Hull and East Yorkshire Hospitals NHS Trust

Meeting of the Trust Board

To be held in Public

Thursday 24 November 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 27 October 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 7.1 – Cyber Security	attached attached	Chief Executive Officer Director of IM&T

Quality

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

Performance

11. Integrated Performance Report	attached	Executive Team
12. Financial and Operating Plan 2017/19	attached	Chief Financial Officer/Director of Strategy & Planning
13. Winter Plan	attached	Director of Strategy & Planning
14. Agency Spend	attached	Director of Workforce & OD

Strategy & Development

15. Implementation of Trust Strategy	attached	Director of Strategy & Planning
16. Transforming HEY's Culture – Progress Report FFT Quarterly Staff Survey	attached	Director of Workforce & OD

Assurance & Governance

17. Charitable Funds Annual Report and Accounts 2015/16 — attached — Chief Financial Officer

18. Unadopted Minutes from Board Standing Committees — Chair of Committee
    18.1 – Performance & Finance 24.10.16, 21.11.16 — attached/verbal
    18.2 – Charitable Funds 17.11.16 — verbal
    18.3 – Quality 20.10.16 — attached

19. Any Other Business

20. Questions from members of the public

21. Date & Time of the next meeting:
Thursday 26th January 2017, 10.30am, The Boardroom, HRI

Attendance 2015/16

	29/10	26/11	28/1	25/2	31/3	28/4	26/5	28/7	29/9	27/10	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	✓	✓	✓	✓	✓	✓	✓	9/10
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
T Sheldon	✓	✓	✓	x	✓	✓	✓	✓	x	✓	8/10
V Walker	x	✓	✓	✓	✓	x	✓	✓	✓	✓	8/10
T Christmas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
E Ryabov	-	-	✓	✓	✓	✓	✓	✓	✓	✓	8/8
In Attendance											
J Myers	x	✓	✓	✓	✓	✓	✓	✓	✓	x	8/10
L Thomas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Nearney	✓	✓	✓	✓	x	✓	✓	x	✓	✓	8/10

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 27 OCTOBER 2016
THE BOARDROOM, HRI

PRESENT	Mr M Ramsden	Chairman
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr A Snowden	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mrs V Walker	Non-Executive Director
	Prof T Sheldon	Non-Executive Director
IN ATTENDANCE	Dr A Samaan	Consultant (Item 15 only)
	Ms L Thomas	Director of Governance & Corporate Affairs
	Mr S Nearney	Director of Workforce & OD
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES

Apologies were received from Mr K Phillips, Chief Medical Officer and Ms J Myers, Director of Strategy & Planning.

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 HELD 29 SEPTEMBER 2016

The minutes of the meeting that was held on 29 September 2016 were approved as an accurate record.

4. ACTION TRACKER

Ms Thomas advised that the next Guardian for Safe Working report would be received at the Board meeting in March 2017 and Miss Cattermole would be invited to the Board to present it. **RT**

An update relating to sepsis would be included in the next Quality report to the Board. **LT**

5. MATTERS ARISING

There were no matters arising.

6. CHAIR OPENING REMARKS

Mr Ramsden reported that Ms Carla Ramsay had been appointed as Director of Corporate Affairs and would replace Ms Thomas as Trust Secretary following her retirement in December 2016.

Mr Ramsden briefed the Board on the pressure that the NHS was under. This was also being experienced locally, particularly in relation to achievement of the Emergency

Department 4 hour standard. He also advised that the General Medical Council had reported low morale amongst medical staff across the country and that the challenges all staff face on a daily basis should not be underestimated.

7. CHIEF EXECUTIVE BRIEFING

Mr Long highlighted the two consultations currently underway by the two Clinical Commissioning Groups, Hull and the East Riding, regarding urgent care services. The Trust would be responding to both consultations.

He advised that NHS Improvement's Single Oversight Framework was now in place and that the indicators used to monitor Trusts would be included in the Trust's integrated performance report. It was noted that new reporting requirements were being introduced for agency spend. The Trust's agency spend was low in comparison to other Trusts, although there was pressure due to a national shortage of consultants.

He briefed the Board regarding the backlog of patients waiting for outpatient treatment or follow up in the Ophthalmology Department. A business case had been developed which involved the services utilising a larger proportion of the Eye Hospital building, which was currently occupied by another service.

8. PATIENT STORY

Mr Wright briefed the Board on a negative and a positive story. The negative story was about a patient who had attended the fracture clinic. The patient had a long wait, a short consultation, little information was given and the doctor had not introduced themselves. Mr Wright advised that the patient had received a letter of apology and had since seen another consultant for reassurance. Feedback had also been given to the doctor who had conducted the first consultation.

The second story related to a patient who was approaching the end of their life and had been admitted to the Intensive Care Unit from a residential home. The patient's friend was allowed to remain with the patient to offer comfort and could not thank the staff enough for their sensitivity and compassion towards their dying friend. Mr Wright advised that the team involved had been thanked personally by the Chief Executive and a copy of the letter had been sent to the Unit.

Prof. Sheldon added his gratitude to the staff involved. However, the pathway followed by the patient also highlighted the wider issue of provision of community care, to enable patients at the end of their life to have the choice to remain at their home.

9. QUALITY REPORT

Mr Wright presented the report and informed the Board that the Quality Committee had received a presentation from the Neurosurgeons about the wrong site spinal surgery Never Event. The complex procedure involved in carrying out this surgery was discussed as well as the interpretation of the x-rays which are taken to confirm the right level of the spine. A new step had now been introduced to the procedure which involved taking a third x-ray whilst the patient was on the operating table. This was an additional step over and above what had been recommended by the Royal College.

The number of Serious incidents declared had decreased compared with the same time period last year. Mr Wright advised that the two maternal death investigations had concluded, with no causes attributable to the Trust.

The National Reporting and Learning System (NRLS) performance data had been released for the 6 months to March 2016 and the Trust had increased its incident reporting levels from being in the lowest 20% into the middle ranking section.

Mr Wright spoke about the Trust's position compared to peers in relation to pressure ulcers and performance remained relatively positive. C difficile performance remained within the threshold although there had been an increase in out of the hospital rates which would need to be monitored closely. There were no cases of norovirus and the scabies outbreak had now been successfully dealt with. In addition, 3750 members of staff had received flu vaccinations at the time of writing the report.

The Trust was seeing a reduction in complaints compared to last year and the Friends and Family Test results showed that 94.9% of patients would recommend the Trust. Mr Wright also reported that the Patient Experience Team was working on a programme to allow patients to raise concerns on-line.

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

10. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and highlighted that 102 nurse graduates had commenced employment with the Trust and had just finished their induction. He advised that the nurses could not be added to the establishment until they had received their pin numbers. Mr Wright advised that nurses now only graduated once during the year but that further recruitment was being undertaken to recruit nurses from the Philippines. The Trust had spoken to several large recruitment agencies and a business case for a more steady flow of nurses from the agency would be presented at the Executive Management Committee in November 2016.

Mr Wright reported that the Trust had not been successful in its bid to become a pilot site for the Associate Nurse Role but was working with Health Education England to strengthen its bid to become a 'Fast Follower'.

There was a discussion around attrition rates in the Trust and what could be done to entice staff back to work in Hull. Mr Nearney added that the Trust was operating a two week nurse induction programme and a buddy up system to help new recruits feel welcome. It was important that new staff settled in quickly to their working environment, that they felt valued and supported which would help with retention rates.

Resolved:
The Board received the report, noted that a paper would be presented at the November Executive Management Committee regarding overseas recruitment and requested information about the reasons why staff leave the Trust. **MW**

11. FUNDAMENTAL STANDARDS

Mr Wright presented the report which highlighted performance on the wards regarding fundamental nursing standards. Information boards are outside every ward so patients and staff can see how the ward is performing against the standards, such as cleanliness, infection rates and nutrition. The wards are audited regularly by ward sisters and also have external scrutiny. Mr Wright suggested that he bring the report back quarterly for the Board to review it.

Mr Ramsden asked if there had been any surprises in setting up the system and Mr Wright highlighted the significant amount of written documentation that nurses are expected to complete and that this would be an area of focus.

The Deputy Chief Nurse met with each ward sister to review the improvement actions agreed. Mr Snowden asked if the Trust's regulatory bodies were aware of the programme and Mr Wright said that the CQC had provided positive feedback as had

patients.

There was a discussion around pressure ulcers being linked to good nutrition and the work ongoing with the nursing teams regarding body mapping and re-assessment. Mrs Walker stated that the information boards would create healthy competition between the wards.

Resolved:
The Board received the report, noted its contents and agreed to receive reports on a quarterly basis. **RT**

12. INTEGRATED PERFORMANCE REPORT

Mrs Ryabov presented the responsiveness section of the report. She reported that the referral to treatment pathway had delivered performance of 87.9% against the NHS Improvement trajectory of 88.9%. The waiting list had increased in September by 1500 patients, 10% of these patients had been waiting over 18 weeks. The increased activity was having a detrimental effect on theatre capacity and diagnostic waits.

There had been one 52 week wait in September due to a pause in the patient's pathway and a planned holiday. The patient had been treated in October 2016.

Mrs Ryabov advised that the standard for diagnostic tests was less than 1% of patients waiting over 6 weeks. In September, the Trust's performance was 2.7%. The main issue was increased activity in the emergency department and requests for MRI/CT scans. There had been an impact on elective work. Prof. Sheldon asked if GP referrals were monitored for appropriateness and whether there was a genuine clinical need for a patient to have a diagnostics investigation. Mrs Ryabov advised that there were times when patients had tests which assured worried patients.

Performance against the A&E standard had been 86.7% in September 2016. Mrs Ryabov reported that 15 Trusts had seen a 10% or more activity increase and that Hull was one of those Trusts. There was discussion around community care and the need for more support from the Clinical Commissioning Groups and other healthcare providers.

The Trust had achieved its cancer targets in September 2016.

Mr Wright advised that the quality issues had already been discussed as part of the separate quality report to the Board. It was noted that the performance against C-sections was higher than 12.1%. Further information would be provided in the next report.

Mr Bond presented the financial section of the report and advised that the Trust had a deficit of £0.93m which was £0.5m above the planned deficit. The reason for this was the non receipt of Sustainability Transformation Plans funding due to performance in A&E and cancer. The Trust had under traded against its income plan by £0.1m. This was mainly in elective and outpatients in surgical specialties.

The Health Groups were £5.53m overspent which was an increase of £1.54m in month. The main drivers continued to be the non-delivery of the CRES, use of agency and lower levels of contract activity.

The Trust's cash position remained weak with £1m in the bank. Mr Bond advised that conversations with creditors were becoming increasingly difficult. The Trust is now forecasting a year end deficit position of £2.36m instead of the break even plan. Mr

Gore expressed concern with respect to the Trust meeting its financial obligations as and when they fall due and sought assurances in respect of this. Mr Bond replied that he would be in a position to seek emergency funding should this be necessary. The Trust had a risk rating of 2.

Mr Ramsden expressed his concern regarding the Health Group CRES positions and questioned what action was being taken to ensure that they met their financial plans. Mr Bond assured him that the Medical Directors were fully engaged but that more work was to be done across the whole organisation. Agency staffing was discussed and Mr Nearney assured the Board that although the Trust was above the agency cap, decisions about filling gaps in rotas was based on clinical safety. Each agency shift needed to be signed off by a director.

Mrs Walker asked if not paying suppliers on time could have a detrimental effect on patient safety due to goods not being delivered. Mr Bond stated that the Trust would not be seeing the benefit of early payment discounts and could be incurring penalty charges.

Resolved:
The Board received the report and agreed to:

- discuss the financial issues at the next Board meeting **LB**
- receive further information on C-section rates **LT**

13. WINTER PLAN

Mrs Ryabov gave an update to the Board regarding the winter plan. She advised that the A&E Improvement Board and the Trust's Executive Management Committee had reviewed the plan. It was felt that the plan could not be finalised until further information was available on partners' plans and alignment with the Sustainability Transformation Plans. Therefore further work was being undertaken.

Mrs Ryabov reported that the winter ward would be opened in December 2016 and work was being carried out to ensure it could be staffed safely. Additional therapy services would be provided as well as additional ambulance services. A social worker had been recruited by the Trust to enable staff to discharge patients more efficiently. Eight beds had been procured in the community but there had been issues around patient criteria and the need for this to be more flexible. These beds would be available from mid-November. The Trust was also discussing further support needed from the councils as there was no funding currently built in for winter planning.

Resolved:
The Board received the update and agreed to receive the final plan at its next meeting. **ER**

14. SUSTAINABILITY TRANSFORMATION PLANS

Mr Long updated the Board regarding the Sustainability Transformation Plans for Humber Coast and Vale. The plans had been submitted to NHS England and NHS Improvement and would be published in the near future. Mr Long reassured the Board that there were no radical changes but an increase in community care packages.

Mr Ramsden expressed concern regarding the approach not including public consultation. It was confirmed that this was a commissioner led process and the Trust was required to adhere to the guidance. He also requested assurance regarding the financial assumptions being made and their deliverability. Mr Bond advised that £90m was being made available to the system and Mr Long assured him that there would be a public consultation after the plans had been agreed internally.

Mr Long reported that the next 2 years contracting guidance was being issued and that this would need to align with the Sustainability Transformation Plans.

Resolved:
The Board received the update.

15. RESPONSIBLE OFFICER REPORT

Dr Samaan presented the report and advised that appraisal rates for doctors was below the NHS England target of 90%. Mr Ramsden asked if the 90% compliance rate would be met in 2017/18 and Dr Samaan assured him that it would.

Mrs Walker asked about the quality of appraisals and Dr Samaan reported that doctors are asked to review their appraisal and give feedback. Positive messages had been received with only a small number of appraisals being scored as unsatisfactory. Appraisers were given specific training and there where currently 63 appraisers in the Trust who completed 10 appraisals each.

Mr Gore asked why performance was not managed at appraisals and Prof. Sheldon advised that the process was more comparable to a peer review rather than performance management, but was linked to job planning. Dr Samaan added that performance was managed through the Revalidation process.

Resolved:
The Board accepted the report and approved the stated level of compliance contained within it.

16. BOARD ASSURANCE FRAMEWORK

Ms Thomas presented the Board Assurance Framework. She highlighted the financial and the NHS Constitution standards as areas for the Board to review due to the increasing pressures. The Board agreed that these risks should be reviewed and Ms Thomas said that she would speak to Mr Bond and Mrs Ryabov and then present the proposed new risk levels at the Audit Committee in December 2016.

Resolved:
The Committee received the report and agreed that the financial and the constitutional standards risks be reviewed and discussed at the Audit Committee in December 2016. **LT**

17. STANDING ORDERS

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

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

18. UNADOPTED MINTES FROM BOARD STANDING COMMITTEES

18.1 – Quality Committee 20.10.16 – Mr Snowden advised that a team of Neurosurgeons had attended the committee to give a presentation around a wrong site spinal surgery Never Event.
18.2 – Performance & Finance 26.09.16 – The minutes were received
18.3 – Charitable Funds 22.09.16 – The minutes were received
18.4 – Audit Committee 20.10.16 – Mr Gore advised that the meeting held on 20.10.16 was a development session. An issue that had arisen was the link between the Quality Committee and the Audit Committee should be strengthened. Mr Gore would discuss this further with Prof. Sheldon. **MG**

19. ANY OTHER BUSINESS

Ms Thomas reported that the Information Governance Toolkit required the Trust to achieve 95% compliance with Information Governance training. The Trust had not yet met this level and provided that the Board agreed to a level that demonstrated year on year improvement, this would be acceptable. It was therefore agreed that the Trust target for 2016/17 would be 90%.

20. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions received from members of the public.

21. DATE AND TIME OF THE NEXT MEETING:

Thursday 24 November 2016, 10:30am
The Boardroom, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD ACTION TRACKING LIST (November 2016)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
October 2016						
01.10	Action Tracker	Guardian for Safe Working report to be presented	HC	Mar 2017		
04.10	Fundamental Standards	Quarterly Fundamental Standards report to be received at the Board	MW	Jan 2017		
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						
October 2016	Action Tracker	Update on sepsis to be included in next Quality Report	LT	24.11.16		Completed
		Further information on C-section rates to be included in the next Quality Report	LT	24.11.16		Completed
	Winter plan	Plan to be received	JM	24.11.16		On Agenda
	Nursing & Midwifery Staffing Report	Information to be received on why staff leave to Trust to be included in the report	MW	24.11.16		Included in report
September 2016	Board Committee Report	Trust Strategies to be discussed at a Board Development Day	LT	03.10.16		Completed
	Matters Arising	The Trust's Operational Plan (to include Health Group workforce plans) to be received.	SN	TBC		On Agenda
	Performance Report	Further information around the frailty model and reduced admissions to be received	ER/KP	27.10.16		Discussed at the Performance & Finance Committee in October 2016

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		
		Financial and the constitutional standards risks be reviewed and discussed at the Audit Committee in December 2016	LT	15.12.16		
	Unadopted Minutes	The link between the Quality Committee and the Audit Committee to be strengthened	MG	TBC		

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

1. NHS Improvement Chief Executive and Chairs meeting 3/4 November 2016

NHSI set out its approach to the Operational Planning guidance 2017/18 -2018/19. The expectation is that the provider sector will return to financial balance in both years through the use of the £1.8b fund. This fund has been divided into 3 allocations – a £1.5b general fund allocated on the basis of emergency care; £0.1b general fund allocated to non-acute providers; £.02b targeted fund. The planning process has been built around the Sustainability and Transformation plans so that the commitments and changes coming out of these plans can translate into operational plans and contracts.

Control Totals have been established for every provider and access to the Sustainability and Transformation Fund (STF) will be dependent on providers agreeing to their control totals and associated conditions. Receipt of STF in 2017/18 will replicate the arrangements in place this year with 70% of the STF dependent on financial performance and 30% dependent on delivery of performance standards. Providers are expected to deliver national standards and are required to submit assurance statements to this effect.

The final submission of operational plans, aligned with contracts is the 23 December 2016.

2. NHS England performance statistics for September 2016

NHS England has released the performance statistics for September, revealing a long-term trend of greater volumes of both urgent and emergency care and elective activity. Emergency admissions have increased by 3.7%, diagnostic tests are up 5.3%, consultant-led treatment is up 4%, and A&E attendances have seen a rise of 4.6%. There were 196,246 delayed days in September, compared to 147,738 in the same month the year before, and the highest number since monthly data were first collected. The delayed transfer of care indicates that is not just NHS Trusts that are feeling the pressure, but also the wider health and social care system.

3. Cyber Security protection

Attached to this briefing (Appendix 1) is a paper which summarises the current approach to Cyber Security in the Trust. This follows an incident at a neighbouring Trust and Martyn Smith,
Director of IT and Innovation is attending the Board meeting today to provide assurance to the Board on the Trust's arrangements.

4 Other items of interest

- **IVF**

Parents in Hull were 'dared to share' their fertility success stories as part of a new campaign by the Hull IVF Unit, supporting National Fertility Awareness Week (31st October to 6 November 2016). Based within the Hull Women and Children's Hospital at Hull Royal Infirmary, the Hull IVF Unit is encouraging couples across the region who have been successful in having a family to share their news openly to give hope and confidence to others who are due to embark on fertility treatment. The #DareToShare campaign, running on social media, involves former patients sharing photos of their babies conceived through treatment, in order to help remove the stigma of IVF and other fertility treatments that assist with conception.

- **National Pathology Week**
  To celebrate National Pathology Week (7-13th November), Sirius Academy, Newland High School, Malet Lambert and Kelvin Hall pupils were invited to visit Caste Hill Hospital and Hull Royal Infirmary, to raise awareness of pathology services, which are instrumental in 70% of all NHS diagnoses. Year 10 students spoke to pathologists at both sites and learned how pathology underpins much of the care the NHS provides, and how varied and satisfying a career in pathology can be.

- **New MRI Scanner**
  Patients requiring potentially life-changing investigations are set to benefit from a new, state-of-the-art scanner which has been installed at Hull Royal Infirmary. The Radiology Department took delivery of the new 1.5T Siemens Aera MRI scanner, valued at around £1 million, last month when it was hoisted into place in the hospital's MRI Centre. The machine performs body scans to help identify and diagnose conditions such as cancer and epilepsy, and can also be used to examine brain development in children, to investigate cartilage and ligament damage, and even look between the ears for the causes of hearing loss.

- **High praise for Trust's antibiotic stewardship**
  According to recent data from Public Health England, the Trust is one of the best in the country when it comes to antibiotic prescribing rates and tackling antibiotic-resistant superbugs. Inappropriate use of antibiotics in recent years has led to the drugs becoming less effective, and a subsequent rise in cases of C Difficile and MRSA. Locally, however, the Trust has not seen a case of MRSA since June 2015, and rates of C Difficile also compare favourably, with 12.9 cases per 100,000 bed days compared to a national average of 14.9 cases per 100,000 bed days. The success is attributed to antibiotic stewardship; a coordinated programme of efforts to optimise the use of antibiotics prescribed in hospital.

- **Thanks to our volunteers**
  The Trust's volunteers received some well-earned praise and media coverage this month. Tom Mathers (79) is one of the Trust's oldest volunteers. He began volunteering on Ward 200, the Elderly Assessment Unit at Hull Royal Infirmary in the summer, joining other local people who give their time to help others. He comes into the unit several times each week for a few hours, to offer a smile, a chat and a listening ear to patients who are there at the time. Many thanks to everyone and anyone who gives their time for free in order to enhance the care we provide to our patients.

Chris Long
Chief Executive
November 2016

TRUST BOARD REPORT – 2016 – 11 - 9	
Meeting date:	Thursday 24 November 2016
Title:	Quality Report
Presented by:	Mike Wright, Chief Nurse
Author:	Mike Wright, Chief Nurse Kevin Phillips, 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 Never Event declared in September 2016 (misplaced naso-gastric tube) is still under investigation and due for completion in December 2016.

2.2 Serious Incidents

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

The Trust has continued to promote an open and transparent reporting culture. The national Serious Incident Framework recognises that it is not always immediately clear that a Serious Incident has occurred. In this reporting period, there have been three incidents that have been de-escalated following investigation. The decision on de-escalation is made by commissioners following a request by the Trust. The incidents relate to two hospital acquired pressure ulcers and one fall. All three incidents were found to be unavoidable. Table top reviews were undertaken for the two pressure ulcer incidents. The table top exercises involved staff from the areas in which the pressure incidents occurred, so that learning still takes place.

There have been five Serious Incidents declared since the last Board report. The categories of these are set out in the table below.

Serious Incidents declared since last Board report

Type of SI	Health Group
Pressure Ulcer	Surgery
Treatment delay (2)	Surgery, Medicine
Un-expected death	Medicine
Surgical Incident	Clinical Support

The pressure ulcer occurred on the vascular ward and the patient had numerous pre-existing co-morbidities. Of the 2 treatment delays, one incident involved a patient who presented to the hospital with a fractured hip. A hip x-ray was taken and a chest x-ray was also taken. The chest x-ray showed a cancer, which was not immediately recognised and therefore there was a delay in implementing a management plan. The second incident was a delay in a patient having a follow up appointment within the medical elderly service.

The unexpected death related to a patient within the Medical Elderly service and the surgical error occurred within radiology, where an unnecessary interventional procedure was undertaken. The decision was based on a scan, which may have been misleading.

All five incidents are still under investigation.

2.3 Serious Incident actions

Examples of two actions taken following recently completed Serious Incidents are:

- An investigation was completed which related to a patient who received the incorrect medication due to their information being merged with the incorrect medical record. The case has been used by administration, medical and pharmacy staff for training to raise awareness so that staff understand the relationship of records and their impact on other services. The Trust has also allowed this report to be used by commissioners for sharing and learning with other NHS organisations who use electronic records.
- Following a Serious Incident investigation on ward 5 relating to a patient fall, the ward is reviewing whether it can designate high observation beds for those patients at risk of falling.

3. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer point prevalence audit results for November 2016 are attached as **Appendix One**. 930 in-patients were surveyed on 11th November 2016, with the results as follows:

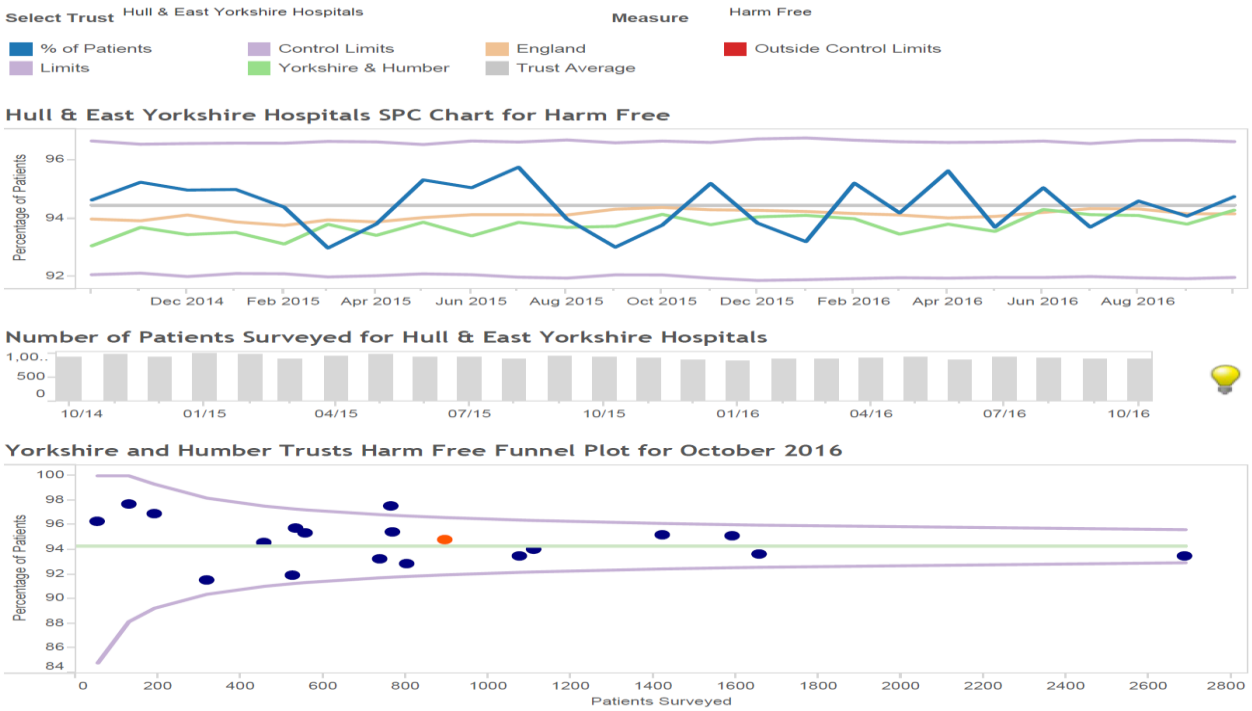
- 94.5% of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- 1.72% [n=16] patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at 98.2%. This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = 90.4% (n=841) compliance. Clearly, this is more positive than is being reported (via Lorenzo) in the Integrated Performance Report and is improving steadily but these rates still need to improve further.
- VTE incidence on the day of audit was 6 patients; 2 with pulmonary embolisms and 4 with a Deep Venous Thrombosis.
- New pressure ulcers remain relatively low (n=1) grade 2.
- There were 10 patient falls recorded within three days of the audit day; 8 of which resulted in no harm to the patient and 2 with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain slightly erratic and this indicator fluctuates. Of the15 patients with infections, 7 were infections that occurred whilst the patient was in hospital. This remains a focused area for the Trust.

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

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

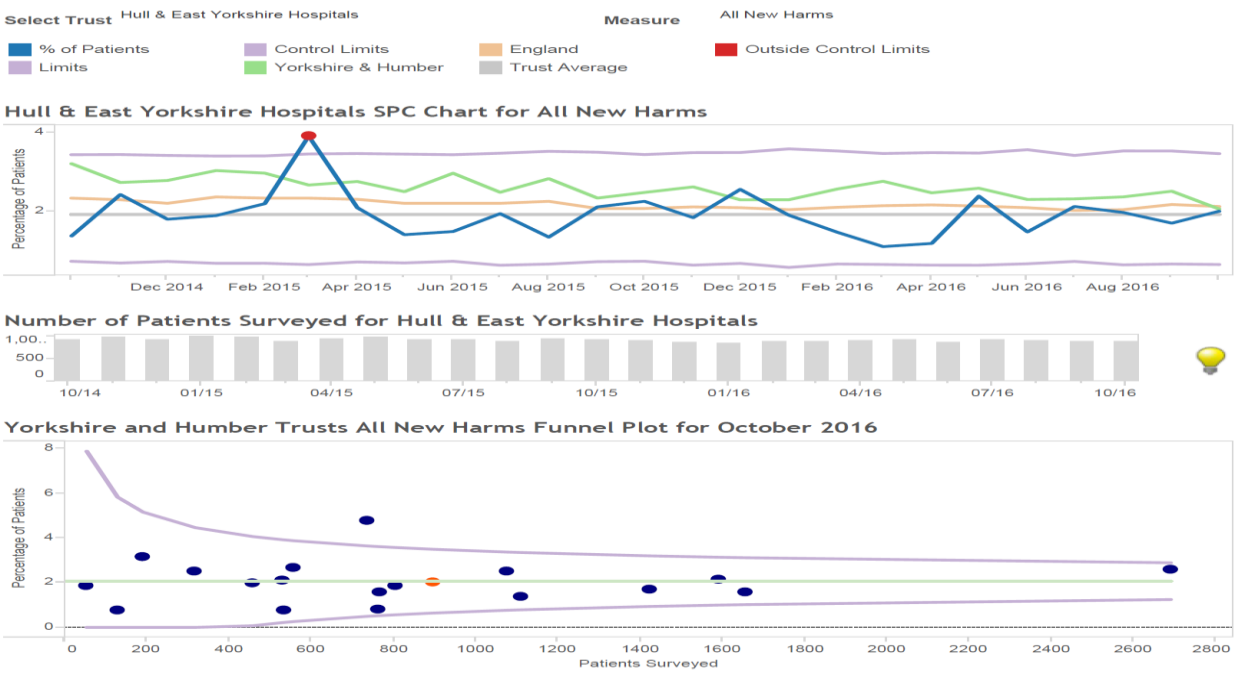
The following table and funnel plot show the percentage of patients that had any of the four harms on the day of the point prevalence audit, that have either been acquired before or after admission to hospital.



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.

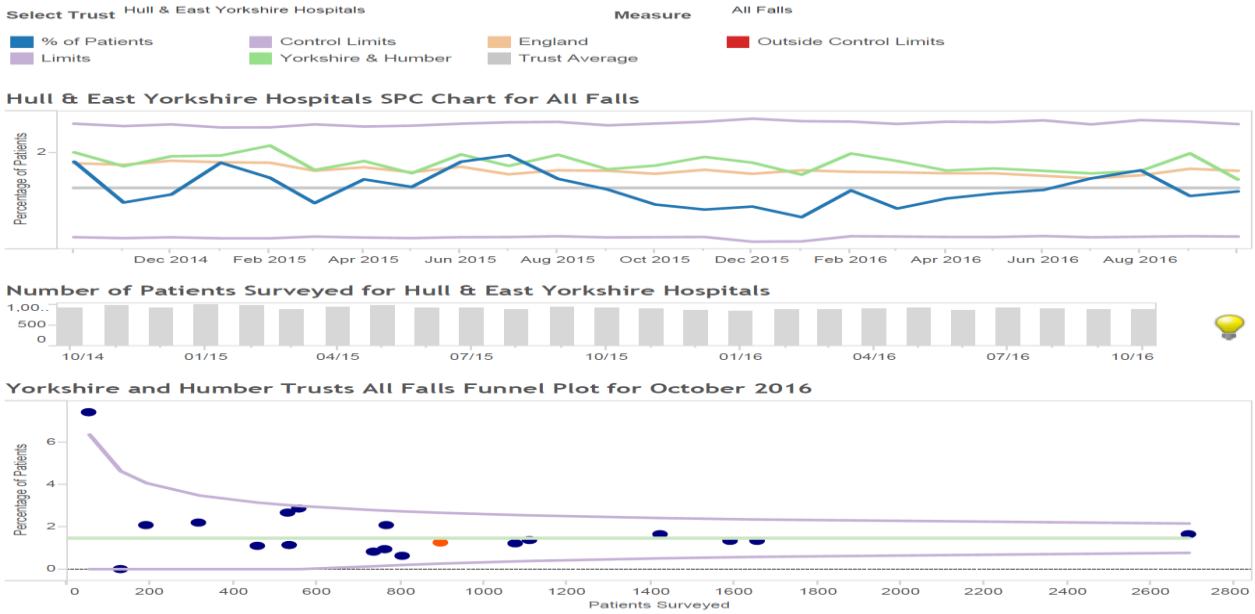


Again, and overall, the Trust performs realtively well against this indicator but there is always room for improvement. These data continues to be reviewed monthly. To take each of the four harms in turn:

3.2 FALLS

3.2.1 Falls (all)

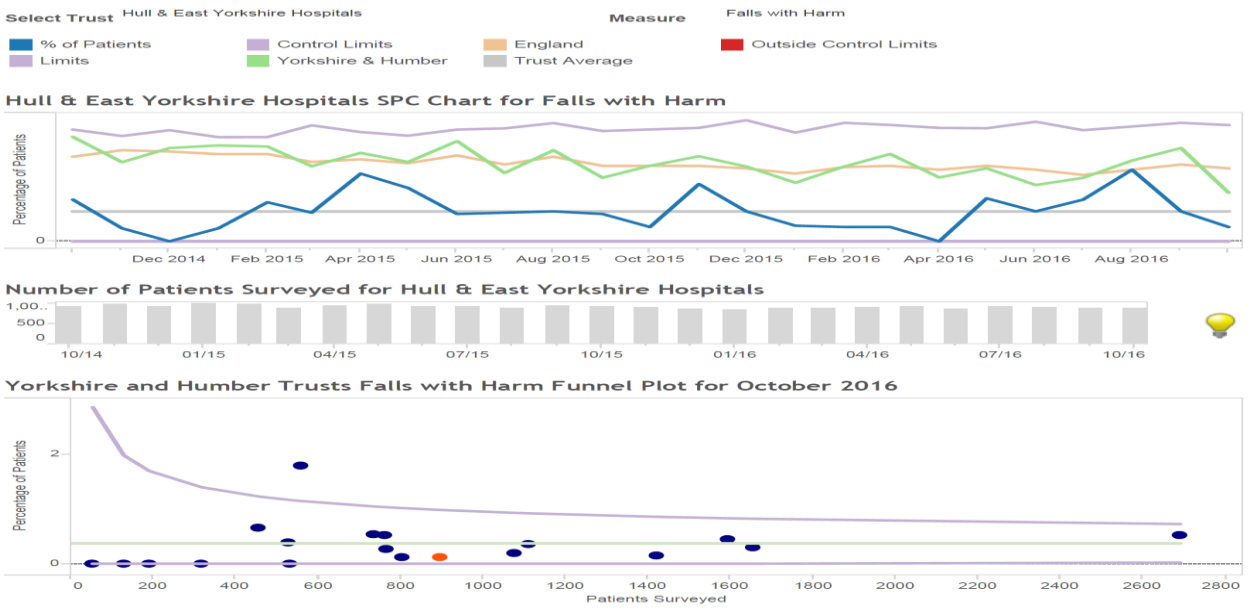
The following tables shows the percentage of patients that have fallen in hospital within the last three days, as at the date of the point prevalence audits.



Followig a steady increase in falls for March 2016 to August 2016, the number of patients falling with harm has reduced again. Overall, apart from the August 2016 levels, this has remained under the regional and national average benchamarking position against this indicator. 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

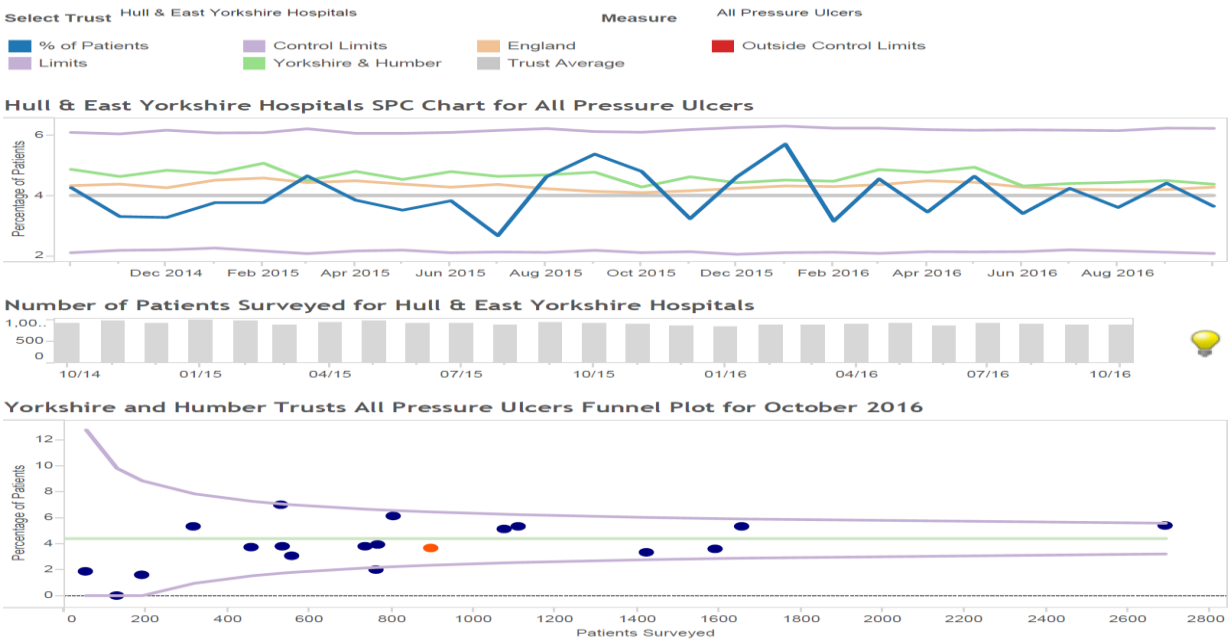
This chart differentiates those patients that fell and sustained harm from those that fell and where there was no harm. Overall though, this remains very positivie perofrmance when compared to peers.



3.3 PRESSURE ULCERS

3.3.1 Pressure Ulcers (All)

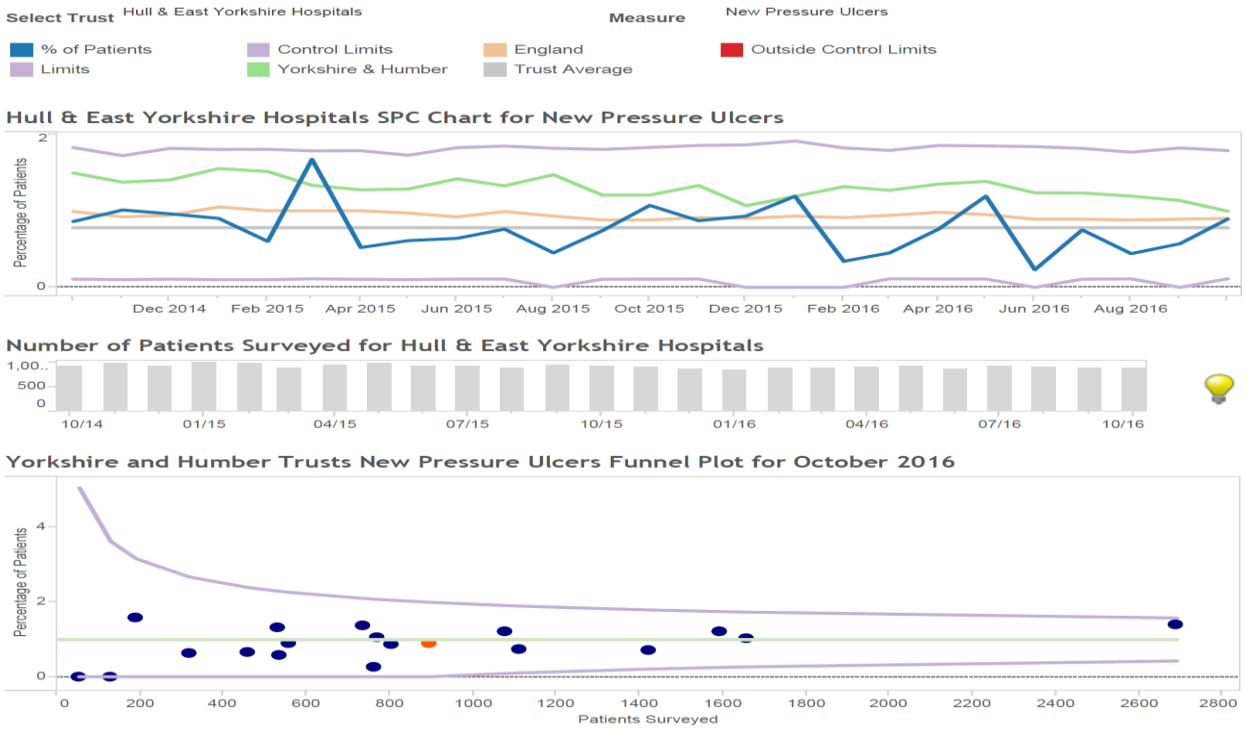
The following graph and funnel plot show variable statistics on this measure. An important factor is the proportion of patients that come into the Trust with exisiting pressure ulcer damage, which is significant, particularly in patients that are admitted via the emergency department and admissions areas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

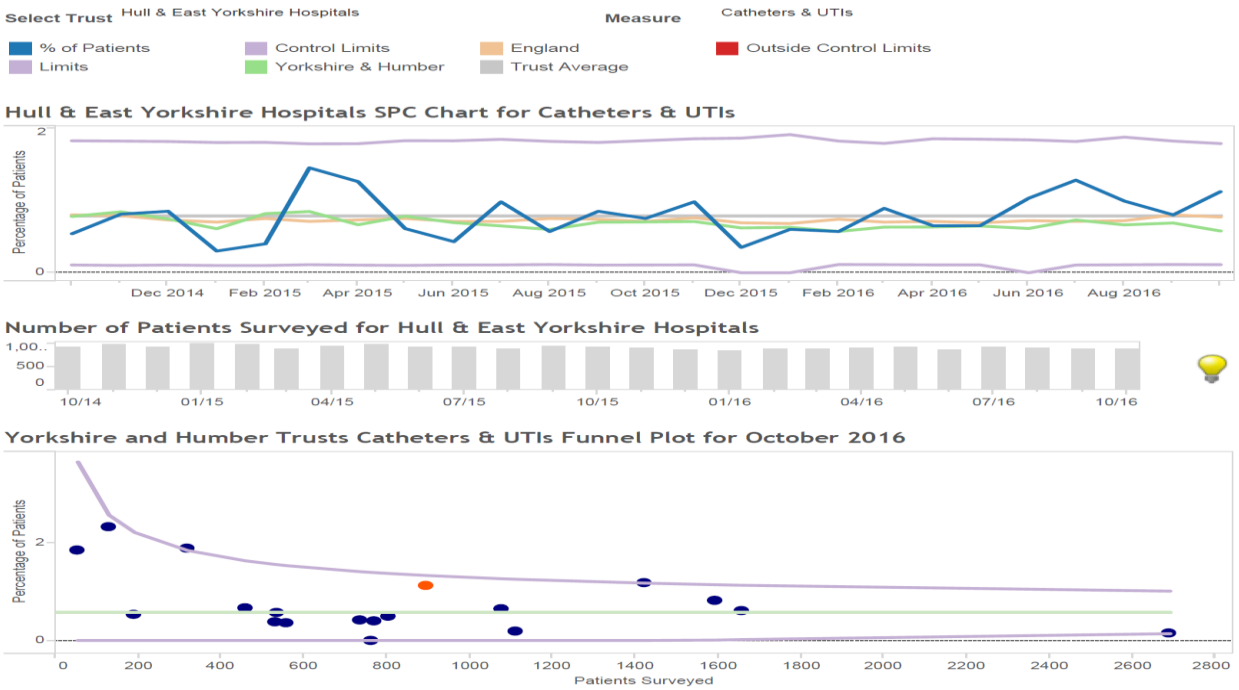


The performance for this indicator is positive overall, although the Trust is not complacent and futher work is underway to ensure further imprvoements in this area.

