Hull and East Yorkshire Hospitals NHS Trust

Meeting of the Trust Board

To be held in Public

Thursday 27 October 2016 at 10.30am

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 29 September 2016	attached	Chair
4. Action Tracker	attached	Director of Governance
5. Matters Arising	verbal	Chair
6. Chair Opening Remarks	verbal	Chair
7. Chief Executive Briefing	attached	Chief Executive Officer

Quality

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

Performance

12. Integrated Performance Report 1	attached	Executive Team
13. Winter Plan	verbal	Chief Operating Officer

Strategy & Development

14. Sustainability Transformation Plans	verbal	Chief Executive Officer

Assurance & Governance

15. Responsible Officer Report	attached	Chief Medical Officer
16. Board Assurance Framework	attached	Director of Governance
17. Standing Orders	attached	Director of Governance
18. Unadopted Minutes from Board Standing Committees		Chair of Committee
18.1 – Quality Committee 20.10.16	verbal	
18.2 – Performance & Finance 26.09.16, 24.10.16	attached/verbal	

18.3 – Charitable Funds 22.09.16 attached
18.4 – Audit Committee 20.10.16 verbal

19. Any Other Business

20. Questions from members of the public

21. Date & Time of the next meeting:
Thursday 27 October 2016, 10:30am,
The Board Room, Hull Royal Infirmary

Attendance 2015/16

	24/9	29/10	26/11	28/1	25/2	31/3	28/4	26/5	28/7	29/9	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
C Long	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	9/10
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	✓	✓	✓	✓	x	7/10
V Walker	✓	x	✓	✓	✓	✓	x	✓	✓	✓	8/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
E Ryabov	-	-	-	✓	✓	✓	✓	✓	✓	✓	7/7
In attendance											
J Myers	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	9/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
D Taylor	✓	-	-	-	-	-	-	-	-	-	1/1
S Nearney	x	✓	✓	✓	✓	x	✓	✓	x	✓	7/10

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 29 SEPTEMBER 2016
THE BOARDROOM, HRI

PRESENT	Mr M Ramsden	Chairman
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr A Snowden	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Gore	Non-Executive Director
	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)

1. APOLOGIES

Apologies were received from Prof. T Sheldon, Non Executive Director

2. DECLARATION OF INTERESTS

2.1 – Changes to directors' interests since the last meeting

There were no new declarations made.

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

There were no declarations made.

3. MINUTES OF THE MEETING 28 JULY 2016

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

4. ACTION TRACKER

The Action Tracker was reviewed by the Board. Ms Thomas advised that Trust Strategies would be discussed at the Board Development Day on Monday 3rd October 2016.

5. MATTERS ARISING

Item 3 - Health Group Workforce plans – Mr Nearney advised that Health Group workforce plans would be included into the Trust's Operational Plan, which would be received in due course. **SN**

Item 19.1 – Charitable Funds Minutes 07.06.16 – Mr Snowden clarified that Sue Lockwood was the Chair of the Independent Charity.

6. CHAIR OPENING REMARKS

Mr Ramsden stated that there would be no industrial action from the Junior Doctors as the issue had been settled in the High Court.

The Trust was still waiting for the report from the Care Quality Commission following their inspection of the organisation in June 2016. There was no further information to

report at this time.

Mr Ramsden also advised that the Board would be receiving an update from Ms Myers regarding the Sustainability Transformation Plans and what this would mean for the Trust.

7. CHIEF EXECUTIVE BRIEFING

Mr Long presented his report and stated that it was his 2nd anniversary in the Trust and he was privileged to work with such dedicated and professional staff.

He reported that the Trust was focussed on improving performance although coping with increased demand for emergency admissions. He advised that the Trust was doing well compared with the national picture. Mr Long spoke about the NHS Improvement Single Oversight Framework and how this was still out for consultation and would replace the Accountability Framework set out previously by the Trust Development Authority.

Mr Long reported that NHS Operational Planning and Contracting guidance had been published and control totals had been applied to all Trusts. He stated that the Trust would need to align the STP financial plans with its own which would impact on affordability for the Commissioners.

Mr Snowden praised the CEO report and stated that national context was important to understand how the Trust was performing nationally as well as locally. He also stressed that it was good to see successes and achievements of staff recognised in a formal way.

8. PATIENT STORY

Mr Phillips reported that a patient with shoulder pain had been referred to the hospital by their GP and had no communication from the service administrative staff. The patient had felt ignored and eventually spoke to the Trust's Patient Advice and Liaison Service. Mr Phillips advised that since this incident the administrative system was being reviewed and the patient had received their treatment.

Mr Phillips also spoke about an elderly patient who was at the end of their life and a friend had written to the Trust praising the professional and dignified manner of the staff at the time of the patient's death. They wanted to express their respect and gratitude to the staff who had allowed them to be present.

Mr Hall asked what protocol the Trust had in place to thank staff when they had been praised. Mr Wright advised that a senior member of staff would write to the ward giving their personal thanks and also send them a copy of the compliment letter.

9. QUALITY REPORT

Mr Phillips presented the report to the Board. He advised of 2 Never Events that had taken place, one was a wrong site spinal surgery and the other was a misplaced nasal gastric tube. Both investigations were ongoing and the findings would be presented to the Board in due course. Mr Phillips reported that the Duty of Candour had been followed in both instances with face to face discussions with the patients and their families as well as a formal letter of apology. There were steps and actions in place to minimise these incidents happening again and Mr Phillips assured the Board that the services were safe.

Mr Phillips reported that the overall performance regarding falls was improving. Patients at risk were assessed at the twice daily safety briefings.

Mr Phillips reported that there had been an outbreak of Scabies in the hospital after a patient who had the disease had been admitted. The outbreak was contained and had now been eliminated. Mr Phillips also spoke about the flu vaccination programme which was about to start for all staff to protect themselves and patients.

In the Patient Experience section of the report he advised that there were 12 Parliamentary and Health Service Ombudsman cases currently open but no new cases in August. The Trust now had QR codes on all patient information leaflets to allow them to be read by smartphones. Mr Phillips wanted the Board to note the work being carried out by the volunteers and how more young volunteers were joining the Trust.

Mr Phillips updated the Board regarding the increase in the Standard Hospital Mortality Index. He reported that the national view was to review avoidable deaths and assured the Board that the Trust was not an outlier in this area and deaths within 30 days of admission were being reviewed proactively.

Following an incident of a patient receiving the wrong medication on discharge Mr Hall asked if nurse led discharge was carried out in the hospital. Mr Phillips advised that criteria led discharge was in place and that parameters were clearly set out. Mr Wright added that criterial led discharge had been used for a long time in orthopaedic wards at Castle Hill and worked well.

Resolved:
The Board received the report and noted the areas of concern and areas of good practice being carried out.

10. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report to the Board. He highlighted a new reporting system with a web based portal which he would summarise in future reports to the Board. He advised that 110 new nurses had commenced in the Trust and would spend the next two weeks in an induction programme. He reported the Trust still had a twice daily safety brief to ensure establishments were safe.

Mr Snowden asked how Mr Wright felt about the future supply of nurses and Mr Wright expressed his concern regarding the changes to the training funding system which could have a detrimental effect. However, this was a national problem and not unique to the Trust. Mr Wright reported that the Trust was reviewing new roles and new ways of working to maximise care standards. Mr Phillips added that the new roles being created were not just within the nursing team but across the whole clinical workforce.

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

11. DIRECTOR OF INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2015/16

Mr Phillips presented the report and advised that the team had recruited more nursing staff and the nurses were carrying out root cause analysis reports for all infections within the Trust. He advised that there had been reductions in the number of MRSA and C Difficile cases, a better system of isolation was in place and Antibiotic Stewardship was in place.

The Trust had experienced cases of Norovirus, an outbreak of Vancomycin Resistant Enterococci in the neonatal department and was a designated centre for the Ebola virus. Mr Phillips reported that all of the infections were dealt with efficiently and appropriately.

Mrs Walker asked if the Duty of Candour was applied when dealing with root causes of outbreaks and Mr Phillips assured her that it was.

There was a discussion around sepsis and recognising sepsis in patients. Mr Phillips advised that the Infection Prevention and Control team were using and rolling out the Sepsis Six Bundle and working through the organisation to inform staff.

Resolved:
The Board received the report and asked Mr Phillips to thank Dr Moss and his team for the hard work carried out to date. An update on sepsis would be given in a future report. **MW/KP**

12. PERFORMANCE REPORT

Mrs Ryabov presented the report to the Board which set out the key performance standards for the Trust. She advised that there were challenges in the delivery of these standards both nationally and in the local health economy.

The 4 hour emergency department performance was at 86.6% in August against a NHS planned trajectory of 89.2%. This was due to a combination of an increase in activity, new junior doctors and a shortage of consultants. Mrs Ryabov advised that performance was improving but it was very challenging.

The 62 day cancer performance was at 85.2% in August. This was the adjusted figure after the reallocation of breaches from late referrals.

The NHS Improvement Referral to Treatment Time trajectory was 87.7% and the Trust had delivered 87.9%. Although still challenging the overall waiting list numbers and patients waiting over 18 weeks was reducing. Mr Gore requested that staff were recognised for the hard work carried out to reduce the waiting lists.

There had been 3 breaches relating to the 52 week waits. All patients had now been treated.

Diagnostic performance had deteriorated in August with 313 breaches occurring. The breaches were due to increased volume of activity and equipment breakdowns.

There was a discussion around the frailty model and whether it was being implemented appropriately. Mr Phillips advised that when the capacity was available a Department of Medical Elderly consultant would be available to assess elderly patients as they entered the Emergency Department. Mr Phillips also spoke about a therapies led model.

There was a discussion around outpatient cancellations. Mrs Ryabov advised that the Trust was concentrating on short term cancellations and these had reduced by a third in the last 6 months. Ms Myers added at a Head of Outpatients had been recruited and this post would have better oversight and be focussed on delivering performance. Mr Phillips stated that the Lorenzo system was allowing the patient administration teams to backfill patient cancellations.

Mrs Ryabov reported that length of stay in the hospital was being reviewed on a monthly basis. In the last year length of stay had reduced by 1 day in Medicine which was significant.

Resolved:
The Board received the report and agreed to receive further information around the frailty model and reduced admissions at the Board in October 2016. **ER/KP**

13. CORPORATE FINANCE REPORT

Mr Bond presented the report to the Board. The Trust was reporting a deficit of £1.1m which was an £800k improvement in month 5.

The Trust's cash position was weak and this made it difficult to pay creditors which did not help relationships. The Trust would receive the 2nd quarter of the STP funding and this was being managed. The Trust's risk rating was 2. The Health Groups were overspent by £840k with agency pay being the key contributor.

The Health Groups were struggling with their Cash Realising Efficiency Savings delivery and revised plans were being developed and would be presented to the Executive Team in October 2016.

Mr Bond reported that the Trust was still forecasting a break even position at the end of the year in line with the plan. Mr Ramsden asked how confident Mr Bond was in the Trust maintaining the break even position in quarter 3 and Mr Bond replied that the cash releasing efficiency savings were key. Mr Long added that the Trust was overtrading significantly with the Commissioners and winter was causing concern. A discussion around step down beds in the community had taken place as the main priority would be to keep patient flow effective during the winter months. Mr Gore supported the community beds as it would help the healthcare system and keep patients safe.

Resolved:
The Board received the report and noted the Trust's financial position.

14. SUSTAINABILITY AND TRANSFORMATION PLANS

Ms Myers updated the Board regarding the activity that had taken place over the summer. She advised that the focus of the Sustainability Transformation Plans (STP) was on urgent care and a systems coming together by agreement. She reported that Mr Long now chaired the Hull and East Riding Locality Board where the STP was discussed which helped the Trust be at the forefront of the discussions. The STP would be submitting a 2 year plan by the 21.10.16 which would not give the Board time to review beforehand.

Ms Myers spoke about the STP approach to closing the gap regarding finances for the Trust, Clinical Commissioning Groups and other care providers and reinvestment into the primary healthcare systems.

Mr Ramsden expressed his concern regarding the expectations of the programme and how the reductions in demand would be handled. He advised that some of the issues were controversial and that the Trust should be vigilant and also assertive. Mr Long agreed and added that the STP would have to take on the increase in demand to ensure sustainable quality of service before any costs could be taken out. Mrs Walker stated that the STP had a heavy reliance on the whole health economy working closely together and would not work if some providers worked autonomously.

Resolved:
The Board received the update and noted the work ongoing. A more detailed review would take place at the Board Development Day in October 2016.

15. CAPITAL DEVELOPMENTS UPDATE

Mr Bond presented the report which highlighted capital developments within the Trust. The capital programme for buildings was only a third of the expenditure, the other areas being IT and medical equipment. He advised that the Estates Team was looking at the funding options for the front entrance scheme at Hull Royal Infirmary, taking the lift

improvements into account.

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

16. CULTURAL TRANSFORMATION – PROGRESS REPORT

Mr Nearney presented the quarterly report to the Board. He advised that staff engagement was going from strength to strength with 2261 staff completing the Staff Survey. The Trust was now higher than the national average, Mr Nearney advised that a number of initiatives were being reviewed to encourage more staff to fill in the National Staff Survey being published in October 2016.

Mrs Walker added that on her ward walk rounds she spoke to staff and patients and that there was greater positivity and staff were feeling more inspired to be at work. Mr Gore added that on his walk rounds staff had stated that having a visible CEO was to be praised.

Mr Snowden stated that it would be useful to ask staff what they think the Trust's top values are to see if they were becoming embedded. Mr Nearney said that this would be taking place in January 2017.

Resolved:
The Board received the quarterly update and noted the work ongoing around cultural transformation.

17. GUARDIAN OF SAFE WORKING HOURS – JUNIOR DOCTORS IN TRAINING

Mr Phillips presented the report which was now a statutory requirement. It highlighted how compliant the Trust was to Junior Doctors establishment in each department.

Mr Phillips advised that were there were gaps in services and these had been filled by another doctor and patient care was not compromised. There were areas such as medical elderly where more work was needed to recruit Junior Doctors and reduce the need for agency staff. He advised that Dr Helen Cattermole was the Junior Doctor guardian and Mr Long suggested that she attend a future Board meeting to give a further update on the work ongoing.

Resolved:
The Board received the report and requested that Dr Cattermole be invited to a future meeting. **RT**

18. MODERN SLAVERY STATEMENT

Ms Thomas presented the report which set out the Trust's Modern Slavery Statement for 2015/16. The statement had been received at the operational committees and ratified. Once approved by the Board it would be uploaded to the Trust's website.

Resolved:
The Board received the report and approved the Modern Slavery Statement.

19. STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS

Ms Thomas presented the updated Standing Orders/Standing Financial Instructions and highlighted one area for discussion. At present the agreement of levels of pay for Chiefs was delegated by the Board to the Remuneration Committee, with a summary report presented to the Board. Ms Thomas asked if this was to continue for all Chief posts.

The Board discussed the issues around transparency and it was agreed that as Chief salaries were declared in the Trust's Annual Report, the process would remain the same.

Mr Gore added that the Standing Orders/Standing Financial Instructions had been ratified at the Audit Committee in September 2016 and it recommended approval by the Board.

Resolved:
The Board approved the Standing Orders/Standing Financial Instructions and agreed to keep the process the same for approving Chief salaries.

20. UNADOPTED MINUTES FROM BOARD STANDING COMMITTEES

20.1 – Audit Committee 08.09.16
The minutes were received by the Board. There were no matters of escalation.

20.1.1 – Annual Audit Letter
The Annual Audit Letter was received by the Board. This had previously been received at the Audit Committee 08.09.16 and had been uploaded onto the Trust website.

20.1.2 – Audit Committee Terms of Reference
The Audit Committee Terms of Reference had been ratified at the Audit Committee 08.09.16 and were approved by the Board.

20.2 – Performance & Finance 22.08.16, 26.09.16
The minutes of the Performance & Finance Committee were received by the Board. All matters had been discussed in the performance and finance sections of the Board meeting.

20.3 – Charitable Funds 22.09.16
There was nothing escalated to the Board from the meeting held 22.09.16.

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

22. QUESTIONS FROM MEMBERS OF THE PUBLIC
There were no questions received from members of the public.

23. DATE AND TIME OF THE NEXT MEETING:
Thursday 27 October 2016, 10:30am
The Boardroom, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (October 2016)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2016						
01.09	Performance Report	Further information around the frailty model and reduced admissions to be received	ER/KP	27.10.16		Update to be received
02.09	Guardian of safe working hours	Dr Cattermole to be invited to update the Board	KP	TBC		
03.09	Matters Arising	The Trust's Operational Plan (to include Health Group workforce plans) to be received.	SN	TBC		
04.09	Director of Infection Prevention & Control Annual Report	An update on sepsis to be received	KP	TBC		
July 2016						
01.07	Workforce race equality standard 2016 return	A 6 monthly progress report to be received	SN	Jan 2017		Not yet due
Actions Completed and to be removed from the Tracker						
September	Board Committee Report	Trust Strategies to be discussed at a Board Development Day	LT	03.10.16		Completed

Items referred to other Committees						
Quality Committee	Da Vinci Robot	Quality Committee to review the outcomes post implementation	TS	20.10.16		
	Chaperone Policy	Quality Committee to review the Policy	TS	20.10.16		
Audit Committee	Board Assurance Framework	Audit Committee to discuss the BAF at its December 2016 meeting	LT	15.12.16		

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
CHIEF EXECUTIVE BRIEFING PAPER
October 2016

Consultations on Urgent care

There are two consultations currently underway regarding urgent care services. A 12 week consultation is being undertaken by NHS East Riding of Yorkshire Clinical Commissioning Group (CCG) which is proposing the establishment of urgent care centres which will replace minor injury units. The new centres will be open 16 hours a day throughout the year and will provide the same service across all of the centres. The consultation is running until 17 January 2017 with a number of public meetings arranged during this period. The second consultation is being run by NHS Hull Clinical Commissioning Group (CCG) regarding the future of urgent care services in Hull. The options include the relocation of the Minor Injuries unit (MIU) from the Freedom Centre and out-of-hours GP services currently based at Diadem Health Centre, East Hull to a new Urgent Care Centre within Bransholme Health Centre which would provide care 24 hours a day, 7 days a week. This consultation closes on 6 November 2016. The Trust will be responding to both consultations.

NHS Improvement (NHSI): Single Oversight Framework

NHSI has now published its Single Oversight Framework which became operational on the 1 October 2016. The Framework has 5 themes which will be used to oversee both NHS Trusts and Foundation Trusts. The 5 themes are quality of care (safe, effective, caring, responsive), finance and use of resources, operational performance, strategic change and leadership and improvement capability. The Framework has been developed with the Care Quality Commission so that the two organisations are aligned in their approach, which will eventually lead to a single combined assessment of quality and use of resources. The both CQC and NHSI are committed to sharing data and developing a common data set where possible.

The Framework sets out how each of the 5 themes will be monitored, including the frequency of submissions, metrics used and trigger points for further review. There are 25 quality metrics including Never, Events, Patient Safety Alerts, Friends and Family results, VTE, MRSA etc. The operational performance metrics are the 4 hour A&E standard, 18 weeks (incomplete) standard, 62 day cancer standard and the 6 week wait for diagnostic procedures. The financial and use of resources metrics are divided into 3 elements – financial sustainability (capital service capacity, liquidity), financial efficiency (I&E margin) and financial controls (distance from financial plan, agency spend). Strategic change relates to the delivery of sustainability and transformation plans and leadership will be informed by third party information and organisational health indicators such as absenteeism. The Framework also sets out how NHSI will identify potential support needs across each of the 5 themes.

The Trust's integrated performance report is being reviewed and will include the new metrics.

Agency Spend

The Trust has been advised by NHS Improvement on new reporting requirements in relation to agency spend. The Board will be required to complete a self-certification checklist to confirm that arrangements are in place to reduce excess costs.

Other items of interest

- **Fundraising**

  The inaugural WISHH Ball to promote the Trust's new independent charity will be held on 4th November at the Mercure Hotel in Willerby. Funded by the Trust's staff lottery over 300 staff and their families will enjoy a three course meal, live music and entertainment.

A local charity set up 18 months ago to fundraise for potentially life-saving equipment has achieved its target. Thanks to the generosity of local people, businesses and community groups, the Clarity Appeal has enabled state-of-the-art equipment valued at £80,000 to be installed at Castle Hill Hospital. The Clarity Appeal was set up in April 2015 in order to fundraise to install cutting edge diagnostic facilities within local Breast Screening Services.

Members of the Paediatric Healthcare Team at Hull Royal Infirmary have received a financial donation to help babies and children in need of special care. The Society of MICE, a group of Hull-based artists involved in the entertainment industry, have given £14,000 to the Paediatric High Dependency Unit (PHDU) to purchase specialist equipment including a ventilator.

- **Recruiting future staff**
  More than 70 students from Withernsea High, Trinity House School and St Mary's Academy participated in six scenarios designed to showcase NHS job roles which support people from birth through to end of life. The event was held for the second time after the 2015 Day in the Life event drew excellent feedback from students taking part. The event is designed to a whole new generation of NHS staff.

- **Hospital Choir**
  Two hospital choirs formed to promote positivity, good health and well-being will come together next month for an evening of song, enjoyment, and inspiration. Local NHS choir, *HEY! Let's Sing* will join forces with *Positive Note*, a choir comprising hospital patients and staff from the Queen's Centre for Oncology and Haematology. The concert is being held on November 4th at Hull Royal Infirmary with proceeds funding future workshops and performance opportunities for both choirs.

- **Supporting our patients**
  On Tuesday 18th October Castle Hill Hospital hosted a special event themed on breast screening and awareness. Attended by clinicians and members of the public the event raised awareness of breast cancer issues and provided an educational insight into how the National Breast Screening Programme works.

  The Trust has created two apprentice Recreational Coordinator posts to help improve the experience of older people in hospital. Thought to be the first of their kind employed by any acute hospital in the country, Recreational Coordinators Laura Marks and Emma Smith engage with patients on wards 8 and 80, 9 and 90 keeping them physically healthy and mental well.

  The ward housekeeper on Maple Ward, has driven a project to have mobile phone charging stations installed in the maternity hospital to help new mums and mums-to-be, keep in touch with their loved ones whilst spending time in hospital. This was a Pioneer Team project empowering staff to deliver improvements in their areas of work.

Chris Long
Chief Executive
October 2016

TRUST BOARD REPORT – 2016 – 10 - 9	
Meeting date:	Thursday 27 October 2016
Title:	Quality Report
Presented by:	Mike Wright, Executive Chief Nurse
Author:	Kevin Phillips, Executive Chief Medical Officer Liz Thomas, Director of Governance
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 • 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
OCTOBER 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
- Other Quality Updates

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
OCTOBER 2016

1. PURPOSE OF THIS REPORT

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

- Patient Safety Matters
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates

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 concluded its investigation into the wrong-level spinal surgery incident. This was discussed at the Quality Committee on the 20 October 2016 and 3 members of the Neurosurgical team attended the meeting to discuss the learning and actions taken. Further actions have now been put in place to try to prevent a further occurrence. This includes undertaking a third radiological check perioperatively in order to ensure that the surgery has been carried out correctly.

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. 46 Serious Incidents have been declared since the start of this financial year (120 for the 2015/16 year). Since the last quality report in September 2016, the Trust has declared 6 Serious Incidents. The categories of these are as set out in the table below.

Serious Incidents declared from 28 September 2016

No	Incident	Health Group
2	Treatment Delay	Surgery, Family and Women's Health
1	Sub–optimal care of the deteriorating patient	Surgery
1	Absconded patient	Family and Women's Health
1	Drug Incident	Family and Women's Health
1	Unexpected Death	Medicine

There was no particular pattern to these incidents. There were two incidents relating to delays in treatment. The first involved a patient who did not have a timely follow up appointment and the second incident involved a patient who was re-directed to another hospital for treatment. The suboptimal care Serious Incident concerned a delay in a patient at Castle Hill Hospital being seen by a specialist team. There have been two incidents where young people have left the ward without notifying staff and the most recent was declared at the beginning of October 2016 and is included in the table above. The drug incident relates to an extravasation and the unexpected death to a patient who suffered a pulmonary embolism. All investigations are on-going.

2.3 Serious Incident actions

Examples of actions taken following recently completed Serious Incidents include:

- A security review on a ward where a patient had left without notifying nursing staff

- Training and competency assessment undertaken following an error when a patient's details were wrongly recorded on the Lorenzo system. The introduction of different authorisation levels is also being considered so that it is not possible to alter certain fields of information.
- Revision of the Adult Diabetes Inpatient Guidelines to ensure that it is clear for staff on what action should be taken when a patient has a high blood glucose reading

The two investigations into the maternal deaths that have been reported to the Trust Board previously this year have now concluded. None of the causes were attributable to the Trust.

2.3 National Learning and Reporting System (NRLS)

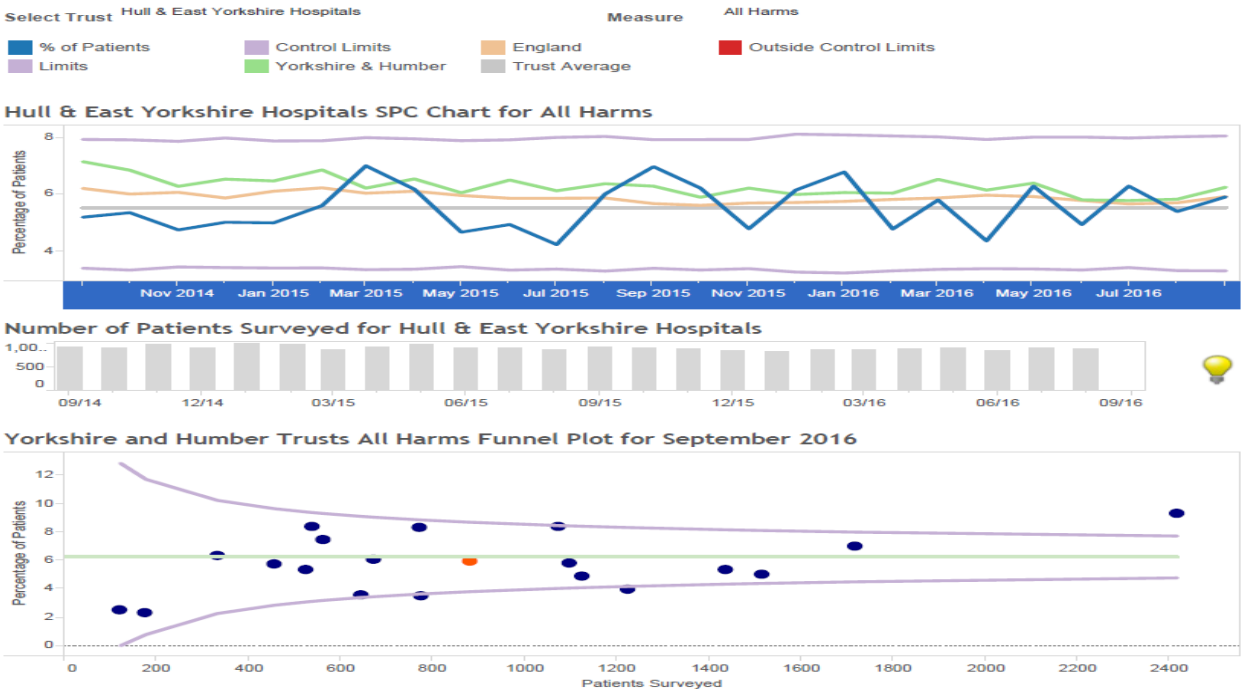
The latest 6-monthly report from NRLS has been published covering the period from 1 October 2015 to March 2016. The Trust is benchmarked against acute (non-specialist) organisations for the number and type of patient safety incidents reported. It has now moved into the middle group of reporter of incidents and has increased its reporting rate from 31.79 incidents per 1,000 beds to 34.44 incidents (medium reporting rage for the cluster 39.31). More importantly, the Trust continues to compare favourably against the degree of harm reported. The Trust reports more incidents than peers with a rating of no harm and has fewer incidents categorised as low and moderate harm. The number of incidents involving a death is the same as peer (0.1%) and the Trust is slightly above peer for severe harm (03.% vs 0.4%) although the numbers involved is extremely small (23). The increase in reporting correlates positively with feedback from the quarterly staff survey results.

