Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held in Public via Webex (details from Trust Secretary)
14 July 2020, 9am – 12pm

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	verbal	Terry Moran - Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 18 June 2020	attached	Terry Moran - Chair
4	**Matters Arising**		
	4.1 Action Tracker	attached	Carla Ramsay – Director of Corporate Affairs
	4.2 Board Reporting Framework 2020-21	attached	
	4.3 Board Development Framework 2017/21	attached	
5	**Chair's Opening Remarks**	verbal	Terry Moran – Chair
6	**Chief Executive Briefing**	attached	Chris Long – Chief Executive Officer
7	**Patient Story**	verbal	Makani Purva – Chief Medical Officer
8	**Board Assurance Framework**	attached	Carla Ramsay – Director of Corporate Affairs
9	**Our Patient Impacts**		
	9.1 Performance Report	attached	Teresa Cope – Chief Operating Officer
	9.2 Quality Report	attached	Beverley Geary - Chief Nurse/ Makani Purva – Chief Medical Officer
	9.3 Covid-19 Recovery Report	attached	Jacqueline Myers – Director of Strategy and Planning
	9.4 Minutes and Escalation from the Performance and Finance Committee	attached	Tony Curry – Chair of Performance and Finance Committee
	9.5 Minutes and escalation from the Quality Committee	attached	Martin Veysey – Chair of Quality Committee
	9.6 Escalation and summary report from the Ethical and Clinical Prioritisation Policy Committee	attached	Stuart Hall – Chair of Ethical and Clinical Prioritisation Policy Committee

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

10	**Our People Impacts**		
	10.1 Staff Overview Report	attached	Simon Nearney – Director of Workforce and OD
	10.2 Escalation from the Workforce, Education and Culture Committee	attached	Una Macleod – Chair of Workforce, Education and Culture Committee and Simon Nearney – Director of Workforce and Organisational Development
11	**Our Finance Impacts**		
	11.1 Finance Summary Report	verbal	Lee Bond – Chief Financial Officer
	11.2 Urgent and Emergency Care Business Case	attached	Lee Bond – Chief Financial Officer & Jacqueline Myers – Director of Strategy and Planning
12	**Items for approval by the Board**		
	12.1 Freedom to Speak Up Guardian report	attached	Director of Corporate Affairs
	12.2 Guardian of Safe Working Hours report	attached	Androniks Mumdzjans – Guardian of Safe Working Hours
	12.3 Standing Orders	attached	Director of Corporate Affairs
	12.4 Fit and Proper Person Report	attached	Director of Corporate Affairs
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 8 September 2020 – 9am – 12pm via Webex		

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

Attendance 2020/21

Name	14/4	12/5	18/6	14/7	8/9	10/11	TBC	TBC	Total
T Moran	✓	✓	✓						3/3
S Hall	✓	✓	Apols						2/3
T Christmas	✓	✓	✓						3/3
M Veysey	Apols	✓	✓						2/3
T Curry	✓	✓	✓						3/3
U MacLeod	Apols	Apols	✓						1/3
M Robson	✓	✓	✓						3/3
L Jackson	✓	✓	✓						3/3
C Long	✓	✓	✓						3/3
L Bond	✓	✓	✓						3/3
T Cope	✓	✓	✓						3/3
M Purva	✓	✓	✓						3/3
B Geary	✓	✓	✓						3/3
J Myers	✓	✓	✓						3/3
S Nearney	✓	✓	Apols						2/3
C Ramsay	✓	✓	✓						3/3

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

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board Meeting
Held on 18 June 2020

Present:	Mr T Moran CB	Chairman
	Mrs T Christmas	Non-Executive Director
	Prof M Veysey	Non-Executive Director
	Prof U Mcleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
In attendance:	Ms J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies:

Mr S Hall, Non-Executive Director and Mr S Nearney, Director of Workforce and Organisational Development

Mr Moran welcomed all Board members and the staff and public members that had joined the meeting. He reflected on the number of deaths the Trust had seen due to Covid-19 and in particular the two members of staff who had sadly died in recent weeks He offered his sincere s condolences to all the families, friends and colleagues who had lost loved ones.

Mr Moran also spoke of the BAME community and the Black Lives Matter campaign. He advised that 12% of staff at the Trust were BAME and that the Trust was working hard to ensure BAME staff felt valued and treated equitably. He added that the Trust's position is to recognise the importance of the issues leading to the Black Lives Matter campaign.

Mr Moran reported that it was learning disability week and that the Trust had signed up to the Learning Disability Pledge. He added that there was a LD Pledge video on YouTube that featured Trust staff committing to it.

Mr Moran also mentioned the A&E After Dark TV programme currently being broadcast on Channel 5 that featured Hull Royal Infirmary. The programme contained a variety of issues and featured the hard working staff in the department. Mr Moran thanked the ED staff on behalf of the Board. Mr Long echoed Mr Moran's thanks and paid tribute to the staff being hampered by PPE but still managing to have energy and good humour when treating patients.

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda
There were no declarations made.

3 Minutes of the previous meeting

3.1 Minutes of the meeting held 12 May 2020
Mrs Geary clarified that Care Hours per Patient Day were measured when reviewing staffing levels. She also advised that the Fundamental Standards report would be received at the Board in September 2020.

4 Matters Arising

4.1 Action Tracker
Ms Ramsay agreed to update the work-plan to incorporate the new Strategy Review date.

Ms Ramsay requested that the full review of the Workforce, Education and Culture Committee, and other Terms of References' took place after the Board Development session to review governance arrangements.

4.2 Any other matters arising
There were no other matters arising.

5 Audited Accounts 2019/20

5.1 Annual Account 2019/20
Mr Bond presented the Accounts and advised that the Trust had an adjusted surplus of £10m and had received a 'substantial' Audit Opinion.

He reported a technical item relating to estate valuations which was highlighted in the Accounts but had not resulted in an been adjustment as it the value was not regarded as material.

Mr Bond advised that the Accounts would be completed by 25 June 2020 and asked the Board to adopt them as the figures would not change between the Board and 25 June.

Resolved:
The Board received and adopted the accounts.

5.2 Letter of Representation
Mr Bond presented the Letter of Representation and advised that it was a standard letter sent on behalf of the Board setting out the financial statements of the Accounts.

Mrs Christmas advised that the Audit Committee prior to the Board meeting had considered the Accounts in detail and that there were no controversial items in them.

Resolved:
The Board received and approved the Letter of Representation.

5.3 Annual Report
Ms Ramsay presented the report and amendments paper to the Board. The Annual Report had received positive assurance from the Auditors. A number of amendments had been made but this had not changed the context of the report. She advised that there had been amendments to the Annual Governance Statement; one was to clarify a name of the College in Pakistan

and one was to add in details about the Workforce, Education and Culture Committee.

The remuneration tables had been tidied up so that zero, dash and blank fields were now consistent and a column that showed any long term bonuses had been added back into a table. Ms Ramsay clarified that there had been no long term bonuses received.

Ms Ramsay reported that Dr Purva's salary had been split into Executive, clinician and Clinical Excellence sections and the added a footnote in respect of the Chairman's salary which made clear that he was also Chair of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) roles.

The pensions table had been amended to clarify deductions, again this had not altered the figures and the median salary calculation now included the range for clarity.

The Director of Audit had been amended to read the Head of Internal Audit and Accounting Officer amended to read as Accountable Officer.

A footnote had been added to the Director of Strategy and Planning's salary to explain that it was £130k wte but that she worked 0.9 wte.

Resolved:
The Board approved the Annual Report subject to the relevant amendments set out in the amendments paper being updated.

5.4 NHS Improvement of Self-Assessments
Ms Ramsay presented the report and advised that the assessments confirmed the governance processes in place and systems of control.

Ms Ramsay had updated the statements but had nothing of significance to highlight.

Resolved:
The Board approved the self-assessments. Mr Moran thanked Ms Ramsay for her work on the document.

6 Our Patient Impacts

6.1 Performance Summary
Mrs Cope presented the reported and advised that ED performance had increased from 89.5% in April to 93% in May 2020. There had been reduced attendances due to Covid-19 but in the last 2 weeks attendances were back up to approximately 350 patients per day. This was concerning due to the social distancing rules. The department was working with the Communications team and partners to manage attendance figures by ensuring only those with serious need attended ED and other minor needs were dealt with in a non-ED environment.

Mrs Cope reported that the waiting list was currently holding, but RTT had been impacted due to the reduced procedures and 18 week and 52 week waits were increasing.

Diagnostic performance had deteriorated due to routine diagnostics being stopped due to Covid. The 6 week standard was currently at 19%.

The Trust achieved the Cancer Faster Diagnostic Standard in March but has not achieved the target in April due to significant restrictions on diagnostic testing. Performance against the 62-day Cancer Standard was 69% for February and is anticipated to be 67% for April.

In response to Covid-19, the National Hospital Care Cell developed some good practice guidance on the management of elective waiting lists in collaboration with the Elective Care Intensive Support Team to help secondary care providers manage referrals, waiting lists and clinical review processes. An assessment against each of the best practice recommendations has been made which has been considered via the Performance and Activity meeting and the Executive Team.

There are 28 standards across 15 themes/areas. The Trust demonstrates good compliance against these standards with comprehensive reporting and oversight mechanisms in place pre-Covid-19 and, during Covid19, capturing any changes that have been implemented as a result of the pandemic. There were 4 standards where additional work was identified and an action plan has been put into place to address these.

Mr Robson asked if the deterioration in performance would continue and whether the harm reviews were showing any patterns emerging. Mrs Cope advised that a paper would be presented to the Performance and Finance Committee in June to describe the journey, any progress made and the recovery timeline. She advised that to date there had been low or no harm following the harm reviews.

The Board discussed diagnostics and the restrictions currently in place. Mrs Cope advised that PPE and air changes were impacting on capacity but work was ongoing within the Integrated Care System and two new mobile scanners with staff had been sourced.

Resolved:
The Board received and accepted the report.

6.2 Covid-19 Recovery Planning

Ms Myers presented the report and advised that there were 23 cases currently in the hospital. This was in line with the national trajectory. The planning for the next phase had begun although there had been no national guidance published to date. An internal process had been launched to review the Trust's state of readiness should there be a second wave and the restoration of non-Covid activities.

The new plan would be implemented over the next two weeks and changes such as re-establishing ED to its pre-Covid function and the new Covid wards would be included. The Network upgrade would be completed before the winter months and the revised activity plan would also be implemented.

Work was ongoing to monitor the Covid impact on staff, track and trace, absence and the revised surge plan. Ms Myers also mentioned the Integrated Care System and how the Trust would be working with partners in the future.

Ms Myers was working through capital bids related to Covid-19 impacts with

the Health Groups as levels of activity were stepped up.

The Board discussed the lack of national guidance and Mrs Christmas asked if the hospital had enough capacity to manage the winter pressures. Ms Myers advised that the physical capacity was available but staffing would be an issue. She reported that work was ongoing with the wider system to enable shorter lengths of stay and Community capacity. Mrs Cope added that the out of hospital capacity was reducing and this would be a risk going into winter.

Mr Long advised that the risks were workforce shortages and the time it was taking to carry out procedures. He added that when the financial assistance from the Government dried up this could also become a risk.

Resolved:
The Board received and accepted the update.

6.3 Quality Summary
Mrs Geary presented the report and advised that the Trust had declared 9 Serious Incidents in May 2020 and the nature of these were detailed in the report. Mrs Geary highlighted falls with harm and advised that a report was being presented to the Quality Committee regarding the actions in place.

The Trust had re-categorised and down-graded a Never Event that had been declared in December 2019 although the incident was still being investigated as a serious incident. Mrs Geary advised that the incident rates had dropped but this was mainly due to less patients in the hospital due to Covid-19. There had also been a reduction in pressure ulcers.

Mrs Geary updated the Board regarding the Section 29 notice from the CQC relating to the Child Sexual Assault Assessment Service. A final report had been submitted and the Trust was now compliant in all areas. This had been published on the CQC website.

The Governance Team had reviewed the CQC report recently received for factual accuracy and this had now been submitted to the CQC with supplementary information.

Mr Moran asked about the compliance assessment relating to the Duty of Candour performance and requested that further assurance be brought to the Board in July 2020. **MP**

Dr Purva reported that papers relating to stroke and diabetes harm reviews during the pandemic would be presented to the Quality Committee for scrutiny.

Prof. Veysey asked if there was an update regarding the Quality Accounts. Ms Ramsay advised that national deadlines had changed and a draft would be presented to the Quality Committee in June 2020.

Resolved:
The Board received and accepted the report.

7 Our People Impacts
7.1 Staff Overview

Mrs Geary presented the report and advised that staff absence was at 9.82% mainly due to Covid-19. This had been compared with the end of year figure which was 3.76%. 519 staff were absent due to Covid-19 which was impacting services across the Trust.

Staff testing was ongoing and the Trust had now started the antibody testing and had completed 1700 to date.

The vacancy rate was at 4.51% and Mrs Geary advised that the risk areas were medicine, ICU and elderly with regards to registered nurses.

The Trust had recruited 132 students on paid placements and would be appointed as registered nurses in September/October 2020. 75 second year nurse students are commencing employment with the Trust during the month of June, 2020 in a Health Care Support Worker (band 3) role with a further 45 due to commence in July 2020. This will enable those students to fulfil their placement hours and complete their second year whilst providing much needed support to treat and care for patients. These students will return to University in September to complete their degree.

The Trust has employed 48 medical students as part of its Covid-19 workforce plan.

The CHPPD for April (10.67) had significantly increased in comparison to previous months, on initial analysis this can be related to the significant reduction in the number of patients that have accessed a number of services in the Trust throughout this period.

A panel to support Black, Asian and Minority Ethnic Staff for the duration of Covid-19 has been introduced.

The National Staff Survey will be distributed to all NHS staff during October and November and this had been changed to reflect the Covid-19 pandemic.

The NHS Test and Trace programme launched on Friday 5th June 2020. If a staff member tests positive for Covid-19 (as outlined above), the Trust is responsible for ensuring all work related 'contacts' are identified and those staff members instructed to self-isolate for 14 days. The Trust Test and Trace operation is managed through the ESC Helpdesk and the nurses supporting the testing process. Prof. Veysey expressed his concern about how whole departments might need to close should a member of the team test positive and colleagues needing to isolate.

Resolved:
The Board received and accepted the report. Mr Moran thanked the teams working behind the scenes to keep staff safe and ensure support was given where it was required.

8 Our Finance Impacts

8.1 Finance Summary Report

Mr Bond presented the report and advised that the Trust was reporting a small surplus of £25k with £2.3m of additional costs related to Covid-19 being offset by savings from reduced activity.

The Trust was reporting shortfalls in Car parking (-£293k), Catering (-£200k)

and private patients (-£55k). This is in line with expectations given the reduction in clinical activity along with the free staff car parking and the free staff meals on offer during April and May.

In the first 2 months of the year the Trust has spent £4.7m on Covid-19 related costs. This has been offset by underspends against the plan due to reduced clinical activity with £3.0m less being spent on theatre implants and other consumables, £1.0m less being spent on Wet AMD drugs and £0.7m on other drugs. There have also been reductions in training expenditure (-£0.3m) and establishment expenses (-£0.4m).

Mr Bond advised that the Trust was now waiting for national guidance setting out the Business As Usual baseline for financial expenditure during the recovery period.

Mr Bond reported that the national supply of PPE was much better and there were no major stock issues.

Mr Bond also advised that the underlying position had remained due to the reactive nature of the Health Groups during the pandemic. He added that 21/22 would be challenging financially, compounded by the cost improvement programme, although this had been built into the recovery plan. Mrs Cope added that the impact of Covid-19 had been significant and the Trust had a huge challenge ahead. She added that a different set of metrics were required to reflect Trust's current assessment and what was required in order to recover following the pandemic. Ms Myers added that new ways of working to capture efficiency savings where being implemented such as outpatient appointments via video conferencing or telephone rather than face to face.

Resolved:
The Board received and accepted the report.

8.2 Capital Plan 2020/21
Mr Bond presented the Capital plan which was £46m for the coming financial year. It was made up of the annual depreciation budget, statement of comprehensive income profits and Public Dividend Capital.

Mr Bond reported that the programme was full with the network replacement programme, cyber security programme, NHS Mail, LDE programme and Windows 10 implementation. £10m of the programme was for the Brocklehurst diabetes centre build and the commencement of the HRI front entrance works. Backlog maintenance was also built into the plan.

Mr Bond advised that there was further capital to be gained linked to Covid-19. These projects included the update to the Trust's oxygen infrastructure, establishment of a Covid ED ward and medical assessment unit.

Mrs Christmas asked if the Trust had the capacity to deliver the programme and Mr Bond advised that capacity was there but there was a chance the schemes could run out of time.

Mr Moran stated that it was important to have an ambitious plan and ensure the majority of it was completed in the financial year.

Resolved:

The Board received and approved the Capital Plan 2020/21.

9 Questions from the public relating to today's agenda

There were no questions from the members of the public or staff members.

10 Chairman's Summary of the Meeting

Mr Moran summarised the meeting. He advised that the Board had approved the Annual Accounts, Letter of Representation and the Annual Report. He highlighted concerns regarding the impact on normal services due to Covid, waiting list issues and the need to look more closely at the reported compliance with our Duty of Candour performance.

Mr Moran also highlighted staffing vacancies, the finance position and utilising capital expenditure as positive areas of the meeting.

11 Any Other Business

There was no other business discussed.

12 Date and time of the next meeting:

Tuesday 14 July 2020, 10am – 12pm via Webex

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
June 2020						
Jun 2020	Duty of Candour	Assurance around the process and compliance to be received	MP/BG	July 2020		
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	Sept 2020		
November 2019						
Nov 2019	7 Day Services Report	Trust benchmarking information to be presented to the Board	MP	Sept 2020		
	Trust Strategy Implementation	Summary arrow to be added to show whether standards were improving or not	JM	Nov 2020		Next report presentation due
COMPLETED						
May 2020	Board Assurance Framework	Updated BAF to be discussed at the Board Development Session in June 2020	CR	June 2020		Board Development Session
	Covid-19 Report	PPE update	JM	June 2020		In Covid-19 updated report
	Our People	Clarification around staff vacancies	SN	June 2020		In Our People updated report
April 2020	Matters Arising	Trust Strategy review date to be updated on the workplan	CR	June 2020		

Actions referred to other Committees

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

Trust Board Annual Cycle of Business 2020 – 2021 - 2022			2020							2021							2022						
Focus	**Item**	**Frequency**	**Apr**	**May**	**Jun**	**Jun Ex**	**July**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**May Ex**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**May Ex**	**Jul**	**Sept**	**Nov**
Opening Items	Declarations of Interest	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes of the last meeting	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Action Tracker	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Reporting Framework 2020-2021-2022	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Development Framework 2017-2021	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Chair's Opening Remarks	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Chief Executive Briefing	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Patient Story	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Staff Experience (Frontline staff team in attendance)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Board Assurance Framework	Quarterly		x			x		x	x		x		x		x	x		x		x		x
Our Patient Impacts	Performance Report	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Quality Report	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Covid-19 Recovery Report	Every Meeting		x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes and Escalation from the Performance and Finance Committee	Every Meeting					x																
	Escalation from Ethical Clinical Policy Prioritisation Committee	As required	x				x																
	Minutes and Escalation from the Quality Committee	Every Meeting					x																
Our People Impacts	Staff Overview Report (Including Nurse Staffing)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Minutes and Escalation from the Workforce, Education and Culture Committee	Every Meeting					x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
Our Finance Impacts	Finance Report (including Statement of Comprehensive Income)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
Items for Approval	Freedom to Speak Up Guardian	Quarterly					x		x	x		x		x		x	x		x		x		x
	Guardian of Safe Working Hours	Quarterly					x		x	x		x		x		x	x		x		x		x
	Quality Accounts	Annually						x	x			x							x				
	Statement of elimination of mixed sex accommodation	Annually				x							x							x			
	Annual Accounts	Annually				x							x							x			
	Going Concern Review	Annually				x							x							x			
	Audit Letter	Annually				x							x							x			
	Annual Report	Annually				x							x							x			
	Workforce Race Equality Standards	Annually						x				x							x				
	Workforce Disability Equality Standards	Annually						x				x							x				
	Modern Slavery	Annually						x				x							x				
	Emergency Preparedness Statement of Assurance	Annually						x							x							x	
	NHS Resolution Maternity Incentive Scheme	Six-Monthly						x		x				x			x				x		
	Business Cases	As required					x																
	Self-Certification and Statement	Annually			x							x							x				
Reports to the Board	Nursing and Midwifery Report (included in Staff Overview Report)	Every Meeting	x	x	x		x	x	x	x	x	x		x	x	x	x	x	x		x	x	x
	Fundamental Standards	Six-Monthly						x			x				x			x				x	
	National Patient Survey	Annually							x							x							x
	National Staff Survey	Annually									x							x					
	Gender Pay Gap	Annually									x							x					
	Digital Exemplar	Annually							x							x							x
	Scan for Safety	Annually							x							x							x
	Fit and Proper Person Report	Annually					x					x							x				
Strategy and Planning	Operating Framework	As required						x		x							x						
	5 Year Plan	Annually								x							x						
	Trust Strategy Refresh	As required																					
	Operational Planning	Annually								x	x						x	x					
	Financial Planning	Annually			x						x	x						x	x				
	Capital Planning	Annually			x						x	x						x	x				
	Winter Planning	Annually							x								x						x
	Equality, Diversity and Inclusion Strategy	Every 3 Years									x												
	Assurance against Equalities Objectives	Annually						x							x							x	
	People Strategy	Every 3 Years																	x				
	IM&T Strategy	Every 3 Years										x											
	Research and Innovation Strategy	Every 3 Years									x												
	Trust Strategy Implementation Update	Every 6 Months						x			x				x			x				x	
	Estates Strategy inc. Sustainability and backlog maintenance	Annually			x						x	x						x	x				
Governance	Standing Orders	As required	x	x			x																
	Safeguarding Annual Reports	Annually						x						x							x		
	Learning from Deaths Report/Mortality and Morbidity	Quarterly		x	x				x	x		x		x		x	x		x		x		x
	Information Governance Update	Six-Monthly				x				x			x				x			x			
	Health and Safety Annual Report	Annually						x						x							x		
	Director of Infection Prevention and Control Annual Report	Annually						x						x							x		
	Quality Improvement Programme	Six-Monthly			x					x		x					x		x				
	Responsible Officer Report	Annually						x							x							x	
	Seven Day Working Assurance Framework	Six-Monthly						x			x				x			x				x	
	Preparation for EU Exit	As required			x			x	x														
	Developing Workforce Safeguards	Six-Monthly						x			x				x			x				x	
	Review of Director's Interests (Inc Fit and Proper Persons)	Annually					x					x							x				
	Cultural Transformation	Six-Montly						x			x				x			x				x	
	Board Calendar of Meetings	As required						x										x					
	Review of Board Effectiveness	Annually						x							x							x	

Hull University Teaching Hospitals NHS Trust
Board Development Programme 2017-21
Overarching aims:
• The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
• To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Board Development Dates 2017-21	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great Clinical Sevices	Great specialist services (until March 19)	Partnership and integrated services	Research and Innovation (from March 19)	Financial Sustainability
25-May-17						Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation			
04 July 2017			Area 1: Trust Board - updated Insights profile	Area 2 and BAF 3: Trust Strategy Refresh and appraoch to Quality Improvement					
10 October 2017			Area 1 and BAF 1: Cultural Transformation and organisational values				Area 2 and BAF 5: Strategic discussion - role of Trust with partner organisation		
28 November 2017			Area 2 and BAF 2 - Nursing staffing risks and strategic approach to solutions		Area 4 and BAF 4 - Trust position on diagnostic capacity - short-term impact and long-term issues; 62 day cancer				
				Area 1: Risk Appetitie - Trust Board to set the Trust's risk appetite against key risk areas					
05 December 2017				Area 1: High Performing Board and BAF 3 - CQC self-assessment and characteristics of 'outstanding'					
16 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - overview, process to review, key considerations		Area 4 and BAF 2 - People Strategy update		Area 4 and BAF 4 - Tracking Access				
30 January 2018	Area 2 and BAF 4, 5, 6: Strategy refresh - key considerations and strategy delivery		Area 2 and BAF 2 - People Strategy update						Area 2 and BAF 7.1 - 7.3 - Financial plan and delivery 2017-18 and financial planning 2018-19
20 February 2018	Area 2 and BAF 4, 5, 6 : Key strategies to achieve our vision and goals and vision for the STP								
Extra meeting	Areas 2 and BAF 4 & 5: Strategy refresh -STP deliberations and direction of travel								
27 March 2018	Areas 2 and BAF 4 & 5: Strategy refresh - key strategic issues (partnerships, infrastructure)								

17 April 2018	Area 2 and BAF 6 & 7.2: Strategy refresh and operational plan	Area 4 and BAF 1: General Data Protection Requirements 2018		Area 2 and BAF 3: Research and Development strategy					
		Area 1 and BAF 1: Draft 2018-19 BAF							
24 May 2018	Area 2 and BAF 6: Chris O'Neill, STP Programme Director	Area 1 and BAF 1: Deep Dive in to Never Events and Serious Incidents							Area 2 and BAF 7.1: 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 - clincial 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 orgnaisaitonal 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 scorecare 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								
29-Jun-20		Area 1 and BAF 1: BAF 2020-21					Area 3 and BAF 5: Stakeholder survey feedback		
14-Jul-20					Area 4 and BAF 4: RTT and Covid-19 recovery				
28-Jul-20									
29-Sep-20									
24-Nov-20									

plan and capital requirements

Other topics to consider:
Board leadership and cultural development
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

	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 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	BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	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 What could prevent the Trust from achieving this goal? That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy	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 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 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 A focus on 62-day cancer targets has brought about improvements and a continued focus is required to	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. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 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. 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 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	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 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 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 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
	Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first						

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

14 July 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:	Covid19 media responses	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 14 July 2020

1. Key messages from April-July 2020

Thank you to all staff

This report is inevitably primarily focused on our response to the Covid19 pandemic, and first and foremost this has to include a thank you to all HUTH staff for their hard work in ensuring our patients received the very best care possible throughout the most difficult period in NHS history.

It is simply not possible to name everyone individually or to cite specific teams for the phenomenal acts of care, kindness, compassion, innovation and creativity we have seen since March 2020. And therefore, on behalf of the whole Trust Board, I would like to extend my continuing gratitude to and express my admiration for everyone who works for this amazing organisation. Well done and thank you to you all.

Acknowledging our lost colleagues

The greatest tragedy for us as an organisation was losing two members of staff to Covid19. Adrian Cruttenden, was an administrator with the medical records team who died on 27 May and Richzeal Albufera a virologist, based at Castle Hill Hospital, who died on 9 June.

We paid tribute to both of our colleagues with messages to all staff, media releases, a minute's silence and books of remembrance. Staff were also able to post online tributes to Rich and Adrian via Pattie.

Once again I would like to express my sincere condolences to their loved ones and their colleagues.

Hospital deaths

On 26 June we had to inform the public that 200 patients had died from Covid19 in our hospitals. It has been our priority throughout this period to stress that this has never been a headline figure to us. We acknowledge that every one of these deaths represents a family devastated by the loss of their loved one. Each one is a tragedy and again, on behalf of our whole organisation, I would like to extend my condolences to everyone who has been affected by Covid19 with the death of a family member, friend or loved one.

500 patients well enough to go home after Covid19

In contrast to the devastating news of 200 deaths we were able to report, three days later, that over 500 patients had been discharged from hospital after contracting Covid19.

This is thanks to the hard work, care and compassion of our staff, we wish those people well as they continue their recovery.

Other Covid19 media communications

Covid19 has dominated all of our media coverage since the pandemic began. So numerous are these stories it is not possible to detail everything we have seen published in that time. What follows are links to a fraction of the messages we have shared with our patients and the public in our region via the media and social media channels. It would also be appropriate for me to publicly thank our local broadcasters and publications for standing with us throughout this period. Their support has enabled us to communicate in a timely and effective manner with the population we serve and has served to remind staff of just how much the public values their efforts.

Here are just some of the headlines we have generated since March:

17 March	New visiting arrangements announced due to Covid19
18 March	Routine operations and outpatient appointments cancelled
21 March	Chief Executive expresses sympathy over death of patient from Covid19
23 March	All visiting stopped at HUTH
24 March	Steps taken to protect the most vulnerable babies
25 March	Social media campaign to invite nurses and midwives to join the Trust
29 March	Chief Executive expresses sympathy after second death of patient
31 March	Infectious disease nurses praised for COVID-19 response
7 April	Hospitals draw up plan to cope with demand during COVID-19 outbreak
9 April	Direct route for urgent care opens
9 April	"Help us keep front line staff caring for the sick"
24 April	City's thank you message to NHS staff
27 April	Appeal to the seriously ill to come to hospital during COVID-19 outbreak
28 April	Nurses supporting Intensive Care families during COVID-19 outbreak
29 April	Chief Nurse asks people to stay at home to support #ClapForCarers
1 May	NHS staff to thank the public
1 May	COVID-19 clinical trial shows encouraging results
7 May	Meet our heroes with brown cardboard boxes
8 May	Key hospital meeting moves online
11 May	Some operations to resume as hospitals move to second phase of COVID-19
12 May	There's no better time to celebrate our nurses
13 May	Hull Royal Infirmary to create new ward block to help people with COVID-19
14 May	Over 300 coronavirus patients return home from hospital
21 May	Team created to help people with breathing difficulties during COVID-19
26 May	Waiting for an appointment? Here are some questions you might have
27 May	Online antenatal classes deliver their first Zoom babies!
3 June	'COVID-19 has had a huge impact on our volunteers service'
17 June	COVID-19: "We now need a different type of public support"
23 June	Pharmacy plays a key role in COVID-19 treatment and research
24 June	Help for cancer patients throughout COVID and beyond
30 June	"If you're coming to Hull's Emergency Department, please come alone"
2 July	Hear our Infectious Diseases consultants talk about Covid-19 at our AGM
3 July	Hospital boss issues warning ahead of pubs reopening this weekend

2. Media Coverage

The Trust's media coverage has been almost exclusively positive during the Covid19 period. A full report on media and social media coverage is being developed for the next Trust board meeting along with key learning points for communications and public relations in the future.

As well as issuing essential public health messages which received widespread coverage, the Communications team produced a raft of positive stories about individual teams/wards/departments and their response to the outbreak. We used the focus on the NHS to issue reminders over the correct use of ED and the importance of using alternative community services. We also used video, audio and social media to its fullest potential to achieve our aims and send out key messages.

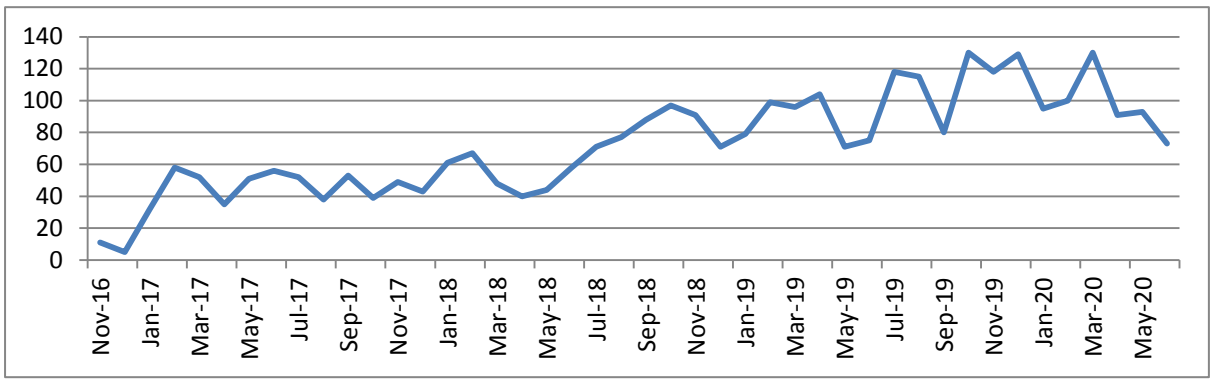
3. Golden Hearts and Moments of Magic

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 April, May and June we received 91, 93 and 73 Moments of Magic nominations, respectively.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2016-2020



Work is currently underway to establish a mechanism for acknowleding the efforts of all of our staff during 2020. The Golden Hearts Awards will go ahead as ever and we will seek to use that scheme and Moments of Magic to ensure they reflect the Covid19 pandemic.

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 July 2020

Title:	Board Assurance Framework 2020-21
Responsible Director:	Carla Ramsay – Director of Corporate Affairs
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	The purpose of this report is to present an updated draft Board Assurance Framework for 2020-21, for review and approval by the Trust Board.	
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	✓
Summary of Key Issues:	Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives. The Board Assurance Framework for 2020-21 is set in the context of the Covid-19 pandemic; in strategy terms, the way that the pandemic has affected business as usual will affect the progress that the Trust will be able to make towards its strategic objectives this year but this will not be the totality of what affects the Trust's ability to make progress on its strategic objectives. The draft Board Assurance Framework for 2020-21 was presented as a draft at the May 2020 Trust Board meeting, and it was agreed to undertake more detailed discussion at a forthcoming Board Development session, which was undertaken on 29 June 2020. The discussion and point of agreement from the Board Development session are incorporated in to the updated draft framework attached to this paper. Once agreed by the Board, the usual process to capture positive assurance and gaps in assurance during the year will commence and draft Quarter 1 ratings will be brought to the next Trust Board meeting, as well as flagging up any exceptions or process 'tweaks' that might have come up in the intervening period.	

Recommendation:	The Trust Board is asked to review and approve the Board Assurance Framework for 2020-21

Hull University Teaching Hospitals NHS Trust

Trust Board

Board Assurance Framework

1. Purpose of this report

The purpose of this report is to present a draft Board Assurance Framework for 2020-21, for review, amendment and approval by the Trust Board.

2. Background

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

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

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

The Board's approach to the BAF was reviewed by the internal auditors in 2019-20 and gave an opinion of 'substantial assurance', the highest level of assurance, for the way in which the BAF was constructed and used by the Board and its Committees. There was one recommendation to further develop the BAF, which was to put timescales on any identified gaps in controls for resolution. This has been built in to the attached BAF for 2020-21.

3. Board Assurance Framework (BAF) 2020-21

Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives.

The Board Assurance Framework for 2020-21 is set in the context of the Covid-19 pandemic; in strategy terms, the way that the pandemic has affected business as usual will affect the progress that the Trust will be able to make towards its strategic objectives this year.

The impact of Covid-19 will affect the return to more business as usual; there are many positive aspects from Covid-19 that the Trust will seek to continue, which are part of the controls and positive assurance captured on the initial risks in the draft BAF – the impact on the Trust being able to make progress on its strategic objectives will have been positively impacted, as well as adversely impacted, by Covid-19, and the attached BAF seeks to reflect this.

Covid-19 will also not be the totality of what affects the Trust's ability to make progress on its strategic objectives; consideration of this has also been captured in the attached draft BAF.

3.2 Corporate Risk Register

An element included in the BAF is the corporate risk register. The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 24 risks on the corporate risk register. Of these 24 risks, 20 map to risk areas on the BAF, as follows:

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 8 corporate risks (pension risk shared with BAF 7.1)

BAF 3 quality of care = 4 corporate risks
BAF 4 performance = 4 corporate risks
BAF 5 partnership working = 0 corporate risks
BAF 6 research and innovation = 0 corporate risks
BAF 7.1 financial plan = 2 corporate risks (pension risk shared with BAF 2)
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 2 corporate risks

The 4 risks that do not map to a specific area on the BAF are the four Trust-wide risks relating to Emergency Planning and Preparedness.

The number of corporate risks relating to staff, quality of care and performance have remained static in the last 2 months so represent the key areas of 'burden' of risk identified for the organisation.

The corporate risk register contains one over-arching corporate risk about the Covid-19 pandemic, which was originally detailed in to 8 operational, Trust-wide risks underneath this. This is being regularly reviewed by the Covid-19 Command structure, and two risks recently closed and the risk ratings revised for a number of these underpinning risks. The Covid-19 corporate risk does not map to one singular BAF area and is an over-arching risk management situation for the whole Trust.

