Hull and East Yorkshire Hospitals NHS Trust

Meeting of the Trust Board

To be held in Public

Thursday 28 July 2016 at 10.30am
The Lecture Theatre, Castle Hill Hospital

AGENDA: Part 1

Opening Matters

1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 26 May 2016, 3.1 Extra ordinary Board 28 June 2016	attached attached	Chair Chair
4. Action Tracker	attached	Director of Governance
5. Matters Arising	verbal	Chair
6. Chair Opening Remarks	verbal	Chair
7. Chief Executive Briefing	verbal	Chief Executive Officer

Quality

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

Performance

11. Performance Report	attached	Chief Operating Officer
12. Corporate Financial Report	attached	Chief Financial Officer

Strategy & Development

13. Sustainability Transformation Plans	verbal	Director of Strategy and Planning

Assurance & Governance

14. Trust Annual Report 2015/16	previously circulated	Director of Governance

15. Board Assurance Framework	attached	Director of Governance
16. Workforce Race Equality Standard 2016 Return	attached	Chief Operating Officer
17. Standing Orders	attached	Director of Governance
18. Board Committee Report	attached	Director of Governance
19. Unadopted Minutes from Board Standing Committees		Chair of Committee
19.1 – Charitable Funds 7.6.16	attached	
19.2 – Quality Committee 23.6.16	attached	
19.3 – Audit Committee 23.6.16	attached	
19.4 – Performance & Finance 27.6.16, 25.7.16	attached, verbal	

20. Any Other Business

21. Questions from members of the public

22. Date & Time of the next meeting:
Thursday 29 September 2016, 10:30am,
The Board Room, Hull Royal Infirmary

Attendance 2015/16

	25/6	30/7	24/9	29/10	26/11	28/1	25/2	31/3	28/4	26/5	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	x	✓	✓	✓	✓	✓	✓	✓	x	✓	8/10
L Bond	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Gore	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
M Wright	✓	✓	x	✓	✓	x	✓	✓	✓	✓	8/10
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
T Sheldon	✓	✓	x	✓	✓	✓	x	✓	✓	✓	8/10
V Walker	-	✓	✓	x	✓	✓	✓	✓	x	✓	7/9
T Christmas	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
E Ryabov	-	-	-	-	-	✓	✓	✓	✓	✓	5/5
In attendance											
J Myers	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	9/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
D Taylor	✓	x	✓	-	-	-	-	-	-	-	2/3
S Nearney	✓	✓	x	✓	✓	✓	✓	x	✓	✓	8/10

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 26 MAY 2016
BOARD ROOM, HULL ROYAL INFIRMARY

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

ACTION

1. APOLOGIES

Apologies were received from Mr A Snowden, Non-Executive Director, Mr K Phillips, Chief Medical Officer and Mrs T Christmas, Non-Executive Director.

2. DECLARATION 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 THE 28 APRIL 2016

The minutes of the meeting held on 28 April 2016 were approved as an accurate record of the meeting.

4. ACTION TRACKER

Ms Thomas advised that there would not be a full Board meeting in June 2016 due to the Care Quality Commission inspection taking place. There would be a short Board meeting arranged to approve the Quality Accounts and if necessary the Sustainability Transformation Plan (STP).

5. MATTERS ARISING

Ms Myers updated on the further work that would be undertaken related to the Trust Strategy, which was approved at the last meeting. She reported that the Trust would now be developing 5 year specialty and service plans. These would be used to inform the STP and would be discussed at a Board Development day. **JM**

6. CHAIR OPENING REMARKS

Mr Ramsden spoke about the Golden Hearts event that had taken place the previous week and acknowledged the winners and teams for the outstanding work within the Trust. He thanked all staff who had been involved with the event.

He also reported that there had been an agreement between the junior doctors and the Department of Health but that it was not unanimous and further discussions would need to take place. Dr Patmore added that not all junior doctors had signed up to the new contract and the problems were not yet resolved fully.

Mr Ramsden wanted the Board to be aware of the HEY Choir which had sang at the Golden Hearts event but had also made it through to the Britain's Got Talent show. He recognised the achievement and how this was having a positive effect on staff morale.

7. CHIEF EXECUTIVE BRIEFING

Mr Long reported that the Trust had launched its new branding 'Remarkable People, Extraordinary Place'. An event was taking place at the time of the Board meeting in the Clinical Skills Department to promote the brand, highlight educational opportunities for staff and to promote recruitment. An invitation had gone out to all staff and he asked that Board members attend to see the good work being undertaken.

Mr Ramsden asked Mr Long about staff morale. Mr Long reported that the there was a positive, optimistic mood and staff were feeling more settled. He advised that the Family and Friends test showed steady improvement and the initiatives that were in place should result in continued progress.

8. PATIENT STORY

Mrs Walker told the story of her father's recent care within the hospital and the wider health community. Her father was 99 years old and receiving end of life care. After becoming very ill he was brought into the hospital via ambulance. Mrs Walker wanted to be with her father in A&E but paramedic staff were initially hesitant. After persuasion Mrs Walker managed to be with her father and the care he received following this was very professional and kind. She advised that the 'Do Not Resuscitate' conversation was carried out in a sensitive way and she and her father were kept up to date and communicated with well. Mrs Walker thanked all the members of staff involved in her father's care and also the wider care teams.

Mrs Walker highlighted two negative aspects to the patient journey. She had difficulty in getting her father's property transferred from ward to ward and had to intervene personally and secondly that call bells were slow to be answered. Mr Wright responded that the nursing staff would have been busy giving care to other patients and there could be a slight delay in responding, depending on what else was happening on the ward at the time.

9. QUALITY REPORT

Mr Wright presented the report to the Board. He advised that Never Event benchmarking information had been reviewed with 189 declared across the country within the last 6 months. The Trust had declared 4 Never Event between October 2015 and March 2016, although one of these had occurred during 2013. A DVD had been made to share the learning from the retained swab incident in maternity services. He reported that a quality dashboard was being developed which provided information at ward, Health Group and Trust level on incidents, serious incidents, healthcare acquired infections and other key quality metrics. There was discussion on how well the Trust was learning from adverse events as there had been repeat incidents of a same type. Ms Thomas advised that the Trust had strengthened its processes for dissemination of information over the last year but further work was needed working with individual clinical teams to ensure that there were changes in practice as a result of adverse events. Ms Thomas added that there were examples of where systems and processes had changed which would prevent the error occurring such as radiology reporting and alcohol gel dispensers.

Mr Long stated that the Trust had a number of processes that had been in place for a long time and that these needed to be reviewed and changed to ensure that they continued to deliver intended outcomes. He wanted the Board to set the example of care, compassion and high quality of care to all staff. Dr Patmore added that staff had a responsibility to take accountability for their actions and that it should not just be a top down exercise.

A number of other benchmarking exercises had taken place using the Improvement Academy. Mr Wright used falls as an example. The Trust was below average (positive performance) on the number of falls and falls with no harm. The Trust pressure ulcer position was similar to other Trusts and VTE performance was being reviewed at the VTE committee.

C Difficile cases were at the expected level and currently stood at 6 cases. A change to the way cases were reported was being implemented by NHS England. There were no current cases of Norovirus and flu cases were past their peak time of year.

Mr Wright advised that patient complaints had decreased but that there was still work to do. Lessons learned from complaints were being disseminated through the Lessons Learnt newsletter.

Mr Wright reported that the Summary Hospital Mortality Indicator (last published data September 2015) was 112.20. This is a measure of in-hospital deaths and deaths within 30 days of discharge from hospital. The divergence from the Trust's peers coincided with the opening of the Ambulatory Care Unit in February 2015. The opening of this unit removed from the denominator between 700 and 1,000 patients per month who were now coded as 'not-admitted'. Mr Phillips to provide more detailed information at the Board meeting in July 2016. **KP**

There was a discussion regarding the Care Quality Commission inspection in June and Mr Wright advised that ward sisters and staff were engaged and prepared. Mr Ramsden added that he had heard positive feedback from his visits to wards and departments.

Mr Wright passed round some 'twiddle muffs' which were hand knitted muffs for dementia patients. The muffs had been knitted by volunteers and had proved to be very helpful when caring for this cohort of patients.

Resolved:
The Board received the report, noted the contents and progress. It was agreed that further information on mortality would be provided at the next meeting. **KP**

10. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that staffing was stable at 80-85% but there were still challenges in recruiting nurses. He advised that the twice daily safety brief was held and there were changes to the e-rostering system which would improve the way that rotas were managed.

Mr Wright highlighted Intensive Care as an area with concern as 14 staff were currently on maternity leave. The Trust was managing to contain the problem and maintaining safe staffing levels. Theatres were also still an area of concern. Mr Wright advised that there were a number of new roles and measures in place. Mrs Walker added that the discharge facilitators were very efficient in their new roles.

Resolved:
The Board received the report and noted the work that was ongoing.

11. INTEGRATED PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted that performance against the Referral to Treatment Time standard was ahead of the planned trajectory in April at 86% (plan 84.9%). Patients waiting over 18 week were reducing and was progress continued to be made. The overall list was 48,964 in May 2016 and all Health Groups were above the planned trajectory.

The Trust had missed 2 cancer standards, but the agreed trajectory was being met against the 62 day standard.

There had been 2 breaches relating to 52 week waits, one was a very complex patient and one pathway had been paused incorrectly. Both patients had now been treated.

The Diagnostic waiting time target had not been met and there had been breakdowns in radiology equipment but was above the planned trajectory.

Mrs Ryabov advised that in April the Emergency Department performance had been at 89.3%. There had been no 12 hour trolley waits. Better performance had coincided with the junior doctor strike as with more senior clinicians were undertaking direct clinical care. The Frailty Team had piloted senior doctor being based in Emergency Department and this had resulted in 37 patients being discharged over a 6 day period who would otherwise have been admitted.

Closing the winter ward capacity had put extra pressure into the system. The Trust was still aiming for 90% performance by the end of quarter 3. There was a discussion around demand facing the Department and what action commissioners were able to take to manage this. Mr Bond stated that alternatives to the Emergency Department would have to be used such as Ambulatory Care and primary care. Dr Patmore added that there were a number of patients attending the Emergency Department that could receive care in an alternative setting and did not need acute care. Mr Long suggested an appointment system for less sick patients and Mr Ramsden suggested this be looked into further.

Resolved:
The Board received the report and noted the failure of standards and also the improvements being made against trajectories. Further work would be undertaken to refine the emergency admission pathway including appointment system.

12. CORPORATE FINANCE REPORT

Mr Bond presented the report which highlighted an actual deficit of £800k against a plan of £600k. He advised that there was still an issue regarding Surgery and Family and Women's Health Groups and their efficiency savings gap. The Trust was reporting £650k income for the month and this was above agreed contracted levels.

There was a discussion around the complex nature of the health economy and the balance of money held within it. Mr Bond stated that the whole economy would have to work together to achieve financial targets set by the Government.

Resolved:
The Board received the report and noted the financial position at month 1.

13. ANNUAL ACCOUNTS 2015/16

Mr Bond presented the Annual Accounts 2015/16 to the Board for approval. He highlighted the Statement of Comprehensive Income and the £8m deficit that the Trust had reported at the end of 2015/16. Mr Bond highlighted the cost of catering, car parking, Education and Research and the MAR scheme as these all impacted on the accounts. He reported that the clinical negligence claims and increasing premiums was a risk to the organisation.

Mr Gore as chair of the Audit Committee advised that the control total had been signed off by the external auditors (KPMG) and that the Accounts had been prepared in an appropriate way by the financial teams. He recommended, on behalf of the Audit Committee, that the Board should approve the Annual Accounts 2015/16.

Resolved:

The Board approved the Annual Accounts 2015/16.

13.1 – LETTER OF REPRESENTATION
Mr Bond presented the letter of representation which formally asked the Board to acknowledge the assurances given to the auditors by the Chief Financial Officer and Chair of the Audit Committee on behalf of the Board in relation to the Annual Accounts 31 March 2016.

Resolved:
The Board formally acknowledged the assurances given to the Auditors by the Chief Financial Officer and Chair of the Audit committee.

13.2 – ANNUAL GOVERNANCE STATEMENT
Ms Thomas presented the Annual Governance Statement to the Board for approval prior to final submission to external auditors/Department of Health and NHS Improvement by 2 June 2016.

Resolved:
The Board approved the Annual Governance Statement.

14. TRANSFORMING HEY'S CULTURE – PROGRESS REPORT
Mr Nearney presented the report which set out the progress regarding transforming the culture at the Trust. He highlighted the mini staff survey and 1500 members of staff had responded in the last quarter of 2015/16. Mr Nearney advised that the Trust was now slightly higher than the national average regarding survey responses but the aim was to be in the top twenty.

Mr Nearney advised that there was still work to do with the medical staff to improve engagement. This work was being co-ordinated by the Communications and Engagement Team.

Resolved:
The Board received the report and noted the continued improvement in the staff survey results.

15. PEOPLE STRATEGY REPORT
15.1 – PEOPLE STRATEGY
Mr Nearney presented the report and the strategy to the Board. He reported that the Trust had relaunched its branding and there had been an open day focussing on education and training within the Trust. He advised of the 7 key themes in the People Strategy that was changing the culture and modernising the way the Trust worked. Key themes included, equality and diversity, health and wellbeing, engagement, communication and recognition. Mrs Walker and Mr Gore both commented on the Strategy in a positive way and Mr Gore asked that Health Group workforce plans reflected the key messages. There was a discussion around how turnover must be reduced, the methodology of future demands managed and how the Trust would respond to the issues. Mr Gore asked if the work carried out regarding the recruitment of nursing staff would be replicated with medical staff and Mr Nearney advised that the issues were being reviewed and managed on a monthly basis though the Workforce Committee.

Resolved:
The Board approved the People Strategy. Mr Nearney to provide an updated report to show Health Group workforce plans and how they were aligned with the strategy.
SN

16. SUSTAINABILITY AND TRANSFORMATION PLANS (STP)
Ms Myers gave an update regarding the STP and highlighted the work that was ongoing to prepare plans by the end of June 2016.

Ms Myers advised that, following a workshop attended by the members of the health alliance 4 key areas had been agreed for review. These were: prevention, development of Primary Care, acute/specialist services and mental health. She advised that the financial stability and models of care were still not clear and needed to be addressed. Mr Long stated that there was an in-balance within the health system with increased demand for Emergency Care and more pressure on the Community and Primary Care to provide services outside of hospitals and this would mean the allocation of funds would be difficult.

Resolved:
The Board received the update and noted the work being carried out by the Trust and wider health alliance.

17. STANDING ORDERS

Ms Thomas presented the report to the Board which highlighted the use of the Trust seal.

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

18. UNADOPTED MINUTES FROM BOARD STANDING COMMITTEES

18.1 – PERFORMANCE & FINANCE 23.05.16

Mr Hall advised that all items within the minutes had been covered by the Board agenda items.

18.2 – AUDIT 05.05.16

The minutes were presented to the Board for information.

18.3 – QUALITY 23.06.16

The minutes were presented to the Board for information.

19. PORTFOLIO BOARD REPORT

Mr Long presented the report which updated the Board regarding the work being carried out by the Improvement Portfolio Board.

Resolved:
The Board received the update and noted the contents of the report.

20. ANY OTHER BUSINESS

There was no other business discussed.

21. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions received from the members of the public.

22. DATE & TIME OF THE NEXT MEETING:

Thursday 28 July 2016, 10.30am in The Boardroom, Hull Royal Infirmary

……
Chairman

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
EXTRAORDINARY TRUST BOARD
HELD ON 28 JUNE 2016
BOARD ROOM, HULL ROYAL INFIRMARY

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

ACTION

1. APOLOGIES

Apologies were received from Mrs T Christmas, Non Executive Director, Mrs V Walker, Non Executive Director, Prof. T Sheldon, Non Executive Director and Mr C Long, Chief Executive Officer.

2. QUALITY ACCOUNTS 2015/16

Ms Thomas presented the Quality Accounts to the Trust Board for approval. She advised that the deadline for uploading the Accounts to the NHS Choices website was Thursday 30th June 2016. The Quality Accounts had been previously reviewed at the Board's Quality Committee and the Audit Committee.

The Audit Committee had discussed the presentation of the information relating to the achievement of the 2015/16 priorities and requested that this was reviewed. The Board was satisfied with the revised presentation, provided that the use of directional arrows was used for those indicators where improvement had not been made. The Audit Committee had also made some further comments and these had been reflected in the revised document.

Resolved:
Subject to the minor alterations highlighted at the meeting the Trust Board approved the Quality Accounts 2015/16.

SUPPLY OF ELECTRICITY – CONTRACT EXTENSION

Mr Bond presented the contract extension which had been reviewed at the Performance & Finance Committee but due to the value of the contract (£3.5m), needed Board approval. Mr Hall advised that the contract represented best value and that the Committee had recommended that the Board approve it.

4. Resolved:
The Board approved the supply of electricity contract extension.

5. ANY OTHER BUSINESS

There was no other business discussed.

DATE AND TIME OF THE NEXT MEETING:
Thursday 28 July 2016, 10.30am in the Boardroom, HRI

…….
Chairman

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (July 2016)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2016						
01.05	Quality Report	Ambulatory care and the effects on the SHMI report – More details to be received	KP	28.07.16		
02.05	Matters Arising	STP to be discussed at Board Development Day	JM	08.08.16		
Actions Completed and to be removed from the Tracker						
02.02	Operating Plan	Update to be received on the development of the Sustainability and Transformation Plans to 2020/21	JM	28.07.16		On Agenda

TRUST BOARD REPORT – 2016 – 07 – 09	
Meeting date:	Thursday 26th July 2016
Title:	Quality Report
Presented by:	Mike Wright, Executive Chief Nurse
Author:	Mike Wright, Executive Chief Nurse
Purpose:	**PURPOSE OF THIS REPORT** The purpose of this report is to inform the Trust Board of the current position in relation to: • Patient Safety Matters • Healthcare Associated Infections (HCAI) • Safety Thermometer • Mortality • Patient Experience Matters • Other Quality Updates
Recommendation(s):	The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required.

QUALITY REPORT
JULY 2016

EXECUTIVE SUMMARY

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Mortality
- Other Quality Updates
- Ward Audits – Fundamental Standards

The Trust Board is requested to receive this report and:

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

TRUST BOARD QUALITY REPORT
JULY 2016

1. PURPOSE FO THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Mortality
- Other Quality Updates
- Ward Audits – Fundamental Standards

The Trust Board is requested to receive this report and:

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

2. PATIENT SAFETY

2.1 NEVER EVENTS

The Trust has not declared any Never Events in this financial year. The last incident was declared in March 2016 and related to a wrong site surgery incident in the Radiology Department. At the June 2016 meeting of the Quality Committee, a presentation was received from a Consultant Neurosurgeon regarding the actions taken following the two wrong-site spinal surgery incidents. In addition, a presentation was received from the clinical lead for Radiology regarding the Never Events that had occurred in that department. Both speakers were able to provide assurance on the actions taken. This included introduction of spinal marking procedures in Neurosurgery and a revised checklist in Radiology. Copies of the presentations can be made available to Board members on request. A CQC inspector was also in attendance at the committee.

2.2 SERIOUS INCIDENTS

The rate of reporting of Serious Incidents in 2016/17 has decreased so far this year compared with the same period last year. 19 Serious Incidents have been declared since the start of this financial year (120 for the 2015/16 year). Since the last Quality report in May 2016, the Trust has declared 13 Serious Incidents. The categories of these are as follows:

Serious Incidents declared from 1 June 2016

No	Incident	Health Group
4	Patient Fall	Medicine (4)
3	Treatment Delay	Medicine, Family and Women (2)
1	Unexpected Death	Medicine
1	Drug Incident	Medicine
1	Absconded Patient	Family and Women
1	Unexplained Injury	Family and Women
1	Unnecessary C-Section	Family and Women
1	Sub-optimal Care of Deteriorating Patient	Clinical Support

Of the four patient falls, two occurred within Elderly Medicine and two in Chest Medicine. There were 31 Serious Incidents involving falls in 2014/15 and this had reduced to 18 declared for the whole of last year, which is a really positive improvement. Further actions are being taken including: a review of the e-learning package, revision of the falls policy, implementation of ‘safety huddles’, and the use of sensory equipment and non-slip footwear. The Improvement Academy is working with the Trust on individual wards to support staff to introduce interventions that have been shown to have positive results in other areas.

The three treatment delays were unrelated. One related to the failure to identify a fractured neck of femur; a second related to a patient who had taken an overdose and the third to a baby being admitted unexpectedly to the neonatal intensive care unit. These Serious Incidents are still under investigation.

Of the remaining 6 incidents, there does not appear to be a pattern. One relates to a patient who had absconded from a ward and the second concerns a child that had sustained an unexplained injury.

The unexpected death related to a patient that attended the Emergency Department with a cardiac arrest and the matter pertaining to a patient receiving suboptimal care relates to a patient who developed sepsis. Information on the drug incident is detailed in section 2.3. Further information will be provided on completion of the investigations in future reports.

2.2.1 Serious Incident Actions

The Trust Board was advised previously of a Serious Incident relating to the printing of paper reports in radiology. A presentation was made to the Board's Quality Committee in June 2016 and Dr Goldstone, Clinical Director for Radiology, was commended for his work in devising a system that has transformed a paper-based system into an electronic system. This is able to track that reports have been received by the requestor and, also, highlights those that need further action. Presentations have since been made to commissioners to support the roll out of the system into General Practice.

The learning from a recent Serious Incident identified that staff were not documenting fully the type of dressing being used in open wounds. A topical negative pressure foam dressing was unintentionally left in an open wound of a patient. The Trust's Tissue Viability team is developing a new wound care plan document and a new theatre record to ensure that there is clear, detailed documentation of any type of dressing used in any open wounds.

Following two Serious Incidents, the Trust is revising its chaperone policy. There has been discussion at the Operational Quality Committee about the need to ensure that both the patient and staff are protected when undertaking sensitive examinations.

A theme from recent Serious Incidents relates to checking that patients are informed fully about the risks and benefits of proposed treatment and that staff take the appropriate pre-operative checks before surgery, including those related to the completion of the World Health Organisation's (WHO) safer surgery checklist. Whilst some improvements have been made, the arrangements for checking compliance are being strengthened and will include observational as well as record keeping audits. It has already been agreed that this area of work will be included in the Trust's Quality Improvement Programme for 2016/17.

2.2.3 Medication errors

There has been one drug incident, which was declared as a Serious Incident. The incident involved an apparent change in the demographic details of patient resulting in medicines reconciliation being undertaken for the wrong patient. The first panel meeting has been set up for the 5 August 2016, which will include the involvement of Yorkshire Ambulance Service. Immediate actions taken included ensuring that the patient was reviewed and on the correct medication. Some initial investigations have been undertaken and the pre-registration Pharmacist involved has received further training. Standard Operating Procedures have also been reviewed. Any further actions arising from the completed SI investigation will be communicated in due course.

At the Board's Quality Committee in June 2016, the Medicines Optimisation Annual Report was presented by the Chief Pharmacist. This identified the improvements made over the previous year, which included: increased pharmacy resource in clinical areas, significant improvements in antibiotic prescribing standards supporting the reduction in *Clostridium difficile and other* health-care associated infections and the introduction of immediate discharge letters using the Lorenzo Patient Administration System. An interface portal has been established with the aim of resolving any queries that are raised by primary care

healthcare professionals following outpatient appointments and a patient's discharge from hospital. A pilot had also been launched, entitled: 'refer to pharmacy', which aims to encourage patients to access reviews through their community pharmacists following discharge from hospital.

The Chief Pharmacist has identified areas where further work will be undertaken in the current year. This includes work to reduce the number of incidents relating to missed medication doses, the expansion of pharmacy assisted medication drug rounds following a successful pilot, and utilising non-medical prescribers to support the completion of the medication section of the patient's immediate discharge letter. In addition, a steering group has been established to consider the Carter Report recommendations, as a Hospital Pharmacy Transformation Plan will need to be in place to support this by April 2017.

In the first quarter of 2016/17, performance has significantly improved in relation to medicines reconciliation within 24 hours of a patient being admitted to hospital. This has been due to increased pharmacy presence in the medical assessment unit.

3. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer point prevalence audit results for July 2016 are attached as **Appendix One**. 937 in-patients were surveyed on 8th July 2016, with the results as follows:

- 93.7% of patients received Harm Free Care (none of the four harms either before admission to hospital or since.
- 2.2% [n=22] patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms.
- VTE risk assessments reviewed on the day = 88.9% (n=833) compliance.
- VTE incidence on the day of audit was 6 patients; 4 with pulmonary embolisms and 2 with deep vein thrombosis.
- New pressure ulcers were 7; all grade 2 but this remains an area of concentrated focus and action.
- There were 14 patient falls recorded on the audit day (having occurred within the previous three days); 11 of these resulted in no harm to the patient, 2 resulted in low harm and 1 resulted in moderate harm.
- Patients with a catheter and a urinary tract infection remain slightly erratic and this indicator fluctuates. Of the 12 patients reviewed, 8 occurred before the patient came into hospital and 4 occurred whilst the patient was in hospital.

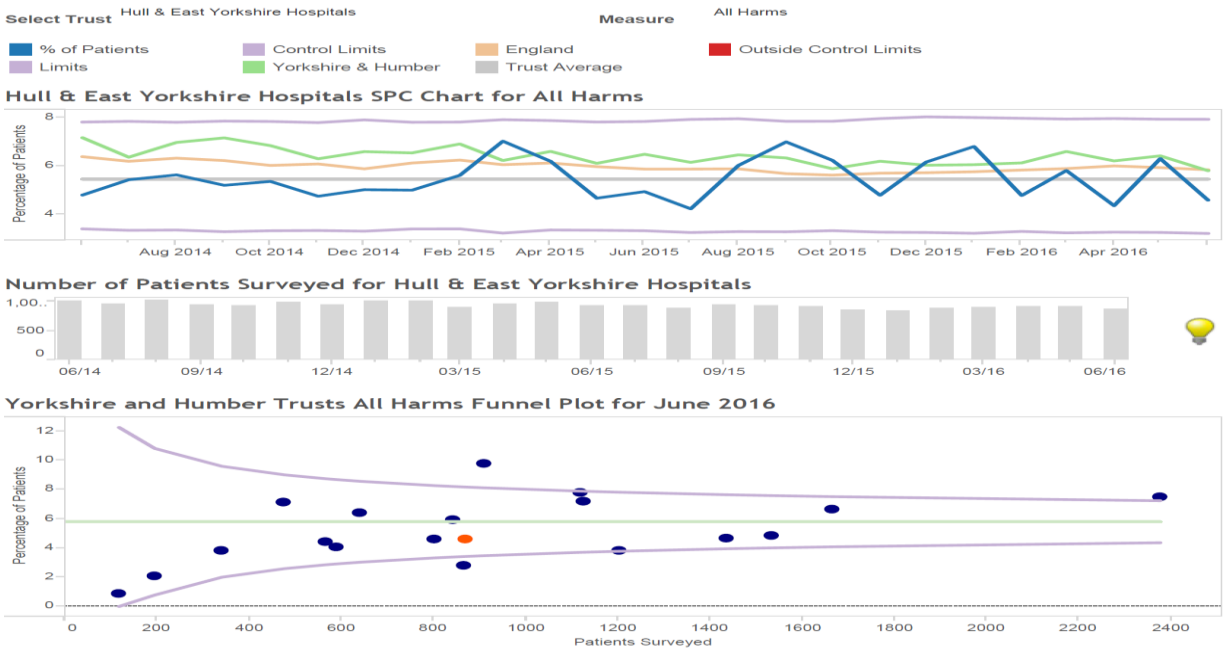
Overall, performance with the Safety Thermometer remains relatively positive but there is always room for further improvement. These data continues to be reviewed monthly. Each ward received its individual feedback and results and is required to take action accordingly.

The following sections provide the latest bechmarking position for the Trust as at t then ed fo June 2016 against the Saferty Thermometer's four harms. These data are produced indepdently by the Improvement Academy (IA), part of the Yorkshire and the Humber Academic Health Sciences Network.

To deal with each of the harms in turn:

3.1 All Harms

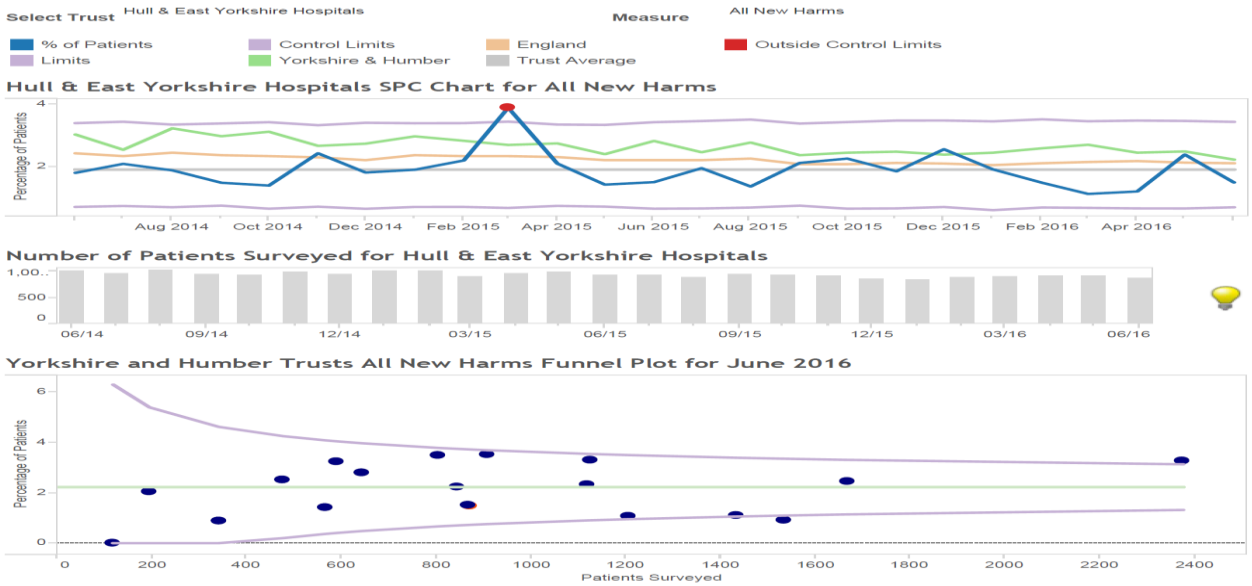
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



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

3.1.1New Harms

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

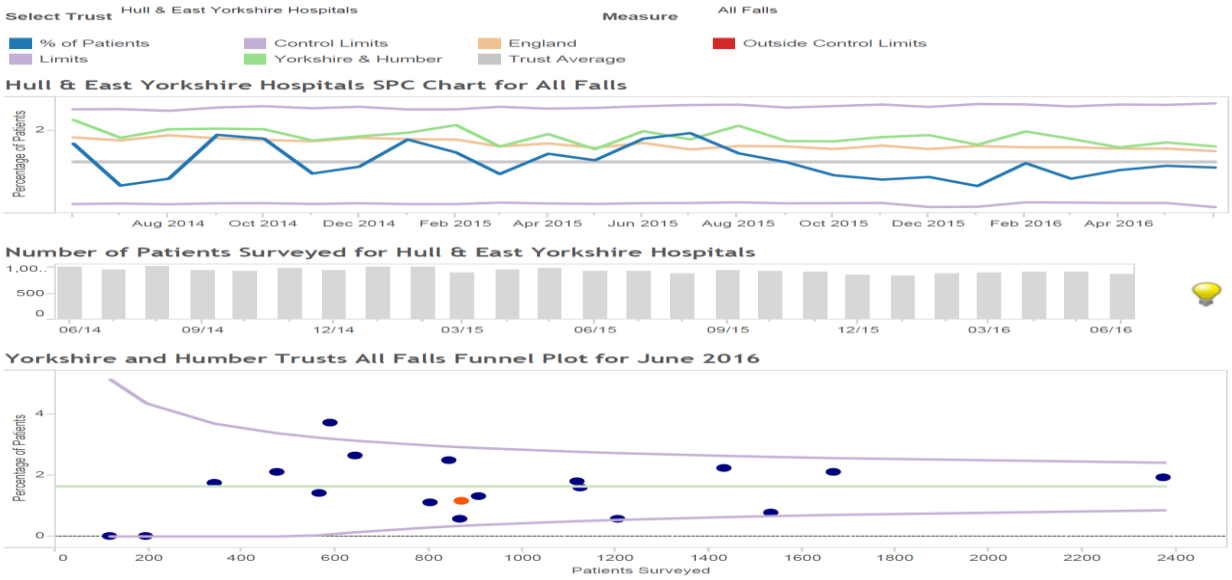


Again, and overall, the Trust performs realtively well against this indicator. To take each of the four harms in turn:

3.2 FALLS

3.2.1 Falls (all)

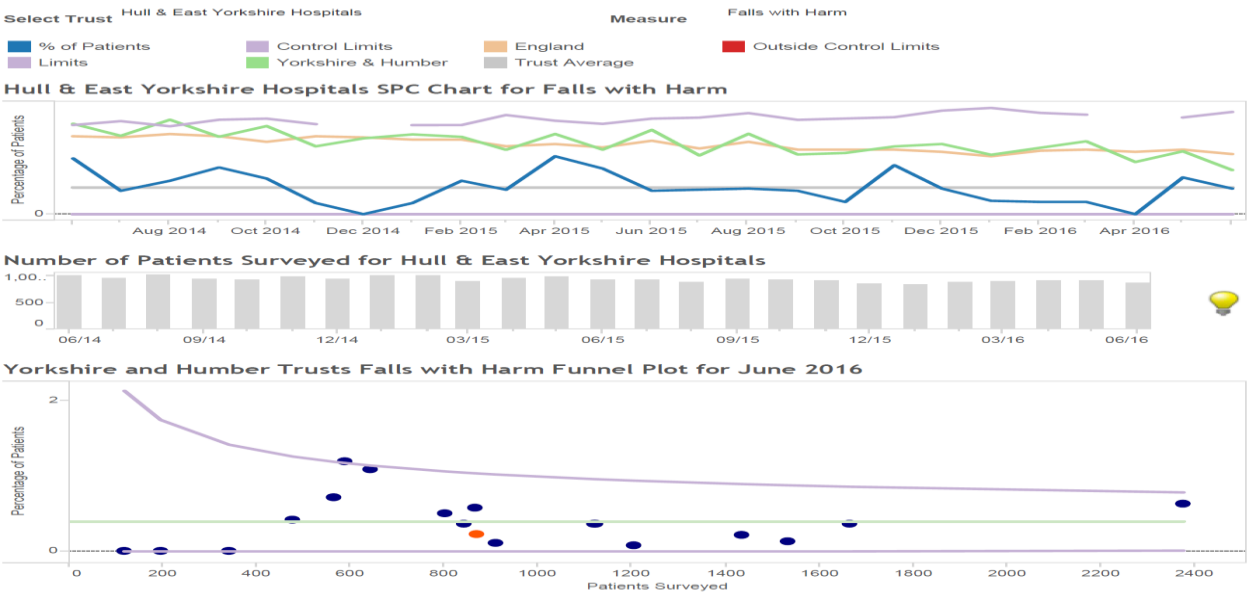
The following tables shows the percentage of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



Again, this is sustained positive performance overall in the 'all falls' category. The proportion of those patients that sustained harm from falls whilst in hospital is now described.

3.2.2 Falls with harm

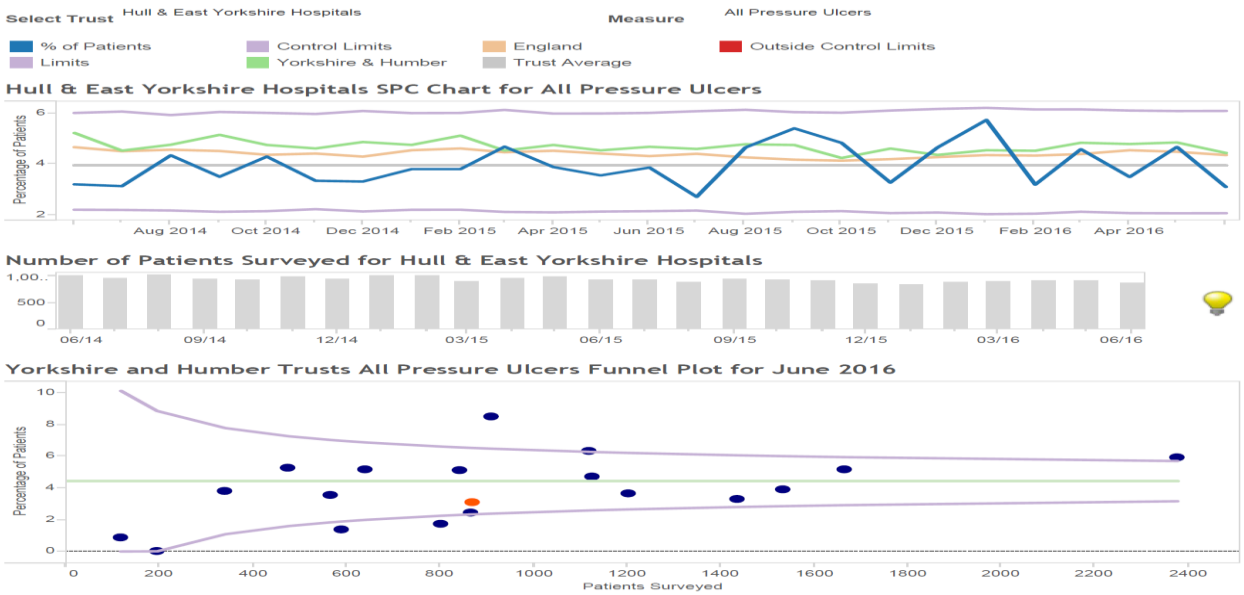
This chart differentiates those patients that fell and sustained harm from those that fell and where there was no harm.



This shows really positive performance overall, both in its own right and when compared to others. This is supported also by the transformation work that is taking place within elderly care in terms of stabilising staffing levels, establishing improved leadership and, also, the support of the transformation team.

3.3 Pressure Ulcers (All)

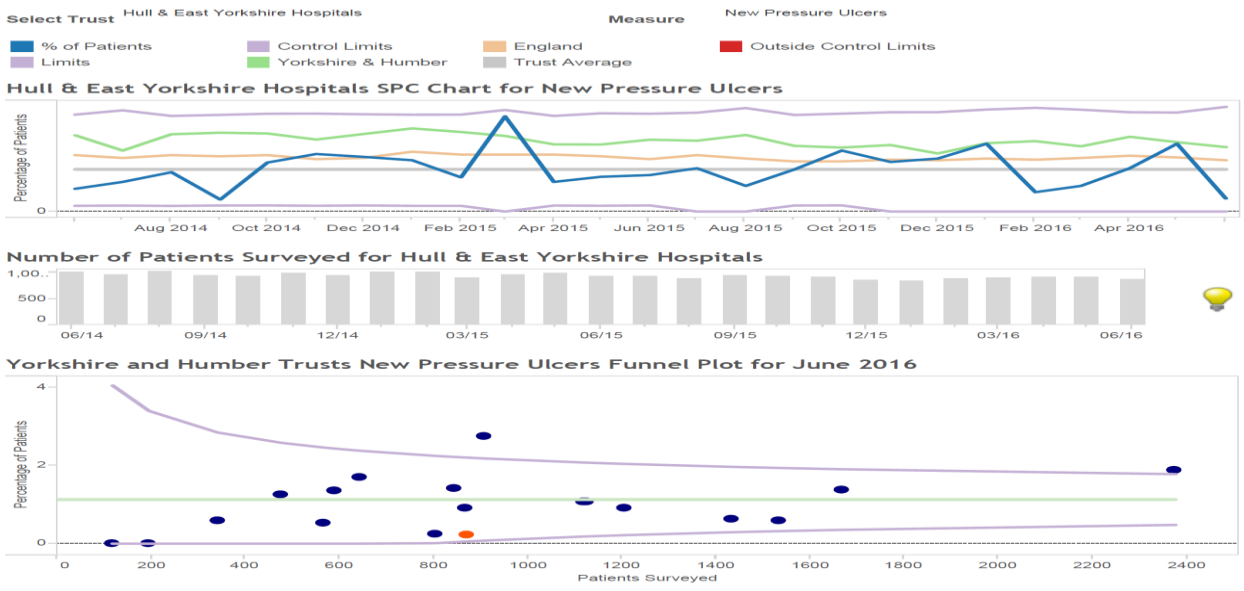
The following graph and funnel plot show variable statistics on this measure. An important factor to realise is the proportion of patients that come into the Trust with exisiting pressure ulcer damage, which is significant, paritcularly in patients that are admitted via the emergency department and admissions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



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

3.3.1 Pressure Ulcers (new)

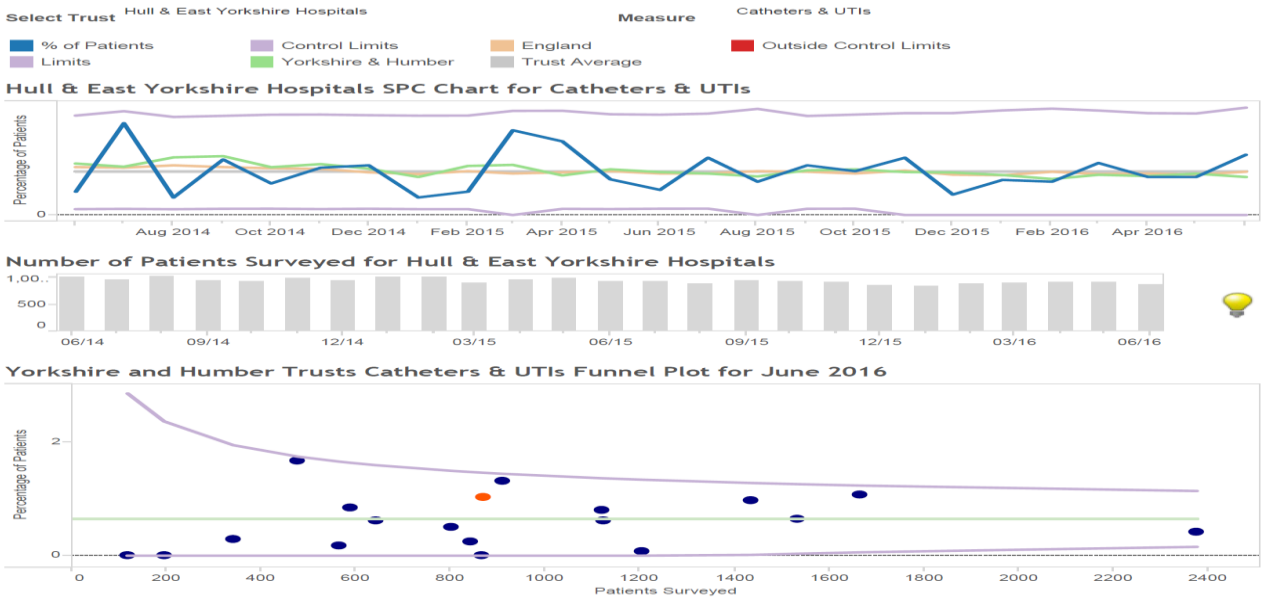
When the data for pressure ulcer harm that is acquired whilst in hospital is considered, this is a very different picture.



