018.

There have been no outstanding alerts year to date.



Integrated Performance Report - August 2018

SAFE

Description	Aggregate Position	Trend	Variation
MRSA Bacteraemia	National objective is zero tolerance of avoidable MRSA bacteraemia	The Trust reported 1 case of acute acquired MRSA bacteraemia during 2017/18. There have been no cases reported year to date.		Further information is included in the Board Quality report
Clostridium Difficile	The Clostridium difficile target for 2018/19 is no more than 52 cases	There were 38 cases during 2017/18 There were 7 incidents reported during July which failed to achieve the monthly trajectory of no more than 4 cases		

SAFE

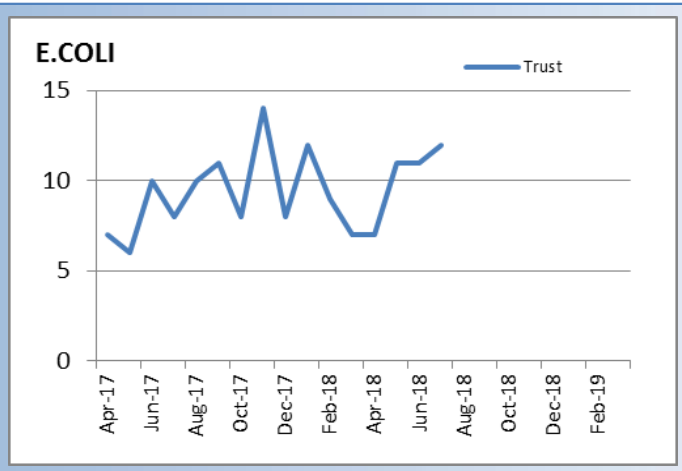
Description	Aggregate Position	Trend	Variation

Escherichia Coli

Number of incidence of E.coli bloodstream infections

There have been 110 cases during 2017/18

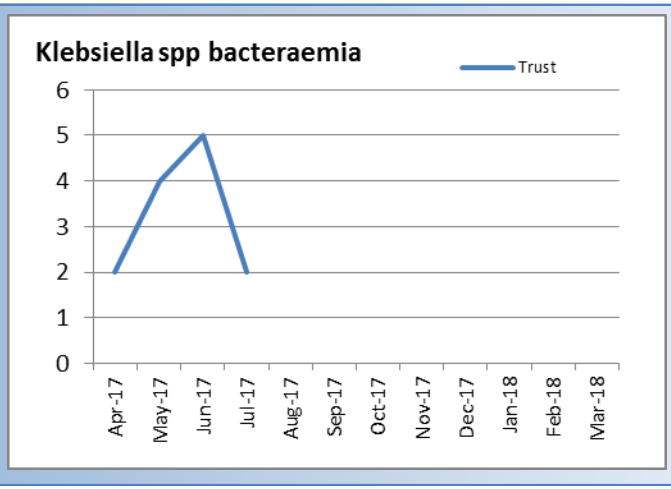
There were 12 incidents reported during July



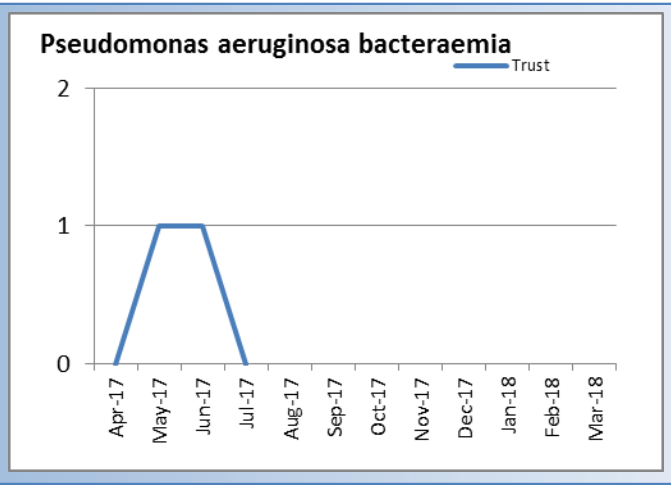
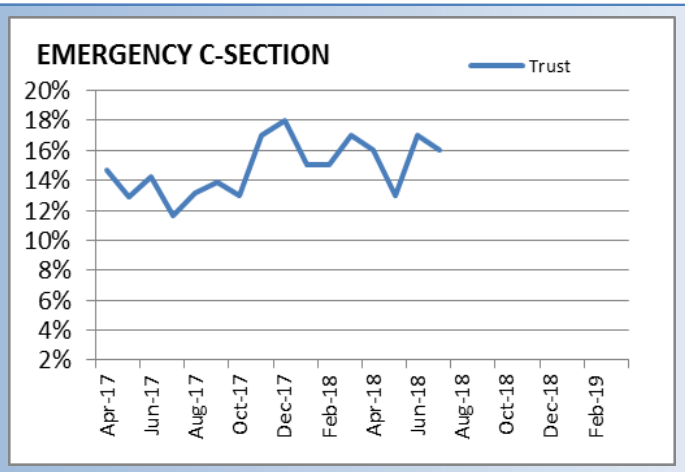
Klebsiella spp bacteraemia

Number of incidence of Klebsiella spp bacteraemia

There have been 13 incidents reported year to date.



SAFE

Description	Aggregate Position	Trend	Variation
Pseudomonas aeruginosa bacteraemia	Number of incidence of Pseudomonas aeruginosa bacteraemia	There has been no incidences during July 2018.	
Emergency C-section rate	Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for July failed to achieve this standard at 16%		Further information is included in the Board Quality report

EFFECTIVE

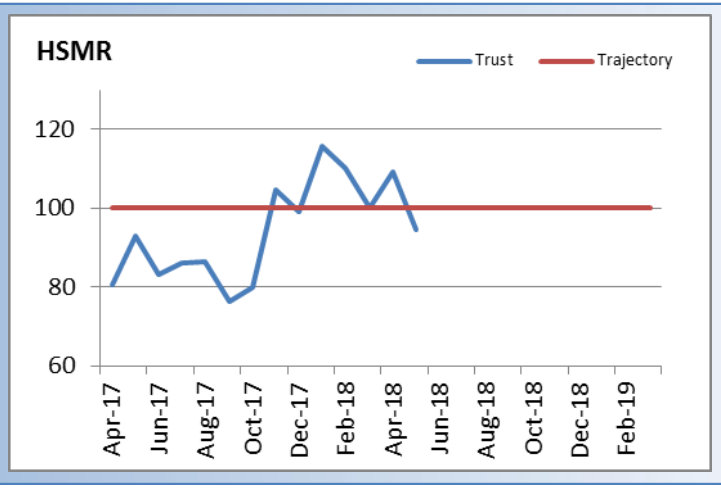
Description	Aggregate Position	Trend	Variation

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

May 2018 is the latest available performance

The standard for HSMR is to achieve less than 100 and May 2018 achieved this at 94.6

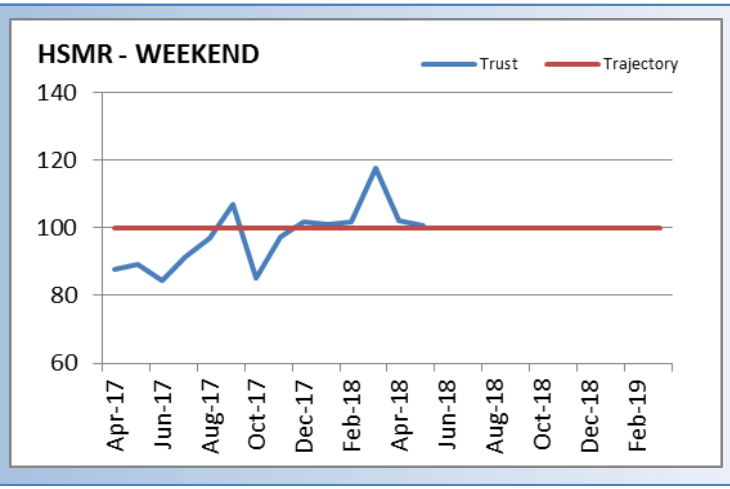


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

May 2018 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and May 2018 failed to achieve this at 100.7



EFFECTIVE

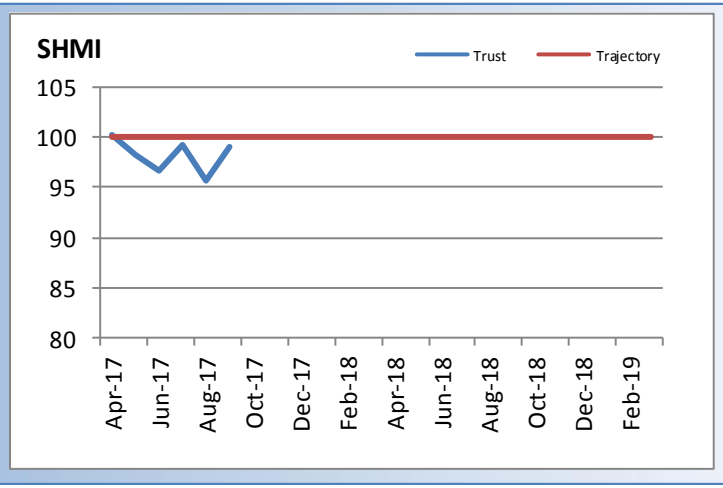
Description	Aggregate Position	Trend	Variation

SHMI

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

September 2017 is the latest published performance

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

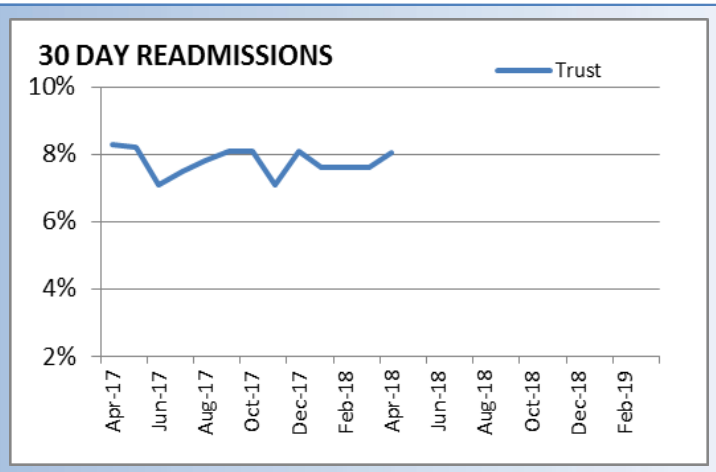


30 DAY READMISSIONS

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

The latest available performance is May 2018

The Trust should aim to achieve less than or equal to 2017/18 performance of 7.8%. The Trust achieved this measure with performance of 7.64%.



CARING

Description	Aggregate Position	Trend	Variation

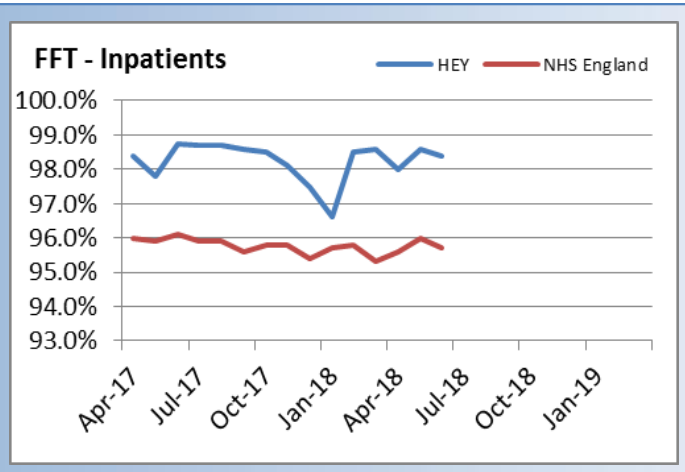
Inpatient Scores from Friends and Family Test - % positive

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

Performance for June was 98.4%

The latest published data for NHS England is June 2018.

July performance will be published on 6th September 2018.



