

Hull University Teaching Hospitals NHS Trust
Trust Board Meeting Held in Public
in the Board Room, Hull Royal Infirmary
10 March 2020

1	Apologies	verbal	Terry Moran - Chair
2	Declarations of Interest	verbal	Terry Moran - Chair
	2.1 Changes to Directors' interests since the last meeting		
	2.2 To consider any conflicts of interest arising from this agenda		
3	Minutes of the previous meeting		
	3.1 Minutes of the meeting held 28 January 2020	attached	Terry Moran - Chair
4	Matters Arising		
	4.1 Action Tracker	attached	Carla Ramsay – Director of Corporate Affairs
	4.2 Board Reporting Framework 2017/20	attached	
	4.3 Board Development Framework 2017/19	attached	
5	Chair's Opening Remarks	verbal	Terry Moran - Chair
6	Chief Executive's Briefing		
	6.1 Chief Executive's Report	attached	Chris Long – Chief Executive Officer Chris Long – Chief Executive Officer/ Teresa Cope – Chief Operating Officer/Lee Bond – Chief Financial Officer
	6.2 Balanced Scorecard (Summary of 12.4)	attached	
	6.3 Coronavirus Update	presentation	
	6.4 Humber, Coast and Vale Health and Care Partnership - Integrated Care System Status Application	attached	Chris Long – Chief Executive Officer
7	Governance		
	7.1 Reports and Escalation from the Performance and Finance Committee – 27 January 2020 and 25 February 2020	attached	Tony Curry – Chair of Performance and Finance Committee
	7.2 Report and escalation from Quality Committee – 27 January 2020 and 24 February 2020	attached	Martin Veysey – Chair of Quality Committee
	7.3 Report and Escalation from the Workforce, Education and Culture Committee 28 February 2020	attached	Simon Nearney – Director of Workforce and Organisational Development

*Items marked * are for information only and will not be discussed unless agreed with the Chairman at the start of the meeting*

8	Great Staff 8.1 Frontline staff	discussion	Sheron Bennett – Site Team
9	Great Care 9.1 Patient Story	verbal	Marie Stern – Chair of Patient Council
10	Great Future 10.1 Board Assurance Framework Risk 3	presentation	Beverley Geary – Chief Nurse
11	Items for approval by the Board 11.1 Operating Plan 2020/21 Update	verbal	Jacqueline Myers – Director of Strategy and Planning
	11.2 Gender Pay Gap Report	attached	Carla Ramsay – Director of Corporate Affairs
	11.3 Contract for External Auditors	attached	Lee Bond – Chief Financial Officer
12	Reports to the Board 12.1 Performance and Finance Minutes 27 January 2020/ 25 February 2020*	attached	Tony Curry – Chair of Performance and Finance Committee
	12.2 Quality Minutes 27 January 2020/24 February 2020*	attached	Martin Veysey – Chair of Quality Committee
	12.3 Workforce, Education and Culture Committee 28 February 2020 Minutes*	attached	Simon Nearney – Director of Workforce and Organisational Development
	12.4 Integrated Performance Report*	attached	Teresa Cope – Chief Operating Officer/Lee Bond – Chief Financial Officer
	12.5 Quality Report* Appendix 1 - Transition of Deprivation of Liberty Safeguards to Liberty Protection Safeguards (LPS)	attached	Beverley Geary – Chief Nurse
	12.6 Learning from Deaths*	attached	Makani Purva – Chief Medical Officer
13	Chairman's Summary of the Meeting	verbal	Terry Moran – Chair
14	Any Other Business	verbal	Terry Moran – Chair
15	Any Questions from Members of the Public	verbal	Terry Moran - Chair
16	Date and time of the next meeting: Tuesday 12 May 2020 – 9am – 1pm, The Board Room, Hull Royal Infirmary		

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Attendance

	2019					2020					
Name	14/5	24/5	30/7	10/9	12/11	28/1	10/3	12/5	28/5	7/7	Total
T Moran	✓	✓	✓	✓	✓	x					5/6
A Snowden	✓	✓	-	-	-	-					2/2
S Hall	✓	x	✓	✓	✓	✓					5/6
V Walker	✓	✓	x	✓	-	-					3/4
T Christmas	✓	✓	✓	✓	✓	✓					6/6
M Gore	✓	x	✓	✓	✓	✓					5/6
C Long	x	✓	✓	✓	✓	✓					5/6
L Bond	✓	✓	✓	✓	✓	✓					6/6
T Cope	xMK	✓	xMK	✓	✓	✓					4/6
M Purva	✓	x	✓	✓	✓	✓					5/6
M Veysey	✓	x	✓	✓	✓	x					4/6
B Geary	✓	✓	✓	✓	✓	✓					6/6
J Jomeen	✓	✓	✓	x	✓	✓					5/6
In Attendance											
T Curry	✓	✓	✓	x	✓	✓					5/6
J Myers	✓	✓	x	✓	✓	✓					5/6
S Nearney	✓	x	✓	✓	✓	✓					5/6
C Ramsay	✓	✓	✓	x	✓	✓					5/6
R Thompson	✓	x	✓	✓	✓	x					4/6

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Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 28 January 2020

Present:	Mr S Hall	Vice-Chair (meeting chair)
	Mrs T Christmas	Non-Executive Director
	Prof J Jomeen	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs B Geary	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Dr M Purva	Chief Medical Officer
In Attendance:	Mr S Nearney	Director of Workforce and Organisational Development
	Ms J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs (minutes)
	Ms M Stern	Chair of the Patient Council
	Dr S Jose	Clinical Lead, Paediatrics (item 8.1)
	Dr C Wood	Clinical Director, Paediatrics (item CCC)
	Ms J Harrison-Mizon	Operations Director, Family & Women's Health Group (item 8.1)
	Ms J Cairns	Head of Midwifery (item 11.4)
	Mr A Mumdjans	Guardian of Safe Working (item 11.5)

No	Item	Action
1	Apologies: Apologies were received from Terry Moran CB, Chairman and Prof M Veysey, Non-Executive Director	

The agenda was taken out of order at this point

8.1 Frontline Staff – Community Paediatrics

Dr Jose, Dr Wood and Ms Harrison-Mizon joined the meeting. The team thanked the Trust for its support across a number of teams (clinical, HR, finance and estates) for everyone's support for a successful transition of the service to the Trust in April 2019.

The team provided a summary of the statutory and non-statutory work undertaken by the team and the strength of the clinical sub-specialisms within the service. The team illustrated how the Community Paediatric service fits in the wider Paediatric service within this Trust and its partnership working in the local health economy.

The team are proud of the clinical service model that has been implemented, which has been reviewed and praised through external validation.

Prof. Jomeen joined the meeting at this stage

Board members shared their reflections and sincere thanks for the hard work of the team to undertake clinical validation of the workload inherited with the Community Paediatric service, the new clinical model and

recruitment put in place and the potential for the service to work in partnership with other paediatric services for the benefit of local families. Some examples of cross-border working were given as well as the current challenges faced by families to access services across a number of organisations.

There is the potential for the HUTH service to become a centre of excellence for a number of sub-specialty clinical areas, and the team is keen to build the reputation and clinical model of the service. This is with a view to the long-term sustainability of the service, which will be more achievable through partnership working. Board members asked follow-up questions regarding the paediatric elements of the Humber Acute Services Review, the priorities for service development and the example of this service showing the ability of the Trust to take on new contracts.

The Chair concluded the item by offering once more the sincere thanks of the Trust Board and acknowledgement of the significant hard work that the team have put in to the service.

The agenda returned to order at this point

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting

None

2.2 To consider any conflicts of interest arising from this agenda

There were no conflicts of interest raised.

3 Minutes of the meeting 12 November 2019

Page 7, paragraph 4 – it was agreed to amend the end of the first sentence as follows: (amendment underlined) ‘. . . and Mr Bond advised that it was not.’

Page 7, item 12.1, paragraph 5 – it was agreed to amend the final sentence as follows (amendment underlined): Prof Veysey stated that freeing up a senior clinician's time from record keeping will create more time to care, enabled by electronic solutions if possible.

It was agreed to remove paragraph 2 on page 8 as this was information already contained in the accompanying report.

Page 8, item 16, paragraph 2 – it was agreed to amend the sentence as follows (amendment underlined): ‘. . . the strategy needed to be ~~was~~ adequately resourced.’

With these amendments, the minutes were approved.

4 Matters Arising

4.1 Action Tracker

Mrs Geary confirmed that trend analysis for ‘red flag’ incidents has been added to the Quality Report on today's agenda – action agreed to be closed

Mrs Christmas confirmed that she attended the most recent Safeguarding Committee with Mrs Geary and had discussed relevant safeguarding

issues with Mrs Geary – action agreed to be closed

Whilst the action is not due until March 2020, Dr Purva confirmed that she had requested the relevant benchmarking information for the next Seven-Day Services report. Action agreed to be closed.

4.2 Board Reporting Framework

Ms Ramsay confirmed that the Board remains up-to-date with its cycle of business; she will ensure that all relevant reports and agenda items are received as appropriately by the Board under the new style of agenda, which will be discussed shortly at today's meeting.

Ms Myers noted that the Operating Framework Guidance is a required agenda item and would normally have been published by now. It was agreed that Ms Myers circulate a briefing note when the Guidance is released, in advance of the next Board meeting.

JM

4.3 Board Development Framework 2017-2020

Ms Ramsay presented the framework. She noted that the future topics for discussion are the Integrated Care System development and the Humber Acute Services Review.

5 Chair's Opening Remarks

Mr Hall conveyed the best wishes of the Board to the Chairman.

Mr Hall welcomed Marie Stern for the Patient Council to the meeting.

As this is her final public Trust Board meeting, Prof. Jomeen was sincerely thanked for her valued contribution to the Trust and Mr Hall conveyed the best wishes of all Board members.

Mr Hall noted the increased demand on all services in the Trust. He commended the newly launched Lung Health Check and all staff involved in the service. This is one of the first of 10 new services ready to commence and staff are to be congratulated for this.

Mr Hall also conveyed his sincere thanks for the considerable work ongoing on the ground floor of Hull Royal infirmary. The new facilities are of high quality and will bring many benefits to patients and staff. Mr Hall also expressed some nervousness about the Trust's current performance in emergency medicine and this needs to be recognised by the Board. The Trust has recorded one 52-week breach this financial year; whilst the patient has been successfully treated, he noted how close to maximum waiting times the Trust is having to work in some services.

Mr Hall concluded with his thanks for the fortitude, dedication and stoicism shown by Trust staff during this winter.

6 Chief Executive's Briefing

6.1 Chief Executive's Report

Mr Long presented his report as read. He noted that the level of philanthropy from the Allam family to local people will help transform the quality of some of the Trust's services, for which the Trust is grateful.

Mr Long referenced in his paper that a number of local authorities are

declaring a Climate Emergency. He asked the Board to make the same commitment and sign up as a local partner alongside our Local Authorities. Mr Long believes that climate change is a key concern of staff, and being able to take action at work around waste reduction, recycling, ceasing use of packaging and single-use plastics, is something in which he would like to engage staff across the organisation. This was supported by the Board.

6.2 Balanced Scorecard

Mr Long stated that there are a number of red-rated indicators on the balanced scorecard at present; whilst the Trust is making improvements in particular service areas, the situation for a number of indicators overall is not where the organisation wishes to be. Mr Curry echoed the concern raised by Mr Hall regarding the Emergency Department four-hour performance; from the Performance and Finance Committee meeting yesterday, Mr Curry understands that a number of initiatives are underway but there remains still a gap in understanding as to when to expect a turnaround in performance.

Mr Long responded that whilst performance is down nationally, the Trust is at the lower end of performance and this is a concern. A number of new schemes are imminent, coupled with some system-wide winter plans that have not had the full desired effect. Mr Long feels there are some lessons to review for next winter's planning cycle; prior to this, he has already spoken with Executive directors about the need to review the medical bed base and to have a plan for medical bed numbers without compromising quality or service delivery across the hot/cold site split.

Mrs Cope added that the Trust has experienced reduced flow through the hospital together with reduced flow out of the hospital, compared with last year. Around 850 bed days were lost due to flow in December 2018, whereas the December 2019 figure was approximately 1,600. This would be the equivalent of 30 beds at 90% occupancy. An extraordinary meeting of the A&E Delivery Board was held in December 2019, which agreed additional actions, including daily system calls. Mrs Cope would like to see strong performance management in the Emergency Care Area, which is less bed dependent. The Trust has recently seen a small reduction in Emergency Department attendances, which it needs to review to determine if this reduction is sustained and the reasons for it.

Mr Hall closed this item with the observation that a number of actions are in place; the discussion on the balanced scorecard in this new agenda format will help to give time to the Board being able to understand the assurance position in relation to performance without having to repeat detailed discussions that have already taken place at Board Committees.

6.3 Standing Orders

Ms Ramsay presented this paper, which asked for Board approval for the use of the Trust's seal on two occasions, and also approval for a set of amendments to Trust Standing Orders, which is to adopt the new OJEU procurement values that are applicable from 1 January 2020.

Resolved:

The Trust Board approved the use of the seal and the amendments to Standing Orders as detailed in the paper

6.4 Trust Board Constitutional Matters

Ms Ramsay presented this paper and the four recommendations being made, with supporting rationale.

Following discussion, it was agreed that there should be specific reference in the Terms of Reference for the proposed Workforce, Education and Culture Committee that one of the three Non-Executive Director members should be the University-appointed Non-Executive Director. It was also agreed that there should be specific reference in these Terms of Reference to quality of training placements.

In relation to the proposal for the post of the Director of Workforce and Organisational Development to become a voting Trust-board member, Mr Long raised the constitution of NHS Trust Boards as set by legislation; on application to the Department of Health and Social Care for an amendment to the Trust's Establishment Order to request this voting Board member position, it may come back that the Department will leave this to the discretion of the Trust Board to implement. In relation to the reference in the paper about the number of duties of the Non-Executive Directors, Mr Long would like to explore the ways in which the time commitment of Non-Executive Directors to duties other than governance and Trust strategy could perhaps be discharged differently, citing the practice of another large teaching NHS trust to have a body of trained lay representatives to be able to undertake Consultant appointment panels, for example. Board members welcomed this. It was agreed that Mr Long would discuss this further with Mr Moran and Ms Ramsay and make a final recommendation on this in due course. **CL**

Resolved:

The Trust Board approved the following recommendations from the paper:

- The principles of the new format Board agenda, including staff and patient voice, are adopted for the January 2020 Trust Board and the following two Trust Board meetings, then reviewed
- The Workforce, Education and Culture Committee established per the draft set of Terms of Reference (as amended at today's meeting), for a start in February 2020, and to meet every two months thereafter
- The Trust Standing Orders are updated as required to include the Workforce, Education and Culture Committee
- That an application is made for an amendment to the Trust's Establishment Order for the Director of Workforce and Organisational Development post to become an Executive Director (voting) post
- The Chairman to make a proposal regarding the number of/ways of managing the workload of the Non-Executive Directors
- That the Chair of the Patient Council invited to attend the January, March and May 2020 Trust Board meetings

Ms Christmas left the meeting at this point

The agenda was taken out of order at this point

7.3 Escalation Report from Audit Committee Chair – 23 January 2020

The report was received as read. There were no items to escalate to the Trust Board.

Resolved:

To receive and accept the report

11.5 Guardian of Safe Working

Mr Mumdzjans attended the meeting to present the report. The report covered the reporting period July 2019 – Sept 2019, during which time 120 exception reports were submitted. The main themes from the reports are staffing shortages, additional hours worked and extra workload. Comparing 2018 to 2019, these are similar trends. 2019 has a small reduction of reports; it is difficult to state whether this represents an improving position or whether there are fewer reports being submitted. Mr Mumdzjans has commissioned a survey to find out more about the exceptions reported and will include the outcomes in a future report.

Ms Ramsay reported that she has been working with the Guardian of Safe Working to promote the support available to doctors in training from the Freedom to Speak Up Guardian role.

Mr Nearney asked what the key concern would be; Mr Mumdzjans stated that the e-rostering system is good but is not in place for all junior doctor rosters, and therefore analysing exceptions to the same extent for all rotas is not available. Mr Nearney agreed that there is further work to do in this area. Mr Nearney, Dr Purva and Mr Mumdzjans will meet to make further progress on e-rostering, which will be monitored through the Performance and Finance Committee.

Mr Gore asked about oncology services as referenced in the report. Mr Mumdzjans stated that there had been some issues but solutions have recently been implemented successfully.

Mr Hall referenced a presentation at the Performance and Finance Committee on Monday, where junior doctor fill rates are 95% across the Trust presently; Mr Nearney stated that he, Mr Bond and Dr Purva were working through some issues between the staffing establishment and budget in some areas, which is why having all junior doctor rotas on e-rostering is important.

Resolved:

- To receive and accept the report

11.4 CNST Maternity Incentive Scheme

Ms Cairns presented this paper, which summarises the new requirements for year three of this scheme. The Trust was notified in December 2019 that it had been successful in its submission against the 10 Safety Standards in relation to the 2019-20 scheme, resulting in a circa £400,000 rebate on the Trust's insurance premium, as well as an additional return from the national fund.

In respect of the new standards, these have been updated for this third year of the scheme. Overall, the maternity team would assess the Trust as currently having partial compliance at, with reasonably good assurance that the Trust will be fully compliant by September 2020. The Trust is

required to submit its self-assessment with Board sign-off in September 2020.

As in previous years of the scheme, the Trust Board is required by NHS Resolution to be sighted on the details of Safety Action 1, 4, 5, 6 and 10 with formal noting in the Board minutes. The Trust Board is required also to permit the Chief Executive to sign the submission declaration on its behalf for submission in September 2020. There are some specific Quarter 3 data requirements that are included in this paper to the Board, which are the results of the MBRACE-UK perinatal mortality review tool audit, which the Board specifically needs to receive.

Ms Cairns flagged up that the Maternity Services Data Set requirements need a number of changes to be made to Lorenzo Maternity, and confirmation as to whether Lorenzo Maternity will be able to pick up and submit the full data set requirements. Ms Cairns gave her thanks to colleagues in the maternity and IM&T/CRS teams who are working tirelessly on this. Ms Cairns noted that the Trust is compliant with the Perinatal Mortality Review Tool and is able to cross-reference where required to NHS Resolution.

Mrs Geary raised that she meets monthly with Ms Cairns and as Maternity Safety Champions they both regularly walk around the unit. Mrs Geary sees positivity within the service from staff and patients, and she is assured by the work that the maternity team are undertaking on these standards to move to full compliance by September 2020.

Mr Nearney noted the recent tweet from Baroness Cumberlege following her recent visit to the Trust's maternity service and how positive this was. The Board passed on their congratulations to the service for this praise from an external visit. Ms Cairns noted that this was part of the work the Trust is doing on transformation of maternity services on the Better Births agenda, which is being picked up nationally.

Mr Bond asked how the team is performing against the new requirements for continuity of carer. Ms Cairns confirmed that this is currently at 15.1% and is on track to meet the trajectory requirement of 35% by March 2020 and the further compliance of 51%. Ms Cairns confirmed that there was an assurance review last week that gave assurance that the team is on track to achieve this. Professor Jomeen noted her congratulations for this, given that these standards are difficult to achieve, and is an example of successful cultural change.

Ms Cairns will bring quarterly updates to the Trust Board to provide assurance on progress towards meeting all requirements of the CNST maternity scheme for the submission deadline of September 2020.

Resolved:

- To receive and accept the team's assessment of the Trust's current level of partial compliance
- To receive and accept assurance from the team that the action plans put in place will address the identified requirements and move the Trust to full compliance by September 2020
- To receive and accept the results of the Q3 MBRACE-UK perinatal

mortality review tool audit (Appendix 1 of the paper)

- 7.1 Reports and Escalation from the Performance and Finance Committee**
- 7.1.1 Performance and Finance Committee Extraordinary meeting 7 November 2019 (including minutes)**
- 7.1.2 Performance and Finance Committee 25 November 2019 (including minutes)**
- 7.1.3 Performance and Finance Committee 16 December 2019 (including minutes)**

Mr Curry presented these escalation reports. There are no further matters for escalation, as the substantive points were raised under the Balanced Scorecard agenda item.

In respect of the Extraordinary meeting in November, Mr Gore asked about day case availability and the GIRFT review outputs, and whether an availability of theatre space is reducing the Trust's opportunity to increase day case rates. Dr Purva confirmed that she is presenting an update at this week's Carter meeting; she has discussed this issue with Mrs Cope and a new cross-health group committee is being set up to optimise day case capacity.

Mr Hall noted that the Extraordinary meeting of the Committee was to a specific briefing, for the Health Groups to provide a position statement and year-end projection on cash-releasing efficiency savings, cancer waiting times and waiting list volumes. The process will be to keep the Committee updated on progress against the Health Groups' projected positions for the remainder of the financial year. The Committee yesterday received presentations on improvements in Outpatient services and how follow-up appointments could be conducted differently. This will remain under review by the Committee. Mrs Cope confirmed that the exception report received by the Committee provides assurance at specialty level as to whether each Health Group is on track to deliver their forecasted out-turn position as given at the Extraordinary meeting.

Resolved:

To receive and accept the escalation reports and minutes

- 7.2 Escalation Report and Minutes from Quality Committee**
- 7.2.1 Quality Committee 25 November 2019**
- 7.2.2 Quality Committee 16 December 2019**

Prof. Jomeen presented these reports. There were no specific items to escalate. The Board will receive a more detailed update on the recent Never Events at the next meeting; the Quality Committee is undertaking a more detailed review of these incidents as well as receiving an action plan following a peer review visit to the Trust's theatres on the WHO Safer Surgical checklist.

Mr Hall thanked Prof. Jomeen for her involvement and input in the Quality Committee, which has been valued.

Resolved:

To receive and accept the escalation reports and minutes

7.2.3 Quality – Summary Report (summary of agenda item 12.3)

Mrs Geary presented this report. In response to a question from Mr Gore, she confirmed that a review of previous CQC actions has been undertaken.

In relation to Never Events, Mrs Geary noted that the Trust had declared a Never Event in December 2019 and welcomes the review by the peer review team on the WHO Safer Surgical checklist. The Chief Medical Officer chaired a staff engagement session on Never Events on 7 January 2020, which was a sharing and learning event, resulting in good discussions between staff on developing the Trust's safety culture

Mrs Geary gave an update on the CQC and noted that the Trust received its NHS Improvement Use of Resources request for information last week, with a date booked for this review.

Mr Hall noted that a lot of effort has been made on the mechanics of the Quality Improvement Programme, and more detailed deep-dive reviews of specific QIP projects started at the Quality Committee yesterday.

Resolved:

To receive and accept the report

The agenda continued out of order

8.2 Nursing and Midwifery Escalation Report (summary of agenda item 12.4)

Mrs Geary presented this escalation report. The key point to note is that the Trust has seen a 1% drop in Care Hours Per Patient Day (CHPPD); it is believed this is due to the transition of new nursing registrants and timing of receiving their PINs. A full review of CHPPD is being undertaken to understand this drop in full. Mrs Geary noted that the opening of new bedded areas using existing staff numbers may also have impacted on CHPPD in the last reporting period.

The Trust is implementing its recruitment plan with the University of Hull on this year's graduating nurses and undertaking a further round of international nurse recruitment as well as a return to profession programme. In response to questions by Board members, Mrs Geary gave more detail on the current recruitment process working in partnership with the University of Hull. Mrs Geary gave assurance that patient safety continues to be reviewed through the Safety Brief meetings throughout the day. Mrs Geary also attended the Band 7 forum to provide feedback on the work the Trust is doing on recruitment and retention, as some of the positive news and improvements have not yet reached front-line staff. Mrs Geary also recognised that while some nursing teams are at full establishment, there are some teams who continue with a number of vacancies. Mrs confirmed the current recruitment work is looking to support these areas as much as possible, recognising staff feedback on how it feels to work in such areas.

Resolved:

To receive and accept the report

9.1 Patient Story

Mrs Stern provided a detailed story and reflection of a family member who is a recent patient of the Trust. The story highlighted some excellent care he received, but also some gaps in communication that he has experienced, which have affected his experience of the Trust's services.

Mr Hall thanked Mrs Stern and their relative for their honesty and candour in sharing this story. Mrs Cope responded with an apology for the issues around communication and connectivity between teams and services, both within the hospital and with our community partners. She will take this back as a learning opportunity.

10.1 Board Assurance Framework Quarter 3

Ms Ramsay presented this report, which included a recommended set of Q3 ratings, which have been reviewed by the Performance and Finance and Quality Committees. Ms Ramsay fed back on the detailed discussion at the Performance and Finance Committee yesterday regarding the risk rating for BAF 4 (meeting contractual performance requirements and a risk to poor patient experience) as well as BAF 7.1 (meeting the Trust's financial plan). Following debate on the points raised by the Committee, the Trust Board endorsed the recommended Q3 ratings, for review in Q4 that may change some risk-ratings.

Resolved:

The Trust Board received and accepted the report, specifically:

- to be aware of the assurance and control needs identified, to inform current and future discussions of these areas in the Committees for this financial year
- approved the proposed Q3 risk ratings

10.2 BAF 2 – Valued, Skilled and Sufficient Staff

Mr Nearney presented this report, which presented an update and assurance on this particular BAF risk and topic.

As a point of feedback, Mrs Cope asked whether the different staffing groups in radiotherapy could be split out, as the recruitment challenges are different between the staff groups. Mr Bond asked whether the Terms of Reference for the new Board Workforce, Education and Culture Committee should include a specific reference to workforce redesign, as part of workforce planning. This was agreed by the Board.

Resolved:

The report was received and accepted, specifically:

1. That the risk score for Goal 2, valued, skilled and sufficient staff is to remain at 15 (likelihood 3 x impact 5 = 15)
2. That a further review of the management of this risk be reviewed during 2020/21
3. That the actions that have been taken to manage this risk are added to the BAF

11. Items for approval by the Board

11.1 Capital Support Loan

Mr Bond presented this request, which included the detailed terms and conditions of the loan request. He confirmed that this is an advance on

part of the £19.3m Wave 4 capital, in order to fund the planning elements of the scheme. The loan value is £727k.

Resolved:

To approve the loan application, per the terms detailed in the paper

11.2 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2019-20

Ms Myers presented this assessment for formal Trust Board approval. This has been subject to review and detailed scrutiny by the Performance and Finance Committee, as well as an independent review by the Director of Corporate Affairs. Ms Myers confirmed that an action plan has developed in response to all required areas flagged up by this assessment. In response to a question from Mr Gore, Ms Myers confirms that the Trust has in place an overarching framework to identify and document Business Continuity Plans and an ongoing process to track the development and approval of these plans.

Resolved:

To approve the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2019-20

11.3 Contract Extension for the continued use of the Healthtrust Europe Total Workforce Solutions Framework Agreement

Mr Nearney presented this request. He confirmed that the Trust uses three national frameworks to access temporary staff; the request is to extend the use of one of these three frameworks for 12 months, as detailed in the paper.

Resolved:

To approve the requested extension for 12 months

Tracey Christmas re-joined the meeting at this point

12. Reports to the Board

12.1 12.1 Partnership with the Sri Ramachandra Institute in Chennai update

Following a request from the Chief Executive, the Chairman agreed that this paper could be brought in to the discussion section of the agenda.

Dr Purva provided an overview of this report; as part of this partnership, a jointly conducted research conference between the Trust and the Institute is being set up to showcase progress. The Trust will have circa 15 researchers attending, representing at least 7 research projects. The partnership will look for further international research opportunities as well as offering clinical service development opportunities, for example, the Institute is looking to develop a clinical specialism in Medical Elderly medicine, which is not as well developed as in the UK.

Prof. Jomeen noted that this partnership has enabled excellent collaborative working between the University of Hull, the Trust and the Institute.

Mr Long confirmed that the Trust is looking at opportunities to partner with further organisations to develop the Trust as an international partner with a

sound reputation. The partnership with the Institute in Chennai is an excellent start with a lot of potential for future development.

Resolved:

To receive and accept the report

12.2 Integrated Performance Report

12.3 Quality Report

12.4 Nursing and Midwifery Report

These papers were received for Board members' briefing purposes.

Resolved:

The reports were received and accepted

13. Chairman's Summary of the meeting

Mr Hall re-iterated his sincere thanks to the Trust's staff for their hard work and dedication. The meeting today has highlighted the number of challenges that the Trust is working with at present. The willingness of staff to maintain and improve performance and care in these circumstances is to be commended.

14. Any Other Business

There were no items of other business

15. Questions from the public

There were no questions from the public

16. Date and time of next meeting

Tuesday 10 March 2020 – 9 am – 1 pm, The Boardroom,
Hull Royal Infirmary

**Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (March 2020)**

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
January 2020						
Jan 2020	Trust Board Constitutional Matters	NHS trust to have a body of trained lay representatives to be able to undertake Consultant appointment panels – to be discussed	CL	March 2020		Update
November 2019						
Nov 2019	7 Day Services Report	Trust benchmarking information to be presented to the Board	MP	May 2020		
	Trust Strategy Implementation	Summary arrow to be added to show whether standards were improving or not	JM	May 2020		
COMPLETED						
Jan 2020	Board Reporting Framework	Operational Guidance to be circulated to the Board	JM	January 2020		Completed
Nov 2019	Nursing and Midwifery Report	Red Flag trend analysis to be added to the next report	BG	January 2020		Added to report
		Mrs Christmas to discuss the safeguarding Red Flags with Ms Rudston	TC	TBC		Completed

Actions referred to other Committees

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

Trust Board Annual Cycle of Business 2018 - 2019 - 2020			2018								2019									2020	
Focus	Item	Frequency	Jan	Mar	Apr	May	May Ext.	July	Sept	Nov	Jan	Feb	Mar	May	May Ext.	July	Sept	Nov	Jan	Mar	
Strategy and Planning	Operating Framework	annual									x								x		
	Operating plan	bi annual			x						x		x						x		
	5 Year Plan	new item															x	x			
	Trust Strategy Refresh	annual			BD			x													
	Financial plan	annual	x	x	x					x	x	x							x	x	
	Capital Plan	annual		x								x								x	
	Performance against operating plan (IPR)	each meeting	x	x		x		x	x	x	x	x	x	x		x	x	x	x	x	
	Winter plan	annual								x								x			
	IM&T Strategy	new strategy				x															
	Research and Innovation Strategy	new strategy			BD																
	Scan4Safety Charter	new item																			
	Equality, Diversity and Inclusion Strategy	new strategy		x																	
	Digital Exemplar	new item																			
	People Strategy	Refresh Strategy									BD			x							
Strategy Assurance	Trust Strategy Implementation Update	annual				x												x			
	Estates Strategy inc. sustainability and backlog maintenance	annual				BD				BD									x		
	Research and Innovation Strategy	annual							x									x			
	Assurance Against Equalities Objectives	annual												x							
	IM&T Strategy	annual												x							
Quality	Patient story	each meeting	x	x		x		x	x	x	x			x	x		x	x	x	x	
	Quality Report	each meeting	x	x		x		x	x	x	x			x	x		x	x	x	x	
	Nurse staffing	monthly	x	x		x		x	x	x	x			x	x		x	x	x	x	
	Fundamental Standards (Nursing)	quarterly		x				x	x		x					x					
	Quality Accounts	bi-annual				x				x								x			
	National Patient survey	annual		x										x							
	Other patient surveys	annual																			
	National Staff survey	annual		x										x			x			x	
	Quality Improvement Plan (inc. Quality Accounts and CQC actions)	quarterly				x								x				x			
	Safeguarding annual reports	annual								x								x			
	Annual accounts	annual					x								x						
Regulatory	Annual report	annual				x									x						
	DIPC Annual Report	annual							x									x			
	Responsible Officer Report	annual							x									x			
	Guardian of Safe Working Report	quarterly		x				x		x	x								x		
	Statement of elimination of mixed sex accommodation	annual				x								x							
	Audit letter	annual					x								x						
	Learning from Deaths Guidance	quarterly	x			x				x				x		x		x		x	
	Workforce Race Equality Standards	annual							x					x				x			
	Workforce Disability Equality Standards	annual																x			
	Modern Slavery	annual				x								x							
	Emergency Preparedness Statement of Assurance	annual								x								x			
	Annual CNST premium/maternity standards	annual																x			
	Information Governance Update (new item Jan 18)	bi-annual	x		BD				x						x				x		
	Corporate	H&S Annual report	annual							x										x	
Chairman's report		each meeting	x	x		x		x	x	x	x			x	x		x	x	x	x	
Chief Executive's report		each meeting	x	x		x		x	x	x	x			x	x		x	x	x	x	
Board Committee reports		each meeting	x	x		x		x	x	x	x			x	x		x	x	x	x	
Cultural Transformation		bi annual				x		x										x		x	
Self Certification and Statement		annual						x													
Standing Orders		as required	x	x		x		x	x	x	x			x	x		x	x	x	x	
Board Reporting Framework		monthly	x	x		x		x	x	x	x			x	x		x	x	x	x	
Board Development Framework		monthly	x	x		x		x	x	x	x			x	x		x	x	x	x	
Board calendar of meetings		annual								x											
Board Assurance Framework		quarterly				x				x	x	x			x			x	x	x	
Review of directors' interests		annual				x									x						
Gender Pay Gap		annual		x										x							
Fit and Proper person		annual				x									x						
Freedom to Speak up Report		quarterly				x					x						x		x		
Going concern review		annual						x													
Seven Day Working Assurance Framework		New item											x		x					x	
Preparation for EU Exit		New item												x							
Developing Workforce Safeguards		bi-annual																x		x	
Review of Board & Committee effectiveness		annual				x												x			

**Hull University Teaching Hospitals NHS Trust
Board Development Programme 2017-20**

Overarching aims:

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

[illegible]

17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy					
		Area 1 and BAF 1: Draft 2018-19 BAF							
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents							Area 2 and BAF 7.1: Tower Block strategy
		Area 1 and BAF 1: Draft 2018-19 BAF							
18/07/2018 - at EMC	Area 2 and BAF 6 & 7.2: Strategy refresh - clinical strategy								
31 July 2018				Area 4 and BAF 3: Deep Dive - Never Events					Area 1 and BAF 7.1: Financial strategy including STP and ICO
				Area 3 and BAF 3 & 4: Elective Care e-Learning RTT					
25 September 2018		Area 1 and BAF 1: What does the Board spend its time on?		Area 1 and BAF 3: Journey to Outstanding					
27 November 2018			Area 1 and BAF 2: People Strategy Refresh	Area 4 and BAF 4: Estates/Tower Block strategy					
29 January 2019			Area 4 and BAF 4: Emergency Department Interim Arrangements						
26 March 2019		Area 1 and BAF 1: 2019-20 BAF							
		Area 1 and BAF 4: Trust Board and organisational improvement capacity and capability							
8-9 July 2019		Area 1 and BAF 1: Two days' time out with Martin Johnson							
30-Jul-19			Area 4 and BAF 1: Staff Survey (Board Minutes)						BAF 7.2 and Area 2: Trust long-term finance plan (including productivity and efficiency opportunity)
12-Aug-19				Area 1 and BAF 3: CQC and journey to outstanding	Area 2 and BAF 4: performance				
				Area 1 and BAF 3 - McKinsey insights (TBC)					
24-Sep-19			Area 1 and BAF 2: cyber security training (via NHSI) - mandated board training (90 minutes)	Area 1 and BAF 3: CQC and journey to outstanding	Area 2 and BAF 4: Same Day Emergency Care standards		Area 3 and BAF 5: Partnership working/ICS development and stock-take		Area 1 and BAF 7.2 - Long-term plan development

							Area 1 and BAF 5: Brexit regional planning		
26-Nov-19	Strategic drivers/balanced scorecard review	Area 1 and BAF 1: Trust Board and cultural development						Area 2 and BAF 6: Research and Innovation strategy and developments	Area 2 and BAF 7.3: Tower Block/infrastructure update
28-Jan-20	Operational and financial planning 2021 onwards								
									Area 2 and BAF 7.3 Long term buildings plan
24-Mar-20									

Other topics to consider:
Workforce data reporting
Strategic drivers/factors Deep Dive
IT Strategy/roadmap and cyber security
Estates/Tower Block update
Research, innovation, partnerships
Commercial strategy
Efficiencies and Productivity
HSJ Patient Safety Awards/ Trust award nominations and profile

Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and Integrated Services	Research and Innovation	Financial Sustainability
	<p>BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation</p> <p>What could prevent the Trust from achieving this goal? Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage</p>	<p>BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust</p> <p>Work on medical engagement and leadership fails to increase staff engagement and satisfaction</p> <p>Lack of affordable five-year plan for 'sufficient' and 'skilled' staff</p> <p>What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need.</p> <p>Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans</p>	<p>BAF 3: Principal risk: There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating</p> <p>What could prevent the Trust from achieving this goal? That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement</p> <p>Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding</p> <p>That the Trust is too insular to know what outstanding looks like</p> <p>That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy</p>	<p>BAF 4: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog</p> <p>What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements</p> <p>In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues</p> <p>A focus on 62-day cancer targets has brought about improvements and a continued focus is required to</p>	<p>BAF 5: Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds.</p> <p>What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP</p> <p>The effectiveness of STP delivery, of which the Trust is one part</p>	<p>BAF 6: Principal risk: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas.</p> <p>What could prevent the Trust from achieving this goal? Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Increased competition for research funding</p> <p>What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP</p>	<p>BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit</p> <p>BAF 7.2 Principal risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year</p> <p>What could prevent the Trust from achieving this goal? Lack of achievement of sufficient recurrent CRES Failure by Health Groups and corporate services to work within their budgets</p>

Risk that some staff do not acknowledge their role in valuing their colleagues
 Risk that some staff or putting patient safety first

Failure to put in place 2-3 credible year plan to address the underlying deficit position
 BAF 7.3 Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability
 What could prevent the Trust from achieving this goal?
 Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality

Principles for the Board Development Framework 2017 onwards

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

Overarching aim:

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

Area 1 – High Performing Board

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



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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

10 March 2020

Title:	Chief Executive Report
Responsible Director:	Chief Executive – Chris Long
Author:	Chief Executive – Chris Long

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	Coronavirus thanks to staff, additional ward capacity, staff survey results	

Recommendation:	That the board note significant news items for the Trust and media performance.
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Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 10 March 2020

1. Key messages from January and February 2020

Coronavirus response

The current Coronavirus outbreak has required teams from across the Trust to respond at short notice to a rapidly developing and constantly evolving situation. Everyone who has been involved in helping to keep patients and staff safe, at the same time as provide reassurance to the public should be commended for their actions to date. On behalf of the board I would like to pass on my sincere thanks and express my confidence that the Trust is as prepared for this situation as we can be.