The performance for this indicator is, again, very positive, overall, although there have been some 'pinch points' in May. The Trust Board is aware already of the concerns of the Chief Nurse in relation to the proportion of severe pressure ulcers (grades 3 and 4) that were acquired by patients in the Trust in the earlier part of FY 2015/16. A great deal of work and attention has been dedicated to this and this remains a much improved position, although there is still work to do. All registered nurses and midwives in the Trust are required to have undertaken the e-learning tissue viability training module and bedside assessment by the end of July 2016. Good progress is being made against this obejctive and the final numbers will be reported after the end of July 2016.

3.4 Catheters and UTI (All)

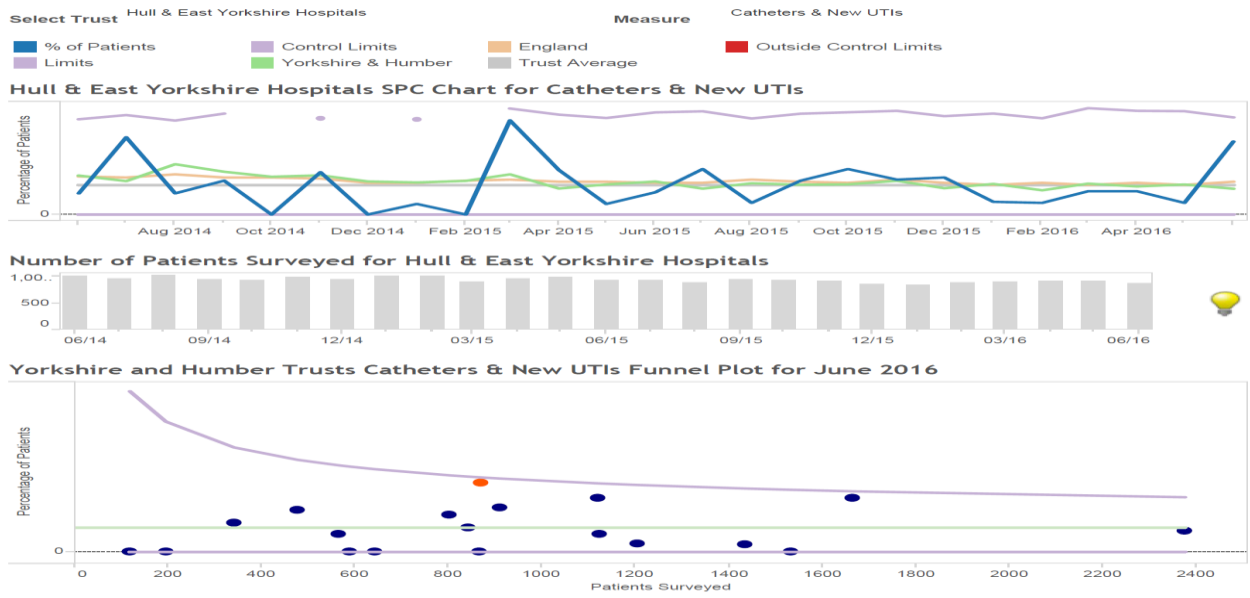
The following chart shows the percentages of patients that have a urinary catheter in place with an associated urinary tract infection. These charts include those that were both admitted with these issues and/or have acquired them whilst in hospital.



Those patients that acuire this harm whilst in hiospital are now described.

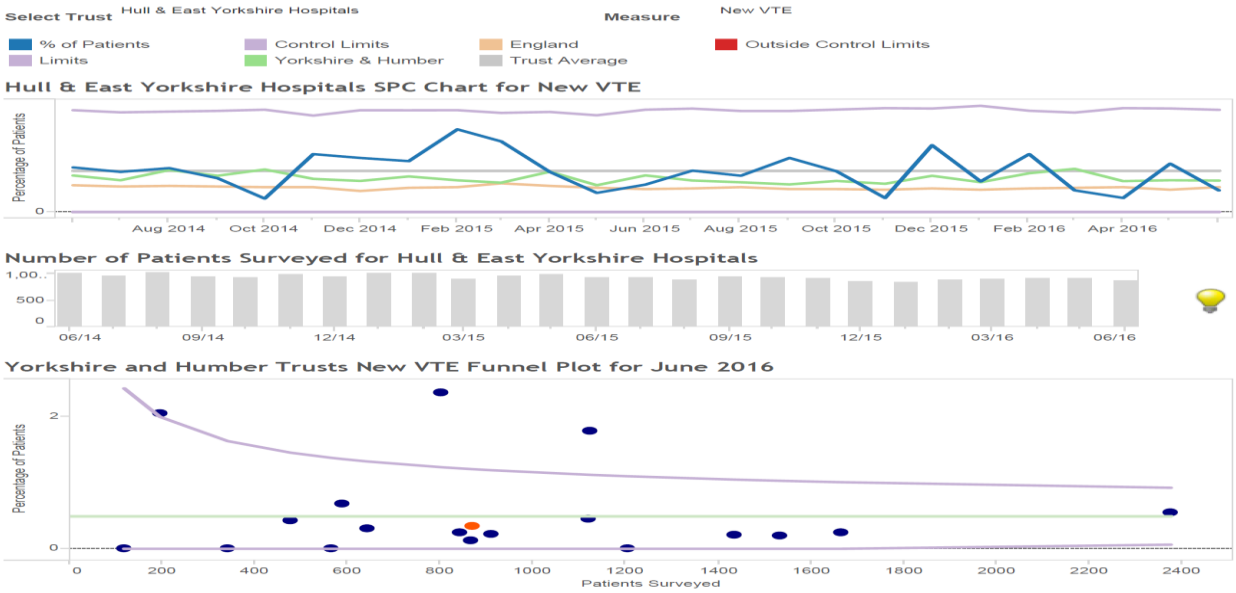
3.5 Catheters and UTI (new)

The following chart shows a more variable picture over time, with a spike in catheter-associated urinary tract infections in June. The reasons for this are not yet understood fully and this is being looked into by the Infection Prevention and Control Team. Anything of note will be provided in the next version of this report.



3.6 New Venous Thrombo-Embolism (VTE)

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



The Thrombosis committee reviews all cases of perceived hospital acquired VTE episodes and provides feedback to each of the areas and team concerned. This continues to be a focused area for the Trust.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 30th June 2016

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

Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**12 (23% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0 (0% of threshold)**
MSSA bacteraemia	**46**	**10 (22% of threshold)**
E.coli bacteraemia	**95**	**22 (23% of threshold)**

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

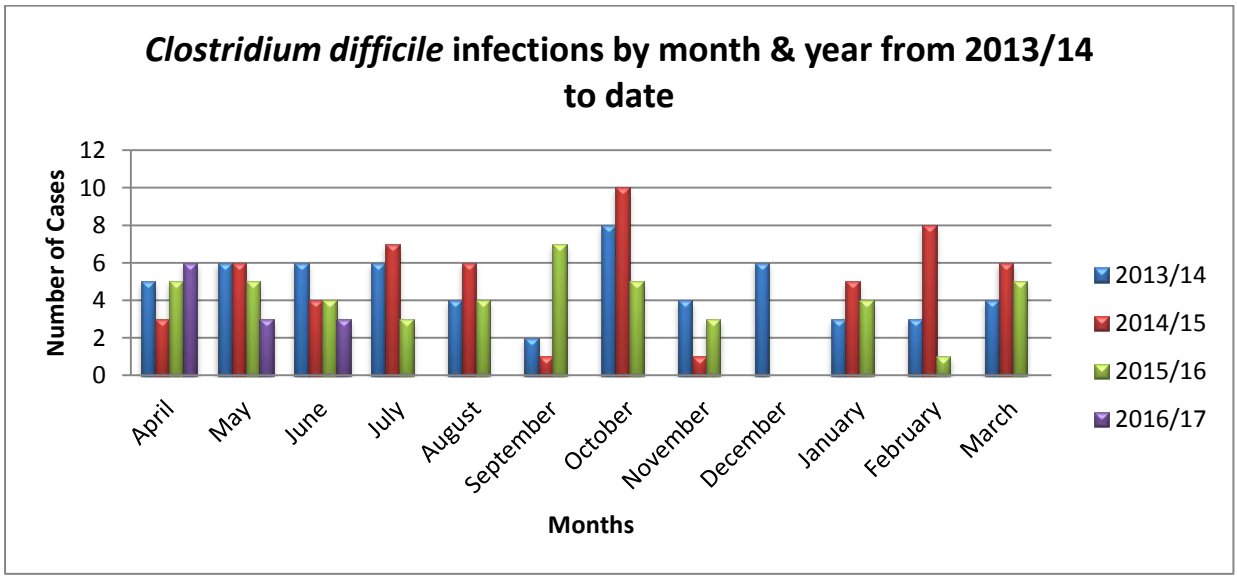
4.1.1. Clostridium *difficile*

For rates attributable to the Trust, 3 cases were reported during June 2016 against an upper threshold of 53 for the year. However, it is likely that factors including prudent patient management and sustained positive antimicrobial stewardship compliance have contributed to a reduction in Clostridium *difficile* infections year on year. The Trust continues to try and reduce these further. Root cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with

commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

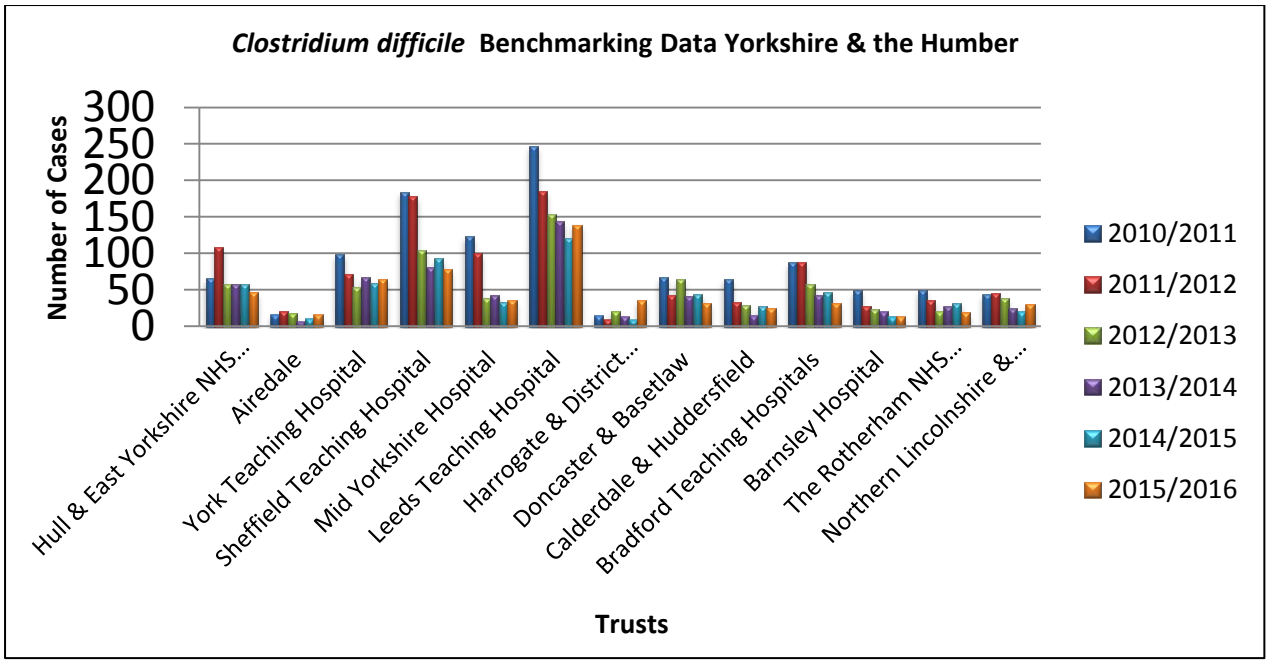
Robust scrutiny of Clostridium *difficile* activity across the Trust identified two toxin-producing Clostridium *difficile* infections apportioned within the Surgical Health Group. Further analysis by Public Health England concluded possible microbiological links to them. This has provided the opportunity to focus improvements and support in surgery.

The following graph highlights the Trust's performance from 2013/14 to date:



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

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

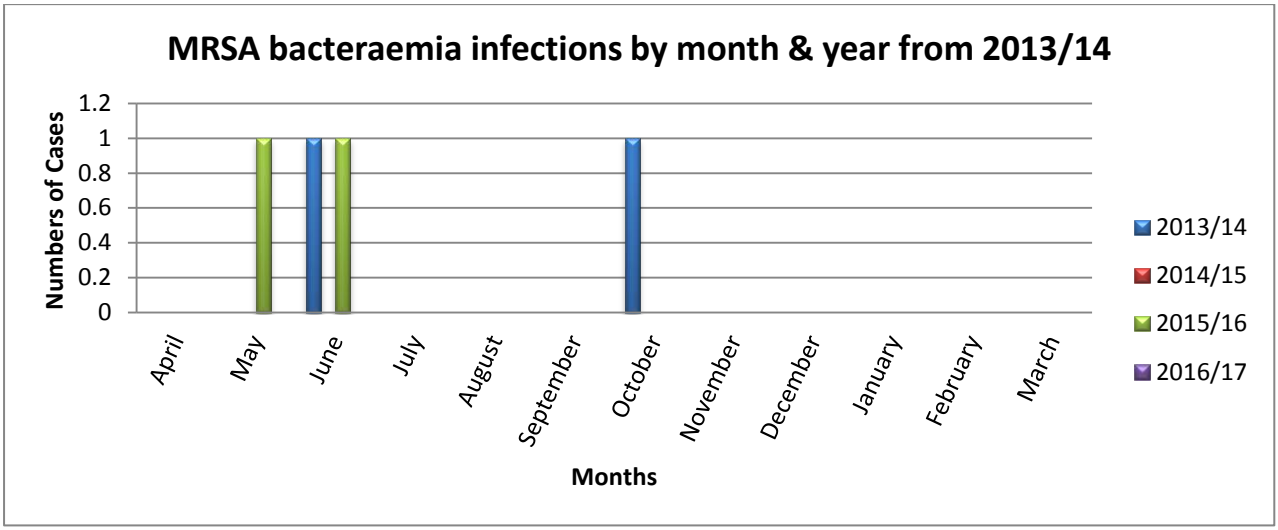


As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers.

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

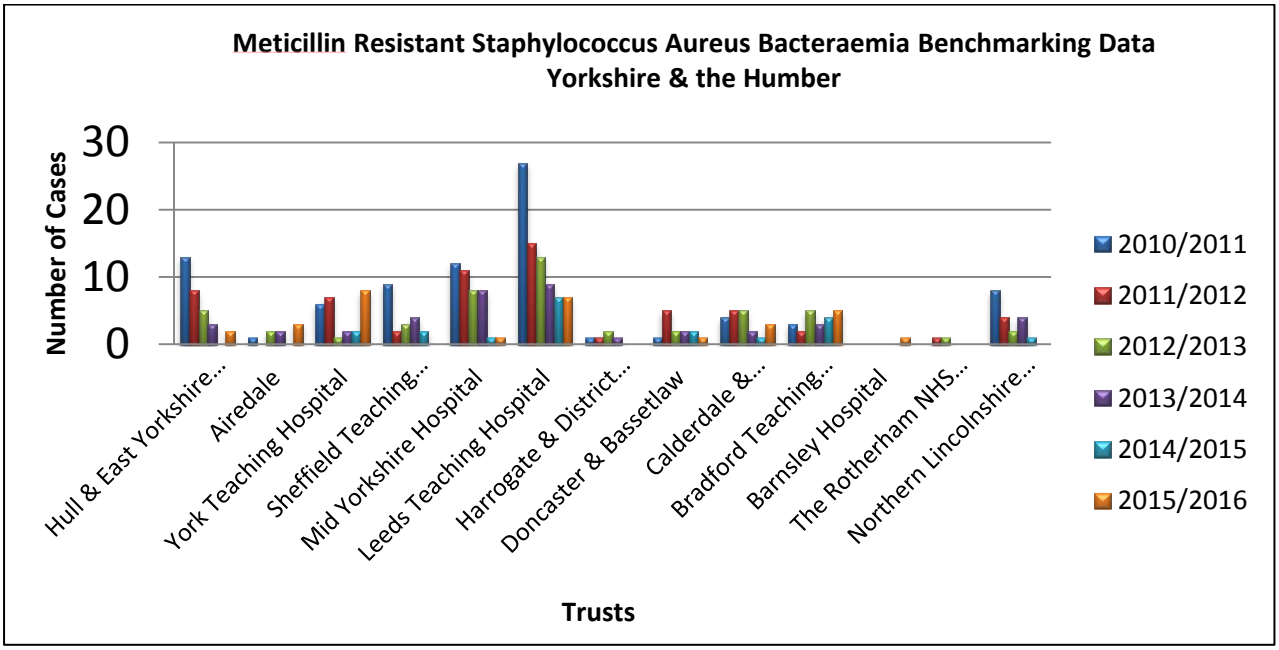
There have been no reported cases of MRSA Bacteraemia infections so far this financial year. This is against a Zero Tolerance objective for 2016/17. The last reportable Trust apportioned case was detected in June 2015.

The following graph highlights that cases of this infection are now extremely rare, thankfully. The performance from 2013/14 to date and demonstrates the variability in numbers year on year.



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

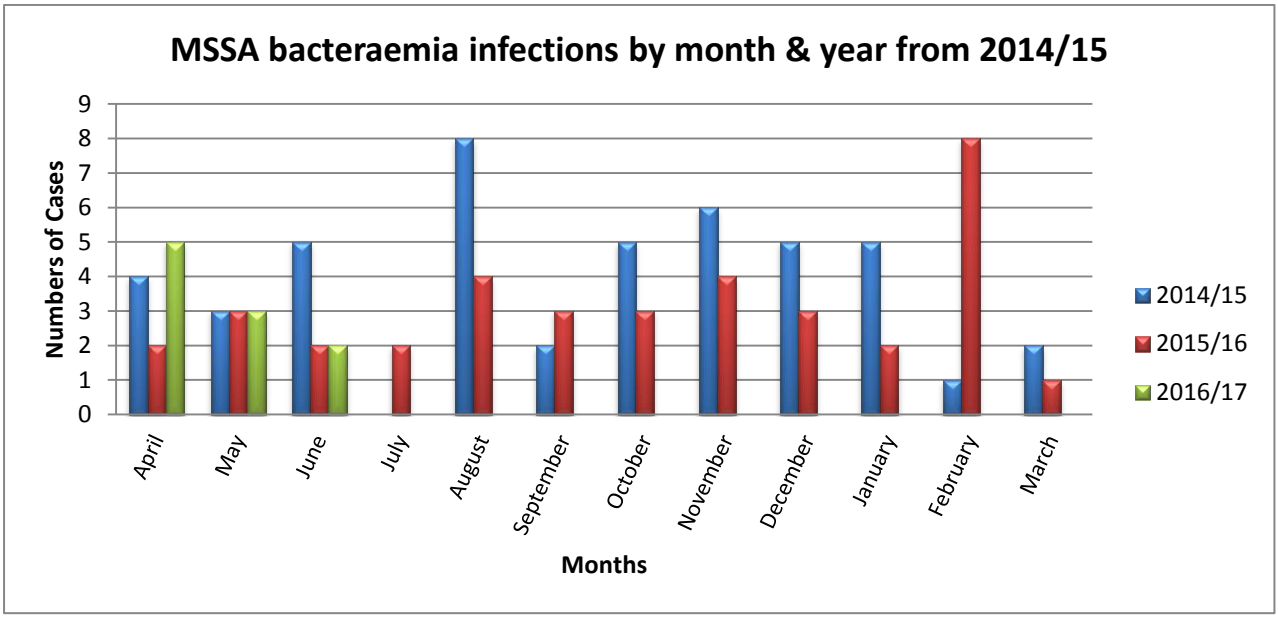
Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases for Yorkshire & the Humber from 2010 onwards



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

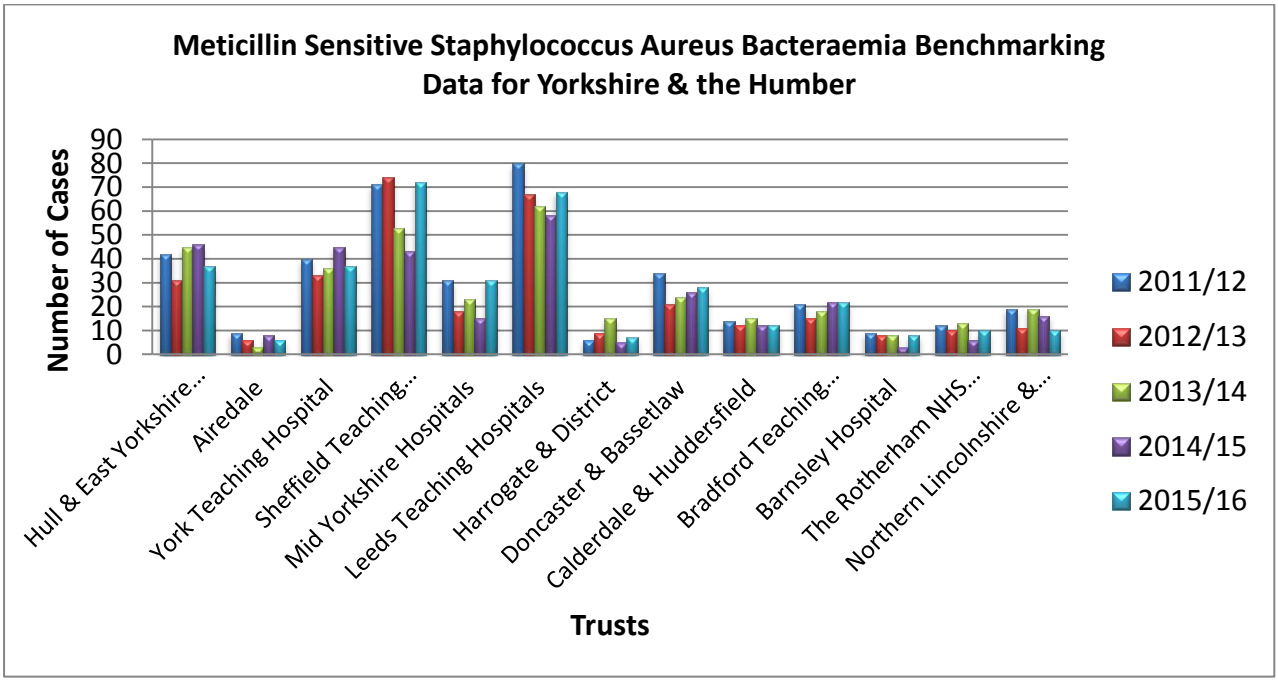
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

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



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

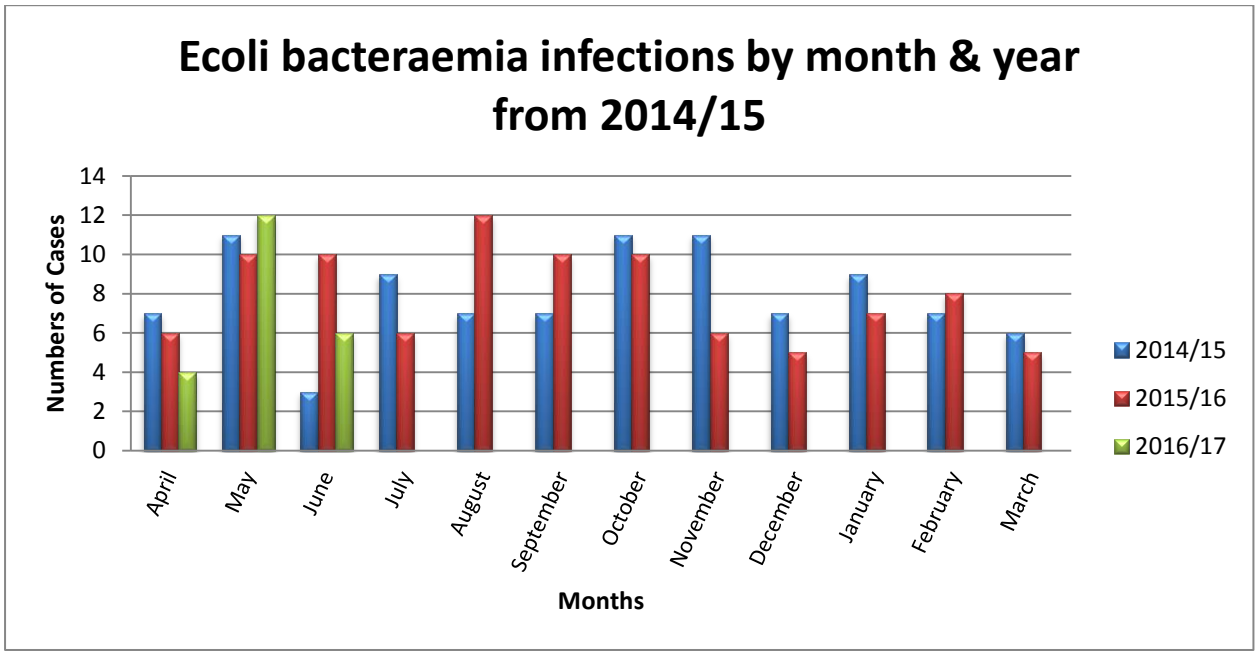
Trust apportioned Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases for Yorkshire & the Humber from onset of surveillance 2011 onwards



As can be seen, this is more evenly spread both across organisations and, also, recent years. The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken in the Trust.

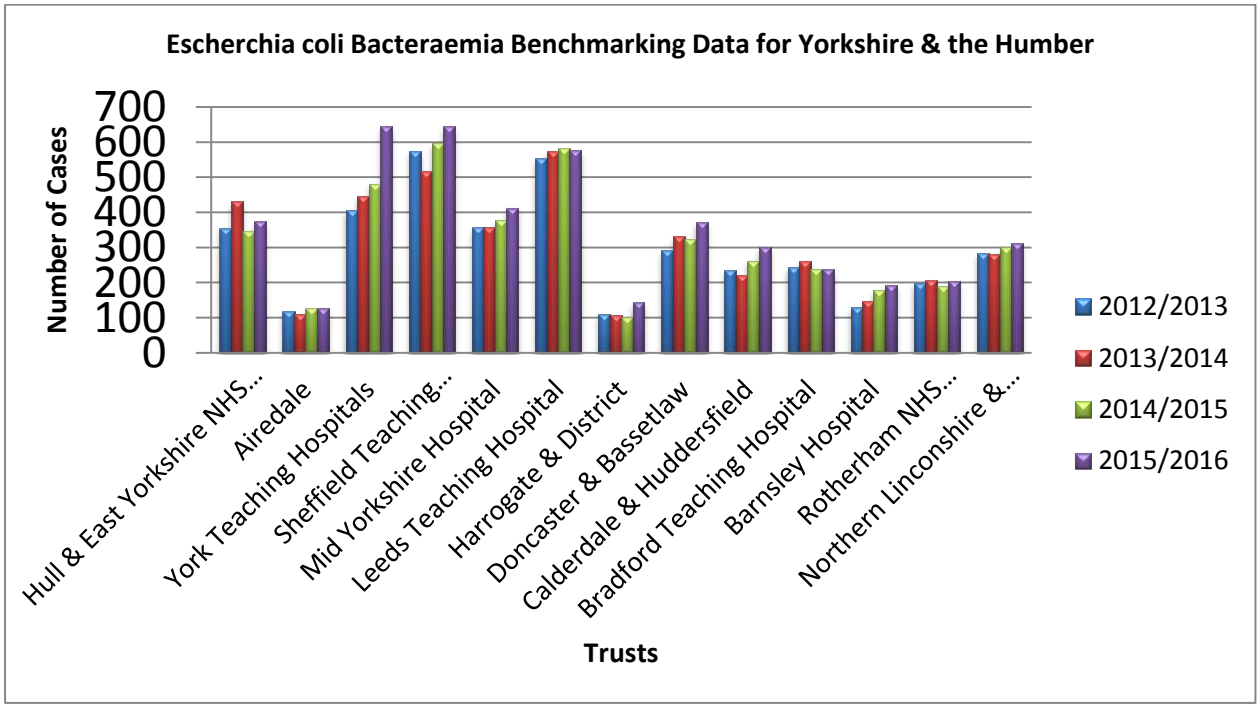
4.1.4 Escherichia-coli Bacteraemia

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



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

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



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

4.2 Infection Outbreaks

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

4.2.1 Diarrhoea and vomiting episodes

H80 and H7 experienced bay closures during June 2016 due to diarrhoea and vomiting but these resolved quickly.

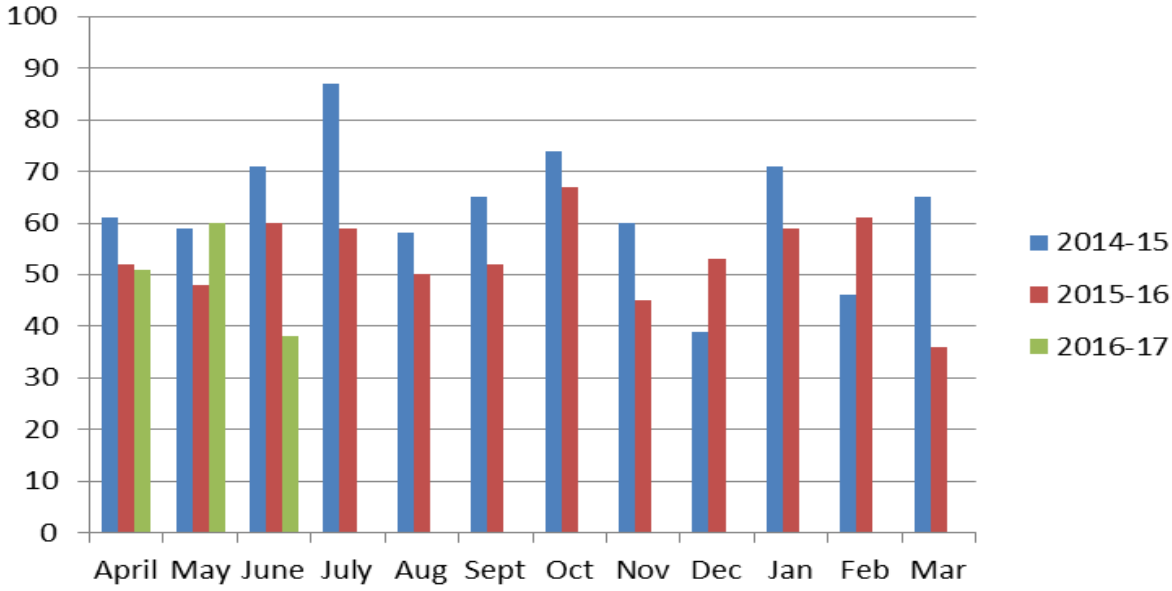
4.2.2 Influenza trends

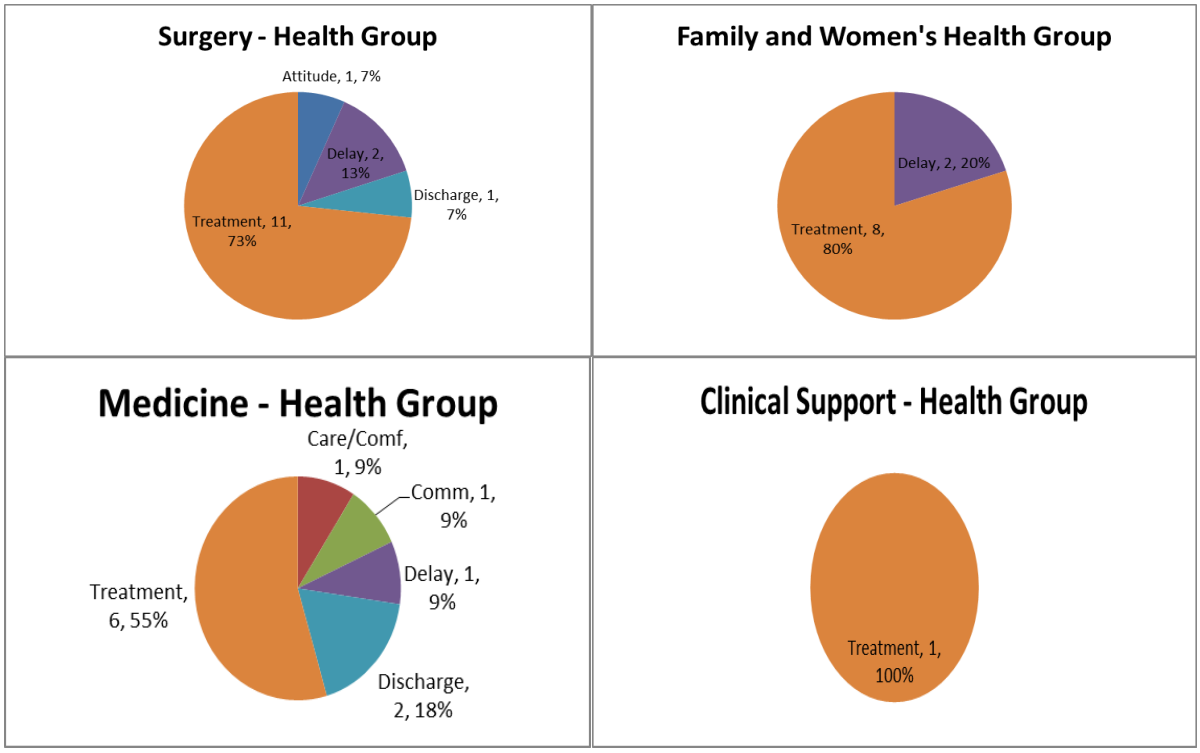
There is nothing of note for this infection during June 2016 and activity has bene low so far this financial year.

5. PATIENT EXPERIENCE

5.1 Complaints

In the month June 2016, 37 complaints were received and 54 closed. Of the closed complaints, 14 were not upheld, 23 were partly upheld and 17 upheld. The following charts show the numbers of complaints received by month for the last three years and, also broken down by Health Group:





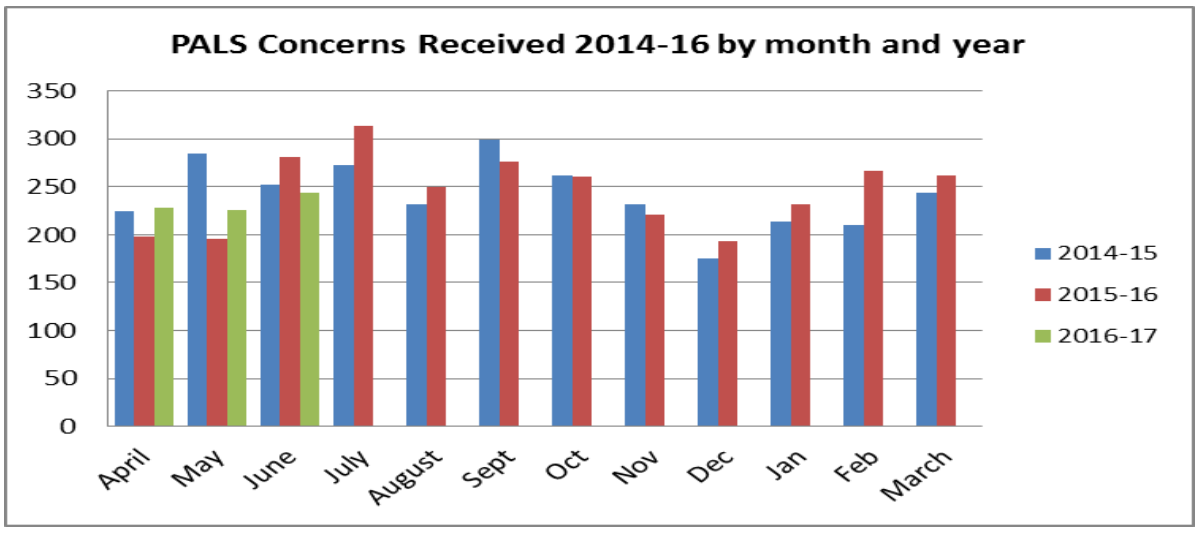
The following table shows current performance against the Trust's standard of closing 90% of complaints within 40 days.

Health Group	Closed	Closed within 40 days
Corporate Functions	1	1 (100%)
Clinical Support	3	1 (33%)
Family and Women's	9	5 (56%)
Medicine	27	19 (70%)
Surgery	24	10 (42%)

As can be seen from this, although performance is still improving, none of the Health Groups are yet meeting this standard. This matter is being picked up with each Health Group at the next performance and accountability meetings, where improvement trajectories will be set for each.

As part of the update of the Trust's internet website and to make it easier for patients to leave compliments, comments/suggestions, concerns and complaints, the Patient Experience Team has developed an on-line response form for patients and relatives to use. This is being piloted currently to ensure that it is sufficiently robust and meets information governance requirements before being rolled out in the next few months.

5.2 Patient Advice and Liaison Services (PALS)
In addition to the 244 PALS concerns received in June 2016, the Trust also received 34 compliments, 2 comments and suggestions and 87 general advice issues. The majority of concerns continue to be regarding delays, waiting times and cancellations. Specifically, these relate to follow up appointments and elective waiting list appointments, as well as some patients not being satisfied with their treatment plan or outcome. The following charts shows PALS activity by month over the last three years



5.3 COMPLIMENTS
The following are some of the compliments received by the Trust:

- A patient wanted to pass his compliments to all staff in the Emergency Department that dealt with him. Despite the department being very busy at 11am, he was very appreciative that all staff dealt with him in an expeditious, professional and polite way.
- A patient's mother was very complimentary about the care and kindness shown by the department when they assisted her small child with a wrist fracture.
- A patient contacted the CEO directly to say how amazing the staff were on the 6th floor and how hard the team worked to ensure that the patients had a positive experience. The patient complimented everyone on the ward.

- The husband of a patient who suffered a miscarriage conveyed his thanks to the Women and Children's Hospital for the care, empathy and support his wife and he received.
- The daughter of a deceased patient passed on her thanks to Ward 16 for the empathy, dignity and care shown to her mother before she died.

5.4 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)
Currently, the Trust has fourteen cases with the PHSO. There have been no new cases in June and one request for information. There is nothing of exception to note as yet from these.

5.5. LESSONS LEARNED FROM HEALTH GROUP REPORTS
The following are extracts from Health Groups' Patient Experience Reports

5.5.1 Family and Women's Health Group
- An 18-month delay for a follow-up appointment has resulted in the worsening of a patient's eye condition. The appointment was overlooked and the patient's treatment regime disrupted.
  Action – A new policy has been introduced for escalation of appointment complaints to senior management.
- A patient expressed concerns regarding her anti-natal care.
  Lessons Learned: The process in place for how results from the antenatal clinic are reviewed in a timely manner will be analysed to see what can be done to improve this. The doctor that saw patient has been asked to reflect on issues regarding antenatal consultation at 34 weeks. Staff will be asked to read the appropriate guidelines to refresh their knowledge in this area. The midwife will reflect on this case with her named supervisor of midwives, also. Areas for improvement in handover both medical and nursing in the neonatal unit have been identified and processes put in place to reduce the likelihood of this happening again.

5.5.2 Surgery Health Group
- A patient was made to feel as though she was a nuisance. The Ward Sister has held a teaching session with the staff to emphasise importance of caring, compassionate work and effective communication.
- A family was unhappy with the treatment their mother had received. The patient's consultant has spoken with the junior doctor's educational supervisor to ensure that some 'attitude-related' concerns are addressed, emphasising that clear communication and a caring attitude are essential for good patient care. There is an action for the educational supervisor to ensure that the doctor concerned is aware and improves.
- A family was very unhappy with care received after a patient had died; this was to do with his belongings. The issue regarding packing of deceased patient's belongings has been raised with the relevant ward staff, also with regard to the possibility of the involvement of relatives in this process.

5.5.3 Medicine Health Group
Elderly Medicine
- Following a resolution meeting with complainant, it was identified that there had been a delay in issuing a death certificate over a bank holiday weekend. Actions are being taken to address this.

Specialist Medicine
- The patient arrived in the outpatient clinic to see the lead consultant for a second opinion relating to headaches. An administration error occurred, despite clear instruction on the referral letter that the patient was to see the consultant. The error has been discussed with the head of patient administration to ensure a similar occurrence does not occur again.

General Medicine
- The majority of complaints for General Medicine include an element of mis-communication with patients. It has been suggested that some meetings could be recorded so that patients could listen to them at a later date to ensure that no information is missed, as it is recognised that at times of distress, some important pieces of information could be missed. This will be

discussed further at the governance meetings to consider the feasibility and practicalities around this.

- A patient was dissatisfied with the menu available to him during his stay in hospital. Information was gained from the Catering Manager who offered to visit the patient for further discussion. The ward was reminded that, if patients complain about the food, it should be discussed with the Catering Manager to try to resolve the issue whilst the patient is still on the ward.
- A patient was sent back to their Care Home in their night wear, although daytime clothes were available. Staff were informed that patients should always be discharged in day time clothes unless all avenues to access clothes have been exhausted. Exceptions should be documented with reasons why and that the staff or persons at the destination are contacted to inform them of why this has happened.

Emergency Medicine

- The department has identified two hospital acquired deep tissue injury pressures sores. All staff have been reminded about the importance of assessing the patient's skin on arrival, including the heels and documenting the SSKIN bundle. It is vital that all care delivered to the patient are documented in the patient's notes. The department has a trolley with a pressure relieving mattress on trial for any patient that is identified on arrival as high risk of developing pressure sores. The Divisional Nurse Manager is looking to try and purchase these mattresses for all trolleys.
- The department is also trialling a pressure relieving device for lower limbs for patients that have vascular conditions or diabetes that are more susceptible to developing pressure sores to their legs.
- **Ward H1:** A patient arrived on the ward only wearing pyjamas and did not have any outdoor clothes to be discharged home in. The 'Ward 1 Boutique' has now been opened. Staff on the ward have worked together to build up a collection of outdoor clothes for less fortunate patients to give them dignity and respect when leaving Ward 1.

5.6 PATIENT INFORMATION AND LEAFLETS (PILS)

The team continues to add new leaflets to the website and are looking at various means of improving access to patient information and leaflets.