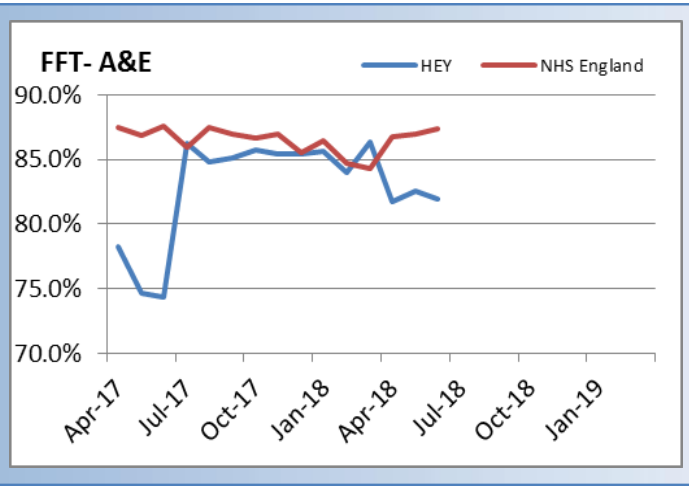
A&E Scores from Friends and Family Test - % positive

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

Performance for June was 81.9%

The latest published data for NHS England is June 2018.

July performance will be published on 6th September 2018.



CARING

Description	Aggregate Position	Trend	Variation

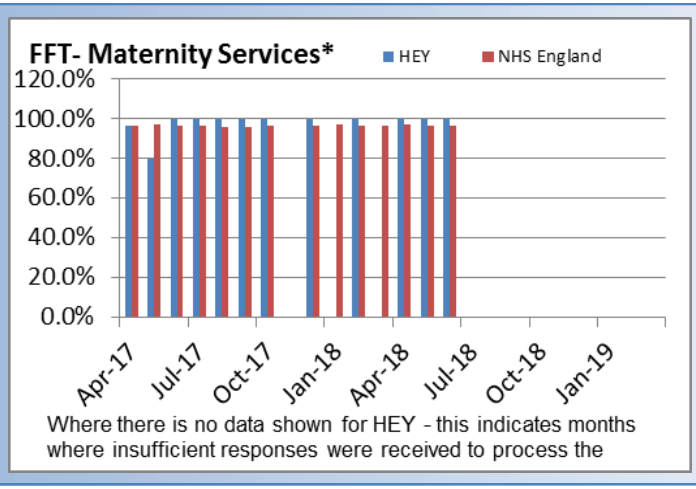
Maternity Scores from Friends and Family Test - % Positive

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

Performance for June was 100%

The latest published data for NHS England is June 2018.

July performance will be published on 6th September 2018.



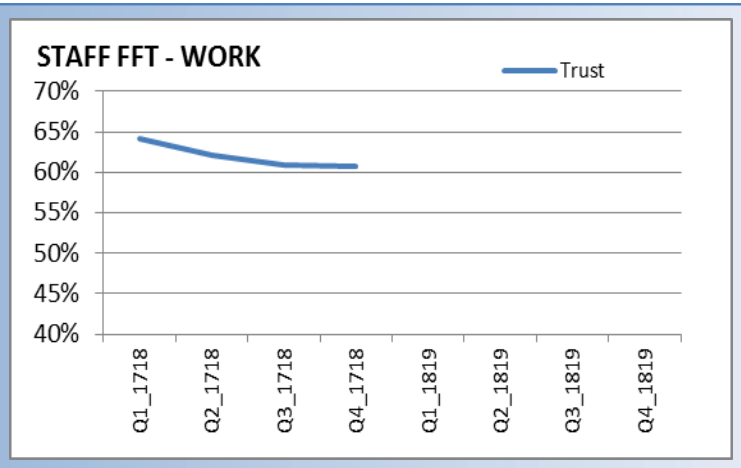
* Question relates to Birth Settings

Relative Position in Staff Surveys

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

Performance for Q4 shows 60.8% of surveyed staff would recommend the Trust as a place to work, this has remained consistent with the Q3 position of 61.0%.

Q1 1819 performance will be published on 23rd August 2018.



Integrated Performance Report - August 2018

CARING

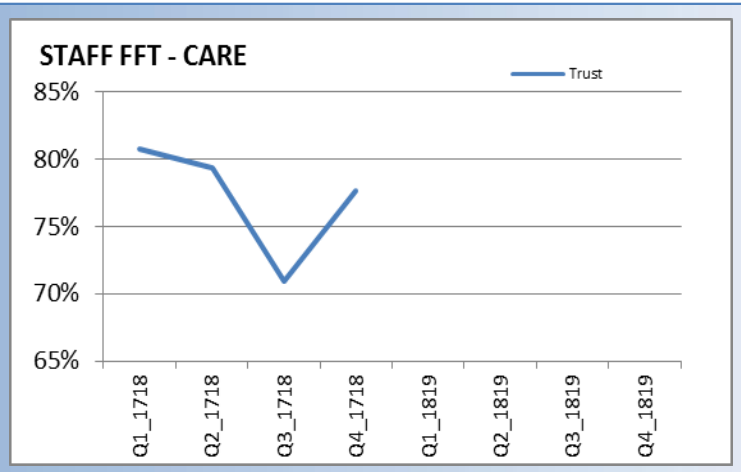
Description	Aggregate Position	Trend	Variation

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?

Performance for Q4 shows 77.7% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has increased from the Q3 position of 71.0%.

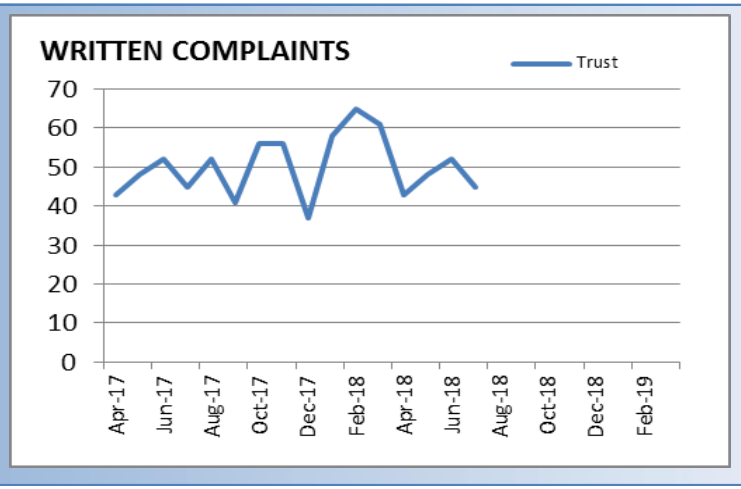
Q1 1819 performance will be published on 23rd August 2018.



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 45 complaints during July, this has decreased from the June position of 52 complaints



There have been 188 complaints year to date

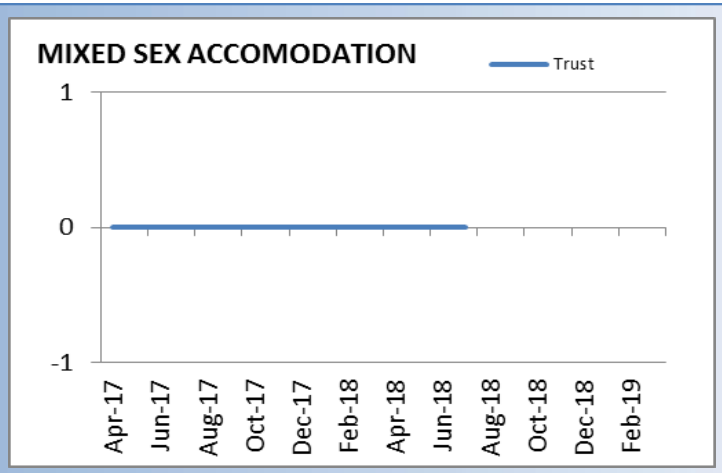
CARING

Description	Aggregate Position	Trend	Variation

Mixed Sex Accommodation Breaches

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

There were no occurrences of mixed sex accommodation breaches throughout July 2018.



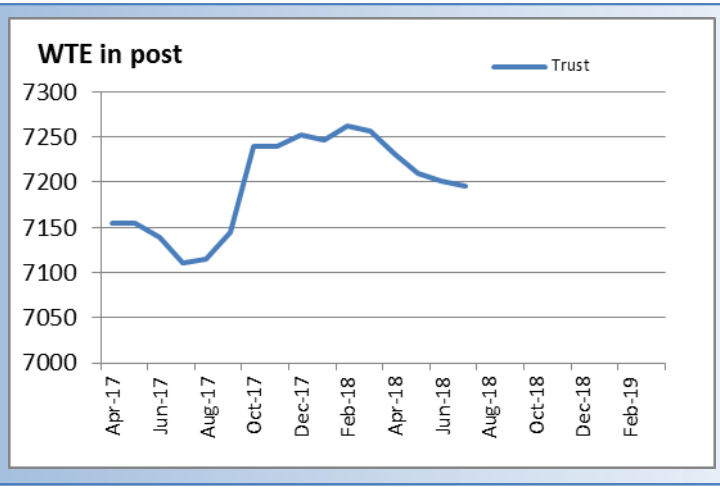
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

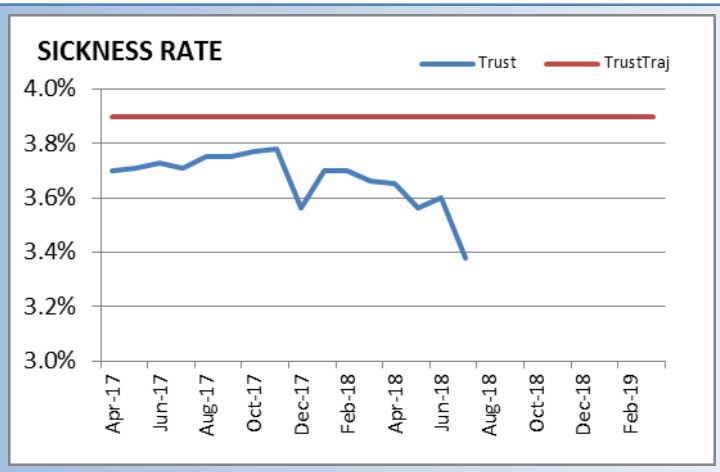
Trust level WTE position as at the end of July was 7195



Sickness Absence Rates

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

Performance for July achieved the standard of less than 3.9% with performance of 3.38%



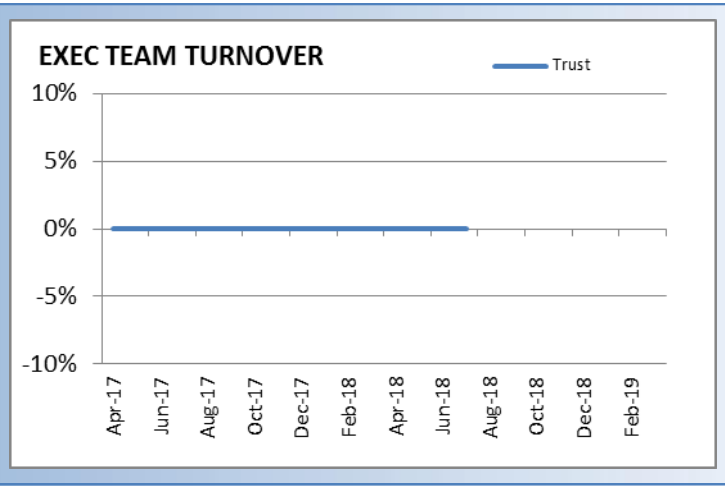
ORGANISATIONAL HEALTH

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.

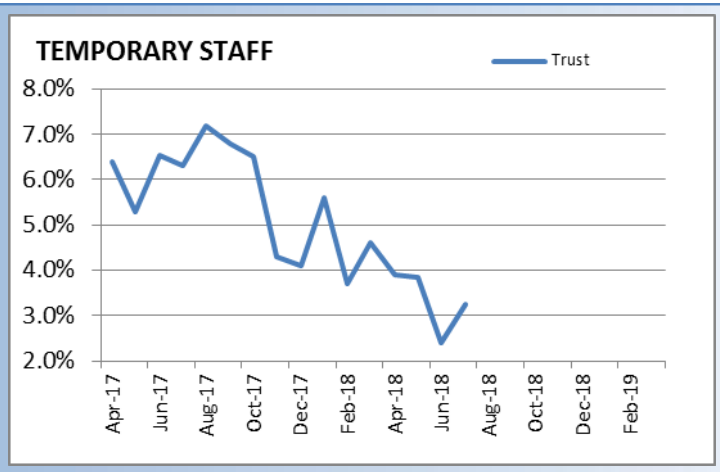


Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

July performance was 3.25%



FINANCIAL SUMMARY: 4 MONTHS TO 31st JULY 2018

1. At the end of July, the Trust is reporting a SOCI deficit of £1.2m which is £0.6m above plan. The shortfall relates to the non delivery of the ED target for quarter 1 and therefore non receipt of the Provider Sustainability Funding (PSF) for this element.