Additional ward capacity to be provided at HRI

NHS Improvement funding has been granted to us at short notice to enable the construction of a two-storey facility on the HRI site. This will see the creation of an additional ward (37) located adjacent to ward 36 to the rear of the tower block. We anticipate that this will result in 22 additional medical beds being made available to improve the assessment of elderly patients. Ward 37 will provide modern, flexible patient accommodation to facilitate the essential upgrade and reprovision of the Trust IT network at Hull Royal Infirmary. It will also mean that ward 200 will become available, enabling paediatrics to move into that space. We expect work to be completed within the next three months.

Due to the short notice of this announcement many staff have been asked to relocate equipment and services and we appreciate that this must be frustrating and a significant inconvenience. I would like to offer an apology for this and again express my gratitude for the co-operation of everyone who has been affected by this development.

Staff survey 2019

The Staff Survey results for 2019 remain relatively unchanged since 2018. The Trust is equal to or better than the national average for 8 of the eleven key themes in the survey, including staff morale, staff engagement, safety culture and health and wellbeing. For the first time in the last five years the Trust is performing better than the national average for scores around bullying and harassment with fewer staff saying they have experienced bullying at work. We do need now to plan a different approach to move us from average into the highest performing categories.

For the key theme of quality of appraisal there is work to be done and we are discussing with health groups how we can address this as a priority area.

Trust awarded £100K to improve disabled facilities

More than £100,000 of funding has been awarded to help improve accessibility, privacy and dignity for disabled people using local hospitals.

The Trust will receive £105,000 of government funding to create four new 'Changing Places' facilities across both Hull Royal infirmary and Castle Hill Hospital. We received the lion's share of half a million pounds of capital funding awarded to ten NHS Trusts in January.

We will match-fund the money received, and create Changing Places in the main entrance to Castle Hill Hospital (above) and near to the main hospital restaurant, as well as in the Emergency Department at Hull Royal Infirmary and within HRI's Clinical Skills Building.

CQC Inspection

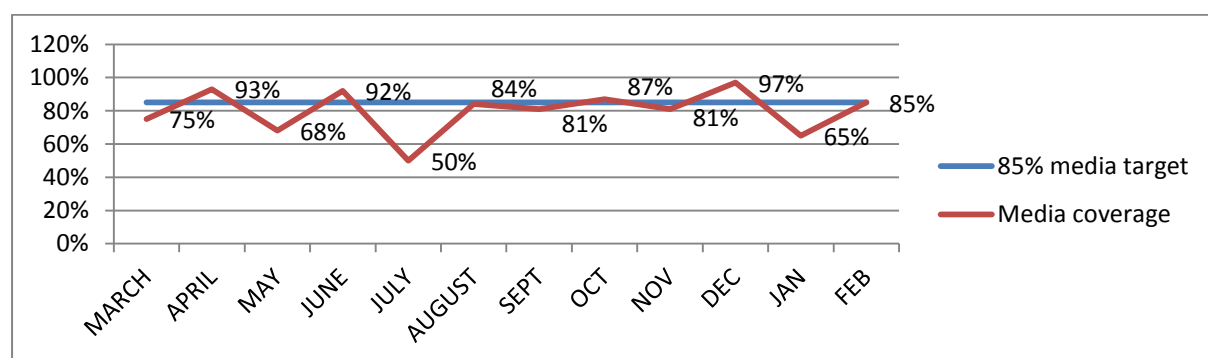
At the time of writing this report, the CQC have just informed us they will be carrying out an unannounced inspection from 3-5 March 2020.

2. Media Coverage

The Communications team issued 13 news releases in January and February 2020.

In January 65% of our media coverage was positive and in February 85% was positive, against a department stretch target of 85%. The Trust strategy target is 75%, which has been met or exceeded in nine months out of the last 12. The annual average performance is current 79.8%.

The January performance was negatively affected by coverage of the change to oncology services on the south bank.



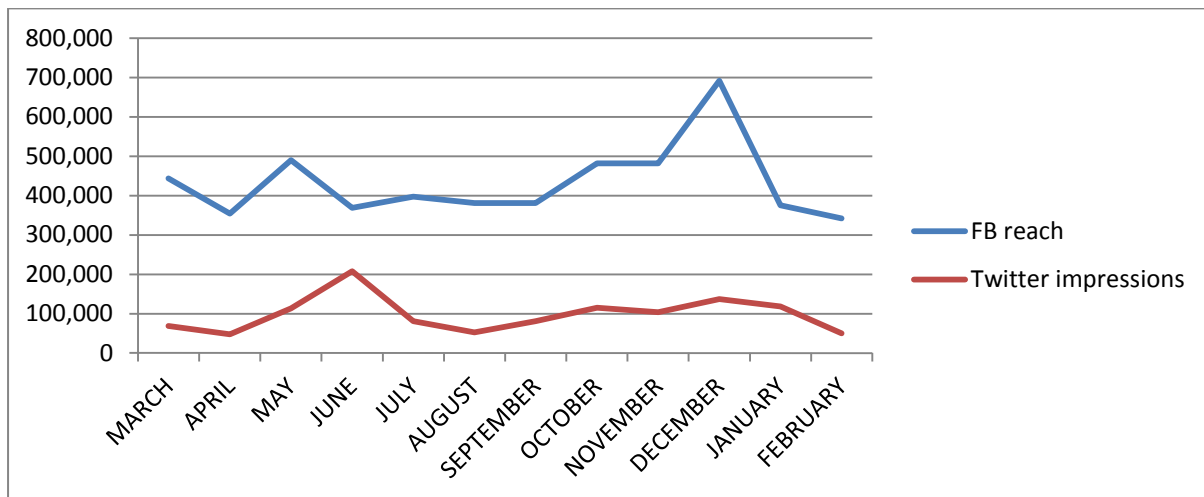
Facebook reach is the number of people that have seen content within a certain period, it can also be called unique impressions.

- In January total “reach” for all posts on trust Facebook pages was 375,223
- In February total “reach” for all posts on trust Facebook pages was 342,029

Twitter impressions are a total tally of all the times a Tweet has been seen. This includes not only the times it appears in a followers’ timeline but also the times it has appeared in search or as a result of someone liking the Tweet.

- @HEYNHS Twitter account impressions 118,600 (January)
- @HEYNHS Twitter account impressions 50,200 (February)

Social media reach and impressions January 2020 – February 2020



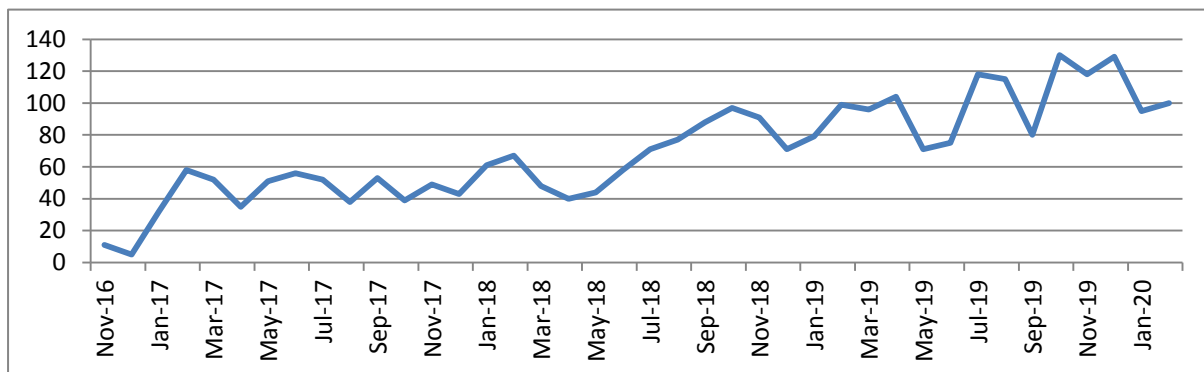
3. Moments of Magic

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

In January and February we received 95 and 100 Moments of Magic nominations, respectively.

[Please visit the intranet to read the most recent nominations.](#)

Number of Moments of Magic submitted by month 2016-2019



4. Visit to India

I accompanied a joint delegation from the Trust, University of Hull and HYMS to visit the Sri Ramachandra Institute (our partner university hospital) in Chennai, India. This visit took place 25 Feb – 1 Mar. The purpose of the visit was to follow up on some of the principles and actions around research, training and recruitment agreed in the memorandum of understanding between our organisations last year. This was a highly successful visit and I would like to congratulate all those who attended. A brief report on the outcomes is attached at Annex A.

Hull University Teaching Hospitals NHS Trust

TRUST BOARD

March 2020

Title:	Research & innovation Strategy Update: International Partnerships
Responsible Director:	Dr Makani Purva
Author:	James Illingworth, R&D Manager

Purpose:	The purpose of this paper is to provide the Trust Board with an update on progress with the development of international partnerships as part of the Trust Research and Innovation Strategy 2018-23.	
BAF Risk:	BAF 6 – Research and Innovation	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great clinical services	X
	Partnership and integrated services	X
	Research and Innovation	X
	Financial sustainability	
Summary Key of Issues:	<p>A delegation representing HUTH, UoH (Faculty of Health Sciences) and HYMS visited Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India from 27th – 29th February 2020 as part of a joint research conference: https://hull.sriher.com/</p> <p>The wider academic and research exchange with SRIHER will support the Trust's long term goal of establishing mature programmes of workforce development and research with our international partners by showcasing the facilities to support and nurture these staff, working in areas of development that will impact positively on key performance and quality indicators and contributing to the generation of a research active and aware workforce.</p>	

Recommendation:	The Trust Board is asked to acknowledge the progress made to date by the Trust in the development of an international partnership with SRI Ramachandra Institute of Higher Education and Research (SRIHER).
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Hull University Teaching Hospitals NHS Trust

Research And Innovation Strategy Update International Partnerships

1. Purpose Of Paper

The purpose of this paper is to provide the Trust Board with an update on progress with the development of international partnerships as part of the Trust Research and Innovation Strategy 2018-23.

2. Background

Since late 2018 the Trust has nurtured a collaborative relationship with SRI Ramachandra Institute of Higher Education and Research (SRIHER) in Chennai, India in support of academic exchange and research. As part of this relationship, a Joint Research Conference was held at SRIHER.

3. Joint Research Conference

A delegation (see *Appendix 1*) representing HUTH, UoH (Faculty of Health Sciences) and HYMS visited Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India from 27th – 29th February 2020 as part of a joint research conference: <https://hull.sriher.com/>

The conference was established following the signing of a Memorandum of Understanding between HUTH and SRIHER in May 2019 ('*Agreement for Academic Exchange and Co-operation*') which sought to explore and exploit mutually beneficial collaborations within the following heads of terms:

- Establishing academic exchange and co-operation
- Establishing mature programmes of workforce development and exchange
- Exploiting opportunities for Intellectual Property Rights and the generation of research funding.

Over the last 12 months colleagues representing HUTH, UoH and HYMS have worked with counterparts at SRIHER to co-ordinate the research conference programme. Over 500 delegates attended the conference across two days of lectures, workshops and academic discussions structured around 9 vertical themes:

- *Endocrinology – Polycystic Ovarian Syndrome & Recent Developments in Diabetic Care (Prof Sathyapalan)*
- *Infectious Diseases – Antimicrobial Resistance (Dr Barlow)*
- *Simulation – Transforming Healthcare through Simulation (Dr Purva)*
- *Nephrology – Dialysis (Prof Bhandari)*
- *Geriatrics – Early detection of Cancer in the Elderly (Prof Macleod)*
- *Microfluidics – Utilising Microfluidics for Individualised Cancer Therapy (Prof Greenman)*
- *Rehabilitation/Sports Science and Wound Healing – Cardiac rehabilitation in the UK (Prof Ingle) and Understanding Wound Repair (Prof Hardman)*
- *Research Methodology – Understanding the role of Geographical Data in Health Research (Dr Lee) and Principles of Publishing Success, (Prof Hayter)*
- *Orthopaedics – Limb Reconstruction in Trauma & Orthopaedics including recent advances (Prof Sharma)*

A number of facilities tours and meetings were arranged throughout the visit as well as a day providing dedicated time for Hull and SRIHER colleagues to work up future plans for collaboration.

4. Impact And Outcomes

The conference served to cement foundations for research collaborations in several mutually beneficial clinical and academic areas (see *Appendix 2*). Plans to scope possible research funding applications have been outlined across multiple themes. All the research conference verticals have recommended further bi-lateral academic exchange programmes are established with a view to exploit recruitment opportunities across clinical, nursing and other allied health professional groups.

Specifically, the wider academic and research exchange with SRIHER will support the Trust's long term goal of establishing mature programmes of workforce development and research through:

- Facilitating research fellowship and scholarship programmes across all verticals including PhD exchange and visiting Professorship schemes.
- Faculty training programmes.
- Student peer-support mechanisms.
- Increased human resource capacity across medical, nursing and AHPs through attractive exchange and research programmes.
- Nursing school initiative to recruit 5 post graduate nurses over the next 12 months with the support of the UoH (including cultural orientation modules to aid better integration of these new nurses into HUTH and the NHS).

A Steering Group is to meet in the next 6 weeks to consolidate plans across each of the vertical themes as well as institution-wide initiatives. This group will also begin the planning for a reciprocal conference anticipated to be held in the summer of 2021. Further updates will be provided to the Trust Board on a quarterly basis.

5. Recommendation

The Trust Board is asked to acknowledge the progress made to date by the Trust in the development of an international partnership with SRI Ramachandra Institute of Higher Education and Research (SRIHER) and the next steps being taken to ensure tangible, mutually beneficial outcomes are delivered over the coming months and years.

James Illingworth

R&D Manager

Hull University Teaching Hospitals NHS Trust

Appendix 1: HUTH, UoH and HYMS Delegates

Name	Role	Institution
Chris Long	Chief Executive Officer	HUTH
Beverley Geary	Chief Nurse	HUTH
Dr Makani Purva	Chief Medical Officer	HUTH
James Illingworth	R&D Manager	HUTH
Prof Sunil Bhandari	Consultant in Nephrology	HUTH
Prof Hemant Sharma	Consultant in Trauma and Orthopaedics	HUTH
Prof Una Macleod	Dean, HYMS	HYMS
Prof Mat Hardman	Chair in Wound Healing	HYMS
Dr Gavin Barlow	Consultant in Infectious Diseases	HYMS
Prof Thozhukat Sathyapalan	Chair in Academic Endocrinology, Diabetes and Metabolism	HYMS
Prof Mark Hayter	Professor of Nursing and Research and Associate Dean (Research) in the Faculty of Health Sciences	UoH
Dr Amanda Lee	Associate Dean (International)	UoH
Prof Lee Ingle	Professor of Sport, Health & Exercise Science	UoH
Prof John Greenman	Professor of Tumour Immunology	UoH

Appendix 2				
Vertical Theme	Hull Lead	Outputs		
		Academic Exchange	Research Proposals	Workforce Development
Microfluidics	Prof John Greenman	Transfer of microfluidic devices and processes to embed technology at SRIHER. Explore use of 3D printing as cost effective method for technology transfer. Further exploratory work on breast cancer biopsy responses, diagnostic work and tissue scaffolds.	2 proposals for research funding initiated (first submitted March 9th (Indian Gov) and second to follow to Bill & Mellinda Gates Foundation)	Research Scholarship Exchange Programme planned.
Infectious Diseases	Dr Gavin Barlow	Indian specific Journal of Antimicrobial Chemotherapy (JAC) supplement planned before the end of 2020 to showcase Indo-UK authors and collaborations	Ongoing systematic review to support funding applications to develop bedside biomarkers utilising data and AI modelling. Bedside tests to be developed using microfluidics. Research supported by Indian funding for a pilot before developing larger funding bid.	Clinical Pharmacists AMR Training (bi-lateral exchange programme). Medical exchange programme 6 months Hull and 6 months SRIHER.
Orthopaedics	Prof Hemant Sharma	Potential to develop UoH Degree in Trauma and Orthopaedics. Observership (4-6 weeks with honorary contracts) or 6 month research fellowship programme. Post Graduate Teaching and Exchange programme (top 2 students to visit Hull)	Gait Lab research (pre and post op with defined modelling) Seek funding to validate. Distraction Osteogenesis (link with Vascular) - pilot with SRIHER then larger RCT funding bid. Use of steroids in bone infection pilot (paediatrics in SRIHER and adults in UK).	Faculty Training Programme (Registrar Level - 1 individual annually on rolling programme as either MSc in research or MD if 2 years).
Simulation	Dr Makani Purva	Create SRIHER Simulation Structure and infrastructure roadmap utilising HILS model. Admin, governance and management to be explored via gap analysis work.	1 publication on simulation already (Sree). Plans to publish pilot model of simulation and explore funding opportunities. 'Train the trainer' model already established.	8 further SRIHER trainees to visit Hull. Develop new specialised training simulation programme and explore curriculum development.
Geriatrics	Prof Una Macleod	SRIHER to set up a geriatric ward. Utilise community cohort of data in India to support research into development of a series of biomarkers to detect frailty.	Explore large datasets available in India (i.e. Responses to commonly used medications). Use of less interventional care in the elderly and value added in technology assisted medical education at home (i.e. wearable technology).	2 year fellowship programme (18 mths in Hull and 6 mths in SRIHER. Provide leadership support for the emerging area in India.
Endocrinology	Prof Sathyapalan	Establish a specific support network to provide external Hull reviewers for SRIHER research.	Focus on PCOS research- pilot study with two arm randomisation using very low calorie diet sources from local Indian ingredients to allow community adoption supporting methods of dietary intervention for weight loss.	DM & Endocrinology Exchange Programme.
Nephrology	Prof Sunil Bhandari	Sharing data and findings from completed Hull research on renal anaemia, CKD progression and the effects of iron therapy on cardiac and renal function (i.e. Iron and Heart study).	Retrospective study of IgA Nephropathy - a south Indian risk prediction model (3-4 year project). Research pilot protocols to be developed based around various vascular access interventions.	Fellowship Programme to be established as part of Prof Bhandari's capacity as International Director and Vice President of the Royal College of Physicians of Edinburgh.
Sports Science	Prof Lee Ingle	Further work to match experts across Hull and SRIHER.	Collaborative work on systematic reviews (Hull supporting SRIHER to publication in high impact journals) as well as physio-oncology research opportunities.	Expected that SRIHER colleagues will visit Hull within 6 months and student exchange within 12 months.
Wound Healing	Prof Mat Hardman	Use of underpinning technologies across all verticals can also support wound healing research (i.e. Microfluidics). Work to scope possible research funding landscape is needed.	Joint research applications planned within 12-18 months	Expected that SRIHER colleagues will visit Hull within 6 months and student exchange within 12 months.
Research Methods	Prof Mark Hayter & Dr Amanda Lee	Development of online CME Research Methods courses assisting all vertical collaborations. Educational work in helping SRIHER colleagues avoid 'predatory journals'. Peer-review of SRIHER manuscripts available from Hull.	Support with scoping of research funding landscape. Utilisation of UoH Global Challenges Initiative Research Funding (pump-priming funding up to £30k per project).	Student exchange programme with elective in research methodology.

Hull University Teaching Hospitals NHS Trust

Trust Board

10 March 2020

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

Purpose:	To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary of Key Issues:	The Trust's seal has been used, for review by the Trust Board.	

Recommendation:	The Trust Board is requested to: <ul style="list-style-type: none">• Authorise the use of the Trust's seal• Note the change to the reporting timetable for the Nursing and Midwifery Staffing Report
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Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders March 2020

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2020/01	North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals – North Yorkshire and Humber AAA Screening Programme – Licence to occupy premises at Scunthorpe for the provision of AAA Screening services – Outpatient Department Level C – Room 6	03.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs
2020/02	Hull University Teaching Hospitals NHS Trust and East Riding Fertility Services Ltd – Deed of surrender relating to IVF facility at HRI site	03.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs
2020/03	Hull University Teaching Hospitals NHS Trust and East Riding Fertility Services Ltd – Renewal Lease by reference to a previous lease at IVF facility at Hull Royal Infirmary site	03.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs
2020/04	Hull University Teaching Hospitals NHS Trust and East Riding Fertility Services Ltd – Option to renew a lease at IVF Facility at Hull Royal Infirmary site	03.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs
2020/05	Langley Concrete Ltd, Hull University Teaching Hospitals Trust and Hobson and Porter Ltd – Development of a new cyclotron and radio pharmacy. Subcontractors deed of warranty in favour of a landlord relating to a development at Castle Hill Hospital – Design, manufacture, supply, carry out and complete the installation of pre-cast concrete stairs.	05.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs
2020/06	Alliance Technical Building Services Limited, Hull University Teaching Hospitals NHS Trust and Hobson and Porter Ltd – Development of a new cyclotron and radio pharmacy. Subcontractors deed of warranty in favour of a landlord relating to a development at Castle Hill Hospital – Design, supply, carry out and	05.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
	complete the installation and testing and commissioning of all the electrical works.		
2020/07	Alliance Technical Building Services Ltd, Hull University Teaching Hospitals NHS Trust and Hobson and Porter Ltd – Development of a new Cyclotron and radio pharmacy. Subcontractors deed of warranty in favour of a landlord relating to a development at Castle Hill Hospital – Supply, carry out and complete the installation and testing and commissioning of all the mechanical and plumbing works.	05.02.20	Chris Long – Chief Executive Officer and Carla Ramsay – Director of Corporate Affairs

3 Nursing and Midwifery Staffing Reporting Timetable

The Board is asked to note that the January 2020 Nursing and Midwifery Staffing Report was received at the Workforce, Education and Culture Committee in February 2020 but will not be received at the March Trust Board as it has already been received at the Board in January 2020.

The next report will be scrutinised by the Workforce, Education and Culture Committee in April 2020 and the escalation points from this will be received at the May 2020 Trust Board.

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Note the change to the reporting timetable for the Nursing and Midwifery Staffing Report

Carla Ramsay

Director of Corporate Affairs

March 2020

LONG TERM GOALS - January 20 data

Great Staff

Great Care

Great Future

Quality

RAG	Indicator	Target	Performance January	Trend v Previous Month
G	Never Events	0	0	↓
G	Healthcare Associated Infections - MRSA	0	0	→
G	Healthcare Associated Infections - C.Diff (YTD target)	80	32	-
R	Safety Thermometer - Harm Free Care	95%	93.76%	→
R	Venous Thromboembolism (VTE) Risk Assessment (Q3 1920)	95%	92.12%	↓
R	Mortality - HSMR (November 2019)	<100	100.3	↑
G	Friends & Family Test - Inpatients (December 19 - Trust v National %)	95.80%	99.23%	↑
R	Friends & Family Test - Emergency Department (December 19 - Trust v National %)	84.20%	78.20%	↓

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

Workforce

RAG	Indicator	Target	Performance January	Trend v Previous Month
R	Staff Retention/Turnover	<9.3%	9.40%	↓
G	Staff Sickness	<3.9%	3.55%	↓
R	Staff Vacancies	<5.0%	5.40%	↑
R	Staff WTE in post (<0.5% from Plan)	7561.6	7672.8	↑
R	Staff Appraisals - AFC Staff	85%	79.90%	↓
G	Staff Appraisals - Consultant and SAS Doctors	90%	92.00%	↓
G	Statutory/Mandatory Training	90%	91.30%	↓
G	Temporary Staff/Bank/Overtime costs (Medical YTD)	12.48m	12.12m	-
G	Staff: Friends & Family Test - Place of Work (Q3 1920 v National)	63%	63%	↓
R	Staff: Friends & Family Test - Place of Care (Q3 1920 v National)	71%	70%	↓

Category	No. of Risks Rated 15 and above
Corporate Staffing Risks	3
Corporate Clinical Risks	1

Performance

RAG	Indicator	Target	STF Trajectory	Performance January	Trend v Previous Month
R	18 Weeks Referral To Treatment	92%	83.60%	68.35%	↓
R	52 Week Referral To Treatment Breaches	0	0	1	↑
R	Diagnostic Waits: 6+ Week Breaches	<1%	-	12.90%	↑
R	Emergency Department: 4 Hour Wait Standard	95%	85.0%	60.43%	↑
R	Cancer: 62 Days Referral To Treatment (December Data)	85%	80.70%	68.20%	↑
G	Length of Stay (November Data)	<5.2	-	5	↑
R	Clearance Times	12 weeks	-	16.8	↓
G	Waiting List Size	52,800	52,833	52,808	↑
G	Available Clinic Slot Utilisation	80%	-	86.40%	↓
R	Theatre Utilisation	90%	-	87.60%	↑
R	Appointment Slot Issues	35% (TBC)	-	42.40%	↓

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

Finance

RAG	Indicator	Target	Performance January	Trend v Previous Month
G	Capital Expenditure	14.99m	13.94m	↓
G	Statement of Comprehensive Income Plan - Year to Date	7.85m	7.86m	-
R	CRES Achievement Against Plan	14.13m	13.28m	-
R	Invoices paid within target - Non NHS	95%	93.2%	↑
R	Invoices paid within target - NHS	95%	84.8%	↑
A	Risk Rating	1	2	→

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

Hull University Teaching Hospitals NHS Trust

Trust Board

10 March 2020

Title:	Humber, Coast and Vale Health and Care Partnership – Integrated Care System Status Application
Responsible Director:	Chris Long – Chief Executive Officer
Author:	Chris Long – Chief Executive Officer

Purpose:	The purpose of this paper is to seek support and approval from the Hull University Teaching Hospitals NHS Trust (HUTH) Trust Board for the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status. This application is provided in the form of a Checkpoint Review Report and this is attached as appendix A.	
BAF Risk:	BAF Risk 5 – Partnership and Integrated Services	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary Key of Issues:		

Recommendation:	<p>The HUTH Trust Board is asked to:</p> <ul style="list-style-type: none">• Consider the Checkpoint Review Report attached as appendix A that summarises the work that we have undertaken and the progress that we have made in strengthening the Partnership and in promoting collaboration within the Partnership to drive improvement; and• Formally support the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status.
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Humber, Coast and Vale Health and Care Partnership – Integrated Care System Status Application

1. Purpose

The purpose of this paper is to seek support and approval from the [insert name of Board] for the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status. This application is provided in the form of a Checkpoint Review Report and this is attached as appendix A.

2. Background

The NHS Long Term Plan, published in January 2019, set out a vision of an NHS focused on prevention and early intervention, working closely with local government and using population health insight to understand need and plan services and initiatives together.

As part of that vision it set out an aspiration for all Sustainability and Transformation Partnerships (STPs) to develop and be designated as Integrated Care Systems (ICSs) by April 2021.

In the "Designing Integrated Care Systems" document published by NHS England/Improvement (NHSE/i) in June 2019, the focus of an ICS is described as the mechanism through which all organisations in each health and care system can join forces, so they are better able to improve the health and wellbeing of their populations and offer well-coordinated efficient services to those who need them. The document sets out how collaborative activity might be undertaken at different scales within an ICS in pursuit of these objectives. It also sets out an expectation that, through the ICS, partner organisations will **coordinate the transformation of health and care across settings and collectively manage system performance**. This will include oversight and assurance of the operational and financial performance of NHS and NHS funded organisations, whilst recognising that individual organisations will retain individual (and statutory) accountabilities.

Taking into account the progress that had been made over the last three years, the Humber, Coast and Vale Partnership last year confirmed its ambition to achieve ICS status by Summer 2020.

3. Current Position

At the start of the current financial year, it was agreed with NHSE/I that the Partnership would receive support to continue its development, with a view to achieving ICS status within the identified timescales. This support was provided in the form of the ICS Accelerator Programme structured around an ICS maturity matrix, which is a tool used by the system development team within NHSE/I. It supports Partnerships to measure the level of maturity of their relationships and collaborative working arrangements.

During the period between October 2019 and January 2020, partner organisations have been working together through a series of activities and events to facilitate the development of the Partnership. We have reaffirmed our purpose, agreed our priorities, strengthened our ways of working and agreed the principles that will underpin our operating and governance arrangements and our approach to financial and performance management. We have also recognised that we need to continue to develop as a Partnership. We have therefore agreed a Continual Development Plan that sets out the actions that we will take over the next 12 months as we seek to become a thriving ICS. Following the progress made by the Partnership over the last three years and more recently through the ICS Accelerator Programme, we have been invited by NHS England and Improvement to submit an application to be considered for ICS status.

The application is made in the form of a Checkpoint Review Report which will be considered initially by the NHSE/I Regional Director for North East and Yorkshire and subsequently by the NHSE/I team at national level. A draft of the report is attached as appendix A.

In the report we have described the progress that we have made and the acceleration of our thinking in respect of partnership working. We have also demonstrated the commitment and ability of our Partnership to work collaboratively. We should be proud of the achievements we have made during the last three years and we are now well placed to develop further as a Partnership and achieve the ambitious objectives and outcomes that we have set out in our Long Term Plan.

4. Recommendation

The HUTH Trust Board is asked to:

- Consider the Checkpoint Review Report attached as appendix A that summarises the work that we have undertaken and the progress that we have made in strengthening the Partnership and in promoting collaboration within the Partnership to drive improvement; and
- Formally support the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status.

Chris Long
Chief Executive Officer

March 2020



Humber, Coast and Vale Health and Care Partnership

Integrated Care System Checkpoint Review

1. Introduction

This document sets out the formal expression of interest for the Humber, Coast and Vale Health and Care Partnership to achieve Integrated Care System (ICS) status.

The document describes the key strengths of our Partnership against the nationally set ICS criteria. It also summarises the successful work that we have undertaken and the progress we have made in strengthening the Partnership and in promoting collaboration within the Partnership to drive improvement.

2. Background / Context

The Humber, Coast and Vale Health and Care Partnership was established in 2016, to enable 28 organisations from the NHS, local authorities, other health and care providers and the voluntary and community sector (listed in appendix A) to work together more effectively, to address the challenges facing the NHS and the wider health and care sector.

From the outset there was extensive agreement across our Partnership that, in order to improve and sustain the health and wellbeing of our population of 1.4m people, we would need to adapt and change the way that we work and the way that health and care services are delivered. Specifically, it was recognised that we would need to take a more collaborative approach to delivering our shared goals. Our approach is therefore fundamentally based on the belief that we will be more successful if we work more closely together to drive improvement and integrate the health and care services that we provide.

In our 2019/20 Operating Plan, we set out our ambition to achieve ICS status by the summer of 2020. This aspiration was supported by NHS England and Improvement in May 2019 and it was agreed that the Partnership would receive support to continue its development, with a view to achieving ICS status within the identified timescales.

During the period between October 2019 and January 2020, partner organisations have been working together through a series of activities and events to facilitate the development of the Partnership. We have reaffirmed our purpose, agreed our collective priorities, strengthened our ways of working and agreed the principles that will underpin our operating and governance arrangements and our approach to financial and performance management with a view to supporting delivery of the Partnership's overarching ambition – to support our population to *start well, live well and age well*.

We are seeking to build on the momentum that has built up over the past four months to ensure that we continue to strengthen the Partnership. We have therefore agreed a Continual Development Plan that sets out the actions that we will take over the next 12 months as we seek to become a thriving ICS.

3. How will the Partnership discharge the roles of an Integrated Care System?

We welcome the clarity around the expected two core roles of an ICS and have put in place robust arrangements and plans to effectively discharge the following responsibilities:

- **Plan and coordinate the transformation of health and care across settings** of place and neighbourhood, including workforce planning, population health management and quality improvement; and
- **Collectively manage system performance** including health outcomes, quality of care, operational and financial performance.

Through the following sections we have described why, as a Partnership, we feel that we have reached the appropriate level of maturity to receive ICS status and have the arrangements in place to continue to mature and deliver against our ambitions and plans.

3.1. Does the Partnership have a clear shared vision and a credible strategy to support transformation of health and care in the system?

Our Partnership Long Term Plan clearly sets out a shared, person centred ambition in respect of health and wellbeing and, through the ICS Accelerator Programme, we have re-affirmed that the primary purpose of the partnership is ***improving and sustaining the health and wellbeing of the population in Humber, Coast and Vale.***

This provides the collective motivation and focus that will help us to deliver our vision of ***helping local people to: start well, live well and age well.*** We want to become a health improving system rather than an ill-health treating system. This will require an increased emphasis on prevention and supporting larger numbers of people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

Our Partnership Long Term Plan has been co-produced by partner organisations and through proactive engagement with stakeholders, staff and local communities. It has been built up from our **local place plans** and our **collaborative programmes**. The plan is focused on the following four priorities:

- Helping people to look after themselves and to stay well
- Providing services that are joined-up across all aspects of health and care
- Improving the care we provide in key areas (e.g. cancer and mental health)
- Making the most of all our resources (e.g. people, technology, buildings and money)

To support us to achieve these ambitions, our senior leaders have agreed where it would make sense for them to focus their collective energy. This will be concentrated around the strategic plans and objectives for the following collaborative programmes that underpin the delivery of our priorities, as well as continuing to develop as a Partnership. These areas of focus are:

- Cancer
- Mental Health

- Population Health
- People/Workforce
- Estates and Capital Investment
- Digital

3.2. How will the Partnership ensure strong system leadership?

In Humber, Coast and Vale, we have had strong credible engagement from leaders across all sectors of our Partnership from the outset. We have been working together through a **distributed leadership model**, which complements and extends the existing responsibilities of the statutory organisations. The key elements are set out in appendix B and include:

- Collaboration at **Place** – centred on improving health and wider wellbeing of citizens; delivering the priorities for health, social care and addressing wider determinants of health for the population and neighbourhoods within a Place. This is undertaken through arrangements that bring together the local authorities, CCGs and health and care providers, working through the Health and Wellbeing Boards or similar governance arrangements.
- Collaboration at **‘Sub System’** – focussed on convening either more than one Place and or sectors across Places including through:
 - commissioning arrangements across the Humber and North Yorkshire
 - well established Provider Alliances / partnerships between Community Interest Companies and NHS Providers
 - the recently established single Chair arrangements for Northern Lincolnshire and Goole Foundation Trust and Hull University Teaching NHS Trust
 - the Mental Health Provider Collaborative and Partnership Board
 - the proposed place based exemplar in York
 - specific pieces of work e.g. strategic acute service reviews and operational planning and financial management.
- Collaboration at **‘Scale’** – formalised through arrangements such as the Humber, Coast and Vale Partnership Executive Group and the Collaborative Programme Boards, bringing together organisations from across the Partnership to work together where it makes sense to do things only once, to deliver better outcomes and make effective use of resources.