5.7 NATIONAL SURVEYS

Patients who have an overnight hospital stay during the month of July will receive a questionnaire in the next few months regarding their experience. The results will be available late 2016/early 2017 and will be compared with the survey undertaken last year as well as against other similar acute Trusts.

5.8 FRIENDS AND FAMILY TEST (JUNE 2016 DATA)

5.8.1 In-patient areas

The Trust's Friends and Family results for June indicate the following:

- Patients who would be likely to recommend the Trust (positive feedback) at **94.30%**
- Patients who would be unlikely to recommend the Trust (Negative Feedback) **1.80%**

There was an increase in the number of responses for the month of June 2016 with 6,600 of inpatients responding, compared to 6,375 in May 2016.

5.8.2 Emergency Department (ED)

In June, the ED Friends and Family responses decreased to 5.60% compared to 10.29% in May 2016. The common theme was waiting for information and medication; this has been reported back to all multi-disciplinary teams within the department.

- **86.50%** of patients were positive and likely to recommend ED to friends and family.
- **5.60%** gave negative feedback saying that they would be unlikely to recommend the ED.
- There are now volunteers within ED and this is helping to improve patients engaging with FFT.

5.8.3 Maternity

Maternity recommendation scores:

- **95.93%** Likely recommend, and;
- **1.02%** Unlikely to recommend the service to friends and family

5.9 VOLUNTEER SERVICE

The voluntary services team continues to receive interest from members of the public that wish to give their time to help the patients and staff of Hull and East Yorkshire Hospitals NHS Trust.

On 11 July 2016, the shop at Castle Hill Hospital re-opened. This will be staffed entirely by volunteers from 8.30am until 3pm Monday to Friday.

The Patient Experience HUB at the main tower block is being utilised by volunteer support groups and is used by the volunteers to sign-post and reassure patients. The Trust has received really positive feedback regarding the HUB and the support it offers.

The 'Jolly Volly' support group had their first meeting and members have shown an interest in developing a social calendar of events for the volunteers of the Trust.

Following a vote, the Patient and Public Council has now appointed a new patient representative Chair and Vice Chair. Mrs Marie Stern has been appointed as Chair and Mr Graham Gedney as Vice Chair.

5.9.1 Young Volunteers

There are over fifty young volunteers within the Trust across both sites in various departments.

On the 27 June 2016, there was another Young Health Champions presentation for youngsters to see what the Trust has to offer. The day was very well attended and enjoyed by the youngsters who were very interactive, asking many questions about the Trust.

Members of the Patient Experience Team have visited Kelvin Hall High School to talk to pupils regarding the Young Health Champions. Ten of the Kelvin Hall pupils are now going through the Volunteers screening to become a Young Health Champion/ Young volunteer in the Trust.

South Hunsley High School has shown an interest in the YHC project and we now have 7 pupils with us in the volunteers programme. Staff members have reported that the young volunteers are doing very well, all showing enthusiasm and dedication to their new role.

We will shortly be starting our partnership with the Princes Trust who are interested in the Young Health Champions project and would like to work with HEY. The project will offer youngsters from the age of sixteen to twenty four the chance to volunteer at the hospital.

5.9.2 Hospital Radio

The hospital radio is coming up to its 55th year and the Patient Experience team is arranging a party for all hospital radio volunteers. The celebration will take place on the 1 August 2016 and there will be radio presenters attending from the BBC who started their careers at Kingstown Radio and have since gone on to have successful full time radio careers.

A number of the radio volunteers have been volunteering for the Trust for over forty years, coming to the hospital each week to air their shows to our patients and staff via Kingstown Radio. Our volunteer radio presenters also supply outside broadcasts and were at the Trust's recent Family Fun Day and, also, will be at the Veterans Day, which will be held in East Park later this year.

5.9.3 Health Expo 2016

The Patient Experience Team attended the Health Expo 2016 and received a commendation in the 'Success in Partnership Working' award it is undertaking with the Princes Trust in respect of the Health Championships

6 OTHER QUALITY UPDATES

6.1 Mortality

The Trust continues to look into the reasons behind the raised Summary Hospital Mortality Indicator, which is measuring 112.3 for January 2015 to December 2015 (data from HSCIC June publication). During this period, both the alternative mortality measures of HSMR (hospital standardised mortality ratio) and RAMI (risk adjusted mortality index) had an index of 100, which is the expected level for the Trust, and nationally. This contrasts with data for the period April 2015 to March 2016, when the Trust's indices for HSMR and RAMI reduced to 95 and 96 respectively. In addition, the Trust's crude mortality rate (total number of deaths in hospital) appears to be declining despite the SHMI increasing.

The mortality committee has been working to try to understand this difference and it appears that, in part, it may relate to the opening of the ambulatory care unit, which removes patients with a low risk of death from the statistics. Analysis suggests that this impacts differentially the respective mortality measures and is contributing to the difference. This may not explain fully the magnitude of the discrepancy and further work is being undertaken to explore the impact of the management of palliative patients on the results. Palliative patients are discounted in the HSMR and to a certain extent in RAMI but are included in the SHMI.

Analysis suggests that there is clear reduction in the number of spells being included in the SHMI indicator and there have been small increases in both in-hospital and out of hospital deaths more recently. (Figure 1)

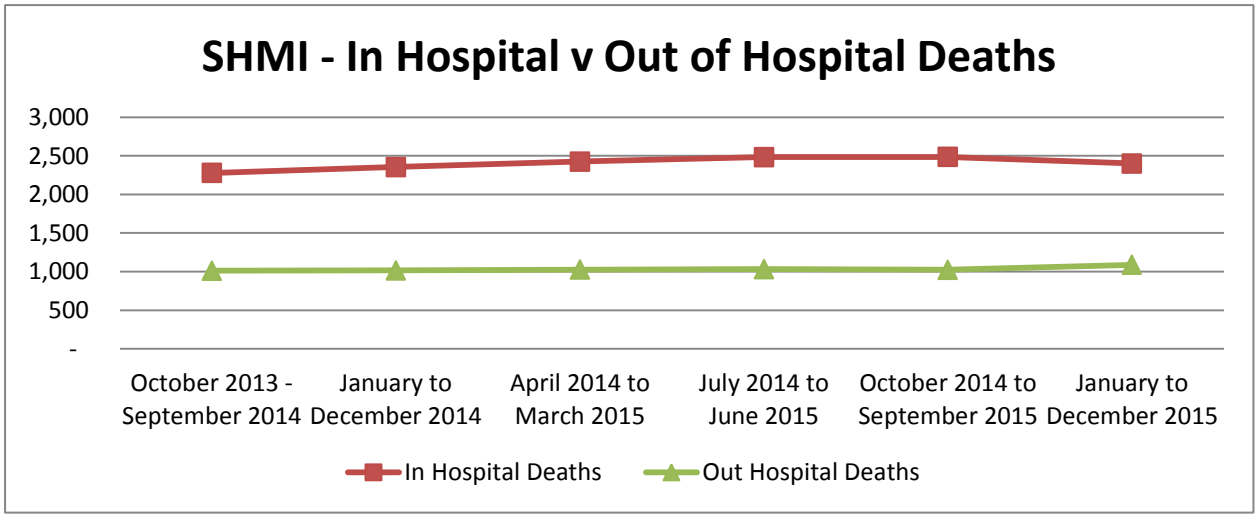
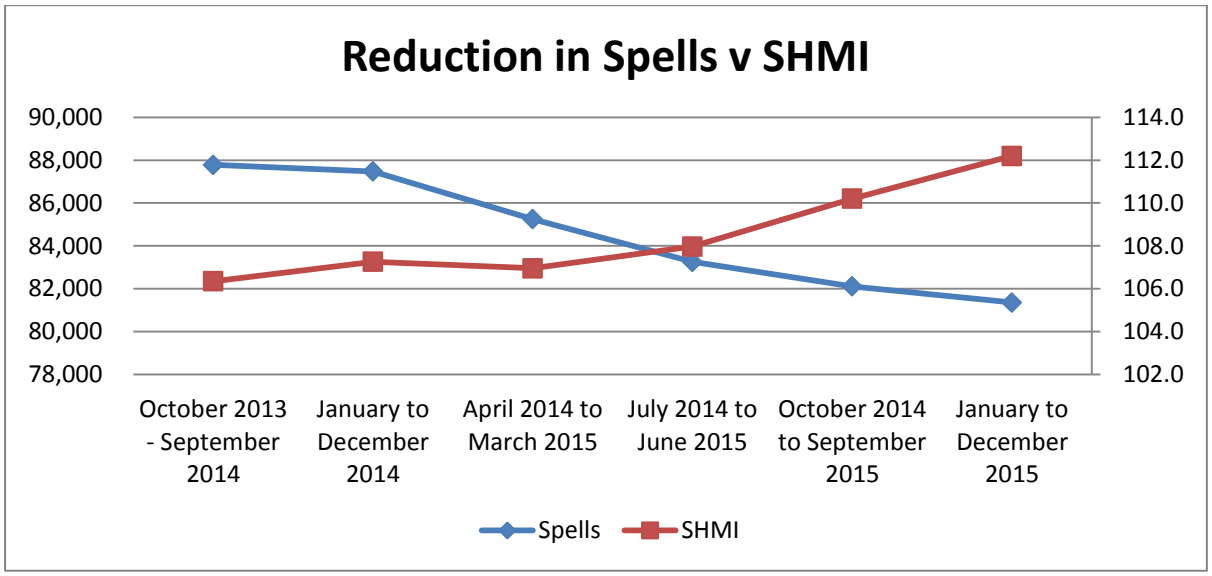


Figure 1: SHMI-In hospital v out of hospital deaths

Deaths with a palliative care code recorded have been variable, with a reduction in the number of patient deaths with the palliative care coding in the specialty and a more recent increase in the deaths with a palliative care coding in the diagnosis. (Table 1Figure 3)



Further work is being undertaken in this rea to try and understand this more fully, supported by CHKS, who help to produce and analyse the mortality data.

It is important that this work is completed before any meaningful interpretation can be made. However, steady progress is being made to help improve that understanding. The Trust also needs to work with its partners to reduce the reliance on secondary care to manage patients towards the end of life as, this will improve their care and the Trust's SHMI position.

An update on the progress of this work will be provided at the next Trust Board meeting.

6.2 Comprehensive CQC Inspection 28 June 2016 – 1 July 2016
The Trust received verbal feedback from the CQC on the final day of the comprehensive inspection on the 1 July 2016. This identified positive areas where the CQC considered that the Trust had made good progress since the last inspection in 2015. This included the appointment of a permanent Board, an overarching five year strategy and a more positive culture. Areas for improvement were also identified and the Trust has agreed that these will be included in its Quality Improvement Programme for 2016/17. The Trust has been advised by the CQC that its draft inspection report is likely to be forwarded to the Trust after the summer for factual accuracy checking, possibly September 2016. As such, the likely date of publication of the final report will be in the autumn.

6.3 Operational Quality Committee 13 July 2016
A key issue discussed at the meeting was the Quality Improvement Programme report to June 2016. Members of the Committee were not assured fully that the RAG status of all the projects reflected current performance or initial feedback received from the CQC following their June 2016 inspection. It was therefore agreed that the next meeting of the Quality Improvement Group would review in detail each project to ensure consistency in rating and evidence to support both current ratings and the forecast ratings.

Other matters discussed included the Serious Incident investigations and outstanding actions and agreed what steps would be taken to address these. The annual claims report was received which provided information on activity and trends. It was agreed that further work would be undertaken with Health Groups so that they understood themes resulting in claims and that more emphasis could be placed on improvement work. An update was received on the implementation of the National Safety Standards for Invasive Procedures. It was recognised that further work was required in order to meet the national deadline of September 2016 and a further update will be received at the next meeting.

7. WARD AUDITS – FUNDAMENTAL STANDARDS

The Chief Nurse and corporate nursing team have undertaken a review of the Ward Audit Framework. Essentially, this was far too complex and, also, was not necessarily measuring the correct parameters. Attached at **Appendix Two** are the first sets of results for these revised audits. This is still work in progress and is a starting point.

This is an incentive based programme, which uses the following assessment parameters:

Colour	Score	Review Date
Red	Less than 80%	3 months
Amber	80% to 89%	6 months
Green	90% to 94%	9 months
Blue	95% or greater	12 months

As Board members visits the wards, you will now see these results on public display in each area. The idea behind this is to be transparent and publically-accountable to patients, relatives and carers for these fundamental care standards. Board members are requested to discuss the findings with ward sisters/charge nurses and their teams not only to recognise and acknowledge good practice but also to discuss what improvements are being taken to address any shortcomings.

Also, on the ward notice boards, more explanation is given in terms of the areas in which the ward is doing well and where they need to improve, against each standard.

Over time, this will be developed to include non-ward areas, including outpatients and operating theatres. In addition, the ambition is to develop a ward/departmental accreditation programme that recognises persistently high performers.

Support will be given to those areas that need to improve. However, these data will also help when looking at quality indicator metrics alongside the safer staffing work.

This is the first step to making this more available and, hopefully, easier to understand and this process will mature over time. It is proposed to bring updates on this programme to the Trust Board quarterly.

8. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to receive this report and:

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

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Liz Thomas
Director of Governance

July 2016

Appendix One: Safety Thermometer Newsletter May 2016
Appendix Two: Ward Audits data

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

Pressure ulcers + Falls + Urinary infections (in patients with catheters) + VTE = Harmfreecare

SAFETY THERMOMETER NEWSLETTER July 2016

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 8h July across both hospital sites. 937 patients were surveyed

93.7% 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.

2.13% (20) 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

97.87% 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 Nov 15 – June 16

	Dec 15	Jan 16	Feb 16	March 16	April 16	May 16	June 16	July 16
Harm Free Care %	94.1%	93.2%	95.2%	94.1%	95.7%	93.7%	95.4%	93.7%
Sample: Number of patients	866	838	879	895	918	921	871	937
Total Number of New Harm	18	16	13	10	10	22	13	20
NEW HARM FREE CARE %	97.9%	98.0%	98.5%	98.8%	98.9%	97.6%	98.5%	97.8%

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	6	0.64%	4	2	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	833	88.9%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	59	6.3%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	45	4.8%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	40	4.27%	35	3	2
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.	33	3.52%	28	3	2
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	7	0.75%	7	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)	14	1.49%
Severity **No Harm**: fall occurred but with no harm to the patient	11	1.17%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.21%
Severity **Moderate Harm**: longer stay in hospital	1	0.11%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number	%
Total Number/Proportion of patients recorded with a Catheter	177	18.89%
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	12	1.28%
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**	8	0.85%
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**	4	0.43%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 12th August 2016

WARD AUDITS - FUNDAMENTAL STANDARDS - APPENDIX TWO

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C20	100%	Oct 16	81%	Sept 16	87%	Oct 16	100%	Mar 17	99%	Feb 17	73%	Sept 16	88%	Oct 16	88%	Dec 16	100%	Oct 16
C29	94%	Oct 16	91%	July 16	80%	Nov 16	100%	Jan 17	89%	Feb 17	**94%**	Mar 17	**84%**	Dec 16	90%	Mar 17	90%	Aug 16
C30	98%	Oct 16	90%	May 17	**90%**	Nov 16	100%	Jan 17	93%	Feb 17	83%	July 16	87%	July 16	**82%**	Dec 16	90%	Dec 16
C31	98%	Feb 17	91%	Mar 17	80%*	Oct 16	92%	Nov 16	94%	April 17	80%*	Sept 16	92%	Nov 16	80%	Dec 16	100%	Mar 17
C32	100%	Mar 17	86%	Nov 16	88%	July 16	100%	Feb 17	87%	Jan 17	87%	Jan 17	**85%**	Nov 16	77%	Sept 16	100%	Mar 17
C33	100%	Jan 17	85%	July 16	**80%**	Nov 16	92%	Jan 17	88%	Dec 16	80%*	Sept 16	90%	Oct 16	60%	Sept 16	100%	Mar 17

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	100%	June 17	87%	Sept 16	85%	Dec 16	92%	Jan 17	88%	Dec 16	80%*	July 16	98%	Jan 17	88%	Dec 16	100%	Mar 17
H30	91%	July 16	93%	Mar 17	80%*	Aug 16	91%	Oct 16	94%	Feb 17	80%*	Sept 16	92%	Jan 16	80%	Dec 16	100%	Oct 16
H31	91%	Aug 16	90%	May 17	**80%***	Aug 15	100%	Feb 17	95%	Mar 17	96%	April 17	100%	Mar 16	NA		98%	Nov 16
H33	88%	May 16	90%	May 17	80%*	Sept 16	92%	Nov 16	94%	Dec 16	100%	April 17	94%	Dec 16	NA		98%	Aug 16
ACORN	92%	Mar 17	94%	Jan 17	80%*	Sept 16	100%	Feb 17	91%	Mar17	80%*	Sept 16	96%	Nov 16	**64%**	Sept 16	100%	Mar 17
H35	95%	Dec 16	95%	May 17	80%*	Sept 16	90%	Oct 16	93%	April 17	80%*	Sept 16	97%	Feb 16	81%	Dec 16	100%	Nov 16
H130	100%	Mar 16	80%	May 16	**80%***	July 16	100%	Feb 17	94%	Mar 17	97%	April 17	88%	Aug 16	**92%**	Mar 17	96%	April 17
Labour	100%	June 17	NA		**80%***	Sept 16	91%	Nov 16	90%	Dec 16	80%*	July 16	83%	July 16	NA		NA	
NICU	**92%**	Mar 17	91%	Feb 16	**80%***	Sept 16	100%	Feb 17	98%	Mar 17	100%	Mar 17			100%	June 17	90%	Aug 16
PHDU	95%	June 17	98%	Nov 16	**84%**	Dec 16	100%	Feb 17	97%	Sept 16	100%	Mar 17	97%	Feb 17	**78%**	Sept 16	100%	Mar 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C8	92%	Jan 17	91%	Mar 17	**89%**	Feb 17	100%	Sept 16	90%	Dec 16	**64%**	Oct 16	87%	Feb 16	**81%**	Dec 16	100%	April 17
C9	96%	July 16	90%	Feb 17	**86%**	Dec 16	84%	Dec 16	87%	Sept 16	**61%**	Oct 16	86%	Mar 16	**68%**	Sept 16	100%	June 17
C10	89%	July 16	95%	May 17	80%	Dec 16	100%	Jan 17	91%	Feb 17	**80%***	Aug 16	90%	Aug 16	98%	May 17	100%	Oct 16
C11	96%	Oct 17	88%	Sept 16	86%	Dec 16	100%	Jan 17	84%	Nov 16	**81%***	Nov 16	83%	Mar 16	97%	May 17	100%	Oct 16
C14	97%	Mar 17	86%	Nov 16	83%	Sept 16	100%	Sept 16	83%	Dec 16	**69%**	Aug 16	81%	Mar 16	68%	Aug 16	93%	Dec 16
C15	93%	April 16	93%	Mar 17	85%	Sept 16	92%	Nov 16	84%	Aug 16	**80%***	Aug 16	81%	Aug 16	53%	Aug 16	97%	Mar 17
C27	98%	Mar 16	93%	Mar 17	94%	Dec 16	100%	Mar 17	89%	Sept 16	**80%***	Aug 16	93%	June 16	**81%**	Dec 16	100%	Mar 17
CICU1	100%	Oct 16	89%	June 16	100%	April 17	100%	April 17	98%	Sept 16	85%	Aug 16	96%	June 17	94%	Mar 17	96%	Oct 16
CICU2	100%	Oct 16	95%	Sept 16	89%	Feb 17	100%	April 17	98%	Sept 16	**92%**	Mar 17	99%	Sept 16	95%	June 17	96%	Oct 16

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	100%	Nov 16	83%	April 16	**80%**	Oct 16	100%	Jan 17	88%	Dec 16	**79%**	Sept 16	92%	Nov 16	**82%**	**Dec 16**	97%	Nov 16
H40	100%	Nov 16	93%	Aug 16	84%	Dec 16	100%	Jan 17	87%	Dec 16	**77%**	Sept16	89%	Nov 16	**76%**	Sept 16	100%	Nov 16

H6	96%	Aug 16	81%	April 16	**80%***	May 16	95%	May 17	96%	June 16	**80%***	Sept 16	70%	Sept 16	**70%**	Sept 16	95%	Nov 16
H60	94%	Aug 16	87%	July 16	**84%**	Dec 16	97%	Feb 17	89%	Aug 16	**93%**	Mar 17	87%	Dec 15	**79%**	Sept 16	90%	Dec 16
H7	100%	July 16	80%	Feb 16	**80%***	Jan 17	100%	Mar 17	81%	Sept 16	**80%***	Sept 16	**77%**	Sept 16	**85%**	Dec 16	100%	June 17
H12	92%	July 17	90%	Feb 17	80%*	Sept 16	92%	Dec 16	84%	Nov 16	80%*	July 16	85%	April 16	**68%**	Sept 16	91%	Jan 17
H120	100%	Nov 16	90%	Feb 17	**71%**	Sept 16	93%	Dec 16	85%	Nov 16	**78%**	Aug 16	85%	Dec 16	**90%**	Mar 17	92%	Oct 16
H100	100%	April 17	80%	Aug 16	**80%***	Dec 16	94%	Dec 16	80%	Aug 16	**66%**	Sept 16	84%	June 16	82%	Dec 16	90%	Jan 17
HICU1	100%	Oct 16	89%	May 16	80%*	July 16	97%	April 17	95%	Sept 16	96%	Feb 17	88%	June 16	**90%**	Mar 17	93%	July 16
HICU2	100%	Oct 16	NA		86%	Nov 16	97%	April 17	97%	June 17	85%	Aug 16	97%	June 17	**89%**	Mar 17	96%	June 17

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	100%	Nov 16	**91%**	July 16	80%*	Aug 16	100%	June 17	95%	Oct 16	80%	Aug 16	**92%**	Dec 16	97%	June 17	95%	Nov 16
C26	100%	Mar 17	93%	Mar 17	89%	Mar 17	93%	Dec 16	89%	Dec 16	80%*	Aug 16	82%	Sept 16	85%	Dec 16	100%	Mar 17
C5DU	94%	July 16	94%	July 16	97%	Oct 16	100%	June 17	94%	Feb 17	100%	April 17	95%	Sept 16	100%	April 17	100%	Oct 16

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	92%	July 16	80%	July 16	80%*	July 16	92%	Oct 16	82%	Nov 16	**80%***	Aug 16	**80%**	Dec 16	**61%**	Sept 16	83%	April 16
H1	100%	Nov 16	95%	June 17	**75%**	July 16	96%	Nov 16	90%	Jan 17	40%	Sept 16	**75%**	Sept 16	**64%**	Sept 16	85%	May 16
H200/EAU	98%	Feb 17	82%	Dec 16	**84%**	Dec 16	95%	Feb 17	86%	Aug 16	**80%***	Dec 16	84%	Aug 16	**76%**	Sept 16	96%	Feb 17
H5	95%	May 17	80%	Sept 16	**80%***	June 16	92%	Dec 16	83%	Aug 16	80%	Aug 16	**69%**	Aug 16	**80%**	Dec 16	91%	Jan 17
H50	97%	May 17	81%	Sept 16	**79%**	Sept 16	100%	Mar 17	94%	Mar 17	**80%***	Aug 16	**71%**	Aug 16	**95%**	June 17	96%	June 16
H500	93%	June 16	81%	Sept 16	**80%***	July 15	92%	Feb 17	82%	Sept 16	**80%***	Aug 16			**77%**	Sept 16	96%	Aug 16
H70	94%	Dec 15	85%	Nov 16	**80%***	July 16	92%	Oct 16	81%	Sept 16	**80%***	Sept 16	**58%**	Sept 15	**58%**	Sept 16	**70%**	July 16
H8	96%	Feb 17	84%	Dec 16	80%*	June 16	**96%**	May 17	82%	Aug 16	80%*	Sept 16	89%	Nov 16	62%	Sept 16	100%	Mar 17
H80	98%	Feb 17	94%	Nov 16	82%	Oct 16	100%	Mar 17	84%	Aug 16	80%*	Sept 16	90%	Nov 16	**53%**	Sept 16	100%	April 17
H9	100%	June 16	86%	Dec 16	84%	Dec 16	95%	Mar 17	87%	Nov 16	80%*	Sept 16	94%	Mar 17	82%	Dec 16	100%	June 17
H90	100%	June16	82%	Dec 16	80%*	Sept 16	89%	Dec 16	86%	Jan 17	**80%***	Sept 16	91%	Mar 17	84%	Dec 16	96%	Nov 16
H11	100%	Feb 17	**80%**	Aug 16	80%*	Jan 17	97%	Mar 17	82%	Aug 16	**71%**	Aug 16	85%	Dec 16	85%	Dec 16	96%	Dec 16
H110	100%	Nov 16	**89%**	Mar 17	80%*	July 16	93%	Oct 16	74%	Nov 16	**70%**	Aug 16	77%	Sept 16	93%	Mar 17	100%	Nov 16

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management				Patient Centred Care (inc TV)		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
Majors ED	94%	Oct 16	**93%**	Oct 16	80%*	June 16	93%	July 16	80%	Sept 16			83%	July 16	95%	Oct 16	83%	July 16
Paeds ED	94%	Oct 16	**90%**	Oct 16	80%*	July 16	96%	Nov 16	89%	Feb 17			90%	Dec 16			90	Sept 16
Minors ED	94%	Oct 16	**90%**	Oct 16	80%*	June 16	96%	Nov 16	83%	Nov 16			89%	Dec 16			93	Sept 16

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

TRUST BOARD REPORT – 2016 – 4 - 10	
Meeting date:	Thursday 28th July 2016
Title:	Nursing and Midwifery Staffing
Presented by:	Mike Wright, Executive Chief Nurse
Author:	Mike Wright, Executive Chief Nurse
Purpose:	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery Staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and The Care Quality Commission. This report introduces the revised safer nursing and midwifery staffing guidance that has been issued by the National Quality Board in July 2016 and the Trust's response to this.
Recommendation(s):	The Trust Board is requested to: • Receive this report • Decide if any if any further actions and/or information are required.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING 28th July 2016

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] and The Care Quality Commission.

2. BACKGROUND

The last report on this topic was presented to the Trust Board in May 2016 (March 2016 position).

This report presents the 'safer staffing' position as at 30th June and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[2].

In July 2016, the National Quality Board updated its guidance for provider trusts, which sets out the responsibilities and accountabilities for trust boards for ensuring safe nursing and midwifery staffing levels. The new guidance sets out specifications for the future format of these reports. Future versions of this report from September 2016 onwards will be structured in line with this guidance.

The Trust Board is requested to:

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

3. EXPECTATION 7

Expectation 7 of the NQB's standards requires Trust Boards to:

- receive monthly updates on workforce information, and that;
- staffing capacity and capability is discussed at a Trust Board meeting in public at least every six months on the basis of a full nursing and midwifery establishment review. This second part was last presented to the Trust Board in January 2016 (as at December 2015).

The first specific requirement of Expectation 7 is for provider trusts to upload the staffing levels for all inpatient areas on a monthly basis into the national reporting database (UNIFY 2). These are then published via the NHS Choices Website.

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

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

These data are summarised, as follows:

[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*
[2] When Trust Boards meet in public

3.1 Planned versus Actual Staffing levels.

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: HEY Safety Brief) and **Appendix Two** (New Roles).

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
May-14	82.56%	95.37%	83.21%	93.09%
Jun-14	88.09%	91.96%	91.61%	94.20%
Jul-14	83.41%	87.43%	84.35%	95.62%
Aug-14	83.58%	89.43%	84.39%	95.77%
Sep-14	84.34%	88.59%	84.36%	102.98%
Oct-14	81.38%	87.54%	85.37%	102.49%
Nov-14	85.35%	90.26%	84.30%	101.38%
Dec-14	79.48%	87.57%	80.51%	96.37%
Jan-15	80.99%	87.74%	83.22%	96.76%
Feb-15	80.46%	84.55%	82.57%	96.31%
Mar-15	79.54%	85.38%	81.81%	98.77%
Apr-15	81.36%	90.39%	82.99%	104.79%
May-15	84.21%	94.33%	87.57%	102.19%
Jun-15	84.03%	92.79%	85.01%	102.89%
Jul-15	83.69%	93.80%	86.28%	103.37%
Aug-15	81.13%	90.95%	83.91%	103.18%
Sep-15	79.77%	84.90%	80.54%	91.38%
Oct-15	84.05%	97.36%	85.85%	98.36%
Nov-15	84.48%	94.74%	85.17%	95.08%
Dec-15	85.39%	97.92%	86.99%	105.33%
Jan-16	85.18%	93.92%	87.14%	104.86%
Feb-16	84.05%	94.29%	85.90%	104.32%
Mar-16	82.93%	92.38%	84.37%	104.05%
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%

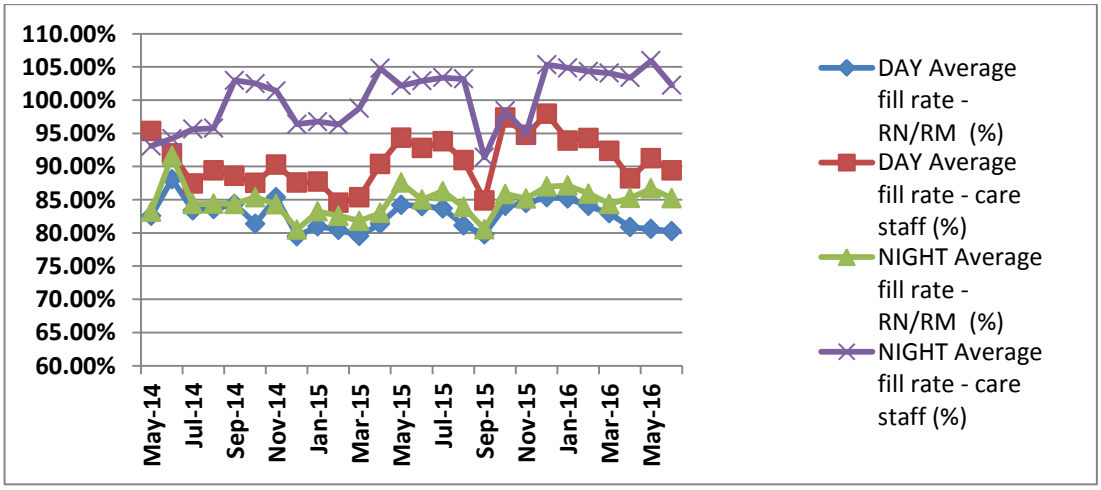
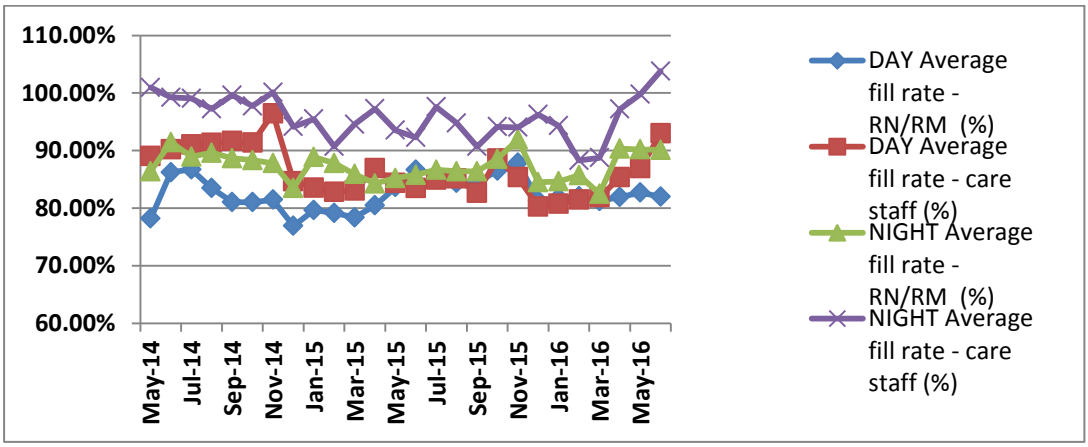


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
May-14	78.19%	89.06%	86.38%	100.95%
Jun-14	86.23%	90.22%	91.44%	99.24%
Jul-14	86.74%	91.05%	88.95%	99.08%
Aug-14	83.47%	91.32%	89.61%	97.23%
Sep-14	81.05%	91.63%	88.67%	99.62%
Oct-14	81.04%	91.36%	88.33%	97.73%
Nov-14	81.47%	96.46%	87.80%	100.13%
Dec-14	76.92%	84.67%	83.50%	94.15%
Jan-15	79.67%	83.55%	88.85%	95.47%
Feb-15	79.15%	82.84%	87.84%	90.74%
Mar-15	78.39%	83.03%	85.92%	94.57%
Apr-15	80.48%	86.92%	84.29%	97.26%
May-15	83.63%	84.39%	85.23%	93.52%
Jun-15	86.65%	83.46%	85.77%	92.28%
Jul-15	85.85%	84.93%	86.68%	97.59%
Aug-15	84.40%	85.16%	86.39%	94.77%
Sep-15	84.44%	82.65%	86.39%	90.71%
Oct-15	86.50%	88.58%	88.56%	94.14%
Nov-15	87.90%	85.36%	91.91%	94.03%
Dec-15	81.31%	80.29%	84.50%	96.26%
Jan-16	81.78%	80.75%	84.64%	94.31%
Feb-16	82.06%	81.50%	85.71%	88.28%
Mar-16	81.22%	81.87%	82.50%	88.74%
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%



Fill rate numbers at Castle Hill Hospital remain relatively stable overall, with improvements in care staff (unregistered), particularly. The situation is slightly different at Hull Royal Infirmary where day registered nursing numbers have seen a steady reduction since November 2015. This is due to a combination of factors, including the re-settling of staff that supported the extra winter capacity ward at HRI

back at CHH and, also, some attrition. Night time registered nursing numbers remain stable and care staff numbers remain stable for both days and night at HRI.

In order to assure the Trust Board and to set this in context, the twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. However, some pressures remain in recruiting to optimal staffing levels in some areas.

The nursing and midwifery staffing escalation policy is under review and it is possible that the Trust may need to reduce bed capacity if alternative solutions to staffing any shortfalls cannot be found. This is always a last resort but is an option that is available if need in order to keep patients safe.

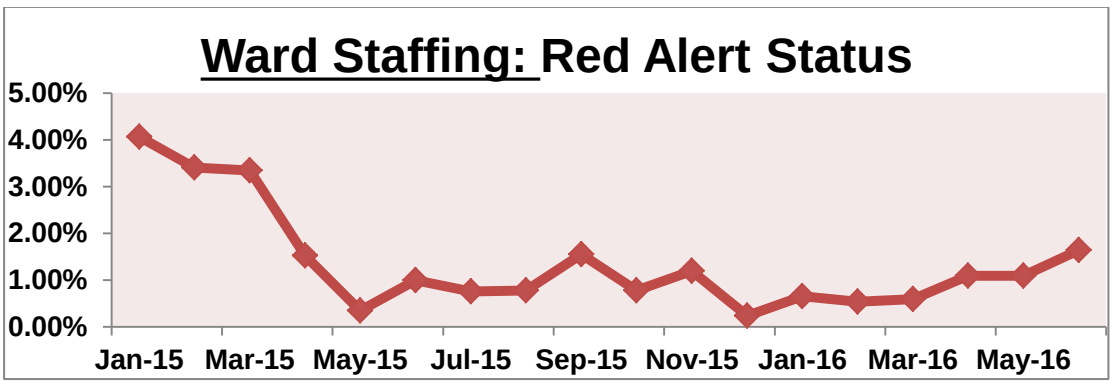
The Trust has offered 74 jobs to the August/September student outtake at the University of Hull. Regular contact is being made with these students to ensure that they feel supported. However, some risk remains as some students block apply for jobs in different trusts and decide which they are taking nearer the time.

The Executive Management Board has agreed a proposal to undertake a recruitment initiative for 101 nurses from the Philippines, subject to final confirmation of the funding needed for this in the context of the Trust's overall financial position. This will be discussed with the health groups at their next performance and accountability meetings. The schedule for this has yet to be determined.

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

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

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



The number of red alert declarations remains relatively small overall but has seen a slight increase in recent months. These are reviewed by nurse directors at the safety briefs and addressed accordingly.

The key areas that remain particularly tight currently are:

- The Clinical Decision Unit (CDU), which is adjacent to the Acute Medical Unit at HRI. Staffing levels in this area should improve in the autumn and jobs have been offered to fill all RN vacancies. In the meantime, staff have been seconded from other wards and, also bank staff are being used.
- H70 (Diabetes and Endocrine). This ward has five RN vacancies which, again, have been offered to new graduates in the autumn. In the meantime, staff from other wards are supporting. There are some quality concerns on this ward but these are being monitored closely by the Divisional Nurse, who provides a lot of additional support to the ward.
- C30, C31 and C33 – Oncology. There are still some staffing gaps in these wards but, again, these are balanced across all wards daily. The Oncology Matron remains ward based and the teaching staff and specialist nurses are supporting the wards, also.
- Critical Care Units and Neonatal Unit. These units each have some vacancies and high levels of maternity leave. Staffing risks are managed on a daily basis and some agency staffing is being utilised in these areas.

However, despite on-going recruitment campaigns, this is still very challenging for the Trust and some risks with securing the required numbers of registered nurses remain.

The inability to recruit sufficient numbers of registered nurses in order to meet safer staffing requirements remains a recorded risk at rating 12 (Moderate - Major and Possible - ID 2671) on the Risk Register, although every reasonable effort to try and mitigate this risk is being taken on a daily basis.

4. NATIONAL QUALITY - REVISED BOARD GUIDANCE - JULY 2016

The National Quality Board issued revised guidance this month[3], which replaces the original 'Ten Expectations' with a revised 'Ten Expectations' alongside other supplementary requirements. The full document is attached at **Appendix Two** and the reason for attaching this is that there are key responsibilities for Trust Boards in this guidance, part of which are the new reporting requirements, which are summarised in the following table:

[3] 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

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

As the Trust Board is aware from these regular reports, just looking at 'planned' versus 'actual' staffing numbers is only part of the information required when helping to decide if a ward is staffed safely or not. Therefore, the new guidance requires not only 'planned' versus 'actual' staffing levels to be published but, also, a range of other measures and indicators (quality and workforce data) alongside these to help determine safe staffing levels and/or the part they play in delivering high quality care. In addition, the new metrics of 'care hours per patient day' and 'nurse hours per patient day' will need to be reported in the future. These are the new measures recommended by Lord Carter.

In themselves, they do not mean a great deal. However, the intention is to analyse these numbers alongside other quality and workforce indicators to help develop a more 'rounded' assessment of whether a ward is staffed safely or not and is well managed or otherwise. In summary, this is about considering a broader range of information, other than just staffing numbers, when considering and concluding on safe staffing matters.

Over time, it is proposed that benchmarking information will be made available for provider trusts to be able to compare performance against that of peers. Furthermore, it is likely that a national dashboard or template will be developed for the reporting of all of this in the future.

The Trust Board may also be aware that there has been a great deal of media attention in recent weeks about nursing and midwifery staffing levels, the affordability of same and where this all sits in relation to emerging evidence and ensuring that patients are safe and well cared for. This is proving to be controversial in many professional nursing and midwifery circles. However, the challenge for provider organisations is to use good data and evidence-based patient acuity assessments alongside professional judgements to determine the required levels of nursing and midwifery staffing. We do this now and none of this new guidance really changes this approach.

In the meantime, work will take place over the coming weeks to refresh the structure of this report and appendices in line with this revised guidance and, also, in an attempt to demystify what could be construed as conflicting guidance from the centre. This will be presented to the Trust Board at its next meeting in September 2016. In addition, the next full revisions of nursing and midwifery establishments will take place in September 2016 and March 2017.

5. NURSING AND MIDWIFERY REVALIDATION

Nursing and Midwifery Revalidation continues to progress well, with no major issues identified to date.

6. SUMMARY

The Trust continues to meet its obligations under the National Quality Board's Ten Expectations.

Nursing and Midwifery staffing establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. However, the challenges remain around recruitment and risks remain in terms of the available supply of registered nurses. Recruitment efforts continue.

Work will take place over the coming weeks to refresh the structure of this report and appendices in line with the revised guidance issued recently by the National Quality Board, with the first version to be presented to the September 2016 Trust Board alongside the next establishment reviews.