2. In month the Trust has underperformed against contract on its clinical activity by circa £1m. Elective activity fell by £0.8m with non elective also falling by £0.2m. Imaging/Direct Access continues to increase and is now above plan by £0.7m. The impact of the AIC contract has reduced to £0.4m as a result of the low level of work in month.

3. The Trust is £0.04m behind plan on CRES delivery at month 4 with £3.65m delivery against a target of £3.69m (99% delivery)

4. HG run rate positions are £0.6m overspent at month 4, up by £0.1m from month 3. The main driver of the overspend is the cost of pass through drugs within the AIC contract (£0.6m). There are other pressures on medical staffing but these are being offset by vacancies in other staff groups..

5. Agency spend to the end of July is £3.4m which is above planned level of £2.7m by £0.7m, a deterioration of £0.4m. The variance is driven completely by agency medical staffing with the main variance relating to junior medical staff. Overall staff budgets remain below plan at month 4 by £1.1m. This is the same as last month.

6. The Trust paid the latest Agenda for Change pay uplift to the vast majority of its staff in month. Funding made available by the Dept. of Health looks to be in line with actual expenditure. The backdated element of the pay award will be paid next month. Concerns still exist regarding the Trusts liability to staff employed by OCS who previously worked for the Trust. The financial exposure to this group of staff could be as much as £0.75m. Work is ongoing to determine the exact size of this liability and the exposure of the Trust to any funding shortfall from the Dept of Health.

7. Health Groups and Corporate budgets are forecasting that they will be £4.1m overspent at year end. The main shortfalls being CRES delivery at £2.9m and £1.1 cost of drugs not reimbursed under the AIC contract. There are a number of significant cost pressures being forecast relating to medical staffing, radiology outsourcing and MRI van hire but these are mostly offset by expected vacancy levels. Income is currently expected to be £1.3m above plan (£4.3 above contract) but after allowing for full cost budget adjustments, principally for pass through drugs and devices, this leaves a £2.4m shortfall. Within this is a £4.2m under trade on planned elective and outpatient activity, some of which will be offset by virtue of a £1.9m gain in emergency activity and some of which will not have a financial impact due to the AIC contract.

8. The Trust can currently offset the forecast overspend by releasing the £2.5m CRES contingency reserve to reduce the CRES shortfall to £0.4m. Review of other specific reserves being held within the financial plan suggests that the Trust can manage the forecast cost pressures as they currently stand, however, further deterioration in the Health Group forecast positions cannot be accommodated. It is therefore absolutely essential that the Health Group reported positions do not deteriorate any further if the Trust is to meet its control total as agreed with NHSI. The Trust will not be in a position to recover the Q1 ED PSF funding loss but is expecting to deliver remaining quarters.

9. In month the Trust has been notified by NHSI that it will not be able to progress its plan to develop an alternative delivery vehicle for the provision of non clinical services, (initially estates and facilities services), to business case approval stage in the current financial year. The Trusts financial plan assumes that a minimum of £2.9m of savings would have been delivered via this route. The Trust now has a significant gap to close if it is to deliver its control total. In addition the Trust has been notified that it will not receive any reduction on its maternity CNST premium as its has not met all 10 standards introduced this year as part of the maternity incentive scheme. The Trust has appealed against this decision and is awaiting a response. If unsuccessful this will place a further significant risk into the system for which a funding solution would need to be identified.

10. The underlying run rate is currently forecast at £23.5m, reduced from the £25.6m reported at year end. This has increased in month to reflect the uncertainty over the alternative delivery vehicle proposal and the risk around the maternity CNST scheme.

11. The reported capital position at month 4 shows gross capital expenditure of £2.3m which is £0.3m below expected levels. The gross forecast is £36m which includes assumptions on receiving capital loan funding of £19.7m. Loan applications for fire (£4.9m) and equipment (£3.6m) have been submitted and the balance of £11.2m relates to the energy business case which is expected to be submitted in September. The capital programme assumes that the planned surplus and CRL carry forward from 17/18 will be available and approved by NHSI. This has not yet been confirmed and therefore remains a risk to the capital programme. The capital programme will also be impacted by the non achievement of the PSF for ED in Q1 as it means that the Trust will not deliver the required surplus to finance it.

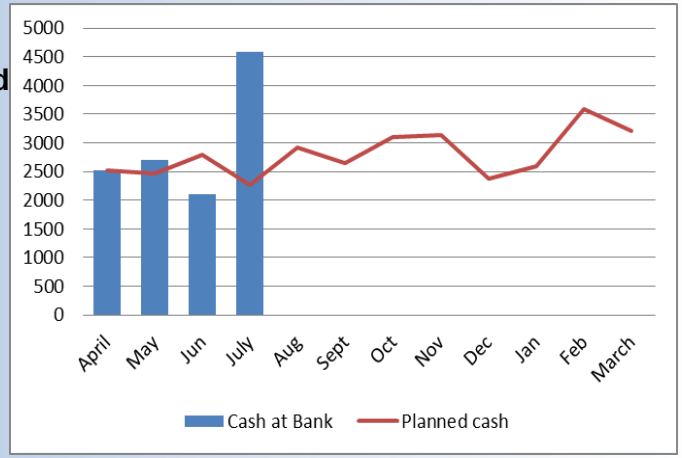
12. The Trusts liquidity position has been relatively stable so far this year however The Trust was recently notified by the Dept of Health that it must repay a working capital loan totalling £4m over the summer period. This was not expected and will place significant pressure on the cash flow over the next 3-4 months. Work is ongoing to improve this position by reducing the aged debtor position held by the Trust with a number of NHS bodies.

Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of July we had positive cash position of £4.6m, comprising of monies in the bank of £4.574m and £0.013m of petty cash floats. Despite the positive cash position we are significantly behind our payables payment target for NHS suppliers. We hope to see an improvement in payment performance to suppliers in the coming months if cash allows. Cash forecasting is now calculated at a more granular level which helps to predict future cash flows more accurately. During September there are some significant payments due for PDC and loans (£4.7m) and this will impact on the cash available to pay suppliers. Our short term loan of £4.177m will fall due for repayment should we receive the PSF funding (October & December)

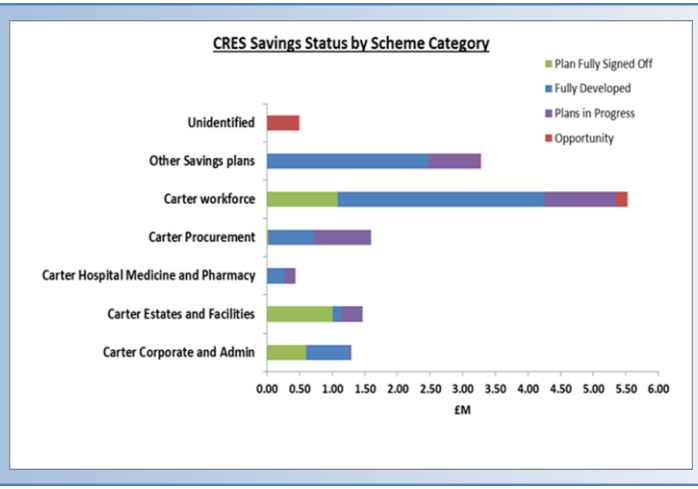


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 4 the Trust's planned level of savings is £3.68m, the actual savings to date is £3.65m thereby creating a £0.37m adverse variance from the plan.

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



Description	Aggregate Position	Trend	Variation

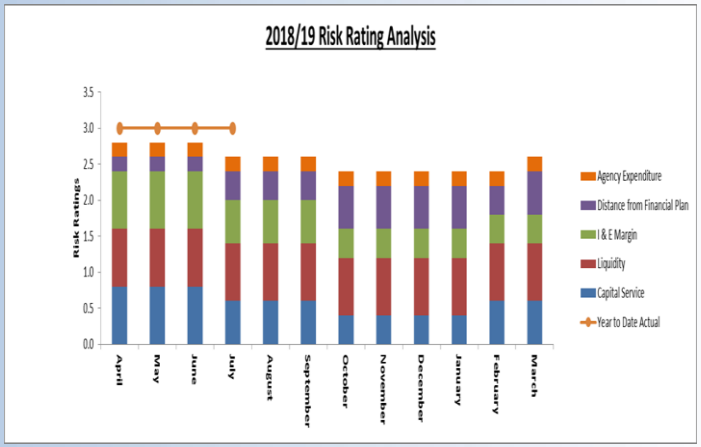
Risk Rating

Financial Sustainability Risk Rating

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess 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 4 the Trust is reporting a YTD deficit of £1.24m against a planned position of £0.7m deficit. This has resulted in liquidity, being rated as a 4, & Capital servicing , & I&E margin being rated as 3. The distance from plan rated as being a 2 and the agency metric rated a 1, giving an overall risk rating of 3

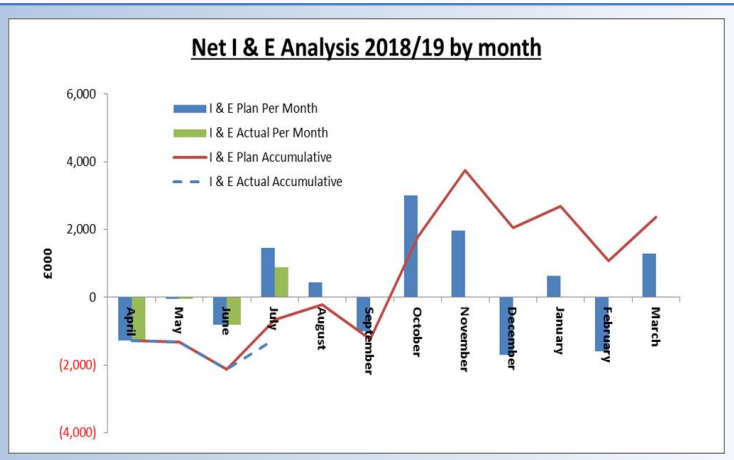


Income & Expenditure

Net income and Expenditure

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

As at month 4 the Trust has delivered a deficit of £1.24m against a planned deficit of £0.7m



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD
11 September 2018

Title:	Elective Care (Stocktake and Expectations)
Responsible Director:	Teresa Cope, Chief Operating Officer
Author:	Teresa Cope, Chief Operating Officer

Purpose:	This paper provide a detailed update on Elective Care as at month 4 and responds to the questions raised in the letter of 22nd August 2018 from NHS Improvement Specifically; • The Trust's delivery against 18/19 elective activity plans and an appraisal of what is driving the elective activity and performance (as set out in the letter; • Forecast for how any year to date elective activity under-performance will be recovered; • Actions being taken by the Trust to Improve theatre in-session productivity; • An assessment of total waiting list size and delivery against the requirement for the total waiting list not to exceed the baseline list size as at 31/3/18. • An assessment of the number of 52 week waiters and delivery of the Improvement trajectory agreed with NHSI.	
BAF Risk:	Goal 4: Great Local Services	
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	
Key Summary of Issues:	As at the end of month 4, Overall referrals to the Trust were 0.1% lower than the same period last year. Cancer 2 week wait referrals across all specialties are 12.5% above the same period last year which is impacting on elective activity. First outpatient attendances (incl outpatient procedures) are 2.7% below planned levels and follow-ups are 4.9% above planned levels. Elective inpatients are 9% lower than plan and the main areas of variance can be seen in Cardiac Surgery, ENT, Gynaecology , Nurosurgery, Orthopaedics and Upper GI. Daycase activity is 2.3% above plan There has been a significant increase in trauma activity over Q1 compared with 2017/18 which has impacted on elective activty in both neurosurgery and orthopaedics The Trust has failed to achieve it trajectory for 52 week waits and a revised trajectory and improvement plan will need to be agreed by the Trust Executive with NHSI. The Trust is currently behind its trajectory for Trust List Size reduction. A Recovery Action Plan is in place which involved a range of validation activities and targetted additional activity.	

Recommendation:	The Trust Board is asked to discuss the content of the paper.

Hull and East Yorkshire Hospitals

Elective Care 'Stocktake'

1. Introduction

Goal 4 of the Trusts Board Assurance Framework identifies the principle risk of the Trust not meeting its operational planning guidance requirements for the Emergency Department (ED), Referrral to Treatment Time (RTT), Diagnostics and 62 Cancer Waiting Times 2018/19.

Goal 4 was subject to a comprehensive review by the Trust Board on 10th July 2018, where it was agreed that the risk rating applied to Goal 4 would remain unchanged at a risk score of 16 (4 x 4).