Our ‘at scale’ collaborative programmes have Chief Executive level sponsors, clinical and managerial leadership as well as clear links back into each Place to ensure strong alignment of plans and delivery of transformation. This is in addition, to the Partnership’s System Lead/Independent Chair, the Partnership Executive Lead (who is also the Chief Executive of a Partner organisation), Partnership Director and Partnership Finance Lead who act as conveners of senior leaders to facilitate collaboration and deliver improvement. In accordance with the guidance on ICS leadership, the Independent Chair and System Leadership arrangements will be reviewed in summer 2020 and will be informed by a 360° exercise to be undertaken with the system leaders from all partner organisations.

The Clinical Advisory Group has been in place from the inception of the Partnership bringing together a range of clinical professions from partner organisations (including social care). Recognising the importance of our clinical leadership we have, through the ICS Accelerator Programme, focussed on improving our health and care professional engagement. This work has been clinically led and we will

continue this work with our Clinical Engagement Lead being supported by our newly appointed Partnership Clinical Lead.

We are proud of the engagement and effective working we have built with the Local Authorities in our Partnership. We have had strong representation from Local Authority Senior Officers, with regular attendance and contribution from them at the Partnership Executive and at a system level, as well as their critical leadership at Place. A number of the Senior Officers from our Local Authorities have also taken the Executive Lead / Senior Responsible Officer roles for our collaborative programmes, including Workforce and Digital.

In our Partnership Continual Development Plan we have acknowledged that we have more work to do over the coming year to ensure that the leadership of the Partnership is as effective as possible. This will include;

- Looking to our Local Authorities to take a lead on co-ordinating how the NHS and NHS funded organisations can play a more active role in the development and implementation of Health and Wellbeing Strategies at local level, with oversight being provided by the Health and Wellbeing Boards;
- Strengthening our engagement with the voluntary and community sector and ensuring their effective involvement in the Partnership;
- Supporting the development of Primary Care Networks, enabling them to maximise their involvement and contribution at Place;
- Continuing to explore the role of Non-Executives, Lay Members and Elected Members in the leadership and governance of the Partnership.

We are continuing to strengthen our leadership and collaborative working arrangements in the Humber and North Yorkshire sub-systems. The strategic direction is for Harrogate FT to join the Humber, Coast and Vale Partnership from April 2020. However, in recognition of the Trust's longstanding patient flows and clinical links into West Yorkshire, Harrogate FT will continue to be a key player in the West Yorkshire system.

3.3. How does the Partnership make collective and effective decisions for the system and hold each other to account for delivery?

We have discussed and agreed our operating arrangements and have committed to formalising these arrangements. To this end we are developing a Memorandum of Understanding that will set out a mutual accountability framework to ensure we have collective decision-making and ownership of delivery. Our established governance arrangements are set out in appendix C. The key groups are as follows:

- The **Partnership Executive Group** - responsible for setting and overseeing the strategic direction of the Partnership and building collective responsibility for delivery.
- A **Partnership Oversight and Assurance Group** – that takes an overview of system performance, allowing partners to hold each other to account for delivery.
- Quarterly **Partnership Assembly** – providing the opportunity for all executive and non-executive leaders to be informed, involved and engaged in the strategic direction and development of the Partnership.

3.4. How will the Partnership streamline its commissioning arrangements?

Our Clinical Commissioning Groups (CCGs) are currently developing a clear view of what streamlined commissioning functions would look like in the future, based around two geographical areas of Humber and North Yorkshire. This is being supported by other Partners across Humber, Coast and Vale and NHSEI as an alternative to a single strategic commissioner coterminous with the Partnership boundary.

We currently have a single Accountable Officer covering three of our CCGs (Hull, East Riding and North Lincolnshire) in the Humber and a merger of three North Yorkshire CCGs in Scarborough and Ryedale, Hambleton, Richmond and Whitby (currently in North East and Cumbria ICS) and Harrogate and Rural District (currently in West Yorkshire and Harrogate ICS) which will become the North Yorkshire CCG on 1 April 2020 with a single Accountable Officer.

Over recent weeks, work has been undertaken to draw up plans for the future development of commissioning arrangements across the Partnership. The four CCGs across the Humber have agreed to establish strategic commissioning arrangements with effective leadership and supporting resources. A Strategic Commissioning Board will be put in place from April 2020 which will be led and chaired by the Accountable Office for Hull, East Riding and North Lincolnshire. The Board will also have clearly delegated functions and authorities from all four CCGs in the Humber area. The North Yorkshire CCG and Vale of York CCG are working on the development of a joint commissioning committee to oversee delivery of a single set of priorities, a shared delivery model where appropriate and an aligned delivery plan.

For both the Humber and York & North Yorkshire commissioning plans are being developed which will also demonstrate how the proposed arrangements will:

- Tackle inequalities and improve outcomes for patients across the Humber
- Ensure resources and capacity are in the right place to support integrated place-based integration and consider the devolution of traditional commissioning functions to local partnerships/organisations
- Rapidly streamlining functions to reduce duplication of commissioning processes, governance arrangements and the use of staff time therefore being affordable, reducing running costs and supporting longer term financial sustainability
- Support a consistent approach to standards and outcomes
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Meet the well-led requirements of the commissioner assessment framework.

The new commissioning arrangements will be reviewed on a quarterly basis during 2020/21. It is anticipated that commissioning arrangements in the Humber and North Yorkshire areas will evolve further to meet national policy requirements. Our intention is to agree longer term arrangements from April 2021.

3.5. Does the Partnership have strong and collective financial and resource planning and management arrangements in place?

As a Partnership, we have developed a financial strategy for the next five years that will enable us to meet our financial improvement targets and deliver significant financial improvement towards financial balance by 2023/24.

We recognise that improving our financial performance at the required scale is a significant challenge, but it is an area in which we are currently delivering improvement. The efficiency gain requirements in the short term have and continue to exceed the levels set out in national guidance. We agreed a plan for 2019/20 to meet our financial targets and performance in the year to date has been in line with the agreed trajectories. We are working collaboratively to identify in-year financial risks and have taken actions to manage and mitigate these risks. This has involved flexible use of the financial resources available across the system, which has been possible because of the strong collaborative relationships within the Partnership. As a consequence our forecast financial outturn for 2019/20 is looking positive.

Although we are still dealing with significant financial challenges, we have reduced our overall deficit this year and plan to achieve a further reduction in 2020/21. Our planned deficit for 2020/21 is fully covered by our Financial Recovery Funding.

	18/19 Actual Deficit	19/20 Forecast Deficit	20/21 Planned Deficit
North Yorkshire and York	£46m	£46m	£43m
Humber	£75m	£52m	£40m
Partnership Total	£121m	£98m	£83m

Over the last two years we have strengthened our collaborative working through the operational and strategic planning rounds. This is demonstrated in the progress that we have made in:

- Agreeing and working to financial improvement targets and managing risk associated with our Financial Recovery Funding by grouping our organisations into the two geographies of the Humber and North Yorkshire;
- Continuing to establish alternative payment mechanisms that focus on managing activity levels and reducing cost;
- Developing and integrating out of hospital care with a focus on keeping demand for hospital services under control.

We are continuing to build on this way of working as we develop and finalise our 2020/21 Operational Plan.

We have been successful in securing capital funding through the Wave 3 and Wave 4 capital bidding exercises. Our bids for capital funding have been set in the context of the strong Estates Strategy that we have developed as a Partnership. Under Wave 3, funding of £8.2 million was secured to support the development of a new Tier 4 Children and Adolescent Mental Health inpatient facility in Hull. This scheme has now been completed and the facility is operational. Under Wave 4, funding of £88.5 million

was secured to support the development of urgent and emergency care and diagnostic facilities at four of our hospital sites. Strategic Outline Cases for the schemes supported by this funding have been submitted and should be formally approved before the end of March 2020. This programme of development is critical to the successful implementation of our plans to transform urgent and emergency care services and improve our performance against national cancer targets.

3.6. How is the Partnership redesigning and integrating care and introducing a system approach to population health?

The complexity of our health and care system can make it difficult for patients to navigate between different organisations and services. It frequently places responsibility on individual patients, their families and carers to coordinate between the different organisations and aspects of their care, often when they are least equipped to do so. We are working together, particularly at Place, to fundamentally reshape services so that they are properly joined up. This includes:

- Developing **primary care** – so that every neighbourhood has access to a single team of health and care professionals who can meet a wide range of their needs both locally and in a joined-up way; such as the South Hambleton and Ryedale Primary Care Elderly Care Services.
- Joining up **services outside of hospital** – so that care is designed around the needs of the person not the needs of the different organisations providing it. Integrated models have been developed to support the needs of key groups (e.g. frailty). Successful examples include the Jean Bishop Centre in Hull, Mental Health Services in North East Lincolnshire and Urgent Care Practitioners in York.
- Securing a long-term, **sustainable future for our hospital services** – so that our hospitals are working together more closely and more effectively to provide high quality care for our populations when they need to be in hospital. Plans for the future provision of hospital-based services are being developed through our Acute Service Reviews across the Humber and in Scarborough.

Across the Partnership, making better use of available data and local intelligence is key to improving health and wellbeing outcomes for our population and supporting integration of services. The Partnership has commenced the national Population Health Management (PHM) Development Programme supported by NHS England and Optum. Working with seven of our Primary Care Networks (PCNs) and covering each of our Places, we will apply advanced analytics and intelligence to design interventions that will improve the health of local populations, in particular, specific groups or cohorts of populations. This is an intensive 20 week programme following which each PCN/Place will produce a case study to demonstrate the impact of the programme.

As part of the programme we will agree how we will ensure that PHM becomes business as usual across the Partnership, in support of our ambition to improve and sustain the health and wellbeing of the Humber, Coast and Vale population.

3.7. How will the Partnership maintain and improve its track record of delivery?

In our Partnership Long Term Plan we have clearly set out our ambitions to integrate care and transform the lives of people in Humber, Coast and Vale. The Partnership has achieved much over the past three years through effective collaboration both at local level and at scale. Many of the service developments and transformations that have taken place across our region are set out as case studies

in the Partnership Long Term Plan (attached as Appendix D). The progress that we have has helped to strengthen relationships between partner organisations and strengthen our collective commitment to working collaboratively. We are confident that, by adopting this approach, we will continue to deliver improvements in service quality and performance across a range of service areas.

The collaborative work of the Partnership has achieved national recognition, with a number of projects being shortlisted for Health Service Journal (HSJ) Awards this year. These successes include:

- The Jean Bishop Integrated Care Centre gained recognition for partner organisations in Hull, winning the Community / Primary Care Service Redesign Award
- Vale of York CCG was highly commended for its React to Red campaign to reduce pressure sores among care home residents
- Our Mental Health Partnership was shortlisted for the Partnership Working award.

In November, the Partnership was privileged to have a visit from Professor Don Berwick, where we took the opportunity to share three video case studies which showcased the collaborative approaches to providing more holistic healthcare across our Partnership. These included [the Jean Bishop Integrated Care Centre](#) in Hull, [NAVIGO's Safe Space Café](#) in Grimsby and the [South Hambleton and Ryedale Primary Care Network](#)'s work with their frail population in North Yorkshire. Professor Berwick praised the work that we were undertaking to deliver integrated care, and offered his thoughts on the work the Partnership needed to continue to embed collaborative approaches and support us to achieve our aspiration of ICS status.

In addition, we have made good progress through our collaborative efforts in a number of other areas, including:

- Delivery of extended access and online consultations in primary care
- Collectively managing elective and non-elective demand for acute hospital services
- A significant reduction to almost zero in 2019/20 of 52 week waiters for planned care services from one of the most challenging positions nationally
- Managing Acute hospital lengths of stay, delayed transfers of care and stranded patients
- Maintaining cancer 2 week wait and 31 days to treatment at required levels
- Expanding screening services, including bowel screening and lung health checks with the latter successfully launched at the end of January 2020 in Hull
- Improving maternity services and compliance with Better Births, particularly in relation to continuity of carer
- Increasing personalised care including against personal health budgets where a number of our CCGs act as mentors to others nationally,

Our Partnership Long Term Plan also sets out our ambitions to achieve year on year improvement in performance against a wide range of metrics, including constitutional standards as we recognise that our performance against a number of key standards is still below the required levels.

In order to make best use of our skills and resources, we are adopting a collaborative approach to service improvement, transformation and performance management. Our collaborative Programmes are now the main vehicle through which we will drive service transformation and associated improvements in performance in key areas, including cancer, mental health, learning disabilities and

autism. In accordance with our agreed principle of mutual accountability, we will maintain a Partnership-wide focus on service and financial performance to ensure that planned improvements continue to be delivered.

4. Conclusion

In this document we have described the progress that we have made and the acceleration of our thinking in respect of partnership working. We have demonstrated the commitment and ability of our Partnership to work collaboratively and identified some of the ways in which this is making a tangible difference to peoples' lives. We are proud of the achievements we have made during the last three years and we are now well placed to develop further as a Partnership and achieve the ambitious objectives and outcomes that we have set out in our Partnership Long Term Plan.

Having completed the ICS Accelerator Programme, we have re-assessed the maturity of the Partnership against the five key domains of the ICS Maturity Matrix. The results of this re-assessment are very positive and are shown in the schedule attached as appendix D. Through the Accelerator Programme and the subsequent re-assessment we have identified where further work is required for us to continue to develop as a Partnership. The actions associated with this are set out in our Continual Development Plan and will be incorporated in our 2020/21 Operational Plan once finalised.

Appendices

Appendix A – Humber, Coast and Vale Health and Care Partnership - Partner Organisations

Local Authorities

- City of York Council
- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council

NHS Commissioners

- NHS East Riding of Yorkshire CCG
- NHS Hull CCG
- NHS North East Lincolnshire CCG
- NHS North Lincolnshire CCG
- NHS Scarborough and Ryedale CCG*
- NHS Vale of York CCG

(*as of 1 April 2020 will be merged with Harrogate and Hambleton, Richmond and Whitby CCGs to be NHS North Yorkshire CCG which will become part of Humber, Coast and Vale)

Health and Care Providers

- Care Plus Group
- City Healthcare Partnership CIC
- East Midlands Ambulance Service NHS Trust*
- Focus CIC (Independent Adult Social Work)
- Hull University Teaching Hospitals NHS Trust
- Humber Teaching NHS Foundation Trust
- NAViGO
- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust*
- Tees, Esk and Wear Valleys NHS Foundation Trust*
- York Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust*

(*These organisations are also members of neighbouring ICSs)

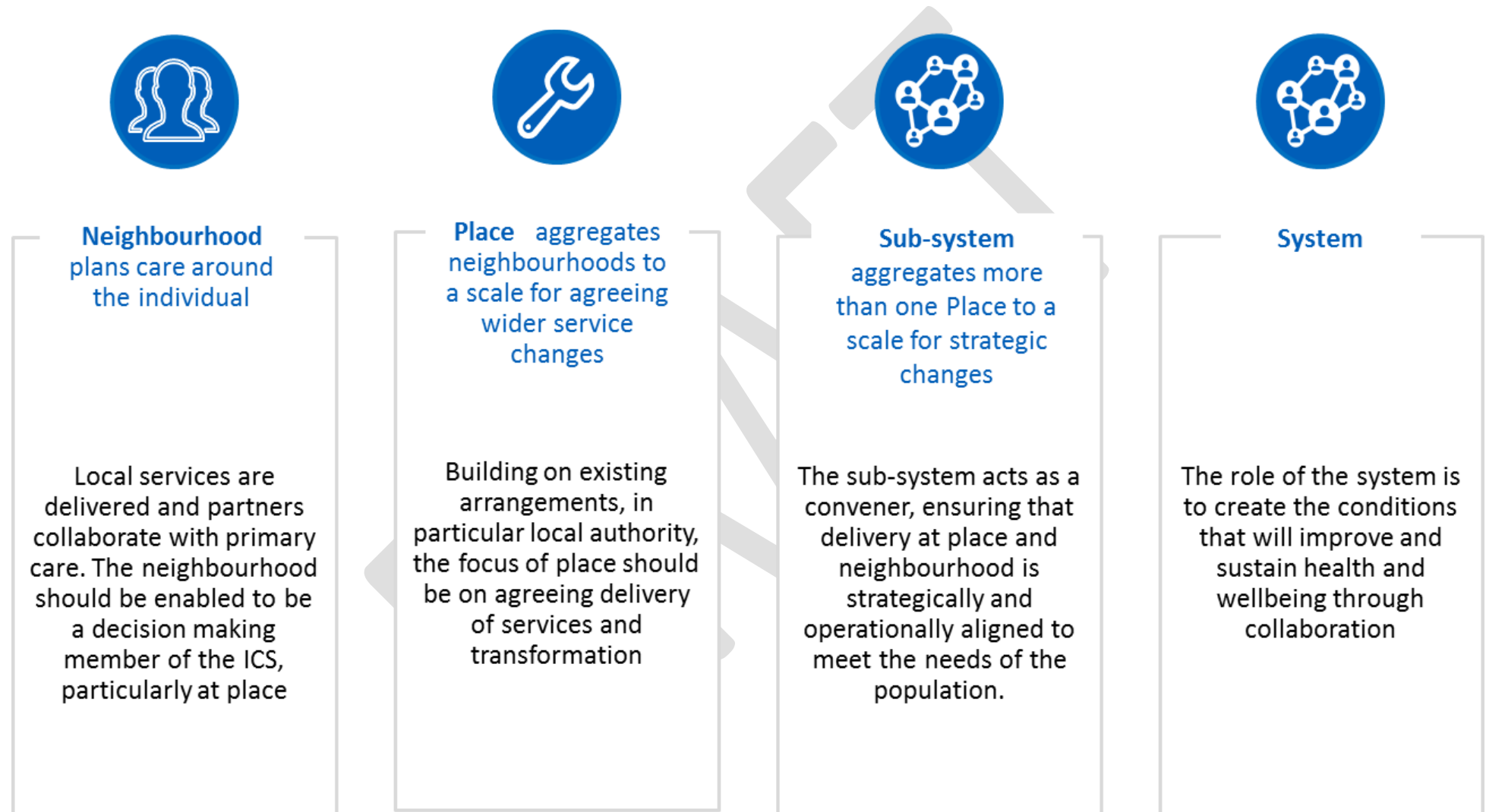
Health Regulator and Arms-Length Bodies

- NHS England and Improvement
- Health Education England
- Public Health England

Other Partners

- Healthwatch
- Yorkshire and Humber Academic Health Science Network
- Voluntary and Community Sector Organisations

Appendix B Humber, Coast and Vale Health and Care Partnership – Collaborative Approach to delivery

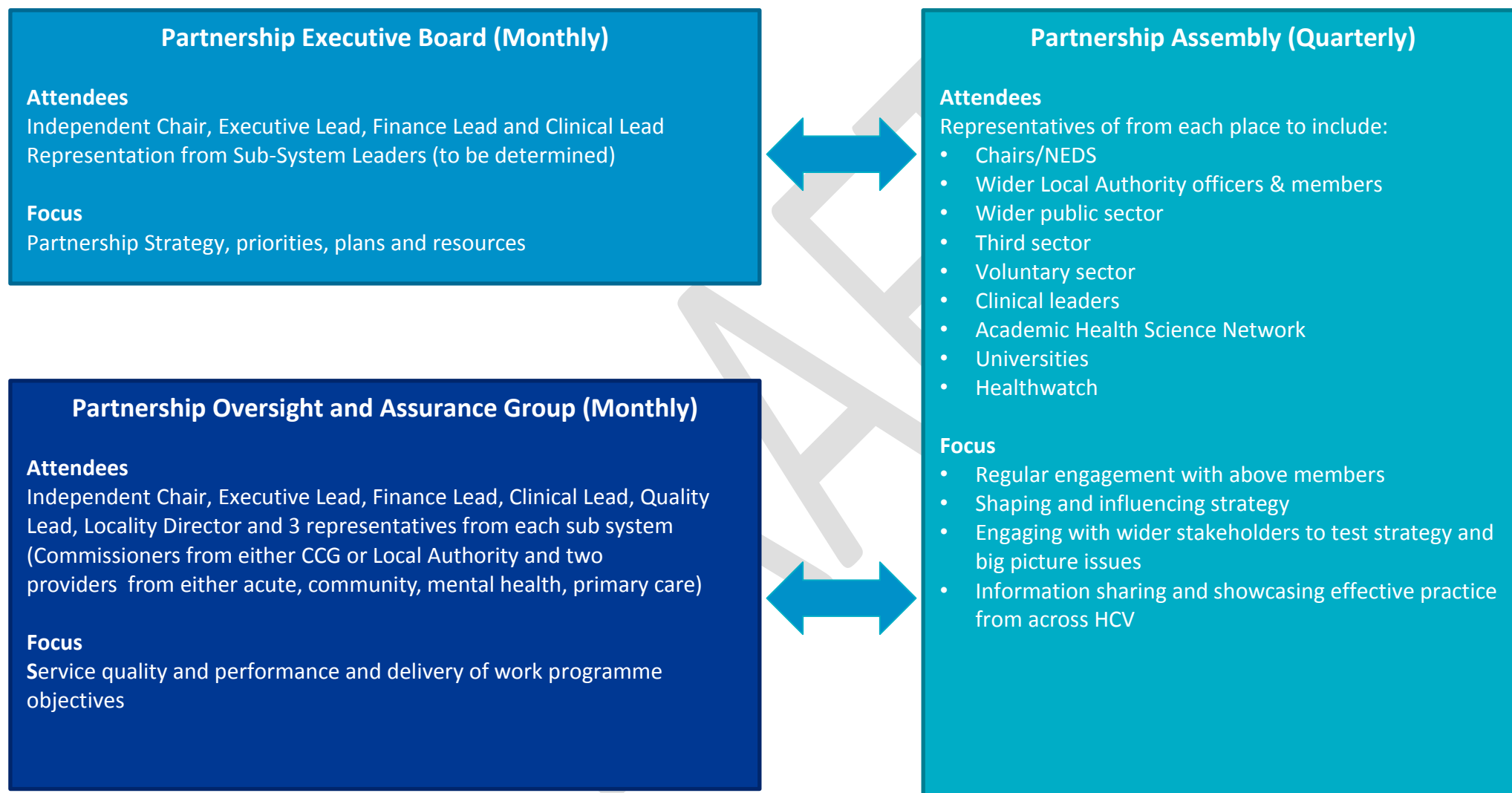


Appendix B continued

Place and Sub-System Collaboration					
East Riding	Hull	North Lincs	North East Lincs	Scarborough	York

At Scale Collaboration		
Strategic Developments	System Resources	Clinical Priorities
1. Humber Acute Services Review	1. Workforce	1. Cancer
2. Scarborough Acute Services Review	2. Digital	2. Mental Health
3. Commissioning Review	3. Estates and Capital Investment	3. Urgent and Emergency Care
4. ICS Accelerator Programme	4. Finance	4. Elective Care
	5. Population Health Management and Analytics	5. Primary Care
	6. Quality Improvement	6. Maternity
		7. Diagnostics

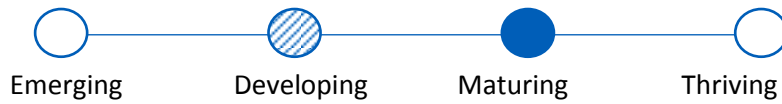
Appendix C – Humber, Coast and Vale Health and Care Partnership - Operating Framework



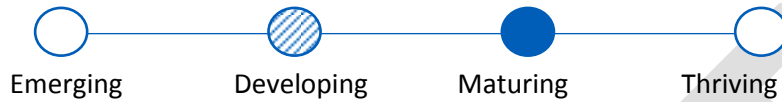
Appendix D – Humber, Coast and Vale Health and Care Partnership – Self Assessment Maturity Matrix

Below is the Partnership's re-assessment against the Maturity Matrix following the completion of the ICS Accelerator Programme.

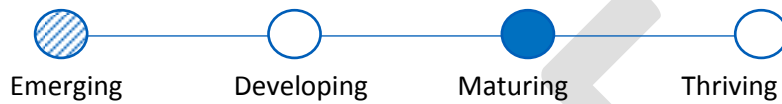
Domain one: System Leadership, Partnerships and Change Capability



Domain two: System Architecture and Strong Financial Management and Planning



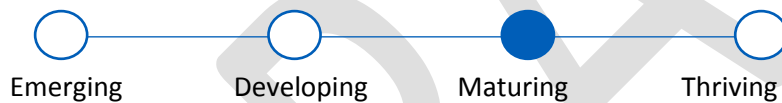
Domain three: Integrated Care Models



Domain four: Track Record of Delivery



Domain five: Coherent and Defined Population



Key

	Initial assessment		Revised assessment
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Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Performance and Finance Committee

Meeting Date:	27 January 2020	Chair:	Mr T Curry	Quorate (Y/N)	Y
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Key items discussed where actions initiated:

- Outpatient Transformation Team – Eileen Henderson and Rachel Joyce presented an update of the Outpatient Transformation Programme including efficiency savings and the aim to reduce face to face appointments.
- The Board Assurance Framework was discussed and the proposed quarter 3 risk ratings were presented. The Committee also discussed changes to ratings in quarter 4, particularly the finance ratings and the possibility of them being reduced.
- The Performance Report was received. ED performance, the new Push Doctor appointment process and the system wide action plan were discussed. RTT was still under trajectory and there had been one 52 week wait declared. The deterioration in 62 day RTT performance was mainly due to the colorectal, gynaecology, upper GI and lung pathways and access to diagnostics, predominantly CT and PET CT. The Lung Health check programme had been launched.
- The rate of Consultants reducing their workloads due to the pensions issue had slowed down.
- The Variable Pay report and the Demand and Activity report were received by the Committee
- Finance – The Trust was reporting a £4.2m surplus in month 9 in line with plan
- CRES – Position was static.

Key decisions made:

- Outpatient Transformation Team – and update to be received relating to DNAs in April 2020
- CT Colonoscopy commissioned through the Spire – performance update to be received in February 2020

Risk and assurance matters to be received by the Board:

- The Trust had commissioned additional CT capacity from the Spire and endoscopy capacity with Pioneer due to the increase in referrals.
- An update to be received regarding the Health Group financial recovery plans at the next meeting
- CRES - at month 9 the Trust is reporting that it has delivered £11.4m of savings against the £12m target
- 2020/21 Financial recovery was discussed. Concerns raised regarding Health Group underlying run rates.

Matters to be escalated to the Board:

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Performance and Finance Committee

Meeting Date:	25 February 2020	Chair:	Mr T Curry	Quorate (Y/N)	Y
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Key items discussed where actions initiated:

- The Workforce, Education and Culture Committee was discussed – it was agreed that the finance and performance aspects of the workforce agenda would still need to be received at the Committee.
- The Board Assurance Framework was received and had been updated in month.
- Finance position £7.9m surplus – discussion around PSF money and whether the Trust would receive it all or it would be shared with the STP.
- CRES position was £2.2m below plan (88%)
- Apprentice Levy Report – an update was received. The Trust was spending the funding appropriately.
- Demand and Activity Report – ENT and Plastics were below plan and capacity was highlighted
- Performance – RTT performance was achieving trajectory, there were still issues around diagnostic performance and work was ongoing regarding Cancer performance.
- External validation has confirmed that the waiting list is correct and the waiting list volumes are real.
- The senior team from ED attended the meeting to give the current performance position within the department. Performance was at 62% for the quarter (type 1) and the system wide performance was around 80%.
- The Operational Plan guidance and expectations was presented at the Committee.
- IM&T Report and action plan was presented which responded to Mr Curry's report to the Board in November 2019.
- Capital Plan - the 3 year programme of capital investment would total £63m.
- Underlying financial strength and the planning process – this item was deferred to the March meeting due to timing issues at the meeting.

Key decisions made:

- The Draft Capital Plan was approved by the Committee
- CT Colonoscopy commissioned through the Spire – performance update to be received in March 2020

Risk and assurance matters to be received by the Board:

- The Trust had commissioned additional CT capacity from the Spire and endoscopy capacity with Pioneer due to the increase in referrals.

Matters to be escalated to the Board:

- The Senior ED team had been invited back to the Committee in March 2020 to give an update regarding performance.

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	27 January 2020	Chair:	Prof M Veysey	Quorate (Y/N)	Y
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Key items discussed where actions initiated:

- The Committee received a presentation relating to the nutrition and deteriorating patient QIPs. Discussion was around the completion of the Matron's handbook and the introduction of electronic data capture.
- The Integrated Performance Report was discussed in detail. ED, Push Doctor (Skype appointments), same day emergency care and cancer performance were discussed.
- The Quality report was scrutinised at the meeting. Never Events and Serious Incidents were discussed as well as the visit from NHS Improvement to Theatres. A full visit report from NHS I would be shared with the Committee.
- Board Assurance Framework quarter 3 ratings was presented. The Committee agreed to recommend no changes to ratings in quarter 3 to the Board.

Key decisions made:

- NHS I visit to Theatres report and action plan to be shared with the Committee.

Risk and assurance matters to be received by the Board:

- The Committee received a briefing paper relating to the reduction in Safeguarding Children referrals. The benchmarking exercise had shown that the Trust was not an outlier.
- Public Health Guidance was being reviewed regarding Coronavirus. The Trust had procedures in place should any cases be presented.

Matters to be escalated to the Board:

- There were no items to escalate.

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	24 February 2020	Chair:	Prof M Veysey	Quorate (Y/N)	Y
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Key items discussed where actions initiated:

- QIP - discussions have started around how projects are designed and measured, and taking a quarterly stock-take to ensure that measures continue match the improvement required.
- Pressure damage – two incidents declared – a task and finish group has been established to review
- Integrated Performance Report – Patients in ED reviewed at times of high pressure in the department from a harm perspective.
- External validation has confirmed that the waiting list is correct and the waiting list volumes are real.
- WHO checklist and SSIPs update was received. Outcomes of the WHO Checklist Audit would be presented to the Committee.
- Serious Incident update was received
- An updated Board Assurance Framework was received
- An update was received relating to Covid -19 and the procedures in place within the Trust and with healthcare partners.

Key decisions made:

There were no decisions made.

Risk and assurance matters to be received by the Board:

- Capital resource to mattresses availability, decontamination and storage. This was referred from the Quality Committee to the Performance and Finance Committee. The Capital Resource Allocation Committee are reviewing this.

Matters to be escalated to the Board:

There were no items to escalate.

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Workforce, Education and Culture Committee

Meeting Date:	28 February 2020	Chair:	Prof J Jomeen	Quorate (Y/N)	Y
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Key items discussed where actions initiated:

- Job Vacancy Report – Areas of concern were a number of Consultant specialties, Radiology and Speech and Language Therapy, but overall Trust vacancy position was 4.94%
- Variable Pay Report – Agency and Bank staff usage were reducing, but overtime usage had increased. This is the correct direction of travel.
- Nursing and Midwifery Staffing Report – Update received relating to Care Hours per Patient Day and the metrics involved. The Trust is performing well against peers and nationally.
- Consultant pension update – 54 consultants to date had reduced their hours due to the pension issue which had resulted in 79 lost PAs.
- The national staff survey results were presented – the Trust was at or above average for 8 out of the 11 standards. Trust held its position at 7 (out of 10) for Staff Engagement overall.
- Flu Report – 82% of staff had been vaccinated.
- Medical Education Report – anaesthetics and cardio thoracic were highlighted as areas under great pressure and as a result Junior Drs less satisfied with training. Work was ongoing to develop standards for each area to ensure that the most effective doctor establishment was being used. Reduction in GP Trainee's in acute setting needed to be quantified further, but flagged as a risk.
- Apprenticeship Programme – The Trust was spending the Apprenticeship Levy and there was a good uptake of posts and training, but this needed to continue or the levy would not be fully utilised. Key strand of our 'grow our own' recruitment strategy.
- A progress update on the Medical Leadership programmes was received.

Key decisions made:

- It was agreed to receive feedback from the Medical Leadership Programme candidates and to undertake a review of the impact of the programme.
- Work was required to understand the Consultant establishment within services based upon Royal College guidance.
- Reduction in GP Trainee's in acute setting needed to be quantified further and impact understood.

Risk and assurance matters to be received by the Board:

- An update relating to research and clinical trials would be received in June 2020 onwards in line with BAF 6 – Research and Innovation.

Matters to be escalated to the Board:

GP training programme will change in August 2021. Trainee's will spend 1 year in HUTH instead of 2. 50% reduction.

Hull University Teaching Hospitals NHS Trust

Trust Board

10 March 2020

Title:	Gender Pay Gap Reporting
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Louise Whiting, Employment Policy and Resourcing Manager Andy Barker, Workforce Planning and Information Manager

Purpose:	The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2019, prior to publication of the data in line with statutory requirements.	
BAF Risk:	Risk 2 – workforce	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	✓
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	
Key Summary of Issues:	<p>New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010.</p> <p>The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2020) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.</p>	

Recommendation:	<p>Given submission deadlines the Board is requested to note and approve content of this report.</p> <p>Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines.</p> <p>The report will be tabled and discussed in detail at the next Workforce, Education and Culture Committee in April 2020.</p>
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Hull University Teaching Hospitals NHS Trust

Trust Board

Gender Pay Gap Reporting

1 PURPOSE OF THIS REPORT

The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2019, prior to publication of the data in line with statutory requirements.

2 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010. The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage. The Government anticipates that highlighting any imbalance and taking steps to reduce the gap at workforce level will help to narrow the gap at a national level, and hence boost the UK economy.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

3 REPORTING REQUIREMENTS

The Trust is required to publish six gender pay gap measures;

- **Mean pay gap** – the difference between the mean hourly rate of pay (excluding overtime) of male and female employees
- **Median pay gap** – the difference between the median hourly rate of pay (excluding overtime) of male and female employees
- **Mean bonus gap** – the difference between the mean bonus paid to male and female employees who received a bonus in the relevant pay period
- **Median bonus gap** – the difference in the median bonus pay for male and female employees who received a bonus
- **Bonus distribution by gender** – the proportions of male and female employees who received bonus pay
- **Pay distribution by gender** – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands

The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2019. The figures must be calculated using the mechanisms set out in the gender pay gap reporting legislation.

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2020) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

4 THE PROPOSED GENDER PAY GAP REPORT FOR 2019

The Trust's overarching Gender Pay Gap Report, the third report since the regulations were introduced, is attached for the Board's approval (see Appendix 1). This includes supporting narrative with key findings following a more in-depth analysis of the data, to help understand the Gender Pay Gap Reporting outcomes.

5 RECOMMENDATION

The Board is requested to note and approve content of this report.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites and discussed in detail at the next Workforce, Education and Culture Committee in April 2020.

Simon Nearney
Director of Workforce & OD
March 2020

Hull University Teaching Hospitals NHS Trust

Gender Pay Gap Reporting

1 BACKGROUND

New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage. The Government anticipates that highlighting any imbalance and taking steps to reduce the gap at workforce level will help to narrow the gap at a national level, and hence boost the UK economy.

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Gender pay gaps are the outcome of economic, cultural, societal and educational factors. Whilst also reflecting personal choice, the outcome of the choice is strongly influenced by matters outside individual control, and it is still the case that women's choices are more constrained than those of men. The key influences, which are complex and feed into each other, include unpaid caring responsibilities, part-time working, differences in human capital, occupational segregation, undervaluing of women's work and pay discrimination.

2 NHS PAY STRUCTURE

The majority of staff at the Trust are paid on the national Agenda for Change Terms and Conditions of Service. The basic pay structure for these staff is across 9 pay bands and staff are assigned to one of these on the basis of job weight as measured by the NHS Job Evaluation System (the system measures the job and not the post holder). This makes no reference to gender or any other personal characteristics of existing or potential job holders. Within each band there are a number of pay progression points.

During 2018 the NHS Staff Council reached agreement on reform of the pay structure for Agenda for Change staff, resulting in a 3-year pay deal covering the years 1 April 2018 to 31 March 2021. The agreement incorporated the reduction of the number of pay points in each pay band (over the 3 year period), the removal of overlaps between pay bands, shortening the amount of time it takes to progress to the top of pay bands, the move away from automatic annual progression, and upskilling of band 1 to band 2.

Medical and Dental staff have different sets of Terms and Conditions of Service, depending on seniority. However, these too are set across a number of pay scales, for basic pay, which have varying numbers of thresholds within them.