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

4. Recommendations

The Trust Board is asked to review and approve the Board Assurance Framework for 2020-21

Carla Ramsay
Director of Corporate Affairs

July 2020

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

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

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

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

Trust does not capitalise on opportunities brought by the name change and growing partnership with the University, missing opportunities for staff and patients

FINANCE
Financial sustainability

Strategic risks:
Failure to deliver annual financial plan and associated increase in regulatory attention

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

PATIENTS
High quality care
Great clinical services

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

INFRASTRUCTURE
High quality care
Financial sustainability

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

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

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

PARTNERS
Partnership and integrated services

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

BOARD ASSURANCE FRAMEWORK 2020-21 – Draft as presented to the Trust Board 14 July 2020

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (mitigate gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	From the Trust's strategy: *One of our key priorities is the creation of a positive working culture, because we know that investing in our staff's development, and supporting and caring for them, will enable them to deliver great care; with commitment, compassion and courage.* *Principal Risk*: There is a risk the Trust does not make progress towards further improving a positive working culture this year *What could prevent the Trust from achieving this goal?* Risk that Covid-19 impacts on staff morale, or staff energy to be on a journey of improvement when working in the reality of a pandemic, +/- working in different teams or settings through redeployment	None	**4 (impact major) x 3 likelihood possible = 12**	Establishment of the Workforce, Education and Culture Committee to provide Board-level oversight and accountability for key elements of the People Strategy Refreshed People Strategy focusses on: leadership capacity and capability, empowering staff to lead improvement, equality, diversity and inclusion, employee engagement, communication and recognition Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development; Workforce, Education and Culture Committee set up to seek assurance on progress being made Engagement of Unions via JNCC and LNC on staff survey and associated action plan Board Development Plan will include development of unitary board and leaders by example Leadership Development Programme	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas – to be tasked to WECC and Workforce Transformation Committee for service plans to be agreed by close Q2 Consideration of a plan specifically for medical engagement – suggest timescale of end Q2 Need to undertake workforce engagement and transformation as part of Humber Acute Services Review – timescales per HASR progress					**4 major x 1 rare = 4**	**<u>Positive assurance</u>** Covid-19 has led to daily/regular communications and updates to all staff – level of staff communication has increased positively and can take lessons from this when returning more to business as usual **<u>Further assurance required</u>** Timing and ability to be able to return to specific work on staff engagement, leadership development and other activities that have been impacted by Covid-18 and whether Q2 Is a realistic timescale for this Understanding impact on staff morale, impact of staff moves and redeployment on training and development and bringing organisation on journey of improvement during a sustained period of managing Covid-19 Understanding of impact on staff morale and engagement if/when central financial support for Covid-19 staff support is ended

		Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage Risk that some staff do not acknowledge their role in valuing their colleagues			commenced April 2017 to develop managers to become leaders able to engage, develop and inspire staff – continued in 2019 with additional cohorts; 2020 virtual programme being developed, using learning from previous programmes Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers Regular reports to the Trust Board on the People Strategy Significant staff support put in place for Covid-19 including 24/7 psychological first aid support Daily/regular messages to staff on Covid-19 activity, Trust Surge plan, PPE, staff support, staff testing Board-level leadership in HASR and maintaining momentum on progress Covid-19 reflection piece – gain insights from staff on successes that should be maintained following Covid-19 surge activity						

Risk Appetite

The Trust has been managing and mitigating the level of risk posed by staff culture since 2014, and has been on a journey of improvement on staff engagement. There needs to be a renewed focus on staff culture to bring about a new level of improvement. The appetite for risk is high, insofar as the Trust has worked in a high-risk environment regarding staff culture, which has been mitigated over time as a result of acknowledging the poor staff culture in 2014 and putting a robust plan in place to engage with staff ever since. The Trust wants to mitigate this to a lower-level risk in respect of the impact that poor engagement and poor behaviours have; the Trust is not prepared to take risks with staff culture where this jeopardises patient care or staff welfare. Additional communications and staff welfare have been brought in during Covid-19, from which positive lessons can be taken, linked to this level of risk appetite – resolutions have been put in place quickly before risks in staff numbers or engagement occurred with Covid-19.

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	From the Trust's Strategy: *We will become the employer of choice locally and in the NHS regionally, with staff choosing to start and continue their careers with us. We will also increasingly attract staff to our posts from across the UK and wider world.* *Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand *What could prevent the Trust from achieving this goal*? National and international shortages Impact of Brexit on availability of EU workers Costs of supporting overseas recruitment Impact on staff health and	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG	**4 (impact major)** **3 (likelihood possible)** **= 12**	Refreshed People Strategy articulates changing workforce requirements Workforce Transformation Committee and WECC assurance – staying ahead to meet changing workforce requirements, international recruitment and the introduction of new roles (such as Nurse Associate, qualified ACP posts etc) Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Review of international recruitment needs for 2020-21 Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place and held to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of	Need to build in *Developing Workforce Safeguards* for visibility at Trust Board on safe staffing across the Trust and staffing metrics – to be completed by close Q2 Understand impact of Covid-19 on education and training, future timelines for trainees, as well as building up organisational capacity for education, training and supervision – undertake assessment through WECC by end Q3				4 x1 = 4	**Positive assurance** Recruitment was in a positive position prior to Covid-19; Covid-19 brought in ability to recruit retired staff and qualifying students quickly **Further assurance required**

		availability due to Covid-19 including long-term trauma and burn-out Productivity decreases due to Covid-19 could place more demands on staff	Capacity of intra-vitreal injection service		choice during and following completion of training Nursing safety brief several times daily to ensure safe staffing numbers on each day Employment of additional junior doctor staff to fill junior doctor gaps Regular reports to the Trust Board from the Guardian of Safe Working Particular focus and investment in staff support during Covid-19 including mental health support Covid-19 redeployment undertaken with support of HGs and undertaken in a planned way						

Risk Appetite

There is a link between patient safety and finances; the Trust draws a 'red line' as compromising quality of care and has built in to the financial plan in 2018-19 and was carefully managed in 2019-20, which saw an increase in agency spend in order to maintain staffing numbers but also investment in new posts and new ways of entering nursing. The Trust needs to reduce the risk to its financial sustainability posed by quality and patient safety but without compromising the Trust's position on patient safety. The Trust is putting a plan in place to encompass new clinical training roles and build these in to workforce plans, so is demonstrating a good appetite to adapt and change to further mitigate this risk. The Trust has shown some agility and willingness to invest as part of this risk appetite but as a carefully managed financial position.

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	Taken from the Trust's strategy: *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* *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 *What could prevent the Trust from achieving this goal?* That the Trust does not develop its patient safety culture That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust	CCSHG: lack of compliance with blood transfusion competency assessments CCSHG: Pathology results reviewed by requesting clinicians CCSHG: Risk to patient safety involving discharge medicines	**4 (impact = major)** **4 – likely = 16**	New Quality Improvement Plan (QIP)I being put in place for 2020-21, focussing on key quality priorities, using project management methodology to set realistic goals to improve. The QIP will run throughout the financial year and monthly updates will be provided to the Quality Committee for confirm and challenge. New CQC action plan being put in place following publication of the partial inspection in June 2020; this will pick up on all 'should do' areas from the CQC, with each HG tasked with setting an action plan to address key points in their own areas Midwifery services have a robust plan to achieve the ambition in Better Births this is overseen at organisational and LMS level The Trust has put in place all requirements to date on Learning from Deaths framework over the last 3 years The Trust regularly monitors quality and safety data to understand quality of care and where further	Need to complete gap analysis against the national Patient Safety Strategy and implement a trust-wide action plan – by end Q2 Need to complete an updated Patient and Public Engagement plan and governance structure by end Q2 Need to assess impact on patient safety and clinical harm due to Covid-19 service delivery and service changes – by end Q1 Need to look at Board-level reporting on patient outcomes – by end Q3					4 x 2 = 8	**<u>Positive assurance</u>** Covid-19 has required temporarily cessation to some activities such as routine meetings; there is an opportunity to refresh the governance structure around patient safety and high quality care to continue in a lean, patient-focussed way **<u>Further assurance required</u>** Outcome of risk assessments/quality impact assessments on changes to patient pathways and delays to patient care in case these flag risks to patient harm

		does not increase its public, patient and stakeholder engagement, detailed in a strategy			response is required Fundamental standards in nursing care on wards are being adapted for Outpatients. Will be monitored at the Trust Board and Quality Committee Participation in the "Moving to Good" Programme Close relationship with commissioners on clinical quality and improvement; have identified areas of partnership working on post-pandemic harm and patient waiting list management							

Risk Appetite

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

GOAL 4 – GREAT CLINICAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	Taken from the Trust's strategy: *The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* *Principal risk:* There is a risk to access to Trust services due to the impact of Covid-19 1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19 2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance 3- 2020-21 planning guidance is not expected until end May 2020 *What could prevent the Trust from*	Cancer and Clinical Support HG: risk of diagnostic capacity vs. continued increases in demand ECHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target Corporate: pensions Corporate: availability of pressure relieving mattresses	**4 (impact = major)** **4 (likelihood = likely)** **= 16**	Quality Impact Assessments being undertaken on changes in service delivery due to Covid-19 Assessment per HG and service for Covid-19 recovery plans Clinical harm reviews being undertaken on patients waiting longer than 52-weeks, on 104 day cancer waits, urgent operations cancelled for the second time, patients not re-booking within 28 days of cancellation and cancellations due to Covid-19 Partnership working during Covid-19 and revised national guidance and emergency legislation reduced significantly Delayed Transfers of Care and hospital patients waiting packages of care Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment Impacts on waiting lists due to Covid-19 measured and published weekly Capacity and demand work in all pathways	National guidance awaited on post-pandemic recovery and service re-instatement – may not be able to deliver same levels of activity or take out costs of previous forms of delivery – guidance expected and plans to be formulated in Q1 - all clinical areas will need to be reconfigured to comply with current national guidance on Covid-19 and this will impact on efficiency and productivity of services					4 x 2 = 8	**<u>Positive assurance</u>** New ways of service delivery adopted due to Covid-19, resulting in more efficient ways of working and ability to step activity back up in different ways, such as clinical triage of all new referrals, increased availability of advice and guidance, telephone consultations – ability to maintain these more efficient ways of working. This includes work with partners on hospital discharge processes and use of Urgent Care Centres as alternatives to ED **<u>Further assurance required</u>** Results of Quality Impact Assessments and service plans to determine impact on waiting lists; realistic recovery times may be protracted and adding to already large waiting list Further work required on ED performance as patient numbers start to rise again

		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 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 Ability to step back up activity following Covid-19 surge has rate-limiting factors on PPE and critical care capacity, as well as staff availability and patient availability			Plan to review medical base ward capacity to meet demand Restoration command structure in place							

Risk Appetite

A range of plans are being put in place to further manage these issues in to 2019-20. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. The Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope of the Aligned Incentives Contract where the activity comes under the local commissioners' contracts, and fit within the funding from NHS England for specialised commissioning services. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes.

GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	Taken from the Trust strategy: *In our strategy we have made a powerful commitment to work in a collaborative and proactive way, at all levels, to foster positive relationships with our partners and more closely integrate our services with other providers in primary, community and mental health and social care* *Principal risk:* That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost *What could prevent the Trust from achieving this goal?*	None	**3 (impact = moderate)** **3 (likelihood = possible)** **= 9**	The Trust has key leadership roles in the current ICS governance structure – this has a breadth and depth of span and senior leaders from HUTH involved in all key groups, chairing many HUTH taking role in continued partnership work and asking for momentum on acute service reviews to be picked back up as soon as possible Undertaken detailed stakeholder feedback survey, and formulating action plan following Board discussion Recent discussions and plans on Humber Acute Services Review	Updated ICS framework for post-Covid-19 surge recovery to avoid duplication of work as well as to reflect ICS priorities on planning and delivery that have been interrupted by Covid-19 – timescales will be per ICS but likely to be concluded in Q3 Ongoing discussions on accountability framework at ICS level, the statutory duties of each ICS member organisation and the governance structures underpinning these – require continued discussion in 2020-21					3 x 1 = 3	**Positive assurance** **Further assurance required**

Risk Appetite

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

GOAL 6 – RESEARCH AND INNOVATION

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Chief Executive Chief Medical Officer	Taken from Trust strategy: *Our purpose in developing a new long term goal of 'great research and innovation' is to demonstrably improve the lives of the population we serve, by establishing the Trust as a nationally recognised research centre of excellence, with a culture of innovation* *Principal risk:* There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships *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 Unknown impact of Covid-19 on partner organisation and	None	**3 (impact = moderate)** **4 (likely)** **= 12**	Strengthened partnership with the University of Hull Trust investment in last 12 months in research capability including jointly funded posts and projects Actions against Strategic Goals within Trust Strategy for Research and Innovation in place – detailed plan in place with milestones and risk assessment Further development of partnership with Sri Ramachandra, India and joint research conference and projects	Understanding impact of Covid-19 in the short- and long-term on Trust's strategy as well as key partners – likely to understand position by close Q3 Understanding relationship and impact on clinical quality and patient outcomes with Trust's R&I and clinical audit activities – to have framework for updating/reporting at high level by end Q3					3 x 2 = 6	**Positive assurance** **Further assurance required**

		research funding availability Recovery of Trust research staff redeployed during Covid-19 into front-line roles back in to research work										

Risk Appetite
As stated above, the Trust needs to balance the risk of investment in R&I capacity and capability against competing priorities, with its organisational reputation and the benefits that being a research-strong organisation will bring, in relation to funding, clinical service development and recruitment of high-calibre staff; there is an appetite to innovate in this area and go on a journey of development

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2020-21 *What could prevent the Trust from achieving this goal?* Planning and achieving an acceptable amount of CRES – the Trust may have to consider greater efficiencies/activity delivery rather than	Corporate: Pensions	**4 (impact = major** **4 (likelihood = possible)** **= 13**	HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Use of NHSI benchmarking and Carter metrics to determine further CRES opportunities Extra PAF Nov 19 to review RTT, cancer and CRES Five-year STP plan required for Nov 19 Working with commissioning colleagues and NHSI/E to agree a recovery plan for 19/20. Monthly meetings taking place to review progress. Ongoing management of Trust cash balances to ensure no liquidity issues. Recovery planning already started – plans being put in place per service and across the Trust in Q1	Assurance over grip and control of cost base; underlying run-rates increasing pressures Accurate forecasting and control Grip and control of locum and agency spend Delivery of recurrent CRES All above controls need to be addressed by end Q1					4 x 2 = 8	**Positive assurance** **Further assurance required**

		cash-releasing schemes Impact of underlying deficit of any unplanned overspends Ensuring Covid-19 block contract funding and cost recovery meet needs; unknown plan post M4 as yet Impact of post-Covid-19 national planning requirements Controls linked with post-Covid-19 service and activity recovery – may not be able to return to normally contracted levels of activity in short-term										

Risk Appetite

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

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *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 (year 2) *What could prevent the Trust from achieving this goal?* Lack of achievement of sufficient recurrent	None	**4 (impact = major)** **4 (likely)** **= 16**	Robust financial planning processes in place Covid-19 recovery planning already commenced Covid-19 funding available nationally – should not increase underlying deficit	Need to update longer term financial plan – planning assumptions may change as well as ability of ICS to be able to meet all financial pressures of system Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution					4 x 1 = 4	**Positive assurance** **Further assurance required**

		CRES or make efficiencies Unknown impact of Covid-19 finances and recovery planning National guidance not yet released for system financial planning during and post Covid-19										

Risk Appetite

The Board has an appetite to discuss a long-term financial plan to address the underlying financial position and to understand the risks that form part of the underlying issues as well as potential solutions. This is becoming an increasing priority.

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; 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	None	**5 (impact)** **4 (likelihood)** **= 20**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Business case for Wave 4 STP capital funding being completed Q1 2020-21; part of the balance accessed in 2019-20 for ground floor capacity and will enable some infrastructure risks in 2020-21 to be addressed Combined Heat and Power Plant capital funding sourced in 2019-20 – CHP being commissioned in 20-21	Insufficient funds to manage the totality of risk at the current time – unable to address internally					5 x 1 = 10	**Positive assurance** **Further assurance required**

Risk Appetite

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

Hull University Teaching Hospitals NHS Trust

Trust Board

July 2020

Title:	Our Patients - Performance Summary	
Responsible Director:	Teresa Cope - Chief Operating Officer	
Author:	Teresa Cope - Chief Operating Officer	
Purpose:	The purpose of this paper to provide an Executive Summary of Performance for May / June 2020 against national standards and the Trust's Operating Plan trajectories for 19/20.	
BAF Risk:	BAF 4 – Performance	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	Performance against a number of standards continues to be severely impacted by the Covid-19 pandemic and the decision to cease all routine out-patient, diagnostic and elective activity in accordance with national guidance in mid-March 2020. Whilst the majority of activity has been able to resume from May, following further national guidance issued on the 29th April, there remain significant restrictions on some activity as well as capacity and workforce challenges which continues to impact on performance.	
Recommendation	That the Trust Board receives and accepts the content of this paper and indicates whether any further assurance is required.	

Performance Report - Executive Summary

July 2020

1. Purpose

The purpose of this paper to provide an Executive Summary on Performance for May / June 2020 against the national standards. It should be noted that Operating Plan trajectories for 20/21 have not yet been set as national planning guidance for Phase 3 (August 2020 – March 2021) has not yet been received.

Performance against all 'responsiveness' indicators is monitored by the Performance and Activity Meetings, chaired by the Chief Operating Officer and the Impact of Covid on key performance standards is monitored weekly and is shown at Appendix 1.

At the time of writing, the Trust remains in Phase 2 of restoration and recovery (which runs to 31st July 2020) and has continued to incrementally scale down its Incident Command Structure which has been in place since early March as the number of suspect and confirmed Covid-19 patients, declines. From week commencing 13th July, the twice weekly Gold Command meetings will be replaced by a weekly Covid Steering Group, which will continue to provide information and assurances to the Trust Board and safely managing all issues relating to the Trust Strategic objectives in respect of Covid-19.

2. Unplanned Care

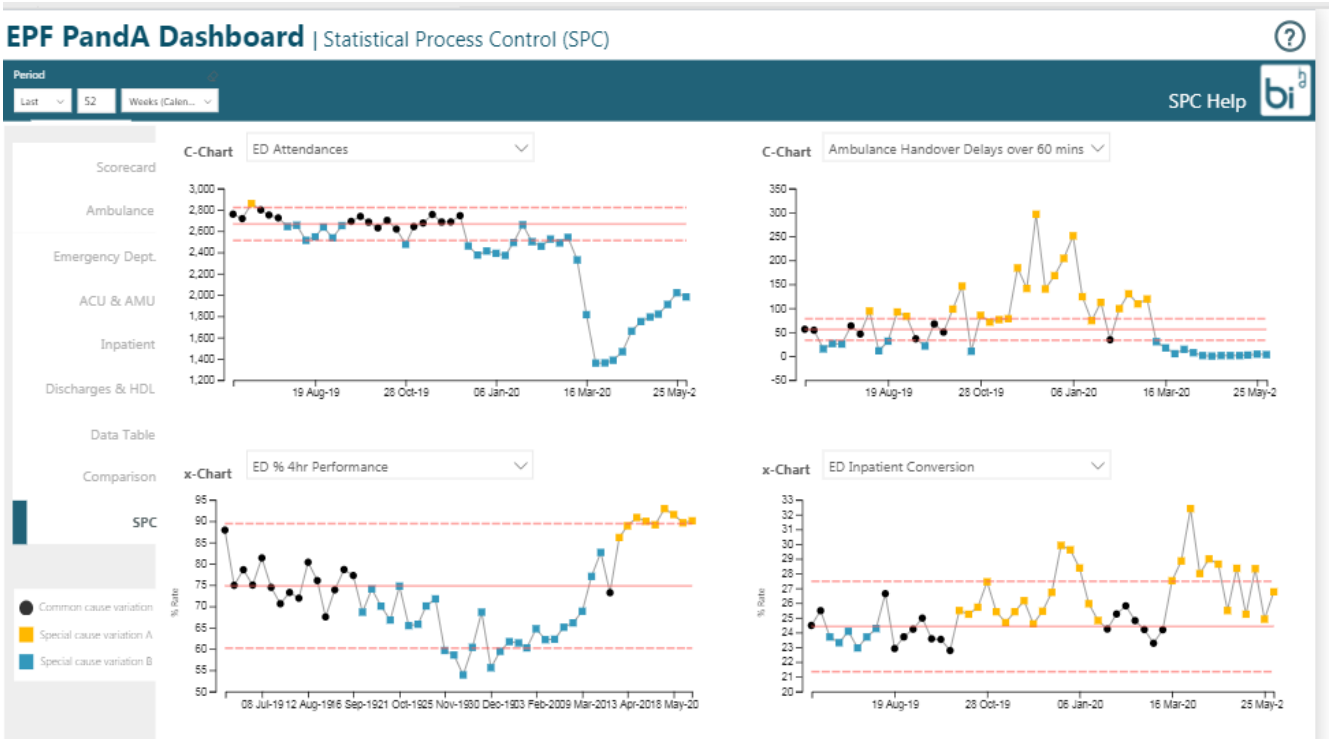
2.1 ED Performance

As the number of covid suspected and confirmed cases in the hospital has reduced the Emergency Department has returned to its usual configuration supported by Ward 1 providing a timely pathway for Covid suspected patients. This has enabled the Emergency Care Area of the ED to accommodate the increased number of ambulatory attends seen over recent weeks. Ward 36 is currently being refurbished to become the Covid assesment unit and this is expected to be completed by the end of July along with Ward 37 and Ward 38 which will be the designated Covid wards in the future.

2.1.1 ED performance for May 2020 was 93% (combined) and 90.7% (combined) in June. Type 1 ED attendances for May continue to increase and were 8,287 which is 31% below pre-Covid levels of attendances.

2.1.2 The reduction in patient attends, increased senior medical presence in ED and improve bed availability has reduced the number of overall breaches. Breach analysis undertaken over recent weeks has identified that access to diagnostics (particularly CT Scanning) and timeliness of speciality reviews are now the main reasons for breaches of the 4 hour standard. Consequently additional metrics have been put in place, agreed across Health Groups to reduce the number of breaches. These are monitored by the Emergency Performance and Flow Performance meeting.

2.1.3 The Trust continues to report Zero 12 hour trolley waits



2.1.4 The Trust monitors the overall time that patients spend within the Emergency Department as this is a key quality metric recommended by Getting it Right First Time (GIRFT) and the Royal College of Emergency Medicine. For May 279 patients (3.4%) of patients spent longer than 6 hours in the ED and 1 patient spend longer than 12 hours in the ED. For June this increased slightly to 495 (5.4%) of patients spending over 6 hours in ED and 18 spending longer than 12 hours. Overall length of stay in the ED is monitored via the Emergency Department and Flow Performance and Activity meeting.

2.1.5 The number of stranded and super-stranded patients continues to reduce. In May there were 57 patients whose Length of Stay was over 21 days and 103 whose stay was over 14 day. Over 21 day LLOS has reduced by 53% from the previous year. Trust Bed occupancy in Quarter 4 2019/20 was 89%.

3. Planned Care

3.1 RTT and Waiting List Volume

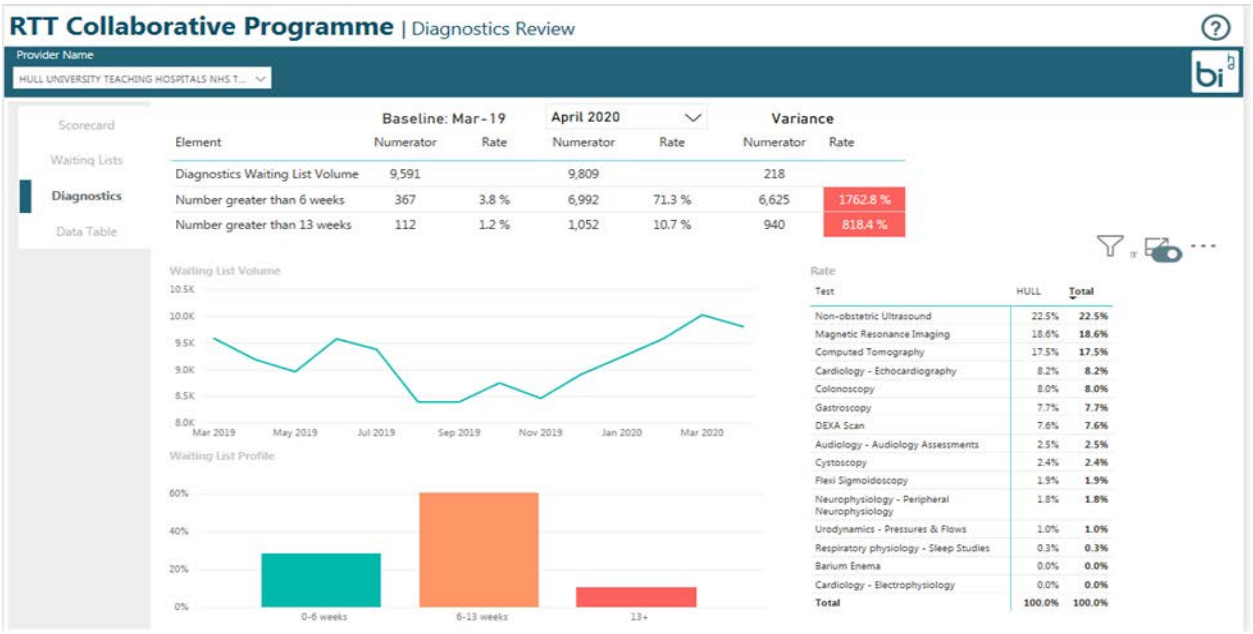
3.1.1 The Trust reported an RTT performance position of 49.91% for May. The requirement was to have no more patients on the RTT list than at the January 2020 baseline which was 53,808. The waiting list volume for May was delivered under the baseline trajectory at 52,746. GP referrals year to date for 20/21 are currently 62.7% reduced from 2019/20 due to Covid, although the Trust is still accepting referrals that are deemed clinically appropriate. This equates to 27,288 reduction in referrals on the same period last year.

3.1.2 The Outpatient New and Follow up waiting lists continue to increase with currently 45,000 patients awaiting a first outpatient appointment and 25,000 patients overdue their follow up >3 months. During the pandemic many services have started to use telephone and video-conferencing to deliver outpatient activity. This is currently at 50% of all out-patients appointments delivered non face to face. Patient initiated follow ups rather than traditional outpatient follow up at a clinically identified time are being implemented through the Optimise programme. Provider cancellation rate has now decreased to 5.6%.

52 week breaches reported in May was 909 which is a significant increase from March (86) and April (364). This will unfortunately continue to rise due to reduced levels of activity. Surgical prioritisation using the Royal College guidelines is underway and currently 70% of the waiting list is prioritised at Level 4. As the Trust is currently delivering the Level 1a, 1b and 2 with some Level 3 this will further compound the 52 week waiters who are mainly routine Level 4 procedures. Harm Reviews are undertaken on all breaches and these are reported into the Performance and Activity Meeting and the Trust Risk Management Committee.

4. Diagnostics

4.1 Performance against the diagnostic 6 week standard deteriorated significantly during April and May with only 18% of patients having their diagnostic test within 6 weeks. This was as a result national guidance issued in March which stipulated only emergency endoscopy and emergency CT Colonoscopy activity could be undertaken combined with the cancellation of routine diagnostic tests. In early May, further guidance was received which allowed some endoscopy work to be reinstated, albeit with a number of restrictions in place which has significantly reduced the capacity and productivity of the service. In addition the Endoscopy services has experienced workforce challenges as a number of clinicians have been redeployed to other areas of the Trust to support the response to the pandemic and not able to fully return to the Endoscopy service.



5. Cancer Standards

5.1 The Trust has continued to undertake cancer activity since the Pandemic was declared. There have been a number of revisions to clinical pathways in line with the national guidance that has been received by the Trust. All changes to the tumour site pathways have been subject to Impact assessments and shared with the Trusts newly established Ethics Committee as well as the Cancer Performance and Activity Meeting, which has continued to meet.

5.2 The Trust achieved the 2 WW standard in March 2020 and April 2020. Performance against the 2 WW Breast Symptomatic standard was 80% in May against the 93% standard.

5.3 Performance against 62 day standard was 70.8% for April, which was a small improvement on March. An inability to undertake the diagnostics phase of the pathway was the primary sources of the breaches against the 62 day standard.

5.4 The Trust achieved 67% for the Faster Diagnostic Standard for April due to the restrictions in place regarding a number of diagnostics test, notably endoscopy and CT colonscopy, however this has Improved to 80% for May (against the 75% standard)

5.5 At the end of April there were 67 patients recorded as having waited more than 104 days. Colorectal (29) and Urology (14) have the largest proportion. The reasons for this are due to the patient anxiety over Covid and the national guidance that has impacted on the diagnostic pathways in both of these services. The Theatre Resource Allocation Panel (TRAP) meets weekly and, to date, all Priority 2 MDT directed cancer work has been able to be accommodated. Concerns are now starting to be raised with capacity for

Priority 3 (patients who require treatment within 3 months of decision to admit) and those that are starting to become overdue. The Executive Team have oversight on this on a weekly basis.

7. Conclusion and Recommendations

The full impact of the Covid 19 pandemic has been seen during April and May 2020. Whilst some activity was permitted to resume from May 2020 workforce availability, PPE, and new Infection Prevention and Control requirements all mean that only a proportion of the usual activity levels is able to be undertaken.

The Trust continues to prioritise cancer and urgent patients and continues to work with the Spire Hospital to use Independent Sector capacity under the current national contracting arrangements. Management of current performance continues to be managed weekly with phase 2 restorations and recovery overseen by the existing command structure.

A Board Development session dedicated to reviewing BAF Goal 4 will will take place on 13th July

Weekly Scorecard

NHS Hull University Teaching Hospitals NHS Trust

Group	Measure	Notes	19/20 Avg. (where appropriate) Baseline	18 May	25 May	01 Jun	08 Jun	15 Jun	22 Jun	29 Jun	Trend (7/52)
RF	GP referrals (Volume)	GP or GP with Special Interest	3,690	1,006	842	1,259	1,220	1,289	1,323	1,266	
RF	GP referrals (Rate)	GP Referrals / OP Referrals	55%	47%	47%	50%	52%	54%	51%	50%	
RF	A&G Requests	Referrals to A&G Team	207	386	266	389	419	468	450	371	
RF	2ww Referrals	All referrals as 2ww priority from a GP	371	301	235	362	333	329	384	371	
RF	2ww seen within 14 days	Cancer Performance	93%	82%	81%	94%	89%	92%	90%	85%	
ED	4hr Performance	Type 1	70%	92%	90%	90%	89%	89%	84%	86%	
ED	Number of attendances	Type 1	2,644	1,910	2,020	1,981	2,060	2,151	2,291	2,126	
ED	4hr Performance	Type 1&3 combined	81%	94%	93%	93%	92%	92%	89%	91%	
ED	Number of attendances	Type 1&3 combined	4,188	2,810	2,987	2,933	3,016	3,127	3,491	3,209	
OP	New outpatient attendances	All mediums	5,001	2,678	2,086	2,639	3,109	3,118	2,975	2,905	
OP	Follow up outpatient attendances	All mediums	10,573	7,324	6,119	7,800	8,196	8,129	8,091	7,856	
OP	2ww Appointment attendances	Appointment Priority of 2ww	439	340	274	258	336	406	402	379	
OP	62 day RTT Cancer Performance		67%	47%	62%	62%	60%	74%	83%	32%	
OP	31 day DTT Cancer Performance		93%	93%	93%	95%	88%	91%	98%	79%	
OP	Number of hospital cancellations	Due to COVID-19	-	1,032	558	642	587	438	529	482	
OP	Number of patient cancellations	Due to COVID-19	-	103	69	73	75	71	71	55	
OP	Rate % OP hospital cancellations (all)	Hosp Cancel / Hosp Cancel + Patient Cancel + DNA + Attend	10%	18%	15%	14%	12%	12%	12%	11%	
OP	Rate % OP patient cancellations (all)	Patient Cancel / Hosp Cancel + Pat Cancel + DNA + Attend	12%	3%	3%	3%	3%	3%	4%	4%	

Weekly Scorecard

NHS
Hull University Teaching Hospitals
NHS Trust

Group	Measure	Notes	19/20 Avg. (where appropriate) Baseline	18 May	25 May	01 Jun	08 Jun	15 Jun	22 Jun	29 Jun	Trend (7/52)
IP	Elective admissions		1,661	741	633	744	780	777	828	857	
IP	Emergency admissions		1,010	768	752	794	754	782	901	814	
IP	Elective cancellations	Due to COVID-19	-	20	12	9	2	10	7	2	
RT	RTT list size	Against baseline March 19	52,808	53,774	54,133	54,017	53,541	54,488	55,131	55,584	
RT	Follow up backlog (over 3 months)	Against baseline March 19	18,761	24,250	24,650	25,305	26,025	27,276	28,405	29,882	
RT	ASI / Holding	Against baseline March 19	16,357	33,899	34,114	33,152	31,940	33,318	33,195	32,685	
RT	52 week breaches YTD	Against baseline 2018/19	2							909	
RR	Total number swabbed		-	1,390	1,332	1,452	1,574	1,671	1,730	1,726	
RR	Total number confirmed		-	92	54	26	46	35	24	10	
BD	Current inpatients as at 08:00 Monday		-	679	661	623	755	803	776	821	
BD	Total G&A Open	Based on yesterday's Monday vs previous Monday	-	1,010	1,011	1,011	1,011	1,007	1,005	1,005	
BD	Total G&A Occupied	Based on yesterday's Monday vs previous Monday	-	644	681	652	678	718	782	742	
BD	Total Crit Care Open	Based on yesterday's Monday vs previous Monday	-	70	70	70	70	70	70	70	
BD	Total Crit Care Occupied	Based on yesterday's Monday vs previous Monday	-	30	24	31	28	30	33	31	
BD	G&A Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	64%	67%	64%	67%	71%	78%	74%	
BD	CC Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	43%	34%	44%	40%	43%	47%	44%	
BD	Trust Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	62%	65%	63%	65%	69%	76%	72%	
DG	Diagnostics Over 6 weeks		1,075	7,107	8,684	6,260	5,793	5,451	4,541	4,664	

Hull University Teaching Hospitals NHS Trust

Trust Board

14 July 2020

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

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board to matters relating to quality governance and patient safety including: • Serious Incidents • Incidents • Infection Prevention and Control • Duty of Candour • CQC • Quality Improvement Programme • Mortality The NHSI IPC Board Assurance Framework assessment is included for briefing purposes	
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 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. The exceptions included in more detail in this report are that: • Incident reporting rates have begun to increase once more in line with increased activity • The Trust has seen an increase in falls resulting in harm • Following the March 2020 CQC inspection the Trust remains 'Requires Improvement'. However, a number of improved ratings were noted in the Medical, Surgery and Critical Care core services across HRI and CHH. The most improvement was noted at CHH, with a 16% increase the in the domains rated as 'Good' • The high level performance data and updates Infection Prevention and Control (IPC) for Q1; the Trust has completed a new IPC Board Assurance Framework and identified relevant actions to make further progress in key areas – this Framework has not identified any new issues that the Trust was not already working towards	
Recommendation:	The Board is asked to receive and accepted this report as assurance on the quality of care being provided in the Trust and that adequate mechanisms are in place to record exceptions and issues requiring further follow up.	

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 to matters relating to quality governance and patient safety.
ITEMS FOR ESCALATION IN MONTH (June 2020)

Safe:

- Six serious incidents were declared in June 2020
- Incident reporting rates have begun to increase once more in line with increased activity.
- Moderate harm and above incidents have increased
- Information in relation to duty of candour is detailed in Appendix 1
- The Trust has seen an increase in falls resulting in harm. Whilst the overall numbers of falls remain within the expected control limits (per SPC chart), the severity of harm has shown a rise in June 2020. The potential reason for this increase has been explored by members of the Falls Prevention Committee with actions and priorities to address this.
- No Trust apportioned MRSA bacteraemia cases were reported during Quarter 1. A community apportioned case was detected on the 22nd June 2020 and is under investigation via a Post Infection Review, and early indications suggest a previous complex medical history and a history of MRSA infection and colonisation.
- By end of Quarter 1, twelve Trust apportioned MSSA bacteraemia cases have been reported – a slight reduction in comparison to the same timeframe for Quarter 1 2019, twelve versus fifteen cases. All Trust apportioned cases are investigated using a root cause analysis (RCA) process.
- Thirteen hospital onset healthcare associated (HOHA) *Clostridium difficile* cases and four community onset healthcare associated (COHA) cases reported by the end of Quarter 1. The external threshold for reportable cases of *Clostridium difficile* has not been published to date from PHE/NHSE but local agreement is no more than eighty cases. To date all seventeen cases are investigated using a root cause analysis (RCA) process and normally tabled at a commissioner led Healthcare Associated Infection (HCAI) review group. To date, no cases have been tabled for discussion with the Commissioners due to competing priorities associated with COVID-19.
- Gram negative bacteraemia: Escherichia coli (E.coli), Klebsiella species and Pseudomonas aeruginosa. The Trust is required to report all cases of these bacteraemia to Public Health England (PHE). To date, twenty E.coli bacteraemia have been reported by end of Quarter 1 (24 in QTR 1, 2019/20), three Klebsiella (7 in QTR 1 2019/2020) and four Pseudomonas aeruginosa (9 in QTR 1, 2019/20). Any differences should be treated with caution due to small numbers and natural variation.
- During Quarter 1, one colonised case of Pseudomonas aeruginosa was detected on the Neonatal Intensive Care Unit (NICU) during April 2020.
- Outbreaks of diarrhoea and vomiting have continued, albeit at small numbers and only affecting bays. Ward H9 did have an outbreak of diarrhoea and vomiting during April 2020 which resulted in the ward being closed, but again was short-lived and no causative organism was found.
- A period of increased incidence of *Clostridium difficile* was detected on H80 with two cases reported during June 2020. At the time of the samples being taken, H80 was being used as a COVID-19 positive ward and both affected patients were being treated for COVID-19.