3.4 CATHETERS AND URINARY TRACT INFECTIONS

3.4.1 Catheters and UTI (All)

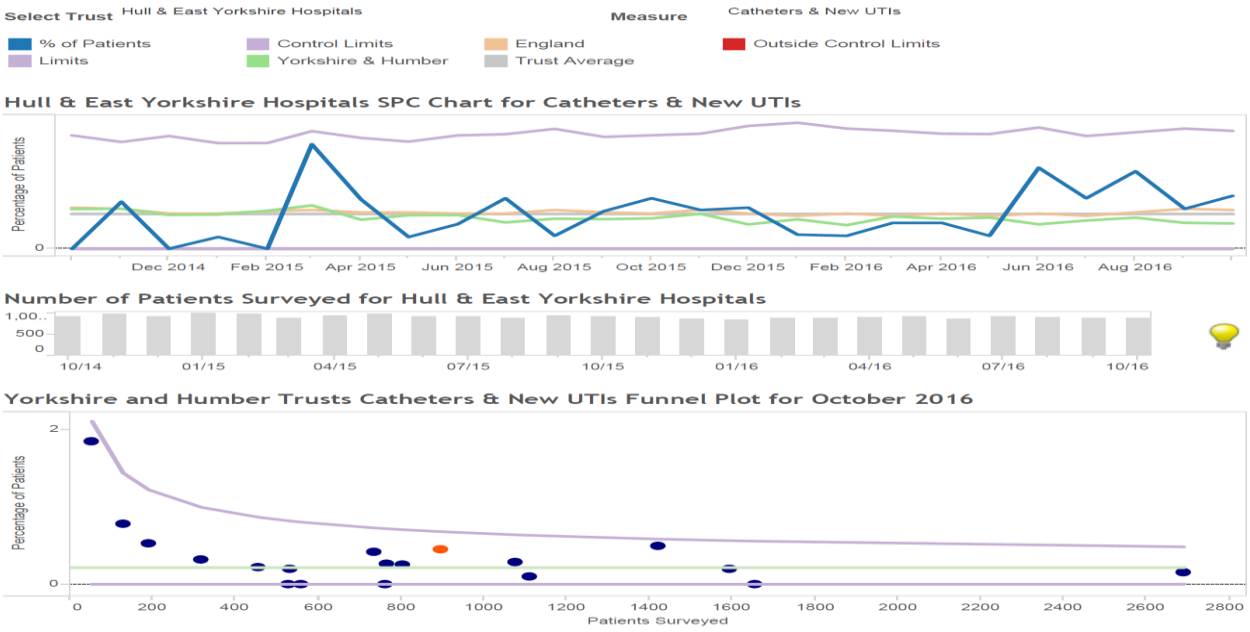
The following chart shows the percentages of patients that have a urinary catheter in place with an associated urinary tract infection. These charts include those that were both admitted with these issues and/or have acquired them whilst in hospital.



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

3.4.2 Catheters and UTI (new)

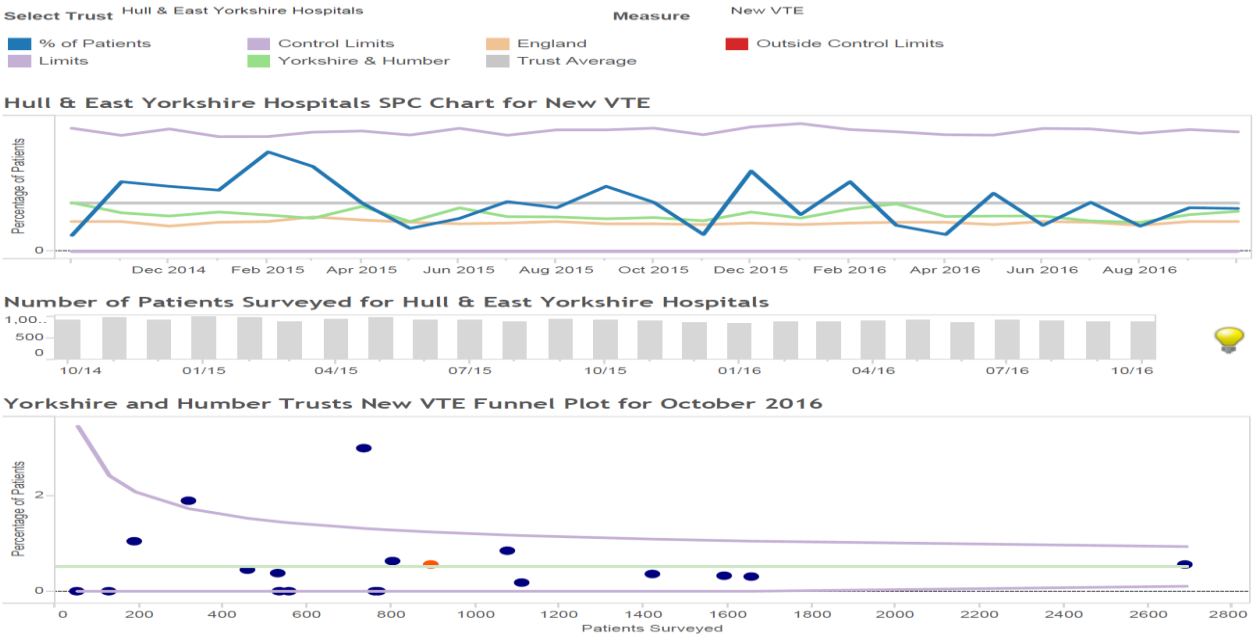
The following chart shows a more variable picture over time, with a spike in catheter-associated urinary tract infections since May but that now appears to be reducing. Concentrated focus is being given to urinary catheter care in an effort to reduce these infections further.



This performance remains concerning and focused attention is being given to this subject area.

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. In the vast majority of cases, these episodes were unavoidable with patient receiving appropriate prophylaxis. However, this continues to be a focused area for the Trust.

4. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

4.1 HCAI performance 2016/17– as of 31st October 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:

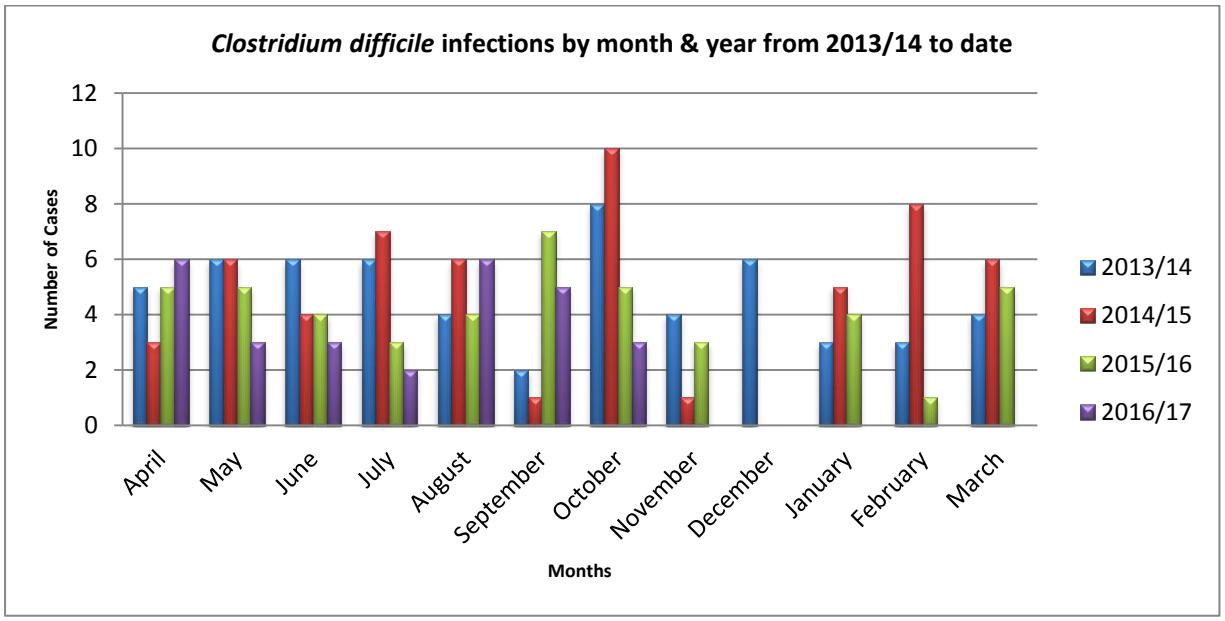
Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**28 (53% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**0 (0% of threshold)**
MSSA bacteraemia	**46**	**28 (61% of threshold)**
E.coli bacteraemia	**95**	**48 (51% of threshold)**

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

4.1.1. Clostridium *difficile*

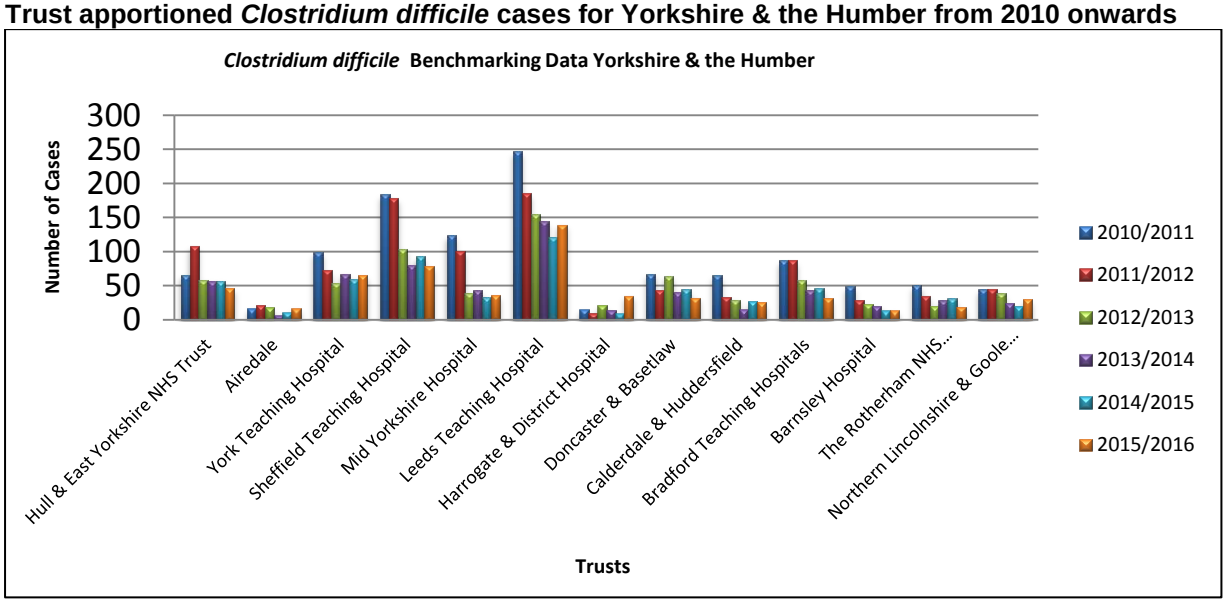
For rates attributable to the Trust, three cases were reported during October 2016 against an upper threshold of 53 for the year. The Trust continues to try and reduce these cases further. Root cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

The 3 cases reported during October 2016 were predominantly identified in the Medical Health Group, with 1 case in Surgical Health Group. Trends following root cause analysis investigation identify the need for continued and sustained improvements on appropriate sampling and antimicrobial stewardship. The following graph highlights the Trust's performance from 2013/14 to date:



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

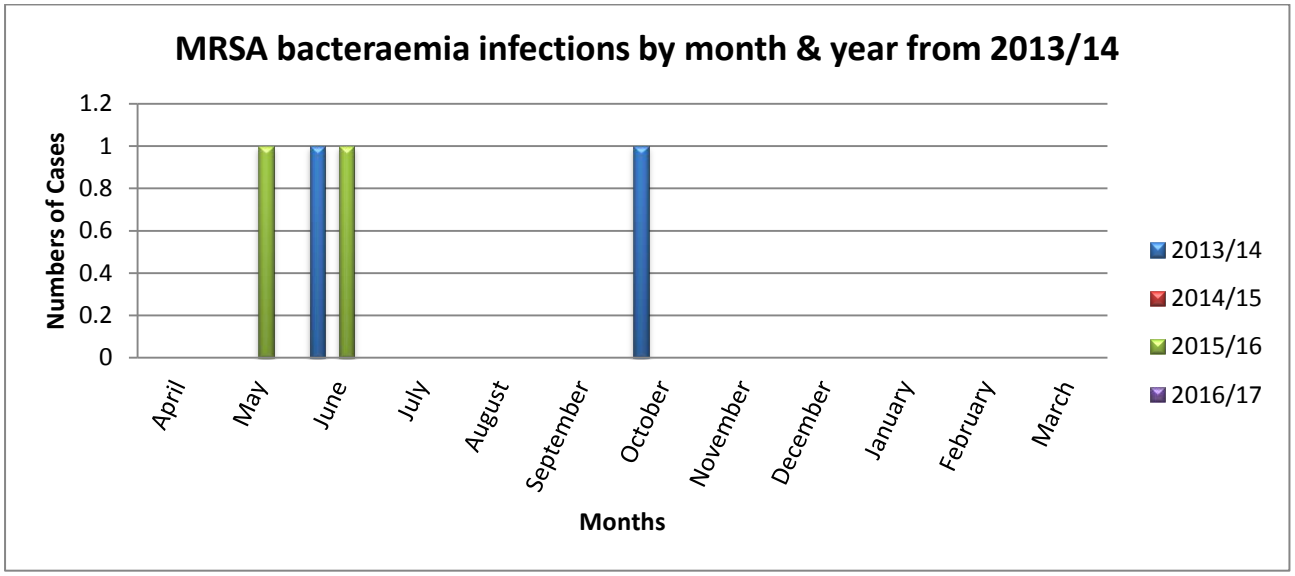


As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers.

4.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

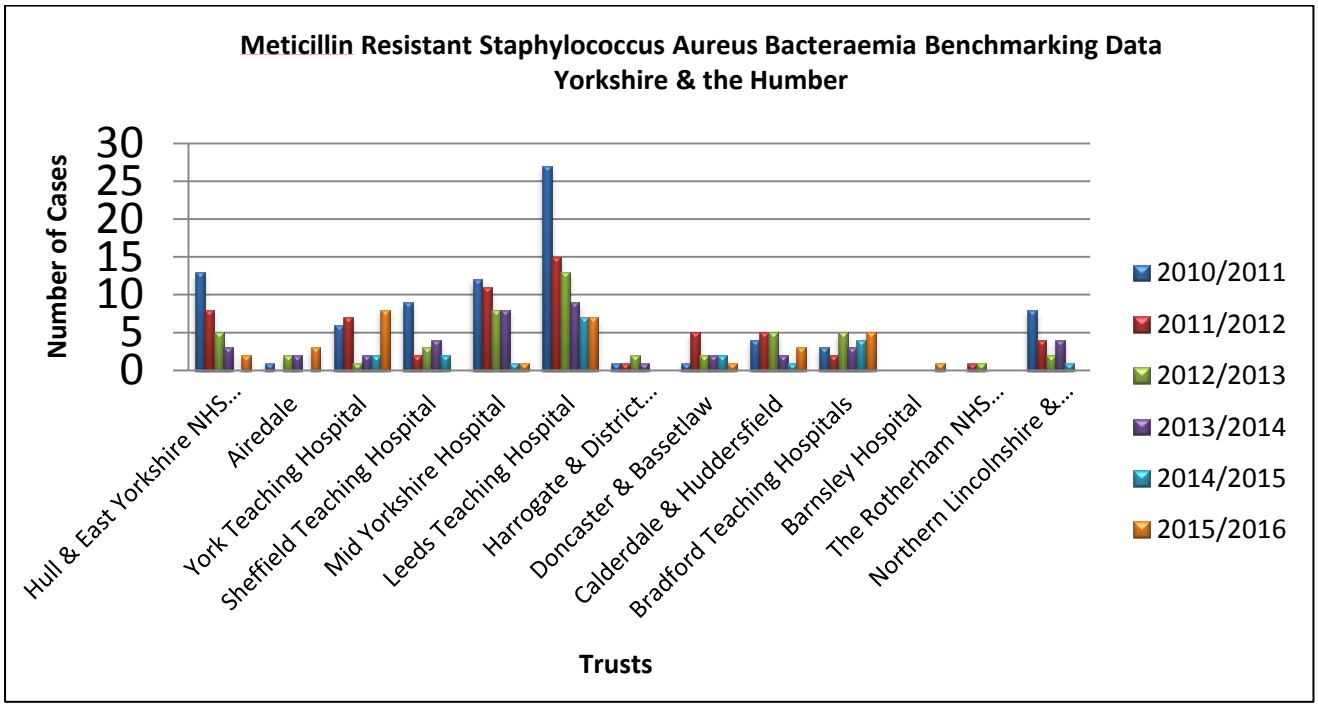
There have been no reported cases of MRSA Bacteraemia infections so far this financial year and a zero tolerance approach has been adopted. The last reportable Trust apportioned case was detected in June 2015.

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



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

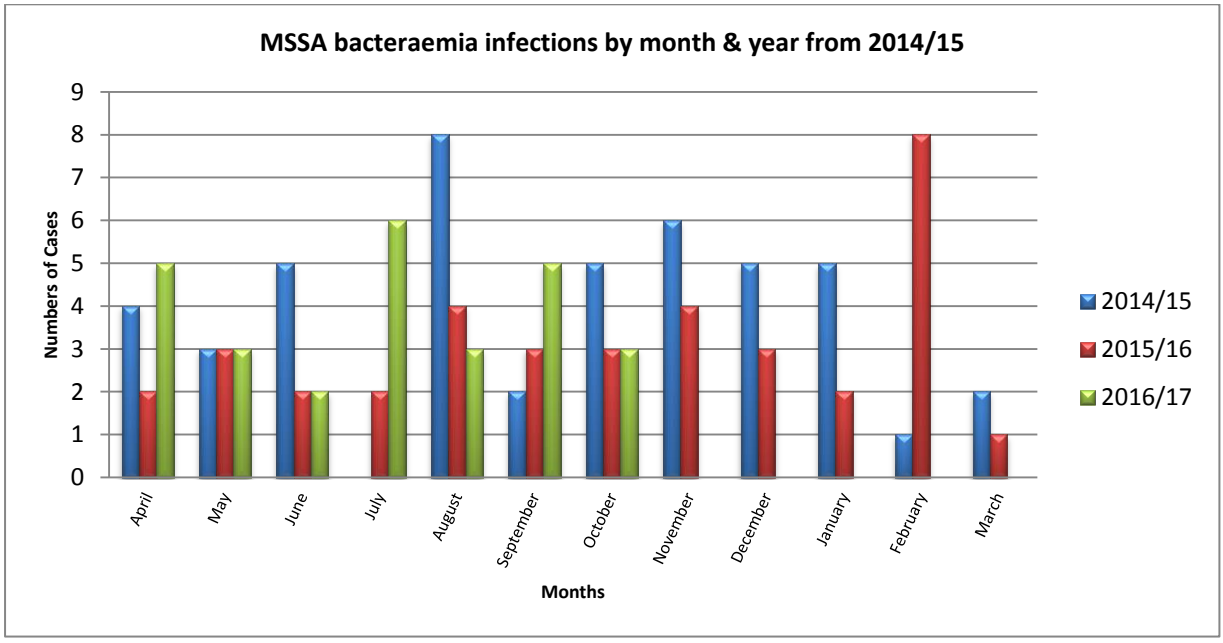
Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia cases for Yorkshire & the Humber from 2010 onwards



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

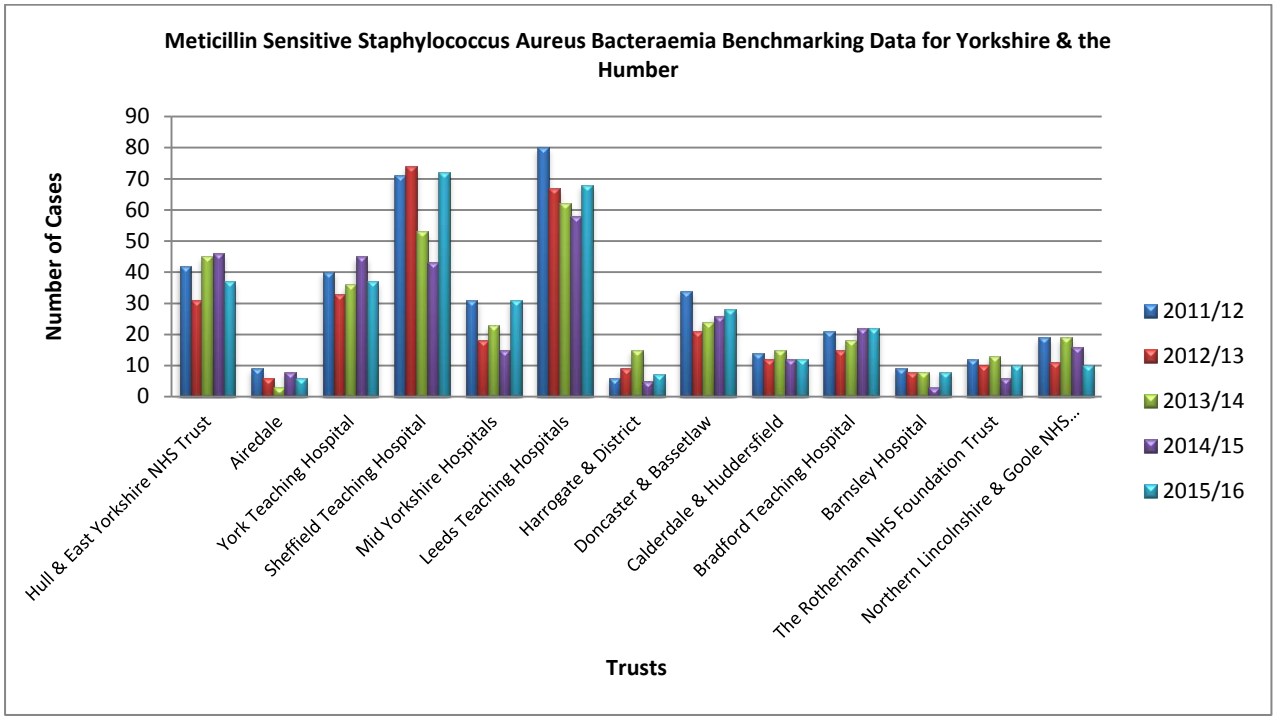
4.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

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 analyse further 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 performance of other trusts accross Yorkshire and The Humber:

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

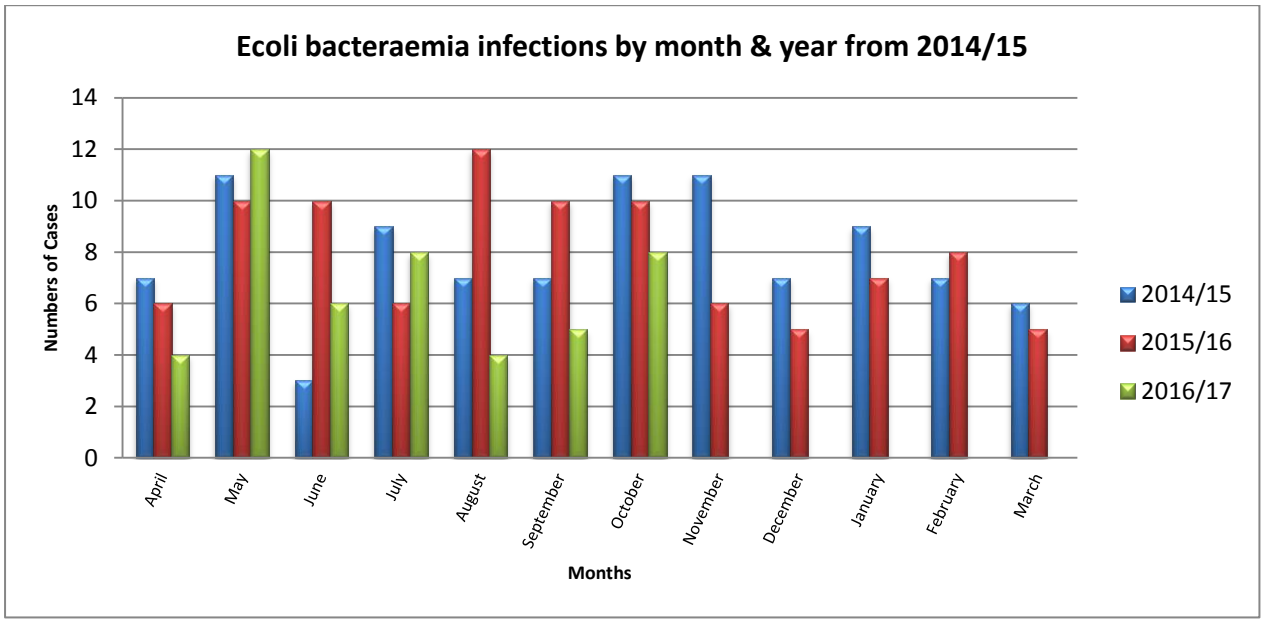


As can be seen, this is more evenly spread both across organisations and, also, recent years. The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken in the Trust. Trends following root cause analysis investigation identify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

4.1.4 Escherichia-*coli* Bacteraemia

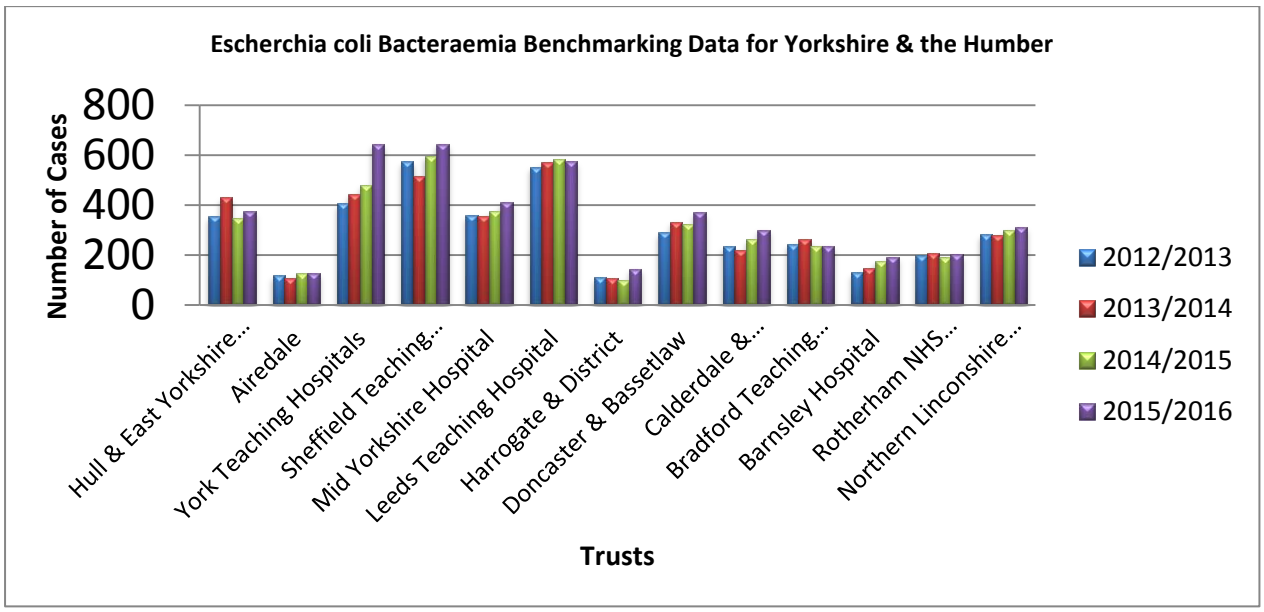
E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Numbers are total numbers reported by the Trust to the national Public Health England 'MESS' database. Most patients are admitted to hospital for treatment of this infection.

For 3 months from July – September 2016 the Trust in collaboration with CHCP Hull Infection Prevention & Control Team are collecting data on E.*coli* bacteraemia cases. The purpose is to understand trends for both Trust and community apportioned cases and develop robust systems and processes for the prevention of these infections. Cases identified during July to 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. A 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 performance of other trusts across 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 at the Hull Royal Infirmary had restricted access to two bays due cases of diarrhoea and vomiting. These bays were initially closed on 29/9/2016 and reopened on 7th October following deep cleaning. No causative organism was identified by laboratory testing. Ward 80, also at the Hull Royal Infirmary also had restricted access to two bays from 23/10/16 due to cases of diarrhoea and vomiting. No causative organism was identified by laboratory testing. Norovirus was confirmed on ward 100 and the ward was closed to admissions on 3 November 2016.

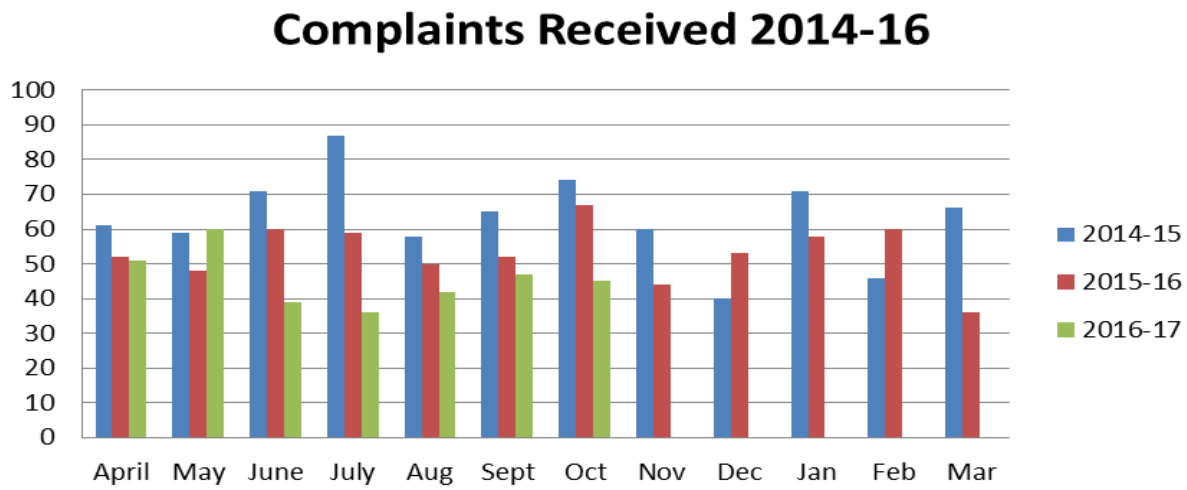
4.2.2 Pertussis (Whooping Cough) Contact in Neonatal Intensive Care Unit (NICU)
On 29/9/16, Hull Royal Infirmary was informed by Sheffield Children's Hospital that a neonate had been identified as having had significant exposure to a member of the transport team involved in transferring the baby to Hull on 15/9/16. The staff member was confirmed as infected with Pertussis. An incident meeting was held on 30/9/2016 whereby all staff and babies exposed were identified. Two staff members having had more than one hour cumulative contact time were identified and contacted by Occupational Health to give advice and guidance and offer immunisation and antibiotics as appropriate. Antibiotic prophylaxis was offered to babies currently and previously on NICU; this was a total of nineteen babies including the index case patient. The parents of the index baby were given Clarithromycin prophylaxis as a precautionary measure and were be vaccinated by their own GP. The parents of the other babies did not require treatment. The index baby was also tested for Pertussis by a throat swab and the PCR result was found to be negative. All of this has now been resolved satisfactorily and treatment has been successful.

4.2.3 Increased incidence of babies diagnosed as MRSA (colonised) positive in NICU
There have been an increased number of babies diagnosed as MRSA (colonised on their skin) positive following screening on NICU, with four positive cases since 13/9/16. Three cases were NICU apportioned as that is where the colonisation was identified, with the fourth being detected at birth. Following diagnosis, affected babies were isolated and all contacts on the unit were screened and found to be negative for MRSA. Laboratory reports confirmed distinguishable isolates in all cases suggesting individual cases rather than a cluster of cases caused by cross infection. All of these colonisations have been treated successfully.

4.2.3 Influenza trends
The Occupational Health Department continues with the 2016 Influenza vaccination campaign with vaccination sessions across both sites being well attended by all groups of staff. 63% of healthcare workers directly involved with patient care had been vaccinated as at 11 November 2016. 5,173 staff had been vaccinated in total.

5. PATIENT EXPERIENCE
5.1 Complaints

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



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

Complaints by Health Group and Subject (primary)	CAREC	COMM	DELAY	DISCH	HOTEL	TREAT	Total
Corporate Functions	0	0	0	0	0	0	0
Clinical Support	1	2	0	0	0	2	5
Family & Women	0	0	2	0	1	6	9
Medicine	2	1	0	2	0	10	15
Surgery	1	1	0	1	0	13	16
Totals:	**4**	**4**	**2**	**3**	**1**	**31**	**45**

Treatment continues to receive the highest number of complaints, with Medicine and Surgery Health Groups having had 10 and 13 complaints respectively for this subject during the month of October. The two key themes relate to lack of communication between clinical staff and families and patients being unhappy with their treatment plan.

5.1.2 Performance against the 40 day standard

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

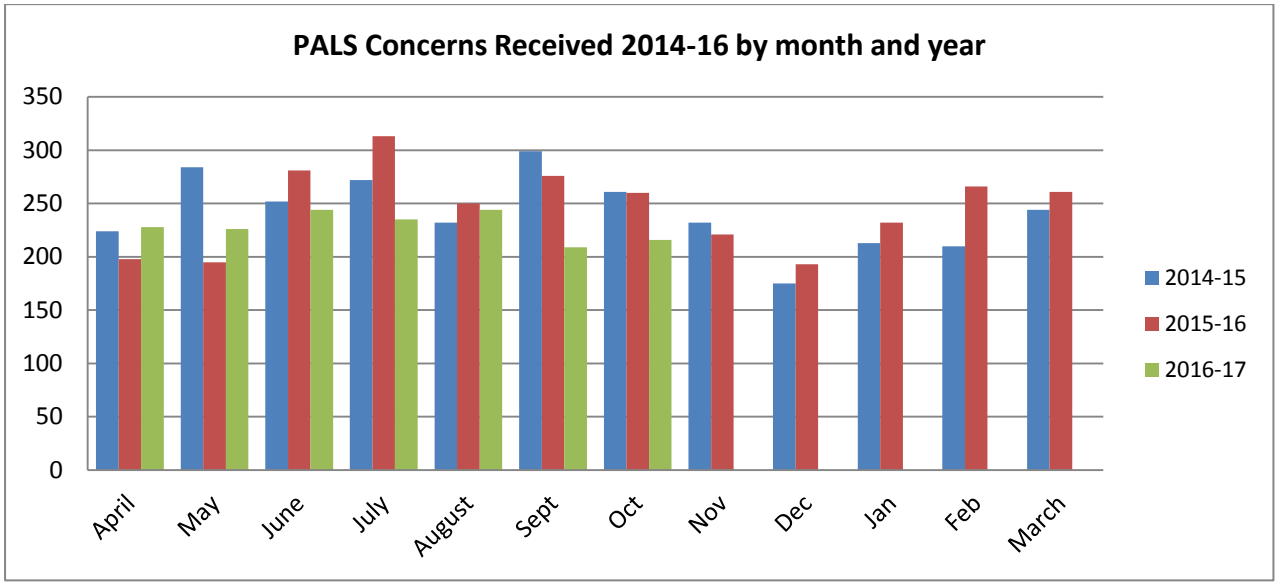
Health Group	Closed	Closed within 40 days
Clinical Support	1	1 (100%)
Family and Women's	10	8 (80%)
Medicine	19	14 (73.7%)
Surgery	11	9 (81.8%)
Total	41	32 (78%)

The Patient Experience Team is continuing to work closely with each of the Health Groups to enable timely responses to complaints whilst maintaining quality. Of the closed complaints 21 were partly upheld and 3 were upheld. 73 cases remained open on the 1st November and 7 complaints had been opened longer than 40 days.

A training day for the handling of complaints has been arranged for the 30th November 2016 to support staff investigating and preparing responses to complainants. The aim of the training is to ensure issues are investigated fully, responded to in a timely manner and openly, whilst lessons learned are implemented and evidenced. Four sessions will be available to maximise opportunities for staff to attend and this has already received applications from senior staff across the Trust. It is anticipated that the training will be repeated on a regular basis to support staff. These sessions have been targeted at staff that will be investigating and responding to complaints in all Health Groups. The Patient Experience Team will aim to carry out more specific sessions following this one, including sessions for ward-based staff.

5.2 Patient Advice and Liaison Service (PALS)

In the month of October, PALS received 219 concerns as well as 16 compliments, 95 general advice issues and 4 comments and suggestions. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of outpatient and elective lists.



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

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

5.2.1 Access to the PALS Service

As part of the Trust's intranet upgrade, patients are able to contact the PALS team with details of compliments, comments, concerns or complaints with one click from the front page. This has been operational for the first time during the month of October and has received 6 compliments, 4 concerns and 2 requests for general advice.

5.3 Internal Audit of Complaints Management
The NHS Constitution enshrines the right to have any complaint made against an NHS organisation dealt with efficiently and to be investigated properly, together with the right to know the outcome of any investigation into the complaint. To improve patient experience it is important that there is an effective complaints system in place. Internal Audit reviewed the Trust's complaints management recently, which obtained a significant assurance rating. Three recommendations have been made to strengthen systems further and these relate to processing and closing of complaints, learning lessons and reporting to the Operational Quality Committee.

5.3 Compliments
A number of compliments have been received by the Trust. The Neurosurgery team was thanked by a carer for performing life-saving surgery on their relative. The professionalism of the infection control team was praised following advice given on a patient with complex needs. Oncology received feedback from a grateful patient for the treatment they had received over the last nine months. The Emergency Department staff were praised for the excellent and prompt care provided to a child and their family in the paediatric A&E.

In addition, relatives of a deceased patient donated substantial funds, which have been used to re-furbish the Day Room on Ward 30 and to purchase a fridge freezer for the stocking of ice-creams for the benefit of all patients.

5.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has nine cases being reviewed by the PHSO currently. Two new cases have been received during October with two cases being closed, both only being upheld partially.

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

5.5.1 Surgery Health Group
There were a number of complaints where communication was a common theme. Actions are being taken within different specialties within the Surgery Health Group to address them. These include the development of patient information leaflets and communication training for staff so that they can reflect on how information is given and what impact this has on the patient's experience.

5.5.2 Medicine Health Group
A family was unhappy with the discharge process for their father. A poster/checklist has been developed for staff to utilise to ensure patients go home with everything they need. The senior nurse will audit compliance with the discharge process in the future.