There are separate arrangements for Very Senior Managers, such as Executive Board Members, and Directors. There are also separate arrangements for Casual Workers.

3 GENDER PAY GAP DATA 2019

The figures set out below have been calculated using the standard methodologies used in the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, utilising the national NHS Electronic Staff Record Business Intelligence report functionality.

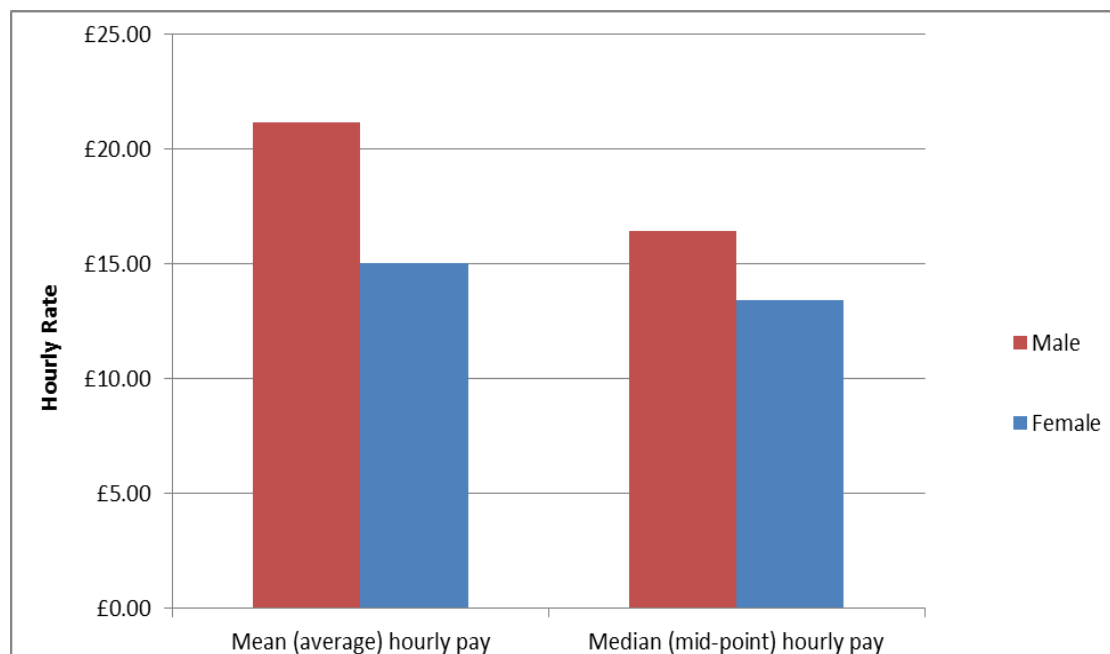
The analysis does not look at whether there are differences in pay for men and women in equivalent posts. Therefore the results will be affected by differences in the gender composition across the Trust's various professional groups and job grades.

National reporting requirements require the Trust to report the six gender pay gap measures to one decimal point (these six measures are shown in bold italics throughout the document), however to assist the Trust better analyse the data and progress made, the data is shown to two decimal places.

Hull University Teaching Hospitals NHS Trust's Gender Pay Gap Data for the snapshot date of 31 March 2019 is as follows;

3.1 Mean and Median Gender Pay Gap

Gender	Mean (average) hourly pay	Median (mid-point) hourly pay
Male	£21.18	£16.45
Female	£15.03	£13.46
£s difference	£6.15	£2.99
% difference	29.04% (29.0%)	18.18% (18.2%)



- The mean gender pay gap is 29.04% (i.e. this means that women's average earnings are 29.04% less than men's).
- The median gender pay gap is 18.18% (i.e. this means that women's average median earnings are 18.18% less than men's).

Note; Gender pay gap calculations are based on ordinary pay which includes; basic pay (including for Medical and Dental staff Additional Programmed Activities), allowances (including shift premiums), extra amounts for on-call, pay for leave but excludes; overtime, expenses, payments into salary sacrifice schemes (even though employees opted into the schemes voluntarily, as they provide a benefit in kind), Clinical Excellence Awards and Pensions.

3.1.1 Key Findings

- The Trust has an overall gender split of 76.34% female and 23.66% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 23.66% of the workforce, there are a disproportionate number of males, 39.49% in the highest paid (upper) quartile, (predominantly medical staff) with 60.51% being female.
- The mean gender pay gap for the whole economy (according to the October 2019 Office for National Statistics Annual Survey of Hours and Earnings figures) is 16.2% while the Trust's mean gender pay gap is 29.04% in favour of males. The median gender pay gap for the whole economy is 17.3%, compared to the Trust average of 18.18%.
- Medical staff pay has a strong impact on the mean and median data. If Medical staff were excluded from the data above the mean (average) hourly pay gap is 3.29% or £0.48, and the median (mid-point) hourly pay is -0.23% or -£0.03. Nationally the Consultant workforce is predominately male.
- The median pay gap for the Trust has increased since the last reporting period. This is despite an improvement in the median pay gap for both Medical staff (improving from £11.11 in the 2018 report to £6.28 currently) and for non-medical staff (improving from £0.04 to -£0.03p for the same period) when reported separately. In the current reporting period (2019) the male median pay was between upper middle to upper pay quartiles and female median pay was between the lower middle to upper middle. In the previous 2018 data, the male median was between lower middle to upper middle, and the female median was between lower middle to upper middle. This is due to a shift in the percentages of males in each quartile (see section 3.2.1 for further details).
- The Trust operates a number of salary sacrifice schemes. Given 79.11% of those who pay into salary sacrifice schemes are female staff (compared to 20.89% of male staff) this has a significant impact on the Trust's gender pay gap data, including the mean and median female averages and also where females fall in pay quartiles (i.e. they might otherwise fall into a higher quartile).

This is because the gender pay gap calculations are based on pay excluding the value of payments made into salary sacrifice schemes (even though employees opt into the schemes voluntarily, as they provide a benefit in kind). Payment into these schemes reduces the basic salary and hourly rate of pay.

Exacerbating the Trust's gender pay gap data particularly in the Lower Middle and Upper Middle quartiles and thus mean and median pay gap data has been the introduction of an additional high value salary sacrifice scheme during this reporting period. This enables staff to save money on Home Electronics. This has proven popular amongst staff. Of the 898 staff who pay into the scheme, 84.63% (760) are female. This is on top of the existing high values schemes which again more female staff pay into (Family Car Lease 76.14% and Childcare Vouchers 71.01% of female staff respectively). 124 staff pay into 2 of the high value schemes, 5 staff pay into three of the high value schemes.

3.2 Pay Quartiles by Gender

	Male			Female			Total
Quartile	Headcount	% Headcount	Mean (Average) Hourly Pay	Headcount	% Headcount	Mean (Average) Hourly Pay	
Lower	387	18.19% (18.2%)	£9.10	1740	81.81% (81.8%)	£9.27	2127
Lower Middle	378	17.78% (17.8%)	£12.07	1749	82.22% (82.2%)	£11.99	2127
Upper Middle	408	19.18% (19.2%)	£16.17	1719	80.82% (80.8%)	£16.36	2127
Upper	840	39.49% (39.5%)	£33.28	1287	60.51% (60.5%)	£25.19	2127
Total	2013	23.66% (23.7%)	£21.18	6495	76.34% (76.3%)	£15.03	8508

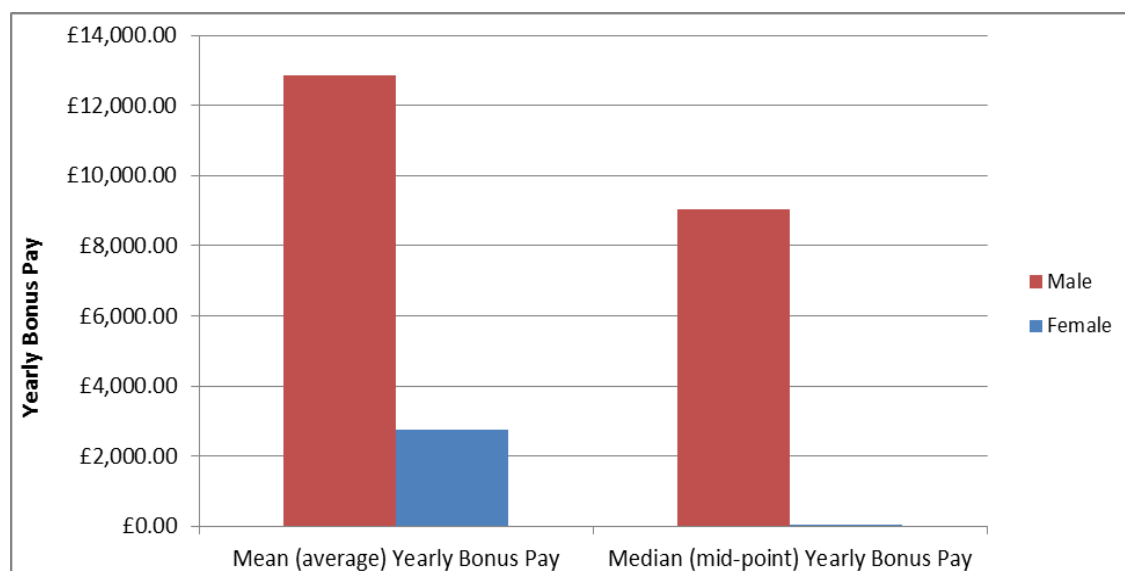


3.2.1 Key Findings

- Based on the Trust's overall gender split (76.34% female and 23.66% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. There are a disproportionate number of males, 39.49%, in the upper quartile compared to 60.51% being female. This accounts for the mean gender pay gap of 24.31% and £8.09 in the upper quartile, which is a 4.09% and £1.41 improvement on the previous reporting period.
- Analysis of the percentages of males within each pay quartile (as opposed to the gender pay split for each quartile) in this reporting period compared to the 2018 return highlights a shift, with -1.3% less males in the lower quartile, and an increase of +0.5% in both the lower and upper middle quartile, and a +0.4% increase in the upper quartile. This shift is attributed to the impact of the high percentages of females who pay into high value salary sacrifice schemes and the introduction in this reporting period of the high value Home Electronics scheme in particular.
- Within the Medical staff group there is a disproportionate gender split (35.56% females and 64.44% male). In the Upper Quartile for Medical staff the split is 34.30% female and 65.70% male. Medical staff account for the majority of the Trust's highest earners.
- The Trust has a split of 58.90% full time and 41.10% part time staff. 92.39% of part time staff are female. The majority of part time staff are in the lower quartiles (58.39% are in the lower and lower middle).
- Only 27.97% of staff in the upper quartile are part time. This is disproportionate when compared with the Trust wide figure of 41.10% of staff being part time. 88.91% of these are female staff.

3.3 Mean and Median Gender Bonus Gap

Gender	Mean (average) Yearly Bonus Pay	Median (mid-point) Yearly Bonus Pay
Male	£12,871.79	£9,048.00
Female	£2,742.82	£50
£s difference	£10,128.97	£8,998.00
% difference	78.69% (78.7%)	99.45% (99.5%)



3.3.1 Key Findings

- The mean gender bonus gap is 37.43% when long service awards¹ are excluded from the data, rising to 78.69% when they are included in line with national guidance.
- The median gender bonus gap is 33.33% (£3,016 per year) when long service awards are excluded from the data, rising to 99.45% when they are included. This is an improvement from 36.67% (£3,314.89) in the 2018 reporting period.

3.4 Bonus Distribution by Gender

Gender	% Receiving Bonus
Male	7.30% (7.3%)
Female	2.12% (2.1%)

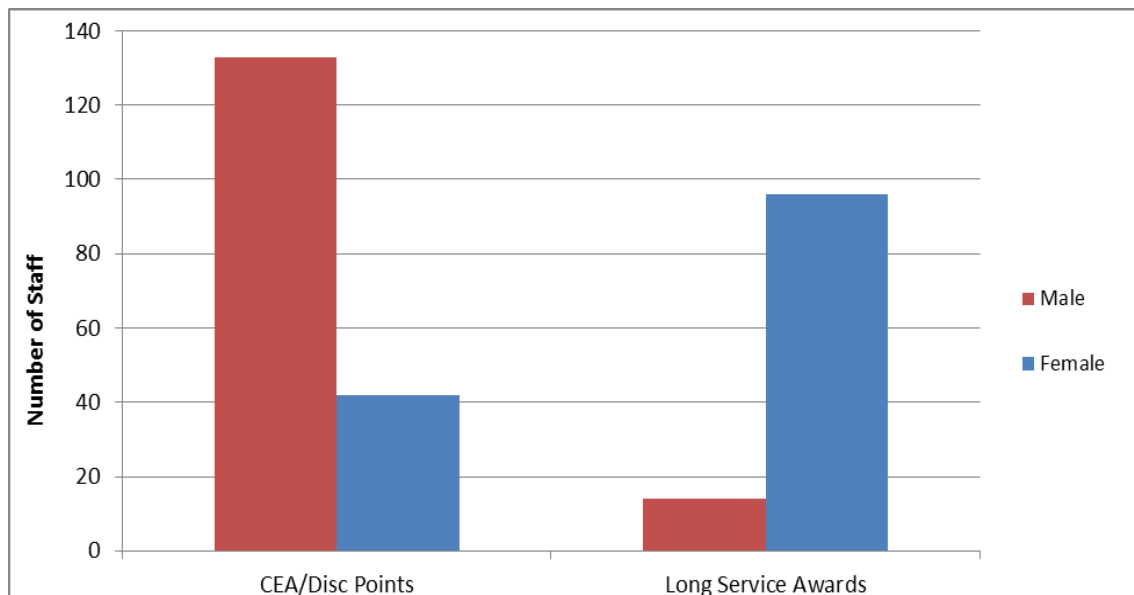
- The proportion of male employees receiving a bonus is 6.61% excluding long service awards (7.30% when included) and the proportion of female employees receiving a bonus is 0.65% excluding long service awards (2.12% when included).

3.5 Bonus Type by Gender

Male	Female
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¹ The Long Service Award scheme is applicable to any employee, whether male or female, who has achieved 25 years substantive service within the NHS. Staff are invited to attend an awards ceremony to be presented with a certificate and a token gift to the value of £50 in recognition of their contribution and commitment.

Bonus Type	Headcount	%	Headcount	%	Total Headcount
CEA/Discretionary	133	76.00	42	24.00	175
Long Service Awards	14	12.73	96	87.27	110
Total	147	51.58	138	48.42	285



3.5.1 Key Findings

- This year the Trust has two types of bonus that meet reporting requirements – Long Service Awards and Clinical Excellence Awards (CEAs - which are awarded based on the performance of Consultant Medical staff subject to national and local eligibility criteria in recognition of excellent practice over and above contractual requirements).
- The Trust's gender bonus data is significantly distorted by the Trust's Long Service Award scheme as, given the gender makeup of our workforce, more females receive an award. Calculations have therefore been made both including and excluding this data. Including long service awards, the median bonus pay for females is £50. Excluding long service awards, the median bonus pay for females is £6,032.00. This compares to £9,048.00 for males (the figure is the same inclusive or exclusive of the long service award).
- The gender split for bonus pay is 48.42% female and 51.58% male, however as 87.27% of female bonus pay is the £50 long service award, this results negatively on mean bonus pay.
- There has been a significant increase in female staff numbers receiving long service awards during this reporting period (an increase from 47 in 2018 to 96 in 2019, compared to an increase in eligible male staff from 7 in 2018 to 14 in 2019), as two long service award ceremonies were held. This has resulted in an increase in the mean bonus pay gap compared to the 2018 reporting period.
- If long services awards are excluded, the mean bonus pay gap reduces from 78.69% (£10,128.97) to 37.43% (£5,323.61) and the median bonus pay gap reduces from 99.45% (£8,998.00) to 33.33% (£3,016.00).
- Nationally agreed changes to the local Clinical Excellence Awards scheme effective from 1 April 2018 will gradually impact on the Trust Gender Pay Gap data, commencing with this, the 2019 Gender Pay Gap report, as awards are made retrospectively. This is evident in the small 3.34% improvement this year in the median bonus pay gap (excluding long service awards).

- *Existing* local awards awarded prior to April 2018 will remain consolidated and pensionable and the associated payments will remain protected until at least 31st March 2021.
- New local awards post-April 2018 (including new awards to existing award holders) are: time limited, (payable for up to two years within Hull University Teaching Hospitals NHS Trust), paid as a lump sum, non-consolidated, non-pensionable and do not include uplifts for Consultants undertaking Additional Programmed Activities.
- CEA and Discretionary points account for 61.40% of all bonuses awarded.
- The difference in bonus pay is also driven by the payment of higher (accumulated) bonuses for Consultant Medical staff where there is a greater proportion of men.
- The proportion of male medical staff currently receiving accumulated CEAs (i.e. including both old and new style CEA's) is higher than females (the gender split of those receiving a CEA/Discretionary award is 76.00% male compared to 24.00% female).
- Of the CEA's held under the old pre-April 2018 CEA scheme, 77.8% are held by male staff compared to 22.2% by female staff.
- Under the new post-April 2018, CEA scheme 63.6% of awards are held by male staff, 36.4% by female staff.
- Eligibility for the new CEA/Discretionary points (27.79% female, 72.21% male) was broadly consistent with the Consultant gender split (26.17% female and 73.83% male), however, when it came to applying, of those eligible, a slightly higher percentage of females (29.17%) applied compared to males (20.83%).
- Within the 12 months up to 31 March 2019 the percentage of applications resulting in a successful new CEA award was 41.18% for male medical staff, and for females this was higher at 57.14%, i.e. for females this was considerably above the Consultant gender split.
- A greater number of the Trust's female Consultants work flexibly on a part-time basis (6.98% male, 25.86% female). This distorts both the mean and median bonus pay as CEA bonus payments are pro-rated for part-time employees. This part-time split is broadly reflected in those with CEAs (3.01% of male CEAs are for part-time Consultants, 23.81% of female CEAs are for part-time Consultants).
- The number of applications for Clinical Excellence Awards has been gradually decreasing. This may be due to the changes in the local award scheme from April 2018 as well as the changes in the pension scheme for Consultants and the annual allowance.

4 NATIONAL CHANGES

In April 2018 the Department of Health and Social Care commissioned an independent review to advise on action to improve gender equality in the NHS. The interim update from the Gender Pay Gap in Medicine Review (published 29 March 2019) has found that the continued dominance of men in senior medical positions is one of the main causes of the gender pay gap in medicine. The update includes; that the gender pay gap for doctors is 17% based on their total pay, women are not yet represented in equal proportions in senior medical grades, two-thirds of doctors in training grades are women, but within consultant grades this drops to under half, women are over-represented in lower paid specialties, but under-represented in the highest paid specialties. The final report is due imminently.

There is currently no identifiable impact on the Trust's gender pay gap data of the 2018 Agenda for Change contract refresh, although it is envisaged this will gradually have an impact for staff paid under these terms and conditions.

Any national changes will be pivotal in helping reduce the Trust's gender pay gap.

5 SUMMARY OF RESULTS AND ACTIONS

The Trust is committed to ensuring all staff are treated and rewarded fairly irrespective of gender.

The Trust is using the workforce gender pay gap figures to help understand the underlying causes for its gender pay gap and to identify suitable steps to minimise it.

Some elements of the Trust's gender pay gap have a historical/national context which will take a period of time to resolve.

The Trust's gender pay gap data, which shows the difference in average pay between men and women in the workforce, reflects that the Trust has a majority of men in higher-paid roles, predominantly medical staff.

The mean and median hourly pay gap percentages across the health sector and bonus pay gaps are significantly affected by the presence of the Medical Consultant body - due to both their high base wage and the historical differences in bonuses awarded under the Clinical Excellence Awards scheme.

This year's gender pay data has been particularly impacted by the introduction of the Trust's Home Electronics salary sacrifice scheme, and the large increase in staff numbers receiving a long service award.

The Trust's mean gender pay gap at 29.04% has reduced since the 2018 report (30.74%) but remains higher than the average national figure of 16.2%. The Trust's median gender pay gap is above the national average of 17.3%. Excluding medical and dental staff these figures would be 3.29% and -0.23% respectively, an improvement on the 2018 reporting period (2018 data; 3.61% and 0.32%). The overall NHS gender pay gap is 23%.

Whilst the impact of the new CEAs is not reflected in the overall CEA bonus gap data (due to the historically awarded CEAs that consultants are still in receipt of), analysis of those who have achieved a new style local CEA for the first time suggest positive changes in addressing the bonus pay gap for future years. Notably, when it came to applying, of those eligible, a slightly higher percentage of females applied compared to males. In addition the percentage of applications resulting in a successful new CEA award was higher for female medical staff.

Actions to address the gender pay gap will be taken within the context of the Trust's People Strategy 2019-22 and programme plan.

5.1 What Have we Done to Date?

- Continued to review output of exit data to better understand blocks to gender pay progression, to help identify and implement actions to improve this.
- Analysed data from recent retention surveys. This included both a nurse retention survey and a survey sent to nursing staff who were within 5 years of retirement, to ascertain what would make them consider flexible retirement and remain working for the Trust.
- Put in place an approach to talent management which ensures that the talent of all individuals in Hull University Teaching Hospitals NHS Trust are maximised and continue to work to open up professions to under-represented groups, particularly through apprenticeships.

- Embedded the Trust's commitment to developing a comprehensive 'grow our own' approach across all staff groups and promoted development opportunities for non-stereotypical male/female roles
- Invested in a number of new medical workforce roles and medical associate professions including advanced clinical practitioners, physicians associates, advanced critical care practitioners, anaesthetic associates, surgical care practitioners which provides career development opportunities at a more senior, higher paid level.
- In 2019 the Trust participated in a research project funded by the Government Equalities Office, conducted by the Gender and Behavioural Insights programme team, examining whether there is any gender bias in Clinical Excellence Awards. For this evaluation, the Trust provided pseudonymised data on our consultant population and CEA applications and awards, to help understand any gender disparity in local award schemes and why it may be occurring. The results of this analysis are forthcoming.
- The benefits of providing flexible working options for Doctors in Training are well documented and the Trust has, therefore, set up a quarterly forum for those doctors already working, and those considering working, less than full-time. The forums, run in partnership with the BMA, have been supported by a number of speakers covering impact on pay, pensions and rotas. The Medical Staffing Team have identified a Less Than Full-Time Champion to support existing doctors and those returning to training or returning from, for example, family friendly leave.
- Following funding received from Health Education England the Trust has appointed to the role of SuppoRRT Champion for a 3 year period. This role is to provide advice and guidance to medical trainees who are returning to work after a lengthy period of absence (for example maternity leave) as well as supporting trainers with this process.
- From August 2019, Medical and Dental staff returning to the Trust following a period of family friendly leave were provided with 3 paid supernumerary days (funded by Health Education England) to support their return to work.
- Continued to; encourage a greater proportion of eligible female Consultants to apply for local Clinical Excellence Awards; provide mentorship from some of the Trust's current higher level local female award holders to female Consultants who were thinking of submitting an application, run local CEA Information sessions led by the Chief Medical Officer available to any eligible Consultants (both male and female) who were thinking of applying for a local award. These sessions provided guidance on how to complete an application form for a local Award, as well as changes to the local scheme with effect from April 2018.
- The Trust continues to deliver the Equality, Inclusion and Diversity training programme and forms part of the Trust's Recruitment and Selection training. Equality and Diversity training now forms part of the Trust's mandatory training programme.
- To support our leaders to fully model a compassionate, inclusive leadership approach a range of leadership programmes for both medical and non-medical leaders (including Trust Board) have been delivered including; Great Leaders – Be Remarkable, a Supervisors+ programme, a Rise and Shine programme, and Great Leaders Bitesize.
- A Coaching and Mentoring Network, with over 30 accredited coaches in place within the Trust. Three senior coaches have attended a National Leadership Academy programme on Coaching for Inclusion.
- Set up a weekly Pay Group to consider elevated starting salary requests for Agenda for Change staff, to ensure fairness and equity of application in light of the new pay structure.

5.2 **Next Steps**

The Trust is committed to addressing the gender pay gap and is undertaking a range of actions and initiatives to reduce this including;

- Further developing the evidence base of data to ensure effective gender monitoring is in place, for example increasing the frequency of targeted recruitment reports for the upper pay quartile, for example for vacancies band 8 (and above), and Medics.
- Continue to review and update appropriate policies and practises, for example flexible working, in partnership with staff side representatives and managers.
- Continue to take steps to make the most of flexible working, including a review of flexible working arrangements across the Trust, removing barriers to this, and ensuring that the Trust's culture supports staff to do so at all levels, including senior staff and Medics.
- Continue to encourage female participation in leadership development programmes and review career and talent development opportunities so that capable employees of both genders can progress.
- Consider the findings, and take action in light of the final Government commissioned Gender Pay Gap in Medicine review, which is due imminently.
- Given the reducing numbers of Consultants applying for Clinical Excellence Awards, opening up the mentorship scheme to all Consultants (both male and female) who were thinking of applying for an award.
- Bring forward the next Gender Pay Gap report (for the period to 31 March 2020) to help ensure contemporaneous information is published and actions agreed at an earlier stage.

Solutions to the gender pay gap lie in culture changes both in society and organisations. None of the initiatives will, in themselves, remove the gender pay gap, and it may be several years before some have any impact at all. In the interim the Trust is committed to reporting on an annual basis on what it is doing to reduce the gender pay gap, and the progress it is making.

Nationally most of the issues driving gender pay gaps require a longer term view. The Trust will continue to take steps to reduce it's pay gap and continue to explore best practise across the sector and beyond.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Board Meeting

Date 10.03.2020

Title:	Contract renewal recommendation paper for the provision of External Audit Services (HEY/18/742)
Responsible Director:	Lee Bond, Chief Financial Officer
Author:	Carla Ramsay (Director of Corporate Affairs) Karen Towse (Head of Finance – Financial Accounting) Rebecca Thompson (Corporate Affairs Manager) Stephen Evans (Deputy Director Finance) Alison Drury (Deputy Director Finance)

Purpose:	The purpose of this paper is to seek approval of the Board to award a 3 year contract with up to 1 year extension to Mazar for the provision of External Audit Services from 01.04.2020 to 31.03.2023.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	✓
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	✓
Summary Key of Issues:	This is an official contract renewal for the provision of external audit services.	

Recommendation:	The Board is requested to approve the awarding of this contract for the provision of external audit services a direct award process.
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HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

CONTRACT RECOMMENDATION PAPER FOR THE PROVISION OF EXTERNAL AUDITORS

COMPLIANT CONTRACT RECOMMENDATION

Trust Reference:	HEY/18/724
Type:	Contract Renewal
Form:	Service
Period:	36 Months
Extension Option:	Up to 12 Months
Anticipated Contract Start Date:	01/04/2020
Health Group:	Corporate
Division:	Finance and Business
Department:	Finance admin
Procurement Process Used:	Direct Award (NHS Shared Business Services)
Total Contract Value (Ex. VAT):	£292,500.00 Fixed
Cost Centre:	127350
Terms and Conditions which apply:	Call-off Terms and Conditions for the Supply of Goods and the Provision of Services (NHS Shared Business Services)
G.D.P.R. Applicable:	No
Procedure compliant with Trust SFI's:	Yes

1. PURPOSE

The purpose of this paper is to seek approval from the Board to appoint external Auditors in line with the recommendation made by the Auditor Panel.

The Board is recommended to appoint Mazars as the Trust's external auditors from 2020/21 for a period of 3 years with the possibility of a 1 year extension.

2. BACKGROUND

2.1 This is the renewal of a contract for the provision of External Auditors.

2.2 The Local Authority and Accountability Act 2014 allows the Trust to make its own appointment. An "Auditor Panel" set up by the Trust oversees the appointment process. The panel comprises of members of the Audit Committee and Trust Officers which are detailed later on in this paper.

2.3 The Trust currently receives external audit services from Grant Thornton UK LLP.

2.4 Grant Thornton UK LLP has indicated to the Trust that they do not wish to continue to provide external audit services to the Trust after the 31/03/2020.

2.5 Consequently, the Procurement Department explored the options of procuring via East of England NHS Collaborative Procurement Hub, Crown Commercial Services, HealthTrust Europe and North of England commercial Procurement Collaborative.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

- 2.6 Each framework provider offered a compliant route to market, a decision was taken by the audit panel to utilise the NHS Shared Business Services framework agreement for the Internal and External Audit, Counter Fraud and Well Led Governance Review (SBS/16/PC/ZY/8952). As the process was straightforward and the audit panel was fully assured that the chosen supplier offered the most economically advantageous solution. This was based solely upon the review of the audit pricing offered by each external audit provider, as each company offered a comparable solution that would meet the Trusts external audit requirements.

Below justifies the reasoning taken to direct award to Mazars.

Company	Justification	Outcome
BDO Ltd	£550 – Blended day rate more, senior staff lower rate	No
Deloitte LLP	Expired	No
Ernst & Young Region 1	£630 - blended day rate more, Audit role rates more expensive	No
Grant Thornton LLP	Incumbent supplier does not wish to continue with the Trust	No
KPMG	£957.5 - blended day rate more, Audit role rates more expensive	No
Mazars LLP	£525 – Lowest blended day rate, Audit Manager competitive pricing	Yes
PriceWaterhouse Coopers LLP	£625 – blended day rate more, Audit manager rate same as Mazars	No

- 2.7 To ensure that the Trust received the most economically advantageous offer the Trust undertook a market research exercise, the outcome is which detailed below:

BDO Ltd: Confirmed that they will not be responding as they do not have a public sector external audit team in our area.

Deloitte LLP: Confirmed that they would not be providing a response, due to a conflict of interest.

Ernst & Young Region 1: Did not provide a response by the deadline date. Ernst and Young were called and a message taken a follow up email was sent.

Grant Thornton LLP: The Trust's finance team have been informed by Grant Thornton that they will not be responding.

KPMG: Confirmed that they do not wish to be considered.

Mazars: The only company which have confirmed that they are willing to provide external audit services.

PriceWaterhouse Coopers LLP: They have confirmed that they do not have a team available that could do justice to our proposal or perform a high quality audit the Trust would expect.

- 2.8 The audit panel also met with Mazars to ensure the Trusts service requirements could be met by Mazars. The audit panel was fully assured.

3. PROCUREMENT PROCESS

- 3.1 The Procurement Department undertook a direct award process under the NHS Shared Business Services framework agreement for the Internal and External Audit, Counter Fraud and Well Led Governance Review (SBS/16/PC/ZY/8952) for external audit services.
- 3.2 Following a financial review it was deemed that Mazars had the lowest blended rate, therefore Mazars was approached.

The blended rate is the value that is used for comparison purposes and is a way of being able to compare the prices between those organisations on the framework.

Some organisations were far higher than others, Mazars was deemed to have the lowest blended rate.

The Trust is fully assured that all relevant external audit standards are met and Mazars can provide the relevant external audit services to the Trust, as NHS Shared Business Services framework is for organisations which already provide external audit services.

In addition, the audit panel has met with Mazars, who confirmed that they can meet the Trust's specification of requirements. The Audit Panel agree that they will be able to work successfully with the team identified to work alongside the Trust.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

4. FINANCIAL IMPLICATIONS

- 4.1 Appendix one (as below) details the justification of award, comparison summary and Mazars 3 years and 1 year extension offer in line with the framework prices.



Appendix 1
HEY-18-724 review.x

4.2 CURRENT COSTS FOR EXISTING CONTRACT

Current cost exclusive of VAT per annum:	<u>£59,800.00</u>
Current cost inclusive of VAT per annum:	<u>£71,760.00</u>
Current contract end date:	<u>31.03.2020</u>
Comments <i>None</i>	

4.3 NEW COSTS

Proposed cost exclusive of VAT per annum:	<u>£97,500.00</u>
Proposed cost inclusive of VAT per annum:	<u>£117,000.00</u>
Proposed contract start date:	<u>01.04.2020</u>
Duration of contract:	<u>3 years (36 months)</u>
Value of total contract including VAT:	<u>£351,000.00</u>

4.4 FINANCIAL IMPACT

ON COSTS

Cost pressure per annum including VAT:	<u>£45,240.00</u>
Start Date of On-cost:	<u>01.04.2020</u>

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4.5 FUNDING DETAILS

Source of Funding:	<u>Revenue</u>
Cost Centre:	<u>127350</u>
Expense Code:	<u>744000</u>
Financial Implications approved by:	<u>Lee Bond (Chief Financial Officer)</u>

5. EVALUATION TEAM

5.1 The following colleagues were involved in the decision of recommending an award to Mazars and are responsible for this recommendation:

- Lee Bond (Chief Financial Officer)
- Carla Ramsay (Director of Corporate Affairs)
- Karen Towse (Head of Finance – Financial Accounting)
- Tracey Christmas (Non-Executive Director)
- Rebecca Thompson (Corporate Affairs Manager)
- Stephen Evans (Deputy Director Finance)
- Alison Drury (Deputy Director Finance)

6. RECOMMENDATION

6.1 The Board is requested to approve the awarding of this contract to Mazars, for the provision of external audit services.

Lee Bond
Chief Financial Officer

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Procurement Department comments

This recommendation is compliant with Trust Standing Orders, Standing Financial instructions and EU Regulations.

Procurement Department additional comments: None

Please indicate approval or rejection of this paper by signing in the appropriate box below.

Scheme of Delegation as per Section D Point 9.12 of Corporate Policy 105 – Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions (February 2017)

Total estimated contract value less than £500,000.00 (Inc. of VAT)

Contract title: External Auditors

Contract ref: HEY/18/742

The above recommendation **is** accepted.

Signed: Date:
Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Total estimated contract value less than £500,000.00 (Inc. of VAT)

Contract title: External Auditors

Contract ref: HEY/18/742

The above recommendation **is not** accepted.

Signed: Date:
Chief Executive – Christopher Long / Chief Finance Officer – Lee Bond

Reasons for rejection of recommendation:

Contracts Ref:	HEY/18/742	Supplier Ref:	N/A
Contracts Contact:	HL	Date submitted for approval:	05/03/2020

**Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
Held on 27 January 2020**

Present:	Mr T Curry	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs M Kemp	Deputy Chief Operating Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Ms E Henderson	Head of Outpatient Services (Item 8.2)
	Mrs R Joyce	Improvement Programme Director (Item 8.2)
	Mrs S Cooke	Programme Manager (Item 8.2)
	Mrs R Thompson	Corporate Affairs Manager

No	Item	Action
1	Apologies Apologies were received by Mrs T Cope, Chief Operating Officer	
2	Declarations of Interest There were no declarations made.	
3	Minutes of the meeting held on 25 November 2019 Item 10.1 – Finance Report October 2019 – 5 th paragraph should read, “Mr Gore queried the contract income in month gain of £877k. Mrs Drury replied that the income schedule was not in line with the accounts due to the timing of the report”. Following this change the minutes were accepted as an accurate record of the meeting. Minutes of the meeting held on 16 December 2019 The minutes were approved as an accurate record of the meeting.	
4	Matters Arising from the Minutes There were no matters arising from the minutes.	
5	Action Tracker Mrs Kemp updated the Committee regarding new pathways in Emergency Care and advised that the Trust was now using Push Doctor which was a Skype like GP service that patients (who made the criteria) could contact from home. The Trust was aiming to have 15 patients per day use this service. Mrs Kemp agreed to provide a briefing note to the Committee regarding the impact on ED performance and patient experiences. Mr Evans to update the Committee regarding consultant activity (PLICs). It was agreed that all other items could be removed from the tracker.	 MK SE
	<i>The agenda was taken out of order at this point</i>	

8.2 Outpatients Transformation Programme

Ms Henderson presented an overview of the Outpatients Transformation Programme which included reviews of patient partnership working, outpatient governance, corporate risks, complaints and PALs to create a better patient experience.

Ms Henderson advised that the staff felt empowered and morale was better and work was ongoing with the culture in Outpatients. She reported that the service was being clinically lead which would improve management of pathways in and out of secondary care, reduce follow up backlog and review clinical best practice. She added that the service was reviewing alternative methods of face to face activity.

Ms Henderson advised that the team had a new recruitment campaign to attract more staff to the service.

The Trust was sharing its Outpatients story in Manchester, York and London and a clinically lead GP event was being organised for October 2020.

Mrs Joyce also gave an update relating to Optimise as part of the Outpatient Transformation Programme. She spoke of the end to end admin review, the efficiency savings and how the Trust was looking to reduce face to face appointments which was in line with the strategic plan. The Trust had already seen a reduction in the follow up backlog.

