Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held in Public via Webex (details from Trust Secretary)
8 September 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 14 July 2020	attached	Terry Moran - Chair
4	**Matters Arising**		
	4.1 Action Tracker	attached	Rebecca Thompson – Corporate Affairs Manager
	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	Rebecca Thompson – Corporate Affairs Manager
9	**Our Patient Impacts**		
	9.1 Performance Report	attached	Teresa Cope – Chief Operating Officer
	9.2 Minutes and Escalation from the Performance and Finance Committee	attached	Tony Curry – Chair of Performance and Finance Committee
	9.3 Quality Report	attached	Beverley Geary - Chief Nurse & Makani Purva – Chief Medical Officer
	9.4 Minutes and escalation from the Quality Committee	attached	Martin Veysey – Chair of Quality Committee
	9.5 Update from the Ethical and Clinical Prioritisation Policy Committee	verbal	Stuart Hall – Chair of Ethical and Clinical Prioritisation Policy Committee
10	**Our People Impacts**		
	10.1 Staff Overview Report	attached	Simon Nearney – Director of Workforce and OD

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

	10.2 Escalation and minutes from the Workforce, Education and Culture Committee	attached	Una Macleod – Chair of Workforce, Education and Culture Committee and Simon Nearney – Director of Workforce and OD
11	**Our Finance Impacts**		
	11.1 Finance Summary Report	attached	Lee Bond – Chief Financial Officer
	11.2 Operating Plan Guidance and Recovery Planning	attached	Jacqueline Myers – Director of Strategy and Planning
12	**Items for approval by the Board**		
	12.1 Quality Accounts	verbal	Beverley Geary – Chief Nurse
	12.2 Workforce Race Equality Standards	attached	Simon Nearney – Director of Workforce and OD
	12.3 Workforce Disability Equality Standards	attached	Simon Nearney – Director of Workforce and OD
	12.4 Trade Union Facility Time Reporting Requirements Regulations	attached	Simon Nearney – Director of Workforce and OD
	12.5 Trust Strategy Delivery – 6 Month Update	attached	Jacqueline Myers – Director of Strategy and Planning
	12.6 Emergency Preparedness Statement of Assurance – Update	attached	Jacqueline Myers – Director of Strategy and Planning
	12.7 Standing Orders	attached	Rebecca Thompson – Corporate Affairs Manager
13	**Reports to the Board**		
	13.1 Health and Safety Report	attached	Beverley Geary – Chief Nurse
	13.2 Director of Infection Prevention and Control Annual Report	attached	Greta Johnson – DIPC
	13.3 Escalation and minutes from the Charitable Funds Committee	attached	Tony Curry – Charitable Funds Committee Chair
	13.4 Calendar of Board and Committee Meetings	attached	Rebecca Thompson – Corporate Affairs Manager
14	Chairman's Summary of the Meeting	verbal	Terry Moran – Chair
15	Any Other Business	verbal	Terry Moran – Chair
16	Any Questions from Members of the Public	verbal	Terry Moran - Chair
17	**Date and time of the next meeting:** Tuesday 10 November 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	✓	✓	✓	✓					4/4
S Hall	✓	✓	Apols	✓					3/4
T Christmas	✓	✓	✓	✓					4/4
M Veysey	Apols	✓	✓	✓					3/4
T Curry	✓	✓	✓	✓					4/4
U MacLeod	Apols	Apols	✓	✓					2/4
M Robson	✓	✓	✓	✓					4/4
L Jackson	✓	✓	✓	✓					4/4
C Long	✓	✓	✓	✓					4/4
L Bond	✓	✓	✓	✓					4/4
T Cope	✓	✓	✓	✓					4/4
M Purva	✓	✓	✓	✓					4/4
B Geary	✓	✓	✓	✓					4/4
J Myers	✓	✓	✓	✓					4/4
S Nearney	✓	✓	Apols	✓					3/4
C Ramsay	✓	✓	✓	✓					4/4

*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

Trust Board
Held on 14 July 2020 via WebEx

Present:	Mr T Moran CB	Chair
	Mr S Hall	Vice-Chair
	Mrs T Christmas	Non-Executive Director
	Prof M Veysey	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs T Cope	Chief Operating Officer
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
In attendance:	Mr S Nearney	Director of Workforce and OD
	Ms J Myers	Director of Strategy and Planning
	Ms C Ramsay	Director of Corporate Affairs
	Mrs L Jackson	Associate Non-Executive Director
	Mrs R Thompson	Corporate Affairs Manager

No **Item** **Action**

1 **Apologies**
There were no apologies received.

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 meeting held on 18 June 2020
Mr Bond asked to make an amendment to the technical language of the Annual Accounts section of the minutes and present it as part of matters arising to the meeting in September 2020.

Mr Bond asked that on page 7, paragraph 4 that the item relating to PPE should read, "there were no major supply issues" and "the Capital plan would be made up of retained profits from previous years..". These were agreed.

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

Post meeting note: Mrs Cope advised that the 2 mobile scanners mentioned in the minutes were actually mobile X-Ray machines.

4 Matters Arising
There were no matters arising from the minutes.

4.1 Action Tracker
The Action Tracker was reviewed by the Board. There were no outstanding issues raised.

4.2 Board Reporting Framework
The Board Reporting Framework was received by the Board.

4.3 Board Development Framework
Ms Ramsay presented the framework and advised that she would meet with Mr Moran and Mr Long to establish the development sessions for the remaining dates.

5 Chair's Opening Remarks
Mr Moran thanked all staff on behalf of the Board for the efforts being made during the difficult recovery period following the peak of the pandemic. He offered his sincere apologies to patients, families and carers for the frustrating timescales relating to timings of treatments. He added that at the Trust's AGM yesterday there had been a useful discussion about the action the Trust can take to keep patients informed and being open and honest about the recovery programme and where appropriate the delays. Mr Moran thanked Mr Long for his media coverage and how he had been open and realistic about the difficulties ahead, rather than raising false expectation. He also thanked the Executive Directors for their leadership and commitment.

6 Chief Executive's Briefing
The report was presented to the Trust Board; there were no issues raised.

7 Patient Story
Dr Purva shared a video of a staff member who had been critically ill due to Covid-19. He told the story of how he survived due to the outstanding care he had received at this Trust and in Leicester, for which he gave his heartfelt thanks.

Dr Purva added that the hospital systems worked well to pick up his early deterioration and from that the care he received was amazing. Mrs Jackson was very moved by the story, in particular the call that was arranged from the patient's father. Dr Purva advised that the patient's father was in Pakistan at the time. Mr Nearney added that the whole journey had been difficult but it was great to see him doing so well after his illness and it was an example of how staff go the extra mile time and time again for patients.

8 Board Assurance Framework
Ms Ramsay presented the Board Assurance Framework and advised that she had captured the discussions from the Board Development session to inform the BAF. She asked that the Board sign off the BAF and then it could be used throughout the year to shape discussions at Committees and the Board and any mitigating actions added.

Mr Bond stated that he thought the performance risk BAF 4 should be higher due to the challenges the Trust was facing after the pandemic. Ms Ramsay agreed that this would be the case in light of recent discussions. Ms Ramsay asked the Board toapprove the BAF as presented and proposed that updates and changes be brought to the September 2020 Trust Board for consideration alongside Q1 risk ratings.Mr Long supported

this approach.

Ms Myers stated that she was bringing progress report against the Trust Strategy to the next meeting which would discuss the strategic goals and progress against them, which would dovetail with the BAF and Q1 risk-ratings review.

Mrs Cope added that although there were issues with RTT there was also positive assurance around ambulance turnaround times, ED and Cancer to include.

Prof Veysey added that the Board should consider BAF 3 linked to quality as part of the performance risks and review any patients with potential harm due to long waiting times for treatment.

Resolved:
The Trust Board approved the Board Assurance Framework and the Trust Board to receive proposed Q1 risk ratings at the September 2020 Board.

9 Our Patient Impacts

9.1 Performance Report

Mrs Cope reported that the Trust was focussed on restoration plans and a workshop was being held tomorrow to review August and beyond. She advised that the Gold and Silver Command structures had been scaled down.

ED performance had stabilised at around 90% and any Trusts falling below this would be subject to additional scrutiny. Mrs Cope advised that the number of stranded and super stranded patients had continued to reduce and in May there were 57 patients whose length of stay was over 21 days.

RTT performance was deteriorating but the Trust was holding its waiting list volume. A review at speciality level was being carried out to look at restoring activity. Digital solutions were being used where possible. The 52 week position continued to rise; all patients have been given a clinical priority following new national guidance based on acuity of condition, priority 4 being the category of procedures that can wait longest. In the Trust, the majority of 52-week breach patients are assessed as priority 4 patients.

The Trust had maintained its cancer position of 80% at May and work was ongoing to clear the backlog relating to 104 day waits. The issue was around diagnostics, particularly in the colorectal service. All urology patients had now been allocated dates.

Mrs Jackson asked how confident Mrs Cope was about maintaining the 90% ED performance and also asked whether there was any guidance available for managing the 52 week wait patients. Mrs Cope advised that the number of breaches overnight in ED was being addressed as well as diagnostic waits and GPs not referring patients to ED but directly to the speciality. She added that it was important that medical leaders were accountable and owned the issues and a performance meeting was being put into place to address this.

Regarding the 52 week position a workshop was being held to review the restoration plans. Mrs Cope stated that staff being re-deployed back to

theatres would help the situation but it would be a 2-3 years before the situation would be fully resolved and help from wider system was required.

Prof Veysey asked about diagnostic testing and when would clinicians be able to run at 100% capacity as currently it was still at the 50% mark. Mrs Cope advised that guidance was being reviewed and work was ongoing with the clinical teams as well as the Infection Control team for each diagnostic procedure.

Dr Purva advised that the 52 week waits were being reviewed by the new Primary/Secondary Care Group to look at alternate ways to treat patients and ensure patient safety was not compromised.

Mr Moran asked for clarity as to what a typical category 4 patient would include and Mrs Cope advised that it was a patient requiring routine surgery but deemed by their consultant that they could wait the longest amount of time, although this was not always without pain.

Mr Bond asked about the follow up backlog and was there anything that could be done and Mrs Cope reported that use of digital platforms is being accelerated. She expressed her concern about how the wider system understand and accepted the importance of each part of it sharing and owning the issues for resolution.

Mr Hall asked if patients requiring treatment on a regular basis were being monitored and Mrs Cope advised that the specialities were managing their waiting lists, but that a number of patients did not want to come into the hospital yet for their treatment. Mrs Geary added that she was reviewing patient choice and had engagement sessions arranged with patients and the public to understand concerns about attending appointments at present.
.
Mrs Cope reported that the Trust was working to reduce its length of stay and was working currently at Opel 1 and 2 which was a positive position. Mr Moran added that at a recent Chairs' meeting there had been a willingness to review the issues faced by Trusts in a supportive, collaborative way.

Resolved:
The Trust received and accepted the report.

9.2 Quality Report
Mrs Geary presented the Quality Report. Mr Moran noted the Duty of Candour section that had covered the matter arising from the minutes.

Mrs Geary advised that the Trust's final CQC report had been published; due to the Covid-19 pandemic the full inspection could not be completed. The CQC was not able to review the Trust's overall rating as a result, which therefore remains 'requires improvement', which is disappointing. The CQC noted a number of improved ratings in the Medical, Surgery and Critical Care core services across HRI and CHH, which Ms Geary highlighted. The greatest amount of improvement was noted at CHH, with a 16% increase the in the number of 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 included.

The Trust is completing an action plan to address the issues raised by the CQC report, which is due on 20 July 2020 and will be monitored through the Quality Committee.

Mrs Geary advised that there had been a reduced level of incidents reported during the pandemic but were now increasing again in line with patient activity.

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 (12 vs. 15 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 were 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.

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 small numbers and only affecting individual bays. Ward H9 did have an outbreak of diarrhoea and vomiting during April 2020, which resulted in the ward being closed, but 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.

Mrs Geary advised that at Appendix 2 was a Board Assurance Framework sent to all Trusts by NHSI, focussing on infection risks and the mitigating actions. The CQC have requested that the Trust submit the BAF as an assurance document.

Dr Purva advised that the mortality figures gave an overview of the number

of deaths the Trust had seen in the last quarter. Mr Moran asked if she had any concerns regarding the data and Dr Purva advised that she did not and the Trust was not an outlier. Mrs Cope asked if there would be a review relating to the pandemic and whether the Trust would still look favourable as it had not seen as many Covid-19 cases as other Trusts. Dr Purva advised that the Standard Hospital Mortality Index would give a better idea but the information was 6 months behind. Mr Moran added that the Chair of the CQC had reported that an had undertaken a desk top exercise to review performance across trusts and would no doubt continue to assess Trust performance during the Covid-19 pandemic.

Mr Hall asked if Mrs Geary was comfortable with the annual local threshold of 80 *C Difficile* cases being set, and she reported that she was.

Resolved:
The Committee received and accepted the report.

The agenda was taken out of order at this point.

9.4 Minutes and escalation from the Performance and Finance Committee – May and June 2020
Mr Curry presented the minutes and highlighted RTT and restoration phase as the main items of escalation.

9.5 Minutes and escalation from the Quality Committee – May and June 2020
Prof Veysey advised that there was a new Quality Improvement Plan in place which was being monitored at operational level and any issues escalated to the Quality Committee.

The Committee had received assurance around the management of 2 safeguarding incidents.

The Committee had received a report which highlighted patient waits and any harm received when the Trust was at Opel 4. There was evidence to support that all patients received high quality care and there were no instances of harm reported.

Mrs Geary advised that the adult safeguarding incident had been externally investigated and had been downgraded and the incident relating to a child would be concluded this week. Action plans will be put in place for both. Mrs Christmas, as the Non-Executive Safeguarding Champion, has had the full details of both cases.

9.6 Escalation and summary report from the Ethical and Clinical Prioritisation Policy Committee
Mr Hall advised that the Committee was currently revising its Terms of Reference to review membership to include a patient representative, and timings of the Committee. The updated Terms of Reference would be presented to the Board for approval.

9.3 Covid-19 Recovery Report
Ms Myers presented the report and advised that progress was underway for the planning of Phase 3 which would run from August to March 2021. There was no updated planning guidance as yet and this was presenting a

challenge.

The Trust was looking at service restoration rather than recovery and additional resources would be required to ensure the plans were met. Work was ongoing to ensure that wards and departments had been risk assessed and was Covid-19 secure. This would allow for staff who have been shielding to return to work. Ms Myers advised that the planning was going ahead even whilst awaiting guidance to cover every point of delivery and the workforce required.

Mr Robson asked if the 19,000 additional diagnostic tests noted in the report would be enough to meet the backlog as well as routine demand. Ms Myers advised that it was not sufficient to get back into balance but it would help, although the tests were heavily weighted to February and March 2021.

Ms Myers reported that the Trust was also planning for a second peak and was reviewing models to understand the numbers. The Trust was taking a cautious, pragmatic approach and was confident that the new Covid-19 facility on the HRI site would provide good baseline capacity to be built in to the Trust's surge plan.

Mr Bond added that a number of capital bids had been submitted recently in the areas of infrastructure, winter planning, infection prevention and control and replacement equipment. He reported that with the exception of one MRI machine all of the MR/CT and breast screening scanner fleet had been replaced and were no longer over 10 years old.

Mr Moran had spent time with Mr Taylor and had seen the new Covid-19 wards. He was impressed by the quick turnaround and how the Trust had responded in the pandemic.

.

Mr Curry asked about the Integrated Care System and how services were being modelled across it. Ms Myers advised that there were active discussions taking place and clinical priorities being highlighted. The ICS was reviewing joint opportunities and additional capacity solutions.

Mr Moran asked that a development session be put into place with NLAG and the ICS to discuss matters further.

CR

Resolved:
The Board received and accepted the report.

10 Our People Impacts

10.1 Staff Overview Report

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 in 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.

Mr Nearney advised that there were three tests being carried out. The Covid-19 Staff Test, which is an antigen testing facility and has been operating since April 2020. From 1st April to 30th June 2020, 2,696 staff had been tested. 2,252 (83.54%) have tested negative and 444 (16.46%) have tested positive. The Trust also tests staff from CHCP, Yorkshire Ambulance Service, Humber FT, CCGs, care homes and other smaller providers.

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

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.

Overall the Trust vacancy position is 4.85% and is 4.8% in medical and dental staff. The Consultant vacancy rate is 13.94% but including locum, casual and agency staff, the vacancy rate is 2.8%.

The vacancy rate for Registered Nursing and Midwifery is currently 3.17% across the organisation.

The Care Hours Per Patient Day (CHPPD) for May 2020 was 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-19 norms.

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 end; the Trust will continue this until the end of August 2020 at least.

The Board had a detailed discussion around the learning points to be taken from teams relating to the new ways of working since the pandemic started in March 2020. In particular the Board discussed new video conferencing methods and fewer face to face appointments. Mr Moran added that the recording of sessions could lead to learning opportunities and professional development and a more accurate record of what was said and how the discussion was conducted and therefore providing safeguards for both patient and clinician.

Mr Nearney advised that the Medical Education Training programme had been interrupted because of Covid-19 and that Health Education England were reluctant to have this training interrupted again if a second wave hit the

Trust. Dr Purva advised that the Trust had pushed back on this as the Junior Doctors had been excellent during the pandemic and the learning they had received should form evidence for their qualification.

Mrs Christmas asked if the support for childcare, free car parking and meals would be taxable and Mr Nearney advised that as they were benefits in kind they would likely be subject to tax. Mr Nearney is currently looking into this situation.

Resolved:
The Board received and accepted the report.

10.2 Escalation from the Workforce, Education and Culture Committee
Prof Macleod presented the summary report and highlighted the impact on staff during Covid-19 and the support given by the Trust.

11 Our Finance Impacts
11.1 Finance Report
Mr Bond updated the Board and advised that the Trust's financial position continued to be impacted by Covid-19 and had a cost of £2.7m in month.

Overall the underspend of £5.9m was offset by the £7.5m of Covid-19 spend.

The Trust is still awaiting clarity for the financial plan requirements for the remainder of the financial year. The current planning system would likely be extended into August and possibly September. Mr Bond advised that a more detailed report would be presented at the Performance and Finance Committee at the end of the month.

Mr Bond highlighted a potential risk around the Junior Doctor pay and how they had been rostered to work weekends during the pandemic. He advised that this could have an impact on the pay budget. More details would be included in his next report.

Resolved:
The Board received and accepted the update.

11.2 Urgent and Emergency Care Business Case
Mr Bond presented the business case and thanked Fionnuala Raitt, Mrs Cope and Ms Myers for their hard work. The Business Case was to provide a new main entrance to HRI, create better patient access to emergency care, move paediatrics from the 13th floor to nearer the Women and Children's Hospital and create family accommodation, and create more CT and MRI facilities. The cost of the business case was £19.2m and Mr Bond was confident it could be delivered within the timescales.

Mr Bond discussed the revenue costs associated with the capital expenditure and how avoidance of admissions and reduced length of stay would be quantified to be included in the financial underpinnings and savings.

Mrs Cope added that there was strong clinical engagement and she also thanked Fionnuala Raitt for her hard work on the case. Ms Myers advised that the business case gave good value for money and the paediatric

services move was a real highlight.

Mr Robson asked if there were any diagrams of what the ground floor and front entrance to HRI would look like after completion and Mr Bond agreed to share the designs with the Board via email. **LB**

Resolved:
The Trust Board approved the Final Business Case and approved the release of the Business Case to NHS I/E.

12 Items for approval by the Board

12.1 Freedom to Speak Up Guardian Report

Ms Ramsay presented the annual report which also included quarter 1 information.

The main areas of concern raised by staff were around poor behaviours and poor communications within teams or between individuals. Ms Ramsay advised that her role fed into the Workforce Transformation Committee as well as working with the Organisational Development Team to improve cultures across the Trust.

During Covid-19 there had still been a number of issues raised but in the main staff had taken up the vast amount of additional support available other than the Freedom to Speak Up Guardian route, which felt appropriate to meet their needs.

Ms Ramsay reported that she had supported the BAME network panel processes for BAME risk assessments as an objective, external person as and when required.

Issues raised during the Covid-19 surge were mainly around staff not social distancing and not giving the right message to other staff and patients. Ms Ramsay fed these in to key corporate messages being circulated at the time.

Ms Ramsay added that the Trust was well placed when benchmarked against others as part of the National Guardians Office index, although the national average had caught up with the Trust in a set of data published after this report was written. This will be included in the next Board report

Resolved:
The Board received and accepted the report.

12.2 Guardian of Safe Working Report

Mr Mumdzjans presented the annual report and advised that he had received 384 exception reports from Junior Doctors in the last year. He thanked Dr Purva, Mr Nearney and Ms Ramsay for their support during the year.

He advised that the exception reports mainly covered the relationships between senior and junior doctors and how the supervision could be better. Mr Mumdzjans was looking for support from the Organisational Development Team to review cultures and behaviours.

E-Rostering was still an issue as not all areas were using the Trust system

but using stand-alone systems or paper systems. These areas were being identified. Mr Nearney advised that there had been a reluctance in some medical areas to use the e-Rostering system and Mr Long added that the Executive team would set a deadline for the entire workforce to be using it. **CL/MP**

Resolved:
The Board received and accepted the report. A deadline to be set for all staff to be included on the e-Roster system.

12.3 Standing Orders Report
The report was presented to the Board and highlighted the use of the Trust seal.

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

12.4 Fit and Proper Persons Report
The report was presented to the Board and it highlighted full compliance against the fit and proper person standards. There is one slight spelling error of Mrs Jackson's name in the report. Mr Nearney advised that his wife was leaving the Trust on 3 August 2020 and would be updating his declaration of interests.

Resolved:
The Board received and accepted the report.

13 Chairman's summary of the meeting
Mr Moran reported that the Urgent and Emergency Care Business Case had been approved, that the Board was well briefed on the performance and restoration position, and that the Board had received good assurance from the Freedom to Speak Up Guardian and the Guardian of Safe Working.