3. SAFETY THERMOMETER – HARM FREE CARE

The following sections provide the latest bechmarking position for the Trust as at the end of 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

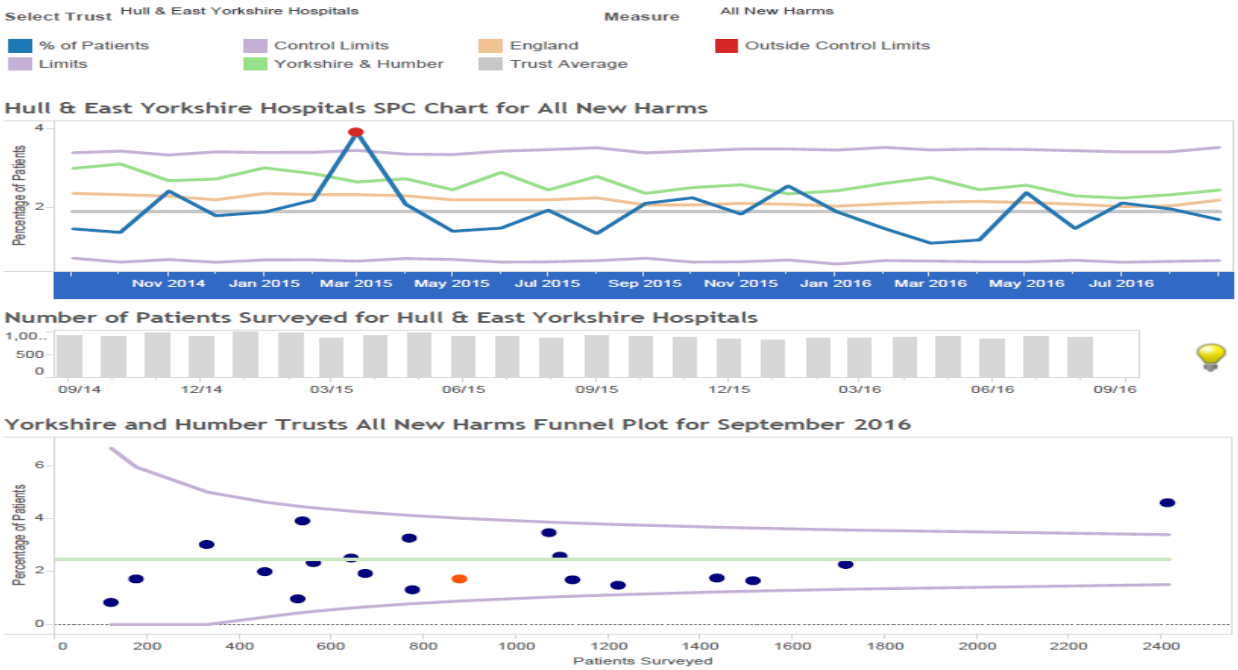
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



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

3.1.1 New Harms

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

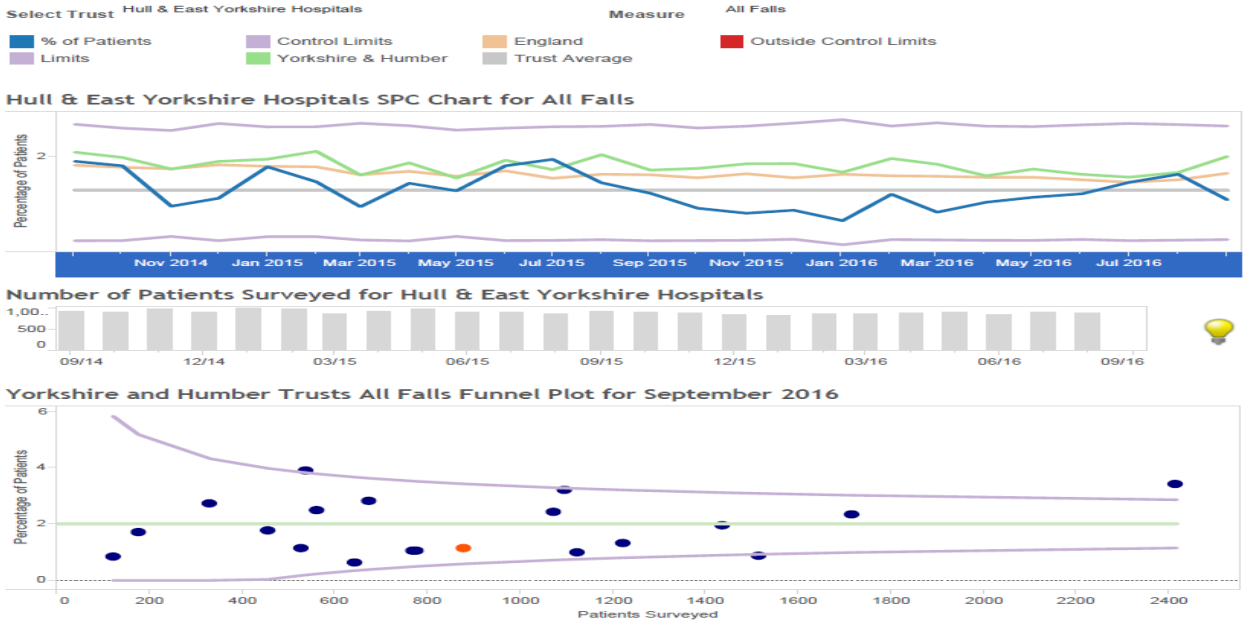


Again, and overall, the Trust performs realtively well against this indicator but there is always room for improvement. These data continues to be reviewed monthly. Each ward received its individual feedback and results and is required to take action accordingly. To take each of the four harms in turn:

3.2 FALLS

3.2.1 Falls (all)

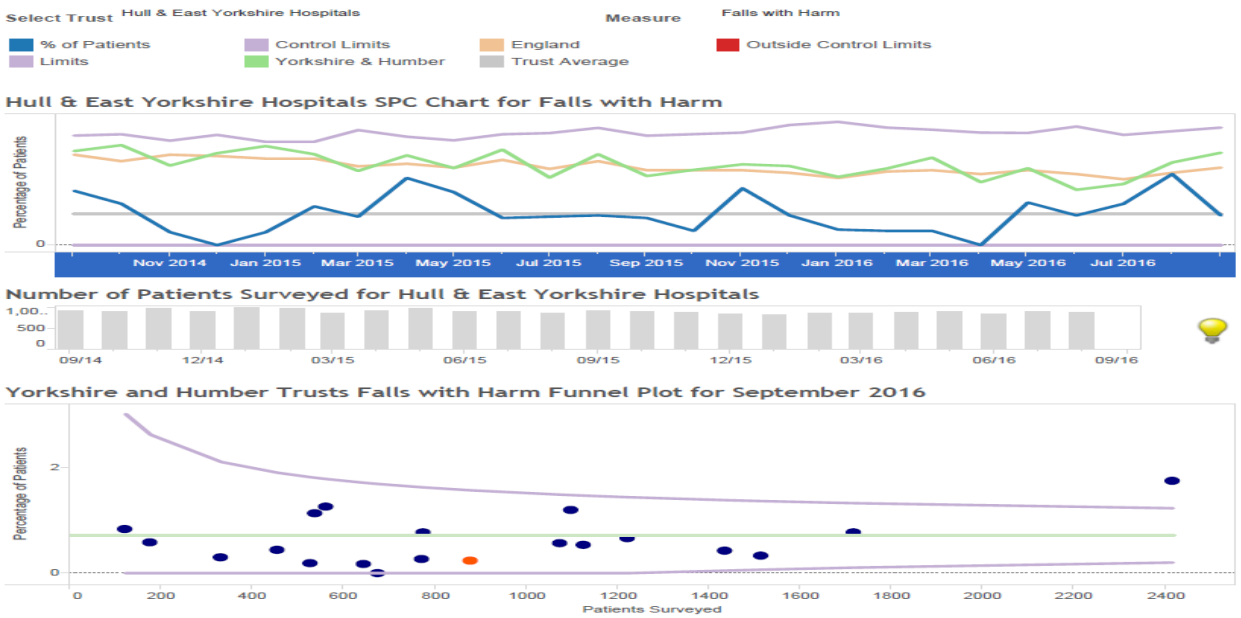
The following tables shows the percentage of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



Although retaining a relatively positive benchamarking position against this indicator overall, this chart shows an increase above the Trust's average for this indicator since June 2016 and steadily since March but has decreased again in September. Improvement work continues to be rolled-out across wards as part of the Trust's transformation work to help to try and address this.

3.2.2 Falls with harm

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

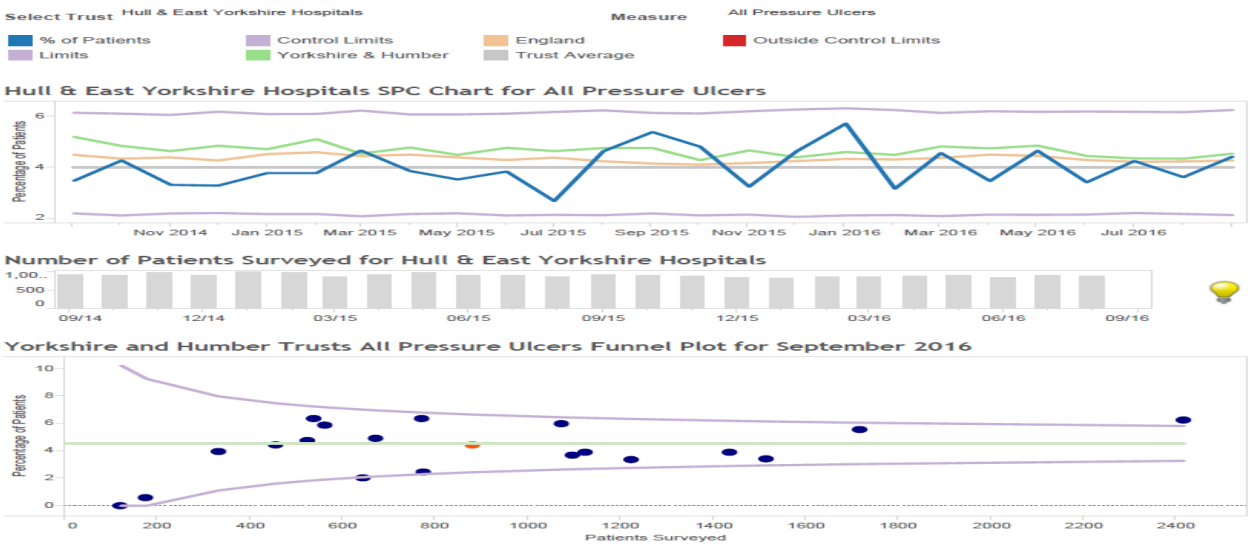


Following a recent increase in the number of patients falling resulting in harm, this has reduced again in Spetpember 2016. Overall though, this remains very positivie perofrmance when compared to peers.

3.3 PRESSURE ULCERS

3.3.1 Pressure Ulcers (All)

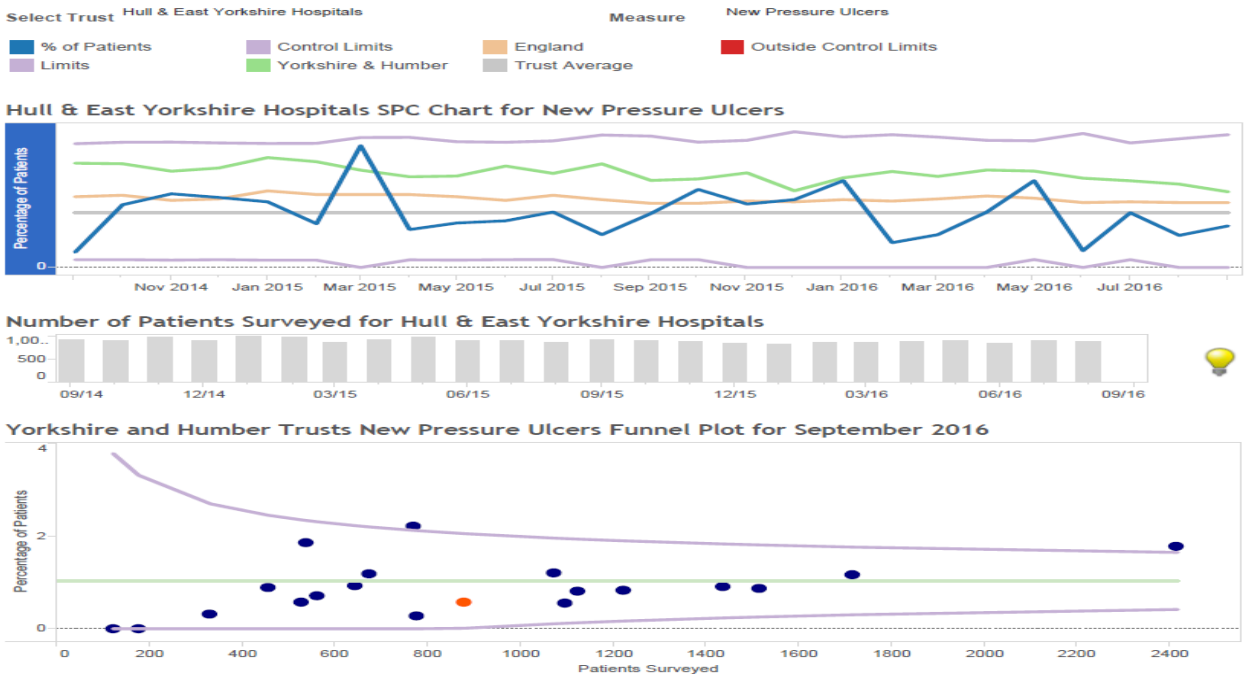
The following graph and funnel plot show variable statistics on this measure. An important factor is the proportion of patients that come into the Trust with exisiting pressure ulcer damage, which is significant, particularly in patients that are admitted via the emergency department and admissions areas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



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

3.3.1 Pressure Ulcers (new)

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

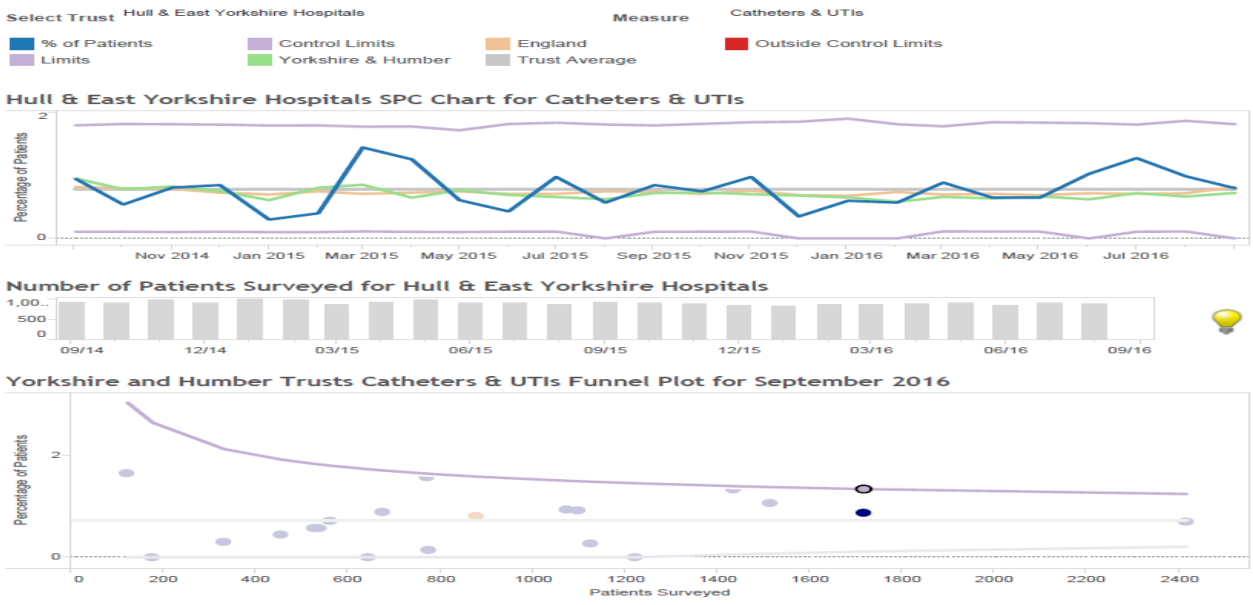


The performance for this indicator is positive overall, although the Trust is not complacent and futher work is underway to ensure further imprvoements in this area.

3.4 CATHETERS AND URINARY TRACT INFECTIONS

3.4.1 Catheters and UTI (All)

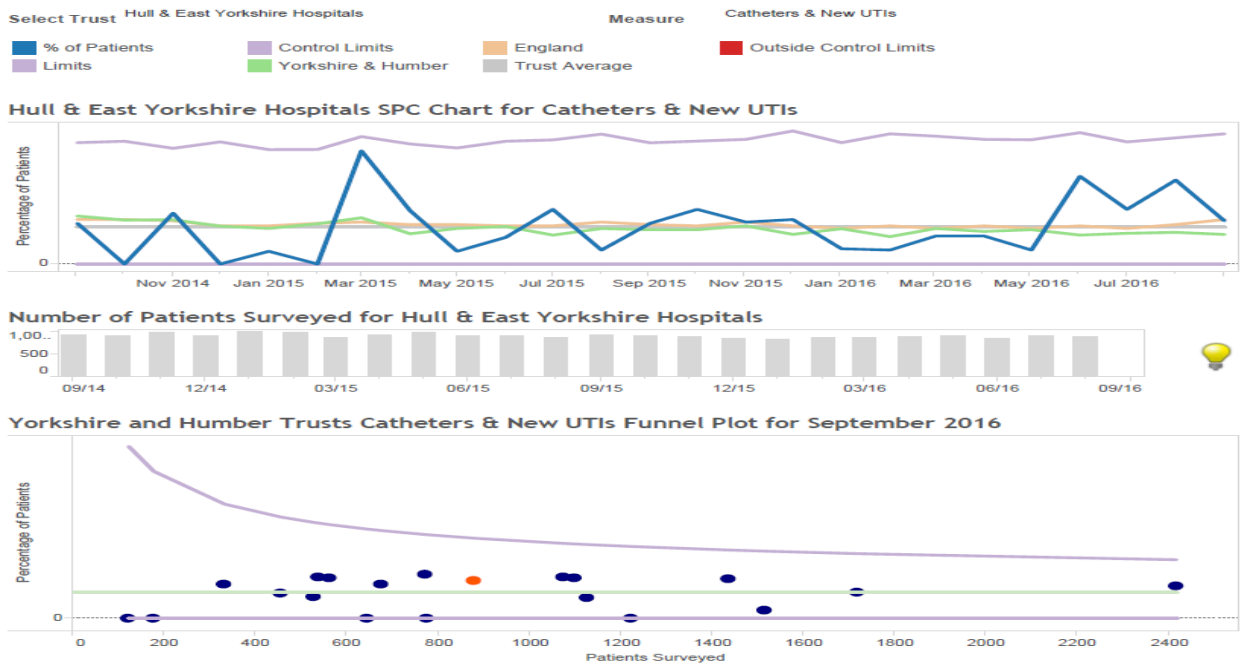
The following chart shows the percentages of patients that have a urinary catheter in place with an associated urinary tract infection. These charts include those that were both admitted with these issues and/or have acquired them whilst in hospital.



Those patients that acquire this harm whilst in hospital are now described.

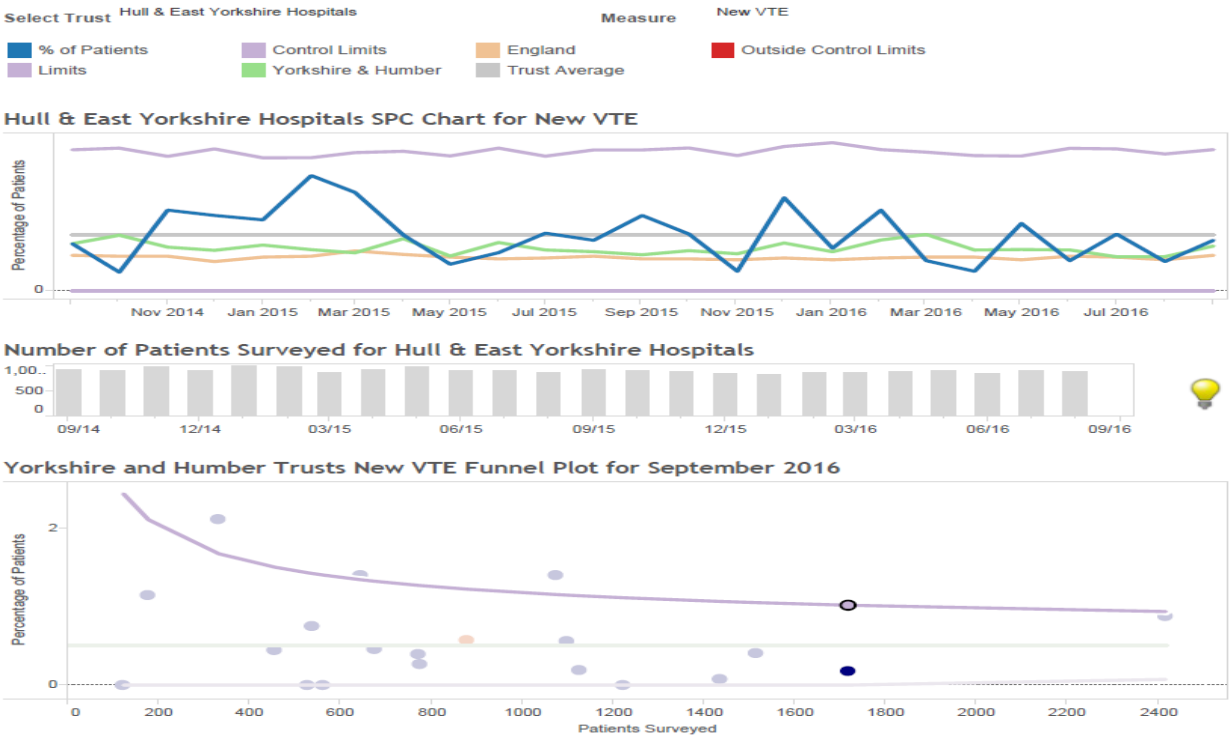
3.4.2 Catheters and UTI (new)

The following chart shows a more variable picture over time, with a spike in catheter-associated urinary tract infections since May but that now appears to be reducing. Concentrated focus is being given to urinary catheter care in an effort to reduce these infections further.



3.5 NEW VENOUS THROMBO-EMBOLISM (VTE)

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



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

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 30th September 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**	**25 (47% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0 (0% of threshold)**
MSSA bacteraemia	**46**	**24 (52% of threshold)**
E.coli bacteraemia	**95**	**39 (41% of threshold)**

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

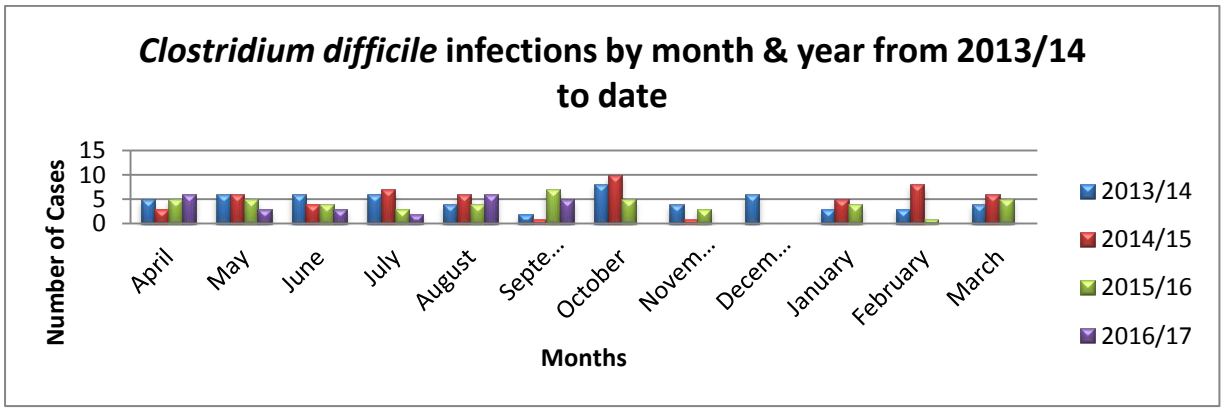
4.1.1. Clostridium *difficile*

For rates attributable to the Trust, five cases were reported during September 2016 against an upper threshold of 53 for the 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.

The five cases reported during September 2016 were predominantly identified in the Medical Health Group, with 1 case in Surgical Health Group and a further case within Family & Women's.

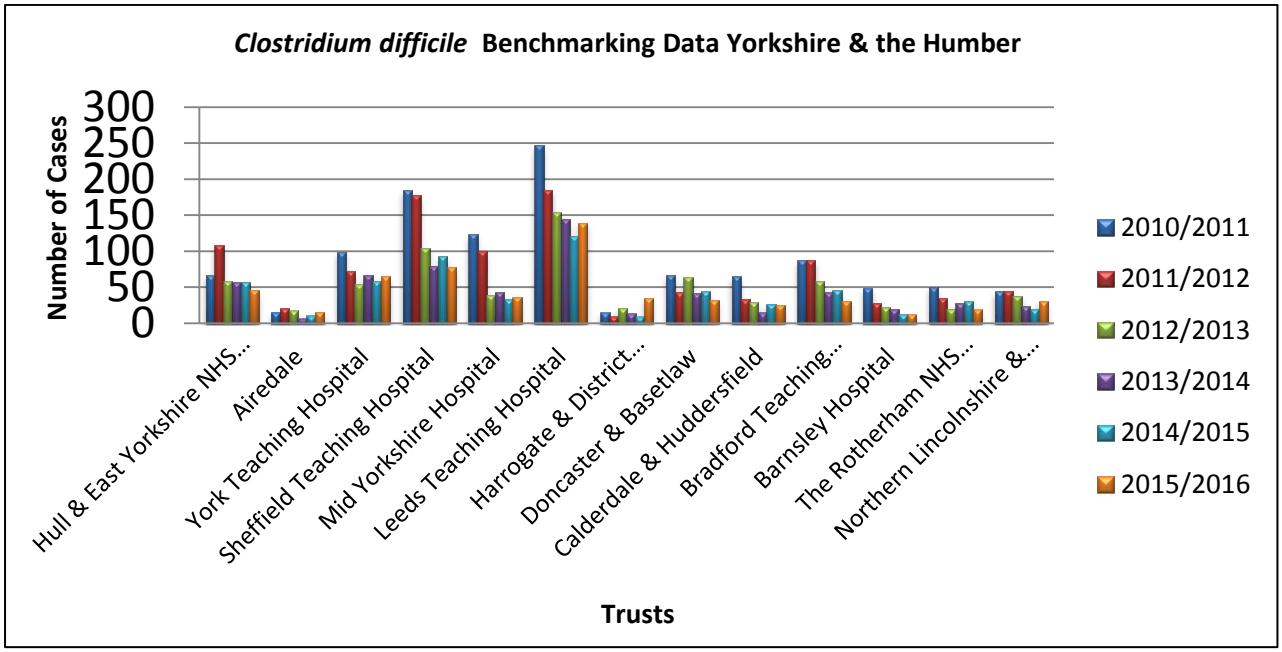
An Incident Control Group meeting was held in September 2016 to discuss two cases of *Clostridium difficile* infection with identical ribotypes identified with two patients on ward 110 during August 2016. The meeting concluded that antibiotic usage was implicated and there was a delay in isolating the patient in both cases. The occurrence of cross infection could not be discounted due to reported environmental and cleaning issues identified during the subsequent ward audits, which have subsequently resolved. However, ongoing support continues to be provided by the Infection Prevention and Control Team PCT to the ward.

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



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

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

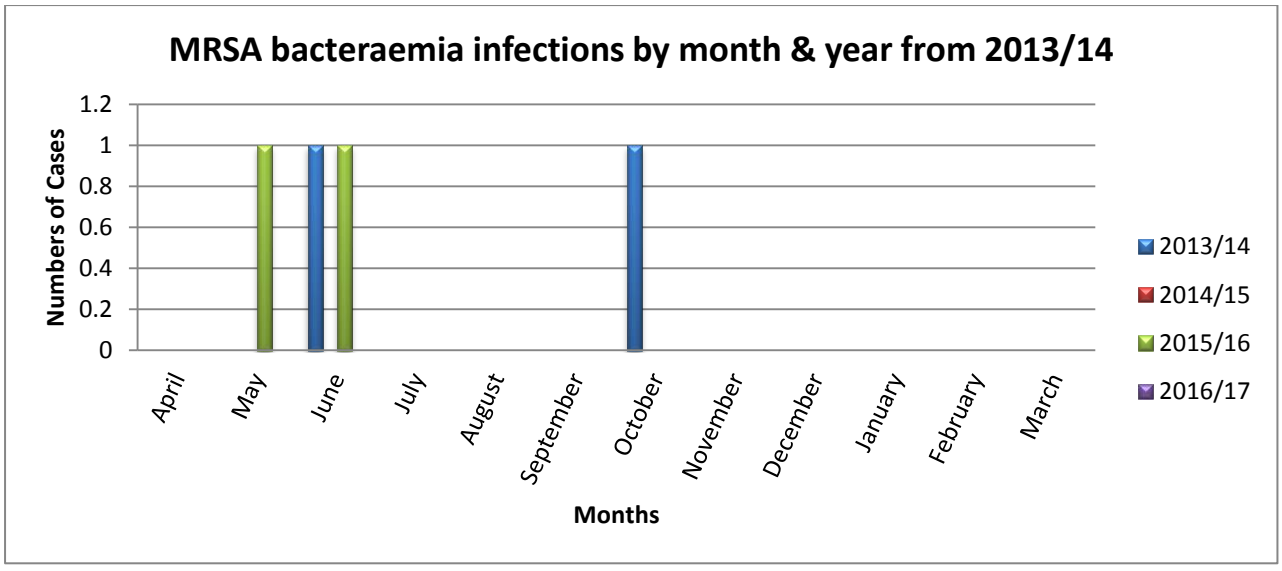


As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers.

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

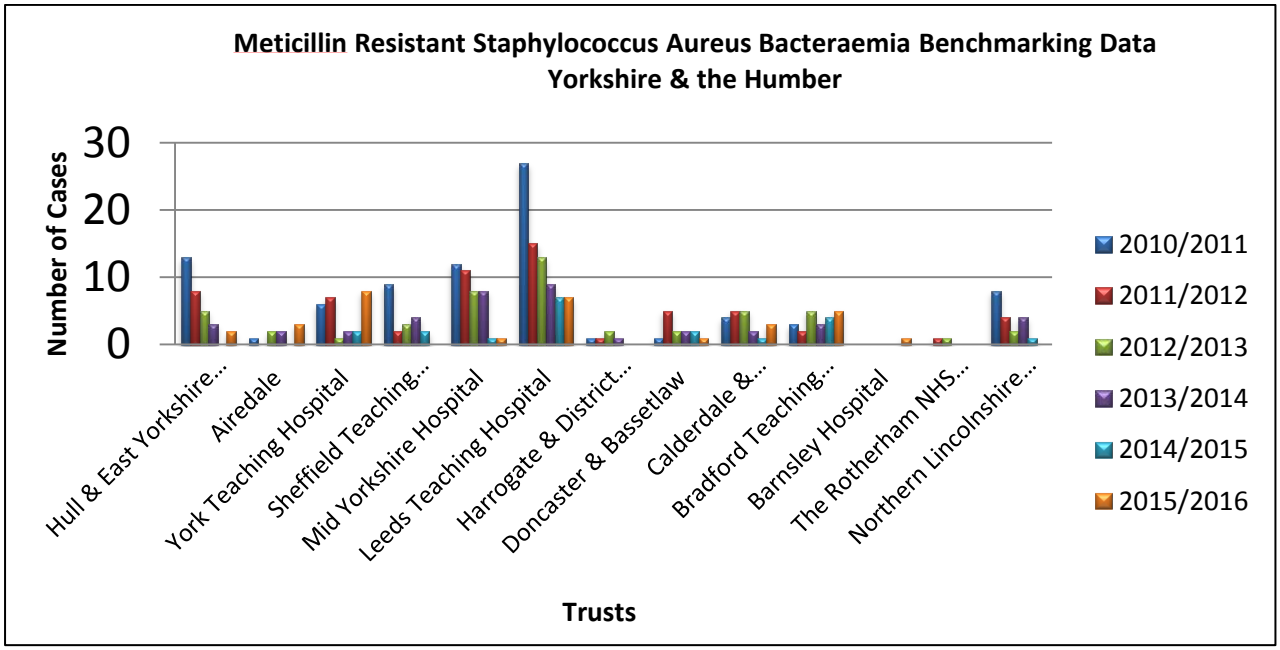
There have been no reported cases of MRSA Bacteraemia infections so far this financial year. This is against a Zero Tolerance objective for 2016/17. The last reportable Trust apportioned case was detected in June 2015.