Effective: • No areas in Clinical Audit, NICE or Mortality for upward escalation.
Caring: • No areas of reporting and escalation fall within this domain.
Responsive: • No areas in Claims and Coroners for upward escalation.
Well-led: • Following the March 2020 CQC inspection the Trust remains 'Requires Improvement'; the Trust's overall rating was not considered by the CQC, in line with the CQC's inspection methodology put in place for COVID-19. However, a number of improved ratings were noted in the Medical, Surgery and Critical Care core services across HRI and CHH. The greatest amount of improvement was noted at CHH, with a 16% increase the in the domains rated as 'Good'. Areas of outstanding practice were noted to be compassion and care in neurosurgery and end of life care at HRI and CHH. A reference to the support offered to patients and families' by the organ donation specialist nurses was also documented. • The priorities for the Quality Improvement Plan 2020/21 and the Quality Accounts 2020/21 were approved at the June 2020 Quality Committee, the detailed plans are now being will be approved at the July 2020 Quality Committee. • As a result of COVID-19 NHS Improvement confirmed that the publication of the Quality Accounts is delayed and Trusts were not required to publish them by 30 June as normally required. NHS Improvement has provided a revised publication date of 15 December 2020 and a date of 15 October 2020 for submission to Stakeholders for review and statements. NHS providers are not expected to obtain assurance from their external auditors for the 2019/20 Quality Accounts.

SAFE

NEVER EVENTS AND SERIOUS INCIDENTS

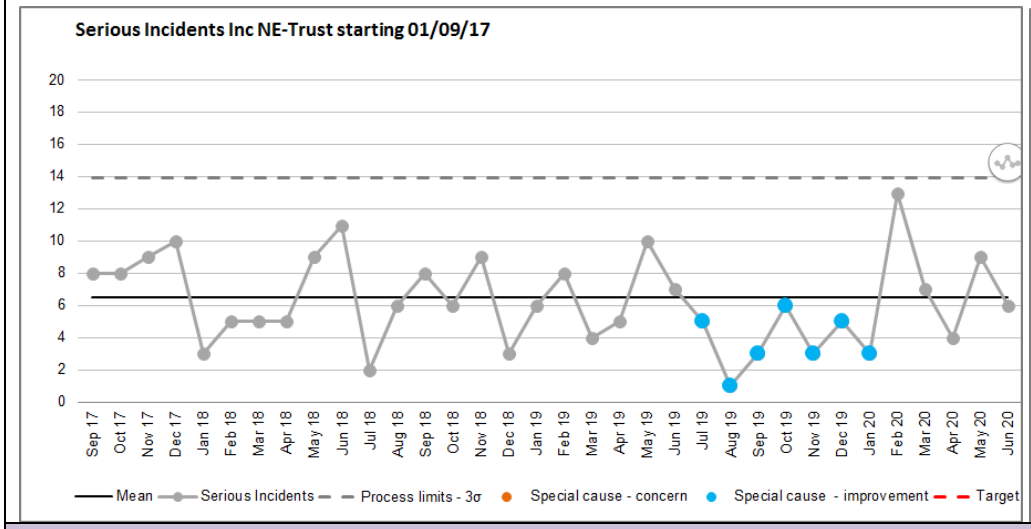
AREAS FOR ESCALATION

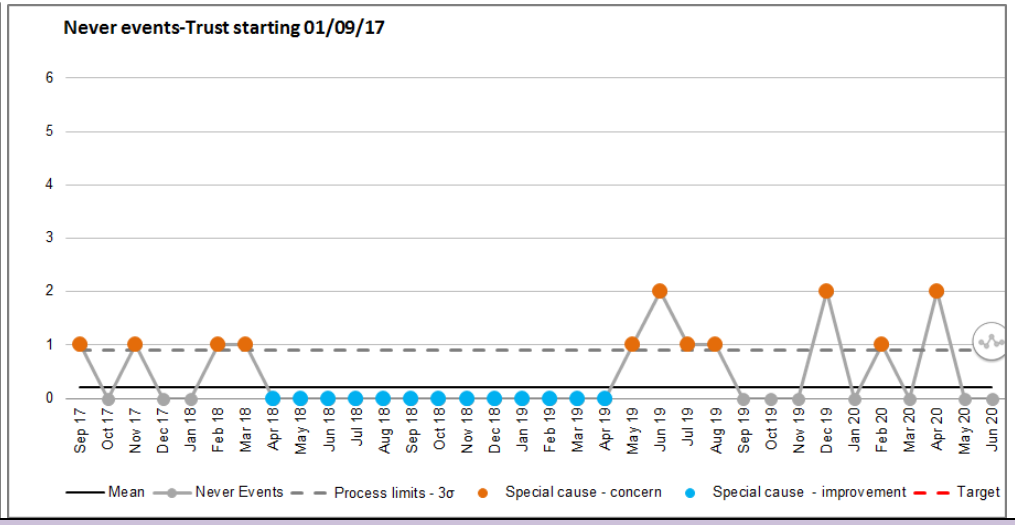
There were six serious incidents declared in June 2020, relating to two in-patient falls, two delayed diagnosis and a treatment delay and a safeguarding issue.

The June 2020 Trust SI committee received a presentation from members of the Trust Falls Prevention Committee, as the number of falls SI being declared appears to be on the increase. A QIP has been developed for Falls, which will include some of the learning identified from the SI investigations, including a focus on falls prevention in patients with dementia.

KEY UPDATES IN MONTH

The chart below indicates the trend in Never Events and Serious Incidents, in June 6 Serious Incidents were declared, no Never Events were declared.





RISKS TO DELIVERY

None noted

INCIDENT REPORTING RATES

AREAS FOR ESCALATION

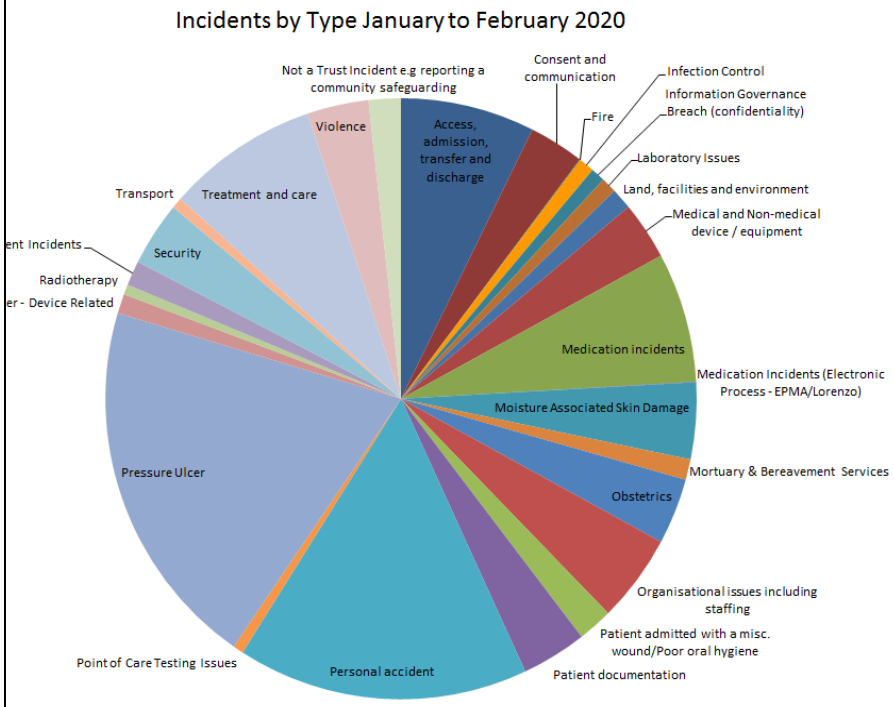
Following a reduction in the numbers of incidents reported during the month March to May 2020, we are now seeing an increase in incident reporting, the numbers are consistent with in-patient activity.

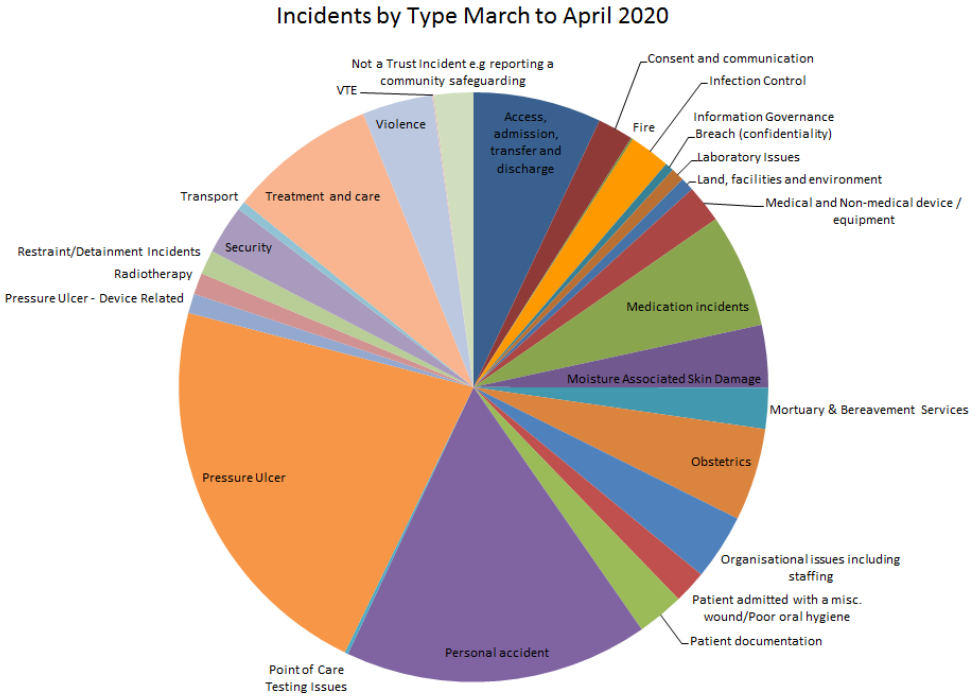
KEY UPDATES IN MONTH

Changes in the types of incidents being reported

The two charts shown below show the incidents reported in January and February 2020 (before the impact of Covid-19) and March and April 2020. The incidents reported during January and February are consistent with the Trust's normal reporting rates. The incidents reported during March and April, while less in total, are comparable in type of incident reported to previous months.

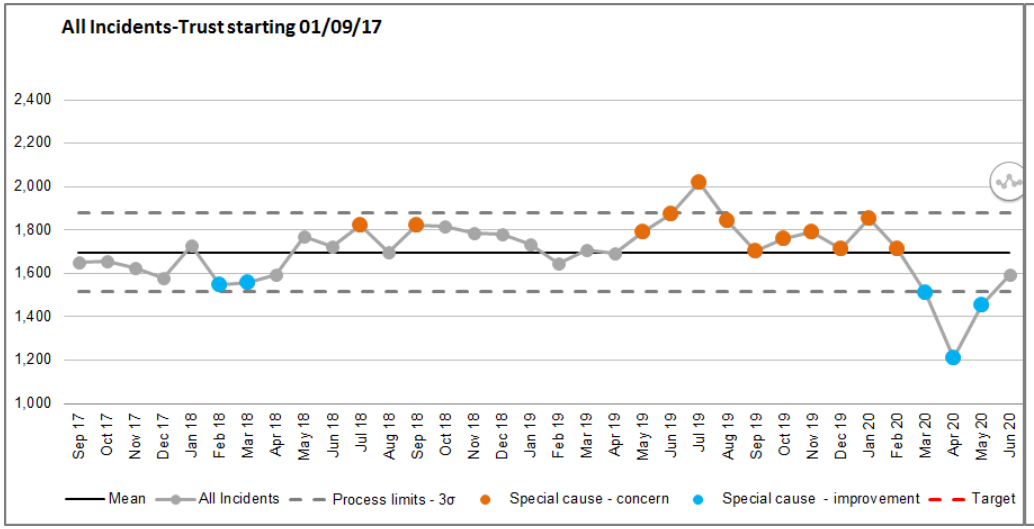
All Incidents reported in January to February and March to April 2020

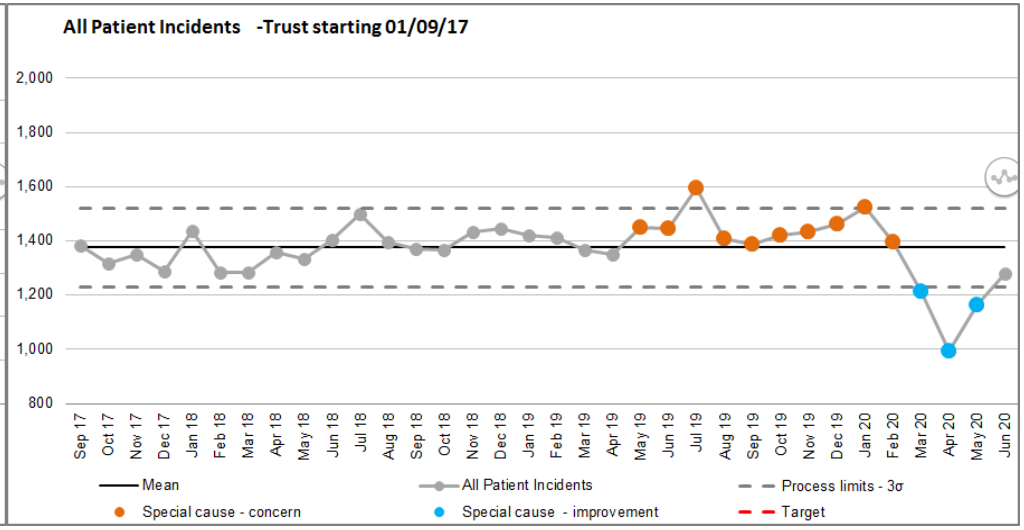




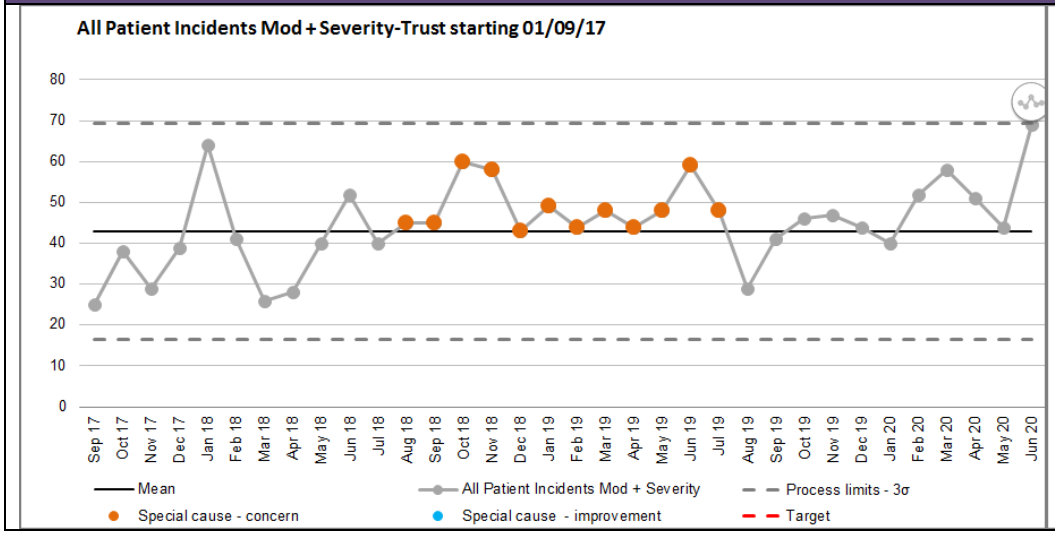
INCIDENT REPORTING RATES

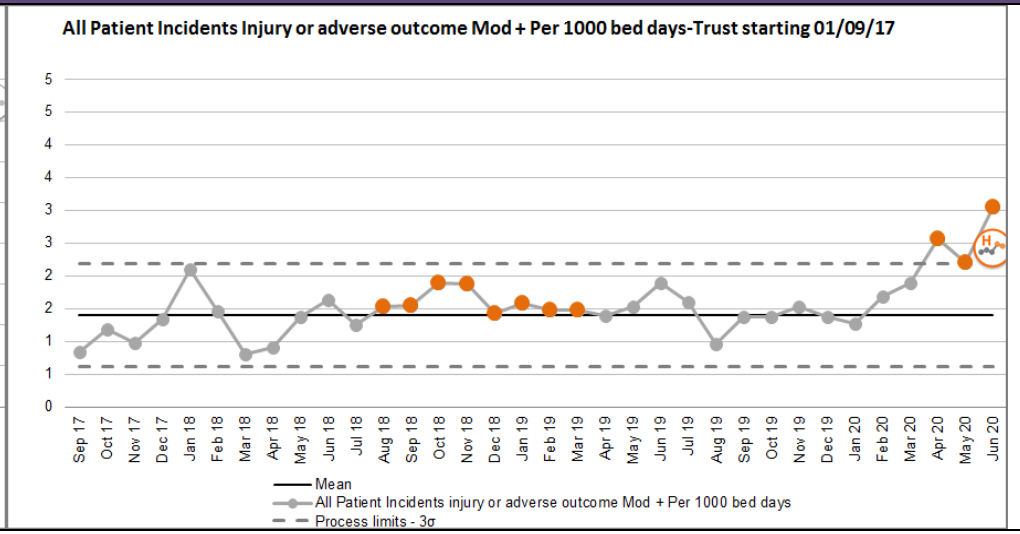
Incident Reporting Rates:
The charts below indicate that Trust incidents overall and patient incidents are both within expected parameters per SPC methodology. It is of note however, that moderate harm and above incidents, both in overall number, and per 1000 bed days, have increased. This equates to on average 3 moderate harm and above incidents per 1000 bad days in June 2020. This is due to the impact of Covid-19 and includes increased IPC reporting, discharge issues and pressure ulcers.





INCIDENT REPORTING RATES



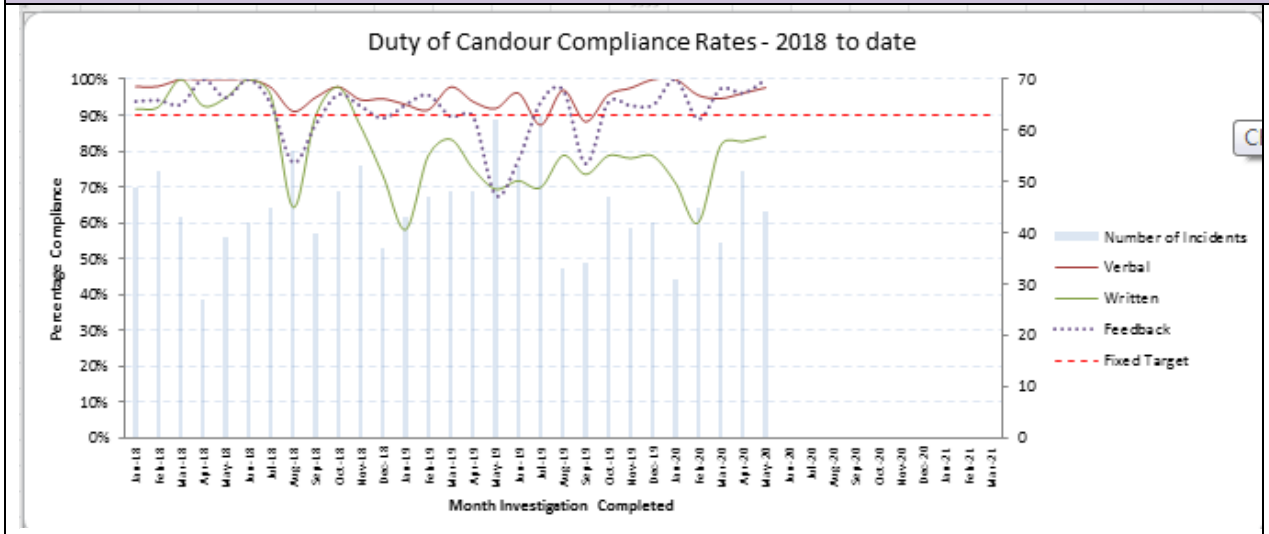


DUTY OF CANDOUR

AREAS FOR ESCALATION

A detailed report on Duty of Candour is attached at **appendix 1**

KEY UPDATES IN MONTH



Overall compliance for completed Duty of Candour incidents for May 2020

Duty of Candour incident categories/severity

FALLS

AREAS FOR ESCALATION

The Trust has seen an increase in falls resulting in moderate or major harm. Although the overall number of falls remain within the expected control limits, the severity of harm appeared to indicate a rise in June 2019, this trend has continued has continued. Plans to address this have been agreed at health group level with and organisational QIP to ensure sharing is learned.

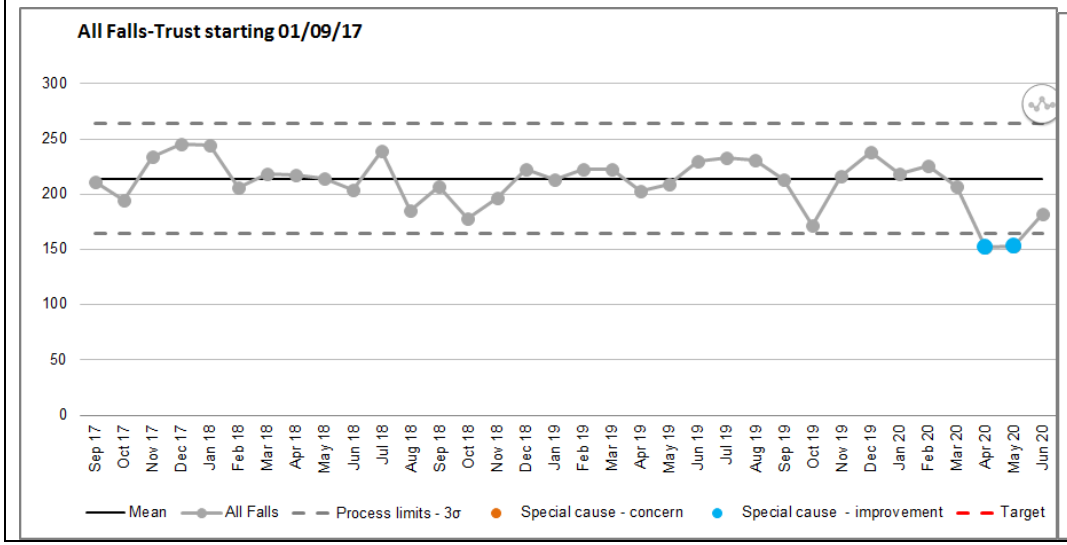
KEY UPDATES IN MONTH

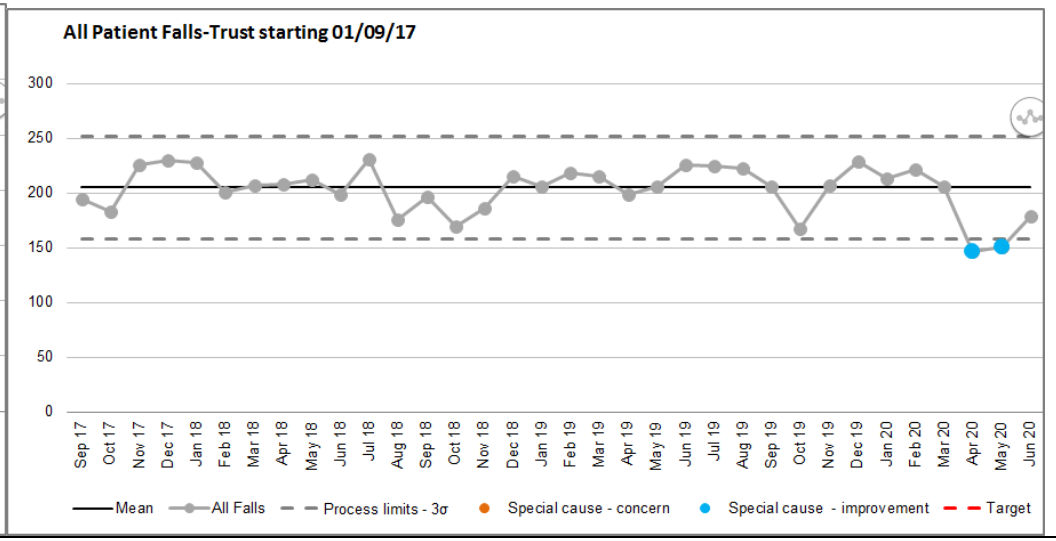
The Trust has seen an increase in falls resulting in moderate or major harm. Although the overall number of falls remain within the expected control limits, the severity of harm has shown a rise in June 2019, which has continued to June 2020. The potential reason for this rise has been explored by members of the Falls Prevention Committee; representation from this group attended the Serious Incident group to agree next steps.

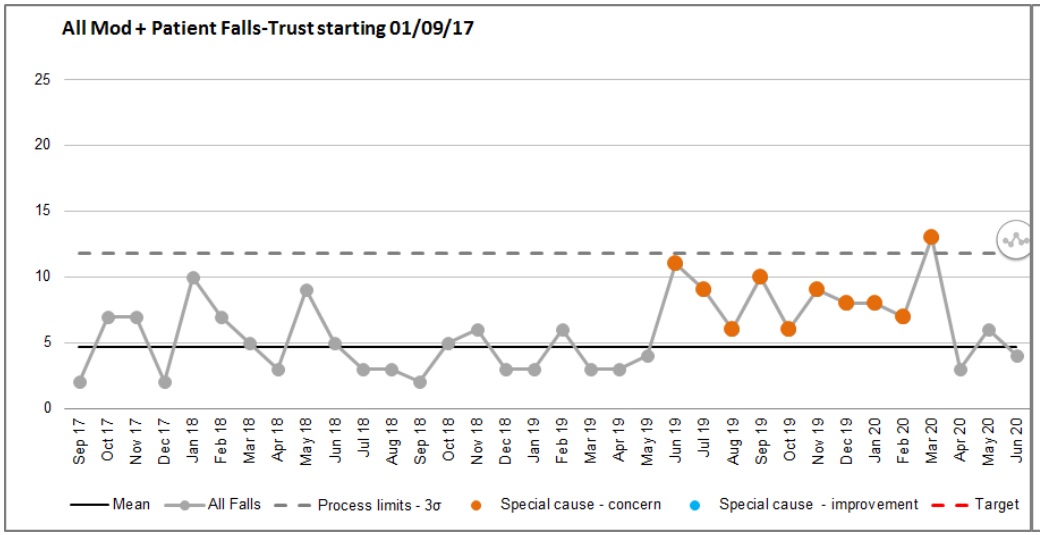
In June 2020, agreement was made to re-focus the purpose of the Falls Prevention Committee. Focus Groups are to be introduced; primarily these will be set up in Elderly Medicine and Oncology, where the highest numbers of falls are reported. The Elderly Medicine Focus Group will specifically look at the link between falls and patients with dementia or delirium.

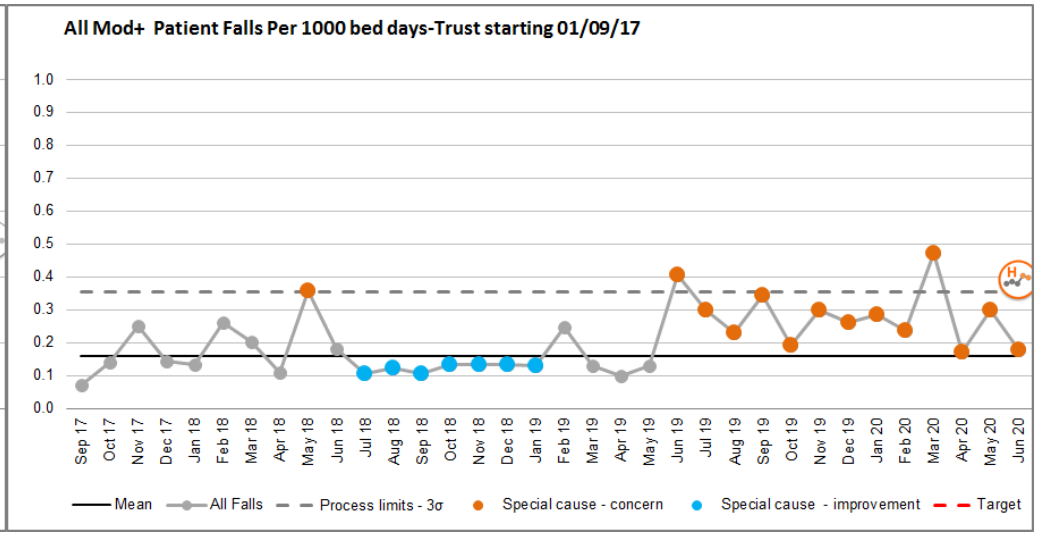
A monthly escalation report has been requested from each Health Group which will highlight to the Committee any increase/decrease in falls per ward, narrative around themes and trends, and any areas of concern and actions taken.

An update on the above has been provided to the Quality Committee and SI Committee, and is planned to be delivered at July's Operational Quality Committee.

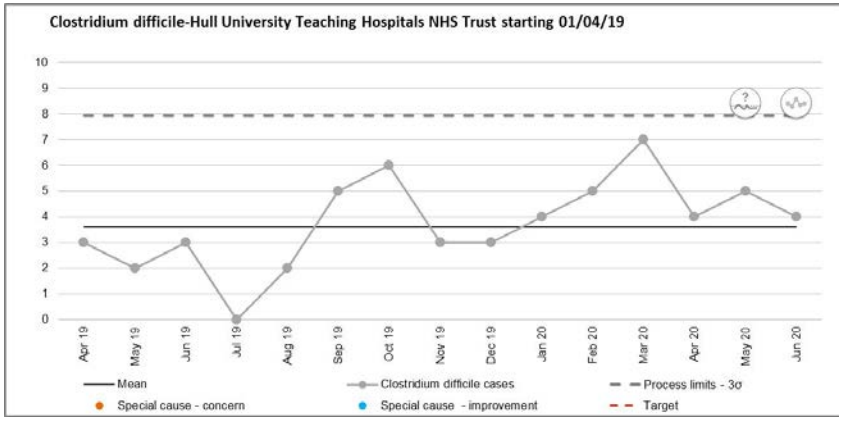





All Mod + Patient Falls-Trust starting 01/09/17
25
20
15
10
5
0
Sep 17
Oct 17
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Mean
All Falls
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


All Mod+ Patient Falls Per 1000 bed days-Trust starting 01/09/17
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
Sep 17
Oct 17
Nov 17
Dec 17
Jan 18
Feb 18
Mar 18
Apr 18
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Jun 20
Mean
All Falls
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

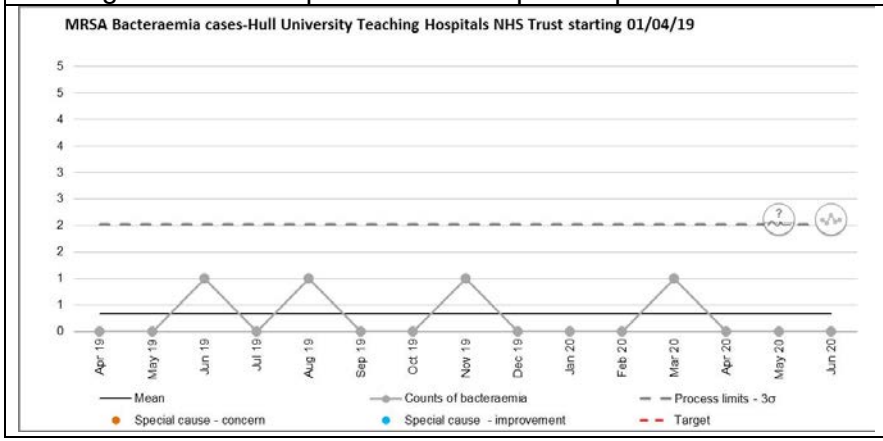
Healthcare Associated Infections update Quarter 1 2020/21
Lead: Greta Johnson, Director of Infection Prevention & Control
Items for Escalation at close of Quarter 1 (30th June 2020)
• No Trust apportioned MRSA bacteraemia cases were reported during Quarter 1, a community apportioned case was detected on the 22nd June 2020 and is under investigation via a Post Infection Review, and early indications suggest a previous complex medical history and a history of MRSA infection and colonisation. • By end of Quarter 1, twelve Trust apportioned MSSA bacteraemia cases have been reported – a slight reduction in comparison to the same timeframe for Quarter 1 2019, twelve versus fifteen cases. All Trust apportioned cases are investigated using a root cause analysis (RCA) process. • Thirteen hospital onset healthcare associated (HOHA) *Clostridium difficile* cases and four community onset healthcare associated (COHA) cases reported by the end of Quarter 1. The external threshold for reportable cases of *Clostridium difficile* has not been published to date from PHE/NHSE but local agreement is no more than eighty cases. To date all seventeen cases are investigated using a root cause analysis (RCA) process and normally tabled at a commissioner led Healthcare Associated Infection (HCAI) review group. To date, no cases have been tabled for discussion with the Commissioners due to competing priorities associated with COVID-19. • Gram negative bacteraemia: Escherichia coli (E.coli), Klebsiella species and Pseudomonas aeruginosa. The Trust is required to report all cases of these bacteraemia to Public Health England (PHE). To date, twenty E.coli bacteraemia have been reported by end of Quarter 1 (24 in QTR 1, 2019/20), three Klebsiella (7 in QTR 1 2019/2020) and four Pseudomonas aeruginosa (9 in QTR 1, 2019/20). Any differences should be treated with caution due to small numbers and natural variation. • During Quarter 1, one colonised case of Pseudomonas aeruginosa was detected on the Neonatal Intensive Care Unit (NICU) during April 2020. • Outbreaks of diarrhoea and vomiting have continued, albeit at small numbers and only affecting bays. Ward H9 did have an outbreak of diarrhoea and vomiting during April 2020 which resulted in the ward being closed briefly, no causative organism was found. • A period of increased incidence of *Clostridium difficile* was detected on H80 with two cases reported during June 2020. At the time of the samples being taken, H80 was being used as a COVID-19 positive ward and both affected patients were being treated for COVID-19.
***Clostridium difficile* (CDI)**
2020/21 threshold – 80 cases, HOHA and COHA. Root cause analysis (RCA) investigations are conducted for each infection and outcomes of RCA investigations for all hospital onset (HOHA) cases shared collaboratively with commissioners. In addition, to reflect the CDI reporting algorithm, the Trust are responsible for investigating the community onset healthcare apportioned (COHA) cases where a patient has had a hospital admission in the previous 4 weeks. The NHS Improvement CDI case objective for 2019/20 for the Trust was 80 cases and due the COVID-19 pandemic an updated 2020/21 CDI case objective has not been published. Therefore, the Trust will endeavour to make month on month reductions. During Quarter 1, a total of thirteen HOHA cases and 4 COHA cases have been reported and investigated via RCA processes. Outcomes of RCA processes will be discussed in subsequent reports but challenges have included a lack of previous in reach by the Infectious Diseases team to provide guidance on appropriate antimicrobial prescribing and treatment regimens for COVID-19 which includes high risk antibiotics, for example, quinolones responsible for causing *Clostridium difficile.*



Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia

2019/20 threshold - Zero tolerance

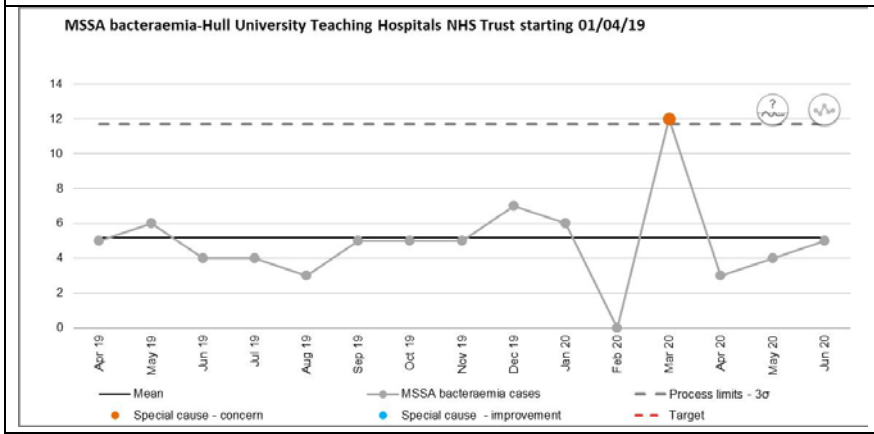
No Trust apportioned MRSA bacteraemia cases reported during Quarter 1. On the 22nd June 2020, a community apportioned case was reported and is at present being investigated via PIR process by both the Trust, because of previous hospital admissions and also by the Commissioners. Outcome of PIR investigation will be reported in subsequent reports.



Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia

2020/21 threshold - there are no national thresholds for this infection but for 2020/21 there remains a locally agreed CCG stretch target of 50 cases

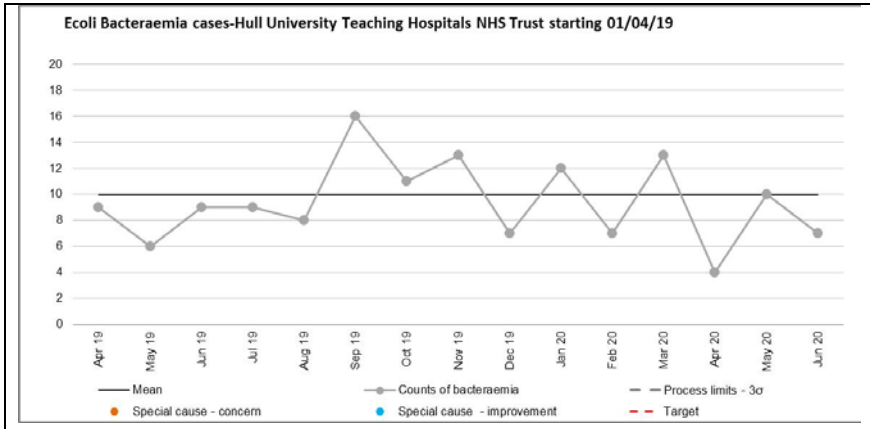
During Quarter 1, a total of 12 Trust apportioned MSSA bacteraemia cases have been reported. Early indications suggest a mixture of causes including deep seated infections, skin and soft tissue infections, ventilator association pneumonia and also still some device related cases which remain the focus of the Infection Prevention & Control team's attention for 2020/21.



Ecoli Bacteraemia

For the operational period 1st April 2020 to 31st March 2021, PHE and NHS England require a year on year reduction in E.coli bacteraemia cases. In addition, NHS Trusts will continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections (GNBSIs) by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024. There was an expectation that Acute Trust providers would be allocated an annual threshold for provided GNBSIs during 2020/21, but this has not been published to date.

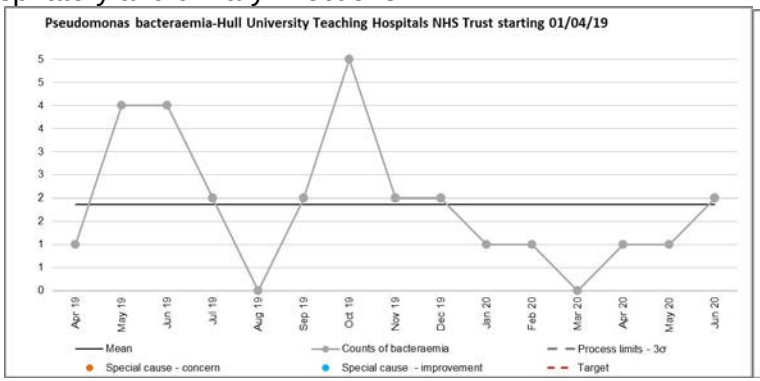
During Quarter 1, 20 E.coli bacteraemia have been reported, 2 cases were reported for the same patient Nine cases were reported in the Surgical Health Group, eight in the Medicine Health Group, two in Families & Women's and one in the Clinical Support Health Group. All have been subject to a case review by the IPCT to ascertain causality and whether warrant a full RCA being completed by the respective Health Group. Trends and causes associated with E.coli bacteraemia continue to be biliary, urinary, previous abdominal surgery and occasionally respiratory, following cases of aspiration pneumonia.

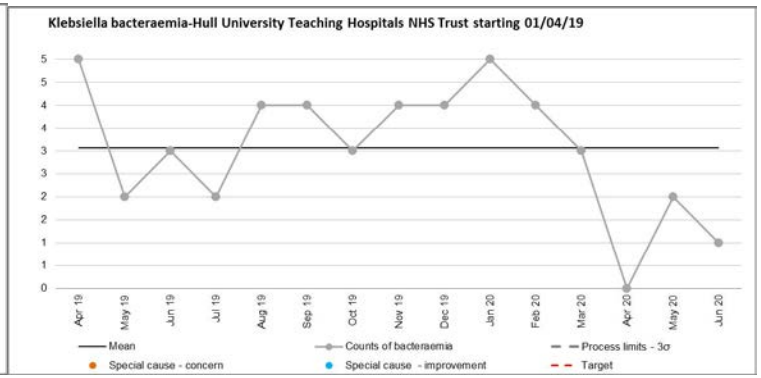


Klebsiella & Pseudomonas Aeruginosa Bacteraemia (Gram-negative bloodstream infections)

PHE and NHS England require NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024. There was an expectation that Acute Trust providers would be allocated an annual threshold for provided GNBSIs during 2020/21, but this has not been published to date.

Review of cases to date suggests similar risk factors as those found with E.coli bacteraemia, with both Klebsiella and Pseudomonas aeruginosa associated with respiratory and urinary infections.





Reduced reporting of cases in both Pseudomonas and Klebsiella bacteraemia has been noted during Quarter 1 ongoing monitoring continues.

Incidents

Pseudomonas aeruginosa in NICU

During Quarter 1, the screening of babies for Pseudomonas aeruginosa has continued on the Neonatal Intensive Care Unit (NICU). During April 2020 a colonised case of Pseudomonas aeruginosa was detected in a baby nursed on the unit. The affected baby was isolated and discharged home when well enough with no additional treatment was required. PHE were informed and no further cases were identified during May and June 2020. Incident meetings have been held at regular intervals with Public Health England involvement. Environmental cleaning remains a priority and the Estates team have undertaken water sampling of the whole unit during June 2020 in adherence to HTM 01-04

Norovirus outbreaks

There were no reported outbreaks of Norovirus during Quarter 1; however, during April & May 2020 there were a number of incidences of D&V which in most cases caused bay closures, there were 3 episodes of ward closures of medical and DME wards for short periods. No cases of Norovirus were confirmed but *Clostridium difficile* cases were detected amongst affected patients during this time period

COVID-19

On the 12th March 2020, COVID-19 was declared a pandemic by the World Health Organisation (WHO) and the Trust enacted the Pandemic Influenza Plan and then developed the COVID19 Surge Plan. On the 19th March 2020, COVID-19 was no longer considered to be a high consequence infectious disease (HCID) in the UK, which resulted in national changes in policy with regards the management of patients and the use personal protective equipment (PPE).
The IPC team have been fundamental in all aspects of the response and are currently to the delivery of the worked alongside A further report will follow primarily on COVID-19, its effects on patients, staff and from a Trust perspective, lessons learned
The Trust is now required to report incidences and outbreaks of COVID-19 via a formal reporting route to both NHSE and PHE.

Infection Prevention & Control Board Assurance Framework

On the 22nd May 2020, NHS England sent an updated version of an Infection Prevention & Control Board Assurance Framework to organisations. The purpose of the framework, although not compulsory, provides the opportunity to assess measures taken to mitigate the risks associated with HCAIs and COVID-19 and be a source of internal assurance in maintaining quality standards. The Framework has been completed by the Director of Infection Prevention & Control, in collaboration with members of the Trust's Gold and Silver Command and an action plan developed to accompany the framework. The framework and respective action plan are intended to be live documents and updated as and when required, they will report via Infection Reduction Committee and exceptions to Quality Committee and Board. A copy of the assessment is attached at appendix 2.

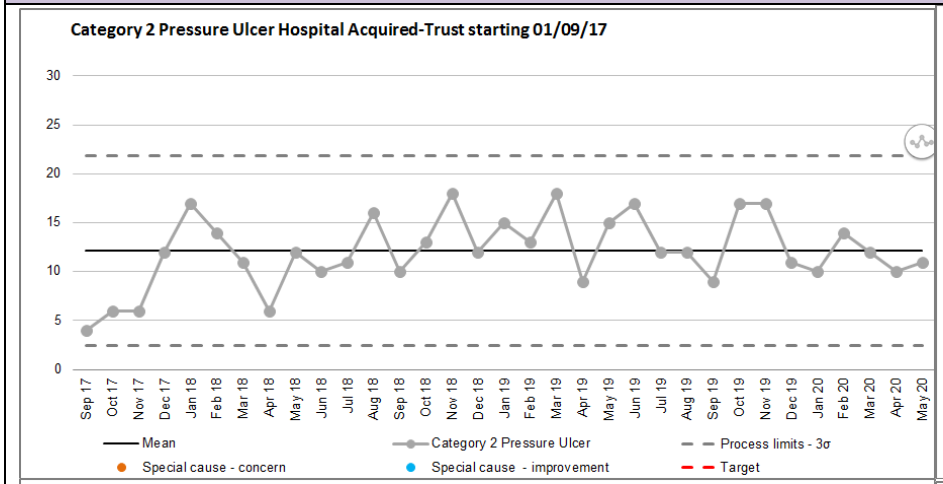
COVID-19 Risk Assessments

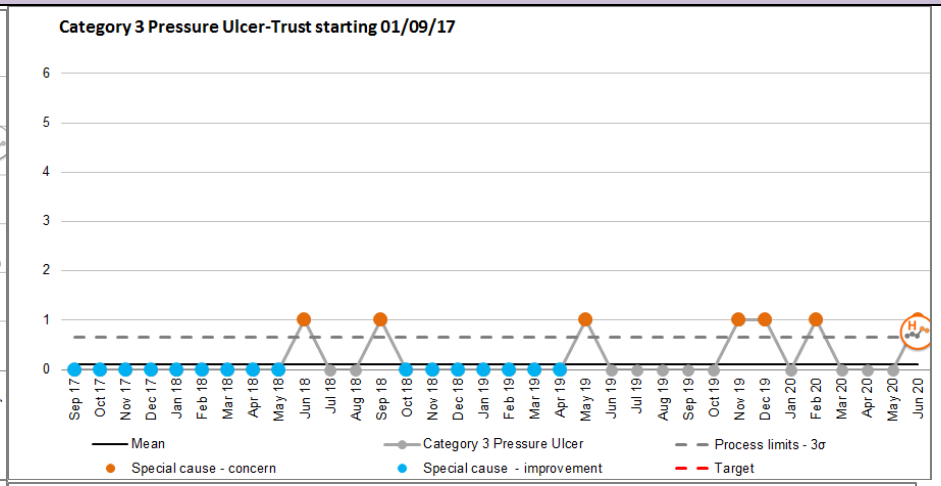
COVID-19 and the risks associated with transmission in healthcare settings are well documented and as a result the Trust are required to undertake risk assessments to ensure risks are identified and mitigated where possible to maintain both patient and staff safety. Utilising the Health & Safety Executive's Working safely during the coronavirus (COVID-19) outbreak documentation formed the basis of risk assessments for both clinical and non-clinical areas. In addition a review of bed capacity across the Trust is being undertaken to identify areas which compromise patient safety, this work is on-going.

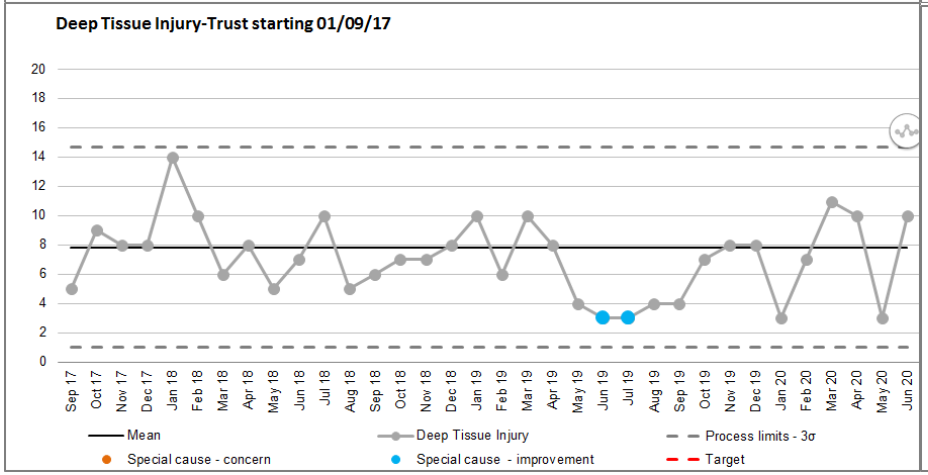
Gram-negative Bloodstream Infection (GNBSI) ambition and Antimicrobial Resistance (AMR)
No further update has been recently provided other than the need for the SRO to locally inform and assure NHSE and PHE on systems and processes associated with measures to reduce the burden of HCAIs, COVID-19 and the reduction in antimicrobial resistance. This must be done collaboratively with system partners, respective Directors of Infection Prevention & Control (DIPC) and clinical leads for infection prevention & control/ AMR.
Infection Reduction Committee
For the beginning of Quarter 1, a refreshed Infection Reduction Committee structure was introduced. From May 2020 onwards, the Infection Reduction Committee has been split into two separate meetings. A Strategic Infection Reduction Committee, chaired by the DIPC attended by the Chief Medical Officer, Chief Nurse and Medical and Nursing Directors from the respective Health Groups which meets bimonthly and an Operational Infection Reduction Committee which meets monthly, chaired by the DIPC and/or IPC nurses, with representation from the Health Groups, Allied Health Professionals, Estates & Facilities, Pharmacy and Occupational Health. This latter meeting reviews HCAIs, by exception and provides the opportunity to discuss the wider implications in meeting the requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections. Additional meetings such as the Water Safety Committee, Trust Decontamination Meeting and Antibiotic Control and Advisory Team (ACAT), formally feed into the meeting structure along with the Catheter & Continence Group and the Devices, Task, Challenge & Finish Group.
Quality Improvement Programmes
For 2020/21 the Infection Prevention & Control Team will be responsible for the development and monitoring of a Quality Improvement Programme (QIP), they will also be working closely with the Surgical Health Group in developing a QIP aimed at reducing the burden of MSSA and GNBSIs, especially with regards invasive device management. Further updates to follow in subsequent reports.

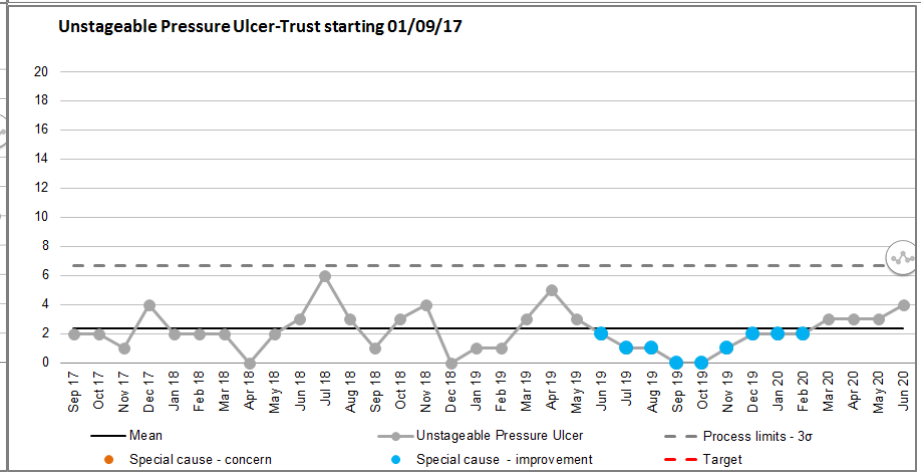
PRESSURE ULCERS

KEY UPDATES IN MONTH









The graphs indicate that the Trust has had zero grade 4 pressure damage in June 2020, 1 x Grade 3, 11 x Grade 2 (which is in line with the average number per month), 10 x DTIs (Deep Tissue Injures) (which is slightly above the monthly average of 8) and currently 4 x unstagable pressure damage incidents (above the monthly average of 2). This is being closely monitored by the senior nursing team.

MORTALITY

KEY UPDATES IN MONTH

The following table provides a breakdown of patient deaths that occurred within the Trust during Q4 2019/20, drawing comparison to last year:

	Total number of In-hospital deaths in Q4	Of which were elective admissions / Day case deaths	Of which were Non-elective admissions
2018/19	633	23	610
2019/20	626	34	592

Most Common Conditions at Time of Death

The following illustrates the 3 most common clinical conditions at time of death of death during Q4 2019/20:

1. Pneumonia – **129**
2. Acute Cerebrovascular Disease – **45**
3. Septicaemia – **38**

Annual Mortality 2019/20

Following data shows the full year mortality statistics for 2019/20:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2019/20	552	516	626	623	**2317**
2018/19	523	532	621	614	**2290**

Top 5 Main Clinical Conditions at Time of Death

Clinical Conditions	Number of patients Died
Pneumonia	358
Septicaemia (except in labour)	183
Acute Cerebrovascular diseases	154
Acute myocardial infarction	88
Cancer of Bronchus; lung	81

Minimal Criteria for Structured Judgement Review (SJR) per National Learning from Deaths Framework)

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	N/A
LeDeR Reviews (internal HUTH patients reviews)	2/2
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	Ongoing focus on Neck of Femur Fracture patient SJR's.
Number of deaths that underwent a Serious Incident Investigation and completed, within Q4, where it is likely that problems in care contributed to patient death.	0

The National Quality Board set minimum criteria for undertaking structured judgement case note reviews. Reviews undertaken by the Trust have been compliant with these criteria.

Appendix 1

Duty of Candour

1. Purpose of the Report

Following discussion at the June 2020 Trust Board, this report provides information in relation to the Trust duty of candour process, and compliance with the process.

2. How Duty of Candour is Monitored

The Duty of Candour regulations ask that trusts follow three key stages: a verbal apology, written apology and written feedback when an investigation is completed.

While the formal CQC regulations refer to informing patients/families *'as soon as reasonably practical'*, it does also refer to the notification being as *'within at most 10 working days of the incident being reported to local system'*. Therefore the Trust's approach is to monitor each stage to be completed to a deadline of 10 working days. There is a compliance level set for 90% compliance across all elements of verbal apology, written apology and written feedback. Therefore the Trust expects that 90% of all responses at each stage will be delivered within 10 working days of the incident occurring (for verbal and written apology) and 10 working days of the investigation being completed (for written feedback).

Monitoring data on duty of candour is run by the Governance Team, and this is reported to Health Groups, Operational Quality Committee and is reported in the Trust Quality Report monthly.

Compliance is monitored as a percentage and sometimes the relatively small numbers of incidents will have an impact on the figures. For example, Surgery Health Group completed 16 duty of candour incidents in May 2020, and did not achieve a written apology within the 10 working days on 4 of these incidents. This means the compliance is at 75%, and these delays were established as being due to waiting for incident and patient details and clarification of the actual level of harm caused. In these cases, it would not be appropriate to move forwards with duty of candour without all the information known.

3. Process and Compliance Issues

The process for completing duty of candour is delivered jointly between the Health Groups and the Governance Team. Health Groups deliver the verbal apology and then provide information to the Governance Team so that the Governance Team can write and send the written apology and written feedback.

Delays can mainly be attributed to communication of key information which allows the next stage of the process to begin. For example, missing information in relation to patient details, such as contact details or next of kin, can cause delays in sending letters out. The actual level of harm (formal duty of candour is triggered at moderate or above harm) must be confirmed and if the harm is not confirmed or is awaiting clarification, again delays in the process occur. These delays are resolved through regular, communication between the Governance and Health Group teams, and through detailed reviews of the patient's medical records.

4. Summary

Duty of candour is monitored regularly and Health Groups work with the Governance Teams to ensure all information is appropriate and accurate and delivered to patients who have experienced harm event in our care. The compliance is reported at Executive Performance and Accountability meetings monthly.

The Trust's internal target is to deliver the written element of Duty of Candour to patients within 10 days. This is sometimes very challenging as some of the information is not readily available or the investigation is on-going. The relatively small numbers can impact adversely on the reported percentage of compliance.

Appendix 2

Hull University Teaching Hospitals NHS Trust – Completed Board Assurance Framework for Infection Prevention and Control

Completed in accordance with detailed guidance available at:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0542-IPC-Board-Assurance-Framework-v1-2.pdf
The yellow highlight reflects updates made to the template in May 2020 and no particular significance should be given to this

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	Yes patients streamed via ED/ AMU/ACU and infection risk assessed and documented. Screening patient as per NHSE/PHE guidance with symptoms suggestive of COVID-19. Now all patients should be screened with a decision to admit regardless of symptoms commenced on the 4th May 2020	Are all patients with a decision to admit having a COVID-19 screen	Admissions versus screening data with 100% compliance
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Prior to decision to admit/ screen those with symptoms and move to 'warm' wards or if confirmed positive or known positive moved to a 'hot' COVID-19 positive wards. However, clinical need takes precedence over COVID-19 status and patients should be managed appropriately within the correct clinical environment.	Management of positive patients in non COVID-19 areas following decision to admit – measures to mitigate risks associated with nursing positive patients in non COVID-19 areas	Receiving areas advised to designate areas for awaiting results and positive cases. In reach and follow up of patients and to maintain support to clinical teams
• compliance with the national guidance around discharge or transfer of COVID- 19 positive patients	COVID-19 positive patients are discharged/ transferred appropriately. Discharge liaison team involved, liaison with system partners/PHE/ social care and residential care. Discharge is planned and patients are screened as necessary – with discharge/ transfer dependent upon results. Screening is undertaken 48 hours prior to discharge to allow sufficient time to receive results back	Gaps in effective discharge planning noted with regards medication and booking of district nursing teams.	

	to aid discharge planning. Notification of status also via Nervecentre, Lorenzo and via IDLs		
• **all staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	PPE is supplied as per national guidance and staff strongly advised to wear PPE commensurate to the healthcare activity being undertaken. Senior nursing workforce/ supplies team/ finance teams review PPE levels and availability. Also involvement of medical and Allied Health Professionals with regards access and use of PPE.	Supply and demand NHS Supply Chain dependent	Regular review of stock levels, PPE supplied to areas as needed. Identifying critical levels and escalating/ liaison via Supplies. Use of HUTH PPE global email
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Regularly tabled at Silver and Gold Command and circulated accordingly. Updates on Pattie and via E.newsletter	Nil identified	Nil required
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Yes tabled at Silver & Gold Command and circulated to respective teams	Nil identified	Nil required
• risks are reflected in risk registers and the board assurance framework where appropriate	COVID-19 risk register drafted and reviewed at intervals	Robust need for highlights and documenting risks	Review and documentation of risks on respective HG risk registers localised and tailored to their needs along with COVID-19 risk register. Risks may exist for some HGs but not for others
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens are effectively communicated to staff in a timely way	Yes – HCAI cases identified, investigated, documented via IPC database/ IPC HCAI DCS Assessment of cases, need for isolation and additional IPC measures instigated along with prudent communication to patient and teams	Nil identified	Nil required

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	As per surge plan, wards and teams identified to manage suspected and confirmed cases. Additional support and input provided by ID specialist nurse teams. In reach from IPCT.	Documentation of training and identification of training needs on the practical aspects of delivering care to COVID-19 patients Training documentation/ records	Development of a COVID-19 care plan, identifying key patient needs and reinforcing the message of 'every contact counts'
• designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas	OCS provided with appropriate training on wearing PPE and also fit testing for OCS staff in the early stages of the pandemic. Support provided by IPCT with regards training. OCS aware of the need to use Tristel and disposable microfiber cloths which is actioned for any HCAI identified in the Trust. OCS have allocated cleaning teams to COVID-19 and non COVID-19 wards	Cleaning Action Team (CAT) may be required to work across Trust site on both COVID-19 and non COVID-19	OCS / IPCT and E&D to formulate training records not dependent on HEY247. IPCT to ensure OCS provide and cascade appropriate 'tool box talks'
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Yes with Tristel and disposable microfibre cloths and by OCS staff wearing appropriate PPE	Reliant on effective and prudent communication between ward/ department and domestic services teams	Ensure that appropriate measures are instigated – wearing appropriate PPE between teams. Endeavour to identify and segregate CAT to COVID-19 and non COVID-19 wards/ depts. Robust need for highlighting and documenting risks
• increased frequency, at least twice daily, of cleaning in areas that have	Yes enhanced cleaning introduced to wards/ departments with COVID-19 positive cases.	Reliant on effective and prudent communication between ward/ department and domestic services teams	OCS domestics advised to make contact at commencement of shift with ward sister/ charge nurse and vice versa to impart current ward

higher environmental contamination rates as set out in the PHE and other national guidance			information with regards COVID-19 and other HCAI/infection risks
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	Enhanced cleaning has included toilets and bathrooms but OCS requested to pay particular attention to these areas across the Trust since this information has been shared OCS to implement a cleaning regime of 2 full cleans and 1 check clean daily in all toilet and bathroom areas within the Trust. Public toilets are cleaned at a minimum of 2 hourly intervals as per the contract specification.	Reliant on effective and prudent communication between ward/ department and domestic services teams	OCS advised to enhance clean toilets and bathrooms as standard. OCS domestics advised to make contact at commencement of shift with ward sister/ charge nurse and vice versa to impart current ward information with regards COVID-19 and other HCAI/infection risks
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	The use of neutral detergent has been discussed with OCS. Currently looking into the practicalities of how this can be dosed/measured. OCS will need to order stock and plan to implement this in all areas in a phased approach of priority i.e. • COVID-19 and VHR areas • High risk areas • OPD departments • Low risk areas	Current cleaning regimes include reusable microfibre cloths/mops and water only and Tristel and disposable microfibre cloths/mops when suspected and/or known infection	Actions being undertaken by OCS and Facilities (as per evidence column)
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products	This is followed as per the recommended product guidance. Tristel used according to manufacturer's guidance including making up, storage and contact time OCS will notify the clinical team once the cleaning of a room/area has been completed.	Nil identified	Nil required
• as per national guidance:	This would need to be a 'shared' responsibility with the clinical team.	Reliant on effective and prudent	

o ‘frequently touched’ surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice • daily and when known to be contaminated with secretions, excretions or body fluids	Currently OCS adhere to the 2 metre rule when cleaning a bed space that is occupied with a COVID-19 patient so would not clean the over bed table and bed rails until the patient was discharged. This can be implemented in all non COVID-19 areas at a frequency of 2 full cleans and 1 check clean daily or by an agreed frequency following discussion with the IPCT team.	communication between ward/ department and domestic services teams	Robust need for highlighting and documenting risks and liaison with ward teams and IPCT
• electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	Staff in wards and departments are cleaning electronic equipment at least twice daily with Clinell wipes and in some areas wipes specific for mobile phones, IPODS and IPADS	IT concerns raised with regards damage to electronic computer equipment, especially laptops	Guidance provided on cleaning equipment safely and appropriately. Specific wipes for touch screens available in certain clinical areas
• rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Arrangements already in place with ward team – housekeeping staff. OCS to implement an increased frequency cleaning regime to all ‘lobby’s/reception areas where donning and doffing takes place under the guidance of the IPCT team.	Other than ICUs and C7, the vast majority of ward areas do not have dedicated donning and doffing areas so increased cleaning outside bays and side rooms is vital	Prudent communication between ward/ department and domestic services teams - robust need for highlighting and documenting risks
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Yes, treated as infectious linen as per Trust and national guidance. National guidance advocates the tagging of linen bags.	Infectious linen is not tagged with current contractor. Facilities have spoken to Linen provider who were not aware of this. (Document has been forwarded for information). They suggested that tracking at this level is unlikely to happen unless it is an RTS item (return to sender) of the customers own products.	Staff to continue to follow Trust policy and use red alginate bags for the processing of infected linen
• single use items are used where possible and according to single use	Yes – areas managing suspected/ positive patients are strongly advised to use single use items and/or single patient use items as per Trust policy which can then be disposed of when the patient either gets discharged or dies Reusable equipment is cleaned in between	Availability of single use items such as BP cuffs Cleaning checklists not completed thoroughly with gaps noted on weekend and/or periods of annual leave	Reliant on visits by ID, IPCT and senior nursing workforce to reinforce and remind staff to use single use/ single patient use items/ equipment. Review of availability of said equipment

policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	patient use with Clinell wipes and/or Tristel, if contaminated with blood and bodily fluids. Equipment is cleaned as per ward/ departmental cleaning checklist, Estates and facilities reviewing ventilation across the Trust not just admission and waiting areas. Reviewing existing air conditioning in areas, the opportunity to provide additional ventilation such as windows and extra air conditioning	Trust waiting areas noted in some areas to be internal and compromised with regards natural ventilation	For ward/ departmental managers to agree cleaning processes and responsibilities Estates to scope opportunities to improve ventilation

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: ☐ arrangements around antimicrobial stewardship are maintained	Antibiotic audits continue to be completed by Pharmacy team and dissemination provided by respective Infection Reduction Committees. Antibiotic Control and Advisory Team (ACAT) continue to meet to discuss areas of good practice and concerns with regards antimicrobial stewardship. Cases of HCAI are reviewed as per PIR/RCA processes to monitor for lapses in practice with regards inappropriate antimicrobial prescribing. Update of adult antimicrobial prescribing guidance disseminated prior to COVID-19 and also antimicrobial prescribing guidance specific to patients with COVID-19.	Recent antimicrobial prescribing audit data and evidence with regards PIR/RCA processes suggest a reduction in compliance with regards antimicrobial prescribing.	Dissemination of information with regards prescribing to Quality Committee and HG governance meetings. ID 'in reach' and ongoing audits
☐ mandatory reporting requirements are adhered to and boards continue to maintain oversight	Yes via respective committees	Nil identified	Nil required
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting	Yes as per Surge Plan and national guidance	Nil identified	Nil required
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	Yes – restrictions in place. All wards and departments denoted with a red line – all visitors to wash hands and don appropriate PPE and on leaving, remove PPE, dispose appropriately and again wash/ decontaminate hands.	Nil identified	Nil required
• information and guidance on COVID-19 is available on all trust websites with easy read versions	Yes – versions available on Pattie, via global email and via news bulletins	Nil identified	Nil required
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Yes – infection status and status with regards possible infection in the absence of a positive screen e.g. suspicion via CT and/or CXR. Notification of status also via Nervecentre, Lorenzo and via IDLs	Nil identified	Nil required

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • frontdoor areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	ED and admission units streaming patients as they attend the Trust, enabling suitable placement, ongoing assessment and subsequent admission if required to respective area - 'cold' if known negative, 'warm' if awaiting a COVID-19 screen result and/or 'hot' if COVID-19 positive. Decision to admit screen and screen on suspicion of symptoms has aided processes	Capacity and acuity of patients may impact on effective streaming, especially if an increase noted in either suspected COVID-19 cases or other non COVID-19 admissions e.g. trauma/ patients requiring resus	Monitored by medical/ nursing teams and site teams throughout the day and night
• mask usage is emphasized for suspected individuals	Yes – both for staff as standard and also for patients if appropriate	Nil identified	Nil required
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	Where possible 2m distancing is applied within the same space and use of separate spaces is also utilised. The use of screens for reception staff has also been applied and the wearing of FRSM	Capacity and acuity of patients may impact on effective segregation	Monitored by medical/ nursing teams and site teams throughout the day and night
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Where possible, patient with new symptoms are isolated and contacts traced. In some cases patient have been cohorted with contacts in a bay, with the bay subsequently closed if isolation facilities are not available. Contacts are then tested within the same bay.	Reliant on effective and prudent communication between ward/ department and respective teams	In reach from IPCT /ID as capacity dictates along with Senior Matrons
• patients with suspected COVID-19 are tested promptly	Yes – screened promptly with result dependent on the urgency of the screen requested. Decision to admit screen and screen on suspicion of symptoms has aided processes	Delays occurred due to availability of screening swabs in line with NHS supply chain issues	Supplies working alongside Microbiology and Virology to ensure consistent supply. Escalation via

• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	Yes – discussion with ID and IPCT for advice on patient management. In some cases patient have been cohorted with contacts in a bay, with the bay subsequently closed if isolation facilities are not available. Contacts are then tested within the same bay. The patient is then managed according to screening result – if clinically indicated, transferred to a COVID-19 positive ward or nursed in a side room on a base ward.	Reliant on effective and prudent communication between ward/ department and respective teams	In reach from IPCT /ID as capacity dictates along with Senior Matrons
• patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	There has been a significant reduction in the number of routine appointments taking place since the declaration of the pandemic and subsequent lockdown. But patients who attended for appointments have been appropriately managed and signposted accordingly, if relevant to clinical need patients have been isolated and screened appropriately.	Nil identified	Nil required

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	Staff received 'in house' training at ward/ departmental level to ensure personal safety and a safe working environment. Additional bespoke training has been delivered to individual teams by both ID and IPCT. Further training with regards facemasks and respirators has also been delivered.	The inability to capture all staff due to shift rotations.	Drafted and disseminated SOPs, posters, guidance on Pattie and via global email. Band 7 meetings and team/ departmental meetings to disseminate key messages. Visits by ID and IPCT reinforcing safe working practices.
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	Yes – training video developed by IPCT. Pictorial guidance available and displayed in clinical areas Teacher practitioners cascading training information to ward/ department teams	Staff may choose to wear PPE not in line with national guidance e.g. long sleeve gowns/ FFP3 facemasks for routine clinical care	Ongoing training/ education Reinforcing key messages Underpinning polices/ procedures Specialist support as and when required
• a record of staff training is maintained	Yes via HEY24/7	Face to face 1:1 training, especially with regards wearing facemasks and also donning and doffing PPE ensuring attendance list is completed. Various teams delivering training and need to ensure competency and consistency	IPCT and respective departments to work together to ensure training is both contemporaneous and meets staff training needs
• appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	The only reuse of PPE is with regards reusable FFP3 facemasks and safety goggles. We have not advocated as a Trust the reuse of other PPE items and have ensured sufficient PPE is available to support single and/or sessional use	Assurance required with regards the effective cleaning and safe reuse of PPE items	SOPs drafted on the safe use, cleaning and storage of PPE. Where possible staff have been issued with personal PPE items
• any incidents relating to the re-use of PPE are monitored and appropriate	Yes – only regulated approved reuse of PPE is permitted within the Trust including the	Potential for individual/ team not	Guidance, posters and SOP's drafted

action taken	cleaning and reuse of eye protection and reusable facemasks. Where incidents occur these are investigated and reported accordingly via DATIX	following due process regarding the safe cleaning and reuse of PPE	and disseminated and shared with Medical/ Nursing Directors and Senior Matrons and AHPs
• adherence to PHE national guidance on the use of PPE is regularly audited	Yes – enhanced ward audits completed by IPCT	Nil identified	Nil required
• staff regularly undertake hand hygiene and observe standard infection control precautions	Yes – 5 moments HH audits completed by respective wards and departments. Enhanced audits completed by IPCT to ensure staff remain compliant with both standard infection prevention & control precautions (SICPs) and transmission based precautions (TBPs)		
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Locations of hand dryers reviewed by Estates and Facilities. Hand dryers switched off in admin areas (suites) several weeks ago because thought to be a vector for transmission and hand towel dispensers erected. Risk assessment undertaken as hand driers are also located in toilets adjacent to ED waiting areas. Paper towels were not originally in these areas due to used sharps been disposed of in waste bins and a risk to domestics	Risk assessment undertaken as hand driers are also located in toilets adjacent to ED waiting areas. Paper towels were not originally in these areas due to used sharps been disposed of in waste bins and a risk to domestics Review risk assessment and consider removing hand driers in ED toilets and replace with paper towel dispensers.	Review risk assessment and consider removing hand driers in ED toilets and replace with paper towel dispensers.
• staff understand the requirements for uniform laundering where this is not provided on site	Yes, compliant – pictorial posters available and displayed	Nil identified	Nil required
• all staff understand the symptoms of COVID-19 and take appropriate action in	Yes – guidance and information provided to teams/ departments	Need to encourage staff to change out of uniforms and scrubs at the end of a shift	Advice and guidance provided to staff. Donated cloth uniform bags provided for staff to use.

line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	Yes – staff advised to contact the ESR helpdesk to report their own symptoms and that of their household contacts. Consideration being taken with regards innocuous mild symptoms and Trust identified anosmia as a key localised symptom of COVID-19 prior to being nationally recognised. Symptoms listed to inform staff and also that of ESR helpdesk	prior to going home. Also staff utilise safe means with which to take uniforms home Nil identified	Nil required