7. 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 2016

Appendix 1: HEY Safer Staffing Report - March 2016
Appendix 2: New Roles – March 2016
Appendix 3: 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

HEY SAFER STAFFING REPORT JUNE-16

NURSE STAFFING

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	MONTHLY AVERAGE		DAY		NIGHT		PATIENT TO RN RATIO		RN & AN	ACUITY MONITORING [AVERAGE]				
				Supervisory Charge Nurse	Nurse Staffing Red Alert Status	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	EARLY SHIFT [8:1]	LATE SHIFT [8:1]	NIGHT SHIFT [10:1]	0	1a	1b	2	3
MEDICINE	ED	ACUTE MEDICINE	NA	0%	3%	101%	74%	99%	81%								
	AMU	ACUTE MEDICINE	45	16%	19%	96%	98%	98%	98%	6 : 1	6 : 1	6 : 1	47%	20%	33%	0%	0%
	H1	ACUTE MEDICINE	22	6%	0%	79%	113%	97%	122%	9 : 1	11 : 1	7 : 1	51%	17%	32%	0%	0%
	EAU	ELDERLY MEDICINE	21	6%	0%	100%	85%	73%	98%	6 : 1	6 : 1	7 : 1	46%	1%	53%	0%	0%
	H5	RESPIRATORY	20	3%	0%	82%	96%	91%	102%	10 : 1	10 : 1	8 : 1	27%	24%	49%	0%	0%
	RHOB	RESPIRATORY	6	6%	6%	95%	79%	85%	93%	3 : 1	3 : 1	2 : 1	0%	1%	3%	95%	0%
	H50	RENAL MEDICINE	19	10%	0%	85%	99%	105%	95%	7 : 1	9 : 1	6 : 1	46%	6%	48%	0%	0%
	H500	RESPIRATORY	24	16%	10%	80%	95%	95%	101%	9 : 1	9 : 1	8 : 1	58%	5%	36%	1%	0%
	H70	ENDOCRINOLOGY	30	6%	3%	80%	99%	80%	102%	8 : 1	8 : 1	10 : 1	17%	15%	67%	0%	0%
	H8	ELDERLY MEDICINE	27	10%	0%	86%	79%	98%	100%	7 : 1	9 : 1	9 : 1	5%	1%	95%	0%	0%
	H80	ELDERLY MEDICINE	27	16%	0%	84%	97%	80%	83%	8 : 1	9 : 1	9 : 1	2%	2%	96%	0%	0%
	H9	ELDERLY MEDICINE	31	6%	3%	83%	88%	80%	103%	8 : 1	9 : 1	10 : 1	5%	1%	94%	0%	0%
	H90	ELDERLY MEDICINE	29	19%	3%	83%	91%	80%	100%	8 : 1	9 : 1	10 : 1	16%	2%	83%	0%	0%
	H11	STROKE / NEUROLOGY	28	39%	0%	80%	100%	80%	100%	8 : 1	9 : 1	9 : 1	37%	11%	51%	1%	0%
	H110	STROKE / NEUROLOGY	24	13%	0%	97%	109%	107%	96%	6 : 1	6 : 1	7 : 1	29%	13%	55%	3%	0%
	CDU	CARDIOLOGY	9	29%	0%	88%	80%	100%		3 : 1	5 : 1	8 : 1	24%	76%	0%	0%	0%
	C26	CARDIOLOGY	26	26%	0%	91%	91%	98%	93%	5 : 1	6 : 1	7 : 1	46%	25%	26%	2%	0%
	C28	CARDIOLOGY	17	32%	0%	81%	91%	87%	80%	6 : 1	7 : 1	6 : 1	12%	37%	50%	1%	0%
	CMU	CARDIOLOGY	10	26%	0%	81%	91%	87%	80%	3 : 1	3 : 1	3 : 1	0%	18%	18%	62%	1%
SURGERY	H4	NEURO SURGERY	30	26%	0%	83%	122%	80%	119%	8 : 1	9 : 1	9 : 1	32%	0%	67%	0%	0%
	H40	NEURO HOB / TRAUMA	15	26%	0%	80%	99%	85%	96%	4 : 1	5 : 1	4 : 1	2%	47%	51%	0%	0%
	H6	ACUTE SURGERY	28	32%	3%	86%	93%	80%	203%	7 : 1	9 : 1	9 : 1	48%	13%	39%	0%	0%
	H60	ACUTE SURGERY	28	19%	0%	95%	98%	92%	204%	7 : 1	9 : 1	8 : 1	39%	12%	49%	0%	0%
	H7	VASCUALR SURGERY	30	19%	3%	82%	116%	87%	115%	7 : 1	8 : 1	9 : 1	30%	12%	58%	0%	0%
	H100	GASTROENTEROLOGY	24	32%	0%	83%	102%	83%	102%	7 : 1	8 : 1	8 : 1	68%	0%	32%	0%	0%
	H12	ORTHOPAEDIC	28	16%	19%	84%	89%	88%	100%	8 : 1	9 : 1	8 : 1	11%	2%	87%	1%	0%
	H120	ORTHO / MAXFAX	22	16%	3%	84%	88%	87%	126%	6 : 1	7 : 1	6 : 1	15%	12%	73%	1%	0%
	HICU	CRITICAL CARE	22	52%	0%	90%	93%	88%	79%	2 : 1	2 : 1	2 : 1	0%	1%	1%	55%	43%
	C8	ORTHOPAEDIC	18	6%	0%	79%	80%	83%	91%	8 : 1	9 : 1	6 : 1	56%	1%	43%	0%	0%
	C9	ORTHOPAEDIC	29	10%	0%	80%	91%	103%	106%	8 : 1	9 : 1	10 : 1	43%	0%	57%	0%	0%
	C10	COLORECTAL	21	26%	0%	83%	83%	79%	97%	6 : 1	8 : 1	6 : 1	51%	2%	47%	0%	0%
	C11	COLORECTAL	22	35%	0%	85%	81%	88%	95%	6 : 1	8 : 1	7 : 1	61%	1%	39%	0%	0%
	C14	UPPER GI	27	39%	0%	89%	79%	92%	172%	6 : 1	8 : 1	7 : 1	60%	2%	38%	0%	0%
	C15	UROLOGY	26	13%	3%	81%	90%	93%	99%	6 : 1	7 : 1	7 : 1	59%	3%	38%	0%	0%
	C27	CARDIOTHORACIC	26	13%	0%	87%	89%	84%	93%	6 : 1	6 : 1	6 : 1	30%	1%	69%	0%	0%
	CICU	CRITICAL CARE	22	58%	0%	91%	101%	93%	95%	2 : 1	2 : 1	2 : 1	0%	0%	1%	64%	36%
FAMILY & WOMEN'S	C16	ENT / BREAST	30	48%	0%	91%	77%	86%	71%	9 : 1	10 : 1	9 : 1	42%	37%	18%	4%	0%
	H130	PAEDS	20	3%	0%	86%	79%	86%	79%	5 : 1	6 : 1	5 : 1	55%	0%	45%	0%	0%
	H30 CEDAR	GYNAEOCOLOGY	9	19%	0%	87%	82%	109%		5 : 1	6 : 1	6 : 1	77%	18%	5%	0%	0%
	H31 MAPLE	MATERNITY	20	29%	0%	83%	83%	78%	92%	5 : 1	5 : 1	6 : 1	97%	3%	0%	0%	0%
	H33 ROWAN	MATERNITY	38	48%	0%	88%	89%	90%	93%	7 : 1	8 : 1	9 : 1	100%	0%	0%	0%	0%
	H34 ACORN	PAEDS SURGERY	20	48%	6%	78%	81%	92%	164%	5 : 1	6 : 1	7 : 1	91%	0%	9%	0%	0%
	H35	OPHTHALMOLOGY	12	10%	0%	101%	79%	107%		6 : 1	6 : 1	6 : 1	69%	6%	25%	1%	0%
	LABOUR	MATERNITY	16	52%	0%	118%	68%	108%	80%	3 : 1	3 : 1	3 : 1	65%	29%	6%	0%	0%
	NEONATES	CRITICAL CARE	26	42%	0%	82%	81%	81%	91%	3 : 1	3 : 1	3 : 1	3%	2%	47%	38%	10%
	PAU	PAEDS	10	6%	0%	85%		94%		5 : 1	5 : 1	5 : 1	54%	0%	43%	2%	0%
	PHDU	CRITICAL CARE	4	39%	0%	100%		100%		2 : 1	2 : 1	2 : 1	2%	0%	21%	77%	0%
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	3%	0%	94%	74%	79%	106%	7 : 1	7 : 1	6 : 1	56%	0%	44%	0%	0%
	C29	REHABILITATION	15	19%	0%	80%	98%	100%	93%	7 : 1	8 : 1	5 : 1	40%	10%	49%	0%	0%
	C30	ONCOLOGY	22	45%	0%	88%	100%	92%	100%	7 : 1	8 : 1	8 : 1	48%	19%	32%	1%	0%
	C31	ONCOLOGY	27	35%	0%	80%	99%	98%	115%	8 : 1	9 : 1	9 : 1	39%	7%	54%	0%	0%
	C32	ONCOLOGY	22	26%	0%	99%	100%	99%	97%	7 : 1	8 : 1	7 : 1	15%	2%	83%	0%	0%
	C33	HAEMATOLOGY	28	13%	0%	80%	80%	82%	79%	5 : 1	7 : 1	7 : 1	47%	6%	47%	0%	0%
		AVERAGE:		22.9%	1.6%			AVERAGE:		6 : 1	7 : 1	7 : 1	38%	10%	42%	8%	2%

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

HEALTH GROUP	WARD	HIGH LEVEL			FALLS				HOSPITAL ACQUIRED PRESSURE DAMAGE						QUALITY INDICATOR TOTAL
		REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	GRADE 2	GRADE 3	GRADE 4	DEEP TISSUE INJURY	UNSTAGEABLE	PRESSURE SORE TOTAL	
MEDICINE	ED		3	5	1		1	2						0	10
	AMU	3	1	6				0						0	10
	H1							0						0	0
	EAU		1	1	2			2						0	4
	H5		1	1		1	1	2	2					2	6
	RHOB							0	1					1	1
	H50				2			2						0	2
	H500				1			1						0	1
	H70	5		3	4			4				1		1	13
	H8				2			2						0	2
	H80		1	1	2			2						0	4
	H9				1		1	2						0	2
	H90	2	1	5	5			5						0	13
	H11	1	1		3			3						0	5
	H110				3			3				1		1	4
	CDU				1			1						0	1
	C26		1					0						0	1
	C28		1					0	1					1	2
	CMU							0						0	0
SURGERY	H4		2					0						0	2
	H40							0						0	0
	H6		2		2			2	1					1	5
	H60		1	1	1			1						0	3
	H7	2	1	1	1			1				1		1	6
	H100							0				1		1	1
	H12							0	1					1	1
	H120		1					0	1					1	2
	HICU		1	5				0	1				1	2	8
	C8							0				1		1	1
	C9							0						0	0
	C10							0	1					1	1
	C11							0						0	0
	C14							0						0	0
	C15			2				0	1					1	3
	C27							0						0	0
	CICU							0						0	0
FAMILY & WOMEN'S	C16		1		1			1					1	1	3
	H130							0	1					1	1
	H30 CEDAR	1						0						0	1
	H31 MAPLE	1						0						0	1
	H33 ROWAN							0						0	0
	H34 ACORN				2			2						0	2
	H35							0						0	0
	LABOUR	1		1				0						0	2
	NEONATES	3						0						0	3
	PAU							0						0	0
	PHDU				1			1						0	1
CLINICAL SUPPORT	C20				2			2						0	2
	C29				1			1						0	1
	C30		1		2			2	2					2	5
	C31				3			3						0	3
	C32				2			2						0	2
	C33			2	1			1	1				1	2	5
	TOTALS:	19	21	34	46	1	3	50	14	0	0	5	3	22	146

Jun-16	DAY		NIGHT	
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
HRI SITE	80.3%	89.4%	85.2%	102.2%
CHH SITE	82.0%	93.0%	90.1%	103.8%

Steve Jessop
Chief Nurse Information Officer

WARD SUPPORT ROLES

HEALTH GROUP	WARD	SPECIALITY	HOUSE KEEPER	HYGIENIST	DISCHARGE FACILITATOR / WARD PA	PROGRESS CHASER	SURGERY ADMISSION SUPPORT	DEMENTIA CARE APPRENTICE	NUTRITION CARE APPRENTICE	OTHER	[PLEASE STATE]
MEDICINE	ED	ACUTE MEDICINE	YES	YES	NO	YES	NO	NO	NO	NO	
	AMU	ACUTE MEDICINE	YES	YES	NO	NO	NO	NO	NO	NO	
	H1	ACUTE MEDICINE	YES	YES	YES	NO	NO	NO	NO	NO	
	EAU	ELDERLY MEDICINE	YES	YES	YES	NO	NO	NO	NO	NO	
	H5	RESPIRATORY	YES	YES	YES	NO	NO	NO	NO	NO	
	RHOB	RESPIRATORY	YES	YES	YES	NO	NO	NO	NO	NO	
	H50	RENAL MEDICINE	YES	YES	YES	NO	NO	NO	NO	NO	
	H500	RESPIRATORY	YES	YES	YES	NO	NO	NO	NO	NO	
	H70	ENDOCRINOLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	H8	ELDERLY MEDICINE	YES	YES	YES	NO	NO	YES	POTENTIAL	NO	
	H80	ELDERLY MEDICINE	YES	YES	YES	NO	NO	YES	POTENTIAL	NO	
	H9	ELDERLY MEDICINE	YES	YES	YES	NO	NO	POTENTIAL	NO	NO	
	H90	ELDERLY MEDICINE	YES	YES	YES	NO	NO	POTENTIAL	NO	NO	
	H11	STROKE / NEUROLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	H110	STROKE / NEUROLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	CDU	CARDIOLOGY	YES	YES	NO	NO	NO	NO	NO	NO	
	C26	CARDIOLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	C28	CARDIOLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	CMU	CARDIOLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
SURGERY	H4	NEURO SURGERY	YES	YES	YES	NO	POTENTIAL	NO	NO	NO	
	H40	NEURO HOB / TRAUMA	YES	YES	YES	NO	POTENTIAL	NO	NO	NO	
	H6	ACUTE SURGERY	YES	YES	YES	NO	YES	NO	NO	NO	
	H60	ACUTE SURGERY	YES	YES	YES	NO	YES	NO	NO	NO	
	H7	VASCUALR SURGERY	YES	YES	YES	NO	YES	NO	NO	NO	
	H100	GASTROENTEROLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	H12	ORTHOPAEDIC	YES	YES	YES	NO	YES	POTENTIAL	POTENTIAL	NO	
	H120	ORTHO / MAXFAX	YES	YES	YES	NO	YES	POTENTIAL	POTENTIAL	NO	
	HICU	CRITICAL CARE	YES	YES	POTENTIAL	NO	NO	NO	NO	NO	
	C8	ORTHOPAEDIC	YES	YES	YES	NO	NO	NO	NO	NO	
	C9	ORTHOPAEDIC	YES	YES	YES	NO	NO	NO	NO	NO	
	C10	COLORECTAL	YES	YES	YES	NO	NO	NO	NO	NO	
	C11	COLORECTAL	YES	YES	YES	NO	NO	NO	NO	NO	
	C14	UPPER GI	YES	YES	YES	NO	NO	NO	NO	NO	
	C15	UROLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
	C27	CARDIOTHORACIC	YES	YES	YES	NO	NO	NO	NO	NO	
	CICU	CRITICAL CARE	YES	YES	POTENTIAL	NO	NO	NO	NO	NO	
FAMILY & WOMEN'S	C16	ENT / BREAST	YES	YES	NO	NO	NO	NO	NO	NO	
	H130	PAEDS	YES	YES	NO	NO	NO	NO	NO	NO	
	H30 CEDAR	GYNAEOCOLOGY	YES	YES	NO	NO	NO	NO	NO	NO	
	H31 MAPLE	MATERNITY	YES	YES	NO	NO	NO	NO	NO	NO	
	H33 ROWAN	MATERNITY	YES	YES	NO	NO	NO	NO	NO	NO	
	H34 ACORN	PAEDS SURGERY	YES	YES	NO	NO	NO	NO	NO	NO	
	H35	OPHTHALMOLOGY	YES	YES	NO	NO	NO	NO	NO	NO	
	LABOUR	MATERNITY	YES	YES	NO	NO	NO	NO	NO	NO	
	NEONATES	CRITICAL CARE	YES	YES	NO	NO	NO	NO	NO	NO	

Steve Jessop
Chief Nurse Information Officer

WARD SUPPORT ROLES

HEALTH GROUP	WARD	SPECIALITY	HOUSE KEEPER	HYGIENIST	DISCHARGE FACILITATOR / WARD PA	PROGRESS CHASER	SURGERY ADMISSION SUPPORT	DEMENTIA CARE APPRENTICE	NUTRITION CARE APPRENTICE	OTHER	[PLEASE STATE]
	PAU	PAEDS	YES	YES	NO	NO	NO	NO	NO	NO	
	PHDU	CRITICAL CARE	YES	YES	NO	NO	NO	NO	NO	NO	
	H10	WINTER WARD	YES	YES	NO	NO	NO	NO	NO	NO	
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	YES	YES	NO	NO	NO	NO	NO	NO	
	C29	REHABILITATION	YES	NO	NO	NO	NO	NO	NO	NO	
	C30	ONCOLOGY	YES	NO	YES	NO	NO	NO	NO	NO	
	C31	ONCOLOGY	YES	NO	YES	NO	NO	NO	NO	NO	
	C32	ONCOLOGY	YES	NO	YES	NO	NO	NO	NO	NO	
	C33	HAEMATOLOGY	YES	YES	YES	NO	NO	NO	NO	NO	
		TOTALS:	54	50	35	1	5	2	0	0	
		POTENTIAL TOTAL:	0	0	2	0	2	4	4	0	

APPENDIX 3

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

This document has been developed by the National Quality Board (NQB), which comprises:

Care Quality Commission
NHS England
NHS Improvement
National Institute for Health and Care Excellence
Health Education England
Public Health England
Department of Health

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Foreword

In 2013, the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put patients first.[1] Putting people first remains our collective and individual responsibility and is central to the delivery of high quality care that is safe, effective, caring and responsive.This NQB document builds on our 2013 guidance to provide an updated safe staffing improvement resource.

Key to high quality care for all is our ability to deliver services that are sustainable and well-led. In the past, quality and financial objectives have too often been regarded as being at odds with each other and therefore pursued in isolation. As set out in the Five Year Forward View,[2] it is vital that we have a single, shared goal to maintain and improve quality, to improve health outcomes, and to do this within the financial resources entrusted to the health service. This means a relentless focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles:

- **Right care:** Doing the right thing, first time, in the right setting will ensure patients get the care that is right for them, avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.
- **Minimising avoidable harm:** A relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduce costs associated with litigation.
- **Maximising the value of available resources:** Providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

As the Carter productivity and efficiency report[3] makes clear, improving **workforce efficiency** can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need, and reduced dependency on agency staff.

The development of new service models means building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings. As provider and commissioner organisations work together to develop Sustainability and Transformation Plans,[4] staffing decisions must support these new models of care.

All this represents a significant people challenge. Now more than ever we need to help staff improve and innovate, enabling new ways of working in an environment of growing demand and rapid change.

This safe staffing improvement resource can only set the context and offer support to local decision making. It is local clinical teams – and local providers and commissioners – who will ensure we continue to provide high-quality and financially sustainable services. The challenges we face are steep – but our teams have a track record of delivery when we work together and focus on putting patients first.

Policy Context

In February 2013, Sir Robert Francis QC published his final report of the inquiry into failings at Mid Staffordshire NHS Foundation Trust.[5] The report told a story of appalling suffering of many patients within a culture of secrecy and defensiveness, and highlighted a whole system failure. Compassion in practice,[6] the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, Hard truths: the journey to putting patients first,[7] led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. The National Quality Board[8] in November 2013 set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of Safe staffing for nursing in adult inpatient wards in acute hospitals[9] and Safe midwifery staffing for maternity settings.[10]

The Carter report[11] and the NHS Five Year Forward View planning guidance[12] make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Jim Mackey, Chief Executive of NHS Improvement, and Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, stated in a letter to trusts[13] that provider leaders have to deliver the right quality outcomes within available resources. They reiterated their joint commitment to working together on a single national regulatory framework for this purpose.

Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value[14]. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 Shape of caring report[15] recommended changes to education, training and career structures for registered nurses and care staff. We need to continue this work and identify both nationally and locally how we maximise the capabilities and contribution of healthcare assistants/ support workers/nursing associates[16] to meet patient needs and provide fulfilling job roles and career pathways.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the rights skills, values and behaviours in sufficient numbers and in the right locations. This updated NQB safe staffing improvement resource provides advice and support to help NHS providers and commissioners as they go about this vital task.

About this document

The National Quality Board's 2013 guidance, 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*[17] focused on supporting NHS provider boards to achieve safe nursing and midwifery care staffing. If we are to achieve the Five Year Forward View's ambitions,[18 19] the principles contained in this guidance now need to apply to nursing and midwifery staff and the broader multiprofessional workforce in a range of care settings, and do so in a way that optimises productivity and efficiency while maintaining the focus on improving quality.

This document includes an updated set of NQB expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource. In preparing this document we spent time talking with and listening to directors of nursing and chief nurses (in both provider and commissioner organisations) and to other key stakeholders, at local meetings, national events and via correspondence, to understand the impact of the previous safe staffing improvement resource, and to share ideas and early drafts of this document. This engagement and the feedback received were important for testing and ensuring that this updated document continues to provide a helpful framework for NHS provider boards when they are reviewing staffing and making decisions.

The Carter report[20] identified that one of the obstacles to eliminating unwarranted variation in the deployment of nursing and healthcare support workers has been the absence of a single means of recording and reporting how staff are deployed. From May 2016, CHPPD is the principal measure of nursing, midwifery and healthcare support worker deployment. This data collection is an important first step in the journey to providing a single, consistent metric for NHS providers to record and report all staffing deployment.

Another Carter recommendation was to develop a model hospital so trusts can learn what 'good' looks like from other trusts and adopt their best practice. Through the work on the model hospital, NHS Improvement is developing tools including a live model hospital dashboard that collects and presents patient outcome measures and staffing information in a standardised way.

In Sections 1, 2 and 3, we have updated the 2013 NQB guidance by bringing it together with the Carter report's findings, to set out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.

In Section 3, we identify three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They 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. Appendix 1 shows measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that people are receiving in acute inpatient wards.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Publishing this updated NQB safe staffing improvement resource is the first step in a journey to developing other resources that will support NHS provider trusts with making staffing decisions that will deliver safe, effective, caring, responsive and well-led care.

NHS Improvement is also coordinating work to develop safe staffing improvement resources for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, children's services, maternity services, and community services. The core principles underpinning this work are: to identify and review the best available evidence on safe, sustainable staffing; to be multi-disciplinary in approach to staffing; to be outcomes focused; to complete an economic impact assessment on any proposed safe staffing improvement resource; and to develop these staffing resources with the appropriate experts, focus groups and other key stakeholder groups, including patients, families and carers. NHS Improvement will begin to release these improvement resources later in 2016/17, with approval from the NQB.

As this safe staffing improvement resource is implemented and used by NHS provider boards, clinicians and frontline managers, through their feedback and engagement, we will review and evaluate the impact of this resource over the next year to 18 months, to inform plans for future publications.

Section 1: Safe, sustainable and productive staffing: measurement and improvement

Patient outcomes, people productivity and financial sustainability

Providing high quality care to all patients means that NHS organisations and health economies must use their available resources in the most efficient way possible for the benefit of their community. There should be individual and collective responsibility as an NHS provider board for deploying staff in ways that ensure safe, sustainable and productive services. There should be clear lines of accountability for all professional staff groups. There should be collaborative decisionmaking between clinical and managerial staff, reporting to boards. NHS provider boards should have a proactive approach to reporting, investigating and acting on incidents and to driving continuous improvement.

NHS provider boards will need to collaborate across their local health and care system, with commissioners and other providers, to ensure delivery of the best possible care and value for patients and the public. This may require NHS provider boards to make difficult decisions about resourcing as local Sustainability and Transformation Plans are developed and agreed.

In this context, it is critical that boards review workforce metrics, indicators of quality and outcomes, and measures of productivity on a monthly basis – as a whole and not in isolation from each other – and that there is evidence of continuous improvements across all of these areas.

To help optimise allocation of workforce resources and improve outcomes, NHS provider boards should implement in full the Carter recommendations, together with the findings from the model hospital and its equivalents for other care settings. This includes:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, including the use of nationally agreed quality metrics that will be published at provider level
- developing metrics that measure patient outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and the views of NHS experts, taking account of any underlying differences
- reducing wasted time by supporting and engaging staff in using their time in the best way possible to provide direct or relevant care or care support

- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers.

Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability create risks for quality, commissioners work in partnership with providers and consider how best to bring about improvements. Quality Surveillance Groups provide an opportunity for commissioners and local partners to work together to identify any risks to quality and safe staffing and coordinate actions to drive improvement.

NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources. While boards will use published national metrics to support the discharge of those responsibilities, more timely and more detailed local sources of data and information are typically available for local monitoring and improvement. Boards should use this local quality monitoring to support their judgements and decisions about safe staffing. While staffing capacity and capability are vital to all aspects of quality, they are particularly likely to affect specific quality indicators or measures. The NQB has developed recommendations for local providers to consider when monitoring the impact of staffing on quality: see Appendix 1.

Reporting, investigating and acting on incidents

High quality care produces excellent outcomes for patients, and is safe, effective, caring, responsive and well led. NHS providers should follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis[21] for serious incidents.[22] As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance,[23] [24] and any other incident where a patient was or could have been harmed,[25] as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication)[26] clinical audits[27] or locally agreed monitoring information, such as delays or omissions of planned care.

NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

Staff in all care settings should be aware that they have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk.[28] Policies[29] should be in place supporting staff who raise concerns as and when they arise.

All NHS providers should have an identified Freedom to Speak Up guardian and should be able to demonstrate commitment to the principles in the Freedom to Speak Up Review of February 2015[30].

NHS providers should adhere to Duty of Candour requirements,[31] which require them to publish an annual declaration of their commitment to telling patients if something has gone wrong with their care and have support staff to deliver this commitment.

Boards should ensure that they support and enable their executive team to take decisive action when necessary. Commissioners, regulators and other stakeholders should be involved in

considering any decision to close a care environment, or suspend services due to concerns about safe staffing, and identifying alternative arrangements for patients should be a priority.

Patient, staff and carer feedback

NHS providers need a co-ordinated approach and the right leadership skills in place to drive continuous improvements in patient outcomes and productivity. They should do this by developing the appropriate culture and behaviours, where staff and teams are engaged in developing their organisations and they are supported, respected and valued.[32]

Boards must ensure that their organisations foster a culture of professionalism and responsiveness in healthcare professionals,[33] so that staff feel able to use their professional judgement to raise concerns and make suggestions for change that improves care. This includes ensuring the organisation has policies to support clinical staff to uphold professional codes of practice.

NHS providers should proactively seek the views of patients, carers and staff and the board should routinely consider any feedback relevant to staffing capacity, capability and morale, such as national and local surveys, stories, complaints and compliments.

As the Carter report says, good staff engagement and robust local policies and procedures should be in place to tackle bullying and harassment, and to address variation in sickness absence and staff turnover.

NHS providers should have a strong staff engagement plan, which routinely monitors the impact of their policies, demonstrates an understanding of the links between staff experience, patient experience and outcomes, and which supports staff retention, as documented by available research.[34 35]

Staff should work in well-structured teams. They should be engaged, enabled to practice effectively and able to make changes to delivery of care to improve quality and productivity.[36]

When an establishment review has taken place within an organisation, the board should ensure it considers feedback from frontline staff as part of its assurance activities.

Section 2: Care hours per patient day (CHPPD)

CHPPD for nurse staffing in acute inpatients

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. Over time, this will allow trusts to review the deployment of staff within a specialty and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

The introduction of CHPPD for nurse and healthcare support staffing in the inpatient/acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as allied health professionals (AHPs).

As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses, clinical matrons and hospital managers make safe, efficient and effective decisions about staff deployment: see Appendix 1.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and **split by registered nurses and healthcare support workers** to provide a complete picture of care and skill mix.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

During the pilot, data sets were used from 25 acute trusts, representing a variety of acute trust types from across England, testing a variety of local data collection methods to collate actual hours worked by registered nurses and support staff.

The pilot supported the future use of CHPPD at a national level by:

- developing consistent 'rules' for capturing data (eg whether or not to include senior supervisory sisters/charge nurses)
- considering how in future to capture important contextual factors that affect nurse workload (eg whether a ward has high or low levels of housekeeping and ward clerk support, percentage single rooms)

- undertaking in-depth reviews to understand the impact of acuity and dependency
- exploring the challenges of collecting accurate data on patient hours/days for the CHPPD metric denominator
- reviewing international best practice where nursing hours per patient day (NHPPD) are used, including Western Australia, New Zealand and South Africa.[37]

In testing the CHPPD data collection with 27 trusts before implementation in May 2016, it was found that, although collecting patient count at midnight did not capture all the activity on ward areas, it was the least burdensome on trusts and ensures consistency in the data for comparison. As NHS Improvement develops the CHPPD metric further with NHS providers, it will continue to review and refine ways of reflecting activity throughout the day.

NHS Improvement will be working with NHS providers to develop and inform the 2016/17 implementation plan for CHPPD. The programme's initial focus will be to assess and evaluate the acute inpatient data collection for nurse staffing by October 2016 to inform the next phase of implementation. In parallel, NHS Improvement will engage with providers to scope the development of the CHPPD metric for other care settings and consider application for other healthcare professionals, such as AHPs.

A robust process for review and evaluation will underpin NHS Improvement's programme to assure the validity of CHPPD and its impact in supporting frontline decisions about staff deployment, as well as to inform future plans.

Section 3: Updated NQB expectations

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

Expectation 1: Right staff

Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.

Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.

Boards should ensure:

1.1 Evidence-based workforce planning

- The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).
- The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.
- Workforce plans contain sufficient provision for planned and unplanned leave, eg sickness, parental leave, annual leave, training and supervision requirements.

1.2 Professional judgement

- Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.
- Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.

1.3 Compare staffing with peers

- The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.
- The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.
- The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: eg for acute inpatients, the model hospital dashboard will include CHPPD.

Expectation 2: Right skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

Boards should ensure:

2.1 Mandatory training, development and education

- Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.[38]
- Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.[39]
- Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.
- The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.[40]
- The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.
- The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.
- The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

2.2 Working as a multiprofessional team

- The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.
- The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.[41]
- The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

2.3 Recruitment and retention

- The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap[42] demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.
- The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.
- In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development[43]

Expectation 3: Right place and time

Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

Boards should ensure:

3.1 Productive working and eliminating waste

- The organisation uses 'lean' working principles, such as the productive ward,[44] as a way of eliminating waste.
- The organisation designs pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queueing.
- Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.
- The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.
- The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.[45]
- Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.

3.2 Efficient deployment and flexibility

- Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.
- Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.
- Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.

- Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.
- Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers[46] and the Carter Review Rostering Good Practice Guidance (2016).

3.3 Efficient employment, minimising agency use

- The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.[47]
- The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.[48]
- The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP)[49], the place-based, multi-year plan built around the needs of the local population.
- The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.
- The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.

Appendix 1

NQB recommendations for wider measures to monitor the impact of staffing on quality

The definitive judgement of a provider's quality is its CQC inspection rating. Alongside this, a range of metrics relevant to aspects of patient safety, clinical effectiveness and patient experience are suitable for both regulatory and public use, either to compare aspects of a provider's quality with other providers, or to measure changes in aspects of quality over time. All NQB partners are committed to ensuring metrics used for regulation and performance management are increasingly aligned into a 'single version of the truth' to reduce burden and ensure effective commissioning and provider oversight.

Here we offer guidance for local providers on using other measures of quality, alongside care hours per patient day (CHPPD), to understand how staff capacity may affect the quality of care. It is important to remember that CHPPD should not be viewed in isolation and, even alongside this suggested suite of measures, does not give a complete view of quality.

The suggested measures draw on data sources in most or all providers without additional collection, are likely to be already in use locally, and provide up-to-date information. The suggested indicators in this Appendix are best considered as 'balancing measures' where the impact of any changes in workforce capacity may become visible. They are not intended to include all aspects of quality; other quality indicators will be needed to provide a rounded view of the overall quality in a care setting and the wider systems and structures that support the delivery of care.

Given that the initial rollout of CHPPD is in acute inpatient settings, the examples and suggestions for other measures of how staffing capacity affects quality have been selected as particularly relevant to acute hospitals, but have been organised in a framework that could be applied to any setting. Even within acute hospitals these suggestions can and should be locally adapted: for example, specialist areas such as maternity units will need tailored metrics; providers with sophisticated data systems will have more options available to them; and specialist providers may have to develop monitoring more relevant to their specialties. Although initial collection of CHPPD relates to nursing staff, healthcare requires a multidisciplinary team approach, and the suggested list of quality indicators to use alongside CHPPD relates to a range of staff groups.

It is vital that boards read and hear staff and patient voices and the findings of incident and serious incident investigations alongside the suggested list of quality indicators so that the nature and causes of any issues can be rapidly identified and acted on.

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	Example indicators *Italics = published indicator*	Existing local sources
Patient and carer feedback	Patient and carer feedback provides insight into the quality of their own care, and often extends into observations of the wider care environment and staff capacity	*Friends and Family Test (inpatient and maternity)* *National patient surveys overall rating of care and questions related to staff capacity*	Local patient FFT data[50] submitted to UNIFY (published monthly but earlier data available to providers) National patient surveys[51] Local complaints and compliments data
Staff feedback	Staff feedback provides insight into their own and their colleagues' capacity, capability and morale, and of their perception of the quality of care	*Staff Friends and Family Test (place to be treated/place to work)* *National staff surveys (place to be treated/ place to work and questions related to workload)* GMC trainee survey *(questions related to workload)*	Local staff FFT data[52] submitted to UNIFY (published monthly but earlier data available to providers) National staff surveys[53] Annual GMC trainee survey[54] Local staff 'barometers' or feedback routes Local incident reports of lack of sufficient staff numbers, capacity or skills[55]
Access to care	While staffing capacity will never be the sole factor, lack of staff capacity will affect access to care; for example, operations will be cancelled if any key staff in theatre or ward are unavailable	Cancelled elective operations – proportion of last minute cancellations *Those not treated within 28 days of a last minute cancellation*	UNIFY submissions (published quarterly but earlier data available to providers)
Completion of key clinical processes	Clinical process measures provide a very early indication of changes in the quality of care delivery, so action can be taken before outcomes are affected Processes are often the responsibility of a specific staff group, and so can help pinpoint staffing capacity issues for that group	Medication omitted for non-clinical reasons (registered nursing staff) Observations/Early Warning Scores not taken/calculated as planned (nursing staff) MRSA screening/decolonisation completion rates VTE risk assessment completion (medical staff) Mobilisation within 24 hours of surgery (AHPs) *National Clinical Audits (range of staff)*	Electronic prescribing systems Electronic patient records Electronic observation systems Pathology databases National Clinical Audits with continuous local data submission (eg Stroke Sentinel Audit) UNIFY submissions (published quarterly but earlier data available to providers) Local audits, CQuINS, process measures collected for local QI projects (eg Medication Safety Thermometer for omitted medication[56])

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	**Example indicators** *Italics = published indicator*	**Existing local sources**
Harm during healthcare	While a wide range of measures need to ensure the system of care supports staff to do the right thing, some types of harm are particularly likely to be affected by staff capacity Pressure ulcer prevention typically requires constant nursing intervention in terms of skin care and position changes, and therefore monitoring of pressure ulcers can help pinpoint staffing capacity issues for that staff group Effective inpatient falls prevention relies on identifying underlying medical causes, medication review, early mobilisation, and nursing observation. Therefore monitoring falls can help pinpoint staffing capacity issues across medical, pharmacy, AHP and nursing staff	*Pressure ulcer prevalence* Pressure ulcer incidence *Prevalence of inpatient falls* Incidence of inpatient falls	Safety Thermometer data (published monthly but earlier data available to providers) alongside local assessments of data completeness[57] Local incident data on falls and pressure ulcers and subsequent investigations alongside local assessments of data completeness[58] *'Occurred in this trust'* field in National Hip Fracture Database Local data on post-admission transfers to orthopaedics as potential indicator of serious injury from falls

Notes on indicator presentation

This guidance cannot encompass detailed advice on how local quality monitoring is presented, but it is important local presentations help leaders and boards see where changes are significant rather than likely to be due to chance or anticipated seasonal patterns, including the use of appropriate denominators. In the best trusts, wards, leaders and the board use statistical process control techniques both to understand change and identify sustained improvement, rather than just looking at the month-to-month change.

Additional areas important for monitoring

Investigation and learning from patient safety incident and serious incident data

As set out in Section 1 of this document, *"Best practice guidance should be followed in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified".* Summarising these findings is a vital part of contextualising any quantitative data used for quality monitoring.

Workforce metrics that provide a window on staff capacity

While this Appendix on quality monitoring does not encompass wider workforce metrics (these will be developed as part of the NHS Improvement work on the model hospital) provider boards may wish to consider the wider quality implications of some workforce metrics. For example, staff turnover and staff sickness rates, particularly stress-related absences, can be an indicator of workload pressures. An additional example is completion of mandatory training; this is a direct measure of training completion, but as staff capacity issues can lead to cancellations of mandatory training, it can also act as a proxy indicator for workload pressures.

Workload metrics that provide context to CHPPD

As set out in Section 3, Expectation 1.3 *"the organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency."*

Selection criteria for wider measures to help monitor the impact of staffing on quality

Healthcare is delivered by people; there is arguably no aspect of healthcare quality that staff capacity and capability will not affect. But in suggesting metrics to accompany CHPPD, selections have to be based on those areas of quality where changes in staff capacity are most likely to have a visible impact. This means any suggested areas:

- need to have very recent data available to providers or act as a periodic more robust source to compare with more frequently collected local data
- need to have a rationale where it is plausible or is shown that staff capacity is the major, or one of the major, factors affecting the metric (including a rationale for whether capacity of all staff groups or specific staff groups would be expected to have an impact)
- need adequate numbers (statistical power) if any true improvement or deterioration is to be distinguishable from random variation within a reasonable period in a typically sized provider
- if used to compare providers, have to be confirmed as appropriate for that purpose (ie not affected more by patient characteristics, differences in data collection, etc than by differences in actual quality)
- if used for a provider to compare against its own baselines, need to have stable data collection and completeness, and may need adjustment for seasonal factors (eg comparing against equivalent seasonal period, not past quarter, etc.)

Appendix 2

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Staff to patient rates/ ratios	Care hours per patient day (CHPPD) reported as total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix	CHPPD is a unit of measurement that can be applied to any aspect of staffing, registered staff and/or whole care team. The Carter Report defines CHPPD as registered nurse hours plus healthcare support staff hours in a 24-hour period, divided by number patients at midnight (as a proxy for 24 hours of a patient stay). The concept of CHPPD can be adapted to all other staff groups with time allocated to wards or units: for example, physiotherapy hours per patient day, occupational therapy hours per patient day, etc.
	Nursing hours per patient day (NHPPD)	NHPPD is a unit of measurement used in inpatient settings internationally. It is able to summarise variations in numbers of staff and numbers of patients over the course of a 24-hour period. It typically refers to the number of registered nursing hours available per patient.
Patient to staff rates/ ratios	x patients per registered nurse x service users on caseload x women per midwife per year one-to-one observation	Typically used as a 'snapshot' of current responsibilities or as an average of responsibilities over a longer period. Actual numbers of staff and of patients/women/ service users will tend to vary over the course of a day in inpatient settings and over days/ weeks in community settings.
Registered to unregistered staff rates/ ratios	xx% of team are registered nurses xx% of team are midwives x:y ratio of registered nurses/ healthcare assistants	Difficult to interpret in isolation from other units of measurement, as a higher percentage/ ratio can be achieved by reducing healthcare assistants or by increasing registered nursing staff, but does give an indication of staff that will require supervision by registered nurses/midwives, in addition to their direct responsibilities.

Units of staffing measurement		
Type of measure	**Examples**	**How these can be used**
Whole-time equivalents (WTE)	Ward/unit/team has xx WTE in post Ward/unit/team is funded for xx WTE	Provides a unit of measurement that overcomes local differences in the proportion of staff who work part-time, converting all part-time contracts into their whole-time equivalent, *eg two staff working 30 hours per week plus one staff member working 15 hours is the equivalent of two staff working 37.5 hours per week, therefore 2.0 WTE*
Head count	Ward/unit/team headcount is xx registered nurses xx healthcare assistants x physiotherapists x occupational therapists	Provides a unit of measurement that is important when counting activity every employed staff member has to undertake, regardless of how many hours they work, *eg mandatory training.*
Fill rates	The ward/unit/team had xx% of planned staff overall The ward/unit/team had xx% of planned registered nurse/ midwifery staffing The ward/unit/team had xx% of required staff overall The ward/unit/team had xx% of required registered nurse/ midwifery staffing	This was previously calculated by dividing actual staff by planned or required staff and multiplying by 100 to convert to a percentage. Difficult to interpret in isolation from other units of measurement, as previous plans may not reflect patient acuity/dependency on the day, and the percentage total cannot distinguish between 'aiming high but delivering less' and 'aiming low and delivering even lower.' Where registered nursing/midwifery staffing gaps are covered by a higher number of healthcare assistants, or where fluctuating numbers of staff are required for special observation, overall fill rates become even more difficult to interpret.
Headroom/ uplift	xx% uplift xx% headroom	Building in capacity to deal with planned and unplanned but predictable variations in staff available, such as annual leave, maternity and paternity leave, compassionate leave, jury service, sickness and study leave. If the headroom/uplift allowance is lower than actual requirements this can lead to greater use of temporary/agency staff.
Note: for all units of staffing measurement, creating averages over days, weeks or months can potentially be misleading: a ward/unit/team that fluctuates markedly between too few or too many staff to meet patients' needs on different days of the week, or from week to week, will not be able to deliver the same quality of care as a ward/unit/team where staffing is more consistent.		

Appendix 3

Methods of workforce planning		
Type of workforce tool	Summary	Examples
Acuity/ dependency models	Using a decision matrix, patients are categorised according to their requirements into levels of care with associated evidence-based staffing multipliers derived from wards delivering good quality care. In this way, it discriminates between patients with differing needs. Some models also factor in additional workload demands such as patient turnover.	Safer nursing care tool for adults, inpatient wards, acute admissions units, children and young people wards: http://shelfordgroup.org/library/documents/Shelford_Group_Safety_Care_Nursing_Tool.pdf Mental health and learning disability tools: https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability
The professional judgment model	Based on clinical staff views of the number of staff required for the usual patient casemix and usual activity on a particular ward/unit/ team (or in high dependency environments, the number of staff required for a typical patient)	Telford method http://www.who.int/hrh/documents/hurst_mainreport.pdf
Activity Monitoring tools	Uses care plans/care pathways and related nursing time. Data are collected based on the tasks undertaken/assigned to nurses, providing insights into the needs of and intelligence to inform decisions about staffing numbers, staff deployment, models of care, and skill mix.	Birthrate plus http://www.birthrateplus.co.uk/

Appendix 4

Key existing evidence-based guidance for nursing and midwifery staffing			
Title	Summary	Link	Year
Strengthening the commitment; the Report of the UK Learning Disabilities Nursing Review	A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK, published in 2012, made recommendations related to workforce planning	http://www.scotland.gov.uk/Resource/0039/00391946.pdf	2012
Safe staffing for nursing in adult inpatient wards in acute hospitals	NICE inpatient guidelines	www.nice.org.uk/guidance/sg1	2014
Safe midwifery staffing for maternity settings	NICE maternity guidelines	www.nice.org.uk/guidance/ng4	2015
Mental health staffing framework: a practical approach	Mental health toolkit	https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf	2015

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[1] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf *How to ensure the right people, with the right skills, are in the right place at the right time*

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[4] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

[5] http://webarchive.nationalarchives.gov.uk/content/20150407084003/http:/www.midstaffspublicinquiry.com

[6] https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

[8] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[9] https://www.nice.org.uk/guidance/sg1

[10] https://www.nice.org.uk/guidance/ng4

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[12] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

[13] 15 January 2016. Available at: http://www.cqc.org.uk/sites/default/files/20160115_letter_nhstrusts_quality_and_finances.pdf

[14] https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

[15] https://hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

[16] http://www.healthwatchcambridgeshire.co.uk/sites/default/files/hee_nursing_associate_consultation_document.pdf

[17] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[18] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[19] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf

[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[21] https://www.england.nhs.uk/patientsafety/root-cause

[22] https://www.england.nhs.uk/patientsafety/serious-incident

[23] http://www.nice.org.uk/guidance/SG1

[24] https://www.nice.org.uk/guidance/ng4

[25] https://www.england.nhs.uk/patientsafety/report-patient-safety

[26] https://www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=3&Itemid=10

[27] http://www.hqip.org.uk/national-programmes

[28] http://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp; http://www.hpc-uk.org/registrants/raisingconcerns/howto

[29] http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing

[30] https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[31] http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

[32] https://www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care

[33] http://www.hpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf

[34] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[35] http://qualitysafety.bmj.com/content/early/2013/07/08/bmjqs-2012-001767

[36] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

[37] http://ro.ecu.edu.au/cgi/viewcontent.cgi?article=7278&context=ecuworks

[38] Health Education England is developing a set of e-learning modules on safe staffing for sisters, charge nurses and team leaders that will be published in 2016.