14 Any Other Business
None

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

16 Date and time of the next meeting:
Tuesday 8 September 2020, 9am – 12pm via Webex

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
July 2020						
01.07	Covid-19 Recovery	ICS Discussion with NLAG to be arranged	CR	TBC		
02.07	UEC Business Case	Mr Bond to share ground floor diagrams with the Board via email	LB	Sept 2020		
03.07	Guardian of Safe Working	Deadline to be set regarding all clinical staff being on E-Rostering	CL/MP	Sept 2020		Update to be received
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						
Jun 2020	Duty of Candour	Assurance around the process and compliance to be received	MP/BG	July 2020		Completed

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
	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	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					Area 4 and BAF 4: RTT and Covid-19 recovery - operational planning and service recovery				
29-Sep-20			Area 2 and BAF 2: Presentation from Intensive Care Team - Impact of Covid-19	**Area 4 BAF 3:** 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	Area 4 and BAF 4: Phase 3 Service Recovery, Financial Plan M7-M12, ICS planning and patient impacts				
24-Nov-20		**Area 4 BAF 1:** There is a risk the Trust does not make progress towards further improving a positive working culture this year					**Area 4 BAF 5**: 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		**Area 4 BAF 7.2:** 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)

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

8 September 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:	Covid staff survey, AGM, ED abuse, 200 Covid deaths	

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 8 September 2020

1. Key messages from July-August 2020

Annual General Meeting

The Trust's AGM was attended by over 80 staff and members of the public on Monday 13 July. Attendees heard presentations from the Chief Executive and Chief Finance Officer. Our infectious diseases consultants also gave a presentation on Our Covid19 Story, which shared details of how the ID team has responded to the pandemic ever since the first patients in the UK tested positive at Castle Hill Hospital on 29th January.

Subsequently the Infectious Diseases story has attracted media attention and featured in several local publications as well as BBC Look North.

Covid staff survey

Almost 1000 HUTH staff responded to our Covid-19 survey which we ran during July. Over 65% of those who completed the survey felt that the whole HUTH response to the pandemic had been effective while only 3% strongly disagreed, which overall is positive and encouraging.

When asked what had gone well, respondents felt that communication had been effective with many staff saying that they appreciated the regular updates from gold command and from workforce silver command. Many were pleased with the overall operational response, citing the discharge of patients, the establishment of Covid-19 wards and the separation of ED into hot and cold areas as being the right approach. Lots of staff described the improved teamworking, support for each other, compassion and valuing of staff as a major positive, along with the support for staff in terms of free meals, childcare, accommodation, parking and the psychosocial support. We also received positive comments about the roll out of PPE and the redeployment of staff.

Top five areas that went well:

32%	Communication
20%	Operational management
11%	Teamworking
9%	Staff Support/Benefits
9%	PPE

Areas which could have been improved included making PPE more widely available earlier in the pandemic and in areas other than the Covid wards. Some staff felt we should have imposed the need to wear face masks much earlier and been quicker to organise social distancing in busy areas. Some told us that protocols and guidance were confusing, although many staff acknowledged that this was often due to rapid changes at national level.

Top five areas that could have been better:

20%	PPE
17%	Mask wearing
13%	Operational management
12%	Social distancing
9%	Protocols and guidance

Staff had strong views on the most positive changes we made during the pandemic. Many told us that flexible/homeworking must continue to enable us to support them and to provide responsive services, with improved work-life balance for staff. Associated to this was a

wave of support for new digital technologies including video conferencing and webex, which staff cited as having had a very positive impact on homeworking, the focus (and therefore the length) of meetings. Almost a fifth of all respondents supported a siginifcant focus on virtual patient clinics, suggesting that this was better for both patients and NHS staff. Many felt that these were long overdue and in some cases that they should be the default offering to patients, with only a small minority needing to come into hospital for follow up clinics.

Top five improvements which should remain in place:
24% Fexible/homeworking
19% Virtual clinics
11% Free car parking
9% Video conferencing
9% Visitor restrictions

Many thanks to everyone for giving us their feedback.

Number of Covid19 deaths
Tragically, on July 28th we confirmed that 206 patients have died in our hospitals after testing positive for Covid19. We express our sincere condolences to the families and loved ones of each and every person who has died from this terrible virus.

ED staff appeal for abuse to stop
Since new rules have been implemented limiting the number of people who can attend our Emergency Department with a patient. Staff have experienced significant levels of verbal abuse. Clinical Director Ben Rayner appeared in numerous media outlets to appeal to the public to be more tolerant of the new rules which are aimed at improving social distancing and reducing the risk of infection.

Letter to patients
All patients waiting for an appointment will be written to over the next few weeks. The letter assures patients that they have not been forgotten and that everyone on a waiting list is being assessed by clinicians and will be seen according to their clinical need. York and NLAG are also contacting their patients with a similar message.

Over 70s sought for Covid vaccine trial
In August the Trust extended its involvement in the Oxford vaccine trial to healthy participants aged 70 and over. Media coverage was instrumental in helping us to recruit more than the number initially agreed with Oxford, with over 100 people expressing an interest in participating.

2. Media Coverage

We have reviewed our press and broadcast (tv/radio) media coverage for the 142-day period from the 5.3.20 to 15.8.20. Despite the multiple tragedies which have befallen the local population and the Trust itself, the vast majority of the coverage the NHS and HUTH has received has been sympathetic and positive. NHS staff have been routinely recognised for their efforts in the media.
Much of the coverage has been factual reporting, including regular updates on the numbers of cases and the number of deaths in hospital.

Across the 182 day period:

- HUTH appeared in the media on 142 separate days
- We generated a total of 483 news stories
- Of those articles and broadcasts 351 were unique stories

- 73 stories were reports of numbers of Covid cases and deaths in our hospitals
- We appeared 266 times in the Hull Daily Mail
- BBC Look North has featured the Trust 27 times
- ITV calendar has featured the Trust 11 times
- Radio Humberside has interviewed a HUTH representative 24 times
- HUTH has featured 10 times in the Daily Mirror and twice in The Guardian
- We also featured in The Metro, Cambridge News, Grimsby Telegraph, Daily Express, The Independent, The Yorkshire Post and BBC News Online

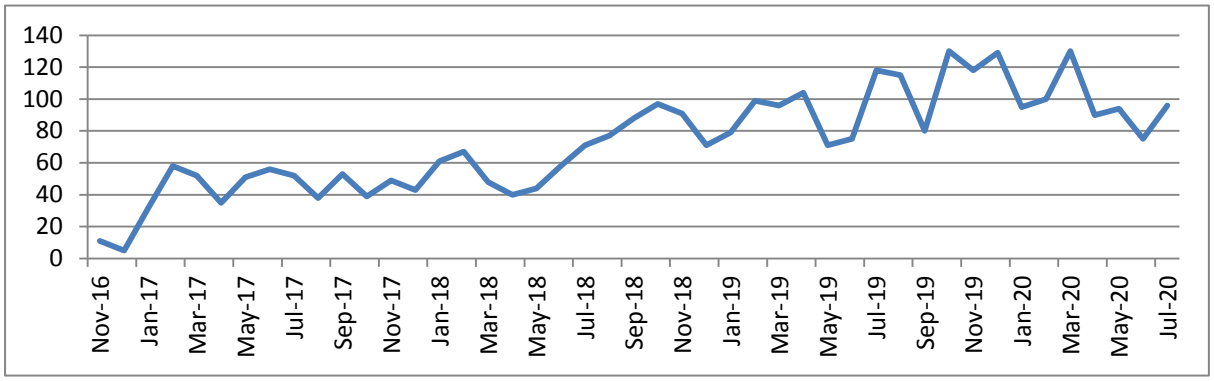
3. Golden Hearts and Moments of Magic

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 July we received 96 Moments of Magic nominations.

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 acknowledging 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 8 September 2020

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

Purpose:	The purpose of this report is to present proposed Quarter 1 risk ratings for Board approval.	
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 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 Trust Board approved the Board Assurance Framework at its meeting in July 2020. This report sets out the suggested ratings for Quarter 1, following updates from Board Committee meetings and discussions with the Executive Team.	

Recommendation:	The Trust Board is asked to review and approve the proposed Quarter 1 risk ratings detailed in the report

Hull University Teaching Hospitals NHS Trust

Trust Board

Board Assurance Framework

1. Purpose of this report

The purpose of this report is to present proposed Quarter 1 risk ratings for Board approval.

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. Quarter 1 Board Assurance Framework

As part of the process for signing off the first quarter Board Assurance Framework, each of the strategic objectives have been considered in a number of Trust forums.

The following section provided a summary of the discussions and sources of assurance relating to each strategic objective.

BAF 1 Honest Caring and Accountable Culture

Principal Risk: There is a risk the Trust does not make progress towards further improving a positive working culture this year

Positive assurance was received at the Workforce, Education and Culture Committee following the Staff Survey results mainly around flexible home working and the use of new technology. There were also positive Covid-19 staff survey results relating to communication and staff working together during the pandemic. There are risks around staff morale as the Covid-19 related benefits such as free childcare and lunches come to their conclusion. However, these risks do not pose a significant risk to the direction of travel on this BAF area

Risk rating at the start of the year = 12
Proposed Q1 risk rating = 12

BAF 2 Valued, Skilled and Sufficient Staff

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

There is positive assurance around the Great Leaders programme re-starting in virtual form, but there are still risks relating to sickness absence following the pandemic.

Risk rating at the start of the year = 12
Proposed Q1 risk rating = 12

BAF 3 High Quality Care
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

Positive assurance was received relating to Infection prevention and control, but further assurance was required around patient falls which had increased slightly.

Risk rating at the start of the year = 16
Proposed Q1 risk rating = 16

BAF 4 Great Clinical Services
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- Planning guidance being released in stages across the year

The Chief Operating Officer and the Chief Medical Officer are meeting monthly with the Medical Directors to discuss ED performance and clinical engagement. The Adopt and Adapt work for diagnostics is being progressed both at HUTH and across the HCAV.

The main area of concern was around the Phase 3 recovery letter and the performance targets set out in it. The risks were being managed but clinical priority remains the main focus.

Risk rating at the start of the year = 20
Proposed Q1 risk rating = 20

BAF 5 Partnership and Integrated Services
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

Although work was ongoing with the ICS and HCAV Acute Services Review there have been no detailed updates reported through the committees.

Risk rating at the start of the year = 9
Proposed Q1 risk rating = 9

BAF 6 Research and Innovation
Principal Risk: There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships

There have been no specific updates relating to research and innovation in the June and July round of committees. There have also been no specific concerns or significant risks in this BAF risk area escalated to the Quality Committee or Workforce, Education and Culture Committee.

Risk rating at the start of the year = 12
Proposed Q1 risk rating = 12

BAF 7.1 Financial Sustainability
Principal Risk: There is a risk that the Trust does not achieve its financial plan for 2020-21

The Trust had achieved its financial plan for the first quarter of the year. Until the updated financial plan from the Centre had been received it was difficult to frame the degree of risk and action required to achieve it.

Risk rating at the start of the year = 12
Proposed Q1 risk rating = 12

BAF 7.2 Underlying Financial Position
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)

NHS Finance details future performance being measured at a system (ICS) Level. As this is an evolving picture it is unclear how this will impact on the Trust's underlying position.

Risk rating at start of the year = 16
Proposed Q1 risk rating = 16

BAF 7.3 Capital Planning
Principal Risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability

Critical Infrastructure funding of £6m had been received to reduce the backlog and a comprehensive maintenance programme was in place. As the risk was being managed and controlled it is proposed that the risk rating severity be reduced from a 4 to a 3 and the likelihood (3) remain.

Risk rating at start of the year = 12
Proposed Q1 risk rating = 9

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. Recommendation

The Trust Board is asked to review and approve the proposed Quarter 1 risk ratings detailed in the report.

Rebecca Thompson
Corporate Affairs Manager

September 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 – Version updated 2 September 2020 following Board Committee meetings

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 Failure to act on	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 commenced April 2017 to develop managers to	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	**12**				**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 Detailed papers to Trust Board on staffing picture including additional psychological support, access to additional support, risk assessments and support to BAME Leadership Network At the WEC Committee in August the 2020 Staff Survey results showed that the Trust is above average in the following themes: equality, diversity and inclusion, morale, safe environment – bullying & harassment, violence and safety culture. **<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-19 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

		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			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**				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 Staffing levels subject to daily review during pandemic; risk assessments and support put in place for all staff, staff supported by testing, working from home and ability to shield without affecting pay There are plans to restart virtually the 'Great Leaders' Be Remarkable and Bitesize programmes in October 2020 Introduction of 'virtual classrooms' to ensure medical education can continue during the pressurised Winter months **Further assurance required** Absence remains 1% above 5 year average due to staff needing to self isolate and have tests due to Covid 19 like symptoms.

		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	**16**				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 Monthly update to the Trust Board on quality of care, monitored for Covid-19 as well as usual service delivery – no escalating risks on quality of care to report The Trust has undertaken a self-assessment against the NHSE Infection, Prevention and Control Board Assurance Framework. The CQC have reviewed the intelligence and have confirmed that the Trust has effective infection prevention and control measures in place in response to COVID and that the Trust continues to ensure that the health needs of patients and staff are met. 2 Never Events declared in April 2020 (relating to Robinson drains) had been downgraded and were now being investigated as serious incidents. **<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 The Trust has seen a slight increase in falls overall. In July 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 Group will focus on the link between falls and patients with Dementia or Delirium.

		does not increase its public, patient and stakeholder engagement, detailed in a strategy The impact on harm due to longer waiting times, delayed activity and less capacity from Covid-19 is not carefully managed. Capacity of organisation potentially compromised to be able to make Trust-wide improvements in quality of care			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 Regarding Falls - 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.						

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	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)** **5 (likelihood = almost certain)** **= 20**	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 process updated; service recovery plans require clinical review and prioritisation of all current patients on an open pathway; this includes reviews of harm if triggered 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		**20**				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 Detailed briefing shared with Trust Board Development in July 2020 – Board fully sighted on waiting list position, recovery position, national requirements (as currently published) and the partnership working underway for service restoration COO and CMO meeting monthly with the Medical Directors to discuss ED performance and clinical engagement The Adopt and Adapt work for diagnostics is being progressed with the COO at HUTH being the SRO lead across HCV The triaging of the referrals in the RAS is working well for services. Positive engagement from all services to maintain and increase different ways of working across outpatient services Primary Care Collaborative Group had been established to review non-Covid harm

		2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance 3- Planning guidance being released in stages across the year 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 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			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 Plan to review medical base ward capacity to meet demand Restoration command structure in place							**<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 – new weekly meeting in place between Health Group Medical Directors Following receipt of the Phase 3 planning letter there are risks around the performance expectations set out. Diagnostic performance is improving in July 2020, but there are still issues around endoscopy.

Risk Appetite

A range of plans were 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. This concern has increased significantly in light of actions required during the Covid-19 first surge. Whilst there is an opportunity to use technology to a greater extent and make pathways more efficient, 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 when the financial plan for the year is confirmed. 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. This will require risk-sharing across system partners, which is yet to strongly emerge in practice.

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	**9**				3 x 1 = 3	**<u>Positive assurance</u>** Output of Humber Acute Services Review Interim Clinical Plan will move forward partnership working ICS status and new meetings bringing together acute providers to work more collaboratively **<u>Further assurance required</u>**

<u>Risk Appetite</u>
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	**12**				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?* Inability of Trust to restrict Covid related expenditure to within nationally prescribed expectations Inability of Trust to	Corporate: Pensions	**4 (impact = major** **3 (likelihood = possible)** **= 12**	HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Ongoing management of Trust cash balances to ensure no liquidity issues. Process in place to agree level of activity planned for remainder of year. Cannot be concluded until financial envelope known Monthly analysis and interrogation of Covid and non-Covid spend using established accounting processes and develop better understanding of the cost base Review of income generating activities taking place with assumption of charging for all relevant services (except staff car parking) from early September	Need to see financial plan from Centre to be able to frame the degree of risk and action required to achieve 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	**12**				4 x 2 = 8	**<u>Positive assurance</u>** Monthly block contract arrangement and access to Covid-19 funding reported to Trust Board; Trust continues to monitor capacity and demand, income and cashflow in detail Achieved revised plan for first quarter of the year **<u>Further assurance required</u>**

		generate income from non-clinical activities to pre-Covid levels Trust's desire to deliver activity levels above planned levels will generate a level of cost that is not covered by the nationally calculated plan for the period Prospective financial plan for periods (07-12) required excessive levels of cost reduction in order to meet plan										

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, on a non-recurrent basis. Unclear what recurrent impact of Covid will be both in terms of income and expenditure	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 Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews	**16**				4 x 1 = 4	**<u>Positive assurance</u>** **<u>Further assurance required</u>** Emerging direction of travel for NHS Finance sees performance being measured at a system (ICS) level. It is not clear just how this evolving picture will impact on the Trusts underlying position.

		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	**4 (impact)** **3 (likelihood) Possible = 12**	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 completed. This 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 Critical infrastructure funding of £6m received to help reduce	Insufficient funds to manage the totality of risk at the current time – unable to address internally	**9**				4 x 2 = 8	**<u>Positive assurance</u>** Increased capital plan for 2020-21, successfully application for additional capital funding to address some long-term infrastructure needs The Capital Resource Allocation Committee were informed that the Government has announced an additional £600m capital to address high risk critical infrastructure backlogs. This funding is to improve estates resilience and is expected to deliver maximum reduction in reported critical infrastructure risks (CIR). The HCAV's proportion of this bid is £14.9m for critical care infrastructure, with HUTH's proportion being £6.2m. HCaV Urgent and Emergency Care Business Case Update has progressed to NHSEI and DHSC for evaluation. **<u>Further assurance required</u>**

					backlog.							

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

Appendix 2

Board Assurance Framework 2020-21
Trust Board topics mapped to Board Development and public Trust Board meetings as development or deep dive topics

BAF 1: There is a risk the Trust does not make progress towards further improving a positive working culture this year
To be discussed:
November 2020 Board Development

BAF 2: 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
To be discussed:
November 2020 Trust Board

BAF 3: 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
To be discussed:
September 2020 Board Development

BAF 4: 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- Planning guidance being released in stages across the year
Discussed:
12 July 2020 public Trust Board meeting and June 2020 Board Development
To be discussed – will be included in Performance report to each public Trust Board meeting
Detailed update to be brought November 2020 and March 2021 Trust Board

BAF 5: 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
To be discussed:
November 2020 Board Development

BAF 6: There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships
Update brought: to June 2020 Quality Committee – to be shared with Trust Board membership
To be discussed: January 2021 Trust Board

BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2020-21
To be discussed:
Reported at each public Trust Board meeting
Detailed update to be brought to March 2021 Trust Board

BAF 7.2: 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)
To be discussed:
November 2020 Board Development

BAF 7.3: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **To be discussed:** January 2020 Board Development.

Weekly Scorecard

Hull University Teaching Hospitals NHS Trust

Group	Measure	Notes	19/20 Avg. (where appropriate) Baseline	06 Jul	13 Jul	20 Jul	27 Jul	03 Aug	10 Aug	17 Aug	Trend (7/52)
RF	GP referrals (Volume)	GP or GP with Special Interest	2,398	1,457	1,550	1,494	1,401	1,511	1,460	1,192	
RF	GP referrals (Rate)	GP Referrals / OP Referrals	55%	51%	50%	51%	49%	49%	48%	46%	
RF	A&G Requests	Referrals to A&G Team	207	460	489	499	465	484	482	410	
RF	2ww Referrals	All referrals as 2ww priority from a GP	371	402	414	410	340	379	397	395	
RF	2ww seen within 14 days	Cancer Performance	93%	86%	92%	79%	74%	74%	79%	86%	
ED	4hr Performance	Type 1	70%	87%	85%	84%	86%	84%	83%	86%	
ED	Number of attendances	Type 1	2,644	2,166	2,232	2,321	2,229	2,334	2,389	2,331	
ED	4hr Performance	Type 1&3 combined	81%	92%	91%	90%	91%	90%	90%	92%	
ED	Number of attendances	Type 1&3 combined	4,188	3,393	3,520	3,657	3,670	3,856	3,926	3,891	
OP	New outpatient attendances	All mediums	5,001	3,363	3,371	3,534	3,519	3,681	3,519	3,376	
OP	Follow up outpatient attendances	All mediums	10,573	8,588	8,817	8,479	8,364	8,489	8,649	7,639	
OP	2ww Appointment attendances	Appointment Priority of 2ww	439	428	436	378	444	515	409	380	
OP	62 day RTT Cancer Performance		67%	62%	72%	67%	59%	66%	78%	65%	
OP	31 day DTT Cancer Performance		93%	87%	95%	89%	92%	93%	97%	97%	
OP	Number of hospital cancellations	Due to COVID-19	-	446	463	265	231	377	329	285	
OP	Number of patient cancellations	Due to COVID-19	-	60	52	54	43	40	38	38	
OP	Rate % OP hospital cancellations (all)	Hosp Cancel / Hosp Cancel + Patient Cancel + DNA + Attend	10%	10%	11%	9%	9%	10%	9%	10%	
OP	Rate % OP patient cancellations (all)	Patient Cancel / Hosp Cancel + Pat Cancel + DNA + Attend	12%	4%	4%	5%	5%	6%	6%	7%	

Weekly Scorecard

NHS
Hull University Teaching Hospitals
NHS Trust

Group	Measure	Notes	19/20 Avg. (where appropriate) Baseline	06 Jul	13 Jul	20 Jul	27 Jul	03 Aug	10 Aug	17 Aug	Trend (7/52)
IP	Elective admissions		1,661	841	924	980	1,000	985	993	1,007	
IP	Emergency admissions		1,010	876	837	886	888	888	902	889	
IP	Elective cancellations	Due to COVID-19	-	7	5	6	3	6	3	3	
RT	RTT list size	Against baseline March 19	52,808	55,691	55,813	56,584	57,383	57,633	57,966	58,431	
RT	Follow up backlog (over 3 months)	Against baseline March 19	18,761	30,811	31,598	32,258	32,910	33,064	33,528	33,623	
RT	ASI / Holding	Against baseline March 19	16,357	31,807	31,113	31,255	31,385	30,581	30,694	30,766	
RT	52 week breaches YTD	Against baseline 2018/19	2	909	1,886	1,886	1,886	1,886	3,307	3,307	
RR	Total number swabbed		-	1,747	1,863	1,845	1,881	1,918	1,911	1,999	
RR	Total number confirmed		-	10	8	11	8	1	6	2	
BD	Current inpatients as at 08:00 Monday		-	744	849	832	879	857	829	829	
BD	Total G&A Open	Based on yesterday's Monday vs previous Monday	-	1,013	1,012	1,012	1,012	1,012	1,012	1,012	
BD	Total G&A Occupied	Based on yesterday's Monday vs previous Monday	-	741	747	815	787	751	743	782	
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	-	28	34	28	27	26	30	25	
BD	G&A Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	73%	74%	81%	78%	74%	73%	77%	
BD	CC Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	40%	49%	40%	39%	37%	43%	36%	
BD	Trust Bed Occupancy Rate	Based on yesterday's Monday vs previous Monday	-	71%	72%	78%	75%	72%	71%	75%	
DG	Diagnostics Over 6 weeks		1,075	4,386	4,288	4,072	3,735	3,681	3,451	3,468	
IP	Medical Beds Avg LoS (Trimmed)		3.8	3.8	3.7	4.1	3.5	3.8	3.4	3.6	
CN	Cancer 62 Day PTL (104+ days)	Pending									

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Performance and Finance

Meeting Date:	24 August 2020	**Chair:**	Tony Curry	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Nursing and Midwifery redeployment plans during Covid-19 and their financial impact.
- Board Assurance Framework was received.
- The Trust is still reporting a break even position
- Junior Doctor annual leave was discussed and the potential financial impact.
- Performance: ED performance was at 90%, cancer performance was static and the RTT position was worsening.
- Discussions around the Phase 3 letter and recovery plans
- NECs PTL Diagnostic Report was received
- Hospital Improvement Team – Annual report received with an update around Getting it Right First Time programme
- Scan4Safety update was received, the programme was now live across 12 areas

Key decisions made:

- Variable Pay Report to be received at the Performance and Finance Committee and not the Workforce Education and Culture Committee
- Contract extension paper for the provision of clinical waste was approved.