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:

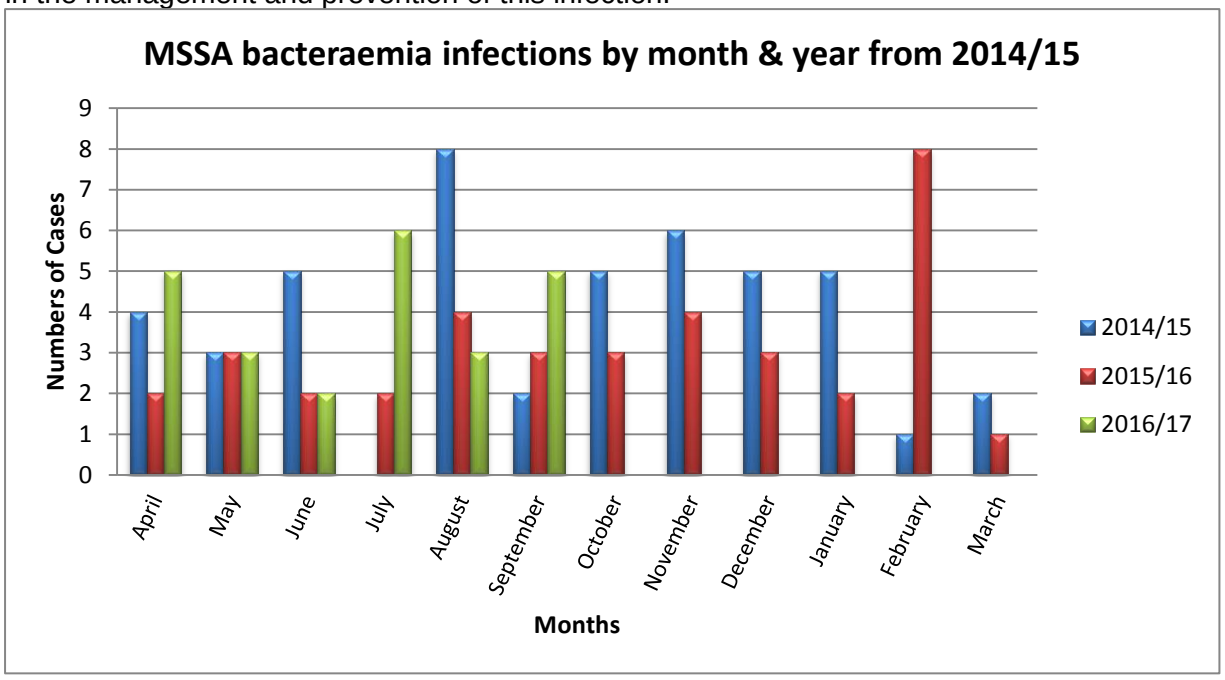
Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases for Yorkshire & the Humber from 2010 onwards



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

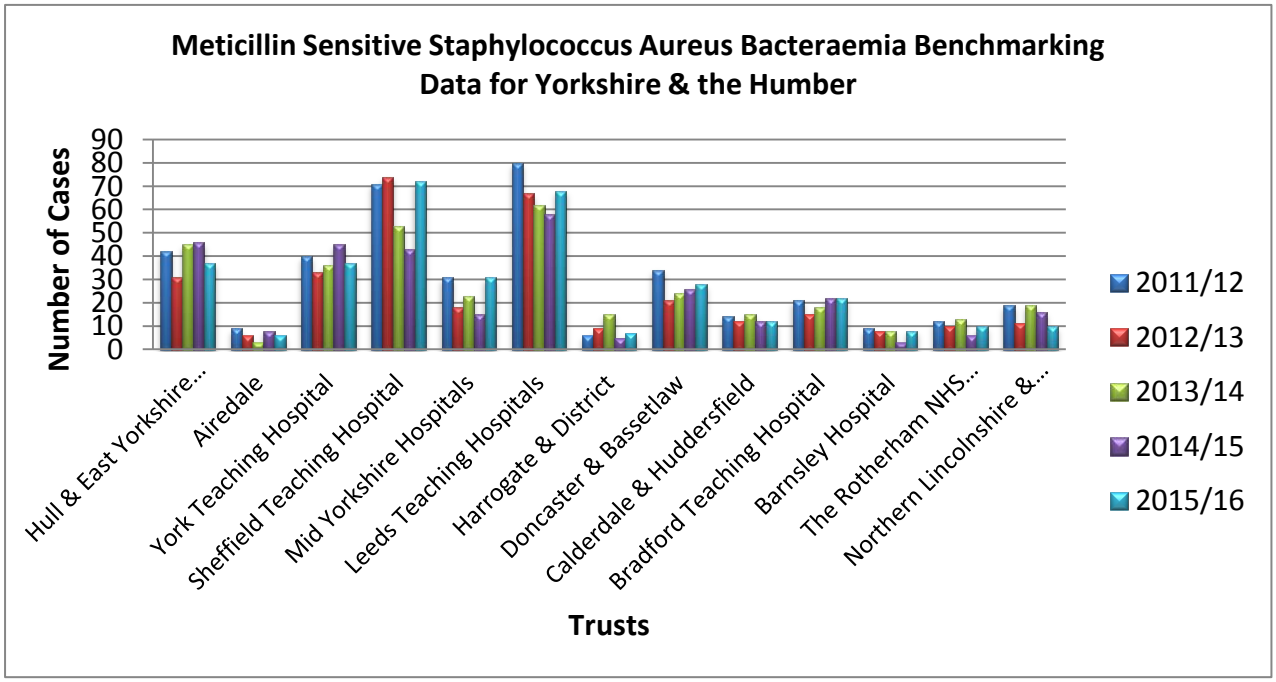
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

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



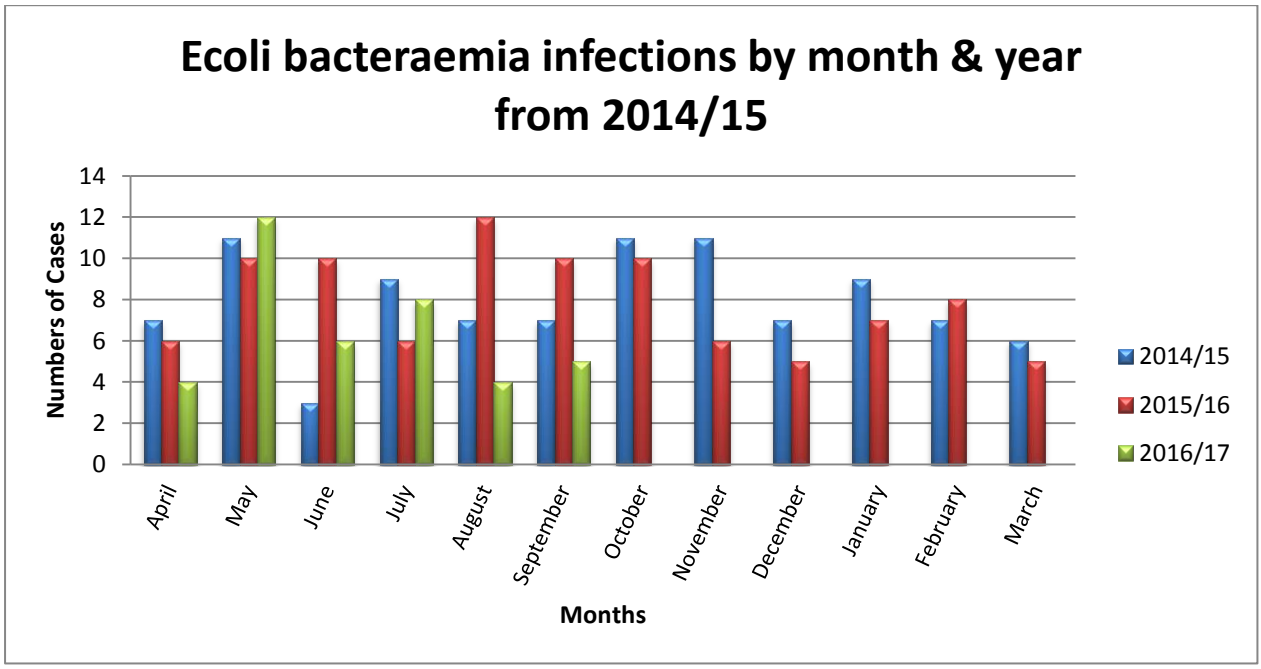
As can be seen, this is more evenly spread both across organisations and, also, recent years. The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken in the Trust.

Trends following root cause analysis investigation identify the need for continued and sustained improvements on device/ line management.

4.1.4 Escherichia-coli Bacteraemia *(E.coli)*

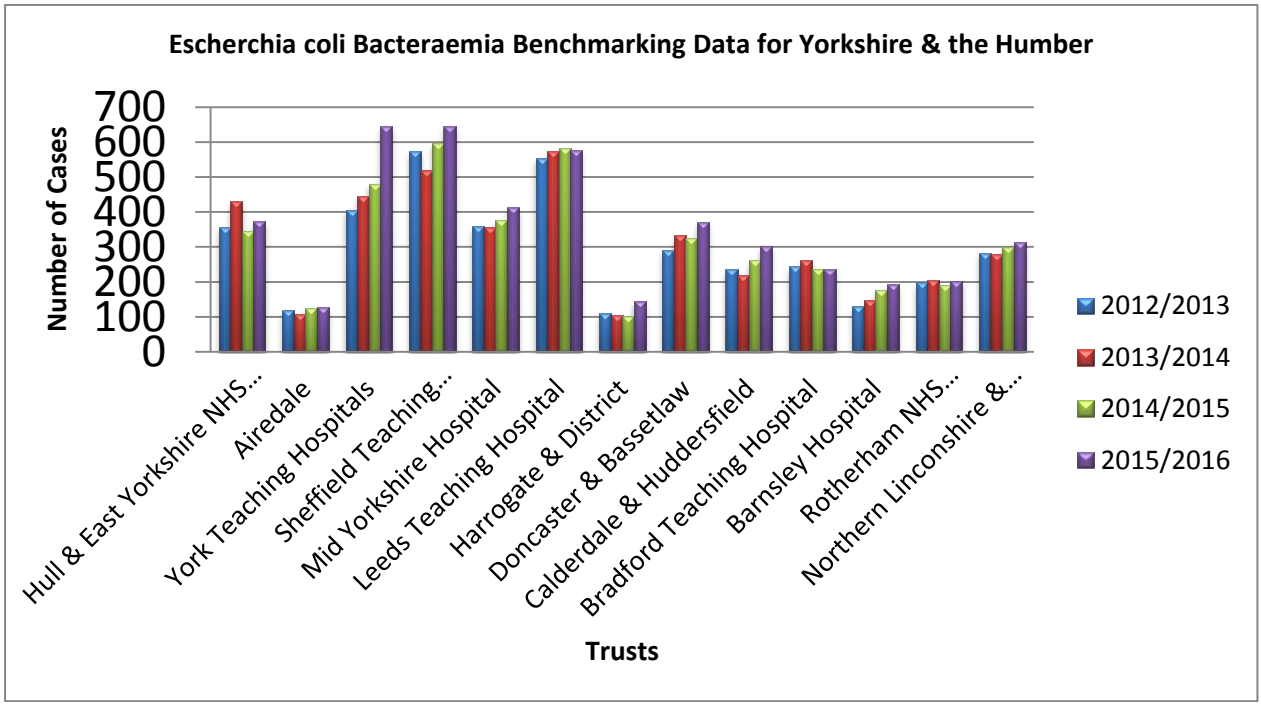
E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Numbers are total numbers reported by the Trust onto the national Public Health England 'MESS' database. Most patients are admitted to hospital for treatment of this infection.

For the three months from July – September 2016, in collaboration with City Healthcare Partnership's Infection Prevention and Control Team, the Trust has collected data on E.*coli* bacteraemia cases. The purpose of this is to understand trends for both Trust and Community apportioned cases in order to help try and develop robust systems and processes for the prevention of these infections. Cases identified during July and August 2016 with further data being analysed for September 2016 for both Trust and Community apportioned infections confirm a trend associated with urinary tract infections (UTI's) with a greater burden of infection in the community. The collaborative approach to understanding these infections will inform future improvements in the management of patients.



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 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

Ward 70 had restricted access to two bays from 29th September 2016 due a number of patients experiencing symptoms of diarrhoea and vomiting. These bays were reopened on 7th October following deep cleaning. Norovirus was not detected during sampling.

4.2.2 Scabies Outbreak

An outbreak of scabies was identified on a surgical ward at Hull Royal Infirmary, patients and staff were treated with appropriate follow up of discharged patients and communication to GP's and partners in collaboration with Public Health England. Outbreak meetings were held during September 2016 with no further actions required. All affected people were treated quickly and effectively.

4.2.3 Influenza trends

The Occupational Health Department has commenced the 2016 Influenza vaccination campaign with vaccination sessions across both sites from September 2016 onwards. To date, more than 3,000 staff have been vaccinated.

5. PATIENT EXPERIENCE

5.1 Complaints

5.1.1 National Data on Written Complaints in the NHS 2015-16

Benchmarking information has been published by the Department of Health (DOH) in September 2016, relating to the numbers of written complaints made by (or on behalf of) patients, that were received in all Hospital and Community Services (HSCS) between 1 April 2015 and 31 March 2016. (The full report is available on request).

Key Findings

- The total number of all Hospital and Community Services related written complaints was 116,180 in 2015-16. This is a fall of 4,598 (3.8%) from the previous year and the first decrease nationally since 2010-11. Hull and East Yorkshire Hospitals NHS Trust reported a total of 620 written complaints during the period, which is a decrease of 17% when compared to the same period the previous year.
- Nearly half (46%) of all HCHS complaints are raised by patients rather than someone doing so on their behalf. This compares to 55% of patients for this Trust, higher than the national average.
- For new written complaints received from someone whose age was known/declared, the largest proportion was for those aged between 25 and 55 years old at 36.9%. This compares similarly at this Trust at 34.8%.
- Nationally there still appears to be disparity in the number of older people who complain and these are still considered to be a 'hard to reach' group. However, the table below shows that at HEY we receive an equal amount of complaints of 55 years and below and 56 years and above.

	England		Hull and East Yorkshire Hospitals NHS Trust	
Total all ages	**116,180**	**100%**	**640**	**100%**
Age 0-5	3,618	3.1%	22	3.4%
Age 6-17	4,001	3.4%	24	3.7%
Age 18-25	5,123	4.4%	48	7.5%
Age 26-55	29,006	25.0%	216	33.7%
Age 56-64	9,371	8.1%	86	13.4%
Age 65-74	11,088	9.5%	95	14.8%
Age 75 and over	16,321	14%	145	22.6%
Age Unknown	37,652	32.4%	4	0.6%

The Department of Health suggests that the factors that affect the numbers of written complaints an organisation receives include:

- Processes in place to resolve potential and verbal complaints before they escalate to written complaints. These include some organisations making staff available to discuss and resolve issues. A contributory factor which appears to have helped reduce formal Hull and East Yorkshire Hospitals NHS Trust is the opening of the 'Hub' in the foyer of Hull Royal. This is open daily and is well used by patients and carers to resolve their concerns quickly.
- Staff making patients aware of other helpful services such as PALS which has been introduced to ensure that the NHS listens to patients, their relatives, carers and friends and answers questions and resolves concerns as quickly as possible. PALS provide information about the NHS complaints procedure and how to get independent help if a further complaint is being considered. PALS information is available in all out clinical areas, receptions and on the Trust's intranet. We have posters to advertise the service displayed all over the Trust.
- Organisations have a responsibility to highlight the complaints procedures/processes and alternatives to patients through a variety of methods including leaflets, poster adverts and through direct discussions with patients. The better awareness of the written complaints process may lead to more patients complaining. The Trust promotes all of these initiatives actively. In addition, a new mechanism is being introduced in October whereby patients can register concerns or complaints on line.

Improving the patient experience is a key priority for the government and it was recognised that simply counting the number of complaints made to an organisation did not indicate how an organisation was performing. From 2011-12, an additional data item, 'Number of Complaints Upheld', was added to the data returns, to assess how many complaints were upheld in addition to the number of complaints made to an organisation. The table overleaf shows that of the 620 complaints raised at Hull and East Yorkshire Hospitals NHS Trust, 289 (43.1%) were upheld, 166 (24.8%) were partially upheld and 215 (32.1%) were not upheld.

The following table compares a sample of other acute Trust's in England, detailing the number of complaints received and whether they were upheld, partially upheld or not upheld. Some Trusts do not record partially upheld complaints and opt to either upheld or not upheld only. Hull and East Yorkshire Hospitals will partially upheld a complaint if the main issues were not upheld but other elements of the complaint were upheld, this is in line with how the Parliamentary and Health Service Ombudsman record their decisions.

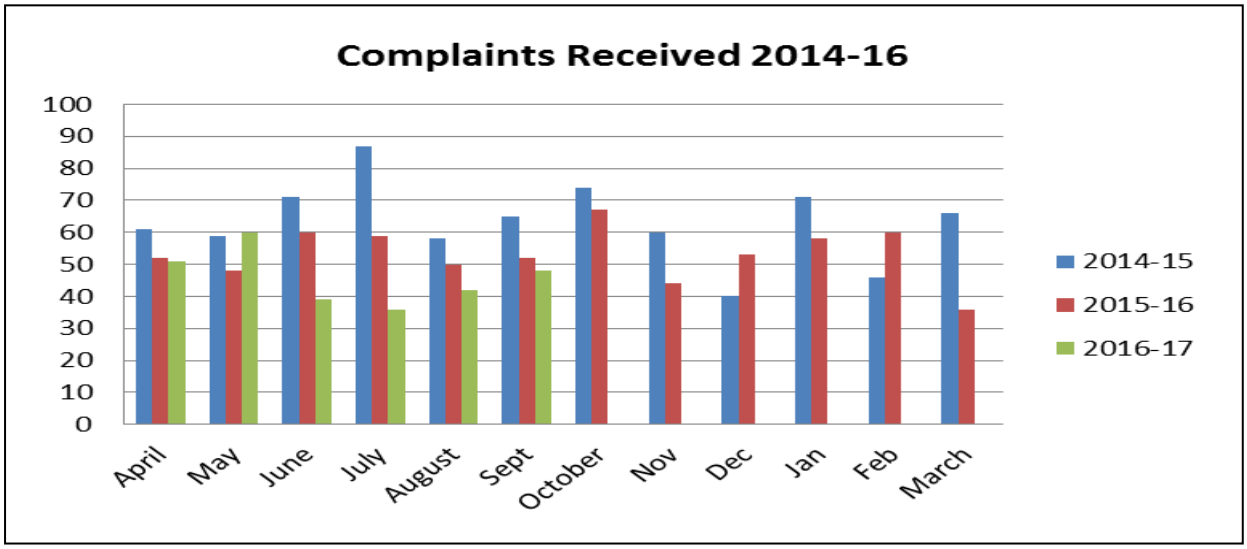
Hospital Written Complaints and Complaints Resolved 2015-16

	Total New Complaints	Total Resolved	Number Upheld	Number Partially Upheld	Number Not Upheld
England	**116,180**	**103,442**	**39,817**	**27,323**	**36,302**
Hull and East Yorkshire Hospitals NHS Trust	620	670	289 (43%)	166 (25%)	215 (32%)
Sheffield Teaching Hospitals NHS Foundation Trust	1,148	1,091	511 (46%)	-	580 (53%)
Newcastle Upon Tyne Hospitals NHS Foundation Trust	627	552	106 (19%)	209 (38%)	237 (43%)
City Hospitals Sunderland NHS Foundation Trust	537	522	165 (32%)	163 (31%)	194 (37%)
Central Manchester University Hospitals NHS Foundation Trust	1,152	760	612 (80%)	-	148 (20%)
Pennine Acute Hospitals NHS Trust	607	391	270 (69%)	-	121 (31%)
University Hospital of South Manchester NHS Foundation Trust	552	545	309 (57%)	66 (12%)	170 (31%)
Lancashire Teaching Hospitals NHS Foundation Trust	551	575	171 (30%)	215 (37%)	189 (33%)
Derby Teaching Hospitals NHS Foundation Trust	722	712	308 (43%)	205 (29%)	199 (28%)
Nottingham University Hospitals NHS Trust	599	278	70 (25%)	119 (43%)	89 (32%)
University Hospitals of North Midlands NHS Trust	875	914	157 (17%)	486 (53%)	271 (30%)
Sandwell and West Birmingham Hospitals NHS Trust	874	1,029	338 (33%)	418 (41%)	273 (26%)
University Hospitals Coventry and Warwickshire NHS Trust	574	594	264 (44%)	157 (26%)	173 (30%)
Luton and Dunstable University Hospital NHS Foundation Trust	673	195	41 (21%)	52 (27%)	102 (52%)
Cambridge University Hospitals NHS Foundation Trust	519	393	191 (49%)	141 (36%)	61 (15%)
Colchester Hospital University NHS Foundation Trust	793	947	198 (21%)	368 (39%)	381 (40%)

Mid Essex Hospital Services NHS Trust	1,002	1,008	505 (50%)	311 (31%)	192 (19%)
Norfolk and Norwich University Hospitals NHS Foundation Trust	936	924	921 (99%)	-	3 (1%)
Barking, Havering and Redbridge University Hospitals NHS Trust	775	849	153 (18%)	366 (43%)	330 (39%)
Guy's and St Thomas' NHS Foundation Trust	1,122	1,057	394 (37%)	430 (41%)	233 (22%)
King's College Hospital NHS Foundation Trust	823	453	225 (50%)	430 (3%)	216 (47%)
Kingston Hospital NHS Foundation Trust	456	505	424 (84%)		81 (16%)

In September 2016, 48 complaints were received by Hull and East Yorkshire Hospitals NHS Trust and 58 were closed. Of the closed complaints, 14 were not upheld, 29 were partly upheld and 13 were upheld. One complaint has been progressed to a Serious Incident and, therefore, closed as a complaint. One complaint was closed as the complainant is not currently in a position to take it forward.

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



As can be seen the overall reduction in the number of formal complaints received this year continues.

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

Complaints by HG and Subject (primary)	ATT	CAREC	COMM	DELAY	DISCH	TREAT	Total
Corporate Functions	0	0	0	0	0	0	0
Clinical Support - Health Group	0	1	1	0	0	4	6
Family and Women's Health Group	1	0	2	2	0	4	7
Medicine - Health Group	0	3	2	0	0	11	16
Surgery - Health Group	1	2	1	3	1	11	19
Totals:	2	6	5	4	1	30	48

Treatment continues to receive the highest category for complaints, with Medicine and Surgery Health Groups both having had 11 complaints in this category.

5.2 Performance against the 40-day complaints closure standard

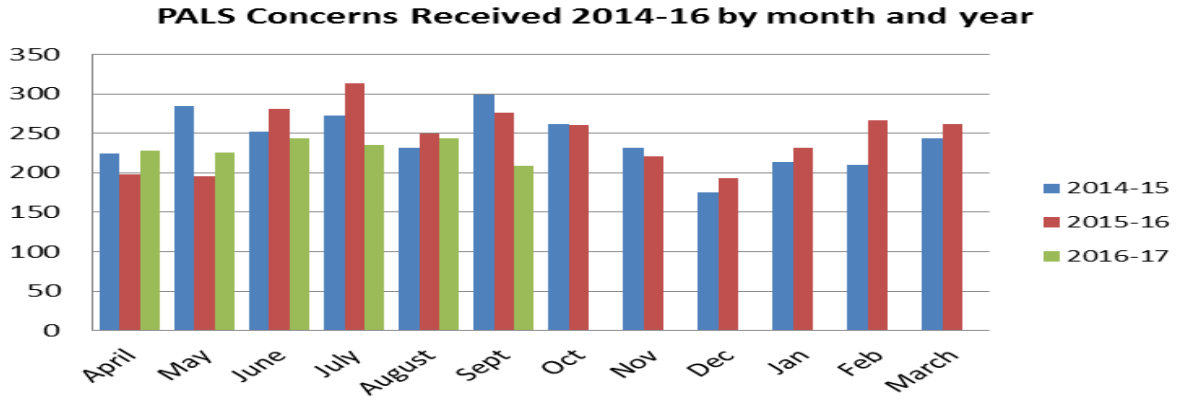
The following table sets out performance against the Trust's standard of closing 90% of complaints within 40 days

Health Group	Closed	Closed within 40 days
Clinical Support	3	1 (33%)
Family and Women's	12	7 (58%)
Medicine	15	9 (60%)
Surgery	28	12 (43%)

The Health Groups are still not yet achieving the 90% standard; however the majority of over 40 day complaints have now been closed and we expect this standard to be achieved before the end of 2016. The Patient Experience Team is continuing to work closely with each of the Health Groups to enable timely responses to complaints to be achieved whilst maintaining quality.

5.2 Patient Advice and Liaison Service (PALS)

In the month of September 2016, PALS received 209 concerns as well as 19 compliments, 83 general advice issues and 2 comments and suggestions. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of outpatient appointments and elective lists.



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

	ADVICE	ATT	CAREC	COMM	DELAY	DISCH	ENVIRO	HOTEL	SAFEG	SPECNE	TREAT	Total
Corporate Functions	0	3	0	6	3	0	2	0	0	1	0	15
Clinical Support	0	2	0	3	6	1	1	0	0	0	13	26
Family and Women's	0	4	0	7	21	0	0	1	1	0	13	47
Medicine	4	2	3	11	23	3	0	0	0	0	10	57
Surgery	2	5	3	9	35	1	0	0	0	0	9	64
Totals:	6	17	6	36	88	5	3	1	1	1	45	209

5.3 Compliments

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

- The patient wished to express her gratitude for the way she was dealt with by ACU staff when admitted recently. There had been no bed available in AAU or Ward 1 but, recognising how ill this lady was, the nurse caring for her recognised the patient may have Sepsis. Within 15 minutes, the patient had an x-ray and was admitted into a bed on Ward 1 under the Sepsis pathway.
- A grandmother wanted to thank staff who looked after her 12-year old grandson when he attended ED following an injury.
- A parent wanted to thank a member of staff in the call centre for how he handled her telephone call regarding her son's appointment.
- Compliments were sent in from a patient for the staff on ward 60 for their efficiency, cheeriness, good humour and compassion.

5.4 Parliamentary and Health Service Ombudsman (PHSO)

The Trust has ten cases being reviewed by the PHSO, currently. No new cases have been received during September 2016 and three cases being closed. One case was not upheld and two were partially upheld.

5.5 Lessons Learned From Health Group Reports

5.5.1 Surgery Health Group

- An elderly patient had attended a consultation where the consultant apparently made flippant comments. The consultant has apologised for his behaviour and will reflect on the way he conducted the consultation in order to not offend other patients in the future.

- At an outpatient's appointment, a patient was given complex information and had further questions regarding his condition and treatment after the appointment. However, he was unsure of how to raise these queries and with whom. The Divisional Nurse Manager is assessing the possibility of providing contact detail cards to patients and families at clinic appointments so there are clear points of contact if there are issues of concern after the appointment.

- A patient was concerned as to why his surgery was cancelled then delayed and not performed sooner. The complaint will be discussed at the next neurosurgical governance meeting for reflective learning.

- A complainant raised concerns regarding events leading to death of their father after he underwent heart surgery and was discharged home. The Divisional Nurse Manager is working with the cardiothoracic surgical team to review the discharge process and the type of information provided to patients and their families at the point of discharge from hospital.

5.5.2 Medicine Health Group

- A relative was unhappy at the treatment provided to the patient prior to his death. Staff reflected on this and agreed to be more considerate and compassionate in their tone and manner in the future.

- A patient was given no breakfast or morning medication and was sent home with a cannula in his arm and ECG pads still attached. The Ward Sister reiterated to nursing staff to follow the correct discharge checking processes. This includes that all patients must be given prescribed medications in a timely manner and to ensure all cannulas and ECG pads are removed before a patient leaves the ward.

5.5.3 Family and Women's Health Group

- A complainant raised concerns regarding the difficulties in securing timely appointments for treatment. Two additional administrative posts have been appointed to support the service.

- A patient was not happy that the pre-operative information supplied to them was out of date and not sufficient. In addition, they expressed dissatisfaction with the follow-up care provided following surgery. These processes have now been revised and updated.

5.5.4 Clinical Support Health Group

- A complainant was unhappy at the way bad news was given to her husband when she accompanied him to a consultation. The consultant met with the complainant in a resolution meeting and apologised personally that he had concentrated on the clinical facts without taking into account the emotional needs of the patient in receiving such news. The consultant agreed to reflect on this experience and to be more considerate when meeting with patients in the future.

5.6 Friends and Family Test (September 2016 Data)

5.6.1 Inpatient areas

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

- Patients who would be likely to recommend the Trust (positive feedback) at **94.9%**
- Patients who would be Unlikely to recommend the Trust (Negative Feedback) **2.1%**

These are really positive results. There was an increase in the number of responses for the month of September 2016 with 6,739 of inpatients responding compared to 6,245 in August 2016.

5.6.2 Emergency Department (ED)

- In September **87.9%** of patients were positive and likely to recommend the ED to friends and family compared to **83.4%** in August.
- **6.6%** gave negative feedback saying that they would be unlikely to recommend the ED compared with **10.8%** in August.
- We have just set up SMS feedback in ED and already we have a response rate of **23%**. Response rates in ED are normally **7.5%.** The increase in responses is great news as we are now going to see more rich data.

5.6.3 Maternity

Maternity recommendation scores:

- **95.2%** likely to recommend maternity services.
- **0.8 %** unlikely to recommend.

5.7 Voluntary Services

The Volunteer Service continues to recruit interested members of the local community who are willing to give of their time to support the hospital. Recruitment is steady with a good level of retention as volunteers are involved in the decisions of where they provide support.

Several hospital volunteers have recently been successful in obtaining permanent paid positions within the Trust due to their experience of volunteering. One volunteer in Pathology has been successful at interview and has just started as a Phlebotomist in the Trust. Another volunteer within the Emergency Department has been successful at interview and has been appointed as a Hygienist. Both volunteers have expressed a desire to carry on with the volunteering as they have enjoyed this experience so much.

5.7.1 Young Volunteers

The second phase of Young Health Champions (YHC) are about to start their induction at the Trust. Some are going into business administration and others are starting out volunteering at the HEY shop in Castle Hill Hospital. One of the new YHC's is starting out in the Radio Station.

The Trust hosted another YHC information day this month with many young people attending to find out more about YHC. The patient experience team was invited along to St Mary's College to their celebration day were they spoke with students and handed out information. The team has also been along to talk with students in assembly at St Mary's College. Areas for further work with the YHC include with Hymers' College, who approached the Trust for more information and the Princes Trust.

Kingstown Radio

5.7.2 Hospital Radio
Volunteers in the radio station have been arranging to set up another studio so that they can train trainees. There have five new presenters who have joined the radio station one of them being a Young Health Champion.

6 OTHER QUALITY UPDATES
6.1 Learning Disability Mortality Review (LeDeR) pilot – Yorkshire and the Humber
The Trust has received notification from NHS England about new reporting requirements for deaths of people with learning disabilities. The LeDeR Programme has been established as a result of one of the recommendations of the Confidential Enquiry into premature deaths of people with learning disabilities. From 1 November 2016 the Trust is required to notify the LeDeR programme of any patient between the ages of 4 to 74 with learning disabilities who dies whilst in the care of the Trust. All deaths of people with learning disabilities within this age range will have an initial review of their death. Where there are concerns about the sequence of events leading to the death, or it is felt that further learning could come from a review of a death, a full multi-agency review of the death will be recommended. The Programme applies to all people with learning disabilities, not just those currently known to health and social care services and will include community and family/carer forums.

The Trust is required to identify an organisational contact, and this has been agreed as Kate Rudston, Assistant Chief Nurse. In addition, organisations have been requested to bring the existence of the Programme to the attention of the Trust Board.

6.2 Comprehensive CQC Inspection 28 June 2016 – 1 July 2016
There was an engagement meeting with the CQC on the 19 October at which further information was provided on issues arising during the inspection. No date has yet been given for the publication of the inspection report.

6.3 Operational Quality Committee 12 October 2016
Key issues discussed at the Operational Quality Committee included:

- Review of the Quality Improvement Programme (QIP)
- VTE assessment and Health Group commitment to work with their teams to improve the level of compliance
- Transition of patients from children to adult services and the need for additional support to take this work forward
- Safeguarding training and action being taken.
- An update on the work to amend the consent form to ensure that patients vCJD status is identified
- WHO checklist compliance and project plan

6.4 Major Trauma peer review
The Major Trauma peer review visit took place on the 11 October 2016. The formal report is awaited but verbal feedback indicated that the Trust has made significant progress since the last

visit in a number of areas including the Emergency Department, Radiology and the ward. Action have been identified where further improvements can be made which relate to the collection of audit data, use of the risk register and rehabilitation arrangements. A further update will be provided in due course

7. ACTION REQUESTED OF THE TRUST BOARD
The Trust Board is requested to receive this report and:

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

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Liz Thomas
Director of Governance

October 2016

TRUST BOARD REPORT – 2016 – 4 - 10	
Meeting date:	Thursday 27th October 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.
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 27th OCTOBER 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)[1,2] and The Care Quality Commission.