5.5.3 Family and Women's Health Group
A recent complaint highlighted that a patient had not had a telephone consultation and there was no escalation procedure in place. The administrative staff have been reminded of the correct process to follow so that the necessary appointment can be provided.

5.5.4 Clinical Support Health Group
Following an increase in patient falls, the ward 30 Sister has introduced a new Falls Prevention Nurse Champion. The 'Staying Safe in Hospital' (falls prevention leaflet) is now given to patients in all admissions packs. In addition, all staff have been asked to undertake the HEY 24/7 training on falls entitled 'Falls - assessment and intervention'. Compliance with this will be audited by the ward sister. Further work is to be undertaken by the Falls Champion. This includes the development of a falls prevention board to ensure that there is more awareness around the completion of the risk assessments.

5.6 Friends and Family Test (October 2016 Data)

5.6.1 Inpatient areas

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

- Patients who would be likely to recommend the Trust (positive feedback) at 95.17%
- Patients who would be unlikely to recommend the Trust (negative feedback) 2.17%

There was a decline in the number of responses for the month of October 2016 with 5,243 of inpatients responding compared to 6,744 in September 2016.

5.6.2 Emergency Department (ED)

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

- In October 87.03% of patients were positive and likely to recommend ED to friends and family compared to 94.90% in September.
- 9.95% gave negative feedback saying that they would be unlikely to recommend the ED, compared with 2.14% in September.
- SMS feedback has now been arranged in ED resulting in an increase in the response rate to 22%. Response rates in ED are normally 7.5%. The increase in responses is great news as this will provide more rich data. 82% of patients gave positive feedback and 13% negative.

5.6.3 Maternity

The Maternity are as follows:

- 96.18% likely to recommend maternity services.
- 1.91% unlikely to recommend.

5.7 Interpreter Services

Patient Experience is working closely with the Institute for the Deaf to improve access to British Sign Language (BSL) interpreters for patients who require this support. A focused piece of work has been commissioned to review the current provision of language interpreter services at the Trust. Technological solutions as well as traditional face to face interpretation methods will be explored to ensure that patients receive quality support in a cost effective way.

5.8 Patient Information Leaflets

The Patient Experience Team has now attached QR codes (barcodes) to each approved leaflet used within the Trust. This enables people with iPhones to download the leaflets.

A poster has been designed to inform patients how they can obtain a digital copy of a leaflet direct to their mobile device, which can then be translated into over 100 languages, have audio functions and the font enlarged, where required. It is expected that this will be launched early 2017, with posters displayed in outpatient departments and staff information distributed. The digital leaflets will be up to date, reduced printing costs and storage requirements, as well as meeting the personal needs of the patient.

5.9 NHS National Patient Survey Programme

The 2016 inpatient survey has been undertaken and results from this are awaited currently. Following consultation, the CQC has advised of the proposal for the outpatient survey to be incorporated into the inpatient survey in the future. This new approach will be tested in 2017 before a final decision is made to proceed. It is also proposed that the adult surveys will be undertaken annually to enable reliable trend data and regular performance monitoring to inform commissioning decisions.

With regard to the Emergency Department survey, questionnaires are with 1,250 patients currently who attended the ED in the month of June and it is expected that the report from this survey will be available in early 2017. The CQC has advised however that future A&E surveys will be re-developed to broaden the scope to cover a wider range of urgent and emergency care services to include Emergency Departments, GP out of hour's services, urgent care centres, NHS 111 and ambulance services. It is proposed that this be undertaken on a two year survey cycle.

The Children and Young People's survey will be incorporated into a regular programme so that organisations can benchmark themselves and monitor improvement, comparing experiences over time. The next Children and Young People's survey will be undertaken early 2017 and it is proposed that the survey cycle will change from three to every two years.

The maternity survey will continue to be undertaken on a two year cycle; however the CQC will work closely with NHS England to determine the feasibility of conducting the maternity survey annually, at least up to 2020.

A pilot survey in community health is currently under development by the CQC to provide information on the whole care pathway and therefore an understanding of where improvements can be made. It is considered that an understanding of community health services could help reduce the number of people needing hospital-based care, therefore relieving pressures on hospitals and help to reduce delayed patient discharges from acute care. It is also seen to potentially help prevent 'wasted use of hospital services' and bring some insight into resource allocation.

5.10 Voluntary Services

The Voluntary Services continues to recruit steadily and there are now volunteers in most areas of the Trust enhancing patient experience positively. There are now 520 volunteers and recruitment is ongoing.

5.10.1 Young Volunteers

The second phase of the Young Health Champions induction has recently been concluded with the young people now being actively involved in their chosen departments within the Trust. A further YHC information day was hosted, which was well attended by local young people. The Patient Experience team has also met with the Prince's Trust in readiness for partnership working in 2017 and the Trust Board will be informed of developments in the next Board Report.

6 OTHER QUALITY UPDATES

6.1 C Section rates

At the October 2016 Trust Board, further information was requested on the emergency Caesarean Section rate, which showed performance for September 2016 at 15.10% (August 13.7%) against an aim of being lower than 12.1%.

The 12.1% figure was the national average for emergency caesarean rates in 2015/16. There are several factors why the emergency rate in Hull is higher than the national average. The Trust has a level 3 Neonatal Intensive Care Unit and will always have preterm births, some of which will be delivered by caesarean section. The level 3 Intensive Care service also means that women are transferred from other units for specialist care and there has been a slight increase in such transfers. There are more women with extremely high Body Mass Index (BMI's) and the unit has a large caseload of women with a BMI over 30 and their associated co-morbidities. There has been an increase in complex medical factors impacting on delivery such as patients with a history of substance misuse and diabetes and Hull also has a higher than average smoking rate at booking and delivery. The introduction of the Royal College of Obstetricians and Gynaecologists 'Management of Small for Gestational Age Guideline' and the 'Growth Assessment Protocol' has increased noticeably the number of inductions of labour due to growth problems in the foetus. This has an associated increase in intervention which may or may not lead to caesarean section.

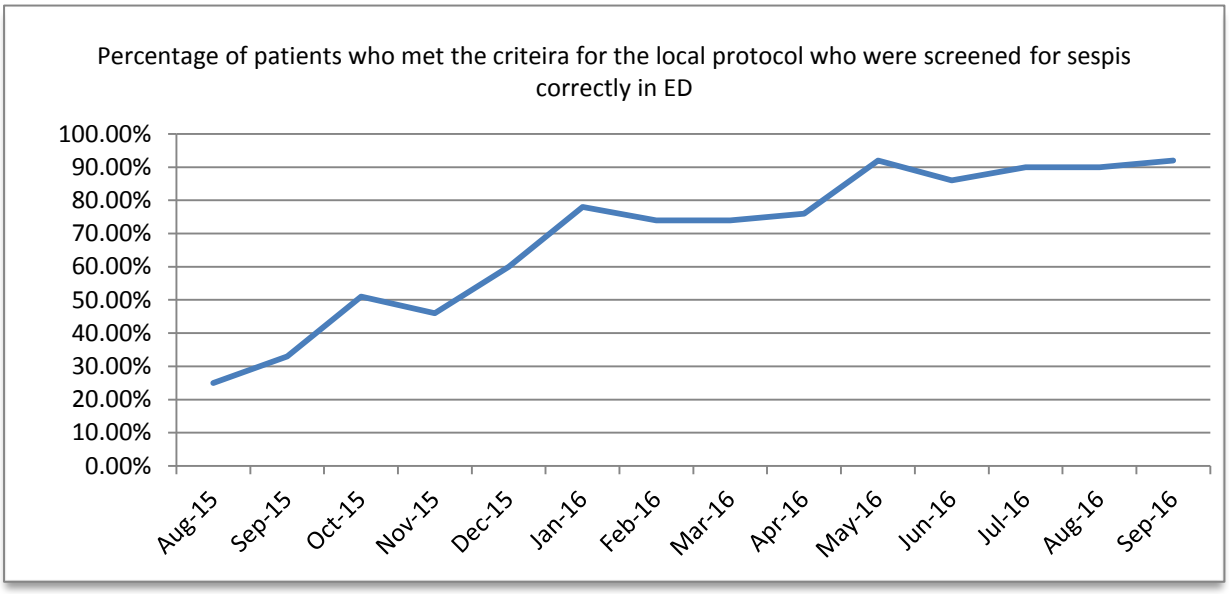
The unit is auditing the Growth Assessment Protocol currently and will report on this early in 2017.

The emergency caesarean rate is discussed regularly at the Family and Women's governance meeting and Hull contributes to the Yorkshire and Humber maternity dashboard.

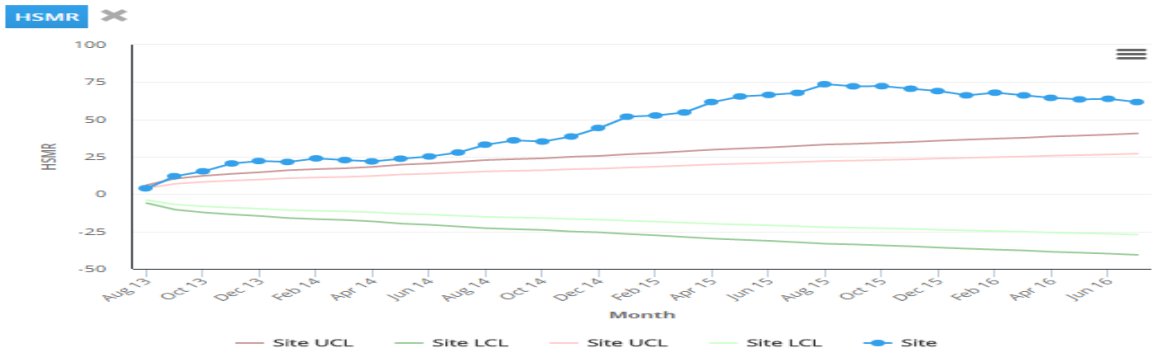
6.2 Sepsis

The Board requested an update on the management of patients with sepsis. This has been one of the Trust's Quality Improvement Projects. A number of actions have been taken that are demonstrating improved performance. These include the appointment of a sepsis nurse, identification of sepsis link nurses on every ward, a training programme for the link nurses, the development of a sepsis intranet site and training for GPs, ambulance staff and medical students. A programme is in place to roll out the sepsis pathway throughout the Trust. Initial focus has been on the acute adult medical admission pathway to ensure that patients admitted through this route are screened appropriately. This has been extended to children admitted via the Emergency Department as well as oncology, haematology and acute surgery. A number of other wards at both Hull Royal Infirmary and Castle Hill Hospital have been identified for the next cohort.

The graph below demonstrates the improvements in the screening of patients in the Emergency Department over time.



The second graph shows that the Hospital Summary Mortality Ratio (HSMR) for septicaemia has been reducing since August 2015.



6.3 Mortality

The Trust has been undertaking work to standardise its retrospective case note review system. Arrangements have been in place for some time in each of the Health Groups to undertake mortality reviews. However, in order to understand and learn from problems that contribute to avoidable patient deaths and harm, it was recognised that mortality governance arrangements needed strengthening and a consistent approach adopted Trust-wide. A standardised judgemental case note review system has now been developed, using the Improvement Academy methodology. Training for clinicians undertaking the review is now well underway. The new system is being trialled in the Surgical Health Group in Neurosurgery, Vascular and Cardiothoracic surgery with roll out to the rest of the Surgical Health Group in early 2017.
By establishing a consistent approach to reviewing care through a structured analysis of patient records, the aim is to improve the quality of care through learning from good practice and also identify the problems that contributed to death through poor quality care. The mortality case note review form has been made available via Lorenzo and the new arrangements will allow the identification of every death by a central database collection of every death in the hospital. These are all positive improvements.

6.4 Outpatient follow-up appointments

The Trust Board has been notified previously of patients that have not had a follow-up appointment in the timescale advised by their clinician. The number of patients waiting follow up has now begun to reduce and all specialties have agreed a trajectory for eliminating all overdue appointments. Three specialties do not have a backlog, 6 specialties will have addressed their backlog by December 2016 and a further 13 specialties will have done so by the end of the financial year. There are 14 specialties that will confirm their elimination timescales by December 2016. A business case has been developed for Ophthalmology, which is the service facing the most significant challenge. Clinical validation processes are in place and agreement has been reached with GPs to discharge those patients that do not require ongoing hospital monitoring. This work is on-going and progress is monitored at the weekly Performance and Access meeting (PandA), which is chaired by the Chief Operating Officer and attended by Chief Finance Officer.

6.5 Venous Thrombo-Embolism (VTE)

The Trust's performance against the VTE risk assessments has been gradually improving but is still short of the required standard. The Deputy Chief Medical Officer (quality) is to undertake some improvement work with the Medicine Health Group, which has the lowest compliance levels. This is partly due to the shorter lengths of stay that patients have in the assessment areas.

6.6 Operational Quality Committee 9 November 2016

Key issues discussed at the Operational Quality Committee included:

- Review of the Quality Improvement Programme (QIP), particularly those areas rated amber
- VTE assessment and Health Group commitment to work with their teams to improve the level of compliance
- Compliance with training rates relating to Safeguarding Children level 3 training and blood transfusion and action being taken
- The claims quarterly report, which included the increase in the CNST premium and those specialties with the highest value claims
- WHO checklist compliance
- Possible emerging themes related to the microbiology cover and Operating Department Practitioner cover

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

November 2016

Appendix One – Safety Thermometer Results – November 2016

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

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

SAFETY THERMOMETER NEWSLETTER November 2016

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 11th November across both hospital sites. 930 patients were surveyed

94.5% of our patients received HARM FREE CARE

Harm Free Care is defined as the number/percentage of patients who have not suffered any of the four harms measured by the safety thermometer before or since admission to hospital.

1.72% (16) of our patients suffered a New Harm

New Harm is defined as the number/ percentage of patients who have suffered or have started treatment for one of the four harms measured by the safety thermometer since admission to hospital

98.2% Of our Patients received NO NEW HARM

No New Harm is defined as the number/ percentage of patients who have not suffered any of the four harms measured by the safety thermometer since admission to hospital.

HARM FREE CARE %: How is HEY performing Apr 16 – Nov 16

	April 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16
Harm Free Care %	95.7%	93.7%	95.4%	93.7%	94.6%	94%	94.7%	94.5%
Sample: Number of patients	918	921	871	937	907	879	896	930
Total Number of New Harm	10	22	13	20	18	15	18	16
NEW HARM FREE CARE %	98.9%	97.6%	98.5%	97.8%	98.0%	98.3%	98%	98.2%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	6	0.65%	2	4	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	841	90.4%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	52	5.5%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	37	3.98%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	32	3.44%	25	2	5
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	31	3.33%	24	2	5
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	1	0.11%	1	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	10	1.08%
Severity **No Harm**: fall occurred but with no harm to the patient	8	0.86%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	2	0.22%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number	%
Total Number/Proportion of patients recorded with a Catheter	191	20.5%
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	15	1.61%
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu **An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital**	8	0.86%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu **An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital**	7	0.75%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 9th December 2016

TRUST BOARD REPORT – 2016 – 11 - 10	
Meeting date:	Thursday 24th November 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 24th NOVEMBER 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 October 2016 (September 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 October 2016 Trust Board report. This format will be adopted as soon as it is released and available.

This report presents the 'safer staffing' position as at 31st October 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].
The Trust Board is requested to:

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

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

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

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

These data are summarised, as follows:

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

3.1 Planned versus Actual Staffing levels.

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: Allocate e-roster software & HEY Safety Brief) and **Appendix Two** (New Roles). The New Roles are settling in well and are helping to support both registered nurses and care staff in reducing their administrative burden, thus allowing the nursing team to be more clinically facing.

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%
Oct-16	88.51%	100.79%	90.58%	106.38%

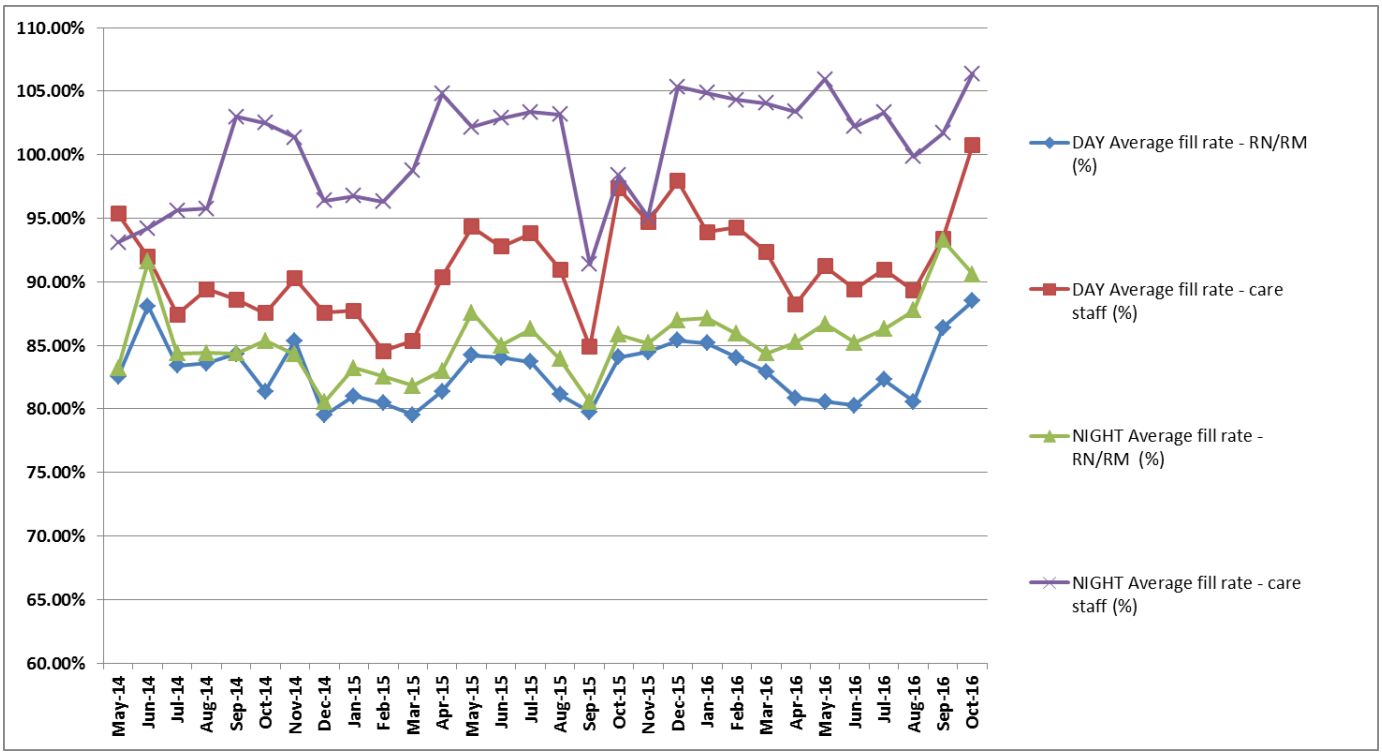
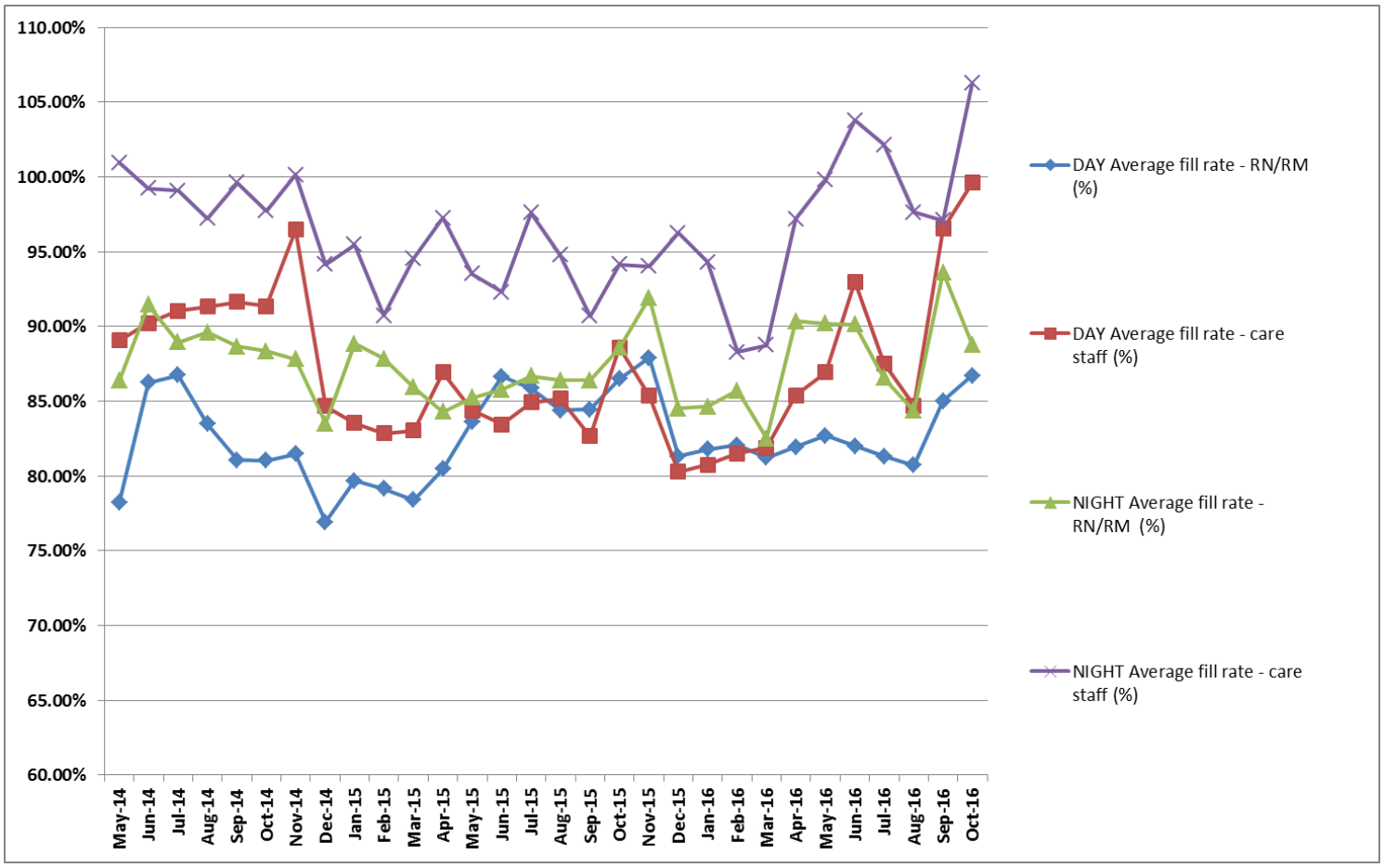


Fig 2: Castle Hill Hospital

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%
Oct-16	86.70%	99.59%	88.79%	106.24%



The Trust has seen an increase in both registered and unregistered fill rates over October 2016 compared to the previous month. This is predominantly related to the number of newly qualified nurses who were employed recently by the Trust. Some of these are care staff (unregistered) until they receive their NMC Registration. As such, they feature currently in the unregistered numbers. As they gain their NMC PIN numbers they will transfer into the registered staff numbers.

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.

Following the successful recruitment of 102 student nurses from the University of Hull plus more from other universities, the Human Resource (HR) and Organisational Development (OD) Team will continue the 'Remarkable People Extraordinary Place' recruitment campaign in 2017 to recruit more experienced and skilled staff, particularly OPD's (Theatre Practitioners in February) and newly qualified nurses in August / September.

HR with the Nursing management team is also finalising the proposal to undertake an overseas recruitment drive to recruit registered nurses from the Philippines. The Trust is developing the plan with an experienced local partner based in Hull. The proposed initiative will be made in context of the Trusts overall financial position.

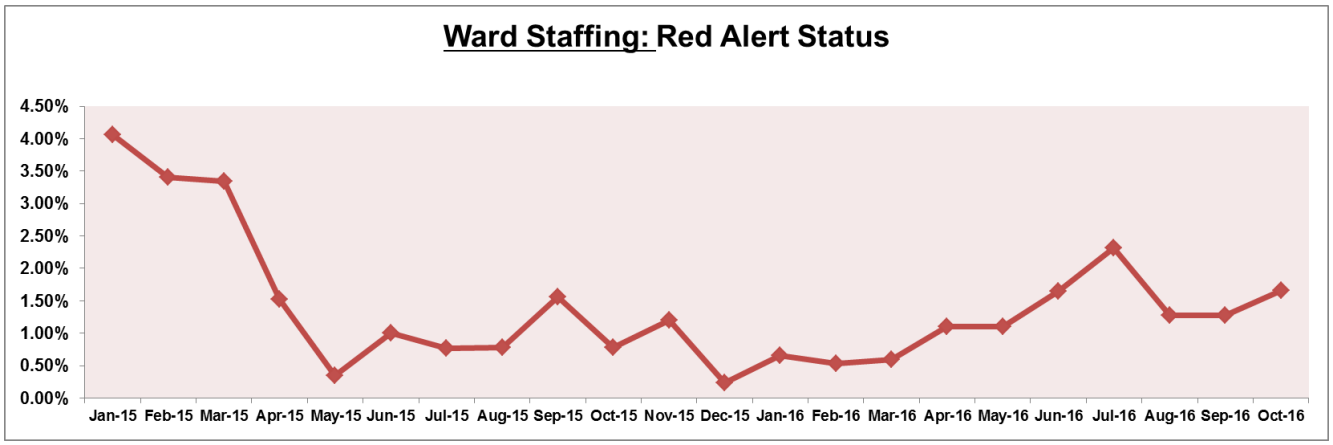
The plan in summary is to bring in manageable numbers of staff commencing May, 2017, on a bi-monthly basis. This way the agency can prepare and attract the candidates, whilst the Trust can provide a more tailored and effective induction to

Hull and the team they will join and provide our new colleagues with the support they will need.

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 a slight increase seen in the October data, compared to that of September 2016. These are reviewed by the nurse directors at the safety briefs and addressed accordingly.

Throughout October the following key areas that remain particularly tight 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.
- 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.
- C8 (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, staff have also be redeployed from ward C20 to provide additional support.

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, as presented in the previous Board Report, 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 continues to work 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, a further update will be provided in the December 2016 Board Report.

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 then applied to refine the initial assessment in order to conclude what is required for each area. To date these reports have focused on in-patient areas, in line with NQB requirements. Work continues now to include all theatre and outpatient areas. Progress in relation to each of these areas will be reported in the December 2016 Board Report.

The Trust has invested recently in a 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 detailed comparisons with similar sized Trust's within the Shelford Group of Hospital`s and Acute Trusts that use the same software.

The Chief Nurse has requested that this information is reviewed formally by the Deputy Chief Nurse and Nurse Director for Surgery on a monthly basis with each of the Senior Matrons. Performance trajectories will be set and progress monitored on a monthly basis for each individual clinical area. The outputs of this work will be reported to the Trust Board in due course.

The Trust has successfully completed the implementation of `SafeCare`, which is another function of the new e-rostering software. SafeCare provides staffing level

and skill mix information across all wards alongside the dependency ratings for all patients.

The current safety brief template will be replaced by the SafeCare “Wheel” as illustrated in appendix 3. SafeCare provides information in a `live` state, supporting the following functions:

- Calculation of the required staffing from patients acuity and dependency, three times a day.
- Site-wide overview of required versus actual staffing, highlighting hotspots as well as clinical areas that may be able to support.
- View staffing status across many dimensions including hours short/excess, missing skills.
- Track attendance and sickness of rostered staff
- Redeploy staff safely with full visibility of skills and the impact of moving staff on both areas
- Request bank or agency cover if needed
- Track red flags to identify potential staffing issues.

The current safety brief template will be replaced by SafeCare from the beginning of December 2016. In order to incorporate all aspects of the current safety brief a request has been made by the Chief Nurse to expand the current census.

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
November 2016

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

Tuesday 15 November
Today · 5m ago

Hull & East Yorkshire Hospitals

Ward Zones

T W T F S S M

Time period

All-day AM PM Night

Data Metric

Overall

Sites

- Hull & East Yorkshire Hospitals
- Out Patients / Day Units
- Specialist Nurse
- Theatres
- Units / Wards (Non-Bedded)
- Unknown

HULL & EAST YORKSHIRE HOSPITALS

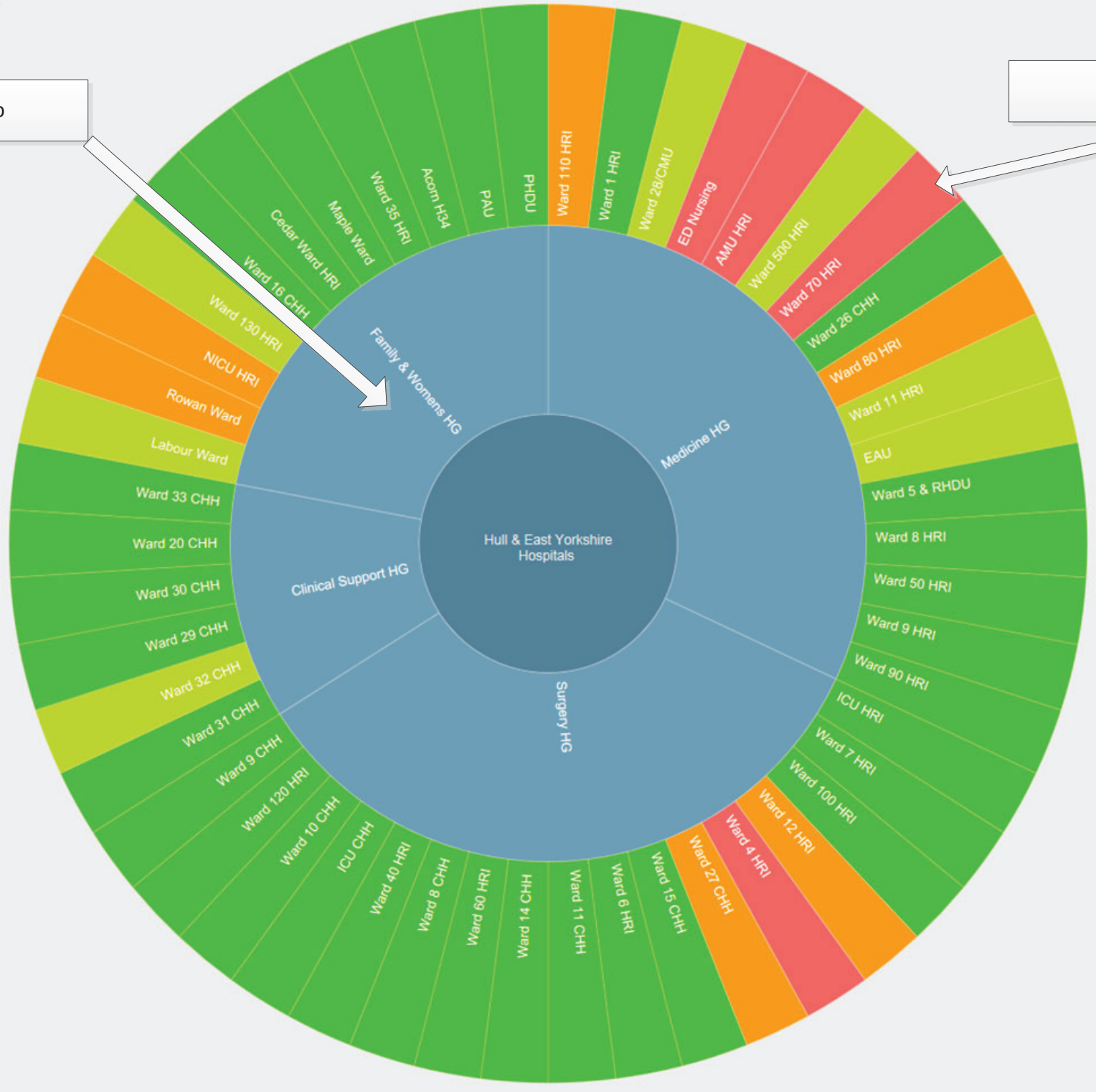
Overall

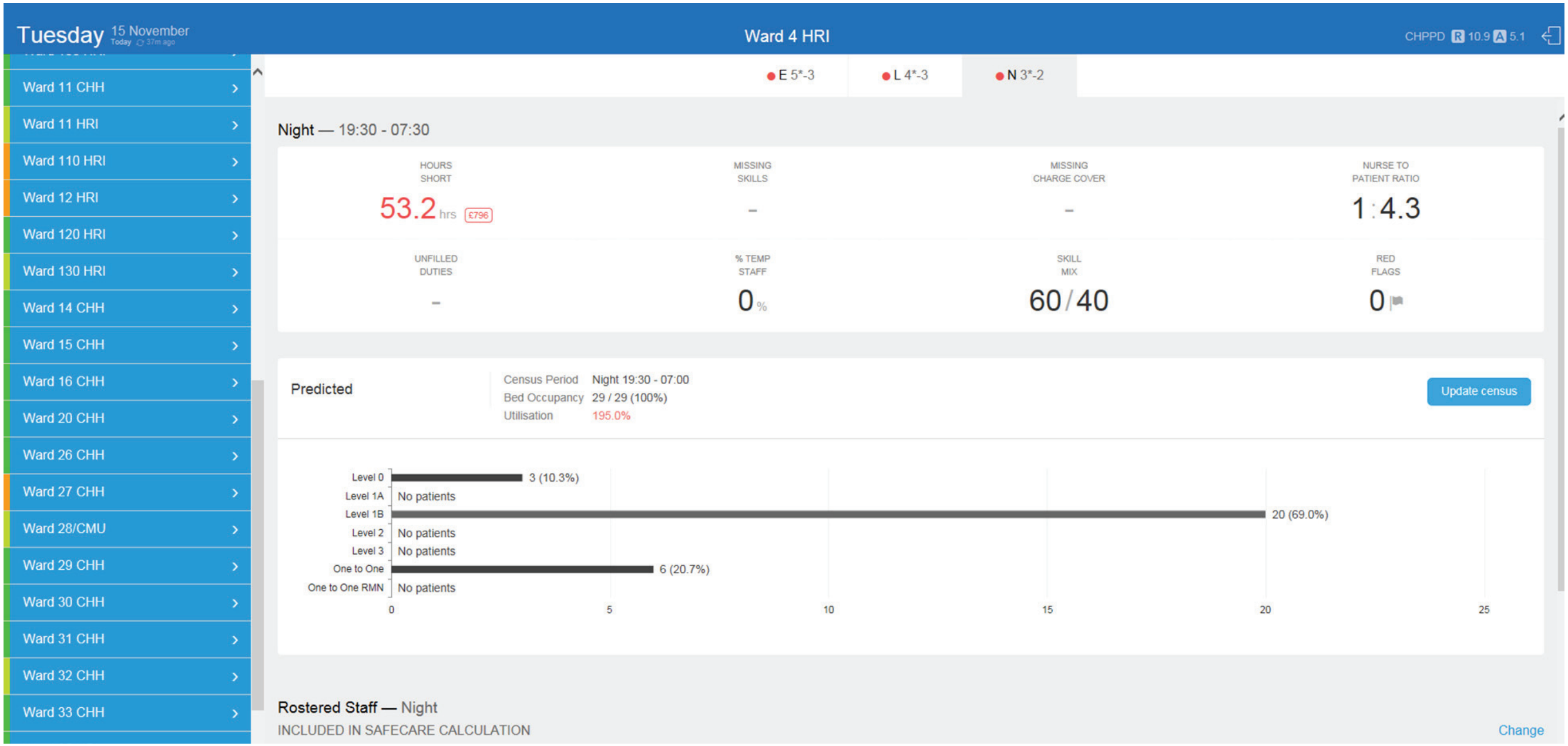
Night

Zone for Each Health Group

Red Wards with Short Falls

Other Rota Zones





- Shift by Shift Analysis
- Census updated x3 times a day
- Hours Shortfall Identified
- Nurse to Patient Ratio
- Attendance Confirmation

HEY SAFER STAFFING REPORT OCTOBER-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	1%	89%	75%	90%	76%									1	2	3	3	1		4						0	10
	AMU	ACUTE MEDICINE	45	3%	88%	101%	74%	103%	7 : 1	7 : 1	6 : 1	39%	21%	38%	2%	0%	1	3	1				0				1	1	2	7
	H1	ACUTE MEDICINE	22	10%	83%	136%	93%	97%	8 : 1	9 : 1	7 : 1	27%	22%	51%	0%	0%							0						0	0
	EAU	ELDERLY MEDICINE	21	3%	86%	106%	80%	116%	7 : 1	7 : 1	7 : 1	65%	1%	34%	0%	0%				1			1						0	1
	H5	RESPIRATORY	20	0%	90%	105%	85%	92%	10 : 1	10 : 1	8 : 1	22%	24%	54%	0%	0%	1			3			3						0	4
	RHOB	RESPIRATORY	6	10%	90%	105%	85%	92%	4 : 1	4 : 1	3 : 1	0%	3%	16%	81%	0%							0						0	0
	H50	RENAL MEDICINE	19	3%	78%	102%	100%	100%	7 : 1	10 : 1	6 : 1	45%	4%	51%	0%	0%	1	1					0						0	2
	H500	RESPIRATORY	24	0%	92%	94%	100%	95%	10 : 1	10 : 1	8 : 1	39%	5%	56%	0%	0%				2			2						0	2
	H70	ENDOCRINOLOGY	30	6%	90%	111%	80%	103%	8 : 1	10 : 1	10 : 1	17%	17%	66%	0%	0%			1	1			1	1			3		4	6
	H8	ELDERLY MEDICINE	27	0%	80%	54%	80%	81%	9 : 1	10 : 1	9 : 1	6%	0%	94%	0%	0%		1		1			1						0	2
	H80	ELDERLY MEDICINE	27	0%	83%	100%	98%	102%	8 : 1	10 : 1	10 : 1	13%	4%	83%	0%	0%				2			2	2					2	4
	H9	ELDERLY MEDICINE	31	0%	89%	104%	100%	100%	10 : 1	10 : 1	11 : 1	13%	1%	86%	0%	0%				6			6						0	6
	H90	ELDERLY MEDICINE	29	3%	92%	96%	100%	98%	10 : 1	10 : 1	10 : 1	21%	3%	76%	0%	0%		1	1	5			5				1		1	8
	H11	STROKE / NEUROLOGY	28	0%	83%	136%	80%	97%	9 : 1	10 : 1	10 : 1	31%	16%	53%	0%	0%	1		1				0						0	2
	H110	STROKE / NEUROLOGY	24	6%	82%	131%	97%	98%	7 : 1	8 : 1	7 : 1	21%	21%	54%	3%	0%	2			5			5	1					1	8
	CDU	CARDIOLOGY	9	0%	93%	46%	100%		4 : 1	5 : 1	8 : 1	19%	81%	0%	0%	0%		1					0						0	1
	C26	CARDIOLOGY	26	0%	80%	87%	80%	97%	6 : 1	7 : 1	7 : 1	36%	27%	36%	2%	0%							0	2					2	2
	C28	CARDIOLOGY	17	0%	92%	129%	99%	65%	6 : 1	7 : 1	6 : 1	21%	30%	45%	2%	2%							0						0	0
	CMU	CARDIOLOGY	10	3%	92%	129%	99%	65%	3 : 1	3 : 1	3 : 1	1%	18%	24%	57%	0%							0						0	0
SURGERY	H4	NEURO SURGERY	30	0%	86%	112%	87%	105%	8 : 1	8 : 1	9 : 1	27%	0%	73%	0%	0%		1					0	1					1	2
	H40	NEURO HOB / TRAUMA	15	0%	96%	107%	87%	107%	5 : 1	5 : 1	4 : 1	0%	46%	50%	4%	0%							0	1					1	1
	H6	ACUTE SURGERY	28	6%	87%	94%	83%	202%	8 : 1	9 : 1	8 : 1	41%	17%	42%	0%	0%	1	1	1				0						0	3
	H60	ACUTE SURGERY	28	0%	95%	94%	88%	210%	7 : 1	9 : 1	8 : 1	35%	19%	47%	0%	0%	4	1		1			1						0	6
	H7	VASCULALR SURGERY	30	1%	95%	74%	94%	95%	7 : 1	8 : 1	9 : 1	32%	12%	57%	0%	0%	4		2				0				1		1	7
	H100	GASTROENTEROLOGY	24	0%	84%	115%	89%	98%	7 : 1	8 : 1	8 : 1	41%	2%	56%	0%	2%		1		2			2						0	3
	H12	ORTHOPAEDIC	28	1%	80%	102%	93%	121%	7 : 1	9 : 1	8 : 1	11%	6%	83%	0%	0%	1						0				1		1	2
	H120	ORTHO / MAXFAX	22	3%	90%	107%	89%	116%	6 : 1	7 : 1	7 : 1	16%	13%	71%	0%	0%	1			1			1					1	1	3
	HICU	CRITICAL CARE	22	6%	89%	189%	89%	100%	1 : 1	1 : 1	1 : 1	0%	4%	0%	39%	56%			3				0	3					3	6
	C8	ORTHOPAEDIC	18	3%	84%	86%	75%	81%	8 : 1	8 : 1	9 : 1	47%	0%	53%	0%	0%		2					0						0	2
	C9	ORTHOPAEDIC	29	0%	87%	92%	97%	99%	7 : 1	9 : 1	9 : 1	47%	0%	53%	0%	0%			2				0						0	2
	C10	COLORECTAL	21	0%	84%	94%	88%	103%	6 : 1	8 : 1	6 : 1	46%	3%	51%	0%	0%							0	1			1		2	2
	C11	COLORECTAL	22	0%	89%	81%	88%	104%	6 : 1	8 : 1	7 : 1	46%	2%	52%	0%	0%				1			1						0	1
	C14	UPPER GI	27	0%	85%	89%	85%	176%	7 : 1	8 : 1	8 : 1	60%	1%	39%	0%	0%		2					0						0	2
	C15	UROLOGY	26	0%	86%	74%	91%	98%	6 : 1	7 : 1	7 : 1	55%	5%	40%	0%	0%					1		1						0	1
	C27	CARDIOTHORACIC	26	3%	85%	97%	83%	100%	6 : 1	7 : 1	7 : 1	37%	5%	58%	0%	0%				2			2						0	2
	CICU	CRITICAL CARE	22	3%	80%	160%	81%	139%	2 : 1	2 : 1	2 : 1	0%	0%	2%	59%	38%							0						0	0
FAMILY & WOMEN'S	C16	ENT / BREAST	30	0%	85%	100%	118%	103%	9 : 1	10 : 1	9 : 1	40%	30%	27%	3%	0%		2		1			1	1					1	4
	H130	PAEDS	20	0%	85%	147%	118%	103%	6 : 1	6 : 1	5 : 1	49%	50%	1%	0%	0%	1						0						0	1
	H30 CEDAR	GYNAEOCOLOGY	9	0%	96%	112%	109%		7 : 1	7 : 1	8 : 1	87%	1%	13%	0%	0%							0						0	0
	H31 MAPLE	MATERNITY	20	0%	73%	86%	82%	94%	5 : 1	6 : 1	6 : 1	100%	0%	0%	0%	0%							0						0	0
	H33 ROWAN	MATERNITY	38	0%	81%	85%	84%	94%	8 : 1	9 : 1	10 : 1	92%	4%	5%	0%	0%	5		2				0						0	7
	H34 ACORN	PAEDS SURGERY	20	0%	91%	72%	96%	143%	5 : 1	5 : 1	7 : 1	78%	22%	0%	0%	0%		1					0						0	1
	H35	OPHTHALMOLOGY	12	0%	94%	99%	109%		6 : 1	6 : 1	6 : 1	68%	5%	27%	0%	0%							0	1					1	1
	LABOUR	MATERNITY	16	0%	102%	82%	104%	74%	3 : 1	3 : 1	3 : 1	74%	14%	10%	3%	0%	2	1	1				0						0	4
	NEONATES	CRITICAL CARE	26	3%	88%	93%	95%	120%	3 : 1	3 : 1	3 : 1	0%	71%	4%	13%	12%			2				0						0	2
	PAU	PAEDS	10	0%	99%		99%		5 : 1	5 : 1	5 : 1	53%	42%	6%	0%	0%							0						0	0
	PHDU	CRITICAL CARE	4	0%	99%	106%	100%		2 : 1	2 : 1	2 : 1	0%	10%	12%	78%	0%			1				0						0	1
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	3%	112%	89%	102%	97%	8 : 1	9 : 1	7 : 1	56%	0%	44%	0%	0%			1				0						0	1
	C29	REHABILITATION	15	0%	90%	108%	96%	110%	7 : 1	8 : 1	5 : 1	41%	1%	58%	0%	0%		1					0						0	1
	C30	ONCOLOGY	22	0%	91%	107%	100%	118%	7 : 1	8 : 1	7 : 1	41%	22%	37%	0%	0%		1	3				0						0	4
	C31	ONCOLOGY	27	0%	79%	118%	98%	103%	8 : 1	10 : 1	9 : 1	41%	6%	53%	0%	0%				3			3						0	3
	C32	ONCOLOGY	22	3%	96%	96%	96%	99%	7 : 1	8 : 1	8 : 1	23%	1%	74%	0%	1%							0				1		1	1
	C33	HAEMATOLOGY	28	1%	97%	182%	89%	165%	6 : 1	7 : 1	8 : 1	52%	29%	18%	0%	0%		1					0						0	1
			AVERAGE:	1.7%			AVERAGE:		6 : 1	7 : 1	7 : 1	36%	14%	41%	7%	2%														
																	TOTALS:	26	24	25	40	2	0	42	14	0	0	9	2	25	142