Risk and assurance matters to be received by the Board:

- Winter Plan/Revised Surge Plan and the Emergency Planning Framework to be presented to the September meeting
- Diagnostics was a key focus area to review levels of activity and work with the Humber Coast and Vale to address the capacity issues and where possible involve Primary Care.

Matters to be escalated to the Board:

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 27 July 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
	Mr S Evans	Deputy Director of Finance
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Nearney	Director of Workforce and OD
In Attendance:	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs A Drury, Deputy Director of Finance	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes of the meeting held 29 June 2020** Item 8.1 Performance Report – paragraph 2, last sentence should read; the equivalent of 7 extra consultants working in ED and AMU had been added to the establishment. Following this alteration 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** The paediatric performance had been updated at the last meeting and would be removed from the tracker. Mr Nearney agreed to share an update regarding AHPs via email to the Committee members. The email would include speech therapy and dietetics as they had the largest vacancy rates.	**SN**
6	**Workplan** Ms Ramsay presented the item and advised that all committee workplans had been reviewed and any national timings changed due to Covid incorporated. Ms Ramsay added that she had read across the PAF and Workforce Education and Culture committees in order to satisfy the terms of reference. Mrs Christmas asked why the winter planning line did not have timings in it and Ms Ramsay advised that it was due to the Covid recovery timings. Mrs Cope added that the winter plan was being developed and would bring it to the September 2020 meeting along with the refreshed Covid surge plan.	**TC**

7 Board Assurance Framework

Ms Ramsay presented the framework which had been signed off by the Trust Board in July 2020. She advised that the highest risk rating was BAF 4 which was around performance and achieving great clinical services.

The Committee was asked to review the BAF and highlight any positive or any gaps in assurance and escalate any concerns to the Board as necessary. Ms Ramsay added that the document had been received at the Quality Committee that morning as well for scruitiny. Positive assurance had been given by the Auditors regarding the process.

Mr Hall stated that BAF 5 which related to partnership working would come into play as the Humber Acute Services Review progressed.

SH Goal 4 great clinical services – BAF 5 humber acute services review – more interplay with HASR. Mrs Cope advised that the risk position would be better known in a couple of months.

Mr Curry asked if the national planning guidance would impact on the restoration planning and Mrs Cope advised that it should not alter the Trust's plan a great deal. Mr Bond added that there was an expectation on all levels to work harder and achieve more with existing resources.

Mr Bond advised that he would make a judgement on the financial risks over the next 3 months. He was working with the operational teams to review additional capacity, overtime and the use of the independent sector and would update the risks accordingly.

Resolved:

The Committee received and accepted the report.

8.1 Statement Of Comprehensive Income – June 2020

Mr Evans advised that the Trust was in a similar position as the previous months with the monthly block income in place. The in-month position was a deficit of£1.2m with continuing covid costs (£2.7m) offset by reductions in activity from the baseline.

The reported position assumes that the Trust will receive a further £1.5m to reach a breakeven position. This is known as 'true up' income and is expected from NHSE&I via the agreed national process. The payment of £0.3m for the first 2 months was received in June and the additional £1.2m is expected to be received in August.

The Trust has seen a reduction in income across health group budgets with the main shortfalls being in Car parking (-£438k), Catering (-£297k), private patients (-£87k) and injury compensation scheme (-£87k). 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 the first quarter.

For the year to date the Trust has identified £7.4m of specific, additional Covid costs, as shown in the table below. This includes an additional £2.7m in month 3, the highest expenditure month so far. Pay costs in dealing with the impact of covid have increased in month by £1.4m to £3.2m with increases in the number of aspirant junior doctors and nurses and increased cost of accruals for the cost of annual leave for junior doctors who will be

unable to take their leave before they rotate out of the Trust in August. An estimate of £0.2m has been made for the cost of paying the outstanding leave to this group of staff.

The Trust will undertake an analysis of non-pay spend to look at whether movements in spend have been consistent with movements in activity. Mr Hall asked if the outcomes of the analysis could be presented to the Committee in due course. **SE**

Resolved:
The Committee received and accepted the report.

8.2 Statement Of Financial Position – June 2020
Mr Evans presented the report and advised that the cash flow position remained good with £20m for one month. The level of debts over 90 days was high but the debts outstanding for NHS E were being cleared in July/August and other NHS debts were being chased by the finance teams.

Work was ongoing with the operational teams to maximise activity. Mr Bond advised that £6.1m had to be spent this year relating to critical infrastructure to reduce the backlog maintenance and there would be an announcement regarding the upgrades to the ED department this week.

Mr Robson asked how the Trust's expenditure relating to Covid costs compared to others and Mr Bond advised that the Trust was in a similar area but that there was no detailed information to date.

Mrs Christmas expressed her concern regarding the debtor performance but Mr Evans advised that he had no concerns or disputes.

Resolved:
The Committee received and accepted the report.

8.3 NHS Finance and Planning Framework Update
Mr Bond advised that the planning guidance had not yet been released so the Trust did not yet know how the second half of the year would look like. He was hopeful that the guidance would be available in the next couple of weeks.

Resolved:
The Committee received and accepted the update.

8.4 - Variable Pay Report
Mr Nearney presented the report and advised that in month 2 the Trust had spent £5m with all Health Groups apart from Emergency Care being over spent on their pay budgets.

Mr Nearney advised that the figures were artificial due to the pandemic is less being spent on variable pay and agency spend in a better position.

From 1st August staff members who have been shielding will be returning to work and re-deployed staff returning to their original roles. Anyone not returning to work would be classed as on sick leave. As activity increases there will be more demand on the workforce and the requests for variable pay will increase. Priorities going forward were recruitment, engagement

and leadership programmes to ensure staff were supported in the restoration phase.

Resolved:
The Committee received and accepted the report.

8.5 - Vacancy Report
Mr Nearney presented the report and advised that the current vacancy rate was 5.5% and that the Trust was in a good position regionally. Each of the Health Groups had plans in place to review their agency spend to reduce it were possible. The Junior Doctor changeover was at the beginning of August and Mr Nearney agreed to update the committee regarding doctors once this had taken place.

The nursing position was good at 3% and the main area of concern was in medicine (elderly), but a plan for additional overseas nurses was in place.

There had been 800 applications for jobs during the Covid pandemic but only 50 had been appointed as the majority of applicants did not want to work in Covid areas.

Mr Nearney agreed to update the Committee via email regarding dietician and pharmacist vacancies.

Mrs Christmas asked if the activity recovery planning included the staffing costs such as overtime and agency costs and the impact on the Trust. Mr Nearney advised that he was working through the numbers but the demand to reduce the waiting lists was taking priority.

There was a discussion around waiting list initiatives and that other Trusts were paying more, so it was proving difficult to get staff to work overtime. Mr Nearney advised that the Trust was reviewing an increase in the rates. Mr Curry asked about long term locums and the impact on the Trust and Mr Nearney advised that risk assessments took place for each position and consultants were recruited when it was possible to do so.

Mrs Christmas expressed her concern regarding the high rates of pay paid to consultants and Mr Nearney advised that Hull's rates were much lower than NLAG and York. Mrs Cope added that the acute collaborative work would mean that costs would be neutralised before any other costings were reviewed, meaning Trusts' costs would be aligned.

Resolved:
The Committee received and accepted the report.

9.1 Performance Report
Mrs Cope presented the report and advised that ED performance was just below 90% and the combined rate was 91.5% for June. Levels of activity were at 75% and the Trust's position was the same as before Covid at the bottom of the table. Any Trusts that dipped below 90% performance will be reviewed.

Mrs Cope advised that the ICS was looking at opportunities using the Urgent Treatment Centres such as 'talk before you walk', ambulatory care and same day emergency care.

Mrs Cope advised that the Chief Executive was meeting with the Medical Directors weekly to address the issues and review the medical leadership and behaviours in the Emergency Department.

Mrs Cope advised that the Trust had met its 2 week wait cancer performance in May 2020.

Diagnostic performance was still a concern with lots of issues around CT and endoscopy waits. The Trust was reviewing national models as part of the ICS work to support recovery.

Mrs Cope advised that she was carrying out deep dives relating to RTT and each speciality to determine what has been delivered, agreed recovery trajectories and review variable pay.

Inappropriate referrals were now being rejected, captured and monitored and there had been 16% of all referrals rejected so far. Advice and guidance useage was high.

There was a discussion around ED and the time to see first clinician performance. Mrs Cope advised that the CEO/Medical Director weekly meetings were to ensure a clear set of metrics were in place and the right things being measured. Reviewing patients going straight to their speciality was also being reviewed. Mr Robson added that he had taken over as the GIRFT lead and had been impressed with the clinical engagement in the innovative work being carried out.

Mrs Cope advised that the right pathways to remove patients from the ED needed to be established so that the patient could get to the right service such as an Urgent Care Centre.

Work was ongoing with the outpatient models and reviewing different ways to follow up or having nurse led or GP follow ups. Secondary care was key to help reduce the backlogs, but Mrs Cope expressed her concern around the effectiveness of secondary care.

The new metrics for the Emergency Department were now included on the dashboard and was monitored through the ED Performance and Accountability meeting.

Mr Curry asked how the Trust compared to other large major trauma centres and Mrs Cope advised that the Trust usually ranked mid table.

Resolved:
The Committee received and accepted the report.

9.1.1 Harm Reviews April and May 2020
Mrs Cope presented the harm reviews for information and assurance.

Resolved:
The Committee received and accepted the harm reviews.

9.2 Covid-19 Recovery Planning
Mrs Cope advised that there would be deep dives into specialities to ensure

the right patients are prioritised, there would be a review of national guidance and the Covid Steering Group meetings would be maintained.

Resolved:
The Committee received the update.

10.1 Capital Resource Allocation Committee
The minutes were presented for information. There was a discussion around Webex costs and Microsoft Teams. Mr Bond advised that the Trust had a license for Webex but once NHS Mail was in place the Trust could move to Microsoft Teams which was free. The NHS Mail migration was due for completion in the financial year.

Resolved:
The Committee received and accepted the minutes.

10.2 Review of Committee Effectiveness
Ms Ramsay presented the item and asked that all Committee members complete the form to allow her review the responses and report back to the next meeting. **CR**

10.3 Da Vinci XI Contract –HEY/19/467
Mr Bond advised that the contract was for the purchase and maintenance of the robot.

Resolved:
The Committee approved the contract.

10.4 Renal Replacement Therapies Service Contract – HEY/20/034
Mr Bond presented the contract for approval. Mr Hall queried the on-cost in the future and Mr Bond advised that it was due to the type of patient being treated and the type of dialysis.

The Contract was slightly overdue due to the time taken to obtain the information.

Resolved:
The Committee approved the contract.

10.5 Orthopaedic Trauma Products Contract
Mr Bond advised that the contract was a 2 year extension to the original contract.

Resolved:
The Committee approved the contract.

9 Any Other Business
There was no other business discussed.

10 Date and time of the next meeting:
Monday 24 August 2020, 1.30pm – 3.30pm

Hull University Teaching Hospitals NHS Trust

Minutes of the Performance and Finance Committee
Held on 24 August 2020

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
	Mrs T Cope	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mr S Evans	Deputy Director of Finance
In Attendance:	Mrs J Ledger	Deputy Chief Nurse
	Mrs R Joyce	Programme Director – Hospital Improvement Team
	Mrs R Ellis	Programme Director – Scan4Safety
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No.	Item	Action
1	**Apologies for absence:** Apologies were received from Mr S Nearney, Director of Workforce and OD and Mrs A Drury, Deputy Director of Finance	
8.7	**Nursing and Midwifery Redeployment Plans during Covid-19 and associated financial impact for Q1 20/21** Mrs Ledger presented the report which highlighted the financial impact following redeployment of nursing staff during the pandemic. Mrs Ledger reported that there had been a number of vacancies due to sickness and staff shielding which had resulted in a significant amount of the workforce not being available (34%). This was offset somewhat by the reduced amount of patients in the hospital. Mrs Ledger advised that there had been a £1.1m overspend relating to staffing and this was broken down within the report. The nursing teams were working through the recovery plans and all staff that had been redeployed would be back to their usual roles by the end of August. Financial forecasts were in place for year 1,2 and 3 students. The new maternity leave guidance had been reviewed and would create a cost pressure for the Trust. Mr Hall asked about the flexibility of the redeployed staff and whether the Trust could continue to utilise them in future pressurised areas. Mrs Ledger advised that it was possible but depended on skill sets in different areas. There was a discussion around ICU and how they were struggling due to vacancies. Some redeployed staff were staying with ICU to ease the pressure.	

The Committee also discussed the Phase 3 planning requirements, winter and the surge plan and how prepared the Trust was. Mrs Ledger advised that the Trust was in a much better position staffing wise but it would depend on Covid and maternity impacts.

Mr Robson stated that he was impressed by the aspirant nursing programme and asked how this had helped with recruitment generally. Mrs Ledger advised that it was a help but there was a big difference between non-registered to registered. She added that a lot of work was ongoing regarding retention and keeping nurses working for the Trust.

Mr Bond asked about the equivalent doctor review and Mrs Cope advised that she was carrying out speciality review meetings with clinical leads to discuss redeployment and support for doctors. There was strong evidence to suggest that waiting lists had been reviewed and validated and advice given to patients.

Resolved:
The Committee received and accepted the report.

2 Declarations of Interest
There were no declarations of interest made.

3 Minutes of the meeting held on 27 July 2020
Item 9.1 Performance Report
Paragraph 10, second sentence should reference Primary Care and Mrs Cope expressed her concern regarding Primary Care's preparedness and structures.

Following the above alteration 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
Mrs Cope advised that she would present the Winter Plan/Revised Surge Plan and the Emergency Planning Framework at the next meeting in September. **TC**

Mrs Cope advised that the Trust had received the Phase 3 planning letter from the Centre and that the level of ambition regarding the recovery activity was high. The Trust was still adrift on what was expected and the last date of planning submission was 21 September 2020.

Mr Evans advised that regarding the financial aspects of the letter the Trust was below the expected levels. Mr Bond added that the financial plan would include loss of income due to the activity levels achievable. He advised that the Trust was not alone and that he was working with other Trusts and the CCGs to address the complicated situation.

6 Workplan 2020/21
Ms Ramsay presented the workplan and advised that at the Workforce Education and Culture Committee it had been decided that the Variable Pay report would be better placed at the Performance and Finance committee.

The impact of variable pay costs on the People Strategy would be discussed at the Workforce, Education and Culture Committee.

7 Board Assurance Framework

Ms Ramsay presented the BAF and reported that it had been updated following the first round of Committees after approval of the BAF in July 2020. Ms Ramsay advised that she had captured positive assurance and any gaps in assurance as well as reviewing the CQC outcome report and the ICS updates.

The BAF would be updated again following this Committee and the risks reviewed to enable quarter 1 ratings to be recommended to the Board meeting in September 2020. Ms Ramsay did not think that the risk ratings had changed significantly in the first quarter.

There was a discussion around how often the BAF was reviewed and whether anything would be missed in between reviews. Mr Bond assured the Committee that any major issues would be flagged up immediately and the Executive Team would not wait until the next report was due.

Resolved:

The Committee received and accepted the report.

8 Finance

8.1 Statement of Comprehensive Income – July 2020

Mr Evans presented the report and that at Month 4 the Trust was reporting a break even position. The level of top up income had increased in month although the Covid expenditure was also the highest month so far at £3m. An accrual for junior doctor increased on call allowance had been built into the budget as had the cost of the aspirant nurses.

Other Covid spend included PPE and PPE stock. This expenditure would being to fall over the next few months.

Mrs Christmas asked about buying back junior doctor leave rather than have a number of doctors taking leave at once. Mr Evans advised that the Trust had no plans to buy back annual leave currently and was actively encouraging staff to take leave on a quarterly basis. Mr Bond added that in some cases a number of days would be carried forward.

Mr Robson asked what would happen if the Trust's spend was higher than the top up funding and whether there were plans in place to cover this. Mr Evans advised that it would depend on the cost base and if this increase and as yet the Trust did not know what the baseline would be.

Resolved:

The Trust received and accepted the report.

8.2 Statement of Financial Position – July 2020

Mr Evans presented the paper and advised that the PPE stock levels had reduced and that the debts over 90 days had also come down by £700k. Mr Robson stated that the trend analysis on the report was very useful.

Mrs Cope advised that at the end of September 2020 there would be greater clarity around funding priorities, winter, Covid and ED planning. She added

that a joint presentation detailing performance and finance delivery expectations would be useful for the Committee. Ms Ramsay stated that it would be useful for the whole Board to see the report and suggested it coming to Performance and Finance at the end of September and then to the Board Development the next day.

TC/LB

Resolved:
The Committee received and accepted the report.

8.3 NHS Finance and Planning Framework Update
Mr Bond advised that following receipt of the Phase 3 planning letter from the Centre, there was much more work to do.

8.4 Variable Pay Report
Mr Evans presented the report and advised that the pay costs were reduced compared to the previous year, but that this was due to the difficulty in getting agency staff during Covid. Also there had been less patients in the hospital so there had been less need for agency staff.

Mr Hall noted that there was a discrepancy between Emergency Care and bank staff and he asked if the staff redeployment had offset this. Mr Evans agreed to look into it and respond to Mr Hall. **SE**

Resolved:
The Committee received and accepted the report.

8.5 Procurement Strategy Update
Mr Bond presented the report and advised that an update had been given against each area of the strategy. Mr Curry asked if an executive summary could be received highlighting any risks or positive assurance.

Mr Bond agreed to provide a supplementary paper to the next meeting. **LB**

Resolved:
The Committee received and accepted the report.

8.6 Efficiency Update
Mr Bond updated the Committee and advised that the Carter efficiency group had not met since the beginning of the pandemic. He added that all productivity unit cost scores had been halted due to the current financial framework. There had not been any efficiency requirements in the first 6 months of the year due to the pandemic but this could change in the second part of the year. Mr Bond advised that the teams had not been tasked with making efficiency savings yet.

There was a discussion around ethics and reducing the waiting lists by removing any patients wanted rather than needed treatments. Mr Hall advised that the Ethical Prioritisation Policy Committee was meeting on Friday 28 August to discuss the Phase 3 recovery planning and any ethical decisions that might need to be made.

Mrs Cope advised that there were a number of approaches that could be made to prioritise patients differently but that technical guidance was significant as well as good practice from other Trusts.

Resolved:
The Committee received and accepted the report.

9 Performance

9.1 Performance Report

Mrs Cope presented the report and advised that ED performance was at 90% and there had been a 20% reduction in activity.

Mrs Cope reported that she was meeting with the Medical Directors on a monthly basis to discuss waiting times to see a doctor, the time taken to a decision to admit, speciality response and diagnostic response.

The Unplanned Care Delivery Group was reviewing benefits following the pandemic, such as the reduction in levels of delayed transfers due to partnership working, and how the Trust can keep up the level of good performance.

Mrs Cope advised that cancer performance was static and the 100 day patients was reducing. Endoscopy patients had been reviewed and re-evaluated and were waiting for diagnostics.

The RTT position was worsening with the number of patients waiting increasing. Work was ongoing with specialities to review lists, review inappropriate referrals and look at new ways of working to reduce the backlogs. Mrs Cope advised that Primary Care input was key to highlight different ways of working and identify opportunities.

Mrs Cope reported that the Health Groups had produced summaries of their workloads as baselines and the recovery planning and additional sessions would be monitored through the PANDA meetings.

Mr Hall queried the timing and inconsistency of some of the data presented in the report which related to June's performance (vs July) and stressed the importance of making sure the committee received consistent up to date information. **TC**

Mr Robson commented about the continuing development of the report and its usefulness but referred to the current report structure and the fact that commentary was sometimes elsewhere in the report from the graphical information which made it difficult to read. **TC**

Mrs Christmas asked about benchmarking and how the Trust compared to others in relation to performance standards. Mrs Cope agreed that benchmarking was important and advised that in the case of 52 week waits the Trust was at the bottom of the list against other Trusts.

Mr Hall asked for an update on the recent initiative led by the Chief Executive to manage ED performance using four key metrics. This information was not available for the meeting but a commitment was made to provide an update at the next PAF with an explanation of the metrics used together with progress. **TC**

Mr Hall asked about the meetings with the Medical Directors and the progress against the key metrics put into place. Mrs Cope advised that the

aim was to ensure that there was clinical engagement and there was an improved position regarding diagnostics and MRI/CT. Work was ongoing with ED to match the workload with the workforce and to share data between the Medical Directors.

Mrs Cope reported that diagnostics was a key focus area to review levels of activity and work with the Humber Coast and Vale to address the capacity issues and where possible involve Primary Care. Plans included extended sessions and additional scanning capacity, although workforce was an issue.

Mr Curry expressed his concern about the Phase 3 plan and how the Trust would bridge the performance gap that was expected. Mrs Cope advised that risks were being managed and services such as endoscopy were being prioritised for investment. The teams were planning to incorporate the increases in demand but clinical priority was the main focus.

The Committee discussed the high expectations that the Phase 3 letter set out and Mr Robson suggested that there should be a priority list of areas for the Committee and Board to focus on. Mrs Cope added that what was affordable and the resources available would be the main drivers. She added that there would be more clarity at the end of September as to which areas would be prioritised for investment.

Resolved:
The Committee received and accepted the report.