This paper provide an update on RTT as at month 4 and responds to the questions raised in the letter of 22nd August 2018 from NHSI (Appendix 1)

Specifically;

a. The Trust's delivery against 18/19 elective activity plans and an appraisal of what is driving the elective activity and performance (as set out in the NHSI letter)

b. Forecast for how any year to date elective activity under-performance will be recovered;

c. Actions being taken by the Trust to Improve theatre in-session productivity;

d. An assessment of total waiting list size and delivery against the requirement for the total waiting list not to exceed the baseline list size as at 31/3/18.

e. An assessment of the number of 52 week waiters and delivery of the Improvement trajectory agreed with NHSI.

2. Contract Position – Month 4

2.1 Referrals

As at the end of month 4, overall referrals to the Trust were 0.1% lower than the same period last year which equates to -64 referrals. GP referrals are 1.9% below last year (-846) (see below).

At CCG level, Hull CCG are lower -1483 (-6.1%) referrals lower than plan and East Riding CCG 175 (+0.97%) higher than plan. Trauma and Orthopaedic referrals from GPs in the East Riding have increased to +686 (+ 20%) compared with last year.

GP referrals from NLincs and NE Lincs CCGs have increased by 25% compared with last year. The specialties seeing the largest increase in these referrals are Maxillo-facial Cardiology, Gynaecology, Plastics and Vascular.

North Yorkshire CCG GP referrals are 35% (214) above plan with the growth in referrals mainly in Neurosurgery but with some increases also noted in plastics, cardiology and urology.

Figure 1 – All GP referrals

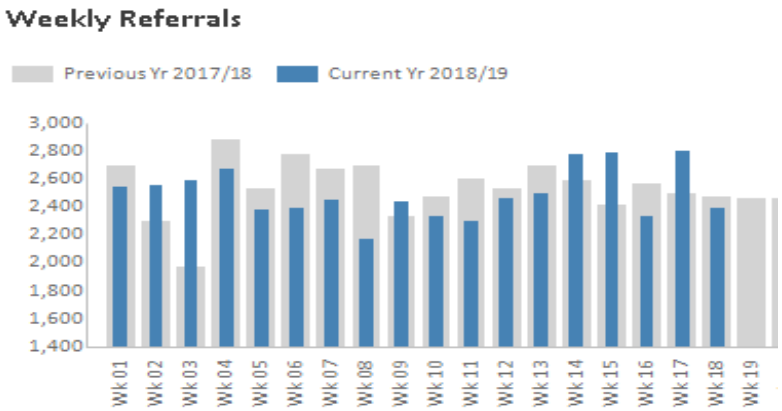
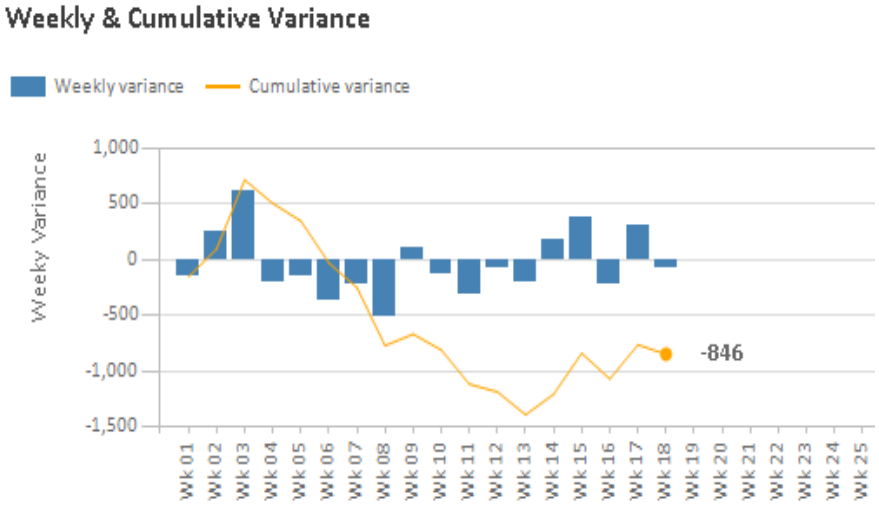


Figure 2 - All GP referrals – variances to last year



Urology continues to be a concern overall with referrals still increasing to 568 higher than last year- equating to 35% . (Figure 3). A meeting has been arranged next month with GPs, commisioners and the Urology service to understand the significant increase.

In addition, 2-week wait referrals are increasing and impacting on service capacity. Of the increase, the element relating to Cancer 2 week waits is 257 referrals (Figure 4).

Figure 3 - Urology all referrals

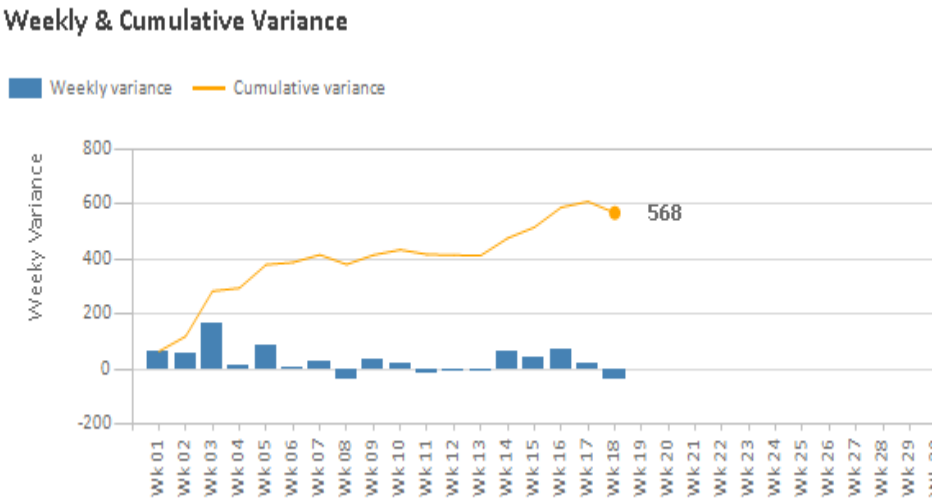
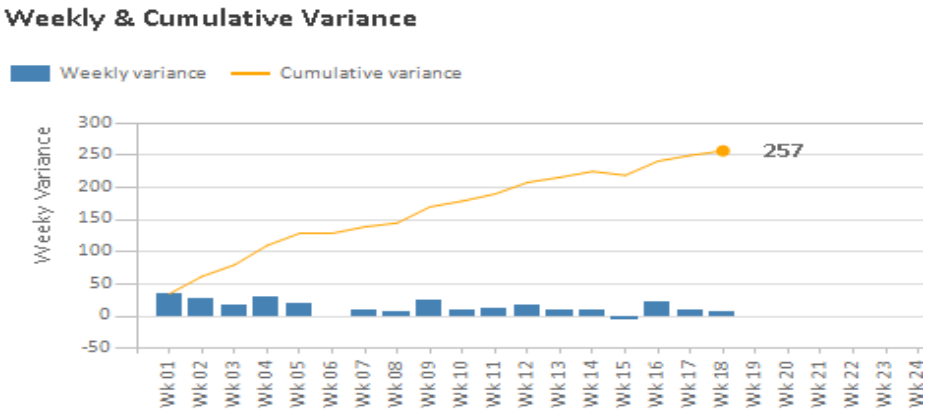
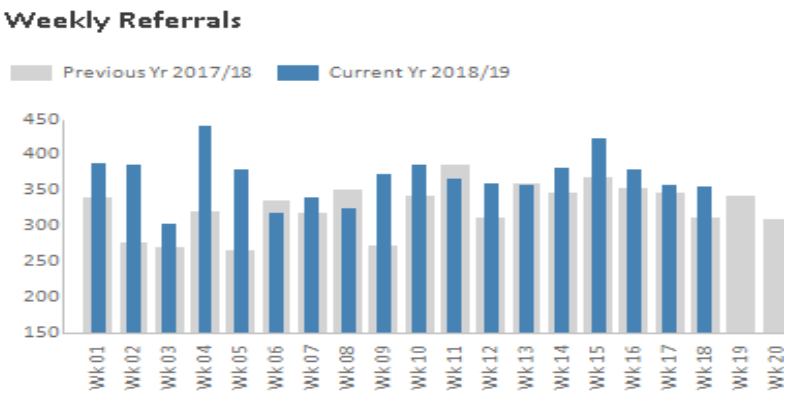


Figure 4 Urology 2ww referrals



Cancer 2 week wait referrals across all specialties are 12.5% above the same period last year (737 referrals), with most weeks being above that of last year, as shown in Figure 5.
As well as Urology, Breast, Upper GI, and Dermatology have also seen large increases in 2 WW referrals.

Figure 5 All 2 week wait referrrals



2.2 Outpatient Activty

At month 4, first outpatient attendances (incl outpatient procedures) are 2.7% (1803) below planned levels and follow-ups are 4.9% above planned levels (5747). Within these variances, in Clinical Oncology there has been a change in the recording of outpatient procedures for radiotherapy from new to follow-up which accounts for 2299 of the undertrade in first attendances therefore excluding this issue, new attendances are in fact above plan by 496.

Breast Surgery and Dermatology are the main areas of increase above plan at 435 (20%) increase for Breast Surgery and 856 (52%) increase for Dermatology. Within Dermatology, 685 of the variance is in East Riding CCG and due to delay in the uptake in their newly commissioned service. ENT and Ophthalmology report lower new outpatients than plan by circa 7% and whilst there are small increases in advice and guidance in these areas this does not account for the lower attendances.

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2.3 Admitted Elective Contract Performance (Elective IP and DC)

As at Month 4, elective inpatients continue to trade at 9% lower than plan (-579) and the main areas of variance can be seen in Cardiac Surgery (-137), ENT (-87), Gynaecology (-52), Neurosurgery (-86), Orthopaedics (-155) and Upper GI (- 116).

Daycase activity continues to trade above planned levels by 2.3% (+543 cases)

The main reasons for the lower elective inpatient position is;

2.3.1 Cardiac Surgery (-137 against plan)

An increase in the non elective demand (+52% / 48 cases against plan) has impacted on the elective plan. The Surgery Health Group triumvirate, supported bby the Chief Operating Officer are meeting fortnightly with the service and have an agreed range of actions in place to increase the number of theatre session being delivered and improve the productivity of existing theatre sessions, given there is a 10% theatre productivity opportunity to be realised.

A business case for a locum Cardiac Surgeon is currently being developed which, if approved, would be in post from the beginning of October.

Additionally, plans have been developed to the implement a Post Anaesthetic Ventiliation Unit (PAVU) which would help to increase CTS activity however this is not anticipated to be operational until March / April 2019 and remains subject to approval of a business case.

2.3.2 Gynaecology (-52 against plan)

The service has a long term Clinical Fellow vacancy and has experienced higher than anticipated theatre session cancellations due to lack of anaesthetic staff during July. The restriction of elective activity winter 2017-18 including Gynae ward closure to support medical patients between January to April 2018 created a backlog of major cases causing

fewer cases and therefore treatments per operating session during the first 4 months of 18/19.

To address the under performance against contract the service has developed a recovery plan with short, medium and long term actions which intend the service to be back to plan by January 2019. Recruitment to the clinical fellow role is underway.

2.3.3 ENT (-87 against plan)

The service currently has 2 Consultant vacancies and an Associate Specialist vacancy and has also been affected by the challenges with anaesthetic cover which has resulted in the cancellation of a number of theatres lists during July.

The service has a recovery plan in place which includes improve theatre session utilisation (12% productivity opportunity) and is working with the HEY Improvement Team to fully implement the theatre scheduling tool. Recruitment is underway for the 9th consultant and the Clinical Fellow posts and the Health Group is exploring options to use locums in the short term if available/suitable. Saturday theatre sessions are being scheduled from September when staffing is available and a small amount of work has been transferred to the local Independent Sector Provider during July and August. Validation of the ENT PTL is currently taking place and the Health Group is expecting to deliver their 18/19 activity plan by March 2019.

Given the ENT service has the largest number of 52 week breaches YTD and has the greatest number of future potential breaches additional resources is likely to be required in this specialty to mitigate this position for the remainder of 18/19.

2.3.4 Neurosurgery (-86 against plan)

The service has seen a 22% increase in referrals (below) overall against plan and an increase in the non elective demand in Q1 (Figure 7) both impacting on delivery of the elective plan. Additional clinics are planned to meet the increase in demand commencing in September. Additionally from September to the end of December Trauma services (Neurosurgery and Trauma) will reallocate theatre resources across the HRI and CHH sites which will create additional flexibility at the HRI site to undertake the complex neurosurgical spine cases and reduce the complex long wait cases. The specialty is expected to be back on plan from December 2018.