[39] https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf

[40] https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf

[41] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf http://www.ncbi.nlm.nih.gov/books/NBK269522

[42] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf

[43] http://www.nhsemployers.org/~/media/Employers/Documents/Plan/Mind%20the%20Gap%20Smaller.pdf

[44] http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

[45] Further support and guidance will be issued at a future date.

[46] http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering

[47] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478691/Agency_letter_to_trusts_post_consultation_final.pdf

[48] https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

[49] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp

[50] Local patient FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness, but cannot be used to compare providers with each other, as data collection will vary.

[51] National patient surveys can be used to compare providers with each other, so even though they are only published annually, they provide important context for local FFT data. National patient surveys include questions on patients' perceptions of sufficient staffing and questions that act as indicators of staff capacity.

[52] Local staff FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary.

[53] National staff surveys can be used to compare providers with each other, so though they are only published annually, they provide important context for local staff FFT data. National staff surveys include questions directly asking about staff perception of sufficient staffing, or that act as indicators of staff capacity.

[54] The annual GMC national training survey collects medical trainee feedback on a wide range of topics and pivotal issues, such as intensity of work (by day and night), work beyond rostered hours, an expectation to cope with clinical problems beyond the trainee's competence or experience and the ability to attend regular specialty-specific training.

[55] Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and serious incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (http://www.sciencedirect.com/science/article/pii/S0965206X15000935) and case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.

[56] These local sources can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes.

[57] Safety Thermometer data can be used to measure change over time where providers have local insight into any changes in data collection and completeness (eg annual skin surveys http://www.sciencedirect.com/science/article/pii/S0965206X15000935 but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes (eg age-related risk of falling).

[58] Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and Serious Incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (see above), case note review and the FallSafe under-reporting survey (see https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original) for inpatient falls.

TRUST BOARD REPORT – 2016 – 7 - 11	
Meeting date:	28 July 2016
Title:	Performance Report
Presented by:	Ellen Ryabov – Chief Operating Officer
Author:	Ellen Ryabov – Chief Operating Officer
Purpose:	The purpose of the report is to inform the Board of performance relating to the 'responsiveness' standards
Recommendation(s):	The Trust Board is asked to note the contents of the report.

PERFORMANCE REPORT 2016/17

Report Month:	July 2016
Data Month:	June 2016

Great Staff - Great Care - Great Future

PERFORMANCE REPORT

RESPONSIVENESS EXCEPTION REPORT
JULY 2016

1 Executive Summary

The Performance Report for June details the following 'responsiveness' indicators (May for cancer standards) which have failed to meet the required standard:-

- The 95% 4-hour Emergency Care Standard;
- The Breast Symptomatic Two Week Wait Standard;
- The 31 day Decision to Treat (DTT) for subsequent surgery standard;
- The 62 day Referral to Treatment Cancer Standard;
- The 3 RTT standards – Admitted, Non-Admitted and Incomplete, the Trust is still required to submit performance again the admitted and non-admitted standards albeit that only the Incomplete standard is a national reporting requirement;
- 52 week breach standard

All Health Groups have been asked to outline the reasons for failure of each of the above standards, outlining the agreed actions required to address underperformance against each standard, to identify and agree a timeline for recovery of performance at the required level.

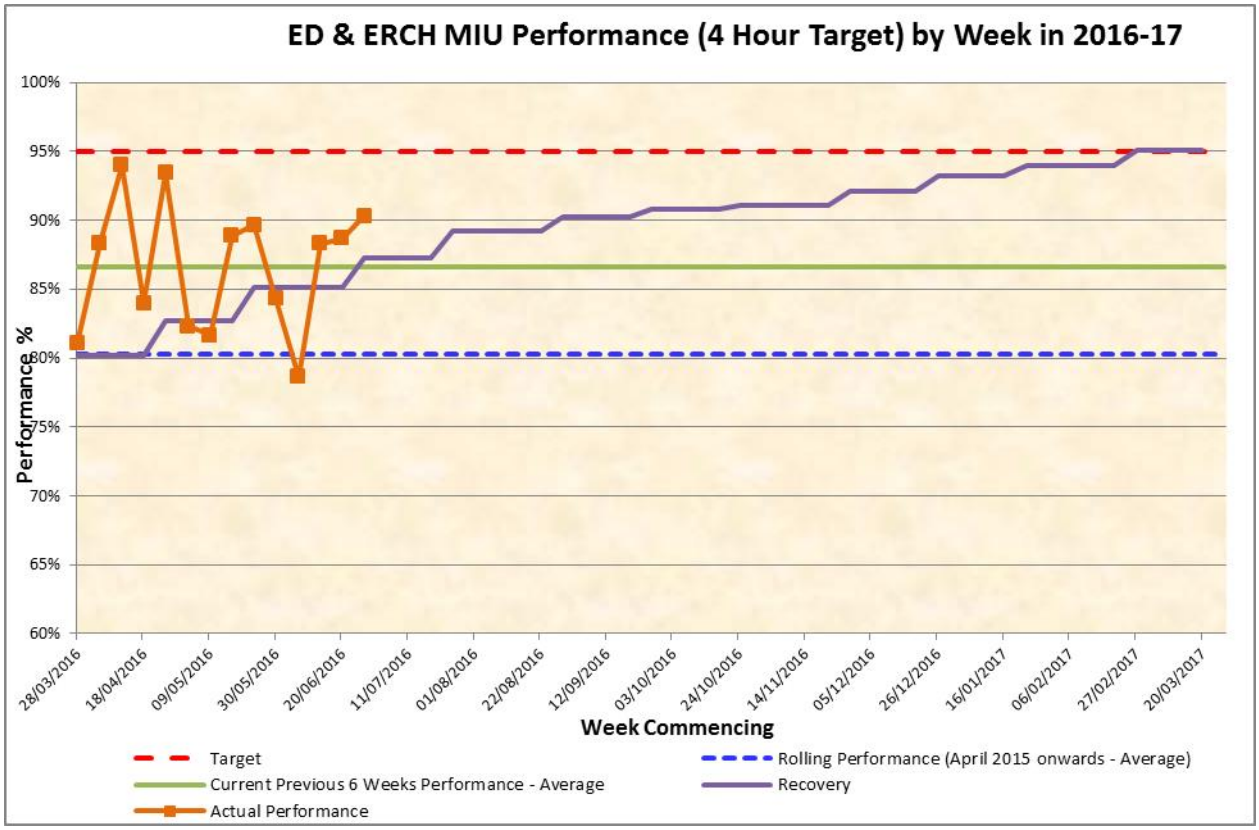
Exception Reporting Template

Target Reporting Upon	Breach Reported Month
Emergency Department 4 Hour Performance	**June 2016**

Month Performance	Benchmark Position/Trust Ranking
85.87%	

Variance from Target/Trajectory	Target/Recovery Trajectory
0.77%	**85.1%**

Reason/Cause of Breach



Overall 4-hour performance was above the planned trajectory for June, repeating the positions of April and May so we have now seen achievement of our plan for three consecutive months.

Analysis of breach causes of the 4 hour standard for the calendar month of June are identified in Table 1 below:

Table 1: Breach Causes by Departure Week

	Week Commencing							
Breach Causes	**30/05/2016**	**06/06/2016**	**13/06/2016**	**20/06/2016**	**27/06/2016**	**Week Total**	**Daily Average**	**% of Breach Causes**
A and E Triage	0	0	0	1	0	**1**	**0.0**	**0.1%**

Awaiting Bed	161	246	123	101	24	**655**	**21.8**	**37.0%**
Awaiting Mental Health Review	5	8	8	16	5	**42**	**1.4**	**2.4%**
Awaiting Transport	5	20	11	10	2	**48**	**1.6**	**2.7%**
Clinical	13	27	28	17	14	**99**	**3.3**	**5.6%**
Wait for First Clinician	92	228	80	108	48	**556**	**18.5**	**31.4%**
Waiting for Diagnostics	26	56	43	31	11	**167**	**5.6**	**9.4%**
Waiting for Specialist Opinion	24	34	29	38	12	**137**	**4.6**	**7.7%**
Other / No Cause given	10	18	13	13	11	**65**	**2.2**	**3.7%**
Grand Total	**336**	**637**	**335**	**335**	**127**	**1770**	**59.0**	

Actions Taken

As indicated by the information presented in Table 1 the five predominant breach causes are recorded as follows :

Awaiting Bed 37% (May 29.5%)

The Trust saw deterioration in performance in June compared to 29.5% in May 2016.
The Trust remains in Strategic Command status, meetings are held daily with requests for representation from partner organisations should they be required. Information is obtained from all ward areas in relation to delays in transfer of care, any aspect that cannot be resolved are escalated to the Strategic meeting in order to initiate a System- wide response.

Progress to date;

This process continues and a further supportive daily Executive/Senior Leaders forum at 8am to review Trust wide performance is in place, this meeting reviews the previous 24 hours performance, undertakes a systematic examination of all breaches via a RCA process, identifying any areas of concern for the organisation (or wider system) and agreeing action required to resolve/deal with the issues in the coming day/s.

Additional senior management support has been agreed to assist out of hours to aid the achievement of the 4 hour performance target.

A plan to review the current AMU model in accordance with ECIP recommendations has commenced.
Morning and 4pm Board rounds have been established in AMU, this is led by the Acute Physicians and attendance includes the AMU Senior Nurses/ 'in reach' teams for each of the specialities, along with the junior doctors for the day. This process has been embedded within the service and has resulted in an increased discharge rate, a reduction in the LOS on the assessment area and improvements in flow much earlier in the day.

A weekly review of all patients with a length of stay greater than 7 days chaired by the COO and CNO has commenced with all Nurse Directors present. Daily DTOC meetings continue in the Discharge hub.

This is in place and continues on a daily/weekly basis, any issues from excessive delays within the Trust are being addressed with individual teams, and for those impacted by partner organisations these are being discussed at Strategic command with the relevant partner organisations.

Ongoing work continues within Medicine with all clinical teams to ensure discharge trajectories are met in conjunction with early morning discharges.

Early morning discharges are now pre-planned by the clinical teams at a 4pm ward Board round, in order to ensure the patient is ready for a timely am discharge. A piece of work has been undertaken which clearly highlights that early morning usage of the Discharge Lounge is not fully utilised, further work to be undertaken with all wards throughout the Hull Royal Infirmary site. The Discharge Lounge plans are for further estates work to be developed, which will allow greater flexibility and utilisation.

The Site Team are working closely with AMU to identify where beds are required throughout the day and then escalating directly to appropriate Specialties to ensure patient transfers are expedited as quickly as possible.

Wait for First Clinician 31.4% (May 37.5%)
The Trust saw an improved position in performance in relation to time to see first clinician, from 37.5% in May to 31.4% in June.

Progress to date;
Performance fluctuated across the month but signs are positive and consistency of delivery is being supported by the Executive and Senior Clinical/Operational leaders to ensure longer term sustainability.

The introduction of the Frailty model whereby a Senior Clinician at the 'front door' who specialises in Elderly medicine has been successfully trialled. The intention of this initiative was to reduce the high number of frail patients being admitted via the Emergency Department. Early indicators show that between 30-50% of patients will avoid admission.

In order to progress this model the service is reviewing existing space within the surrounding footprint of the Emergency Department. Initial meetings and discussions have taken place and are being progressed through the senior management team; plans are in the process of being drawn up to understand the viability of the use of the existing ED footprint and surrounding area.

A series of meetings with the senior clinical leaders have taken place, agreement has been reached on the implementation of 24 specific actions which are now incorporated in to the Urgent & Emergency Care Plan and implementation of the agreed actions continues. These actions are expected to increase the pace of delivery to improve patient flow, and to support and embed established clinical practice that has been demonstrated to deliver a sustainable emergency and urgent care service.

Recruitment of Consultant level staff is ongoing with interviews being scheduled August 2016. Alternatives such as Education Fellow posts (part clinical part academic) are being progressed. The new clinician rota has been agreed which matches capacity to demand. Although there are not currently enough substantive post-holders to fully deliver the optimal rota locums are being utilised to bridge the gaps. Recruitment of a GP to support the Integrated Emergency Care model is ongoing with interviews planned August 2016.

Wait for Diagnostics 9.4% (May 8.5%)
There is a recognised need for a robust feed-back loop in relation to breaches which occur as a result of waits for diagnostics. This is now incorporated into the Tuesday Emergency Department Performance meeting.

Progress to date;
The main concern is around CT and MRI turnaround times and therefore the pathways for this diagnostically dependent group of patients are being reviewed. Breach analysis is being undertaken in conjunction with the diagnostic specialities to determine bottlenecks and any associated issue preventing seamless timely processes.

Wait for Specialist Opinion 7.7% (May 9.6%)
There is a recognised need for a robust feed-back loop in relation to breaches which occur as a result of waits for specialist opinion. An escalation process for specialist review is now in place with an agreed 30 mins from referral for a speciality opinion.

Progress to date;
Specialist review continues to be challenging. Daily Executive/Senior Leaders forum at 8am are in place to review Trust wide performance, this meeting reviews the previous 24 hours performance, undertakes a systematic examination of all breaches via a RCA process, identifying any areas of concern for the organisation in relation to both measures, agreeing action with the relevant Medical Director as required to deal with any failures in the escalation process. In addition to this daily feedback is given to each speciality area to ensure that all health groups are aware of their contribution to the 4 hour performance target.

Progression towards a Surgical Assessment Unit has commenced which would support timely review of suspected surgical patients.

The Back Pain pathway is nearing completion which would streamline the patient pathway and minimise the length of time the patient is in the Emergency Department.

Clinical 5.6% (May 7.6%)
The position improved in June from 7.6% in May.

Timeline for Delivery
March 2017

SIGN OFF	
Completed by	Dawn Brannan
Operations Director Signature	
Date	15th July 2016

Hull and East Yorkshire Hospitals NHS
NHS Trust

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
Ambulance Turnaround Times	**June 2016**

Reason/Cause of Breach

The Emergency Department had 3638 ambulance arrivals with 51 % of handovers being undertaken in less than 15 minutes.
Please note – this data has not been validated

Actions Taken

Ambulance activity continues to be high, with circa 10-15% increase for Yorkshire as a whole and activity into ED up 12% in June. New ED staffing rotas are in place and are fully expected to support an improved ambulance turnaround at the entrance of A&E. In addition, the site management team will continue to support ED in ensuring adequate flow throughout the hospital, and alleviate the potential for crowding as a result of holding lodged patients in the ED, which inevitably leads to ambulance turnaround delays.

Timeline for Delivery

Ongoing as part of the Urgent and Emergency Care Improvement Plan.

SIGN OFF	
Completed by	Dawn Brannan
Operations Director Signature	Operations Director Medicine Health Group
Date	15/07/2016

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
2WW Breast Symptomatic	**May 2016**

Month Performance	Benchmark Position/Trust Ranking
92.9%	

Variance from Target/Trajectory	Target/Recovery Trajectory
-0.01%	**93%**

Reason/Cause of Breach

The Trust failed the target achieving 92.9% in month just short of the required 93% target; the analysis of the breaches overwhelmingly demonstrates that patients are choosing not to be seen within the standard time.

Further discussions with the CCGs to address lack of communication to patients within the GP arena on the requirement to be seen within two weeks continue and it is hoped that this will help reduce the number of patients who are referred but then choose not to attend within the required timeframes.

Actions Taken

The Breast Service has undertaken a detailed investigation to understand the issues; it is clear that hospital capacity issues are not preventing patients from accepting an appointment within 14 days of a referral being received by the Trust.

The Breast Service regularly provide feedback to primary care outlining specific patient details highlighting the reasons for patients not accepting appointments within target dates. The breaches can all be attributed to patient choice.

The Breast Service continues to monitor and analyse compliance with the standard/target

Timeline for Delivery

June 2016

SIGN OFF	
Completed by	Margaret Parrott
Operations Director Signature	Jonathan Wood
Date	15 July 2016

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
31 Day Subsequent Surgery	**May 2016**

Month Performance	Benchmark Position/Trust Ranking
91.4%	

Variance from Target/Trajectory	Target/Recovery Trajectory
-2.6%	**94%**

Reason/Cause of Breach

The Trust's performance reached 91.4% due to 5 patient breaches of the treatment target.

1. 3 patient breaches can be attributed to ineffective tracking and escalation to service to prevent breach.
2. 1 patient experienced a delay due to a lack of capacity to treat within target date due to Consultant annual leave commitments.
3. 1 patient breach was due to a late referral from other organisation leaving the Trust insufficient time to plan and treat within target date.

Actions Taken

1. Tracking and escalation errors have been corrected; staff made fully aware of the requirement to escalate to service as soon as 'any' patient is 'off track' to allow the service to manage the pathway wherever possible to avoid unnecessary delays.
2. Discussion with service in relation to 'pooling' cases wherever possible to cover absences to ensure patients' treatment is not delayed.
3. Late referral – RCA will be reviewed with referring Trust to ascertain the reason for late referral to Hull and East Yorkshire Hospitals NHS Trust for treatment.

Timeline for Delivery

June 2016

SIGN OFF	
Completed by	Margaret Parrott
Operations Director Signature	Jonathan Wood
Date	15 July 2016

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
62 Day Referral to Treatment	**May 2016**

Month Performance	Benchmark Position/Trust Ranking
80.1% (Open Exeter) 85.5% (adjusted)	

Variance from Target/Trajectory	Target/Recovery Trajectory
+4.7%	**80.8%**

Reason/Cause of Breach

The Trust's STP trajectory was 80.8% with a final Open Exeter performance of 80.1%. Although it appears that the organisation has failed to meet its commitment it must be noted that the *actual* performance for the Trust was 85.5% post late referral breach allocation to other organisations.

The cause of the Trust's failure to meet the STP trajectory was as a result of 16 late referral for treatment from referring organisations

Actions Taken

Trust Lead Cancer Manager continues to work closely with Cancer Manager's from referring organisations to share Root Cause Analysis outcomes to establish delays in the pathway

Timeline for Delivery

September 2016

SIGN OFF	
Completed by	Margaret Parrott
Operations Director Signature	Jonathan Wood
Date	15 July 2016

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
18 week RTT	**June 2016**

Month Performance	Benchmark Position/Trust Ranking
87.04%	

Variance from Target/Trajectory	Target/Recovery Trajectory
+1.34%	**85.7%**

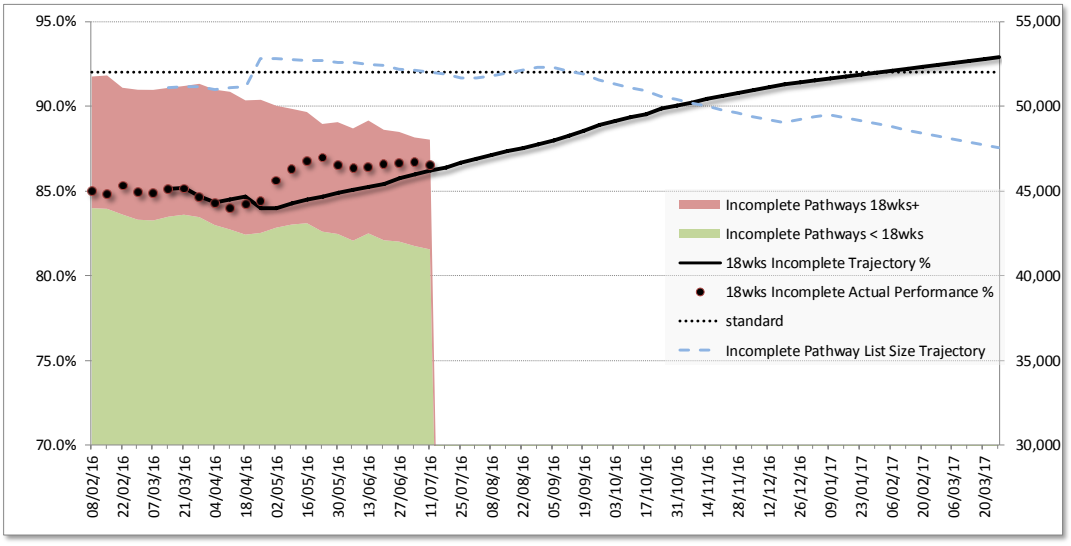
Reason/Cause of Breach

June 2016 performance reached 87.01%; this is above our planned trajectory of 85.7% and replicates the above performance achievement seen in April and May.

The Health Groups have maintained achievement of the targets and identified specific actions within specialties to improve performance. The Health Groups monitor and report performance through the Performance and Access meetings weekly. The main areas of concern are:

- ICU capacity for emergency care affecting elective capacity
- Over referral into the pain service due to scaling back of community services in other Trust
- Day case capacity in colorectal surgery
- Capacity in operational management – a number of vacancies and span of responsibility with competing priorities.
- Waiting times for first outpatient appointments
- Lorenzo system training and error reduction

Table shows current performance against trajectory.



Actions Taken
The Trust continues to work to reduce the overall waiting list. The actions taken, particularly in surgery is to: • increase capacity through agreement with clinicians on activity levels and actions to reduce day case waiting time • discussions with CCGs on referrals to the Pain Management service following community provision changes and increased outpatient capacity • validation to catch up on long waiters and duplicate entry Lorenzo issues. Capacity and Demand is being modelling using the Intensive Support Team modelling tool to establish baselines and match capacity going forward.

Timeline for Delivery
January 2017

SIGN OFF	
Completed by	Peter Watson
Operations Director Signature	
Date	18 July 2016

Exception Reporting Template

Target Reporting Upon	Breach Reported Month
52 week breaches	**June 2016**

Month Performance	Benchmark Position/Trust Ranking
2 breaches	

Variance from Target/Trajectory	Target/Recovery Trajectory
-1 breach	**3 breaches**

Reason/Cause of Breach

Trauma and orthopaedics had 1 breach due to a late identification of data error, and then the patient chose to delay treatment until after his holidays. Capacity was available to treat before 52 weeks if the patient was available.

Upper Gastrointestinal surgery had 1 breach due to a late identification of data error, and then the patient chose to delay treatment until after his holidays. Capacity was available to treat before 52 weeks if the patient was available.

Actions Taken

The Division and Trust continue to monitor performance and observe for data errors and reserve capacity to deal with these cases. A training programme is underway and individuals identified with errors are trained and monitored.

There remains a risk due to the previous period errors which emerge when the new activity with individual patients triggers a clock review in Lorenzo. The Surgery Health group is establishing a Lorenzo User Group to improve compliance with Lorenzo and waiting time rules.

Health Groups are tasked with bringing forward plans to treat all patients waiting over 36 weeks by the end of December 2016.

The Trust Performance and Activity Group meet weekly and is chaired by the Chief Operating Officer. This is the forum used to monitor compliance, ensure the organisation of remedial action and mitigate risk.

Timeline for Delivery

December 2016

SIGN OFF	
Completed by	Peter Watson
Operations Director Signature	
Date	18 July 2016

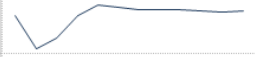
Responsiveness

Emergency Department

Indicator Description	Target	Lead Director		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Trend
A&E All Types Monthly Performance	>=95%	ER	*	72.09%	86.25%	80.88%	82.05%	80.74%	80.04%	81.37%	75.75%	77.87%	77.23%	89.38%	85.89%	85.87%	
12 hour Trolley waits	0	ER	*	0	0	0	0	0	0	0	0	0	0	0	0	0	
A&E All Types Monthly Attendance		ER		11007	11340	11436	11087	11708	11357	11639	11500	11331	12463	11550	13002	12546	
A&E All Types Monthly Attendance Contract Plan 2015-2016		ER		9810	10137	10137	9810	10137	9810	10137	10137	9483	10137	11151	11523	11151	
Ambulance turn around - number over 30 mins	0	ER		748	434	375	155	186	222	197	306	361	566	305	297	not yet published	
Ambulance turn around - number over 60 mins	0	ER		170	33	35	13	24	18	18	81	156	144	22	21	not yet published	
Delayed Transfers of Care	< 3.5%	ER	*	1.15%	1.03%	0.63%	1.07%	0.71%	0.80%	0.87%	1.75%	1.51%	1.41%	1.10%	1.03%	not yet published	

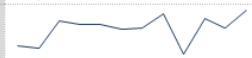
* TDA Oversight and Escalation Indicator

Cancer

Indicator Description	Target	Lead Director		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Trend
Two Week Wait Standard	>=93%	ER	*	84.00%	86.36%	85.37%	90.77%	96.54%	96.50%	96.13%	94.98%	97.97%	96.32%	95.41%	94.44%	not yet published	
Breast Symptom Two Week Wait Standard	>=93%	ER	*	88.06%	55.70%	66.46%	87.50%	98.98%	96.25%	94.04%	93.73%	94.24%	92.83%	91.73%	92.91%	not yet published	
31 Day Standard	>=96%	ER	*	97.69%	98.18%	96.72%	96.38%	97.54%	96.97%	98.54%	98.57%	97.33%	98.14%	97.84%	98.77%	not yet published	
31 Day Subsequent Drug Standard	>=98%	ER	*	98.36%	100.00%	100.00%	98.53%	100.00%	100.00%	100.00%	98.67%	96.88%	98.08%	97.73%	98.78%	not yet published	
31 Day Subsequent Radiotherapy Standard	>=94%	ER	*	98.06%	98.49%	96.18%	96.26%	97.65%	97.18%	97.93%	98.77%	98.96%	98.92%	98.33%	97.53%	not yet published	
31 Day Subsequent Surgery Standard	>=94%	ER	*	95.95%	90.91%	97.10%	93.75%	87.64%	96.83%	98.51%	88.52%	100.00%	96.10%	87.27%	91.38%	not yet published	
62 Day Standard	>=85%	ER	*	75.98%	75.96%	77.38%	77.97%	70.16%	81.02%	78.81%	77.33%	80.52%	81.23%	81.97%	80.97%	not yet published	
62 Day Screening Standard	>=90%	ER	*	87.10%	84.91%	83.33%	92.16%	82.54%	80.95%	90.14%	91.67%	87.23%	91.84%	82.14%	93.55%	not yet published	
Cancer 104 Day Waits	0	ER	*	13	9.5	6	10.5	16	7	9	7.5	10.5	7	5	5.5	not yet published	
* TDA Oversight and Escalation Indicator																	

Cancer performance data is collected nationally one month in arrears from other national standards.

Stroke & Cardiac Care

Indicator Description	Target	Lead Director		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Trend
Stroke 60 mins	30% (SSNAP)	ER	*	49.37%	41.98%	60.29%	52.86%	44.29%	58.33%	42.67%	58.33%	49.23%	50.00%	54.24%	55.56%	not yet published	
Stroke Care	>=80%	ER	*	82.93%	82.35%	89.19%	88.31%	88.10%	87.18%	87.36%	90.79%	80.77%	89.66%	87.34%	91.95%	not yet published	
ST-Elevation myocardial infarction call to primary percutaneous coronary intervention within150 minutes	>=90%	ER	*	92.68%	90.32%	93.75%	84.85%	85.71%	92.11%	86.67%	86.36%	88.46%	85.71%	not yet published	not yet published	not yet published	
* TDA Oversight and Escalation Indicator																	

Referral to Treatment (RTT) and Diagnostics

Indicator Description	Target	Lead Director		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Trend
Referral to Treatment Incomplete pathway	>=92%	ER	*	89.38%	86.49%	86.98%	87.42%	82.38%	80.22%	79.92%	85.17%	85.19%	84.59%	86.00%	87.01%	87.04%	
Referral to Treatment Incomplete numbers over 18 weeks		ER		4690	7745	8489	8829	12206	13317	11497	7746	7572	7892	6991	6376	6247	
Referral to Treatment Incomplete numbers away from 92%		ER		1157	3160	3271	3217	6665	7932	6917	3567	3481	3795	2995	2448	2390	
Referral to Treatment Incomplete 52+ Week Waiters	0	ER	*	2	3	1	2	1	3	9	3	3	1	2	2	2	
Referral to Treatment Non Admitted pathway		ER		90.07%	91.19%	91.79%	90.12%	86.04%	85.77%	82.20%	82.75%	86.99%	86.78%	86.56%	87.74%	85.25%	
Referral to Treatment Admitted pathway		ER		63.27%	67.92%	73.97%	71.66%	75.79%	75.66%	69.37%	64.34%	67.21%	63.23%	63.19%	65.70%	65.91%	
Diagnostic waiting times	<= 1%	ER	*	1.19%	0.63%	0.61%	0.31%	0.62%	0.36%	0.64%	0.67%	0.51%	1.67%	2.06%	1.08%	not yet published	
Proportion of patients not treated within 28 days of last minute cancellation	0	ER	*	8	3	1	4	0	0	1	1	0	0	1	0	0	
Urgent Operations Cancelled for 2nd time (Number)	0	ER	*	0	0	1	0	0	0	0	0	0	0	0	0	0	
% of Outpatient appointments cancelled by Hospital		ER		10.23%	10.40%	11.68%	12.29%	11.67%	11.46%	13.04%	12.04%	11.45%	12.40%	14.30%	12.50%	12.50%	

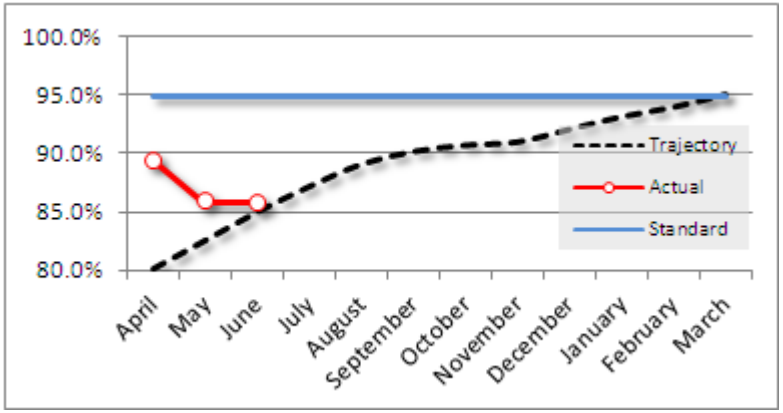
* TDA Oversight and Escalation Indicator

Sustainability and Transformation Fund Improvement Trajectories

A&E Four Hour Waiting Times

TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
attendances	11151	11523	11151	11523	11523	11151	11523	11151	11523	11523	10408	11523
breaches	2206	1999	1662	1468	1249	1088	1062	997	906	781	621	562
% performance	80.2%	82.7%	85.1%	87.3%	89.2%	90.2%	90.8%	91.1%	92.1%	93.2%	94.0%	95.1%

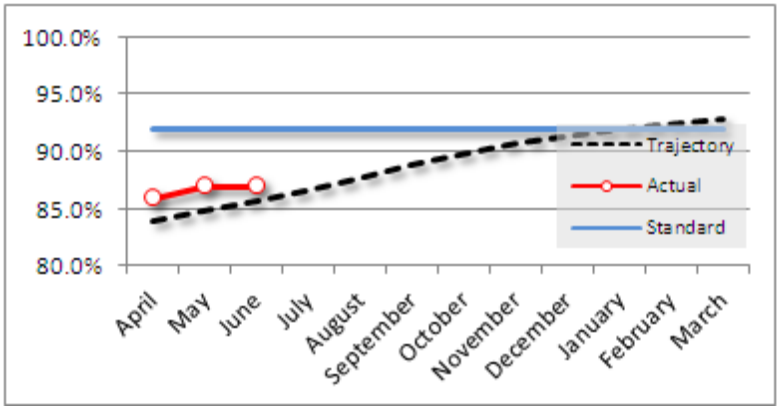
ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
attendances	11550	13002	12546									
breaches	1227	1835	1773									
% performance	89.4%	85.9%	85.9%									

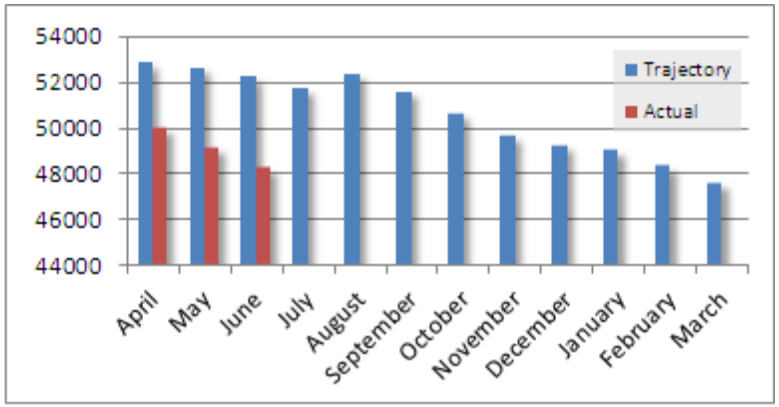


18Wks Incomplete Pathways

TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
waiters	52819	52608	52207	51695	52323	51570	50603	49612	49212	48971	48276	47556
breaches	8448	7942	7445	6882	6412	5714	5129	4573	4230	3910	3637	3373
% performance	84.0%	84.9%	85.7%	86.7%	87.7%	88.9%	89.9%	90.8%	91.4%	92.0%	92.5%	92.9%

ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
waiters	49950	49099	48211									
breaches	6991	6376	6247									
% performance	86.0%	87.0%	87.0%									

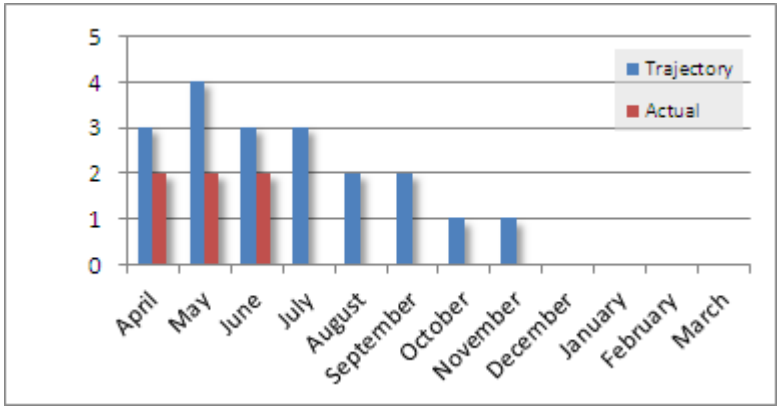




52wk trajectory

TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
waiters	3	4	3	3	2	2	1	1	0	0	0	0

ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
waiters	2	2	2									

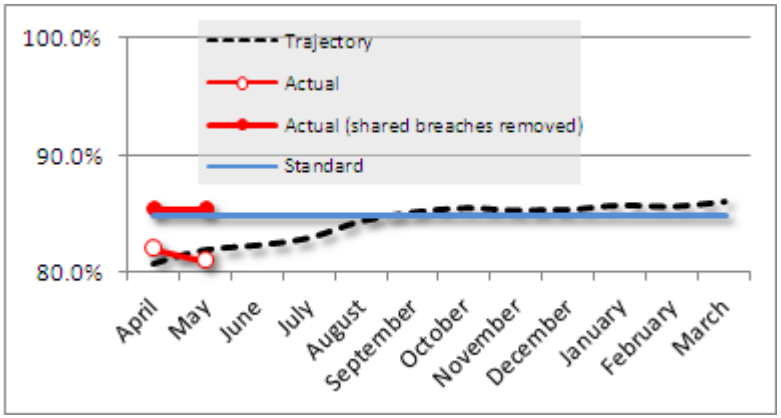


62d Cancer Waiting Times

TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
treatments	120	116	130	135	135	115	125	130	110	120	112	130
breaches	23	21	23	23	21	17	18	19	16	17	16	18
% performance	80.8%	81.9%	82.3%	83.0%	84.4%	85.2%	85.6%	85.4%	85.5%	85.8%	85.7%	86.2%

ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
treatments	147	144.5										
breaches	26.5	27.5										
% performance	82.0%	81.0%										
Shared Breaches removed	85.4%	85.5%										

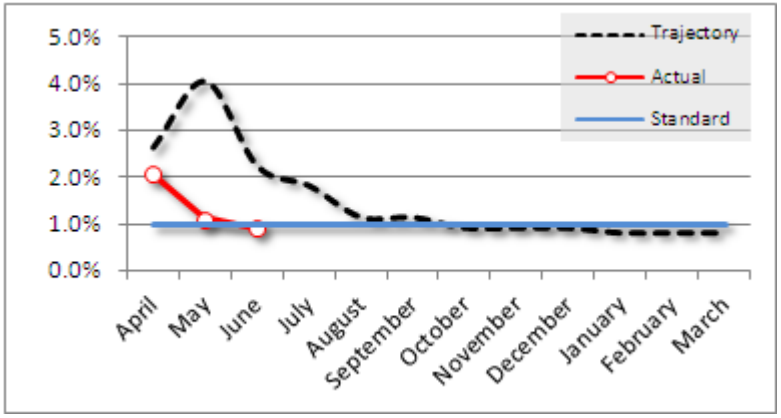
note: cancer data is released 1 month behind



Diagnostic Waiting Times

TRAJECTORY	April	May	June	July	August	September	October	November	December	January	February	March
waiters	8730	8650	8857	8130	8491	8491	8491	8491	8000	8130	7766	8025
breaches	230	350	200	150	100	100	81	81	76	69	66	68
% performance	2.6%	4.0%	2.3%	1.8%	1.2%	1.2%	1.0%	1.0%	1.0%	0.8%	0.8%	0.8%

ACTUAL	April	May	June	July	August	September	October	November	December	January	February	March
waiters	9205	8515	9664									
breaches	190	92	86									
% performance	2.1%	1.1%	0.9%									



Appendix A - Indicator Definitions

Indicator Definitions

Emergency Department

Indicator Description	Target	Lead Director		Definition
A&E All Types Monthly Performance	>=95%	ER	*	Patients seen within 4 hours by A&E department (both HRI & ERCH)
12 hour Trolley waits	0	ER	*	Patients waiting over 12hours from decision to admit to hospital and time left department for admission to take place
A&E All Types Monthly Attendance		ER		Patients seen by A&E department (both HRI & ERCH)
A&E All Types Monthly Attendance Contract Plan 2015-2016		ER		2015-16 contract plan of numbers of patients to be seen by A&E department (both HRI & ERCH)
Ambulance turn around - number over 30 mins	0	ER		Number of ambulance visits where the time taken from arrival to departure of ambulance is over 30 minutes
Ambulance turn around - number over 60 mins	0	ER		Number of ambulance visits where the time taken from arrival to departure of ambulance is over 60 minutes
Delayed Transfers of Care	< 3.5%	ER	*	Number of discharges delayed due to Trust issues as percentage of all discharges
* TDA Oversight and Escalation Indicator				

Cancer

Indicator Description	Target	Lead Director		Definition
Two Week Wait Standard	>=93%	ER	*	Percentage of GP referrals for suspected cancer seen within 2 weeks
Breast Symptom Two Week Wait Standard	>=93%	ER	*	Percentage of breast sympotomatic referrals seen within 2 weeks
31 Day Standard	>=96%	ER	*	Percentage of patients who begin treatment within 31 days of diagnosis
31 Day Subsequent Drug Standard	>=98%	ER	*	Percentage of patients who begin additional treatment with Chemotherapy within 31 days of diagnosis
31 Day Subsequent Radiotherapy Standard	>=94%	ER	*	Percentage of patients who begin additional treatment with Radiotherapy within 31 days of diagnosis
31 Day Subsequent Surgery Standard	>=94%	ER	*	Percentage of patients who begin additional treatment with Surgery within 31 days of diagnosis
62 Day Standard	>=85%	ER	*	Percentage of GP referrals who are treated within 62 days of initial referral
62 Day Screening Standard	>=90%	ER	*	Percentage of patients who were referred as a result of a screening test who are treated within 62 days
Cancer 104 Day Waits	0	ER	*	Number of patients on a 62day pathway waiting over 104 days

Stroke & Cardiac Care

Indicator Description	Target	Lead Director		Definition
Stroke 60 mins	30% (SSNAP)	ER	*	Patients with symptoms of stroke who have CT scan within 60 minutes of attending hospital
Stroke Care	>=80%	ER	*	%age of Patients with symptoms of stroke who spend 90% of time on a stroke ward
ST-Elevation myocardial infarction call to primary percutaneous coronary intervention within150 minutes	>=90%	ER	*	Patients with ST-Elevation myocardial infarction who receive a primary percutaneous coronary intervention within 150 minutes of ambulance call

Referral to Treatment (RTT) and Diagnostics

Indicator Description	Target	Lead Director		Definition
Referral to Treatment Incomplete pathway	>=92%	ER	*	Percentage of patients waiting under 18wks at month end (admitted and non-admitted pathways)
Referral to Treatment Incomplete numbers over 18 weeks		ER		Number of patients waiting over 18wks at month end (admitted and non-admitted pathways)
Referral to Treatment Incomplete numbers away from 92%		ER		Amount that the admitted and non-admitted waiting list needs to be reduced by to meet 92% standard
Referral to Treatment Incomplete 52+ Week Waiters	0	ER	*	Number of patients waiting over 52wks at month end (admitted and non-admitted pathways)
Referral to Treatment Non Admitted pathway	>=95%	ER	*	Percentage of clock stops within 18 weeks of patients on an non-admitted pathway.
Referral to Treatment Admitted pathway	>=90%	ER	*	Percentage of clock stops within 18 weeks of patients on an admitted pathway.
Diagnostic waiting times	<= 1%	ER	*	Percentage of patients who waited over 6 weeks for diagnostic test
Proportion of patients not treated within 28 days of last minute cancellation	0	ER	*	Patients cancelled after admission to hospital who are not readmitted within 28days for same procedure
Urgent Operations Cancelled for 2nd time (Number)	0	ER	*	Number of patients cancelled more than once for a procedure classed as urgent
% of Outpatient appointments cancelled by Hospital		ER		Number of Hospital cancelled OP appointments as proportion af available appointments

Corporate Finance Summary Report 2015/16

July 2016

(3 Months to 30th June 2016)

Great Staff - Great Care - Great Future

Hull and East Yorkshire Hospitals NHS Trust

FINANCIAL SUMMARY: 3 MONTHS TO 30th JUNE 2016

Key Points:

1. At the end of quarter 1 the Trust is reporting an actual deficit of £1.94m which is a balanced position against the month 3 planned deficit of £1.94m. The Trust is planning a breakeven position by the end of the financial year. The in month underspend of £0.35m was mainly due to an improved income position.