9.2 NECS PTL Diagnostic Report
Mrs Cope presented the PTL Diagnostic Report and advised that there has been a considerable change to the findings of the analysis on this report compared to that previously shared with the Trust. Where previously 5.7% of pathways were flagged as a validation priority this now stands at 30%.

NECS suspects that measures taken during the suspension of elective activity will have contributed to this. In particular; 7,654 incomplete pathways where the last appointment has an outcome of discharged and 3,490 where there is no outcome for the last appointment.

The NECS report detailed 3 pathways highlighting data that is technically wrong. The pathways were missing consultant code, direct to waiting list and decision to admit. This could mean a validation opportunity or could simply be an immaterial user error. Mrs Cope advised that the team was resubmitting the data to check.

Mrs Cope added that during the pandemic the Hubs were cancelling high volumes of activity, but were keeping abreast of validation and updating systems. There had been a number of admin staff absent from the Trust and the remainder of staff were in very pressurised situations. The Trust had developed a Business Intelligence report prior to this external work which identifies Validation Opportunities which covers most of the areas identified.

Resolved:
The Committee received and accepted the report.

10 Assurance and Governance

10.1 Capital Resource Allocation Committee Minutes

Ms Ramsay presented the minutes and advised that the Committee had discussed the Capital Programme and how the teams were working at pace. There were no year end risks highlighted to date.

Resolved:

The Committee received and accepted the report.

10.2 Review of Committee Effectiveness

Ms Ramsay reminded Committee members to return their effectiveness reviews so that the results could be discussed at the next meeting.

Resolved:

Committee members to return their questionnaires to Ms Ramsay before the next meeting.

10.3 Improvement Programme Update

Mrs Joyce presented the report and advised that the Hospital Improvement Programme (HIP) Team supported operational teams and the unplanned care programme, redesigned the clinical administration review and supported the GIRFT programme in 2019/20.

The team supported the improvement approach and continuous improvement culture and was aligned with the People and Trust strategies. During the pandemic the team had supported the control structures, the Communications Team, nursing and MDT recovery programmes.

Mr Robson commended the GIRFT process and the clinical engagement and suggested that the governance, deliverables and ideas could be lifted from it.

Mr Hall asked about the ICS system approach and did the team have shared working with other organisations. Mrs Joyce reported that the team supported the Unplanned Care Group and had a good network with a number of organisations.

Mr Bond stated that he had found the report very good but asked if there could be testimonies from service users to give tangible examples to the work the Team had carried out. Mrs Joyce agreed that it would be useful to have the testimonies and was keen to build in a patient strand to the programmes of work.

Resolved:

The Committee received and accepted the report.

10.4 Scan4Safety Update

Mrs Ellis presented the report to the Committee and advised that Scan4Safety was now live across 12 areas and that 100,000 procedures had been captured to date.

Mrs Ellis gave an example of a ventilator recall and how the system had flagged them and within an hour retrieved all of the relevant information. Done manually this could have taken 50 hours of nursing time.

Mrs Ellis advised that a report from GS1 recorded that the Trust was the only Trust not to be a demo site and that it was performing to best practice standards.

The Scan4Safety system had highlighted approximately £100k of sock due to expire in the next 12 weeks. It was clear that this was key information for stock planning and rotation.

Mr Bond advised that the programme was being resumed and rolled out to specialities but Covid had slowed the process.

There was a discussion around which areas would give the greatest benefit not just volume wise but also the most expensive items. Mrs Christmas asked how confident the team was with the accuracy of the data and Mrs Ellis advised that an audit was carried out a month after the 'go live' date. Peer reviews also provided robust checks.

Resolved:
The Committee received and accepted the report.

11 Any Other Business

11.1 Contract Extension paper for the provision of Clinical Waste Disposal

Ms Ramsay presented the report and advised that the Committee had already signed off the contract but that a contract novation was required due to a change of provider. She advised that the contract terms in place had not changed.

Resolved:
The Committee received and accepted the report.

12 Date and time of the next meeting:

Monday 28 September 2020, 1.30pm – 4pm

Hull University Teaching Hospitals NHS Trust

Trust Board

August 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: • Infection Prevention and Control • Serious Incidents • Incidents • Harm Free Care – Including Falls & Pressure Ulcers • Safeguarding • Mortality • Claims • CQC	
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:	This report provides information on key quality indicators. Exceptions are noted in more detail in the report in relation to: • Healthcare Associated Infections • Serious Incidents • Harm Free Care – Including Falls & Pressure Ulcers • Safeguarding • Mortality • Claims • CQC	
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. This report has been subject to review by the Quality Committee in August 2020.	

QUALITY REPORT

LEAD: Beverley Geary, Chief Nurse

PURPOSE OF THE REPORT

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

ITEMS FOR ESCALATION IN MONTH (July 2020)

Safe:

- The Trust has had no MRSA bacteria case in the financial year to date. During Q1, 12 Trust apportioned MSSA bacteraemia cases have been reported, this remains within threshold for the locally agreed CCG stretch target. A period of increased incidence of *Clostridium difficile* was detected on H80 with two cases reported during July 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
- There were five serious incidents declared in July 2020.
- 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 dementia patients.
- The Trust continues to report incidents in an open and honest manner. Of note in June there was an increase in moderate harm and above incidents. Following review, two Health Groups have seen specific increases that have led to the overall Trustwide increase. Surgery Health Group relates to Cat2 Pressure Ulcers and F&W Health Group relates to treatment delays for ophthalmology patients. These have begun to reduce once more in July.
- The Trust has had zero grade 4 or grade 3 pressure damage in July 2020

Effective:

- No areas for upward escalation

Caring:

- No areas for upward reporting

Responsive:

- No areas for upward escalation

Well-led:

- The Trust has undertaken a self-assessment against the NHSE Infection, Prevention and Control Board Assurance Framework. The CQC have reviewed the intelligence and have confirmed that the Trust has effective infection prevention and control measures in place in response to COVID and that the Trust continues to ensure that the health needs of patients and staff are met.

RISKS TO DELIVERY

- *None noted*

SAFE DOMAIN

HEALTHCARE ASSOCIATED INFECTIONS

AREAS FOR ESCALATION

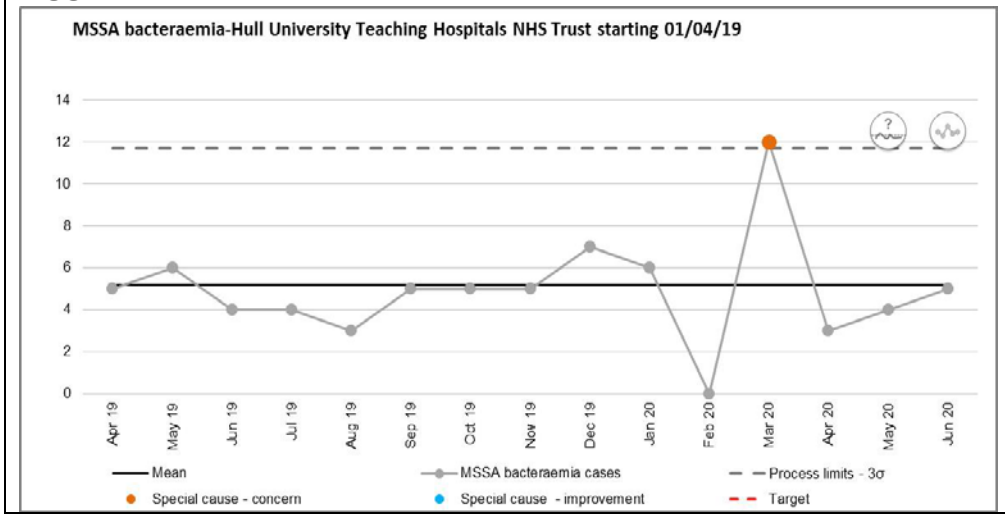
The Trust has had no MRSA bacteria case in the financial year to date. A community apportioned case was detected on the 22nd July 2020 and is under investigation. During Q1, 12 Trust apportioned MSSA bacteraemia cases have been reported, this remains within threshold for the locally agreed CCG stretch target. 13 C.difficile infections have been reported in Q1, this remains within the locally agreed threshold (*NB: national threshold are yet to be published for the year).* A period of increased incidence of *Clostridium difficile* was detected on H80 with two cases reported during July 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

KEY UPDATES IN MONTH

MRSA

No Trust apportioned MRSA bacteraemia cases were reported during Quarter 1, a community apportioned case was detected on the 22nd July 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.

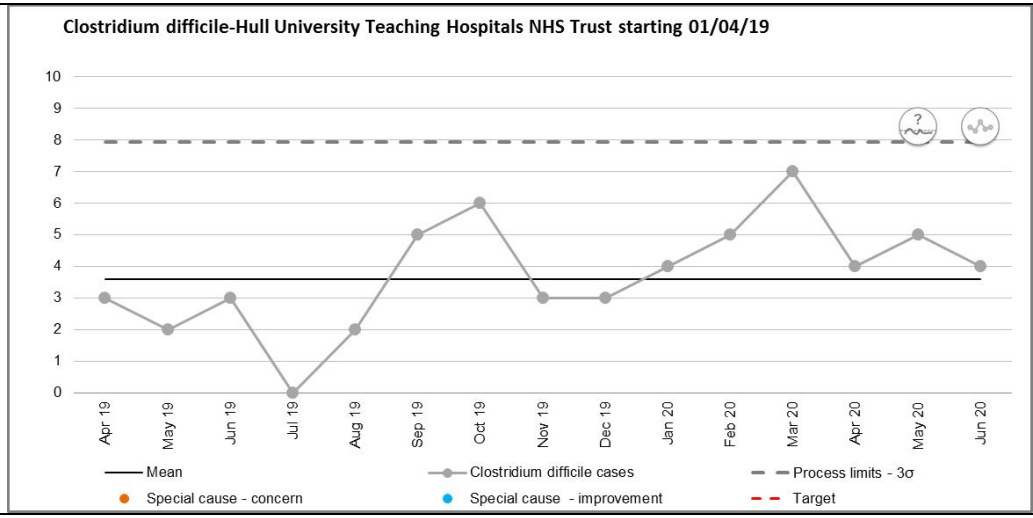
MSSA



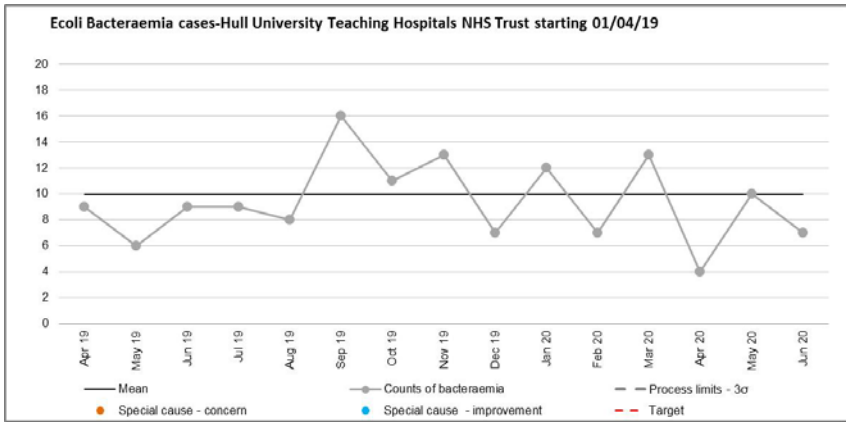
By end of Quarter 1, twelve Trust apportioned MSSA bacteraemia cases have been reported – a slight reduction in comparison to the same timeframe for Quarter 1 2019, twelve versus fifteen cases. All Trust apportioned cases are investigated using a root cause analysis (RCA) process. Early indications suggest 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.

Clostridium difficille

NHSI objective for 2019/20 for the Trust was 80 cases and due the COVID-19 pandemic an updated 2020/21 has not been published. Therefore, the Trust will endeavour to make month on month reductions. During Q1, a total of thirteen HOHA cases and 4 COHA cases have been reported and investigated via RCA processes. Outcomes of RCA note 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



E.coli



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.

RISKS TO DELIVERY

None noted

MSSA Bacteraemia	There have been no Trust apportioned MSSA bacteraemia cases reported during July 2020 which is encouraging. To date 13 Trust apportioned MSSA bacteraemia cases have been reported versus 19 cases for the same time period during 2019/20. These thirteen cases represent a mixture of causes including deep seated infections, skin and soft tissue infections, ventilator association pneumonia and also still some device related cases	Medicine Health Group - 7 cases Surgical Health Group - 5 cases Clinical Support Health Group - 0 cases Families & Women's Health Group - 1 case
***Clostridium Difficile* (*Clostridioides difficile*)**	During July 2020, 2 Hospital onset healthcare associated (HOHA) *Clostridium difficile* cases were reported along with 4 community onset healthcare associated cases (COHA). By the end of July 2020, there have been 15 HOHA cases reported and eight COHA cases, by comparison with 2019/20 the COHA number remain the same with 8 cases but a noted increase on HOHA cases with only 9 cases reported for the same time period during 2019/20.	HOHA cases: Medicine Health Group - 10 cases Surgical Health Group - 3 cases Clinical Support Health Group - 2 cases Families & Women's Health Group - 0 case
E.coli Bacteraemia	During July 2020, 9 Trust apportioned E.coli bacteraemia were reported. Since the 1st April 2020 until 31st July 2020, 29 Trust apportioned E.coli bacteraemia cases have been reported, versus 33 cases for the same time period during 2019/20, demonstrating a reduction in reported cases. The same trends and sources of infection continue to be identified, being biliary, urinary and respiratory.	Medicine Health Group – 11 cases Surgery Health Group – 12 cases Clinical Support Health Group – 4 cases Families & Women's Health Group – 2 cases
Klebsiella Bacteraemia	No Trust apportioned Klebsiella bacteraemia cases were reported during July 2020. Since the 1st April until 31st July 2020, 3 Trust apportioned Klebsiella bacteraemia cases have been reported, versus 13 cases for the same time period during 2019/20,	Medicine Health Group – 2 cases Surgery Health Group – 1 case Clinical Support Health Group – 0 cases Families & Women's Health Group – 0 cases
Pseudomonas aeruginosa Bacteraemia	1 Trust apportioned Pseudomonas aeruginosa bacteraemia case was Reported during July 2020. Since 1st April 2020 until 31st July 2020, 6 Trust apportioned Pseudomonas aeruginosa bacteraemia cases have been reported, versus 11 cases for the same time period during 2019/20, demonstrating a reduction in reported cases. Each case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required.	Medicine Health Group – 1 case Surgery Health Group - 4 cases Clinical Support Health Group - 1 case Families & Women's Health Group - 0 case

	Similar themes as noted above.	
Outbreaks / Incidents of Infection	No outbreaks of diarrhoea / vomiting have been reported during July 2020 A community apportioned Legionella case was detected on the 21st June 2020, the patient was admitted to H1 with community acquired pneumonia on the 17th June 2020, and Ward H1 had been closed 3 days prior to this and had reopened on the day the patient was admitted. An incident meeting was held with PHE investigating the case as a community acquired case due to the timing of illness and presentation to the Trust. The incident meeting provided the opportunity to review flushing regimes on H1 in light of the recent ward closure and undertake subsequent water sampling. This identified a significant problem with Legionella affecting the water supply, specifically hand wash basins and showers. In spite of hand wash basins, taps and showers being replaced, follow up water sampling still identified Legionella suggesting a systemic problem requiring extensive replacement plumbing to ward H1. The ward has therefore been closed since the 16th July 2020 whilst ongoing work is completed.	
Neonatal Intensive Care Unit (NICU)	No further issues related to Pseudomonas aeruginosa and HCAIs have been identified on NICU. Incident meetings are still held and twice weekly screening continues. During July 2020 all sinks were environmentally re-sampled on NICU with a high percentage still screening positive for Pseudomonas aeruginosa. Commencing in August 2020, now products are sourced, the unit will start to clean with TechCare once again to reduce the burden of contamination.	
COVID-19	During July 2020, 40 patients were screened for COVID-19; of these 33 were decision to admit screens and the remaining 7 patients were screened in OPDs and/or pre-assessment. 21 of the forty patients had previous positive screens from as early as April & May 2020, suggesting ongoing shedding of non-viable virus. All patients were managed appropriately and isolated as a precaution.	
Other relevant information	PHE HCAI Data Capture System have updated the site during July 2020 with all HCAIs (not just *C.difficile*) determined as follows: **Hospital onset healthcare associated (HOHA) -** cases that are detected in the hospital two or more days after admission sample taken after 48 hrs. following admission **Community onset healthcare associated (COHA) -** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks **Community onset indeterminate association (COIA) -** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks **Community onset community associated (COCA) -** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks. The reason for the change could be associated with the assessment of all HCAIs in particularly apportionment of cases to determine future thresholds, including Gram negative bloodstream infections (GNBSIs).	

SERIOUS INCIDENTS (Including Never Events)

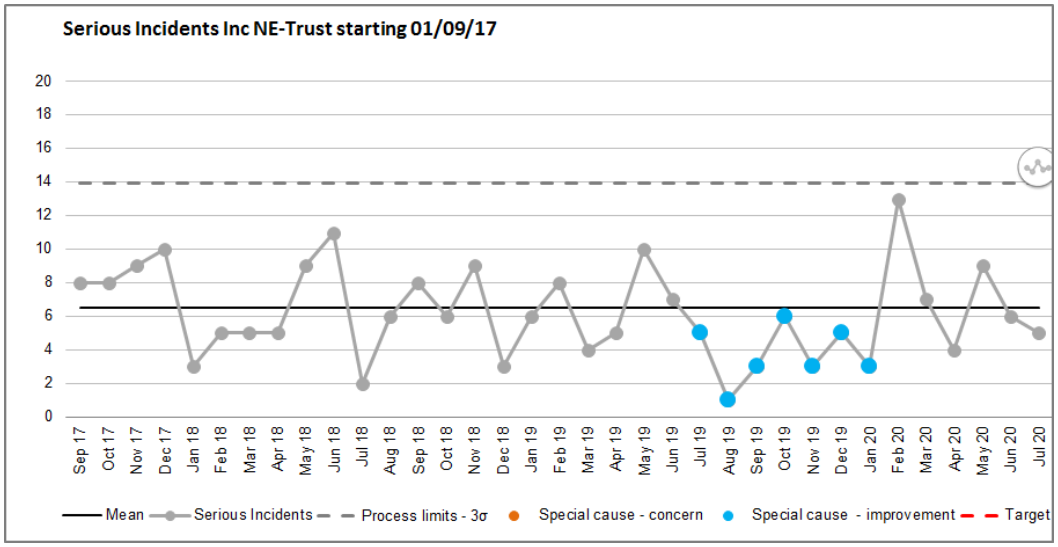
AREAS FOR ESCALATION

There were five serious incidents declared in July 2020.

The July 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.

In April of this year we declared 2 Never Events due to retained Robinson drains. Following investigation and a review these events have now been downgraded by commissioners as the incidents do not meet the threshold for reporting as Never Events. These will now be categorised as Serious Incidents.

KEY UPDATES IN MONTH



Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that result in moderate harm, server harm of death. It is a statutory requirement for the Trust to be open and transparent, ensuring patients / their families are informed about patient safety incidents that affect them receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences.

In July 2020 Zero Never Events were reported. 5 Serious Incidents were declared. The Duty of Candour process has been initiated in all cases.

They were: Medication Incident, An in patient fall, Medical Equipment/Device incident (partial finger amputation), Surgical/invasive procedure (a stylet) and a suspected self-inflicted

RISKS TO DELIVERY

None noted

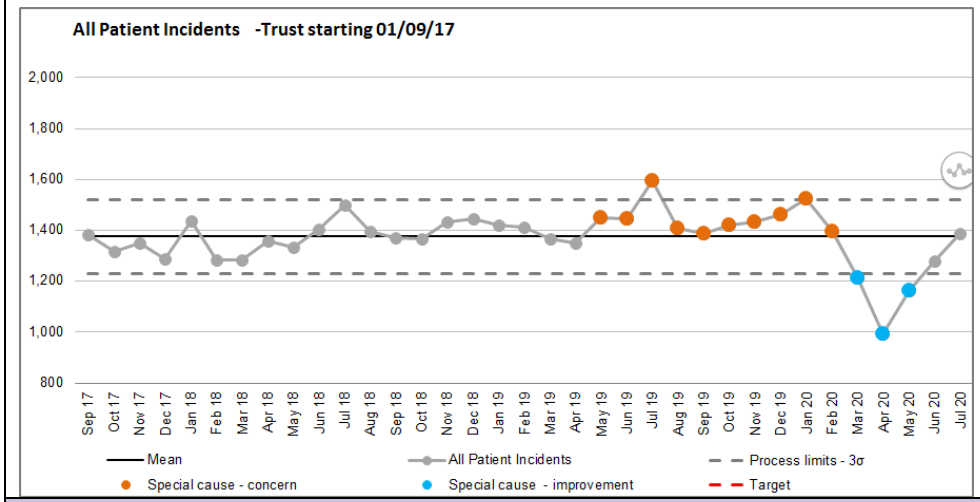
INCIDENT REPORTING RATES

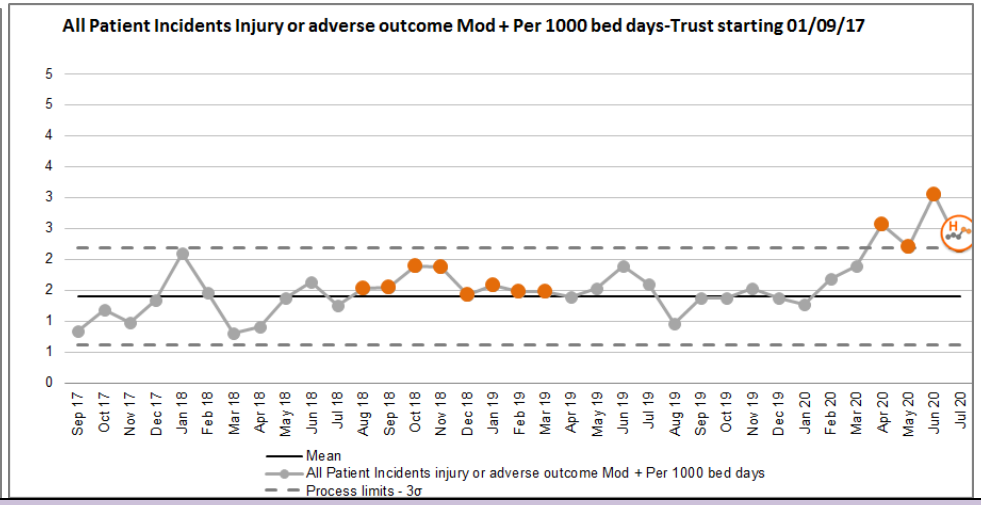
AREAS FOR ESCALATION

The Trust continues to report incidents in an open and honest manner. Of note in month is the increase in moderate harm and above incidents. Following review, two Health Groups have seen specific increases that have led to the overall Trustwide increase. Surgery Health Group relates to Cat2 Pressure Ulcers and F&W Health Group relates to treatment delays for ophthalmology patients.