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Yes – 'warm' screening wards identified and 'hot' wards for confirmed cases. Patients managed in either side rooms and/or bays Yes, compliant - all the listed points are being adhered to on a daily basis and reviewed accordingly to patient acuity and need. Patients who have additional healthcare associated infections are being managed as per Trust policy with review from the IPCT both in COVID-19 and non-COVID-19 areas, with priority for appropriate isolation e.g. patient with *Clostridium difficile*.	Nil identified Nil identified Nil identified	Nil required Nil required Nil required

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure: • testing is undertaken by competent and trained individuals	Yes – both within patient admission areas, wards and departments. Staff who facilitate staff testing have also been trained and deemed competent by IPCT and ID	Screening undertaken by teams unfamiliar with process	Documented processes and posters displaying testing rationale and instructions on taking correct screening tests
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Yes – screening undertaken in line with PHE and national guidance. Processed locally and when capacity dictates sent off to regional labs for processing. Rapid PCR processes also available for patient and staff screening. Staff screening is undertaken within 48 hours of staff reporting symptoms	Nil identified	Nil required
• screening for other potential infections takes place	Yes inclusive for all HCAIs, infectious diseases and opportunistic infections	Nil identified	Nil required

9. Have and adhere to policies designed for the individual's care and provider organisations that will help preventand control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms	Yes – IPCT providing in reach along with ID team. Support provided by Medical & Nurse Directors along with Senior Matrons	Supply and demand of PPE and relevant consumables e.g. hand hygiene products are NHS Supply Chain dependent and may impact on prudent management of patients with infections	A regular review of stock levels, PPE supplied to areas as needed. Identifying critical levels of consumables and PPE and escalating/ liaison via Supplies. Use of HUTH PPE global email
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Yes – via HUTH PPE group, global email, Pattie.	Nil identified	Nil identified
• all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	Yes – handled, stored and managed as Category B waste	Reduced availability of orange bags via Supply Chain	Waste management and supplies team, reviewing supply of orange bags to the Trust on a daily basis. As an approved alternative to use clear bags, with orange tags and to mark bag with Cat B waste
• PPE stock is appropriately stored and accessible to staff who require it	Yes – within supplies and ward/ departmental areas	Nil identified	Nil identified
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	Staff in 'at risk' groups identified. Measures in place to support staff who are shielding at home due to existing health conditions, providing support to work from home with regular in reach by managers. Pregnant staff either shielding and or re-deployed to low risk environments again with manager support. Other staff that are not shielding but are still 'at risk' redeployed to low risk areas. Staff who are working in both COVID-19 and non COVID-19 areas offered and provided with both physical and psychological support.	How are staff identified as being 'at risk' – are processes robust enough.	Staff advised to make their manager aware of concerns with regards their health. Utilise a risk assessment tool to assess risk and determine process to follow to ensure staff safety is maintained.
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	All staff required and likely to undertake AGPS and wear FFP3 reusable respirators, identified and provided with fit test training and training on care of a respirator. Record of training available on Pattie and via HG records.	Need to ensure staff have been fit tested and are not reliant on fit checking only. Some staff will fail fit testing on qualitative methods of testing/ quantitative methods.	Global emails, messages on Pattie and training access via HEY24/7 – encouraging staff to alert IPCT of their fit testing needs. Various options available dependent on fit testing methods and failure. Other mask options available e.g. full face mask/ powered respirators should staff fail on other mask options
consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Yes – from the start of the pandemic and the inception and commencement of the Trust surge plan. Elective pathways significantly reduced to include only cancer and urgent cases. Teams of staff have been redeployed according to risk assessment into designated areas to support the Trust surge plan. Dedicated teams on COVID-19 areas – staffing of areas is reviewed 5 times a day by the senior nursing team to ensure patient safety in line with acuity/dependency/ and capacity .	Gaps in assurance relate to variability of the absence due to COVID-19 related issues e.g. shielding/ sickness absence and/or self-isolation requirements.	Reduced elective capacity provided the opportunity to identify 'warm', 'hot' and 'cold' areas in ED and in general medicine. Screening processes for staff and patients have enabled prudent placement of staff
• all staff adhere to national guidance on social distancing (2 metres) wherever	Yes – clinical staff in ward/ departmental encouraged to observe social distancing. To	Gaps include size of clinical areas/ accommodation to allow for safe social	Review of clinical and non-clinical areas to assess ability to apply social

possible, particularly if not wearing a facemask and in non-clinical areas	consider office / admin spaces in assessing the ability to socially distance, if not, allow the wearing of surgical facemasks. In non-clinical areas staff encouraged to observe social distancing and if due to team size this would prove difficult alternative ways of working reviewed and implemented	distancing	distancing – segregate/ mark areas off, remove chairs/ desks
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Yes – implemented in both clinical and non-clinical areas	Staff encouraged to stagger breaks and utilise areas across the Trust to facilitate this e.g. use of outside eating areas and Trust restaurants	Managers to facilitate team working to allow the staggering of breaks
• staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing	Yes – staff are advised to contact the ESR helpdesk who support and sign post staff accordingly including arranging testing. Helpdesk also liaises with managers of individuals who report sickness and/or need to self-isolate	Staff records not contemporaneous up to date contact numbers e.g. telephone/ mobile no.	HR record needs to be up to date with current staff details especially with regards current contact details e.g. up to date telephone/ mobile no.
o staff who test positive have adequate information and support to aid their recovery and return to work	Yes – staff are supported by the ESR helpdesk, occupational health and staff member's manager. Staff advised to report if their symptoms alter or worsen.	Need to ensure two way communication takes place and that staff confidentiality is maintained	Factor in welfare calls

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

14 JULY 2020

Title:	Covid 19 Recovery Planning	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this document to provide the Trust Board with a further update on the arrangements for the next phase response to Covid 19 and the revision of its operating plan for the remainder of 2020/21	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	• The Trust has developed and is implementing a recovery plan within the resources currently available • A bid has been made for additional capital and revenue to support additional activity; the timeline and process for a decision of this bid is not yet clear • Elective activity levels remain significantly limited due to a range of factors	
Recommendation	That the Trust Board notes the content of this paper and indicates whether any further assurance is required.	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

Planning the next phase response to Covid 19 and maximising the safe delivery of non-Covid 19 clinical activity

1 Purpose

The purpose of this document to provide the Trust Board with a further update on the arrangements for the next phase response to Covid 19 and the revision of its operating plan for the remainder of 2020/21

2 Update on Covid 19 activity in the Trust as at 6 July 2020

2.1 Within the Trust, Covid Activity peaked in the general inpatient bed base on 21 April 2020, with 110 confirmed Covid 19 inpatient cases and critical care demand peaked on 2 May with 20 confirmed cases. This later peak for critical care was to be expected because of the longer length of stay for these patients.

The Trust has maintained sufficient capacity to care for these patients throughout the peak in activity

As at 6 July 2020, the Trust had 6 confirmed inpatient cases of Covid-19, of which 1 was in critical care.

2.2 Further developments in the Covid -19 response
Since the last update provided to Trust Board, the Trust has implemented a number of further initiatives to strengthen its response to Covid-19 whilst seeking to restore non Covid-19 activity. These include:

- Work has commenced on the creation of the Covid -19 receiving area on H36
- Acute general surgery has returned to HRI
- Emergency Care has returned to its usual location

3 Planning for the next phase of Covid and non-Covid response

3.1 National guidance
At time of writing, NHS England has still not issued the planning guidance for the period termed 'Phase 3' of the Covid Response; August 2020 – March 2021. It is not clear when this will be received.

As previously reported, the Trust launched an internal recovery planning process, which is working to produce the following outputs:

1. A new set of planning assumptions, agreed at ICS level (complete)
2. A revised bed model and bed configuration (complete)
3. A revised activity plan (complete)
4. A revised staff deployment plan (partially complete)
5. A revised surge plan to respond to any further peaks in Covid demand (outstanding)
6. An expanded clinical prioritisation process to include diagnostics and

outpatients (in progress)

7. A revised financial plan (awaiting further national guidance)

3.2 ICS and Humber System Planning

Last month it was reported that system recovery planning has been commenced by the Humber, Coast and Vale Integrated Care System (HCAV ICS), with the planned output being system plans for the North Yorkshire and York and Humber sub-systems, addressing all aspects of the health and care system and that HUTH is co-ordinating the acute sector input into the Humber plan, working closely with colleagues from NLAG.

A first draft of the Humber system plan was submitted to the ICS for review at the end of June. As part of this, the acute sector was asked to set out what additional activity it could undertake in the 'Phase 3' period (Aug 2020 – March 2021) if additional resources were made available.

3.3 Activity forecasts

As reported in the last meeting, Health Groups have re-established a limited level of activity and have forecast the levels of activity they anticipate being able to deliver for the remainder of 2020/21, within existing resources. Table 1 sets out this activity plan at Trust Level and compares it to 2019/20 activity levels:

Provider	2019/20	2020/21	Variance (%)	Variance (#)
HUTH - Revised	**867,770**	**527,355**	**-39.2%**	**-340,415**
Elective IP	15,162	7,370	-51.4%	-7,792
Daycase IP	72,923	36,149	-50.4%	-36,774
New OP	245,505	138,171	-43.7%	-107,334
Follow-up OP	534,180	345,665	-35.3%	-188,515

Table 1

In response to a request from the NHE England Regional Team, the Trust has also set out the additional activity it believes it could deliver if additional capital and revenue were made available. Table 2 sets out these higher levels of activity.

Provider	2019/20	2020/21	Variance (%)	Variance (#)
HUTH - Revised	867,770	553,702	-36.2%	-314,068
Elective IP	15,162	8,776	-42.1%	-6,386
Daycase IP	72,923	41,608	-42.9%	-31,315
New OP	245,505	152,123	-38.0%	-93,382
Follow-up OP	534,180	351,195	-34.3%	-182,985

Table 2

The Trust restoration plan for phase 3 also includes the delivery of 19,000 additional diagnostic tests.

These additional levels of activity are dependent on £22m of additional revenue being made available to the Trust.

In addition to this the Trust is hopeful of continued access to additional capacity within the independent sector under an extension of the national NHS contract with independent sector providers. There have been a number of issues with productive

utilisation of this capacity but work in in hand to increase its use and this would make a further small but significant contribution to closing the gap in capacity versus demand; in the region of 2000 - 3000 additional day cases.

3.3 The workforce plan

Workforce is the largest constraining factor in the delivery of the recovery plan. This is for two reasons: first that absence levels continue to be adversely impacted by Covid, with 7.6% of staff absent as at 6 July v a pre-Covid rate of 3.6%, secondly because the delivery of segregated Covid and Non-Covid care requires additional workforce to be deployed to ED, critical care and the Covid wards.

A detailed deployment plan has been completed; some additional discussion is taking place to ensure that the optimal balance has been achieved between the Covid areas, the non-elective areas and the elective areas. This will be finalised in the next two weeks.

3.4 Capital bids

The Trust has submitted a range of carefully prioritised capital bids, which support the recovery plan. They total £13.8m in value. The top priorities amongst these are:

Bid	Value £000s
Creation of Covid 19 ED/Combined Assessment Unit	3,800
Diagnostic Equipment	2,815
Additional Vascular Lab	1,000
Cancer Assessment Unit	700
Oxygen Infrastructure	700

In addition the Trust is party to an ICS wide bid for funding to improve the digital infrastructure to support outpatient activity which does not require patients to attend appointments in person.

4 Next steps

The Trust is implementing its ‘within existing resources’ recovery plan while it awaits a response to its proposals to undertake further activity, with the benefit of additional resources.

5 Recommendation

That the Trust Board notes the content of the paper and indicates whether any further assurance is required

Jacqueline Myers
Director of Strategy and Planning

Hull University Teaching Hospitals NHS Trust
Committee Summary Report to the Board
Performance and Finance Committee

Meeting Date:	26 May 2020	**Chair:**	Tony Curry	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Worplan prioritisation for the rest of the year – it was agreed that the Committee should review: the forward plan, capacity vs demand, financial risks (sourcing extra capacity), data validation, system performance, activity, innovations and new ways of working. The Committee also agreed to reviewing the Humber Coast and Vale system performance.
- Annual Accounts audit progression was discussed and the findings would be presented at the June 2020 Board meeting.
- The 2020/21 budget had been set by NHS I using the Winter cost base and at month 1. The Trust was experiencing a healthy cash flow. The Trust was reporting a break even position
- Discussions were ongoing with budget holders regarding Covid expenditure and how funding was managed. PPE stocks and systems were in a resilient position.
- There were pressures in the Medicine and Clinical Support Health Groups as well as Covid expenditure not yet approved by the centre. The Covid expenditure mainly related to procurement and decontamination.
- The Trust was waiting for its capital settlement which was around £30m.
- ED performance for April 2020 was 90%. The Trust had seen a reduction in attendances due to the Covid-19 situation but attendances were now increasing.
- The number of breaches had reduced due to less patients in the department, increased senior doctor presence and bed availability. Breach analysis undertaken over recent weeks has identified that access to diagnostics (particularly CT Scanning) and timeliness of speciality reviews are now the main reasons for breaches.
- There are continued challenges in meeting sustainable list size, the issues for RTT sustainability is the significant numbers in excess of the sustainable list size for first outpatient appointment and the COVID 19 pandemic.
- The total number of 52 week breaches as at the end of April has risen to 364.
- The Trust has continued to undertake Cancer activity since the Covid Pandemic was declared.
- the Trust was working through its recovery planning holding weekly meetings with Health Groups and specialities. The planning process was reviewing what activity could be carried out in May and June taking into account any constraints and issues.
- Mrs Cope presented a report which highlighted the National Hospital Care Cell's good practice guidance on the management of elective waiting lists. The Performance Team had assessed each standard and made recommendations that would be discussed in the Performance and Activity meetings.

Key decisions made:

- Contract for the supply of a da Vinci Xi Surgical Robotic System together with Service Maintenance Support was approved by the Committee
- Contract for the supply of an automated allergy testing system with associated service maintenance and reagents was approved by the Committee

Risk and assurance matters to be received by the Board:
Key items discussed to be received by the Board.

Matters to be escalated to the Board:
None

Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
Held on 26 May 2020 by Webex

Present:	Mr T Curry	Non-Executive Director (Chair)
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
In attendance:	Mrs R Thompson	Corporate Affairs Manager

No	**Item**	**Action**
1	**Apologies for absence** Apologies were received from Mr S Nearney, Director of Workforce and Organisational Development	
2	**Declarations of Interest** Mr Hall advised that he had been appointed as an Associate Non-Executive Director of North Lincolnshire and Goole Hospitals NHS Trust.	
3	**Minutes of the meeting held 25 February 2020** Item 7 – Board Assurance Framework – paragraph 3 – removal of the word 'it' to correct the sentence. Following this change 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 tracking list** Crawford and Company Adjusters – payments were being received in stages and there were no issues to report. Income and Expenditure Report was included on the agenda. Paediatric Surgery performance update would be carried over to the next meeting.	**AD**
	PTL Validation – Report shared with the Committee, to be removed from the tracker. 62 day action plan – this item to be removed due to Covid-19. Plans had been superseded. ED Update was included on the agenda. Push Doctor pilot – this had not been conclusive due to there not being enough attends at ED due to Covid-19. Mrs Cope advised that a new initiative being introduced by the ICS called 'talk before you walk', would	

encourage patients to call the hospital first and then be re-directed to the most appropriate place of care.

Outpatient DNA/cancellations update had been superseded due to Covid-19.

CT performance – due to Covid-19 and the restrictions put on the Trust it would be a while before performance was back to anywhere near normal.

Update on AHPs to be received at a future meeting. **SN**

Mr Evans advised that the PLICs review of Ophthalmology consultant performance would be included in the next quarterly report. **SE**

6 Workplan re-prioritisation discussion for full year

The Committee discussed what the key items of discussion should be for the coming year and what assurance was required. Ms Ramsay advised that any mandatory items would be picked up through the Workplan and Mr Hall added that the next Board Development session would ensure the right information was received at the right committee.

Mr Robson asked that capacity vs demand be considered and Mrs Cope advised that new planning guidance for phase 3 was expected and this would help set the recovery plan. She added that there were significant financial and workforce risks and use of the Spire and other facilities would be key. The Trust would need to manage a large waiting list and manage the volume of Outpatients using new ways of working.

Mr Bond stated that the role of the Committee should not change but become more forward looking. It would be a long time until performance trajectories would return to normal and it would be the Committee's role to review the future and whether the Trust was moving quickly enough to keep up with the changes.

Mr Hall advised that the Board Development Session would look at the key issues, review how the Trust should manage them and ensure the correct level of assurance was being reached. He added that the Phase 3 guidance would be important to plan how activity was allocated, how patients were validated and how the Trust worked along with the ICS. Ms Ramsay added that the Committee should be seeking whether assurance exists and how effective plans are rather than delving into the detail.

Mr Curry summarised the discussion and stated that the Committee should review: the forward plan, capacity vs demand, financial risks (sourcing extra capacity), data validation, system performance, activity, innovations and new ways of working. Mr Bond added that the Trust should look beyond its own performance and look at the Humber system performance too. Mr Robson added that working closely with social care would also be necessary to review new ways of working.

Resolved:

The discussion outcome was captured under Any Other Business.

7 Finance

7.1 Finance Report May 2020

Mr Curry asked how the Annual Accounts audit was progressing and Mr Bond advised that the Auditors were working through the detail and would present their findings at the June 2020 Board meeting.

Mr Bond reported that the 2020/21 budget had been set by NHS I using the Winter cost base and at month 1 the Trust was experiencing a healthy cash flow. The Trust was reporting a break even position with a risk of £330k. Discussions were ongoing with budget holders regarding Covid expenditure and how funding was managed. Mr Bond added that PPE stocks and systems were in a resilient position.

Mr Bond advised that there were pressures in the Medicine and Clinical Support Health Groups as well as Covid expenditure not yet approved by the centre. The Covid expenditure mainly related to procurement and decontamination.

The Trust was waiting for its capital settlement which was around £30m. Mr Robson asked if Covid capital would be additionally funded and Mr Bond advised that all Covid capital expenditure required sign off by the centre.

There was a discussion around capital expenditure and the bids for kit, ward upgrades and backlog maintenance. Mr Bond explained that wards 36, 37 and 38 would become the hospitals Covid receiving unit and could be used as an intensive care unit should the need arise.

Resolved:
The Committee received and accepted the report.

7.2 Balance Sheet – Underlying strength of the business

Mr Evans presented the report and advised that the report would provide the Committee with the Statement of Financial Position (SOFP), it was still work in progress and the report would be developed over time. He advised that the Trust had good levels of cash at the moment and there were no issues to raise.

Mr Robson asked if the report could show each monthly balance sheet so that they could be compared and Mr Evans agreed to build these into his report. **SE**

Resolved:
The Committee received and accepted the report.

7.3 Capital Planning Report

Mr Bond presented the report and advised that the capital planning process had changed and the Trust could use any SOCI surplus plus public dividend capital to develop its plan. PFI loan repayments were still required and these payments would be deducted from the total figure.

This meant that the Trust had a capital plan of £36.4m. This would be used to finish the IT Network installation before the end of the calendar year, review the backlog infrastructure, purchase medical equipment and complete the CT/MRI installation on the ground floor.

Mr Bond advised that the risks to the plan were Covid-19 and the ground floor renovations. He added that the final business case for the ground floor works would be received at the Trust Board in June 2020.

He advised that he was working closely with the ICS and their finance directors to agree the draft capital plan. A further paper would be presented to the Committee in June 2020 with an updated position. **LB**

Resolved:
The Committee received and accepted the report.

8 Performance

8.1 Performance Report

Mrs Cope presented the report and advised that ED performance for April 2020 was 90%. The Trust had seen a reduction in attendances due to the Covid-19 situation but attendances were now increasing. This was causing problems due to social distancing.

The number of breaches had reduced due to less patients in the department, increased senior doctor presence and bed availability. Breach analysis undertaken over recent weeks has identified that access to diagnostics (particularly CT Scanning) and timeliness of speciality reviews are now the main reasons for breaches.

There are continued challenges in meeting sustainable list size, the issues for RTT sustainability is the significant numbers in excess of the sustainable list size for first outpatient appointment and the COVID 19 pandemic. The Trust was experiencing significant capacity issues and clinical triage at the front end of pathways was in place to review whether patients needed to be seen urgently. Where possible, specialties have established virtual clinics to maintain activity. All issues are being monitored by the Performance and Accountability meetings.

The total number of 52 week breaches as at the end of April has risen to 364. This is expected to increase further to circa 600 by end of May. Mrs Cope advised that all patients would be reviewed and clinically prioritised.

Performance against the diagnostic 6 week standard deteriorated significantly during April with only 18.8% of patients having their diagnostic test within 6 weeks. Mrs Cope advised that in May endoscopy work had been reinstated but with restrictions due to PPE donning and doffing. This meant that full sessions were available but only half were being utilised.

The Trust has continued to undertake Cancer activity since the Covid Pandemic was declared. There have been a number of revisions to clinical pathways in line with the national guidance that has been received by the Trust. All changes to the tumour site pathways have been subject to Impact assessments and shared with the Trusts newly established Ethics Committee as well as the Cancer Performance and Activity Meeting, which has continued to meet.

Mrs Cope advised that there has been a 65% reduction overall in 2 WW referrals during April and she expressed her concern regarding the patients that had not sought advice. The numbers are starting to increase

during May.

Mrs Cope advised that cancer screening such as the lung health check would be re-instated but there were no firm dates at the moment. A view from the whole ICS would be taken.

Resolved:
The Committee received and accepted the report.

8.2 Recovery/Restoration summary to end June 2020
Mrs Cope advised that the Trust was working through its recovery planning holding weekly meetings with Health Groups and specialities. The planning process was reviewing what activity could be carried out in May and June taking into account any constraints and issues.

Mr Robson asked about governance arrangements around increasing activity and Mrs Cope advised that Performance and Activity meetings, the Theatre Resource Allocation Panel and clinical teams were all reviewing the prioritisation of activity being stepped back up and the capacity required.

The Committee discussed the diagnostic performance and how clinicians had become heavily dependent on diagnostic testing.

Mr Hall informed the Committee that the Ethics Committee had established a Care Decision Framework which supported medics making difficult ethical decisions during an influx in demand. He added that the Committee would be reviewing ethical decisions during the recovery period also.

Mr Curry asked about recovery timescales and Mrs Cope advised that there would be more clarity over the next few months but that the Trust would be nowhere near where it needed to be. She added that more forward thinking would be required with careful elective programming through the Winter. Mr Hall added that performance measurements would need to change to ensure the correct focus was given to ensure patient safety.

Mrs Cope agreed to review the longer term restoration plan and guidance to suggest new performance indicators and the rationale behind them. **TC**

Resolved:
The Committee received and accepted the report.

Elective Care Standards
Mrs Cope presented the report which highlighted the National Hospital Care Cell's good practice guidance on the management of elective waiting lists. The Performance Team had assessed each standard and made recommendations that would be discussed in the Performance and Activity meetings.

The recommendations included a different clinical harm process aligned with the ICS, surgical prioritisation process and new functionality on Lorenzo to capture theatre allocation prioritisation.

Resolved:
The Committee received and accepted the report.

9 Any Other Business

Mr Hall advised that the Board Development session in June would focus around the Board Assurance Framework to structure the meeting and validate the risks included. Ms Ramsay welcomed any comments regarding the 2020/21 draft BAF.

Mr Curry asked how the discussions from today's meeting relating to prioritisation of business for the Committee would be captured for future agendas. Ms Ramsay agreed to review mandatory items from the workplan and draft an agenda to pick up the points raised in the meeting. **CR**

9.1 Contract for the supply of a da Vinci Xi Surgical Robotic System together with Service Maintenance Support

Mr Bond presented the contract and advised that it related to the purchase of the 2nd da Vinci robot and that the funds had been donated from an external source.

Resolved:
The Committee received and approved the contract.

9.2 Contract for the supply of an automated allergy testing system with associated service maintenance and reagents

Mr Bond presented the 5 year contract and advised that the only bid received was from the existing supplier. It was only due to the value of the contract why it had been presented to the Committee.

Resolved:
The Committee received and approved the contract.

10 Date and time of the next meeting:

Monday 29 June 2020, 1.30pm – 4.30pm

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Performance and Finance Committee

Meeting Date:	29 June 2020	**Chair:**	Tony Curry	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- The Trust was reporting a break even position which included 'top up' money of £300k.
- The Committee discussed childcare and car-parking costs and whether these would be re-instated in the short term at a cost to the Trust.
- The Trust was waiting for updated guidance on how the financial system will operate from August 20 to March 21. This is now expected to be received week beginning 29th June 20.
- The UEC Business Case would be presented at the next Board meeting on 14th July 2020.
- The RTT pathways were of concern and that the waiting list volume was increasing due to normal patterns returning. ASI and holding was over 30k and had doubled since January 2020. Follow up appointments had increased and the 52 week position was getting worse.
- The Trust's waiting list volumes continued to grow and was being compounded by lost activity due to winter capacity issues. Mrs Cope reported that HUTH's waiting list was the 10th largest in the Country and the average wait was currently 14.69 weeks.

Key decisions made:
There were no decisions made by the Committee

Risk and assurance matters to be received by the Board:
All key items above to be received by the Board.

Matters to be escalated to the Board:
None

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 29 June 2020

Present:	Mr T Curry	Chair
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr S Evans, Deputy Director of Finance	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held 26 May 2020** The minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** There were no matters arising.	
5	**Action Tracker** Paediatric Performance – Mrs Drury advised that the non-electives being lower than plan was a blip and there were no coding issues. It was agreed to take this item off the tracker. Balance Sheet – Mr Bond advised that the report was on the agenda but was still being developed.	
6	**Workplan** An updated workplan would be presented to the Committee in July 2020.	**RT**
7	**Finance** **7.1 Statement of Comprehensive Income – May 2020** Mr Bond advised that the Trust was reporting a break even position which included 'top up' money of £300k. The Trust had incurred £4.7m in Covid costs year to date. Mr Bond reported that the Trust forecast to the end of July was to break even. At the present time he was confident that this would be achieved. The Committee discussed PPE and the relaxation of safeguards and air changes and how this would help session utilisation. Mr Bond advised that the availability of staff was concerning productivity. Mrs Cope advised that clinical judgement was being observed in relation to the 14 day isolation rule, although the Spire was still adhering strictly to it.	

Mrs Christmas asked what would happen when the Covid support funding came to an end and Mr Bond reported that the Trust would revert to a block contract and would only receive 'top up' payments until August 2020. He added that the centre would be looking for the Integrated Care System to break even which could become problematic for the Auditors reviewing Trust's separately.

The Committee discussed childcare and car-parking costs and whether these would be re-instated in the short term at a cost to the Trust. Mr Bond advised that providing childcare was not too expensive but car-parking would incur costs of around £750k. He added that it was important to do as much as possible for staff at this difficult time.

Resolved:
The Committee received and accepted the report.

7.2 Statement of Financial Position – May 2020
Mr Bond presented that report and advised that the Trust had good liquidity and most of the debt was within the NHS which the Finance Teams were dealing with. Once the accounts had been closed off it would show a more detailed cash flow statement and stock movements.

Mr Robson asked if the finance reports could show monthly trends in the future. Mr Bond agreed to add this into the report. **LB**

Resolved:
The Committee received and accepted the report.

7.3 NHS Finance and Planning Framework Update
Mr Bond advised that the Trust was waiting for updated guidance on how the financial system will operate from August 20 to March 21. This is now expected to be received week beginning 29th June 20.

Resolved:
The Committee received and accepted the update.

7.4 Urgent and Emergency Care Business Case
Mr Bond reported that the UEC Business Case would be presented at the next Board meeting on 14th July 2020. Mr Curry asked if there was a summary document and Mr Bond agreed that this would be produced.

Resolved:
Mr Bond to arrange a summary document for the Board members. **LB**

8 Performance
8.1 Performance Report
Mrs Cope presented the report which had been prepared in a new format with the exception reports taken out. She advised that it was still work in progress and welcomed any comments to develop it further.

Mrs Cope had added SPC charts to demonstrate activity levels. The Trust was seeing the volumes of patients return with ambulatory steams increasing. Initiatives such as 'talk before you walk' were being introduced to encourage patients not to just turn up at ED.
Cancer performance had dropped during April but Mrs Cope advised that

cancer patients had been prioritised throughout the Covid pandemic.

Mrs Cope reported that the RTT pathways were her main concern and that the waiting list volume was increasing due to normal patterns returning. ASI and holding was over 30k and had doubled since January 2020. Follow up appointments had increased by 5000 and the 52 week position was getting worse.

Mr Robson stated that he found the new report helpful to understand the trends and the areas that the Trust was not performing. He asked about ED messages to the general public and whether these could be re-iterated. Mrs Cope advised that the teams were working hard with partners, but because of the low level provision of GPs in the areas plus a marginalised population it was proving difficult to stop people attending ED. Mrs Cope added that she had re-introduce the performance and activity meetings for ED and was reviewing pathways and learning from the Covid pandemic. 7 extra consultants had been working in ED during the pandemic and it was important to carry on with any good practice and processes they had put into place.

Mr Bond asked about walk-in centres and Mrs Cope advised that there were barriers to what work they could do and they were not open 24/7, so members of the public deferred to A&E. She added that the ICS was reviewing the 46% of patients that did not need to be seen at ED. Mr Robson asked about shared IT systems with the walk-in centres and Mrs Cope reported that working towards sharing systems and creating new pathways had been progressing up until the Covid pandemic, but at the moment many pathways were unavailable.

The Committee discussed the Blackpool model and how this had streamed 22% of patients away from ED.

Mr Bond queried the 104 day cancer waits and Mrs Cope reported that it was due to endoscopy capacity in the main and the risks were being managed.

Mr Curry thanked Mrs Cope for the new style report and asked if explanations could be added to explain failures or successes.

Resolved:
The Committee received and accepted the report.

8.2 Recovery/Demand vs Capacity Report
Mrs Cope presented the item relating to RTT and advised that she had taken stock, going back to 2014 to review historic issues.

She reported that 2014 had shown the largest backlogs, 2015 had seen external reviews and introduction of Lorenzo and 2016 the Trust had worked with the Emergency Care Improvement Team. In 2018 the Trust had tracking access issues and an external company (MBI) were brought in to help. Demand and capacity had been out of kilter throughout and was a recurring theme.

Nationally the Trust's waiting time performance had deteriorated as the list size increased beyond 2.8m. She advised that the current national

position was 3.94m.

The Trust's waiting list volumes continued to grow and was being compounded by lost activity due to winter capacity. Mrs Cope reported that HUTH's waiting list was the 10th largest in the Country and the average wait was currently 14.69 weeks.

The Trust had been ranked 1st in the Country for its 52 week wait performance before Covid and currently stood at 118th out of 121.

An external diagnostic undertaken on the Trust's PTL (incomplete waiting list) in February 2020. This evidenced that the Trust's data quality is good and the issue with waiting list volume is due to capacity.

There was a detailed conversation regarding the issues and Mrs Cope advised that she had been discussing high volume specialties with her opposite number at NLAG with a view to merging the PTLs.

Mrs Cope advised that it was key that the work programmes going forward were clinically led and had clinical engagement.

Mr Bond stated that every year the Trust identified areas of activity for Commissioner investment but the Trust had never delivered what had been planned.

Mrs Christmas stated that the Trust was very keen to have external help and guidance which was shown in the presentation. She added that a lot of money was spent on external help but the Trust repeatedly did not make sufficient progress and improvement.

Mr Hall asked if all patients waiting over 52 weeks needed to be seen as they had learned to live with their condition or no longer required treatment and Mrs Cope advised that some ethical decisions would need to be made.

Mr Robson suggested that the issues raised should be the last slide of the presentation when presented to the Board Development session. Mr Hall added that him, Linda Jackson and Terry Moran could help with joint working and clinical engagement across the Trusts.

Resolved:
The Committee received and accepted the presentation.

9 Any Other Business

Mr Hall thanked Mrs Cope and her team for the hard work being carried out during the recovery phase.

10 Date and time of the next meeting:

Monday 27th July 2020 – 1.30pm – 3.30pm

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	20 May 2020	**Chair:**	Prof. M Veysey	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Workplan discussion to include the quality priorities for the Covid-19 recovery programme
- New Quality Improvement Plan - a different approach was being taken to triage complaints, claims and incidents to draw out themes. National initiatives would also be included. End of Life Care, Dementia and falls with harm were some of the areas to be included in the new QIP. Key deliverables would be highlighted in each area and progress and outcomes reported to the Committee.
- The Infection Reduction Committee had been re-started as had the Infection Prevention Group which monitored risks, local data and national guidance.
- There had been 7 Never Events during the last year with the majority happening in theatres. NHS Improvement had visited the Trust and had suggested a number of recommendations and actions. Dr Purva presented the action plan and the progress being made.
- The Getting It Right First Time report had been compiled following a review of all speciality GIRFT reports received so far. Key recommendations have been identified which would have the most impact across multiple specialities and improve service delivery during the "Recover and Restore" phase of the COVID19 pandemic, which could be used for refining the new pathways and embedding the changes that could deliver benefits for the organisation and patients alike.
- The draft CQC report had been received and that she was currently working through it to review the detail and implications.
-

Key decisions made:

- No specific requests made of the Committee; all reports were accepted

Risk and assurance matters to be received by the Board:

- Following 2 Safeguarding incidents, NHS Improvement was to visit the Trust to review the Safeguarding, Clinical Governance and Patient Experience functions. The outcome of the visit would be presented to the Committee.

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust
Quality Committee Minutes
Meeting held on 20 May 2020 by Webex

Present:	Prof M Veysey	Non-Executive Director (Chair)
	Mr S Hall	Vice Chair
	Mrs L Jackson	Associate Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Acting Deputy Director of Quality Governance
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Representative
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs T Cope, Chief Operating Officer and Prof U Macleod, Non-Executive Director	
2	**Declarations of Interest** Mrs Jackson advised that she was the Vice Chair of North Lincolnshire and Goole NHS Foundation Trust. Mr Hall welcomed Mrs Jackson to the Committee and introduced her to the members.	
3	**Minutes of the meeting held 24 February 2020** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Mrs Geary advised that the Section 29A had been inspected by the Police and the Trust had received verbal approval. The CQC were carrying out a re-inspection following receipt of photographs and further evidence which would be submitted this week.	
	3.2 Action Tracker There was a discussion around the frequency of Never Events and it was agreed that Dr Purva would circulate information to the Committee members.	**MP**
	Mr Corral advised that the action relating to checklists outside of theatres had been completed and could be removed from the tracker.	
	3.3 Any Other Matters Arising There were no other matters arising.	
	3.4 Workplan 20/21 – Re-prioritisation discussion for the year Prof Veysey stated that the discussion would focus on what the Committee thought the priorities were for the rest of the year, taking into account any statutory items to enable the Committee to provide assurance regarding quality and patient safety to the Board.	

Prof Veysey suggested that the Quality Improvement Plan, CQC updates and Learning from Deaths framework should all be regular items. Mrs Geary added that she would presenting Safeguarding reports more frequently due to the risk currently in the organisation.

Mr Hall was keen to see processes replicated with other committees and risks captured in the BAF and within reports presented. He added that these processes could be discussed further in a Board Development session.

Mrs Jackson suggested deep dives using the Quality Improvement Programme to indicate any areas of concern. She added that a number of actions would be indicated following received of the inspection report and these could also be used for deep dives.

Mrs Green stated that one of the objectives of the Committee was to be responsible for increasing the rate of harm free care and how the Committee could assure itself that patients waiting longer had not come to harm. Prof Veysey added that patients could be worried about attending hospital which could delay treatment further and what information was available to assure the Committee that harm was being reviewed.

Dr Purva advised that the Mortality and Morbidity working group and Risk Management Committee had been established to review harms and risks to the organisation following the Coronavirus outbreak. Prof Veysey asked if any escalation from these new meetings could be presented to the Quality Committee for the next few months.

Ms Ramsay suggested that she, Dr Purva and Mrs Geary get together to prioritise the workplan for 20/21 and also to work on how the information would be presented to the committee to provide assurance.

Resolved:
The Committee agreed to prioritisation of the workplan and reporting process being reviewed. **CR/BG/MP**

4.1 Quality Improvement Programme Update (including CQC)
Mrs Geary presented the report which had been refreshed and a different approach was being taken to triage complaints, claims and incidents to draw out themes. National initiatives would also be included. End of Life Care, Dementia and falls with harm were some of the areas to be included in the new QIP. Key deliverables would be highlighted in each area and progress and outcomes reported to the Committee.

Any actions arising from the CQC action plan would be managed separately and a task and finish group set up to address the actions. This group would report to the Quality Committee.

Mrs Geary advised that the Quality Account process was going ahead and in February and March the Trust's stakeholders had reviewed them. The Quality Accounts would be presented to the Board on 18th June 2020 and published on 30th June 2020 as usual.