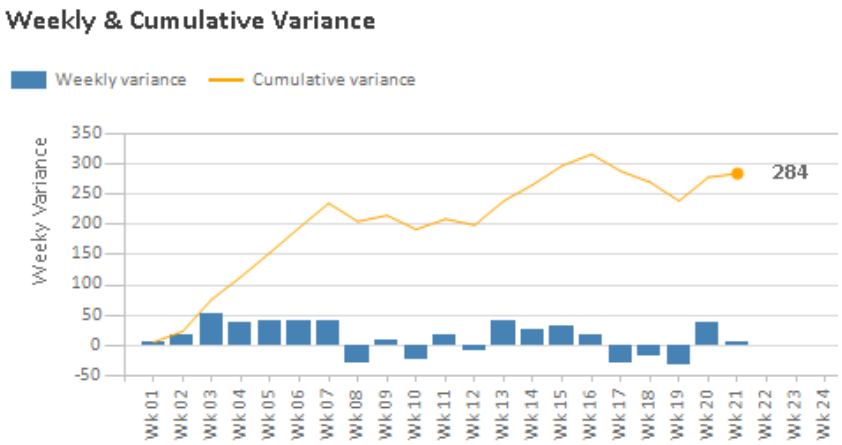
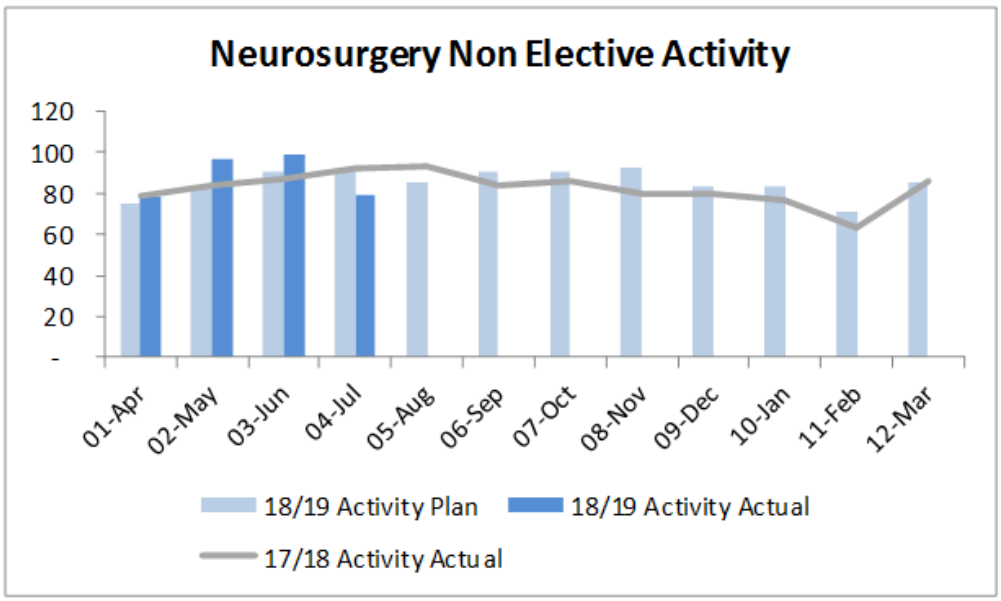


Figure 7 - Neurosurgery Non Elective Activity



2.3.5 Orthopaedics (-155 against plan)

There has been an increase in all categories of Trauma activity during Q1 2018/19, compared with Q1 last year which has impacted on the delivery of elective activity. YTD 242 trauma patients have been treated in elective theatre resource equating to between 25- 30% reduction in elective activity at the Castle Hill Hospital (CHH) site.

Not only does there appear to be an increase in volume, but from reviewing the Multiple Trauma HRG codes for patients admitted to HEY, it would appear that the incidence of complex trauma has also increased year on year (see below)

Multiple Trauma HRG	2015/16	2016/17	2017/18	2018/19 Q1
Total	578	666	722	189

A full review of trauma capacity is currently being undertaken by the Surgical Health Group and discussed with the Executive Team to consider sustainable medium and long term plans for managing the higher level of trauma demand that is being experienced and minimising the impact on elective activity.

2.3.6 Upper GI (-116 against plan)

The service has seen an increase in cancer work ytd which has resulted in a number of routine operating lists being cancelled to enable the team to accommodate urgent cancer cases which require all day operating. In additon to this, the Upper GI Service lost 24 theatre lists compared to planned timetable over the last 4 month period due to consultant unavailability and was unable to backfill from the existing consultant team.

The service is currently exploring the options available to recover this lost activity over the next 4 months and a plan will be developed by mid September, which will be monitored by the Performance and Activty meetings.

The Trust has undertaken substantial work over the last 18 months to Improve in-session productivity in theatres however there continues to be productivity opportunity across the majority of speciality and consequently an external consultant has been re-engaged to review theatre capacity and demand analysis, review and update theatre timetables and ensure the theatre scheduling tool is fully embedded across the Trust.

d) Non-elective admissions

As at 4 months, excluding maternity, the variance on non-elective activity is only 26 cases above plan (0.15%).

The main areas of variance are in surgical specialties (7.8% above plan) and cancer (43% above plan). Cardiothoracic Surgery, Trauma and Orthopaedics, Urology, Gastroenterology, Clinical Haematology & Oncology are reporting the largest variances and postcode analysis shows that in Surgery the increases are mainly from DN postcodes from the south bank.

e) Financial Summary of Contract Position at M4.

The income position reported at month 4 was a gross variance of £1.2m above plan before contract adjustments, which reduced to £0.8m after applying the usual contract adjustments and the estimated impact of the Aligned Incentive Contract (AIC).

The key variances are related to pass through £1m above plan, elective activity £2.5m below plan, outpatients above plan and increased income in non-elective inpatients £0.5m and direct access/imaging £0.7m. Most of the elective undertrade is in the specialised contract which is PbR. The main area of overtrading within the AIC block relates to pass through drugs.

f) Activity Planning Assumptions for Winter

The Trust has reviewed its elective activity performance for Winter 2017/18 and taken account of the National Operational Planning Guidance for 2018/19 in setting its activity elective activity profile for 2018/19.

In our Trust Operational Planning Guidance for 2018/19, we therefore asked services to reduce inpatient activity by 30% for the eight weeks following 26 December 2018, unless they had confidence they would not be impacted by the winter bed pressures. In the final plans we accepted that those services with elective inpatient activity taking place on our Castle Hill Site, which does not have an ED or any acute medical cover and so is not used for medical outliers, did not need to reduce their activity, providing they did not need access to critical care.

Although we have a critical care unit on both of our sites, we do use the staff flexibly across both to respond to peaks in activity. Cardiac Surgery, which does rely heavily on critical care did reduce its activity, by 15%, for the period outlined. We further asked those services who were reducing their elective activity for Winter, to look to do additional activity across the remaining months of the year. This proved difficult in relation to elective inpatients, as

theatre staff vacancies meant the opportunity to run additional sessions was extremely limited. We then held a number of workshops to look at whether we could increase outpatient activity to mitigate the impact of the elective inpatient work reductions on the RTT position and many agreed plans to undertake additional outpatient work on top of their original plan to this end. As we are working within an Aligned Incentive Contract for the majority of our activity, we have the flexibility to make these changes in partnership with our local commissioners.

In relation to the anticipated impact of Winter 2018/19 on delivery of our plans, we have undertaken detailed bed modelling to understand the changing requirement of beds for acute medical services both across the year and during the winter months and also closely scrutinised out stranded and super stranded patient profiles. The Trust has a very small number of these in its medicine bed base, equating to fewer than 6 beds. As a result of this work, in addition to having plans to provide additional medical beds for the Winter period, we are reconfiguring our bed base to reduce outlying and provide medicine with sufficient beds year round.

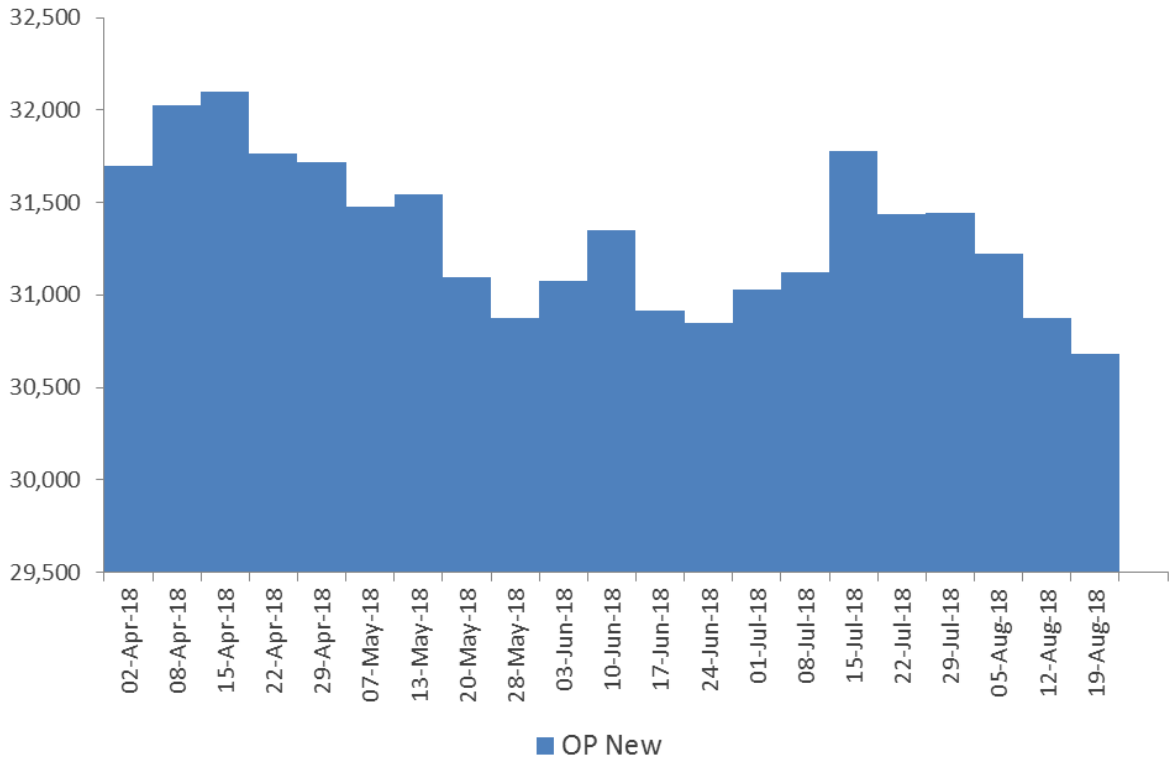
3. Waiting List Volume

The Trust list size at the 31st March 2018 was 54,642. The Trust's Improvement Trajectory identifies that the Trust will reduce its list size by 3,000 from the 31/3/18 baseline by 31/3/19.

As at 19/08/18, the list size was 56,556 which is 1,914 above the baseline position at 31/3/18 and 4131 above the Improvement trajectory for end of August. The majority of the growth in the list size relates to Outpatients.

The Trust has a List Size Improvement Action Plan, which was drafted in July 2018 which includes both speciality level validation, reducing the backlog of typing and additional activity in specialities where this is possible and additional cost have been approved.

During the first 3 weeks of August the Trust list size reduced by approximately 1000 via a range of validation activities (see below). This work is planned to continue throughout September and will be monitored weekly within the Performance and Activity meeting and Executive Team meeting.



The Trust implemented the NHS Improvement's RTT training modules in 2017. In 2018/19 there have been 2054 clinical and non-clinical staff members with RTT e-Learning identified in their mandatory training on HEY 24/7. Of those 718 have passed at least some of their mandated modules which is a 35% uptake; 45.5% of admin staff have completed all of their mandated modules. The Performance team are working with NHSi on the development of clinician RTT training and this will be implemented in the near future. There are face to face training packages for new starters and apprentices and also one to one training is given where a member of staff has specific needs identified. Ongoing support is offered to all admin and clinical teams and there are at least two RTT support sessions run every month for staff and these are always well attended.

4. 52 Week Waits

The 18/19 planning guidance requires the Trust to reduce the number of patients waiting over 52 weeks by at least 50% on 17/18 breaches. The Trust reported 157 x 52 week breaches in 17/18 and therefore set a trajectory to have no more than 78 breaches in 18/19 and achieve zero 52 week waits from October 2018.

The Trust met its trajectory for for April, May and June 2018, however reported 12 breaches as at the end of July, against a trajectory of 6 and will be reporting 16 breaches in August against a trajectory of 3.