Mrs Joyce advised that there was increased system wide collaboration and the Trust was joining the NHS I Elective Care Transformation Programme. There would also be HCV collaboration, Modality roadshows, GP/consultant events as well as patient engagement surveys and patient focus groups.

There was a discussion around DNAs and cancellations and work was ongoing to address these issues. Mrs Henderson advised that the overall cancellation rate was 24%. A review and recovery plan was to be put into place and the Committee requested that an updated cancellation rate was presented in 3 months.

EH

Mr Gore asked about error rates within the patient tracking system and Mrs Joyce advised that there were systems and processes in place to address this as well as rolling audits which the 18 week RTT group were picking up.

Resolved:

The Committee received and accepted the presentations.

6 Workplan

Ms Ramsay presented the Workplan and advised that the December 2019 meeting had been stepped down due to availability of reports as the meeting had been brought forward due to the Christmas break. Cancelling the 2020 meeting was discussed and Ms Ramsay advised that if the Committee wanted to do this it would mean changing Standing orders and approval by the Board.

7 Board Assurance Framework

Ms Ramsay presented the BAF and advised that it had been updated with positive assurance and any gaps in assurance captured in the last two PAF meetings. The BAF had been updated up to the end of quarter 3 and recommended risk ratings to be discussed. The risk ratings had been recommended to remain the same in Q3 for all of the risks. It was anticipated, however, that some of the risks could change in quarter 4.

Mr Gore suggested that the risk for BAF 4 should be increased as the Trust was not achieving its performance targets. The Committee discussed the consequences of poor patient experience and the impact on the backlog and whether the mitigating actions in place were effective.

The Committee agreed to increase the narrative around the risk to highlight the concerns raised but leave the risk rating for quarter 3.

Mr Gore stated that BAF 5 should reflect the new oncology situation and service changes and any impact on patients. It was agreed that this would be raised at the Board meeting and possibly have a Board Development session dedicated to it.

The Committee discussed reducing the risk of the Financial BAF risk from 4 to 3 due to the likelihood of the Trust achieving its Control Total in quarter 4. It was agreed that the quarter 3 rating would remain the same.

The Committee also discussed the Capital risk BAF 7.3 and whether this too could be reduced by year end. It was agreed to leave the risk at 20 and review in quarter 4.

Resolved:

The Committee received and accepted the report.

8.1 Performance Report

Mrs Kemp presented the report and advised that the ED 4 hour performance was not achieving planned trajectory and was at a deteriorated position of 84%. The Trust had not had any 12 hour breaches.

The additional capacity had been opened and additional winter funding had been secured. There was a system wide improvement plan in place and this was being monitored through the A&E Delivery Board.

The online GP Service Push Doctor was being piloted in ED to make the streaming of patients not requiring urgent care more efficient. Mrs Kemp advised that attendances were below plan but admissions were above plan. Mrs Christmas stated that this could be due to patients reviewing other options rather than just coming to the Emergency Department.

Mrs Kemp advised that the RTT incomplete standard was still challenging at 70% which was under trajectory. At the end of December the Trust's clearance rate was 15.9 weeks and was being managed well. There had been an increase in advice and guidance.

Mrs Kemp advised that the Trust had reported one 52 week breach which was unavoidable.

There had been 2 patients cancelled due to lack of inpatient beds and were not able to be accommodated within 28 days. This was due to reliance on surgical beds.

Diagnostic performance had remained static since December 2019 with performance at 10.7%. From September 2019 CT Colonoscopy activity had been commissioned from the Spire Hospital which was helping with improving waiting times. Mrs Kemp agreed to update the Committee in the February report regarding this position. **MK**

Mrs Kemp advised that cancer standard in the Breast Service had failed in November 2019 due to high levels of demand. Early reports suggested that the services was achieving the standards again in December.

The Trust was monitoring itself against the 28 day faster diagnosis standard which was being formally introduced in April 2020. The Trust is currently achieving 81% against the standard of 90%.

The Trust had seen an increase in GP referrals of 9.3% overall compared with last year. Breast, skin and colorectal were driving the increases in demand.

The deterioration in 62 day RTT performance was mainly due to the colorectal, gynaecology, upper GI and lung pathways and access to diagnostics, predominantly CT and PET CT. The Trust had invited the Intensive Support Team to review upper and lower GI pathways and gynaecology. Any actions from the review would be fed back to the Committee.

Mrs Kemp spoke of the commissioned additional CT capacity from the Spire and endoscopy capacity with Pioneer due to the increase in referrals. She advised that patient choice was becoming a significant contributing factor to breaches, particularly in diagnostics where cancer is either confirmed or ruled out. A pilot had been agreed with the Head and Neck Services to look at how patient compliance could be improved.

The Trust was launching its Lung Health Check programme on 27th January 2020. This scheme would allow patients that met the criteria would have a free assessment of their lung health. Additional workforce had been recruited to ensure any early cancers identified could be treated in a timely way.

Mr Bond asked if the increase in 2 week wait referrals was the result of GPs making non-urgent referrals as well as urgent ones. Mrs Kemp advised that work was ongoing with the GPs to ensure the referrals were appropriate. Mr Bond suggested that the conversion rates were checked which would give an indication of appropriate referrals.

Mr Gore asked why ED performance was worse than the same time last year even though the patient attendance was similar. He added that some of the recent countermeasures to improve performance had still not taken full effect and wanted to understand their impact. He also asked for further information relating to the average time of discharge outside of the meeting.

There was a discussion around performance and how the flow of patients through the hospital was key. It was suggested that staff had become immune to the issues and busy times were now seen as normal. These issues were being managed at the Performance meetings.

Resolved:

The Committee received and accepted the report.

10.4 Impact of Pension Issue

Mr Nearney presented the report and advised that 42 consultants had reduced their workloads or where not doing additional sessions due to the pension issue.

Mr Nearney advised that the rate of consultants reducing their workloads had slowed down but there were still consultants coming forward to review their options.

Mr Bond added that some consultants were keen to set up their own private companies and this was happening in other organisations. Mr Nearney advised that the main area of concern was anaesthetics as a large amount of capacity had been lost.

Resolved:

The Committee received and accepted the report.

11.1 Variable Pay Report

Mr Nearney presented the report and advised that the Trust was at £23m at the end of month 9 which was in line with plan. He advised that the Trust was reducing the Bank and extra session costs but overtime costs were high.

He reported that there was a £2.6m overspend at Month 9 with Surgery and Family and Women's Health Groups being the main areas of concern.

Mr Nearney advised that the internal bank had been launched and Junior Doctor and Consultant pay rates had been discussed with LNC and implemented. There were 41 doctors on the bank and Liaison were managing it. There had been a number of breaches, mainly in ED and usually at night when RMO cover was difficult to achieve.

Mr Nearney reported that the Surgery Health Group was the biggest over service user and this was usually for medical staff.

Resolved:

The Committee received and accepted the report.

9.1 Demand and Activity Report

Mrs Drury presented the report and advised that a change in the reporting of referrals in-year to include the Appointment Slot Issues (ASI) was having an impact on the ability to provide like for like comparisons with last year.

Further work is ongoing to ensure the 2018/19 numbers can be restated and more meaningful comparisons can be made at speciality and

commissioner level. Mrs Drury agreed to update the Committee in her next report in February 2020.

ED attendances were below planned levels at the end of December 2019, with increases in attendances from the East Riding area being offset by reductions in Hull. Non-elective inpatients were 1.7% above plan driven largely by growth in cancer specialities and paediatrics. Elective admitted activity overall was 2.8% lower than plan and outpatient activity was above plan for both first and follow-ups.

Overall GP referrals were up and cancer 2 week wait referrals had increased in demand. Advice and guidance had not been affected.

The Trust has estimated that the level of contract income delivered at month 9 is £6.5m above plan after accounting for the AIC. This is £0.9m above plan in month but was mainly in pass through devices income £0.2m and specific funding in month of £0.9m for specific initiatives such as lung health check, winter funding, diagnostics reporting and RTT support.

Resolved:

The Committee received and accepted the report.

10.1 Finance Report January 2020

Mr Evans presented the report and advised that the Trust was reporting a £4.2m surplus at month 9 in line with plan.

Mr Evans advised that Surgery Health Group expenditure was away from plan by £1.5m in month and this was a position they needed to recover in quarter 4. Also there were pressures relating to medical staffing. Non pay costs had increased due to concerns relating to Brexit and over inflated stock levels.

Mr Hall asked if more narrative could be given at the next meeting regarding what was being done to recover the Health Group positions and what progress had been made. Mr Curry asked that the Finance section be first on the agenda next month.

RT

Resolved:

The Committee received and accepted the report.

10.3 Quarter 2 Patient Level Costing Report

Mr Evans presented the report and advised that the Trust ranked highly in the Benchmarking report at 87% above peers. He reported that the current data quality was improving and a full update would be received with his next report. Mr Evans advised that the PLICs audit had taken place in November 2019 and the results of this would also be included in his next report.

Resolved:

The Committee received and accepted the report.

10.2 CRES Report

Mr Evans presented the report and advised that the CRES position had been static for a number of months and the Health Groups did not have

much time to turn their positions around. He added that the positions were not getting worse.

At month 9 the Trust is reporting that it has delivered £11.4m of savings against the £12m target.

Resolved:

The Committee received and accepted the report.

10.5 Financial Recovery Plan

Mr Bond advised that the Centre was concerned that organisations were not ready for 1st April 2020 and the next financial year. Improvements were required regarding underlying positions and cost improvement measures. He added that Trusts were under pressure to spend their capital allowance and finish on budget.

Mr Bond stated that there would be an increase in funding for integrated care packages.

Resolved:

The Committee received the update.

13.1 Capital Resource Allocation Committee Minutes

The minutes were received by the Committee.

13.2 Items delegated by the Board

There were no items delegated by the Board.

14 Any Other Business

There was no other business discussed.

15 Date and time of the next meeting:

Tuesday 25 February 2020, 8.30am – 11.30am, The Committee Room, Hull Royal Infirmary

**Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
Held on 25 February 2020**

Present:	Mr T Curry	Non-Executive Director (Chair)
	Mr M Gore	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
In Attendance:	Mrs E Ryabov	Director of Operations (Medicine Health Group)
	Mr B Raynor	Consultant A&E
	Mrs N Ross	Divisional General Manager (Emergency Medicine Health Group)
	Ms J Myers	Director of Strategy and Planning
	Ms T Sowersby	Director IM&T
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	Apologies: Apologies were received from Mr Nearney – Director of Workforce and OD The Committee discussed the establishment of the new Workforce, Education and Culture Committee and the impact that this would have on the Performance and Finance Committee. It was agreed that Ms Ramsay would discuss this further with the Chairman and that the Terms of Reference for both Committees would be received at the next meeting in March 2020.	
2	Declarations of interest There were no declarations of interest raised.	
3	Minutes of the meeting held on 27 January 2020 The minutes of the meeting held on 27 January 2020 were approved as an accurate record of the meeting.	
4	Matters arising from the minutes There were no matters arising.	
5	Action Tracking List Mrs Cope updated the Committee regarding the CT Colonoscopy performance and how the outsourcing to the Spire had not brought the diagnostic waits down significantly. There had been some improvement in January 2020 but the Trust was still off its trajectory. There would be a further update in the costing report to the March 2020 Committee.	TC
6	Workplan The Workplan was received by the Committee. It was noted that the Variable Pay Report and the Job Vacancy Report had not been received by the Committee. Mrs Thompson advised that these reports had been	

transferred to the new Workforce, Education and Culture Committee which was being held 28 February 2020. Ms Ramsay agreed to discuss this further with the Chairman and report back to the Committee.

CR

7 Board Assurance Framework

Ms Ramsay presented the report and advised that the discussions had by the Committee had been included in the report. The risk ratings would be discussed at the next meeting with a view to whether the risk should be reduced, increased or remain the same for the year end. A board development session regarding the 2020/21 BAF would be held in March 2020. Risk mitigation and controls would be discussed along with Board engagement and how effective the BAF as a tool is. The end of year 2019/20 risk ratings would feed into the Annual Report.

There was a discussion around BAF 4 and concerns were raised around the targets not being achieved in year. Mr Gore was keen to review the risk rating and increase the likelihood. Mrs Cope added that the Health Group stock take that had taken place in November 2019 should be revisited to review the current position.

Mr Curry advised that it realistic mitigating actions should be agreed when discussing the 20/21 BAF.

Resolved:

The Committee received and accepted the report.

8 Finance and CRES Reports

Mr Evans presented the Month 10 Finance and CRES report and advised that the Trust was in line with plan and reporting £7.9m surplus. The stock issues reported in February 2020 had been resolved. Mr Evans advised that following receipt of the £4.5m PSF money the Trust was still forecasting to achieve its financial plan at year end. The main risk related to medical staffing pay.

The year end CRES position was £2.2m below plan (88%). The risk was the level of non-recurrent CRES within the figures.

Mr Bond stated that discussions were ongoing regarding the PSF money and whether this would be received wholly by the Trust or would be shared as part of the STP programme to bring the patch into balance.

There was a discussion around the capital budget and how the £33m was being spent. Mrs Drury advised that to date £14m had been spent and IT orders had been placed. The Finance Team was working closely with the Director of Estates to ensure the money was spent.

Mr Gore asked about Crawford and Company Adjusters, who they were and what they owed £240K for. Mr Evans agreed to investigate this amount and report back to the Committee.

SE

There was a discussion around the underlying financial position and what the Trust was doing to improve it. Mrs Cope advised that maximising productivity and efficiency was key. Mr Bond added that all clinical teams using e-Roster efficiently and linking to job plans would mean the correct controls were in place.

Mr Gore asked about vacancies being declared as CRES and Mrs Cope advised that there were no posts kept vacant deliberately, the reason for the vacancies was due to difficult to recruit to positions and shortages in the market place.

Mr Hall suggested that a review of the Health Group stock take to include CRES for 20/21 should take place. Mr Gore added that benchmarking productivity against Trust performing well would also be beneficial.

Mr Bond advised that he would be presenting an Income and Expenditure Report and a Balance Sheet report to the Committee in April.

LB

Resolved:

The Committee received and accepted the report.

8.3 Apprentice Levy Report

Mr Bond presented the report and advised that the Trust had commissioned £1.3m in Apprenticeship programmes and was actually spending £940k. He advised that this was not a mis-management of funds. He reported that there was more work to do around the Apprenticeship programmes and would be working with the Workforce, Education and Culture Committee to consider the options.

Resolved:

The Committee received and accepted the report.

The agenda was taken out of order at this point

11 11.1 Demand and Activity Report

Mrs Drury presented the report and advised that work had concluded around the 2019/20 referrals and there were no material issues to record. Work was ongoing to restate the 2018/19 referrals.

The Trust was below plan on its elective work and the main areas were day case and bowel scope (despite recent recruitment in that area). ENT and plastics were below plan and Mrs Cope advised that there was no capacity in the timetable for ENT for the 3 extra sessions required. Mr Gore expressed his concern regarding ENT and its downward performance trajectory. Mr Bond advised that ENT was a complex speciality and a number of procedures such as earwax and tonsillectomies had been stopped completely to create capacity.

Mrs Drury reported that A&E activity was above plan by 1.5% predominantly within the AIC. The main areas of variance are in vascular surgery and cancer specialities.

The level of income delivered at month 10 is £8.7m above plan after the AIC adjustment of £0.9m.

There was a discussion around outpatient activity and patient follow up appointments and how these could be reduced by changes in practice. Mrs Cope advised that work was ongoing with clinical leads to review different ways to follow up.

Mr Hall asked about paediatric surgery and how it was 20% lower than expected. Mrs Drury agreed to review this and report back to the Committee. **AD**

Mr Gore asked about Trauma and Orthopaedics and why it was showing an adverse figure of £1.5m. Mrs Cope agreed to review this and report back to the Committee. **TC**

Resolved:

The Committee received and accepted the report.

9.1 Performance Report

Mrs Cope presented the report and advised that RTT performance was achieving trajectory against the waiting list volume. Mrs Cope advised that she would share a report from an external company regarding the PTL and how it was validated. External validation has confirmed that the waiting list is correct and the waiting list volumes are real. Work was ongoing to review the backlog sizes and how these would be managed. The aim was to create capacity by reducing the number of follow ups or managing them differently. **TC**

There had been a 52 week wait reported but this was a complex care package taking longer than planned.

There were still issues around diagnostic performance and the endoscopy service was working to respond to the growth in demand.

There was work ongoing regarding the cancer standards and where investments were needed. Mrs Cope advised that the cancer targets had been reviewed in the new operating guidance which would be favourable for the Trust. She advised that the tumour site action plans had been appended to the performance report and the Health Groups were reviewing on a fortnightly basis.

Mr Hall expressed his concern regarding colorectal and endoscopy and asked how the Trust compared nationally. Mrs Cope advised that other areas including the STP were also struggling and it was mainly due to increased levels of referrals for scoping.

Mr Hall asked for clarity around the 62 day action plan as it currently stated To Be Agreed. Mrs Cope advised that the Performance and Accountability meeting were picking up the issues. Mr Hall asked for a further update at the March 2020 meeting. **SH**

There was a discussion around delayed transfers of care and discussions were ongoing with the Commissioners and Social Work teams to work through the issues with capacity. Mrs Cope advised that the Leeds model had been reviewed but they had capacity for step down beds on their estate rather than the Community.

Resolved:

The Committee received and accepted the report.

9.2 ED Performance

Mrs Ryabov and Mr Rayner attended the meeting to give a presentation relating to ED Performance. The key issues raised were around time to see first clinician and patients not being transferred out of the ED in a timely manner. Workforce shortages and paediatric performance has compounded the issues.

Mrs Ryabov also reported that transferring patients out of AMU was difficult as beds were not available. The Trust was also seeing an increase in delayed transfers of care into the Community. Mrs Ryabov expressed her concern that there were still patients being cared for from the previous day before the department could attend to the new attendees.

Performance was at 62% for the quarter (type 1) and the system wide performance was around 80%. Mrs Ryabov showed performance in the regional context and this showed a steady decline. The Committee asked if the Trust's figures could be removed to reveal whether this was impacting on the regional performance figures.

There was a discussion around the increase in testing that was being carried out by the clinicians which took longer to complete meaning that patients were spending longer in the department before being either discharged or added to the correct care pathway.

Mrs Ryabov advised that a full streaming service was now in the department and there was an increased primary care workforce in place. The Push Doctor service had also been implemented and the initial feedback was positive. There were additional beds in AMU and the social care unit at Castle Hill was being utilised and was now at full capacity.

The actions required to improve performance were; improving time to be seen by a doctor, reducing processing time, reducing the number of discharge breaches and continuing to support the Medicine Health Group to improve flow out of AMU.

Mrs Cope stated that it needed to be clear which improvements were within the Trust's control and which areas (such as delayed transfers of care) were not.

Resolved:

The Committee received the presentation and requested that Mrs Ryabov and Mr Rayner attend the meeting in March 2020 to highlight any improvements made.

ER/BR

10.1 Operational Planning

Ms Myers attended the meeting to brief the Committee on the operational guidance and key implications. Ms Myers advised that the Trust must make material improvements in ED performance and general and acute bed occupancy. Work was ongoing to revise the bed model.

The guidance also highlighted Same Day Emergency Care as well as ambulance handovers and corridor care.

RTT guidance stated that the Trust must have a smaller waiting list on 31st

January in 2021 than it did in 2020 and there should be no 52 week wait breaches.

Cancer improvements were against the 62 day performance and the Trust was already meeting the threshold.

The financial settlement was to be a surplus control total with no recovery funds. There would be a 0.5% reward if the Trust achieved its financial plan. If the system did not meet its target as a whole, half of these funds would be lost.

Mr Gore stated that benchmarking against the model hospital and increasing productivity and efficiency would require a change in mind set for the Health Group senior leaders. Ms Myers added that transformational work was happening in Outpatients and with some GIRFT initiatives.

Mr Hall asked about joint working with system partners and Ms Myers advised that Trusts were still producing individual plans and aligning them with system plans that were jointly owned.

The final plan would be presented to the Trust Board in April 2020 for approval.

Resolved:

The Committee received the plan and approved the approach being taken.

12.2 IM&T Report

Ms Sowersby presented the report and gave an update regarding the progress to deliver the Digital Strategy and Appendix 1 responded to the paper written by Mr Curry that was received by the Board in November 2019.

She advised that the network improvements were ongoing and would be in place by March 2020. The NHS mail upgrade had been deferred until the Summer of 2020 and the Windows 10 upgrade would be in place by December 2020. E-Observations and E-Prescribing were being rolled out.

An audit of the estate had been undertaken to determine what needed replacing and upgrading. There was much work to be completed regarding medical devices and equipment. A project manager had been appointed to work on technical and capital projects within the plan.

Ms Sowersby advised that the Trust was 87% compliant regarding Cyber Security and work was ongoing to upgrade the servers. Cyber Security software had been purchased.

Mrs Sowersby reported that the risks were around funding streams but clear visibility of the schemes were in place with the Trust Board and there was support from the Executive Team.

Mr Gore asked if any areas were of particular concern to Ms Sowersby and she advised that endoscopy and prosthetics systems would be reviewed.

Resolved:

The Committee received and accepted the report.

12.1 Capital Resource Allocation Committee Minutes

The minutes were received by the Committee.

10.2 Draft Capital Plan 2020/21

Mr Bond presented the draft capital plan for approval by the Committee. He advised that over the 3 year programme the capital investment would total £63m. The Capital Resource Allocation Committee had prioritised backlog maintenance and IM&T infrastructure works as the main areas of focus.

The main change was the inclusion in the plan of £5m of the 2019/20 uncommitted SOCI surplus within the plan.

Resolved:

The Committee received and approved the Draft Capital Plan.

10.3 Underlying financial strength and the planning process

Mr Bond advised that the financial planning guidance for next year had change fundamentally and the Trust needed to respond with productivity gains to address the £10m underlying problem.

Mr Bond advised that he was discussing planning with the Health Groups and ways to focus on increasing productivity rather than taking costs out.

The Committee agreed that the item required further discussion and it was agreed to add it to the March 2020 agenda.

Resolved:

The Committee received the update and agreed to discuss the item further at the March 2020 meeting.

LB

13 Any Other Business

Mr Hall stated that at the Quality Committee there was a discussion around pressure ulcers and the inflatable mattresses used. He advised that in 12 months 50% of the mattresses would not be functioning and the cost of replacement was £1m. Mr Bond advised that this was being reviewed at the Capital Resource Allocation Committee.

Mr Bond stated that the Trust was looking to come out of the replacement radiology equipment contract and negotiations were in place. The contract was 4 years into a 7 year term and this could mean financial consequences for the Trust. Mr Bond agreed to update the Committee once he had met with the Company.

14 Date and time of the next meeting:

Monday 30th March 2020, 1.30pm – 4.30pm, The Committee Room, Hull Royal Infirmary

**Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 27 January 2020**

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Ms C Ramsay	Director of Corporate Affairs
	Mrs B Geary	Chief Nurse
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Representative
	Mrs K Southgate	Acting Deputy Director of Quality Governance
	Dr M Purva	Chief Medical Officer
	Mrs T Cope	Chief Operating Officer
	Prof J Jomeen	Non-Executive Director

In Attendance:	Mrs J Ledger	Deputy Chief Nurse (Item 4.4 only)
	Mr S Jessop	Director of IT and Innovation (Item 4.4 only)
	Mrs C Grantham	Practice Development Matron (Item 4.4 only)
	Mrs J Donaldson	Acting Deputy Head of Dietetics / Adult Cystic Fibrosis Dietician (Item 4.4 only)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	Apologies: Apologies were received from Mr D Corral, Chief Pharmacist.	

The agenda was taken out of order at this point

4.4 Nutrition/Deteriorating Patient QIP Update

Ms Donaldson attended the meeting to present the Nutrition QIP and what was being done to ensure that the recording of nutrition was consistent and the nutrition screening tools were being used.

There was a discussion around the food chart in place at HRI and CHH and how wards had fallen down due to not having 8 ticks for each meal consumed. Mrs Geary advised that not all patients wanted to eat 8 times in a day so some narrative was required.

Ms Donaldson advised that when electronic forms for hydration and nutrition were in place it would mean that the form could not be submitted unless every section was completed. Mrs Ledger added that a different level of understanding was required from the Band 7 nurses around calorific values rather than how many times a patient has been fed. Mrs Geary was keen to make the process as simple as possible to assess and record once the system was electronic.

Prof Veysey asked how patients were encouraged to eat and Mrs Grantham advised that risk assessments were carried out for all patients and high risk patients were given a care bundle plan. Patients and carers were also given advice around VTE and pressure ulcers when they left the hospital.

Ms Donaldson spoke of the cake and shake round which was offered to patients as snacks and an additional source of calories.

Ms Donaldson advised that a roll out of good practice and projects to improve nutrition had been carried out, such as assistance with feeding and

staggered ward services. The catering staff were working closely with ward staff to ensure patients were being fed appropriately as part of their care package.

Mr Jessop presented the Deteriorating Patient QIP and advised that the CQC had highlighted the risk around escalation when using the National Early Warning Scores. He reported that there were a number of different systems for recording escalation and it was up to the registrants to do so. He advised that once the electronic systems for deteriorating patients were in place it would improve performance and BI reports would be available.

Mr Jessop advised that cardiac arrest survival rates had improved.

Mr Hall asked why the Matron's handbook was not being completed in some cases and Mr Jessop advised that the Wards were being held to account and Mrs Ledger was going through the process with the Matrons to ensure data capture.

Mr Jessop advised that by October 2020 the Trust would be digital and able to receive the electronic systems.

Resolved:

The Committee received and accepted the presentations. Prof Veysey stated that the Committee was assured that the work ongoing would improve these areas of the QIP.

The Meeting returned to order at this point

2 Declarations of Interest

There were no declarations made.

3 Minutes of the meeting of 16 December 2019

The minutes were approved as an accurate record of the meeting.

3.1 Matters Arising

There were no matters arising from the minutes.

3.2 Action Tracking List

The Committee reviewed the tracker and it was agreed that all actions were either on the agenda or could be closed.

3.3 Any Other Matters Arising

There were no other matters arising.

3.4 Workplan 2019/20

The Workplan was reviewed by the Committee.

4.1 Quality Improvement Plan

The Committee reviewed the plan and agreed that the key issues had been discussed in item 4.4.

4.2 Integrated Performance Report

Mrs Cope presented the report and advised that ED performance was poor overall and that the team had begun to record the amount of time patients were in the department and if any harm was occurring.

Mrs Cope advised that a thematic review would be undertaken linked to the turnaround time of ambulances and any Serious Incidents reported as a result. The Trust was the busiest receiving single site ED in the region with approximately 150 ambulances per day. Full capacity protocol had been running for the last 6 months which was impacting on turnaround times. This was being compounded by delays in discharges with patients who were fit to leave the hospital.

Mrs Cope advised that the Trust was working with Push Doctor which was a Skype type system where patients who met the criteria could access a GP from home. Work was also ongoing around Same Day Emergency Care and Ambulatory Care. ED attends had reduced slightly but Mrs Cope expressed her concern about the bed base and not holding patients unnecessarily.

Mrs Cope advised that there had been 1 patient waiting 52 weeks and this had been declared. The waiting list volume was on track and holding.

Mrs Stern stated that patients on the waiting lists would feel comforted by learning that they would not come to any harm and how this could be communicated. Mrs Cope advised that harm reviews were being undertaken and work with the clinicians was ongoing.

The new Cancer metric (28 day) was performing well at 81% against the national standard of 90%. The Intensive Support Team had been invited to review the upper and lower GI pathways.

Mrs Cope added that GP referrals for 2 week waits had increased overall and the new Lung Health check initiative was underway which was good news for Hull and the Trust.

Resolved:

The Committee received and accepted the report.

4.3 Quality Report

Mrs Geary presented the report and highlighted the Never Event that had occurred relating to wrong site surgery in December 2019. She advised that this brought the total to 7 Never Events for the year to date. Mrs Geary reported that a Never Event learning session with presentations from consultants had been held and this had generated good discussions.

Mrs Geary advised that there had been 5 Serious Incidents declared in December 2019.

Mrs Geary advised that she had met with the new relationship manager at the CQC and would be meeting on a monthly basis in preparation for the inspection.

Mrs Geary also state that she was attending a 'Moving to Good' event on 30th January 2020. The Trust had been buddied with Leeds Teaching Hospital.

The new Serious Incident Committee was working well and recommendations made following investigations were being shared in the organisation.

Dr Purva advised that NHS I had visited the Trust to review application of the WHO Checklist and compliance with policy. Mr Hall expressed his concern regarding the few members of staff not feeling empowered to stop the line. Dr Purva advised that statistically the Trust was performing well and only 1 of the 7 Never Events was due to not stopping the line.

Mrs Geary advised that the report from the NHS I visit would be made available to the Committee along with the action plan.

MP/BG

Resolved:

The Committee received and accepted the report.

4.5 Mortality - Learning from Deaths

Dr Purva presented the report to the Committee. The report provided a summary of mortality statistics for quarter 3.

Resolved:

The Committee received and accepted the report.

4.6 NHS Improvement Visit to Theatres – January 2020

This item was discussed in the Quality Report item 4.3. It was agreed that the report and any actions following the visit would be shared with the Committee.

MP

Resolved:

The Committee received and accepted the report.

5.1 Serious Incidents – Lessons Learned – Themes and Trends

Mrs Southgate presented the report and advised that there had been 2 completed investigations last month.

Resolved:

The Committee received and accepted the report.

6.1 Board Assurance Framework

Ms Ramsay presented the BAF and advised that the report had been updated following the Committees held in December 2019. She also advised that she had met with the Executive leads to discuss any gaps in assurance or mitigating actions. The report also recommended the quarter 3 risk ratings which would be discussed and agreed at the Board. The recommendation for quarter 3 was that the risks remained the same, although there had been a number of improvements in some areas which might result in the risk ratings decreasing in quarter 4.

Mr Hall asked that more narrative be included in BAF 4 relating to the cancer standards and how time impacted on patients. Mrs Cope agreed and suggested there should be more assurance around harm when patients are waiting longer for treatment which could affect their quality of care.

Resolved:

The Committee received and accepted the report.

6.2 Safeguarding Children Referrals

Mrs Geary presented the briefing paper which responded to a question by the Committee relating to the reduction in referral rates. The conclusion of

the paper showed that the Trust was not an outlier. Work was ongoing with external partners and agencies to ensure the Trust was in line with the appropriate level of referrals.

Resolved:

The Committee received and accepted the briefing paper.

6.3 Operational Quality Committee Summary

Dr Purva presented the summary and advised that there had been issues around the Admin Hubs and how long it was taking to produce patient letters. A review of this had highlighted the amount of time clinicians were taking to complete and sign off letters which was adding to the timescales. Good progress had been made to this area and it was thought that the teams would be back on KPI trajectory by the end of February 2020.

Resolved:

The Committee received and accepted the summary.

7 Any Other Business

Mr Hall raised the Trust's amputation rates that had been reported in the Media. He advised that the Trust was at the high end of the amputation rates. Dr Purva advised that Emma Hardy MP was involved with this issue and wanted more funding for the service which was stretched due to poor health regarding diabetes and smoking in the local area. The Vascular team was reviewing working more closely with York and NLAG to ensure the resources were in place as there was a lack of clinicians in this field.

Mrs Geary advised that the CQC would be inspecting the Trust's Forensic Unit and the PIR had been received for the Use of Resources inspection.

Mrs Geary also stated that the Trust was reviewing the Public Health guidance and recommendations relating to the Coronavirus.

8 Chairman's Summary to the Board

The Chair of the Committee agreed to summarise the key points to the Board.

9 Date and Time of the next meeting:

Monday 24th February 2020, 9am – 11am, The Committee Room, Hull Royal Infirmary

**Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 27 January 2020**

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr S Hall	Non-Executive Director
	Ms C Ramsay	Director of Corporate Affairs (minutes)
	Mrs B Geary	Chief Nurse
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Representative
	Mrs K Southgate	Acting Deputy Director of Quality Governance
	Dr M Purva	Chief Medical Officer
	Mrs T Cope	Chief Operating Officer (from item 4.3)

In Attendance: Dr Sharon Fan Clinical Leadership Fellow in Patient Safety

No	Item	Action
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1. Apologies

Apologies were received from Prof Julie Jomeen, Non-Executive Director

2. Declarations of Interest

There were no declarations made.

3. Minutes of the previous meeting 27 January 2020

These were accepted as an accurate record

3.1 Matters Arising

There were no matters arising from the minutes.

3.2 Action Tracking List

The Committee reviewed the tracker and it was agreed both open actions on the tracker could be closed.

3.3 Any Other Matters Arising

There were no other matters arising.

3.4 Workplan 2019/20

The Workplan was reviewed by the Committee. Ms Ramsay confirmed that the Committee was up-to-date with the cycle of business and all scheduled items had been received.

4. Increase the rate of harm-free care each year

4.1 Quality Improvement Plan

Mrs Southgate presented this report. She noted the detailed presentations on nutrition and the deteriorating patient received at the last meeting. The QIP for 2020-21 will be prepared on the basis of the Quality Account priorities and will include the feedback from the imminent CQC inspection when received.

Mr Hall asked about a comment in one of the Quality Improvement Projects in that it stated that the milestones have been achieved but there was not full evidence to support the progress that this had made. Mr Hall reflected that it appears that these are complex projects that concern clinical outcomes/improvement and people, which are more difficult to design than quantitative projects, but projects should have clear goals and measures.

Mrs Southgate and Ms Geary were in agreement. Ms Geary stated that discussions have started around how projects are designed and measured, and taking a quarterly stock-take to ensure that measures continue match the improvement required. Ms Geary is seeking to implement these sorts of process changes for the 2020-21 Quality Improvement Programme.

Prof Veysey noted that the completion of the Matrons' Handbook this month gave better evidence on the position on nutrition and the deteriorating programme, as well as other QIPs, but the accurate data would suggest that there is still some work to do on improvements in these QIPs. Other Committee members agreed.

Dr Purva confirmed that clinical audit work has demonstrated that patients with higher NEWS scores have the correct actions taken. Ms Southgate confirmed that the feedback from the CQC is regarding patients with lower NEWS scores and being able to demonstrate that appropriate action is being taken for those patients against the Trust's policy. The QIP is designed around making improvements in this area.

Dr Purva suggested that further sub-sector analysis is undertaken; Ms Geary confirmed that this has been added through the Fundamental Standards audits, with a new standard on Recognise and Respond. These data can be collated as an evidence source.

Ms Ramsay noted that there are two principles around the QIP that are being rightly challenged by the Committee; one is the standard of care against the relevant Trust's policy and whether this is improving; and the second is how well the QIP as a project is managed; rightly there is challenge in to this process, to ensure the measures are well-designed and getting ahead of the programme for next year to ensure there are more frequent checks on the process of the QIP.

Prof Veysey asked about the current position on pressure damage; Mrs Geary responded that there has been some increase in pressure damage and two Serious Incidents very recently declared. As a result, Mrs Geary is setting up a task and finish group to look at organisational responses and an organisation action plan on common issues with pressure care and how to improve these across the organisation.

Mr Hall asked if the issue about stocks of pressure mattresses had been escalated in the organisation. He also noted that the organisation has an infrastructure in place to support good skin care and asked what the underlying issues are in respect of skin damage.

Mrs Geary gave an explanation of the factors that affect why patients' skin breaks down and is affected by different aspects of clinical care. Mrs Geary is asking for a year-end review on each QIP, including what has been achieved and what remains outstanding, and a thematic review of what has happened; this will help provide more evidence around the challenge of where pressure ulcers are occurring, how quality of care can improve by being more precise about where to target a response and improvement. Mrs Stern agreed with this approach; she shared some of her own patient experience that reflects good care and training in some areas, but some times where risks of pressure damage have been identified but not

addressed.

Mr Hall noted that the organisation is being effective in picking up patients who are admitted with pressure damage; Ms Geary confirmed that she will be taking discussions to commissioners on the Trust's evidence base with this area.

Prof Veysey commented that the programmes are designed to intervene early, prevent deterioration and harm and measure improvement. In response to a question from Dr Purva, Ms Southgate confirmed that the current root cause analysis figure is correct and reflects an increase in volume of pressure ulcers reported.