Oct-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	88.5%	100.8%	90.6%	106.4%
CHH SITE	86.7%	99.6%	88.8%	106.2%

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	
	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	

Integrated Performance Report 2016/17

November 2016

October data

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

Integrated Performance Report - November 2016

RESPONSIVE

Description	Aggregate Position	Trend	Variation

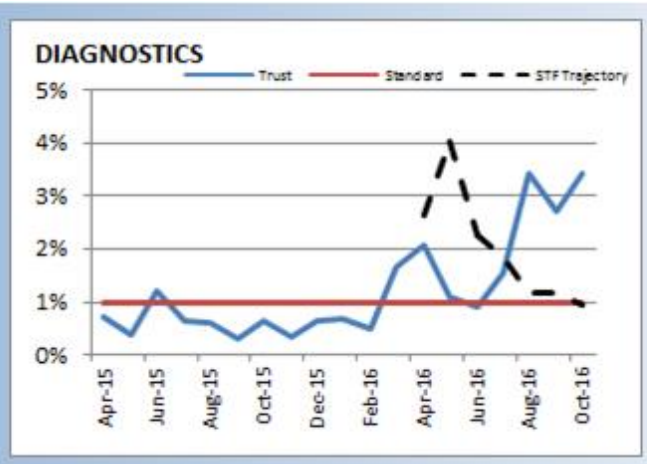
Diagnostic Waiting Times: 6 Weeks

All diagnostic tests need to be carried out within 6 weeks of the request for the test being made

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target with a performance of 3.44% in October

Sustainability and Transformation trajectory is 1.2% the Trust also failed to meet this trajectory



>6 Week Breaches:

MRI = 139
CT = 131
Non-obs U/sound= 2
Echocardiography = 9
Colonoscopy = 7
Cystoscopy = 24
Gastroscopy = 5

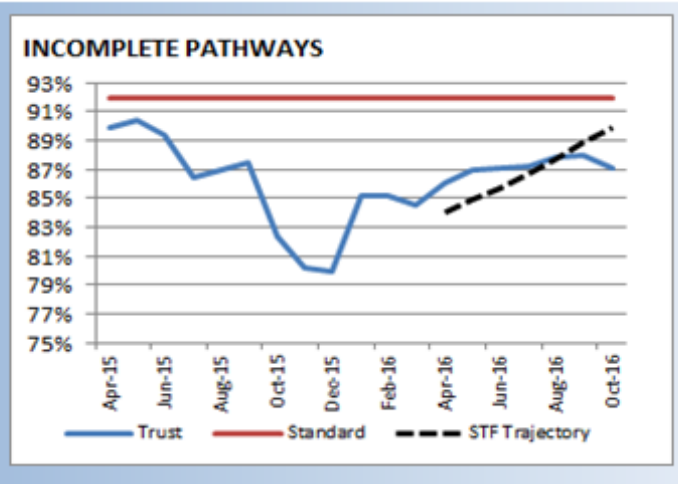
TOTAL 317

Referral to Treatment Incomplete pathway

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

The Trust failed to achieve the October Sustainability and Transformation trajectory of 89.9%

October performance was 87.1%

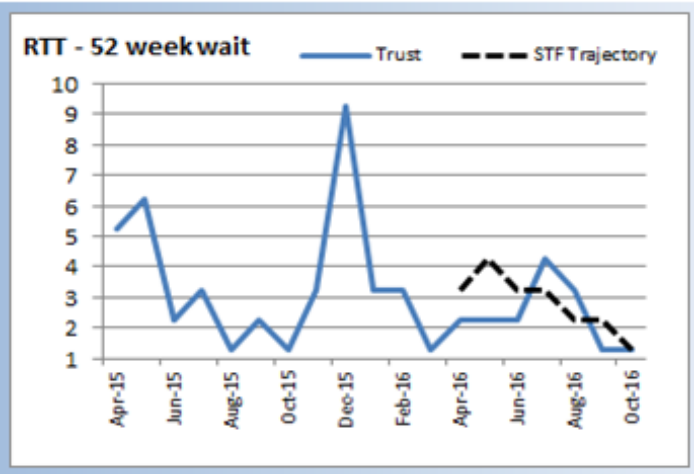
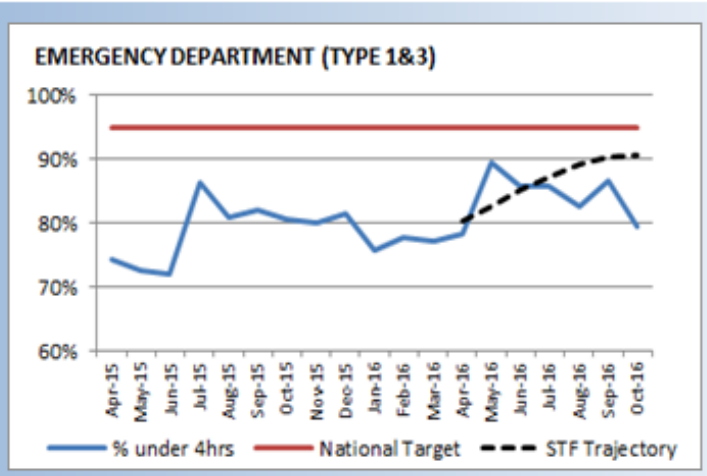


The RTT return is grouped in to 19 main specialties.

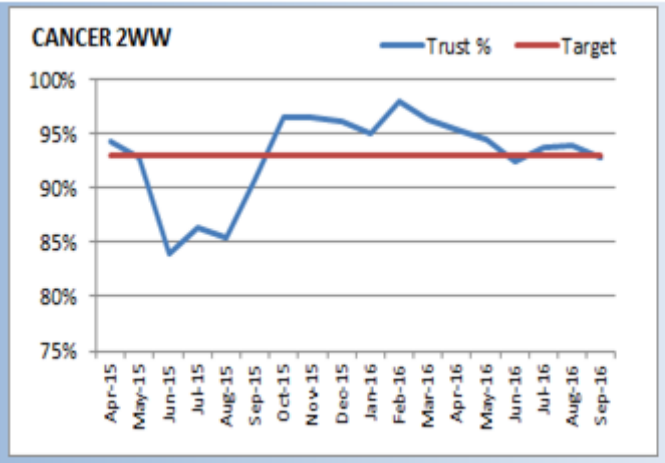
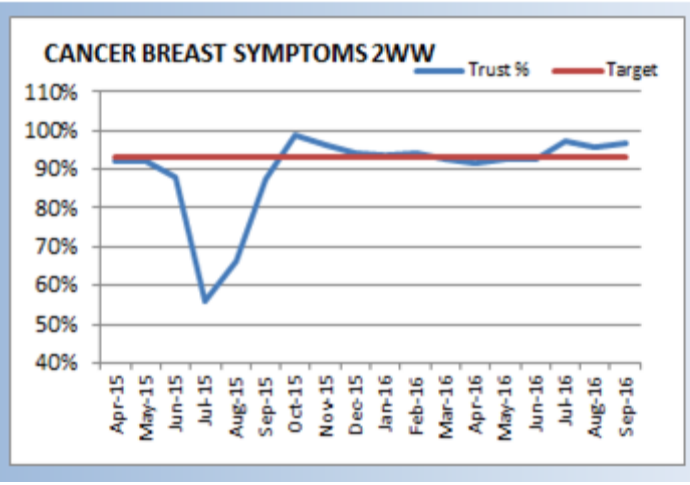
During October there were 10 specialties that failed to meet the STF trajectory

Integrated Performance Report - November 2016

RESPONSIVE

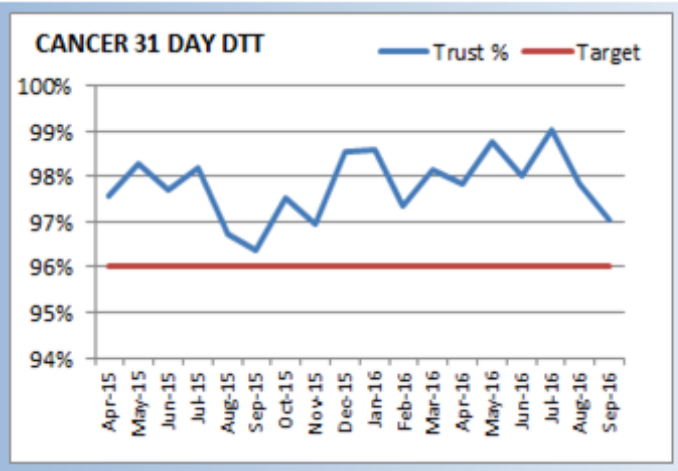
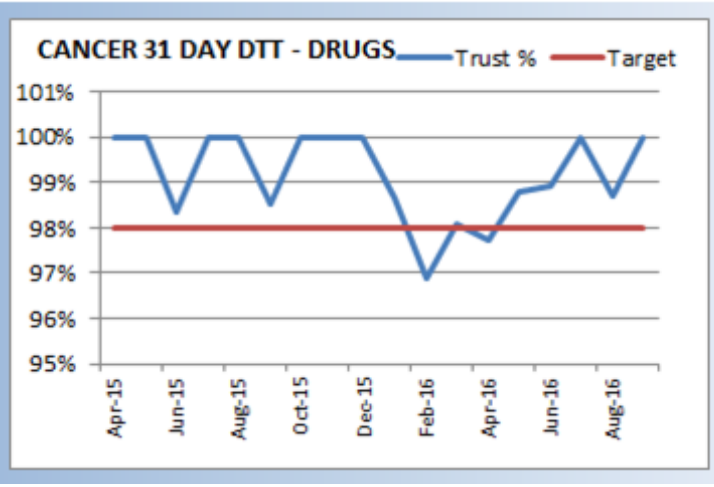
	Description	Aggregate Position	Trend	Variation
Referral to Treatment Incomplete 52+ Week Waiters	The Trust aims to deliver zero 52+ week waiters	The Trust failed to deliver the national standard of zero breaches with 1 breach for October The Trust achieved the STF trajectory of no more than 1 breach during October		The reported breach specialty was Ear, Nose & Throat
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 79.4% for October which was also below the agreed Sustainability and Transformation trajectory of 90.8%		Performance has deteriorated by 7.4% during October compared to September performance of 86.8%.

RESPONSIVE

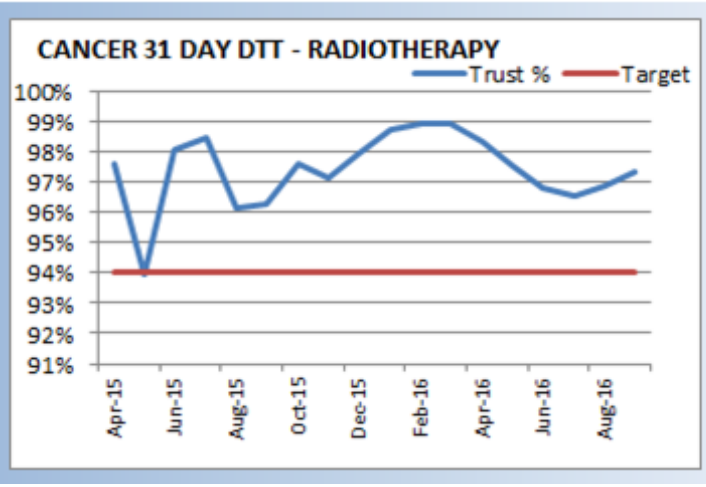
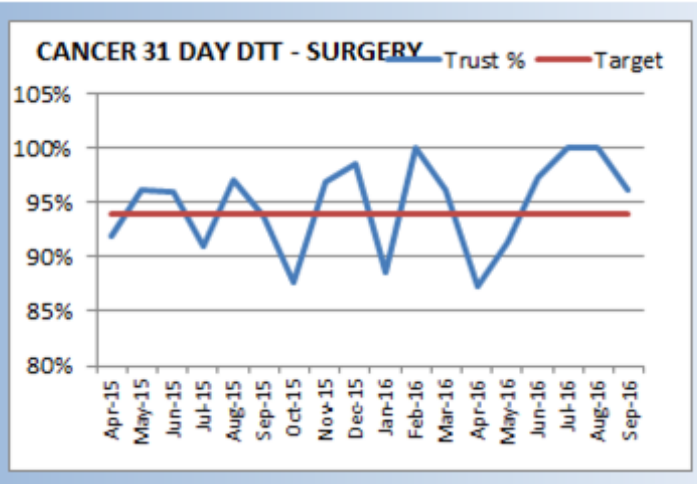
	Description	Aggregate Position	Trend	Variation
Cancer: Two Week Wait Standard	All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.	September performance failed to achieve the 93% standard at 92.8%		Tumour Sites failing to meet the 93% standard: Gynaecological 92.65% Haematological 90.91% Head & Neck 87.39% Lower GI 88.39% Urological 86.25%
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.	September performance achieved the 93% standard at 96.8%		

Integrated Performance Report - November 2016

RESPONSIVE

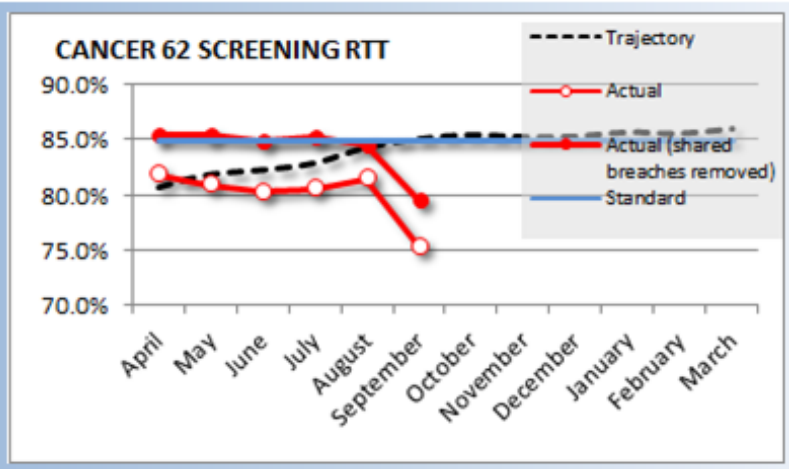
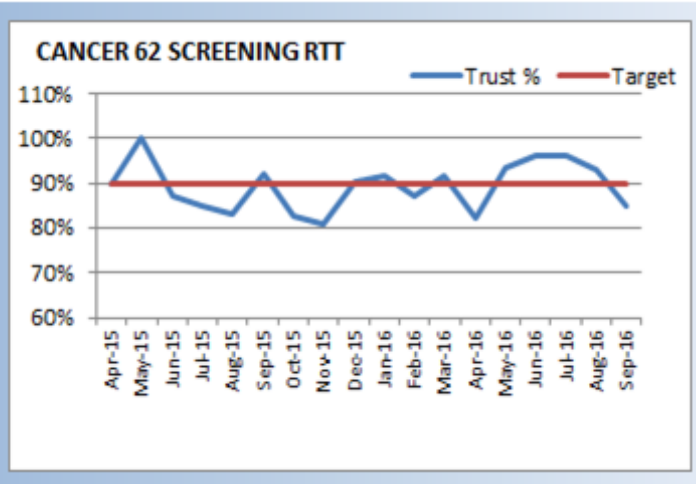
	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Standard	All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.	September performance achieved the 96% standard at 97.0%		Tumour Sites failing to meet the 96% standard: Gynaecological 89.47% Lung 91.84% Upper GI 94.44%
Cancer: 31 Day Subsequent Drug Standard	Subsequent Anti Cancer Drug	September performance achieved standard at 100%		

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: 31 Day Subsequent Radiotherapy Standard	Subsequent Radiotherapy	September performance achieved standard at 97.4%		Tumour Sites failing to meet the 94% standard: Gynaecological 91.7% Head & Neck 85.7%
Cancer: 31 Day Subsequent Surgery Standard	Subsequent Surgery	September performance achieved standard at 96.1%		Tumour Sites failing to meet the 94% standard: Breast 89.5% Lung 93.8% Urological 93.8%

Integrated Performance Report - November 2016

RESPONSIVE

	Description	Aggregate Position	Trend	Variation
Cancer: ADJUSTED - 62 Day Standard	All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85% Sustainability and Transformation trajectory is 85.2%	The adjusted position allows for reallocation of shared breaches September failed to achieve the STF trajectory of 85.2% with performance of 79.5%		
Cancer: 62 Day Screening Standard	62 Day Screening	September performance failed to achieve standard at 85.1%		Tumour Sites failing to meet the 90% standard: Gynaecological 50% Lower GI 62.5%

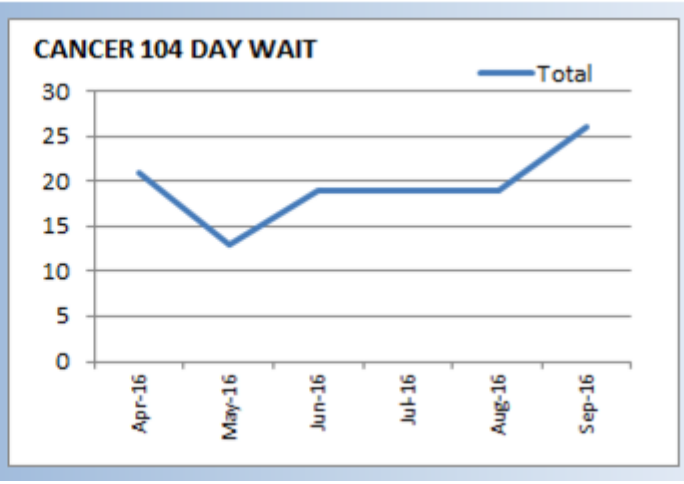
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

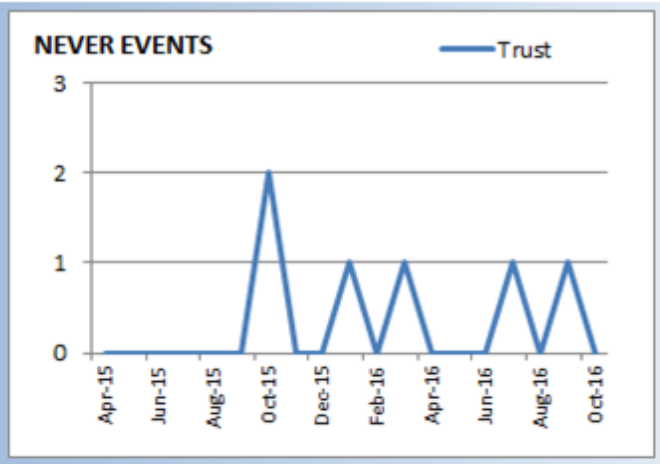
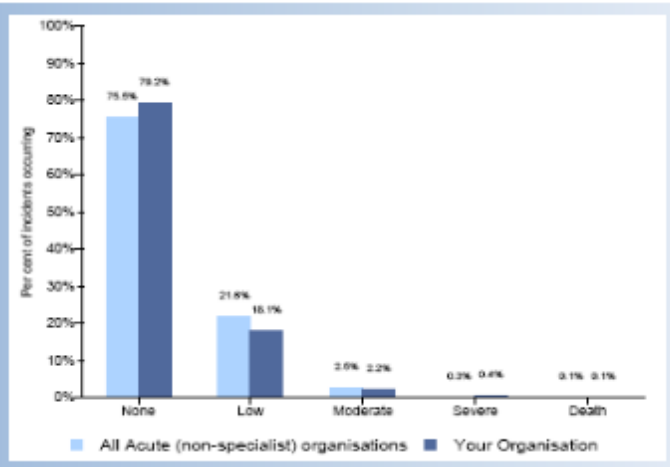
There were 26 patients waiting 104 days or over during September



September by Tumour Site:

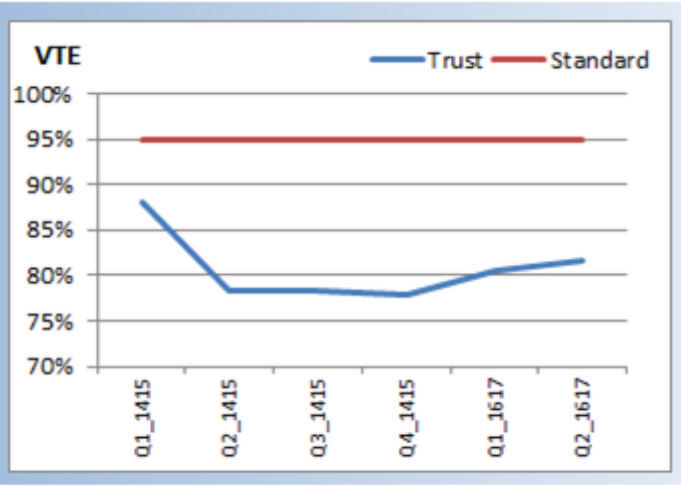
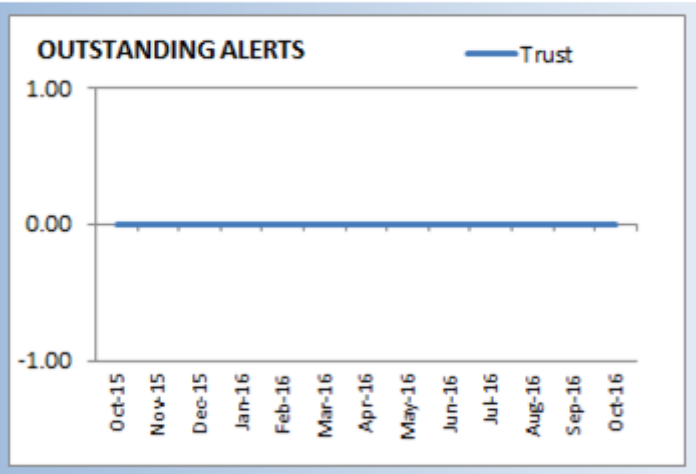
Breast x1
Colorectal x4
Gynaecology x3
Haematology x2
Head and Neck x2
Lung x6
Sarcoma x2
Upper GI x3
Urology x3

SAFE

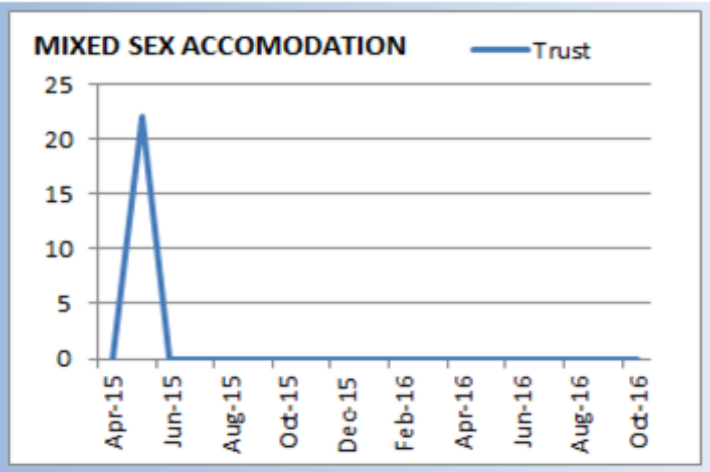
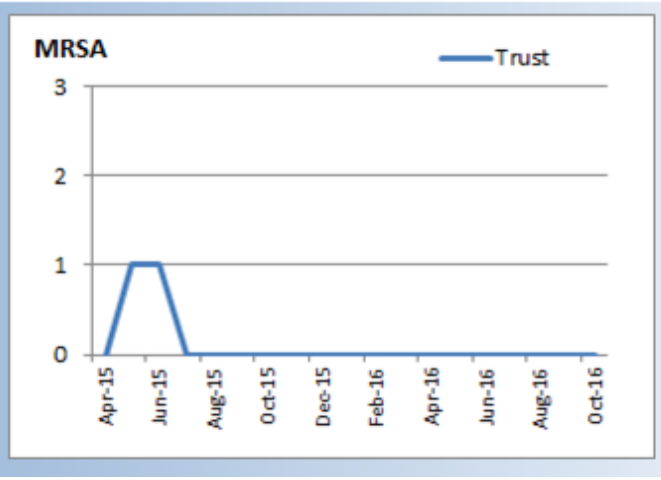
	Description	Aggregate Position	Trend	Variation
Occurence of any Never Event	Occurence of any Never Events	There were zero Never Events reported during October		Further information is included in the Board Quality report
Potential under-reporting of patient safety incidents	Number of incidents reported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

Integrated Performance Report - November 2016

SAFE

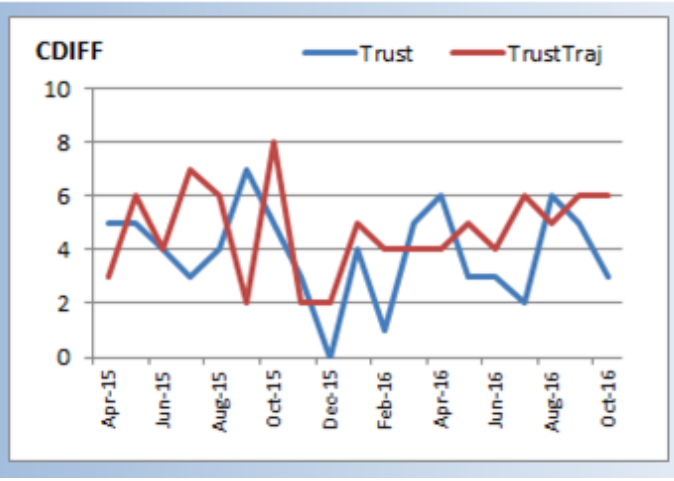
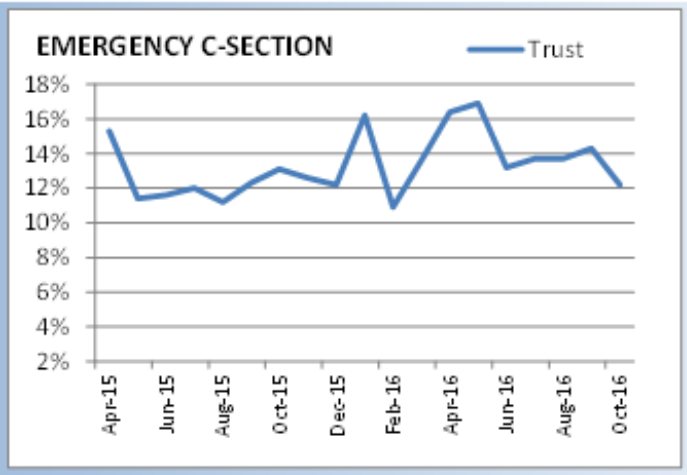
Description	Aggregate Position	Trend	Variation
VTE Risk Assessment	All patients should undergo VTE Risk Assessment	This measure is reported quarterly The Trust is currently failing to achieve this indicator with performance of 81.59% Q2 2016/17.		Health Group Performance: Clinical 93.51% Family &Women 90.34% Medicine 59.74% Surgery 88.92% Further information is included in the Board Quality report
Patient Safety Alerts Outstanding	Number of alerts that are outstanding at the end of the month	There have been zero outstanding alerts reported at month end for October 2016. There have been no outstanding alerts year to date.		

SAFE

	Description	Aggregate Position	Trend	Variation
Mixed Sex Accommodation Breaches	Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.	There were no occurrences of mixed sex accommodation breaches throughout October 2016.		
MRSA Bacteraemias	National objective is zero tolerance of avoidable MRSA bacteraemias	The Trust maintained its zero tolerance position for MRSA		Further information is included in the Board Quality report

Integrated Performance Report - November 2016

SAFE

Description	Aggregate Position	Trend	Variation
Clostridium Difficile The Clostridium difficile target for 2016/17 is no more than 53 cases	There have been 28 cases year to date There were 3 incidents reported during October which was below the monthly trajectory of no more than 6 cases		Health Group Performance: Clinical - 1 Family&Women - 0 Medicine - 1 Surgery - 1 Further information is included in the Board Quality report
Emergency C-section rate Maternity: Emergency C-section rate per month	The Trust aims to have less than 12.1% of emergency C-sections Performance for October was slightly above this at 12.2%		Performance improved during October from the September position of 14.3% Further information is included in the Board Quality report

EFFECTIVE

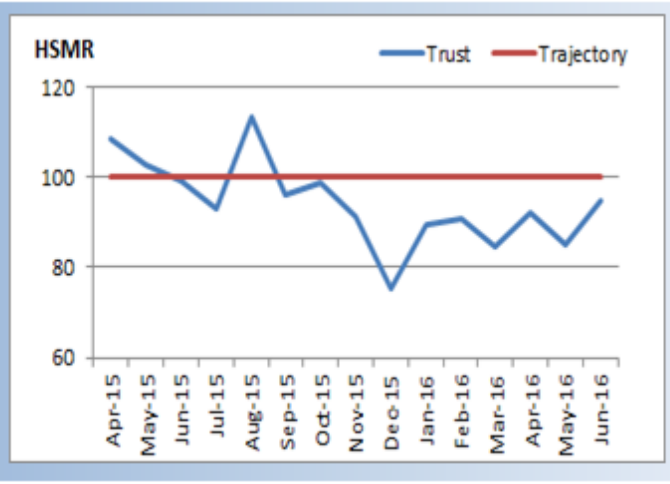
Description	Aggregate Position	Trend	Variation

HSMR

HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups

June 2016 is the latest available performance

The standard for HSMR is to achieve less than 100 and June 2016 achieved this at 94.7

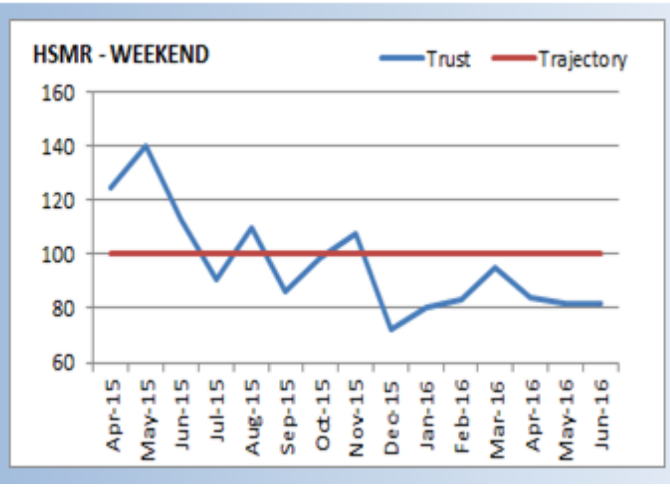


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

June 2016 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and June 2016 achieved this at 82.0



Integrated Performance Report - November 2016

EFFECTIVE

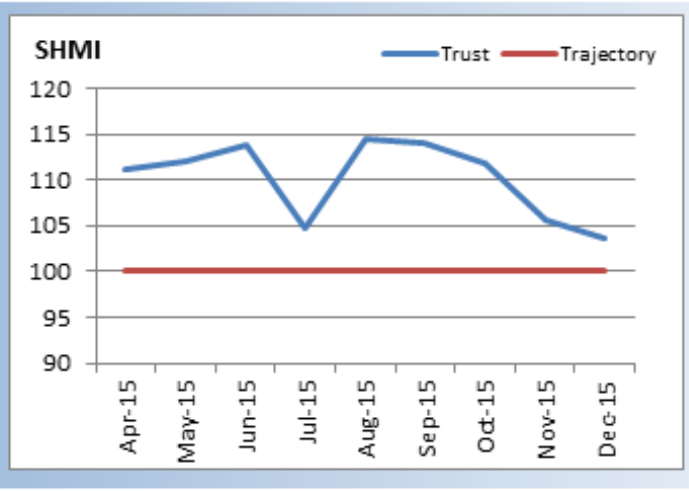
Description	Aggregate Position	Trend	Variation

SHMI

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

December 2015 is the latest published performance

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

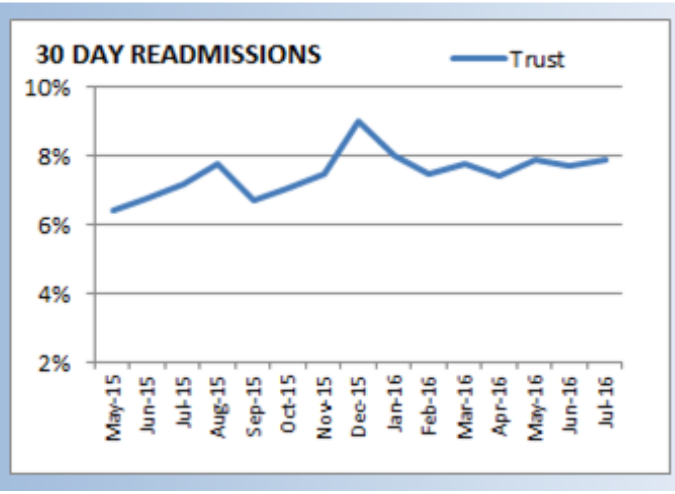


30 DAY READMISSIONS

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

The latest available performance is July 2016

The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than 7.8%. The Trust failed to achieve this measure with performance of 7.9%

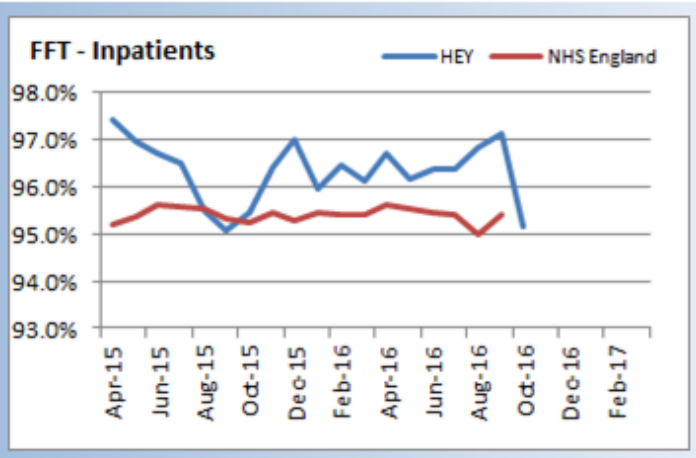
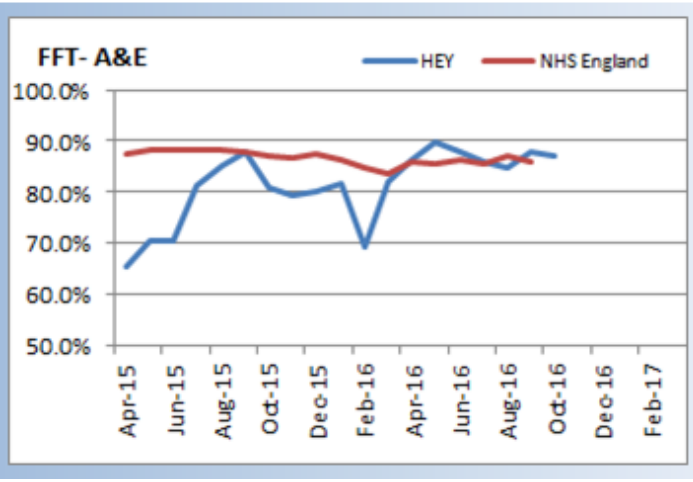


Health Group Performance:

Clinical Support	8.7%
F&WH	5.4%
Medicine	14.5%
Surgery	4.9%

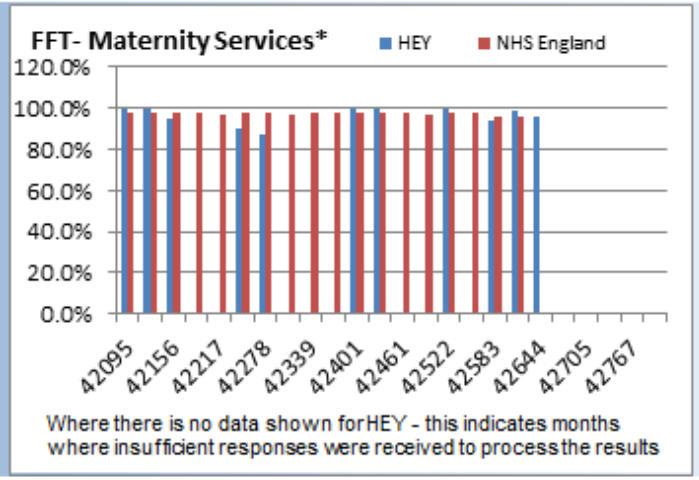
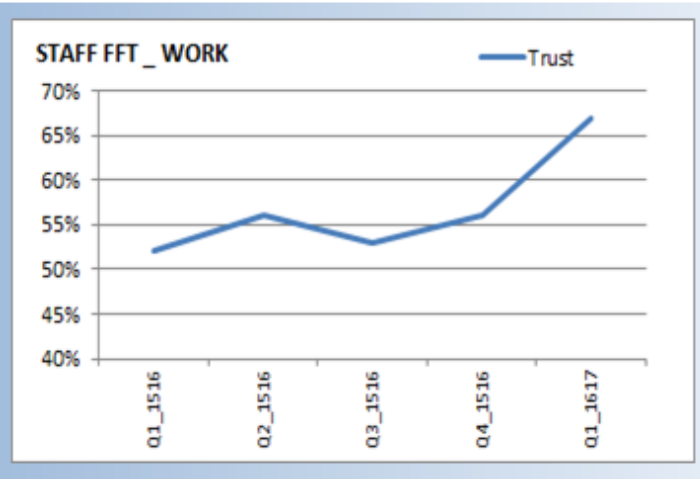
The Quality Committee will receive a detailed report showing readmission information at the December 2016 meeting

CARING

	Description	Aggregate Position	Trend	Variation
Inpatient Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for October was 95.17% The latest published data for NHS England is September 2016		
A&E Scores from Friends and Family Test - % positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for October was 87.03% The latest published data for NHS England is September 2016		

Integrated Performance Report - November 2016

CARING

	Description	Aggregate Position	Trend	Variation
Maternity Scores from Friends and Family Test - % Positive	Percentage of responses that would be Likely & Extremely Likely to recommend Trust	Performance for October was 96.18% The latest published data for NHS England is September 2016 Months with no data for HEY is due to insufficient responses		* Question relates to Birth Settings
Relative Position in Staff Surveys	Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?	The 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. Data for Quarter 2 will be available after publication on 24th November 2016.		The overall response rate for Quarter 1 was 28.73%

CARING

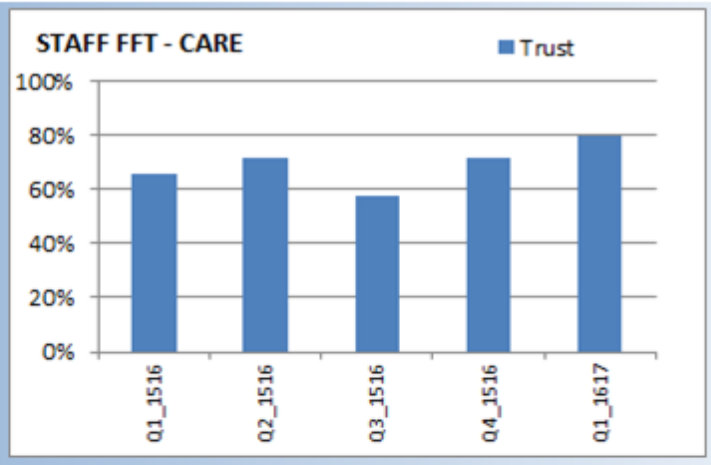
Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

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

The 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.