The Committee discussed areas that were no longer on the QIP such as

Nutrition and Mrs Geary advised that this would be monitored through the Fundamental Standards audit and reported to the Committee.

Resolved:
The Committee received and accepted the recommendations set out in the report.

4.2 Infection Prevention and Control Report
Mrs Geary presented the report which highlighted any infection control issues. Mrs Geary advised that the Infection Reduction Committee had been re-started as had the Infection Prevention Group which monitored risks, local data and national guidance. Any issues would be escalated to the Committee. The Infection Control annual report would be presented to the Committee next month. **BG**

Mrs Geary outlined the work around wards 36/37/38 and how they would purely be for future Covid patients with the ability to turn into ICU if required. The Committee discussed how patients would be treated in the future and how risks would be managed.

Resolved:
The Committee received and accepted the report.

4.3 Never Events Action Plan/Update
Dr Purva advised that there had been 7 Never Events during the last year with the majority happening in theatres. NHS Improvement had visited the Trust and had suggested a number of recommendations and actions. Dr Purva presented the action plan and the progress being made.

The key recommendation from NHS Improvement was to introduce the surgeon as the lead when managing the WHO checklist and the time out, sign out process. New e-Learning packages relating to this were now mandatory and any non-compliance would be managed.

Mrs Jackson asked where non-compliance was reported and Dr Purva advised that it was picked up during the regular auditing process, and reported to the governance meetings and monthly Performance and Accountability meetings. Mr Hall added that ownership and leadership of the documents was key.

Resolved:
The Committee received and accepted the report.

4.4 GIRFT Update
Dr Purva presented the report and advised that The GIRFT national team has visited over 30 HUTH specialities over the last 4 years and have made around 260 recommendations to improve safety and effectiveness of patient care. The report had been compiled following a review of all speciality GIRFT reports received so far. Key recommendations have been identified which would have the most impact across multiple specialities and improve service delivery during the "Recover and Restore" phase of the COVID19 pandemic, which could be used for refining the new pathways and embedding the changes that could deliver benefits for the organisation and patients alike.

Mr Hall asked what the next steps would be and Dr Purva advised that each of the Health Groups was meeting with the Chief Operating Office to review which actions could be easily be incorporated and which needed more work.

Work was ongoing in Outpatients and Dr Purva advised that all actions should be completed in the next quarter.

Mrs Jackson spoke of the non-face to face initiatives in place at the moment and asked what would stop the consultants inviting patients back in to the hospital. Dr Purva advised that a number of reasons would prevent the return such as patients not wanting to come to the hospital due to the pandemic, the implementation of national guidance and the benefits that the consultants had witnessed when seeing patients remotely.

Resolved:
The Committee received and accepted the report.

5 Any Other Business

The Committee discussed the general feeling outside of the hospital and the fear some patients had about attending it. Mr Hall asked if this was reflected in Primary Care and Dr Purva advised that she was working with the Commissioners to ensure that patients were seen in an appropriate way and that this could be more community based in the future.

5.1 Any Other Emerging Quality Issues

Mrs Geary advised that the draft CQC report had been received and that she was currently working through it to review the detail and implications.

Mrs Geary also reported that 2 separate Serious Incidents had been declared relating to Safeguarding. External support had been requested to help with the investigation. The results of the investigations would be presented to the Committee once completed.

Mrs Geary advised that she had invited NHS Improvement to visit the Trust to review the Safeguarding, Clinical Governance and Patient Experience functions over the next few weeks. The outcome of the visit would be presented to the Committee.

Mrs Green asked who the End of Life Care Non-Executive representative would be as the previous NED had now left the Trust. Ms Ramsay agreed to follow this up. **CR**

6 Chairman's Summary of the Meeting

The meeting summary would be received by the Board.

7 Date and time of the next meeting:

29 June 2020, 9am – 11am by Webex

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Quality Committee

Meeting Date:	29 June 2020	**Chair:**	Prof. M Veysey	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Research and Development Update was received which highlighted Covid and Non-Covid research within the Trust.
- Projects for the 2020/21 QIP included: development of a standardised safety briefing, reduction of patient falls with harm and patient experience for Mental Health patients with long waits in ED.
- Falls update - a sub-committee had been established to review the increase in harm in the elderly and patients with dementia due to falls. Inpatient falls had increased by 4% and the majority of the patients were over 78 and had some cognitive impairment.
- Safeguarding update - Safeguarding processes had continued through the Covid pandemic and working relationships had remained unchanged.
- The Patient Experience Team were pro-actively reviewing themes and trends of Complaints and PALs and looking at long waits and the impact on patient experience. NHS I/E had suggested an improvement framework with a detailed workplan which involved patients and members of the public.
- Learning from Deaths Report highlighted the number of hospital deaths. The reasons for the deaths were mainly due to pneumonia, stroke and sepsis which were not out of the ordinary. Structured Judgment Reviews had been carried out where appropriate.
- Non-Covid Harm and its Impact – The Committee discussed patients not coming into the hospital due to Covid-19 and the impact (harm) of this. Work was ongoing with the clinical teams and the Community to review the issues.
- Opel 4 and patient safety report which highlighted a review carried out on 41 sets of case notes during Opel 4 when patients were having long waits in ED.
- The CQC Report had been published on the CQC website. She advised that the inspection had included Medicine, Emergency Care, Critical Care and Surgery but due to Covid the Well Led and Use of Resources inspections had not gone ahead. The action plan in place would be monitored by the Executives and would be presented to the Operational Quality Committee, the Quality Committee and the Board.

Key decisions made:

- No specific requests made of the Committee; all reports were accepted

Risk and assurance matters to be received by the Board:

- The Quality report highlighted that 9 Serious Incidents had been declared in May 2020 and the Never Event declared in December 2019 had been downgraded.

- Duty of Candour performance was at 75% compliance, but that the standard of 10 days was an internal measure set by the Trust. The verbal apology performance was higher but the written apology sometimes took longer to compile. Duty of Candour was being discussed with Health Groups at the Performance and Accountability meetings.
-

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust

Minutes of the Quality Committee
Held on 29 June 2020

Present:	Prof M Veysey	Chair
	Mr S Hall	Vice Chair
	Mrs L Jackson	Associate Non-Executive Director
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Ms C Ramsay	Director of Corporate Affairs
	Mrs K Southgate	Deputy Director of Quality Governance and Assurance
	Mrs A Green	Lead Clinical Research Therapist
	Mrs M Stern	Patient Council
In Attendance:	Mr J Illingworth	Research and Development Manager
	Mrs R Hoyle	Practice Development Matron
	Dr S Fan	Clinical Leadership Fellow
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Prof U Macleod, Non-Executive Director	
2	**Declarations of interest** There were no declarations received.	
3	**Minutes of the meeting held May 2020** The minutes were approved as an accurate record of the meeting.	
	3.1 Matters Arising Mrs Geary advised that the Infection Control Annual Report would be presented at the Operational Quality Committee and then the Quality Committee.	
	3.2 Action Tracking List Ms Ramsay agreed to update the workplan following the Board Development Session. The Committee agreed that Research and Development would be brought to the Committee on a quarterly basis (linking to the Quality agenda) and this would be added into the workplan. The Committee discussed the End of Life Care lead and Ms Ramsay advised that she would speak to Prof Macleod with a view to her being the sponsor. Mrs Geary added that she would pick up the Exec Lead role.	
	3.3 Workplan 2020/21 The Committee agreed that the workplan would be updated following the Board Development session.	**CR**

4 Increase the rate of harm-free care each year

4.1 Research and Innovation Report

Mr Illingworth presented the report. He advised that the exit strategy following the Covid-19 pandemic relied on research. The National Institute for Health Research was reviewing the severity, causes and effect of the pandemic and the Trust was involved with the research trials.

Mr Illingworth advised that the Trust had around 1000 volunteers supporting trials and 50% were frontline staff. This was being managed carefully due to workloads. Work was ongoing regarding the drug trials as well as studies to review genetics and the impact of acute diseases in Covid cases. Therapeutics were working on rehabilitation of patients and ethically approved protocols were being developed for use during future outbreaks.

Mr Illingworth reported that the research teams were keen to start looking at their non-Covid research which had been paused since mid-March and would now need to be balanced with Covid research.

There was a discussion around staffing, resource and quality issues, but Mr Illingworth advised that teams were focussed and that there was an in-house quality assurance team reviewing the studies. Mrs Jackson asked how the Trust compared to other similar sized Trusts and Mr Illingworth reported that the Trust had done well, ranking 19th in the Oxford trials.

The Committee discussed R&D and frequency of reporting. Ms Ramsay advised that the BAF risk would be discussed at Board and the Committee, but that it should come to the Committee on a quarterly basis to review the risks to capacity and resource and any links to the Quality agenda. Prof Veysey was keen to see any adverse incidents linked to R&D where harm had occurred and Dr Purva assured him that any Serious Incidents would be reported to the Committee. Mrs Green added that the Committee could influence the R&D agenda if there were any areas of concern raised at the Committee that would be suitable for trials.

Resolved:

The Committee received the report and agreed that R&D should be presented to the Committee on a quarterly basis. **CR/RT**

4.2 Quality Improvement Programme Update (including CQC)

Mrs Geary presented the QIP and advised that it had been updated as some of the projects had been superseded or they were no longer relevant. She advised that she had discussed the QIP with the Health Groups and a task and finish group had been established to develop and scope the projects.

Mrs Geary advised that the projects for the 2020/21 QIP included: development of a standardised safety briefing, reduction of patient falls with harm and patient experience for Mental Health patients with long waits in ED.

The Governance arrangements would be monthly reporting to the sub-committees and quarterly reporting to the Quality Committee. If there were any serious concerns these would be escalated to the Quality Committee

rather than waiting for the quarterly report.
Ms Ramsay added that the Operational Quality Committee would be the monthly oversight Committee.

Mrs Geary advised that the QIP had been started late in the year due to Covid-19 and the project timeframes would reflect this. Prof Veysey advised that it was important to set realistic objectives due to the late start. Mrs Stern asked about Patient Council involvement and Mrs Geary reported that the Patient Experience Improvement Framework stated that Patient Council involvement was key.

Resolved:
The Committee received and accepted the report.

4.2.1 Falls Update
Mrs Hoyle presented the report and advised that a sub-committee had been established to review the increase in harm in the elderly and patients with dementia due to falls. Inpatient falls had increased by 4% and the majority of the patients were over 78 and had some cognitive impairment. The reason for the fall was usually due to the patient getting out of bed to go to the toilet.

The Committee was reviewing staff training and working with the moving and handling team as well as physiotherapy. Work was ongoing for the Health Groups to deliver and embed the training and report any themes and trends.

Mrs Hoyle also reported that she was working with a multi-disciplinary team to provide an e-learning framework to support nursing staff and reduce the risk of falls.

A number of initiatives had been put into place such as a new bed rail assessment, the post fall protocol had been changed to make it less ambiguous and vision tests given to patients in line with NICE guidance.

The Committee discussed the impact of falls and how all members of staff should be educated in monitoring vulnerable patients. Mrs Hoyle advised that all patients should be risk assessed and that the Dementia and cognitively impaired patients should be prioritised.

Resolved:
The Committee received and accepted the update.

4.2.2 Safeguarding Update
Mrs Geary presented the update and advised that the Safeguarding processes had continued through the Covid pandemic and working relationships had remained unchanged.

Mrs Geary advised that the Enhanced Care Team had been established and were reviewing the whole service to include the reduction of absconders and protect staff from being harmed. The ECT were also reviewing security with vulnerable patients and looking at new ways of working to not only reduce the spend but to enhance the patient experience.

Mrs Geary reported the Section 29a relating to the Child Sexual Assault department had now been lifted due to the actions put into place.

Safeguarding training was at 76% due to Covid, but a recovery plan was in place.

There had been two Serious Incidents declared, one relating to an adult, which had been downgraded and another relating to a child and the investigation was ongoing.

Mrs Jackson expressed her concern regarding the statement that 94% of all logged cases were overdue. Mrs Geary advised that this was due to a reporting time delay and was not a true reflection. Mr Corral asked if the Trust was an outlier and Mrs Geary advised that it was not.

Resolved:
The Committee received and accepted the update.

4.3 Quality Report
Mrs Geary presented the report and advised that 9 Serious Incidents had been declared in May 2020 and the Never Event declared in December 2019 had been downgraded.

Mrs Geary advised that the Duty of Candour performance was at 75% compliance, but that the standard of 10 days was an internal measure set by the Trust. The verbal apology performance was higher but the written apology sometimes took longer to compile. Duty of Candour was being discussed with Health Groups at the Performance and Accountability meetings.

Mr Hall asked about pressure ulcer performance and asked if the reduction in category 3 and 4 pressure ulcers was due to low bed occupancy. Mrs Geary advised it was but that the quarterly report could change due to a number of staff who had pressure damage because of PPE and had not reported it.

Resolved:
The Committee received and accepted the report.

4.3.1 Patient Experience Report
4.3.2 Complaints and PALs
Mrs Geary reported that the number of complaints and PALs had reduced due to the Covid situation.

Mrs Geary reported that the Patient Experience Team were pro-actively reviewing themes and trends and looking at long waits and the impact on patient experience. NHS I/E had suggested an improvement framework with a detailed workplan which involved patients and members of the public.

The Patient Experience Team have introduced a new process during COVID-19 and implemented a risk rated database for complaints. This allows the Trust to keep a close oversight and monitoring on the progress of the complaints and rates each complaint in a RAG rating based on timescales and complexity. Mr Hall asked if the Committee could have

sight of the database and Mrs Geary agreed to present it at a future Committee. **BG**

There had been a reduction in volunteers due to Covid but a supporting strategy was being put into place to ensure they could come back to work safely.

Resolved:
The Committee received and accepted the report.

4.4 Learning from Deaths – Covid Related Mortality and Morbidity
Dr Purva presented the quarterly report which highlighted the number of hospital deaths in line with national requirements. She reported that the reasons for the deaths were mainly due to pneumonia, stroke and sepsis which were not out of the ordinary. Structured Judgment Reviews had been carried out where appropriate.

Dr Puva advised that 8 Medical Examiners had been recruited and a skeleton rota was in place. She advised that having the MEs was providing excellent learning for the Junior Doctors and hoped to have a full service in place soon.

Resolved:
The Committee received and accepted the report.

4.5 Non Covid harm and its impact
Dr Purva presented the report and advised that a number of patients were not attending their hospital appointments due to Covid even though departments were open and had social distancing measures in place.

Dr Purva highlighted Stroke and Diabetic Foot as two areas that had been reviewed.

Stroke had seen a drop in patients both in the hospital and community setting and work was ongoing to review this decrease and any impacts due to delay in the provision of care. A review of deaths in the community was also ongoing.

The Diabetic Foot service had also seen a reduction and patients not attending regular check ups. Dr Purva advised that in extreme cases this can lead to amputation. She added that this set of vulnerable patients could also be heavily impacted by Covid-19. The service had factored all the issues into their recovery plan.

Mr Hall asked how the Trust could educate patients to ensure they came to their appointments and Dr Purva advised that the Vascular Team were identifying their high risk patients and contacting them to make sure they are ok and encouraging them to visit their GP were possible.

Dr Purva advised that a recovery group was being established to identify areas of risk and look at ways of delivering care to these patients. Prof Veysey asked if all areas would be reviewed and Dr Purva advised that it would be carried out on a need based approach.

Resolved:

The Committee received the update and it was agreed that the report should be a regular item on the agenda and any concerns escalated to the Board. **MP**

4.6 Any escalation from Risk Management Committee/Ethical Clinical Policy Prioritisation Committee
There was nothing to escalate from the Risk Management Committee

Ms Ramsay advised that the minutes from the Ethical Clinical Policy Prioritisation Committee were received at the Board. Mr Hall advised that the Committee was evolving to align with the Trust's activity recovery processes.

5 Any Other Business
5.1 Any other emerging quality issues
There were no other emerging quality issues.

5.2 Report on Opel 4 and Patient Safety
Dr Fan presented the report which highlighted a review carried out on 41 sets of case notes during Opel 4 when patients were having long waits in ED.

70% of the patients were reviewed within 4 hours. There were 5 patients with Sepsis but only 2 got their antibiotics within one hour. Premature discharges were reviewed and 9 patients re-attended the Trust within 72 hours. 2 patients had passed away but there was no evidence to suggest the wait had contributed to their deaths.

All patients were reviewed as quickly as they could have been. Work was ongoing to review frequent attenders and to discuss treatment pathways with GPs.

Dr Fan advised that another review would be carried out if the Trust declared Opel 4 again to capture learning and any improvements.

Prof Veysey thanked Dr Fan as the report provided assurance to the Committee. Dr Purva added that once patients got into the ED they had a good quality of care. There were issues around queuing and waiting in ambulances.

Resolved:
The Committee received and accepted the report.

5.3 CQC Report Briefing
Mrs Geary updated the Committee and advised that the CQC Report had been published on the CQC website. She advised that the inspection had included Medicine, Emergency Care, Critical Care and Surgery but due to Covid the Well Led and Use of Resources inspections had not gone ahead.

The Trust had maintained its 'Requires Improvement' rating despite the improvements made and the number of 'Good' ratings within the report.

A robust challenge had been submitted to the CQC and a significant amount of work to submit further evidence had been carried out. Mrs

Geary thanked Mrs Southgate and her team for the hard work they had put into the process.

An action plan had been submitted by the CQC and had been shared with Health Groups as well as a task and finish group being established to review the actions. The action plan would be monitored by the Executives and would be presented to the Operational Quality Committee, the Quality Committee and the Board.

Mrs Geary highlighted the Neurology Service as they had received a rating of 'outstanding'.

Resolved:
The Committee received and accepted the report.

6 Chairman's Summary to the Board
The Chair agreed to summarise the meeting at the July Board.

7 Date and time of next meeting
Monday 27 July 2020, 9am – 11am by Webex

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting: Ethics Clinical Policy Prioritisation Committee (ECPPC)

Meeting Date:	April – July 2020 (weekly/fortnightly)	**Chair:**	Stuart Hall	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Development and agreement of a Trust-wide Care Decision Framework, designed by a clinical Task and Finish Group of the ECPPC membership; this Care Decision Framework is an ethically-based process to prioritise patient care and maximise resources should the organisation find itself in a position during the Covid-19 pandemic that demand outstrips inpatient capacity. The CDF is currently being trialled within specific services in the Trust to gain feedback on the applicability and the IT system supporting implementation; it is intended that the Framework is further refined from the feedback received from this trial period. This has been the most significant piece of work and activity of the Committee in the last 2 months.

Key decisions made:

- Principles agreed for the ethical considerations of waiting list management and service recovery post the first Covid-19 surge; this set of principles is being shared with relevant teams and decision-making committees in the Trust, as well as the primary and secondary care service recovery group
- Set of principles agreed on the future form and purpose of the Committee, to be shared further once refined in to a proposal, for Trust Board review

Risk and assurance matters to be received by the Board:

- Assurance that the ECPPC has identified the need for an ethically-based Care Decision Framework and put this together based on the available evidence base, are trialling this process, and will be publishing this framework for use, in the hope that it will not be needed

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust

Trust Board

14th July 2020

Title:	Our People
Responsible Director:	Simon Nearney - Director of Workforce and Organisational Development
Author:	Simon Nearney - Director of Workforce and Organisational Development

Purpose:	The purpose of the report is to provide the Board with an overview of the key people issues during the Covid-19 pandemic and as the Trust resumes clinical activity.	
BAF Risk:	Goal 1 – Organisational Culture, Staff Engagement Goal 2 – Valued, skilled and sufficient staff	
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:	The Trust staff vacancy rate is currently 4.85%. Staff absence is currently 7.58% including Covid-19 related. The staff wellbeing and support arrangements continue to work well, however Government funding for free parking, staff meals, accommodation and childcare is likely to end on 31st July, 2020.	

Recommendation:	The Trust Board are requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

14th July 2020

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues during the Covid-19 pandemic and as the Trust resumes clinical activity.

2. Background

For the last 5 months the Trust has been proactively managing its response to the Covid-19 pandemic. Robust surge plans were developed and deployed which included staff redeployment and refresher training. The peak surge has now past and whilst the Trust continues to treat and care for Covid-19 patients, the Trust has begun to resume elective clinical activity.

Communication across the Trust remains vital to keep staff informed and engaged every step of the way and therefore the daily briefing on clinical and workforce matters continues which is well received by staff. The Trust also continues to request that all staff clinical and non-clinical practise social distancing and good hygiene measures to ensure staff are as safe as possible. The Trust also continues to meet virtually with trade unions to keep them informed of activity, workforce plans and redeployment.

3. Staff Absence

The total staff absence for the financial year 2019-20 was 3.67%. This is excluding Covid-19 absence. The Trust attendance target for attendance was 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 315 staff absent due to Covid-19 which is 3.19% of the workforce. Total absence including maternity leave and all other reasons for absence is 7.58%. This is a reduction from 9.82% as at the last Board meeting (18th June, 2020).

Staff absence usually runs at 3.6%, so whilst absence is reducing the Trust is still 4% above its norm which means available workforce is a key challenge to resuming services.

The Government have announced that staff shielding can return to work from 1st August, 2020, as long as their work environment is deemed to be 'Covid-19 Secure'. Work is underway to assess and determine which clinical and non-clinical areas can be deemed as Covid-19 secure. If a work place is not Covid-19 secure then the staff member will be redeployed to a secure area and one that will utilise the individuals' skills. The Trust has 143 staff shielding, 30 staff with underlying health conditions who have been risk assessed and placed at home during the pandemic and 6 staff over 70 years old who are also currently at home. Managers and HR are now in contact with these staff to supportively bring them back to work.

4. Staff Testing

The Trust continues with two staff test programmes and are supporting the National NHS Test and Trace Scheme. The two tests are:

Covid-19 Staff Test

This is the antigen testing facility and has been operating since April, 2020. From 1st April to 30th June 2020, 2696 staff have been tested. 2252 (83.54%) have tested negative and 444 (16.46%) have tested positive. The Trust also tests staff from CHCP, Yorkshire Ambulance Service, Humber FT, CCG's, care homes and other smaller providers.

Antibody Test
The Trust commenced antibody testing on 3rd June, 2020. Currently 7,576 staff have been tested for antibodies with 12% showing positive that the staff member is likely to have had coronavirus and have anti-bodies within their symptom. Staff who tested negative are offered a further test in 1 month and staff who test positive are offered another test at 6 months.

Test and Trace
The NHS Test and Trace programme launched on Friday 5th June 2020. If a staff member tests positive for Covid-19, the Trust is responsible for ensuring all work related 'contacts' are identified and those staff members instructed to self-isolate for 14 days. The Trust Test and Trace operation is managed through the nursing team attached to the ESC Helpdesk. To date the Trust has requested 78 staff to self-isolate as a result of a 'contact' within their workplace.

5. Staff Vacancies
The Trusts overall vacancy position as at 31st May, 2020 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Vacancies WTE	Vacancy Rate %
Healthcare Scientists	347.74	281.75	65.99	18.98%
Medical & Dental - Consultants	463.85	399.19	64.66	13.94%
Medical & Dental - SAS	63.8	47.37	16.43	25.76%
Medical & Dental – Trainee Grades	639.55	665.02	-25.47	-3.98%
NHS Infrastructure	2048.58	1974.66	73.92	3.61%
Other Scientific Staff	291.37	282.31	9.06	3.11%
Other Support to clinical staff	745.28	688.74	56.54	7.59%
Registered AHP	483.3	457.99	25.31	5.24%
Registered Nursing	2369.96	2294.95	75.01	3.17%
Unregistered Nursing	798.33	759.34	38.99	4.88%
Trust Total	8251.76	7851.32	400.44	4.85%

Overall the Trust vacancy position is 4.85% and is 4.8% in Medical & Dental. Consultant vacancy rate is 13.94% but including locum, casual and agency staff, the vacancy rate is 2.8% (12.66wte). Trainee Grades for Medical Dental staff are showing as being over established, however this is due to 48 5th year medical students who have been employed as part of the Trusts Covid-19 workforce plan. Whilst our vacancy position remains in a positive position the Trusts recruitment plans have been somewhat interrupted and recent recruitment may be temporary, for example staff recruited under 'return to practice' initiatives.

Registered Nurse and Midwifery
The vacancy rate for Registered Nursing and Midwifery is currently 3.17% across the Organisation. However, the wards currently have a vacancy rate of 13%, ICU 10% and ED 9%. The Trust is currently pursuing 110 adult branch nurses, the majority of whom are currently employed by the Trust as Aspirant Nurses (band 4 role) and are due to register with the NMC from August 2020 onwards.

There are currently 51 Nurse Associates in training with a further 26 that commenced in March, 2020. 4 more will commence in September, 2020. In addition the Trust has 21 Student Nurse Apprentices and 23 Health Care Support Worker Apprentices. A further 15 apprentices will commence in September (12 nursing and 3 ODP) and 22 more Health Care Support Worker Apprentices will commence in September, 2020, subject to funding being finalised.

An additional 25 overseas registered nurses were expected in March and April, 2020, 5 nurses commenced employment with the Trust in February 2020, however the remaining staff could not travel due to the Government lockdown and no international travel. Plans have commenced to

support a further 13 nurses to commence employment with the Trust in October 2020. The Trust has also received notification from the NMC that the OSCE testing centres will be reopening from 20th July, therefore supporting these staff to obtain their NMC registration.

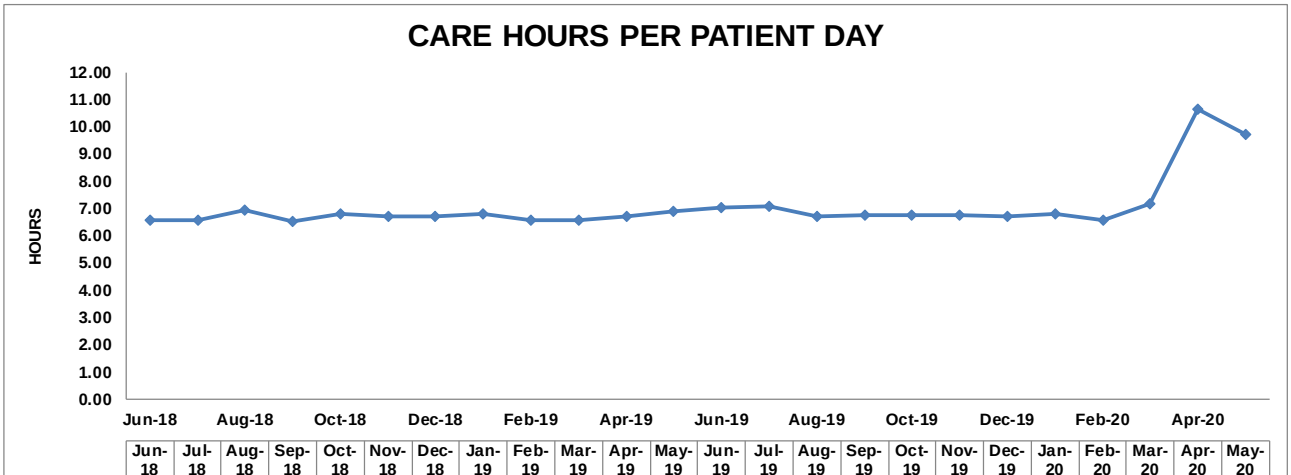
Recruitment of 3rd and 2nd year nurse students
121 third year student nurses are currently working for the Trust as Aspirant Nurses (band 4). Some of these staff will leave the Trust as they complete their studies, but we have a further 21 students that are currently finishing their programme elsewhere who will be commencing employment with us in September 2020.

76 second year nurse students commenced employment with the Trust during the month of June 2020, in a Health Care Support Worker (band 3) role and a further 57 were planned for July, however the Government have recently announced that funding will cease on the 31st August 2020, so these staff will return to their studies on 1st September, 2020.

Recruitment of 5th year medical students
The Trust has employed 48 medical students as part of its Covid-19 workforce plan.

6. Care Hours per Patient Days

Care Hours Per Patient Day (CHPPD)
As illustrated below the CHPPD for May is 9.74 this has reduced from 10.67 from the previous month. The CHPPD remains significantly higher in comparison to previous months. Initial analysis suggests this is due to a reduction in the volume of patients seen in the Trust in this period compared to pre Covid norms.



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
CHPPD	6.57	6.56	6.93	6.52	6.83	6.70	6.70	6.81	6.60	6.56	6.73	6.88	7.03	7.10	6.70	6.76	6.78	6.78	6.72	6.79	6.59	7.18	10.67	9.74

7. Staff Support Arrangements

Ensuring staff had every means of support available to them has been a priority for the Trust ever since the Covid-19 pandemic began. Cognisant that the emotional impact of the pandemic would be significant for staff we understood from the very outset that providing additional support would be an important means of maintaining morale, improving engagement and delivering on our duty of care for the workforce.

From March, the Trust provided free childcare, accommodation, meals and free car parking. However the Chief Finance Officer has indicated that the additional funding for Covid-19 to pay for this support is likely to cease on 31st July therefore the arrangements will end at that point.

The feedback from staff to all of these services has been unanimously positive. It has enabled staff to continue to attend work and care for our patients, so ending the arrangements may impact upon staff attendance and morale. All staff have been informed of the position.

The Trust has conducted a lessons learned review of the Trusts response to the pandemic and as part of this will be requesting feedback from all staff.

Incidents reporting staff harms related to Personal Protective Equipment.
A separate reporting form for staff harms related to PPE was launched on 21st April 2020 to enable staff to report incidents when they had sustained harm from wearing PPE. 25 incidents have been reported. Injuries included redness, swelling, pain and broken spots.

8. Staff Wellbeing and Support Arrangements

The Staff Psychosocial Support Team was created week commencing 16th March 2020 and is a collaborative effort of our Psychological Services, Pastoral and Spiritual Care, Occupational Health and Organisational Development (OD)Teams. A full review of the programme has been undertaken by the Workforce Education and Culture Committee on Wednesday 8th July. Below is an overall summary of the services currently being provided and future plans.

The service continues to run with the 24/7 helpline in place and is now staffed fully by our chaplaincy team (with support from psychologist as required) from the beginning of July 2020 through to 31st August where it's on-going need will be reviewed. The staff support email will also remain in use to act as a central place for staff to request support and information. Team reflection session are underway led by the psychology and chaplaincy support teams to understand their experiences, thoughts and feelings in a safe and secure setting. Staff can also request 1:1 sessions from the psychologists, chaplains and coaches depending on their needs. Going forward it's important to ensure we have long term psychological wellbeing services in place as trauma responses can be delayed and emerge once the intense phase has begun to become less intense. Many of our staff have been redeployed and the longevity of this upheaval is likely to be an unprecedented experience for many. We now must ensure we support our staff to come to terms with new ways of working, potentially changing team mates for the foreseeable future and an on-going risk of a Covid-19 second wave.

A 12 month Clinical Psychologist post has been funded to ensure that we have the psychological input we need to support staff and enable us to follow the British Psychological Society Guidance on psychosocial support as we move into the restoration phase of the Covid-19 response. This ensures that our staff are provided with the right level of assessment and intervention from the most appropriately qualified member of staff. This is in addition to the already outstanding support offered from our occupational health and our chaplaincy teams.

Ensuring our leaders are equipped to support mental wellbeing is also vital. Our Great Leaders "Management Clinics" for leaders have been well received and provide a mixture of a reflective space plus hot topic experts to support their leadership through Covid-19 and beyond. Six sessions have been held so far via WebEx. Hot Topic experts have been from Human Resources, Occupational Health and the Trusts Freedom To Speak Up Guardian) and future session will include creating conversations about race and prejudice to support managers to tackle these issues in the workplace.

"Alone Together" will be further built upon with a focus on creating capacity, content and support in three key areas:

- Fun and social activities
- Wellbeing
- New ways of working – practical and social support

A survey is currently underway to understand the needs of those who have been shielding, home working, socially isolated (e.g. live alone) and many other reason people may be experiencing loneliness despite coming to work. The result will further support and direct any future interventions required. Our morning and lunch clubs are still underway and a Facebook group is beginning to thrive and increase its membership.

9. Conclusion

Staff vacancy levels within the Trust has been improving for the last 2 years plus which is positive, but the Trust will need to review its future recruitment plans and supply in the medium term to ensure the organisation continues its trajectory.

Staff absence for self-isolation will continue to cause the Trust difficulties in providing services and resuming more clinical activity even with 'shielders' returning to work effective from 1st August, 2020. The staff wellbeing programmes will continue to support our staff, however those practical support arrangements will end as the national funding is withdrawn.

10. Recommendations

The Trust Board are requested to note the content of the report and provide any feedback.

Simon Nearney
Director of Workforce and OD

Beverley Geary
Chief Nurse

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Workforce Education and Culture Committee

Meeting Date:	8 July 2020	**Chair:**	Prof. U Macleod	**Quorate (Y/N)**	**N**

Key items discussed where actions initiated:

- Updated Workplan with 20/21 priorities and timings.
- Job Vacancy Report – highlighted vacancies around the Trust and the work ongoing to fill them as well as staff absence due to Covid .The overseas nurse programme had been delayed due to Covid but was now being reviewed for September 2020 intake.
- Guardian of Safe Working quarterly and annual reports were received. There were no concerns raised. Work was ongoing to ensure all doctors were on e-Roster to assist with job planning.
- Variable Pay Report was received. It was agreed that the report would be reviewed at the next meeting as the figures were artificial due to the Covid situation over the last 3 months.
- Freedom to Speak Up Report was received with the main theme of staff behaviours highlighted. Work was ongoing with the BAME network to encourage members to work with the Freedom to Speak Up Guardian as part of the support network.
- Covid Staff Support Report. An update was received regarding the support networks put into place by the Trust during the Covid pandemic including working with the Psychological Services, the Chaplaincy team and having drop in centres and 1:1 sessions with staff.
- Medical Education Update. Thank you to the Junior Doctors who had worked over and above in a professional way during the Covid pandemic. Work was ongoing to catch up with doctors training after the pandemic.

Key decisions made:

- No specific requests made of the Committee; all reports were accepted

Risk and assurance matters to be received by the Board:

- No specific risks or assurance matters to be received.

Matters to be escalated to the Board:

- None

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

14 July 2020

Title:	Outline / Full Business Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at Hull Royal Infirmary
Responsible Director:	Teresa Cope, Chief Operating Officer
Authors:	Lee Bond, Chief Financial Officer Fionnuala Raitt, Head of Capital Planning Alison Drury, Deputy Director of Finance

Purpose:	The purpose of this paper is to present for Trust Board approval the Outline / Full Business Case (OBC / FBC) for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at Hull Royal Infirmary.	
BAF Risk:		
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 of Key Issues:	The combined impact of increasing volumes and complexity of patients being admitted to the Hull Royal Infirmary, increased length of stay, delayed transfers of care and insufficient assessment/ambulatory capacity to meet demand, is impacting negatively on the ability of the Trust to manage the urgent and emergency care patient pathway from admission to discharge in a timely manner, resulting in increased waiting times in the Emergency Department, increased waiting times for diagnostic tests, longer lengths of stay in the Acute Medical Unit and a poor patient experience. The Strategic Outline Case was approved by DHSC on 25 February 2020. The Trust was cleared to progress the project to the next stage via a single Outline / Full Business Case (OBC / FBC) prior to commencement of commercial activity in order to progress the scheme as quickly as possible. The attached OBC / FBC seeks approval to invest £19.3m of capital funding in the reconfiguration and transformation of urgent and emergency care facilities at Hull Royal Infirmary to enable the better management of the acutely ill patient. This involves the remodelling of the area around the font entrance of the tower block and the relocation of paediatric services to the 2nd floor. It also involves the provision of additional diagnostic capacity (CT and MR) on the ground floor of the tower block.	

Recommendation:	The Trust Board is asked to: • note the contents of this paper • approve the Outline / Full Business Case; and • approve the release of the Case to NHS England/Improvement (NHSE/I) for external approval.

Hull University Teaching Hospitals NHS Trust

Trust Board – July 2020

Outline / Full Business Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at the Hull Royal Infirmary

1. Purpose of Paper

The purpose of this paper is to present for Trust Board approval the Outline / Full Business Case for the Reconfiguration and Transformation of Urgent and Emergency Care Facilities at Hull Royal Infirmary.

2. Background

In July 2018 the Trust submitted a capital bid totalling £19.3m to improve the provision of urgent and emergency care at Hull Royal Infirmary through the reconfiguration and transformation of patient pathways, modernisation and expansion of clinical facilities and the supporting infrastructure. In particular, the bid aimed to:

- Reconfigure the ground floor of the Tower Block to provide:
  - increased assessment unit capacity
  - increased diagnostic scanning capacity (additional MRI and CT scanners and associated infrastructure).
- Increase adult inpatient capacity through the relocation of paediatric inpatient services from the 13th floor of the Tower Block to the Women's and Children's Hospital to create two 24-bedded wards allowing the reconfiguration of medical and surgical inpatient services[1].
- Provide replacement and additional endoscopes to meet the increasing demand for endoscopy services.