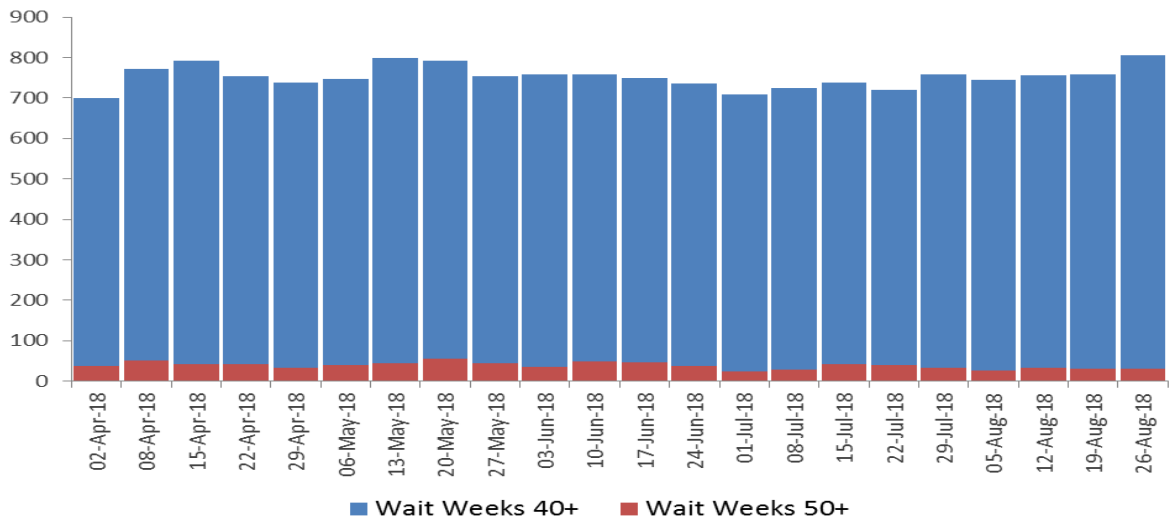
A detailed route cause analysis of each breach is undertaken and these are reported to the Performance and Finance Committee each month.

Details of the 52 week breaches YTD are shown below, by month and by speciality.

Count of Patient		Month					
HealthGroup	SpecialtyTFDescGroup	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Grand Total
CLINICAL SUPPORT SERVICE	Interventional radiology		1	1			2
CLINICAL SUPPORT SERVICES Total			1	1			2
FAMILY & WOMENS HEALTH	ENT	2	13	2	6	5	28
	Gynaecology		1			2	3
	Ophthalmology		2			1	3
	Plastic surgery		1	1			2
FAMILY & WOMENS HEALTH Total		2	17	3	6	8	36
MEDICINE	Cardiology			1		1	2
	Neurology	1			1		2
MEDICINE Total		1		1	1	1	4
SURGERY	Cardiothoracic surgery	6	3	3	1	3	16
	Colorectal surgery	1		1		2	4
	Neurosurgery				1	1	2
	Upper gastrointestinal surgery				1		1
	Urology	5	1	2	2	1	11
	Vascular surgery	3					3
SURGERY Total		15	4	6	5	7	37
Grand Total		18	22	11	12	16	79

The Trust has therefore failed to meet its trajectory. A revised weekly trajectory will therefore be agreed with Health Groups which will meet the requirement to have no 52 week breaches by March 2019.

The number of patients waitng 40 weeks have increased slightly since from the baseline position, this remains a focus for the Trust at weekly performance meetings to target all patients waiting 36 weeks.



5. Follow Up Backlog

As at 22nd August the FU backlog was 37,769. As at 4th April 2018 it was 35,306 so there has been an increase of 2463 against the baseline, despite follow up activity being 5% above plan. The variance at Health Group level is shown below.

Health Group	4/4/18	22/8/18	Variance
Clinical Support	2061	1015	-1046
Family & Women's	15597	16705	+1108
Medicine	12587	13516	+929
Surgery	5061	6533	+1472

The specialties showing the largest increase from the baseline position are Ophthalmology (+973), Plastic Surgery (+597), Cardiology (+179), Diabetic Medicine (+231), Neurology (+335), Rheumatology (+196), Gastroenterology (+734) and Urology (+607).

Alternative ways of offering follow up appointments is being explored. One of the initiatives is for an "open access" approach whereby the patient has access to follow up within 1 year. If their symptoms are stable and they do not make contact with the hospital they are discharged back to their GP. If the patient requires to be seen they are given a contact number to book an appointment. This has been successfully implemented in Respiratory Medicine, Dermatology and Paediatrics

Summary

At Month 4, the main areas of concern for the Trust is the under delivery against the elective plan and the 52 week wait position. The Trust is taking remedial action to return to contracted activity levels and has instigated a range of validation activities.

The 52 week trajectory has not been met and this will require revising immediately with the intention of ensuring that 52 week waits are eliminated by March 2019.

Teresa Cope,
Chief Operating Officer
5th September 2018

Wellington House
133-155 Waterloo Road
London SE1 8UG

Wednesday 22nd August 2018

To: Chris Long, **CEO**
Copy: Terry Moran, **Chair**
Lyn Simpson, **Regional Director**

Dear colleague

Elective care expectations

I recognise this year has already been very challenging and staff are working very hard to deliver high quality care to patients right across the NHS and transform services for patients despite operational pressures.

Whilst I acknowledge the challenges associated with the delivery of the emergency care pathways, we are seeing a worrying picture where overall Trust activity levels and service performance are not in line with recently submitted plans. In addition we are seeing only seasonal reductions in long stays in hospital and bed occupancy is not being sufficiently reduced to enable appropriate flow and performance. This is of significant concern and requires our collective focus.

We have previously outlined our expectations with regards to the delivery and management of elective activity and these expectations were supported by additional national funding to support a step increase in activity levels. These were reflected in the 2018/19 plan your Board developed, approved and submitted back to us.

Under current trajectories, trusts will not deliver for current elective care patients and there is a future significant financial performance risk resulting from non-delivery of activity income plans.

52 week waiters

I am writing to you with a focus on long waiters on the RTT waiting list specifically patients waiting over 52 weeks. The position on 52 weeks requires urgent attention and the delivery of elective care performance is critical to this to ensure patients receive timely, reasonable and appropriate level of care.

It is important that not only do waiting lists not increase, but the number of long waiters on the RTT waiting list are reduced. The expectation, at a minimum, is that the number of patients waiting over 52 weeks is reduced by at least 50 per cent with the overall objective of zero 52 week waiters.

Your trust's performance

Appendix one shows the Q1 position for your Trust and the variance against your plan. I am sure that you and your Board will have reviewed your Q1 activity performance and activity figures with concern.

This autumn provides an important window of opportunity to get back on track with delivering your agreed elective plan ahead of winter. Focus needs to be given to reducing long waiters but also delivering the required reductions in long stays in hospital to reduce patient harm and bed occupancy, as set out in Pauline Philip's letter of 13th June.

Action required

I would therefore ask you to ensure:

1. the importance of delivering elective care performance and activity levels alongside emergency care and finance is recognised by your trust's senior leadership and given sufficient scrutiny at Board level;
2. there is an appropriate week by week trajectory in place and being met, for reducing the number of 52 week waiters to eliminate these ahead of winter wherever possible, in order to ensure that the March 2019 commitment is delivered; and
3. by early September the trust has reviewed and forecast its 2018/19 activity and performance commitments to ensure you are back on track. Where you determine that you will no longer be able to meet the activity and performance commitments in your Board approved plan you work with your commissioners to determine how these gaps will be closed through use of capacity in other trusts and/or the independent sector. Any contingency plan for work carried out by other trusts or the independent sector should be available to mobilise by mid-September.

Please see appendix two for further assurance requests to enable the delivery of the above.

Please can you therefore provide the following information to your regional director by Wednesday 5 September:

- your appraisal of what is driving the elective activity and performance set out above;
- forecast for how and by when, any year to date elective activity under-performance will be recovered; and
- the actions you are and will take to realise the theatre in-session productivity opportunity that your trust has agreed currently exists.

Activity monitoring

We shall be monitoring elective activity and performance levels very closely. As part of this we shall be publishing the RTT PTL each week to all acute trusts and CCGs showing by trust the number of 52 week waiters, with the expectation that we see week by week improvements throughout the rest of the year. You can access this data by registering at https://future.nhs.uk/ and accessing the 'National Reporting' section of the website.

NHS England is writing to CCGs to also inform them of the above requirements.

Your regional director(s) and Pauline Philip will be working closely with you during this period to provide support as required. Please do not hesitate to contact them with any queries.

Thank you for your continued effort and support.

Yours sincerely,

Ian Dalton CBE
Chief Executive, NHS Improvement

Appendix one – current performance as at Q1

	Provider	**Hull and East Yorkshire Hospitals NHS Trust**
	Region	North
RTT waiting list	Total waiting list size (March 2018)	54,627
	Total waiting list size (June 2018)	57,250
	RTT waiting list size in provider plan for March 2019	51,412
52 week waits	52 + waits (March 2018)	25
	52+ waits (June 2018)	11
	Number of 52 week waiters in provider plan for March 2019	0

Demand	Variance in referrals (GP) received YTD (percentage variance from provider plan)	1.59%
Outpatients	Total first outpatient activity YTD variance from plan (percentage variance from plan)	3.35%
Day case	Day case elective volume (Spells) YTD variance from plan (% variance from plan)	5.92%
Elective ordinary	Elective ordinary admissions YTD (percentage variance from plan)	-15.95%
Total elective	Total Elective (% variance from plan)	1.17%

Key to colour coding in appendix 1 – Q1 summary

Total waiting list size (March 2018)	No data		
Total waiting list size (June 2018)	>March 18	<March 18 but > March 19	<March 19
RTT waiting list size in provider plan for March 2019	>March 18		
52 + waits (March 2018)			
52+ waits (June 2018)	>March 18	<March 18 but > March 19 plan	=0
Number of 52 week waiters in provider plan for March 2019			

Variance in referrals (GP) received YTD (percentage variance from provider plan)	>6% above trust plan	>3% above trust plan	
Total first outpatient activity YTD variance from plan (percentage variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Daycase elective volume (Spells) YTD variance from plan (% variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Elective ordinary admissions YTD (percentage variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Total Elective (% variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan

Appendix two: Further assurance requests

a) Assurance that your organisation is:

   - delivering planned activity and RTT treatment (clock stop) volumes;
   - booking patients in (clinically appropriate) chronological order ;
   - clear about what is driving elective underperformance – recognising that it is often not due to a capacity /demand imbalance that people may assume. The elective care intensive support team have developed a range of tools for Trusts to use to assist with this;
   - ensuring as a first step that there are zero 52 week waiters on non-admitted pathways or where day case treatment is required; and
   - actively validating elective pathways

b) Where referral demand and clock starts are above plan you are working with commissioners to ensure they address this situation.

c) Reporting and reviewing progress as a board each month until you are assured these leading measures are back on track, including:
   - number of patients waiting over 40 and 52 weeks by specialty, by admitted/non-admitted pathway, with and without TCI dates.

d) By early September the trust has reviewed its forecast its 2018/19 activity and performance commitments to ensure it is back on track. Where you determine that you will no longer be able to meet the activity and performance commitments in your Board approved plan you work with your commissioners to determine how these gaps will be closed through use of capacity in other trusts and/or the independent sector. Any contingency plan for work carried out by other trusts or the independent sector should be available to mobilise by mid-September.

Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

Meeting Date:	30 July 2018	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Board Assurance Framework – BAF risk 2 increased to a risk rating of 20
- ENT recovery plan presented to the Committee and an update would be received in October 2018
- Surgical Improvement paper presented to the committee – Additional laminar flow theatre, enhanced cardiac recovery unit, surgical admissions lounge and bowel-scope roll out
- Performance report highlighted ED, trauma and orthopaedic super clinics to reduce waiting lists, diagnostics showing an improved position and tracking access almost completed
- It was highlighted that a small scale survey had reported that 70% of ED patients had been in contact with other health care providers and subsequently referred to the Trust
- Outpatient cancellation report – work ongoing to review clinics and booking system rules
- Operational Productivity Dashboard – report to be received on Cath Labs August 2018
- Bed remodelling report was received which also highlighted the issues regarding super stranded patients and the plans to reduce them in 2018/19
- Finance and CRES reports received – deficit is in line with the plan at the first quarter. More work to be done regarding CRES savings
- Capital bids were highlighted including a winter money bid to build a modular ward at the back of the Emergency Department

Decisions made by the Committee:

- The full business case relating to energy innovation upgrade schemes was approved by the Committee and would recommend approval by the Board in September 2018

Key Information Points to the Board:

Matters escalated to the Board for action:

- Fire Safety – Funding bids for the tower block have been approved by NHS Improvement and are with the Department of Health for final approval.

Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee Minutes
30 July 2018

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mrs M Kemp	Operations Director (Item 8.3 only)
	Mr M Lowry	Head of Finance (Item 8.5 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr Nearney, Director of Workforce and OD	
2	**Declarations of Interest** There were no declarations of interest received.	
3	**Minutes of the meeting held on 25 June 2018** The minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** Mr Bond advised that there had been no communication regarding the Trust's Digital Exemplar status yet, but would update the Committee when he had more information.	**LB**
	Mrs Drury reported that the growth in neurosurgery referrals in North Yorkshire was still to be confirmed.	**AD**
5	**Action Tracking List** Cancelled operations information to be received in September 2018	**ER/TC**
	ED Task and Finish Group update to be received in August 2018	**ER/TC**
	Scan4Safety – Mr Bond advised that the business case presented to the Executive Management Committee had been revised and would be presented again at the August 2018 meeting. He added that the new Health Secretary had prioritised the digitisation since being appointed and that this project featured highly on this agenda.	
6	**Workplan** Mr Hall presented the workplan and advised that he would be meeting with Mrs Thompson to review the workplan to ensure all priority work streams were captured in 2018/19.	

7 Board Assurance Framework

Mrs Thompson presented the report to the Committee. She advised that the only change made to the Board Assurance Framework was the risk relating to staffing (BAF 2) and that it had been increased from 16 to 20 following discussion at the Board meeting in July 2018.

Resolved:
The Committee received and accepted the report.

The agenda was taken out of order at this point

8.3 ENT Update

Mrs Kemp attended the meeting and reported that the service was under pressure with head and neck cancer surgery performance being 41% for June 2018 which made it the worst performing cancer pathway.

Mrs Kemp presented the service efficiency plan which would mean delivery of contact activity for 2018/19.

She reported that the current list size for July was 5983 with an average of 43 patients being added per week.

Mrs Kemp advised that there were key areas to improve to deliver the plan which included:

- Recruitment of medical staff, consultant and a senior medic
- Development of PA retraction plan linked to business as usual within 3 years
- Work with CCGs to further reduce demand
- Continue strategic service development via the STP

Mr Bond had concerns regarding recruiting medics once the backlog had been cleared and the service returned to business as usual. He added that the medics could help the South Bank after this time if required which would fit with the Acute Services Review.

Mr Gore asked if the senior clinicians were engaged with the recovery plan and Mrs Kemp advised that the clinical leads were motivated and engaged to provide the service.

Mr Hall asked about day case rates which were at 59% against the national average of 65% and Mrs Kemp agreed that the service needed modernising to ensure sustained delivery.

Mr Hall asked for an update at the October 2018 committee to review the continuing process and any progression made. **MK**

Resolved:
The Committee received and accepted the report.

8.5 Surgical Improvement Agenda

Mr Lowry presented the paper and highlighted key issues for the Surgery Health Group.

An additional laminar air flow system was required to help support additional trauma capacity. The cost to the Trust would be £400k, but it could increase its trauma work by 10% per year and have more capacity to deal with peaks in demand.

He reported that an enhanced cardiac recovery unit would enable the ring-fencing of critical care capacity protecting activity from peaks in critical care bed demand. The additional 4 beds would support the closure of the second 10 bed general ICU unit at Castle Hill Hospital at weekends. A business case to progress this development is being finalised.

He reported that work was underway to develop a proposal to introduce a surgical admissions lounge, the benefits of which would free up ward capacity, reduce bed days and save on nursing staffing costs. It would help with pre-op assessment as it would be in the same location as the surgery.

The combination of the increase in demand for endoscopy and reductions in capacity have led to an increase in the waiting list and increase in diagnostic breaches. Work was ongoing to improve endoscopy planning by aligning staff and scoping capacity at 6 and 2 weeks.

The Bowel Scope screening programme is currently being finalised. The phased roll-out over the next 5 years will mean that the Trust will eventually undertake a further 8,000 procedures per year. The increased costs of £1.2m will be offset by the £2.4m additional income which will be included in the Health Group CRES plan.

Resolved:
The Committee received and accepted the report.

8.4 Bed Modelling Report

Ms Myers presented the report which compared 2017/18 bed usage with a forecast for 2018/19 which allowed for marginal increase in activity and a reduction in occupancy from 92% to 90%.

She reported that Trusts must have been set a target of reducing their super-stranded patients (patients that have been in a bed for longer than 21 days) by 25% in 2018/19. For this Trust this equated to approximately 30 beds.

Ms Myers advised that the Trust was not an outlier regarding length of stay. One cause of excess length of stay was due to delays when transferring patients into the community.

Mr Hall asked how the Trust would be able to create more beds with limited resources and Ms Myers advised that the winter planning was commencing and an additional ward was being reviewed. Assistance from health partners and the community were also key. It was agreed that Ms Myers bring an update to the Committee in October 2018. **JM**

Resolved:
The Committee received and accepted the report.

8.1 Performance Report

Mrs Cope presented the report and advised that the Emergency Department performance was at 84.3%. Work was ongoing with system partners, including GPs, to review pathways and get the right model of delivery in place.

There was a discussion around the Integrated Care Centres and their contracted levels versus the hospitals contracted levels. Mrs Christmas expressed her concern around patients being referred to A&E by GPs and other healthcare providers and Mr Bond agreed, stating primary care resource at the front door would help to ease the flow of patients.

Mrs Cope advised that the Trust and Yorkshire Ambulance Service had a joint action plan in place to improve performance around ambulance turnaround times. She added that the escalation policy had also been updated.

Referral to Treatment Times continued to be challenging but was showing small improvements. There was an increase in the amount of urgent trauma work coming through the system. Mrs Cope advised that the Trust had been at OPEL 3 in trauma for the last 4 months which was having an effect on the size of the waiting list. The Committee discussed super clinics as a way of reducing list sizes.

The 62 day cancer performance was being impacted by delays in histology results and a detailed piece of work was being carried out to review each tumour site. Mrs Cope advised that there could be scope to work with Northern Lincolnshire and Goole NHS Foundation Trust with potential capacity in this area.

Mrs Cope highlighted diagnostics and tracking access as improving positions and a report would be submitted to the committee once the tracking access was completed.

Mr Bond asked if the harm free care indicator would be discussed at the Quality Committee and Mr Hall agreed to raise this at the August 2018 meeting.

SH

Resolved:
The Committee received and accepted the report.

8.1.1 Outpatient Cancellations Report

Mrs Cope presented the report which highlighted by Health Group the number of patients affected. As processes were being tightened up the number of patients would reduce. Mrs Topliss had identified the Trust's methodology around coding cancellations was different than the national methodology, which had meant that the Trust had an improved performance by 2%.

Mrs Cope advised that housekeeping work was ongoing and formed part of the service improvement work being carried out by the Hospital

Improvement Programme.

Mr Hall asked if the report could be broken down by Health Group and if the Committee could receive an update in October 2018 highlighting any progression and reduction in outpatient cancellations. **TC**

Resolved:
The Committee received and accepted the report.

8.2 Operational Productivity Dashboard
The Committee reviewed the report and highlighted the Cath Labs as an area of concern. Mrs Cope agreed to present a report relating to Cath Labs at the August 2018 meeting. **TC**

Resolved:
The Committee received and accepted the report.

The agenda returned to order at this point

9.1 Variable Pay Report
Mr Bond presented the report to the Committee. Mr Gore asked for clarity around overtime and extra sessions and Mr Bond advised that clinical staff did not receive overtime pay but booked extra sessions instead.

Resolved:
The Committee received and accepted the report.

9.2 Job Vacancy Report
Mr Bond presented the report, which had previously been presented at the July 2018 Board meeting.

There was a discussion around the staffing risk rating being increased to 20 from 16 compared to the financial risk rating of 20. Mrs Christmas felt that it was comparable and that the Trust was struggling to recruit the staff needed.

Resolved:
The Committee received and accepted the report.

10.1 Activity and Demand Report
Mrs Drury presented the report which highlighted the Trust's activity and demand for quarter 1.

Mr Gore requested that key specialities be picked for a deep dive and stated that the 3 that stood out to him were trauma and orthopaedics, upper GI and obstetrics. Mrs Drury agreed to include these areas in more detail in her next report. **AD**

Resolved:
The Committee received and accepted the report.

11.1 Corporate Finance Report and CRES Report 2018/19
11.2 Mr Bond presented the report and advised that the Trust was reporting a £2.1m deficit which was in line with plan.

He reported that the position included £1.9m funding from the Provider Sustainability Funding due to being on target with its financial plan and had achieved its A&E target at system level.

Post meeting note:
The assumption made regarding qualification for quarter 1 PSF related to achievement of the ED target was incorrect. As such the reported financial performance is overstated by £0.6m.

The Trust had a gross contract income gain of £0.8m and an under-trade of £1.7m in elective activity.

He reported that the CRES delivery was marginally behind plan and the risk to achieve the target remained high.

The Health Group run rate positions were £0.5m overspent at month 3 and agency spend was slightly up.

Mr Bond reported that the Trust had been advised by NHS Improvement that it would not receive support for its business case to create an SPV in the current financial year. As a result the Trust must look to alternate means of closing the £2.9m gap that this creates in the financial plan.

Mrs Christmas highlighted the debt position and asked how they were being progressed. Mr Bond advised that the financial leads were working on each account, but the main issue was that the NHS Trusts in particular did not have the cash to pay their debts.

Resolved:
The Committee received and accepted the report.

12.1 Capital Resource Allocation Committee Minutes 4 July 2018

Mr Bond reported that 2 emergency capital applications had been submitted to the centre. One related to fire improvement works required following the receipt of the enforcement notice from the Humber Fire Service, with the second relating to a number of specific items of medical equipment which urgently require replacement. He also reported that a winter capital submission had been made for a CT scanner for the Emergency Department and a modular building to house medically fit for discharge patients. Mr Bond would update the Committee in August 2018 regarding the status of these bids. **LB**

Resolved:
The Committee received and accepted the minutes.

12.2 Carter Minutes 17 July 2018

The Carter minutes were received and accepted by the Committee.

12.3 Improvement Board UECPP Report

The Committee received the report for information.

13 Items Delegated by the Board

The Business case in item 14 regarding replacement boilers was

delegated by the Board for scrutiny at the Committee.

14 Any Other Business

Mr Bond presented the full business case that related to energy innovation upgrade schemes both at the Hull Royal and Castle Hill sites. He advised that the current boilers in place were out of date, inefficient and costing the Trust money for breakdown repairs.

He advised that the Trust would manage the system which would mean being in control of producing energy and maximising any savings potential.

Mrs Christmas asked if the Trust could manage the project and Mr Bond reassured her that the teams were capable.

Mr Hall asked about the governance of the business case and Mr Bond advised that once approved by the Board the Capital Resource Allocation Committee would monitor the project and feed any concerns back to the Performance and Finance Committee.

The Committee received and approved the business case.

Mr Gore stated that the ENT presentation from the Family and Women's Health Group had been useful and informative and wanted to see more presentations from the other Health Groups to highlight recovery plans in difficult areas.

15 Date and time of the next meeting:

Wednesday 29th August 2018, 1pm – 4pm, The Committee Room, Hull Royal Infirmary

Hull and East Yorkshire Hospitals NHS Trust

Performance and Finance Committee

Meeting Date:	29 August 2018	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key issues discussed:

- Mr Goldstone attended the meeting to assure the Committee regarding the radiology reporting process
- Performance – A&E, RTT and Cancer targets had been discussed. There had been a new improvement director appointed to drive performance in A&E, RTT performance was declining and cancer performance was discussed in correlation with diagnostic demand and capacity
- A report was received from FourEyes which detailed the efficiencies made in the Cath Labs
- Variable Pay report highlighted the increase in pay and new NHS Improvement regulations around agency doctors pay levels
- The Workforce Transformation report was received and the Committee discussed consultant job planning and the Memorandum of Understanding with the University of Pakistan
- The Activity and Demand report was received. Referrals were generally down and urology was highlighted as an area of concern
- Finance – the Trust was reporting a deficit of £1.2m, Health Group performance was similar to last month and CRES was reported at 99% of plan
- An update regarding the capital bids including the fire safety bid was received. The fire safety bid was currently with the Department of Health for approval

Decisions made by the Committee:

Key Information Points to the Board:

Matters escalated to the Board for action:

- 62 day RTT performance recovery trajectory – performance has been declining for the last 4 months.