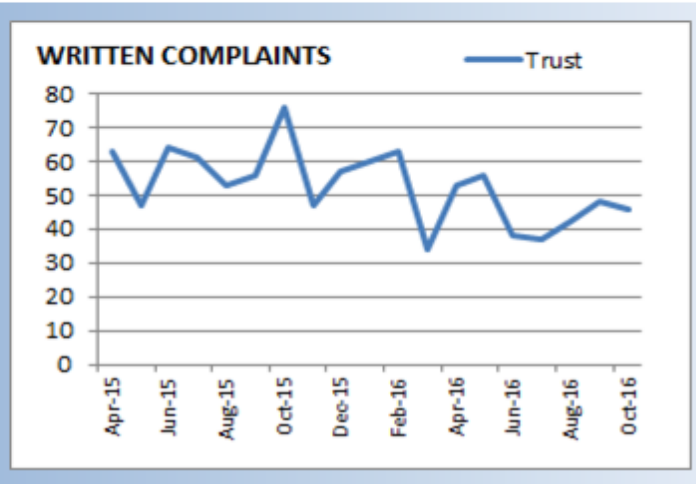
Data for Quarter 2 will be available after publication on 24th



Written Complaints Rate

The number of complaints received by the Trust

The Trust received 46 complaints during October, this is a slight decrease on the September position of 48 complaints



There have been 320 complaints year to date

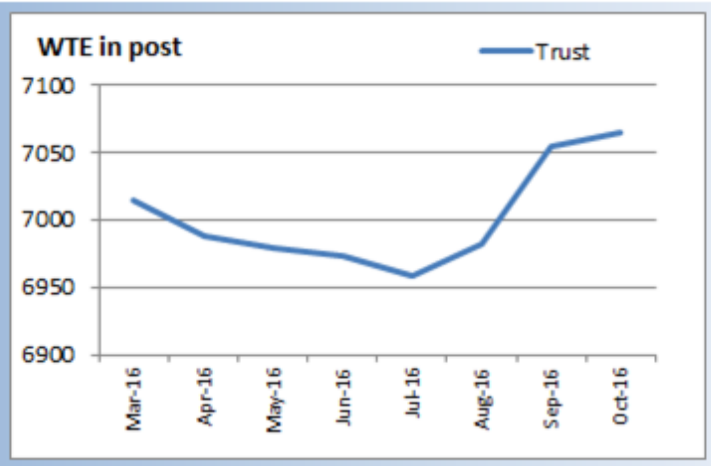
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

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

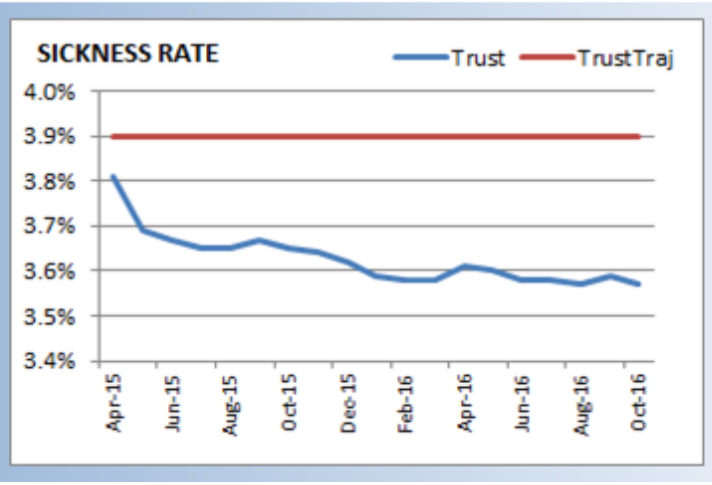
Trust level WTE position as at the end of October was 7064.8



Sickness Absence Rates

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

Performance for October achieved standard of 3.9% with performance of 3.57%



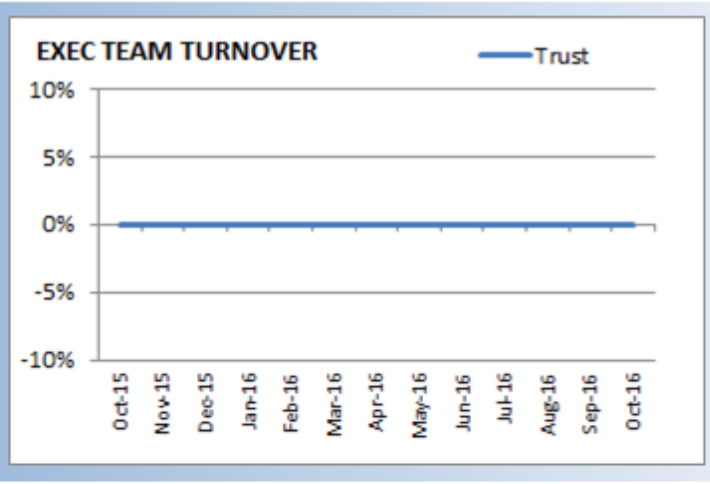
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

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

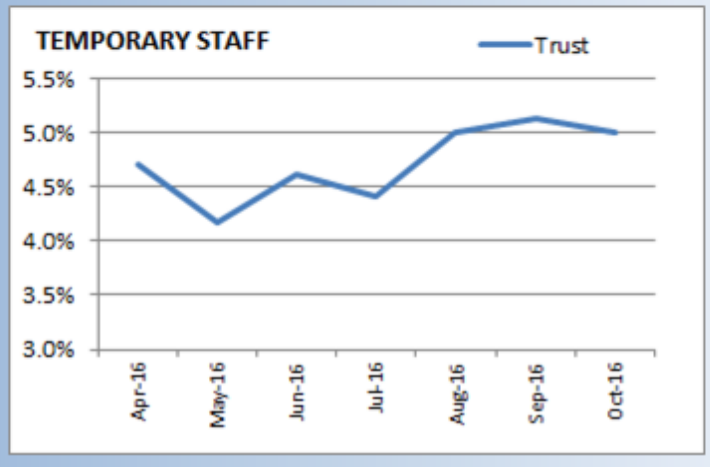


Proportion of Temporary Staff

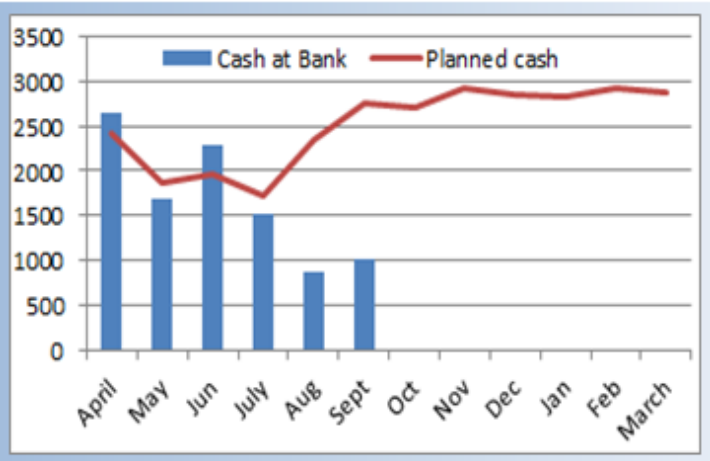
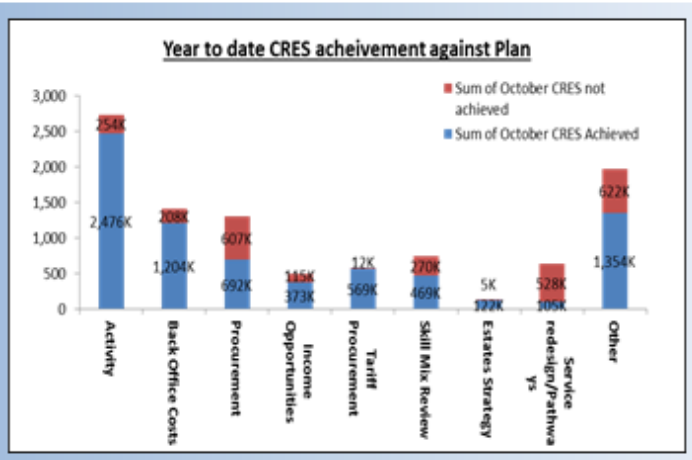
% of the Trusts pay spend on temporary

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

October performance was 5.0%



ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation
Cash Balance	Cash on deposit <3 months deposit	Cash at the end of Sept was £1.047m. 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.		£1.017 was deposited in the Trusts Government Bank account with £30k in petty cash floats.
CRES Achievement Against Plan	Planned improvements in productivity and efficiency	As at month 7 the Trust has achieved £7.4m of CRES savings against a plan of £10.0m, an adverse variance of £2.6m. The breakdown of the CRES programme by major work streams is shown on the chart with the red and blue combined reflecting the overall plan as at October, the blue section being that which has been achieved and the red being that which has not.		The Health groups have been tasked with finding additional schemes to cover their CRES shortfall.

Description	Aggregate Position	Trend	Variation

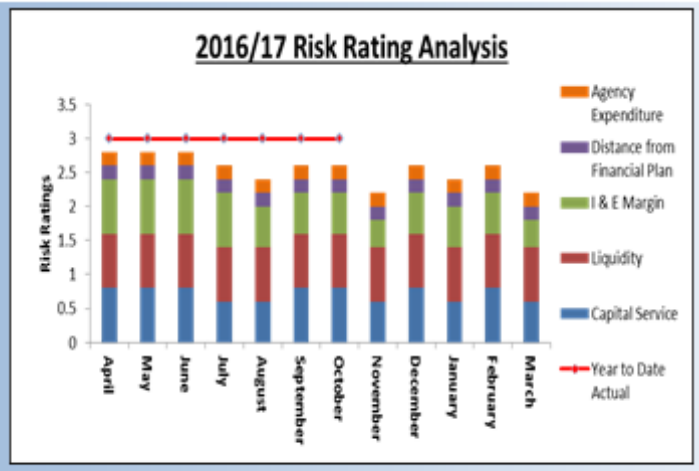
Risk Rating

Financial Sustain-ability Risk Rating

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

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst. The Trusts risk rating is currently 3.

The Trust has drifted further away from I&E surplus plan in month and is now £0.9m adrift at month 7, this is putting additional pressure on liquidity which was already under significant pressure.

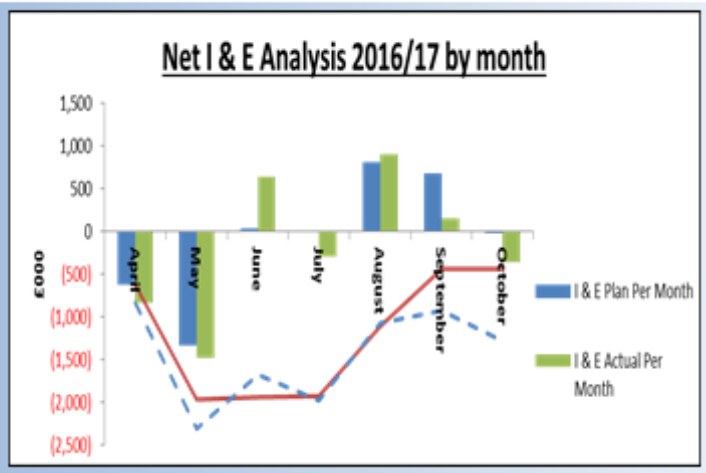


Income & Expenditure

Net income and Expenditure

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

At month 7 the Trust is £0.9m below plan this is a deterioration of £0.4m in month.



TRUST BOARD REPORT – 2016 – 11 - 12	
Meeting date:	24 November 2016
Title:	**FINANCIAL PLAN 2017/18 – 2018/19**
Presented by:	Lee Bond – Chief Financial Officer
Author:	Lee Bond – Chief Financial Officer
Purpose:	This paper sets out the approach to the Trusts financial planning for the next 2 years covering 2017/18 in detail with an overview of the longer term impact for 2018/19.
Recommendation(s):	The Board is asked to note: • The challenging financial position that the Trust is forecasting for 2017/18 and 2018/19 • The level of risk facing the Trust in contract negotiations, cost pressures and managing underlying costs pressures • The level of efficiency savings that will need to be delivered to achieve plans. • That the Trust will need to submit is final plan on 23rd December 16. The Board is asked to consider: • whether the Trust should accept the NHS Improvement control total as part of its submission to NHS Improvement on 24th November.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

FINANCIAL PLAN 2017/18 – 2018/19

1. INTRODUCTION

This paper sets out the approach to the Trusts financial planning for the next 2 years covering 2017/18 in detail with an overview of the longer term impact for 2018/19. The focus is primarily on the SOCI and the capital program rather than the entirety of the Balance Sheet.

The Trust has to submit an initial financial plan to NHS Improvement on 24th November with a final version being submitted on 23rd December 16. NHS Improvement and NHS England expect that contracts will be agreed by the 23rd December 16 deadline and hence will underpin the Trust financial strategy.

2. REPORTED 2016/17 FINANCIAL PERFORMANCE

At month 7 the Trust is reporting a forecast deficit of £2.36m following the anticipated receipt of £11.64m of funding from the Strategic Transformation Fund (STF). The deficit reflects the withholding of £2.36m of STF monies for non-delivery of performance target trajectories. The Trust would be reporting break-even without the performance non-delivery.

The forecast financial position requires the use of all the Trusts reserves and balance sheet flexibility. Health Groups and Corporate Directorates are forecasting a year end deficit of £12.3m with an underlying deficit of £21.9m, after removal of the support funding. Work is ongoing to validate this figure but if correct it indicates that the Trusts underlying deficit position has deteriorated in year.

3. 2017/18 AND 2018/19 NATIONAL REQUIREMENTS

The Trust has been set control totals by NHS Improvement for the 2 year planning period. These currently stand at

2017/18	£5.6m surplus
2018/19	£10.4m surplus

Both years include the Trust receiving support from the STF to the value of £11.9m.

The control totals assume that the Trust will receive a gain from the implementation of HRG 4+ of around £2.5m. This is being validated.

The Trust received a letter from NHS Improvement on 17th November indicating that there will be flexibility on the 18/19 control total dependant on achievement of 16/17 control total and acceptance of 17/18 control total. As such this figure may change.

The values of CQUIN will remain the same as previous years with CCG contracts receiving uplifts of 2.5% and NHS England specialist contracts receiving 2.8% where the Trust is a network lead for Hepatitis services. The overall value of CQUINS is expected to be £11.2m. 0.5% of the CCG CQUIN (£1.6m) is linked to the delivery of

the 16/17 control total. If the 16/17 control total is not delivered this funding will be retained by the CCGs for agreement on how it is used in 17/18.

The NHS England CQUINs will be linked to a dashboard of schemes that the Trust will need to select from with the major share being linked to delivery of national targets on spending of new Hepatitis drugs.

The CCG Commissioner schemes have changed. The Trust will receive 0.5% of the 2.5% for committing to work with the Strategic Transformation Programme (STP). Another 0.5% for delivering the 2016/17 outturn control total which will then need to be held in a Trust risk reserve (If the Trust does not achieve the 16/17 control total then the 0.5% will be held by CCGs in a risk reserve). The Trust will only be able to invest this funding if the STP system is delivering its overall control total. This effectively requires the Trust to make additional savings to create a reserve for potential future use. The remaining 1.5% will be badged against specific national schemes. There are no local schemes for 17/18 and 18/19.

There are 2 main risks with the CQUIN schemes:-

1) Any costs to deliver the targets will need to be funded
2) Unrealistic targets will reduce the income received by the Trust

Work is ongoing to clarify the value of these risks.

Further details on the CQUIN schemes can be seen in appendix 1.

4. APPROACH TO FINANCIAL PLANNING

The Trust has looked to build up a thorough understanding of the potential financial pressure that it will face to deliver its control totals in 2017/18 and 2018/19. A SOCI model can be seen at Appendix 2.

The approach will be determined by several factors that will determine whether the overall plan is achievable. These will include the levels of income agreed with Commissioners (based on expected growth, performance target delivery and identified QIPP schemes), the expectation of what will be deliverable by the Trust as an efficiency programme over 2 years, assumed inflation levels compared to tariff assumptions and the identification of any anticipated additional cost pressures.

The Trust has been modelling its elective activity requirements using the recommended IST model as its underlying basis to determine what would be required to deliver sustainable waiting lists. However it has then looked to refine those figures to take account of Commissioner affordability and what the Trust will also be practically capable of delivering in year. In broad terms this equates to forecast outturn plus 2%.

The Trust has assumed a growth of 2% in non-elective activity based on historic trends prior to 2016/17. If growth rates continue as per 16/17 then this will undermine the assumptions made.

The Trust has identified several potential cost pressures that may impact on the Trusts financial position in the next 2 years including the impact of the Junior Doctors contract, the introduction of the apprenticeship levy, overseas recruitment costs, advanced practitioner training and other smaller pressures. The Trust is prudently building reserves against these potential costs but this will require additional efficiency savings to cover. A list of reserves can be seen at Appendix 3

5. EFFICIENCIES

The impact of all of the above cost pressures is that the Trust will be required to deliver a £21.7m CRES program in 17/18 and £15.1m in 18/19 to achieve its control total of £5.6m surplus in 2017/18 and subsequently a £10.4m surplus in 2018/19.

This target is built up as follows:-

	2017/18	**2018/19**
Underlying Run Rates	£21.9m	£11.9m
Move to Surplus control total	£5.6m	£4.8m
2% Tariff Efficiency Target	£8.8m	£8.8m
0.5% CQUIN reserve	£1.6m	
Other Cost Pressures	£1.5m	£1.5m
Total Cost Pressure	**£39.4m**	**£27.0m**
Less: Support Funding	(£11.9m)	(£11.9m)
Less: HRG4+ Gain	(£2.5m)	
Less: Release of Reserves	(£3.3m)	
Net Efficiency Savings required	**£21.7m**	**£15.1m**

The Trust is developing a programme of planned savings in response to the above requirements to deliver savings of 4.1% (£21.7m) in 17/18 and 2.8% (£15.1m) in 2018/19.

6. COMMISSIONER CONTRACT OFFERS

As part of the process for reaching contract agreement by 23rd December 16, Commissioners were expected to make initial offers to Trusts by 4th November. All the Trusts main Commissioners have made offers on those dates and the Trust has responded by the required date of 11th November. The main offers for 17/18 are below with the current Trust view in comparison.

	CCG £m	Trust £m	Difference £m
Hull	169.3	184.7	15.4
East Riding	117.2	129.1	11.9
North Lincs	11.2	12.1	0.9
North East Lincs	7.4	7.3	(0.1)
Scarborough	3.2	3.2	0.0
Vale of York	2.4	3.0	0.6
NHS England Specialist	142.5	143.2	0.7
Total Main Commissioners	**453.2**	**482.6**	**29.4**

The main drivers of the gaps are confirmation of 2016/17 forecast outturn, levels of growth activity for the 2 years, levels of deliverable QIPP, impact of the IR rule changes between Commissioner positions and the impact of the introduction of HRG 4+.

Weekly meetings are being held to close the gap. These need to focus on demand management actions that will be required to reduce the activity coming into the Trust.

7. CAPITAL

The 2017/18 and 2018/19 capital programme will be funded mainly through depreciation with some additional schemes funded from charitable donations. In addition the Trust will also be looking to access the recently announced £130m radiotherapy modernisation fund for the replacement of two linear accelerators.

The capital programme has been developed to facilitate continued delivery of high quality clinical services. Provision has been made for essential investments in the repair and maintenance of existing buildings, the replacement of medical and scientific equipment and the refresh of the Trust's IT network and systems. Provision has also been made for some developmental investments in specific clinical service areas.

The following table sets out at a summary level the anticipated source and applications of capital for 2017/18:

	£m
Resources	
Depreciation	10.4
Donated Assets	1.3
PFI	1.3
PDC Allocation (Linear Accelerators)	1.6
Total	**14.6**
Programmes	
Backlog Maintenance	2.6
Equipment Replacement (Note 1)	3.5
IT Infrastructure	2.1
Other	2.2
	10.4

Matched Funding	
Donated Assets	1.3
PFI	1.3
PDC Allocation (Linear Accelerators)	1.6
Total	**14.6**

Note 1
Low capital availability supplemented by additional, lease funded, equipment replacement subject to funding in revenue plan.

The above programme assumes delivery of the Trust's control total of £5.6m. Failure to meet the control total will lead to a reduction of £1.3m in programme spend. This is the result of the cash being required to meet the Trust's PFI capital cash requirements.

The plan for 18/19 is anticipated to be £13.8m with the reduction being due to lower levels of income for donated assets.

In order to reduce the requirement for Trust capital funding, a number of developments are being taken forward using alternative methods of funding. These are:

The redevelopment of the main entrance at Hull Royal Infirmary will be undertaken in partnership with a commercial developer.
Schemes to improve the energy efficiency will be undertaken in partnership with the Carbon Efficiency Fund.

Some of the larger items of equipment in Radiology will be replaced using lease funding, with only the associated enabling works being funded from the Trust capital programme.

The progression of these schemes will be subject to their affordability against the revenue plan.

The Trust will conclude the first two stages of the sale of land at Castle Hill Hospital for £3m in 2017/18 and a further £3m in 2018/19. The capital receipts from the sale will be used to re-pay part of the revenue support loan of £13.7m taken out in 2015/16. The final stage of the land sale valued at £2.95m will be in 2019/20.

8. CASHFLOW

The impact of all of the issues above could have a significant impact on the Trusts already weak underlying cash position. The receipt of the £11.9m support funding will be paid quarterly in arrears and will have a negative impact on the early months cash position. Also it will be important that CRES plans are not back-loaded towards the end of the year as again this will create in year pressure on cash resources.

9. CONTROL TOTALS

The Trust has to submit its first draft plan to NHS Improvement on 24th November 16. As part of the submission the Trust has to confirm whether or not it accepts the control total that has been imposed by NHS Improvement. This is either a yes or no answer and must be signed on behalf of the Board of Directors by the Chief Executive and Chief Financial Officer.

If the Trust does not accept the control total it will lose the access to the £11.9m STF but would not need to report a £5.6m surplus.

If the Trust does not sign up to the control total by 24th November but agrees to it at a later date it may forfeit eligibility to receive at least the first quarters support.

If the Trust rejects the control total it will affect its rating within the NHS Improvement Single Oversight Framework. If the Trust is in deficit the maximum rating the Trust will be able to achieve is 3 (if still in surplus then can still achieve 2).

If the Trust rejects the control total then the suspension of penalties within the contract will end. This would open up the Trust to being penalised for non-delivery of targets in ED, RTT, Cancer and Ambulance Handovers.

10. NEXT STEPS

The Trust will continue to work on the following issues to refine the plan for the final submission on 23rd December:

1) Confirming Underlying run rate of £21.9m deficit
2) Assessment of CQUIN risk
3) Resolution of contract management gap
4) Development of CRES program and finalisation of reserves
5) Completion of Capital program

11. RECOMMENDATION

The Board is asked to note:

The challenging financial position that the Trust is forecasting for 2017/18 and 2018/19

The level of risk facing the Trust in contract negotiations, cost pressures and managing underlying costs pressures

The level of efficiency savings that will need to be delivered to achieve plans.

That the Trust will need to submit is final plan on 23rd December 16.

The Board is asked to consider:

whether the Trust should accept the NHS Improvement control total as part of its submission to NHS Improvement on 24th November.

Lee Bond
Chief Financial Officer

17 November 2016

CQUIN 17/18 and 18/19

National and Local CCG Schemes:

The Trust will receive a number of CQUIN schemes for the contract years 2017-18 and 2018-19 for both Clinical Commissioning Groups and NHSE specialised commissioners the value is circa 11m. (CCG circa 8m and NHSE spec comm 3m)

CCG CQUIN scheme breakdown:

2.5% with 1.5% mandated for 6 national schemes (0.25% each) 6 schemes listed below

1% spilt (3m) :

0.5% engagement with the STP In effect, this will be a cost free indicator for providers with clear scope for earning the full amount

0.5% of the local CCG CQUIN scheme will also be held within the risk reserve, If a provider delivers its control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release is authorised (with CQUIN for 2018/19 linked to delivery in 2017/18). For providers that do not accept or deliver their control totals in the prior year the 0.5% CQUIN will be held by the CCG prior to potential release. In both instances this element of the risk reserve will be released for investment by the relevant providers when it is demonstrated that the system in question is delivering its control total.

Nationally Mandated 6 schemes for CCGs:

#	**Acute Year 1 2017-18**	1.5% **circa 5m**		RISKS
1	**NHS Staff Health and Wellbeing part a b and c**	**875k**		
a	improvement of 5% **staff survey** compared to 2016 for 2 of the 3 staff survey questions: 9a 'does your organisation take positive action on HWB?' 9b 'have you experienced and MSK problem as a result of work activities?' 9c 'have you felt unwell as a result of work stress?'	290k	Partial payment less than 3% improvement 0% payment 3-4% 50% payment 4-5% 75% payment 5%+ 100% payment	reliant on the results of the staff survey- potential risk for a 5% improvement

b	**healthy food** – build/maintain four changes from 16/17: • maintaining banning of promotions on sugary drinks and food • banning advertisement on premises HFSS • banning HFSS from checkouts • healthy options available staff at night Three new changes for 2017-18 : a) 70% sugar free drinks all b) 60% sweets no exceed a single serving 30g /250kcal c) 60% pre packed sandwiches to be 400kcal or less and reduced fat	145k 145k		extension to 2016-17 scheme no identified risk
c	**Flu** uptake 70% frontline staff by 28th Feb 2018 75% frontline staff by 28th Feb 2019	290k	partial payment <50% no payment 50-60% 25% payment 60-65% 50% payment 65-70% 75% payment 70% + 100% payment	Date moved back to February of the contract year so makes this realistic to deliver
2	**Proactive and Safe Discharge** **part a** • Map and streamline existing discharge pathways • roll out new protocols local systems • establish local process for collection of baseline responsiveness of community services to provide discharge to assess (within 24hrs of transfer home) • undertake clinical audit of discharge to assess pts (approp' referrals) **part b** Agree trajectories for implementation of local initiatives Emergency care data sets (ECDS) **part c**	**875k**	**part a 40% payment end of Q2** **part b split 15%** for submission of ECDS from October 2017 **5%** returning data weekly and 95% of patients have a valid Chief Compliant code set	**Is the unscheduled care group leading on this work? Would suggest a lead responsible for the Trust as our penalty if we fail.** part a achievable as part of unplanned now part b achievable depending on the trajectories and who sets them- we must agree realistic ones part c is this achievable ???

	increase proportion of patients discharged within 7 days of admission by 2.5% points from baseline (Q3-Q4 16/17) or increase to 47.5% across Q3 and Q4 2017-18			
3	**Reducing the impact of serious infections** • part a timely identification for sepsis Inpatient and ED • part b treatment IV within 1 hour • part c empiric review of antibiotic prescriptions • part d reduction in antibiotic consumption per 1000 admissions, reduction in carbapenem, reduction of piperacillin-tazobactam	**875k** each part worth 25% each	**Part a and b** partial payment Q1-Q4 <50% no payment 50-89.9% 5% payment 90%+ 12.5% payment **part c** – audit 30 patients submit to PHE portal Q1 review 25% cases – 25% payment Q2 review 50% cases 25% payment Q3 review 75% cases 25% payment Q4 review 90% cases 25% payment **Part d 33% each of the three elements** 1% reduction for those Trusts with 2016 indicators below 2013/14 median	***roll on from 2016-17 odds within the scheme (antibiotics delivered in 1 hr of sepsis and reduction in antibiotics*!!!)**
4	**Improving services for people with Mental Health needs who present to A&E** • Q1 review top 0.25% of all A/E frequent attenders within 12 months – subset of these identified who benefit from assessment review, care planning with MH staff • Q2 were the cohort from Q1 coded approp' in A/E HES dataset, Joint governance arrangements with NH /CCG , ensure care plans, systems in place , plan in place to reduce A/E attendances • Q3 progress against DQIP/ coding • Q4 20% reduction in A/E attendance of top 0.25% freq attenders	**875k**	**Q1 10% work with mental health teams** **Q2 40%** work with Mental health teams and other local providers to achieve this **Q3 10% improvement plan** **Q4 40%** - 20% reduction in cohort group attendance in A/E	**Need to set up a working group with partners HEYT to lead as trust will lose £ if fail – must include information teams in this group** **Propose Divisional manager / Nurse manger in Medicine to lead on this**

5	**Advice and Guidance - Provide access to A+G service for 75% of GP referrals made to elective OP specialities** • **Q1** agree specialities highest volume of GP referrals for A/G implementation • agree trajectory by at least 35% by Q4 , timetable agreed, implementation plan • agree local stander to A+G response made with I n 2 working days by 80% • **Q2** mobilised first tranche of specialities, baseline data • **Q3** review against Q1 trajectory and plans, • **Q4** A+G in place for specialities receiving 35% of GP referrals by start of Q4	**875k**	**.** **25% per quarter** partial payment >35% 100% payment at Q4 30-35% 80% payment 25-30% 60% payment 20-25% 40% payment	**we have proactively worked on advice and guidance with our own NHS mail boxes with a number of specialities. They are not greatly used by GPs but those who do like them.** **The GPs will have this as an automatic function in NHS e referral in 2017?** **RISK in Q4 for the Trust as the measure is receiving 35% of GP referrals through A+G - Trust cannot control this**
6	**NHS E-Referrals *(Year 1)*** Preventing ill health by risky behaviours – alcohol and tobacco (Year 2) All providers publish ALL services make ALL first OP appt slots available on eRS by March 2018 • Q1 baseline to deliver in Q2,3 and 4 with a plan – provide definitive list of all clinics • Q2 to Q4 services published through DOSeRS, adequate slot polling –reduction in 'appt slot issue' by 4% or less • Q2 80% of referrals to 1st OP to be received through eRS Q3 90% Q4 100%	**875k**	**25% payment per Quarter** Partial payments through Q2 to Q4 for step improvements to meet 80% 90% and 100% by Q4: there is work through the joint GP/Trust e referral group but	**RISK:** **Provider responsible for GPs making referral through eRS!!!!!**

NHSE Specialised Commissioners CQIN schemes

Hull & East Yorkshire Hospitals NHS Trust receives a CQUIN value of 2.8% The CQUIN payment will be based on actual contract expenditure; however CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Tariff Payment System and all other expenditure contracted on “pass through” basis.
CQUIN funding for Operational Delivery Networks previously paid via a 0.1% top slice of the 2.5% acute payment will continue to be made in addition to the 2.8% CQUIN payment outlined above.
CQUINs from previous years will not be repeated unless established in 2016/17 as a multi-year CQUIN.

Proposed Schemes		**circa 3m**		
BI1	Improving HCV Treatment Pathways through ODNs	1,688	year 2	challenge still as part of National delivery
BI2	Haemophilia Haemtrack Patient Home Reporting	120	year 2	achievable
GE2	Activation System for Patients with Long Term Conditions	60	year 2	achievable
TR3	Spinal Surgery: Networks, Data, MDT Oversight	81	year 2	achievable – risk adding to database in 2016-17
IM1/CA1	Enhanced Supportive Care	125	year 2	achievable – electronic issue in 2016-17
GE3	Medicines Optimisation	150 to be increased to nearer 200k	New scheme	may need pharmacy support to deliver scheme
GE4	Locally-Priced Services Redesign and Clinical Practice Benchmarking	Programme costs TBC	New scheme	require full detail and understanding of the milestones associated to this scheme

Local	QIPP Incentivisation scheme 3 elements include (weighting TBC by NHS England): 1. Engagement that can be evidenced; 2. Identification of new Schemes that will be supported by an implementation plan; 3. Delivery of QIPP targets.	350		require full detail and understanding of the milestones associated to this
Remaining CQUIN balance	Potential other schemes to be identified or schemes above to be stretched.	317		Trust will not accept any further schemes – potential to divide between others or suggestion to support national schemes that they will benefit from

Hull and East Yorkshire Hospitals NHS Trust
Indicative Statement of Comprehensive Income 2017/18 to 2018/19

	Plan 2017/18 £000	Plan 2018/19 £000
CCGs	342,108	350,769
Specialised Commissioning (NHSE)	156,058	159,752
Non Contracted Activity	2,941	3,027
SLA Total	**501,107**	**513,548**
STF Funding	11,933	11,933
Other Inc	22,634	22,462
Total	**535,674**	**547,943**
Surgery	(122,096)	(122,096)
Medicine	(88,495)	(88,495)
Family and Women's	(68,448)	(68,448)
Clinical Support	(115,853)	(115,853)
Infrastructure & Development	(35,016)	(35,016)
Corporate Directorates	(52,116)	(52,116)
Educ & R&D	(4,008)	(4,008)
Leases	(1,786)	(1,786)
PFI	(2,012)	(2,012)
Reserves	(14,283)	(22,581)
Total	**(504,114)**	**(512,412)**
EBITDA	**31,561**	**35,532**
Non Operating Expenses		
Interest Receivable	60	60
Interest Payable	(6,732)	(6,732)
Depreciation	(12,743)	(12,743)
PDC Dividend	(5,820)	(5,820)
Retained Surplus/(Deficit)	**6,326**	**10,297**
Reported NHS Financial Performance		
Donation receipts and depreciation of donated assets	(726)	74
Adjusted Financial Performance Surplus/(Deficit)	**5,600**	**10,371**

APPENDIX 2

Hull and East Yorkshire Hospitals NHS Trust **APPENDIX**
Summary of Financial Plans 2017/18 Reserves

Use of Reserves 2017/18-2018/19

	Total 2017/18 £000
Efficiency Requirements	**-21,754**
COMMITTED RESERVES	
Activity Income	**9,123**
Inflationary Pressures	
Pay	7,761
Non Pay Inflation	1,674
Non Operating Inflation	441
CNST Inflation	1,882
TOTAL Inflation Reserve	**11,758**
Other Specific Reserve	
CRES Risk	2,500
CQUIN reserve - 0.5% for STP reserve	1,600
Income to support month 6 run rates	3,017
Activity Risk	1,400
TOTAL COMITTED RESERVES	**29,398**
Discretionary Reserve	
Demolition Fund	600
e-observation	160
e-casenotes	995
Lorenzo	308
Digital Dictation	22
EWA Licences	122
IT Network	500
Intranet	25
New Leases 17/18	700
Programme Management Office	85
Operations Post	61
Site Management Team	127
NICE - residual balance ED nurse staffing	50
Winter Resilience	1,000
Job Planning Software	24
Support for Charitable Donations	15
Patient Administration	300

IMT Structure	151
Emergency Care Programme Admin Support	15
Front Entrance Fees	200
Safe Working Guardian	25
Nurse Practitioners	200
EPS	150
HMRC	140
Friends & Family	50
Marketing Budget	90
Ramp Wards	10
CQC Inflation Increase	107
Junior Dr Rota System	20
Academic Palliative Care 2PA's	22
ACP Report Junior Drs	50
GS1 procurement	250
Staff Survey	8
Residual	56
Discretionary Reserve	**6,639**

OVERALL RESERVES	**14,283**

Self-certification checklist Please discuss this in your board meeting		Yes - please specify steps taken	No. We will put this in place - please list actions
Governance and accountability			
1	Our Trust Chief Executive has a strong grip on agency spending and the support of the agency executive lead, the Nursing Director, Medical Director, Finance Director and HR director in reducing agency spending.	Yes, agency spend is discussed at monthly Executive / HG Performance meetings; Director sign off for agency shifts is in place, and national guidance is being followed. However recruiting more, Drs, nurses, theatre and ICU staff continues to be very challenging.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.		The Chief Operating Officer, Chief Nurse and Chief Medical Officer actively challenge managers to think and work differently to reduce agency spend, however patient safety and quality of care is the Trust's priority. Agency spend reduction will be an objective for HG Medical, Nurse and Operations Directors
3	The agency executive lead, the Medical Director and Nursing Director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Partially, Agency spend is discussed at Executive meetings, Exec Management Committee and PAF Committee	
4	We are not engaging in any workarounds to the agency rules.	Yes we comply with NHSI rules and report all breaches in relation to cap and wage rates, off framework	

		assignments and PSC's via a weekly return	
High quality timely data			
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	Yes. Those areas are identified, data shared and discussions held to reduce spend which does include innovative solutions to staffing shortages. We challenge any manager not complying with Trust processes and rules	
Clear process for approving agency use			
6	The Trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	Partially, Medical and nursing staff are centralised and other areas are de-centralised but book through a single IT system. The plan is to have every area centralised. The Trust does have visibility of what is happening in detail in all areas via the IT system.	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	Yes. The above processes are known and understood. Director sign off for all agency bookings must be secured. The process requires managers to initially consider whether the shift can be covered by bank or overtime etc, before any agency is commissioned.	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors	Yes. All agency shifts must be approved by a Director.	

	personally approve the most expensive clinical shifts.		
Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; e.g. exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Plans are in place, however in some areas it is extremely difficult to deliver those plans. ED attendances have increased by 10% and recruiting additional doctors and nurses on a permanent basis, let alone temporary one, is extremely challenging.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	We have bank staff for some clinical services, not all. The plan is to develop a bank of staff for all areas, but there are challenges to delivering this.	
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by E-rostering.	Yes, rostering is completed 6 weeks in advance and E-rostering is in place for nursing. E-rostering is currently being rolled out to Junior Doctors and then the rest of the Trust. It is being considered in tandem with the bank development	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	The Trust has implemented TRAC recruitment system, so the entire recruitment process is automated. The time to fill a vacancy, including advertising, interviewing and securing employment checks is longer than 21 days. However, recruitment timescales are monitored and reviewed at the WT Committee and	

		improvements continually made.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	Yes, the Trust has developed many different roles to address recruitment shortages - ACPs, apprenticeships, Progress Chasers, Recreational Assistants, Trainee posts and Physician Associates.	
14	The Board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	Workforce plans are developed by Health Groups using workforce, finance and activity data. It is led by the HR Business Partners. Plans are triangulated and put through 'Confirm & Challenge' groups. EMC approves operational plans.	
Working with your local health economy			
15	The Board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	Yes, ED, Acute Medicine, Elderly, Theatres and ICU.	
16	The Trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Yes with NLAG and York and an operational group has been commissioned to do some further work.	
	Signed by	[Date]	
	Trust Chair:	[Signature]	
	Trust Chief Executive:	[Signature]	

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016			

Hull and East Yorkshire Hospitals NHS Trust

TRUST BOARD REPORT 2016 – 11 - 13	
Meeting date:	24 November 2016
Title:	Winter Plan 16/17
Presented by:	Jacqueline Myers Director of Strategy and Planning
Author:	Jacqueline Myers Director of Strategy and Planning
Purpose:	To agree the Trust's Plan for Winter Readiness
Recommendation(s):	That the Trust Board approves the plan.

TRUST WINTER PLAN

2016/17

1 PURPOSE

This plan sets out the actions that the Trust will take to manage increased workloads over the winter period both safely and efficiently. The plan has been developed with the Health Groups and corporate directorates, and through consultation with partner organisations in the local health economy.