Ms Ramsay suggested a referral from Quality Committee around capital resource to mattresses availability, decontamination and storage. Work is being undertaken to quantify what is required and will lead well in to next year's capital allocation and the Quality Committee would have a role in referring the issues to the Performance and Finance Committee, who receive updates and the minutes from the Capital Resource Allocation Committee, from the point of view that the Quality Committee is aware of a clinical risk relating to capital and equipment and would recommend that this is taken up by the Performance and Finance Committee. Mr Hall agreed to take this issue to tomorrow's Performance and Finance Committee.

SH

Mr Hall noted that the design of this particular QIP on pressure damage has shown particular progress, in that the organisation is reporting what it should in line with the new national definitions of pressure damage, and is being transparent about patient care and patient harm.

Mrs Green asked how the additional capital that has come to the organisation can be used for areas where there is increasing risk, such as pressure-relieving mattresses. Ms Ramsay clarified the current position and the ability of the Quality Committee to refer issues relating to care and capital funds to Performance and Finance Committee.

The Committee reviewed each QIP and individual comments were answered. Mrs Geary noted as an overall action that she is looking at developing an organisational strategy next year on the care of individuals with learning disabilities, mental health needs and dementia. Mrs Geary is also looking at an improvement plan, which may not need to be a QIP, on complaint responses.

4.2 Integrated Performance Report

Ms Ramsay raised that the IPR and exception reporting is being reviewed, and will come to the Quality Committee for input. The updated version will include SPC as well as narrative around what the metrics particularly performance measure mean in respect of patient care. Mr Hall gave an example of the exception reporting at PAF that provides more of the quantitative narrative on exceptions and the relationship between performance and quality of care.

Dr Purva noted the work that Dr Fan is undertaking on reviewing patients in ED at time the Trust was at OPEL 4; the reviews are considering whether there was any patient harm at the time of highest organisational pressure.

Mr Hall noted that the Friends and Family Test (FFT) for the scores overall remain positive and do not follow national trend, which is declining. The specific ED FFT however is a decreasing score, at a time that performance is also decreasing. Dr Purva noted the impact that this sustained level of pressure is having on staff, which is reflected in staff survey results. Dr Green noted that a King's Fund report that has just been published from the staff survey that reflects this situation.

Mrs Cope joined the meeting at this stage

4.3 Quality Report

Mrs Geary noted that the Trust has declared an eighth Never Event, which was a wrong site nerve block. Ms Geary noted also that the interim Nurse Director in Medicine Health Group has undertaken a deep dive on some aspects of quality of care; as a result, circa 9 historic Serious Incidents will be declared in medicine.

Mrs Geary noted that the Trust has received a Section 29a notice from the CQC regarding the Sexual Assault Referral Centre and whether the level of forensic cleaning is adequate. This is being responded to and Ms Geary gave further detail on this.

Mrs Geary gave a detailed overview of the latest 'Moving to Good' session attended by Ms Geary and other senior colleagues, which focussed on governance and there were some useful points of learning.

Mr Hall asked if there were any data regarding Never Event frequency; Dr Purva will provide this. Ms Ramsay emphasised the value of the Never Event definition and investigation process, which is to help the organisation to challenge internal systems and processes and how these keep patients safe, or what can be done where these have not been followed.

MP

Mrs Cope gave explanation of the response submitted to the CQC last week regarding follow-up backlogs. Some areas have made significant progress in reducing their backlogs and some areas have further work to do. The paper includes the Trust's harm review process and in what situations these are triggered, which Prof Veysey asked about. This paper will be circulated.

Mrs Cope spoke to a report received over the weekend; the Trust has been offered external validation of the Trust's PTL, which has been taken up. The report states that the Trust has an accurate PTL in the main and the particular issue is that waiting list volumes are significant. This will need a different conversation with the Trust's commissioners about managing the size of the waiting list, given that the external validation has confirmed that the waiting list is correct and the waiting list volumes are real. Mrs Cope will raise this at Performance and Finance Committee tomorrow.

TC/RT

4.4 WHO Checklist and SSIPs

Dr Purva presented this report, which detailed the feedback from the NHS I peer review and the actions being taken. The checklist and audit process have been updated and an updated checklist is being introduced from 1 April 2020. An intensive piece of support work will be starting alongside this for 4 weeks, to re-train circa 600 staff and audit against the new checklist. The Trust has consulted with the LNC on the Stop the Line Policy and made changes for staff who persistently do not uphold the WHO checklist process,

in order to better support staff who raise concerns and attempt to 'stop the line'.

Mr Hall asked about feedback after completion of the audit, and how consistently this is being done, which was captured numerically in the report. Dr Purva agreed and this was also picked up by NHSI, and is included on the action plan. The feedback will be given to the speciality governance meetings as well as fed back in theatres. Data will also be shared in theatres as to which theatres are performing well on the audits to create an incentive to improve. The transparency of the data has improved and is available to all staff through the Trust's business intelligence system.

Mr Corral asked about the list of procedures undertaken outside of theatre and how this captures different staff undertaking the same procedure. Dr Purva confirmed that this list was a process to confirm what procedures are undertaken outside of theatres and to confirm that there is a checklist applicable to each procedure. Mr Corral will confirm the procedures he is aware of with the project lead.

DC

5. Increase the average length of time between serious incidents, including never events

5.1 Serious Incident Report

Mrs Southgate presented this report. Prof Veysey raised that there were two Sis involving results from chest x-rays. Mrs Southgate confirmed that the circumstances are different and was not a failure of the Trust's safety net system. One was around an error in the x-ray report itself and the other was around a clinician understanding the safety net system alert.

Mr Hall raised that the actions for the Serious Incident involving a patient's body appeared to be comprehensive and was assured by this, and would encourage this level of action planning.

6. Received for Assurance/Review

6.1 Board Assurance Framework

Ms Ramsay outlined the process for the year-end position, in to which the Committee has the opportunity to input at this meeting and the next Committee meeting. There will be a at the Board Development session in March 2020 to consider the key risks against the Trust's strategic objectives for next year's Board Assurance Framework, so asked all to consider their input in to this. Ms Ramsay confirmed that the new Trust Board Workforce, Education and Culture Committee would provide oversight of the BAF risk relating to Research and Innovation.

6.2 Operational Quality Committee Summary

This summary was received and accepted; there were no queries or concerns relating to it.

7. Any Other Business

Mrs Cope gave an detailed overview on the current situation with Wuhan novel Coronavirus (Covid-19). Daily Gold Command meetings were in place when the first patient cases were identified in the UK; these Gold Command meetings are currently scheduled three times per week in HUTH.

The Trust is well prepared and clinical teams have responded very well to the first clinical presentations and the changing definition of Covid-19. The

Trust has a robust pathway in place, which has been tested, for patients calling 111 and being transported to the Infectious Disease ward for screening. This pathway also includes patients presenting at ED, ventilated patients, paediatric patients, and the process for the use of the Pod that has been installed.

Mrs Cope is expecting a further geographical definition change due to the cases seen in Italy, Iran and Turkey.

Work is underway with partner organisations about home screening, as it is looking likely that this global outbreak will affect people for a prolonged stretch of time. From the Trust's perspective, Mrs Cope confirmed that Covid-19 has required a significant amount of work and the Trust's teams have responded extremely well, as have NHS trusts nationally. It is not known what some of the longer-term impacts on service provision and supporting activities might be. This will be closely monitored.

8. Chairman's Summary to the Board

Nothing new to add to this; the key points are the referral to the Performance and Finance Committee around capital to support mattress provision, the review process for the QIP and seeing the outcome of the updated WHO Checklist/SSIPs checklist and audits.

9. Date and time of next meeting

Monday 30 March 2020, 9.00 am – 11.00 am, The Committee Room, HRI

**Hull University Teaching Hospitals NHS Trust
Workforce, Education and Culture Committee
28 February 2020**

Present:	Prof J Jomeen	Non-Executive Director (Chair)
	Mr T Moran CB	Chairman
	Mr S Nearney	Director of Workforce and OD
	Mr M Howell	Director of Communications
	Mrs J Ledger	Deputy Chief Nurse
	Miss H Cattermole	Director of Medical Education
	Mrs L Vere	Head of Organisational Development

In Attendance:	Mrs R Thompson	Corporate Affairs Manager
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No	Item	Action
	<i>Mr Moran chaired the meeting until Prof Jomeen arrived</i>	

Mr Moran welcomed everyone to the inaugural meeting of the Committee and stated that it had been established as our workforce was our most important asset and how well we lead them and value is key to delivering quality patient care. Workforce issues had previously been within the remit of the Performance and Finance Committee (PAF) but the breadth of business it covered risked workforce and education issues not being fully considered as in the future.

He added that the financial aspects of this committee's business would still fall within the remit of PAF and that whilst Mr Nearney would no longer be a member of PAF he would need to attend for those items relevant to workforce and education.

- | | | |
|----------|---|-----------|
| 1 | Apologies:
Apologies were received from Mrs Geary, Chief Nurse and Dr Purva, Chief Medical Officer who were on related workforce and education business in India. | |
| 2 | Declarations of interest
There were no declarations of interest received. | |
| 3 | Minutes of the last meeting
As this was the first meeting there were no minutes to approve. | |
| 4 | Matters Arising
As this was the first meeting there were no matters to consider. | |
| 5 | Action Tracker
As this was the first meeting there were no actions to approve. | |
| 6 | Workplan
Mr Nearney presented the Workplan and advised that it was a draft and would be subject to changes. A few minor date changes were required and Mrs Thompson agreed to update the workplan for the next meeting in April 2020. | RT |

7 Board Assurance Framework

Mrs Thompson presented the paper and advised that the report would be received regularly by the Committee to review the risks directly and indirectly linked to the meeting. The Committee members were asked to highlight any gaps in assurance or give any positive assurance they thought should be captured in the document.

Mr Nearney highlighted BAF 6 – Research and Innovation and advised that research and clinical trials would be brought to the Committee in June 2020 to be discussed further.

Resolved:

The Committee received and accepted the report.

Prof Jomeen joined the meeting and took over as Chair

8 8.1 Job Vacancy Report

Mr Nearney presented the report and advised that the Trust vacancy rate was at 13.8% as of December 2019.

There was a discussion around filling vacancies and Mrs Ledger advised that vacancies would be filled where possible with bank and agency staff but there were some specialities that were very difficult to fill.

The Committee discussed issues around radiology and moving their premises to make way for a new decant ward. Mr Moran asked whether our handling of communications could have been managed to deliver a better engagement with those impacted as he had picked considerable unhappiness. Mr Nearney advised that the funding for the extra ward had come from NHS I at short notice and the Trust had been instructed to spend the money as soon as possible. Plans were in place to restore communications and resolve the issues but accepted we should take some learning from this.

Mr Nearney reported that the Trust's sickness rate was below the national average and the Junior Doctor fill rate was relatively good at 94% as was registered nurses. The pressure areas were ED, radiology and speech therapy. Mr Moran wanted to open dialogues with NLAG to discuss hard to recruit to posts and the possibility of sharing resource. Mrs Ledger advised that this work had already been started with the lead midwives from both Trusts communicating on issues such as recruitment.

Prof Jomeen was keen to keep the work between the University of Hull and the Trust relating to recruitment and training going to ensure the trainees were being placed in all areas including the complex ones. Mrs Ledger also mentioned the new roles such as the Nurse Associates to ensure fill rates were maximised.

Resolved:

The Committee received and accepted the report.

8.2 Variable Pay Report

Mr Nearney presented the report and advised that at Month 10 the Trust had spent £26.4m on variable pay. The good news was that agency and bank usage were reducing. This however, meant that overtime was

increasing.

The Trust was £3.5m overspent on pay budgets and agency spend was slightly above the capped rate. The majority of agency spend was on consultant pay. Mr Moran asked how the Trust benchmarked with other Trusts and Mr Nearney advised that data was shared with NLAG and York but better benchmarking would come through the model hospital statistics.

Mr Nearney advised that Surgery and Medicine Health Groups had both seen a reduction in variable pay since last year but Family and Women's and Clinical Support Health Groups had seen an increase. ED was the only department where the capped hourly rates were not working due to pressure to fill the rota gaps.

Mr Moran asked if the Trust was heading in the right direction and was performance sustainable and Mr Nearney said that vacancy rates were on a reducing trend and Mrs Ledger added that she was working with ward sisters to ensure the correct controls were in place.

There was a discussion around the Corporate Directorates and their overtime figures and Mr Nearney explained that the increases were due to overtime and agency in the Patient Admin hubs. He advised that this should balance itself out. Mrs Ledger suggested that a finance lead could attend the meeting in future to ensure the finance issues were covered.

Resolved:

The Committee received and accepted the report.

8.3 Nursing and Midwifery Staffing Report

Mrs Ledger presented the report that had been received at the Trust Board in January 2020.

Mrs Ledger advised that the report now followed the required new format for reporting safer staffing metrics around the Care Hours Per Patient Day methodology.

The Trust still remains in the lower 25th Quartile with a peer median of 8.7 CHPPD against the national median of 8.0. With regards to the Quality and Safety metrics the Trust continues to perform well against both peers and national performance.

Further work is required to manually check the posts against rotas to ensure the electronic system is aligned. Mrs Ledger advised that from a harm point of view there was nothing untoward to report.

Recruitment and retention were showing positive results with Trainee Nurse Associates, Student Nurse Apprenticeships and Health Care Support Worker Apprentices all completing their programmes throughout 2020/21.

There was a discussion around how rotas were being managed and Mrs Ledger advised that all staff got involved with the rota policy and the Band 7s were dealing with specific issues.

Mr Moran asked about the Midwifery Team and cross referred to the staff survey which was showing more negative responses for this area. Mrs

Ledger advised that the Health Group were working through the issues that were related to culture rather than performance.

Resolved:

The Committee received and accepted the report.

8.4 Pension Return Update

Mr Nearney presented the report which highlighted that 54 consultants had reduced their hours due to the pension cap issues which had resulted in 79 PAs being lost.

The issue was a real challenge when consultants needed to see patients and not doing extra sessions. Miss Cattermole added that the DCC sessions had also been reduced which had an impact on education as consultants found dropping supervision the easiest route. Prof Jomeen added that dropping training sessions could have an effect on trainees wanting to join the Trust and their education placement expectations.

Resolved:

The Committee received and accepted the report.

9 9.1 National Staff Survey Results (Quarter 3)

Mr Howell presented the report and advised that it still remained the Trust ambition to be in the top 20% of organisations. He reported that the Trust measured engagement 4 times per year and the response rate in November last year was 3600 staff. Some organisations were reporting response rates of upwards of 60% so there was more work to do.

Mr Howell went through some of the questions that made up the 11 key themes and reported that the Trust was equal or better than the national scores in 8 of the 11 themes.

Quality of appraisal was the Trust's worst performance and work was ongoing to review this. The Bullying and Harassment score had moved ahead of the national average for the first time in around 6 years and other Trusts had contacted the Communications Team to determine what was being done differently to turn this score around.

Mr Howell reported that the Trust could now review each Health Group and service to see where the problem areas were.

There was a discussion around Cardiology and whether it would be useful to invite the service to the Committee to discuss their scores further. Mrs Vere advised that it was key to find out what the contributory factors were and to help the team understand the issues.

Mr Howell also mentioned Corporate Services, Estates and Finance and Business who had answered negatively. The Patient Admin teams had also been affected by the changes made in the Administration End to End review and this had come across in the survey. Miss Cattermole asked for the Patient Admin Team Hubs to be named rather than a number used for easy identification.

Mr Howell also highlighted that the overall result in relation to engagement whilst remaining the same as last year had bucked the national trend where

the top scores nationally had reduced and the lowest scores had fall further. For the trust to have remained stable is a very positive outcome.

Resolved:

The Committee received and accepted the report.

10 10.1 Flu Update

Mr Nearney presented the report and advised that 82% of staff had been vaccinated. He congratulated the volunteer vaccinators and gave credit to front line staff for ensuring as many people as possible were vaccinated.

Resolved:

The Committee received and accepted the report.

11 11.1 Medical Education Report

Miss Cattermole presented the report which highlighted the areas in which Health Education England where funding placements and what the money was being spent on.

Miss Cattermole reported that the Trust was still feeling the effects of the doctor's strikes but was better staffed than it had been. Sickness was being managed but sickness procedures could be more robust.

Exception reports from the doctors were being received generally around workload intensity and staying late.

There was a discussion around whether or not the Trust's establishment of doctors was correct and how robust standards for each area could be developed. The GMC Survey was attached at the appendix and Miss Cattermole advised that there were action plans in place for each department with red ratings. The response rate of the survey was 98%.

Mr Moran highlighted anaesthetics as an outlier and Miss Cattermole advised that the main concern in the department was due to pressure of work. Trainees were pulling out of sessions as they did not want to put unnecessary pressure on the Trainers. There was pressure on the department to cover the lists in place.

There was also pressure in the Cardio Thoracic team due to pressure of work. Mr Moran was keen to understand the standards in these areas and where the greatest risks were. Mr Nearney advised that he was working with Dr Purva to understand the number of doctors required to ensure patient safety.

Resolved:

The Committee received and accepted the report.

11.2 Apprenticeship Programme Report

Mr Nearney presented the report and advised that the Trust was spending its Apprenticeship levy and had £4.6m of commissioned programmes with 210 apprentices to date through the Trust. He added that another 89 were planned as well as more in the future.

Mr Nearney reported that apprenticeships were not necessarily linked to Band 2 roles, but that it was about the training programme in place for the

apprentice. Miss Cattermole added that there were also medical leadership apprentices in place.

Resolved:

The Committee received and accepted the report.

12 12.1 Leadership Programme Update

Mrs Vere presented the report to the Committee and highlighted the leadership initiatives that staff could access. Mrs Vere advised that the Be Remarkable programme was based around the work of Prof Michael West and the contribution that leadership makes to high quality care.

Mrs Vere highlighted the following programmes; Medical Leaders, Rise and Shine (for staff aspiring to be leaders), Great Leaders Bitesize, a BAME programme and level 3 Apprenticeships.

Mr Moran asked how the Trust evaluated the impact the programmes were having and Mrs Vere suggested bringing feedback from participants to the Committee.

LV

Resolved:

The Committee received and accepted the report.

13 Any Other Business

Terms of Reference

The Terms of Reference were received by the Committee.

Mr Moran agreed to clear the minutes due to Prof. Jomeen stepping down from the Trust. He thanked Prof Jomeen for her continued promotion of the links between the Trust and the University of Hull. Prof Jomeen thanked him and advised that her replacement would continue to work with the Trust.

Date and times of the next meeting:

Friday 17th April 2020, 1pm – 3pm, The Committee Room, Hull Royal Infirmary

Integrated Performance Report

2019/20

March 2020

January 2020 data

The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined by NHS Improvement.

Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

Variation

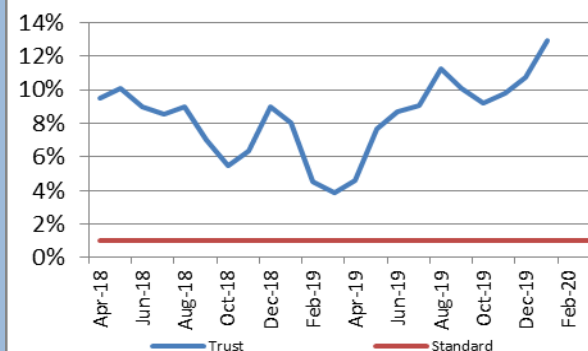
Diagnostic Waiting Times:

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 the target during January with performance of 12.9%

DIAGNOSTICS



Breaches in month were:

Magnetic Resonance Imaging	81
Computed Tomography	326
Non-obstetric ultrasound	3
Cardiology - echocardiography	24
DEXA Scan	1
Neurophysiology - peripheral neurophysiology	1
Respiratory physiology - sleep studies	2
Urodynamics - pressures & flows	5
Colonoscopy	410
Flexi sigmoidoscopy	1
Gastroscopy	271
Cystoscopy	68
Total	1193

Referral to Treatment Incomplete pathway

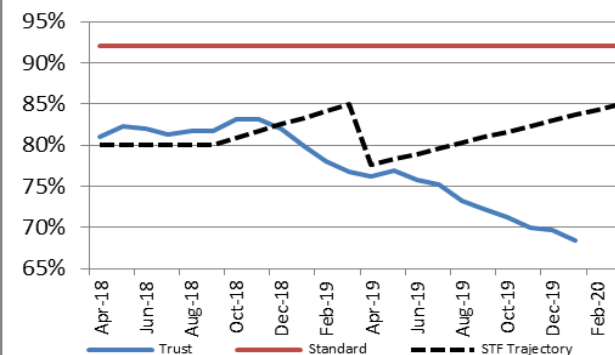
Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%

The latest confirmed position available is January.

The Trust failed to achieve the January improvement trajectory of 83.6%

January performance was 68.35%. This failed to meet the national standard of 92%.

INCOMPLETE PATHWAYS



The RTT return is grouped in to 19 main specialties.

During the month there were 15 specialties that failed to meet the improvement trajectory

Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

Variation

**Referral to
Treatment
Incomplete 52+
Week Waiters**

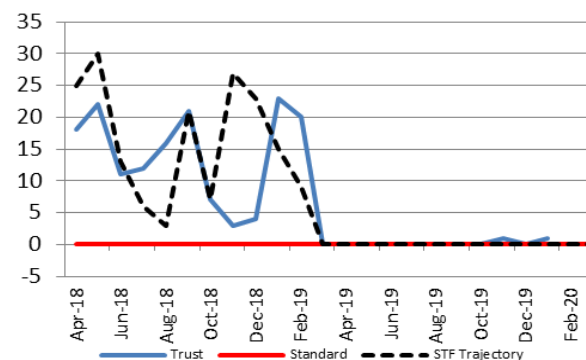
The Trust aims to deliver zero 52+ week waiters

The latest confirmed position available is January 20.

There was 1 breach reported during January this failed to achieve the improvement trajectory of zero breaches

The Trust failed to achieve the national standard of zero breaches.

RTT - 52 week wait



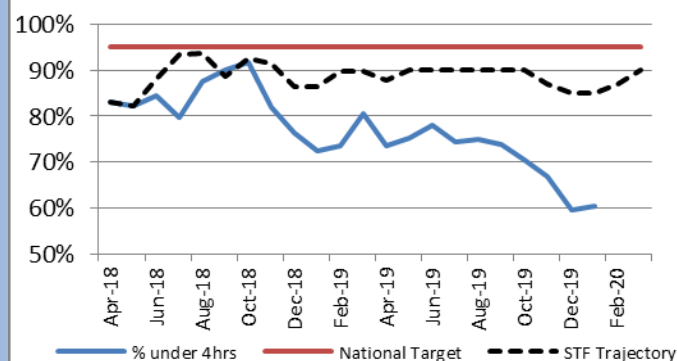
**ED Waiting
Times
(HRI only)**

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

Performance failed to achieve the planned trajectory of 85% with performance of 60.4% for January

This has failed to achieve the national 95% threshold.

EMERGENCY DEPARTMENT (TYPE 1 HRI ONLY)



Performance has increased 0.8% during January

Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

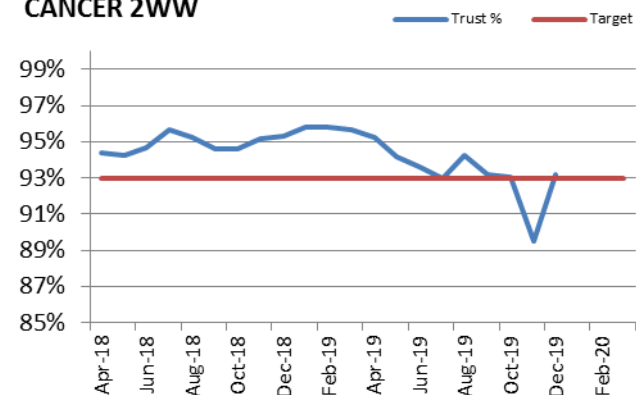
Variation

Cancer: Two Week Wait Standard

All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.

December performance achieved the 93% standard at 93.2%

CANCER 2WW

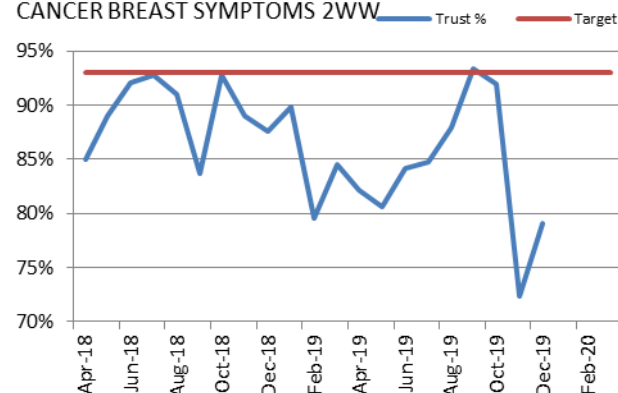


Cancer: Breast Symptom Two Week Wait Standard

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

December performance failed to achieve the 93% standard at 79.1%

CANCER BREAST SYMPTOMS 2WW



Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

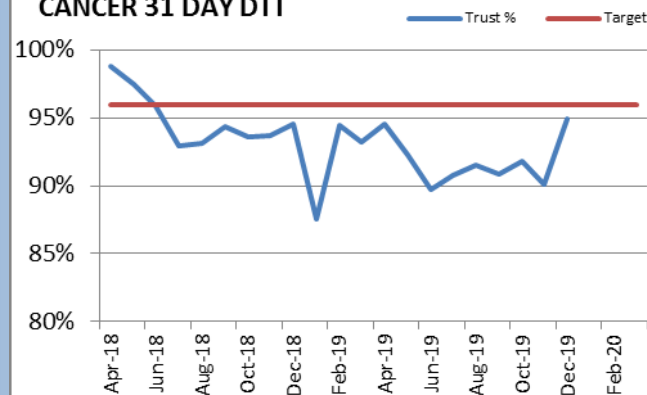
Variation

Cancer: 31 Day Standard

All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.

December performance failed to achieve the 96% standard at 94.9%

CANCER 31 DAY DTT

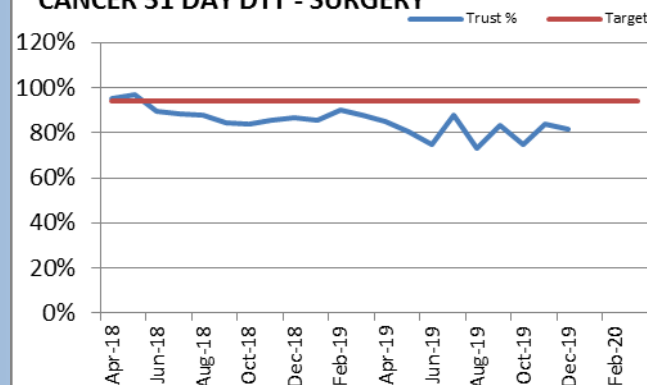


Cancer: 31 Day Subsequent Surgery Standard

All patients to receive first treatment for cancer subsequent radiotherapy within 31 days of decision to treat. Threshold of 94%.

December performance failed to achieve the 94% standard at 81.5%

CANCER 31 DAY DTT - SURGERY



Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

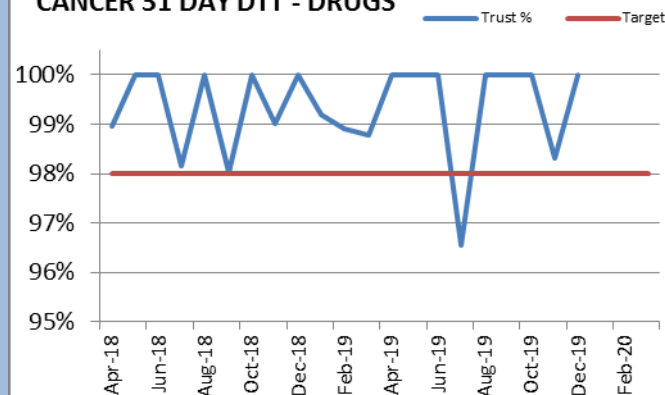
Variation

Cancer: 31 Day Subsequent Drug Standard

All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days of decision to treat. Threshold of 98%.

December performance achieved the 98% standard at 100%

CANCER 31 DAY DTT - DRUGS

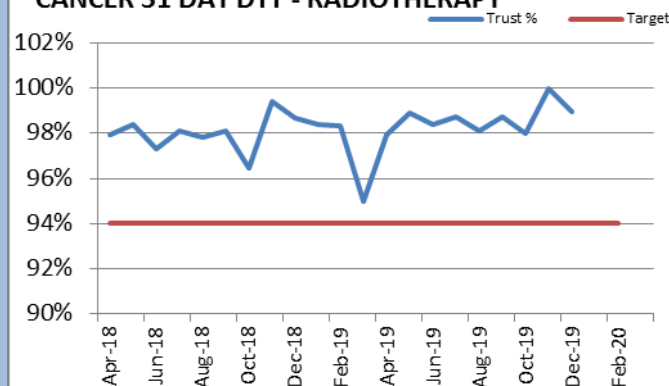


Cancer: 31 Day Subsequent Radiotherapy Standard

All patients to receive first treatment for cancer subsequent radiotherapy within 31 days of decision to treat. Threshold of 94%.

December performance achieved the 94% standard at 99%

CANCER 31 DAY DTT - RADIOTHERAPY



Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

Variation

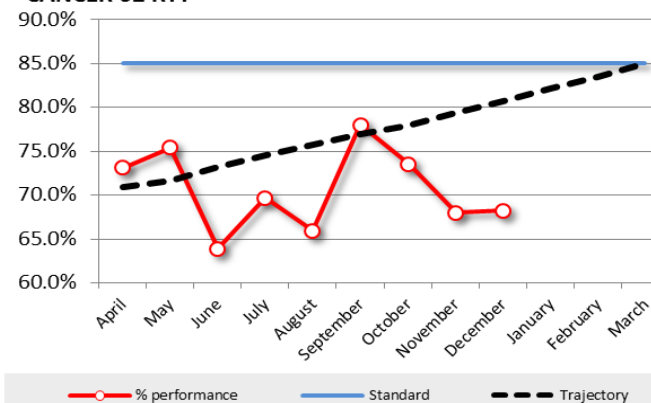
Cancer: 62 Day Standard

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

December performance failed to achieve the 80.7% improvement trajectory with performance of 68.2%.

Performance failed to achieve the national standard

CANCER 62 RTT

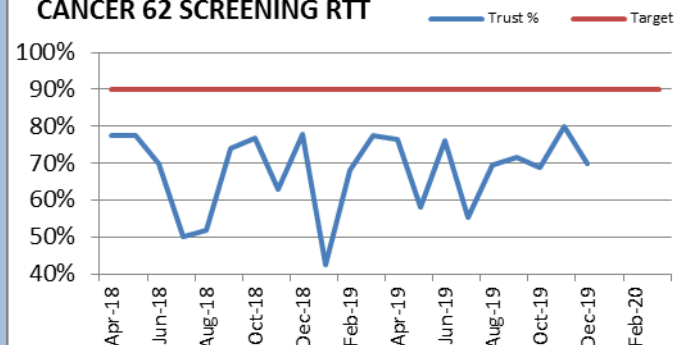


Cancer: 62 Day Screening Standard

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

December performance failed to achieve the 90% standard at 70.0%

CANCER 62 SCREENING RTT



Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

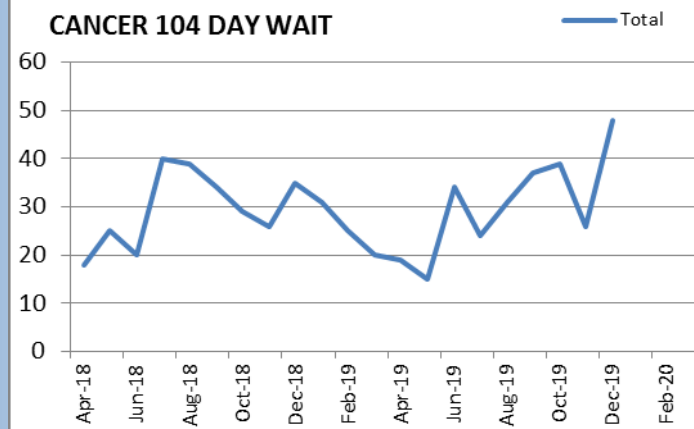
Variation

**Cancer: 104
Day Waits**

**Cancer 104 Day
Waits**

There were 48
patients waiting
104 days or over at
the end of
December

CANCER 104 DAY WAIT



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

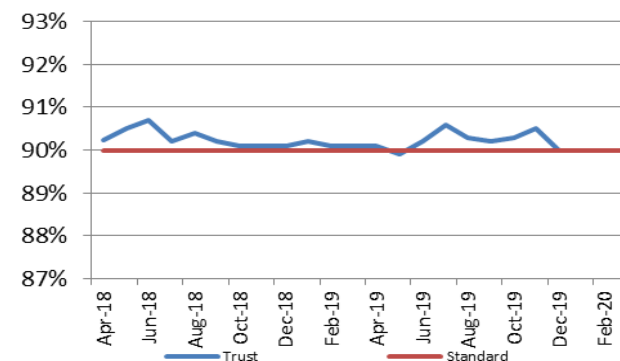
% of all patients asked
the dementia case
finding question within
72 hours of admission,
or who have a clinical
diagnosis of delirium
on initial assessment
or known diagnosis of
dementia, excluding
those for whom the
case finding question
cannot be completed
for clinical reasons.

The latest performance
available is December
2019.

The standard for this
indicator is to achieve
90%.

Performance for
December achieved
this standard at 90.0%

DEMENTIA: FIND



Integrated Performance Report

RESPONSIVE

Description

Aggregate Position

Trend

Variation

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

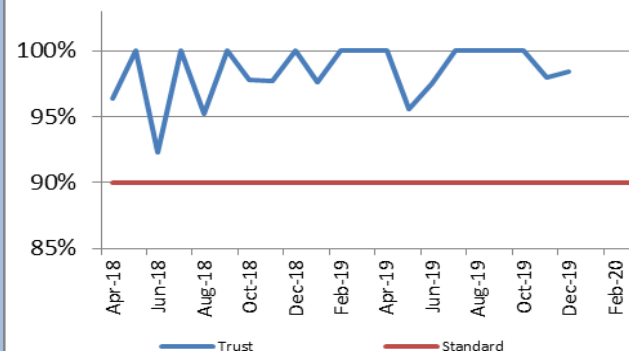
% of patients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations.

The latest performance available is December 2019

The standard for this indicator is to achieve 90%.

Performance for December achieved this standard at 98.0%

DEMENTIA: ASSESS/INVESTIGATE



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

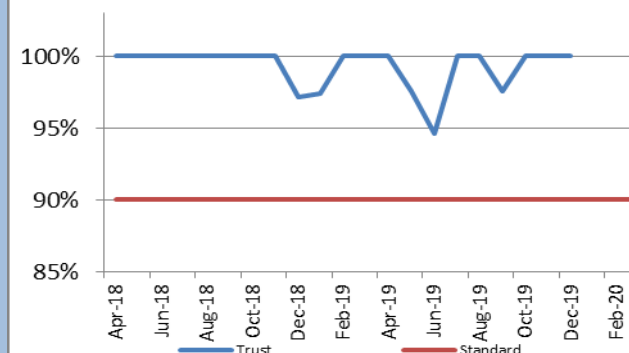
% of patients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.

The latest performance available is December 2019.

The standard for this indicator is to achieve 90%.

Performance for December achieved this standard at 100%

DEMENTIA: REFERRAL



Integrated Performance Report

SAFE

Description

Aggregate Position

Trend

Variation

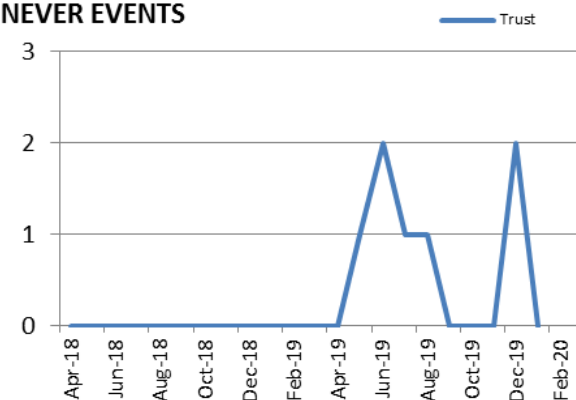
Occurrence of
any Never
Event

Occurrence of
any Never
Events

There have been 7
cases reported year
to date.

There were no cases
reported during
January 2020.