2. BACKGROUND

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

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

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

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

The Trust Board is requested to:

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

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

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

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

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

These data are summarised, as follows:

3.1 Planned versus Actual Staffing levels.

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: Allocate e-roster software & HEY Safety Brief) 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%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%

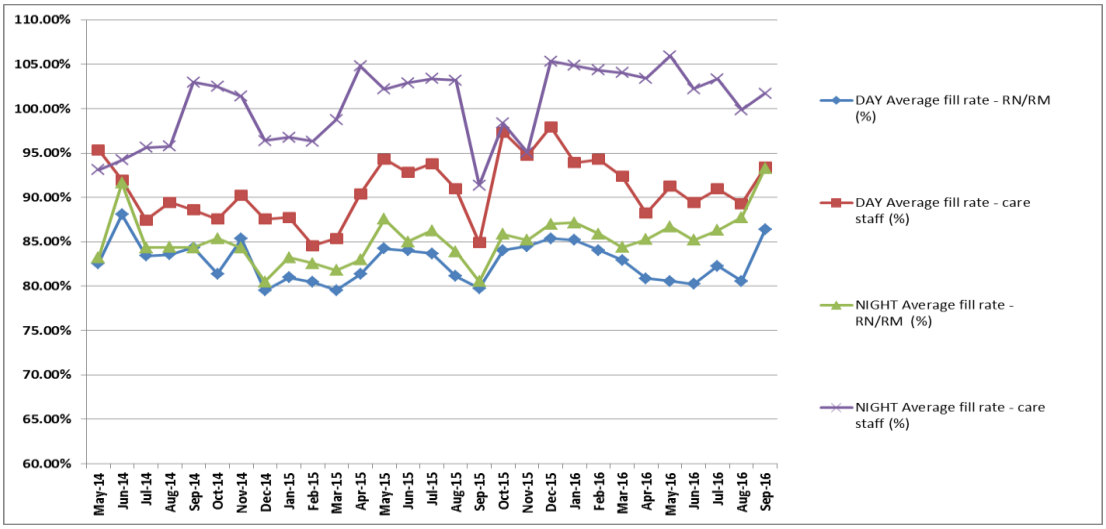
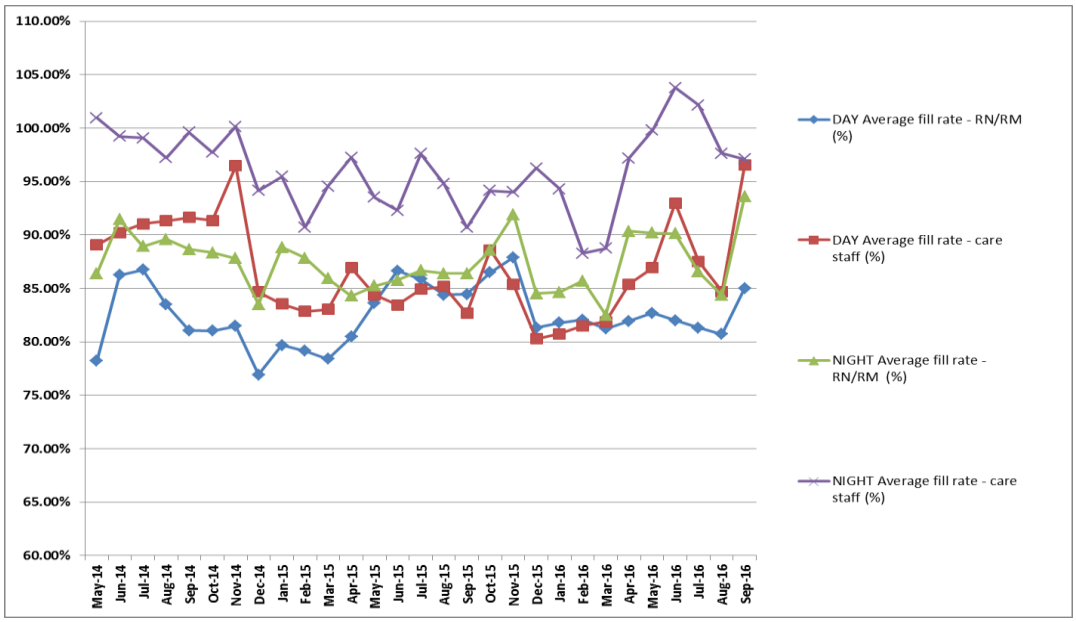


Fig 2: Castle Hill Hospital

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%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%



The Trust has seen a significant increase in both the registered nurse and care staff (unregistered) fills rates over September 2016 compared to previous months. This is predominately due to the recent review and validation of the current nursing rotas and improved availability of Bank and Agency staff to support vacancies.

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 Trust appointed 102 of the August/September student outtake from the University of Hull. The student nurses have just completed a comprehensive induction programme and are due to consolidate this on the 2nd of November 2016 in the presence of the Chief Nurse. They will be given the opportunity to reflect on the success of the induction programme and define their future development needs in accordance with the Trust's `People Strategy` 2017.

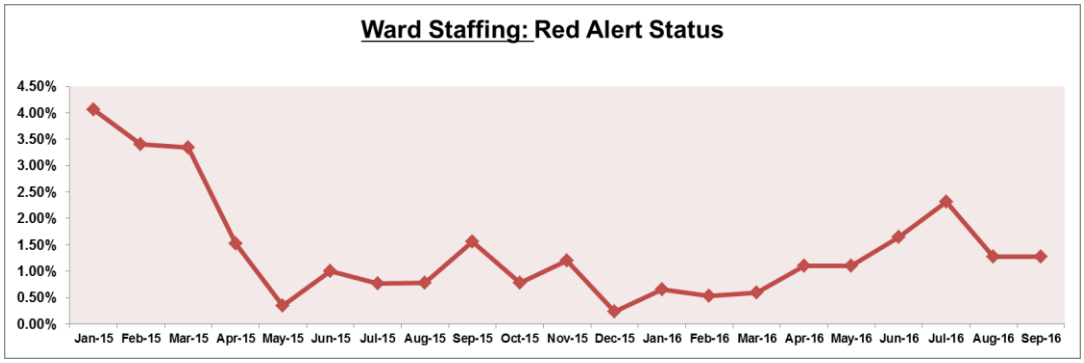
In terms of further recruitment, the Chief Nurse and Senior Nursing team continue to work with Human Resources to attract and recruit to the remaining nurse vacancies. The Executive Management Committee has approved a proposal to undertake an overseas recruitment drive to recruit registered nurses from the Philippines. Work is currently being undertaken to finalise the required number, considering current vacancies, maternity leave and staff turnover, over the next year. Whilst the exercise will seek medical and surgical nurses, the team will also be looking to recruit theatre and intensive care nurses.

The Trust has spoken to several large recruitment agencies, to assist in delivering this plan and a final decision on our preferred partner will be made this month. Instead of trying to bring in a large number of nurses all at once, the Trust is looking to bring manageable numbers in on a bi-monthly basis. This way, the Trust can manage the induction more effectively and ensure new staff receive the support they need. A final decision with regards to the progression of the proposed initiative will be made in context of the Trusts overall financial position.

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 with no increase seen in the September data, compared to that of August 2016. 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. Support continues to be provided by all Health Groups, bank and agency staff. Staffing levels in this area should improve sustainably as the new recruits obtain their NMC registration.
- H1, H70, H9 and H500 (Acute Medicine, Diabetes and Endocrine, Medical Elderly and Respiratory). These wards have a number of RN vacancies which, again, have been offered to new graduates, who will obtain their NMC registration November 2016. In the meantime staff from other wards continue to provide support.
- The Neonatal Unit and Paediatric High Dependency Unit (PHDU) have a number of vacancies and high levels of maternity leave. Staffing risks are managed on a daily basis and some agency staffing is being utilised in these areas.
- C8 and C9 (Elective orthopaedics) have reduced capacity to support acute surgery over at HRI, this has resulted in a bed reduction as reflected in the Nurse to Patient Ratio and an improved registered nurse fill rate throughout September 2016.
- C29, C31, 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.

However, despite on-going recruitment campaigns and the successful recruitment of 102 newly qualified nurses, registered nurse recruitment is still very challenging for the Trust and some risks with securing the required numbers of registered nurses remain.

Unfortunately, the Trust was not successful in its bid to become a pilot site for the Associate Nurse Role, recently introduced by Health Education England (HEE). However, given the significant interest in the role, HEE has decided that there will be a second wave of funding for a further 1,000 nursing associate trainees through `fast followers` test sites starting in Spring 2017. The Trust is working currently in conjunction with representatives from HEE, local educational and community partners to strengthen the initial bid in order to become one of the `Fast followers` test sites.

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. EXPECTATION 1 – RIGHT STAFF

Expectation 1 of the NQB's revised standards requires:

1.1. Evidence-based workforce planning
1.2. Professional judgement
1.3. Comparison with peers

As reported to the board previously, the Trust's nursing and midwifery establishments for in-patient areas have been revised. This process is comprehensive in that validated tools are used to guide these assessments (where they are available). Professional judgement is the applied to refine the initial assessment in order to conclude what is required for each area. Work continues now to include all theatre and outpatient areas.

The Trust has invested into some rota efficiency reporting software called Allocate-Insight. This provides the Trust with a Monthly Reporting Dashboard of Key Metrics from the nurse staffing dataset. The report provides details comparisons with sized Trust's the Shelford Group of Hospital and Acute Trusts. This will be added to the appendices of this report from November 2016.

5. SUMMARY

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

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, although this position has improved and will continue to do so as the newly qualified recruits obtain their NMC registration throughout November 2016. The Chief Nurse and Senior Nursing Team continue to develop innovative solutions to address the supply and demand issues faced by the Trust. Recruitment efforts continue, including reviewing the proposal to undertake a recruitment campaign in the Philippines.

6. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
October 2016

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

HEY SAFER STAFFING REPORT SEPTEMBER-16

NURSE STAFFING

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

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	MONTHLY AVERAGE	DAY		NIGHT		PATIENT TO RN RATIO		RN & AN	ACUITY MONITORING [AVERAGE]					HIGH LEVEL			FALLS				HOSPITAL ACQUIRED PRESSURE DAMAGE						QUALITY INDICATOR TOTAL
				Nurse Staffing Red Alert Status	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	EARLY SHIFT [8:1]	LATE SHIFT [8:1]	NIGHT SHIFT [10:1]	0	1a	1b	2	3	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	GRADE 2	GRADE 3	GRADE 4	DEEP TISSUE INJURY	UNSTAGEABLE	PRESSURE SORE TOTAL	
MEDICINE	ED	ACUTE MEDICINE	NA	3%	89%	55%	90%	76%											3				0						0	3
	AMU	ACUTE MEDICINE	45	10%	91%	78%	98%	92%	6 : 1	7 : 1	6 : 1	47%	16%	37%	0%	0%		3	2	1			1						0	6
	H1	ACUTE MEDICINE	22	3%	67%	96%	95%	106%	9 : 1	11 : 1	8 : 1	69%	0%	30%	0%	0%		1	1	1			1						0	3
	EAU	ELDERLY MEDICINE	21	3%	84%	111%	66%	123%	6 : 1	8 : 1	7 : 1	38%	22%	40%	0%	0%	1	1	2	2			2						0	6
	H5	RESPIRATORY	20	0%	71%	82%	90%	91%	10 : 1	10 : 1	8 : 1	0%	2%	7%	90%	0%		2					0	3						3	5
	RHOB	RESPIRATORY	6	0%	71%	82%	90%	91%	3 : 1	4 : 1	3 : 1	48%	0%	52%	0%	0%		1					0						0	1
	H50	RENAL MEDICINE	19	0%	72%	104%	98%	100%	6 : 1	9 : 1	6 : 1	47%	6%	48%	0%	0%							0						0	0
	H500	RESPIRATORY	24	3%	69%	89%	100%	107%	10 : 1	11 : 1	8 : 1	16%	18%	66%	0%	0%							0						0	0
	H70	ENDOCRINOLOGY	30	3%	88%	112%	66%	101%	8 : 1	10 : 1	10 : 1	9%	1%	90%	0%	0%	1		1	2			2	1			1		2	6
	H8	ELDERLY MEDICINE	27	3%	79%	93%	99%	98%	8 : 1	9 : 1	9 : 1	13%	3%	84%	0%	0%			1	2			2				1	1	2	5
	H80	ELDERLY MEDICINE	27	0%	81%	106%	98%	98%	8 : 1	10 : 1	9 : 1	14%	1%	84%	0%	0%				3			3	1					1	4
	H9	ELDERLY MEDICINE	31	6%	69%	91%	100%	95%	9 : 1	12 : 1	10 : 1	23%	0%	76%	0%	0%			1	2			2						0	3
	H90	ELDERLY MEDICINE	29	0%	99%	80%	98%	103%	8 : 1	10 : 1	10 : 1	34%	19%	47%	0%	0%			2	1			1						0	3
	H11	STROKE / NEUROLOGY	28	0%	88%	118%	99%	100%	8 : 1	9 : 1	10 : 1	22%	20%	52%	6%	0%				5			5	2					2	7
	H110	STROKE / NEUROLOGY	24	3%	80%	132%	98%	106%	7 : 1	7 : 1	6 : 1	21%	79%	0%	0%	0%				1			1	1					1	2
	CDU	CARDIOLOGY	9	0%	91%	51%	100%		4 : 1	4 : 1	8 : 1	27%	43%	26%	4%	0%		1					0						0	1
	C26	CARDIOLOGY	26	0%	92%	84%	97%	100%	6 : 1	6 : 1	7 : 1	12%	21%	64%	3%	0%			1				0						0	1
	C28	CARDIOLOGY	17	0%	79%	126%	84%	57%	6 : 1	7 : 1	6 : 1	0%	18%	22%	60%	0%				1			1						0	1
	CMU	CARDIOLOGY	10	0%	79%	126%	84%	57%	3 : 1	3 : 1	3 : 1	32%	3%	62%	2%	1%							0						0	0
SURGERY	H4	NEURO SURGERY	30	0%	87%	109%	87%	94%	8 : 1	8 : 1	9 : 1	0%	46%	50%	5%	0%		2		1			1	1					1	4
	H40	NEURO HOB / TRAUMA	15	0%	96%	94%	98%	90%	5 : 1	5 : 1	4 : 1	35%	25%	40%	0%	0%							0						0	0
	H6	ACUTE SURGERY	28	0%	88%	93%	91%	195%	8 : 1	9 : 1	8 : 1	38%	23%	39%	0%	0%		1	2				0						0	3
	H60	ACUTE SURGERY	28	0%	93%	86%	88%	200%	7 : 1	9 : 1	8 : 1	33%	13%	54%	0%	0%				2			2						0	2
	H7	VASCULALR SURGERY	30	3%	80%	78%	90%	100%	7 : 1	8 : 1	9 : 1	56%	1%	42%	0%	0%	3		2				0						0	5
	H100	GASTROENTEROLOGY	24	0%	81%	101%	85%	95%	7 : 1	8 : 1	8 : 1	12%	3%	85%	0%	0%		1	1	1			1	1					1	4
	H12	ORTHOPAEDIC	28	3%	75%	90%	89%	111%	7 : 1	9 : 1	8 : 1	21%	9%	71%	0%	0%			2				0				1		1	3
	H120	ORTHO / MAXFAX	22	0%	87%	99%	91%	103%	6 : 1	7 : 1	6 : 1	0%	1%	0%	59%	40%			1	1			1	1					1	3
	HICU	CRITICAL CARE	22	6%	90%	173%	92%	93%	2 : 1	2 : 1	2 : 1	61%	0%	39%	0%	0%		1		1			1	1					1	3
	C8	ORTHOPAEDIC	18	0%	98%	98%	102%	100%	8 : 1	8 : 1	8 : 1	50%	1%	49%	0%	0%							0						0	0
	C9	ORTHOPAEDIC	29	0%	92%	85%	103%	97%	8 : 1	9 : 1	10 : 1	44%	1%	54%	1%	0%	1	2					0						0	3
	C10	COLORECTAL	21	0%	80%	76%	78%	96%	6 : 1	8 : 1	7 : 1	52%	3%	45%	0%	0%							0				1		1	1
	C11	COLORECTAL	22	0%	87%	83%	82%	99%	6 : 1	8 : 1	6 : 1	54%	1%	45%	0%	0%			1				0	1					1	2
	C14	UPPER GI	27	0%	81%	81%	90%	169%	7 : 1	8 : 1	7 : 1	68%	2%	30%	0%	0%							0						0	0
	C15	UROLOGY	26	0%	82%	65%	93%	87%	6 : 1	7 : 1	7 : 1	38%	0%	62%	0%	0%		1	2				0						0	3
	C27	CARDIOTHORACIC	26	0%	92%	95%	100%	93%	6 : 1	7 : 1	7 : 1	0%	0%	1%	55%	44%			1	1			1	1					1	3
	CICU	CRITICAL CARE	22	10%	88%	197%	97%	89%	2 : 1	2 : 1	2 : 1	37%	25%	33%	5%	0%		1					0	1					1	2
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0%	91%	73%	94%	66%	8 : 1	10 : 1	8 : 1	43%	40%	17%	0%	0%							0						0	0
	H130	PAEDS	20	0%	97%	53%	100%	96%	5 : 1	5 : 1	4 : 1	90%	0%	10%	0%	0%				1			1						0	1
	H30 CEDAR	GYNAEOCOLOGY	9	0%	105%	68%	111%	-	6 : 1	6 : 1	6 : 1	88%	11%	1%	0%	0%							0						0	0
	H31 MAPLE	MATERNITY	20	0%	79%	97%	79%	94%	5 : 1	6 : 1	7 : 1	100%	0%	0%	0%	0%							0						0	0
	H33 ROWAN	MATERNITY	38	0%	84%	90%	87%	91%	8 : 1	9 : 1	10 : 1	92%	7%	1%	0%	0%	5		3				0						0	8
	H34 ACORN	PAEDS SURGERY	20	0%	78%	73%	93%	138%	6 : 1	6 : 1	7 : 1	59%	12%	29%	0%	0%		1					0						0	1
	H35	OPHTHALMOLOGY	12	0%	82%	74%	108%		6 : 1	6 : 1	6 : 1	68%	16%	12%	4%	0%							0						0	0
	LABOUR	MATERNITY	16	3%	107%	67%	109%	59%	3 : 1	3 : 1	3 : 1	2%	38%	17%	29%	14%							0						0	0
	NEONATES	CRITICAL CARE	26	0%	91%	86%	87%	101%	3 : 1	3 : 1	3 : 1	53%	33%	14%	0%	0%			2				0						0	2
	PAU	PAEDS	10	0%	92%		96%		5 : 1	5 : 1	5 : 1	2%	15%	3%	80%	0%							0						0	0
	PHDU	CRITICAL CARE	4	0%	63%	105%	103%		2 : 1	2 : 1	2 : 1	54%	0%	46%	0%	0%							0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0%	97%	89%	93%	100%	9 : 1	10 : 1	6 : 1	36%	1%	63%	0%	0%				1	1		2						0	2
	C29	REHABILITATION	15	0%	79%	92%	98%	100%	6 : 1	8 : 1	5 : 1	43%	12%	44%	0%	0%			1				0						0	1
	C30	ONCOLOGY	22	0%	90%	100%	98%	97%	7 : 1	8 : 1	7 : 1	32%	5%	63%	0%	0%					1		1						0	1
	C31	ONCOLOGY	27	3%	70%	112%	97%	100%	9 : 1	10 : 1	9 : 1	29%	5%	67%	0%	0%		1		1			1						0	2
	C32	ONCOLOGY	22	0%	89%	101%	100%	99%	7 : 1	9 : 1	7 : 1	35%	25%	38%	1%	0%				1			1	1					1	2
	C33	HAEMATOLOGY	28	0%	76%	179%	93%	117%	6 : 1	7 : 1	7 : 1							1					0						0	1
			AVERAGE:	1.3%				AVERAGE:	6 : 1	7 : 1	7 : 1	37%	13%	40%	8%	2%															
																	TOTALS:	11	21	32	32	2	0	34	16	0	0	4	1	21	119

Sep-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	86.4%	93.4%	93.3%	101.7%
CHH SITE	85.0%	96.5%	93.6%	97.1%

WARD SUPPORT ROLES

HEALTH GROUP	WARD	SPECIALITY	HOUSE KEEPER	HYGIENEST	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	

WARD SUPPORT ROLES

HEALTH GROUP	WARD	SPECIALITY	HOUSE KEEPER	HYGIENEST	DISCHARGE FACILITATOR / WARD PA	PROGRESS CHASER	SURGERY ADMISSION SUPPORT	DEMENTIA CARE APPRENTICE	NUTRITION CARE APPRENTICE	OTHER	[PLEASE STATE]
	NEONATES	CRITICAL CARE	YES	YES	NO	NO	NO	NO	NO	NO	
	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	

TRUST BOARD REPORT 2016 – 10 - 11	
Meeting date:	27 October 2016
Title:	**FUNDAMENTAL STANDARDS**
Presented by:	Mike Wright – Chief Nurse
Author:	Mike Wright – Chief Nurse
Purpose:	To assure the Board of the quality of care we deliver to our patients is evidence based and appropriate.
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

GREAT STAFF, GREAT CARE, GREAT WARD:
FUNDAMENTAL STANDARDS

1. INTRODUCTION

Delivering high quality, safe and effective care to patients is of paramount importance, and is one of the Trust's key strategic objectives. As a Trust, we must account for the quality of care we deliver to our patients and ensure that care is both evidence based and appropriate to the needs of each individual patient. In an endeavour to demonstrate the above, the Chief Nurse and his Senior Nursing Team have developed a formal review process, which reviews objectively the quality of care delivered by our clinical teams.

The initial results of this work were presented to the Trust Board three months ago.

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

Table to illustrate the Nine Fundamental Standards

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

Table 1

2. ASSSESSMENT PROCESS

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

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

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

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

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

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

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

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

Reassessment of each fundamental standard will take place at a time interval dependent upon the result, as illustrated in the table 2. If the ward achieves a 'Red' rating for any fundamental standard then the Ward Sister/Charge Nurse will have an appraisal completed by the Divisional Nurse, with clear objectives set. If the ward gets a second consecutive Red then the Senior Sister/Charge Nurse will have an appraisal completed by the Nurse Director, the outcome of which will be discussed with the Chief Nurse/Deputy Chief Nurse.

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

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

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

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

Figure 1

An example of the information presented in relation to a specific standard is illustrated in appendix 1.

3. CURRENT POSITION

Fifty Four Clinical areas have been reviewed which consist of Ward Areas, Critical Care Units & our Emergency Department. Appendix 2 provides an overview of individual ratings by clinical area. The following tables illustrate progress made in relation to each fundamental standard from July 2016 to October 2016, across the four Health Groups. Please note that in some instances, given the reassessment time period discussed earlier in the paper, there may be no change in results.

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

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

Staff Experience									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
36	**36 wards**	5	**5**	5	**5**	14	**14**	12	**12**
17	**17 wards**	1	**1**	4	**4**	5	**5**	7	**7**
1	**1 ward**	0	**0**	1	**1**	0	**0**	0	**0**
0	**0 wards**	0	**0**	0	**0**	0	**0**	0	**0**

Progress since July: No audits required to be completed in this time period.

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

Patient Environment									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
5	**7 wards**	0	**0**	2	**3**	2	**3**	1	**1**
25	**28 wards**	3	**5**	5	**4**	9	**11**	8	**8**
21	**15 wards**	3	**1**	2	**2**	7	**3**	9	**9**
1	**1 Ward**	0	**0**	0	**0**	0	**0**	1	**1**

Progress since July: The number of clinical areas rated both Blue and Green have increased in number, in both Family and Women`s and Surgery. The Red rating in Medicine relates to H11 as the Patient Representatives felt the ward appeared cluttered around the nurse's station and notice boards. This has subsequently been actioned by the Ward Sister.

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

Infection Control									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
2	**2 wards**	0	**0**	0	**0**	1	**1**	1	**1**
5	**6 wards**	1	**1**	0	**0**	3	**3**	1	**2**
44	**44 wards**	5	**5**	10	**10**	14	**14**	15	**15**
3	**2 wards**	0	**0**	0	**0**	1	**1**	2	**1**

Progress since July: The number of Green rated clinical areas has increased, with a reduction in the number of areas rated Red within the Medicine Health Group. The two remaining red ratings within the Surgical Health Group and Medical Health Group are due predominantly to failure of the clinical areas to adhere sustainably to local equipment cleaning regimes. A review of the current cleaning requirements across a seven-day period is being completed currently in conjunction with the Infection Control Team to support improved performance in the above element.

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

Safeguarding									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
34	**35 wards**	4	**4**	5	**5**	14	**14**	11	**12**
19	**18 wards**	2	**2**	5	**5**	4	**4**	8	**7**
1	**1 ward**	0	**0**	0	**0**	1	**1**	0	**0**
0	**0 wards**	0	**0**	0	**0**	0	**0**	0	**0**

Progress since July: The number of Blue rated clinical areas has increased in the Medical Health Group with no clinical areas rated Red within this standard.

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

Medicines Management									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
10	**9 wards**	1	**1**	3	**3**	5	**5**	1	**0**
18	**21 wards**	3	**3**	6	**6**	4	**3**	5	**9**
25	**23 wards**	2	**2**	1	**1**	10	**11**	12	**9**
1	**1 ward**	0	**0**	0	**0**	0	**0**	1	**1**

Progress since July: There has been an increase in the number of Green rated clinical areas. The remaining Red rated ward is H110 and is predominantly due to 24 hour checks not being completed sustainably and documentation on the patient's drug card not correlating with the patient's nursing evaluation. Introduction of monthly security checks have commenced with the Ward Pharmacist and Sister. Early indications demonstrate a positive improvement and therefore should address the above issues.

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

Tissue Viability									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
7	**9 wards**	0	**0**	5	**6**	1	**1**	1	2
3	**4 wards**	1	**2**	0	**0**	2	**2**	0	0
30	**26 wards**	4	**4**	5	**4**	9	**9**	12	9
11	**12 wards**	1	**0**	0	**0**	7	**7**	3	5

Progress since July: Overall results show an improvement in pressure ulcer prevention care, this is demonstrated through the increase in the number of Blue and Green rated clinical areas in Family and Women's, Clinical Support and Medicine Health Groups. Clinical areas not achieving fundamental standards require additional support in the completion of `Patient Body Maps` and `Individualised Care Planning` .This work is ongoing and is currently being addressed through the completion of competency based `Bed Side Training by all Registered Nurses.

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

Patient Centred Care									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
9	**9 wards**	0	**0**	5	**5**	3	**3**	1	**1**
15	**14 wards**	2	**2**	2	**2**	4	**3**	7	**7**
21	**23 wards**	4	**4**	2	**2**	10	**11**	5	**6**
8	**6 wards**	0	**0**	0	**0**	2	**2**	6	**4**

Progress since July: There has been an increase in the number of Amber rated scores within both the Medical and Surgical Health Groups and a reduction in Red rated Scores. The remaining Red rated scores relate predominantly to incomplete documented re assessments, when patients are transferred between clinical areas. In order to address this, the Chief Nurse has commissioned a piece of work reviewing the current nursing documentation.

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

Nutrition									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
7	**9 wards**	0	**0**	1	**3**	3	**3**	3	**3**
8	**8 wards**	1	**1**	1	**1**	4	**4**	2	**2**
16	**18 wards**	3	**3**	3	**3**	5	**4**	5	**8**
18	**14 wards**	2	**2**	2	**0**	7	**8**	7	**4**

Progress since July: As illustrated above there has been a decrease in the clinical areas rated Red for this fundamental standard and overall increase in those rated Blue. Work to improve this standard across all clinical areas is ongoing. The nutritional care bundle has been re - formatted and the clinical teams are working closely with the dieticians to improve compliance with its completion.

3.9 PATIENT EXPERIENCE – this fundamental standard assesses whether the clinical area has an active process of obtaining feedback from patients. That there is

demonstrable evidence that practice is reviewed and changed where appropriate on the basis of patient feedback.

Patient Experience									
TRUST		**Clinical Support**		**Family & Women's**		**Surgery**		**Medicine**	
JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**	JULY	**OCT**
37	**37 wards**	4	**4**	8	**8**	13	**13**	12	**12**
12	**12 wards**	2	**2**	1	**1**	6	**6**	3	**3**
3	**3 wards**	0	**0**	0	**0**	0	**0**	3	**3**
1	**1 ward**	0	**0**	0	**0**	0	**0**	1	**1**

Progress since July: No audits required to be completed in this time period.

3.10 SUMMARY:

- 23 clinical areas have one or more fundamental standard rated as Red
- 11 clinical areas have one red standard
- 11 clinical areas have two red standards. 7 of the 11 have Red in Tissue Viability and Nutrition
- H70 currently has four red fundamental standards (tissue viability, patient centred care, nutrition and patient experience). The Chief Nurse has commissioned a comprehensive review of this clinical area to commence in November 2016.

4. AREAS FOR IMPROVEMENT

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

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

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

5. SUMMARY

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

Work has also commenced on further developing the fundamental standards for both Theatres and Outpatients, with a view that the assessment process will commence in these areas January 2017.

6. ACTION REQUESTED OF THE TRUST BOARD

The Trust Board is requested to:

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

Mike Wright
Executive Chief Nurse
October 2016

Appendix 1: Examples of the information presented in relation to a specific standard.

Appendix 2: Overview of Individual Ratings by Clinical Area.

WARD 40

FUNDAMENTAL STANDARD

STAFF EXPERIENCE

What we do well...

- We are a flexible team who can respond to changes in demand for our service. We are an appropriate skilled & competent clinical team.
- Our staff know how to raise concerns with regards to patient safety if required.
- The majority of our staff have completed the trust's mandatory training programme.
- We provide feedback to our staff on incidents they have reported to ensure that lessons are learnt.
- We provide information to our staff regarding the impact of sickness & maternity leave on our rotas.

Date of Review: Nov 2015

Next Review Due: Nov 2016

WARD 40

FUNDAMENTAL STANDARD

PATIENT ENVIRONMENT

What we do well...

- Our patients are cared for with compassion & care in a clean and safe environment.
- Our staff are competent in raising concerns if the standard falls short.
- We work with our Facilities & Estates colleagues to ensure our environment remains safe & clean.
- The environment in our clinical area supports good care.

Areas for improvement...

- We need to make sure our public facing information is kept up to date.

Date of Review: July 2016

Next Review Due: April 2017

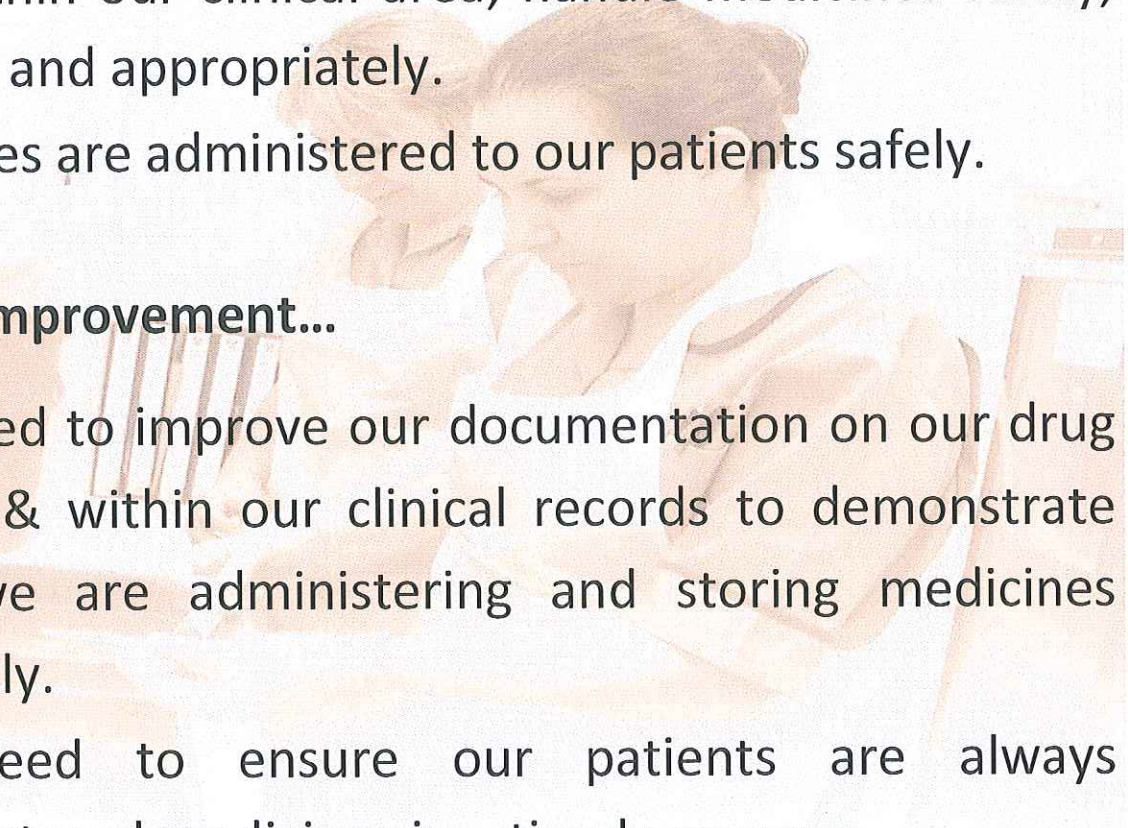
WARD 40

FUNDAMENTAL STANDARD

MEDICINES MANAGEMENT

What we do well...

- Staff within our clinical area; handle medicines safely, securely and appropriately.
- Medicines are administered to our patients safely.



Areas for improvement...

- We need to improve our documentation on our drug charts & within our clinical records to demonstrate that we are administering and storing medicines correctly.
- We need to ensure our patients are always administered medicines in a timely manner.