2 PLAN OBJECTIVES

The objectives of the Winter Plan are as follows:

- To ensure that the Trust has appropriate resources and processes in place to cope with increased workloads over the winter period
- To ensure that the Trust has appropriate escalation arrangements in place to cope with significant peaks in demand
- To ensure that services are properly prepared for the winter period and that staff understand their roles and responsibilities
- To ensure that the Trust works effectively and efficiently with partner organisations during the winter period
- To ensure that the Trust's performance against Emergency Department (ED) performance indicators continues to improve
- To minimise the extent to which increases in emergency workloads adversely affect the provision of cancer services and performance against other waiting time targets
- To ensure that the Trust has appropriate arrangements in place for dealing with severe weather events, such as snow and flooding
- To ensure that the Trust has appropriate arrangements in place for dealing with a severe seasonal influenza outbreak

3 LEARNING FROM LAST WINTER

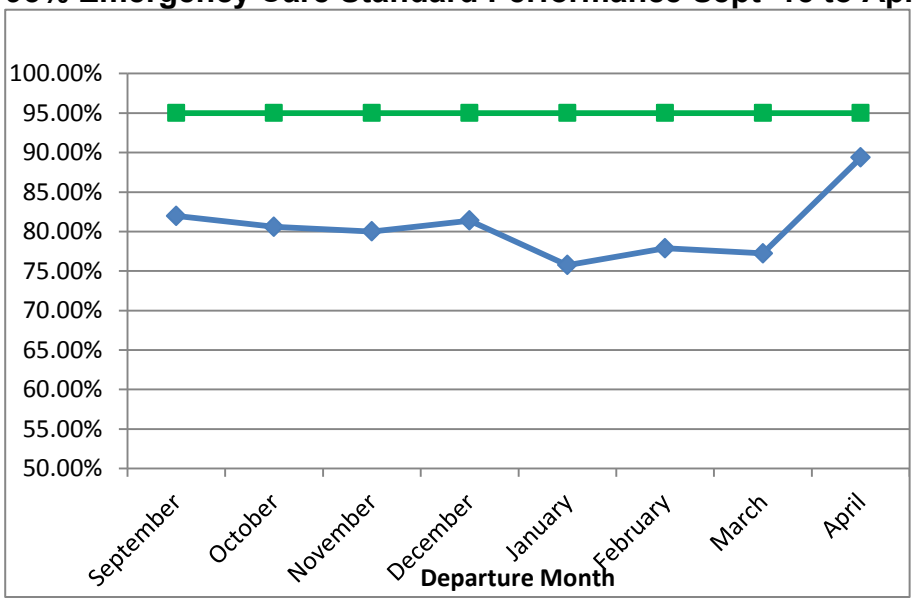
Actions that were implemented as part of the 2015/16 Winter Plan are summarised in the following table.

Action	**Status**
Creation of additional bed capacity through improved use of existing accommodation in the tower block	Implemented recurrently
Establishment of a dedicated Major Trauma ward	Implemented recurrently
Relocation of services between the 9th and 12th floor wards in the tower block	Implemented recurrently
Relocation of the EAU to Ward 200	Implemented recurrently
Expansion of the AMU	Implemented recurrently
Establishment of the Oncology Assessment Unit and increase in Specialist Rehabilitation bed capacity	Implemented recurrently

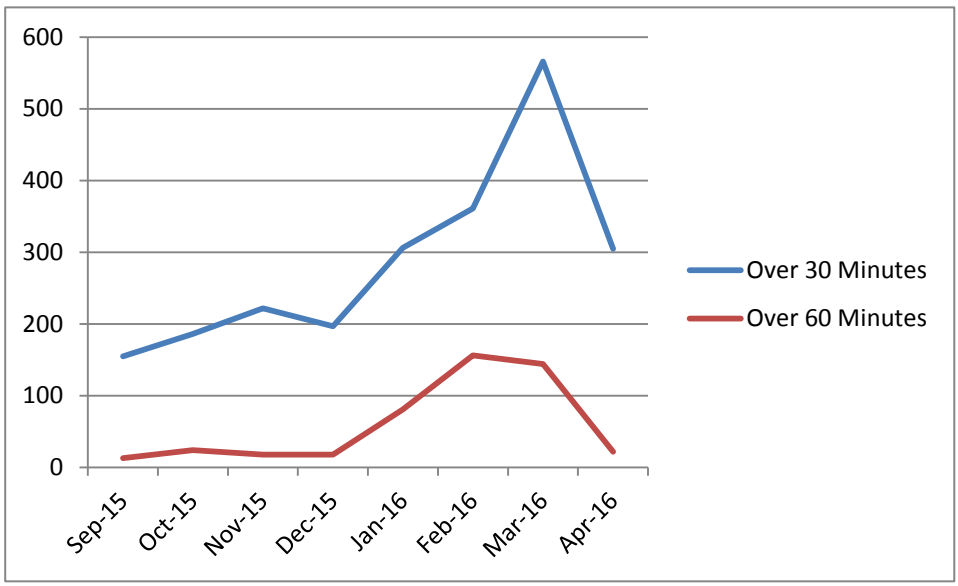
Improved processes resulting in a reduction in delayed transfers/discharges, numbers of long stay patients and average lengths of stay	Implemented recurrently
Implementation of a new site management model	Implemented recurrently
Establishment of a Winter Ward	Winter period only
Provision of additional same day ambulance transport	Winter period only

Following a significant period of improvement during Q2 of 2015/16, both performance against the 95% Emergency Care Standard and ambulance handover times deteriorated during the winter Months of December - March.

95% Emergency Care Standard Performance Sept '15 to Apr '16



Ambulance Handover Delays Sept '15 to Apr '16



Winter typically does not see an increase in ED attendances, but does see both an increase in acute medical admissions and length of stay. During Winter 15/16, acute admissions did increase, but we actually managed to reduce length of stay in the acute medical beds, from an average of 6.4 days in Q2 to an average of 5.5 days in Q4, for acute medical patients, excluding those with a length of stay of less than 1 day.

In considering how we were able to achieve this reduced length of stay, the factors are thought to be:

- Relatively low incidence of outbreaks of diarrhoea and vomiting on the wards
- Ongoing impact of the centralisation of acute medical beds
- Improved clinical model for, and leadership, of the Winter Ward
- Escalation and response to pressure for beds being more effectively deployed than in previous years (implementation of the site model/deployment of Gold Command)

4 PROJECTED WORKLOADS AND BED REQUIREMENTS FOR WINTER 16/17

4.1 Baseline Position

Detailed analysis of baseline activity and bed use figures has been undertaken to inform the development of this year's Winter Plan. The results of this analysis were discussed and endorsed at the Executive Management Committee (EMC) meeting held on 17 August 2016. The analysis showed that, if the Winter Ward is discounted from the establishment, the baseline imbalance between capacity and demand in Medicine is around 50 bed equivalents (in quarter 4). The Winter Plan has therefore been developed with a view to addressing this imbalance as a minimum.

4.2 Patients Lodged in ED

The baseline analysis has been extended to include patients lodged in ED for more than 4 hours during the night. During Q4 of 2015/16, the number of patients in this category averaged 7. On numerous occasions the number was 10 or more, with the 90th percentile figure being 15. Assuming the patients were lodged because inpatient beds were not immediately available, the baseline bed capacity shortfall should be increased by a further 15. Taking this issue into account, the Q4 baseline capacity shortfall is around 65 beds.

4.3 Growth in Demand

Further analysis has been undertaken to quantify the extent to which emergency workloads have increased since last year. ED activity and non-elective bed use for the financial year to date (April to September inclusive) are both significantly higher than the figures recorded in the comparable period last year. The increases are summarised in the following table.

Category	**Increase Qs1&2 15/16 v 16/17**
Emergency Department (HRI):	
Majors	11.5%
Minors	13.0%
Paediatrics	13.3%

Total	11.5%
Bed Use – Short Stay Medical Patients(<1day)	19.1%
Bed Use – Longer Stay Medical Patients (>1day)	6.2%

The percentage increases in demand have been applied to the Q4 baseline activity figures to produce revised workload forecasts for the winter period. If growth in demand continues through the coming winter period at the levels experienced in the financial year to date, around 37 additional beds (or bed equivalents) would be required to accommodate the increased workload (19 for short stay patients and 18 for longer stay patients). This makes the total additional beds required 102, if all of these requirements were to be met.

5 PROPOSED WINTER PLAN ACTIONS 2016/17

It is proposed that a number of actions be taken over the winter period in order to maintain flow and reduce the requirement for inpatient medical beds. Key actions are summarised in the following sections.

5.1 Additional acute medical beds 'The Winter Ward'

Ward 10 at Hull Royal Infirmary (HRI) will be used as a winter ward for the 5 month period from 5 December 2016 to 30 April 2017, providing an additional 27 beds.

The Medicine Health Group is liaising with the Nursing Directorate and the other Health Groups to ensure that appropriate arrangements are in place prior to the additional ward being opened. Medical cover will be provided by 2 junior doctors and 1 Consultant. Action is being taken to recruit locum junior doctors who have previously worked at the Trust. Consultant cover will be provided by existing members of staff on a rota basis. Plans have also been agreed to create an experienced team of nurses for the ward, primarily through redeployment of existing members of staff from all 4 Health Groups.

A Standard Operating Procedure is being developed for the winter ward. It has been agreed that for the coming winter, the ward will accept new patients directly from the Acute Medical and Ambulatory Care Units. A Project Team has been established to oversee implementation and is meeting on a weekly basis.

The Clinical Support Health Group will support the winter ward with additional therapy and pharmacy input. This support will be fully provided 5 days per week, with a more limited service being provided at weekends as per current arrangements with other wards. The additional staffing will be provided in part through use of agency and overtime.

The Facilities Team have also developed plans to support the Winter Ward: Essential staffing and service support will be provided to the winter ward and additional portering support will be provided to the Emergency Department. Provision has also been made to cover set up costs for the winter ward.

5.2 'Time to think beds'

The Trust has agreed to commission 8 nursing home beds to facilitate the early

transfer of patients that are medically fit to leave the acute hospital but are still waiting for ongoing care arrangements to be finalised. This was initiated to respond to the increased demand for acute medical beds as a result of the growth beyond plan in acute medical admissions over the summer, rather than as part of the Winter Plan, but will only come online at the end of November, so will in effect increase bed capacity for the Winter by 8 beds.

5.3 Length of stay

A Ward Improvement Programme is currently being rolled out, facilitated by the HEY Improvement Team. One of the key intended benefits of this programme is a reduction in lengths of stay and demand for inpatient beds. The programme has been re-phased and re-prioritised over the winter period to allow sufficient time for improved processes to be implemented and embedded within each ward area. This will help to secure achievement of benefits, including a reduction in demand during Q4 equivalent to 6 beds.

5.4 Decant of suitable surgical patients from HRI to CHH

The Surgical Health Group have reviewed each of their specialties with inpatient beds on the HRI site to identify cohorts of patients that could be decanted to the CHH site for part of their inpatient stay during the Winter, to create additional capacity for Medicine to utilise on the acute site.

They have identified that there is potential to transfer orthopaedic non-weight bearing patients and that there may be suitable general surgery or vascular cases. Over the Winter period they will ensure that suitable patients are sought on a daily basis and feed this into the lunchtime bed meetings.

5.5 Medicine medical staffing

Following discussion at EMC meeting, it has been agreed that current acute medical staffing rotas will be retained through the coming winter period. Although there are strategic ambitions to develop a self-sufficient Acute Physician rota and to implement new models of emergency assessment in some service areas (eg Gastroenterology and Neurology) these are not considered to be achievable in the short term. Specialist Physician input to the acute medical rota will therefore continue to be provided for the foreseeable future.

5.6 Critical Care

The Critical Care Team has an escalation plan in place and also works closely with The Critical Care network to ensure capacity across the region is used optimally.

Critical Care has a current maximum of 44 beds across sites. There are 22 in HRI and 22 in CHH. There are 30 beds in HOB areas. There are 6 closed ICU beds in CHH (in a separate unit).

In extremis the service would look to:

- staff the critical care beds to care for Level 3 patients
- staff the HOBs to look after Level 2 and Level 1+
- Use 10 recovery spaces, utilising theatre monitors for Level 3 or 2 patients
- commission the 6 closed CHH ICU beds

In these circumstances skills would be scarce and need supplementing with

recovery nurses, HOB nurses and general nurses backfilling HOBs. The skill mix would be diluted and risk would be raised.

5.7 Trauma capacity

The Surgical Health Group has developed plans to increase capacity for Trauma surgery which has been experiencing significant pressures. This has resulted in delays for patients and inefficient use of orthopaedic trauma beds.

The Health Group intends to increase trauma lists at the beginning of December by:

- Transferring neurosurgical back lists, on a Monday, to CHH – 2 lists
- Replacing those with 2 trauma lists in HRI
- Overrunning 4 days per week by 2 hours at HRI giving equivalence of 2 lists. This needs to be monitored to ensure additional activity.
- Displacing other specialties, on a rolling rota, for 2 lists per week
- Enabling 2 equivalence of 2 additional theatres through efficiency gains

This gives up to 8 additional trauma theatres per week.

5.8 Patient Transport

The Trust will procure additional patient transport to facilitate speedy discharge. This will take the form of a call off contract arrangement which will enable the site team to call in additional crews as needed to support the YAS provision.

5.9 Enhanced patient flow management model

During the Winter Period, the Trust will be implementing an enhanced patient flow management model, which will be led by a Director of the day, supported by a General Manager of the day. Key features include:

- Revised command and control arrangements, led by the Director of the day, who will be freed of normal duties
- Allocated lead managers for zoned portions of the bed base
- Twice daily meetings with ED team.
- Daily reporting of tomorrow's discharges at 16:30 each day
- Weekly progress meeting to review 'stranded patients' chaired by the Chief Operating Officer.

6 CHRISTMAS AND NEW YEAR PLANS

6.1 Bank Holiday weekend plans

The Medicine Health Group has reviewed the staffing profiles for all its specialities, with the aim of bolstering consultant support in preparation for, and over, the bank holiday weekends. Many outpatient clinics scheduled for Friday 23rd December, Wednesday 28th December, and Friday 30th December will be cancelled in order to release consultants to provide assessment unit and ward based senior decision making support which will help to expedite patient discharges. Urgent or cancer-related outpatient clinics will not be stood down.

In addition to this intervention, DME will benefit from having additional Consultant support on Christmas Day and New Year's Day; and Medicine will benefit from

having a 4th and 5th RMO rota-ed to work both bank holiday weekends. Cardiology will also ensure that there are Consultants in reaching into CHH over the bank holiday period.

The Surgical Health Group has confirmed that the medical rotas are all in place with appropriate senior (Consultant and Registrar) cover. The specialties have a robust internal system in place to cover any sickness which arises over this period. In addition to this, the nursing rotas have been reviewed and senior leadership is available across the period.

The Surgical Health Group intends to continue with outpatient and endoscopy sessions except where individual consultant leave occurs. However, if required these sessions could be stepped down, except for cancer clinics, 2WW and urgent endoscopy. This would free up between 5 – 15 PAs for each specialty in consultant time, which could be used for additional ward rounds, working into the Emergency Department, or as required. It would also free up approximately double this in nursing time available to support the inpatient wards.

The Family and Women's Health Group and Clinical Support Health Group have both confirmed that plans are in place for all services (including Breast, Plastics, ENT, Ophthalmology and Dermatology) to ensure appropriate cover is available during this period. The medical staffing rotas have been reviewed and are covered to appropriate levels; and all usual emergency cover will be in place.

The Medicine Health Group are also presently liaising with the Surgical and Family and Women's Health Groups to identify whether additional medical inpatient capacity can be generated by utilising any available ward 30 capacity, and / or decanting stable HRI surgical patients to CHH and re-allocating the released capacity for medical admissions. More work is required to finalise these arrangements.

6.2 System partner Bank Holiday weekend plans

GPs in Hull and East Riding will be providing additional same day appointments on Saturday 24th and 31st December and Pharmacists will be opening for short periods on each of the bank holiday days (26th, 27th December 2016 and 2nd January 2017).

The Yorkshire Ambulance Service will be running its 'Charlie Papa' initiative on the evenings and nights of 16th, 17th, 23rd and 31st December. This involved pairing a paramedic with a police office to respond to 999 calls and police calls involving drunkenness, which has previously been shown to reduce conveyances to the Emergency Department.

6.3 Post New Year Surge Recovery Plan

In a bid to maintain emergency flow following the Christmas period, the elective throughput within surgery and orthopaedics will be reduced. Surgery plans to undertake cancer, trauma / emergency and urgent cases from Christmas Eve until the 15th January. Day Surgery at HRI is scheduled for closure for maintenance between the 28th – 30th December for maintenance; however it will maximise throughput from the 2nd – 15th January 2017. This will help to reduce the requirement for inpatient beds on both hospital sites. This will create admission bedded capacity at HRI for the emergency pathway and will help to release staff

from the CHH site to support the increased patient demand at HRI.

In light of the theatres and inpatient beds used by the Family and Women's Health Group for their electives, it was not deemed necessary to reduce their elective activity in the new year. The need to effectively manage the 18 week wait referral to treatment target, in some of its specialities, namely Ophthalmology and ENT, was also a consideration for this decision. The approach is also similar for Clinical Support.

7 ESCALATION PLAN

7.1 The actions that will be taken to deal with significant peaks in demand are set out in the Trust's Escalation Plan. This plan is currently being reviewed and revised as part of the Trust's Emergency Services Improvement Programme. In accordance with recently issued national guidance, the revised plan will be based around 4 levels of escalation as follows.

OPEL 1	**Steady State / Low levels of Pressure**
OPEL 2	**Moderate Pressure**
OPEL 3	**Severe Pressure**
OPEL 4	**Extreme Pressure**

Examples of the actions to be taken in periods of extreme pressure (OPEL 4) include:

- Repeat, where considered appropriate, all actions outlined in OPEL 1 – OPEL 3
- Establish Control Team, (consisting of Director of Operations, Director of Nursing, Medical Director and Ops Support within hours, and On Call Director, Manager and Duty Matron out of hours) to command, control and coordinate tactical response to crisis through to de-escalation
- All clinical on-call teams to attend the hospital for instructions from the Control Team.
- All inpatients to be reviewed with a view to discharge

7.2 System Escalation Plan

The Hull and East Riding System Partners will undertake a daily assessment of the system pressure level utilising the same 4 level system. At levels 3 and 4 system leaders will be convened via conference call to agree the system response.

8 EMERGENCY PREPAREDNESS

8.1 Cold Weather Plan

The Trust has in place a Cold Weather Plan that sets out actions that will be taken at the four Cold Weather Alert levels up to a major emergency. The approach is based on the established Heatwave Plan and is linked to the weather warning system, developed by the Met Office which has been in place for nine years.

This plan includes, for example, the maintenance of a list of 4x4 vehicle driver volunteers and the ability to call on support from the British Red Cross to facilitate transporting staff to and from work, and where appropriate, patients to and from hospital.

8.2 The Flu Plan

The Trust also has a well-established Pandemic Flu Plan. The plan was updated In 2015/16 and signed off by the Trust Resilience Committee.

The Trust has a Flu Vaccination Plan that has proven to be effective in meeting and exceeding national targets for the vaccination of staff. This year the national target is to vaccinate 75% of staff by the end of December 2016 and the team are confident this target will be met.

8.3 The Outbreak Plan

The Trust has a well-established outbreak response, including the management of outbreaks of Norovirus (Winter Vomiting Bug), which has been shown to be effective in limiting the spread and timespan of outbreaks and therefore their impact on bed availability.

As part of the Hull and East Riding System Winter Plan, work is taking place to agree a protocol for health and social care assessments and discharges to care homes to take place in wards closed for infection outbreaks, which will be in place for Winter.

8.4 Business Continuity

Over the last two years there has been significant investment in both time and resource into the development of a structured approach to business continuity across the organisation. ISO 22301 standards have been adopted, resulting in the roll out of a business continuity system, based on best practice and in line with Civil Contingencies Act (2004) statutory requirements. Good progress has been made in a number of service areas (eg Radiology, Pathology, Estates Operations and IM&T) and revised ISO compliant Business Continuity Plans (BCPs) have been produced. Work is ongoing to ensure that BCPs are updated in other key service areas.

8.5 Major Incident Response

The Trust's Major Incident Plan was revised and approved earlier this year. Desktop training sessions have been held to ensure that key members of staff are familiar with the actions to be taken in the event that a Major Incident is declared. Preliminary discussions have taken place with partner organisations, with a view to holding a larger scale Major Incident training exercise next year.

In addition, members of the Senior On-call Rota have received training in leading a response to a major incident.

9 PARTNER ORGANISATIONS

9.1 **The system winter plan**

A system wide plan has been developed, involving the following partners:

- City Healthcare Partnership CIC
- East Riding Council
- East Riding CCG
- Hull City Council
- Hull CCG
- Hull and East Yorkshire Hospitals NHS Trust
- Humber Foundation NHS Trust

A number of elements of the emerging system plan have already been covered in earlier sections of this plan. In regard to plans specifically aimed at meeting the need for additional bed capacity, the plan is as follows:

Hull

- Provision of 13 additional intermediate care beds in Highfields (9) and Rose Villa (4)
- Provision of 4 'step-down' beds
- Provision of additional Home Care packages in Hull (equivalent to 10 beds)

East Riding

- Changes to community hospital service models to facilitate improved use of existing beds which they believe is equivalent to 9 beds, but this assumes 100% occupancy with all spare capacity including Bridlington being available to HEY patients plus approximately 9% improvement in length of stay, from December 2016
- Provision of additional Home Care packages in the East Riding (equivalent to 1 or 2 beds)

The system wide plan has been reviewed through the local Winter Planning Group and has been considered by the local A&E Delivery Board. The Board did not accept the plan was sufficiently comprehensive and as Chair of this Board, the Trust CEO formally wrote to the system CEOs to ask them to review their plans. In particular, he has raised concerns about the community bed and home care package provision being made by East Riding.

The plan was also submitted to NHS England to an end of October 2016 deadline. Feedback from NHS England on the system plan was that they were 'Not Assured' that the plan was sufficiently robust and comprehensive.

9.1 Delayed transfers of care

Work is currently being undertaken with partner organisations in the local health economy to establish a robust and shared understanding of the different causes of delayed transfers and the scale of potential improvement in the short and longer term. Over the next few weeks actions will be agreed and implemented that will achieve immediate benefits. It is anticipated that this will at least prevent an increase in the number of delayed transfer of care patients in acute hospital beds relative to the last winter period. There are, however, numerous systemic factors (eg care home capacity) that could affect the timeliness of transfers and complex discharges, so there is a risk that the position will not be improved over the winter period.

Last Winter we agreed with partners that the target number of patients on the

Discharge Hub active list which were 'medically fit for discharge' would be no greater than 50. The list is currently running at 80 -100 and has been for a number of months. New plans from partners to address this gap would help address the approximately 30 bed shortfall in our combined capacity plans for Winter.

10 IMPACT OF PLANS ON BED REQUIREMENTS

The anticipated impact on inpatient bed requirements of the proposed Winter Plan actions is summarised in the following table.

Action	Impact on Medical Beds
Use of Ward H10 as an additional winter ward	27
Time to think beds	8
Ward Improvement Programme – reductions in length of stay	6
Hull system community beds and packages	27
East Riding system community beds and packages	11*
Total	**79**
Requirement	102
Gap	23*

*Gap may be as much as 30 if ER plans are not delivered.

11 APPRAISAL OF OPTIONS FOR RESPONSE TO THE GAP IN BEDS

11.1 Analysis

The predicted gap in bed provision this Winter is being driven by 2 key factors. First, the growth in acute medical admissions, which is a current and potentially recurrent rather than seasonal issue, equates to the need for 37 additional acute medical beds, based on the difference in activity between Q1&2 15/16 and Q1&2 16/17 continuing. Secondly, the minimal provision of winter capacity by East Riding partners, is contributing to the gap.

There are no easy solutions to bridging this gap; all the options have potential downsides in terms of deliverability, or financial, performance or quality impact. Four options have been identified:

1. Prevail upon our partners to remove c30 patients from the medically discharged list held by the discharge hub
2. Trust to purchase further community bed capacity
3. Create an additional acute medical ward
4. Reduce elective activity at CHH and create a step down facility for patients on the medically discharged list.

11.2 Option 1

This option is considered the most appropriate course of action as it does not raise financial, performance or quality concerns for the Trust and we know there are suitable patients for step down to a more appropriate community setting or to home with domiciliary care support.

Its downside, however, is that it is not within the Trust's gift to deliver. Despite our system winter plan having been deemed as not assuring NHS England that we are 'winter ready' it is not clear what levers we can use to prevail upon partners to do more.

At the A&E Delivery Board on 16 November, continued commitment to achieve a maximum of 50 patients on the medically discharged list was agreed. Achievement of this would require approximately 30 additional patients on the list to be discharged above the daily run rate to 20 being added and 20 removed.

11.3 Option 2

The Trust has already committed to purchase 8 'time to think' beds for East Riding residents. This is costing £100k for 5 months. Subject to more funding being made available, further beds could be purchased in both Hull and East Riding (the exact numbers is not clear but perhaps up to 12, this would cost a further £150k). Furthermore, we know that there are delays in discharge due to waits for care packages and more care packages could be procured if additional funded were made available. However, time is growing short to agree this as a plan as there is a leading time to get contracts and capacity in place.

11.4 Option 3

This option would be extremely difficult to deliver given the pressure on nursing numbers and the lack of a suitable location on the HRI site. It could only conceivably be achieved by compromising another service such as gynaecology or ophthalmology and would also stretch acute medical cover leading to inefficiencies in length of stay.

11.5 Option 4

This option could be delivered but would have a significant financial and performance impact as it would require a reduction in elective activity on the CHH site. Bed occupancy levels are lower at CHH in the surgical services (although this partly reflects the natural peaks and troughs of elective activity). Our benchmarking data suggests there is significant opportunities to reduce length of stay across most of the CHH based specialties including most of surgery, cardiology, infectious diseases and oncology.

A recent attempt to create a therapy led ward on the CHH site for medically discharged patients highlighted that these patients often have significant care needs. As such if this option were to be adopted, there would be work to do on the staffing model and also a need for some degree of medical cover.

11.6 Recommendation

It is recommended that the plan is at this stage approved as it stands, with Option 1 being further pursued for a further 2 weeks. At the same time, plans to implement Option 4 should be worked up, so they can be implemented either in a planned way or as part of an escalation response.

12 FINANCIAL IMPLICATIONS

The revenue consequences of the proposed Winter Plan actions are summarised In the following table. The figures show the costs that will be incurred in the Current financial year, assuming a start date of the 1st December 2016. If service

enhancements continue beyond the 31st March 2017, additional costs will be incurred in the new financial year.

Action	Cost (£000)
Use of Ward H10 as an additional winter ward	534
Maintaining medical staffing rotas	-
Ward Improvement Programme – reductions in length of stay	-
Reduction in number of Delayed Transfers of Care	-
Clinical support services – enhanced provision	166
Non-clinical support services:	
Additional patient transport	92
Support to the winter ward	79
Winter ward set up costs	34
Portering support to ED	41
8 'time to think' beds for 5 months, inc equipment and social work cover	100
Additional cover for bank holiday weekends	71
Total	1,117

13 COMMUNICATION

A Communication Plan is being developed with a view to ensuring that:

- All relevant members of staff are properly briefed regarding the service arrangements set out in the Winter Plan, the SOP for inpatient flow and the System Escalation Plan
- All relevant members of staff are familiar with their individual responsibilities in implementing the service arrangements set out in the Winter Plan, the SOP for inpatient flow and the System Escalation Plan

The Communication Plan recognises that a limited amount of information about the Winter Plan can be cascaded to staff through established departmental briefing systems. A series of specific communications and events will therefore be organised in order to ensure that awareness is raised to the required levels.

14 RISKS

A risk assessment has been undertaken to identify risks associated with the t Winter Plan and is attached as appendix 1.

14 RECOMMENDATION

The Performance and Finance Committee is asked to approve the 2016/17 Winter Plan.

Jacqueline Myers
Director of Strategy and Planning
17 November 2016

WINTER PLAN RISK REGISTER

Risk	Pre Mitigation			Mitigating Action	Lead	Post Mitigation		
	L	I	Tot			L	I	Tot
It will not be possible to deploy all of the additional staffing resources identified in the plan	4	4	16	All options (planned redeployments, substantive appointments, interim appointments, bank, overtime and agency) will be used to ensure that clinical staffing is deployed to the required levels. Additional capacity will only be deployed as safe staffing levels allow.	Medicine HG	2	4	8
There is failure to finalise senior medical staffing rotas	3	4	12	EMC has agreed that no major changes should be made to the acute medical rota over the winter period	Medicine HG	1	4	4
There will be insufficient acute medical beds for the numbers of patients requiring admission	4	4	16	Workload forecasts for the winter period include a provision for growth that is consistent with increases seen in the first 6 months of 2016/17. Escalation plans and procedures are being reviewed at organisation and system level to ensure that any peaks in demand can be managed safely and efficiently.	Medicine HG Surgery HG	3	4	12
Service capacity in the community and support to discharge and transfer of care processes will be adversely affected by reductions in Social Care budgets	3	4	12	Plans for the provision of adequate levels of health and social care services through the winter period will be reviewed and endorsed by the A&E Delivery Board	CEO/COO	2	4	8

The proposed package of actions in respect of patient flow and discharge will not reduce demand for inpatient beds to the level anticipated	3	4	12	New, enhanced patient flow arrangements to be implemented for winter	COO	2	4	8
Reductions in care home bed capacity will adversely affect the flow of patients through the system, creating capacity pressures in the acute hospitals	3	4	12	The provision of planned levels of health and social care provision will be reviewed by the A&E Delivery Board and remedial actions taken if necessary	CEO/COO	3	3	9
Emergency service capacity will be adversely affected by severe weather or by an outbreak of flu	3	4	12	Remedial actions will be taken in accordance with the Trust's agreed severe weather and flu outbreak plans	Medicine HG Surgery HG	3	3	9
Actions set out in the Trust's Escalation Plan will not be implemented because staff are not familiar with the agreed arrangements	4	3	12	The Trust's Escalation Plan is currently being updated as part of the Emergency Services Improvement Programme. A comprehensive Communications Plan will be implemented to ensure that staff members are familiar with the agreed arrangements.	Jonathan Wood (Project 5)	3	3	9

TRUST BOARD REPORT 2016 – 11 - 15	
Meeting date:	24 November 2016
Title:	Trust Strategy Implementation Plan
Presented by:	Jacqueline Myers Director of Strategy and Planning
Author:	Jacqueline Myers Director of Strategy and Planning
Purpose:	To agree the Plan for Implementation of the Trust Strategy
Recommendation(s):	That the Trust Board approves the plan.

TRUST STRATEGY 2016-2021

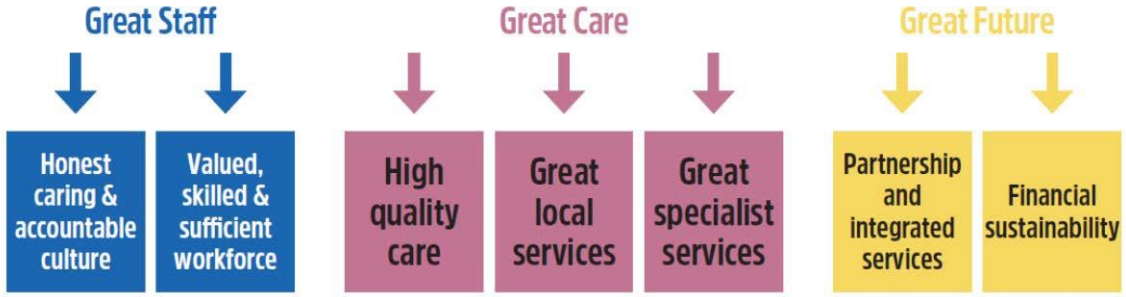
IMPLEMENTATION PLAN

1 PURPOSE OF THE PAPER

The purpose of this set out an approach to the implementation of the Trust Strategy, for agreement by the Trust Board.

2 BACKGROUND

The Trust Strategy 2016-2021 was approved by the Board in April 2016. The Strategy sets out the Trust's approach to the achievement of our vision and does so by defining a number of long term goals, setting the scope and level of ambition for each goal over the next five years, and providing guidance on the approach or 'strategy' we plan to take in achieving those goals.



3 IMPLEMENTATION PLAN

3.1 Governance of plan delivery

The recommended approach for governance of the implementation of the Trust Strategy, is for each goal to have a named lead manager and Trust Committee. Once this is agreed, chairs of these committees will be asked to review their terms of reference to ensure the remit of the committee includes oversight of delivery of this goal. (In most cases this will already be the case). The named lead managers in each case are members of the relevant Trust Committee and will take the lead for reporting progress towards the goals.

Overall responsibility for implementation of the plan will sit with the Executive Management Committee (EMC).

Following approval of this implementation plan, the Strategy and Planning Team will co-ordinate a process of agreeing the yearly milestones for progress towards the goals, with the lead managers and submit the outcome of this work to EMC, for approval. Thereafter, twice yearly progress reports will be submitted to EMC.

Health Groups will be required to support the delivery of the goals and this will be managed via the annual planning round. Where relevant, health group responsibilities will be set out in the planning guidance and their responding plans will be captured within their operational plans.

Annually, the Trust Board will receive a progress report and also revisit the Trust Strategy to either recommit to it or commission a refresh.

3.2 High level implementation plan.

To provide assurance on the process to date, a high level implementation plan, which has been approved by EMC, is attached as appendix 1. The Plan identifies the following:

- Domain
- Five year goal
- Actions to deliver the goal
- Key performance indicators
- Timescale for delivery
- Lead responsibility
- Progress to date
- Monitoring committees

3.3 Supporting Strategies

As discussed at the Board Development Day, the recommended suite of supporting strategies is:

- Quality Strategy
- Clinical Services Strategy
- People Strategy
- Estates Strategy
- Information Management and Technology Strategy
- Research and Innovation Strategy

The People Strategy was recently approved by the Trust Board. The remaining strategies are in the process of being revisited and will come forward for approval during Q4 of 2016/17 and Q1 of 2017/18.

4 RECOMMENDATION

The Trust Board is asked approve the recommended approach to the implementation of the Trust Strategy

Jacqueline Myers
Director of Strategy and Planning

Trust Strategy Implementation Plan 2016 **Appendix 1**

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
Honest, caring and accountable culture		Move our NHS Staff Satisfaction Survey results into the Top 20% of Trusts	Implementation and delivery of the Trust's People Strategy.	We will be in the top 20% of Trusts for staff who would recommend the organisation as a place to work and receive treatment. (Baseline: Ranked as the lowest (worst) 20% in 2015)	2019	Director of Workforce and Organisational Development	Score of 3.57 in 2015	Workforce and Transformation Committee	
		Improve the 'overall engagement' score on the NHS Staff Satisfaction Survey to the Top 20% of Trusts	Implementation and delivery of the Trust's People Strategy	We will be in the top 20% of Trusts for 'overall engagement' in the National Staff Survey (Baseline: Ranked as below (worse than) average in 2015	2019	Director of Workforce and Organisational Development	Score of 3.74 in 2015	Workforce and Transformation Committee	
		Evidence that we are a learning organisation, as per the objective set under our patient safety goal.	Creation of a learning focussed culture	Reduce the occurrence of moderate, severe and catastrophic harm to patients to less than the peer average	Annual Progress To 2021	Chief Medical Officer		Operational Quality Committee	
		Increase the proportion of positive media stories about the Trust	Promotion of service developments and the initiatives undertaken to improve patient care and experience.	Positive stories form more than 75% of the total number of stories about the Trust appearing in the media.	Annually	Director of Communications and Engagement		Executive Management Committee	
Valued, Skilled and Sufficient Workforce		Increase the percentage of staff recommending us as a place to work	Implementation and delivery of the Trust's People Strategy.	Over 80% of staff will say that they would recommend the Trust as a place to work, as reported in the National Staff Satisfaction Survey. (Baseline: 53%	2019	Director of Workforce and Organisational Development	53% in 2015	Workforce and Transformation Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		Reduction in the number of vacancies	Implementation and delivery of the Trust's People Strategy	Vacancy factor of less than 5%	2019	Director of Workforce and Organisational Development		Workforce and Transformation Committee	
		Reduction in staff turnover	Implementation and delivery of the Trust's People Strategy	Staff turnover is less than 8% per annum	2019	Director of Workforce and Organisational Development		Workforce and Transformation Committee	
		Create a range of new roles and working arrangements to improve cover in our hardest pressed teams	Development and deployment of novel roles, including physician associates, assistant practitioners and nursing associates.	50% reduction in medical rota gaps	2021	Director of Workforce and Organisational Development		Workforce and Transformation Committee	
High Quality Care		Achieve and sustain an overall CQC rating of 'Good' or 'Outstanding'	Through achievement of the goals set out in the Trust's Strategy.	Trust achieves overall rating of 'Good' or 'Outstanding' from CQC (Baseline – 'Requires Improvement' May 2015)	2021	Chief Executive Officer	Overall rating of 'Requires Improvement' (May 2015)	Executive Management Committee	
	Safe Care	Reduce avoidable deaths within the Trust	Creation of robust mortality and morbidity team review system across the Trust and a structured review of the patient record for all deaths Development and delivery of improved identification and management of deteriorating patients	Avoidable deaths reduced by 50% (Baseline:	2021	Chief Medical Officer		Mortality Committee	
		Reduce avoidable harm within the Trust	Improved performance on our wards and	Avoidable harm reduced by 50%	2021	Chief Medical Officer		Operational Quality	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
			departments in the fundamentals of care. Reduced medication errors, supported by an E-prescribing system.	(Baseline:				Committee	
		Increase the level of incident reporting	Improvement of the organisation's culture and further development of our learning systems to support increased reporting of incidents and evidence of lessons learnt, including the use of patient stories.	Trust is in the highest 25% of organisations reporting incidents	2021	Chief Medical Officer		Operational Quality Committee	
		Reduction in the occurrence of moderate, severe and catastrophic harm to patients.	Reduced errors during surgery or other procedures, including never events, through further development of operating team safety culture and systems	Incidence of occurrence is less than the peer average (Baseline:	2021	Chief Medical Officer		Operational Quality Committee	
		Increase in 7 day working within our urgent care services	Implement further changes to our acute services to ensure equitable service provision.	Compliance with the Seven Day Services clinical standards (2013), in particular the 4 'must do' standards.	Nov 2017	Chief Medical Officer	Audit in progress 2016)	Operational Quality Committee	Stocktake of progress against the Seven Day standards in progress (Oct 2016)
	Great Patient Experience	Reduce the number of outpatient appointments cancelled by the Trust	Delivery of the Outpatient Improvement Project, including provision of a booking system that offers patient choice of appointment time, identification and removal of causes of appointment cancellations, elimination of the backlog of overdue follow up appointments.	50% reduction in the number of outpatient appointments cancelled by the Trust (Baseline:	2021	Programme Director (Improvement)		Portfolio Board	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		Reduce complaints and PALS concerns relating to outpatients	Delivery of the Outpatient Improvement Project, including provision of a booking system that offers patient choice of appointment time, identification and removal of causes of appointment cancellations, elimination of the backlog of overdue follow up appointments.	50% reduction in the number of complaints and PALS concerns	2021	Programme Director (Improvement)		Portfolio Board	
		Move our benchmark score in the NHS In patient Survey responses on discharge to the top 20% of Trusts	Working with partners, deliver enhanced discharge arrangements, including the use of the 'Ticket Home' system and the SAFER bundle, including daily ward 'board rounds'.	We will be in the Top 20% of Trusts for discharge in the NHS Inpatient Survey. (Baseline: Score of 6.8 in the 2015 Leaving Hospital section. Lowest = 6.1, Highest = 8.4)	2021	COO/ Chief Nurse	Score of 6.8 in the Leaving Hospital section of the 2015 Inpatient Survey	Operational Quality Committee	
		Increase the percentage of patients who would recommend the Trust to friends and family	Delivery of the Outpatient Improvement Project. Improved discharge arrangements. Delivery of Dementia Strategy Improvements to the patient environment Development and delivery of responsive and accessible communications with patients in call care settings	The Trust will be in the Top 20% of Trusts in the Friends and Family Test. (Baseline:	2021	Chief Nurse		Operational Quality Committee	
	Great Outcomes	Define and develop the scope and reach of our research	Development of our Clinical Trials Unit in association with the	Unit in place X Increase in trial activity	2021	Chief Medical Officer		Executive Management Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		programmes	University of Hull. Delivery of a research plan to develop our strengths.	Trust renamed as University Teaching Hospital					
		Achieve upper quartile performance in the peer review programmes for our specialist services	Provision of leadership and support to our specialist services. Implementation of nationally approved best practice guidance and care bundles	We will be in the Top 25% of Trusts for each of our specialist services as measured by the individual peer reviews.	2021	Chief Operating Officer		Operational Quality Committee	
		Deliver 10,000 health prevention interventions, aimed at reducing smoking, obesity and alcohol abuse	Deployment of a 'Making Every Contact Count' plan in conjunction with public health and other provider partners, utilising our staff to provide advice and signposting to prevention services	Monitoring in place to evidence 10,000 interventions Improved uptake of smoking cessation across health economy	2021	Chief Medical Officer/ Chief Nurse		Operational Quality Committee	
		Further develop our diagnostic services, accessing the latest technology and meeting demand	Invest in renewed diagnostic equipment. Increase productivity of diagnostic services. Eliminate unnecessary tests. Development of partnership and network relationships	<=1% of patients waiting over 6 weeks for a diagnostic test.	Annually	Chief Operating Officer	3.4% Aug 2016	Performance and Finance Committee	
Great Local Services	**Great Local Urgent Care Services**	Achieve sustained delivery of the emergency care standards	Continued focus and support on the delivery of our Emergency Care Recovery Programme.	>=95% of patients seen within the Emergency Department within 4 hours Nil 12 hour trolley waits	Annually Annually	Chief Operating Officer	86.62% Aug 2016 0	Performance and Finance Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
				Nil ambulance turnaround times of over 30 minutes Nil ambulance turnaround times of 60 minutes and over			Aug 2016 402 July 2016 94 July 2016		
		Collaborate with our patients and partners to transform our services for older people with complex needs	Contribute to clinical expertise and system leadership in the development of new models of care, including community-based, integrated service for the care of frail older people, and fully integrated services for people with long term conditions, starting with COPD, heart failure and diabetes	New model of care for frail older people in place in Hull and East Riding	2021	Director of Strategy and Planning		Executive Management Committee	
		Involve our patients in the development of their future care plans, giving them the chance to influence the way they access and receive care	Further development of scope of Patient Council	Evidence of patient involvement in all key for a and developments	2021	Head of Patient Experience		Operational Quality Committee	
		Improve the number of patients who are able to die in their place of choice	With our partners, develop and enhance our approach to advanced care planning	Increased deaths in place of choice	2021	Medical Director, Clinical Support Services		Operational Quality Committee	
		Reduce unnecessary admissions to hospital and length of stay to below peer average	Implement the Urgent and Emergency Care Improvement Programme	X reduced admissions for conditions amenable to ambulatory care Length of stay below CHKS peer group average	2018	Chief Operating Officer		Performance and Finance Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		Ensure our integrated teams have access to shared care records	Implement the Digital Roadmap	Portal for shared access across Hull and East Riding implemented.	2021	Director of IM&T		Performance and Finance Committee	
		Deliver further improvements to our acute pathways	Implement the Urgent and Emergency Care Improvement Programme	Revised pathways and models in place and improved performance against baseline	2017	Chief Operating Officer		Operational Quality Committee	
	Great Local Elective (Planned) Services	Reduce our over 18 week RTT waiting list and achieve sustained compliance with the 92% incomplete target in 2016/17	Delivery of Theatre and Outpatient Improvement Projects. Completion of RTT recovery plan	Sustained compliance with requirement that >=92% of patients waiting less than 18 weeks from referral to treatment (incomplete pathway)	March 2018	Chief Operating Officer	87.9% Aug 2016	Performance and Finance Committee	
		Reduce our longest waits from referral to treatment to 40 weeks by 2017/18	Delivery of Theatre and Outpatient Improvement Projects. Completion of RTT recovery plan	No patients waiting 40 weeks or more from referral to treatment.	March 2017	Chief Operating Officer		Performance and Finance Committee	
		Achieve sustained delivery of the cancer waiting time standards in 2016/17	Delivery of Theatre and Outpatient Improvement Projects. Completion of RTT recovery plan	Compliance with each of the cancer waiting times standards	March 2018	Chief Operating Officer	62 day cancer screening - 80.68% July 2016	Performance and Finance Committee	
		Move our benchmark score in the NHS Outpatient Survey into the Top 20% of Trusts	Delivery of Outpatient Improvement project	The Trust will be in the Top 20% of Trusts in the NHS Outpatient Survey (Baseline: Overall rating of 85 in the 2011 Survey)	2021	Chief Operating Officer	Overall rating of 85 in the 2011 Survey (Top 20% threshold = 86)	Operational Quality Committee	
		Ensure we provide our elective patients with a	Delivery of Theatre and Outpatient Improvement	Evidence of patients being offered a choice of	2018	Chief Operating Officer		Operational Quality	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		choice of appointment and operation date	Projects. Improved demand and capacity modelling and planning at service level	appointment				Committee	
		Work with our commissioners on the 'Right Care' Programme	Agreed suite of clinical thresholds and revised pathways in place	Evidence of reduced clinical variation and demand	2021	Chief Operating Officer		Performance and Access Group	
		Broaden the range and volume of services we offer in the community	New community services in place Increased use of virtual technology	Increased activity volumes outside CHH and HRI sites Increased virtual clinic activity	2021	Chief Operating Officer		Executive Management Committee	
Great Specialist Services		Improve our patients' experience of cancer, as measured by the Cancer Patient Survey and increase our 1 and 5 year survival rates	Development of Trust Cancer Strategy. Development of network relationships with Sheffield and Leeds Trusts	Improve on the baseline average rating of 8.8 in the Cancer Patient Survey (July 2016) Increase the number of cancer patients surviving beyond 1 year Increase the number of cancer patients surviving beyond 5 years	2021	Medical Director, Clinical Support Services	Average rating of 8.8 (July 2016)	Performance and Finance Committee	
		Move our Major Trauma Centre into the top 50% of centres in the National Peer Review	Delivery of the Major Trauma Action Plan and development of a strategy for the phase of development and improvement	The Trust is ranked in the Top 50% of MTCs as measured by the National Peer Review process.	2018	Director of Strategy and Planning		Performance and Finance Committee	
		Work with our provider partners to create a portfolio of high	Agreement of the future configuration of vascular services	Designation of Vascular Centres completed	2018	Director of Strategy and Planning		Executive Management Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
		quality, network and commissioner supported specialist services	Continued joint working with York and NLAG Trusts Development of network relationships with Sheffield and Leeds Trusts	Memorandum of understanding in place between Trust Boards and refreshed governance structure implemented.					
Partnership and Integrated Services		Support the development and delivery of the STP and the Hull and East Riding transformation plans	Provision of resources, leadership and expertise Participation, support and alignment to system wide efforts on IM&T, workforce and estate Continued partnership working with neighbouring and regional acute provider partners	STP agreed Hull and East riding Transformation Plan agreed and implemented	2021	Chief Executive		Executive Management Committee	
		Develop clinical and service networks and partnership arrangements to support the sustainability of acute and specialist services across our region	Establish new Cardiac Network and Cancer Alliance	New Cardiac Network and Cancer Alliance in place	2018	Director of Strategy and Planning		Executive Management Committee	
Financial Sustainability		Agree and implement plans with partners to achieve financial balance across our health system	Performance and Finance Committee	Financial balance achieved across the system	2021	Chief Finance Officer		Performance and Finance Committee	
		Make savings in our cost of supplies and purchases	Development and delivery of ambitious procurement programme	Savings identified and delivery (TBC)	2021	Chief Finance Officer		Performance and Finance Committee	