2. Delivery of the financial plan at the end of quarter 1 will secure the first quarters payment from the Sustainability and Transformation fund of £3.5m.

3. The position gives the Trust a risk rating of 2 driven by the I & E Margin Variance which stands at a level of 3. The other indicators (Capital Serving, Liquidity and I & E margin) are all rated at level 1.

4. Health Group positions are £1.86m overspent. Surgery and Family and Women's Health groups are the main areas of concern Surgery £1.17m overspent at month 3 due to unidentified CRES, agency nursing and medical staff cost pressures. Family and Women's £0.56m overspent due to non delivery of CRES, winter ward spend and issues with ENT/Plastic Surgery which have recently transferred to this Health Group.

5. To the end of June CRES of £2.7m has been delivered against a target of £3.6m. An adverse variance of (£0.9m). This is in line with the £4.1m CRES shortfall currently reported by Health Groups.

6. The Trust has an over trade against its income plan of £0.09m at the end of June (£3.3m above the contract plan an improvement in month of £0.3m). Elective income, including day cases, is £16k below plan. Non-elective income is £0.88m above plan year to date. Outpatients is under trading at month 3 by £0.79m.

7. Planning is underway to launch a dedicated/focussed exercise in August designed to close the £4.1m CRES gap and manage the growing financial pressures.

8. At month 3 the Trust has spent £2.89m on agency staff against a month 3 year to date target of £2.61m.

9. Non recurrent reserves of £2.6m have been released to offset CRES shortfall (£0.9m) and Health Group and Corporate Directorate expenditure pressures (£1.7m).

10. Due to the implementation of the new finance systems the variances reported in month 3 still need to be treated with a degree of caution. The current issue has led to delays in paying some suppliers which is causing some difficulties and has led to some stops being put on deliveries until outstanding balances have been cleared. The Trusts Best Practice Payment performance has deteriorated from 87% at 15/16 year end to around 46% at end of month 3.

11. There is a pressure on the cash position which is being managed through delayed payments to creditors. This relates to non payment of the STF, increased debtors and stock partially offset by shortfall on fixed asset purchases.

INCOME: CONTRACTING

The Trust is reporting an over trade of £3.3m or 2.8% against the contract plan of £117.1m for month 3. However due to the contract plan being below the Trust's financial plan for the year this translates to a £0.1m (0.1%) over trade against the Trusts Financial plan.

In Month Variance	Point of Delivery	Income Variance to End of June						Forecast Month 12
		Medicine £000	Surgery £000	CSS £000	F & WH £000	Other £000	Total Month 3 £000	£000
(355)	Elective Inpatients	(51)	(373)	62	(57)		(419)	(1,677)
27	Daycases	217	(204)	241	149		403	1,612
672	Non Elective	727	220	185	(253)		879	2,574
(179)	Outpatients	28	(544)	50	(323)		(789)	(3,154)
146	Emergency Department	443					443	887
152	Critical Care	(7)	20		19		32	128
105	Excess Bed Days	(21)	(128)	101	22		(26)	(104)
37	PBR Excluded Devices	278	43	(62)	(23)		236	236
106	PBR Excluded Drugs/Blood			(98)			(98)	(98)
(81)	Radiotherapy			(16)			(16)	(63)
(48)	Chemotherapy delivery		(9)	(35)			(44)	(176)
(63)	Renal Services	(132)					(132)	(529)
143	Imaging/Direct Access	3	39	311			353	1,414
32	AMD				175		175	175
3	Therapies			(67)			(67)	(268)
50	Maternity				142		142	568
(419)	Other	12	5	16	11	(1,023)	(979)	(4,092)
328	**Total**	**1,497**	**(931)**	**688**	**(138)**	**(1,023)**	**93**	**(2,567)**

Commissioner Breakdown	Hull £000	East Riding £000	NHS England £000	Other £000	Total £000
Total	941	(469)	(374)	(5)	93

Overall income increased by £0.3m above plan in month to move from a small under trade to a small over trade. This is against the Trust financial plan and represents a £3.3m over trade against Commissioner Contracts.

The main overtrade in month 3 was in non-elective activity which increased by £0.7m. Activity was broadly in line with previous months but the planned level for June was lower based on historical trends. This over trade was reinforced by increase in ED overtrade which continues its previous upwards trends.

Elective activity and outpatients were both slightly below planned level of activity.

Most other Pods traded close to plan with over trades beginning to grow on a cumulative basis in Wet AMD, Maternity Pathway and Imaging/Direct Access services.

The Trust is not expecting to deliver the full income position in the financial plan due to timing differences between setting the plan and signing the contracts. However, this expected shortfall has been built into the Trust contingency plan. The forecast going forward assumes that the current level of contract over trade will not continue. An element of risk management has been built into the position to reflect potential Commissioner challenges that may arise due to affordability issues, for example, more stringent application of CQUIN targets. An assessment of the potential risk will be made following Q1 submission.

Note: The Trust has not yet had confirmation of its total income budget for Training of medical and other clinical staff from Health Education England so the reports assume that the level will remain as planned. There is a risk that the budget will be cut by 2% which would lead to an income pressure of around £350k. Recent reports indicate that the 2% reduction may only apply to an element of the budget and therefore the size of risk may be reduced. The Trust is still awaiting confirmation from Health Education England.

INCOME & EXPENDITURE: PERFORMANCE

Health Group	Year to Date Position						Forecast Outturn	Forecast Variance	Variance Comments
	Budget	Expend	Variance	Income Allocation	Revised Variance	Revised Variance			
	£000	£000	£000	£000	£000	%	£000	%	
Surgery	(29,973)	(30,992)	(1,019)	(147)	(1,166)	3.9%	(3,409)	2.9%	Surgery position is £1.2m overspent at month 3. The key drivers are unidentified CRES (£0.5m), higher use of agency mainly due to nursing vacancies in ICU and junior doctors gaps within Acute Surgery and T&O (£0.26m), continued medical staff pay pressures (£0.14m), increased non pay costs including drugs, bedwatch and patient transport (£0.14m). The Health Group also reports an income delivery shortfall of £0.15m
Medicine	(21,638)	(22,251)	(613)	556	(57)	0.3%	(2,213)	2.6%	Medicine is £0.06m overspent at month 3. The current to date positon masks the CRES variance of (£0.31m) and ED pressures of (£0.28m) as there are vacancies in nursing, Cardiac technicians and other medical staffing to offset most of these pressures. The forecast reflects the nurse recruitment and known medical staffing appointments
Clinical Support	(29,246)	(29,491)	(245)	161	(84)	0.3%	(965)	0.8%	Clinical Support is overspent by £0.08m at month 3. Various non recurrent non pay pressures e.g mattresses, repairs.
Family & Women's	(16,705)	(17,291)	(586)	29	(557)	3.3%	(1,888)	2.8%	Family & Women's is overspent by £0.56m at month 3. The main driver is non delivery of CRES (£0.12m), unfunded winter ward (£0.10m), Medical agency staffing and Obstetrics. £108k relates to ENT and Plastic Surgery.
Health Group Sub-total	**(97,562)**	**(100,025)**	**(2,463)**	**599**	**(1,864)**	**1.9%**	**(8,475)**	**2.2%**	
Corporate	(21,205)	(21,473)	(268)	0	(268)	1.3%	(671)		Corporate is £0.27m overspent at month 3 driven by Patient Administration.
Other (Including Income)	116,827	119,558	2,731	(599)	2,132		9,146		The release of reserves to support the position of £2.6m is included in this line.
Trust Total	**(1,940)**	**(1,940)**	**0**	**0**	**0**		**0**		

STATEMENT OF COMPREHENSIVE INCOME

The Trust is reporting a deficit of £1.94m as at 30th June 2016 which is a balanced position against the month 3 plan submitted to NHS Improvement.

	YEAR TO DATE				FORECAST			
	BUDGET £'000	ACTUAL £'000	VARIANCE £'000		BUDGET £'000	ACTUAL £'000	VARIANCE £'000	
NHS Contract Income	120,570	120,663	93	Favourable	488,025	485,458	(2,567)	Adverse
Patient Care Income	7,678	8,404	726	Favourable	30,727	31,530	803	Favourable
Other Operating Income	8,709	8,368	(341)	Adverse	35,794	33,771	(2,023)	Adverse
Total Income	**136,957**	**137,435**	**478**	Favourable	**554,546**	**550,759**	**(3,787)**	Adverse
Pay Costs	(79,988)	(80,608)	(620)	Adverse	(317,629)	(321,130)	(3,501)	Adverse
Non Pay Costs	(48,172)	(50,743)	(2,571)	Adverse	(193,012)	(198,424)	(5,412)	Adverse
Reserves	(4,501)	(1,863)	2,638	Favourable	(18,094)	(5,394)	12,700	Favourable
Total Expenses	**(132,661)**	**(133,214)**	**(553)**	Adverse	**(528,735)**	**(524,948)**	**3,787**	Favourable
Donated Asset Adjustment	(75)	0	75	Favourable	(1,150)	(1,150)	0	Favourable
EBDITA	**4,221**	**4,221**	**0**	**Favourable**	**24,661**	**24,661**	**0**	**Favourable**
Depreciation	(3,185)	(3,185)	0	Favourable	(12,743)	(12,743)	0	Favourable
Asset Impairments	0	0	0	Favourable	0	0	0	Favourable
PDC Dividend	(1,455)	(1,455)	0	Favourable	(5,820)	(5,820)	0	Favourable
Interest Receivable	15	15	0	Favourable	60	60	0	Favourable
Interest Payable	(1,679)	(1,679)	0	Favourable	(6,732)	(6,732)	0	Favourable
Other Gains and (losses)	0	0	0	Favourable	0	0	0	Favourable
Accounting Surplus / (Deficit)	**(2,008)**	**(2,083)**	**(75)**	**Adverse**	**576**	**576**	**0**	**Favourable**
UK GAAP vs IFRS (IFRIC)	0	0	0	Favourable	0	0	0	Favourable
Asset Impairments	0	0	0	Favourable	0	0	0	Favourable
Donated Reserve Adjustment	68	143	75	Favourable	(576)	(576)	0	Favourable
Performance Surplus / (Deficit)	**(1,940)**	**(1,940)**	**0**	**Favourable**	**0**	**0**	**0**	**Favourable**

Contract income is £0.09 over plan with non elective and other over trades offset by an under trade on outpatient activity.

Operating expenditure is overspent by £0.55m with the release of risk reserves offsetting the contract to plan gap on income and unachieved CRES.

Pay is overspent due high spend on agency and bank. Non Pay is overspent due to non delivery of CRES and overspends on Medical and Surgical Equipment.

NHS I KEY DATA

Key Data Item	2015/16 Accounts £000s	Plan £000s	Current Year to Date Actual £000s	Variance £000s	Plan £000s	Forecast Outturn Forecast £000s	Variance £000s
Reported Financial Performance							
Retained Surplus/(Deficit) for the Year	(14,952)	(2,008)	(2,083)	(75)	576	576	0
Adjustments for impairments, Donated and Government Granted assets, IFRIC 12 and Transfers by Absorption	6,901	66	141	75	(576)	(576)	0
Adjusted Financial Performance Retained Surplus/(Deficit)	(8,051)	(1,942)	(1,942)	0	0	0	0
Adjusted Financial Performance Retained Surplus/(Deficit) as a percentage of Turnover (%)	(1.5)	(1.4)	(1.4)	0.0	0.0	0.0	0.0
Performance Against Control Total					0	0	0
Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)							
Total EBITDA	5,474	4,220	4,219	(1)	24,661	24,661	0
EBITDA as a percentage of Turnover (%)	1.0	3.1	3.1	(0.0)	4.5	4.5	0
Capital Position							
Gross Capital Expenditure		3,991	1,407	(2,584)	20,671	20,671	0
Capital Receipts/Losses		0	0	0	(8,690)	0	8,690
Other adjustments relating to grants, losses on disposal of donated assets and Donations		(75)	0	75	(1,150)	(1,150)	0
Charge against Capital Resource Limit		3,916	1,407	(2,509)	10,831	19,521	8,690
Capital Resource Limit (CRL)		3,916	1,407	(2,509)	10,831	19,521	8,690
Under/(Over) spend against CRL		**0**	**0**	**0**	**0**	**0**	**0**
CIPs / Efficiencies							
High Risk Efficiencies			592			4,043	
Medium Risk Efficiencies			320			2,930	
Low Risk Efficiencies			1,748			8,021	
Total Efficiencies	23,505	3,728	2,660	(1,068)	19,189	14,994	(4,195)
Unidentified Efficiencies	0		0			0	
Recurrent Efficiencies	19,144	2,944	2,175	(769)	15,956	12,484	(3,472)
Non-Recurrent Efficiencies	4,361	784	485	(299)	3,233	2,510	(723)
Efficiencies as a % of total expenditure excluding efficiencies	4.2	2.6	1.9	(0.7)	3.4	2.6	(0.7)
Normalised Position							
Underlying Surplus / (Deficit)	(19,662)				(14,733)	(14,733)	0
Underlying Surplus / (Deficit) as a percentage of Turnover (%)	(3.7)				(2.7)	(2.7)	0.0
Agency Ceiling							
Performance against Agency Ceiling					9,499	10,260	761.00
Financial Sustainability Risk Ratings							
Liquidity Ratio (days)	1	1	1	0	1	1	0
Capital Servicing Capacity (times)	1	1	1	0	2	2	0
I&E Margin Rating	1	1	1	0	3	3	0
I&E Margin Variance from Plan	4	4	3	(1)	4	4	0.0
Overall Financial Sustainability Risk Rating	**2**	**2**	**2**	**0**	**2**	**2**	**0**

CASH AND WORKING CAPITAL

Cash is £2.3m at the close of month 3 which equates to 1.5 days of operating expenditure.

Cash

Cash at 30 June was £2.3m which represents around a day and a half of operating expenditure.

Other than the £1.6m relating to PFI payments and the £1.7m relating to capital schemes, cash has been used to pay salaries and suppliers for the general goods and services.
With £8m of supplier invoices ready for payment at 30 June, against a cash balance of £2.3m, there is mounting pressure on cash.

The main drivers of the pressure on cash are:

1. No cash has been receievd against the £14m allocated from the strategic transformation fund (STF) - £3.5m.
2. The Trust is awaiting reimbursement from the NHSE for drugs – £2m
3. The amount of cash that is tied up in stock is steadily increasing. There has been an increase of £2.25m (20%) in the last 15 months, £623k of which is since 1 April.
4. The impact of transferring to ELFS and new processes around prioritising cash resources bedding in.

The pressure will continue during the second quarter not least as payments for loans and dividends £3.7m) fall due during August and September, and the continued risk around payments from the STF.

Inventory

The Trusts inventory at month 3 is £13.0m, this is an increase of £0.62m on the balance held at the end of 2015/16.

Stock days are at 37 days at month 3.

Capital Programme

At month 3 there has been expenditure of £1.41m on the Capital programme, This is £2.5m below plan at month 3.

The forecast level of expenditure for 2016/17 is £20.7m.

Debtors

The largest outstanding debtor is with NHS England at just under £2m which relates to Cancer Drug Fund . A credit note for £80k has now been agreed with the Commissioner which should now enable these bills to be settled.

BPPC

The Trust aims to pay 95% of all invoices within 30 days.

The BPPC performance for Non NHS suppliers in June is 51% by value and 57% by volume, this has resulted in a year to date performance which is 46% by value and 48% by volume.

NHS invoices paid for June are at 65% by value and 59% by volume. The year to date performance is at 15% by value and 21% by volume.

	NHS		Non NHS	
	Volume	Value	Volume	Value
June	59%	65%	57%	51%
Year to Date	21%	15%	48%	46%

The above percentages are low due to the transfer of invoices to ELFs financial services.

Balances past 90 days overdue

The total outstanding receivables that were 90 days past the due by date during month 3 total £4.99m. (14.3% of total debt) . The largest contributors to the over 90 days debt are:-

	£m
NHS England	1.47
Northern Lincolnshire And Goole NHS Foundation Trust	0.29
City Health Care Partnership	0.60
Kingston Upon Hull City Council	0.56
Fresenius Medical Care Renal Services Ltd	0.31
Alliance Medical Ltd	0.13
University of Hull	0.15

The total outstanding payables that were 90 days past the due by date during month 3 total £2.67m.

TRUST BOARD REPORT - 2016 – 7 - 15	
Meeting Date:	28 July 2016
Title:	Board Assurance Framework (BAF)
Presented by:	Liz Thomas – Director of Governance & Corporate Affairs
Author:	Liz Thomas – Director of Governance and Corporate Affairs Mark Green – Head of Risk, Claims & Safety
Purpose:	The purpose of the paper is for the Trust Board to review the Board Assurance Framework risks at quarter 1 and satisfy itself that these are being managed.
Recommendation(s)	The Board is asked to review the BAF and satisfy itself that the risks are being appropriately managed and agree to the removal of the risk relating to delivery of the cash releasing efficiency savings

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
BOARD ASSURANCE FRAMEWORK (BAF) 2016/17

1. PURPOSE OF THIS REPORT

The purpose of the paper is for the Trust Board to review the Board Assurance Framework risks at quarter 1 and satisfy itself that these are being managed.

2. KEY ISSUES

- At the beginning of 2016/17 there were 10 risks on the Board Assurance Framework
- No risks have had their rating increased
- The highest rated risks relate to workforce (Q3), learning lessons (Q2) and the Strategic Transformation Plan (P1)
- It is proposed that the risk relating to cash releasing efficiency savings is removed as it is already incorporated into the risk relating to the financial deficit.

3. INTRODUCTION

The Board received the BAF at its meeting in April 2016. This set out the principal risks that should be carried forward to 2016/17 and proposed a new risk relating to the Strategic Transformation Plan (STP). There was discussion on whether the cultural transformation risk should remain on the BAF and also whether a new risk relating to productivity should be added. It was therefore agreed that the Audit Committee would review the BAF.

The Audit Committee reviewed the BAF at its meeting on the 5 May 2016. It concluded that productivity was linked to both achievement of the Trust's financial plan and also to the risk of not achieving NHS Constitution standards and therefore did not need to be included as a separate risk. The risk rating to the STP would be added and the risk relating to cultural transformation should remain, with a focus on strengthening accountabilities.

The Audit Committee also received the internal audit report relating the Assurance Framework. It concluded that the BAF was structured to meet the NHS requirements, was visibly used by the Board and reflected discussion at the Board. Two areas were identified for consideration. The first related to Board Committees and the BAF, as both the Quality Committee and the Performance and Finance Committee provide assurance on some of the risks on the BAF. It concluded that the Board should consider its expectations in terms of committees and how it uses the updates provided in conjunction with the BAF. This has been discussed with the Chair of the Performance and Finance Committee and is reflected in the committee work plan. It will also be considered by the Quality Committee as part of its effectiveness review.

The second area identified by internal audit was greater evidence of the Board relating risks in papers and discussion to the BAF. To support this, the assurances recognised within the BAF should be reviewed to ensure they remain focussed at Board level and include the reporting route to Board and regularity. This will be taken forward by the Director of Governance.

4 BOARD ASSURANCE FRAMEWORK (BAF)

The BAF is attached at appendix A for review.

Following discussion with the Chief Financial Officer, it was agreed that the risk relating to delivery of the financial plan at the end of quarter 1, 2016/17 would be reduced and aligned with the risk rating on the corporate risk register. However, the risk increases in Q2 based on the current position, without further action being taken. It was also proposed that the separate risk relating to the CRES should be removed (F2) as this is already reflected in the risk of not resolving the financial deficit.

5 RECOMMENDATIONS

The Board is asked to review the BAF and satisfy itself that the risks are being appropriately managed and agree to the removal of the risk relating to delivery of the cash releasing efficiency savings

Liz Thomas
Director of Governance and Corporate Affairs

Mark Green
Head of Risk, Claims & Safety
July 2016

BOARD ASSURANCE FRAMEWORK Q1 – 2016/17

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q1	Chief Medical Officer, Chief Nurse Operational Quality Committee	8 risks • Bed availability Outpatient capacity(4) • Dietetic Reviews • Repatriation • Bed spaces in the Tower Block • Radiology capacity & reporting (2) • Staffing risks (7)	**The Trust is non-compliant with CQC regulatory requirements** There is a risk that the Trust does not achieve the fundamental standards and that regulators and service users may have concerns about the quality and safety of our patient services.	**20** **L-4** **X** **S-5**	• QIP established • Fortnightly QIP meetings chaired by CMO to monitor achievement of milestones • QIP programme reviewed at Operational Quality Committee and deviations from plan escalated • Internal inspection programme in place during Q1 • NHSI involved in 'health check' • Governance toolkit developed to support staff to prepare for inspection • CN meetings with ward sisters	Informal feedback from the CQC identified areas where further work needs to be undertaken. This includes embedding checking procedures, adherence to escalation procedures, documentation and staffing. An initial review has been undertaken of the QIP following CQC feedback and the QIP will be updated **Leads**: CN, CMO and Director of Governance **Completion**: August 2016	12 L3 X S4				**4** **L1** **X** **S4**	**Positive assurance** • Informal feedback received from the CQC following the comprehensive inspection at the end of June 2016 identified a number of areas where positive improvements had been made • Review by Internal Audit that the QIP was complete and accurate – reported to the Audit Committee at May 2016 meeting • Internal reports giving significant assurance during 2015/16 – Fit and Proper persons, discharge planning, safe staffing levels, performance management arrangements **Further assurance required** • Internal audit reports giving limited assurance in 2015/16 – locality reviews, infection control, incident reporting, medical staff absence, responding to Francis. • The ratings on the current QIP (June 2016) to be reviewed (ref Board Quality report July 2016)

Q – High Quality Care												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q2	Director of Governance Operational Quality Committee	0 risks	**Lessons learned** There is a risk that the Trust does not learn from adverse events and that errors continue to occur which could affect patient care and safety	**20** **L4** **X** **S5**	• Learning lessons QIP project group established • Monthly Lessons learned newsletter • Quality Bulletin • Lessons Learned Intranet site • Monthly SI summary report distributed to Health Groups • Analysis of incidents and trends • Use of videos to replicate incidents in order to improve learning • Application of Root cause analysis techniques and training • Operational Quality Committee • Health Group Governance meetings • Health Group performance reviews	• Themes and trends in incidents and Serious Incidents (SIs) are continuing from 2015/16 into 2016/17 although at the end of Q1 there was a reduction in the number of SIs reported. • Revised incident reporting system launched April 2016. This allows staff to report both incidents and concern. Further work needs to be completed to ensure that improvement work is agreed from those issues reported as concerns **Lead:** Director of Governance **Completion:** September 2016 • Further work is required to integrate issues arising from SIs, complaints, claims, incidents and to move away from silo reporting **Lead:** Director of Governance **Completion:** September 2016	16 L4 x S4				4 L2 X S2	**Positive assurance** • Significant Assurance – internal audit, lessons learned review, March 2016 • Positive feedback received from staff who attended the learning lessons workshops (May 2016) which included the training video of the Never Event retained vaginal swab • Positive feedback received from CQC that staff were aware of the Lessons Learned Bulletin and the safety brief and that work had been undertaken to improve learning from incidents including human factors training • Information about changes in practice now being included in the Board's Quality report related to complaints and Never Events/Serious Incidents **Further assurance required** • New processes for dissemination of information strengthened during 2015/16. However, there is evidence that changes in practice are not always occurring across the Trust and further work needs to be put in place so that learning occurring in one part of the Trust is transferred to other areas.

Q – High Quality Care												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
Q3	Director of Workforce and OD Workforce Transformation Committee	7 risks • Consultant staff • Nursing staff • Junior doctors • Blood transfusion staff	**Workforce** There is a risk that the Trust is unable to recruit to the numbers of staff required to deliver high quality and safe services	**20** **L5** **X** **S4**	• Overseas recruitment programme for nursing staff • Improved working environment in ED and AAU • Recruitment and retention premia for designated posts • Apprentice scheme • New roles in place – 27 Advanced Practitioner posts in a number of services to off-set shortages in junior doctors • Development of non-registered nursing staff • Innovative recruitment strategies, utilising social media and active advertising campaigns to attract skilled and experienced staff in place • Ward establishments review twice a year • New roles e.g. ward based A&C Personal Assistants, Ward Hygienists and Discharge Facilitators	• Working with Universities and Health Education England to develop new 2 year programmes for Advanced Practitioners and Physicians Associates **Lead:** S Nearney **Completion**:31.9.17 • "Values' based Recruitment s is being rolled out throughout the Trust **Lead:** L Vere **Completion**:31.07.16	16 L4 x S4				6 L3 X S2	**Positive assurance** • Monthly nursing and midwifery staffing report to Board • Significant assurance – internal audit, Recruitment 205/16 • Significant assurance – internal audit, Safe staffing levels, 2015/16 • Staff sickness levels below Trust target of 3.9% (May 2016) • Mandatory training levels above Trust target of 85% (May 2016) • Staff turnover below Trust target of 9.3% (May 2016) • Staff FFT results showing continuous improvement over each quarter **Further assurance required**

H – Honest, Caring and Accountable Culture													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H1	Chief Nurse Operational Quality Committee	1 risk • Over-crowding ED	**Patient Experience** There is a risk that patients receive and report a poor experience through complaints, PALS, Family and Friends Test and the National Patient Survey. The impact of this poor experience is loss of confidence and trust in the care provided for new and existing patients along with reputational damage for the Trust	**16** **L4** **X** **S4**	• Patient Experience Forum • Ward audit programme (replacement of 3Gs) • FFT being used as improvement tool 'You said we did'. • Patient Council established • Complaint Policy • Inpatient survey top quartile for improvements in patient experience	• Response times to complaints. Further work needs to be undertaken to improve response times to complaints within 40 days **Lead** :S Bates Completion:30.09.16	9 L3 X S3				8 L2 X S4	**Positive assurance** • Quality Report to every Trust Board including lessons learned • Patient Stories presented at every Trust Board • The FFT report for March 2016 identifies • Average score of 4.77 • 94.59% patients likely to recommend the Trust (1.28% unlikely to recommend) • PHSO – Complaints about acute trusts 2014-15 identified Trust has a low conversion rate of 1.61 per 10,000 clinical episodes • 17% decrease in the number of complaints received when comparing 2015/16 to 2014/15 **Further assurance required** Health Groups are not meeting the Trust's standard of responding to complaints within 40 days

H – Honest, Caring and Accountable Culture												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
H2	Chief Executive Cultural and Transformation Committee	0 risks	**Cultural Transformation** Staff do not continue to report an improvement in the Trust's culture (via the cultural survey and the national staff survey)	**25** **L5** **X** **S5**	• Professionalism and Cultural Transformation Committee • The Trust has implemented a Staff Advisory Liaison Service (SALS) where staff can report bullying incidents in a safe environment. • FFT (staff) survey • Line Manager cultural briefing sessions. • People Strategy which identifies 7 goals which will connect to individuals and service objectives	• Role Charters for staff are being developed **Lead** :L Vere **Completion**: 31.09.16	**12** **L3** **X** **S4**				8 L2 X S4	**Positive assurance** • Barrett Values survey (April Board 2015) • New values approved (April 2015 Board) • Positive feedback from GMC and Deanery following Junior Doctors review • FFT survey completed by 2200 staff (Q1 2016/17). Overall engagement score improved to 3.88 (out of 5). This would place the Trust in the top 20% of Trusts nationally. **Further assurance required**

G – Great Performance and Reliability

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
G1	Chief Operating Officer Trust Board	0 risks	**NHS Constitution standards** There is a risk that the Trust will not improve on its current TDA Oversight Category (note: this risk will be reviewed once the Single Oversight Framework is introduced)	**16** **L4** **X** **S4**	• Increased management support • Emergency Care Improvement Programme (ECIP) support • Action plans for emergency care recovery including ED • Action plan for RTT recovery • Action plan for Cancer recovery • Agreed trajectories with NHSI • SAFER bundles agreed and implemented. • Urgent and Emergency Care Programme established	• RTT is not expected to deliver fully until January 2017. Trajectories have been confirmed for 18 weeks, Cancer and Diagnostics with NHSI. • **Lead:** Chief Operating Officer **Completion**:31.03.17	**12** **L3** **X** **S4**				4 L2 X S2	**Positive assurance** • Operating plan approved at April 2015 Trust Board. • Performance and Finance Committee & Performance Report (Monthly) • Currently meeting trajectories agreed with NHSI **Further assurance required** • Current TDA rating level 2 – significant delivery issues and TDA concern • Internal audit - Performance reporting/Management - April 2015 Significant assurance – corporate. Limited assurance – Health Group • Being able to demonstrate that the Trust is able to deliver improved performance on a sustainable basis

P – Partnership and integrated services													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
P1	Director of Strategy and Planning Trust Board	0 risks	**Strategic Transformation Plan** There is a risk that the emerging plan will not be developed with sufficient Trust input and will herald changes to the provider sector that are either unrealistic or pose risks to the achievement of the Trust's long term goals	16	We are ensuring meaningful engagement by credible Trust leaders in all STP development activities. We are developing a close working relationship with the STP leadership team and providing support in the drafting of key STP documents and shaping the Acute Trust Provider Alliance	The remit and governance of the Trust Provider Alliance is still to be agreed. The work is being led by the NLaG CEO.	**16**				12	**Positive assurance** We are in receipt of the initial Humber Coast and Vale STP submission and are comfortable with the content. . **Further assurance required** Input and sign off of further iterations of the plan as they emerge.

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F1	Chief Finance Officer Finance & Performance Committee	0 risks	**Financial Deficit** There is a risk that the Trust will not resolve the financial deficit	**25** **L5** **X** **S5**	• Financial plan agreed with NHSI • Robust performance management arrangements with Health Groups • Contingency reserve • Close monitoring of CQUIN schemes	• The Trust is not delivering the planned level of elective activity at the end of Q1 **Lead:** Operations Director Surgery **Completion**: Q2 • Agency spend on medical staff **Lead:** Medical Directors **Completion**: Q2 CRES programme and identification of further schemes **Lead**: health Group triumvirates **Completion**: August 2016	**12** **L3** **X** **S4**				10 L2 X S5	**Positive assurance** • Declared deficit at 2015/16 year end of £8.1m (versus plan of £18.3m) • Delivery of the financial plan at the end of quarter 1, 2016/17 and securing the first quarter payment from the Sustainability and Transformation fund. **Further assurance required** • Variance reported at month 3 needs to be treated with a degree of caution due to the implementation of the finance systems and delays in paying some suppliers • Closing the gap on the unidentified CRES (£4.1m) • Income budget for training of medical and other clinical staff from health Education England to be confirmed • Winter costs • Overseas recruitment

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F2	Chief Finance Officer Finance & Performance Committee	2 risks Inability to deliver CRES programme	**Cash Releasing Efficiency Savings (CRES)** There is a risk that the CRES Programme for 2016/17 will not be delivered which will impact on the overall delivery of the financial plan. – Proposals to remove this risk as it is already reflected in the management of the financial deficit (F1)	**20** **L4** **X** **S5**	• Operating plan submitted to NHSI • Financial plans prepared by Health Groups. • Strengthened financial controls within Health Groups, weekly/bi-weekly meetings focussing on delivery of revised plans • Monthly Health Group performance reviews with Chiefs	To the end of June 2016, CRES of 2.7m has been delivered against a target of £3.6m (£0.9m adverse variance) which is in line with the £4.1m CRES shortfall reported by Health Groups. Dedicated/focussed exercise to be held in August designed to close the gap **Lead**: Health Group Operations Directors **Completion:** August 2016						**Positive assurance** • £2.7m CRES delivered to end of June 2016 **Further assurance required** • Unidentified CRES to be resolved

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F3	Chief Finance Officer Finance & Performance Committee	6 risks • Imaging equipment • IT system resilience • Ageing telephone system • Cardiology analyser	**Capital Programme** There is a risk that the capital programme is insufficient to meet all of the identified priorities and therefore has the potential to impact on the delivery of clinical services (both volume and quality of services).	**16** **L4** **X** **S4**	• Medical Equipment group meets regularly to prioritise programme for replacement • CRAC committee meets monthly and manages in-year emerging pressures • on the committee • Where clinical risk is deemed to be so significant arrangements are put in place by CRAC/EMC to provide service using alternative methods (e.g. IRT3 taken out of use)	Expenditure being managed within capital budget	**12** **L3** **X** **S4**				8 L2 X S4	**Positive assurance** • Monthly Performance and Finance Committee and updates to the Board • No incidents reported resulting in Serious Incident/RCA investigations. • Agreed plan in place for 2016/17 with Health group support. Risk assessment process built into our reporting structure. Capital committee to oversee this issue on monthly basis **Further assurance required**

Hull and East Yorkshire Hospitals NHS Trust

TRUST BOARD REPORT – 2016 – 7 - 16	
Meeting date:	28 July 2016
Title:	**WORKFORCE RACE EQUALITY STANDARD (WRES) TRUST SUBMISSION 2016**
Presented by:	Ellen Ryabov – Chief Operating Officer
Author:	Jackie Railton-Chair–Diversity and Inclusion Steering Group
Purpose:	The purpose of this paper is to present for approval the Trust's Workforce Race Equality Standard (WRES) submission for 2016. The WRES return and draft Action Plan have been considered and endorsed by the Executive Management Committee at the meeting on 20 July 2016.
Recommendation(s):	The Board is asked to note the content of this report and approve the WRES return and Action Plan.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

WORKFORCE RACE EQUALITY STANDARD (WRES)
TRUST SUBMISSION 2016

1. PURPOSE

The purpose of this paper is to present for approval the Trust's Workforce Race Equality Standard (WRES) submission for 2016.

2. BACKGROUND

The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce race equality, including a specific indicator to address the low levels of BME Board representation.

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.

The submission date for the WRES return is 1st August 2016 and all submissions must be signed off by the Trust Board.

3. WRES SUBMISSION 2016

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

- Data Template – The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2015 and 2016. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations and is uploaded via the Unify2 system.

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

- WRES Action Plan 2016/17 (Appendix 3) – The action plan is based on the WRES data and is intended to address the disparities in the experiences of BME staff compared to White staff.

4. KEY FINDINGS

The key findings from the data analysis are:

- 8,690 staff were employed within the Trust at the date of the analysis.

- Of the 8,690 staff, 1.76% (153) had not declared their ethnicity.

- The Trust employs 893 staff who self-define as being from a Black or Minority Ethnic background. This represents 10.3% of the total staff employed in the Trust.

- The analysis of data for Indicator 1 (Percentage of staff in each pay banding compared to the percentage of staff in the overall workforce) shows that BME staff are under-represented in the higher pay bandings for clinical and non-clinical posts

when compared to White staff. Whilst the percentage of White and BME medical and dental staff is broadly similar, there is an absence of BME representation in the senior medical managerial posts, ie Health Group Medical Director and Chief Medical Officer levels.

- Indicator 2 – Relative likelihood of staff being appointed from shortlisting – Whilst the gap between the 2015 and 2016 returns has decreased, it is still the case that BME applicants are less likely to be appointed from shortlisting than White applicants.

- Indicator 3 – Relative likelihood of staff entering the formal disciplinary process – BME staff are twice as likely to enter the formal disciplinary process as White staff.

- Indicator 4 – Relative likelihood of staff accessing non-mandatory training and CPD – The gap between White and BME staff had decreased since the previous year, however White staff still have marginally better access.

- Indicator 5 – Staff Survey KF25 – Whilst the percentage of White staff experiencing harassment, bullying or abuse from patients, relatives or public had decreased, the percentage of BME staff experiencing this behaviour had increased.

- Indicator 6 – Staff Survey KF26 – 57% of BME staff who responded to this question reported experience of harassment, bullying or abuse from staff.

- Indicator 7 – Staff Survey KF21 – Only 73% of BME staff reported believing that the Trust provides equal opportunities for career progression and promotion compared to 85% of White staff.

- Indicator 8 – Staff Survey Q17 – 16% of BME staff reported personal experience of discrimination at work from their manager/team leader or other colleagues compared to 8% of White staff experiencing the same.

- Indicator 9 – Percentage difference between the Board's voting membership and its overall workforce. The Trust is reporting a negative value: -10.5% as none of the Trust Board's voting membership is from a BME background. The Board is therefore not representative of its workforce or the population it serves.

5. WRES ACTION PLAN

Attached at Appendix 3 is the draft WRES Action Plan which identifies a series of actions aimed at addressing the issues identified under each of the WRES Indicators.

The Executive Management Committee has reviewed and endorsed the actions identified in the plan.

6. RECOMMENDATION

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

Jackie Railton
Chair – Diversity and Inclusion Steering Group
21 July 2016

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Hull and East Yorkshire Hospitals NHS Trust

Date of report: month/year

March 2016

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

Ellen Ryabov, Chief Operating Officer

Name and contact details of lead manager compiling this report

Jackie Railton, Head of Strategic Planning

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

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

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

Hull Clinical Commissioning Group

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

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

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

The data has been collected from the Trust's Electronic Staff Record, however the ethnic status of 153 staff is not stated. This represents 1.76% of the total workforce.

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

None

2. Total numbers of staff

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

8,690

b. Proportion of BME staff employed within this organisation at the date of the report

10.3% of total staff employed.

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

98.2%

b. 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 the Electronic Staff Record (ESR).

In 2016 the Trust introduced a new electronic Employee Self Service system which enabled staff to check their ESR record and update their personal information.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

Staff will continue to be encouraged to self-report at key stages in their career path, such as when they apply for new posts. In addition, staff will be reminded to periodically check their personal details held on the ESR and to inform the Human Resources Department of any gaps in personal information.

4. Workforce data

a. What period does the organisation's workforce data refer to?

Staff in post as at 31 March 2016 and activity during the financial year 2015-16.

Report on the WRES indicators, continued

5. Workforce Race Equality Indicators

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

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See attached for breakdown by pay banding. Where ethnicity is known for 31 March 2016: * Non-clinical workforce (White)	See attached for breakdown by pay banding. Where ethnicity is known for 31 March 2015: * Non-clinical workforce (White)	The data shows that BME staff are under-represented in the higher bandings (Bands 8-9 and VSM) for clinical and non-clinical posts compared to White staff. Whilst the percentage of White and BME medical and dental staff is broadly similar, there is an absence of BME representation in the senior	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
2	Relative likelihood of staff being appointed from shortlisting across all posts.	White = 0.15 BME = 0.09 Relative likelihood = 1.67	White = 0.15 BME = 0.08 Relative likelihood was 1.98	Whilst the gap between the two years has decreased, it is still the case that BME applicants are less likely to be appointed from shortlisting than White applicants.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	White = 0.0027 BME = 0.0055 Relative likelihood = 2.04	White = 0.0029 BME = 0.0034 Relative likelihood = 1.18	In 2015/16 BME staff were twice as likely to enter the formal disciplinary process compared to White staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4	Relative likelihood of staff accessing non-mandatory training and CPD.	White = 0.95 BEM = 0.91 Relative likelihood = 1.04	White = 0.50 BME = 0.47 Relative likelihood = 1.07	In 2015/16, the gap between White and BME had decreased, however White staff are still marginally more likely to access non-mandatory training and CPD more than BME staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 26 BME 27	White 35 BME 22	Whilst the percentage of White staff experiencing bullying and abuse from patients, relatives and the public had declined since the last survey, the percentage of BME staff experiencing this behaviour had increased.	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 35 BME 57	White 36 BME 28	The Trust was concerned to note that 57% of BME respondents to the survey had reported experience of bullying by staff, almost twice the number reported in the previous survey.	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 85 BME 73	White 87 BME No data	Whilst there had been an insufficient number of BME responses in the previous survey to allow a comparison year on year, the Trust was concerned to note that less BME staff than White staff believed that the Trust provides equality of	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 8 BME 16	White 12 BME No data	Whilst the percentage of White staff experiencing discrimination at work had declined since the last survey, the percentage of BME staff experiencing this behaviour was twice that of 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.	-10.5%	-10.4%	The voting membership of the Board is 12, all of whom are White. The Trust acknowledges that, in respect of ethnicity, the Board is not representative of the population it serves or its workforce.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

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

None

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

The Draft WRES Action plan is attached.

Click to lock all form fields and prevent future editing

Produced by NHS England, April 2016

NHS WORKFORCE RACE EQUALITY STANDARD 2016

Indicator 1: Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (Very Senior Manager), including Executive Board members, compared with the percentage of staff in the overall workforce.