Date of Review: April 2016

Next Review Due: Dec 2016

WARD 40

FUNDAMENTAL STANDARD

SKIN CARE TISSUE VIABILITY

What we do well...

- The majority of our staff have attended or completed a "Tissue Viability" educational programme / session

Areas for improvement...

- We need to improve our documentation to demonstrate the level of care we are delivering.

Date of Review: Sept 2016

Next Review Due: Dec 2016

FUNDAMENTAL STANDARDS

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	90%	July 17	87%	Oct 16	100%	Mar 17	99%	Feb 17	94%	June 17	88%	Oct 16	88%	Dec 16	100%	Oct 16
C29	94%	Oct 16	90%	May 17	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	88%	Jan 17	87%	July 16	**82%**	Dec 16	90%	Dec 16
C31	98%	Feb 17	91%	Mar 17	86%	Mar 17	92%	Nov 16	94%	April 17	80%*	Sept 16	92%	Nov 16	80%	Dec 16	100%	Mar 17
C32	100%	Mar 17	80%	April 17	88%	July 16	100%	Feb 17	87%	Jan 17	89%	Jan 17	**85%**	Nov 16	77%	Sept 16	100%	Mar 17
C33	100%	Jan 17	90%	May 17	**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	100%	Oct 17	85%	Dec 16	92%	Jan 17	88%	Dec 16	87%	Jan 17	98%	Jan 17	88%	Dec 16	100%	Mar 17
H30	91%	July 16	93%	Mar 17	80%*	Nov 16	91%	Oct 16	94%	Feb 17	80%*	Jan17	92%	Jan 16	80%	Dec 16	100%	Oct 16
H31	91%	Aug 16	90%	May 17	**80%***	Aug 16	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%*	Mar 17	96%	Nov 16	**98%**	Sept 17	100%	Mar 17
H35	95%	Dec 16	95%	May 17	80%*	Sept 16	90%	Oct 16	93%	April 17	86%	April 17	97%	Feb 16	92%	June 17	100%	Nov 16
H130	100%	Mar 16	88%	April 17	**80%***	July 16	100%	Feb 17	94%	Mar 17	97%	April 17	88%	Aug 16	**86%**	Mar 17	96%	April 17
Labour	100%	June 17	NA		**80%***	Sept 16	91%	Nov 16	90%	Dec 16	100%	Sept 17	83%	July 16	NA		NA	
NICU	**92%**	Mar 17	88%	April 17	**80%***	Sept 16	100%	Feb 17	98%	Mar 17	100%	Mar 17			100%	Sept 17	90%	Aug 16
PHDU	95%	June 17	98%	Nov 16	**84%**	Dec 16	100%	Feb 17	100%	Oct 17	100%	Mar 17	97%	Feb 17	**100%**	Sept 17	100%	Mar 17

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C8	92%	Jan 17	91%	Mar 17	**89%**	Feb 17	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	88%	April 17	**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	**71%**	Dec 16	81%	Mar 16	68%	Aug 16	93%	Dec 16
C15	93%	April 16	93%	Mar 17	85%	Sept 16	92%	Nov 16	88%	April 17	**80%***	Nov 16	81%	Aug 16	53%	Aug 16	97%	Mar 17
C27	98%	Mar 16	93%	Mar 17	94%	Dec 16	100%	Mar 17	94%	Aug 17	**80%***	Nov 16	84%	Feb 17	**81%**	Dec 16	100%	Mar 17
CICU1	100%	Oct 16	94%	May 17	100%	April 17	100%	April 17	99%	Oct 17	85%	Aug 16	96%	June 17	94%	Mar 17	96%	Oct 16
CICU2	100%	Oct 16	95%	Sept 17	89%	Feb 17	100%	April 17	100%	Oct 17	**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	91%	April 17	**80%**	Oct 16	100%	Jan 17	88%	Dec 16	**67%**	Dec 16	92%	Nov 16	**77%**	**Dec 16**	97%	Nov 16
H40	100%	Nov 16	93%	Jan 17	84%	Dec 16	100%	Jan 17	87%	Dec 16	**77%**	Sept16	89%	Nov 16	**66%**	Dec 16	100%	Nov 16

H6	96%	Aug 16	81%	April 16	**80%***	May 16	95%	May 17	83%	Jan 17	**80%***	Dec 16	70%	Sept 16	**63%**	Dec 16	95%	Nov 16
H60	94%	Aug 16	95%	April 17	**84%**	Dec 16	97%	Feb 17	96%	Oct 17	**93%**	Mar 17	87%	Dec 15	**82%**	Mar 17	90%	Dec 16
H7	100%	July 16	93%	April 17	**80%***	Jan 17	100%	Mar 17	81%	Sept 16	**80%***	Dec 16	**77%**	Sept 16	**78%**	Dec 16	100%	June 17
H12	92%	July 17	90%	Feb 17	80%*	Sept 16	92%	Dec 16	84%	Nov 16	75%	Oct 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	**80%***	Nov 16	85%	Dec 16	**90%**	Mar 17	92%	Oct 16
H100	100%	April 17	80%	Aug 16	**80%***	Dec 16	94%	Dec 16	82%	April 17	**77%**	Dec 16	84%	June 16	81%	Mar 17	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	80%*	April 17	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	92%	May 17	100%	June 17	89%	July 17	77%	Nov 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	**77%**	Dec 16	**80%**	Dec 16	**60%**	Dec 16	83%	April 16
H1	100%	Nov 16	95%	June 17	**75%**	July 16	96%	Nov 16	90%	Jan 17	80%*	Sept 16	**75%**	Sept 16	**83%**	Mar 17	85%	May 16
H200/EAU	98%	Feb 17	82%	Dec 16	**84%**	Dec 16	95%	Feb 17	92%	May 17	**80%***	Dec 16	84%	Aug 16	**86%**	Mar 17	96%	Feb 17
H5	95%	May 17	80%	Sept 16	**84%**	Jan 17	92%	Dec 16	89%	July 17	75%	Dec 16	**81%**	Oct 16	**84%**	Mar 17	91%	Jan 17
H50	97%	May 17	81%	Sept 16	**84%**	Mar 17	100%	Mar 17	94%	Mar 17	**80%***	Feb 16	**71%**	Aug 16	**95%**	Sept 17	96%	June 16
H500	93%	June 16	81%	Sept 16	**80%***	July 16	92%	Feb 17	82%	Sept 16	**77%**	Dec 16			**73%**	Dec 16	96%	Aug 16
H70	94%	Dec 15	85%	Nov 16	**80%***	Dec 16	92%	Oct 16	81%	Sept 16	**67%**	Jan 17	**58%**	Sept 15	**77%**	Dec 16	**70%**	July 16
H8	96%	Feb 17	84%	Dec 16	81%	Feb 17	**96%**	May 17	90%	Mar 17	80%*	Jan 17	89%	Nov 16	81%	Mar 17	100%	Mar 17
H80	98%	Feb 17	94%	Nov 16	82%	Oct 16	100%	Mar 17	82%	Feb 17	80%*	Jan 17	90%	Nov 16	**83%**	Mar 17	100%	April 17
H9	100%	June 16	86%	Dec 16	84%	Dec 16	95%	Mar 17	87%	Nov 16	97%	Sept 17	94%	Mar 17	82%	Dec 16	100%	June 17
H90	100%	June16	82%	Dec 16	80%*	Dec 16	89%	Dec 16	86%	Jan 17	**86%**	April 17	91%	Mar 17	69%	Dec 16	96%	Nov 16
H11	100%	Feb 17	**80%**	Aug 16	80%*	Jan 17	97%	Mar 17	83%	April 17	**80%***	Dec 16	85%	Dec 16	89%	Mar 17	96%	Dec 16
H110	100%	Nov 16	**89%**	Mar 17	80%*	Nov 16	93%	Oct 16	74%	Nov 16	**80%***	Nov 16	77%	Sept 16	90%	May 17	100%	Nov 16

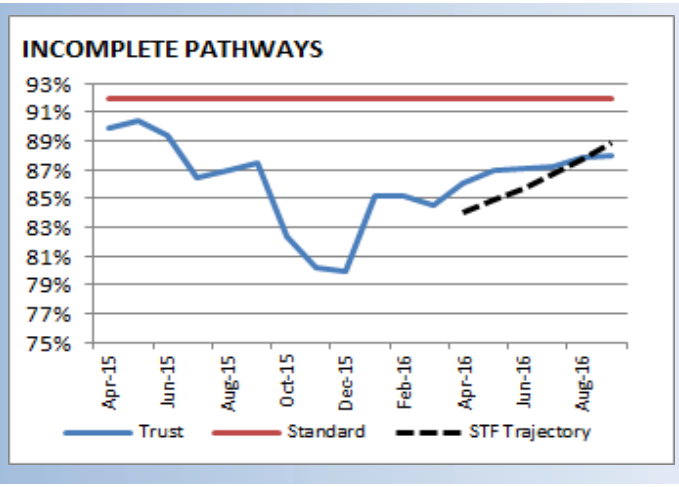
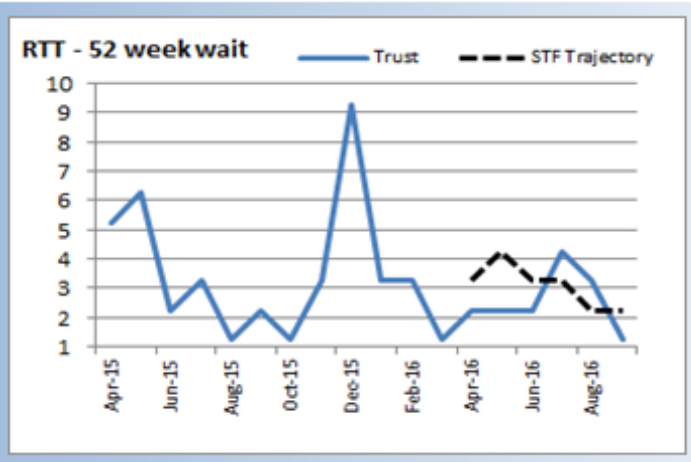
EMERGENCY MEDICINE HRI

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	100%	Aug 17	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

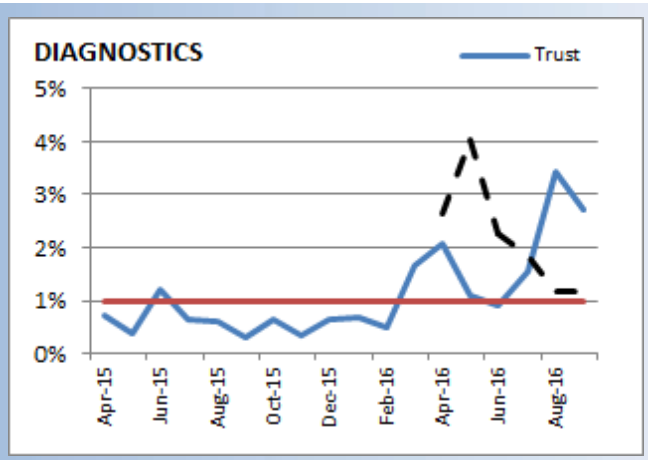
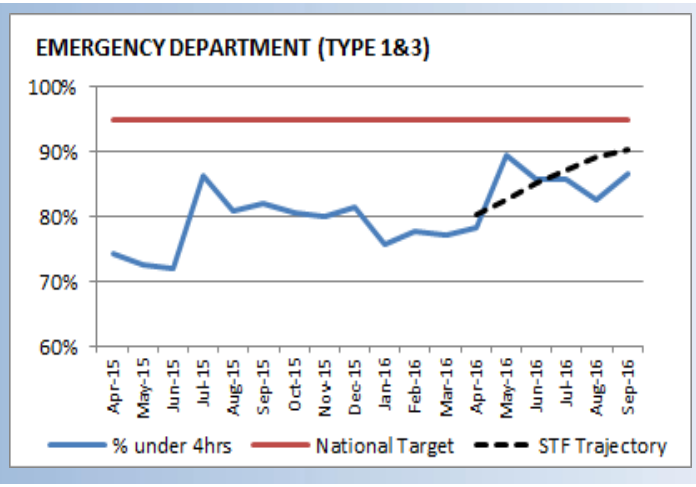
RESPONSIVE

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Referral to Treatment Incomplete pathway	Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92% Sustainability and Transformation trajectory for September is 88.9%	The Trust failed to achieve the STF trajectory of 88.9% but qualified for STF payment by virtue of a 1% tolerance level September performance was 87.9%		The RTT return is grouped in to 19 main specialties. During September there were 6 specialties that failed to meet the STF trajectory
Referral to Treatment Incomplete 52+ Week Waiters	The Trust aims to deliver zero 52+ week waiters	The Trust failed to deliver the national standard of zero breaches with 1 breach for September The Trust achieved the STF trajectory of no more than 2 breaches during		The reported breach specialty was Upper - Gastrointestinal Surgery

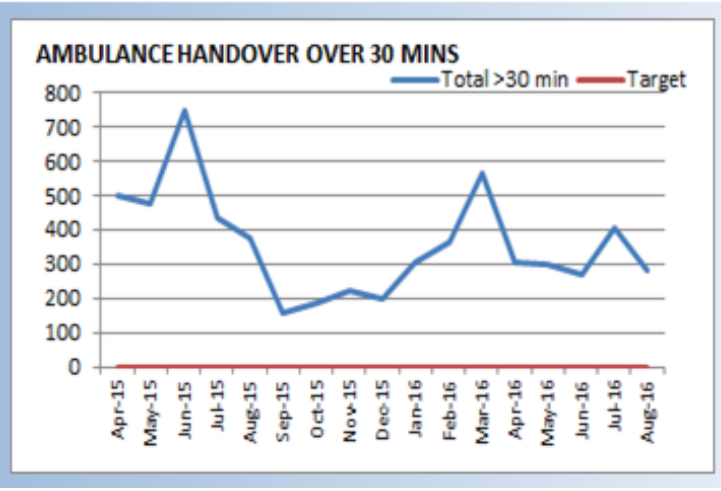
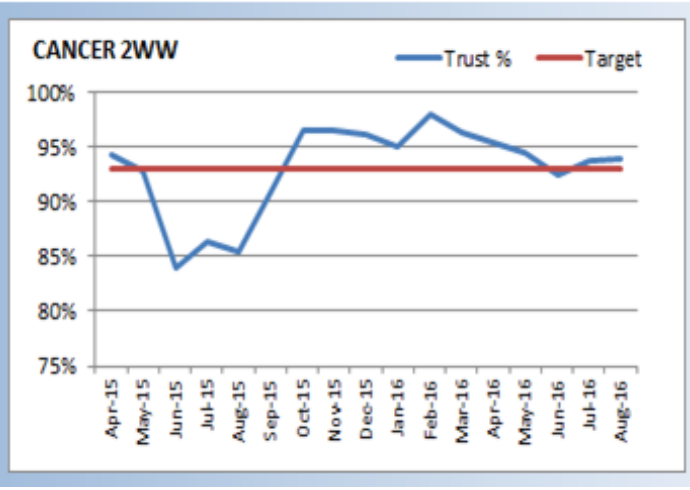
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times: 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made The target is less than 1% over 6 weeks	Diagnostic waiting times has failed to achieve target with a performance of 2.71% in September Sustainability and Transformation trajectory is 1.2% the Trust also failed to meet this trajectory		>6 Week Breaches: Magnetic Resonance Imaging - 108 Comp Tomography -124 Non-obs ultrasound - 4 Peripheral Neurophysiology - 2 Resp - sleep studies - 1 Colonoscopy - 6 Cystoscopy - 1 Gastroscopy - 1 TOTAL 247
A&E Waiting Times	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.	A&E performance has remained below the national 95% threshold with performance of 86.62% for September which was also below the agreed Sustainability and Transformation trajectory of 90.2%		Performance has improved by 4.1% during September.

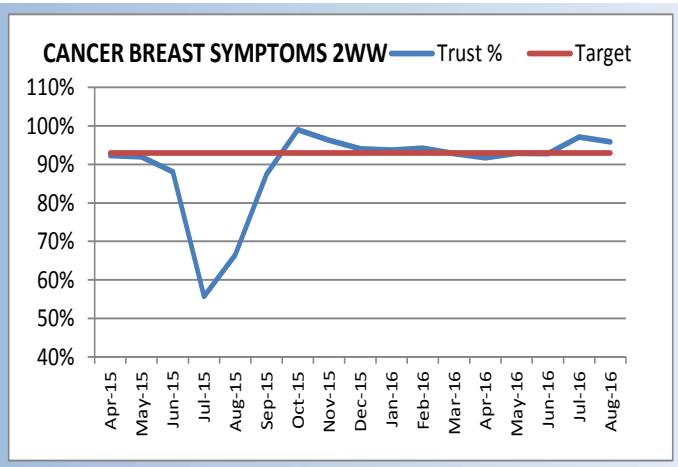
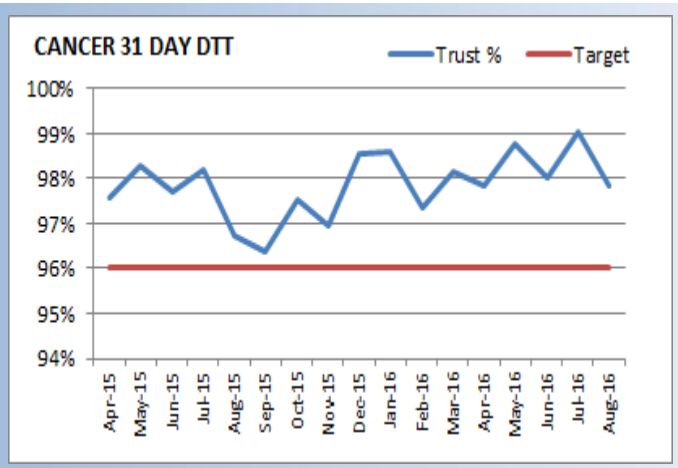
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Ambulance Handovers	All handovers between ambulance and A&E must take place within 15 minutes	The target is 100% for ambulance handovers within 30 minutes Latest confirmed data is August 2016		Performance improved throughout August with 283 patients over 30 minutes and 32 patients over 60 minutes
Cancer: Two Week Wait Standard	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.	August performance achieved the 93% standard at 93.9%		Tumour Sites failing to meet the 93% standard: Head & neck 92.4% UGI 92.4% Skin 91.1%

Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

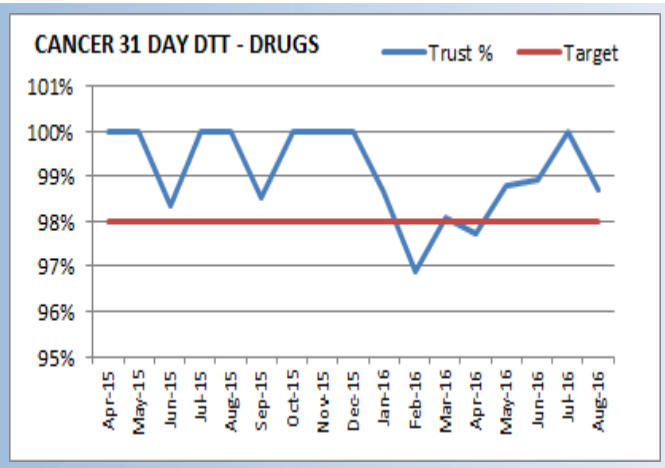
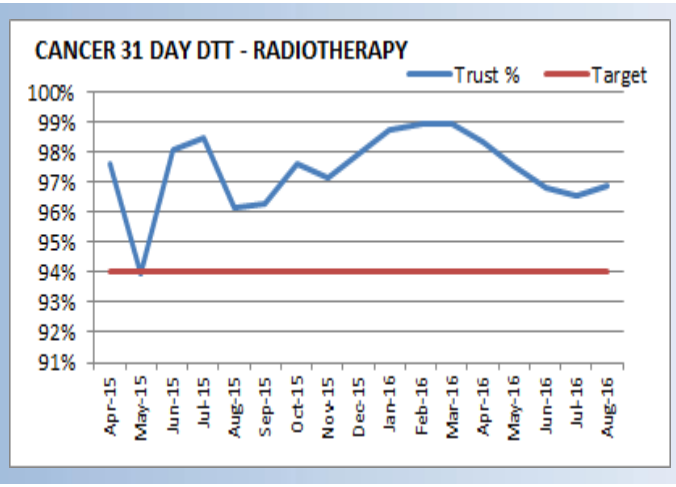
Description	Aggregate Position	Trend	Variation
Cancer: Breast Symptom Two Week Wait Standard	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.	August performance achieved the 93% standard at 95.9%	
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	August performance achieved the 96% standard at 97.8%	

Tumour Sites failing to meet the 96% standard:

Haematological 95.8%
Lung 94.7%
Head & Neck 88.9%
Lower GI 95.7%

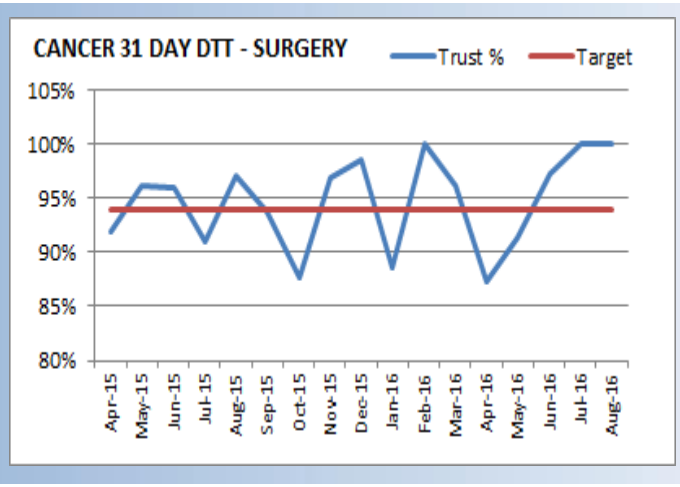
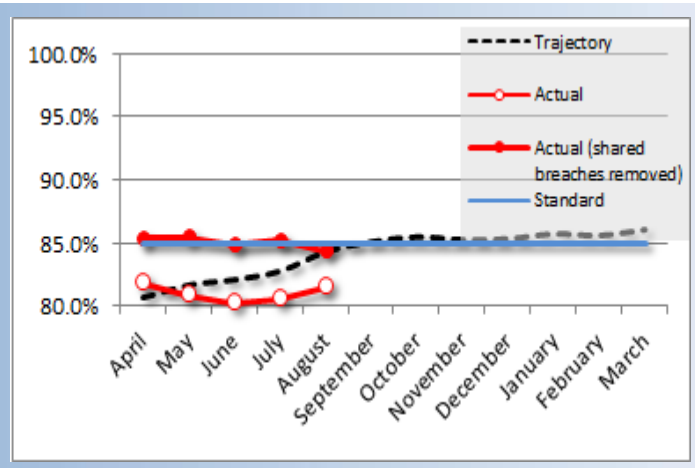
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Drug Standard	Subsequent Anti Cancer Drug	August performance achieved standard at 98.7%		Tumour Sites failing to meet the 98% standard: Urological 94.1%
Cancer: 31 Day Subsequent Radiotherapy Standard	Subsequent Radiotherapy	August performance achieved standard at 96.9%		Tumour Sites failing to meet the 98% standard: Other 75% Head & Neck 50%

Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Surgery Standard	Subsequent Surgery	August performance achieved standard at 100%		
Cancer: ADJUSTED - 62 Day Standard	All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85% Sustainability and Transformation trajectory is 84.4%	The adjusted position allows for reallocation of shared breaches August achieved the STF trajectory of 84.4% with performance of 84.5%		

Hull and East Yorkshire Hospitals NHS
NHS Trust

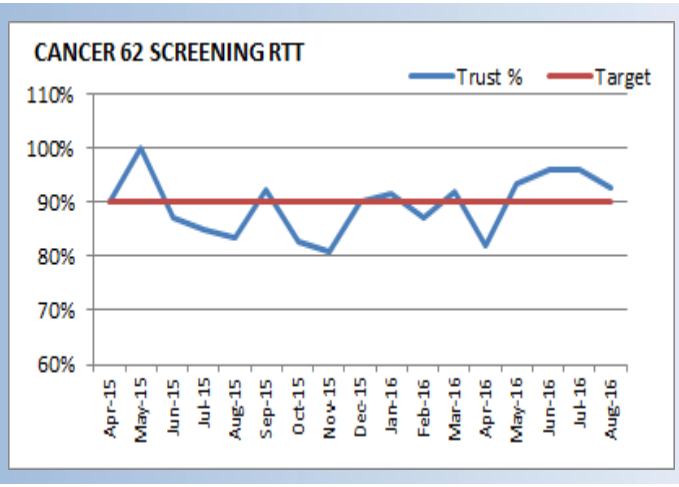
Scorecard - Trust Board - October 2016

Description	Aggregate Position	Trend	Variation

Cancer: 62 Day Screening Standard

62 Day Screening

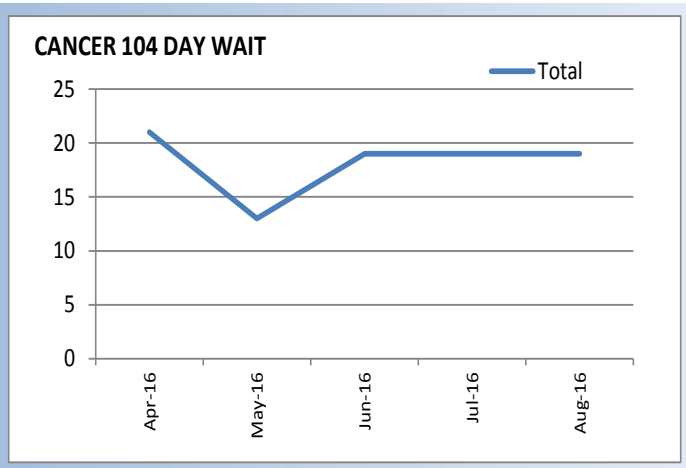
August performance achieved standard at 92.9%



Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 19 patients waiting 104 days or over during August

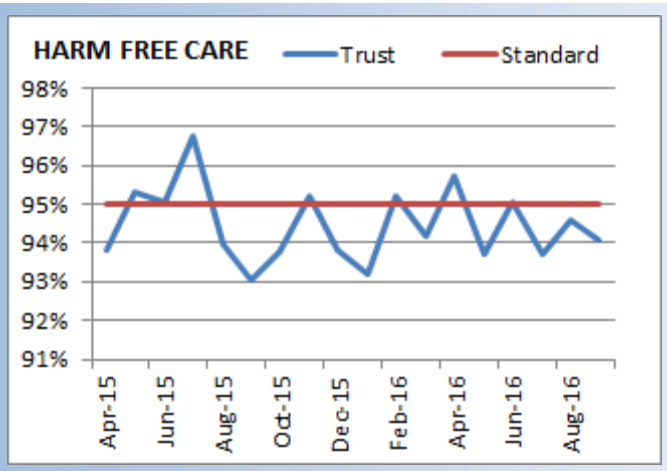
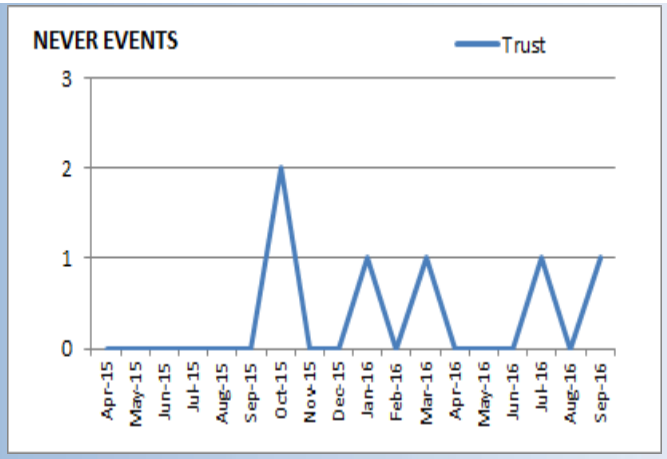


August by Tumour Site:

Breast x1
Colorectal x5
Gynaecology x1
Haematology x1
Head and Neck x3
Lung x3
Sarcoma x1
Skin x1
Upper GI x3

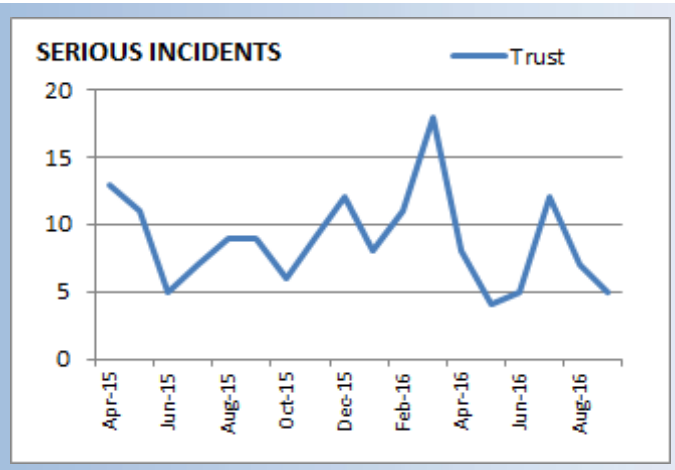
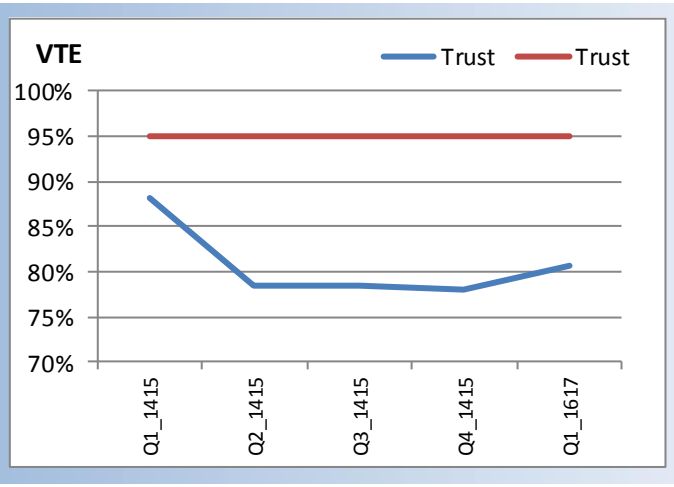
SAFE

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Harm Free Care	Measures percentage of patients that received 'harm free care' – defined by the absence of pressure ulcers, falls, catheter-acquired UTIs	This measure only includes new harms The Trust aim for this measure is achievement of 95% Performance for September was 94.08%		
Never Events	Number of Never Events in month	Never events reported in month - from DATIX There has been 1 Never Event reported During September		

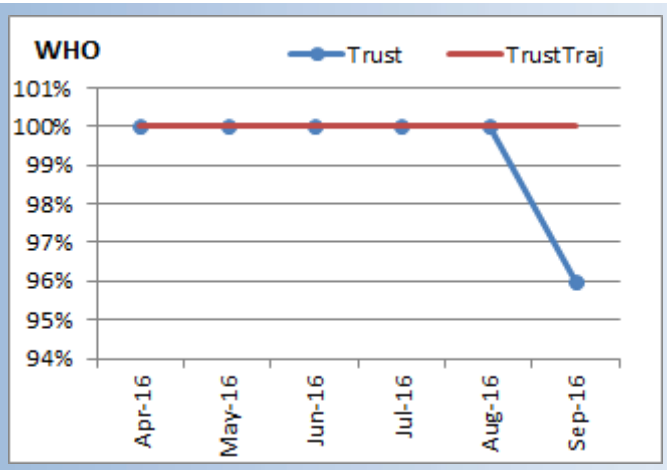
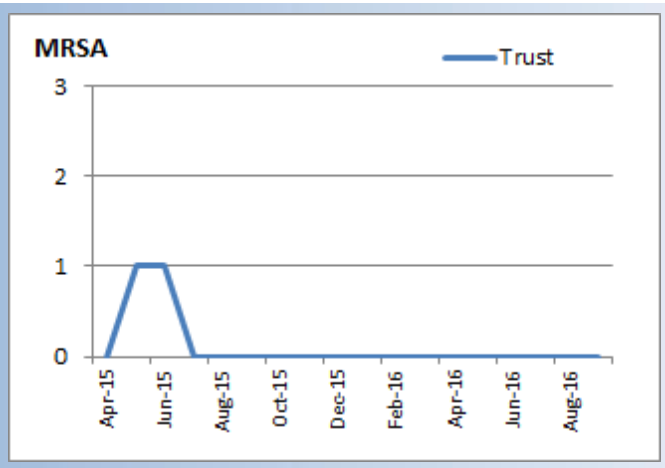
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Number of Serious Incidents in month	Number of Serious incidents reported in month	The Trust has reported 41 incidents year to date There were 5 incidents reported in September		
Potential VTE Risk Assessment	All Patients should undergo VTE Risk Assessment	This measure is reported quarterly The Trust is currently failing to achieve this indicator with performance of 80.61% Q1 201617.		**Health Group Performance:** Clinical 92.20% Family & Women 89.82% Medicine 56.07% Surgery 90.01%