Domain	Sub-Section	5 Year Goal	How we will deliver our goal(s)	How will we know we have achieved our goal(s)? (Key performance indicators)	Timescale	Lead Responsibility	Progress to Date	Monitoring Committee	Supporting Comments
			Roll out of GS1 asset tagging technology Work with staff to identify and eliminate waste, duplication and non-value adding activities						
		Remodel our workforce to optimise our use of human resources	Improve workforce planning and modernisation working with partners and deployment of technology to bridge workforce gaps.	Evidence of new workforce models in place	2021	Director of Workforce and Organisational Development		Performance and Finance Committee	
		Increase our productivity in our theatres and outpatient clinics	Roll out of theatres and outpatient improvement projects across all specialties	Achieve increased activity as scoped by the programme board	2018	Programme Director (Improvement)		Portfolio Board	
		Reduce our overall estate size, whilst increasing our activity	Refresh the Trust Estates Strategy, taking account of system plans.	New strategy implemented	2021	Director of Estates, Facilities and Development		Performance and Finance Committee	
		Eliminate paper usage and facilitate mobile working	Refresh the Trust's IM&T Strategy, taking account of system plans	New strategy implemented	2021	Director of IM&T		Performance and Finance Committee	
		Modernise our 'back office' functions, reduce costs and improve performance	To be delivered as part of the 'Carter' efficiency programme Roll out of GS1 asset tagging technology	Back office savings realised in line with Carter targets and STP plans	2021	Chief Finance Officer		Performance and Finance Committee	

Trust Board 2016 – 11 - 14	
Meeting date:	24th November, 2016
Title:	Agency Spend – Self Certification
Presented by:	Simon Nearney, Director of Workforce and OD
Author:	Simon Nearney
Purpose:	The purpose of the report is to seek Trust Board approval for the agency spend self-assessment that has been completed by the Trust.
Recommendation(s):	The Board is requested to note the current position and approve the self-certification document
Board/Board Committee Review:	Presented at Performance and Finance Committee on 21st November, 2016.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AGENCY SPEND - SELF CERTIFICATION

1. Purpose

The purpose of the report is for the Trust Board to approve the agency staff position self-certification. NHS Improvement has requested all Trusts complete a self-assessment to ensure the Trust is managing, has control and is actively seeking to reduce agency spend.

2. National Context

The Trust received its first NHS Improvement (North) monthly agency performance report in October 2016. This gave Trusts further information and guidance on how to reduce spend on agency staff and to encourage benchmarking with other Trusts to assess their current performance against peers. This was intended to also generate and encourage better collaboration across Sustainability and Transformation Plan (STP) footprints and wider.

It has been one year since NHS Improvement introduced agency rules and overall the sector has reduced agency spending by £600m, i.e. 21% lower than in the first 6 months of last year. However all Trusts in the Northern region are not meeting their agency spend control target for 2016/17, so further work is required.

3. Hull and East Yorkshire NHS Trust (HEY) Current Performance

HEY spent £12.8m on agency staff during 2015/16. The Trust's NHS Improvement control target was set at £9.5m for 2016/17. At month 7 the Trust has spent £7.3M on agency staff which would give HEY a predicted outturn position of between £12-13m.

The control totals were set to achieve a 25% improvement on last year's agency spend. As we spent a relatively lower sum on agency staff than many Trusts, arguably this target was more challenging for us to achieve.

In terms of our position in the northern region the benchmark data released (April to September, 2016) shows HEY's performance as follows:

- We are 27.7% away from our control target at month 6.
- We are ranked 53 out of 73 Trusts for agency spend against our control target.
- We are ranked 31 out of 73 for agency spend as a percentage of the Trust's pay budget.

A Comparison with our STP partners:

Trusts	Agency spend vs control target %	Rank	Agency spend as % of pay bill - Rank
HEY	27.7	53	31
NLAG	1.8	32	65
YORK	14.9	59	59

The Trust has implemented a number of improvements and actions referenced in previous papers to the Board's Performance and Finance (PAF) Committee and most recently all agency expenditure has had to be approved at Director level. Agency spend is also discussed at Health Group monthly performance meetings where Health Groups are challenged to manage and reduce agency spend and importantly to develop innovative solutions to tackle staffing shortages. In addition, monthly reports on agency spend are presented and debated at the Performance and Finance Committee.

Given that most Trusts are not achieving their control target, NHS Improvement has issued further guidance and new reporting arrangements to further assist Trusts to manage and reduce agency spend. These actions have been discussed at PAF Committee and are being implemented.

4. Self-certification

NHS Improvement has requested all Trusts to carry out a self-assessment with regard to the best practice and controls in place to manage and reduce agency spend. The completed self-assessment is attached at appendix 1.

The Trust is actively seeking to manage and control agencies spend. The Trust has reliable information and has identified the services with the highest spend and the reasons for this. This is being managed and innovative solutions are being considered to address staffing shortages. However not all plans can be delivered due to the national shortages in some occupational positions. Also it is likely that "winter pressures" and recovery of shortfalls in activity will impact upon our agency spend position.

5. Recommendations

The Trust Board is requested to note the Trust's position and approve the agency staff self-certification to be submitted to NHS Improvement.

Simon Nearney
Director of Workforce and OD
Tel: 01482 676439

Hull and East Yorkshire Hospitals NHS Trust

Trust Board 2016 – 11 - 16	
Meeting date:	24th November, 2016
Title:	Transforming HEY's Culture – Progress Report FFT Quarterly Staff Survey – September, 2016
Presented by:	Simon Nearney
Author:	Simon Nearney
Purpose:	The purpose of this report is to inform the Trust Board of the results of the 2nd quarter FFT Staff Survey that was completed in September, 2016.
Recommendation(s):	The Board is requested to note the progress that 9is being made across the Trust.
Board/Board Committee Review:	Approved by Workforce Transformation Committee and Executive Management Committee.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRANSFORMING HEY'S CULTURE – PROGRESS REPORT
FFT QUARTERLY STAFF SURVEY

THURSDAY 24th NOVEMBER, 2016

PURPOSE

The purpose of the report is to provide a progress update to the Trust Board regarding the 2nd quarter staff survey results, that was completed in September, 2016.

BACKGROUND

The Trust is required by NHS England to survey staff quarterly with the following two questions:

1. How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend Hull and East Yorkshire NHS Trust to friends and family as a place to work?

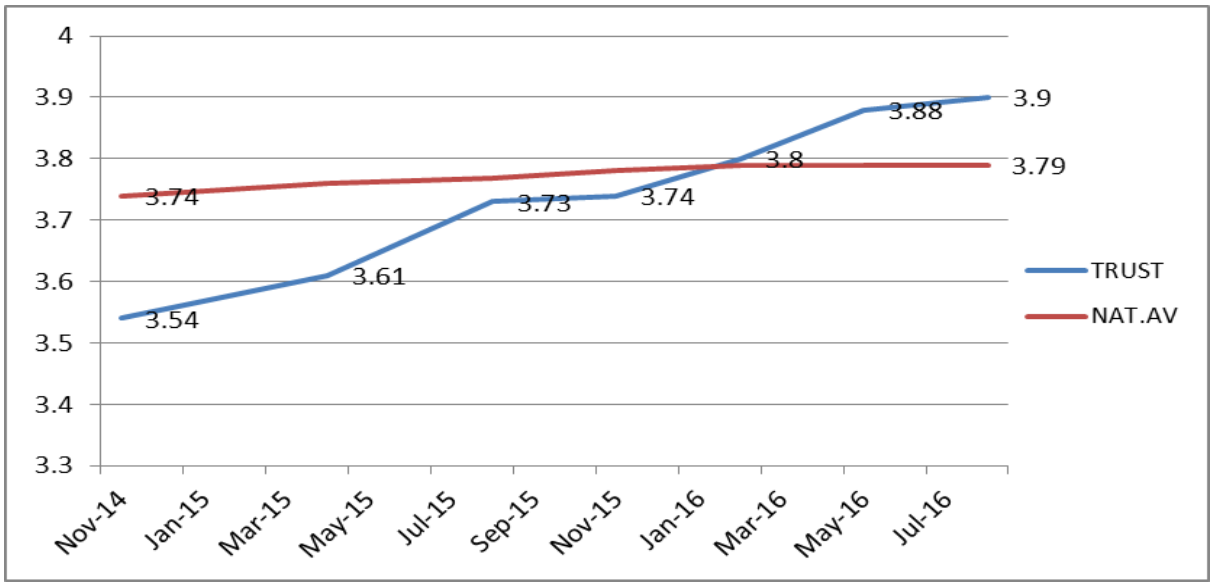
As part of the organisation's ongoing work to improve the culture of the Trust the decision was taken at the beginning of 2015 to extend the survey to reflect the questions in the national staff survey which make up the score for 'overall engagement':

3. I believe care of patients is the Trust's top priority
4. I have frequent opportunities to show initiative in my role
5. I am able to make suggestions to improve the work of my team/dept
6. I am able to make improvements happen in my place of work
7. I look forward to going to work
8. I am enthusiastic when I am working
9. I feel time passes quickly when I am at work

A further two questions were included at the request of the PaCT (Professionalism and Cultural Transformation) Committee:

10. Communication between senior managers and staff is effective
11. My Trust encourages staff to report errors

The overall score for engagement (which is out of a maximum of 5) has improved significantly since the 2014 Staff survey. While the National Average for overall engagement has increased slightly from 3.74 to 3.79 the Trust's score has shifted from 3.54 to 3.90 across the period November 2014 – August 2016:

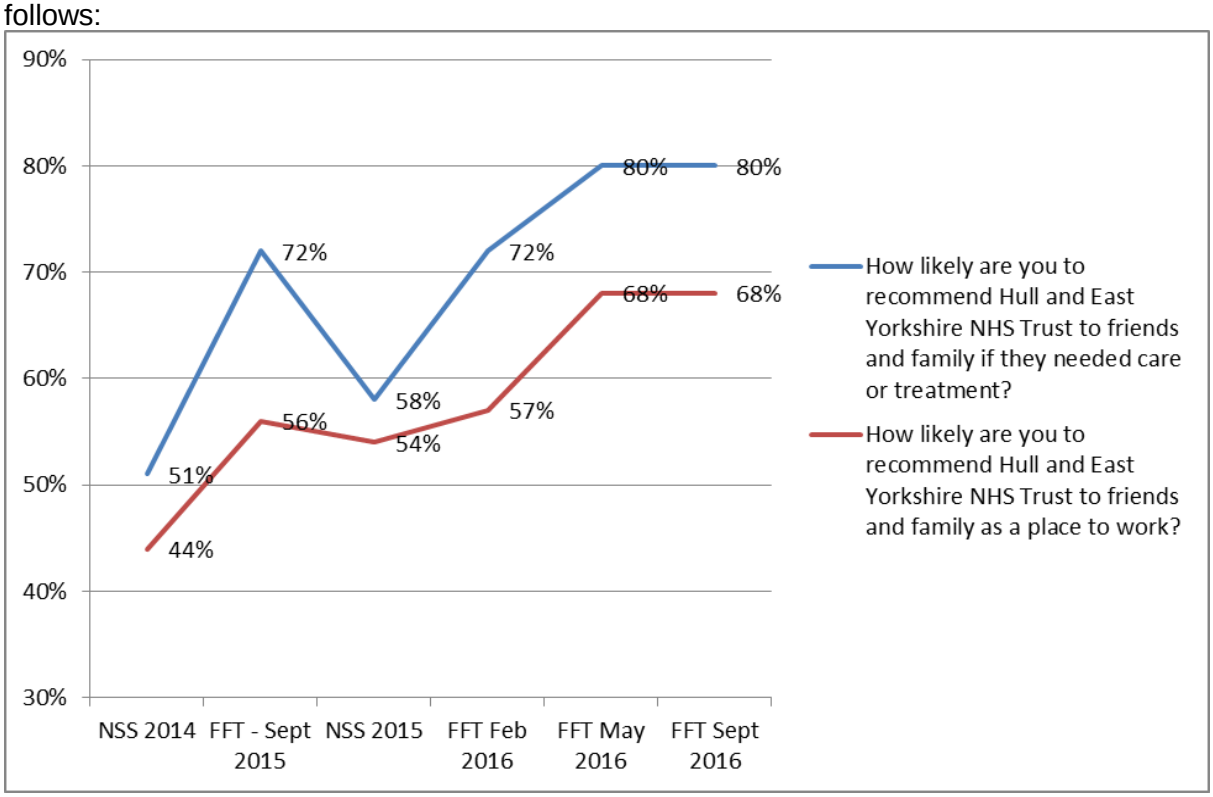


OVERALL TRUST SCORES

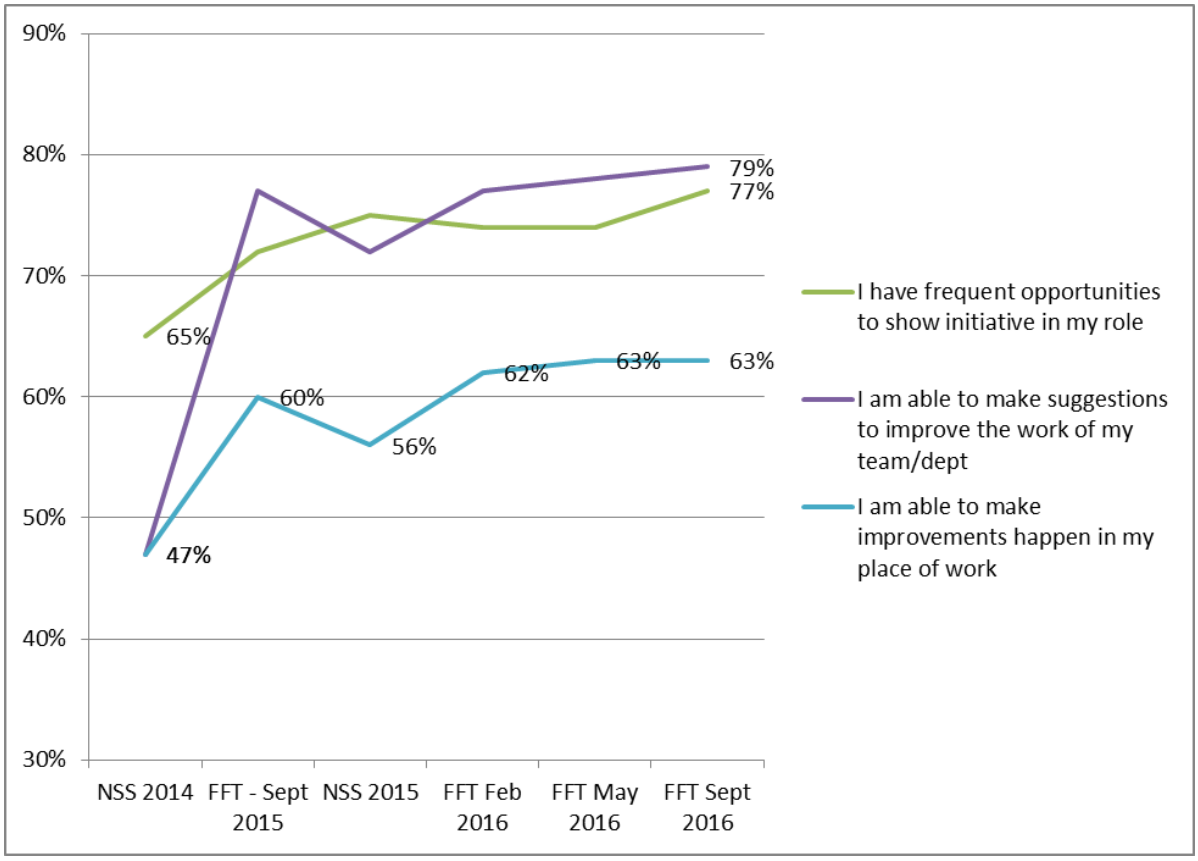
Hull and East Yorkshire Hospitals NHS Trust Staff FFT for Quarter Two 2016/17 operated from 5th September until 19th September 2016. 8,000 staff were invited to participate, with 1,589 responding, equivalent to a 20% response rate.

The comparison table for the latest FFT Staff Survey indicates a continuing improvement across most scores since May 2016.

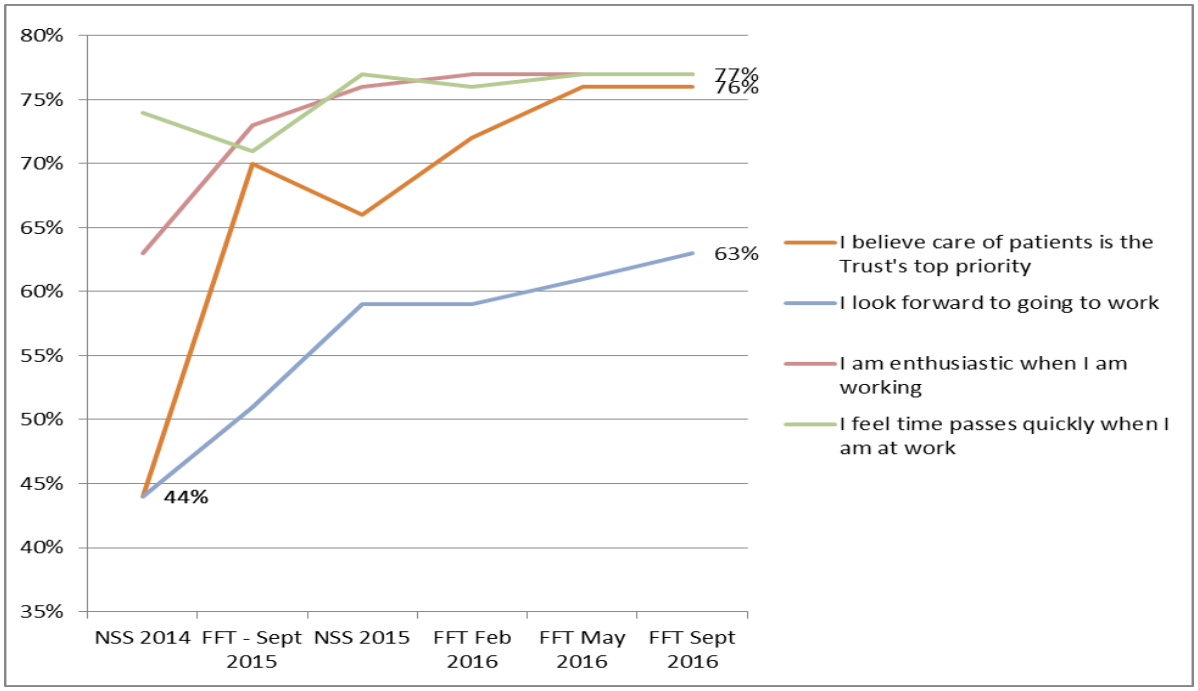
For the two key questions relating to recommending the Trust as a place to receive care (national average 70%) or to work (61%) our performance over the past six surveys is as follows:



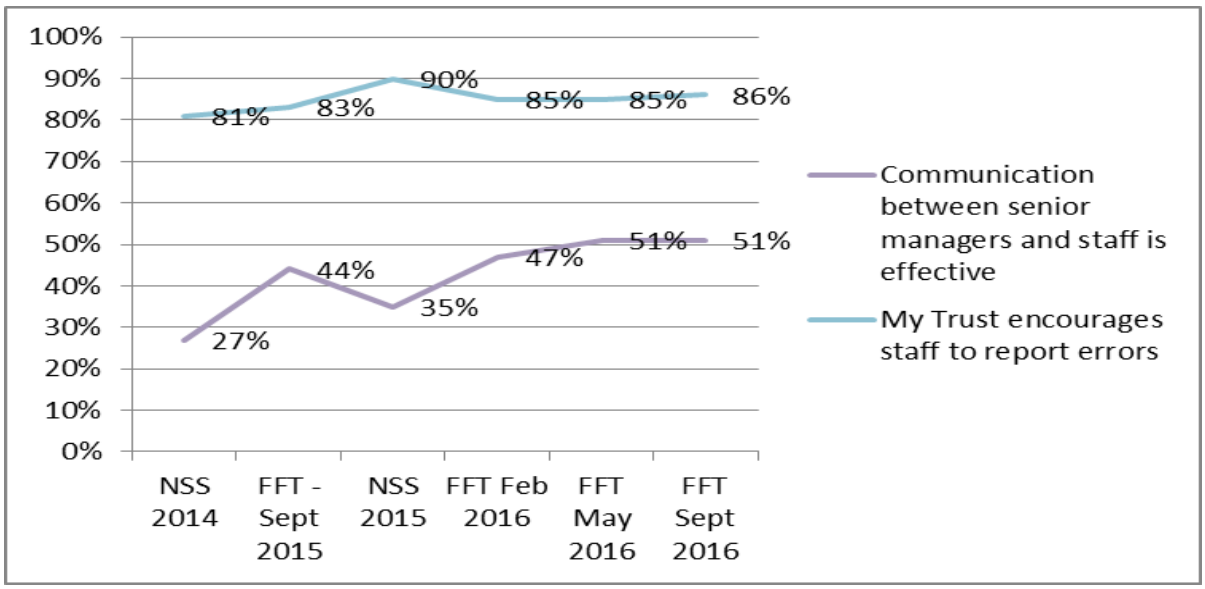
For the three questions relating to making suggestions for improvement (national average 75%), using initiative (73%) and ability to deliver quality improvement (55%) our performance over the past six surveys is as follows:



The Trust is only worse than the national average for one of the nine questions which make up the score for 'overall engagement': I Feel Time Passes Quickly When I'm at Work. Performance against the questions which relate to pride and enjoyment at work, our trend data is as follows:



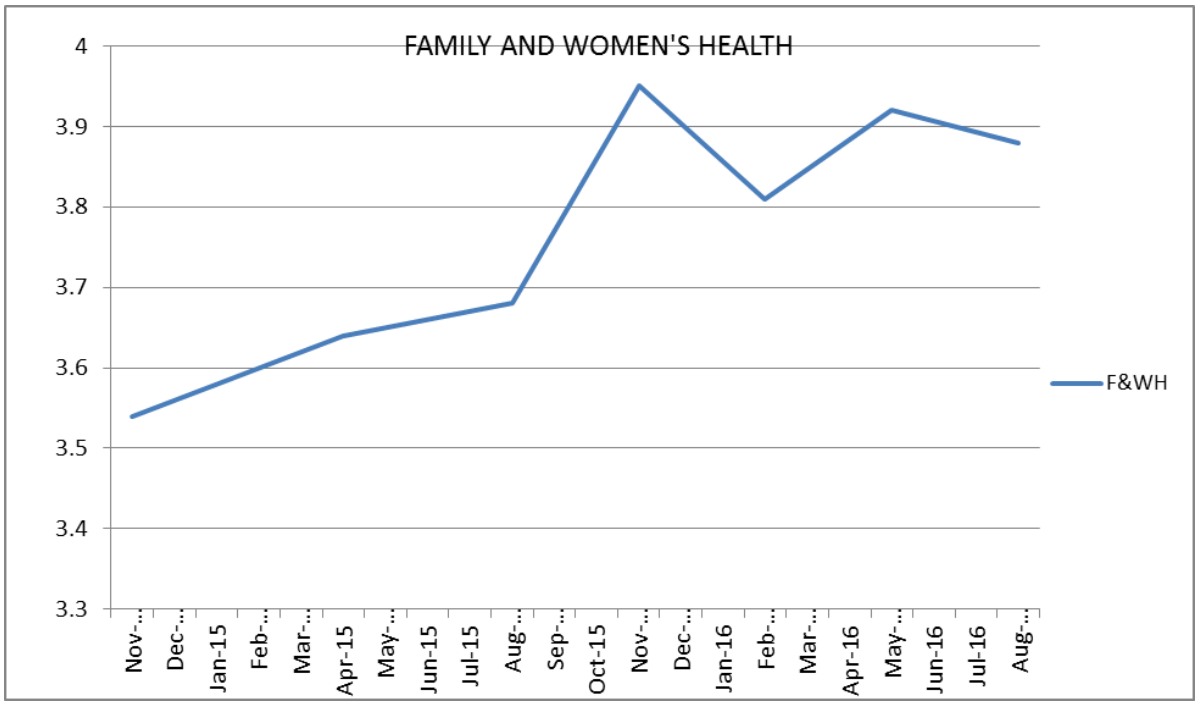
For the two additional questions we ask staff, our trend performance is as follows, where the national average for Communication between senior managers and staff is 39% and the national average for reporting errors is 88%.

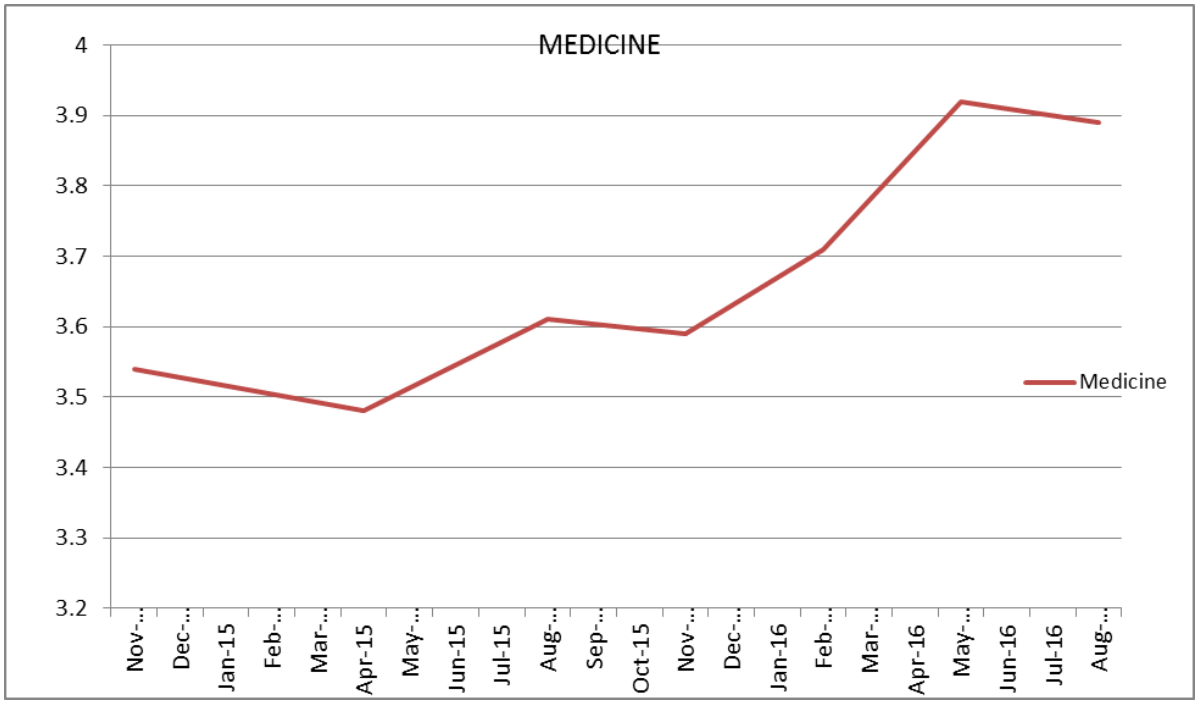


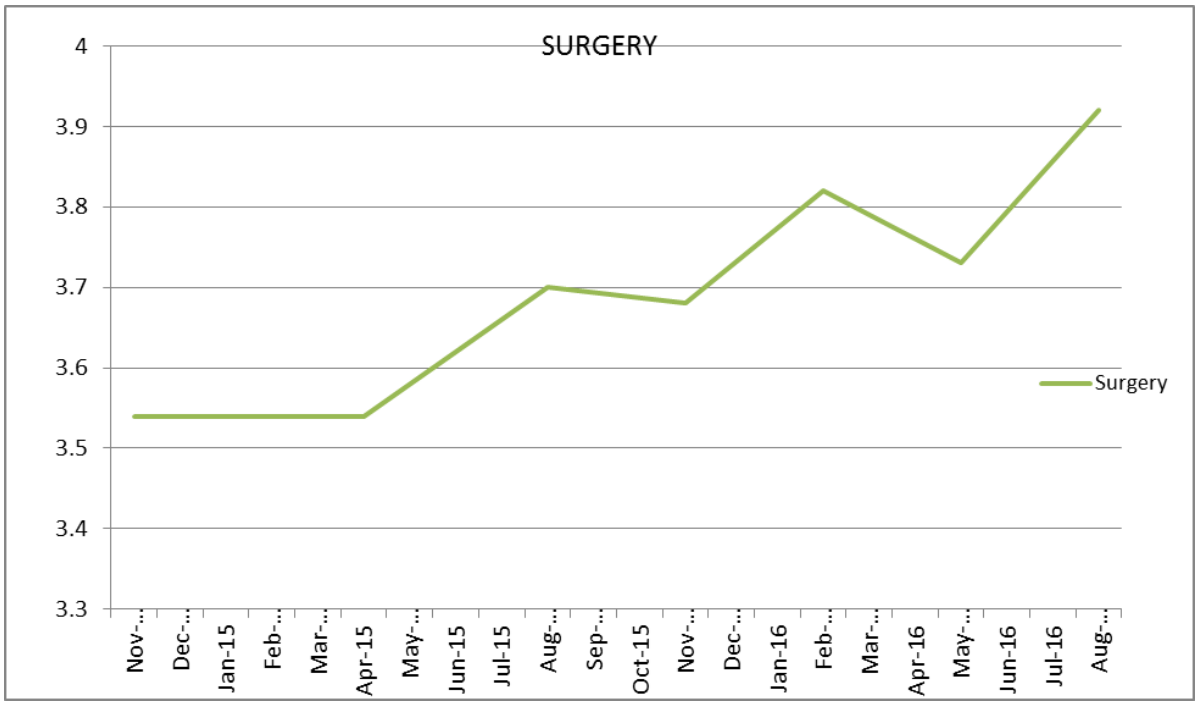
HEALTH GROUPS

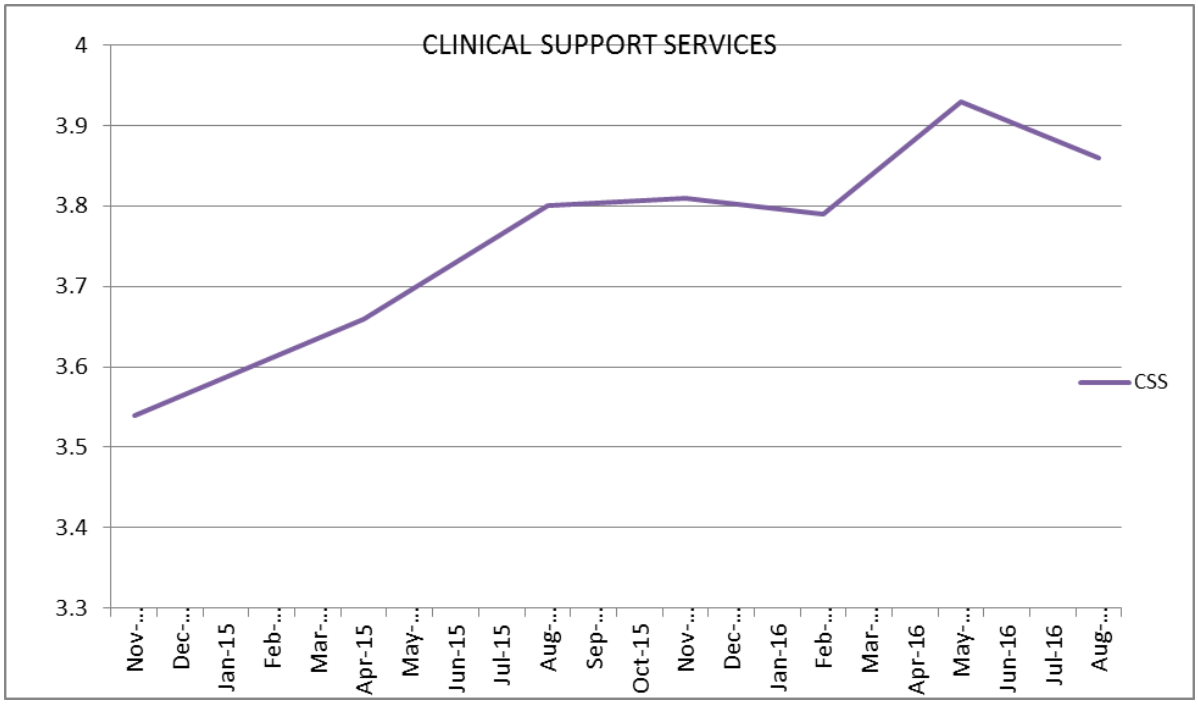
Overall scores for engagement in the Health Groups and Directorates have shown a steady improvement. Surgery is the most improved Health Group since May 2016. Three areas showed a slight deterioration: Family and Women's, Medicine and Clinical Support.