KEY UPDATES IN MONTH

The Trust continues to report incidents in an open and honest manner. Of note in June was an increase in moderate harm and above incidents. Following review, two Health Groups have seen specific increases that have led to the overall Trustwide increase. Surgery Health Group has seen an increase in the number of Category 2 pressure ulcers acquired in hospital. This is currently being reviewed by the Health Group and further information will be provided in future reports. Family & Women's Health group has seen an increase in the number of Treatment and Care related incidents in Ophthalmology. These incidents relate to delays in patients with degenerative eye conditions receiving their planned / routine injections, as a result of measure put in place due to the Covid-19 pandemic. This has led to some loss in vision. As above, this is being reviewed and further information will be provided in future reports. The numbers in July have begun to reduce for moderate and above incidents.





RISKS TO DELIVERY

None noted

FALLS

AREAS FOR ESCALATION

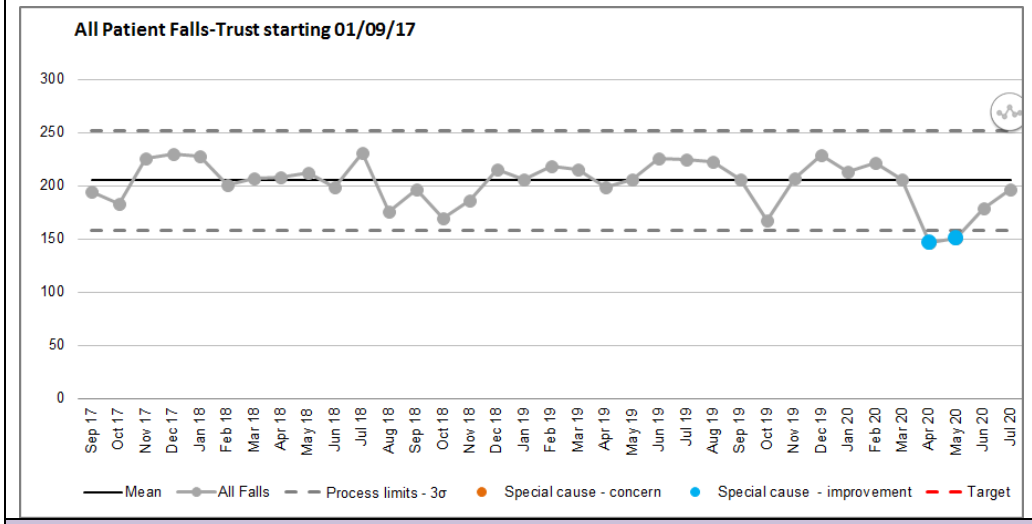
The Trust has seen a slight increase in falls overall in July 2020, however the Trust is seeing a decrease in the number of moderate and above falls per 1,000 bed days..

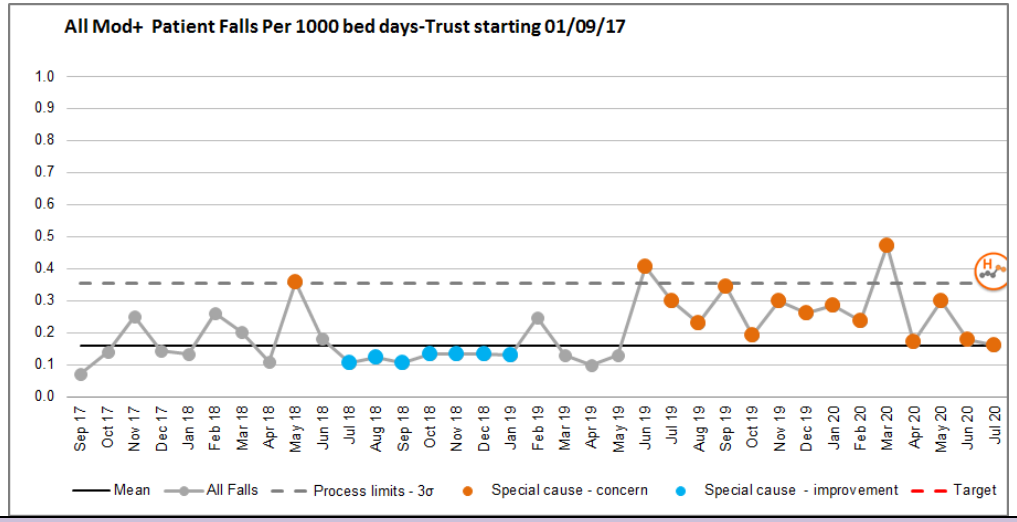
KEY UPDATES IN MONTH

The Trust has seen a slight increase in falls overall. In July 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 Group will focus on 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.

In addition a DME Falls QIP has been developed to seek to reduce the number of falls on DME Wards within the Trust.





RISKS TO DELIVERY

None noted

PRESSURE ULCERS

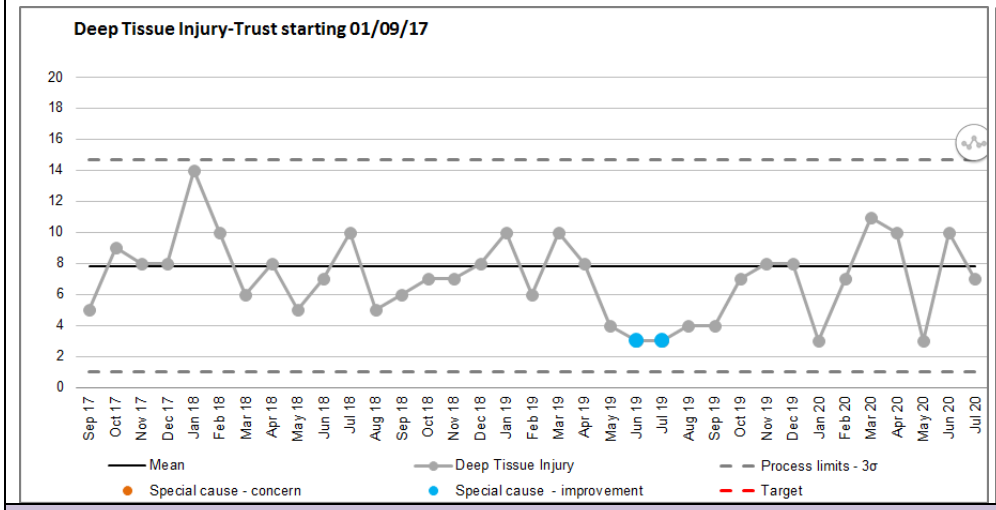
AREAS FOR ESCALATION

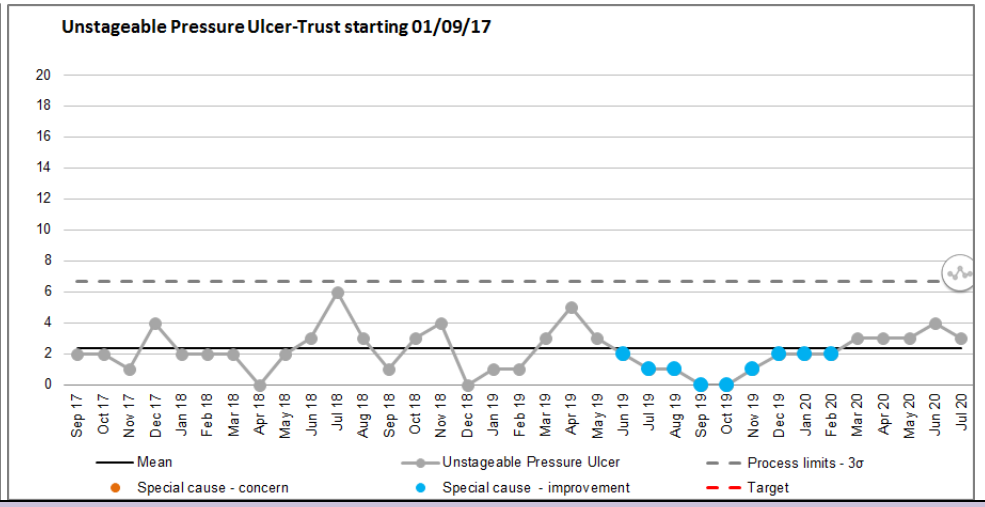
No areas for upward reporting

KEY UPDATES IN MONTH

The Trust continues to see pressure ulcers being reported as the highest number of incidents Trustwide. The Trust did see during April – June skin damage in Covid-19 patients with 18 reported in June 2020. Of the 18 reported pressure ulcers eleven occurred within Critical Care, six within Ear, Nose and Throat and one in Infectious Diseases. The main cause of pressure damage within Critical Care was a direct result from proning the patients for prolonged periods of time as part of their clinical care causing facial pressure damage from tubing placement. It was noted that the first patient safety incident reported by Critical Care regarding pressure damage, a chin support had been used which had inadvertently contributed to the pressure damage developing. Immediate learning was undertaken and chin supports were not used going forwards. It is of note however that in July the numbers had reduced to 1 device related pressure damage

The Trust has had zero grade 4 or grade 3 pressure damage in July 2020, 9 x Grade 2 (which is in line with the avergae number per month), 7 x DTIs (Deep Tissue Injures) (which is slighlty below the monthly average of 8) and 3 x Unstagable Pressure Damage (above the monthy average of 2).





RISKS TO DELIVERY

None noted

RESPONSIVE

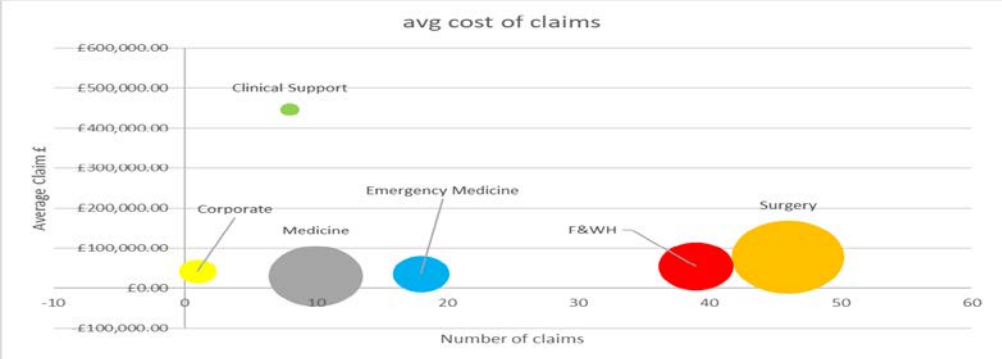
CLAIMS

AREAS FOR ESCALATION

There are no areas for escalation in month.

KEY UPDATES IN MONTH

The graph below shows a breakdown of the claims closed within the last financial year showing; volume, average cost of each claim and total cost by each Health Group:



Category	Claims	Payment value
Diagnosis	50%	53%
Poor Assessment of Clinical Condition	10%	14%
Delay in administration of medication	10%	9%
Lost to follow up	10%	8%
Failure to monitor	10%	8%
Documentation	10%	7%

Analysis of Top 10 Highest Value Settled Claims in 2019/2020

The Trust has 781 claims are currently open, as follows:

- 487 have not yet progressed beyond request for/disclosure of records.
- 43 claims have previously been settled and await formal closure.
- This leaves 251 claims actively being pursued.

The organisation saw a 12% increase in receipt of Letters Before Action with 279 received within the last financial year.

114 Letters of Claim were received and reported to the NHS Resolution in this last financial year, which is an almost static position, with only a minimal increase of <1% increase on the previous financial year.

123 clinical negligence claims closed within the last financial year. Total payments invested within these cases was £10,242,475 through the Trust's insurers. 44 cases were closed following repudiation.

RISKS TO DELIVERY

No identified risks to delivery.

WELL-LED
CARE QUALITY COMMISSION
AREAS FOR ESCALATION
There are no areas for escalation in month.
KEY UPDATES
Comprehensive Inspection The Trust has submitted the action plan to the CQC in response to the areas of improvement identified following the March 2020 inspection. This will be monitored on a monthly basis via the Health Group Performance and Accountability Meetings. A quarterly update will be provided to the Quality Committee for information and assurance. The quarterly report will be provided in October 2020. **CQC Pharmacist Engagement Meeting** As part of routine engagement activities the CQC have organised a CQC / Trust Pharmacy Engagement Meeting to take place with the Trust's Chief Pharmacist on Monday 10 August 2020. Feedback will be provided following this meeting. **CQC Trust Engagement Meeting** As part of routine engagement activities the Trust Engagement Meeting is held with the Trust's CQC Inspection Manager and Inspector approximately every 6 weeks. The next engagement meeting is scheduled for Thursday 13 August 2020. This will be attended by the Chief Nurse, Chief Medical Officer, Acting Deputy Director of Quality Governance and the Compliance Team Manager. Feedback will be provided following this meeting. **NHS England and NHS Improvement Infection Prevention and Control Board Assurance Framework** The CQC agreed that they would gather information from Trusts to assess the take up and use of the board assurance document contained within the new Infection, Prevention and Control guidance and assurance tool published by NHSE. The Trust was required to complete a self-assessment against the board assurance framework of all infection control practices since the pandemic was declared. The CQC has reviewed the evidence and intelligence provided by the Trust and have confirmed that the Trust has effective infection prevention and control measures in place. The CQC stated that appropriate systems in place include having prompt identification of people within the organisation who have, or are at risk of developing an infection. Appropriate isolation facilities and cohorting areas have been established for patients across the Trust. Staff have received, and continue to receive necessary training, in line with national guidance and are updated accordingly. The Trust continues to provide information for carers and the wider public through their website and social media. The Trust continues to ensure that the health needs of staff are met. This is a supportive and holistic approach which considers both the physical and psychological needs of staff. All care workers, including volunteers and external contractors, are given sufficient information to ensure they are aware of, and discharge their responsibilities in preventing and controlling infection. The Trust has a system of escalation in relation to PPE should difficulties arise, which staff can access throughout the 24-hour period, seven days a week.
RISKS TO DELIVERY
There are no risks to delivery.

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Quality Committee

Meeting Date:	24 August 2020	**Chair:**	Martin Veysey	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Quality Impact of CRES process was still in place but to date had no schemes had been identified.
- The Board Assurance Framework was presented.
- Getting it Right First Time update was received
- Medicines Beyond the Trust presentation was received
- Quality report including Serious Incidents and Claims was received. A Community acquired legionella case had been reported.
- An update was received regarding the new proposals for CQC inspections. Inspections were to be risk based in the future.
- Delay of colposcopy and the possible impact on borderline/mild dyskaryosis report was received which highlighted the extra clinics in place to mitigate the risks.

Key decisions made:

Risk and assurance matters to be received by the Board:

- Legionella had been found on the ward of the patient with the disease, but the Director of Public Health was investigating the case as community acquired and had advised it was an incidental finding.

Matters to be escalated to the Board:

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 27 July 2020

Present:	Prof M Veysey	Chair
	Mr S Hall	Vice-Chair
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
	Mrs T Cope	Chief Operating Officer
	Mrs M Stern	Patient Representative
In Attendance:	Mrs V Shaw	Clinical Audit Manager (Items 5.3 and 5.4)
	Mr T Brookes	Lead Chaplain (Item 5.5)
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mrs L Jackson, Associate Non-Executive Director, Mrs K Southgate, Deputy Director of Clinical Governance and Assurance, Prof U Macleod, Non-Executive Director	
2	**Declarations of Interest** There were no declarations of interest received.	

The agenda was taken out of order at this point

5.3 Clinical Audit

Mrs Shaw presented the Clinical Audit Annual Report and advised that 75% of all audits had been completed in the year. The top 3 themes (both negative and positive), based on clinical audit results were compliance with relevant guidance/pathway, documentation and diagnostics. The themes were being discussed at Health Group governance meetings.

The Trust had taken part in all relevant national audits except once and a summary of the results and actions plan was reported via the CEPPD Committee.

Prof Veysey asked if the teams were being proactive when commissioning audits and whether they were linked to quality improvement requirements. Mrs Shaw advised that serious incidents, patient safety incidents, governance issues arising and the corporate risk registers were all used to inform audits. Prof Veysey asked if the links could be included in the next report. **VS**

Prof Veysey asked about patient/service user input into the audits and Mrs Geary advised that she was reviewing patient involvement with NHS I/E.

Dr Purva advised that more work was to be done regarding Quality Improvement projects using the Quality Management methodology.

Mr Corral commended Mrs Shaw on the progress in the Clinical Audit department, monitoring and scrutinising the audits and escalating issues to

the Operational Quality Committee.

Prov Veysey added that the audits provided quality assurance and could result in new ways of working being implemented and procedures tightened up. The key was to include patients and demonstrate learning as part of the process.

Resolved:
The Committee received and accepted the report.

5.4 NICE Guidance Report
Mrs Shaw presented the report and advised that the Trust was fully compliant with the exception of:-
TAG583 Ertugliflozin with metformin and a dipeptidyl peptidase-4 inhibitor for treating type 2 diabetes. Alternative therapies are currently prescribed, as this drug does not have safety data available yet

IPG666 - Reducing the risk of transmission of Creutzfeldt–Jakob disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues - Ophthalmology are fully compliant and Neurosurgery have an action plan in place to work towards compliance. This is on the risk register.

IPG665 Balloon dilation for chronic eustachian tube dysfunction – this is to be discussed at a future ENT meeting

Aspirational work was ongoing with the Quality standards with 9 guidelines in progress. There were a small number of non-compliance and the teams were working through the issues.

The Trust was fully compliant with nearly all of the Covid-19 guidance recently published. Ms Ramsay congratulated the team on the sheer amount of work that had been achieved in a short amount of time which gave positive assurance to the Committee.

Prof Veysey noted that the Trust was more compliant last year than the year before which was another positive step.

Mr Hall asked what 'partially compliant' meant and Mrs Shaw advised that it meant that there were a number of standards within the standard and until each one was completed, the overarching standard could not be classed as compliant, but work was well underway.

Prov Veysey asked how the Trust compared to other Trusts and Mrs Shaw advised that although the team attended the Yorkshire Regional Meeting there were no shared results available yet.

Resolved:
The Committee received and accepted the report.

3 3.1 Minutes of the last meeting held 29 June 2020
Item 5.3 CQC Report – last paragraph – Mrs Geary advised that the CQC had identified a number of practice areas in the Neurology Service that were outstanding.
Following this alteration the minutes were approved as an accurate record of the meeting.

3.2 Matters Arising
There were no matters arising from the minutes.

3.3 Action Tracker
The Committee reviewed the action tracker. Items were either closed or for the August 2020 meeting.

3.4 Any Other Matters Arising
There were no other matters arising.

3.5 Workplan 2020/21
Ms Ramsay advised that the workplan had been updated and a read across other Committee workplans had taken place. National timings that had been delayed due to Covid had been taken into account for items such as the Quality Accounts.

3.6 Board Assurance Framework
Ms Ramsay presented the report and advised that the July Trust Board had signed off the BAF following the Board development session in June 2020.

Mr Ramsay advised that the Committee would be mainly monitoring BAF 3 quality of care, BAF 4 performance linked to harm and BAF 6 Research and Innovation.

Discussion around the Trust's activity, whether patients were being harmed due to long waits for procedures, mortality information and research would ensure assurance or highlight gaps in assurance or any escalation to the Board.

There was a discussion around the CQC action plan and whether it should have its own BAF risk. Mrs Geary advised that the action plan was monitored by the local risk registers and the QIP but any high level risks would be highlighted in the BAF.

Resolved:
The Committee received and accepted the report.

4.1 Trustwide Learning Report
Mrs Geary presented the report which included performance details for falls, pressure ulcers, misinterpretations of Cardiotocography (CTG) and wrong attribution of Pneumonia as main cause of death. The report included the actions taken and next steps to reduce the errors.

Mrs Geary advised that a Governance Learning Group was to be established to analyse the data and to drive quality improvements.

Dr Purva added that the Trust had been an outlier for pneumonia deaths but this was down to the cause of death not being recorded accurately on all occasions. The Medical Examiners now in place would ensure that the correct diagnosis was given. Causes of deaths was also monitored at the Mortality Committee.
There was a discussion around patient falls and whether they happened more frequently at weekends and Mrs Geary advised that they happened more frequently at night when patients were disorientated. She added that

there were less physiotherapists and occupational therapists on a weekend and Mrs Green reported that the therapy teams were assessing patients and providing e-Learning packages to clinical staff to make the wards as safe as possible. Mrs Geary added that there was a Quality Improvement Programme around dementia and delirium to address the issues.

Resolved:
The Committee received and accepted the report.

4.2 Trustwide Learning Annual Report
This item was removed from the agenda as it was in draft and had not been scrutinised by the Operational Quality Committee.

4.3 Lessons Shared Bulletin
The bulletin was shared for information. Prof Veysey asked if the document was shared with the public and Mrs Geary advised that information was shared on the ward information boards in such forms as 'You said, We did'.

5.5 Chaplaincy Annual report
Mr Brookes presented the report and advised that the Chaplaincy Team offered religion, reflective practice and support to patients, carers and staff.

The Team had worked differently during the pandemic and offering a 24 hour/365 day service had been challenging. Mr Brookes stated that the service was not only a religious one, but was spiritual and holistic to provide hope, meaning and purpose to patients, carers and staff.

Mr Brookes advised that the team worked informally with other Trusts but the main areas of work were stand alone adapting to local need. Prof Veysey asked if all patients were informed of the service and Mr Brookes advised that generally nurses informed patients and were working with teams to improve understanding.

The Committee discussed reflective clinical and spiritual programmes (Swartz Rounds) and the added value they could bring to organisations. Mr Brookes added that more promotion of the service was required and Mrs Geary advised that nursing teams had cards and posters on wards to highlight the service. The training and financing of introducing Swartz Rounds was discussed and Mrs Green advised that they were put in place to reduce stress and sickness absence and this could be offset against the costs. Prof Veysey added that the Quality Committee would support any Swartz Round programme development.

Resolved:
The Committee received and accepted the report.

4.5 World Health Organisation Checklist – SSIPS
Dr Purva advised that 42 audits had been completed and many improvements made. Most of the audits were now electronic and generally 100% compliant, but there was still work to do in some areas.