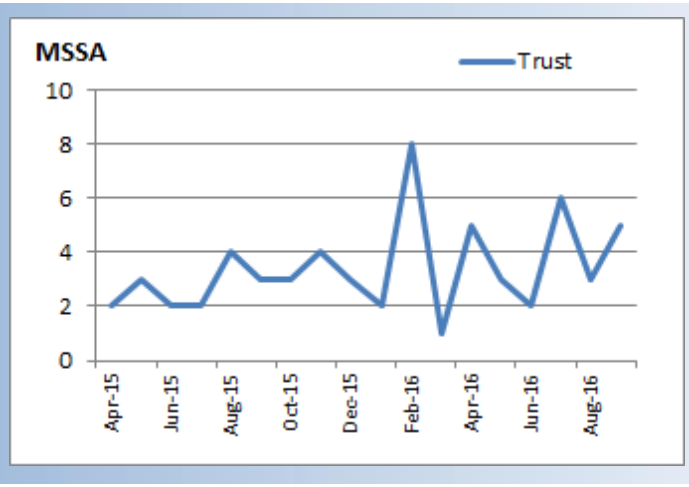
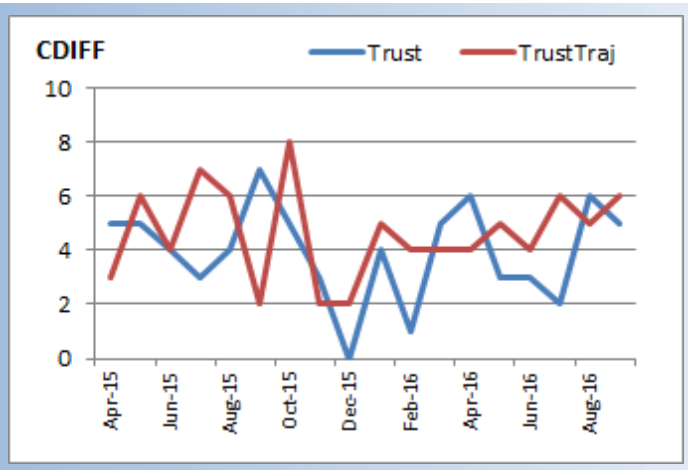
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
WHO Checklist	The Trust aims to deliver 95% compliance with the WHO checklist within it's operating theatres. This checklist provides five steps to safer surgery	Performance for September is 96% This is based on sampled audits of Theatre lists.		The Trust has introduced a new Theatre Quality Assurance Tool which looks at all aspects of Theatre Safety and Cultural Behaviours
MRSA	National objective is zero tolerance of avoidable MRSA bacteraemia.	The Trust maintained its zero tolerance position for MRSA		No Instances

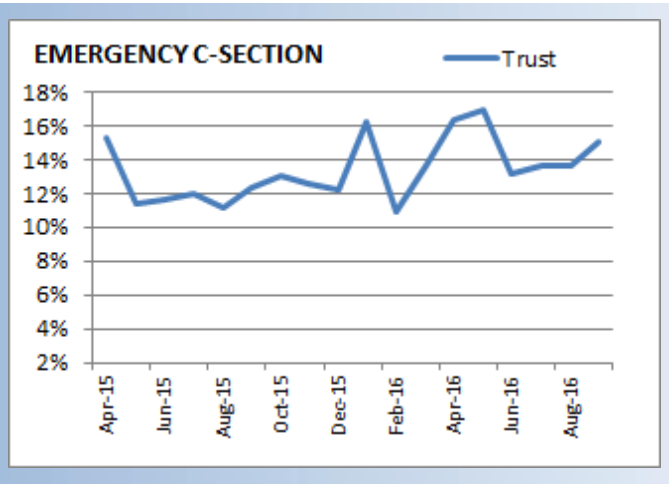
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
MSSA	The Trust's 2016/2017 tolerance level is no more than 45 incidence	There have been 24 cases year to date There were 5 incidents reported during September		Health Group Performance: Clinical - 1 Family&Women - 0 Medicine - 1 Surgery - 3
C.Diff	The Clostridium difficile target for 2016/17 is no more than 53 cases	There have been 25 cases year to date There were 5 incidents reported during September this achieved the monthly trajectory of no more than 6 cases		Health Group Performance: Clinical - 0 Family&Women - 0 Medicine - 3 Surgery - 2

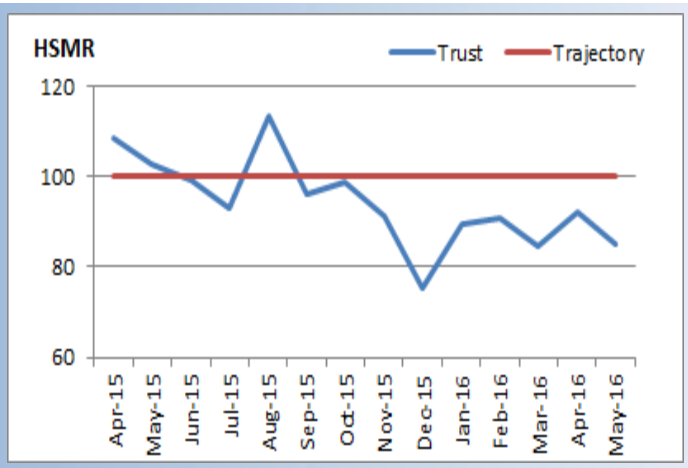
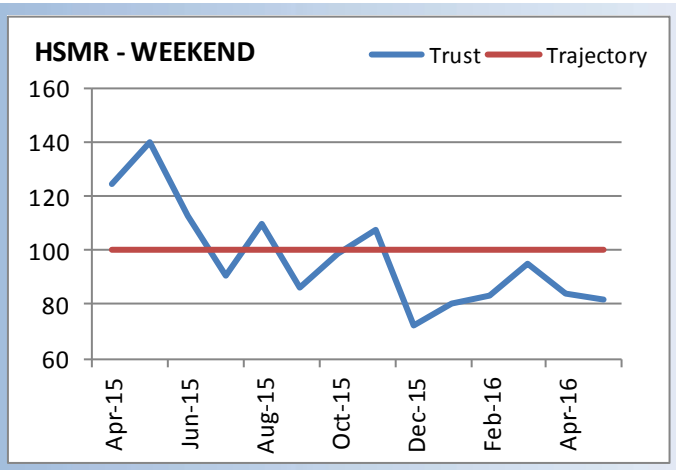
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Emergency C-section rate	Maternity: Emergency C-section rate per month	The Trust aims to deliver less than 12.1% of emergency C-sections Performance for September was 15.10%		Performance deteriorated during September from the August position of 13.7%

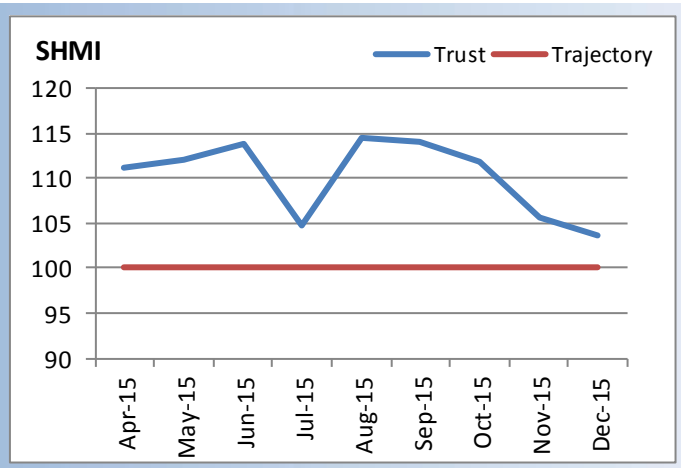
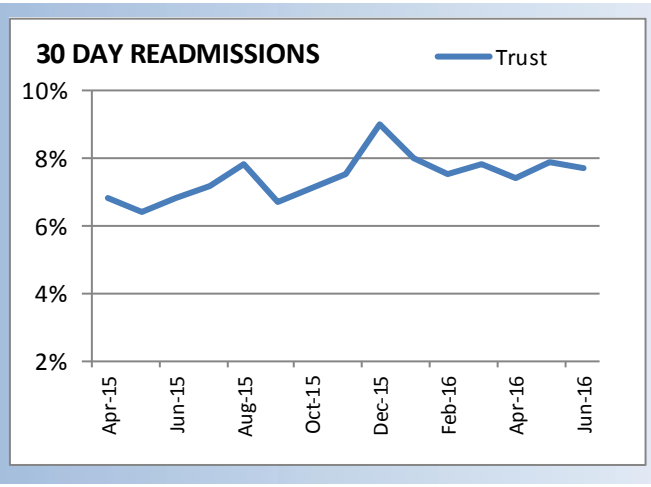
EFFECTIVE

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
HSMR	HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups	June 16 is the latest published performance on CHKS The standard for HSMR is to achieve less than 100 and June achieved this at 94.7		Six alerts at CCS Diagnosis group level for the period July 2013 - June 2016 were included in the latest Mortality Reduction Committee report in October.
HSMR WEEKEND	Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend	June 16 is the latest published performance on CHKS The standard for HSMR at weekends is to achieve less than 100 and June achieved this at 82.0		

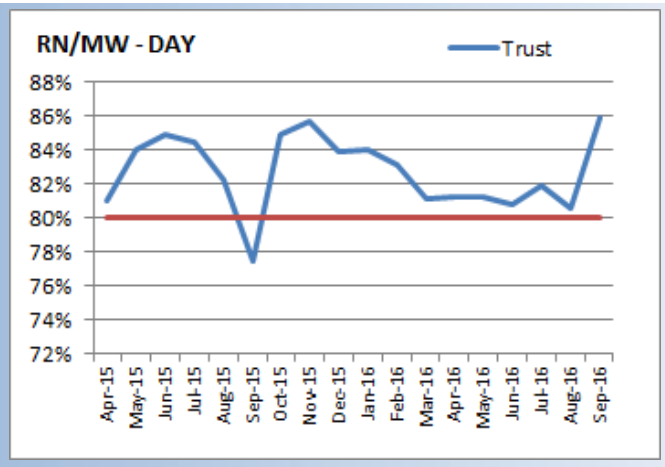
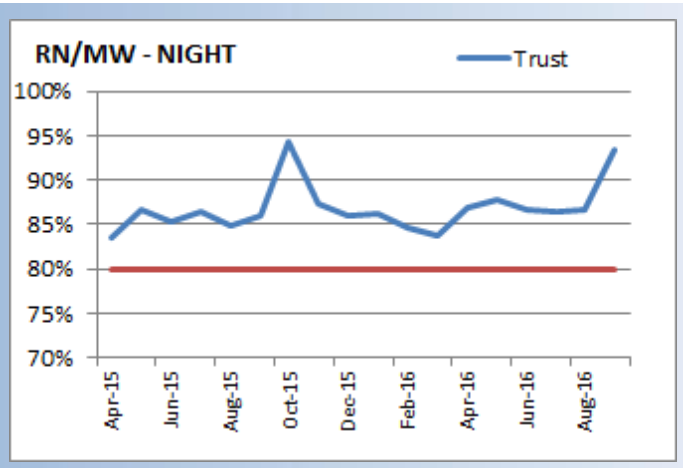
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
SHMI	SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	December 2015 is the latest published performance on CHKS The standard for SHMI is to achieve less than 100 and December failed to achieve this at 103.6		
30 DAY READMISSIONS	Non-elective Readmissions of patients within 30days of discharge as % of all discharges in month	This is an NHS improvement Quality of Care indicator The latest available performance is June 2016 The standard for Readmissions is to achieve less than 6.4% and June failed to achieve this at 7.7%		**Health Group Performance:** Clinical Support 7.4% F&WH 6.0% Medicine 13.8% Surgery 4.8%

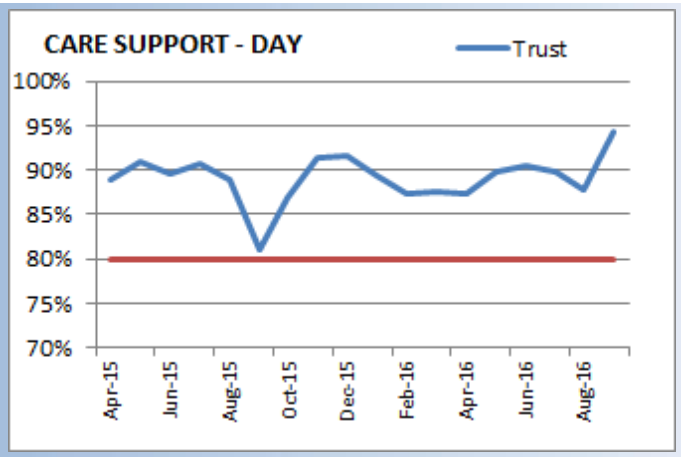
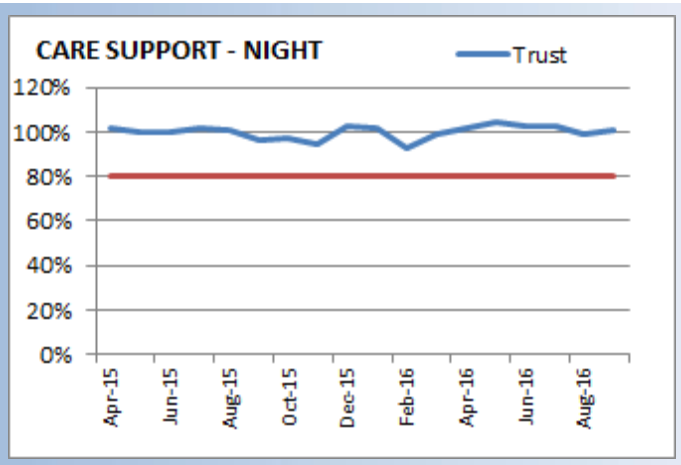
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Registered Staff Day Time	Registered Nurses and Midwives monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	85.92% of expected Registered Nurse/Midwife hours were achieved for day shifts.		There were 14 wards with performance of less than 80% in September, this is a significant improvement from August performance of 22 wards less than 80%
Registered Staff Night Time	Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	93.39% of expected Registered Nurse/Midwife hours were achieved for night shifts.		There were 4 wards with performance of less than 80% in September, this is a significant improvement from August performance of 11 wards less than 80%

Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Clinical Support Worker Day Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	94.42% of expected Care Support Worker hours were achieved for day shifts.		There were 11 wards with performance of less than 80% in September, this is a significant improvement from August performance of 20 wards less than 80%
Clinical Support Worker Night Time	Care Support Worker monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	100.49% of expected Care Support Worker hours were achieved for night shifts.		There were 2 wards with performance of less than 80% in September, this is a significant improvement from August performance of 11 wards less than 80%

Hull and East Yorkshire Hospitals NHS
NHS Trust

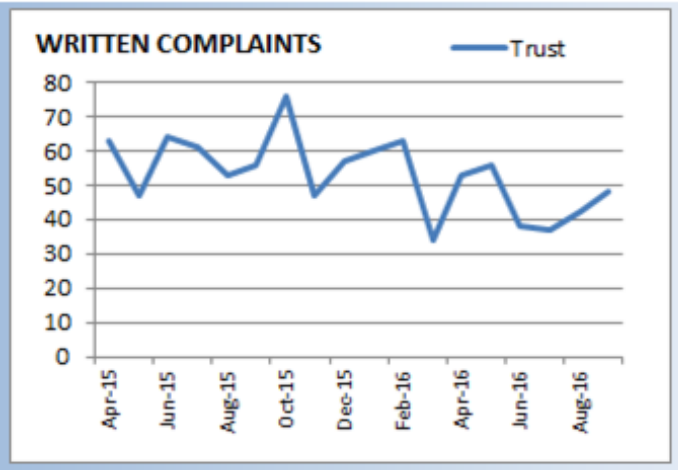
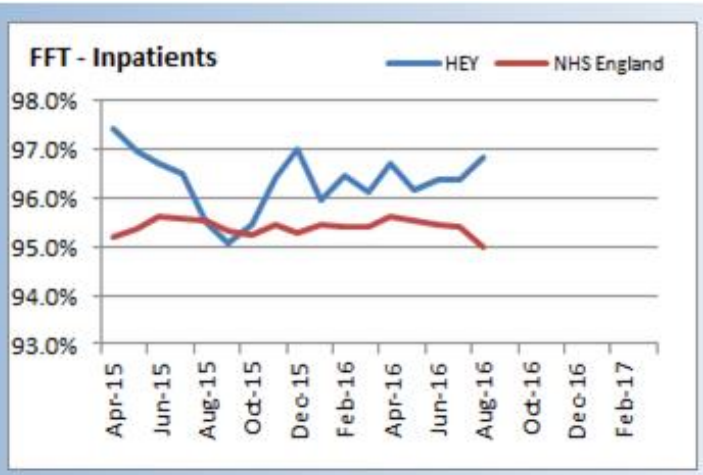
			DAY						NIGHT					
Site	Specialty 1	Ward	Planned RN/MW	Actual RN/MW	Planned CS	Actual CS	Percent RN/MW	Percent CS	Planned RN/MW	Actual RN/MW	Planned CS	Actual CS	Percent RN/MW	Percent CS
HRI	PAEDIATRIC SURGERY	Acorn (H34)	1835.0	1439.0	601.0	438.0	78.4%	72.9%	912.0	852.0	156.0	216.0	93.4%	138.5%
HRI	GENERAL MEDICINE	AAU	3875.5	3543.3	3171.0	2478.5	91.4%	78.2%	2632.0	2587.0	1682.0	1553.5	98.3%	92.4%
CHH	CARDIOLOGY	Cardiac Day Ward	1443.5	1312.0	595.0	302.5	90.9%	50.8%	374.0	374.0	0.0	0.0	100.0%	-
HRI	GYNAECOLOGY	Cedar Ward	840.3	884.8	706.8	477.5	105.3%	67.6%	517.0	575.5	0.0	5.5	111.3%	-
CHH	CARDIOLOGY	CMU / Ward 28 Cardiology	3203.0	2522.5	753.5	951.0	78.8%	126.2%	1980.0	1668.0	660.0	377.5	84.2%	57.2%
HRI	GERIATRIC MEDICINE	EAU	1683.0	1406.5	1305.8	1450.5	83.6%	111.1%	1014.0	672.0	660.5	812.8	66.3%	123.1%
CHH	CRITICAL CARE MEDICINE	ICU CHH	5218.5	4569.6	604.8	1191.1	87.6%	197.0%	4668.0	4525.5	336.0	300.0	96.9%	89.3%
HRI	CRITICAL CARE MEDICINE	ICU HRI	6839.6	6150.3	608.5	1051.3	89.9%	172.8%	6684.0	6172.0	336.0	312.0	92.3%	92.9%
HRI	OBSTETRICS	Labour and Delivery	3010.3	3227.3	1192.0	797.0	107.2%	66.9%	2520.0	2749.0	934.5	556.0	109.1%	59.5%
HRI	OBSTETRICS	Maple Ward 31	2081.8	1646.3	752.5	729.8	79.1%	97.0%	931.5	734.5	630.0	594.5	78.9%	94.4%
HRI	OPHTHALMOLOGY	Ophthalmology Ward / Daycase Unit	1499.0	1226.5	632.0	467.0	81.8%	73.9%	690.0	748.0	0.0	0.0	108.4%	-
HRI	PAEDIATRICS	PAU	732.0	671.5	0.0	0.0	91.7%	-	720.0	694.0	0.0	0.0	96.4%	-
HRI	PAEDIATRICS	PHDU	1170.5	735.5	105.0	110.3	62.8%	105.0%	708.0	727.3	0.0	0.0	102.7%	-
HRI	OBSTETRICS	Rowan Ward 33	1989.0	1661.6	992.3	891.8	83.5%	89.9%	931.5	813.5	630.0	574.5	87.3%	91.2%
HRI	GENERAL MEDICINE	Ward 1	977.5	910.3	716.0	865.2	93.1%	120.8%	626.8	672.0	329.0	396.0	107.2%	120.4%
CHH	GENERAL SURGERY	Ward 10 Colorectal Surgery	1467.5	1169.9	822.5	622.0	79.7%	75.6%	990.0	776.5	330.0	317.8	78.4%	96.3%
HRI	GASTROENTEROLOGY	Ward 100 (Gastro/Gm)	1539.0	1239.4	925.5	933.0	80.5%	100.8%	839.0	709.0	660.0	626.5	84.5%	94.9%
CHH	GENERAL SURGERY	Ward 11 Colorectal Surgery	1488.0	1300.5	816.5	677.5	87.4%	83.0%	983.5	805.0	330.0	327.0	81.9%	99.1%
HRI	REHABILITATION	Ward 11 Eld Med	1578.0	1384.5	810.5	952.5	87.7%	117.5%	682.0	677.0	660.0	660.0	99.3%	100.0%
HRI	GENERAL MEDICINE	Ward 110 Stroke Unit	1837.0	1465.5	692.0	914.5	79.8%	132.2%	675.0	663.8	675.0	712.8	98.3%	105.6%
HRI	TRAUMA & ORTHOPAEDICS	Ward 12 Orthopaedics	1834.0	1384.0	1317.0	1186.0	75.5%	90.1%	955.5	855.0	660.0	735.5	89.5%	111.4%
HRI	TRAUMA & ORTHOPAEDICS	Ward 120 Orthopaedics	1540.5	1336.0	978.0	969.5	86.7%	99.1%	937.0	854.5	660.0	680.5	91.2%	103.1%
HRI	PAEDIATRIC NEUROLOGY	Ward 130	1470.5	1423.3	399.0	211.5	96.8%	53.0%	1428.0	1430.8	360.0	346.0	100.2%	96.1%
CHH	GENERAL SURGERY	Ward 14 Upper GI Surgery	1831.3	1487.3	938.3	759.3	81.2%	80.9%	982.5	886.8	330.0	557.5	90.3%	168.9%
CHH	UROLOGY	Ward 15 Urology	2420.4	1988.4	1778.3	1153.3	82.2%	64.9%	990.0	917.5	649.0	566.0	92.7%	87.2%
CHH	INFECTIOUS DISEASES	Ward 20 Inf Dis	836.0	812.0	801.0	712.5	97.1%	89.0%	704.0	656.5	330.0	331.0	93.3%	100.3%
CHH	CARDIOTHORACIC SURGERY	Ward 26 CT Surgery	2023.0	1865.5	948.0	794.0	92.2%	83.8%	1023.0	990.0	330.0	330.0	96.8%	100.0%
CHH	CARDIOTHORACIC SURGERY	Ward 27 CT Surgery	1863.8	1713.3	818.5	774.5	91.9%	94.6%	979.0	979.0	330.0	308.0	100.0%	93.3%
CHH	REHABILITATION	Ward 29 Rehab	932.8	739.5	971.0	897.0	79.3%	92.4%	660.0	649.0	330.0	330.0	98.3%	100.0%
CHH	CLINICAL ONCOLOGY	Ward 30	1238.8	1112.4	757.5	754.0	89.8%	99.5%	660.0	649.0	330.0	320.0	98.3%	97.0%
CHH	CLINICAL ONCOLOGY	Ward 31	1540.0	1081.0	897.0	1008.5	70.2%	112.4%	660.0	638.8	465.0	466.0	96.8%	100.2%

Hull and East Yorkshire Hospitals NHS
NHS Trust

			DAY						NIGHT					
Site	Specialty 1	Ward	Planned RN/MW	Actual RN/MW	Planned CS	Actual CS	Percent RN/MW	Percent CS	Planned RN/MW	Actual RN/MW	Planned CS	Actual CS	Percent RN/MW	Percent CS
CHH	CLINICAL ONCOLOGY	Ward 32	1142.5	1012.0	732.5	742.0	88.6%	101.3%	660.0	661.0	330.0	326.0	100.2%	98.8%
CHH	CLINICAL HAEMATOLOGY	Ward 33	2376.8	1803.6	696.3	1246.8	75.9%	179.1%	990.0	919.1	330.0	387.0	92.8%	117.3%
HRI	NEUROSURGERY	Ward 4 Neurosurgery	1636.0	1427.8	756.5	827.8	87.3%	109.4%	957.0	830.0	660.0	623.3	86.7%	94.4%
HRI	NEUROSURGERY	Ward 40 Neurosurgery	1148.0	1107.5	734.5	688.5	96.5%	93.7%	1044.5	1028.8	660.0	594.0	98.5%	90.0%
HRI	RESPIRATORY MEDICINE	Ward 5 & RHDU	1961.5	1401.8	1023.0	841.0	71.5%	82.2%	1309.0	1181.8	660.0	599.5	90.3%	90.8%
HRI	NEPHROLOGY	Ward 50 Renal	1449.5	1050.3	738.7	765.3	72.5%	103.6%	660.0	650.0	330.0	330.0	98.5%	100.0%
HRI	RESPIRATORY MEDICINE	Ward 500	1269.8	879.3	1303.0	1164.7	69.2%	89.4%	660.0	658.5	653.0	699.8	99.8%	107.2%
HRI	GENERAL SURGERY	Ward 6 Acute Admissions	1442.5	1276.5	1075.3	995.3	88.5%	92.6%	990.0	904.8	330.0	643.6	91.4%	195.0%
HRI	GENERAL SURGERY	Ward 60 Acute Admissions	1456.0	1360.4	1081.5	933.8	93.4%	86.3%	990.0	871.5	330.0	659.5	88.0%	199.8%
HRI	GENERAL SURGERY	Ward 7 Vascular Surgery	1982.0	1586.8	1344.5	1048.0	80.1%	77.9%	972.0	876.5	660.0	660.0	90.2%	100.0%
HRI	GERIATRIC MEDICINE	Ward 70 (Endo)	1525.1	1346.0	932.0	1045.5	88.3%	112.2%	1032.5	679.8	869.5	882.3	65.8%	101.5%
CHH	PLASTIC SURGERY	Ward 8	653.8	640.3	731.0	715.3	97.9%	97.9%	517.0	526.8	330.0	331.0	101.9%	100.3%
HRI	GERIATRIC MEDICINE	Ward 8	1647.5	1295.9	1128.5	1051.0	78.7%	93.1%	684.0	679.5	660.0	649.5	99.3%	98.4%
HRI	GERIATRIC MEDICINE	Ward 80	1716.8	1387.6	1142.0	1210.5	80.8%	106.0%	682.0	667.0	682.0	668.5	97.8%	98.0%
CHH	TRAUMA & ORTHOPAEDICS	Ward 9	1420.0	1311.0	970.0	821.0	92.3%	84.6%	649.0	667.5	330.0	318.8	102.9%	96.6%
HRI	TRAUMA & ORTHOPAEDICS	Ward 9 Medicine	1347.0	1240.5	1157.5	1167.0	92.1%	100.8%	660.0	638.0	659.5	661.5	96.7%	100.3%
HRI	TRAUMA & ORTHOPAEDICS	Ward 90 Elderley Medicine)	1312.0	1297.0	1321.0	1055.0	98.9%	79.9%	660.0	649.0	660.0	681.5	98.3%	103.3%
HRI	NEONATOLOGY	Women & Childrens NICU	3974.8	3609.0	390.0	335.0	90.8%	85.9%	3192.0	2781.0	315.0	318.3	87.1%	101.0%

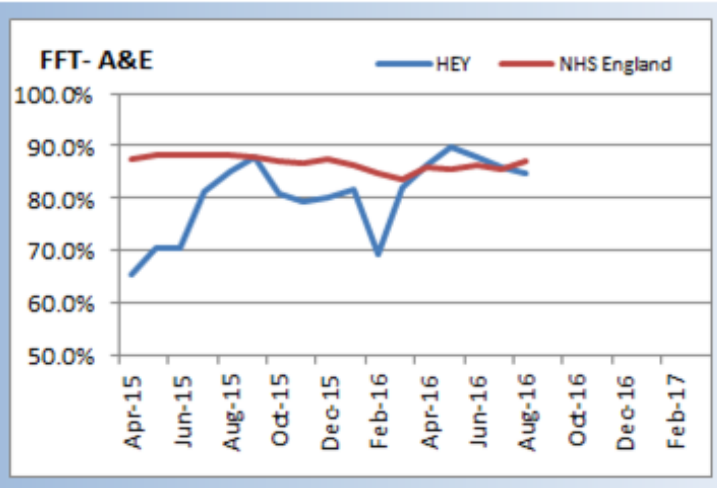
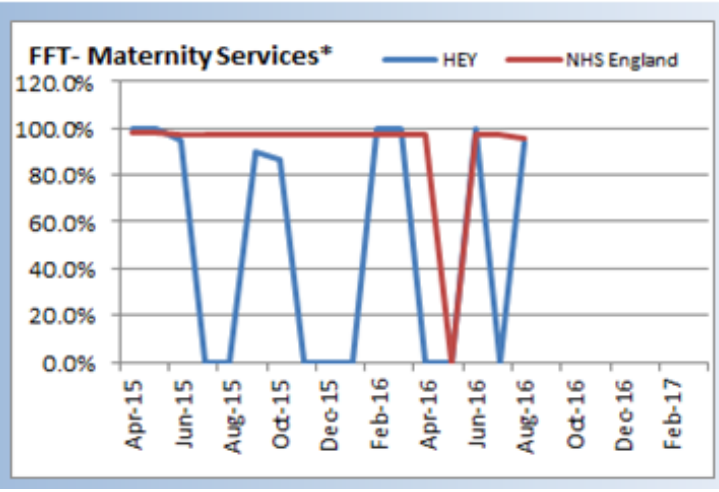
CARING

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Written Complaints Rate	The number of complaints received by the Trust	The Trust received 48 complaints during September, this is a slight increase on the August position of 42 complaints		There have been 226 complaints year to date
Inpatient Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	The latest published data is August 2016 Performance for August was 96.8%		The overall response rate for August was 25.02%

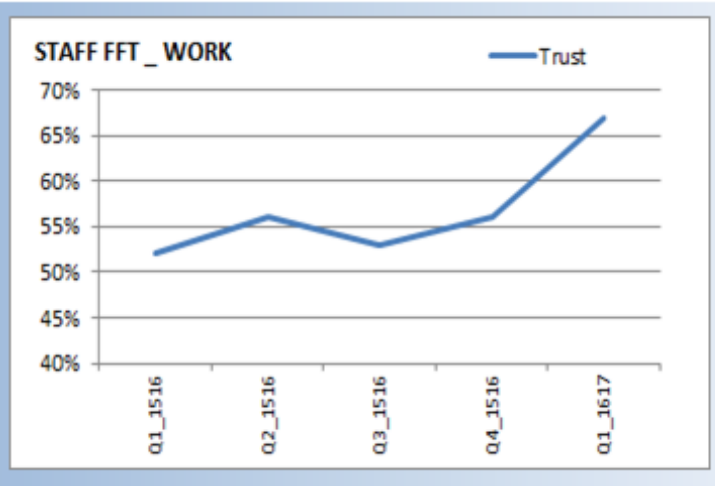
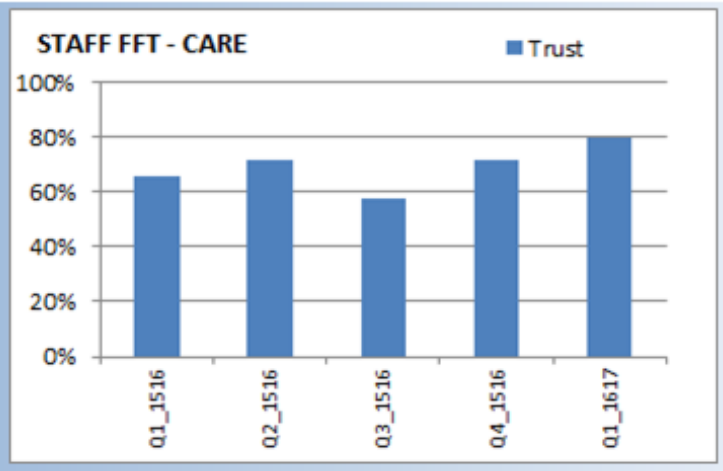
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	The latest published data is August 2016 Performance for August was 84.6%		The overall response rate for August was 7.10%
Maternity Scores from Friends and Family Test - %	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	The latest published data is August 2016 Performance for August was 94.2%		* Question relates to Birth Settings The overall response rate for August was 16.1%

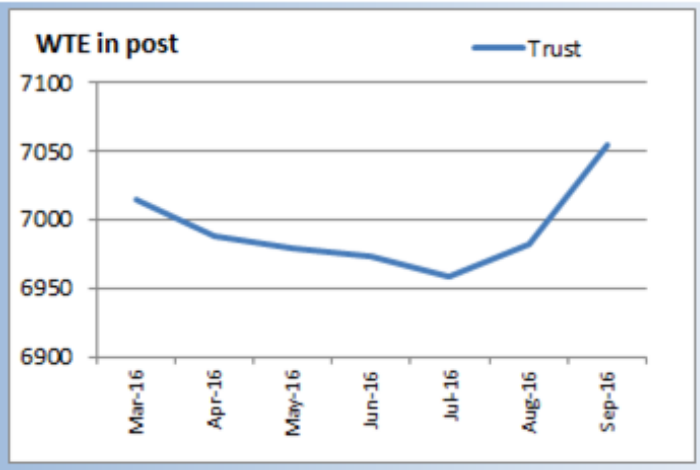
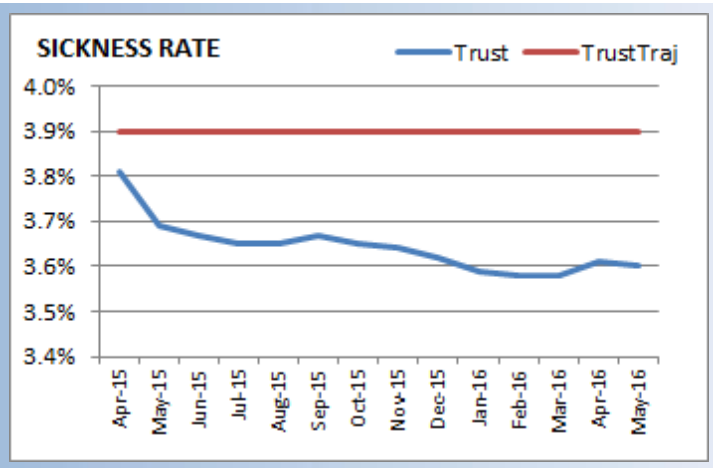
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?	The Friends and Family Test position for Quarter 1 2016/2017 shows that 67% of surveyed staff would recommend the Trust as a place to work compared to 56% for Quarter 4.		The overall response rate for Quarter 1 was 28.73%
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?	The Friends and Family Test position for Quarter 1 2016/2017 shows that 80% of surveyed staff would recommend the Trust as a place to receive care/treatment compared to 72% for Quarter 4.		