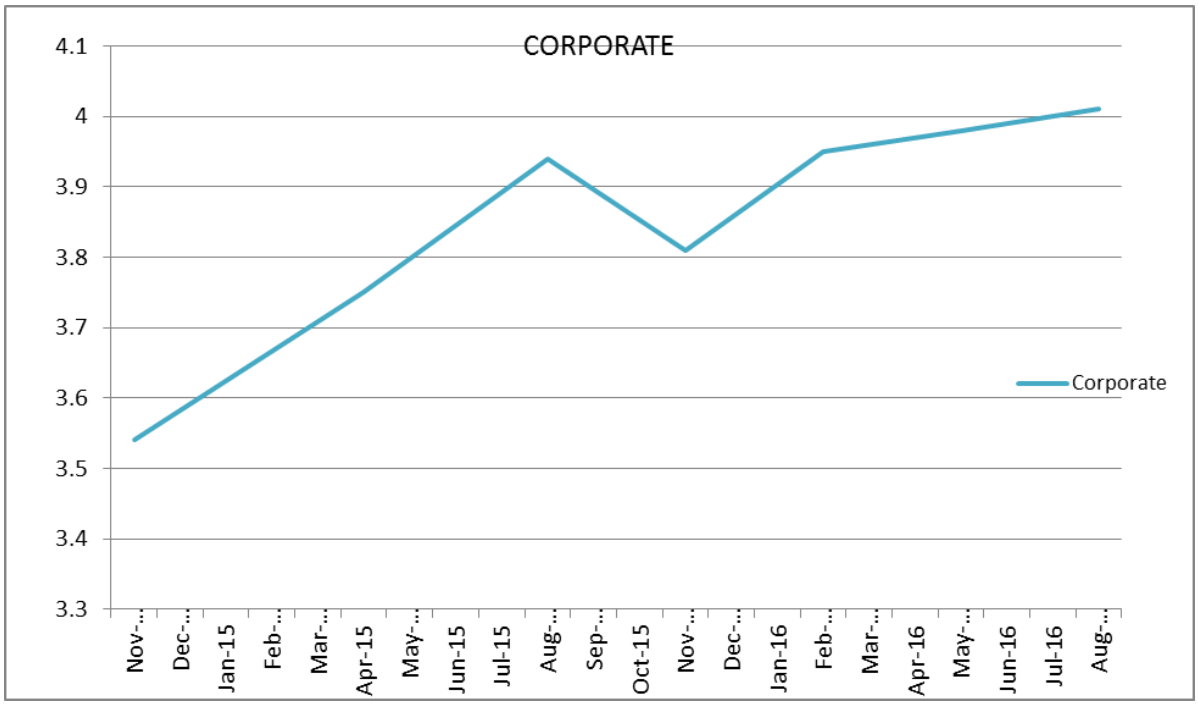
	Nov-14	Apr-15	Aug-15	Nov-15	Feb-16	May-16	Jul-16
F&WH	3.54	3.64	3.68	3.95	3.81	3.92	3.88
Medicine	3.54	3.48	3.61	3.59	3.71	3.92	3.89
Surgery	3.54	3.54	3.7	3.68	3.82	3.73	3.92
CSS	3.54	3.66	3.8	3.81	3.79	3.93	3.86
Corporate	3.54	3.75	3.94	3.81	3.95	3.98	4.01
I&D	3.54	3.58	3.66	3.67	3.76	3.82	3.98

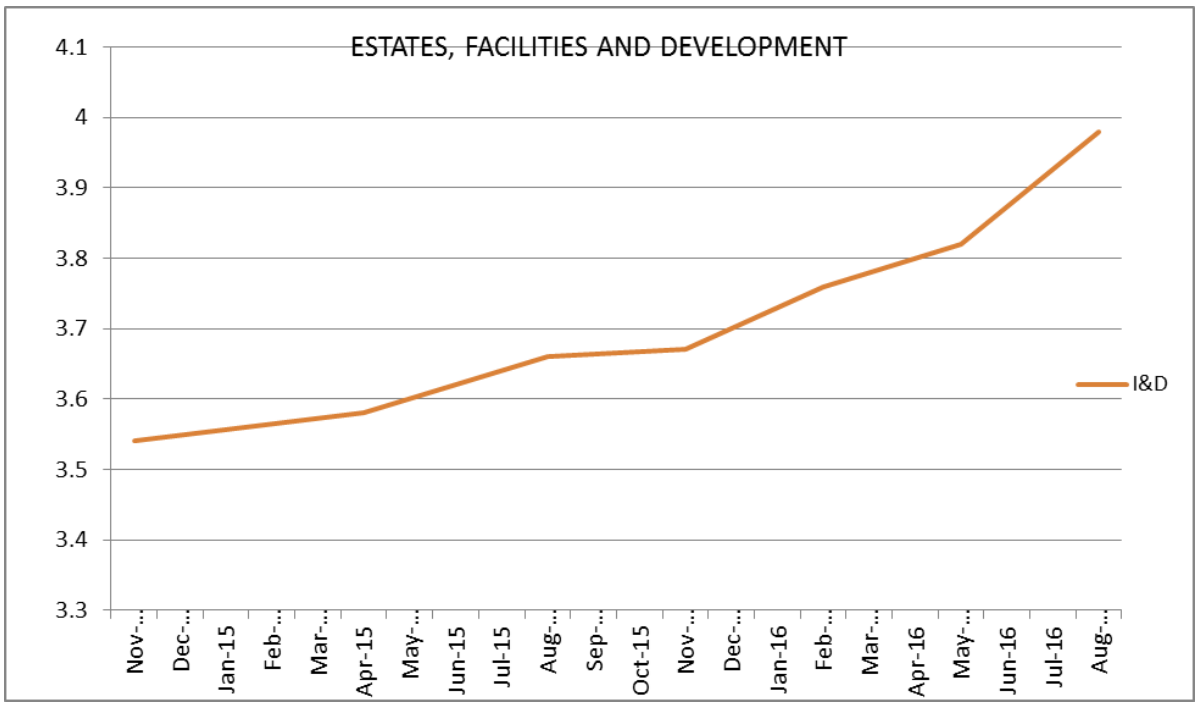

FAMILY AND WOMEN'S HEALTH
4
3.9
3.8
3.7
3.6
3.5
3.4
3.3
Nov-...
Dec-...
Jan-15
Feb-...
Mar-...
Apr-15
May-...
Jun-15
Jul-15
Aug-...
Sep-...
Oct-15
Nov-...
Dec-...
Jan-16
Feb-...
Mar-...
Apr-16
May-...
Jun-16
Jul-16
Aug-...
F&WH


MEDICINE
4
3.9
3.8
3.7
3.6
3.5
3.4
3.3
3.2
Nov-...
Dec-...
Jan-15
Feb-...
Mar-...
Apr-15
May-...
Jun-15
Jul-15
Aug-...
Sep-...
Oct-15
Nov-...
Dec-...
Jan-16
Feb-...
Mar-...
Apr-16
May-...
Jun-16
Jul-16
Aug-...
Medicine


SURGERY
4
3.9
3.8
3.7
3.6
3.5
3.4
3.3
Nov-...
Dec-...
Jan-15
Feb-...
Mar-...
Apr-15
May-...
Jun-15
Jul-15
Aug-...
Sep-...
Oct-15
Nov-...
Dec-...
Jan-16
Feb-...
Mar-...
Apr-16
May-...
Jun-16
Jul-16
Aug-...
Surgery


CLINICAL SUPPORT SERVICES
4
3.9
3.8
3.7
3.6
3.5
3.4
3.3
Nov-...
Dec-...
Jan-15
Feb-...
Mar-...
Apr-15
May-...
Jun-15
Jul-15
Aug-...
Sep-...
Oct-15
Nov-...
Dec-...
Jan-16
Feb-...
Mar-...
Apr-16
May-...
Jun-16
Jul-16
Aug-...
CSS

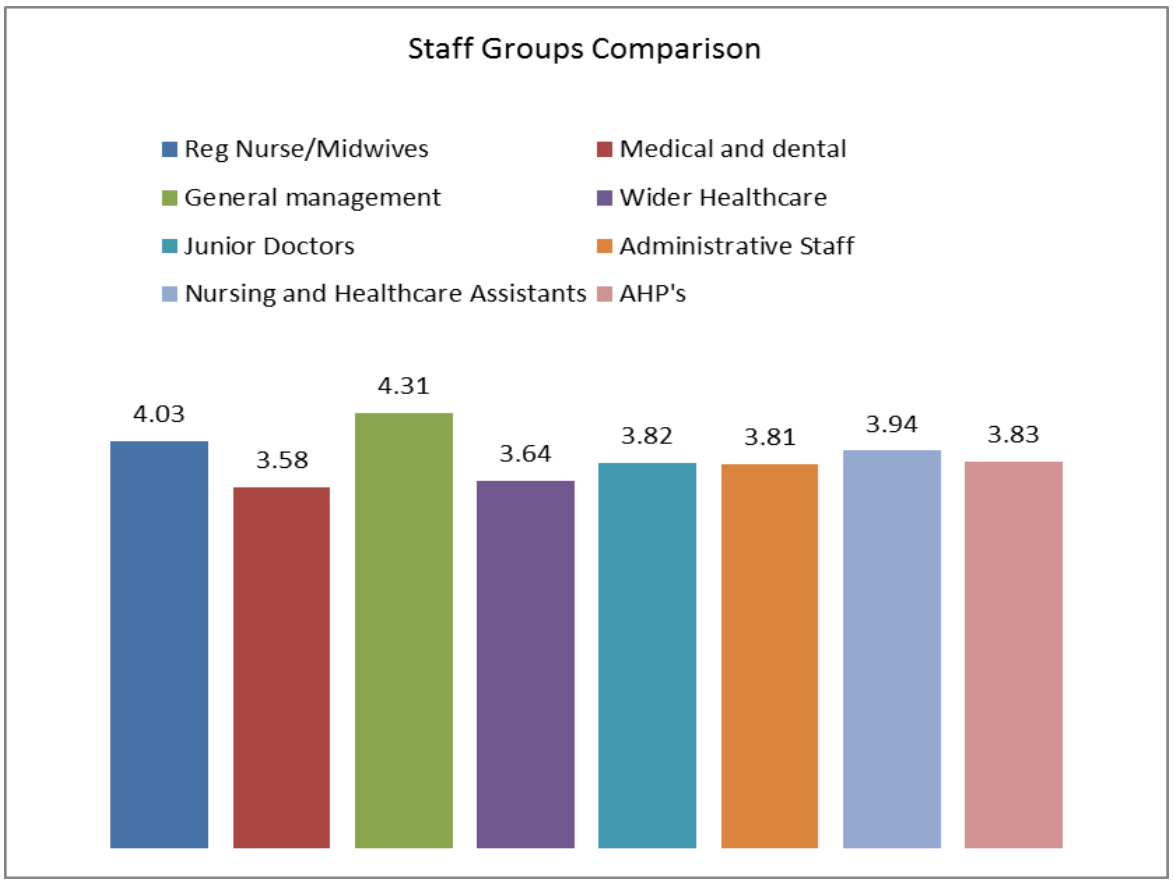




Response rates for the Health Groups/Directorates were:

Health Group	No. Staff	No. Responses	% Staff Response
Medicine	1440	346	24%
Corporate	874	199	23%
Clinical Support	2240	457	20%
Family and Womens	1114	190	17%
Surgery	2193	240	11%
Estates, Facilities and Development	606	56	9%

STAFF GROUPS
There is a clear issue in terms of medical and dental engagement as well as engagement with Wider Healthcare teams (porters, catering etc).



NEXT STEPS
Work to improve medical engagement continues. A further more detailed report has also been received by the Trust highlighting issues which affect medical engagement. This work is being progressed under the leadership of the Chief Medical Officer. A programme to improve medical engagement has been developed which will begin with a 'time out' session on 16th December, 2016 with the Trust's most senior medical leaders together with members of the Executive.

RECOMMENDATIONS
The Trust Board is requested to note the contents of the report.

Simon Nearney
Director of Workforce
November 2016

TRUST BOARD REPORT 2016 – 11 - 17	
Meeting date:	24 November 2016
Title:	Charitable Funds Annual Report and Accounts
Presented by:	Lee Bond
Author:	Lee Bond
Purpose:	To seek approval from the Trust Board for the Charitable Funds Annual Report and Accounts 2015/16
Recommendation(s):	The Trust Board is recommended to approve the Charitable Funds Annual Report and Accounts for 2015/16

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD

CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS 2015/16

1. PURPOSE

The purpose of this paper is to present the 2015/16 Annual Report and Accounts for Charitable Funds for approval by the Trust Board.

2. BACKGROUND

The Corporate Body of Hull and East Yorkshire Hospitals NHS Trust is the sole Trustee of the Trust's registered charities. The Corporate Body, through the Trust Board, remains accountable for the registered charities and is responsible for signing off the Annual Report and Accounts. The Trust Board delegates the day to day running of the charities to the Charitable Funds Committee.

KPMG, have completed their audit and have issued their annual governance report ISA 260 which sets out their key findings in relation to the audit. Before they can formally sign off the accounts they require written representations from "management." Those representations are by way of a formal letter signed by the Chair of the Charitable Funds Committee and are set out in appendix A to this report. The ISA 260 report is reproduced at appendix B

At their meeting on 17 November 2016 The Charitable Funds Committee reviewed the ISA 260 report, approved the content of the letter of representations, and recommended the Annual Report and Accounts 2015/16 for adoption by the Trust Board.

The Annual Report and Accounts need to be lodged with the Charities Commission before 31 December 2016. A copy of the Annual Report and Accounts is included in appendix C

3. RECOMMENDATION

The Trust Board is asked to note the recommendations made by the Charitable Funds Committee and formally approve the Annual Report and Accounts for 2015/16

Lee Bond
Chief Financial officer
17 November 2016

Hull and East Yorkshire Hospitals NHS General Charitable Trust

Audit highlights memorandum and management letter for the year ended 31 March 2016

November 2016

KPMG

Contents

Executive summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of Hull and East Yorkshire Hospitals NHS General Charitable Trust for the year ended 31 March 2016.

Our objective is to use our knowledge of the Charity, gained during our routine audit work, to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form opinions on the Charity's financial statements and it should not be relied upon to disclose all irregularities that may exist, nor to disclose errors that are not material to the financial statements and contributions.

Audit conclusions	
✓	— Unqualified audit opinion proposed on financial statements.
Accounting matters	
✓	— No significant accounting issues arose during the course of our audit.
✓	— Accounting policies appropriate for the annual report and the financial statements are in accordance with disclosure requirements of relevant charities legislation, new UK GAAP and the Statement of Recommended Practice.
Auditing matters	
✓	— We have successfully completed those procedures as set out in the audit plan which was included in the Hull and East Yorkshire Hospitals NHS Trust Audit Plan which was presented to the Audit Committee on 18 February 2016.
✓	— No significant audit issues arose during the course of our audit of the Charity.
✓	— At the date of writing this report, we had the following audit areas outstanding; • Receipt of Management Representations Letter • Completion of final audit review and closure procedures. We will provide a verbal update at the Charitable Funds Committee meeting.
Systems and controls	
✓	— No major weaknesses in the financial systems or controls were identified in the year ended 31 March 2016. We noted that the Charity has had to formally write off £12k of expenditure from a failed fundraising event during a previous year.
Regulatory and tax matters	
✓	— No significant regulatory or tax matters came to our attention during the course of our normal audit work.

Audit approach and findings

We highlight significant findings in respect of the risks and other areas of focus for our audit identified in our discussion with you at the audit planning and strategy stage. We have dealt with them as set out in the right hand column. Other than these standard risk areas we did not identify any specific risks.

Significant risks		Audit area	Proposed work	Our findings from the audit
Significant risk area required by ISA's	Fraud Risk from Revenue Recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.	We will review the terms of legacies and corresponding treatment to ensure the completeness, and restriction on the use, of the revenue. We consider the restricted or unrestricted nature of funding as well as the period of recognition in line with recognition criteria in line with SORP.	All receipted income was recorded in the financial statements. The Charity has appropriate systems and procedures in place to ensure all income is receipted.
Significant risk area required by ISA's	**Fraud risk from management override of controls**	Professional standards require us to communicate the fraud risk from management override of controls as significant. This is because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	We have considered management override of controls as a significant fraud risk. We have not identified any specific risk factors that increase the risk of management override. We will carry out specific testing over journals, judgements & estimates, and any significant or unusual transactions.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, did not identify any instances of fraud. There are no matters arising from this work that we need to bring to your attention.

KPMG

Appendices

1. Mandatory communications
2. Control observations raised in prior years
3. Accounting developments
4. Auditor independence

Mandatory communications

We set out below details of the required communications to the Trustees.

Other information in documents containing audited financial statements	Our responsibility for other information in the Hull and East Yorkshire Hospitals NHS General Charity Annual Report and Financial Statements does not extend beyond the financial information identified in our auditor's report. We have no obligation to perform any procedures to corroborate other information contained in those documents. However, prior to approval and signing we will read the other information included in the Trustees' Report, and confirm that the information given, and the manner of its presentation, is materially consistent with the information, and its manner of presentation, with the consolidated financial statements.
Disagreement with management	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditor's report on the financial statements.
Consultation with other accountants	To the best of our knowledge, management has not consulted with or obtained opinions, written or oral, from other independent accountants during the past year that were subject to the requirements of Statement 1.213 of the Institute of Chartered Accountants in England and Wales Guide of Professional Ethics.
Difficulties encountered in performing the audit	We encountered no difficulties in performing the audit.
Material written communications	In accordance with the communication requirements of Clarified International Standard on Auditing (UK and Ireland) 260, we provide the following written communications to the Trustees for their meeting on 17 November. — Report to the Audit Committee – This is the main body of this report; and — KPMG Independence communication – Appendix 4 to this report.
Management Representations	In accordance with Clarified ISA 580 *Written representations,* we request written representations from those charged with governance. Written representations are necessary information we require in connection with the audit of the Charitable Fund. The draft written representations will be submitted for approval at the meeting on 17 November.
Audit misstatements	Under the requirements of Clarified ISA 260 *Communication of audit matters with those charged with governance*, we are required to report any adjusted audit misstatements arising from our work. No audit adjustments have been made to the accounts and there are no unadjusted audit misstatements.

Follow up of the 2014/15 recommendations

Audit issue	Recommendation	Management's response and Update
Income cut-off The Charity received £1,240 of donations in 2014/15 which were banked in 2015/16. Because there was no review of cash banked in the new financial year, this income was not identified.	The Charity should review cash banked in the new financial year, as it does with cash expended in the new year, to identify income that should be recognised in the old financial year.	For the 2015/16 accounts a more thorough cut-off review will be undertaken. **Deputy Director Finance** **2015/16** We identified no cut off issues as part of the 2015/16 audit WORK COMPLETE

Appendix 3

Accounting developments

The Charity will have to prepare accounts under the new FRS 102 SORP (2015) next year. We have summarised some of the key changes below that you will have to address:

Summary of key differences	
	FRS 102 SORP requirements
SoFA	— The number of headings within the SoFA has been reduced and a 'plain English' style adopted to describe the nature of the income or expenditure included within each heading of the SoFA. Governance costs is no longer a separate heading but are included in support costs. — The treatment of investment gains and losses has changed to reflect FRS 102 requirements. These will be recognised within the 'Income and Expenditure' part of the SoFA instead of the 'STRGL' part where they currently sit, i.e. will now be 'above the line'.
Trustee and management remuneration	— The total remuneration paid to key management personnel must be disclosed. The Charity may disclose the employee benefits received by its CEO or highest paid staff member, or all key management personnel on an individual basis. — Disclose in the Trustees' report the arrangements for setting the pay and remuneration of the charity's key management personnel and any benchmarks, parameters or criteria used in setting their pay. — Any benefits or expenses paid to Trustees are disclosed on an individual basis, including expenses waived by Trustees. — Donations made by Trustees to the charity must be disclosed in total where no conditions apply to those donations.
Income Recognition	— The income recognition criteria have been revised under FRS102 SORP, and requires income to be recognised when it is 'Probable' rather than 'Virtually Certain'. — Additional guidance has been provided in the SORP in relation to accounting for legacies, providing a 3 point test to determine whether it should be recognised.
Other areas	— There are no material uncertainties about the Charity's ability to continue, i.e. the Charity is a going concern. The SORP requires this to be stated. — Disclose judgements and estimates that have the most significant effect on the amounts recognised in the accounts. — The reserves policy of the Charity should be stated in the financial review. — FRS 102 requires the Charity states it meets the definition of a public benefit entity.
Financial institution	— FRS 102 requires additional financial instrument disclosures for entities which fall under the definition of a financial institution.

Appendix 4

Auditor independence

We confirm the independence of KPMG.

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Charity for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Trustees.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Charity's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Charity's financial statements.

Auditor independence

We confirm the independence of KPMG.

- Material uncertainties related to event and conditions that may cast significant doubt on the Charity's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Charity's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of the Charity for the financial year ending 31 March 2016, we confirm that there were no relationships between KPMG LLP and the Charity, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

The contacts at KPMG in connection with this report are:

John Prentice
Director
Tel: 0113 231 3935
john.prentice@KPMG.co.uk

Rob Walker
Manager
Tel: 0113 231 3619
rob.walker@KPMG.co.uk

kpmg.com/socialmedia

kpmg.com/app

Produced by Create Graphics/Document number: CRT056498A

14. Trustee and connected Persons Transactions

There were no payments of Trustee's expenses or remuneration paid in the financial year 2015/16.

Details of transactions with trustees or connected persons

Name of party involved, a description of the transaction and a description of the nature of the relationship	**Amount 2015-16 £**	Amount 2014-15 £
Grants to Hull and East Yorkshire Hospitals NHS Trust	948,184	1,703,100
Amounts owed to Hull and East Yorkshire Hospitals NHS Trust (included within creditors).	143,626	1,148,461
Amounts due from Hull and East Yorkshire Hospitals NHS Trust (included within debtors).	0	534

15. Connected Organisations

Name, nature of connection, description of activities undertaken and details of any qualifications expressed by their auditors	2015-16		2014-15	
	Turnover of Connected Organisation £000	Net Profit/ (Loss) for the Connected Organisation £000	Turnover of Connected Organisation £000	Net Profit/ (Loss) for the Connected Organisation £000
Hull and East Yorkshire Hospitals NHS Trust - Grants to support training, staff welfare & research	**526,253**	**(8,501)**	526,559	2,926

The figures in the table above are taken from the audited accounts of the Hull and East Yorkshire Hospitals NHS Trust. These accounts were unqualified.

16. Future Legacies

The Charity is not aware of any large legacies bequeathed to the Trust at the year end date but not yet paid over.

17. Related Party Transactions

During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Hull and East Yorkshire NHS General Charitable Trust.

The charitable trust has made revenue and capital payments to the Hull and East Yorkshire NHS Trust where the Trustees are also members of the Trust Board.

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON MONDAY 24TH OCTOBER 2016
THE COMMITTEE ROOM

PRESENT:	Mr S Hall (Chair)	Non-Executive Director
	Ms E Ryabov	Chief Operating Officer
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce & OD
IN ATTENDANCE:	Mr M Simpson	Clinical Lead for Emergency Medicine
	Mrs T Proctor	PA to Ellen Ryabov (Minutes)

No	Item	Action
1.	**APOLOGIES** Apologies were received from Mrs T Christmas and Mr S Nearney	
2.	**MINUTES OF THE MEETING HELD ON 26 SEPTEMBER 2016** The minutes of the meeting held on 22 August were reviewed by the Committee **Item 6.2 – Frailty Pathway** – The last sentence was asked to be amended to read "The Trust provides this service where possible and when utilised it cuts down on the number of admissions into the hospital". It had been recorded that there was an action by ER in fact there wasn't one. **Item 6.3 – Length of Stay** – To answer Mr Gores question on discharge coordinators Ms Ryabov advised that there was no intention to provide discharge coordinators for AMU as this was an assessment area. There are three in the EAU. **Item 7.4 – Best Practice Tariffs** – Ms Ryabov confirmed that Health Groups were taking their own specific actions to address missing target deliveries, she would be meeting with the Surgical Health Group that evening and would report back with any findings.	**ER**
	Following these changes the minutes were approved as an accurate record.	
3.	**ACTION TRACKING LIST** The Committee reviewed the Action Tracker. Items discussed above from the Tracker would be updated. Mr Hall would draft a further request to Surgery Health Group to submit a report regarding orthopaedics consultant productivity and theatre activity as nothing had yet been received.	**SH**
	All items marked completed would be removed from the Tracker.	
4.	**WORKPLAN 2016/17** The Committee received the workplan and asked that the Minutes from the Lord Carter of Coles Financial Savings meeting be presented in November and not October 2016.	

5. MATTERS ARISING

5.1 – MORTUARY UPDATE

Mr Bond advised that he had received a response from Hull City Council to say that the matter was closed and that the debt has been offset. He added that he would be responding to this letter to say that this was not an acceptable position. **LB**

6. PERFORMANCE REPORT

Before Ms Ryabov presented the report Mr Bond wanted to note that the workload for the MRI machines was causing significant impact on the RTT delivery. Increased non elective activity was putting pressure on MRI resulting in more breakdowns which in turn created more capacity problems. Mr Bond will be meeting with the Clinical Support Health Group to request a longer term solution. Consideration is being given to acquiring a van to move around three sites (including York) and where it could be sited. Mr D Taylor is looking for space in the Trust to site this and another CT machine. A £1m investment would be needed to clear the bottleneck this problem is causing but the problem not only stems from the machine itself but also staffing needed to produce and analyse reports. The committee raised the question of whether or not the Trust were over diagnosing with MR/CT but Mr Bond confirmed that our referrals for these procedures are less than the national and international average. He was also asked if the vans were being fully utilised when on site and he assured the committee that they were.

Mrs Ryabov advised that the main issues with performance remained the same. The Trust would not hit the A&E trajectory target. There is still work to be done to get a pull model in place and she is meeting teams weekly to work on this. The Trust is still vulnerable out of hours. There has been a positive step change in ED Minors but the performance in Majors has been variable. There are reasonable processes to follow but not all staff have the level of ability necessary to cope.

Michelle Veitch was leading a winter programme involving ambulance turnaround and she has found a whole range of performance indicators that are not being delivered by the ambulance service. Mrs Ryabov to keep the committee updated on any progress. **ER**

The Referral to Treatment standard reached 87.9% in month after a great effort mainly by administrative staff. There were concerns around the 62 day cancer target and not achieving the 80% trajectory in September 2016. The Clinical Support Health Group was having difficulty generating more capacity to cope with the increase in activity. At the request of the committee Mrs Ryabov agreed to check the conversion rate of those patients on the pathway who were finally diagnosed with cancer to identify if this rate is increasing. Two patients breached the 28 day booking standard as a result of emergency work taking priority. This shows the impact that the increase in emergency work is having on elective treatments. **ER**

Resolved:

The Committee received the report and noted the Trust's performance in Month 6.

6.1 – ACUTE MEDICAL UNIT EFFECTIVENESS

Mr Mark Simpson arrived to deliver a presentation which included the

concerns around the acute medical unit. He started by telling everyone of the presentation done by Michelle Veitch and Kevin Phillips to consultants on the Ground Round. The presentation used the situation in ED over the last weekend as an example to show the consultants that the whole Trust can have an effect on the patient journey. A change in culture was required to review the patient journey as a 2 hour not a 4 hour one with the discharge lounge being utilised and patient movement from AMU to the base wards needs to move forward 2-3 hours. This earlier movement will mean beds are free earlier, discharges happen earlier and there is less risk of carrying the workload over into the next shift.
Mr Hall asked why there wasn't a senior person walking the floor to pull patients from ED. A process was required for specialities to take ownership of their patients, as well as being clear who their senior doctor was.
A question was raised on what the bottlenecks were and how they would be identified to ensure action could be taken to reduce them. There is a dashboard in ED but AMU only have access to CAYDER which is not good for real time data. Amendments to Lorenzo will help in the future but in the meantime they are working with a virtual ward on CAYDER.
GP's are coming in to do a 4 or 8 hour shift. It is early days to see the impact of this but the hope is that this service will be for 12 hours a day 7 days a week and that the GP's will see 3-4 patients per hour.
Mr Simpson advised that junior doctors require more in depth training and mentoring before having responsibility for patients in the Emergency Department.
The committee thanked Mr Simpson for his presentation and insight into some of the issues on the ground floor.

7. CORPORATE FINANCE REPORT

Mr Bond presented the report for Month 6 and advised that the forecast for the end of year should the deteriorating financial position continue, would be a deficit of just over £2m. This was against a forecasted break-even position. The Trust would not receive full STF funds (£14m full year) due to non delivery of ED, RTT and cancer targets, which was a risk. Mr Bond explained the month 6 financial performance in detail, highlighting poor income performance, decreasing CRES and increasing levels of Agency spend and a general increase in overspending across the Health Groups in particular. He drew the Committees attention to the level of reserves that had been released to support both the in-month and forecast year end positions.

Mr Bond added that if the month 6 performance was repeated and the Health Groups failed to identify any tangible recovery measures, particularly in surgery, the Trust would risk missing the £14m deficit total required to qualify for STF monies. This was an extremely high risk and it was agreed it should be raised formally with the Trust Board.

Actions have been identified to deal with underactive specialities which included using the vascular non elective theatre activity for elective procedures, a review of outpatient activity, which had taken a hit on strike days. Mr Hall reminded the committee that the Surgical Health Group had assured them that their plan would deliver but it hadn't. The Health Group was meeting with Mrs Ryabov that evening and she advised that they were expected to present their plan and actions for recovery for the next six months.

Resolved:
The Committee received the report for Month 6 and noted the financial position. Mr Hall to raise the deteriorating financial performance and risk to forecast outturn position with the Trust Board. **SH**

7.1 – CRES 2016/17
Mr Bond presented the report and advised that non delivery of CRES was disappointing and an alternative plan was needed for next year. He was not convinced that the transformation programmes were effective and Mrs Ryabov added that it was difficult to make transformational changes when the basics were not being managed.

Mr Hall distributed the minutes from a Non-Executive CRES meeting with the Health Groups which happened on the 27th of September for information. On the whole the outcome lacked assurance that the Health Groups would deliver their plans for CRES.

Resolved:
The Committee received the updated CRES position

7.2 – AGENCY REPORT
The Trust was £1.4m over target for agency spend with medical staffing cap breaches by far the most common as recruiting in some areas remained an issue. Sourcing staff below the cap rate continues to be challenging and has been highlighted as a national problem.

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

7.3 – PATIENT ADMIN UPDATE
Mr Bond updated the committee on the position with Patient Administration. This group was previously included in the Clinical Support Health Group but has transferred under Finance in the Corporate Directorate. There are 24 vacant posts which have caused an overspend in variable pay. The aim was to centralise the patient administration function to create efficiency savings. Once agreed and implemented work would be undertaken to create a further £0.5m savings. There has been a lack of control in the past with historical problems, and installation of Lorenzo. A recovery plan would be presented to the Execs followed by presentation to the Non-Execs and Operations Directors for the Health Groups.

Resolved:
The Committee received the update and will await presentation of the recovery plan. **LB**

8. CAPITAL RESOURCE ALLOCATION COMMITTEE SUMMARY REPORT
A report was not presented as the meeting in October had been cancelled. Mr Bond spoke about his concerns around the current Capital plans. He advised that as soon as they were put in place contractors would need paying and with the current situation with cash flow work could be at risk. Mr Bond said that he needed to ensure that the CCG's were paying the Trust for services supplied. Mr Bond was meeting with Mr Duncan Taylor to review the capital spend.

Mr Gore asked if the Trust had considered approaching the local authority to invest in equipment for the Trust as he thought it would be worth exploring. Mr Bond thanked Mr Gore and said this was an option that could be explored further.

Resolved:
The Committee thanked Mr Bond for his update.

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 27 October 2016.

12. DATE AND TIME OF THE NEXT MEETING:

21 November 2016, 2.00pm – 5.00pm
The Committee Room, HRI

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:		**Chair:**		**Quorate (Y/N)**	Y

Key issues discussed:

- Review of medicines administration incidents and the action being taken.
- Presentation by Neurosurgeons relating to action taken since the most recent Never Event
- Confirmation that there are now more robust arrangements for managing the contract for the provision of real haemodialysis services
- Safeguarding Children Annual Report 2015/16
- An update on VTE performance

Decisions made by the Committee:

- To receive an update at the next meeting on the status of the project for rolling out e-observations across the Trust (and wi-fi)
- To receive further information on the 30 day readmission standard which is not currently being met
- To receive more information regarding compliance levels with the WHO checklist including incidents reported
- To receive a further report on outpatient performance at the next meeting

Key Information Points to the Board:

- Concern about the low number of Quality Impact Assessments relating to CRES reviewed by the Chief Nurse, Chief Medical Officer and Chief Operating Officer. This was linked to the shortfall in identified schemes.
- A further (third) check has been introduced by the Neurosurgeons following the Never Event wrong level spinal surgery incident
- Proposal for reviewing the quality committee arrangements to bring together the Operational Quality Committee and the Board's Quality Committee. This was agreed in principle and will need to be approved by the Trust Board once further developed.

Matters escalated to the Board for action:

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON THURSDAY 20 OCTOBER 2016
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon (Chair)	Non Executive Director
	Mr A Snowden	Vice Chair/Non Executive Director
	Mrs V Walker	Non Executive Director
	Mr M Wright	Chief Nurse
	Mr K Phillips	Chief Medical Officer
	Ms L Thomas	Director of Governance
	Mr P O'Brien	Deputy Chief Pharmacist (for D Corral)
	Mrs A Green	Lead Clinical Research Therapist
IN ATTENDANCE:	Mr G Spinks	Consultant Neurosurgeon (item 5 only)
	Mr K Morris	Consultant Neurosurgeon (item 5 only)
	Mr S Achawal	Consultant Neurosurgeon (item 5 only)
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

ACTION

1. APOLOGIES
Apologies were received from Mr Corral, Chief Pharmacist.

2. MINUTES OF THE MEETING 28 JUNE 2016
Item 8, bullet point 2 was changed to read, "the Physiotherapy Department had been shortlisted for a NICE shared learning aware for their work with patients experiencing acute exacerbation of COPD to prevent unnecessary admission".

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

3. ACTION TRACKING LIST
Fracture neck of femur – Image Intensifier Business Case – Mr Phillips reported that he would find out the latest position and report back to the next meeting. Mr Phillips advised that he would also provide data (when available) to show outcomes post implementation. **KP**

3.1 – WORKPLAN
The Committee reviewed the workplan and no changes were made.

4. MATTERS ARISING
Outpatient Performance – The Committee requested that an update be received at the next committee meeting in December 2016.
Resolved: Outpatient performance to be an agenda item at the December meeting **JM**

e-Observations – Mr Wright reported that this project was included in the Trust's 3 year Capital Plan. In order for e–observations to be introduced the Trust's wi-fi needed to be upgraded first to support the technology. The upgrading of the wi-fi was a significant investment which was why the work was being phased. Prof. Sheldon requested that a summary of the current status of the project was be presented at the next meeting in December 2016 and Mr Smith be invited to the committee discuss this further.
Resolved: Mr Smith to be invited to the next meeting **RT**

VTE – Mr Phillips advised that work was ongoing to ensure that VTE assessment processes were embedded on all wards and entered onto the Lorenzo system in a timely manner. He advised that the 95% target was not being achieved but the Safety Thermometer audits were showing 89.4% compliance.

4.1 – EMERGENCY READMISSIONS WITHIN 30 DAYS
Mr Phillips updated the committee regarding patients being readmitted within 30 days. Mrs Walker asked if this was due to patients being discharged too quickly and Mr Phillips advised that it was more about how patients were cared for in the community after their stay in hospital.

Resolved:
The Committee agreed to receive further information regarding emergency readmissions at the next meeting in December 2016. **KP**

4.2 – QUALITY IMPACT OF CRES
Mr Wright updated the committee regarding the process in place to assess the risks around Cash Releasing Efficiency Schemes. He advised that the Health Groups were able to approve any scheme under £100k but still needed to complete an impact assessment to demonstrate that it did not affect patient safety, service effectiveness or patient experience. Schemes over £100k required the Chief Nurse, Chief Medical Officer and Chief Operating Officer to review the Quality Impact Assessment. A second round of meetings was due to take place with Health Groups. Concern was expressed about the low number of schemes being presented for review which was linked to the scale of unidentified cash releasing efficiency savings. Mr Wright advised that some schemes do not get through to the Chief meeting as they have already been rejected by the Health Group.

Resolved:
The Committee received the report, noted the work ongoing regarding risk assessing CRES schemes and requested a more detailed report at the next meeting. **MW**

4.3 – MEDICINES ADMINISTRATION INCIDENTS
Mr O'Brien updated the committee and advised of the work ongoing to reduce incidents in this area. A new drug card had been introduced, datix reporting had increased and investigations were taking place resulting in agreed recommendations for action. The Trust was previously a low reporter of medicine administration incidents but was now in the middle section of the NRLS reporting matrix.

There was work ongoing to improve communication between departments to reduce patient's length of stay and an on-call pharmacist was available to ensure nurses could get drug advice if necessary. There was a discussion around drug packaging and how it could look similar and the action being taken to reduce the risk of the wrong drug being taken from stock.

Prof. Sheldon asked for a more evidence based report at the next meeting to show the new initiatives, their risks, how they were approached and evidence that they are working.

Resolved:
The Committee received the report and requested a further more evidence based report at the next meeting. **PO**

5. WRONG SITE SURGERY – NEVER EVENT
The Committee received a presentation from the Neurosurgeons which gave information relating to the most recent wrong site spinal surgery Never Event. The team presented a number of x-rays that showed issues relating to the quality of the

images. A third x-ray had been added to the Stand Operating Procedure which is taken after the surgery to confirm that the right level had been completed.

There was a discussion around the environmental and capacity pressures at Hull Royal Infirmary and Mr Snowden asked how the issues were escalated. Mr Phillips advised that risks were escalated through the Health Group governance meetings. Concern was expressed about sterile supplies which causes problems with the timely availability of equipment.

There was further discussion around the confidence of Junior Doctors when carrying out procedures and Mr Morris advised that at any time a trainee could speak to the consultant team and robust training was in place.

Resolved:
The Committee received the presentation and noted the procedures in place to avoid recurrence of this incident.

6. WHO CHECKLIST

Mr Phillips updated the Committee regarding the World Health Organisation checklist. He advised that audits of the checklists were being carried out and that 91.8% of areas were compliant. Prof. Sheldon asked if the WHO checklists were embedded and more information about the levels of compliance. Mr Phillips agreed to get further information which was being collected currently by Mr Jessop (Nurse Director in surgery). Prof. Sheldon suggested it would be useful to see a report that highlighted any serious incidents that had occurred as a result of not following the checklist.

Resolved:
The Committee received the report and agreed to receive further information at a future meeting, detailing incidents relating to staff not following the WHO checklist. **KP**

7. LEARNING LESSONS – THEMES AND TRENDS REPORT

Ms Thomas presented the report that aimed to triangulate themes from a number of sources and to provide information to the Committee on the steps being taken to strengthen learning from adverse events.

Ms Thomas reported that table top exercises were now being carried out with department members following a Serious Incident to collectively go through what had happened and how this could be avoided in the future. This was proving to be a positive step with staff members giving their views, human factors being more readily identified and much richer information being gathered, compared to the traditional approach of collating statements.

There was a discussion around outpatient follow up- appointments and particularly the backlog in ophthalmology. Plans were in place and trajectories agreed with each specialty for reducing the backlog and a business case had been prepared and presented to the Executive Management Committee to address the Ophthalmology position. Validation and clinical reviews were being undertaken for all patients overdue an appointment of more than 12 months and these patients were being referred back to their General Practitioner. The paper presented to the Committee identified that 8 Serious Incidents had been declared and Prof. Sheldon was interested to see a paper bringing together any other incidents relating to the backlog and if any harm was being caused to patients waiting long periods for their treatment.

Corporate risk registers were discussed and Ms Thomas advised that there were 174 risks at the present time. Prof. Sheldon queried how these risks could be managed. Ms Thomas advised that each division managed their own risks in their governance

meetings and all high level risks were received at the executive Management Committee.

Resolved:
The Committee received the report and agreed to receive a further report at the December 2016 meeting which would include outpatient incidents. **LT**

8. FRESENIUS RENAL CONTRACT

Mr Phillips presented the information and advised that a number of issues had been raised with Fresenius since they had been awarded the contract for dialysis services for the Trust. The actions put into place to address these issues were highlighted in the report and were now monitored at the Health Group monthly governance meetings. There had been a meeting held with NHS England to discuss the issues and assurance was given that patient safety was not compromised.

Resolved:
The Committee received the update and noted the actions in place to address the issues raised with Fresenius.

9. SAFEGUARDING CHILDREN ANNUAL REPORT 2015/16

Mr Wright presented the Safeguarding Children Annual report 2015/16 which highlighted that the Trust had met its statutory requirements. Mr Wright reported that the Trust still had a number of staff to train to level 3 and that safeguarding procedures were being embedded but needed to be more robust.

Resolved:
The Committee received the report and noted that the Trust had met its statutory requirements relating to Safeguarding Children.

10. CLINICAL AUDIT REPORT

Ms Thomas presented the report which demonstrated improvements made in practice following actions taken after clinical audits had taken place. Prof. Sheldon asked to see any areas where clinical audit had not had a positive effect and no changes in practice had been made. The Committee also discussed where clinical audit sat as the Audit Committee also reviewed audits being carried out. Ms Thomas advised that the role of the Audit Committee was to ensure that systems and processes were in place but did not provide an opinion on the quality or specific outcomes. Ms Thomas agreed to raise this issue at the next Audit Committee in December 2016.

Resolved:
The Committee received the report and noted its contents and noted that there would be further discussion at the Audit Committee. **LT**

11. QUALITY STRATEGY

Mr Wright advised that a proposal was being developed to combine the Operating Quality Committee and the Quality Committee to form one committee that dealt with quality and safety. The proposed new Quality Committee would be chaired by a Non-Executive Director and have Executive Director leads and representation from the Health Groups. The Committee viewed these changes in a positive way and suggested that the new committee should meet once every month to ensure all quality and safety issues were discussed in a timely way. Mrs Walker offered her support to the proposal and requested that themed meetings relating to patient journeys could be included in the brief.

Resolved:
The Committee approved the development of a proposal to merge the Operational Quality Committee with the Quality Committee. Mr Wright agreed to bring a proposal to a future meeting for further discussion. **MW**

12. BOARD ASSURANCE FRAMEWORK
The Committee reviewed the Board Assurance Framework and the risks associated with quality. The Care Quality Commission, lessons learned and patient experience were discussed and it was agreed that the risks would remain the same. Prof. Sheldon questioned some of the mitigating actions and requested that they should be more robust.

Resolved:
The Committee received the Board Assurance Framework and agreed that the risk ratings for the quality risks should remain the same.

13. RECEIVED FOR INFORMATION:
13.1 – QUALITY IMPROVEMENT PROGRAMME
The Quality Improvement Programme updated report and actions were received for information.

13.2 – INTEGRATED PERFORMANCE REPORT
The Integrated Performance Report was received for information.

13.3 – OPERATIONAL QUALITY COMMITTEE REPORT
This report was received for information.

13.4 – HEALTH GROUP ESCALATION REPORTS
The Health Group escalation reports were received for information.

13.5 – EXTERNAL AGENCIES
The External Agencies report was received for information.

14. EFFECTIVENESS REVIEW
14.1 – TERMS OF REFERENCE
It was agreed that the Terms of Reference would be reviewed following the Chief Nurse's Quality Strategy proposals being approved.

14.2 – FREQUENCY OF MEETINGS IN 2017
It was agreed by the Committee members that the Quality Committee would be a monthly meeting in its new Terms of Reference.

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

16. CHAIRMANS SUMMARY TO THE BOARD
Prof. Sheldon agreed to summarise the key points to the Board.

17. DATE AND TIME OF THE NEXT MEETING:
Thursday 15 December 2016, 3pm – 5pm, The Committee Room, HRI