NEVER EVENTS



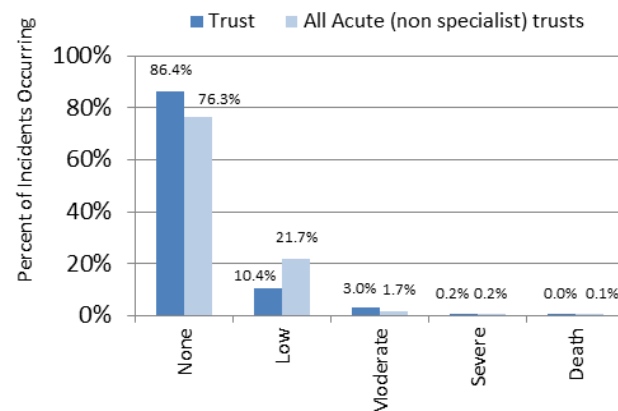
Further
information is
included in
the Board
Quality report

Potential under-
reporting of
patient safety
incidents

Number of
incidents
reported per
1000 bed days

The latest data available for
this indicator is October 2018
to March 2019 as reported by
the National Reporting and
Learning System (NRLS).

The Trust reported 8,585
incidents (rate of 50.75) during
this period. This rates the
Trust in the highest 25% of
reporters



Degree of
Harm:

None 7,417
Low 889
Moderate 259
Severe 18
Death 2

Integrated Performance Report

SAFE

Description

Aggregate Position

Trend

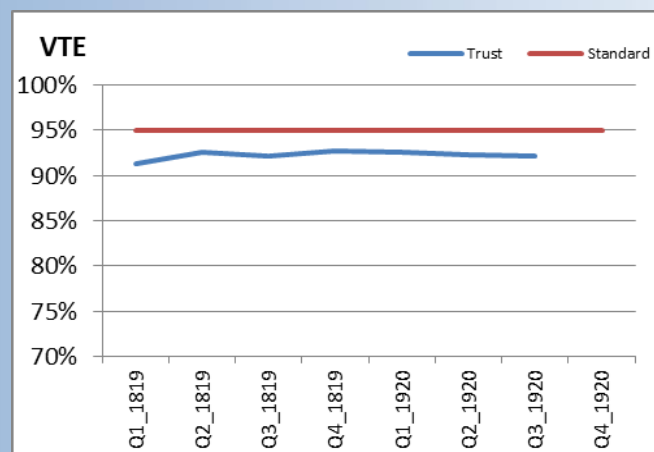
Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve the 95% standard with performance of 92.12% for Q3 2019/20.



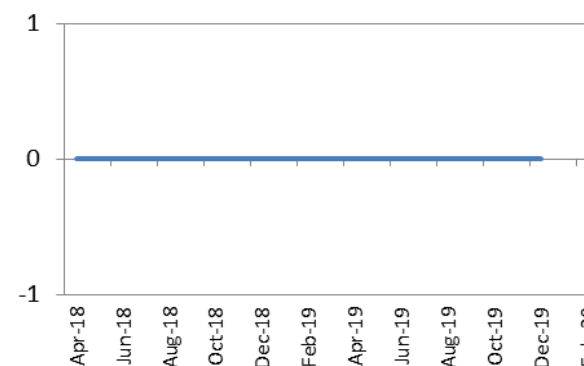
Patient Safety Alerts Outstanding

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

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

There have been no outstanding alerts year to date.

OUTSTANDING ALERTS



Integrated Performance Report

SAFE

Description

Aggregate Position

Trend

Variation

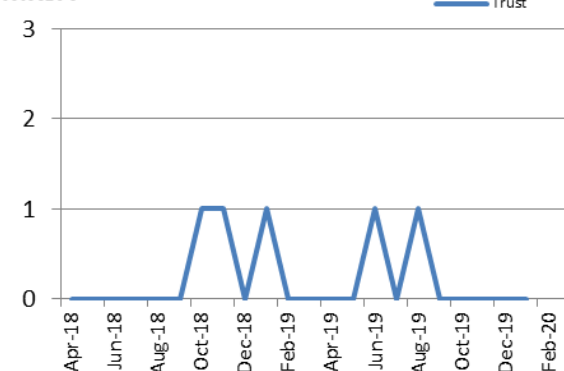
MRSA Bacteraemia

National objective is zero tolerance of avoidable MRSA bacteraemia

The Trust reported 3 cases of acute acquired MRSA bacteraemia during 2018/19.

There were no cases reported during January. There have been 2 cases reported year to date.

MRSA



Further information is included in the Board Quality report

Clostridium Difficile

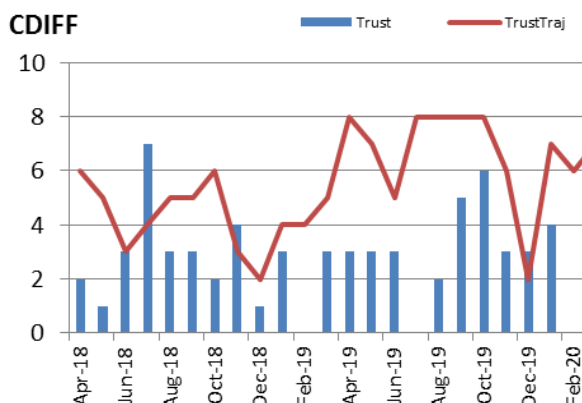
The Clostridium difficile target for 2019/20 is no more than 80 cases

There were 32 cases during 2018/19

There were 4 cases reported during January which achieved the monthly trajectory of no more than 7 cases

Year to date position is 32 cases against the trajectory of no more than 67 cases.

CDIFF



Further information is included in the Board Quality report

Integrated Performance Report

SAFE

Description

Aggregate Position

Trend

Variation

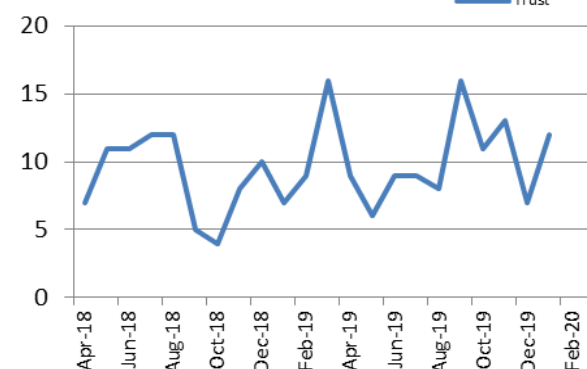
Escherichia
Coli

Number of
incidence of
E.coli
bloodstream
infections

There were 112 cases
during 2018/19

There were 12 incidences
reported during January
2020.
There have been 100
incidences reported year to
date.

E.COLI



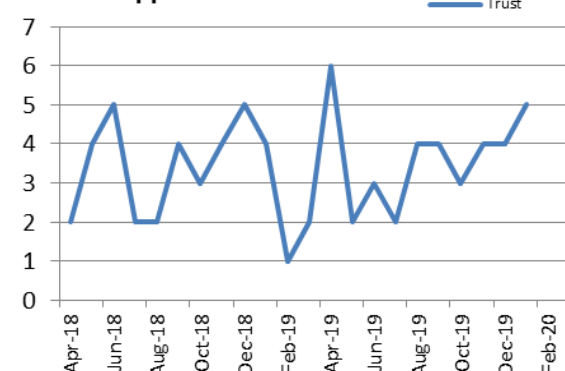
Klebsiella spp
bacteraemia

Number of
incidence of
Klebsiella spp
bacteraemia

There were 5 cases
reported during
January 2020.

There have been 37
incidences reported
year to date.

Klebsiella spp bacteraemia



Integrated Performance Report

SAFE

Description

Aggregate Position

Trend

Variation

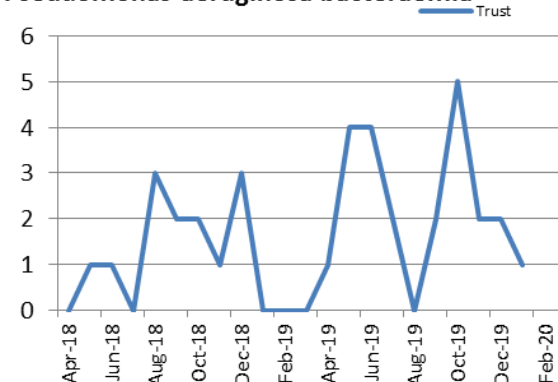
**Pseudomonas
aeruginosa
bacteraemia**

Number of
incidence of
**Pseudomonas
aeruginosa
bacteraemia**

There has been 1
incidence reported
during January 2020.

There have been 21
incidences reported
year to date.

Pseudomonas aeruginosa bacteraemia



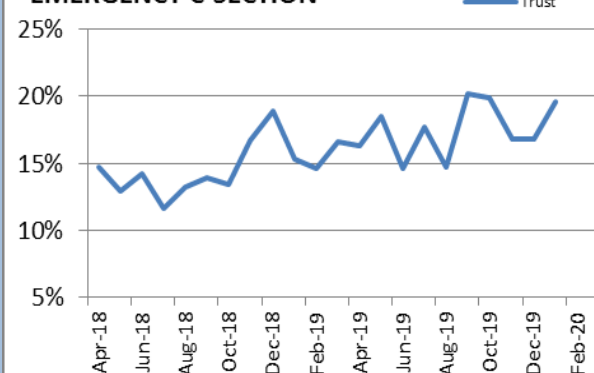
**Emergency C-
section rate**

Maternity:
Emergency C-
section rate per
month

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

Performance for
January failed to
achieve this standard
at 19.6%

EMERGENCY C-SECTION



Further information
is included in the
Board Quality
report

Integrated Performance Report

EFFECTIVE

Description

Aggregate Position

Trend

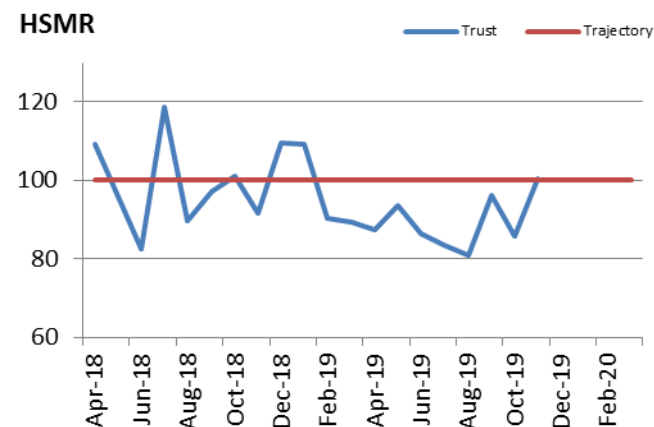
Variation

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

November 2019 is the latest available performance

The standard for HSMR is to achieve less than 100 and November failed to achieve this at 100.3

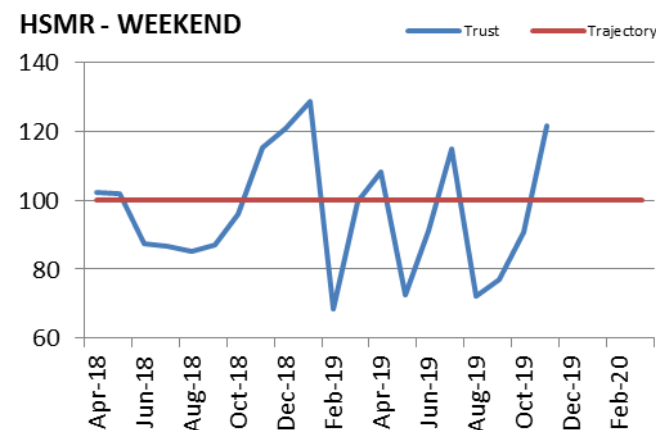


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

November 2019 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and November failed to achieve this at 121.4



Integrated Performance Report

EFFECTIVE

Description

Aggregate Position

Trend

Variation

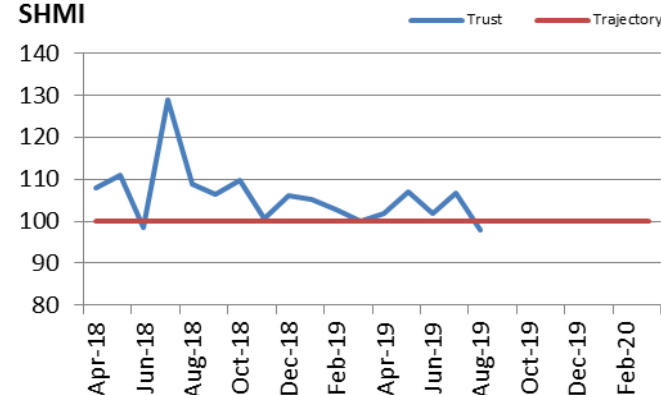
SHMI

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.

August 2019 is the latest published performance

The standard for SHMI is to achieve less than 100 and August achieved this at 97.8

SHMI



30 Day
Readmissions

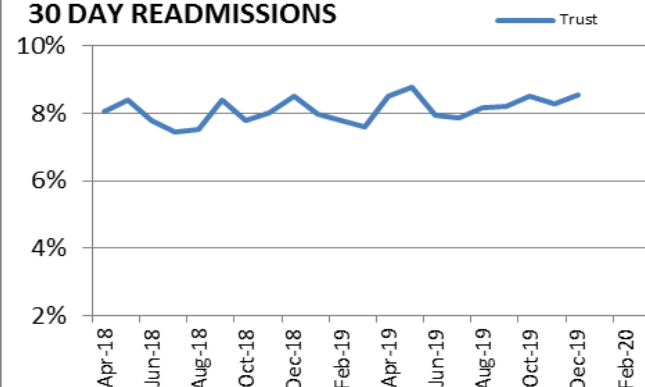
Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is December 2019

The Trust should aim to achieve less than or equal to 2018/19 performance of 7.9%.

The Trust failed to achieve this measure with performance of 8.53%.

30 DAY READMISSIONS



Integrated Performance Report

EFFECTIVE

Description

Aggregate Position

Trend

Variation

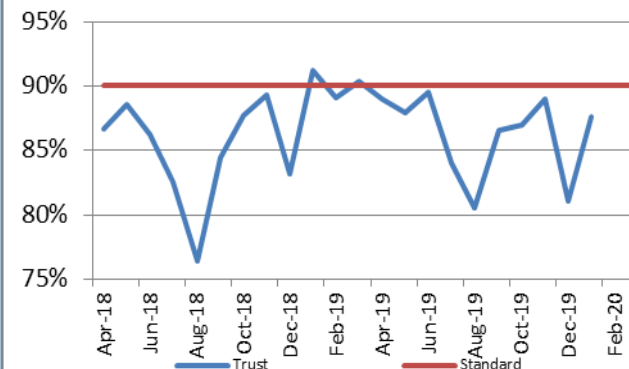
Theatre Utilisation

The % of scheduled session time which has been utilised. Calculation based on anaesthetic to time out of operating room.

The Trust should aim to achieve less than or equal to 90%

January failed to meet this measure with performance of 87.6%

THEATRE UTILISATION



Integrated Performance Report

CARING

Description

Aggregate Position

Trend

Variation

Inpatient Scores from Friends and Family Test - % positive

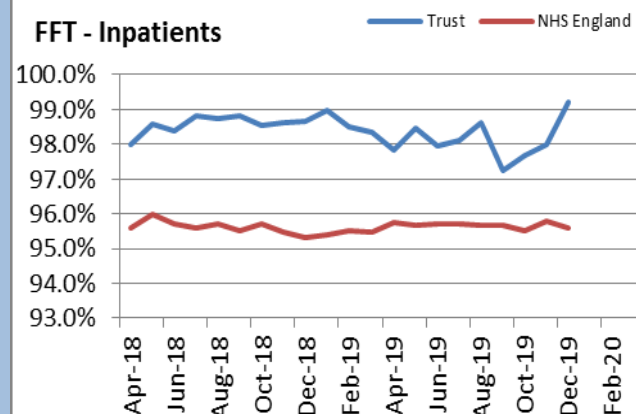
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

The latest published data for NHS England is December 2019.

Performance for December was 99.23%

January performance will be published in March.

FFT - Inpatients



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

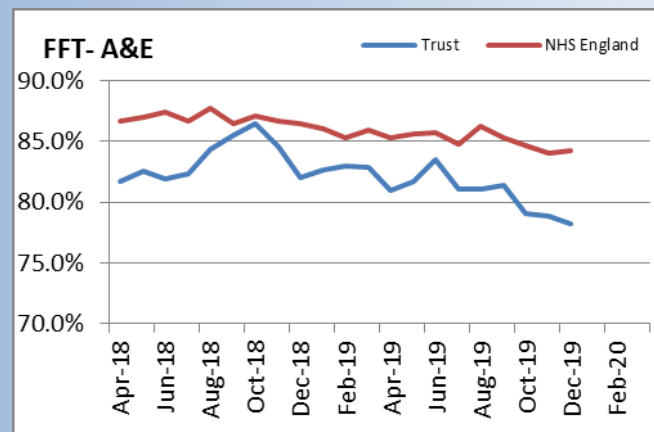
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

The latest published data for NHS England is December 2019.

Performance for December was 78.20%

January performance will be published in March.

FFT- A&E



Integrated Performance Report

CARING

Description

Aggregate Position

Trend

Variation

Maternity Scores from Friends and Family Test - % Positive

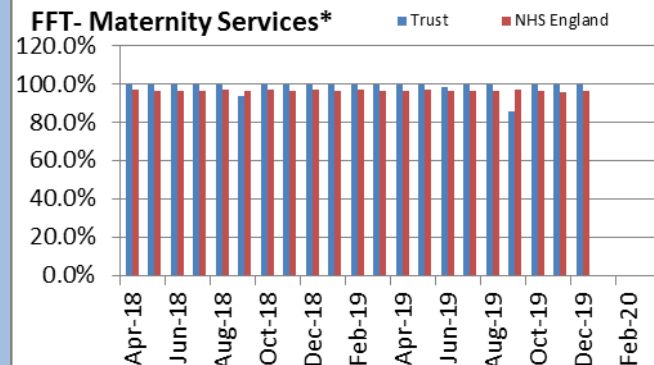
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

The latest published data for NHS England is December 2019.

Performance for December was 100%

January performance will be published in March.

FFT- Maternity Services*



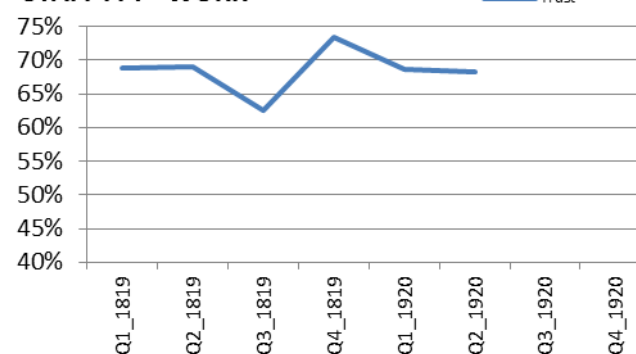
* Question relates to Birth Settings

Relative Position in Staff Surveys

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

Performance for Q2 shows 68% of surveyed staff would recommend the Trust as a place to work, this has decreased slightly from the Q1 position of 69%.

STAFF FFT - WORK



Integrated Performance Report

CARING

Description

Aggregate Position

Trend

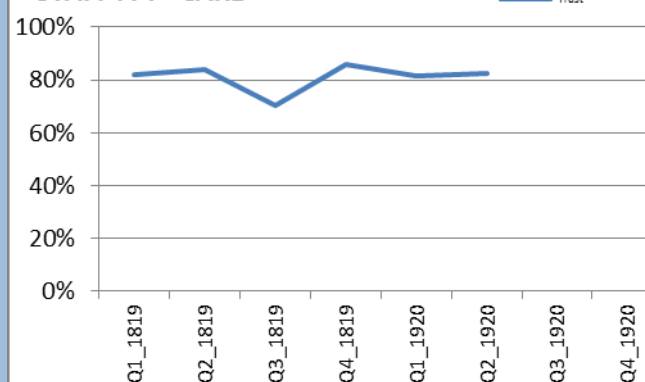
Variation

Relative
Position in
Staff Surveys

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

Performance for Q2 shows 82% of surveyed staff would recommend the Trust as a place to receive care/treatment, this has remained consistent with Q1 position

STAFF FFT - CARE

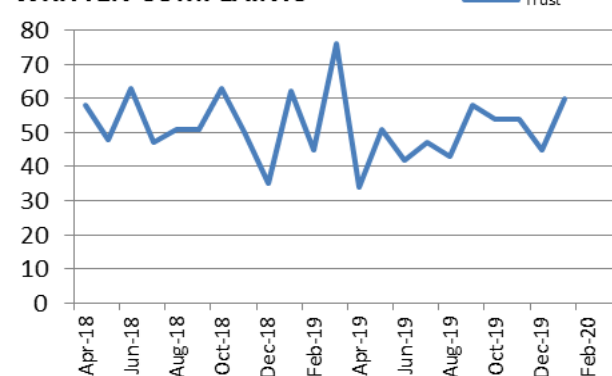


Written
Complaints
Rate

The number of complaints received by the Trust

The Trust received 60 complaints during January

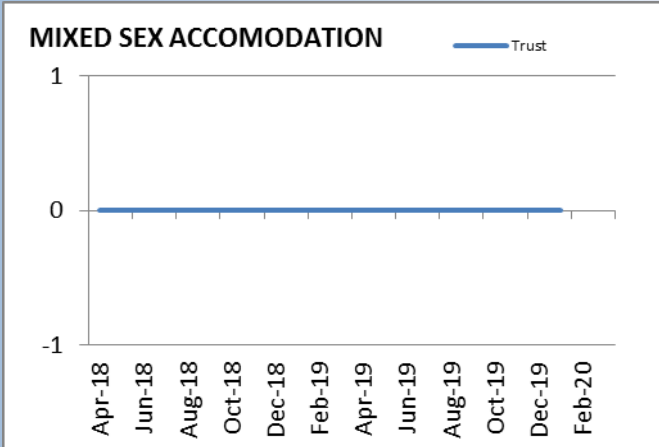
WRITTEN COMPLAINTS



There have been 488 complaints year to date

Integrated Performance Report

CARING

Description	Aggregate Position	Trend	Variation																										
<div>Mixed Sex Accommodation Breaches</div> <p>Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.</p>	There were no occurrences of mixed sex accommodation breaches throughout January 2020.	<div>MIXED SEX ACCOMODATION</div>  <table><tr><th>Date</th><th>Trust</th></tr><tr><td>Apr-18</td><td>0</td></tr><tr><td>Jun-18</td><td>0</td></tr><tr><td>Aug-18</td><td>0</td></tr><tr><td>Oct-18</td><td>0</td></tr><tr><td>Dec-18</td><td>0</td></tr><tr><td>Feb-19</td><td>0</td></tr><tr><td>Apr-19</td><td>0</td></tr><tr><td>Jun-19</td><td>0</td></tr><tr><td>Aug-19</td><td>0</td></tr><tr><td>Oct-19</td><td>0</td></tr><tr><td>Dec-19</td><td>0</td></tr><tr><td>Feb-20</td><td>0</td></tr></table>	Date	Trust	Apr-18	0	Jun-18	0	Aug-18	0	Oct-18	0	Dec-18	0	Feb-19	0	Apr-19	0	Jun-19	0	Aug-19	0	Oct-19	0	Dec-19	0	Feb-20	0	
Date	Trust																												
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Oct-19	0																												
Dec-19	0																												
Feb-20	0																												

Integrated Performance Report

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

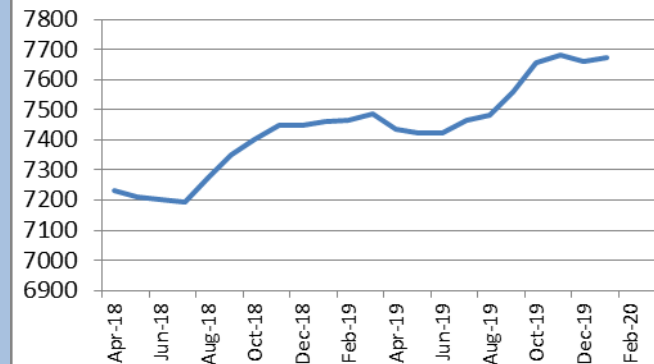
Variation

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 January was 7673

WTE in post

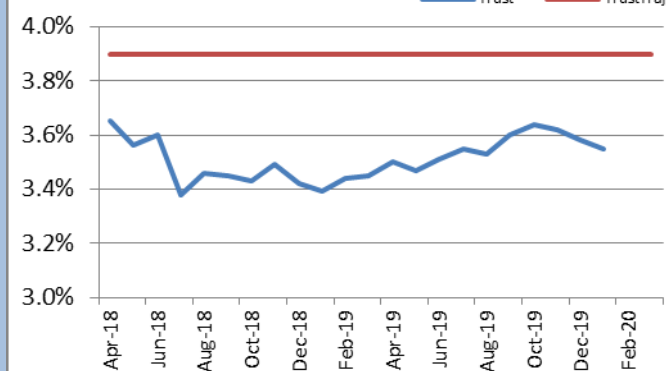


Sickness Absence Rates

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

Performance for January achieved the standard of less than 3.9% with performance of 3.55%

SICKNESS RATE



Integrated Performance Report

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

Variation

Executive Team Turnover

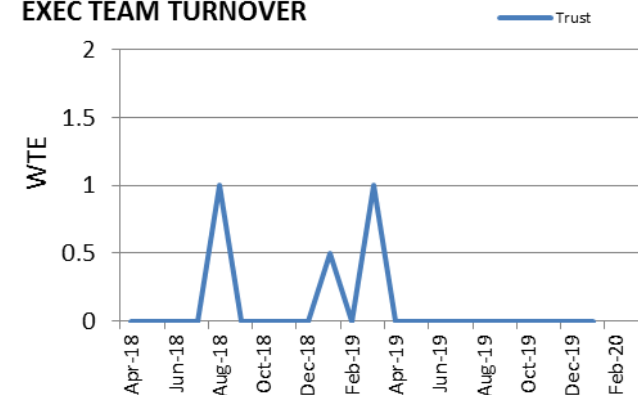
Trust Executive Team turnover

During August 2018 Kevin Phillips resigned as Chief Medical Officer, Kevin continues to undertake Clinical work.

During January 2019 Ellen Ryabov Chief Operating Officer left the Trust and in March 2019 Chief Nurse Director Mike Wright retired.

Turnover has been 0% for the Executive team during January 2020.

EXEC TEAM TURNOVER



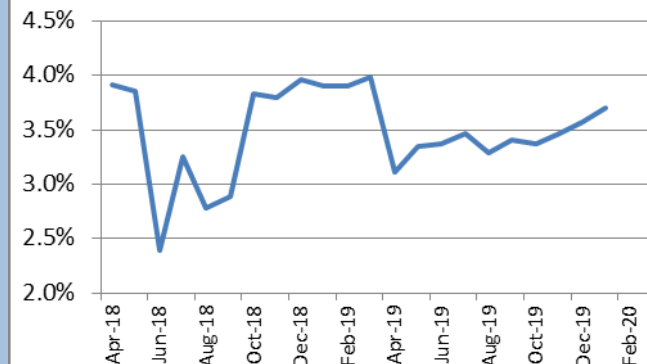
Proportion of Temporary Staff

% of the Trusts pay spend on temporary staff

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

January performance was 3.70%

TEMPORARY STAFF



FINANCIAL SUMMARY: 10 MONTHS TO 31st JANUARY 2020

1. At Month 10 the Trust is reporting a surplus of £7.9m (£1.0m surplus excluding PSF) in line with plan. This position is reliant on additional income from local commissioners totalling £2.2m. This in line with a year end agreement of the Trust receiving an additional £4.5m from system partners.
2. The Trust has estimated that the level of income delivered at month 10 is £8.7m above plan after accounting for the AIC (£0.9m adjustment). This is £2.3m above plan in month and was mainly due to pass through drugs of £1.3m, non electives £0.6m and specific allocations from Hull CCG for agreed investments such as lung health check, winter pressures, diagnostics and RTT risk. A year end deal has now been agreed with Specialist Commissioner in line with the Trusts outturn forecast as per its recovery action plan and removes the risk of further challenges to our forecast. This leaves the smaller CCG contracts and other areas of NHSE (screening, dental) as still to be agreed but reduces the income risk to the Trust.
3. Health groups/Corporate are reporting a gross overspend of £2.9m at month 10 which is a deterioration of £0.5m in month. Pass through drugs improved by £0.1m in month whilst Clinical Support Services Health Group remained broadly unchanged. All other Health Groups deteriorated by around £0.1m related to unidentified CRES. Corporate saw a deterioration of £0.1m related to an invoice for Pension Pay Controls.
4. The above position includes an under delivery in CRES to date of £1.2m, with £13.3m being delivered against a target of £14.5m. This is a shortfall of £0.6m against target in month. Expected delivery in last 2 months is £3.3m and current year end forecast is for delivery of £16.6m (88%) leaving a gap of £2.2m. There remains a small element of risk (£0.2m) in the forecast as health groups look to confirm final delivery.
5. The Trust has spent £8.9m on agency costs at month 10 which is £1.5m above the plan. This is a £0.6m increase in month reflecting the increased pressure on supporting winter. The forecast is currently to be £2.1m above the cap of £9.1m
6. The Trust is forecasting that it will deliver its financial plan in 19/20 following the agreement of another £4.5m of income from commissioners. However there still remains a risk in delivering this forecast based on potential for unexpected movements in Health Group positions. It is essential that Health Groups maintain a tight grip on expenditure in the final 2 months to ensure that the position is delivered. Surgery and Emergency Health Groups need to continue to move back towards the Month 8 forecast positions.
7. The reported capital position at month 10 shows gross capital expenditure of £13.9m compared with plan of £15m. The main areas of variance relate to slippage on IT and the radio-pharmacy development. The forecast position for capital expenditure remains at £33.7m. This assumes receipt of diagnostic imaging funding in March 20. This is now under review by NHSE/I and could be allocated over 2 years which will reduce this years forecast. The forecast is above the submitted plans in July due to the inclusion of notified PDC for winter capital £1.5m, HSLI £0.5m, imaging equipment £4.7m and cyber-security £0.4m. In addition the Trust has received confirmation of a temporary capital loan relating to the urgent and emergency care STP business case for £0.4m. This is in lieu of receiving the PDC once the full business case is approved. The delivery of the capital forecast requires circa £20m of expenditure in the final 2 months of the year and is therefore being closely monitored.
8. The underlying position has improved in month to a deficit of £9.3m in line with month 8, indicating that the month 9 deterioration was a temporary blip. Surgery (-£1.1m) and Family and Women's (-£0.2m) are the 2 Health Groups where the run rate has deteriorated in year and the pressure remains on both Health Groups to bring the underlying positions back below 19/20 opening levels.
9. **Next Steps/Actions**
 - a) Surgery and Emergency Health Groups need to return forecast positions to the Month 8 forecasts to improve the overall position.
 - b) Other Health Groups to retain tight grip on expenditure.
 - c) Surgery and Family and Women's Health Groups to identify solutions to move run rates back to 19/20 opening levels.

Integrated Performance Report

ORGANISATIONAL HEALTH

Description

Aggregate Position

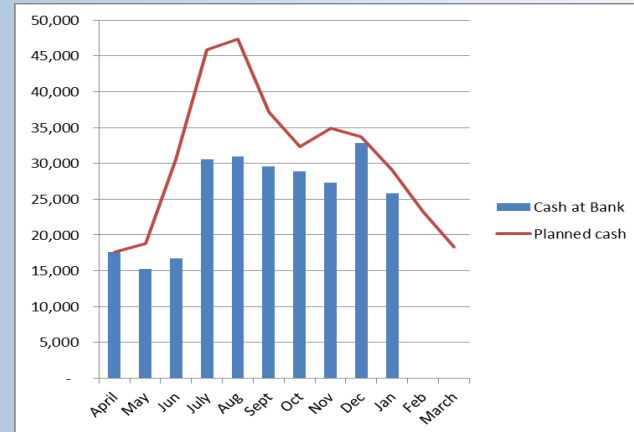
Trend

Variation

Cash Balance

Cash on deposit <3 months deposit

At the end of January we had £25.781m of cash and cash equivalents, comprising of monies in the bank of £25.764m and £0.017m in petty cash floats. The cash position remains stable and the availability of cash is reflected in our BPPC performance, which although lower than the required standard is good and constant. At £25.781m cash was slightly lower than planned as invoices are being processed quicker but we have a number of invoices in query, preventing payments to be made.

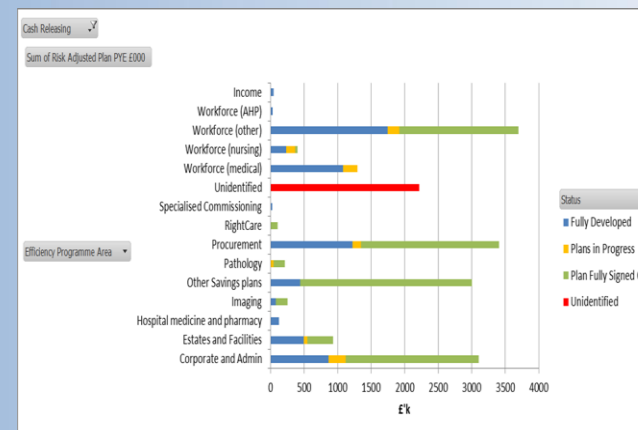


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

At month 10 the planned level of savings is £13.7m, the actual savings are £13.3m thereby creating a £0.4m adverse variance from the plan.

The chart shows an analysis of year to date CRES schemes that are being delivered in terms of fairly broad categories.



The target for the year is to save £19.9m, the Trust is expecting to deliver this target

Integrated Performance Report

ORGANISATIONAL HEALTH

Description

Aggregate Position

Trend

Variation

Risk Rating

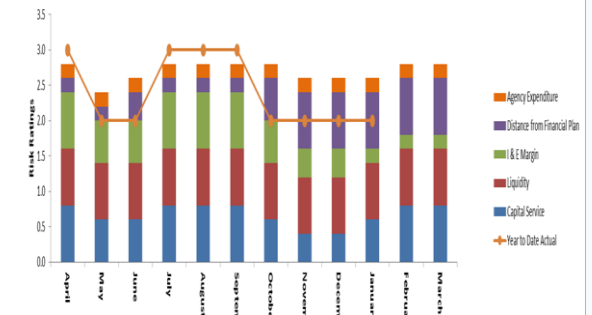
Financial Sustainability Risk Rating

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

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

As at month 10 the Trust is reporting a YTD surplus £7.86m against a planned position of £7.85m surplus. This has resulted in liquidity & capital cover being rated at a 3. I&E margin rated as 1 & , variance from financial plan & Agency rated as a 2. Giving an overall risk rating of 2.

2019/20 Risk Rating Analysis



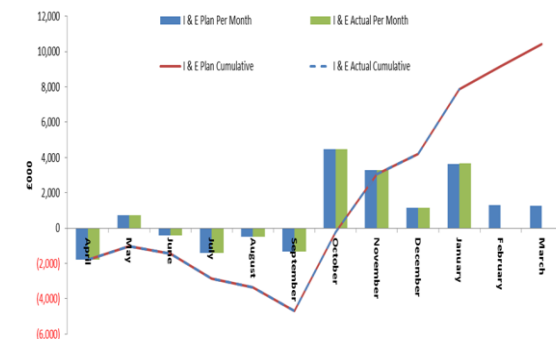
Income & Expenditure

Net income and Expenditure

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

As at month 10 the Trust has delivered a surplus of £7.86m against a planned surplus of £7.85m.

Net I & E Analysis 2019/20 by month



**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
QUALITY REPORT**

**PREPARED FOR THE TRUST BOARD
10th March 2020**

Title:	Quality Report
Responsible Director:	Beverley Geary, Chief Nurse
Author:	Kate Southgate, Acting Deputy Director of Quality Governance and Assurance

Purpose:	To provide assurance to the Committee on the progress being made against key clinical quality indicators including: Never Events and Serious Incidents; Incidents; Duty of Candour; Health and Safety; Clinical Audit; Claims, CQC and the Quality Improvement Programme.	
BAF Risk:	BAF 3 – Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	The report contains all key Quality metrics for the month alongside a focus update on SI themes.	

Recommendation:	It is recommended that the Trust Board receive this report for assurance and determine if further information is required.
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QUALITY REPORT

LEAD: Beverley Geary, Chief Nurse

PURPOSE OF THE REPORT

The purpose of this report is to provide information and assurance to the Trust Board and Quality Committee in relation to matters relating to quality governance indicators.