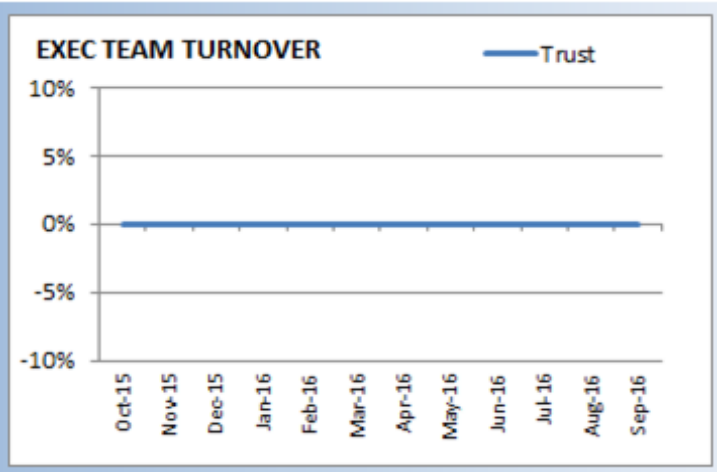
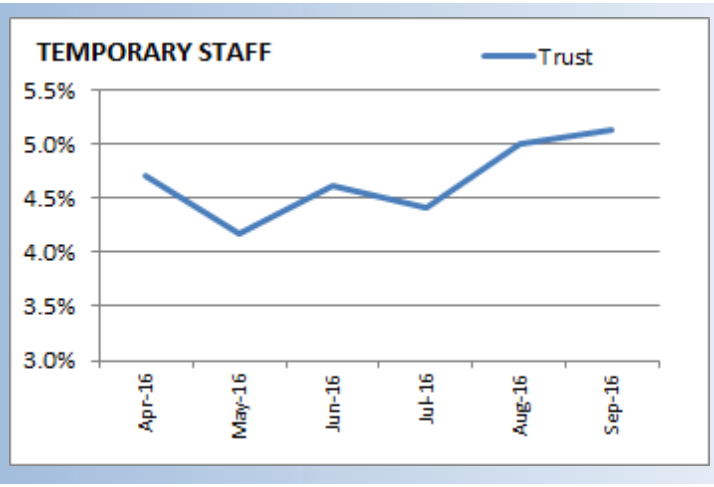
ORGANISATIONAL HEALTH

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
WTEs in post	Contracted WTE directly employed staff as at the last day of the month	Trust level WTE position as at the end of September was 7053.8		Clinical Support Services - 1609.2 Family & Women's Health - 1052 Medicine - 1212.7 Surgery - 1817.6 Corporate Directorates - 804.7 Research & Development - 158.1 Estates, Facilities & Dev - 399.5
Sickness Absence Rates	Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.	Performance for September achieved standard of 3.9% with performance of 3.59%		Clinical Support Services 3.32% Family & Women's Health 3.73% Medicine 3.63% Surgery 3.61% Corporate Directorates 3.14% Estates, Facilities & Dev 5.06%

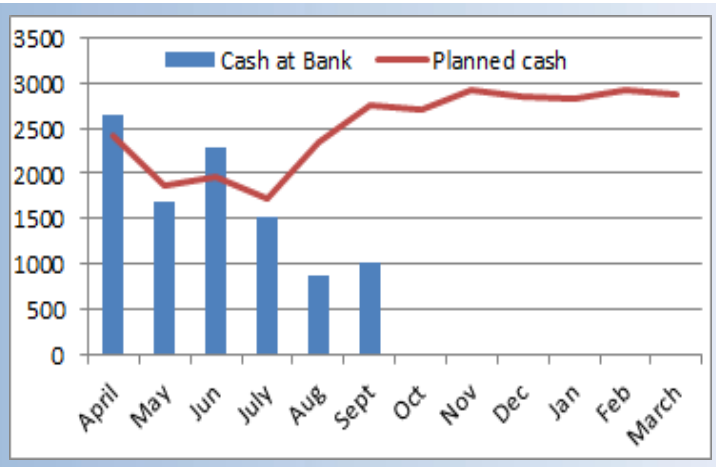
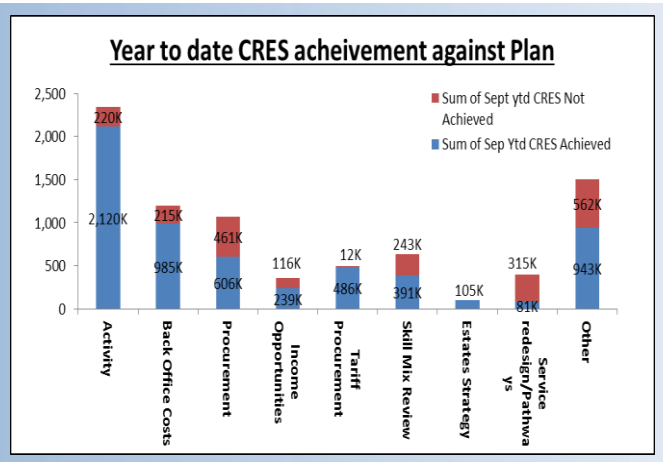
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Executive Team Turnover	Percentage turnover of the Trust Executive Team	Turnover has been 0% for the Executive team within the last 12 month period.		
Proportion of Temporary Staff	% of the Trusts pay spend on temporary	Performance is measured on a year to date basis as at the month end September performance was 5.13%		

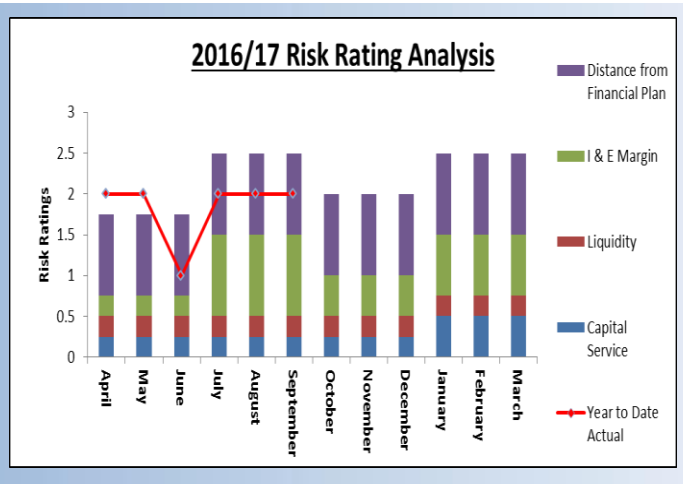
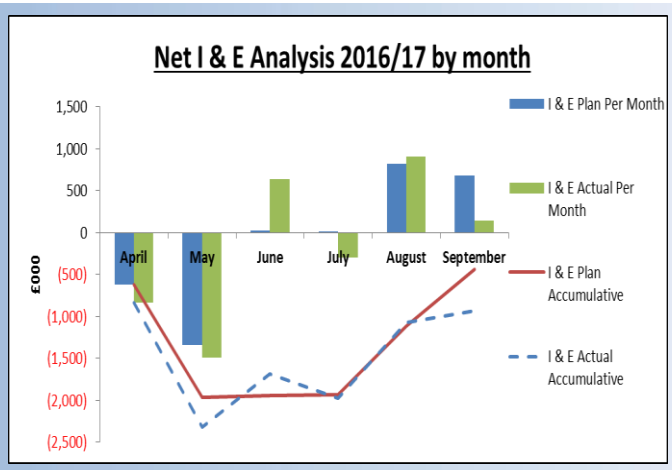
Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

Description	Aggregate Position	Trend	Variation
Cash Balance Cash on deposit <3 months deposit	Cash at the end of Sept was just over £1m. The level of cash is not permitted to fall below £1m or exceed on average £13.4m whilst the Trust is drawing against its revolving working capital loan facility. There is still intense pressure on cash and the Trust is not able to meet obligations to suppliers as they fall due		All cash was deposited in the Trusts Government Bank account.
CRES Achievement Against Plan Planned improvements in productivity and efficiency	As at month 6 the Trust has achieved £6.0m of CRES savings against a plan of £8.2m, an adverse variance of £2.2m. The breakdown of the CRES programme by major work streams is shown on the chart with the red and blue combined reflecting the overall plan as at September, the blue section being that which has been achieved and the red being that which has not.		The Health groups have been tasked with finding additional schemes to cover their CRES shortfall.

Hull and East Yorkshire Hospitals NHS
NHS Trust

Scorecard - Trust Board - October 2016

	Description	Aggregate Position	Trend	Variation
Risk Rating	Financial Sustain-ability Risk Rating The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating	Using the current risk ratings used by NHSI as at month 6 the ratings range from 1-4 with 4 being the best score and 1 the worst. The Trust has so far struggled to achieve it's liquidity plan during the first 6 months of 16/17, achievement of the I & E plan is therefore vital to avoid putting additional pressure on the cash position		
Income & Expenditure	Net income and Expenditure	The Net I & E analysis shows how the trust has performed in each month in terms of the overall performance surplus plan. The bars showing each months performance and plan in isolation and the lines showing the cumulative position of plan and actual. At month 6 the Trust is £0.5m below plan.		

APPENDICIES

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 (1.26% 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	<u>Cultural Transformation</u> 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	<u>Positive assurance</u> • 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. <u>Further assurance required</u>

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	<u>Strategic Transformation Plan</u> 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	<u>Positive assurance</u> We are in receipt of the initial Humber Coast and Vale STP submission and are comfortable with the content. . <u>Further assurance required</u> 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 • Continqency 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**

TRUST BOARD REPORT - 2016 – 10 - 15	
Meeting date:	8th September 2016
Title:	Responsible Officer Report
Presented by:	Mr Kevin Phillips – Chief Medical Officer/Responsible Officer
Author:	Mr Kevin Phillips – Chief Medical Officer/Responsible Officer
Purpose:	The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and Revalidation' (NHS England April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission, and the Trust Development Authority.
Recommendation(s):	The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 2), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England by the end of September.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2016

1. Purpose of the Paper

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

2. Background

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

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

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

Unlike many other NHS organisations the Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail

in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

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

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

The Trust is required to complete an annual report (with quarterly updates) to NHS England describing the extent of compliance with its obligations as a Designated Body: this report (the Annual Organisational Audit (AOA) replaces the previous biannual ORSA (Organisational Readiness Self-Assessment) report).

Policy and Guidance

Appraisal and revalidation are conducted in accordance with the Appraisal and Revalidation for Medical Staff policy. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull and East Yorkshire Hospitals NHS Trust) does not undertake an annual appraisal within the 12 month period required has also been developed. Where the Responsible Officer has concerns about the conduct or capability of Medical Staff, an investigation is conducted in accordance with the Disciplinary and Capability Policy for Medical and Dental Staff Policy. The latter policy is currently being revised to ensure full compliance with Maintaining High Professional Standards in the NHS.

4. Restrictions, Remediation, and Investigations

As at the end of July 2016, the Trust was the Designated Body for 549 Doctors: this included 408 Consultants, 53 Staff Grade and Associate Specialist Doctors, and 88 other Doctors (mainly short term Trust Grade Doctors).

There is 1 Doctor currently in a formal remediation process.

Table 1 shows the number of Doctors for whom the Trust is the Designated Body who are either under active investigation by the General Medical Council, or who have current notices on their licence to practise as a result of previous GMC investigations. In addition to these Doctors, there are also a number of trainees working at the Trust who are either under investigation by the GMC or who have warnings on their licence: the Designated Body for these Doctors is the Deanery.

Table 1. Number of Doctors for whom the Trust is Designated Body who have current GMC notices or investigation:

Type of sanction	Consultant	Non-Consultant
Licence warning	6	0
Undertakings	0	0
Conditions	0	0
Under investigation	8	4

During 2015/16, 17 Doctors with a prescribed connection to the Trust were under investigation. 7 of these cases are now complete and 10 are outstanding.

The outcomes of the investigations are summarised in Table 2. In general, concerns about doctors in training were referred to the Deanery, unless there had been breach of specific Trust policies.

Table 2. Medical disciplinary investigations 2015-16

Grade	Type of Investigation	Investigation Outcome
Consultant	Conduct	Informal Resolution
Consultant	Conduct	First Written Warning
Consultant	Capability	Informal Resolution
Consultant	Conduct	Informal Resolution
Consultant	Conduct	Informal Resolution
Consultant	Conduct	Informal Resolution
Career Grade	Conduct	Summary Dismissal
Specialty Doctor	Capability	Ongoing

5. Medical Appraisal

Appraisal rates

As of the end of July 2016, 87.4% of the Consultant and SAS Doctors for whom the Trust is the Designated Body had had an appraisal within the past 12 months. This represents an increase of 12.2% when compared with the figures for July 2015; 75.2%.

The graph below shows the Consultant and SAS Doctors appraisal rates for August 2014 to July 2015 (14/15) and August 2015 July 2016 (15/16) for comparison:

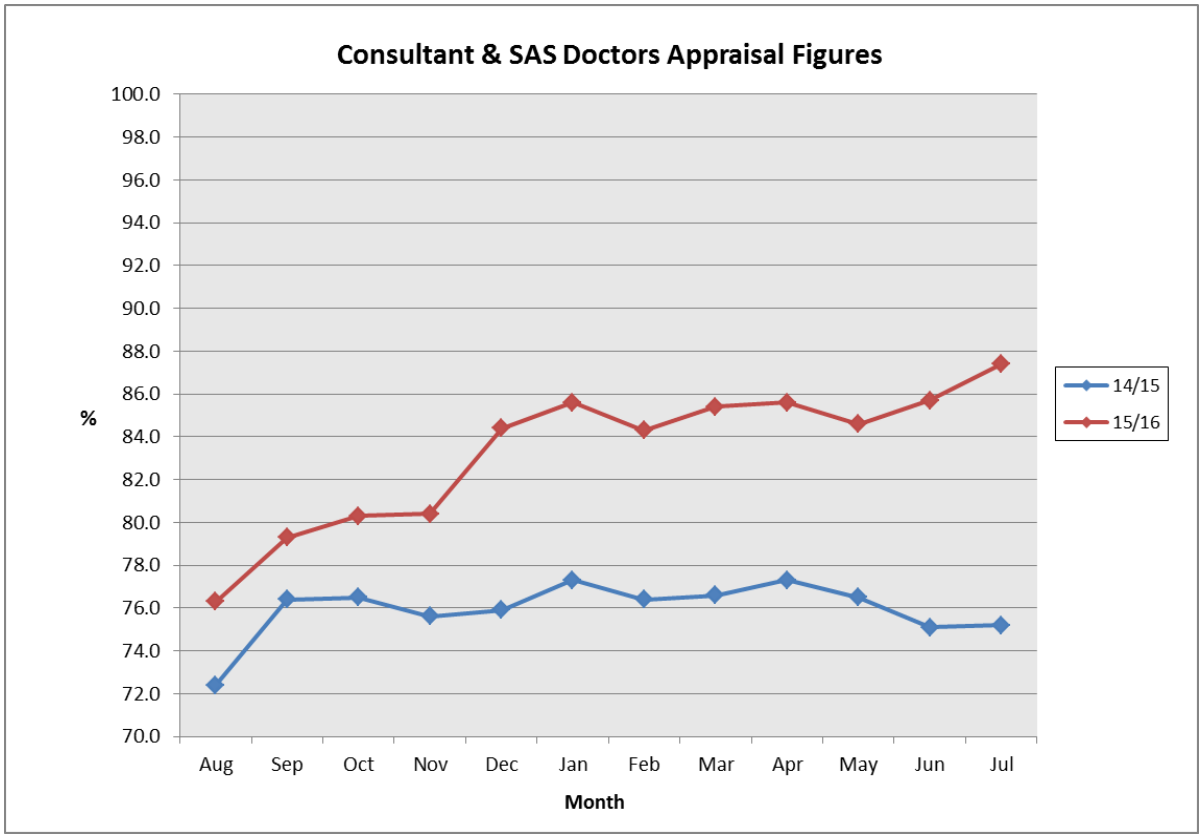


Table 3. Consultant and SAS Doctors appraisals as at end of July 2016 compared with July 2015

Health Group	% with appraisal (12 Month) Jul '16	Last Year's Figure (12 month) Jul '15
Clinical Support Services	89.0	73.1
Corporate Directorates	100	100
Family & Women's Health	88.0	80.8
Medicine	86.2	70.2
Surgery	85.9	76.3
External (Academic & Dove House)	100	66.7
Trust Total	**87.4**	**75.2**

Appraisers

The Trust has 63 trained appraisers, including 4 'senior appraisers'. The senior appraisers are responsible for ensuring that the training of the appraiser team is up-to-date, and for supporting the Appraisal Lead in quality assurance of appraisal. Each appraiser is responsible for carrying out up to 10 appraisals per year.

Quality Assurance

Each Doctor being appraised completes a feedback form on the process and the appraiser. Information from this process is collated and used to support development of the appraisers by the senior appraisers. A formal survey was conducted in June 2016 to seek feedback from Doctors on the appraisal process. 550 Doctors were sent a Survey Monkey link, of whom 24% responded. The key findings were:

96.9% of Doctors who completed the survey understood the revalidation and appraisal process

79.5% of Doctors who completed the survey felt they benefited from this year's appraisal process

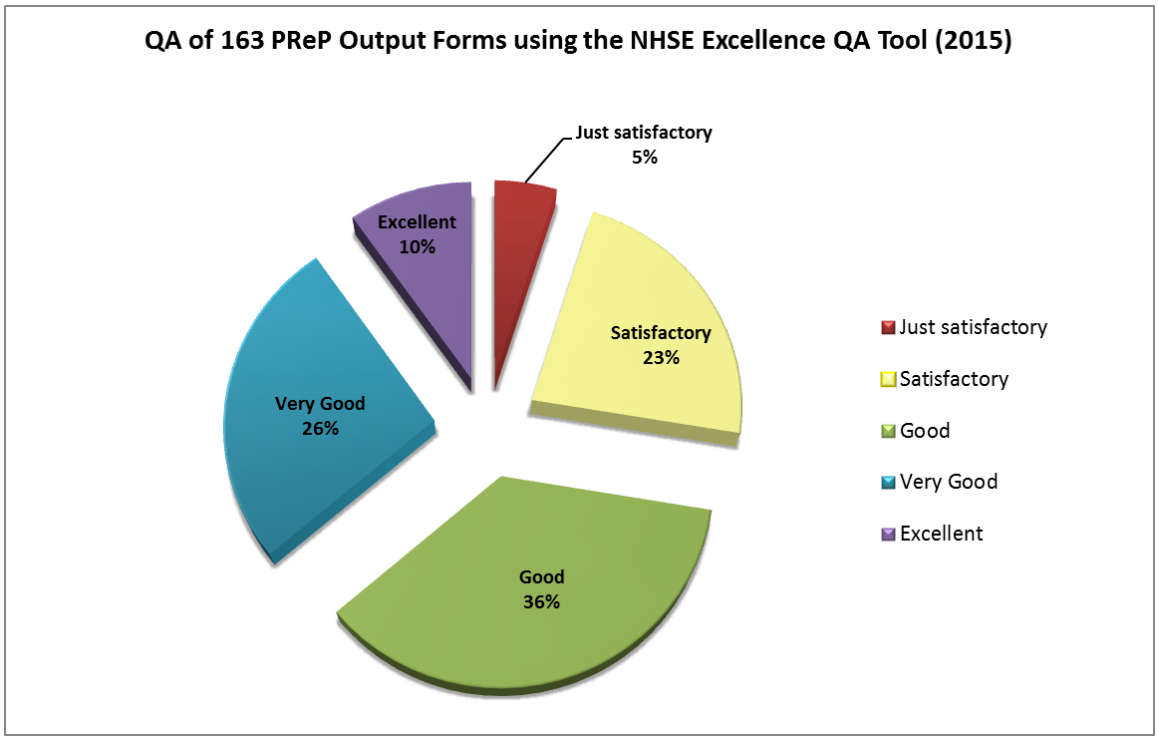
67.2% of Doctors who completed the survey felt the appraisal process benefited patients

93.0% of Doctors who completed the survey rated the Revalidation/System Admin Team as excellent or good

It is planned to repeat the survey next year.

All appraisal inputs and outputs are reviewed at the Revalidation Panel, of which the Appraisal Lead is a member. Reflections on good or bad practice in completing these outputs are then used in the ongoing appraiser training programme. In addition, a random sample of output forms are regularly reviewed against set criteria by the Appraisal Lead. The table below shows the results of the Quality Assurance of 163 PReP appraisal forms (the Trust's electronic appraisal system for Medical staff) conducted by the Appraisal Lead throughout 2015. This was conducted using the NHS England Excellence QA Tool.

Table 4. QA of 163 PReP Output Forms



Clinical Governance

The Trust is still developing systems to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. All Doctors are able to request a report (at any time) which contains information specific to them to support appraisal. Feedback from Doctors has been that the information supplied is very unreliable many incidents being incorrectly attributed, and genuine incidents not appearing. Work is ongoing with the Clinical Governance team to try to resolve these problems. Again this is reported to be a problem across the NHS, and is not specific to this Trust.

6. Monitoring Performance

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

7. Revalidation Recommendations

The Trust made 204 recommendations on revalidation to the GMC between 1st April 2015 and 31st March 2016. No recommendations were missed or delayed. The Responsible Officer has three options in making a recommendation: recommendation for revalidation, deferral, or failure to engage. It is not possible to recommend 'non-revalidation'. The Trust has not made any notifications of failure to engage. The breakdown of recommendations is shown in Table 4.

Table 5. GMC recommendations April 2015– March 2016

Recommendation		Number of Doctors
Revalidate		171
Defer	Sickness, maternity, etc	1
	Under investigation	2
	Appraisal/MSF not complete	25
	Recent starter	5

In total 16.2% of recommendations this year were for deferral, which is an increase of 4.7% when compared with last year's figure of 11.5%. The number of Doctors being deferred because they had not completed all the necessary requirements remains the main cause for concern. In most cases the doctor was fully engaged with the process, but had technical problems, or problems surrounding the gathering of Multi Source Feedback in a timely manner.

8. Recruitment and engagement background checks

The Trust Human Resources department has in place a system for checking identify, current and previous GMC Conditions or Undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance. The Responsible Officer has now approved a 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NCAS investigations, local conditions or undertakings, and any unresolved performance concerns. At present agency locums are not subject to the same checks, and work is in progress to establish a process to check on these doctors (accepting that they are sometimes brought in at very short notice, and should in any case have had all appropriate checks done by their own Designated Body – usually the locum agency).

9. Responding to Concerns and Remediation

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

Where there is concern about a Doctor's performance or behaviour they are investigated under Trust policies relating to conduct, capability, or both. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NCAS. If misconduct is proved a range of disciplinary sanctions, including dismissal, is available. If concerns regarding capability are substantiated the Trust policy on Remediation would be followed, and an appropriate course of action developed in conjunction with NCAS.

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

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice
- There is a good appraisal system in place, which is developmental and formative in nature
- The Trust has developed a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC)
- This is supported by management-led performance assessment. Improvement is needed in the quality of data used to inform this process
- Uptake of appraisal in the Trust is improving steadily. This is reliant on the continued implementation of an electronic platform, and continuing administrative support for this is essential
- The current percentage of Doctors having appraisal between 1st April in any one year and 31st March in the following year is almost in line NHSE target of 90%. Communication from the Regional Revalidation & Appraisal Clinical Lead for NHSE found everything to be satisfactory and the Trust was congratulated on achieving an excellent appraisal uptake rate

11. Recommendations

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

Appendix 1 - Annex E – Designated Body Statement of Compliance

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

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

   Mr Kevin Phillips is the Trust's appropriately trained and appointed Responsible Officer for Hull and East Yorkshire Hospitals NHS Trust and Dove House Hospice

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

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

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

   There are 63 appraisers, conducting between 6 and 10 appraisals each annually

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

   There are routine appraiser network meetings, as well as formal and informal review of appraisal inputs, outputs and user experience. The Appraisal Lead is developing an e-learning module for Appraiser Training which will be introduced in late 2016

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

   Currently 87.4% have an appraisal within the 12 month period specified by NHSE (against a target of 90%). The reasons for this are understood and there is an escalation policy in place to achieve the target.

   100% of Doctors with a prescribed connection to Dove House Hospice have an appraisal within the 12 month period specified by NHSE (against a target of 90%).

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

   The systems are in place

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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

Yes

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

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

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

Yes

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

Yes

Signed on behalf of the designated body

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

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

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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

Hull and East Yorkshire Hospitals NHS Trust

TRUST BOARD REPORT - 2016 – 10 - 16	
Meeting Date:	27 October 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 2 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.

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 2 and satisfy itself that these are being managed.

2. KEY ISSUES

- The highest rated risks are rated at 16 and relate to workforce (Q3), learning lessons (Q2) and the Strategic Transformation Plan (P1)
- No risks have had their ratings changed at Q2

3. INTRODUCTION

There are 9 risks on the Board Assurance Framework. Meetings have been held between the Head of Risk and the lead Chief/Director at the end of quarter 2. Seven risks have been formally reviewed and the two outstanding risks will be reviewed with the relevant Chief at the beginning of November. At these meetings the risk rating has been reviewed together with the mitigating action and assurance received.

Following the recommendation from internal audit as part of their 2015/16 year end assurance work, the Performance and Finance Committee and the Quality Committee have also reviewed those BAF risks that are relevant to their remit.

4. BOARD ASSURANCE FRAMEWORK (BAF)

The BAF is attached at appendix 1 for review.

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

At the Audit Committee's effectiveness review on the 20 October 2016, further consideration was given to how the BAF might be used and developed further. It is therefore proposed that the Board requests that the Audit Committee to give further consideration to this.

5. RECOMMENDATIONS

The Board is asked to review the BAF, satisfy itself that the risks are being appropriately managed and request further scrutiny at the Audit Committee.