1. Breakdown of total workforce by ethnicity

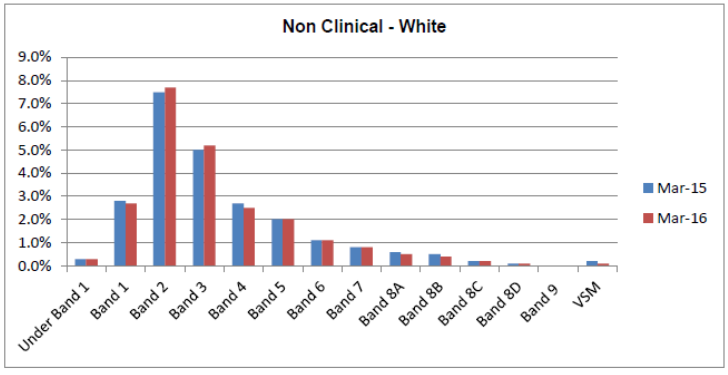
	31 March 2016	31 March 2015	Variance
No. self-defined as White	7,644	7,457	187
No. self-defined as BME	893	863	30
No. where ethnicity not stated	153	166	-13
Total Workforce	**8,690**	**8,486**	**204**

2. Percentage of staff by grouping and ethnicity

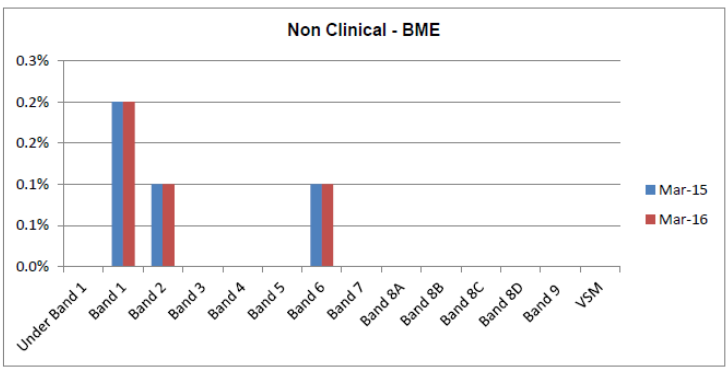
Domain	31 March 2016	31 March 2015	Variance
Non Clinical (White)	23.5%	23.8%	-0.3
Non Clinical (BME)	0.5%	0.5%	0.0
Clinical (Non-Medical) (White)	59.4%	59.5%	-0.1
Clinical (Non-Medical) (BME)	3.7%	3.4%	0.3
Medical and Dental (White)	6.6%	6.4%	0.2
Medical and Dental (BME)	6.3%	6.4%	-0.1
Total	**100.0%**	**100.0%**	

3. Percentage of staff by grouping and ethnicity by pay band (including comparison with March 2015) as percentage of declared workforce

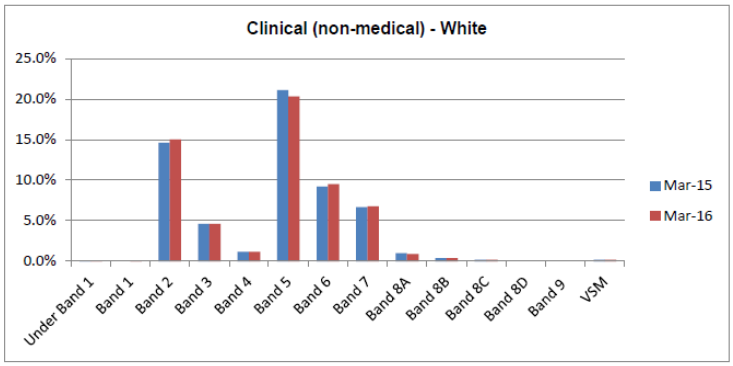
Non Clinical Workforce - White	Mar-15	Mar-16
Under Band 1	0.3%	0.3%
Band 1	2.8%	2.7%
Band 2	7.5%	7.7%
Band 3	5.0%	5.2%
Band 4	2.7%	2.5%
Band 5	2.0%	2.0%
Band 6	1.1%	1.1%
Band 7	0.8%	0.8%
Band 8A	0.6%	0.5%
Band 8B	0.5%	0.4%
Band 8C	0.2%	0.2%
Band 8D	0.1%	0.1%
Band 9	0.0%	0.0%
VSM	0.2%	0.1%



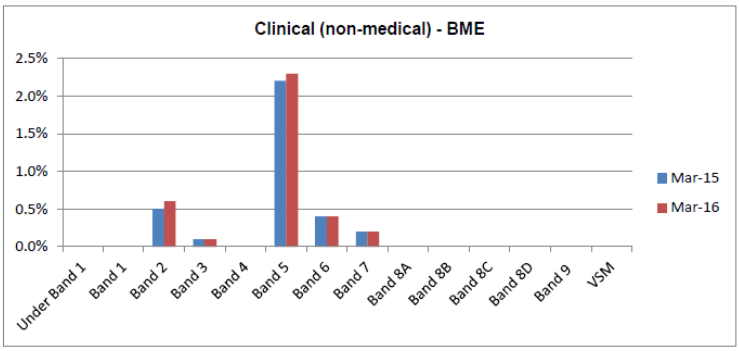
Non Clinical Workforce - BME	Mar-15	Mar-16
Under Band 1	0.0%	0.0%
Band 1	0.2%	0.2%
Band 2	0.1%	0.1%
Band 3	0.0%	0.0%
Band 4	0.0%	0.0%
Band 5	0.0%	0.0%
Band 6	0.1%	0.1%
Band 7	0.0%	0.0%
Band 8A	0.0%	0.0%
Band 8B	0.0%	0.0%
Band 8C	0.0%	0.0%
Band 8D	0.0%	0.0%
Band 9	0.0%	0.0%
VSM	0.0%	0.0%



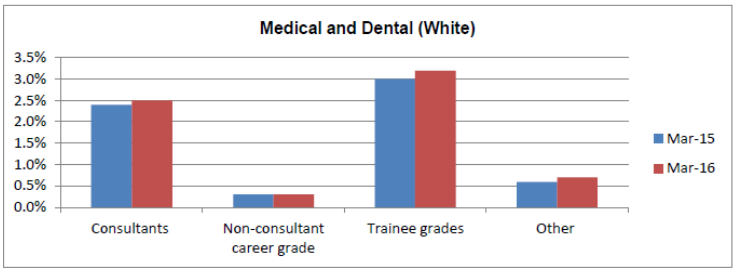
Clinical Workforce - White	Mar-15	Mar-16
of which non-medical		
Under Band 1	0.1%	0.1%
Band 1	0.0%	0.1%
Band 2	14.6%	15.0%
Band 3	4.6%	4.6%
Band 4	1.2%	1.2%
Band 5	21.1%	20.3%
Band 6	9.2%	9.5%
Band 7	6.7%	6.8%
Band 8A	1.0%	0.9%
Band 8B	0.4%	0.4%
Band 8C	0.2%	0.2%
Band 8D	0.0%	0.0%
Band 9	0.0%	0.0%
VSM	0.2%	0.2%



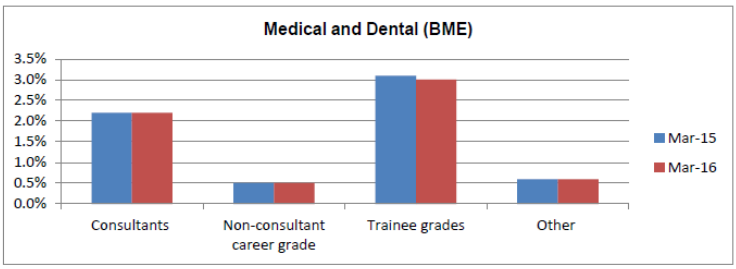
Clinical Workforce - BME	Mar-15	Mar-16
of which non-medical		
Under Band 1	0.0%	0.0%
Band 1	0.0%	0.0%
Band 2	0.5%	0.6%
Band 3	0.1%	0.1%
Band 4	0.0%	0.0%
Band 5	2.2%	2.3%
Band 6	0.4%	0.4%
Band 7	0.2%	0.2%
Band 8A	0.0%	0.0%
Band 8B	0.0%	0.0%
Band 8C	0.0%	0.0%
Band 8D	0.0%	0.0%
Band 9	0.0%	0.0%
VSM	0.0%	0.0%



Medical and Dental White	Mar-15	Mar-16
Consultants	2.4%	2.5%
Non-consultant career grade	0.3%	0.3%
Trainee grades	3.0%	3.2%
Other	0.6%	0.7%
Total	6.3%	6.7%



Medical and Dental BME	Mar-15	Mar-16
Consultants	2.2%	2.2%
Non-consultant career grade	0.5%	0.5%
Trainee grades	3.1%	3.0%
Other	0.6%	0.6%
Total	6.4%	6.3%



Hull and East Yorkshire Hospitals NHS Trust

WORKFORCE RACE EQUALITY STANDARD (WRES)
ACTION PLAN 2016/17

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.	Staff by pay banding, by clinical, non-clinical groupings, and by White/BME (see Indicator 1 data sheet)	• Undertake further detailed analysis to identify any specific departments, job roles and pay bands where BME staff are poorly represented at a senior level. Work with senior managers in these areas to develop action plans to identify the underlying reasons and potential solutions.	December 2016	Director of Workforce and OD
			• Engage with BME staff network to identify potential barriers to the progression of BME staff past Band 7 and to identify appropriate mechanisms by which the Trust can identify and develop BME staff with potential for career progression.	December 2016	Director of Workforce and OD
			• Encourage participation of BME staff in leadership development programmes with a view to preparing BME staff for roles in Bands 8-9 and VSM.	Ongoing	Executive Directors
			• Design a sustainable and effective apprenticeship programme across the Trust, including at senior/Board level.	January 2017	Director of Workforce and OD
			• Implement a system of talent management, including succession planning, to improve performance and address skill gaps.	Ongoing	Director of Workforce and OD
			• Improve collection and analysis of exit interview data to better understand people's reasons for leaving and to identify and implement actions to improve staff retention.	December 2016	Director of Workforce and OD

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	White = 0.15 BME = 0.09 Relative likelihood = 1.67	• Review the content of recruitment and selection training programmes, ensuring sufficient emphasis is given to equality, diversity and inclusion. • Consider the introduction of unconscious bias as a component of recruitment and selection training. • Review arrangements for refresher training for recruiting managers.	December 2016	Head of Education and Development
			• Ensure when external agencies are used to source candidates for senior roles that contracts include requirements relating to equality and diversity which go beyond the statutory minimum. Require agencies to source candidates in a way which encourages applications from as diverse a pool of talent as possible and which demonstrates the Trust's commitment to diversity and inclusion.	September 2016	Director of Workforce and OD Head of Procurement
			• Ensure improvements in recruitment and selection processes are communicated to staff to ensure that they are aware of the Trust's aim to make selection a fairer process.	December 2016	Director of Communications and Engagement
			• Review the Trust's promotional material under the recruitment branding "Remarkable People, Extraordinary Place' to ensure it is reflective of the diverse and inclusive culture that the Trust wishes to develop and sustain.	September 2016	Director of Communications and Engagement
			• Seek to make better use of technology and social media to reach and attract potential candidates from all protected characteristic communities.	December 2016	Director of Communications and Engagement
			• Review and enhance the Trust's leadership programme, ensuring a greater emphasis on the development of a diverse and inclusive culture.	December 2016	Director of Workforce and OD

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	White = 0.003 BME = 0.006 Relative likelihood = 2	• Improve the quality of disciplinary data held and put in place better systems for monitoring and review of disciplinary cases.	November 2016	Director of Workforce and OD
			• Undertake an annual in-depth analysis of the qualitative and quantitative data from the disciplinary process to identify any issues and trends by department/health group/directorate, by profession and pay banding.	Ongoing	Director of Workforce and OD
			• Review and update the Disciplinary and Capability Policy for Medical and Dental Staff, 2009 (CP285)	December 2016	Chief Medical Officer Director of Workforce and OD
			• Review and update the Disciplinary Policy and Procedure (non-medical staff), 2012 (CP024)	December 2016	Director of Workforce and OD
			• Publicise the refreshed disciplinary policies and procedures to ensure that staff are aware of the Trust's expectations in terms of conduct and what the potential consequences are of a failure to comply.	January 2017	Director of Communications and Engagement
			• Encourage managers undertaking disciplinary investigations, hearings and appeals to undertake equality and diversity training prior to carrying out these roles in order to increase awareness of equality issues and how they relate to the disciplinary process.	Ongoing	Director of Workforce and OD

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
			• Review induction and training given to staff to ensure that staff who trained overseas are given sufficient training and information about the NHS, UK culture and behavioural expectations.	December 2016	Head of Education and Development
			• Engage with BME staff via the BME network to gain a greater understanding of this issue and seek feedback on how the Trust can apply the disciplinary policy more consistently and fairly. Seek feedback specifically on: o How staff feel the organisation deals with disciplinary matters generally. o The main reasons they feel staff from BME backgrounds are disciplined. o Aspects of the disciplinary processes they feel might place BME staff at a disadvantage. o Suggested ways to improve the situation for BME staff. o Ways to help improve the situation for managers.	October 2016	Director of Workforce and OD
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White = 0.95 BME = 0.91 Relative likelihood = 1.04	• Explore opportunities to link the Trust's training and development database (HEY247) to the ESR to enable the Trust to capture training data by ethnicity.	October 2016	Director of Workforce and OD
			• Utilise data to understand where there may be pockets of under-representation (either by BME or White staff) in terms of accessing mandatory and non-mandatory training and identify departments, roles or pay bandings where review and action is required.	Ongoing	Director of Workforce and OD
			• Explore ways in which the Trust can increase participation by BME staff in the available	November	Director of

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
			programmes/training events.	2016	Workforce and OD
			• Review and update relevant training policies and procedures, including: o Education and Development Policy 2014 (CP170) o Policy for Statutory and Mandatory Training 2013 (CP275) o Management of Corporate and Local Induction Policy (CP161) o Performance and Development Review (Appraisal) Policy 2013 (CP157)	April 2017	Director of Workforce and OD
5.	KF25 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White = 26% BME = 27%	• Undertake a refreshed communications campaign to all service users and visitors to the Trust regarding the Trust's zero tolerance approach to bullying, harassment, abuse and violence.	October 2016	Director of Communications and Engagement
			• Review mechanisms available to staff to report incidents and to ensure appropriate responses are received by staff who report to ensure that they are aware of actions taken. Publicise these to encourage staff to report instances of harassment, bullying or abuse.	October 2016	Director of Governance
6.	KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White = 35% BME = 57%	• Undertake a refreshed communications campaign to staff regarding bullying and unacceptable behaviours, re-emphasising the Trust's zero tolerance approach.	October 2016	Director of Communications and Engagement
			• Undertake annual review of the Trust's Bullying and Harassment Policy, 2015 (CP269).	December 2016	Director of Workforce and OD
			• In areas where bullying is identified as an issue,		

No.	WRES Indicator	Metric	Actions	Timescale for Delivery	Lead Responsibility
			implement a programme of anti-bullying training, re-emphasising the Trust's values and expectations of behaviour.	Ongoing	Director of Workforce and OD
7.	KF21 – Percentage believing that Trust provides equal opportunities for career progression or promotion.	White = 85% BME = 73%	• Detailed annual review of staff responses to survey question relating to whether the Trust acts fairly in relation to career progression and promotion to establish what changes take place over time.	Ongoing	Director of Workforce and OD
			• Undertake engagement work with staff, with involvement of the BME network, to improve the Trust's understanding of staff perceptions about fairness and equal opportunities.	December 2016	Director of Workforce and OD
8.	Q17 – In the last 12 months have you personally experienced discrimination at work from any of the following: b) Manager/team leaders or other colleagues?	White = 8% BME = 16%	• Review of the role of the Staff Advice and Liaison Service (SALS). • Examine qualitative and quantitative data collected by the SALS to determine trends and identify departments, roles or pay bandings where review and action is required.	December 2016	Director of Workforce and OD
9.	Percentage difference between the organisation's Board voting membership and its overall workforce	-11.7%	• 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 which demonstrates the Trust's commitment to diversity and inclusion.	October 2016	Chairman Chief Executive

TRUST BOARD REPORT – 2016 – 7 - 17	
Meeting date:	28 July 2016
Title:	Standing Orders
Presented by:	Liz Thomas – Director of Governance
Author:	Rebecca Thompson – Assistant Trust Secretary
Purpose:	To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.
Recommendation(s):	The Trust Board is requested to approve the use of the Trust's seal.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

STANDING ORDERS

1 PURPOSE OF THE REPORT

To approve those matters that are reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE
2016/13	Hull and East Yorkshire Hospitals NHS Trust and The Police and Crime Commissioner for Humberside – Lease relating to part of the roof at HRI, Hull	5 May 2016
2016/14	Hull and East Yorkshire Hospitals NHS Trust and Boots UK Limited – Lease relating to the pharmacy space at Queen's Centre, CHH, Cottingham	11 May 2016
2016/15	Hull and East Yorkshire Hospitals NHS Trust and Boots UK Limited – lease relating to pharmacy space at HRI, Hull	11 May 2016
2016/16	Hull and East Yorkshire Hospitals NHS Trust and UK RF (Number 1) Limited and UK RF (Number 2) Limited, Counterpart lease relating to 95 rooms at houses 1-4, The Village, Beverley Road, Hull	11 May 2016
2016/17	Hull and East Yorkshire Hospitals NHS Trust and Cottingham Young People's Sports Foundation Trustees – Lease to Cottingham Young People's Sports Foundation	27 May 2016
2016/18	Hull and East Yorkshire Hospitals NHS Trust and Humber NHS Foundation Trust – Lease relating to rooms at Beverley Community Hospital	8 June 2016
2016/19	Hull and East Yorkshire Hospitals NHS Trust and Infrastructure Investors Castle Hill Ltd – Deed of variation regarding the Project Agreement (Phase V) relating to Castle Hill Hospital	19 July 2016

3 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Assistant Trust Secretary
July 2016

Hull and East Yorkshire Hospitals NHS Trust

TRUST BOARD REPORT – 2016 – 7 - 18	
Meeting date:	28 July 2016
Title:	**REVIEW OF BOARD COMMITTEES 2015/16**
Presented by:	Liz Thomas – Director of Governance
Author:	Liz Thomas – Director of Governance
Purpose:	The purpose of the paper is to report on the review of the Board Committees.
Recommendation(s):	The Board is asked to: • Approve Performance & Finance Terms of Reference • Decide whether responsibility for monitoring Trust Strategies (as outlined in section 3) should be devolved • Approve Board and Committee dates for 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

REVIEW OF BOARD COMMITTEES 2015/16

1. PURPOSE OF THE PAPER

The purpose of the paper is to report on the review of the Board Committees.

2. BOARD COMMITTEES

The Board has established the following committees that report directly to it: Performance & Finance, Audit, Quality, Remuneration and Charitable Funds. It is acknowledged good practice for the Board to review its committees and their effectiveness annually.

2.1 – Performance & Finance Committee

The Performance & Finance Committee has conducted a review of its effectiveness. This has comprised of a questionnaire completed by its members, review of papers received during 2015/16 mapped to both terms of reference and workplan and separate meeting with the Chair of the Committee to discuss the outcome of the review.

Attached at Appendix 1 is the committee's annual report and Appendix 2 revised terms of reference which have arisen from the effectiveness review.

2.2 – Audit Committee

Non Executive members of the Audit Committee attended an event hosted by Internal Audit which explored different models for undertaking a review of Audit Committee effectiveness. The Audit Committee is in the process of discussing how to conduct its effectiveness, which has included consideration of independent input. Information on the Audit Committee's activities during 2015/16 is contained in the Trust's Annual Report and Annual Governance Statement.

The Audit Committee has used the NHS Audit Committee Handbook to review its terms of reference and these will be discussed at the Audit Committee in September 2016 and presented to the Board for approval.

2.3 – Quality Committee

The Quality Committee members have completed a questionnaire on the Committee's effectiveness. Arrangements are in the process of being strengthened under the direction of the Chair of the Committee in conjunction with its members. The Committee has reviewed its workplan but there may be further changes once the effectiveness review has been considered. The Committee's Annual Report for 2015/16 was received at the Committee in April 2016 and is attached at Appendix 3.

2.4 – Remuneration Committee

Members of the Committee reviewed the information received by the Committee during 2015/16 at its meeting in April 2016. It compared this to the Terms of Reference. Gaps were identified in relation to the nomination responsibilities and these were included in the workplan for 2016/17. Information on the Remuneration Committee's activities during 2015/16 is contained in the Trust's Annual Report (accountability section).

2.5 – Charitable Funds Committee

The Charitable Funds Committee has had a change in Chair in 2015/16 as well as a change to its strategic direction. A more proactive approach to fundraising utilising the new Health Charity has been agreed. The new Charity will align its focus on fundraising with the Trust's strategic objectives. The committee's current terms of reference now include this new approach and were approved by the Board in February 2016.

3. Board Strategies

During the review of Board Committees an issue was raised in relation to monitoring delivery of Trust Strategies. Whilst the Board will retain responsibility for reviewing progress against the Trust's Strategy 2016 – 2021, a decision is required on whether the Board wishes to delegate monitoring arrangements to Board Committees for the three supporting strategies in between their formal review by the Board. The three strategies are: IM&T, Estates and People Strategy. It is proposed that, should the Board wish to delegate responsibility, that the first two strategies are monitored by Performance & Finance and People Strategy by Quality Committee.

4. Board and Committee Dates 2017

Please see attached at Appendix 4 Board and Committee dates for 2017.

5. RECOMMENDATIONS

The Board is asked to:

- Approve Performance & Finance Terms of Reference
- Decide whether responsibility for monitoring Trust Strategies (as outlined in section 3) should be devolved
- Approve Board and Committee dates for 2017

Liz Thomas
Director of Governance

Rebecca Thompson
Assistant Trust Secretary

July 2016

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
ANNUAL REPORT OF THE
PERFORMANCE AND FINANCE COMMITTEE
2015/16

1 INTRODUCTION

The Performance & Finance Committee is responsible for seeking assurance on the planning and successful delivery of key performance measures both financial and operational, with a focus on sustained performance and future delivery.

This report sets out the work of the Performance & Finance Committee during 2015/16.

2 MEETINGS

2.1 Compliance with Terms of Reference

Terms of Reference	Compliance	
12 meetings per annum	Met 12 times	√
Quorum: 4 members	Met all meetings	√
Members attending 10/12 meetings	Met all meetings	√
Workplan	Agreed May 2015	√

Mr S Hall chaired the meeting in 2015/16. Members attended 10 out 12 meetings in line with the terms of reference. It was agreed that the Interim Chief of Infrastructure, the Director of Workforce and the Director of Strategy and Planning would only attend the meetings by invitation and Mrs Ryabov joined the committee as the interim Director of Operations.

2.2 Committee Effectiveness Review

A review of Committee effectiveness was undertaken at the end of the financial year and reported at the May 2016 meeting. Members reported positively on the chairing of the committee, the freedom to challenge and appropriate escalation to the Board when necessary. Areas of concern were highlighted as financial items needing more scrutiny and time on the agenda as it is felt that due to the Trust's performance issues these take priority. Further clarification relating to a membership succession plan is required.

A summary sheet is produced after each meeting which shows areas where the committee feel assured and where more assurance is required. This is reported at each Board meeting.

3 WORK OF THE COMMITTEE DURING THE YEAR

The Committee's agenda is divided into three sections. These are performance, finance and capital. The Committee was not fully assured on areas of finance and performance and this will be a key focus in 2016/17 and will be in line with the revised terms of reference.

There was adoption and utilisation of a new assurance document. This document formally requests further assurance, based on performance of the Trust within the immediately preceding month. This process now replicated by Audit Committee.

Focus meetings were held with Health Group Directors and senior staff to scrutinise and gain assurance on progress of specific plans and recommendations. Health Groups involved in this process included the Surgery Health Group presenting their productivity report following an undertrade in 2015/16. Medical Director/Senior Management level attendance is requested at

the committee meetings to discuss progress in terms of productivity and Cash Releasing Efficiency programmes.

Consideration and recommendation was given relating to the format of performance data, both in terms of the monthly update provided to Board and in the form of the weekly update provided to Non Executive Directors.

The Chair of the committee highlights any concerns to the pre-Board meetings and also provides recognition of examples of good progress/practice.

The committee reviews contracts and where appropriate it supports the expenditure. As examples, recommendation to progress business cases for Heart Valve Contracts and Radiology Reporting Services have been reviewed.

The committee considers exceptional business cases/plans such as the Non-Clinical Accommodation report.

Scrutiny of the minutes of the Capital Resource Allocation Committee takes place and the committee requests assurance in areas where it is felt that additional detail is required.

4 WORK DELEGATED FROM THE BOARD

The table below sets out work delegated from the Board and when it was discussed at the committee.

Work Delegated	Date Discussed in the Committee	Outcomes
Locum costs to be reviewed	April 2015	Finance monitor locum costs on a weekly basis and the new agency cap monitoring and reporting of breaches is in place.
Work Delegated	**Date Discussed in the Committee**	**Outcomes**
ED Recovery Plan May 2015	At each meeting	The Trust continues to face challenges in this area. A revised trajectory for recovery of performance against the 4-hour standard has now been submitted to NHSI. This trajectory has been worked through with both CCGs. We await final sign off from NHSI on the planned trajectory and the work to ensure delivery is contained with the revised Urgent & Emergency Care Improvement Plan**.**
Lorenzo Benefits Realisation	June 2015	Lorenzo savings - £1.2m, the anticipated benefits to be gained through more efficient reporting has not materialised during 15/16. Work is ongoing
Cancer Action Plan (June 2015)	Jul, Aug, Sept, Oct, Nov, Dec 2015, Jan, Feb 2016	Work is ongoing internally and externally on improving the timed pathways with partner organisations although it is acknowledged that there is a considerable amount to

		do before significant change can be demonstrated. The Cancer Operations Group is considering a new RCA review proposal to enhance how the Trust MDT's process, review and learn from breach analysis.
Delivery of the Winter Plan	Sept 2015	Monthly reports detailing Trust performance have been presented by the Chief Operating Officer.
Financial Position (Apr 2015)	Apr, May, Jun, Jul, Aug, Sept, Oct, Nov, Dec 2015, Jan, Feb, Mar 2016	The Trust met its statutory requirements but ended the year with a deficit of £8.1m.
Lord Carter of Coles	Feb 2016	The Trust continues to work with Lord Carter and his team to refine this information in order to be able to use it sensibly within with Clinical Services. In addition, the Trust, as part of its internal planning is now organising itself through the Portfolio Board to formally address each of the individual work streams covered by the Carter programme.

5 ESCALATION TO THE BOARD

The Corporate Performance and Financial Performance reports are standing agenda items of the Trust Board. Therefore the views of Performance & Finance members feed into these agenda items rather than being separately raised under the reporting from the Performance & Finance Committee.

6 MATTERS TO BE ADDRESSED 2016/17

Emergency Department Performance

- The Committee to monitor achievement of the Emergency Department action plan and trajectories.

Referral to Treatment times.

- The Committee to monitor achievement of the RTT recovery plan and satisfy itself that the identified risks are being appropriately managed.

Cancer

- The Committee to scrutinise the plans relating to delivery of the 62 day standard to ensure that they are achievable and on target.

Finance Report

- The Committee to review the Financial Plan 2016/17
- The Committee to review the Health Group's progress relating to Cash Releasing Efficiency Savings

7 NEXT STEPS

The Trust Board will be requested to ratify the revised Terms of Reference and membership of the Committee in May 2016.

Rebecca Thompson
Assistant Trust Secretary
June 2016

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE

TERMS OF REFERENCE

1. FORMATION OF THIS COMMITTEE

The Performance and Finance Committee is a Committee of the Trust Board and has been established in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee has formal terms of reference and powers as delegated by the Trust Board.

2. ROLE

The Committee is responsible for seeking assurance on the planning and successful delivery of key performance measures both financial and operational, with a focus on sustained performance and future delivery.

The key performance measures which fall within the remit of the Performance and Finance Committee are the NHS Constitution standards relating to access and indicators relating to the delivery of the Trust's financial plan.

In line with the Trust's scheme of delegation the Committee is charged with reviewing and authorising business cases or recommending business cases to the Board for authorisation, if beyond the Committee's delegated limit.

3. RESPONSIBILITIES

NHS Constitution standards (access)

3.1 To gain assurance that the organisation has, at all times, robust and effective operational planning systems in place (including demand and capacity) for delivering contract levels of activity

3.2 To gain assurance that the organisation has, at all times, robust and effective performance management systems in place relating to delivery of the access targets.

3.2 To seek assurance that controls are in place, and operating effectively to mitigate the risks to the successful delivery of access targets

3.3 Review the plans for winter and make recommendations to the Board for adoption. Monitor delivery of the plans.

3.4 To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken

3.5 To seek assurance that agreed recovery plans are being implemented in a timely fashion and delivering the required outcomes

Financial Performance

3.6 To seek assurance that the organisation has a robust and effective financial planning and performance management systems in place.

3.7 To seek assurance on the production and implementation of long term financial plans (including capital) having regard to relevant national guidance, commissioning plans, and resource availability both internally and within the local health economy in order to support the Board in its decision making.

3.8 To consider loan applications prior to recommending approval by the Trust Board

3.9 To seek assurance that controls are in place and operating effectively to mitigate the risks to the successful delivery of financial performance, including cash releasing efficiency schemes and agency caps.

3.10 To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken

3.11 To seek assurance that agreed recovery plans are implemented in a timely fashion and resulting in improved outcomes

3.12 To receive assurance that Service Line Management is in place and Patient level costing is being developed and used to support delivery of the Trust's financial objectives

3.14 To receive assurance on the work being undertaken in relation to the Lord Carter review

Overall Financial & Operational Planning

3.14 To provide overview and scrutiny to the development of the Trust's annual and longer term plans (as required by relevant National Guidance) for financial and operational performance and is line with the Trust Strategy, ensuring that the Trust's financial plan is consistent with the Trust's operational plan and reflective of the Trust's goals

3.15 Ensure that the annual plans (operations, revenue and capital) are consistent with, and supportive of, relevant Trust wide strategies - Clinical Services, IM&T and Estates

3.16 To recommend to the Trust Board the approval of the Annual Operating Plan in relation to operational performance and financial plans.

Review the risks on the Board Assurance Framework relevant to the remit of the Committee (NHS Constitution Standards and Finance) to ensure that controls are in place and mitigating action is effective

Investment

3.17 In line with the Trust's approved scheme of delegation scrutinise all business cases for proposed capital investment that require either Performance and Finance Committee or Trust Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust's goals

3.18 Evaluate, scrutinise and approve investment (and dis-investment) proposals within delegated limits, making recommendations to the Board in line with Standing Orders, Standing Financial Instructions

3.19 To receive assurance from the Capital Resource Allocation Committee that in year capital investment is being spent as planned and delivering planned benefits.

4. MEMBERSHIP OF THE COMMITTEE

The Committee shall comprise:

Non-Executive Director (Chair)
2 Non-Executive Directors (one of whom will be designated as vice chair)
Chief Financial Officer
Chief Operating Officer
Director of Workforce & OD

Other officers will be invited to attend the Committee to speak to specific agenda items:

- Director of Estates, Facilities and Development
- Director of Strategy and Planning

It is expected that all members will attend at least 10 out of 12 committee meetings per financial year. If Executive Directors are unable to attend a meeting they will be represented by a deputy who has the authority to make decisions on their behalf.

An attendance record will be submitted to the Committee for information and action at each meeting.

The Trust Board will ensure that the Committee membership is refreshed and that undue reliance is not placed on particular individuals when undertaking the responsibilities of the Committee.

5. CHAIRMAN OF THE COMMITTEE

The Chairman and Vice Chairman of the committee shall be Non Executive Directors.

6. QUORUM

The quorum shall be a minimum of 4 out of 5 members. Of these 2 must be Non Executive Directors, one Executive Director and one other officer.

7. MEETINGS

The Committee shall meet 12 times a year. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

8. ATTENDANCE AT MEETINGS

Other senior employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that employee.

9. NOTICE OF MEETINGS

Meetings of the Committee shall be set at the start of the calendar year by the Assistant Trust Secretary. 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.

10. 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 Assistant Trust Secretary.

11. REPORTING ARRANGEMENTS

The proceedings of each meeting of the Committee shall be reported to next meeting of the Board following production of the minutes. 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 or strategy.

12. DUTIES AND RESPONSIBILITIES OF THE COMMITTEE

The Committee is required to fulfil the following responsibilities:

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

12.2 Produce an annual report setting out the achievements of the committee and any gaps in control or effectiveness of reporting arrangements

12.3 Communicate and consult with the Health Groups and Directorates in achieving the objectives of the annual work plan, policy or strategy.

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

13. SCHEME OF DELEGATION

The Performance and Finance Committee will have delegated responsibility as follows:

Capital Cost	Approving Board / Committee
£5m+	Trust Board
£2m – Less than £5m	Performance and Finance Committee
£0.5m – Less than £2m	Executive Management Board
£5k – Less than £0.5m	Capital Resource Allocation Committee

Note: Any business case deemed to be a high financial risk [Trust Business Case Guidance] will also require approval at the next level of authority.

Additional **external** approval is currently required for schemes with a capital cost above £5m as follows:

- NHS Improvement [NHSI] over £5m
- NHSI, Department of Health and Treasury over £50m

14. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek the information it requires from any employee, and all employees are directed to co-operate with any request made by the committee, including representation where appropriate at Committee Meetings.
The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust.

15. RELATIONSHIP WITH OTHER COMMITTEES

The Committee receives information and assurances from the Trust's internal performance review processes and meetings The Committee will receive updates from the Capital Resource Allocation Committee.

The Committee works closely with the Trust Quality Committee. The Trust Board is responsible for ensuring that clarity exists between the Performance & Finance Committee and the Quality Committee in terms of which measures each Committee is

responsible for monitoring performance against. It is the responsibility of the respective Chairs of each Committee to ensure that issues of common interest or overlap are effectively communicated and managed between the Committees.

The Performance and Finance Committee may refer issues to the Audit Committee or be requested to consider issues raised by the Audit Committee.

16. ADMINISTRATION

The Committee is supported administratively by the Assistant Trust Secretary, who will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the Committee.

Date issued: March 2014
Date revised: June 2015, June 2016
Date ratified by Trust Board: July 2015 (planned for July 2016)
Review date: May 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
ANNUAL REPORT OF THE QUALITY COMMITTEE
2015/16

1 INTRODUCTION

The Quality Committee is responsible for providing assurance to the Trust Board concerning all aspects of quality and safety relating to patient care and identifying quality improvement measures. This report sets out the work of the Quality during 2015/16.

2 MEETINGS

2.1 Compliance with Terms of Reference

Terms of Reference	Compliance	
6 meetings per annum	Met 5 times	X
Quorum 6 members	Yes	✓
Workplan	Agreed April 2015	✓

There was a change in the chairmanship of the committee during the year. Professor Sheldon took over as chair in June 2015.

2.2 Committee Effectiveness Review

An effectiveness review was carried out in June 2015 and the following areas were highlighted.

- items requiring decisions should be prioritised on the agenda to give enough time to scrutinise them in detail.
- the size of agendas could compromise a full discussion of all points.
- comments received suggested that time allocation to agenda items could sometimes be compromised due to the amount of detailed items on agendas.

It was felt that further work was required to improve the quality of the information received by the Committee. It was felt that the quality of information was extremely detailed and key messages could be lost in the amount of information received.

- Review the corporate performance report and provide time at the Committee to consider the areas of deviation (including trends and benchmarking)
- Format and length of individual papers

More work was required to provide an adequate induction programme and succession planning. The overlap of agenda items with other committees was also highlighted as a concern.

3 WORK OF THE COMMITTEE DURING THE YEAR

Attached at Appendix A is the workplan of the committee throughout the year.

4 WORK DELEGATED FROM THE BOARD

The table below sets out work delegated from the Board and when it was discussed at the committee.

Work Delegated	Date Discussed in the Committee	Outcomes
Nursing & Midwifery Validation	April 2015	Revalidation came into force on 1st April 2016 in what was hailed as the most 'significant regulatory change' in the regulator's history. It has been introduced to drive up quality of care, patient safety and professionalism. The change means all of the nurses and midwives registered with the Nursing and Midwifery Council (NMC) must provide regular evidence that they can deliver safe, effective and professional care. The first cohort of nurses and midwives who were the first to revalidate in April 2016 at Hull and East Yorkshire Hospitals NHS Trust have all now successfully submitted their applications.
Outpatient Cancellations	January 2016	Cancellations are being reviewed by the Transformation Team.
Clinical Negligence Report	June 2015	The Claims Department has been undergoing service transformational change to improve the overall claims handling process. Proactive management of claims at an early stage facilitates the identification of opportunities for service change; enables full involvement of Trust clinicians from the outset; achieves settlement of claims promptly to save on costs; and provides detailed information to defend unjust claims.
Easy read version Quality Accounts	June 2015	An easy read version of the Quality Accounts is now available.
CQC – Quality Improvement Report	Updates received at each meeting	Regular updates are received at the Committee and Trust Board. Action plans are in place to address the issues raised by the CQC.
Incidents/Lessons Learned	May 2015, January 2016	Reports are received at each Quality Committee and the Board to highlight incident reports ongoing, outstanding and highlight any lessons learned and how these are shared with staff.

5 WHAT WAS ESCALATED TO THE BOARD 2015/16

The following items were escalated to the Board:

- All Never Event reports and implications are now considered at Board meetings in public.
- The priority and importance of completing of Serious Incident investigations
- The backlog of incident investigations to be escalated to the Board.
- Significant risks were highlighted regarding progress made following the Major Trauma Centre Peer Review and the impact this could have on the Trust.
- To agree to a change to the Terms of Reference of the Quality Committee to include oversight of the Quality Improvement Plan.

6 MATTERS TO BE ADDRESSED 2016/17

Assure the Board that the Revalidation and Appraisal process for doctors and nurses is progressing in a timely manner and is robust.

Give assurance that performance against the 2016/17 Quality Account Priorities was achieving the targets and highlight any issues to the Board.

Assure the Board that staff are aware of the priority and importance of completing of Serious Incident investigations in a timely manner and that lessons learnt are shared.

Assure the Board that outpatient cancellations were being addressed, that the numbers are reducing and robust procedures are in place.

More work was required to provide an adequate induction programme and succession planning within the committee structure.

Assure the Board that the Quality Improvement Plan actions are implemented in a timely manner and are robust.

APPENDIX A

Original Workplan	Quality Committee Workplan 2015/16					
Agenda Items	**23-Apr-15**	**18-Jun-15**	**01-Sep-15**	**22-Oct-15**	**17/12/2015 - CANCELLED**	**18-Feb-16**
CQC Compliance/Action Plan/ QIP	✓	✓	✓	✓		✓
CQUIN - Intergrated Performance Report	✓	✓	✓	✓		✓
Quality Accounts Priorities and Targets	✓	✓	✓			
Incident reporting including SIs	✓	✓	✓	✓		✓
Sign up to Safety (incorporated into QIP)	✓	N/A	N/A	N/A		N/A
Claims		✓		✓		Extra
Clinical Audit	Extra	✓		Extra		
Safeguarding		✓				
External reports/publications	✓	✓	✓	✓		✓
Clinical Assurance of CRES / Quailty Impact of CRES		✓	✓			✓
Medicines management	✓	✓	✓	✓		✓
Medicines Optimisation Annual Report	Extra		✓			
Reports from Committees						
Executive Nursing Board Report	✓	✓	✓	✓		✓
Operational Quality Committee Report	✓	✓	✓	✓		✓
Issues delegated from the Trust Board						
Review of Committee Effectiveness	✓	Extra				
Additional Items						
	23-Apr-15	**18-Jun-15**	**01-Sep-15**	**22-Oct-15**	**17/12/2015 - CANCELLED**	**18-Feb-16**
Out Patient Services						
Major Trauma – Serious Concerns Letter						
Joint Advisory Group Report						
Yorkshire and Humber Vascular Stocktake						
Patient Experience Minutes						
Revised Never Events Policy and Framework						
Nurse & Midwifery Revalidation						
Hip Fracture Performance						
Committee Annual Report						
Royal College of Surgeons – Wrong Site Surgery						
Medical Revalidation Training – (Audit June 2015)						
Terms of Reference - Membership						
Patient Story						
Health Group Governance Minutes						

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
DRAFT BOARD AND COMMITTEE MEETING DATES 2017

DATE	TIME	MEETING	LOCATION
TUESDAY 03.01.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
THURSDAY 26.01.17	9.00 – 12.00	Audit	Committee Room
	1.00 – 3.00	NED	Committee Room
MONDAY 30.01.17	9.00 – 11.00	Quality	Committee Room
	11.30 – 1.30	Charitable Funds	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
TUESDAY 07.02.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
THURSDAY 23.02.17	1.30 – 3.00	Remuneration	Committee Room
	3.00 – 5.00	NED	Committee Room
MONDAY 27.02.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
TUESDAY 07.03.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
MONDAY 27.03.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
THURSDAY 30.03.17	9.00 – 12.00	Audit	Committee Room
	1.00 – 3.00	NED	Committee Room
TUESDAY 04.04.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
MONDAY 24.04.17	9.00 – 11.00	Quality	Committee Room
	11.30 – 1.30	Charitable Funds	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
THURSDAY 27.04.17	1.00 – 3.00	NED	Committee Room
MONDAY 02.05.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
THURSDAY 25.05.17	9.00 – 12.00	Audit	Committee Room
	1.30 – 3.00	Remuneration	Committee Room
	3.00 – 5.00	NED	Committee Room
TUESDAY 30.05.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
DRAFT BOARD AND COMMITTEE MEETING DATES 2017

DATE	TIME	MEETING	LOCATION
06.06.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
26.06.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
29.06.17	1.00 – 3.00	NED	Committee Room
04.07.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
27.07.17	9.00 – 12.00	Audit	Committee Room
	1.00 – 3.00	NED	Committee Room
31.07.17	9.00 – 11.00	Quality	Committee Room
	11.30 – 1.30	Charitable Funds	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
05.09.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
25.09.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
28.09.17	9.00 – 12.00	Audit	Committee Room
	1.30 – 3.00	Remuneration	Committee Room
	3.00 – 5.00	NED	Committee Room
03.10.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
26.10.17	1.00 – 3.00	NED	Committee Room
30.10.17	9.00 – 11.00	Quality	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
07.11.17	12.00 – 1.00	NED Pre Meet	Committee Room
	1.00 – 2.00	Board Pre Meet	Committee Room
	2.00 – 5.00	Trust Board	Boardroom
27.11.17	9.00 – 11.00	Quality	Committee Room
	11.30 – 1.30	Charitable Funds	Committee Room
	2.00 – 5.00	Performance & Finance	Committee Room
30.11.17	9.00 – 12.00	Audit	Committee Room
	1.30 – 3.00	Remuneration	Committee Room
	3.00 – 5.00	NED	Committee Room

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	7 June 2016	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	**Y**

Key issues discussed:

- The progress made in relation to establishing the Independent Health Charity and its launch
- Receipt and review of the Financial Report– detailing income, expenditure and investment details for the financial year 2015/16
- The progress being made on various fundraising activities and charitably funded projects in which the Trust is involved or associated
- Fund Balances – A review of fund balances held by Health Groups and their management

Decisions made by the Committee:

- Bids for General Charitable Funds – A number of bids were presented, discussed and approved as appropriate

Key Information Points to the Board:

Matters escalated to the Board for action:

- The Charitable Funds Committee recommended that the Trust Board discuss the Trust's contribution to the City of Culture 2017.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHARITABLE FUNDS COMMITTEE

HELD ON THURSDAY 7 JUNE 2016
THE BOARD ROOM, HRI

PRESENT: Mr A Snowden (Chair), Vice Chair, Non Executive Director
Mr L Bond, Chief Financial Officer
Mrs V Walker, Non Executive Director
Mr D Haire, Project Director - Fundraising

IN ATTENDANCE: Mrs L Roberts, Membership Officer (Minutes)

ACTION

1 APOLOGIES FOR ABSENCE
Apologies were received from Mrs D Roberts, Deputy Finance Director.

2 DECLARATIONS OF INTEREST
There were no declarations made.

3 MINUTES OF THE MEETING 18 FEBRUARY 2016
The minutes were approved as an accurate record of the meeting.

4 MATTERS ARISING
Minute 9 – Financial Report
Mr Bond advised that after the last meeting he had met with Mrs Roberts and Mr Duncan regarding the investment losses and had received clarification that the original figures were correct.

5 ACTION TRACKER
Terms of Reference
Following a request from the Committee Mr Haire advised that information relating to the Kids Company Charity had been included in the papers.

All of the other items on the Action Tracker were not due to be delivered yet. Items marked completed were agreed and these would be removed from the tracker.

6 DRAFT WORK PLAN 2016/17
Mrs Roberts to advise when Brown Shipley would attend the Committee. **DR**

Resolved:
To reschedule Brown Shipley to attend a Committee meeting at a later date. **DR**

7 PROJECT DIRECTOR'S REPORT
Mr Haire presented the report and gave the Committee an overview of the various fundraising schemes and related activities which were currently ongoing.