The bid was part of a wider ICS proposal which required investment in urgent and emergency services at 4 hospitals within the HC&V footprint totalling £88m.

In December 2018, the Department of Health and Social Care (DHSC) confirmed that the total ICS wide scheme had been included in the list of projects that had been allocated funding to support STP transformation across the country. The release of the £19.3m capital allocation to the Trust was dependent upon the approval of a Strategic Outline Case (SOC) and Outline / Full Business Case (OBC/FBC) by NHS Improvement, DHSC and HM Treasury.

The SOC was approved by Trust Board on 10 September 2019 and by DHSC on 25 February 2020. Since the submission of the capital bid and the SOC, there had been a number of developments which needed to be taken into consideration, including the provision of additional in-patient facilities (H36, H37 and H38) and the expansion of the acute assessment unit (AMU) by 10 beds. However, the updated evidential base in the OBS / FBC case reaffirms the need to invest in our facilities to improve our urgent and emergency care pathways and patient flow in the hospital.

The impact of Covid-19 is also considered in the case. The strategic assessment, project scope, and capital solution for this case were defined and developed prior to the Covid-19 pandemic however, the clinical accommodation requirements and the movement of patients

[1] This has been superseded as a result of the investments made in wards 36,37 & 38 and with the agreement of the Trusts long term strategy to relocate clinical services from the upper floors of the Tower Block (4th floor and above) into purpose built accommodation adjacent to it.

within our urgent and emergency pathways have been revisited with the impact of Covid-19 in mind.

The additional investment that this business case seeks to secure, alongside the capital investment received in Winter 2019 and during the pandemic itself will provide the Trust with greater flexibility in the use of its clinical accommodation, ensuring compliance with infection control and prevention requirements. The preferred option has been re-evaluated in light of the Covid-19 situation and the Trust is confident that there are no risks with either the design or delivery of the scheme. The floor plans, including the circulation areas and seating arrangements, have been reviewed and adjustments made to comply with social distancing guidelines.

The impact of the pandemic on the Trust's cost base and its productivity is a concern. Productivity assumptions included in the case and in the benefits section may be impacted by necessary adjustments to working practices. This is likely to be most acutely felt in the use of the additional diagnostic equipment where patient throughput is currently operating at a much reduced level to pre-pandemic levels. It is hoped that this will recover as infection prevention and control measures are relaxed in line with a commensurate reduction in risk from covid-19. The risk is recognised in the case but not quantified. The productivity and financial assumptions included in the case are based on the pre-Covid state

3. Outline / Full Business Case

The Outline / Full Business Case for the Urgent and Emergency Care Development is attached. The format is in accordance with HM Treasury's '*Guide to Developing the Project Business Case'.*[2](2018).

The case for change confirms that, with the current configuration of services, and limited assessment, diagnostic and inpatient capacity, the safety of patients requiring urgent and emergency care is being compromised. Key factors include:

- Poor patient flow from emergency admission to discharge.
- Increasing numbers of attendances to the Emergency Department (ED) by patients whose care could be more appropriately managed in primary care.
- Insufficient assessment / ambulatory capacity for surgical patients resulting in an inpatient admission.
- Insufficient diagnostic capacity in CT, MRI and endoscopy to meet demand leading to increased waiting times for diagnostic tests and increased waiting times in the Emergency Department, assessment units and on the inpatient wards. For example: the daily average number of breaches of the 4 hour waiting time threshold in the Emergency Department attributed to waiting time for diagnostic tests increased from 4.7 breaches per day in 2017/18 to 11.7 breaches per day in February 2020.
- An MRI facility that is located outside of the Tower Block, necessitating the transfer of emergency and inpatients across the hospital site.
- An increase in the number of medical outliers on surgical wards and the cancellation of elective surgical activity.
- Higher bed occupancy rates. In the case of medical beds, bed occupancy exceeds 92% resulting in increased pressure at times of high demand leading to backlogs and overcrowding in the ED.

2

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749086/Project_Business_Case_2018.pdf

- Increased pressure on bed availability due to the number of patients whose transfer/discharge has been delayed (an average of 1190 bed days per month in 2019/20, pre-Covid)
- Inadequate accommodation for children on the paediatric wards leading to privacy and dignity issues.
- Paediatric services on the 13th floor include the inpatient ward, paediatric high dependency unit and paediatric assessment unit. These are remote from the diagnostic facilities and critical care facilities on the 2nd floor of the Tower Block, from the paediatric surgical ward in the Women's and Children's Hospital, and from the Paediatric Emergency Department which is located on the ground floor of the Tower block. This geographical isolation poses a number of quality and access concerns for children using these pathways.
- Lack of parental accommodation, particularly for those whose children are being treated in the Paediatric High Dependency Unit and Neonatal Intensive Care Unit.
- Insufficient capital funding to deal with the backlog maintenance in the HRI estate and the long term strategic intention to move patients from the 4th floor upwards to new clinical accommodation outside the tower block

The poor flow along the urgent and emergency care pathways has resulted in the following:

- Failure to comply with the 15 minute standard for ambulance/ED handover leading to queuing of ambulances outside the ED.
- Failure to comply with the 4 hour waiting time threshold in the ED. The Trust has not met the 95% threshold (annual total) for the last five years.
- Failure to comply with 7 Day Hospital Services Clinical Standard 5 (Timely Access to Diagnostics)
- Inability to meet demand in growth for diagnostic imaging due to lack of capacity in CT, MRI and endoscopy
- Failure to comply with national 18 week Referral to Treatment (RTT), cancer and diagnostic waiting time thresholds.
- Poor patient experience as a result in increased waiting times for assessment, diagnostics, treatment and/or admission to hospital, increased length of stay, and multiple transfers between wards/departments.
- A Care Quality Commission rating remaining at 'Requires Improvement' for responsiveness in Urgent and Emergency Care and for the failure to comply with NHS access standards.

Using the Options Framework within the national business case guidance, the Trust identified a long list of options which in turn led to a Preferred Way Forward at SOC stage. The short-listed options were revisited as part of the development of the OBC / FBC and a Preferred Option selected.

This comprised the following elements:

- Reconfigure the front entrance to the Emergency Department to provide better segregation and access to primary care and emergency care services, provide additional CT, MRI on the ground floor of the Tower Block, replace and provide additional endoscopes, relocate the Elderly Assessment Unit, relocate the paediatric department from the 13th floor of the Tower Block to address the issues with the remoteness of the service.
- This will be realised through the provision of a three storey extension to the front of the Tower Block and the reconfiguration of services to provide a Surgical Ambulatory Care Unit on the ground floor.

- The project will be delivered through the awarding of a series of tenders for individual elements of work carried out through a series of phases.
- The project will be implemented over 2 years.
- It will be funded through STP Wave 4 funding totalling £19.3m.

The table below summarises the outputs from the economic analysis of the short-listed options:

Economic Summary (Discounted) - £'000	Business as Usual	Revised PWF (option 8)	Do Minimum (option 6)
Incremental costs - total	**£0.00**	**-£17,992.37**	**-£17,654.02**
Incremental benefits - total	**£0.00**	**£40,389.13**	**£35,408.69**
Risk-adjusted Net Present Social Value (NPSV)	**£0.00**	**£22,396.76**	**£17,754.67**
Benefit-cost ratio	**0.00**	**2.24**	**2.01**

Detailed Economic Summary (Discounted) - £'000	Business as Usual	Revised PWF (option 8)	Do Minimum (option 6)
Costs			
Incremental cost increase - opportunity cost	£0.00	£0.00	£0.00
Incremental cost increase - capital (including optimism bias)	£0.00	-£15,620.56	-£16,262.55
Incremental cost increase - revenue	£0.00	-£829.76	£0.00
Incremental cost increase - transitional	£0.00	-£153.64	-£144.31
Incremental cost increase - risks	£0.00	-£1,388.41	-£1,247.17
Incremental costs - total	**£0.00**	**-£17,992.37**	**-£17,654.02**
Benefits			
Incremental cost reduction - opportunity cost	£0.00	£1,684.58	£0.00
Incremental cost reduction - capital (including optimism bias)	£0.00	£0.00	£0.00
Incremental cost reduction - revenue	£0.00	£0.00	£81.18
Incremental cost reduction - transitional	£0.00	£0.00	£0.00
Incremental cost reduction - risks	£0.00	£0.00	£0.00
Incremental benefit - cash releasing	£0.00	£37,857.61	£35,211.68
Incremental benefit - non-cash releasing	£0.00	£846.94	£115.83
Incremental benefit - societal	£0.00	£0.00	£0.00
Incremental benefits - total	**£0.00**	**£40,389.13**	**£35,408.69**
Value for Money			
Risk-adjusted Net Present Social Value (NPSV)	**£0.00**	**£22,396.76**	**£17,754.67**
Benefit-cost ratio	**0**	**2.24**	**2.01**

The table shows that the benefit-cost ratio of the preferred option is 2.24 which is above the do minimum option (2.01) and is an improved position compared with the SOC at 1.2.

The estimated capital costs of the preferred option have been reviewed by the Trust Cost Consultant. The costs reflect a start on site of September 2020 and practical completion in January 2022.

A summary showing the capital cost of the preferred option is shown in the table below and the full FB forms are included in the attached case.

Summary Capital Expenditure	**£000**
Equipment	4,077
Building	15,191
Total Capital	**19,268**

STP PDC Funding	**19,268**
(Shortfall)/Surplus Funding	0

As detailed in the economic case, the capital cost includes 7.8% (£860k) for optimism bias on the building works and a further £221k for risk / contingency.

The above costs also include VAT. The Trust will employ an external VAT assessor to carry out a full VAT assessment although the FBC has included a preliminary assessment based on a VAT banding which is a conservative estimate at this stage. This is on the basis of historic experience and initial discussions with VAT advisors and has been reflected in the capital costs above for the building.

The revenue running costs of the scheme make provision for the staffing requirements for the operation of the additional scanners and the additional ambulatory care / assessment capacity, the maintenance of the scanners and the additional endoscopes, as well as the facilities costs of any additional floor area, along with the capital charges associated with the capital investment.

The overall revenue costs of the development is circa £2.8m per annum including capital charges. This is reduced by £0.7m due to the avoidance of costs currently being incurred in outsourcing MRI/CT which will no longer be required, resulting in a net revenue cost of circa £2.1m per annum. This saving from reduced outsourcing is not included within the cash releasing benefits (CRBs) that feed the economic model as the costs of outsourcing are part of the Business As Usual Comparator.

The estimate of the first full year's incremental impact on the Trust's Statement of Comprehensive Income (SOCI) position is shown in the table below:

Revenue Expenditure Full Year Effect	Preferred Option £000
Pay	
Medical Staff	99
Nursing & Midwifery Staff	1,134
Scientific, Therapeutic & Technical Staff	(504)
Administrative & Clerical	98
Healthcare Assistants & Other Support Staff	(282)
Total Pay (Expenditure)/Savings	**545**
Non-Pay Expenditure	
Clinical Supplies & Services	96
General Supplies & Services	34
Establishment Expenditure	(22)
Premises & Fixed Plant (maintenance)	(303)
Purchase of Healthcare from Non-NHS Bodies	734
Miscellaneous	0
Total Non-Pay (Expenditure)/Savings	**539**
Operating (Expenses)/Savings Total	**1,084**
Capital Charges	
Depreciation	(601)
PDC Dividends Payable	(483)
Total Capital Charges	**(1,084)**
Retained Surplus / (Deficit) for the Year	**0**
Add back all I&E impairments/(reversals)	0
Adjusted Financial Performance Surplus/(Deficit)	**0**

The overall position is neutral for the SOCI from year 3 onwards (2022/23). This includes the savings from the equivalent of a ward due to the ability to improve patient flow, increase in Same Day Emergency Care (SDEC), with increased capacity and improved access to diagnostics. The efficiency and productivity gains assumed are on the basis of a pre-Covid state and assume that without the investment from this case, the Trust would require the investment in additional bed capacity by 2022/23 based on business as usual.

In years 1 and 2 there is a deficit position of £0.74m and £0.58m respectively. This is due to the full year impact of the cash releasing benefits not being realised until year 3 and in addition, there are the transitional costs of circa £150k included in year 1. The savings from the outsourcing of the MRI scanner are also not realised until year 2.

The non-recurrent shortfalls in years 1 and 2 will be mitigated via a combination of the Trust's cost reduction and efficiency programme and growth in clinical income. This has been factored into the longer term planning discussions with local commissioners. Given that this is non-recurrent and there is commissioner support for the case, this is not considered a risk to Trust.

The Financial Case shows that the preferred option is affordable taking into account the first full year of costs/benefits (from year 3) and the Trust is able to offset the incremental costs with the cash releasing benefits. Taking year 3, after the impairment (as this is skews the position), the EBITDA is positive at just over £1m, the incremental impact on the overall SOCI position is balanced and there is a neutral impact on the Trust's cash flow, allowing for a reduction in creditors.

The construction phase can be completed in 2 years allowing early delivery of the benefits. The option also delivers on all of the critical success factors and investment objectives and supports national policies, initiatives and targets and fits within the existing business strategies of the organisation and the HC&V ICS.

The project plan below highlights the key milestones and associated dates to deliver the reconfiguration of urgent and emergency care at HRI. A detailed project plan has been developed. This includes the key deliverables for each phase of the project, the activities required to deliver them, the dependencies and associated constraints and when the activities will occur.

Milestone Activity	Timescale
Approval of Single OBC / FBC by HUTH Trust Board	14 July 2020
Submission of OBC / FBC to NHSEI	17 July 2020
Approval of OBC / FBC by DHSC / HM Treasury	6 weeks
Site Preparation works	31 August 2020
Planning Application	22 June 2020
Procurement of Endoscopes	October 2020
Phase 1 construction (ground floor)	14 September 2020
Phase 2 construction (front entrance)	1 October 2020
Phase 3 construction (Paediatric relocation)	September 2021
Project completion	January 2022

4. Next Steps

Subject to Trust Board approval, the Outline / Full Business Case will be submitted to NHS England / Improvement. It is anticipated that Treasury approval will be received by end August 2020.

5. Recommendation

The Trust Board is asked to:

- note the contents of this paper
- approve the Outline / Full Business Case: and
- approve the release of the Case to the NHSEI for external approval.

Lee Bond
Chief Financial Officer
8 July 2020

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 July 2020

Title:	Freedom to Speak Up Guardian update
Responsible Director:	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian
Author:	Carla Ramsay – Director of Corporate Affairs and Freedom to Speak Up Guardian

Purpose:	To provide an overview of 2019-20 from the Freedom to Speak Up Guardian as well as Q1 2020-21 data and reflections	
BAF Risk:	BAF 1	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary of Key Issues:	The Trust Board receives a regular report from the Freedom to Speak Up Guardian on the issues being raised by staff and a 'read-across' of issues raised through other routes. The key concern raised by staff, consistent with previous quarters, is individual examples of poor behaviours and/or bullying behaviours between colleagues. All issues have action taken, as far as the individual who is raising concerns is comfortable with. The intelligence is also used to feed in to wider Trust organisational development programmes.	

Recommendation:	The Trust Board is asked to receive and accept this report, and fee back any observations on how further to develop the Freedom to Speak Up Guardian role in the Trust

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian report

1. Purpose of the paper

To provide an overview of 2019-20 from the Freedom to Speak Up Guardian as well as Q1 2020-21 data and reflections.

2. Introduction

The National Guardian's Office requires Freedom to Speak Up Guardians to be able to report directly to the Trust's Board. This report provides an update on concerns raised by staff through the Trust's Freedom to Speak Up Guardian (FTSUG) and review of other concerns raised by staff.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Whistleblowing Policy
- Staff Advice and Liaison Service (SALS)
- Anti-fraud service
- Through their line manager
- Freedom to Speak Up Guardian
- Through the Bullying and Harassment Policy or through a formal grievance

There are other routes as well as ways in which staff can receive support if they are experiencing difficulties at work. These are captured in Appendix 1.

In addition, professional organisations such as the Nursing and Midwifery Council and the General Medical Council (GMC) also issue guidance such as the GMC's *Raising and acting on concerns about Patient Safety* (2012), which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

All Trusts from 1 April 2017 were required to have a Freedom to Speak Up Guardian in place. The Trust Board agreed an outline position as to how the Guardian role would be used within the Trust; the main purpose of the Guardian role is to be part of creating or furthering a positive culture that supports staff to raise concerns and to make continuous improvement to a culture that supports the highest standards of care and openness.

3. Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting.

3.1 Main activities in 2019-20

The main activities this calendar year have been to promote the role of the Freedom to Speak Up Guardian (FTSUG), to network and learn from other Trust's about the use of the role, and to review key findings that have been published by the National Freedom to Speak Up Guardian, Dr Henrietta Hughes.

Available on Pattie is a page on the Freedom to Speak Up Guardian role, the route available to support staff in speaking up, and an introductory video. Further written guidance on the difference between different speaking up routes (grievance, whistleblowing, etc) has also been uploaded as guidance to staff and managers from a national best practice guide.

The FTSUG has continued to attend staff meetings to introduce the role, and also attended the induction training day for newly qualified midwives. The FTSUG writes a regular blog on speaking up, encouraging staff to report issues through any route with which they are comfortable, and reinforcing positive messages that speaking up makes a difference.

3.1.3 BAME Leadership Network and BAME staff risk assessments

The Trust pro-actively engaged the BAME Leadership Network in the BAME risk assessment process that was put in place in May 2020; at the request of the BAME Leadership Network, the Freedom to Speak Up Guardian role has been offered a support a panel linked to the BAME risk assessment process, in circumstances where a member of staff and their line manager cannot come to an agreement on reasonable steps to take to mitigate the results off an individual risk assessment.

To date, the FTSUG has not been involved in any individual cases but managers have fed back that they appreciate the opportunity to engage the FTSUG and the BAME Leadership Network for objective input and a 'fresh pair of eyes' on a specific situation. This pre-empted a letter from the National Guardian's Office that asked Trusts to consider how to make best use of the supportive role of the FTSUG.

3.1.2 Trust Management Staff Clinics

The Organisational Development team have arranged weekly hot topic management clinics during Quarter 1, which provide an opportunity for managers within the Trust to join a virtual session and ask for guidance or advice from subject matter experts in the Trust. These sessions have included Occupational Health, HR processes and the Freedom to Speak Up Guardian. To date, two sessions have been held with the FTSUG that have been well attended and a number of case studies and examples of good practice have been shared. The FTSUG will write this up in their next blog to further promote the role and also what managers can do to be pro-active and encourage staff to speak up with any concerns they might have.

3.2 National Freedom to Speak Up Guardian

In October 2019, the National Guardian's Office released a report providing a 'Freedom to Speak Up' index measurement for all NHS Trusts. This is calculated on scores from specific National Staff Survey questions, as follows:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

The report provides an index score for each organisation, as well as a national average for same kind of NHS Trust.

Hull University Teaching Hospitals NHS Trust's Freedom to Speak Up index score is 78%, using the 2018 Staff Survey results, against a national average score for acute trusts of 77%. The national average has risen from 75% in 2015 to 78% in last year's survey results.

The highest score of any acute trust is 84% (The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust). The highest score nationally is 87% (Cambridgeshire Community Services NHS Trust).

Whilst the Trust is above the national average, staff culture and the Trust's values remain key drivers for organisational development and staff engagement. The specific questions link closely to patient safety and the Freedom to Speak Up Guardian is linking in closely with the work being undertaken through the Workforce Transformation Committee and the Governance team on supporting a safety culture in the organisation.

4.3 Freedom to Speak Up Guardian – Trust Contacts
The National Guardian's Office also sets out a requirement to report to the Trust Board the number of contacts that the Freedom to Speak Up Guardian has received. The Trust's FTSUG has continued to do so.

The Trust's figures are as follows:

From 1 April 2019 – 31 March 2020, the FTSUG was contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	0
Contacted directly by the member of staff	24
Requesting advice for a colleague	2
Contacted via SALS	1
Signposted by manager	0
Signposted by Occupational Health	0
Signposted by a FTSUG in another Trust	0
Signpost by Trust's Guardian of Safe Working Hours	1
Signposted by Trade Union contact	1
Total	**29**

The following types of concern were raised 1 April 2019 – 31 March 2020:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	8
Concerns about HR process involving the member of staff – concerns about fair treatment	2
Concerns about patient safety	4
Concerns about workload	0
Concerns about inappropriate behaviour	0
Concerned about role within the Trust	0
Concerned about issues directly relating to Covid-19	3
Concerns about service delivery	3
Concerned about poor working relationships within team	7
Unspecified – contacted for general support	2
Totals	29

From 1 April 2020 – 6 July 2020 (Q1 + 6 days), the FTSUG has been contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	0
Contacted directly by the member of staff	8
Requesting advice for a colleague	0
Contacted via SALS	0
Signposted by manager	0
Signposted by Occupational Health	0
Signposted by a FTSUG in another Trust	0
Signpost by Trust's Guardian of Safe Working Hours	1
Signposted by Trade Union contact	0
Total	**9**

The following types of concern were raised 1 April 2010 – 6 July 2020 (Q1+6 days)

Type of concern	**Number of contacts**
Concerns about bullying behaviour	1
Concerns about HR process involving the member of staff – concerns about fair treatment	0
Concern about patient safety	1
Concerns about workload	0
Concerns about inappropriate behaviour	0
Concerned about role within the Trust	0
Concerned about issues directly relating to Covid-19	4
Concerns about service delivery	0
Concerned about poor working relationships within team	3
Unspecified – contacted for general support	0
Total	**9**

For reference, for the period 1 April 2018 – 31 March 2019, the FTSUG was contacted as follows:

Route of contact	**Number of contacts**
Contacted via anti-bullying Tsar	0
Contacted directly by the member of staff	17
Requesting advice for a colleague	5
Contacted via SALS	0
Signposted by manager	0
Signposted by Occupational Health	0
Signposted by a FTSGU in another Trust	1
Total	**23**

The following types of concern were raised 1 April 2018 – 31 March 2019:

Type of concern	**Number of contacts**
Concerns about bullying behaviour	17
Concerns about HR process involving the member of staff – concerns about fair treatment	2
Concern about patient safety	-
Concerns about workload	-
Concerns about inappropriate behaviour	2
Concerned about role within the Trust	1
Unspecified – contacted for general support	1
Totals	23

4.4 Making a difference
There are some specific examples as to where issues have been raised via the FTSUG and action has been taken as a result.

With the permission of the individual raising concerns, the FTSUG has been able to escalate concerns in order that senior managers can support managers who have issues within their teams; on some occasions, the senior managers are not aware of an issue and are able to provide more support as a result.

Some issues have resulted in formal HR action being taken by the individual concerned, having taken advice as to what the process involves and what support is available.

There are some specific positive outcomes that the FTSUG can share at the Board meeting.

4. 'Read across'
The Trust has several data sources that already capture where staff are speaking up about issues of concern.

When presenting the first Freedom to Speak Up Guardian's report to the Trust Board, the Board agreed the following principles:

- That the Guardian's role can help 'sense-check' organisational culture, to see if staff feel increasingly enabled to raise concerns about patient safety and staff welfare, and also report if staff are being treated detrimentally as a result of raising concerns
- That the Trust Board did not want the Guardian to start producing lengthy reports to try to cross-refer numerous data sources
- That the Guardian should not work on rumour or conjecture, or read correlation or causation into issues falsely

On this basis, the Guardian has reviewed the following:
- Each Quality report to the Trust Board from January 2017, including the ward dashboard as an appendix to the report
- Each nursing Safer Staffing report to the Trust Board from January 2017
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The detail of all SALS cases – concern, plus role and grade of staff member and department working in
- The headline National Staff Survey data and the quarterly cultural/staff friends and family test

4.1 Staff Advice and Liaison Service
One such source is the Staff Advice and Liaison Service (SALS). The SALS was established in January 2015 as part of the Trust's approach to tackling a bullying culture. The single issue raised most frequently through either route concerns staff behaviour. This reflects also the national staff survey results, shared with the Board previously, wherein bullying behaviours remain one of the areas of concern for this Trust.

4.2 Whistleblowing
The Trust's *Raising Concerns at Work (Whistleblowing)* Policy is intended to assist staff who believe they have discovered malpractice or impropriety. The Trust's policy was reviewed in 2016 to take account of new NHS national guidance on whistleblowing, to reference the role of the Freedom to Speak Up Guardian and to reference junior doctors' rights to whistleblow to a third party. The Trust's policy is up to date against national NHS requirements as well as employment law requirements.

Since 2015, the following issues have been reported under the Whistleblowing policy or dealt with under the Whistleblowing policy. In order to protect the position of staff raising concerns, the following information does not provide specific details:

Date	Issue
January 2015	Concerns about a support service
February 2015	Concerns about patient care and bullying culture in a particular department
February 2015	Concerns raised through an exit interview about patient care and safety in a particular department
November 2015	Allegations of bullying and harassment against a particular member of staff
February 2016	Concerns about patient care and safety in a particular department
October 2016	Concerns about the clinical practice and conduct of a colleague
December 2016	Concerns about proper application of proper processes to staff recruitment
May 2017	Concerns passed on to the organisation by the Care Quality Commission
May 2017	Concerns about the clinical practice of a particular member of staff

September 2017	Anonymous contact regarding the recruitment of someone external to the Trust
October 2017	Concerns about quality of care in a particular clinical service
March 2018	Concerns about a particular third-party contract with the Trust
May 2019	Concerns about staff behaviour – moved to a Grievance investigation in the first instance
June 2019	Concerns about patient safety within a service
November 2019	Concerns about patient outcomes within a service

All of the above concerns are all formally investigated and the person or persons raising the concern receive a formal response if they have identified themselves. For completed cases, the Trust has followed its own policy in investigating and responding to the concerns raised and is monitoring should any member of staff raise a concern about suffering a detriment to their employment position as a result of blowing the whistle.

4.3 Analysis

There is a consistency between the staff survey results and the issues coming through the SALS service, and with the individual Guardian cases – they largely concern staff behaviours, communication between teams and individuals and the way in which staff and managers are supported to improve team relations or work through difficult issues, such as performance management.

Broadly, the issues being raised are similar to those already known in the organisation. Each specific contact is acted upon relevant to the issues relevant to the member of staff. There are some new, specific cases that the FTSUG is working on that pre-date Covid-19 but are only just starting to be raised in the organisation; there is likely to be an element of 'catch-up' if staff have prioritised dealing with the pandemic situation first.

The Trust's Audit Committee has received regular updates on speaking up arrangements in the Trust, to receive assurance as to whether these are robust. No gaps in process have been identified.

There are some key messages, captured in the conclusion, which are reflected in the updated People Strategy; it is through the workstreams for the People Strategy through which some of the longer-term issues raised by staff might be best improved, for example, support to teams with long-standing relationship issues, managers working in complex and stressful areas, and supporting staff with comprehensive support when they need to raise a concern, to allay the fears of doing so.

4.3.1 Staff Behaviours

In the last 15 months, the issues being raised about staff behaviours with the FTSUG and also through other routes reflect perhaps a changing dynamic. Many of the issues are about poor working relationships and how these are affecting service delivery and/or the health and wellbeing of staff involved. This appears to be a changing dynamic away from bullying behaviours, which have been the predominant issue raised with the FTSUG and through the staff survey; it reflects perhaps more of the frustration expressed in the staff survey about the culture of the organisation about having 'permission' to make positive changes within a team for service improvement as well as the culture of the organisation needing to reduce feelings of bureaucracy and focus more on positive relationships and accountability.

4.3.2 Covid-19 specific issues

From mid-March 2020, the FTSUG has been contacted on a range of issues directly relating to Covid-19. These can be summarised as:

- Concerns about staff social distancing when in public areas
- Staff adherence to changes in the uniform policy and wearing face coverings

- Fair treatment in respect of the Covid-19 risk management process

This feedback from staff has been included in the Director of Workforce and OD daily/regular briefings to staff and thanking staff who are taking the correct steps for our patients, their colleagues and families. A number of the contacts have not been about specific individuals, but a situation, such as not observing social distancing, which has caused distress but also pro-actively seeking to inform the senior management team in order that key messages can be repeated and reinforced. Staff are sincerely thanked for contacting the FTSUG in this way, as it has helped promote messages that reflect what is happening within the Trust.

5. Conclusion

The Trust encourages staff to speak up about concerns at work and has put in place a number of mechanisms to help staff to do so. The Guardian is not aware of any reported issues in respect of a member of staff who has suffered a detriment as a result of blowing the whistle; some staff have raised concerns about the way in which their line manager has responded to their concerns, which needs further work by the Trust. There are also staff who are concerned about raising concerns as they do not think their manager or the Trust will support their position.

In relation to the 'read across' as Freedom to Speak Up Guardian, the Guardian offers the following observations:

- Most members of staff making direct contact with the Freedom to Speak Up Guardian have been isolated cases – in terms of each coming from a different part of the Trust and being individual cases
- There are some cases where staff have contacted more than one area for advice and support, such as SALS and FTSUG – this is encouraged so that staff know there is support available
- The link between speaking up and organisational/team culture is one that the FTSUG will be seeking to support current work within the Trust, including support and training to Trust managers, as the recent staff management clinics have shown that managers are keen to learn best practice as well as share their own management experiences to encourage others

6. Recommendation

The Trust Board is asked to receive and accept this report, and feed back any observations on how further to develop the Freedom to Speak Up Guardian role in the Trust

Carla Ramsay
Director of Corporate Affairs
July 2020

Hull University Teaching Hospitals NHS Trust

Trust Board

14 July 2020

Title:	Annual Report on Rota Gaps and Vacancies: Doctors and Dentists in training 2019/20
Responsible Director:	Makani Purva – Chief Medical Officer
Author:	Androniks Mumdzjans, Guardian of Safe Working

Purpose:	This paper provides an annual summary of gaps and vacancies among junior medical staff in comparison to the exception reports received at Hull University Teaching Hospitals NHS Trust, together with a plan to improve these gaps.	
BAF Risk:	BAF 2: Valued, Skilled and Sufficient Staff	
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:	This report provides a summary of information from April 2019 –March 2020. High level data (As of 31 March 2020) Number of doctors / dentists in training (total): 562 (478.1 March 2019) Number of doctors / dentists in training on 2016 TCS (total): 527 (478.1 March 2019) Annual vacancy rate among this staff group: 93.01% (88.16%) HUTH is now the lead employer for all GP trainees, hence the significant increase in numbers.	

Recommendation:	The Board is asked: • to note the findings of this report, which should be regarded as a baseline for future reports • to support the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

This paper provides an annual summary of gaps and vacancies among junior medical staff at Hull University Teaching Hospitals NHS Trust, together with a plan to improve these gaps.

The Guardian of Safe Working is responsible for monitoring the safe working hours of junior doctors and issues relating to working hours, service support and missed education / training opportunities. Mr Androniks Mumdzjans started in the role as Guardian of Safe Working from September 2019.

The summary of gaps and vacancies is compared to the number of exception reports received by the department for each quarter. The main reason for submitting an exception report relates to the volume of work which leads to trainees working over their contracted hours. Other reasons for working over include staff shortages (gaps / sickness / leave) and in the interest of patient care and patient safety.

The Board should regard this paper as a baseline for future work, and is requested to support the development of a coherent strategy for the medical workforce.

Introduction

This report provides a summary of information from April 2019 –March 2020.

High level data (As of 31 March 2020)

Number of doctors / dentists in training (total): 562 (478.1 March 2019)

Number of doctors / dentists in training on 2016 TCS (total): 527 (478.1 March 2019)

Annual vacancy rate among this staff group: 93.01% (88.16%)

HUTH is now the lead employer for all GP trainees, hence the significant increase in numbers.

Annual data summary

The following table lists all vacancy gaps among the medical training grades (including trust doctors) during April 2019 – March 2020. This is a combined summary of the data from the previous four quarterly reports. This information is shown for the departments where Rota gaps have been identified.

Dept	Grade	Q1	Q2	Q3	Q 4	Total Gaps WTE	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Academic	F2			1	1	2		
Acute Medicine	CT/ST1-2				1			
	ST3	3				4	42	0.81

	CT/ST1-2		2.3	1				
	CT/ST1-2/ST1-2				3			
Anaesthetics	ST3	5				12		
Breast Surgery	ST3	1	1		2	4		
Cardiology	F2				1	1	6	0.12
	F2			1				
Cardiothoracic Surgery	ST3	1	3		2	7	3	0.06
Chemical Pathology	ST3	1	2	2	2	7		
	F1	1	1	1	1			
	GPSTR		2					
Elderly Medicine	ST3	1	0.4			8	16	0.31
	F2			3	3			
Emergency Medicine	GPSTR	1				7		
Endocrinology	ST3	1	0.5	0.5		2	7	0.13
ENT	CT/ST1-2	1						
	ST3	2		1	1	5	1	0.02
Gastroenterology	ST3	1				1		
General Practice	F2	11.2	1					
	GPSTR		2	2	11	28		
General Surgery	CT/ST1-2	2	2			4		
	CT/ST1-2	1	1					
Haematology	ST3	1.4	1.4	1.4		7		
Histopathology	ST3	4	1	1	3	9		
HIV/GUM	F2			1		1		
Infectious Diseases	ST3	3	1	1	3	8	2	0.04
	CT/ST1-2	1			1			
Lower GI Surgery	ST3			1.5		4	4	0.08
Neurology	CT/ST1-2	0.5				1	22	0.42
	CT/ST1-2	2	3	1	1			
	F2	1						
Neurosurgery	ST3	0.2				9		
	CT/ST1-2	1	1	1				
	GPSTR		1	1				
Oncology	ST3		1	1		7	46	0.88
Ophthalmology	ST3	1	1	1	1	4		
Oral & Maxillofacial Surgery	CT/ST1-2	4				4		
Paediatric Emergency Medicine	CT/ST1-2			2	2	4		
Paediatric Neonatal Medicine	CT/ST1-2	2.4	2	2	3			
	ST3	0.5				10		
Paediatric Surgery	ST3	1	1	1	1	4	6	0.12

	CT/ST1-2	1	0.4	0.4				
	F1	1	1.4	1.4	1			
	F2	1						
	GPSTR		1	1	2			
Paediatrics	ST3		1	1		14		
	CT/ST1-2				1			
Plastic Surgery	ST3	2.2	1	1		6		
Psychiatry	F1		0.4	0.4				
	F2	2						
	GPSTR		1	1	1	6		
Radiology	ST3	3.2	3.2	3.2		10		
Renal Medicine	ST3				1	1	4	0.08
Respiratory Medicine	GPSTR	0.5						
	ST3			1		2	27	0.52
	GPSTR	0.5	0.5					
Rheumatology	ST3		1	1	2	5	13	0.25
	CT/ST1-2	2						
	F2	3	1	1	1			
	GPSTR	1						
Trauma & Orthopaedics	ST3	2	2	2	2	17		
	CT/ST1-2	1	1					
Upper GI Surgery	ST3	2		3.5	5	13		
	CT/ST1-2	1						
	F2		1					
Urology	ST3	1	1	1	1	6		
Vascular Surgery	ST3	1.2	0.2	0.2		2		

Summary of Rota gaps and vacancies.

This year's rota gaps have significantly improved compared to previous years. The board has received quarterly updates throughout the year on the gaps across the different specialties and grades.