Hull and East Yorkshire Hospitals NHS Trust
Performance and Finance Committee
Held on Monday 24th September 2018

Present:	Mr S Hall	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce and OD
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mr T Goldstone	Clinical Director – Radiology (Item 8.3 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs T Cope, Chief Operating Officer and Mr S Evans, Deputy Director of Finance	

The agenda was taken out of order at this point

8.3 Radiology Reporting Review

Mr Goldstone attended the meeting to update the Committee regarding the current situation relating to Radiology reporting and the turnaround times.

The review had been instigated following a CQC report relating to Portsmouth Hospital which found a backlog of imaging that had not been reported. Due to a limited number of radiologists in the system it was found that 8 out of 10 Trusts had a backlog of scans that had not been reported within 31 days or longer.

Mr Goldstone reported that the Trust had been the 5th worst in the country but due to the new processes put into place the Trust now had zero backlog cases to report.

He advised that the team was reducing the amount of days taken to produce a report following the scan and was currently at 28 days for complex scans and 14 for plan film scans. The service was intensely monitoring any backlogs and late scans are usually due to technical problems.

Mr Goldstone added accountability into the process and advised that the 6 modality leads were now responsible for reporting and any late reports are escalated to Mr Goldstone.

Mr Goldstone spoke about the scanning capacity of the Trust and the reporting capacity issues. He added that increased referrals from North Lincolnshire and Goole Hospitals in the future was the Trust's biggest risk along with having insufficient staff to run the service.

Mr Bond asked what equipment would be required to run an efficient services and Mr Goldstone advised that 2 CT and 2 MRI scanners would be required on the Hull Royal Infirmary site, with the staff to manage them.

He reported that currently, the Trust had 42 patients on average waiting for an urgent scan.

There was a discussion around outsourcing and Mr Goldstone advised that the team actively monitored the companies involved and there were KPIs in place to ensure reporting was received in a timely manner with non payment on delays over 6 days.

Mr Hall asked about the governance procedure and Mr Goldstone advised that any issues were escalated to the Health Group Governance Board and the Trust Board if necessary. Mrs Drury added that the Cancer Alliance team was developing a radiology network which would look at opportunities related to reporting and different ways of working.

Mr Goldstone commended the team and stated that each milestone that was achieved the teams were rewarded.

Resolved:
The Committee received and accepted the presentation.

The Agenda returned to order at this point

2 Declarations of interest
There were no declarations of interest received.

3 Minutes of the meeting held on 30 July 2018
Item 14 – Any other business – paragraph 6 – Mr Gore stated that that he meant seeing more presentations from other specialties and not Health Groups.

Following this change the minutes were accepted as an accurate record of the meeting.

4 Matters arising from the minutes
Mr Bond advised that there was a capital shortfall at national level relating to the digital exemplar work. The Trust had received no formal notification to date.

Mrs Drury advised that the neurosurgery referrals in North Yorkshire were now reducing and would be picked up as business as usual.

Mr Bond advised that the revised Scan4Safety business cased had been approved at the Executive Management Committee.

Mr Gore asked for clarity regarding the waiting list size as there seemed to be two different versions. Mrs Cope to present the actual numbers at the next meeting. **TC**

Mr Hall reported that he had raised the Harm Free Care indicator at the Quality Committee and discussed further with Mr Wright. He had agreed to raise this at the next Board meeting for clarity. **SH**

Mr Bond highlighted the post meeting note on page 7 and advised that the assumption made regarding qualification for quarter 1 PSF related to achievement of the ED target was incorrect. The reported financial

performance was therefore overstated by £0.6m.

Mr Gore asked if the fire safety money had been approved by NHS Improvement and Mr Bond advised that it had been approved by NHS Improvement but was with the Department of Health for final approval.

5 Action Tracker

Mr Bond updated the Committee regarding capital bids. He advised that the winter bid had been chased and he was hopeful for a ministerial decision in the next week. The fire bid had been escalated to the Department of Health and the equipment bid had not yet been progressed at the centre. An update regarding the digital funds linked to the STP would be reported at the next meeting in September 2018.

Mr Bond advised that due to the SPV initiative being put on hold a paper would be presented to the Board in September highlighting the next steps.

The Breast Service recovery plan to be presented in September 2018.

6 Workplan 2018/19

Mr Hall presented the workplan and advised that he had added in Tracking Access and expected a close down report to be received in October 2018. He had also added Radiology reporting to be presented in December 2018 to ensure the Committee had oversight of this issue.

7 Board Assurance Framework

Mrs Thompson presented the report and advised that Ms Ramsay had updated the report and added in the previous comments raised. Mr Bond expressed his concern regarding deteriorating performance and asked if this should be discussed further at the Board in September 2018.

Resolved:

The Committee received the report and agreed to raise performance issues at the Board in September 2018.

8 8.1 Performance Report

Mr Bond presented the report and advised that the 4 hour A&E target and RTT were not being achieved.

Mr Bond advised that the Trust had appointed an Improvement Director to drive changes and improve the performance. Mr Nearney advised that the team wanted to resolve the issues themselves and had not welcomed the external help being sought.

Mr Gore asked for clarity around the RTT standard and the actual waiting list size. Mrs Cope/Mrs Ryabov to provide this at the next meeting. Mr Bond stated that pro-active work should be ongoing to predict and reduce any 52 week wait 'pop-ups'. **TC/ER**

The Trust was reporting a decline in performance for the 4th month relating to 62 day RTT. The number of breaches had gone up but referrals were down. The Committee agreed to escalate this to the Board. A recovery trajectory was required from the service.

The Committee discussed 62 day screening and it was agreed to invite Mr

Wood to the meeting to discuss the correlation between diagnostics and cancer performance.

Mr Hall reported that at the Quality Committee it had been identified that the Haematology Department was using a paper based system. Mr Bond agreed to discuss this with Mrs Bates and confirm the system being used.

Mr Hall asked that the super stranded patients update be deferred to the next meeting in September 2018.

Resolved:
The Committee received and accepted the report.

8.2 Super Stranded Patient Tracking Report
This item was deferred to the September 2018 meeting.

8.4 Cath Labs – FourEyes update Report
Mr Bond presented the report and advised that FourEyes had been commissioned to review the Cath Labs at the Trust with a view to improving efficiency through more effective scheduling. Mr Bond advised that they have demonstrated a 6 week identification of the patients and a 4 and 2 week confirmation plan which has been implemented.

He reported that the theatres have improved their performance and staff have been surprised as they didn't feel that they were working any harder. Reporting had also improved as well as the governance.

Mr Hall asked about sustainability and Mrs Christmas asked if there was a plan to roll out further. Mr Bond advised that FourEyes would be prepared to work with the Trust on a 'No Win, No Fee' basis but theatres wanted to do it for themselves utilising the Hospital Improvement Team.

Resolved:
The Committee received and accepted the report.

9 **9.1 Variable Pay Report**
Mr Nearney presented the report which and highlighted that the Trust pay expenditure was £700k higher compared to last year. Agency spend was similar to last year.

He advised that there were new regulations in place stating that agency worker should be paid over £100 per hour and should get Chief Executive approval if this happens. He explained that the Emergency Department was still an issue as was highly specialised services. He reported that variable pay would be an issue for a while longer as the medical workforce was stretched nationally.

Mr Gore expressed his concern regarding the extra sessions and the increase in spending regarding the medics. Mr Bond agreed to provide a report which would, by speciality, break down the variances. This would be provided to the October 2018 meeting. **LB**

Resolved:
The Committee received and accepted the report.

9.2 Workforce Transformation – Quarterly Update
Mr Nearney presented the report and reported that there were a number of positive areas that staff should be commended on. Mr Gore asked how robust the consultant job planning process was as the compliance rate was 92%. Mr Nearney advised that the clinical leads should be holding the consultants to account and job plans robust and linked to performance.

Mr Nearney added that a memorandum of understanding with Pakistan had been developed to train doctors from Pakistan at the Trust for a two year period. This would be mutually beneficial for both the Trust and the Pakistan doctors.

Resolved:
The Committee received and accepted the report.

10 10.1 Activity and Demand Report
Mrs Drury presented the report and highlighted that GP referrals were generally down with the exception of urology which was still causing concern. A meeting had been set up with the Commissioners to understand the issues.

Overall elective inpatients continue to trade at 9% lower than plan (-579) and the main areas of variance can be seen in Cardiothoracic Surgery (-137), ENT (-87), Gynaecology (-52), Neurosurgery (-86), Orthopaedics (-155) and Upper GI. The main reasons for the lower elective inpatient position is related to a continuation of non-elective impact on CTS, Neurosurgery and Trauma patients coupled with medical staffing gaps impacting on capacity.

Daycase activity continues to trade above planned levels by 2.3% (+543 cases) – this is mainly in the Cancer specialties of Clinical Haematology, Medical and Clinical Oncology as well as Pain Management and Respiratory Medicine, Urology and Gastroenterology.

Breast Surgery and Dermatoloogy are the main areas of increase above plan.

After 4 months, excluding maternity, the variance on non-elective activity is only 26 cases above plan (0.15%).

Cardiothoracic Surgery, Trauma and Orthopaedics, Urology, Gastroenterology, Clinical Haematology & Oncology are reporting the largest variances and postcode analysis shows that in Surgery the increases are mainly from DN postcodes from the south bank.

The income position reported at month 4 was a gross variance of £1.2m above plan before contract adjustments – which reduced to £0.8m after applying the usual contract adjustments and the estimated impact of the AIC.

Outpatients, direct access and pass through areas are above plan and these variance are mainly in the AIC. The estimated impact of the AIC at this stage is circa £0.4m pressure. A review is being undertaken with commissioners to assess the forecast position and opportunitues to reduce the pressures going forward – particularly within high cost drugs.

At quarter 1 the system position for ED was cumulatively just above the 90% however this was lower than the same period last year which was 93.6%. The System position for July deteriorated mainly due to the impact of the Trust performane in July. There was a week in July which saw the weekly average at 400 attendances and a week which had a record of 460 attends on one day.

There was a discussion around the financial risks and Mr Gore stated that the report showed the net positions that were substantially behind plan. He asked if Health Group managers were using the report and Mr Bond advised that the risks were discussed at the Performance and Accountability meeting. Mr Gore stressed that the plans had been missed by 10% and Mr Bond advised that this would be reviewed in month 5 and the material items would be highlighted.

Resolved:
The Committee received and accepted the report.

11 11.1/11.2 Corporate Finance Report and CRES 2018/19

Mr Bond presented the reports and advised that the Trust was reporting a deficit of £1.2m in month 4. The shortfall related to the non-delivery of the ED target for quarter 1 and therefore non receipt of the Provider Sustainability Funding.

The Health Group performance did not deteriorate in month and Mr Bond advised that the team had separated out drugs and devices which amounted to £600k.

CRES delivery was at £3.65m against a plan of £3.69m (99%).

Agency spend was above the planned level of £2.7m at £3.4m. The variance was driven by agency medical staffing with the main variance relating to junior medical staff.

The Agenda for Change pay adjustments had been made available to staff and funding from the Department of Health was in-line with actual expenditure.

Mr Bond highlighted the cost pressures relating to the outsourcing of radiology and how difficult it was to avoid the outsource solution. Due to this income against forecast was down by £4.2m on planned activity.

There was a discussion around the SPV and not having it in place this financial year as well as the capital funding shortfalls. The Committee also discussed the cash position which had deteriorated due to a loan repayment change in conditions and the Trust's over 90 day debts. Mr Bond advised that he would be raising NHS debt at the next STP meeting.

Mrs Christmas asked if the teams had started planning for next year and Mr Bond advised that work was ongoing but no firm plans were in place as yet.

Resolved:
The Committee received and accepted the report.

12 12.1 Capital Resource Allocation Committee

Mr Bond presented the minutes and advised that the fee bid for the replacement of the boiler houses at NLAG had been submitted but had not yet received a response. Mr Hall expressed his concern as to whether this fee would be forthcoming. Mr Bond reported that this was not material to the Trust's bid being presented to the Board in September 2018.

Resolved:

The Committee received and accepted the minutes.

13 Items delegated by the Board

There were no items delegated by the Board.

14 Any Other Business

There was no other business discussed.

15 Date and time of the next meeting:

Monday 24 September 2018, 2pm – 5pm, The Committee Room, Hull Royal Infirmary