Feedback from the audits suggested that teams were no longer using the checklist as a tick box exercise, but were being used constructively with any issues being highlighted.

There was a discussion around audits that were still paper based and Dr Purva advised that she was working to ensure that all audits were electronic in the future.

Resolved:
The Committee received and accepted the report.

5.1 Quality Report
Mrs Geary reported that the document had been received at the Trust Board in July 2020.

Resolved:
The committee received and accepted the report.

5.2 – CQC Update
Mrs Geary presented the report and advised that a detailed action plan had been submitted in June to address the issues raised by the CQC. Each Health Group had their own plan and would be monitored at the Performance and Accountability meetings. Regular updates would be presented to the Committee.

The Committee discussed RAG ratings but Mrs Geary advised that a comments column had been added instead, any issues would be escalated and progress monitored. Prof Veysey was keen to see a responsible officer for each action on the plan but Mrs Geary advised that job titles would be used rather than names.

Mrs Geary advised that quarterly updates would be received by the Committee but would escalate any urgent matters to the Committee if necessary. Mrs Geary added that the Trust and the CQC met monthly to discuss progress on the action plan.

Resolved:
The Committee received and accepted the report.

5.6 Annual Committee Report On Effectiveness
Ms Ramsay asked Committee members to complete the questionnaires and return to her within the next 2 weeks to gain views on how effectively the Committee was working.

Resolved:
The Committee received and accepted the report.

5.7 Ethical Clinical Policy Prioritisation Committee
Ms Ramsay advised that the Committee had agreed the Care Decision Framework which would be triggered when the trust was running out of inpatient capacity and patients would be clinically prioritised. The Committee's next role was to monitor the recovery and restoration phase of services to ensure any ethical decisions were supported.

Mr Hall added that the Care Decision Framework would be used as reference should a future need arise, especially in the restoration phase as this could be more difficult than the pandemic itself.

Resolved:
The Committee received and accepted the update.

6 Any Other Business

6.1 Operational Quality Committee Summary
Dr Purva presented the summary and highlighted the scrutiny of the policy relating to victims of domestic abuse that was approved by the Operational Quality Committee.

Resolved:
The Committee received and accepted the report.

6.2 Non-Clinical Quality Committee Escalation (by exception only)
Ms Ramsay advised that at the last meeting there had been a thorough review of the Corporate Risk Register particularly reviewing risks around infrastructure and the capital plan. Ms Ramsay added that the Committee had discussed the staff that had been redeployed returning to their original areas and ensuring mandatory training was being completed.

Resolved:
The Committee received and accepted the report.

Mrs Geary advised that she had met with the CQC last week to discuss Infection Prevention and the Board Assurance Framework and action plan relating to it. The CQC were meeting with all providers organisations to discuss Infection prevention and control. The reason was to capture any immediate risks to patients as well as themes regionally and nationally.

Mrs Geary advised that an action plan had been submitted to the CQC relating to the Trusts lack of capacity for isolation for paediatrics. Mrs Geary agreed to share the feedback at the next committee.

Mr Hall asked if Ms Ramsay could develop a document to show committees and groups set up to address phase 2 of the pandemic and the restoration stage. Ms Ramsay agreed to prepare this and circulate to the Committee. **CR**

7 Chairman's Summary to the Board
The Chair agreed to summarise the meeting at the next Board meeting in September 2020.

8 Date and time of the next meeting:
Monday 24 August 2020, 10am – 12pm by Webex

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 24 August 2020

Present:	Prof M Veysey	Chair
	Mr S Hall	Vice-Chair
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr D Corral	Chief Pharmacist
	Mrs A Green	Lead Clinical Research Therapist
	Mrs L Jackson	Associate Non-Executive Director
	Mrs M Stern	Patient Representative
In Attendance:	Dr S Achawal	Associate Chief Medical Officer
	Dr S Fan	Clinical Fellow Patient Experience
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Prof U Macleod, Non-Executive Director, Mrs T Cope, Chief Operating Officer, Mrs K Southgate, Deputy Director of Clinical Governance and Assurance	
2	**Declarations of Interest** There were no declarations of interest received.	
3	**Minutes** **3.1 Minutes of the meeting held 27 July 2020** Item 5.5 – Mrs Green corrected the spelling of Schwartz for the minutes. Following this alteration the minutes were approved as an accurate record of the meeting.	
	3.2 Matters Arising There were no matters arising from the minutes.	
	3.3 Action Tracker Updates would be received for complaints and PALS and Infection Control at the next meeting.	**BG**
	3.4 Any Other Matters Arising There were no other matters arising.	
	3.5 Workplan Ms Ramsay presented the workplan and advised that there had not been any changes from the previous month. The Committee discussed CRES and Ms Ramsay advised that there had been no CRES targets set for the first 6 months of the year and that an update should be programmed onto the workplan for November 2020. Mrs Geary added that the Quality Impact of CRES process was still in place but to date had no schemes had been identified.	

3.6 Board Assurance Framework
Ms Ramsay presented the report and advised that the Board had agreed the 2020/21 BAF and it had been updated following the first round of Board Committees. Focus was given to positive assurance and gaps in assurance. Ms Ramsay advised that the Board was focussing mainly on BAF 4 (performance) and the impact during the Covid recovery phase and also alignment with the Integrated Care System.

Ms Ramsay would present the quarter 1 recommended risk ratings to the Board in September but as yet there were no dramatic changes to report.

Ms Ramsay reported that BAF 7.3 and the level of capital improvements planned would have an impact on the Trust's ability to deliver high quality care.

Mrs Green asked if there was sufficient assurance relating to BAF 3 and patient experience due to the changed ways of working, specifically around video conferencing in outpatients. She added that the Family and Friends questionnaires collection would be hampered due to the low numbers of patients in the hospital. Mrs Geary advised that the Patient Experience Team were reviewing patient feedback regarding video conferencing and were also reviewing patients with mental health needs following a near miss safeguarding alert.

Mr Hall asked about system working and how this would impact BAF 3. Ms Ramsay advised that the Trust had received a Phase 3 recovery letter from NHS I/E that had emphasis on system working. Prof Veysey asked about GP/CCG partnerships and how the Trust gained assurance that patients were being cared for outside of the hospital setting. Dr Purva advised that she was working with the Primary Care Collaborative Group who were reviewing the metrics around non-Covid harm. Dr Purva added that she was meeting with specialities' clinical leads along with the Chief Operating Officer to review issues with diagnostics and follow up appointments. Primary Care needs were being identified and the 4 CCGS lead by Emma Latimer and Stephen Eames were also working to ensure services on both the South and North banks were delivering appropriate, harm free care.

Resolved:
The Committee received and accepted the report.

4 Increase the rate of harm-free care each year
4.1 Medicines Beyond the Trust
Mr Corral gave the presentation that highlighted medication issues, technological advancements, workforce issues, Primary Care involvement and communication with patients.

Mr Corral reported that there were a number of committee's working to standardise procedures for patients both at the Hospital and at in the Community. Committees in place included the Medication Committee, Hull and East Riding Pharmaceutical Committee, Medicines Management Interface Group and the Regional Medicines Optimisation Committee.

Mr Corral spoke of 'Hospital only drugs' and how errors occurred when prescribing discharge medications due to poor communication with GPs, 3 way checks not completed and care homes not having the correct information.

Following an SI around Vitamin D prescribing and the patient being prescribed too much there were plans in place to trial different ways to improve reminder labels, have joint rotational posts and pharmacist prescribers in place.

Other areas of improvement included patients registering with Homecare who delivered drugs to the patient's home which was freeing up clinics, working towards the Model Hospital standards, IT solutions and closer working with NLAG and the ICS.

Dr Purva suggested that any specific issues could be presented to the Area Prescribing Committee led by Emma Latimer, looking at prescribing during the recovery phase. Mrs Stern advised that she frequently received complaints from patients who were confused about their medication and the difference between hospital prescribing and GP prescribing. Also that patients were sent home with lots of medication that was not needed.

Resolved:
The Committee received and accepted the report.

4.2 GIRFT Update Report
Mr Achawal, Consultant Neurosurgeon and Associate Chief Medical Officer updated the Committee regarding the GIRFT programme. He highlighted the Pathology visit and how the action plan was being shared between Hull and York Hospitals.

He reported that Pathology was a large service and a deep dive had been undertaken in areas such as Anaemia and Microbiology to ensure that testing was carried out in the most effective and efficient way.

Mr Achawal advised that there was a GIRFT visit planned for Paediatrics and Orthopaedics in September 2020.

The GIRFT programme work had slowed during the pandemic but with the advancing technology the programme was being re-established.

There was a discussion around ED testing and the testing turnaround time should there be a second surge of Covid-19. Mr Achawal advised that clinical engagement was key.

Resolved:
The Committee received and accepted the report.

5 Reports received for assurance

5.1 Quality Report (Including Serious Incidents and Claims)
Mrs Geary presented the report and advised that there had been no MRSA Bacteraemia this financial year and 12 MSSA cases which was a reduction on last year's figures. Mrs Geary advised that the fewer cases was probably due to reduced number of patients in the hospital. C Difficile was also within the threshold.

Mrs Geary advised that there had been a community acquired legionella case in June 2020. Following this the water was sampled on the ward and legionella had been found. Extensive work was carried out to ensure the plumbing was changed.

Mrs Jackson asked if finding legionella on the ward was coincidental, and Mrs Geary advised that the Director of Public Health was investigating the case as community acquired and it was an incidental finding. Prof Veysey asked if other wards had been checked and Mrs Geary advised that it was being monitored through the Water Safety Committee.

Mrs Geary advised that the 2 Never Events declared in April 2020 had been downgraded and were now being investigated as serious incidents.

In July 2020 5 serious incidents had been declared which included a patient fall, a category 4 pressure ulcer and a failed medical device. The investigations were ongoing.

The Committee discussed the Ophthalmology waiting list and whether patients would come to harm with the long delays. Mrs Geary agreed to provide further information to the next meeting. **BG**

5.1.1 CQC IPC Assessment
Mrs Geary presented the report which the CQC had asked all provider organisations to complete as part of an Infection Prevention and Control assessment. The document was a Board Assurance Framework and was not mandated.

Mrs Geary also advised that the CQC's new approach to inspections and monitoring would be based on risk. As a result of this the planned programme of inspections would not go ahead. The CQC were also reviewing how they would assess organisations for well-led and use of resources.

There was a discussion around how the CQC would know if a Trust had improved if the inspections were only going to be risk based in the future. Mrs Geary advised that this was a national issue and that there were still many unanswered questions around the new ways of working.

Resolved:
The Committee received and accepted the report.

5.2 Clinical Assurance of CRES
This item was discussed in item 3.5.

6 Any other business
6.1 Operational Quality Committee Summary
The summary was received for information and there were no issues raised.

6.2 Non-Clinical Quality Committee Escalation (by exception only)
Ms Ramsay reported that the Committee had discussed the risks to the Capital programme and how the £50m funding was being allocated. Ms Ramsay advised that a major part of the programme was the IT Network upgrade which was due to finish this year and would enable new digital ways of working, which would impact positively on quality of care.

6.3 Ethical Clinical Prioritisation Committee Update
Mr Hall reported that the core team was meeting on Friday 28th August 2020 to discuss the next steps and the Phase 3 planning implications. Mr Hall agreed to update the Committee in September 2020. **SH**

6.4 Review of Committee Effectiveness
Ms Ramsay reminded Committee members to complete the effectiveness reviews to enable her to analyse the results.

6.5 Non-Covid: Delay of colposcopy and the possible impact on borderline/mild dyskaryosis
Dr Fan presented the report and advised that the Gynae team was reviewing the low smear uptake and the communications to patients to ensure screenings took place.

Dr Fan advised that there were around 3,200 new cervical cancer cases in the UK every year with 98.8% of cervical cancer in the UK being preventable. Around a quarter of cervical cancer cases in England are detected by screening and the screening uptake is approximately 70-74%. The role of screening is to allow for earlier detection and screening.

Uptake has improved since the continual campaign 'Smear no Fear' led by the HUTH colposcopy team, and this addresses underlying anxiety with women engaging with the service.

As borderline/mild dyskaryosis have been postponed, the service wanted to evaluate the potential impact this may have on patients who have borderline/mild dyskaryosis and what the colposcopy team can do to minimise their risk caused by COVID.

Assessing risks by reviewing all patients who were referred to colposcopy clinic in Feb-April 2019. This baseline data to be used in comparison with the second cohort of patients which is the COVID impacted patients in 2020 (Feb – April 2020) in the second arm of the study. The service chose 2019 data to provide baseline data of possible significant disease. The data is provided by the national smear result data base and with the use of Lorenzo, the smear test results were analysed with colposcopy finding and histology.

The second objective is assessing the psychological impact the delay has on our patients with borderline/mild dyskaryosis.

From the results, it was found that around 50% of our patient in 2020 cohort who are having their colposcopy clinic postponed with borderline/mild dyskaryosis will have CIN 1-3 diagnosed during colposcopy and about 50% of these patients will need LLETZ treatment to prevent their CIN progressing to cancer.

All women who have had their colposcopy delayed, have had a letter by the colposcopy lead explaining the reason for delay and to reassure them their appointment would be re-appointed as soon as it is safe to proceed. All women were given a number to contact if they have any concerns or worries to speak to our colposcopy nurse.

A ‘Psychological Impact Questionnaire on Colposcopy during Covid’ (PIQCC) was designed and utilised (please see appendix for the questionnaires) to assess the impact on the patients who have had their appointments delayed during COVID.

This study has identified the prevalence of significant disease amongst our local cohort of patients referred to colposcopy clinic with borderline/mild dyskaryotic cervical smears.

Intervention has been put in place in order to mitigate risks in the immediate period following COVID and supported by extra clinics in the recovery phase. The benefit of the extra intervention has been shown to be positive from our PIQCC results.

There was a discussion around clinical priorities and whether the community could be doing more to help. The Committee also discussed the delays in treatment and the impact on patient’s mental health. Ms Ramsay added that the delays were also causing distress to staff who were worried about treating patients and the growing waiting lists and back log.

Resolved:
The Committee received and accepted the report.

7 Chairman’s Summary to the Board
The Chair agreed to summarise the meeting at the next Board meeting.

8 Date and time of the next meeting:
Monday 28 September 2020, 9am – 11pm by Webex

Hull University Teaching Hospitals NHS Trust

Trust Board

8th September 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 post Covid-19 pandemic 1st wave.	
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 3.46%. Staff absence is currently 6.10% including maternity and Covid-19 related. The Trust has plans in place for WRES, WDES and the staff flu vaccination programme for 20/21 and staff wellbeing and support arrangements continue to work well, but some will cease on 13th September, 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

8th September 2020

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues post Covid-19 pandemic 1st wave.

2. Background

The Trust has for the past two months been putting in place plans to restore and resume clinical activity, as per NHSE/I 3rd Phase guidance. Only staff deemed to be extremely medically vulnerable are currently redeployed to a Covid-secure area.

Communication across the Trust continues to be vital to keep staff informed and engaged every step of the way and therefore the regular briefing on clinical and workforce matters continue which are well received by staff. The Trust also continues to request that all staff clinical and non-clinical practise social distancing, wear face masks where appropriate and adhere to good hygiene measures to ensure staff and patients are as safe as possible.

3. Key Issues

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 115 staff absent due to Covid-19 which is 1.16% of the workforce. Total absence including maternity leave and all other reasons for absence is 6.10%. This is a reduction from 7.58% as at the last Board meeting (14th July, 2020).

Staff absence usually runs at 3.6%, so whilst absence is reducing the Trust is still 2.5% above its norm which means available workforce is a key challenge to resuming services.

On a positive note, 143 staff that were shielding during the pandemic have now returned 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 31st August, 2020, 3474 staff have been tested. 3020 (87%) have tested negative and 454 (13%) 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 8,159 staff have been tested for antibodies with 13.9% showing positive that the staff member is likely to have had coronavirus and have anti-bodies within their symptom.

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 85 staff to self-isolate as a result of a 'contact' within their workplace. Only 7 staff have been instructed to self-isolate since the last Board meeting on 14th July, 2020.

5. Staff Vacancies

The Trusts overall vacancy position as at 31st July, 2020 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Vacancies WTE	Vacancy Rate %
Healthcare Scientists	333.32	281.0	52.32	15.70%
Medical & Dental - Consultants	486.84	441.70	45.15	9.27%
Medical & Dental - SAS	64.69	51.04	13.65	21.10%
Medical & Dental – Trainee Grades	638.84	631.23	7.71	1.19%
NHS Infrastructure	2055.48	1983.06	72.42	3.52
Other Scientific Staff	277.42	294.54	-16.12	-5.81%
Other Support to clinical staff	702.81	694.20	8.61	1.23%
Registered AHP	496.65	464.25	32.40	6.52%
Registered Nursing	2428.86	2159.44	269.42	9%
Unregistered Nursing	802.35	1000.95	-198.60	-24.75%
Trust Total	8287.26	8000.39	286.87	3.46%

Overall the Trust vacancy position is 3.46% and is 5.57% in Medical & Dental. Consultant vacancy rate is 9.27% but including locum, casual and agency staff, the vacancy rate is 6.19%. Whilst our vacancy position remains in a healthy position the Trusts recruitment plans have been somewhat interrupted, but as we come out of the 1st wave plans are being reviewed and will be driven hard.

Registered Nurse and Midwifery

The vacancy rate for Registered Nursing and Midwifery is currently 9% across the Organisation. However, the wards currently have a vacancy rate of 13%, ICU 10% and ED 16%. The Trust is currently pursuing 107 adult branch nurses and 4 paediatric 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. A 'Let's Get Started' induction programme is currently being finalised to support the students transition to becoming registered nurses. The registered nurse vacancy will reduce to 5% when the aspirant nurses are confirmed in role.

There are currently 64 Trainee Nurse Associates (TNA) in training with the Trust with a further 5 to commence the programme in September, 2020. The September, 2018 cohort (10 in total) are due to complete their course in October, 2020 following completion of their end point assessment.

The Trust has 21 Student Nurse Apprentices in training with a further 12 commencing the programme in September, 2020. In addition, the first cohort of Health Care Support Worker apprentices successfully completed their programme and have moved on to the TNA or Nurse Apprentice programme or taken up a non-registered posts within the Trust.

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. Those remaining 20 now have plans to travel to the UK in September and October. The Trust is also seeking to recruit a further 31 overseas nurses (21 Medicine and 10 Theatres) subject to funding being confirmed. In addition, the Trust has identified 10 overseas staff who currently work in non-registered posts who will be developed to become registered nurses this calendar year.

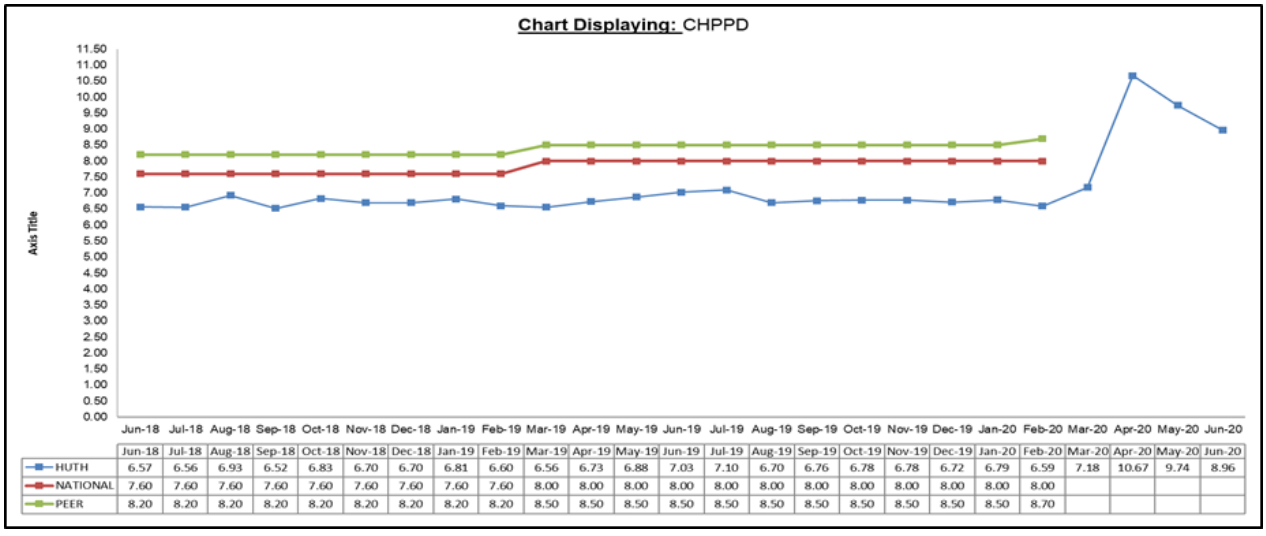
6. Developing Workforce Standards

A new People Strategy performance report has been developed and was presented to the Workforce Education and Culture Committee on 20th August, 2020. It covers, at a high level, progress against the Trust's People Strategy 2019/22. The report specifically covers staff vacancies, permanent, agency and bank spend, staff retention and tenure of leavers, Consultant job plans, future workforce plans and challenges, Trust culture and staff engagement, sickness absence, appraisal, mandatory training with key narrative. Over coming months the report will be reviewed and refined to ensure it gives assurance on staffing that the Board currently receive on registered nursing and midwifery.

7. Care Hours per Patient Days

Care Hours Per Patient Day (CHPPD)

As illustrated below the CHPPD for June is 8.96. This has reduced from 9.74 from the previous month. The CHPPD remains significantly higher in comparison to previous months. Analysis suggests this is due to a reduction in the volume of patients seen in the Trust and additional staff in place during 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	Jun-20
HUTH	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	8.96
NATIONAL	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00				
PEER	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.70				

8. Workforce Race Equality Standard (WRES)

The Trust has submitted its annual WRES data this month as required by the Equality and Diversity Council and NHS England. 13.24% of staff identify as BAME and 1.4% of staff have not declared their ethnicity. The Trust has made progress over the past 12 months with the BAME leadership event held in October, 2020, appointment of a new Chair and Deputy Chairs, re-energised the network, relaunched leadership development including 'compassionate and inclusive leadership'. The Trust also had six staff shortlisted for National BAME awards of which two staff went on to win Clinical Champion of the Year and Groundbreaking Researcher. Trust Executives also met with the BAME network fortnightly during the pandemic and implemented several initiatives to listen, support and help staff. The action plan developed by the BAME leadership network for 2020/21 has been approved by the Workforce Education and Culture Committee. In addition, the Trust Chair in partnership with ICS acute hospitals has also initiated a development programme for BAME people to become NHS Non-Executive Directors.