ITEMS FOR ESCALATION IN MONTH (January 2019)

Safe:

- A new Never Event in relation to Wrong Site Surgery was declared in February 2020
- The NHS Improvement WHO Checklist Peer Review feedback letter has been received. The actions from this visit have been incorporated into the Safety Standards for Invasive Procedures Committee.
- During January 2020 three serious incidents were declared
- Planned changes; the new Transition of Deprivation of Liberty Safeguards to Liberty Protection Safeguards (LPS) (appendix 1)

Effective:

- No areas of escalation within month.

Caring:

- No areas of reporting and escalation fall within this domain.

Responsive:

- It should be noted that a focus will place in Quarter 4 on new processes for learning from claims and links to the GIRFT programme.

Well-led:

- The CQC has commenced the inspection preparation with the Trust. The Trust has received and submitted the Provider Information Request and focus groups are being held week commencing 17th February 2020

RISKS TO DELIVERY

- The declaration of a 8th Never Event in the financial year has been noted as a risk within month.

Included in this month's report:

	SAFE	<ul style="list-style-type: none">• Never Events and Serious Incidents• Incident Reporting Rates and NRLS• Duty of Candour• Update on planned changes to DoLs
	EFFECTIVE	<ul style="list-style-type: none">• Clinical Audit
	CARING	<ul style="list-style-type: none">• None
	RESPONSIVE	<ul style="list-style-type: none">• Claims
	WELL-LED	<ul style="list-style-type: none">• CQC

SAFE

NEVER EVENTS AND SERIOUS INCIDENTS

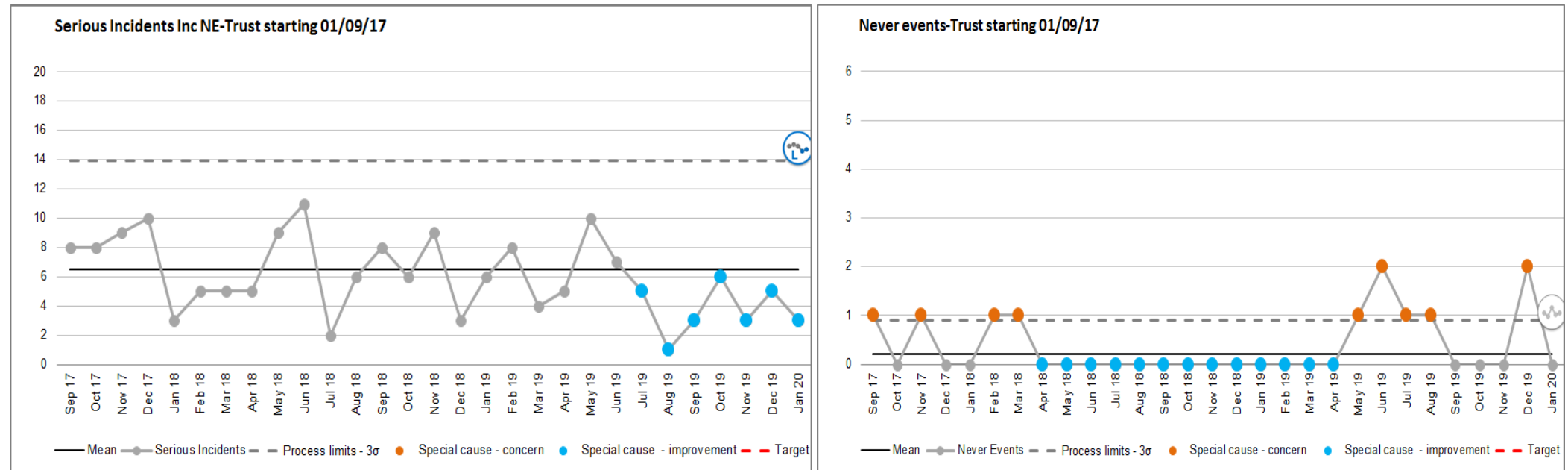
AREAS FOR ESCALATION

Declaration of 8 Never Events within 2019-20 to date. The 8th was declared in February 2020 and related to a wrong site surgery.

During January 2010 three serious incidents were declared, relating to an in-hospital fall, a surgical procedure and a hospital acquired pressure ulcer.

KEY UPDATES IN MONTH

The chart below indicates the trend in Never Events and Serious Incidents. 8 Never Events have been declared in 2019-20.



RISKS TO DELIVERY

Any serious incident is, by its nature, a significantly serious event where an investigation is required to establish if serious harm occurred, or if there is significant opportunities for learning to be identified. Each of the serious incidents declared in January will receive a robust investigation, and the findings of these will be shared throughout the organisation, after discussion and completion of the investigation report within the Trust Serious Incident Committee.

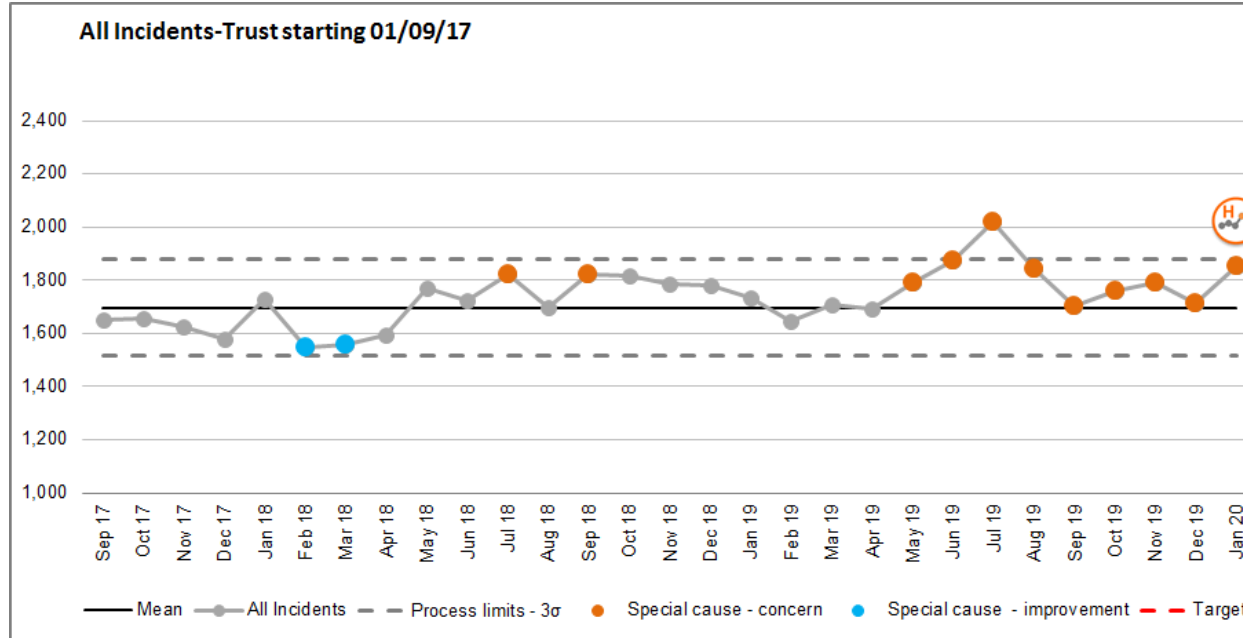
INCIDENT REPORTING RATES

AREAS FOR ESCALATION

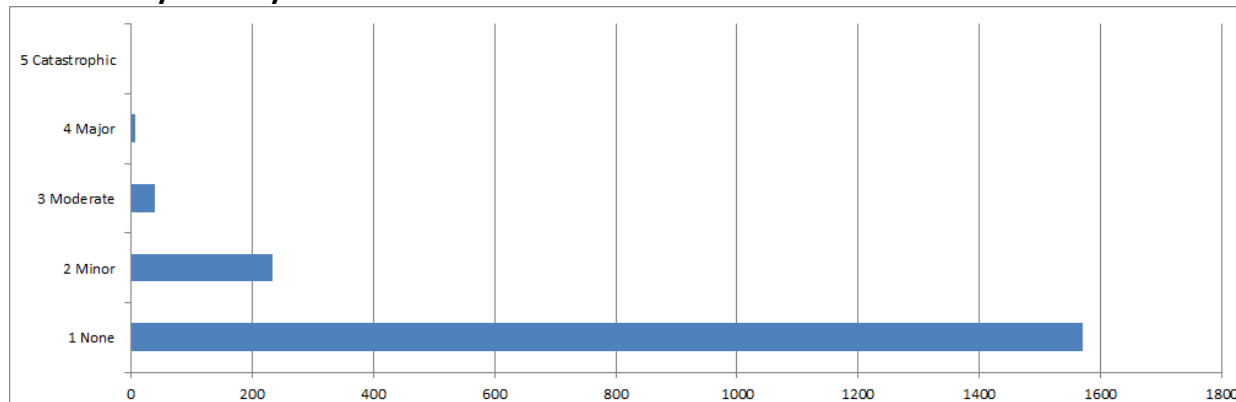
None to escalate this month.

KEY UPDATES IN MONTH

Incident Reporting Rates by Health Group: The number of incidents reported from May 2019 would appear to be an consistent positive reporting rate.



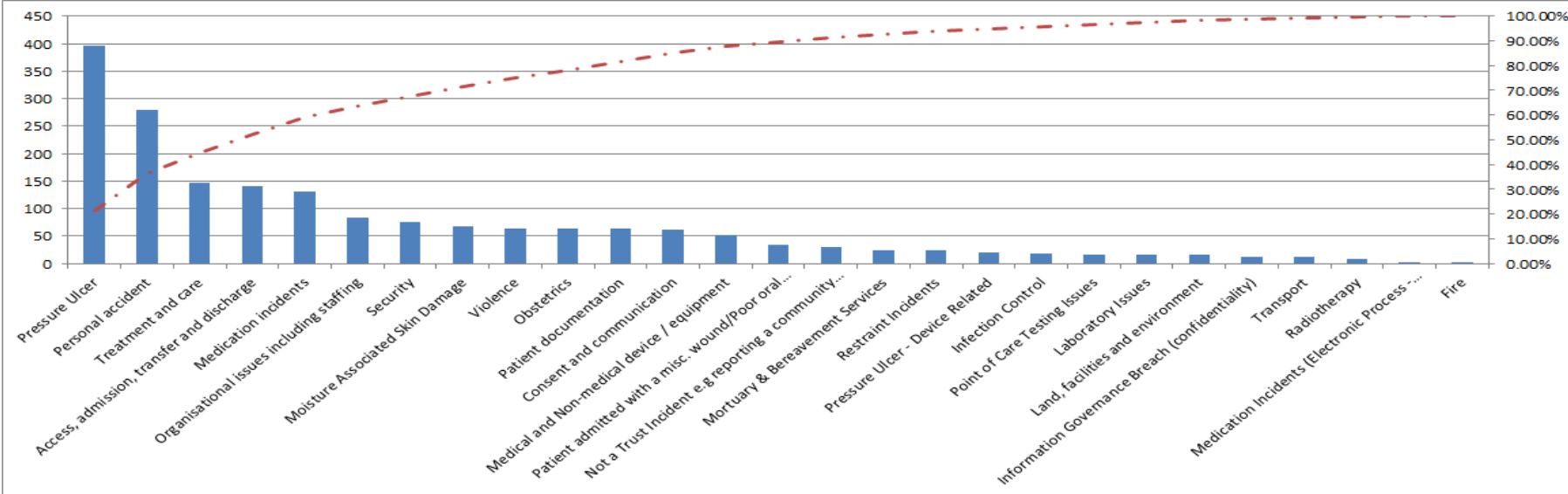
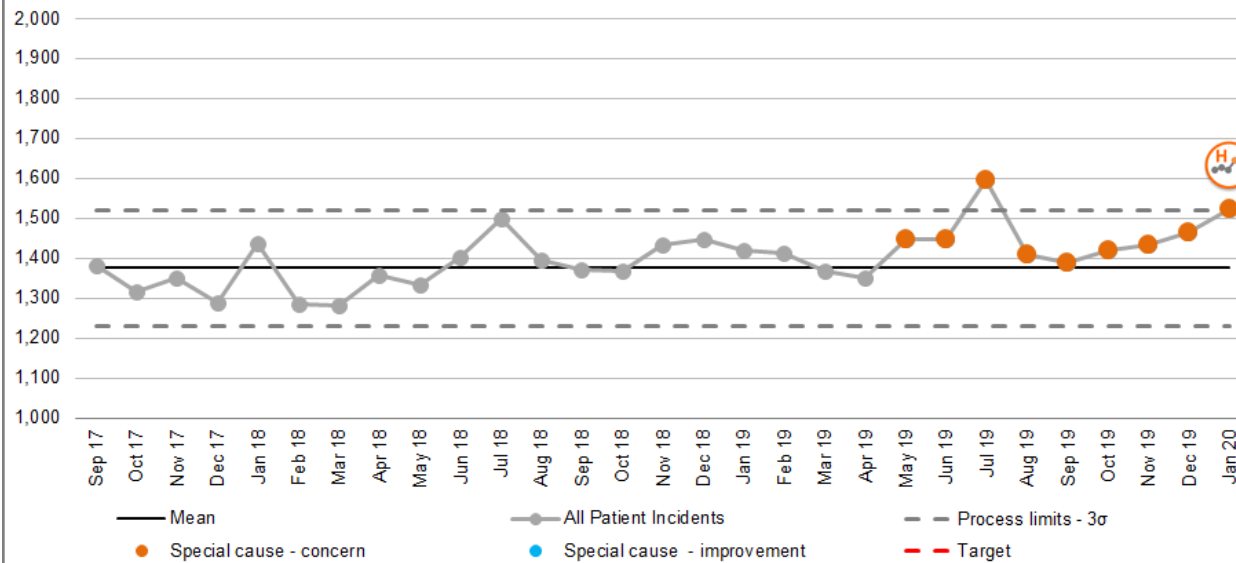
Incidents by severity



The severity of reporting rates remain consistent.

INCIDENT REPORTING RATES

All Patient Incidents -Trust starting 01/09/17



The Graph shows that the top five reported types of incidents account for around 50% of the total incidents reported. The top ten types of incidents reported account for around 80% of incidents reported (applying the pareto 80/20 rule).

RISKS TO DELIVERY

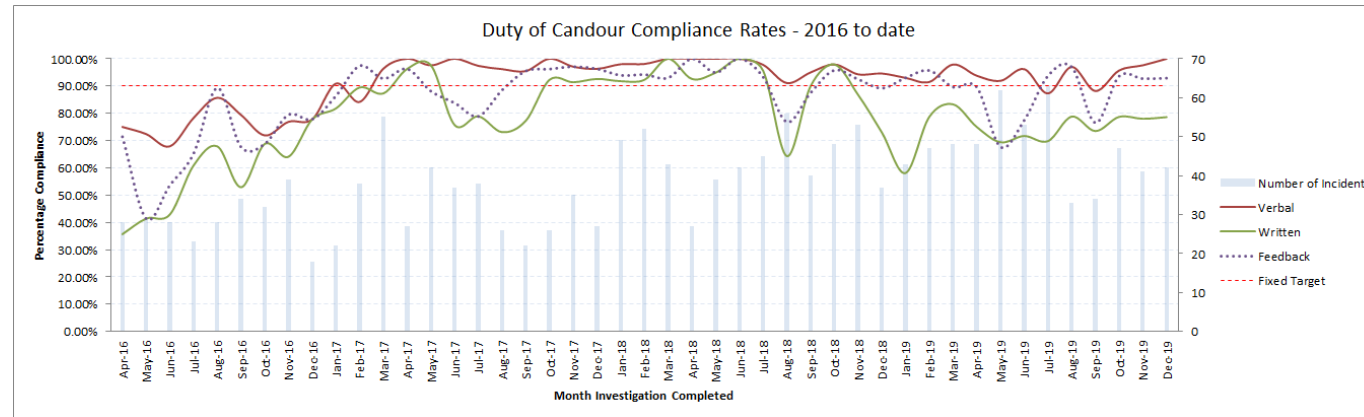
No risks to delivery have been identified within month.

DUTY OF CANDOUR

AREAS FOR ESCALATION

No items to escalate this month.

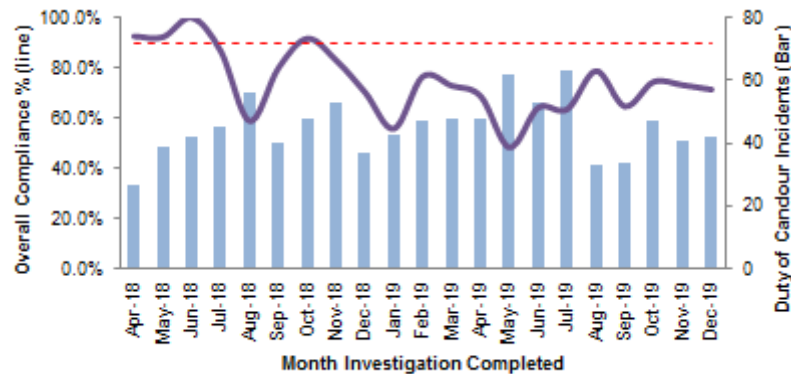
KEY UPDATES IN MONTH



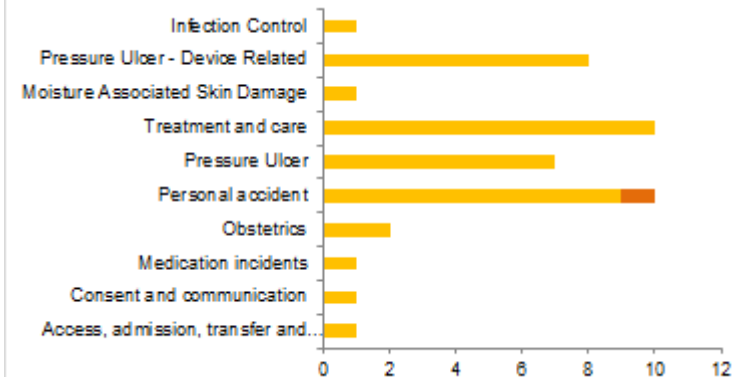
The Quality Governance Team continues to monitor the duty of candour process.

Incidents investigated in the last 12 month period with the compliance circles and types of incidents investigated– date remains one month behind to the time lag for completion of Duty of Candour.

Overall compliance for completed Duty of Candour incidents



Duty of Candour incident categories/severity



RISKS TO DELIVERY

No areas of risk identified, however, the Quality Governance Team continue to monitor the duty of candour process.

CLINICAL AUDIT
AREAS FOR ESCALATION
There are no areas for escalation in month.
KEY UPDATES IN MONTH
The Trust continues to comply with all requirements for national audits. Key learning has been identified in year and all requirements as outlined in the Quality Accounts have been adhered to.
RISKS TO DELIVERY
No identified risks to delivery.

RESPONSIVE

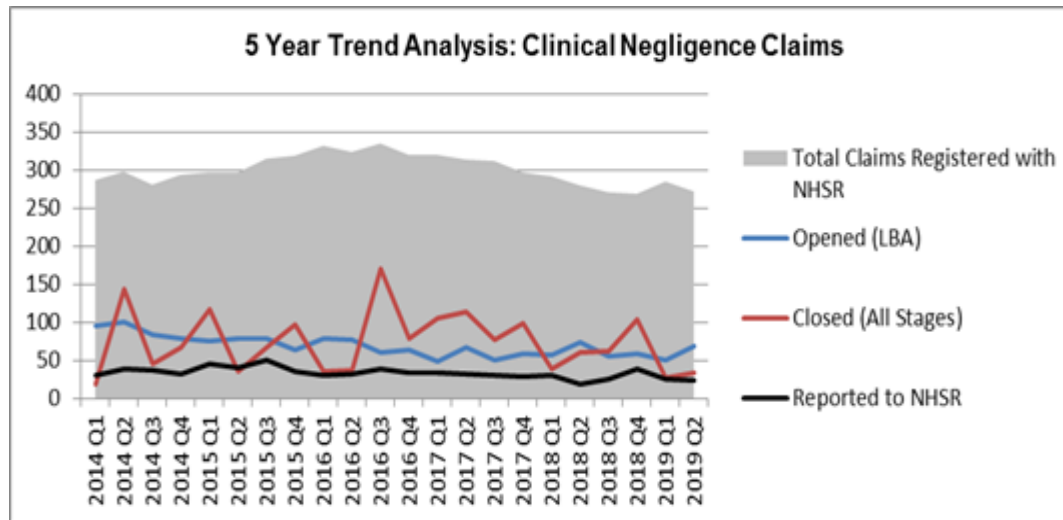
CLAIMS

AREAS FOR ESCALATION

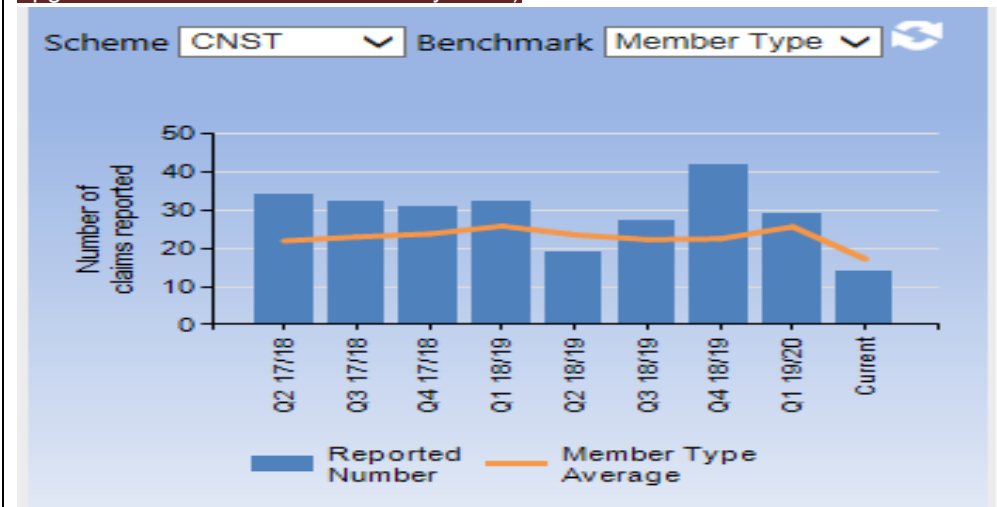
It should be noted that a focus will place in Quarter 4 on new processes for learning from claims and links to the GIRFT programme.

KEY UPDATES IN MONTH

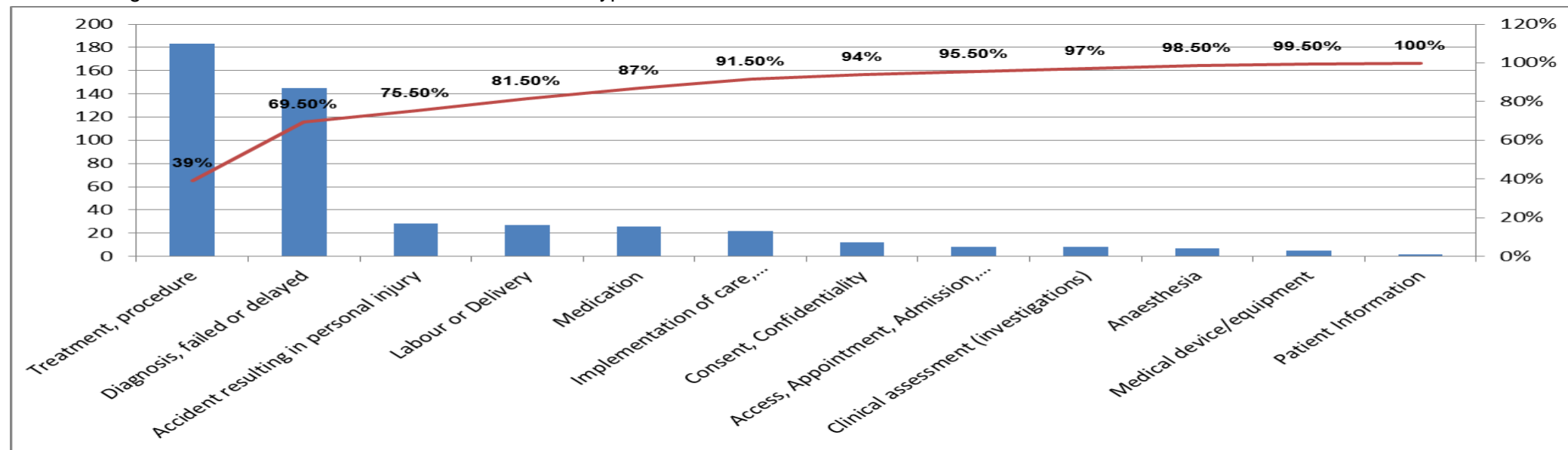
5-Year Trend Clinical Negligence Claims



Number of Claims reported to NHSR (Data not available– Extranet currently being upgraded and back on line February 2020)



5-Year rolling trend settled claims at Q2 2019/20 – Incident type



RISKS TO DELIVERY

No identified risks to delivery.

WELL-LED

KEY UPDATES

Care Quality Commission:

- The Trust continues to interact with the CQC on a regular basis. General information requests continue to be received on; for example, completed Serious Incidents, Coroners Cases and Complaints.
- The quarterly engagement meeting took place on 17th February 2020
- As reported previously, the Trust received the Provider Information Request (PIR) in October 2019. This commences a three month timetable cumulating in both an announced Well-led inspection and an unannounced Core Service Inspection. During the week commencing 17th February 2020 focus groups were held between the CQC and professional staffing groups
- The Trust continues to play an active part in the NHSI/E Moving to Good Programme. A Governance course / workshop is being held on the 20th February 2020 which will be attended by Chief Nurse, Deputy Director of Quality Governance , Deputy Chief Nurse and Director of Corporate Governance

RISKS TO DELIVERY

All projects within the QIP are progressing well, however some delays have been noted and the projects highlighted above could pose a risk to the achievement of the overall plan and the Board Assurance Framework (BAF) Risk 3 which is linked to the Trust receiving an overall rating of good.

Transition of Deprivation of Liberty Safeguards to Liberty Protection Safeguards (LPS)

Trust Board Update

On October 1st 2020 The Mental Capacity Act (2005) Deprivation of Liberty standards will be replaced by Liberty Protection Safeguards (LPS). Until this point the operational and legal framework remains the same and currently clinical processes should continue. There will be a year's transitional process from October 2020 after which the LPS must be fully embedded within the Trusts' safeguarding practices.

Background

The Liberty Protection Safeguards started life as a proposal from the Law Commission about how the changes to current legislation might look in relation to people who are deprived of their liberty. In 2014 two very significant events triggered the end of the Deprivation of Liberty Safeguards.

First, the Lords Select Committee on the Mental Capacity Act branded the Deprivation of Liberty Safeguards as not fit for purpose and recommended an overhaul of the Act. Soon after, a collection of cases were heard by the Supreme Court which lowered the threshold for who might be considered to be deprived of their liberty. A huge increase of DoLS referrals ensued and both Local Authorities (acting as Supervisory Bodies) and the Court of Protection were inundated with applications. This left many people in care homes, nursing homes and hospitals potentially deprived of their liberty illegally and without the necessary safeguards in place.

It has been proposed that the Liberty Protection Safeguards take both of these factors into account and provide safeguards for vulnerable adults who need it without unnecessary assessment duplication from health and social care professionals. As mentioned above, the Liberty Protection Safeguards would apply in all settings whereas the current Deprivation of Liberty Safeguards (DoLS) regime only applies to registered care homes and hospitals. Anyone who lives outside of these settings such as their own home or supported living would need an order from the Court of Protection to be deprived of their liberty lawfully. Second, the Liberty Protection Safeguards would apply to anyone over the age of 16. This would bring it in line with other aspects of the Mental Capacity Act which apply to anyone over the age of 16. The current Deprivation of Liberty Safeguards only apply to people aged 18 or over. A statutory authority to deprive a person of their liberty temporarily would replace the current Urgent Authorisation and would only be permitted in truly urgent situations and sudden emergencies.

These safeguards will include regular reviews by the responsible body; and the right to an appropriate person or an Independent Mental Capacity Advocate to represent a person and to protect their interests.

The change to legislation also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

It's important to say that the five principles of the MCA 2005 remain in place; from a person being assumed to have capacity unless it is established that they don't; to a person not being treated as unable to make a decision merely because they make an unwise decision.

Key changes to the process are

- The LPS will incorporate 16 and 17 year olds to bring the age range in line with the MCA(2005)
- It will be transferrable between community and in-patient setting including domestic residences
- Potential changes to the relationship with the Mental Health Act
- The managing and authorising bodies will become one and the same

Currently, under the Deprivation of Liberty Safeguards the Supervisory Body is the local authority; the organisation who has responsibility for authorising a deprivation of liberty under the scheme. When the Liberty Protection Safeguards start, there will be others who also authorise deprivations of liberty and they will be called Responsible Bodies. If a person's care is funded through Continuing Healthcare, the Clinical Commissioning Group will be the Responsible Body. If they are in an acute hospital, the hospital manager will be the responsible body and for all other cases it will be the local authority.

The role of the Best Interests Assessor is replaced under the Liberty of Protection Safeguards. A new role has been created entitled Approved Mental Capacity Professional (AMCP). Under DoLS the BIA carried out a series of detailed assessments for every person as part of the standard authorisation process. Under LPS, assessments are undertaken by other staff (general social workers, nurses, AHPs etc.) and the AMCP will read and review these LPS assessments completed by others, this is called the pre-authorisation review. Whereas, at present, DoLS signatories read assessments, an AMCP also meets the person and speaks to other interested in their welfare. It is likely that the AMCP will have to assess too. For example, if they disagree with the original assessor's mental capacity assessment, they would need to evidence why they disagree and therefore, record the assessment. AMCPs will not be required for all pre-authorisation reviews.

It is expected that existing BIA's will be fast tracked into the new role by undertaking a reduced approval course. It is not clear what this course looks like at the present time so further information is expected from the Department of Health and Social Care about this matter in due course.

Current position and Potential Risks

An action plan is been developed by the Trust MCA/ECT Lead to anticipate the LPS Code of Practice which is to be published imminently. Working closely with Local Authorities and CCG the MCA Lead will support the on-going reciprocal relationship to meet the new legal requirements and a smooth operational transition, which will include briefing sessions, communication tools are relevant and up to date, addressing immediate and long term training and education needs of Trust clinical staff and documentation is fit for purpose.

The MCA/ECT Matron is reviewing the Trust Consent Policy in line with expected changes and is also updating the Trust Intranet pages. An email to Health Group Directors was sent on 2nd March 2020 to provide an update on this subject with the Department of Health and Social Care Implementation Plan and briefing.

A delay in the publication of the Code of Practice poses a key risk to the implementation of LPS. This will reduce the time the Trust has in making the required changes and will be

particularly challenging if there are unanticipated recommendations. A further risk is the governance of the LPS process as the Trust will authorise and manage any LPS application and guidance on this will be part of the Code of Practice.

It is unclear regarding funding for additional training and there are concerns about the capacity of the nursing and AHP teams to be able to undertake the additional assessments which can be lengthy.

The latest figures show there were 48,980 DoLS raised by acute hospitals in the year ending March 2019 so this is a huge change in moving the assessment process to the provider.

This Trust applies for over 120 DoLS per year but this is expected to increase in line with the increased awareness of this subject and the impact of the new role of the MCA/ECT Lead Matron.

Both Hull and East Riding Directors of Adult Services are working with the Hull and East Riding CCG Executive Safeguarding Leads as part of an executive group overseeing this work locally. This oversees and steers the local operational group to which the Trust is member of.

Report Author: Kate Rudston, Assistant Chief Nurse
March 2020

**Hull University Teaching Hospitals NHS Trust
Trust Board**

March 2020

Title:	Learning From Deaths Trust Board Report, Quarter 3, 2019 Update.	
Responsible Director:	Executive Chief Medical Officer	
Author:	Chris Johnson, Clinical Outcomes Manager	
Purpose:	The purpose of this report is to provide the Committee of the Trusts continuing commitment to learning from patient mortality and improving quality, in line with the Learning from Deaths Framework.	
BAF Risk:	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals:	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	Information is provided in the report on the following topics: <ul style="list-style-type: none"> • Mortality Statistics as per National LFD framework 	

	<ul style="list-style-type: none"> • Themes • Actions Taken • Any other updates
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Recommendation:	<p>The Committee is requested to receive this report and:</p> <ul style="list-style-type: none"> • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required
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Learning from Deaths Trust Board Report Quarter 3 2019 Update

Executive Summary

The purpose of this report is to provide a summary of mortality statistics and learning in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 3, 2019/20.

The Committee 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

Learning from Deaths Trust Board Report Quarter 3 2019 Update

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide a summary of mortality statistics and learning in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 3, 2019/20.

Information relating to themes and actions taken are obtained from the Trust Datix reporting system, for cases that were completed within Quarter 3, 2019/20.

2. SUMMARY OF TRUST MORTALITY IN Q1 2019/20

The following table provides a breakdown of patient deaths that occurred within the Trust during Q3 2019/20, drawing comparison to last year:

	Total number of In-hospital deaths in Q3	Of which were elective admissions / Day case deaths	Of which were Non-elective admissions
2018/19	621	28	593
2019/20	626	27	599

2.1 Most Common Conditions at Time of Death

The following illustrates the 3 most common clinical conditions at time of death of death during Q3 2019/20:

1. Pneumonia – 93 deaths
2. Septicaemia – 65 deaths
3. Acute Cerebrovascular Disease – 39 deaths

2.2 Minimal Criteria for Structured Judgement Review (National LFD Framework)

The National Quality Board set minimal criteria for undertaking structured judgement case note reviews. These are illustrated below, along with the Trusts compliance against these criteria during Q1 2019/20 (number of patients receiving review against total number of patients in criteria):

Criteria	Number of cases receiving full SJR (out of total amount of deaths)
Deaths where a concern was raised about the quality of care provision	2/2
LeDeR Reviews (internal HEY patients)	1/1
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	Alerted for outlier for Neck of Femur Fracture mortalities – sample of 10 case notes reviewed via SJR methodology
Number of deaths that underwent a Serious Incident Investigation and completed, within Q3, where it is likely that problems in care contributed to patient death.	0 (2 currently ongoing)

In addition to the Structured Judgement Review, cases receive other reviews outside of the SJR methodology within the M&M setting.

The Trust has signed up to the LeDeR program and has trained reviewers who undertake reviews on patients who die both within the Trust and outside of the Trust.

2.3 Structured Judgment Review Statistics

During Q3 2019/20, a total of 23 Structured Judgement Reviews were undertaken. The following table provides a breakdown of review types:

Total Number of SJR undertaken in Q3	Cases escalated to Tier 2	Cases requiring Triumvirate decision	SJR cases escalated and declared as a Serious Incident
22	2	0	0

2.4 Deaths Investigated and Finalised as Serious Incidents

There were 0 Serious Incident Investigations that completed within Quarter 3, where the patient deaths were more likely than not to have been due to problems in care.

However, there are currently 2 Serious Incidents that are awaiting completion that *may* indicate that death was more likely than not to have been due to problems in the delivery of care. These outcomes will be available in the next report.

3. NEXT STEPS

The Trust continues to learn lessons from not only mortality, but also morbidity. This is reflected in the new format of the Trust Morbidity and Mortality Committee, focusing morbidity and mortality.

New Electronic Methodology for Recording Mortality and Morbidity Discussion

The Trust is currently developing a new electronic morbidity and mortality form (M&M) that will allow Mortality and Morbidity (M&M) meetings to be undertaken in a structured and standardised manner. This will make for better identification of themes and trends, which will in turn better inform future quality improvement work to help improve patient outcomes. The idea has been developed within the Datix reporting system to allow for deeper analysis to be undertaken, via the numerous reporting tools that are provided with the platform; including performance dashboards and graphs to show trends.

Multi-agency Patient Review with Yorkshire Ambulance Service

A multi-agency review is currently underway, with contributions made from both the Trust and the Yorkshire Ambulance Service. One of the key aims of this review is to assess the level of care delivered to patients who attended the Major/Resuscitation areas of the Emergency Department, during a time period at which the ED was under extreme pressure and declared as an Op4 alert status. The review will allow us to not only focus on care that was delivered within the hospital setting, but also look at the pre-admission side, with the opportunity to also involve General Practice, along with the ambulance service. This system-

wide approach will allow for better insights into the quality of care delivered to patients and will help direct future quality improvement work.