Mark Green
Head of Risk, Claims & Safety
October 2016

Appendix 1

BOARD ASSURANCE FRAMEWORK Q2 – 2016/17

Q – High Quality Care

Risk Ref:	Accountable Chief / Director. Responsible Committee	No of high level risks on Risk Register that relate to this risk	Principal Risk What could prevent the Trust from achieving its objectives?	Initial Risk Rating (no controls)	Mitigating Actions What is being done to manage the risk? (controls)	Mitigating Actions Where controls are still needed or not working effectively	2016/17 risk ratings Q1	Q2	Q3	Q4	Target risk rating	Effectiveness of mitigation/commentary
Q1	Chief Medical Officer, Chief Nurse Quality Committee	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 • Fortnightly Charge Nurse meetings with ward sisters	Informal feedback from the CQC identified areas where further work needs to be undertaken. This includes embedding checking procedures, adherence to escalation procedures, documentation and staffing. A review has been undertaken of the QIP following informal CQC feedback and the QIP has been updated. This will be reviewed on receipt of the formal report **Leads**: CN, CMO and Director of Governance **Completion**: December 2016	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**			**4** **L1** **X** **S4**	**Positive assurance** • Informal feedback received from the CQC following the comprehensive inspection at the end of June 2016 identified a number of areas where positive improvements had been made • Review by Internal Audit that the QIP was complete and accurate – reported to the Audit Committee at May 2016 meeting • Internal reports giving significant assurance during 2015/16 – Fit and Proper persons, discharge planning, safe staffing levels, performance management arrangements and lessons learnt • Internal Audit provided positive feedback on the Duty of Candour arrangements (May 2016). • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days. **Further assurance required** • Internal audit reports giving limited assurance in 2015/16 – infection control, incident reporting, planned medical staff absence and responding to Francis. • Recently established Heath Care Delivery Improvement Group. This group will be responsible for ensuring learning is shared and embedded throughout the Trust. • The ratings on the current QIP (June 2016) to be reviewed (ref Board Quality report July 2016) • 2 Never Events declared in 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**
Q2	Director of Governance Quality Committee	0 risks	**Lessons learned** There is a risk that the Trust does not learn from adverse events and that errors continue to occur which could affect patient care and safety	**20** **L4** **X** **S5**	• Learning lessons QIP project group established • Monthly Lessons learned newsletter • Quality Bulletin • Lessons Learned Intranet site • Monthly SI summary report distributed to Health Groups • Analysis of incidents and trends • Use of videos to replicate incidents in order to improve learning • Application of Root cause analysis techniques and training • Operational Quality Committee • Health Group Governance meetings • Health Group performance reviews • Clinical Incident Review Creating a Learning Environment **(**CIRCLE) • Table top RCA's being piloted for some SI's • Trialling PDSA cycles for learning	• At the end of Q2 there was a reduction in the number of SIs reported when compared to 2015/16 .The themes and trends in incidents and Serious Incidents (SIs) are continuing from 2015/16 into 2016/17 • Revised incident reporting system launched April 2016. The national coding structure implemented at the same time is causing some concerns when analysing themes and trends and is being reviewed **Lead:** Director of Governance **Completion:** November 2016	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**			**4** **L2** **X** **S2**	**Positive assurance** • Significant Assurance – internal audit, lessons learned review, March 2016 • Positive feedback received from staff who attended the learning lessons workshops (May 2016) which included the training video of the Never Event retained vaginal swab • Positive feedback received from CQC that staff were aware of the Lessons Learned Bulletin and the safety brief and that work had been undertaken to improve learning from incidents including human factors training • Information about changes in practice now being included in the Board's Quality report related to complaints and Never Events/Serious Incidents • The National Reporting and Learning System (NRLS) report published in September 2016 for the period 1 October 2015 to 31 March 2016 reported an increase in incident reporting 34.44/1,000 bed days, the previous position was 31.79/1,000 bed days. • Training videos produced and PDSA cycle being introduced **Further assurance required** • New processes for dissemination of information strengthened during 2015/16. However, there is evidence that changes in practice are not always occurring across the Trust and further work needs to be put in place so that learning occurring in one part of the Trust is transferred to other areas. • 2 Never Events declared in 2016/17 • Recurrent themes in Serious Incidents

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 • 'Values' based recruitment now implemented in Trust recruitment process • Recruitment and retention premia for designated posts • Apprentice scheme • New roles in place – 27 Advanced Practitioner posts in a number of services to off-set shortages in junior doctors • Development of non-registered nursing staff • Innovative recruitment strategies, utilising social media and active advertising campaigns to attract skilled and experienced staff in place • Ward establishments review twice a year • New roles e.g. ward based A&C Personal Assistants, Ward Hygienists and Discharge Facilitators	• Working with Universities and Health Education England to develop new 2 year programmes for Advanced Practitioners and Physicians Associates **Lead:** S Nearney **Completion**:31.9.17	**16** **L4** **X** **S4**	**16** **L4** **X** **S4**			**6** **L3** **X** **S2**	**Positive assurance** • Monthly nursing and midwifery staffing report to Board • Significant assurance – internal audit, Recruitment • Significant assurance – internal audit, Safe staffing levels, 2015/16 • Internal Audit report identified significant assurance for nurse revalidation (September 2016) • Staff sickness levels below Trust target of 3.6% (September 2016) 0.3% below the target • Mandatory training levels above Trust target of 88.1% (September 2016) 3.1% above the target • Staff turnover below Trust target of 9.2% (September 2016) 0.1% below the target • Staff FFT results showing continuous improvement over each quarter • People Strategy approved at May 2016 Trust Board **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 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**	• Ward audit programme • FFT being used as improvement tool 'You said we did'. • Patient Council established • Complaint Policy • Inpatient survey top quartile for improvements in patient experience • Intentional Rounding in ED every 2 hours • Two hourly Board Rounds in ED, led by Emergency Physician in Charge • Monthly Health Group Performance reviews	• Response times to complaints. Further work needs to be undertaken to improve response times to complaints within 40 days **Lead** :HG Medical Directors Completion:30.11.16	**9** **L3** **X** **S3**	**9** **L3** **X** **S3**			**8** **L2** **X** **S4**	**Positive assurance** • Quality Report to every Trust Board including lessons learned • Patient Stories presented at every Trust Board • The FFT report for September 2016 identifies • Average score of 4.75 • Trust information indicates 94.9% patients likely to recommend the Trust (2.1% unlikely to recommend) • ED information indicates 87.9% likely to return and 6.6% would not return • PHSO – Complaints about acute trusts 2014-15 identified Trust has a low conversion rate of 1.61 per 10,000 clinical episodes • 17% decrease in the number of complaints received when comparing 2015/16 to 2014/15 **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 • Health and Wellbeing Strategy 2016-18 launched	• Leadership programme to be launched **Lead** :L Vere **Completion**: 1.3.17 • PaCT Training V2 commenced **Lead** :M Purva **Completion**: 31.3.18 • Medical engagement programme in development **Lead** : K Philips **Completion**: 31.10.16 • Values survey to be repeated in Jan 2017 **Lead** :L Vere **Completion**: 31.1.17	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**			8 L2 X S4	**Positive assurance** • Barrett Values survey (To be repeated in Jan 2017) • New values approved (April 2015 Board) • New Trust goals in place (April 2016) • Positive feedback from GMC and Deanery following Junior Doctors review • PaCT training undertaken by 6,500 staff • Remarkable People campaign has doubled nurse recruitment numbers on last year • Equality and Diversity Steering group established • BME staff network commenced in Sept 2016 • FFT survey completed by 1600 staff (Q2 2016/17). Overall engagement score improved to 3.9 (out of 5). This would place the Trust in the top 20% of Trusts nationally. **Further assurance required** Staff charges for catering and car parking are potential barriers to the identified risk.

G – Great Performance and Reliability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
G1	Chief Operating Officer Performance and Finance Committee	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**	**12** **L3** **X** **S4**			4 L2 X S2	**Positive assurance** • Operating plan approved at April 2015 Trust Board. • Currently meeting trajectories agreed with NHSI **Further assurance required** • 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 • Internal Audit report identified limited assurance for medical staffing planned absence management (June 2015)

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

F – Financial Sustainability												
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F1	Chief Finance Officer Performance and Finance Committee	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**: Ongoing	**12** **L3** **X** **S4**	**12** **L3** **X** **S4**			**10** **L2** **X** **S5**	**Positive assurance** • Forecast break even position (at month 5) • Delivery of the financial plan at the end of quarter 1, 2016/17 and securing the first quarter payment from the Sustainability and Transformation fund. **Further assurance required** • Closing the gap on the unidentified CRES • Health Group overspends • Agency spend • Winter costs • Undertrade against income plan • Delivery of STF targets

F – Financial Sustainability													
Risk Ref:	**Accountable Chief / Director. Responsible Committee**	**No of high level risks on Risk Register that relate to this risk**	**Principal Risk** **What could prevent the Trust from achieving its objectives?**	**Initial Risk Rating (no controls)**	**Mitigating Actions** **What is being done to manage the risk? (controls)**	**Where controls are still needed or not working effectively**	**2016/17 risk ratings** **Q1**	**Q2**	**Q3**	**Q4**	**Target risk rating**	**Effectiveness of mitigation/commentary**
F3	Chief Finance Officer Performance and Finance Committee	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**	**12** **L3** **X** **S4**			**8** **L2** **X** **S4**	**Positive assurance** • Monthly Performance and Finance Committee and updates to the Board • No incidents reported resulting in Serious Incident/RCA investigations. • Agreed plan in place for 2016/17 with Health group support. Risk assessment process built into our reporting structure. Capital committee to oversee this issue on monthly basis **Further assurance required**

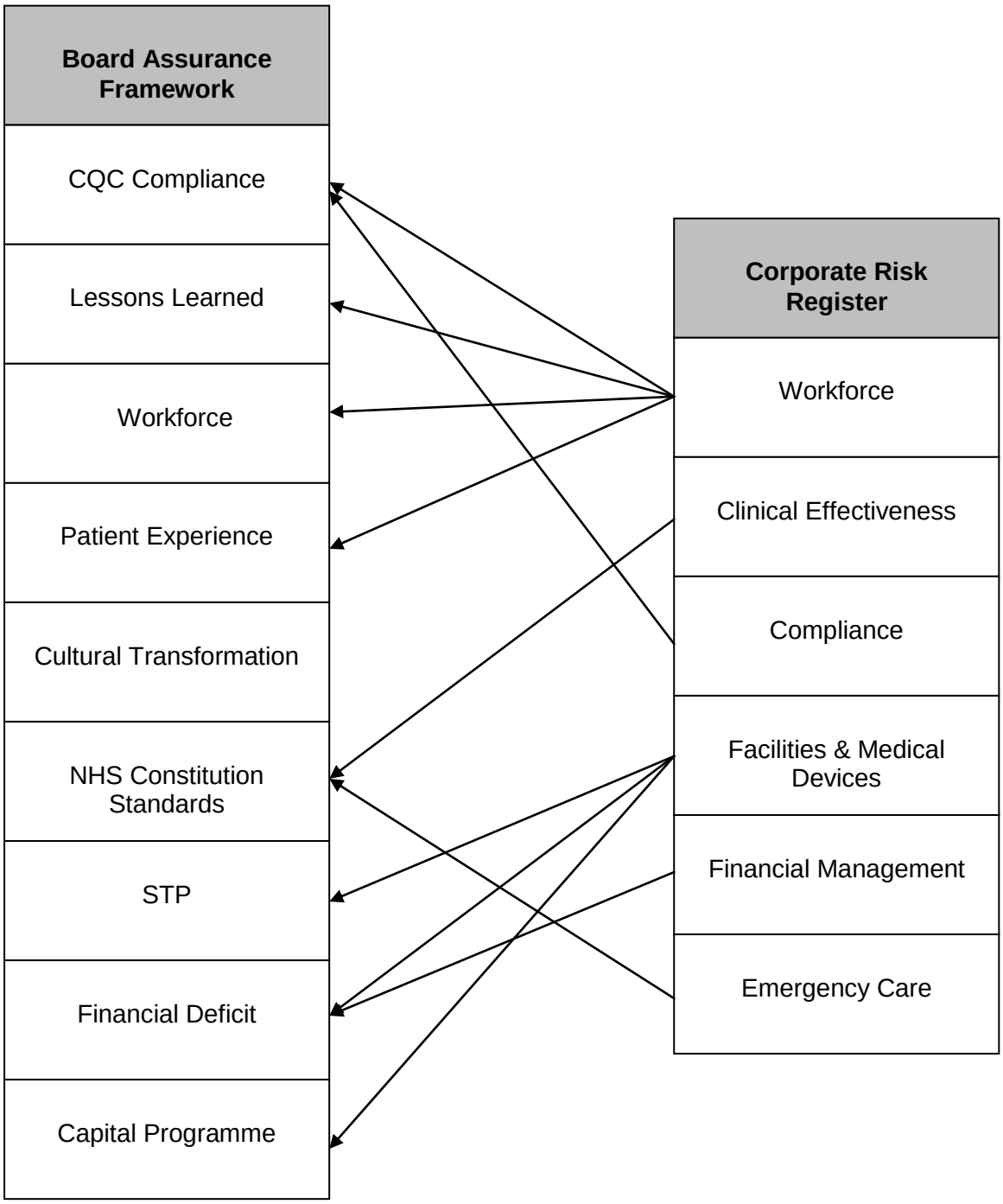
Appendix 2

Board Assurance Framework risks and Trust Board agendas

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

Appendix 3

Relationship between Board Assurance Framework and the Corporate Risk Register



Hull and East Yorkshire Hospitals NHS Trust

TRUST BOARD REPORT – 2016 – 10 - 17	
Meeting date:	29 September 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 authorise 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
2016/23	Hull and East Yorkshire Hospitals NHS Trust and Hull Maternity Development Ltd – Deed of variation relating to alarm and detection systems in Hull Women's and Children's hospital	7 October 2016

5 RECOMMENDATIONS

The Trust Board is requested:

- to authorise the use of the Trust's Seal

Rebecca Thompson
Assistant Trust Secretary
October 2016

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON MONDAY 26 SEPTEMBER 2016
THE COMMITTEE ROOM

PRESENT:	Mr S Hall (Chair)	Non-Executive Director
	Ms E Ryabov	Chief Operating Officer
	Mr M Gore	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce & OD
IN ATTENDANCE:	Mrs R Joyce	Programme Director - Transformation
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

No **Item** **Action**

1. APOLOGIES

Apologies were received from Ms J Myers, Director of Strategy and Planning.

2. MINUTES OF THE MEETING HELD ON 22 AUGUST 2016

The minutes of the meeting held on 22 August were reviewed by the Committee. Mr Gore asked for further clarification regarding the Trust's reserves and Mr Bond agreed to discuss this with him outside of the meeting.

Ms Ryabov's apologies were added to the minutes.

Item 7.3 – Patient Level Costing – The project was launched in December 2015 and not 2016 as stated in the minutes.

Following these changes the minutes were approved as an accurate record.

3. ACTION TRACKING LIST

The Committee reviewed the Action Tracker. All items marked completed would be removed from the Tracker.

3.1 – CRES – OUTPATIENT TRANSFORMATION PROJECT

Mrs Joyce presented the report to the Committee. She advised that the Transformation Team were making improvements but that there was still work to be done to embed project management with operational staff.

Mrs Joyce explained that as part of the Urgent and Emergency Care Programme (UEC) the Trust's Ward Roll Out Programme was making improvements in length of stay, more efficient discharges and improving theatre productivity. There was a discussion around culture and how the clinicians were engaging with the team and Mrs Joyce advised that there had been good results in the areas already identified.

Mr Bond asked what the timeframe was for the exemplar ward roll outs and Mrs Joyce advised that this was a 6-8 week rolling programme and was tied into the winter plan.

Resolved:

The Committee received the report and requested a follow up report in December 2016 to review the savings and improvements made so far. **RJ**

3.2 – BOARD ASSURANCE FRAMEWORK
The Committee received the paper and reviewed the risks highlighted as the responsibility of the Performance & Finance Committee.

There was a discussion around the risk relating to the Trust's financial position and it was agreed that more commentary was required to explain the risk and assure the Committee that it was being managed.

Resolved:
The Committee received the report and agreed that more commentary was needed in the control and assurance sections of the report. There were no changes made to the severity of the risk. **LT**

4. WORKPLAN 2016/17
The Committee received the workplan and noted the contents.

5. MATTERS ARISING
5.1 – MORTUARY UPDATE
Mr Bond advised that there was nothing new to report but would report back to the Committee when this issue had been resolved.

5.2 – LINEAR ACCELERATOR REPLACEMENT
Mr Bond presented the report which set out the strategy to replace 6 Linear Accelerators between 2016 and 2022. Mr Bond advised that the machines were 10-11years old and servicing them was becoming very expensive. He reported that the new machines would be leased and had been included in the Trust's revenue programme.

Resolved:
The Committee received the report and supported the phased approach to the replacement of the machines over the timescales within the report.

5.3 – GET IT RIGHT FIRST TIME (GIRFT) – UPDATE
Mrs Ryabov advised the committee that the GIRFT initiative was part of the Urgent Emergency Care Plan. The clinical team headed by Mr Symes and Mrs Laws had carried out work in this area and it was suggested that they attend the committee to discuss further.

Resolved:
The Committee received the update and agreed to invite Mr Symes and Mrs Laws to a future meeting. **RT**

6. PERFORMANCE REPORT
Mrs Ryabov presented the report and spoke about the A&E Delivery Board and working with health partners to approach the issues around community beds and how alternative solutions could be reached to ease the pressure on the Emergency Department. The Trust was working with City Health Care Partnership to provide community beds as a number of care homes had been closed by the councils.

Mrs Ryabov spoke about cancelled cancer appointments and that a number were cancelled by the hospitals but the number of patient cancellations or did not attends was higher. She advised that the GPs had a role to play in having meaningful discussions with patients to ensure patients were clear of the importance of attending their appointments.

The current A&E 4 hour targets was below trajectory (89.2%) at 86.6%. She advised that the reasons for this was that activity was high and the Junior Doctors change over in August 2016 had also proven hugely problematic in terms of continutity and consistency. The breaches were due to waiting for doctors and waiting for beds. There were 4 new consultants in A&E and the consultants had been registrars working in the service previously.

Cancer performance was 85.2% after adjustments with late referrers now picking up a percentage of the breaches.

There had been two 'pop up' 52 week waiters. The patients had incorrect clock stops and were on holiday when their appointments were due. Both patients had since been treated.

The Referral to Treatment standard was at 87.9% with 500 patients less on the waiting list in month. Mrs Ryabov advised that there was more work to be done. There had been issue with diagnostic performance with 330 breaches, 294 of these were due to an increase in demand for MRI/CT scans and machinery breakdowns. There was a discussion around over diagnosing and sending patients for a scan as a matter of course. Mrs Ryabov advised that Junior Doctors could be over cautious and this was being addressed.

Resolved:
The Committee received the report and noted the Trust's performance in Month 5.

6.1 – WINTER PLAN
Mrs Ryabov advised that the Winter Planning was being finalised and would be presented to the Board in October 2016. **ER**

6.2 – FRAILTY PATHWAY
Mrs Ryabov reported that this project of having a doctor on the front door assessing frail and elderly patients was ongoing and depended on whether there where staff available. The Trust provided this service where possible and when utilised if cut down on the number of admissions into the hospital. **ER**

6.3 – LENGTH OF STAY
Mrs Ryabov reported that length of stay was incorporated into the Emergency Care Plan and was reducing but there was more work to be done. Mr Gore asked if there were discharge coordinators in the Acute Medical Unit and Mrs Ryabov advised that she would check and email the Committee.

7. CORPORATE FINANCE REPORT
Mr Bond presented the report and advised that the Trust was currently reporting a Month 5 deficit of £1.1m which was an improvement in month of £800k. He reported that the Trust's cash position was weak mainly due to a delay in the STP funding, long term debtors and income payments from the Commissioners. The Single Oversight Model risk rating for the Trust was 2 and the Health Groups were overspent by £4m with the biggest challenges being the Medicine Health Group and their variable pay costs and surgeons expenditure position.

The Trust was over trading by £1.4m, day cases were increasing in month

and emergency figures were also higher than previously stated.

There was a discussion around variable pay costs and what more could be done to reduce them. Mr Nearney advised that the Trust was not overspent on its total pay budget and that the Trust was well below its peers in terms of agency spend. Mr Gore expressed his concern regarding the corporate level of agency spend and Mr Bond agreed to update the Committee regarding the Patient Administration project at its next meeting in October 2016. Mr Nearney also advised that the Trust had 120 nurses commencing work in September and this would create a reduction in the bank and agency costs.

Resolved:
The Committee received the report and agreed to receive an update regarding Patient Administration at its next meeting in October 2016. **LB**

7.1 – CRES 2016/17
Mr Bond presented the report and advised that all of the Health Groups had been asked to revisit their CRES forecasts as none of them were achieving their target levels in Month 5. Mr Hall added that the Non Executive Directors who attended the Performance & Finance Committee were meeting with the Health Group Medical Directors to understand the issues relating to CRES under delivery.

Resolved:
The Committee received the updated CRES position and agreed to feedback any alterations to the Health Group forecasts at the next meeting in October 2016.

7.2 – AGENCY REPORT
Mr Nearney presented the report to the Committee. He reported that the Trust had a pay variance of £1m (adverse) and would be £2m overspent at the end of the year. The main areas of concern were nurses in Surgery, ICU, theatres and ED. Mr Nearney highlighted that the Trust had a number of challenges regarding recruitment but that there were additional doctors in ED, 120 new nurses appointed at the Trust and new roles created to assist with the workloads of the clinical staff.

Mr Gore expressed his concern regarding the overspend within the Corporate Health Group. Mr Nearney advised that more apprentices would be employed under the new Apprentice Levy and this would help alleviate some of the administration issues.

There was a discussion around the good work that the volunteers did and how these could be used in different ways.

Mr Gore was also concerned regarding the attendance at the Variable Pay Group, but highlighted the good work that was ongoing.

Resolved:
The Committee received the report and noted the work ongoing to reduce the variable pay expenditure.

7.3 – PATIENT PATHWAY CHARGES
Mr Bond presented the report which highlighted the approved process for

agreeing new patient pathways and the methodology for ensuring the Trust recovered the appropriate costs through the agreement of revised pricing mechanisms with local Commissioners.

Resolved:
The Committee received the report and noted the contents.

7.4 – BEST PRACTICE TARIFFS
Mr Bond presented the report which updated the Committee regarding best practice tariff achievement. He spoke about hip fracture and major trauma performance as being the main areas of concern. Mr Bond highlighted £256k in lost income due to missing target deliveries.

Resolved:
The Committee received the reported and noted the lost income opportunities.

7.5 – NATIONAL TARIFF PROPOSALS 2017/18 2018/19
Mr Bond presented the report which updated the Committee on the proposals regarding the national tariff for the next two years.

There was a discussion around the proposed tariffs and how it would affect the Trust. Mr Bond advised that following the price adjustments the Trust has provisionally modelled a small gain; however this could change as the Tariff had not yet been finalised.

Resolved:
The Committee received the report and noted the Tariff changes due in 2017.

8. CAPITAL RESOURCE ALLOCATION COMMITTEE SUMMARY REPORT
Mr Bond highlighted the following areas to the Committee:

- The Family and Women's Health Group were preparing a business case to address capacity shortfalls in Ophthalmology.
- The budget for relocating Maxillofacial Surgery to Castle Hill Hospital was being refined.
- The relocation of the Infectious Diseases Ward was under review by the project team due to the costs exceeding the current allocation.
- The strategic outline case for the Carbon Energy Fund would come to the Performance & Finance Committee in November 2016 for approval.

Mr Bond also advised that the Capital Resource and Allocation Committee would be reviewing the 2017/18 and 2018/19 capital programmes at its next meeting.

Resolved:
The Committee received the report and noted the contents.

9. ITEMS DELEGATED BY THE BOARD
Items delegated by the Board were discussed in items 6 (Performance) and 7 (Finance).

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

11. CHAIRMAN'S SUMMARY OF THE MEETING

The Chairman agreed to summarise the meeting to the Board on 29 September 2016.

12. DATE AND TIME OF THE NEXT MEETING:

Monday 24 October 2016, 2.00pm – 5.00pm
The Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	22 September 2016	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- The progress made in relation to the launch of the Independent Health Charity
- Receipt and review of the Financial Report– detailing income, expenditure and investment details
- The progress being made on various fundraising activities and charitably funded projects in which the Trust is involved or associated
- The Draft Annual Report and Accounts 2015/16 were presented. Following discussion it was agreed that after amendments they would be formally approved at the November meeting
- A Review of Charitable Funds Policies
- Charitable Funds investment update

Decisions made by the Committee:

Key Information Points to the Board:

Matters escalated to the Board for action:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

HELD ON THURSDAY 22 SEPTEMBER 2016
THE MAXILLOFACIAL MEETING ROOM, HRI

PRESENT:	Mr A Snowden (Chair), Vice Chair, Non Executive Director Mr L Bond, Chief Financial Officer Mrs V Walker, Non Executive Director Mr D Haire, Project Director – Fundraising Mrs D Roberts, Deputy Director of Finance
IN ATTENDANCE:	Mr D Herdsman, Brown Shipley Mrs L Roberts, Membership Officer (Minutes)

ACTION

1 APOLOGIES FOR ABSENCE
No apologies were received.

2 DECLARATIONS OF INTEREST
There were no declarations made.

3 MINUTES OF THE MEETING 07 JUNE 2016
There were two amendments to the minutes:

Minute 7 – Project Director's Report – Da Vinci Robotic Surgical System
An amendment was made to paragraph 4
"Mr Haire advised that there was a national database for urological procedure outcomes."

Minute 15 – Any Other Business – e-Obs
An amendment was made to paragraph 1
"Mr Bond advised the Committee that the e-Obs project had been implemented across a small number of wards."

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

4 MATTERS ARISING
Minute 15 – Any Other Business – e-Obs
Mr Haire advised the Committee that he understood that the Clinical Support Heath Group had identified charitable funds in the region of £55k from which to purchase the e-obs handsets required. Work was ongoing with the other Health Groups to identify the extent to which other funds were available to be used for this purpose.

Minute 15 – Any Other Business – Mental Health Awareness event
The funding for this event was approved following the enquiries made by Mr Haire. A number of agencies were involved including Age UK, Humber NHS Foundation Trust, Mind and Mencap. A total of 69 people attended the session and a report on the event had been produced. Mrs Walker requested a copy of the report. **DH**

Resolved:

- Mr Haire to forward a copy of the Mental Health Awareness event report to Mrs Walker. **DH**

5 ACTION TRACKER

There was a discussion around the changes to the NHS charities arrangements and regulations item on the action tracker. It was restated that the aim was to use charitable funds more strategically and in accordance with the charities rulings.

Mr Haire informed the Committee of the work carried out by a local charity, the Smile Foundation, which offers advice and support to other local charities. This charity had supported Northern Lincolnshire and Goole NHS Foundation Trust and Humber NHS Foundation Trust in establishing and promoting their respective charities. Mr Haire agreed to keep the committee informed of any matters of significance that resulted from this ongoing dialogue. **DH**

The other actions due were included in agenda items. All remaining 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.

Resolved:

The Committee:

- agreed to receive further information from the Smile Foundation dialogue which was of relevance to this topic **DH**

6 DRAFT WORK PLAN 2016/17

The Committee noted the workplan.

7 PROJECT DIRECTOR'S REPORT

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

Hull & East Yorkshire Hospitals Health Charity

Mr Haire informed the committee that a Just Giving page had now been created for the Hull & East Yorkshire Hospitals Health Charity, WISHH.

A meeting regarding the WISHH charity launch was held on 20 September 2016; however neither Mr Haire nor Mr Bond were able to attend. The charity is expected to be launched at a low key event at the end of October 2016 with a publicised Charity Ball being held on 4 November 2016. Mr Haire will advise the Committee of the official launch date once confirmed. **DH**

Creating a Dementia Friendly Environment – Wards 8 and 80

A project group for Creating a Dementia Friendly Environment – Wards 8 and 80 had been established and proposals for the phase 2 works were currently being compiled. Once the project content was finalised it would be expected to be completed by the end of this financial year.

Mr Haire agreed to arrange a visit of wards 8 and 80 for Mr Snowden, Mrs Walker and Mrs Roberts **DH**

Da Vinci Robotic Surgical System
It was reported that the robotic system had been transferred from Theatre 10 to Theatre 12 at Castle Hill Hospital. This change enabled all clinical specialties to have sessional access on the days required. In addition Theatre 12 was larger than Theatre 10 and therefore enabled a better layout of the theatre equipment.

Gynaecology would commence using the robotic system from October 2016 and planning was ongoing for other specialities in the next financial year, subject to affordability.

Mr Bond enquired about the business rational for the robotic system's use in gynaecology. Mr Haire indicated he was awaiting information to finalise this paper, but expected it to be ready shortly. Mr Haire also confirmed that he had commenced work on the post implementation review. **DH**

Mr Haire advised that he was also giving detailed consideration to the strategic development of robotic surgery within the Trust and a report would be produced in due course.

Integrated Cyclotron and Radiopharmacy Development
It was noted that there had been a delay in tendering for the construction works, due to construction companies being extremely busy, but that these had now been issued. Work on this project had subsequently been delayed and is expected to commence in January 2017, with a completion date of December 2017.

Proposed Paediatric Development
Proposals for the Paediatric Development had been received by the Facilities Directorate but had yet to be circulated for detailed consideration. It was expected that a paper setting out the proposed next steps would be produced for consideration by the Capital Resource Allocation Committee and subsequently a Trust Board meeting, in due course.

Midwifery Led (Self Care) Unit
The costings for the Midwifery Led (Self Care) Unit project had been estimated at £450k, but were yet to be confirmed. Mr Bond commented that this appeared to be more than expected. Mr Haire indicated he was reviewing the breakdown of costs to ascertain if they could be reduced. The work is envisaged to be completed by the end of December 2016. **DH**

Mr Haire advised that the benefactor had agreed in principle to increase their contribution towards this project and overall costs and funding sources would be confirmed. In order to meet the above timeline it was expected that the necessary approvals form would need sign-off prior to the next meeting of the committee.

Mr Bond raised concerns regarding the linings of the birthing pools being compliant with infection prevention and control and it was agreed to seek assurance on this matter. **DH**
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Health Group Charitable Funds
A report would be presented to the Committee at the November 2016 meeting regarding the Health Group's Charitable Funds spending plans. **DH**

Resolved:
The Committee:

- received the report and noted its contents
- agree to receive details of the WISHH charity official launch date **DH**
- Mr Haire would arrange visits to wards 8 and 80 for those who had expressed an interest **DH**
- would finalise the summary business plan related to gynaecology using the robotic system as soon as possible **DH**
- would be informed of the overall costs and funding for the Midwifery Led Unit **DH**
- agreed to receive confirmation of the birthing pool liners compliance with control of Infection requirements **LB**
- agreed to receive a report regarding the Health Group spending plans at its next meeting **DH**

8 FINANCIAL REPORT - SEPTEMBER 2016

Mrs Roberts presented the report which set out the financial activities for the 4 month period ending 31 July 2016, payments in access of £100 for the period 1 April 2016 to 31 August 2016 and investment details as at 30 June 2016.

She advised that income was £126k which was below the estimated budget of £262k. Expenditure was £104k which was also below an estimated budget of £275k.

The value of the Trust's investments with Brown Shipley was £975k. The value of the Trust's investments with COIF was £469k and cash of £340k was in the bank account.

Mr Bond questioned the calculation for the fund balances of £1.6m on appendix A. Mrs Roberts advised that not all of the financial information was available at the time of writing the report. Mr Haire commented that not all of the information in the report related to the same time span. Mrs Roberts agreed that this was unsatisfactory and reported that not all of the data had been available. A consistent report would be presented to the next meeting.

Resolved:
The Committee:

- received the report and noted its contents

9 DRAFT ANNUAL REPORT AND ACCOUNTS 2015/16

The draft Charitable Funds Annual Report and Accounts 2015/16 were presented to the Committee by Mrs Roberts for review.

Following a discussion a number of amendments were identified. Mrs Roberts agreed to bring the amended document back to the next meeting for formal approval. **DR**

Mr Snowden advised the Committee that a Charitable Funds induction had been planned to take place at a future Board Development Day.

Resolved:
The Committee:

- received the draft Charitable Funds Annual Report and Accounts 2015/16 for review
- agreed to receive the amended Annual Report and Accounts for formal approval at the next meeting **DR**

10 REVIEW OF CHARITABLE FUNDS POLICIES

Mrs Roberts presented the updated charitable funds policies to the committee for consideration and review. It was noted that the policies had been updated to include the new arrangements with East Lancashire Financial Services.

It was agreed that any comments on the polices would be brought back to the next meeting for formal discussion and agreement. **ALL**

Resolved:

The Committee:

- received and considered the updated charitable funds policies
- will formally consider comments at the next meeting and finalise the policies. **ALL**

11 INVESTMENT UPDATE

A paper was tabled by Mr Herdsman of Brown Shipley. Mr Herdsman said there had been an increase in investments over the last year by 7.77% and the value of investments with Brown Shipley was £1,054,866

Mr Herdsman advised that there were periods of instability in the stock market during January and February 2016 due to the concerns of the slowdown of trading in China. A significant decline in global indices was seen in June 2016 as a result of the "leave" vote in the EU referendum. The FTSE 100 rapidly recovered as a result of overseas earnings and was 6,830 as at 20 September 2016.

There was a discussion around the stock market's past performance and future predictions. The Committee were informed of the current asset allocation which included reduced UK exposure, increased global exposure, maintained fixed interest, maintained alternative investments and the purchase of structured products.

Mrs Walker questioned why charitable funds were invested in structured products. It was agreed to discuss structured products investments once the health group spending plans had been received.

Resolved:

The Committee:

- received the updated charitable funds policies
- agreed to discuss investment in structured products at a later date **ALL**

12 CHAIR'S SUMMARY OF THE MEETING

Mr Snowden summarised the meeting.

13 ANY OTHER BUSINESS

Christmas 2016 expenditure

Mrs Roberts tabled a paper which highlighted Christmas expenditure in 2015 which was granted from charitable funds. It was brought to the committees' attention that last year a set amount of money was allocated for patients and wards for which a total of £3506 was released.

The committee agreed to the expenditure for Christmas 2016 to be released from the appropriate funds. **DR**

Song for Hull Proposal

Mr Bond advised the Committee that he had received an update from Mr Gore in relation to the Song for Hull Proposal. Funding of £10k had been granted from the Hull 2017 Creative Communities Programme. Mr Gore had met separately with Mr Long, Chief Executive Officer and Mr Haire, Project Director – Fundraising, regarding the remaining funding for the proposal. Mr Haire offered assistance from a fundraising perspective.

14 *DATE AND TIME OF THE NEXT MEETING:*

Thursday 17 November 2016, 1:00pm – 3:00pm, The Committee Room, HRI