9. Workforce Disability Equality Standard (WDES)

The Trust has submitted its annual WDES data this month as required by the Equality and Diversity Council and NHS England. 2.19% of staff have self-declared as disabled and from ESR records the Trust has 36.63% of staff that have not declared themselves as disabled or non-disabled. The Trust has made progress over the past 12 months in some of the 10 indicators but there remains work to be done to close the gap in workplace experience between disabled and non-disabled staff to ensure our disabled staff do feel this Trust provides them with equal opportunities. The action plan for 2020/21 has been approved by the Workforce, Education and

Culture Committee. The Trust is investing in a full-time equality post to work with HR, managers, staff and external agencies to drive change, for HUTH to become an inclusive employer.

10. Staff Flu Campaign

In 2019/20 the Trust vaccinated 83% of frontline staff. NHSE/I target was 80%. This year NHSE/I have not set a target, but have made it clear that all staff should be offered a vaccination. The Trusts flu campaign for 20/21 has already commenced with specific communications to staff to bust those long held myths. The Trust has agreed an action plan and has received 7,500 vaccines for staff. The vaccination programme will start in October and staff will be able to receive the vaccine until the 31st March, 2021. The action plan includes volunteer vaccinators being recruited from each clinical area to administer the vaccine, 'drop in' clinics being held in dining rooms for non-clinical staff (strict adherence to social distancing) and attending Occupational Health.

With the prevalence of Covid-19 within our communities the flu vaccine is extremely important to protect staff and patients from influenza. The Trust will continue to incentivise staff to have the flu vaccine by offering 1 day annual leave in return.

11. 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.

As the Trust returns to normal activity the Psychosocial support provided by our Psychological Services, Pastoral and Spiritual Care, Occupational Health and Organisational Development (OD)Teams remains in place and the Trust is seeking to recruit to a full-time Psychologist post specifically for staff care and support.

From March, the Trust provided free meals, childcare, accommodation and car parking. However, with children returning to school full-time after the summer holidays the free childcare places will cease on Sunday 13th September. At this time free meals and accommodation will also end. Free car parking will continue until further notice. Staff have been informed. Staff have known for some time these arrangements would need to come to an end as the pandemic 1st wave has come to an end.

12. Covid-19 Staff Survey

The Trust has conducted a lessons learned review of the Trusts response to the pandemic. Almost 1,000 staff completed the survey. Over 65% of those felt that the whole HUTH response to the pandemic had been effective while only 3% strongly disagreed.

Top five areas that went well:

32% Communication (regular updates from gold and silver command)
20% Operational management (hospital configuration, staff redeployment, discharge of patients)
11% Team working (culture of compassion, integrated working, valuing staff)
9% Staff Support/Benefits (meals, childcare, accommodation, parking, psychosocial support)
9% PPE (well organised roll out)

Top five areas that could have been better:

20% PPE (non Covid areas slow to receive PPE)
17% Mask wearing (should have been mandated earlier)
13% Operational management (as above)
12% Social distancing (should have been enforced earlier and more rigorously)
9% Protocols and guidance (changed too often)

Top five improvements which should remain in place:

24% Fexible/homeworking

19% Virtual clinics
11% Free car parking
9% Video conferencing
9% Visitor restrictions

The report has been discussed and recommendations made at Workforce Transformation Committee and Workforce Education and Culture Committee.

13. Conclusion

As the Trust returns to its new norm, recruitment plans will be reviewed and relaunched. The WRES and WDES action plans are innovative and exciting and will bring about change and improvement. The staff flu vaccination plan is robust and will achieve its goal. The Trust has learned valuable lessons from the pandemic first wave and will be ready for a second wave.

As we progress toward winter the major workforce concern is a Covid-19 second wave. 1% staff absence represents 80 WTE staff not being at work. A further wave coupled with flu could mean up to 10% staff absence which represents 800 WTE not being at work (worst case scenario, based upon planning assumptions). This, together with pressure on hospital beds could mean significant challenges for the Trust.

14. Recommendations

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

Officer to contact:

Simon Nearney
Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Workforce, Education and Culture Committee

Meeting Date:	20 August 2020	**Chair:**	Una Macleod	**Quorate (Y/N)**	**N**

Key items discussed where actions initiated:

- Medical Undergraduate Progress Report – Work is ongoing to ensure simulation training went ahead at the University facilities. A Quality Manager post to work between the Trust and the University to be created.
- Great Leaders and Great Leaders Bite-size programmes to be re-started virtually.
- Remuneration Committee to review succession planning proposals.
- Apprentice Schemes back on track after the pandemic
- Virtual classrooms to be developed to ensure staff received relevant training
- Nursing and Midwifery staffing report was presented and action plans were in place to reduce the number of vacancies.
- Covid-19 staff feedback – flexible home working, virtual meetings and good communications had been the key areas of good practice.
- A presentation was received regarding employee relations cases.
- Health and Safety Annual Report was received
- Occupational Health Annual Report was received
- Workforce Race Equality Standard report was received – BAME recruitment and career opportunities and a deep dive into the Bullying and Harassment Policy was discussed
- Workforce Disability Equality Standard – Equalities Officer post to be established
- People Strategy Update was received – post Covid absence, mandatory training and appraisals were discussed.
- Flu vaccination report – 2021 would be more difficult due to Covid and social distancing, but the team had plans in place to address.

Key decisions made:

Risk and assurance matters to be received by the Board:

- Change in pension tax rules have eliminated the pension issues.

Matters to be escalated to the Board:

Hull University Teaching Hospitals NHS Trust
Workforce Education and Culture Committee
Held on 8 July 2020

Present:	Prof U Macleod	Chair
	Mr S Nearney	Director of Workforce and OD
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Miss H Cattermole	Director of Medical Education
	Mrs L Vere	Head of Organisational Development
In Attendance:	Mr R Horner	ESC Manager (Item 7.4)
	Ms R Fitzmaurice	Guardian of Safe Working Medical Staffing Analyst (Item 7.4)
	Mr J Robson	ESC Manager (Item 7.4)
	Mrs R Thompson	Corporate Affairs Manager

No	Item	Action
1	**Apologies for Absence:** Apologies were received from Prof. M Veysey, Non-Executive Director	
2	**Declarations of Interest** There were no declarations of interest received.	
3	**Minutes of the meeting held 28 February 2020** Item 11.2 – Apprenticeship Leadership Report - Miss Cattermole advised that the medical leadership apprenticeships were still being developed and not yet in place. Following this alteration the minutes were approved as an accurate record of the meeting.	
4	**Action Tracker** Mrs Vere advised that there was no feedback from the Leadership Programme as it had been put on hold due to Covid-19.	
5	**Workplan Priorities 2020/21** Ms Ramsay reported that she had reviewed and updated the Workplan to take into account the revised national changes to items such as the Modern Slavery statement and the updated version would be presented to the Committee at the next meeting. Prof Macleod stated that the Committee should be discussing Equality and Diversity more especially in light of the Black Lives movement. Mr Nearney advised that lots of work was being done around the BAME staff and was being covered by Board as well as WECC. The Committee discussed a review of the Terms of Reference at the end of the year to ensure that they were current and relevant.	

7 Recruitment and Retention

7.1 Job Vacancy Report

Mr Nearney presented the report which highlighted the number of vacancies the Trust was holding. He reported that additional work was ongoing with North Lincolnshire and Goole NHS Foundation Trust (NLAG) in relation to vacancies and recruitment.
The Trust was also working with the college in Pakistan and had recruited 48 5th year medical students to help with the Covid pandemic.

Mr Nearney reported that the Trust was expecting 19 nurses from the Philippines over the next 3 months and that the Nurse Associate and Apprentice programmes were in place and well established.

There were challenges in some services such as Speech Therapy and Dietetics and the Trust was working collaboratively with York and NLAG to recruit to these difficult posts.

Mr Nearney informed the Committee of the staff absence rate which was at 4.62%. During lock down this had reached 12.5% but was now continuing to decrease.

Ms Ramsay advised that areas of high vacancy rates, such as therapies had added the risk to their risk registers and managing the risks accordingly. Colleagues were engaging positively and new roles were being created where possible. Clear plans were in place to mitigate the high risk areas.

Mrs Geary added that the Nursing workforce was in a positive position with a low vacancy rate. The high risk areas were in the Medical Health Group and in particular Medical Elderly. She added that the overseas programme had been delayed due to Covid and there were risks going into Winter.

Dr Purva spoke of consultant vacancies and advised that it was a dynamic picture. She reported that the ICU department was operating at the bare minimum but were grateful for what they had. The Trust was working with the overseas sponsorship body to get highly trained doctors on a fellowship programme which meant that the turnaround was much faster. The doctors were not at consultant level but being in post would address some key speciality vacancies.

Miss Cattermole added that she felt the Junior Doctor establishment was not where it should be and needed reviewing. Dr Purva advised that it was difficult to identify what the ideal number of doctors should be as it depended on local requirements and demands. She added that the effort required would be massive and many service pathways were changing due to Covid. Dr Purva stated that it would be useful to focus on a small area to start to identify what resources were required. It was agreed that the discussion would be continued outside of the meeting.

Resolved:
The Committee received and accepted the report.

The Agenda was taken out of order at this point

7.4 Guardian of Safe Working Report
Mr Horner presented the quarterly reports which highlighted doctor exception reports up until 31st March 2020. He reported that the exception reporting tended to increase in August/September when the doctors changed roles. He added that there were no issues to escalate.

Mr Robson advised that the trainee establishment fill rates and rota establishments for 2020/21 had seen a slight decrease from 94 to 93% and this would be reviewed regularly.

Miss Cattermole added that there was nothing significant to report from a Medical Education perspective other than she expected to get more reporting. Miss Cattermole added that more work was needed to improve the time taken to resolve the reports with a few areas being worse than others. She also highlighted that some Junior Doctors were reluctant to put in exception reports due to a fear of the consequences.

Mr Horner also presented the Annual Report for 2019/20 and advised that the number of doctors in post was 88.16%. The Trust was due to have more trainees this year as well as being the lead employer for Junior Doctors working in GP surgeries. The report also highlighted the hard to fill posts, which had contributed to the unfilled gaps as well as a summary of the exception reports.

Fines had been introduced in December 2019 for areas were exception reports were received relating to unsafe rotas. The fines were put into place to encourage departments to meet their responsibilities.

The Junior Doctor's Forum was working well and enhancements have been made such as creating restrooms and purchasing sofas etc. Mr Horner advised that doctors were engaged and enthusiastic and that members of the Committee would be welcome to attend a Junior Doctor's Forum.

There was more work to be done around e-Rostering to enable the team to review the working patterns.

Resolved:
The Committee received and accepted the reports.

The Agenda returned to order at this point

Variable Pay Report
Mr Nearney presented the report which highlighted the Trust's spending on variable pay including; agency, bank and overtime payments.

The Trust was reporting a spend of £5m on variable pay which was lower than last year. NHS I/E regulations stated that the Trust should not spend any more than £9m per year.

Mr Nearney advised that the May 2020 figures were artificial due to the Covid pandemic as costs in surgery and theatres were also supporting the Medicine Health Group. Very little elective activity had happened since lock down and Emergency Care had seen 100 staff redeployed to them,

although departments were now starting their recovery planning.

Resolved:
The Committee received and accepted the report.

8 Communication, Engagement and Recognition

8.1 Freedom to Speak up Report

Ms Ramsay tabled the report and advised that it would also be presented at the Trust Board next week due to the timings.

Ms Ramsay explained that the Freedom to Speak Up Guardian had been established after the second Francis Report and the issues around staff not feeling supported to raise concerns.

Ms Ramsay advised that there had been 29 members of staff who had raised issues and the main theme was around staff behaviours. This could be behaviours with peers or line managers. Ms Ramsay stated that her role was a support role and more about help to broker conversations between staff.

During the Covid pandemic staff had mainly put their issues on hold but there had been issues raised relating to staff not social distancing and sending out poor messages and not protecting the NHS name. There had been no issues raised relating to PPE.

The National Guardians Office regularly send out briefings relating to good practice and how to support vulnerable staff. Ms Ramsay advised that as part of her role she was supporting the BAME network which was also supported by Mr Nearney and Mr Long.

Mr Nearney advised the BAME network had met recently and had been a positive and constructive meeting. He added that staff still did not feel comfortable in speaking up. The Trust was looking for ways to work differently to encourage staff to speak up.

Ms Ramsay also mentioned the Organisational Development Team and the Education Team as support and developing networks. Prof Macleod stated that it was important to have a joined up approach between the University and the Trust around any students who reported racism or misogyny. Dr Purva added that more BAME staff needed to be appointed into management roles and concerns taken seriously to regain the momentum. She advised that the Trust was in a far worse position 5 years ago.

Prof Macleod asked about the mechanism for dealing with bulling behaviours and Ms Ramsay advised that the Trust had a Bullying and Harassment Policy with clear steps on the disciplinary process.

Resolved:
The Committee received and accepted the report.

9 Health and Wellbeing

9.1 Staff Wellbeing and Support during Covid-19

Mrs Vere presented the report and advised that she had chaired the Bronze Command for staff support during the Covid pandemic. She reported that a multidisciplinary team had been established with the Psychology Team and the Chaplaincy Team to help support staff who had been deployed or staff struggling with the situation.

Guidance proposed by the British Psychology Society was implemented and a telephone line and drop-in centres set up. There was concern around people burning out and wobble rooms were put into place to help staff take time out.

A number of themes were identified such as anxiety, stress, mental health conditions and low mood linked to access to information and re-deployment. The drop-in centres helped to identify lonely, older, divorced staff who needed extra support. The support teams also worked with ICU staff on the front-line.

Mrs Vere reported that there had been some tensions between professions regarding support to staff but that the Trust would be taking a multidisciplinary approach and use the processes put into place during the Covid pandemic. Bronze command would be continued to identify areas that needed support.

Miss Cattermole asked what the uptake of doctors in training was in using the service and Mrs Vere advised that the data was very high level so would need to find out the specific numbers. There had been a good uptake amongst nurses and allied health professionals.

Prof Macleod suggested that a framework be developed and any issues tracked and monitored.

Resolved:

The Committee received and accepted the report.

10 Innovation, Learning and Continuous Improvement

10.1 Medical Education Progress Report

Miss Cattermole presented the report and wanted to thank the Junior Doctors during the Covid pandemic stating that they had got on with the difficult jobs allocated to them with professionalism and flexibility.
Miss Cattermole advised that once training had been halted due to Covid the Medical Education team started the deployment process, backfilling posts and delivering clinical upskilling were necessary. Posts would not be fully re-deployed until August and the Trust was accepting another 250 new doctors also in August.

Miss Cattermole expressed her concern regarding the Medical Education Technical Team becoming a Trust technical team due to the wider use of Video Conferencing as she thought this would disadvantage the Medical Education Team.

The GMC Survey had been cancelled although there would be a voluntary survey published in the summer. The National Education and Training Survey had produced poor data quality due to the current situation.

The Junior Doctor forum had been very active during the Covid pandemic and multiple meetings were called due to the many changes in the Rotas.

Miss Cattermole was keen that the Medical Education Department was involved in the command structures in the future as this would be beneficial to communicate with the Junior Doctors.

Miss Cattermole highlighted the appendix relating to workforce issues around Junior Doctor establishments and advised that work was ongoing managing Job Descriptions and e-Rostering.

Prof Macleod asked about the FY1s and if there was any feedback. Miss Cattermole advised that there was no feedback as yet, but they were enthusiastic and keen to learn. Out of the 48, 20 were staying with the Trust and the remainder were going to work elsewhere.

Miss Cattermole was developing an extended shadowing period and stated that two weeks would be better than one.

Prof Macleod advised that the Junior Doctors would have to catch up and that the Universities had moved them up into the next year. She added that the Trust appreciated how hard and professionally the students had worked throughout the pandemic.

Resolved:
The Committee received and accepted the report.

11 Any Other Business
Prof Macleod requested that future reports be a maximum of 6 sides, focussing on the key issues.

12 Date and time of the next meeting:
Thursday 20th August 2020, 13.00 – 15.00 (Webex)

Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee
Held on 20 August 2020

Present:	Prof U Macleod	Chair
	Mr S Nearney	Director of Workforce and OD
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
	Mrs L Vere	Head of Organisational Development
	Mr M Howell	Director of Communications
	Mr D Bovill	Safety Manager
	Mrs L Harding	Head of Workforce
	Mrs H Knowles	Head of Corporate HR
In Attendance:	Ms C Precious	Medical Education Manager
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies for Absence** Apologies were received for Prof M Veysey, Non-Executive Director and Miss H Cattermole, Director of Medical Education	
2	**Declarations of Interest** There were no declarations received.	
3	**Minutes of the last meeting held 8 July 2020** The minutes were approved as an accurate record of the meeting. **Post meeting note:** Mrs Geary requested that the minute relating to the Job Vacancy report should read, "Mrs Geary added that the Nursing workforce was in a fairly positive position".	
4	**Matters Arising** There were no matters arising from the minutes.	
5	**Action Tracking List** The workplan had been updated. The Leadership update was an agenda item and to be removed from the tracker.	
6	**Workplan** The updated workplan was presented to the Committee. It was agreed that the Medical Undergraduate Progress Report would be received more regularly than annually and this was to be updated on the workplan.	**RT**

The agenda was taken out of order at this point

10 Innovation, Learning and Continuous Improvement

10.1 Medical Undergraduate Progress Report

Dr Purva presented the report and advised that it covered activity up to the end of July 2020. An overview of the challenges relating to Covid had been highlighted and how the recovery period would look in the future.

Educational requirements and how risks would be managed at the front line were being reviewed.

Dr Purva spoke of the new Allam Centre at the University and how this simulation facility would take students away from the front line and the Covid challenges.

A new Quality Manager post had been created to work with students to ensure all quality issues were addressed. Prof Macleod stated that the post holder should be working closely with the University teams also.

Resolved:
The Committee received and accepted the report.

10.2 Leadership Update

Mrs Vere presented the update and advised that due to the number of staff redeployed during the pandemic there had been little leadership coaching activity taking place.

Mrs Vere advised that the Remarkable and wider cultural transformation programmes such as Great Leaders would be re-started by October 2020. The current cohorts that had been paused due to Covid were now being completed.

Other programmes such as Great Leaders bitesize, Rise and Shine and Supervisors Plus would be back on line by the end of the calendar year and would be held in a virtual format.

Resolved:
The Committee received and accepted the report.

10.3 Talent Management Update

Mrs Vere presented the paper and advised that a paper was due to be presented at the Remuneration Committee to review succession planning at director and senior management levels. Staff had fed back that there was a lack of career progression within the Trust. Work was ongoing to ensure the BAME network and other areas felt included and progress was shared with staff.

Resolved:
The Committee received and accepted the report.

10.4 Non-Medical Education Report

Mr Nearney presented the report and highlighted 3 key areas. The first was the apprenticeship schemes which were now back on track after the pandemic. Mr Nearney advised that the Trust had a £5m budget for apprenticeships and that they were not only administration based but that there were more clinically facing schemes in areas such as nursing and therapies.

Mr Nearney also highlighted the way that the Trust had started using the virtual classroom as the online training platform and how well this was working. The Trust was using a new initiative called "The Big Blue Button" which meant that students dial into a classroom environment. He reported that 40 trained educators within the Trust were ready to start training staff.

Mr Nearney also reported that MedShed TV was being launched in the Autumn along with Health and Social Care partners and would include programmes, lectures and Q&A sessions for students to access.

Prof Macleod asked about horizon scanning for the future workforce and Mr Nearney advised that the Workforce and Trust plans included horizon scanning. Mrs Geary added that she was working with the University to review the nursing workforce and a Workforce Board was being established. Prof Macleod asked if more details around this could be added to a future agenda. **BG**

Resolved:
The Committee received and accepted the report.

The agenda returned to order at this point

7 Recruitment and Retention

7.1 Variable Pay Report

Mr Nearney presented the report to the Committee. It was agreed that the report was focussed on the financial aspect and that it should be presented to the Performance and Finance Committee instead. Ms Ramsay added that the financial content should be presented to the Performance and Finance Committee but the workforce elements would need to be presented to this Committee but in a different way.

Resolved:
The Committee received the report and agreed that it would be presented at the Performance and Finance Committee in the future.

7.2 Nursing and Midwifery Staffing Report

Mrs Geary presented the report which highlighted Care Hours Per Patient Day and nursing vacancies. She advised that Nurse vacancies were at 9% and work was ongoing to address areas such as ED and ICU and plans were in place.

Mrs Geary advised that the international recruitment was back on track after the pandemic and there were a number of nurses due to qualify in September. She gave assurance that robust plans were in place to reduce the number of vacancies.

Mrs Geary reported that a paper was being presented to the Performance and Finance Committee with regards to the nurses that had been deployed during the pandemic and the future forecasting of the nursing workforce.

Mrs Geary added that the Trust was reviewing risks from a quality perspective to ensure that any high risk areas were highlighted and action plans put into place.

Mr Nearney commended the nursing workforce plan for its detail and robustness. He added that this was testament to the nursing teams.

Resolved:
The Committee received and accepted the report.

7.3 Pension Update

Mr Nearney presented the update and advised that although a number of mainly consultants had been caught out last year the Government had changed the tax rules which had eliminated the issues. He added that the Trust had kept its local scheme allowing consultants to opt out should they want to. A review of the situation would be taken in the next financial year.

Resolved:
The Committee received and accepted the report.

8 Communication, Engagement and Recognition

8.1 Covid-19 Staff Feedback

Mr Howell updated the Committee regarding a post pandemic survey sent to all staff asking if there had been anything the Trust did well, could have done better or if there had been any improvements made that should remain.

Mr Howell advised that flexible home working had got a positive response as staff felt that they were safe, had better work/life balance and were more productive. Video conferencing had been rolled out by IT and many staff thought it more flexible and a more effective way to have meetings.

Virtual clinics for patients had been seen as positive both from the patients perspective and also the consultants. It was easier to set up appointments and there was no issues around parking or travelling to the hospital. It was also easier for staff to set up the meetings and respond quickly and even older patients were embracing the technology.

The other area that staff had given positive feedback was around communications from the Trust during the pandemic and keeping staff up to date with Covid issues. Staff also felt valued as the Trust had offered support in areas such as free parking, free lunches and free childcare.

Resolved:
The Committee received and accepted the report.

8.2 Employee Relations Progress Report

Mrs Harding gave a presentation that highlighted the annual review of Employee Relations cases. The report covered 2019 and the first 6 months of 2020.