There are consistent gaps in the following departments:

- Ophthalmology with 1 gap at ST3 level
- Elderly Medicine with 1 gap at F1 level
- Pediatrics' with 1 gap at F1 level
- Trauma & Orthopedics' with 2 gaps at ST3 level
- Urology with 1 gap at ST3 level

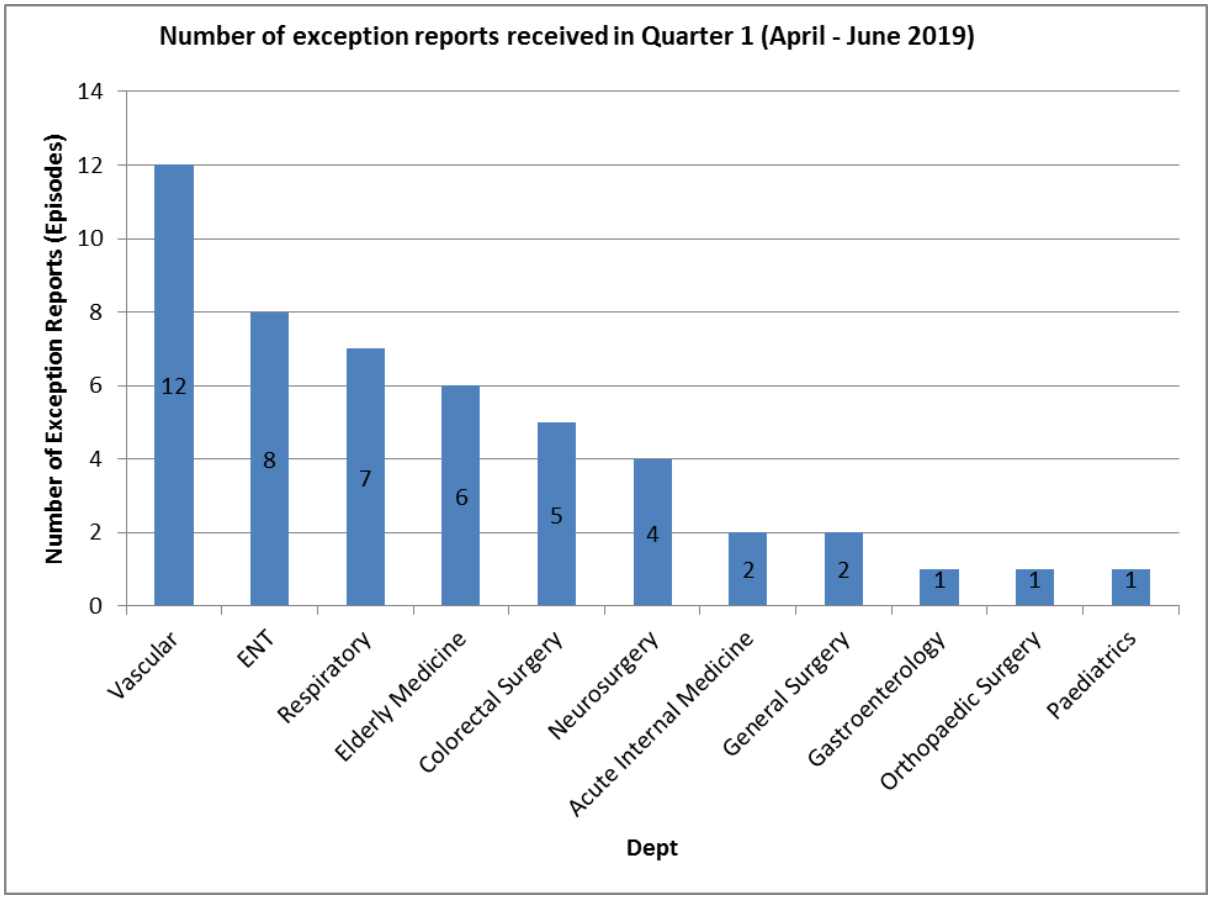
The reason for these gaps could be due to deanery and trust doctor vacancies. To address these gaps, recruitment is taking place / has recently taken place in the following areas:

- Ophthalmology – Clinical Research Fellow in Orthopedics' out to advert.
- Elderly Medicine – Recruitment for CT level in process.
- Trauma & Orthopedics' – Recently advertised.
- Trust doctor recruitment took place in 2019 to support changes to surgical training.

The Trust aims to fill as many shifts as possible internally. In 2019, the Trust set up its 'Remarkable Bank' for doctors that are not currently working directly with the Trust. This is an expansion on its use of internal Locums and helps to reduce the number of Locum Agency Staff.

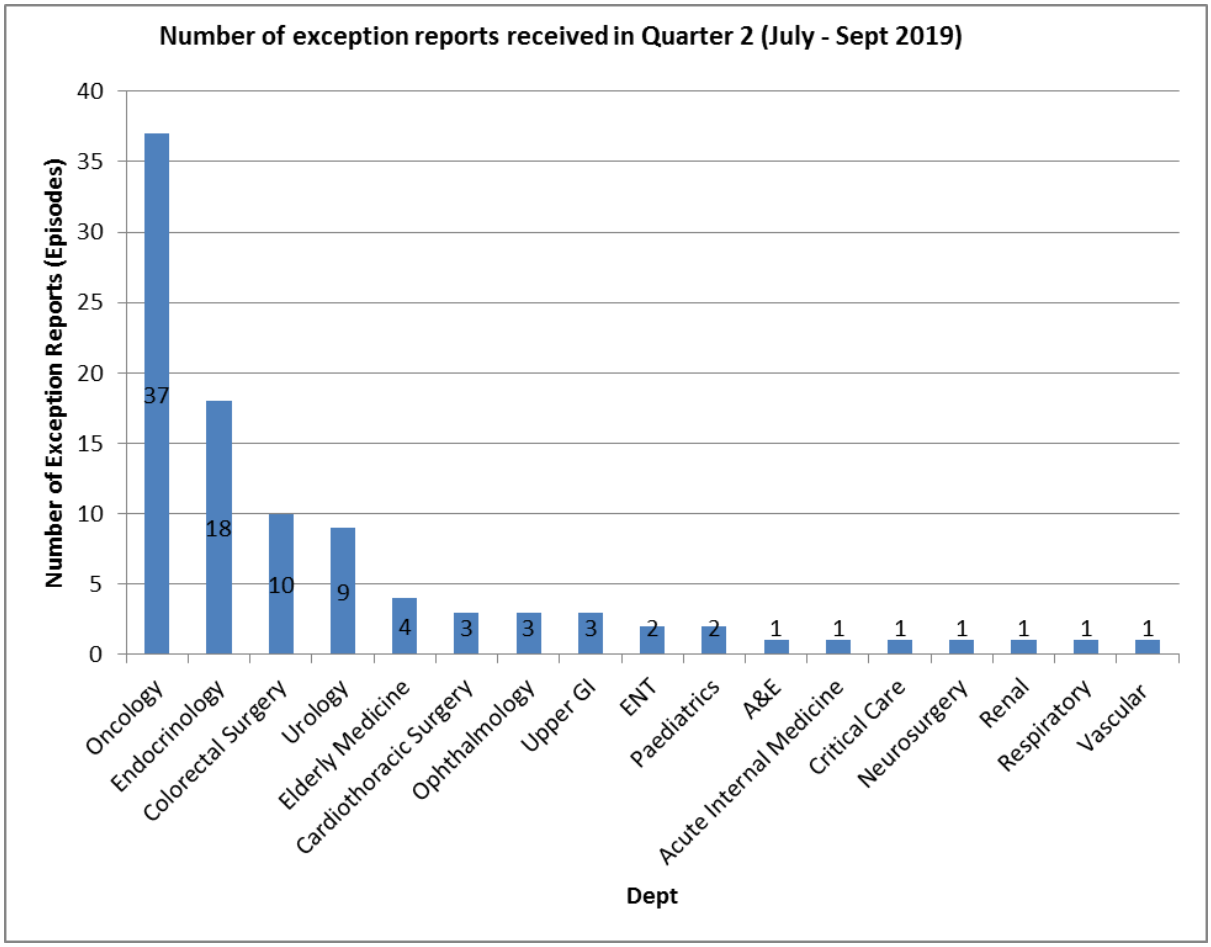
Summary of exception reports.

There have been a total of 384 exception reports that were submitted between March 2019 - April 2020 and on average we have received approximately 40 exception reports each month. As exception reporting is becoming the norm for our trainees, we are seeing an increase in the number of reports submitted year by year. The main reason for exception reporting is due to volume of work which leads to trainees working over their hours. Other reasons for exception reporting include missed training opportunities.



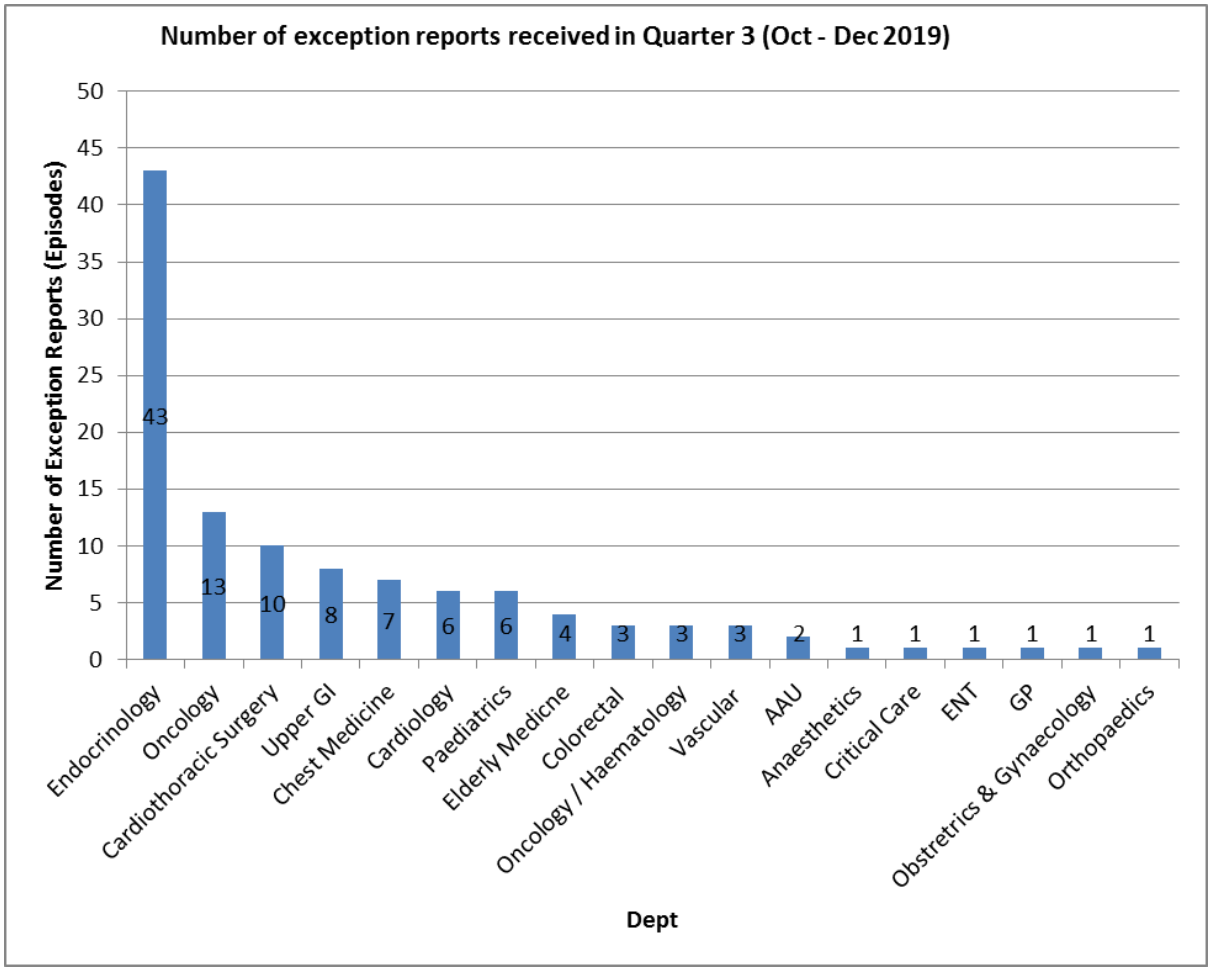
Vascular Surgery received the highest number of exception reports in quarter 1 with a 1.2 vacancy gap. This gap was filled by the end of the year and a reduction to the number of reports was also seen.

ENT received 8 exception reports within quarter 1. There were 3 gaps within the department, but improvements were made and the number of gaps was reduced towards the end of the year and this seemed to have a positive impact on the number of exception reports.

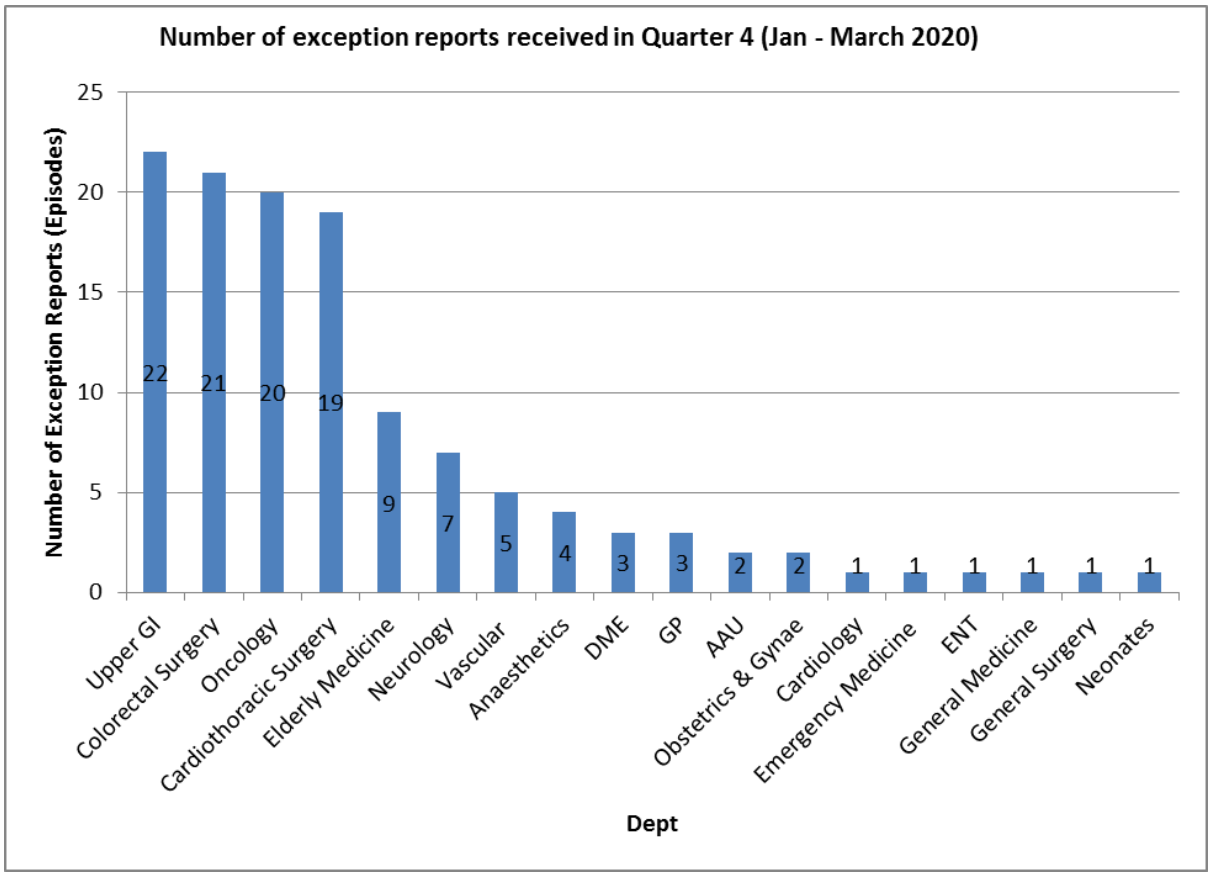


Oncology has received the highest number of exception reports within quarter 2 with 3 gaps. Although there were no gaps across the department in quarter 4, we continue to see a high number of reports for this department relating to workload. The following causes were highlighted within the exception reports raised by the Oncology department in quarter 2:

- Lack of support from the Phlebotomy service which is impacting on the junior doctor's workload. Meetings were put in place to address these issues and the Junior doctors reported at the JDF improvements had been made to the Phlebotomy service and that there seemed to be more staff now covering this.
- Lack of doctors on the ward due to sickness (may also be due to the summer holidays)
- Missed training opportunities.

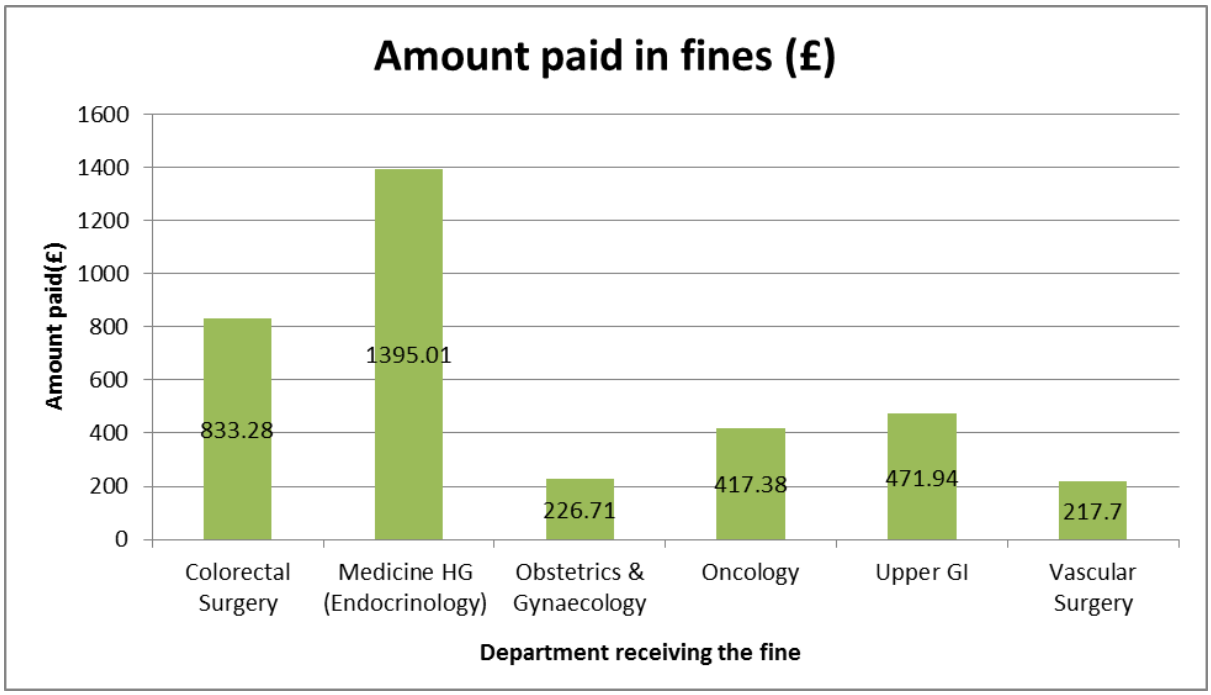


Endocrinology have received the highest number of reports for quarter 3, however, there was only a 0.5 gap at ST3 level. Three of these exception reports within the department led to breaches to the maximum number of hours worked and less than 11 hours rest. The trainee that submitted these reports was based in the Endocrinology department, but the exception occurred due to having no RMO cover so the fines were applied to the Medicine HG.



There was a reduction in the number of exception reports received for March 2020, this was mainly due to the COVID-19 Pandemic. All educational activity was stopped towards the end of March and although trainees were encouraged to continue to exception report for the difference in hours and service support, they were also advised not to exception report for educational activity until this was introduced back in to their training programme.

Upper GI received the highest number of exception reports within the quarter with a total of 5 gaps at ST3 level. The main reason for these exceptions was due to increased workload caused by staff shortages.



Summary of Fines

A small number of fines were previously issued in 2017/18 but due to not having the support or a process in place to be able to investigate exceptions, it was not always possible to identify where a breach had occurred. A GoSW and Medical Staffing Analyst was appointed in November 2019. From December, a process had been put in place to be able to analyse exception reports and cross check against e-Roster to identify any breaches to the Junior Doctors terms & Conditions. When an exception report is submitted for the difference in hours, E-roster is updated to reflect the hours worked and the system then highlights any breaches.

As soon as the exception is submitted, the GoSW Medical Staffing Analyst will highlight any potential breaches to the supervisor and discuss if possible any options such as taking time back in lieu to prevent a breach from occurring.

The JD contract states, the department should incur a fine for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13 hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168 hour period.
- Where 11 hours rest within a 24 hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved

The trust has incurred 9 fines which total the amount of £3,562.02. This includes £1335.61 paid to the doctor and £2417.14 to the Guardian of Safe Working. The decision on how the Guardian of Safe working budget is used is discussed and agreed by the JDF. In the past money has been spent to purchase a sofa for the Junior Doctors Mess.

The following fines have been issued (December 19 to March 20):

- A fine has been levied against Upper GI surgery due to an FY1 trainee working 3.25 hours over due to an exceptionally high workload. This resulted in breaching the maximum 13 hour shift and less than 11 hours rest rules.
- A fine was issued to the Obstetrics and Gynecology department due to a trainee working 1.5 hours over. This was again due to workload and breached the maximum 13 hour shift rule.
- There were 3 exception reports submitted in December by an ST7 trainee in Endocrinology. The trainee had worked a total of 3.75 hours over 3 occasions due to no RMO cover and worked over to ensure patient safety. On all 3 occasions, this had resulted in breaches to the maximum 13 hour shift and less than 11 hours rest. The Medicine HG incurred these fines, rather than the Endocrinology department.
- An ST1 in Oncology submitted an exception report for working an additional 2 hours. This was due to an increased workload following 2 bank holidays and staff shortages. This exceeded the maximum 13 hour shift rule.
- An FY1 trainee in Vascular Surgery worked an extra 2.5 hours over due to a busy workload, breaching the maximum 13 hour rule.
- An exception report was submitted by an FY1 trainee in Colorectal Surgery. The trainee worked 3 hours over due to staff shortages. This breached the maximum 13 hour shift, maximum 72 hour week and less than 11 hours rest rule.
- An FY1 in Colorectal Surgery reported working 1 hour over time to complete jobs following a ward handover. This highlighted a breach to the maximum 72 hour week rule.

Multiple fines were issued for multiple breaches. Evidence is required via exception reporting to highlight breaches / unsafe working hours.

JDF Meeting

JDF meetings take place on the second Friday of each month. Trainees across the trust in all specialties are invited to attend to represent their colleagues and the forum is currently well represented by the Junior Doctors. In November 2019, Dr Tana Perinpanathan was appointed as the Co-chair. Membership also includes Medical Staffing, Director of Medical Education and the BMA. The purpose of this meeting is to allow juniors to raise and highlight any concerns or issues that the juniors are currently facing as well as discussing any trends or patterns highlighted via the exception reports.

Actions taken to resolve issues

There are some departments that are not currently using the e-roster system and compliance is required across all departments to ensure safe working hours are maintained.

International recruitment including Doctor's from Pakistan and GMC sponsorship will improve the vacancy gaps.

A Rota approval process has been put in place. It has been agreed that all rota changes will be discussed and approved at the Junior Doctors Forum and then sign off is also required by the Chief Medical Officer and Guardian of Safe Working.

Projects

1. Exception Reporting in Yorkshire (ERIY)

This research looks into the attitudes of junior doctors, managers and consultants towards the exception reporting process that was introduced in December 2016 as part of the new, controversial, junior doctors' contract.

The qualitative interviews, conducted in both structured and semi-structured format at Hull University Teaching Hospitals NHS Trust (HUTH), provide a range of themes that lead to numerous recommendations for consideration by central government and lobbyists such as the British Medical Association (BMA) as to how the process could be improved.

The research was completed in March 2020 and has been submitted to the BMJ Leader journal, which is part of the Faculty of Medical Leadership and Management's (FMLM) Portfolio of publications.

2. An exception reporting survey at HUTH

It was issued to all Junior Doctors in training. This was completed by 64 trainees and the results highlighted the following:

- 70% of respondents had not submitted a report.
- Only 8 % of trainees who completed the survey feel they have been positively encouraged to complete exception reports. Whereas 47% have negatively responded to this question.
- Some of the barriers for submitting reports include: fear of exception reporting impacting on their career, culture, unacceptable to colleagues / supervisors.

3. Physician Associate - Consultant Survey at HUTH

It was designed to gain a view of their perspective on the roles of physician associates in order to see if they had a place in the organisation. From the perspective of those who would be working long term with them, should they be employed by the Trust?
The results provided by the survey demonstrate that Physician Associates are an overall positive step in the division of labour in the management of healthcare organisations. They do, however, come with their limitations. These limitations mainly focus on the lack of prescribing rights for medications and ionising radiation.

Moving forward, this survey demonstrates a positive step in the role of PAs to take the pressure off junior doctors in the work of the NHS. However, their role would need to be more adequately described and this is outlined in a future survey of the PA students themselves at Hull York Medical School (HYMS).

4. Physician Associate -Student Survey at HYMS

Physician associates are a new and poorly understood profession in the modern-day NHS. There have been mixed responses to their implementation, and some profoundly pessimistic responses from junior doctors in particular who believe they area replacement for their own roles, rather than a complement.

This survey conducted on HYMS PA students, was designed to gain a perspective on their perceived future role in the NHS moving forward. The project allowed us to look at the perceptions of where the students see themselves and their expectations of employers.

Summary

One of the main concerns reported by trainees has been linked to the subjectively excessive workload and extra hours performed. This is a well-known fact that a heavy unbalanced workload can affect performers' mental health and general well-being, as low junior doctor's self-confidence can negatively impact their performance, patient-centred care as well as their training. I had several face-to-face meetings with different grade of trainees with clearly identified degree of anxiety and even suspected depression. Some of them mentioned decreased motivation and difficulty to concentrate on their duties. Therefore, to avoid issues associated with the hidden curriculum, more effective support from their clinical and educational supervisors is required. In addition, I would like to encourage communication and network building between trainees and their senior colleagues as well as progressive inter-collaboration with different groups of professionals including managers and other technical staffing.

The following details the positive outcomes of issues that were initially raised at the JDF:

- Improvements made to the services in Phlebotomy and ECG.
- Funding received to upgrade the Doctors Mess and duty rooms.
- Issues were escalated and resolved in relation to the lack of doctors (sickness) and missed training within the departments
- Training concerns addressed.
- An induction video was put together to ensure all doctors receive a local induction who cross cover departments.
- Security and Resus worked together to put a process in place to ensure all wards can be accessed in emergencies.
- The set-up of Environmental group meetings.
- Improvements made to induction from a Human Resources prospect. This includes the issuing of security cards and car park permits on day 1.

Issues arising

Over the preceding years of quarterly reports, as a Trust we have seen the numbers of Doctors in Training and Trust Doctor Vacancies reduce significantly due to the increased fill rates by Health Education England and easier processes in recruiting Trust Doctors to backfill HEE vacancies or funded by the Trust to support our rotas.

As these Annual Reports become more imbedded, a clearer picture of issues arising linked to exception reporting and recruitment will be available.

Questions for consideration

The Workforce, Education and Culture meeting has requested to receive this report and decide if the report provides sufficient information and assurance and decide if any further information / actions are required.

To urge all departments to adopt the full use of E-Roster as quickly as possible so that both the working conditions of the staff involved are improved and thereupon the quality of care to the patients is improved as well. Therefore, a dynamic transition to the use of E-Roster must be made an utmost priority for the second half of 2020.

Hull University Teaching Hospitals NHS Trust

Trust Board

14 July 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: • Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders July 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: This paper summarises all use of the Trust seal since March 2020 as this paper was deferred as non-urgent business until this month. Where the old Trust name is used, it relates to a contract in place under the previous Trust name, which has been updated/amended. As an existing contract, it is correct to retain the name of the organisation under which the original agreement was formed. Each case is double-checked with the Trust solicitors before proceeding.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
2020/08	Hull and East Yorkshire Hospitals NHS Trusts and Leisure Technique Ltd – for the design, construction and installation of new fire doors and the design, construction, repair and installation of existing fire doors, including associated electrical installation.	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/09	Glass and Framing Solutions Ltd and Unico Construction Ltd and hull University Teaching Hospitals NHS Trust – Sub-contractor collateral warranty agreement between the parties for the MRI scanner external door	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/10	Griffin Toomes Consulting Engineers and Unico Construction Ltd and Hull and East Yorkshire Hospitals NHS Trust – sub-contractor collateral warranty between the parties for: • Installation of a polystorm retention tank • Installation of a petrol interceptor • Installation of a hydra brake For the HRI helipad	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/11	Hull University Teaching Hospitals NHS Trust and Zenith Developments Ltd – for the formation of new AMU Rooms including ancillary rooms, mechanical and electrical services and drainage	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/12	Hull University Teaching Hospitals NHS Trust and Leisure Technique Ltd – form of agreement for the formation of a new MRI	20.03.20	Lee Bond, Chief Financial Officer and Carla

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
	suite including demolitions and alterations, internal walls and partitions, internal doors and windows, wall, floor and ceiling finishes, fittings, sanitary appliances, drainage, mechanical and electrical services		Ramsay, Director of Corporate Affairs
2020/13	Hull University Teaching Hospitals NHS Trust and Hobson and Porter Ltd – for the formation of a new CT Room including associated ancillary rooms and reconfiguring an existing Control Room all into a former Elderly Assessment Unit	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/14	Hull and East Yorkshire Hospitals NHS Trust and Leisure Technique Ltd – for the design and construction of a new Surgical Skills Unit, Block 42, Castle Hill Hospital	20.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/15	Hull University Teaching Hospitals NHS Trust and Kingston Upon City Council – Lease for the Mortuary at Hull Royal Infirmary	24.03.20	Terry Moran, Chairman and Lee Bond, Chief Financial Officer
2020/16	Hull University Teaching Hospitals NHS Trust and TM Trustees Ltd – Short term commercial lease for storage space (Gillett Street), Hull	30.03.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/17	Hull University Teaching Hospitals NHS Trust and Hugh Steeper Ltd – Lease of part of the ground floor, Sykes Street Clinic, Skyes Street, Hull	30.04.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/18	Hull University Teaching Hospitals NHS Trust and Cardtronics UK Ltd – ATM agreement at Castle Hill Hospital and Deed of Surrender	09.06.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/19	Hull University Teaching Hospitals NHS Trust and Cardtronics UK Ltd – ATM agreement at Hull Royal Infirmary and Deed of Surrender	09.06.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/20	Hull University Teaching Hospitals NHS Trust and Persimmon Homes Ltd – Deed of variation of an option agreement dated 12 July 2018 and made between 1) Hull and	11.06.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTOR
	East Yorkshire Hospitals NHS Trust and 2) Persimmon Homes Ltd relating to land at Castle Lane, Cottingham (Phase 3)		of Corporate Affairs
2020/21	Hull University Teaching Hospitals NHS Trust and Persimmon Homes Ltd – TPI Land Registry – Transfer of part of registered title - Land to the South of Castle Road, Cottingham, East Riding of Yorkshire	24.06.20	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs
2020/22	Persimmon Homes Limited and Hull University Teaching Hospitals NHS Trust – Legal charge relating to Land at Castle Lane, Cottingham (Phase 3)	2020/22	Lee Bond, Chief Financial Officer and Carla Ramsay, Director of Corporate Affairs

3 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Carla Ramsay
Director of Corporate Affairs
July 2020

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 July 2020

Title:	Declarations of Interest and Fit and Proper Persons Declarations
Responsible Director:	Terry Moran CB – Chairman
Author:	Carla Ramsay – Director of Corporate Affairs

Purpose:	To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.	
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 Board receives an annual report on any issues raised by the latest Declarations of Interests by Board members, as well as any issues relating to a Board member's suitability as a Fit and Proper Person, in respect of CQC requirements. A full review has been undertaken for all Trust Board members. There are no issues of concern or non-compliance to report to the Board.	

Recommendation:	The Trust Board to review and confirm there is assurance that: • that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons • that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Hull University Teaching Hospitals NHS Trust

Trust Board

Declarations of Interest and Fit and Proper Persons Declarations

1. Purpose

To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.

2. Background

In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non-Executive Directors.

The Trust Board confirm compliance annually for all Board members and Trust Directors. In addition, arrangements are in place through the Disclosure and Barring Service to ensure that the Trust is informed of any subsequent issues that may be a cause of concern in relation to Board members.

3. Procedure

At the end of every financial year all Board members and Trust Directors are asked to complete a declaration of interest form which includes the Fit and Proper Person declaration. Any material issues included on the declarations are reviewed by the Chairman and/or Director of Corporate Affairs to determine if it is relevant to the individual remaining a Fit and Proper Person.

Any changes in, or conflicts of, declared interests are entered onto the declaration register held by the Director of Corporate Affairs and reported in the Trust's Annual Report as well as to the Trust Board in-year. Board members' interests are also published on the Trust's website and kept up to date as interests change.

Appendix A details the most recent completed declarations by Board members and Trust Directors, for review by the Trust Board for assurance. Appendix B details declared interests of Trust Board members. Appendix C contains the Fit and Proper Person Assessment criteria, for reference.

4. Recommendation

The Trust Board to review and confirm there is assurance that:

- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Carla Ramsay
Director of Corporate Affairs
July 2020

Appendix A

Fit and Proper Person Declarations for Board Members and Trust Directors Completed July 2020

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Mr Terry Moran	Chair	✓	No	No
Mr Stuart Hall	Vice Chair/Non-Executive Director	✓	No	No
Mrs Tracey Christmas	Non-Executive Director	✓	No	No
Prof. Martin Veysey	Non-Executive Director	✓	No	No
Mr Tony Curry	Non-Executive Director	✓	No	No
Mr Mike Robson	Non-Executive Director	✓	No	No
Prof. Una Macleod	Non-Executive Director	✓	No	No
Ms Linda Jackson	Associate Non-Executive Director	✓	No	No
Mr Chris Long	Chief Executive Officer	✓	No	No
Mrs Beverley Geary	Chief Nurse –	✓	No	No
Dr Makani Purva	Chief Medical Officer	✓	No	No
Mr Lee Bond	Chief Financial Officer	✓	No	No
Ms Teresa Cope	Chief Operating Officer	✓	No	No
Ms Jacqueline Myers	Director of Strategy and Planning	✓	No	No
Mr Simon Nearney	Director of Workforce and Organisational Development	✓	No	No
Ms Carla Ramsay	Director of Corporate Affairs	✓	No	No

Appendix B

Declarations of Board Members' Interests

Any declarations of interest made by Board members in 2019 and currently on the Trust's Register of Business Interests

Name	Role	Declared interest
Mr Terry Moran	Chair	Trustee of Cat Zero (charity) Chair of SLP College (charity) Chair of Northern Lincolnshire and Goole NHS Foundation Trust from February 2020
Mr Stuart Hall	Vice Chair/Non-Executive Director	Partner is member of Clinical assembly, Clinical Senate Yorkshire and Humber Associate Non-Executive Director at Northern Lincolnshire and Goole NHS Foundation Trust
Mrs Tracey Christmas	Non-Executive Director	Trustee at SLP College
Prof. Martin Veysey	Non-Executive Director	Locum Consultant Gastroenterologist at York Teaching Hospitals NHS Foundation Trust Professor of Gastroenterology and Programme Director MBBS, Hull York Medical School Wife works at York Teaching Hospital NHS Foundation Trust
Mr Tony Curry	Non-Executive Director	None
Mr Mike Robson	Non-Executive Director	Non-Executive Director at Hull Truck Theatre
Prof. Una Macleod	Non-Executive Director	Dean, Hull York Medical School Interim Dean, Faculty of Health sciences, University of Hull Trustee, Medical Schools Council (charity) Research income to University of Hull from Yorkshire Cancer Research and National Institute of Health Research
Ms Linda Jacson	Associate Non-Executive Director	Vice Chair and Non-Executive Director at Northern Lincolnshire and Goole NHS Foundation Trust
Mr Chris Long	Chief Executive Officer	None
Mrs Beverley Geary	Chief Nurse	None
Dr Makani Purva	Chief Medical Officer	Success at Medical Interviews – training and interview practice consultancy Director of the Association of Simulated Practice in Healthcare (ASPIH) Husband works at North Lincolnshire & Goole Hospitals NHS Foundation Trust
Mr Lee Bond	Chief Financial Officer	Trustee of WISHH Charity Trustee of the HFMA Partner - Deputy Chief Nurse at HUTH Step-daughter – Staff Nurse at HUTH
Ms Teresa Cope	Chief Operating Officer	Trustee with Cornerhouse Yorkshire Husband is employed by Nottinghamshire Healthcare NHS Foundation Trust
Ms Jacqueline Myers	Director of Strategy and Planning	Trustee of St Leonards Hospice, York

Mr Simon Nearney	Director of Workforce and Organisational Development	Directorship of Cleethorpes Town FC (CTFC LTD) Wife is a nurse auxiliary at HUTH Daughter is an apprentice nurse at HUTH
Ms Carla Ramsay	Director of Corporate Affairs	Trustee - The Warren Hull Civil Partner works for the Environment Agency

Appendix C

Fit and Proper Persons Declarations

Detail of what declarations must be made

Disclosure	Y/N
Have you been convicted of a criminal offence in the UK or elsewhere?	
Do you consent to the Trust obtaining an automatic annual notification under the DBS?	
Are you on the Safeguarding (children and adults) barred list?	
Have you been prohibited from holding office under the Companies Act or the Charities Act?	
Do you have undischarged creditors?	
Do you have a debt relief order?	
Are you an undischarged bankrupt?	
Do you have a bankruptcy restriction order?	
Are there any reasons related to health that mean that you are unable to fulfil your role?	
Have you ever been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals?	
Do you have an outstanding referral to your professional body for an issue relating to a CQC regulated activity?	
Are there any other factors that you consider your employer should be aware of that could impact on the Fit and proper persons Test?	