Hull & East Yorkshire Hospitals Health Charity
Mr Haire along with Mrs Lockwood had met with Mr Ramsden and Mr Snowden to inform them of the progress in relation to the charity's launch, which had been tentatively scheduled for July 2016.

It was envisaged that the charity would be called WISHH – Working independently to support HEY Hospitals.

The Trustees of the charity were scheduled to meet to discuss the launch and the actions required in regards to promotion. Mr Haire agreed to inform the committee of the launch details once finalised. **DH**

Creating a Dementia Friendly Environment – Wards 8 and 80
The completion of Phase 1 of the work is expected before the Care Quality Commission inspection in June 2016.

Dr Harman, Consultant Geriatrician is scheduled to meet with and present to the Trustees of the charity on 14 June 2016 regarding their support for subsequent phases of the project.

Mr Snowden asked what the completion of Phase 1 of the works would mean for patients. Mr Haire advised that a number of improvements had been made which included the appearance of the reception area to be “hotel like” and more responsive with having a staff presence at the ward entrance. Other features included a relative’s overnight room with en-suite facilities, a memory cafe, which would facilitate communal meals being taken; together with familiar items e.g. board games that would assist with patient reminiscences.

Da Vinci Robotic Surgical System
To date 126 urological procedures had been performed using the robot and the Colorectal Service had recently begun using the system.

The robotic system had, in addition, been used to provide treatment for a number of private patients (5). It was agreed that there was capacity for the Trust to continue to extend the use of the system to increase the overall activity undertaken and to strengthen its position as a tertiary centre.

The summary Business Case for use of the robotic system by the gynaecology service to perform hysterectomy procedures would be finalised shortly. An update from Mr Haire would be received at a future meeting. **DH**

Mrs Walker advised that there was a national database for urological procedure outcomes. She asked if those procedures carried out by the robotic system could be identified and how they had affected the outcome of patient care. It was noted that an initial audit of the first 50 radical prostatectomy procedures had been undertaken and significant patient benefit identified. Mr Haire advised that he would prepare a post implementation review set against the benefits included in the original business case. Mr Snowden suggested that this maybe something that the Quality Committee would be interested in. **DH** **LR**

Integrated Cyclotron and Radiopharmacy Development
The Daisy Charity continued to progress this significant research project in conjunction with the University of Hull and the Trust.

Following new EU guidance being issued it had been found necessary to appoint a specialist Good Manufacturing Practice (GMP) advisor to ensure full compliance with regulatory requirements.

Health Group Charitable Funds
Work was ongoing with the Surgery and Medicine Health Groups to review the Health Groups charitable funds and related spending plans. Mr Haire advised that once details had been finalised a report would be submitted to the Committee. **DH**

Resolved:
The Committee:

- received the report and noted its contents
- agreed to receive details of the Health Charity's launch **DH**
- agreed to receive a post implementation report detailing the procedures performed using the Da Vinci Robotic Surgical System and including outcomes information **DH**
- agreed to receive a report regarding the Health Group funds **DH**

8 SONG FOR HULL PROPOSAL
The background to this proposal, which would potentially involve the Trust Choir, was explained as were the possible funding requirements.

Following discussion the committee agreed that whilst it was supportive of the initiative it was not appropriate to consider providing funds from the Trust's charitable funds.

Mr Snowden suggested that he would raise the Trust's contribution to the City of Culture at the Trust Board meeting in July 2016. **AS**

Resolved:
The committee:

- did not consider it appropriate to provide support to the project from charitable funds
- agreed that a discussion regarding the City of Culture and the Trust's involvement should be held at the Trust Board meeting in July 2016 **AS**

9 FINANCIAL REPORT AS AT 31 MARCH 2016
Mr Bond presented the report which set out the income, expenditure and investment details of the Trust's Charitable Funds for the financial year 2015/16.

He advised that income was £1.365k; this was £855k above the estimated budget mainly due to a large legacy received during the year. Expenditure was £1.051k for the same period, which was £440k more than predicted.

The value of the Trust's investments with Brown Shipley was £982,976. The value of the Trust's investments with COIF was £450,810 and cash was valued at £258,132.

Mr Bond informed the Committee that the draft accounts had been completed and submitted to KPMG. Formal sign off of the accounts would take place at the next Committee meeting. **DR**

Resolved:
The Committee:

- received the report and noted its contents
- agreed to receive the accounts for approval at the next meeting **DR**

10 FUND BALANCES

Mr Bond presented the report which set out the Health Group fund balances as at 31 March 2016. The total of £1,350,395 represented an increase of £33,507 since 31 December 2015.

Mr Bond expressed concerns regarding the available portfolio and summary of funds by Health Group. He advised that he would communicate with each Health Group advising them of their available funds and encourage them to spend. If an appropriate shift in balances was not identified this would be discussed further at the next Committee meeting. **LB**

There was a discussion on slow moving fund balances. Mr Haire advised that work on spending plans was ongoing and agreed to bring a paper to the next Committee meeting detailing the Health Group's spending plans. **DH**

Resolved:

The Committee:

- received and noted the contents of the report.
- would be notified of the Health Group's response regarding available funds at its next meeting **LB**
- agreed to receive a report on Health Group's spending plans to the next Committee meeting **DH**

11 LEGACY UPDATE

Mr Bond presented the paper which notified the Committee that £160k of legacies had been received since the last report submitted to the meeting in September 2015.

Resolved:

The Committee:

- received and noted the contents of the report

12 PUBLIC FUNDRAISING REPORT

The Committee were informed that over £72k has been raised by members of the public during 2015/16.

Following discussion it was agreed that such fundraising activities should be channelled through the Hull & East Yorkshire Hospitals Health Charity, WISHH once launched.

Resolved:

The Committee:

- received and noted the contents of the report

13 BIDS FOR GENERAL CHARITABLE FUNDS

Mr Bond presented this report which contained a number of bids for general funds. The bids included:

Bid 1 Provision of Televisions and Fundamental Standards Quality Boards - £22,488 Confirmation of Urgent Approvals already given

This funding request comprised of:

- Top-up funding for televisions for the Centenary Building, £2,000
- The provision of televisions for Ward 1 and Surgical Outpatients (Hull Royal Infirmary) was £4,888
- The Trust-wide provision of Fundamental Standards Quality Boards was £15,600

The committee confirmed approval of these urgent approvals against the funds indicated.

It also agreed that all future urgent requests would be circulated to all committee members for consideration.

Bid 2 Midwifery-Led Unit – Contribution of Charitable Funds - £100,000

The project would provide a 3 bedded Midwifery-Led Unit within the Labour and Delivery suite at the Women and Children's Hospital. The unit would enable patients to give birth in a "homely" environment with minimal clinical intervention.

The Midwifery Led Unit project had received support from a local benefactor and it was anticipated that additional funding would be required to meet the full cost, albeit the final cost had yet to be confirmed. In order not to delay the project it was agreed that a sum of £100,000 be earmarked towards the project from fund reference 00012.

The bid was approved and Mr Haire agreed to notify the Committee once figures have been finalised. **DH**

Bid 3 Wards 8 and 80 Dementia Friendly Environment - £40,000

Whilst the phase 1 improvements were close to completion some additional expenditure had been incurred.

In addition a bid of £40,000 had been made to enable phase 2 works to be progressed. It was also envisaged that the WISHH charity would assist with promoting fundraising for this and possible subsequent phases of project.

The bid was approved and expenditure would be charged to the charitable fund reference 00012. **DH**

Bid 4 Kingstown Radio – Request for Financial Support - £6,000

A bid to provide financial support of £6,000 p.a. towards the running costs of the Kingstown Radio for each of the next three years was approved. The cost in 2016-17 would be charged to charitable funds reference 00001 and 00030.

The source of funding for years two and three would be confirmed at a date closer to the time the payments were to be made. **DH**

Resolved:
The Committee received the report and reviewed the bids submitted. All bids were formally approved by the Committee.

14 CHAIR'S SUMMARY OF THE MEETING

Mr Snowden summarised the meeting and agreed to raise the Trust's involvement in the City of Culture 2017 at the Trust Board meeting in July 2016. **AS**

15 ANY OTHER BUSINESS

e-Obs

Mr Bond advised the Committee that the e-Obs project had been successfully implemented across a small number of wards. To ensure that all wards and ward staff had access to the required handsets it was envisaged that funding in the order of £500k would be required. This cost was not in the budget.

Mrs Walker commented that she had shadowed staff using e-Obs and thought the system was very effective.

It was proposed that further consideration be given to the potential that exists to identify appropriate funding elsewhere to support the role out of the system to other wards. **DH**

Mental Health Awareness event

A request had been submitted for £1,000 to support a mental health awareness event which would be jointly hosted with other health partners. The event would be aimed at staff focusing on the issues that can be faced when caring for patients with learning disabilities and mental health problems.

Following a discussion is was agreed that Mr Haire and Mrs Walker would meet to discuss this request in more detail. Mrs Walker would investigate further to assess whether her link with MIND could support the event **DH / VW**

The bid was approved subject to the enquires by Mr Haire and Mrs Walker.

16 *DATE AND TIME OF THE NEXT MEETING:*

Thursday 22 September 2016, 12:30pm – 2:00pm, Max Fax meeting room (HRI)

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	28 June 2016	**Chair:**	Prof T Sheldon	**Quorate (Y/N)**	Y

Key issues discussed:

- Learning from Never Events (Radiology and Neurosurgery)
- Learning from the Serious Incident relating to Radiology batch printing of reports
- Performance against VTE
- Performance against time to theatre for fractured neck of femur
- Process for assuring that CRES does not adversely impact on quality of care
- Medicines optimisation annual report

Decisions made by the Committee:

- To receive clarity on the status of the business case for progressing e-observations
- To receive further detail of the outcome of the assessments of CRES and confirmation that schemes were not having a detrimental impact on the quality of care provided
- To note the positive improvements made with medicines optimisation in 2015/16 which included increased pharmacy support to clinical areas, antimicrobial stewardship and fast track ward based trolley dispensing. Further information was requested on why there had been an increase in administration incidents
- To receive further information on the emergency readmission rate and the reasons for not meeting the target

Key Information Points to the Board:

- Not all patients with fractured neck of femur are operated on within 36 hours in line with best practice. The reasons for breaches of the standard was noted and further update to be received
- Positive assurance received on the new arrangements for electronically dispatching radiology results to referring clinicians and the benefits that this system will bring to both hospital consultants and General Practitioners
- Positive assurance received on the actions taken by the Radiology Department and the Neurosurgery Department following the Never Events
- Review of VTE incidents occurring in the last quarter of 2015/16 had not identified significant issues

Matters escalated to the Board for action:

- To note the situation relating to the e-observation business case and that this system has identifiable quality benefits for patient care

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON THURSDAY 23 JUNE 2016
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon (Chair)	Non Executive Director
	Mr A Snowden	Vice Chair/Non Executive Director
	Mrs V Walker	Non Executive Director
	Mr S Jessop	Nurse Director (for Chief Nurse)
	Ms L Thomas	Director of Governance
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
IN ATTENDANCE:	Mr M Gore	Non Executive Director
	Mrs C Pacey	Improvement Director (NHSI)
	Mr T Goldstone	Consultant Radiologist (Item 5 only)
	Mr O Byass	Consultant Radiologist (Item 5 only)
	Mr S Achawal	Consultant Neurosurgeon (Item 5 only)
	Mr T Franklin	Care Quality Commission
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

ACTION

1. APOLOGIES

Apologies were received from Mr M Wright, Chief Nurse.

Prof. Sheldon welcomed Mr Franklin (Care Quality Commission) to the meeting. Mr Franklin was present as an observer to the Committee prior to the comprehensive inspection of the Trust due to commence the following week.

2. MINUTES OF THE MEETING HELD 21 APRIL 2016

Mrs Green advised that she had been at the meeting but was not on the attendance list. Mrs Thompson to add her to the list of attendees.

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

3. ACTION TRACKING LIST

Outpatient performance – there would be an update received in October 2016 and this would include the outcomes and reduction in harm figures linked to outpatient performance improvements.

e-Observation Business Case – Mr Jessop advised that there were funding issues relating to this business case. Prof. Sheldon requested clarity regarding the project and for the Board to be made aware of this issue.

Case Note System – Mr Phillips reported that there had been a few difficulties during the transition to the Electronic Patient Record system but that all clinicians had access to patient notes. This was being monitored at the Operational Quality Committee.

3.1 – WORKPLAN

The workplan was reviewed by the committee.

4. MATTERS ARISING

4.1 – ROOT CAUSE ANALYSIS – FRACTURE NECK OF FEMUR

Mr Jessop presented the paper which updated the committee regarding the time to theatre for patients with fractured neck of femur.

Performance had been improving. The main reasons for patients breaching the standard had been due to theatre capacity, clinical complexity and clinically unfit for surgery. Mr Jessop advised that there had been issues regarding lost capacity due to the theatre refurbishment programme currently underway and there had also been 10 complex pelvic cases in the last 6 weeks. Mr Snowden stated that one of the reasons for breach in the RCAs was that patients were clinically unfit for surgery and Mr Jessop advised that some patients were elderly, had complex conditions and surgery was delayed whilst interventions were put in place to prepare them for surgery.

Current performance was reported to be on average at 70.3% from July 2015 – March 2016.

Mr Jessop reported that a business case was being worked up to buy an image intensifier. This would enable some hip operations to be diverted to day surgery and therefore free capacity in the main theatres for those patients with more complex conditions.

Resolved:
The Committee received the update, noted the increase in performance and requested a further report once the business case had been developed. **SJ**

4.2 – QUALITY IMPACT OF CRES
Mr Phillips presented the paper and advised that a framework and guidance were in place to assess all CRES. Any scheme of £100k or less required Health Group Medical Director, Nurse Director and Operations Director approval. Schemes greater than this would require Chief Nurse, Chief Operating Officer and Chief Medical Officer sign off. The first meetings involving the Chiefs and the Health Groups were taking place in June 2016. Quarterly reviews would take place thereafter.

Prof Sheldon requested that future reports should provide information in tabular form which identified the savings schemes and a statement in relation to its impact on quality.

Resolved:
The Committee received the report, noted that the quality impact assessment process was in place and that future reports would contain information on the quality impact of CRES schemes being delivered/planned. **MW**

4.3 – VTE PERFORMANCE
Mr Phillips presented the paper which gave an update regarding VTE performance. Prof. Sheldon advised that the report received at the previous meeting had not identified whether the VTE episodes were avoidable, whether prophylaxis had been given or what actions had been taken.

Mr Phillips advised that the VTE performance had been subject to external audit and it was found that assessments were not always recorded on Lorenzo but were being conducted appropriately. The Lorenzo system had been amended to ensure assessments could not progress until it had been recorded on the system that they had been completed. Mr Phillips added that all 11 episodes had previously been in care and all patients had been given appropriate prophylaxis.

Resolved:
The Committee received the report and noted the improvements to the VTE performance and processes in place.

5. LEARNING LESSONS

5.1 – NEVER EVENTS – RADIOLOGY

Mr Byass gave a presentation which highlighted the 3 Never Events relating to wrong site surgery that had occurred in the Radiology Department and the measures put in place to prevent a reoccurrence. The three incidents related to different procedures. One was a vertebroplasty, one related to a lung biopsy and the third was a ureteric stent.

Each of the incidents resulted in recommendations being made but there were some overarching themes. These included variations in the way that the safety checklist was carried out between Consultants and teams, more than one type of checklist being in existence and safety huddles not being consistently carried out. As a result new checklists had been introduced and a system of spot checks was in place to monitor adherence to the new arrangements. Assessments of new and existing staff had been carried out, a full audit of the WHO checklist was planned and mechanisms for feeding back to staff after an incident had occurred and to share the leaning that had arisen had been strengthened.

Resolved:
The Committee received the update and assurance that new processes were in place following these incidents.

5.2 – SERIOUS INCIDENTS – RADIOLOGY PRINTING

Mr Goldstone gave a presentation relating to the serious incident regarding the batch printing of radiology reports. This related to a failure of some radiology reports to be printed and therefore consultants not acting on the results of investigations.

Mr Goldstone advised that a new electronic system was now in place and reports were sent to the requesting consultant daily. The paper based system had ceased and it was now possible to track that reports had been dispatched and confirm that they had been opened by the requesting clinician. Reports that contained concerning information that required follow up were flagged so that the receiving clinician was alerted to the results. The system was in place within the Trust and work was ongoing with the GPs to ensure that the system was rolled out to practices, although this would require some modifications.

Resolved:
The Committee thanked Mr Byass and Mr Goldstone for their presentations and assurance that measures had been implemented to avoid recurrence of the incidents.

5.3 – NEVER EVENT – NEUROSURGERY

Mr Achawal gave a presentation relating to two Never Events regarding wrong site spinal surgeries. He explained the background to both incidents. Unfortunately the second incident had occurred whilst the first incident was still under investigation.

Mr Achawal advised that a review had taken place following the Never Events from the Royal College of Surgeons and standard operating procedures were developed to ensure marking protocol was followed. Mr Achawal also advised that an annual training quiz was being carried out with all consultants, registrars and locums performing this type of surgery. The outcome of the Never Events had been shared at a national conference so that others could also learn from the incidents that had occurred.

Resolved:
The Committee thanked Mr Achawal for his presentation and noted the measures put into place to avoid recurrence.

5.4 – THEMES AND TRENDS REPORT

The Themes and Trends report was not presented to the committee as further work was to be carried out. Prof. Sheldon advised that the report would review the patient journey and look at all aspects of patient safety and triangulate complaints, serious incidents and any claims made.

Resolved:

The report would be presented to the next meeting in September 2016 and would be reviewed by Prof. Sheldon and Ms Thomas ahead of the meeting. **LT**

6. MEDICINES OPTIMISATION

Mr Corral presented the Trust's annual medicines optimisation report.

Achievements highlighted included the continued benefits from the investment into Pharmacy with more clinical Pharmacy cover , including weekends and significant improvements in antimicrobial stewardship. Transformation projects had been targeted to improving the patient experience eg fast-track ward based trolley dispensing. The success of the joint working with Boots was highlighted as well as the Board approval of the inpatient e-prescribing module.

The Committee noted the increase in administration errors and requested further information on this for the next meeting. The number of prescribing incidents had reduced.

Resolved:

The Committee received the report and requested further information relating to medication incidents at the next meeting in September 2016. **DC**

7. REPORTS RECEIVED FOR INFORMATION

7.1 – QUALITY IMPROVEMENT PROGRAMME

The Quality Improvement Programme was received for information. Mr Phillips advised that each improvement project would be reviewed in detail at the Operational Quality Committee.

7.2 – HEALTH GROUP ESCALATION REPORT

The Health Group escalation reports were received for information. Prof. Sheldon asked for the pressure ulcer training status and Mr Jessop advised that this was now at 100% following a training drive initiative with nursing staff.

7.3 – INTEGRATED PERFORMANCE REPORT

The committee received the report for information. Prof. Sheldon requested further information relating to emergency readmissions within 30 days as this was increasing. Mr Phillips agreed to give an update at the next meeting. **KP**

8. ANY OTHER BUSINESS

Prof. Sheldon requested the effectiveness review of the committee be discussed at the next meeting as well as the frequency of the meetings.

There were a number of good news stories reported:

- Mr Phillips stated that he had attended the Obstetric World Congress in Birmingham
- Mrs Green reported that the Physiotherapy Department had contributed to NICE guidance published relating to COPD
- Mrs Walker had spoken to a number of patients on her ward walk rounds that had fed back positive comments about their stay

9. CHAIRMAN'S SUMMARY TO THE BOARD

Prof. Sheldon agreed to summarise the meeting to the Board in July 2016.

10. DATE AND TIME OF THE NEXT MEETING:

Thursday 8th September 2016, 3pm – 5pm, The Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AUDIT COMMITTEE

Meeting Date:	23 June 2016	**Chair:**	Mr M Gore	**Quorate (Y/N)**	**Y**

Key issues discussed:

The key issues discussed at the Committee were:

- Quality Accounts 2015/16 and Directors representations letter
- Consultant job planning
- Internal audit progress report
- Terms of reference of the committee and effectiveness review
- Gifts and hospitality and external business interests registers
- Clinical audit annual report 2015/16
- Claims report
- Risk register report
- Reference costs

Decisions made by the Committee:

- To seek further assurance on overdue actions arising from clinical audit activity. The committee requested specific follow up of two audits to determine action taken by Health Groups. The Committee was not assured that actions were being completed in a timely manner
- To seek assurance regarding declarations relating to Consultant study leave
- To seek further clarity on responsibility for winter planning to ensure that there are more formalised planning processes in place for the winter 2016/17
- To invite the Director of Strategy and Planning to the October meeting of the Audit Committee to gain assurance on the processes in place to deliver of the Trust's annual plan
- To receive further information on the corporate risk register and risks on the risk register
- To receive further information on how clinical negligence claims are weighted

Key Information Points to the Board:

- Limited assurance was provided on the internal audit report on the Information Governance Toolkit. An action plan is in place for the 8 areas where level 2 could not be substantiated and a review of the Trust arrangements would be taking place
- There have been operational issues relating to the late payment of invoices following the implementation of the they financial system
- The approach to reviewing the committee's effectiveness would be agreed at the next meeting
- The follow up of actions identified during clinical audits were not being followed up by health groups

Matters escalated to the Board for action:

- To approve the two contract approved outside of Standing Orders (window cleaning and MRI scanners) – minute 14

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE MINUTES
HELD ON THURSDAY 23 JUNE 2016
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr M Gore (Chair)	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
IN ATTENDANCE:	Mr L Bond	Chief Financial Officer
	Ms L Thomas	Director of Governance
	Mr J Prentice	KPMG
	Mr G Baines	MiAA
	Mrs C Hibbert	Director of Operations (Item 4.1 only)
	Mrs N Scott	Finance Management Trainee
	Mrs R Thompson	Assistant Trust Secretary (part meeting)

Action

1. APOLOGIES
Apologies were received from Mrs D Roberts, Deputy Director of Finance.

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

3. MINUTES OF THE MEETING 5 MAY 2016
Internal Audit – Mr Bond wanted to assure the committee that new company supplying the Trust with financial services (East Lancashire Financial Services) had robust processes in place but that there had been some operational difficulties initially on change over. Regular project board meetings had been set up to monitor performance. The last sentence on the third paragraph would be amended to reflect this position.

Any other business - An amendment was made to the last sentence under 'Any Other Business'. The end of the sentence 'and financial controls were now much more robust' would be removed.

Locality Reviews had been discussed at the last meeting but had not been reflected in the minutes. It was noted that action plans were in place and any outstanding urgent issues had been addressed.

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

3.1 – MINUTES OF THE EXTRAORDINARY MEETING 26 MAY 2016
It was noted that Mrs Christmas had given apologies. Subject to this amendment the minutes of the extraordinary meeting held on 26 May 2016 were approved as an accurate record of the meeting.

4. MATTERS ARISING/ACTION TRACKER/WORKPLAN
Recruitment of external auditors – Mr Gore and Mrs Roberts would meet outside of the meeting to discuss further. **DR/MG**
NHS Providers Update – Ms Thomas agreed to update the committee following her attendance at the Trust Secretary meeting. **LT**
Internal audit - The review of ordering systems relating to pharmacy, catering and estates to be placed on the tracker. **RT**

Bribery Act – Ms Thomas to include information in the Chief Executive briefing **LT**
Credit Card Expenditure - Web hosting/diamond ring – Further information to be received by Mrs Roberts at the next meeting. **DR**

The committee meeting dates for 2017 were discussed and Mrs Thompson agreed to put a draft schedule together for the July Board meeting. **RT**

4.1 – CONSULTANT JOB PLANS
Dr Hibbert attended the meeting to provide an update to the committee on consultant job planning. A new computer system had been developed and this would allow managers to view job plans and look at how staff were deployed. The system would be managed corporately by the HR team and could include monitoring of annual leave. Dr Hibbert advised that it would take approximately a year for all doctors to be added to the system and their job plans to be available electronically.

There was a discussion around productivity and Mrs Christmas asked who decided the level of productivity. Dr Hibbert advised that the Trust determines contract levels. The system is not yet sophisticated enough to also link this explicitly to individual and specialty productivity levels. Performance management was discussed. Dr Hibbert reported that peer pressure and competition would motivate the doctors in a more positive way in relation to productivity, rather than managing their performance. As well as productivity, case mix and more complex work would also need to be analysed as well as the type of procedures undertaken and how experienced the Consultant was, with the implication that more recently qualified consultants might not managed the same workload. The new system would improve transparency and provide more assurance when job plans were in place.

Resolved:
The committee thanked Dr Hibbert for attending the committee and noted the progress being made regarding consultant job planning.

Previous data showing reducing productivity would be reissued to Dr Hibbert for analysis and comment **RT**

5. BOARD COMMITTEE MINUTES:
5.1 – PERFORMANCE & FINANCE 23 MAY 2016
The Performance & Finance minutes 23 May 2016 were received for information.

6. TECHNICAL UPDATE
Mr Walker presented the report which highlighted collaborative working with Health Education England and the national impact of agency staffing. Mr Gore stated that a new EU directive had been released relating to Data Protection and Ms Thomas advised that this would be reviewed at the Information Governance Committee to ensure compliance. Committee

The 2016 NHS Premises Assurance Model (PAM) was discussed and Mr Bond advised that this was reviewed quarterly at the Non Clinical Quality Committee as part of the Trust planning process. The PAM includes changes in policy, strategy, regulations and technology and Mr Bond advised that no major issues had been raised.

Mr Walker advised that KPMG would discuss the fees accumulated following the preparation of the Trust's annual accounts with Mr Bond.

Resolved:

The committee received the Technical update and noted the contents. Mrs Thompson to email the committee and electronic version to allow the links to be accessed. **RT**

6.1 – QUALITY ACCOUNTS

Ms Thomas presented the Quality Accounts to the committee and advised that they would need to be signed off by the Trust Board. The External Auditors would also give their opinion once the accounts had been approved by the Board. There were concerns raised relating to the scoring of quality improvement indicators and Ms Thomas agreed to clarify the scoring system before the Board approval took place.

Once the Quality Accounts were approved they would be uploaded to the NHS Choices website.

6.2 – QUALITY ACCOUNTS LETTER OF REPRESENTATION

The Quality Accounts Letter of Representation was presented to the committee for information and would be signed by Mr Bond on behalf of the CEO. Mr Bond advised that the Quality Accounts would be signed off by the Trust Board at an extraordinary meeting on 28 June 2016.

Resolved:

The committee recommended approval by the Board subject to the changes being made relating to the quality improvement indicators.

7. INTERNAL AUDIT PROGRESS REPORT

Mr Baines presented the report and highlighted the progress to date relating to the internal audits.

The Information Toolkit audit had been given limited assurance and Ms Thomas advised that the Trust had maintained its level 1 status. There had been a number of issues including a change in leadership from the Chief Financial Officer to the Director of Governance, IG Officer engagement due to the service being outsourced to Humber Mental Health Trust and not enough evidence to support procedures in place.

Going forward a more proactive approach would be given to the Toolkit with all 40 standards being reviewed in 2016/17. Contract arrangements would also be reviewed in 2016/17.

Internal audit had reviewed the winter planning process and issued a report setting out the key findings and areas for further consideration. There was discussion around the need to strengthen the arrangements. Mr Gore asked which director was responsible for winter planning and Mr Bond agreed to clarify this via email. **LB**

Mr Gore asked that a standard item relating to follow up reviews of audits be placed back onto the agendas at each meeting to ensure that any outstanding actions were closed down.

Resolved:

The committee noted the contents of the report. Mr Bond would clarify executive responsibility for winter planning. **LB**

8. TERMS OF REFERENCE

Ms Thomas presented the terms of reference to the committee. There was a discussion around mapping the Audit Handbook to the terms of reference as well as the Trust's strategic objectives. The committee wanted a half year review of the Trust's

annual plan and invited Ms Myers (Director of Strategy and Planning) to attend the Audit Committee in October 2016 to discuss further.

There was also a discussion around the Board Assurance Framework and the corporate risk register and how risks are escalated up and down. Ms Thomas agreed to provide more information relating to risks and the registers to the next meeting in September 2016.

Resolved:
The committee reviewed the terms of reference and agreed:

- Ms Thomas would develop the TOR and Mr Gore would review them before being presented at the September 2016 meeting. Any comments from the committee to be sent to Ms Thomas.
- Ms Myers to be invited to the meeting in October to review the Trust's annual plan
- Ms Thomas to provide a paper to the next meeting in September highlighting risk mapping from the BAF and the corporate risk registers

9. DECLARATION/GIFTS & HOSPITALITY POLICY

Ms Thomas presented the policy to the committee. There had been two changes to the policy which were including information relating to the 'Fit and Proper Person Test' and new reporting information relating to pharmaceutical companies and any gifts received by staff.

Resolved:
The committee noted the changes in the policy and approved it.

9.1 – GIFTS AND HOSPITALITY REGISTER

The committee reviewed the gifts and hospitality register and a number of questions were raised regarding requests for study leave and management approval by the medical directors.

There was a discussion around the value of foreign travel to conferences and the time taken off the individuals job. The Committee picked two consultants from the register and asked for confirmation that the Medical Directors were informed and that their attendance was appropriate.

Resolved
The committee reviewed the list and requested further information relating to a number of study leave declarations to give assurance that activity was under control.

9.2 – EXTERNAL BUSINESS INTEREST REGISTER

The committee received the register relating to business interests. There was a discussion around consultants declaring private work. Mr Bond stated that any agreed private work should form part of the consultant's job plan.

Resolved:
The Committee reviewed the external business interest register and noted the declarations made.

10. CLINICAL AUDIT ANNUAL REPORT

Ms Thomas presented the report which highlighted clinical audit activity during 2015/16 and the audit plan for 2016/17.

Mr Gore expressed his concern that follow up actions from local audits were being carried out by the central team and not the Health Groups. Ms Thomas advised that there had been centralisation of finance, HR and governance and that previously each Health Group organised activities in different ways. There was an opportunity with the centralisation of the Quality and safety Managers to redefine responsibilities.

There was a discussed around the number of overdue audits and Mr Gore asked for a follow up on two audits. The committee asked for reassurance relating to the status of the following audits:

- Use of Longlines and Umbilical Catheters on the NNU – Current Practice and complications
- Auditing the Management of Paediatric Inpatients with Head Injury according to Nice guidelines

Resolved:
The committee received the report and requested follow up information and reassurance of two audits.

11. CLAIMS REPORT

Ms Thomas presented the report which highlighted the costs associated with claims and the Trust's annual premium. This issue had been raised during the sign off of the Annual Accounts and it had been agreed that the Audit Committee would receive further detail.

There was a discussion around the value of claims and how they were weighted. Mr Gore asked if claims were analysed by consultant and whether the consultants were made aware of the claims made. Ms Thomas advised that work was ongoing triangulating serious incidents, complaints and claims to give a detailed picture of the issues. Ms Thomas advised that claims were being settled at a quicker rate even though the number of claims had gone up in 2015/16.

Resolved:
The committee received the report and requested further information around how the claims were weighted.

12. RISK REGISTER REPORT

Ms Thomas presented the report which highlighted the Trust's top risks. The risks had been reviewed at the Executive Management Committee and a consensus reached. External support had been received to assist in the development of the corporate risk register which would sit below the Board Assurance Framework.

Mr Bond stated that there had been a debate regarding the financial risk rating and this had now been reduced. The committee agreed with the top risks identified.

Resolved:
The Committee received the reported and approved the risk management and assurance strategy.

13. REFERENCE COSTS REPORT

Mr Bond presented the report which gave assurance to the committee that the reference cost process was able to meet the national guidance. He advised that PWC was completing an audit relating to the reference cost processes and the Trust was awaiting the final report. Once this was available Mr Bond agreed to share this with the committee.

Resolved:
The committee received the report and noted its contents.

14. ANY OTHER BUSINESS

Mr Gore raised the effectiveness review of the committee and stated that it would be good practice for an external peer group to conduct the review. Mr Bond agreed but wanted another acute trust of the same size to review the committee to give a fair view. Mr Baines offered the help of MiAA to carry out the review.

Resolved:
It was agreed that the MiAA information on Committee effectiveness would be circulated to the committee **RT**

Mr Bond notified the committee of contracts that had been signed outside of standing orders and would need retrospective approval by the Board. These contracts were window cleaning and the replacement mobile MRI scanners. He also spoke about the electricity supply contract which would be presented to the Board for approval at the extra-ordinary meeting on 28 June 2016.

15. CHAIRS SUMMARY OF THE MEETING

Mr Gore agreed to summarise the meeting to the Board in July 2016.

16. DATE AND TIME OF THE NEXT MEETING:

The next meeting will be held on Thursday 8th September 2016, 9am – 12pm in the Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON MONDAY 27 JUNE 2016
THE COMMITTEE ROOM

PRESENT:	Mr S Hall (Chair)	Non Executive Director
	Mrs E Ryabov	Chief Operating Officer
	Mr M Gore	Non Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs T Christmas	Non Executive Director
IN ATTENDANCE:	Ms J Myers	Director of Strategy & Planning (item 5.3 only)
	Mrs T Proctor	PA to Chief Nurse (Minutes)

No **Item** **Action**

1. APOLOGIES

There were no apologies received.

2. MINUTES OF THE MEETING HELD ON 25 JANUARY 2016

The Minutes were approved as an accurate record of the meeting

2.1 – P&F ASSURANCE DOCUMENT

The Assurance Document had been circulated to the Committee, Agency pay and CRES will be further discussed with the reports presented at item 7.

3. ACTION TRACKING LIST

Overtime in the MRI Department. – Mr Bond advised that discussions had taken place with the Clinical Support Health Group at their Health Group Performance and Accountability meeting and that paying overtime was not an option, partly because of rules and regulations around Agenda for Change and also because of the low numbers of staff wanting to work.

National Benchmarking information (Agency Cap) – This information is yet to be received so the item would stay on the action tracker.

4. WORKPLAN

Mr Hall told the committee that the current workplan was now out of date but will be reissued following review of the Terms of Reference. **SH**

5. MATTERS ARISING

5.1 – TERMS OF REFERENCE/EFFECTIVENESS REVIEW

A draft Terms of Reference had been circulated to the committee and it was expected that everyone had had a chance to read the document. Membership of the committee was discussed and it was agreed that the Deputy Chief Operating Officer did not need to be listed in the membership as they would only attend if the Chief Operating officer was absent. Later discussions agreed that Director of Workforce be added to the membership list and invited to attend the Committee each month.

As there isn't a Vice Chairman of the Committee Mrs Christmas was proposed to take up this role. Mr Hall will discuss the procedure to be followed in appointing a Vice Chairman with Liz Thomas. **SH**

The overall scheme of delegation is to be approved by the Trust Board in July 2016 and then amended for the Performance & Finance Committee

acoordingly. This standard scheme will be updated on the Terms of Reference.

An exercise to assess the effectiveness of this Committee had been performed and, based on a simple numerical scoring system, the results of the lowest scoring areas were discussed. Mr Bond took over facilitating the meeting so that Mr Hall could give his own views on the subjects discussed rather than those as the chair of the committee.

- **Insufficient Allocation of Time**. It was agreed that the agenda could be structured in terms of importance of items being discussed. In the past focus has been on the Emergency Department but going forward there needs to be a more balanced strategic discussion. It was also agreed that workforce should be brought back onto the agenda.
- **Influence within the organisation**. A lengthy discussion followed on this subject. Points discussed included how much influence the committee should have, were the views of the committee taken seriously by the Trust Board and was the Annual Report to the Board efficient. Conclusions from the discussion were that the committee did have influence with the Board. This committee gave the Non Executive Directors an opportunity to discuss the detail on issues that the Board doesn't see and therefore give assurance that these issues have been discussed and challenged. The Committee agreed that expanding the membership would not make it any more influential. Everyone broadly agreed that the information documented could be better but there is always the opportunity for a Chair to Chair discussion on any issues.

Resolved:
The committee agreed to make the above amendments and take the Terms of Reference to Trust Board for approval. **SH**
Going forward the Agenda will be structured in order of importance of items and time be allocated to each item accordingly.
Workforce to be brought back onto the Agenda and Simon Nearney to be invited to the meeting. **RT**

5.2 – ANNUAL REPORT OF THE COMMITTEE
The updated annual report had been circulated and the Committee were now in agreement with the content.

Resolved:
The Committee received the report and noted the contents.

5.3 – OUTPATIENT CANCELLATIONS
Ms Myers gave a presentation on the Outpatient Project which forms part of the HEY Improvement programme. The key aims of the project are to improve the patient experience by reducing cancellations and 'did not attend's' (DNA's) and to increase productivity and efficiency by better utilisation of slots and rooms to increase activity within the existing clinics. Discussions and questions were raised during the presentation covering the following points:

- The numbers of cancellations are monitored in the weekly Performance and activity meetings, cancelling slots needs to be a difficult process to perform.
- Variations in the patient administration process across the Trust need to be evened out. The importance of Patient Services has been

underestimated.

- Rota's, annual leave etc need to be standardised and better controlled to prevent spikes occurring during school holidays.
- With staff engagement and provision of the correct tools, KPI's, SOP's improvements can be made to the outpatient service which will have an effect on the referral to treatment targets.

6. INTEGRATED PERFORMANCE REPORT

Mrs Ryabov presented the Integrated Performance report. She told the Committee that she has had discussions with Mr Bond regarding the content of the report and the views that this should be reviewed. The Committee agreed that this does need further discussion and agreed that comments on the report content can be fed back to Mr Hall who will take this forward with Mrs Ryabov and Mr Bond who will draft an amended report.

Resolved:

The committee received the report and noted the contents. Any comments on the structure and content of the report to go to Mr Hall for inclusion during discussions with Mrs Ryabov. **SH/ER**

6.1 – RESPONSIVENESS EXCEPTION REPORTS (ED)

Mrs Ryabov took the committee through the exception report templates and highlighted the following.

- The Emergency Department exception report showed a stepped increased in performance, pressures affected this at the beginning of May when the Winter Capacity was closed. Concerns were raised on the waits for doctor review in the department, sometimes because of short notice annual leave. Senior presence at the front door had made a difference in performance. Overall the emergency department was showing improvements as was outflow but there was still an issue with patients who were medically fit for discharge but remain in hospital. There were 90-100 at this time and the aim was to reduce this number to 50. Activity was up by 14% in the year to date and discussions would be held with the CCGs regarding the number of patients to be seen and contractual arrangements. The Trust manages to see 365 patients per day but the actual number of patients had been nearer 429. Performance out of hours still continues to be an issue. Specialist review remains challenging especially when waiting for diagnostic tests and work on pathways was ongoing.

- Further work by the estates department on the Discharge Lounge is to be developed so the Committee asked that this be a future agenda item to advise what is being done and the timescales for completion. **LB**

- Two week wait standards for referral to the Breast symptomatic service had failed due to patient choice and GP referrals.

- Cancer subsequent surgery standard had failed but the service was above trajectory for the 62 day standard.

- There was a long term plan for improvement in the radiology department which included procurement and installation of new equipment. This committee asked to be notified if there were any issues or delays in the plan.

Resolved:
The committee received the report and noted the contents.

7. CORPORATE FINANCE REPORT

Mr Bond presented the Corporate Finance report to the Committee and highlighted the areas of concern.

The lack of systematic practices in the Trust is causing problems with the company we have outsourced the Trust's financial services to. There are too many non-stock purchases without purchase order numbers so the culture and processes used by different departments need to be standardised. There were concerns that the Trust will start to incur some late payment interest debt and there could be issues around suppliers holding deliveries of goods and equipment in lieu of payment.

The Trust is struggling for cash at the moment because of issues such as £1.5m from the cancer drug fund being on hold because of contention over £80k.

Discussions were ongoing regarding the outstanding mortuary bill and Mr Bond advised that he would speak to Mr Long regarding his discussion with Hull City Council and report back to the Committee. **LB**

The Committee raised a query against the figures on the statement of comprehensive income statement so Mr Bond agreed to review the figures and report back to the Committee. **LB**

Resolved:
The Committee received the report and noted its contents. Mr Bond would report back to the Committee the outcome of his discussion with Mr Long regarding Hull City Council.

7.1 – CRES REPORT 2016/17

Mr Bond presented the CRES report to the Committee. An update was requested by the Committee of the effect of the Lord Carter programme on any savings. The Health Groups will be invited to come in and present their CRES Schemes to the committee and explain any mitigating risks and actions around CRES. Mr Bond advised that a review of CRES Schemes with each of the Health Groups was planned for the end of August so it was agreed that the presentations to this Committee would take place after that.

Resolved:
The Committee noted the report and the Trust's CRES position for 2016/17. Presentation of the Health Groups CRES by the individual Health Groups to be added to the agenda from September. **RT**

7.2 – AGENCY REPORT

Mr Bond presented the Agency report to the Committee and highlighted the areas of concern.

There are 30-40 agency posts within patient administration. The Trust is looking to convert some of these to permanent posts whilst redesigning the Patient Administration function to make it more efficient. There was a discussion around using temporary staff for non clinical admin roles and Mr Bond agreed to bring a report back to the Committee next month on clinical

administration.

Resolved:
The committee received the report and noted its contents.
Mr Bond will present Non Clinical administration agency report for the next meeting. **LB**

8. CAPITAL RESOURCE ALLOCATION COMMITTEE SUMMARY REPORT

Mr Bond presented the Capital Resource Allocation Committee's summary report and asked that the concerns regarding significant service challenges (relating to purchasing new medical equipment) and funding issues were escalated to the Trust Board.

Resolved:
The Committee noted the contents of the report and will escalate concerns regarding the service challenges to Trust Board **SH**

9. ITEMS DELEGATED BY THE BOARD

Items delegated by the Board were discussed in item 6.0 and 7.0

10. ANY OTHER BUSINESS

10.1 – SUPPLY OF GAS EXTENSION.

The Chairman was asked to approve the contract for an extension to the gas supply on behalf of the Committee. Mr Bond explained that the contract would take up the original option for an extension allowing for continued negotiations. The original contract was the best price available found by the Trust Brokers. Assured that the Trust was getting the best price for this supply the Chairman was happy to sign the contract.

A second request was made to sign the contract for an extension to the supply of electricity under similar conditions. This was also approved and signed.

Mrs Christmas asked if the papers for the Performance and Finance Committee could be sent out earlier as she didn't receive them until the day of the Committee. It was agreed that she would receive the papers electronically along with all other members. **RT**

11. CHAIRS SUMMARY OF THE MEETING

Mr Hall to summarise the meeting to the July 2016 Board meeting.

12. DATE AND TIME OF THE NEXT MEETING:

Monday 25 July 2016 2.00pm – 5pm, The Committee Room, HRI