Mrs Harding highlighted centralising the HR Advisory Service, the policy refresh, the introduction of accepted responsibility and learning lessons.

There had been an increase in supporting and managing attendance cases and the highest percentage of these were in Estates and Medicine Health Groups. The average length of time cases took was 52 days and work was ongoing to reduce this number, although the complexity of cases usually meant that timescales were longer. The highest number of cases were

disciplinary cases and 60 of these had an outcome of accepted responsibility which was better for staff and the organisation.

Mrs Harding gave the demographics for the staff most likely to be involved in an employee relations case and these were; Estates or ED staff, Band 2 staff, men and staff aged between 50-60.

Mrs Harding advised that the teams were working with Health Groups to ensure managers were keeping in touch with their staff, the discipline policy was embedded, staff attended conflict resolution courses and self-managed any issues.

Mrs Harding reported that during the pandemic the HR teams worked very differently and some staff were redeployed into other departments and others worked from home. Different ways of managing cases were put into place such as video conferencing where this was appropriate.

The next steps were to review the disciplinary, bullying and harassment and grievance policies to incorporate any new ways of working.

Dr Purva thanked the HR service and the teams for their work during the pandemic and for chasing individuals to ensure cases were dealt with efficiently. Any issues with hearings being held up would be escalated to Dr Purva.

Resolved:
The Committee received and accepted the report.

8.3 Trade Union Facility

Mrs Knowles presented the item which highlighted the facility time and percentage of the pay bill given to Trade Union Representatives.

Mrs Knowles reported that the representatives gave healthy challenge to the teams and there was a good working partnership. The area to work on was around efficiently and accurately recording both time spent and information relating to cases. Ms Ramsay declared an interest as she was a paid Union Representative. Ms Ramsay agreed with Mrs Knowles that there was a good working relationship between the Trust and the Unions. She added that perceptions of bias towards her being a senior manager within the Trust were becoming less.

There had been issues during the pandemic as staff had to prioritise their clinical roles as priority over Trade Union issues.

Resolved:
The Committee received and accepted the report.

9 Health and Wellbeing

9.1 Health and Safety Annual Report

Mr Bovill presented the report and advised that the Trust was performing well against its KPIs and had a good relationship with HSE.
There had been 10 Riddor reportable incidents in the past year which was the lowest the Trust had ever reported. There had also been decreases in slips, trips and falls and needle stick injuries. Claims against the Trust was down at 10 from 14 in the previous year.

Mr Bovill advised that the Trust had increased the number of link staff available as well as moving and handling trainers.

Key areas of safety management focus in 2019/20 included working at height and slips, trips and falls prevention. In the area of manual handling, additional training is also now being provided on induction, increasing practical knowledge and skills for new starters.

Resolved:
The Committee received and accepted the report.

9.2 Occupational Health Annual Report

Mr Nearney presented the report and advised that the Trust had retained its national accreditation and that it had retained it for some years now.

Mr Nearney spoke of the work of the Occupational Health Team and how they had carried out 4000 medical assessments, had given personal counselling and offered a referral service for muscle skeletal issues.

The Trust had been in the top 10 of all Trusts for its Flu vaccination figures. The flu vaccination campaign planning for 20/21 was underway and would be adapted due to Covid restrictions.

Mrs Vere added that the Organisational Development Team worked closely with the Occupational Health Team and was impressed with the staff support they offered.

Resolved:
The Committee received and accepted the report.

11 Equality, Inclusion and Diversity

11.1 Workforce Race Equality Standard

Mrs Knowles presented the report and advised that the information regarding the performance information presented had been a National requirement since 2015.

The BAME network had been established and the membership was growing. Mrs Knowles reported that 13.24% of staff identify as BAME and the network was reviewing recruitment selection and career opportunities for BAME staff.

Work was ongoing with the OD Team to review CPD, bullying and harassment and discrimination issues. A deep dive into the bullying and harassment policy was being undertaken.

Mrs Knowles advised that the report would be published on the Trust's website.

Prof Macleod added that discrimination was not just between staff members but that patients could discriminate against staff also. Mrs Vere advised that positive promotion to address the issues was key.

Resolved:
The Committee received and accepted the report.

11.2 Workforce Disability Equality Standard

Mrs Knowles presented the report and advised that the standards had been established in 2019. The Trust had just over 2% of staff who had declared they were disabled and there were 36% on the ESR system who hadn't declared either way.

Work was ongoing to establish who disabled staff felt and whether they are being supported and integrated into the Trust. Mr Nearney added that the Trust was appointing a full time equalities officer who would focus on an inclusion and awareness programme.

Mrs Knowles advised that the report would be published on the Trust's website.

Resolved:
The Committee received and accepted the report.

12 Other Items

12.1 People Strategy Update

Mr Nearney presented the report and highlighted the vacancy statistics within the Health Groups. The ED was the highest vacancy rate at 13%. The report highlighted the temporary and agency staff usage.

Turnover was healthy and more work was being done to ensure new staff were made to feel welcome and remained with the Trust.

Work was ongoing with Consultant job plans, the current performance was 50% completed.

Absence was good at 3.6% and this was being monitored during the Covid pandemic as it could easily become higher with staff self-isolating and shielding.

Mr Nearney stated that the Trust was now moving to its Winter planning phase and resuming services and that staff were tired and being moved around due to the intensive capital programme and staff support was key at this time.

Other areas being reviewed was appraisals, mandatory training and the staff survey results.
Prof Macleod suggested that a deep dive of one area be explored at the next meeting. **SN**

Resolved:
The Committee received and accepted the update.

12.2 Board Assurance Framework

Ms Ramsay presented the report and advised that the 3 areas of the BAF that fit into the Committee's Terms of Reference were staff engagement, valued staff and research and innovation.

Ms Ramsay advised that the Board had agreed the BAF in July 2020 and the Committee was asked to highlight any positive assurance or any gaps in assurance that should be recorded following the discussions at the

meetings and the reports presented.

Prof Macleod asked if the discussion points to be raised at the next meeting be added to the executive summary of the report on the cover sheet.

Resolved:
The Committee received and accepted the report.

12.3 Flu Vaccination 20/21 Report

Mr Nearney presented the report and advised that the campaign would be more difficult this year due to Covid. The drop in clinics usually held would not be able to go ahead due to the numbers of staff attending them, but staff would still be encouraged to be vaccinated and would be offered an extra day's annual leave if they did.

Resolved:
The Committee received and accepted the report.

13 Date and time of the next meeting:

Monday 19th October 2020, 2pm – 4pm via Webex

Hull University Teaching Hospitals NHS Trust

Trust Board

8 September 2020

Title:	2020/21 Month 4 Financial Position
Responsible Director:	Lee Bond, Chief Financial Officer
Author:	Lee Bond, Chief Financial Officer

Purpose:	To inform the Trust Board on the month 4 reported financial position and update on the level of expenditure committed in managing Covid19.	
BAF Risk:	BAF Risks 7.1, 7.2 and 7.3	
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:	The NHSE&I normal operating planning system has been suspended for the first four months of 20/21 and Trusts are being monitored against a plan based on historical levels of expenditure (based on an average of months 8-10 spend in 2019/20). A series of block and top-up payments are being made to enable the Trust to achieve a month on month breakeven position. This report shows the actual month 4 position compared to this revised national reporting target.	

Recommendation:	The Trust Board is asked to note the contents of this report.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

2020/21 MONTH 4 FINANCIAL POSITION

1. Purpose of Paper

To inform the Trust Board on the month 4 reported financial position and update on the level of expenditure committed in managing Covid19.

2. Background

The NHSE&I normal operating planning system has been suspended for the first four months of 20/21 and Trusts are being monitored against a plan based on historical levels of expenditure (based on an average of months 8-10 spend in 2019/20). A series of block and top-up payments are being made to enable the Trust to achieve a month on month breakeven position.

This report shows the actual month 4 position compared to this revised national reporting target.

3. Month 4 Reported Position

The table in appendix 1 shows the month 4 reported position against the NHSI plan with a high-level commentary on the variance. The in-month position was a deficit of £2.3m with continuing covid costs (£3.2m) offset by reductions in activity from the baseline.

4. Income

The reported position assumes that the Trust will receive £3.87m to reach a breakeven position. This is known as 'true-up' income and is expected from NHSE&I via the agreed national process. A payment of £1.5m for the first 3 months has already been received in June and the additional £2.3m is expected to be received by mid-September.

The Trust has seen a reduction in "other" income across health group budgets with the main shortfalls being in Car parking (-£642k), Catering (-£558k), private patients (-£69k) and injury compensation scheme (-£37k). 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 the first 4 months.

5. Expenditure

For the year to date the Trust has identified £10.6m of specific, additional Covid costs, as shown in the table below. This includes an additional £3.2m in month 4, the highest expenditure month so far. Pay costs in dealing with the impact of covid have increased in month by £1.5m to £4.7m. This includes an accrual for £0.3m for the potential cost of paying junior doctors additional on-call rates. Subsequent to month-end it has been confirmed that alongside other Trusts in the region this will not be paid. This may still be subject to appeal. The costs also include £0.5m for the aspirant nurses who are working for the Trust and £0.1m for the cost of University staff who have been working for the Trust during the outbreak. The position also includes a further accrual of £0.1m for the potential cost of claims for annual leave that junior doctors were unable to take before they rotated out of the Trust in August.

As can be seen below the majority of spend is in Corporate and Clinical Support. Corporate spend includes a number of organisation wide issues that have been managed centrally, including much of the PPE spend, costs of Aspirant Nurses, costs of Staff accommodation, and Nursery Provision.

	Pay	Non-Pay	TOTAL
	£000	£000	£000
Surgery	39	319	358
Medicine	701	253	954
Emergency	30	18	48
Clinical Support	1,404	1,015	2,419
F&W	82	83	165
Estates	31	648	679
Corporate	2,421	3,591	6,012
TOTAL	**4,708**	**5,927**	**10,635**

The breakdown of YTD costs into NHSE&I Covid categories is shown below:

	M1	M2	M3	M4	Total
	£000	£000	£000	£000	£000
Expanding NHS Workforce	294	577	565	1,136	2,572
Virus Testing	31	-8	179	100	302
Support for stay at home models	58	157	36	35	286
Increased ITU capacity	106	79	91	121	397
Segregation of patient pathways	36	32	25	24	117
Existing workforce - additional shifts	188	41	189	101	520
Decontamination	644	21	212	168	1,045
Backfill for higher sickness absence	190	50	442	255	936
Remote working for non-clinical staff	6	136	92	139	373
National Procurement - PPE	141	751	620	784	2,295
National Procurement - Other	534	62	84	39	719
Other categories (excl PPE)	164	440	172	298	1,074
Total Additional Covid Costs	2,393	2,337	2,704	3,201	10,635

Most of this additional cost will continue over the coming months, with ongoing costs for Testing (including staff antibody testing), PPE and additional staffing (including Aspirant Nurses until September 20). The costs may fall in some areas as we revert back closer to normal ways of working (reducing back to a single ED department and Critical Care beds back to historic levels), plus the potential to source more PPE through the national procurement route (free to the Trust).

The above costs have been offset by underspends against the plan due to reduced clinical activity with £5.1m less being spent on theatre implants and other consumables, £1.5m less being spent on Wet AMD drugs. The level of underspend on drugs reduced by £0.6m in month with increased spend on cancer drugs and home delivery drugs. There have also been reductions in establishment expenses (-£0.8m)

Pay budgets, excluding covid costs, are also below the average spend in 19/20 month 8-10 (adjusted for inflation) with spend on Consultants being £1.2m below the average monthly spend. This reflects the reduction in additional waiting lists and

reduced agency costs. Junior Doctor costs are also £0.5m below the average (excluding potential on-call costs and annual leave payments charged to covid).

Covid costs of £10.6m have been offset by underspends of £6.8m – the bulk of the underspend being in non-pay as expected due to the lower levels of clinical activity.

6. Next Steps

The Trust is still awaiting updated guidance on how the financial system will operate from October. The current arrangements in months 1-4 have been extended to month 6 whilst NHSE&I finalise the approach to adopt for the remaining months.

Health Groups have started working on forecasts for months 5 and 6. These indicate that an additional £8.9m of 'true-up' income may be required to break-even in the 2 months. This is £4.3m more than was required for month 4 with £1.7m extra in month 5 and £2.6m in month 6. This reflects expected increases in high cost drugs, additional activity being undertaken on a premium basis and the use of outsourcing to undertake additional activity.

	Month 5 £m	Month 6 £m
High Cost Drugs	£0.8	£0.8
Activity/Outsourcing	£0.9	£1.8
Total	£1.7	£2.6

These estimates assume all potential schemes to increase activity start on time. They include additional triage in Cardiology, use of Pioneer in gynaecology and Paediatric Gastroenterology, use of SpaMedica in Ophthalmology, introduction of associate type contracts to deliver activity in ENT and Plastic Surgery and an increase in waiting list initiatives. Some of the schemes require final agreement and sign-off and may not commence until September. The cost estimates are likely to be a maximum of the 'true-up' required and it is possible that there will be some slippage. Health Groups will provide updates each month on which schemes have commenced and delivered the planned activity levels. All of these schemes are only approved until the end of September to ensure that funding will be received under the current 'true-up' system. Agreement for any continuation going forward will depend upon the financial framework put in place from October onwards.

In terms of financial planning, a draft submission covering the remainder of the year was made to NHSIE on the 1st of September, this will be followed by a more detailed, and hopefully final, submission on the 16th September. It is hoped that the revenue allocations for the HC&V ICS will be received in time to inform this final submission.

The major challenge facing the ICS will be the way in which the overall financial allocations split down by organisation. We are led to believe that the allocations that we receive will relate to the North Yorkshire and Humber sub systems and will not contain sufficient granularity to enable the ICS to easily passport to relevant organisations. A detailed, but ultimately very quick exercise, will be needed to agree how the allocation feeds into individual organisations.

7. 2020/21 Capital

The reported capital position at month 4 shows gross capital expenditure of £6.5m. The main areas of expenditure relate to Capital for covid, Ward and equipment (£2.4m); backlog maintenance (£0.7m) and Robotic Scheme (£0.6m).

The forecast position for capital expenditure (incl PFI/IFRIC12 impact) is £61.4m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£10.5m); Backlog Maintenance (£4.9m); Capital Covid (£2.6m); ED UEC (£4.3m) and Critical Infrastructure (£5.9m). The Trust is also expecting the final receipt from the sale of land at CHH in Q3 (£3m). The capital programme is extremely challenging at £61.4m and all budget holders/project managers are reviewing the profile of expenditure to the end of March 21.
The Trust is also likely to receive an allocation of circa £1.5m related to the Adopt & Adapt Diagnostic programme and approximately £2.5m for critical care which will increase the capital program to circa £65m

The Wave 4 business case for Urgent & Emergency Care which was approved recently by the Board is due to go to the NHSIE/DH Joint Investment Committee for consideration in early September. Approval at that point will mark a major milestone for the trust as it will enable us to continue the redevelopment of the ground floor

The major risk at this time is failure to receive timely notification of approval for each of these allocations leading to difficulties in delivery this financial year.

8. Summary

The Trust is working within the revised guidelines produced by NHSE&I for the first 4 months of the financial year. The expectation is that the Trust will break-even each month during that period with additional top-up funding received from the centre to offset any excess costs of dealing with the outbreak.

For month 4 the Trust incurred costs of £3.2m in dealing with covid but this was offset by reduced expenditure due to the lower levels of activity. The Trust also saw reduced income levels in some areas. A top up of £3.9m is required to break-even, of which £1.5m has been received via NHSE&I. The level of 'true-up' required increased in month due to accruing for the potential cost of junior doctors on-call, increased cost of aspirant nurses and costs of university staff working in the Trust.

The Trust is looking to ramp up activity in August and September to recover some of the RTT position but this comes at a cost that will require funding under the 'True-up' process.

The Trust continues to work, with system partners to develop its plans for the second half of the year. Early notification of the revenue resource envelopes from NHSIE will help accelerate this process.

Finally, the Trust is working very hard to deliver a significant capital programme this year which is expected to total circa £65m. Official approval for each of the capital allocations from NHSIE/DH has not yet been received and this poses a risk to delivery of the overall plan.

Lee Bond
Director of Finance
2nd September 2020

APPENDIX 1

Month 4 2020/21	Budget £000	Actual £000	Variance £000	Comments
Nhs Contract Income (Blocks and central top up)	196,228	196,228	0	
Additional True-up income (to deliver balance)		3,867	3,867	Additional True-up income. Increase of £2.3m in month due to additional covid costs for junior doctors and aspirant nurses and additional costs of activity delivery.
Education + Training Income	6,534	6,560	26	
Other Income	954	720	(234)	Lower injury cost recovery and EHIC income
Total Income	**203,716**	**207,375**	**3,659**	
Surgery	(45,637)	(41,401)	4,236	Lower activity offsetting Covid pressures
Medicine	(26,881)	(26,352)	529	Lower activity offsetting Covid pressures
Emergency Care Health Group	(5,693)	(5,401)	292	Lower activity offsetting Covid pressures
Clinical Support Services	(32,409)	(33,855)	(1,446)	Covid pressures of £2.4m
Clinical Support Services - pass through drugs	(18,613)	(19,248)	(635)	Increase in cancer drugs spend
Family + Womens Health	(27,484)	(24,088)	3,396	Lower activity offsetting Covid pressures
Corporate Directorates	(36,165)	(44,056)	(7,891)	Covid costs £6.7m plus income shortfalls due to covid (car parking/catering), £1.2m
Other Operating Expenditure	(2,550)	(2,630)	(80)	
Reserves	604	(872)	(1,476)	Central estimate for unprocessed invoices
Total Operating Expenditure	**(194,828)**	**(197,903)**	**(3,075)**	
EBITDA	**8,888**	**9,472**	**584**	
Total Non Operating Expenditure	**(8,893)**	**(9,624)**	**(731)**	Depreciation above last years spend
Net Surplus/Deficit	**(5)**	**(152)**	**(147)**	
Donated Asset Adjustment	0	152	152	
Adjusted Financial Performance Surplus/Deficit	**(5)**	**0**	**5**	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

8 SEPTEMBER 2020

Title:	NHS Operational Planning Guidance and Recovery Planning Update	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this document to apprise the Trust Board of the guidance issued by NHS England/Improvement in relation to the planning requirements for the remainder of 2020/21 and to set out the ways in which the Trust plans to respond.	
BAF Risk:		
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	X
	Financial sustainability	X
Key Summary of Issues:	• The NHS has issued further operational planning guidance pertaining to 2020/21, which includes target activity levels • The NHS has also set out a financial framework to incentivise acute trusts to increase elective activity • The Trust is well advanced in the development of its plans for Winter and to respond to a further surge in Covid 19 cases • The restoration of elective activity is progressing and volumes are increasing, however, full restoration remains challenging.	
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

NHS Operational Planning Guidance and Recovery Planning Update

1 Purpose

The purpose of this document to apprise the Trust Board of the guidance issued by NHS England/Improvement (E/I) in relation to the planning requirements for the remainder of 2020/21 and to set out the ways in which the Trust plans to respond.

2 NHSE/I operational planning guidance for Aug 2020 – March 2021

2.1 The NHS set out 4 phases in the response to Covid 19, set out below in figure 1.

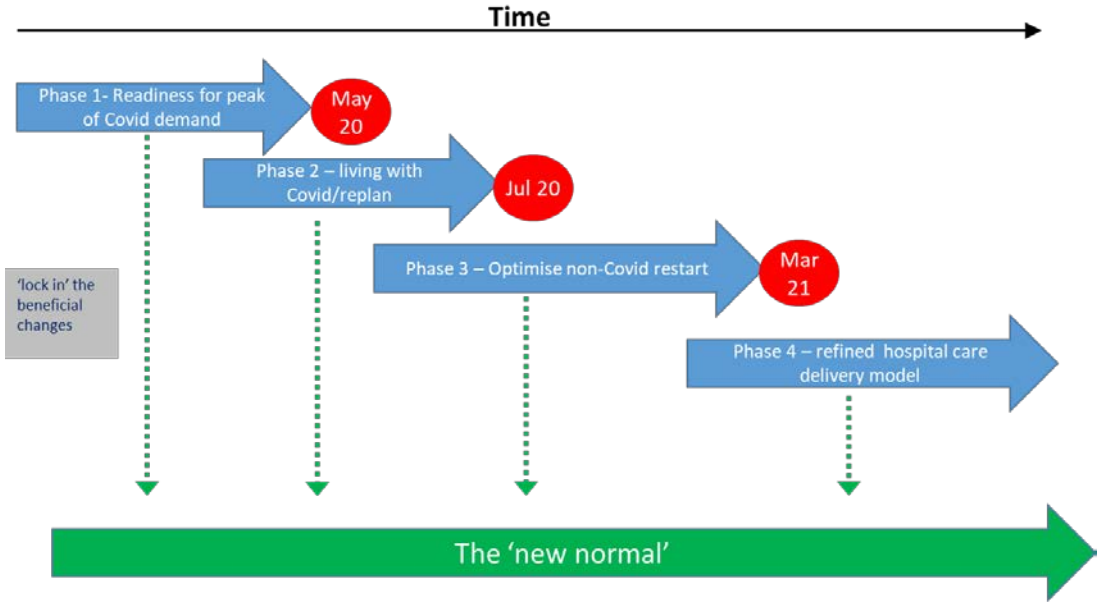


Figure 1: The four phases of the NHS response to Covid 19

On 31 July 2020, NHSE/I issued a letter to NHS Trusts and clinical commissioning groups, which set out a range of expectations for the remainder of 2020/21 (Phase 3). These are:

- Accelerating the return to near-normal levels of non-Covid health services
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

For acute providers in particular, it set out target monthly elective activity volumes.

Using the months of 2019/20 as a baseline, the requirements are set out below in table 1:

	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Elective IP, DCs and OP w proc	70%	80%	90%	90%	90%	90%	90%	90%
MRI/CT/ Endoscopy	-	90%	100%	100%	100%	100%	100%	100%
OP	-	100%	100%	100%	100%	100%	100%	100%

Table 1: % of activity to be delivered relative to equivalent month in 2019/20

On 21 August 2020, a further NHSE/I letter was issued, which outlined a financial mechanism designed to incentivise acute provider trusts to increase elective activity. Building on the targets in the earlier letter, it elucidates the a plan to pay for elective activity as follows:

For elective activity and outpatient procedures, this will be valued using the 2020/21 tariff prices set out in the earlier statutory consultation. Outpatient attendances will be valued at a separate, nationally determined flat rate for first and follow-up attendances.

Where the activity delivered is in line with the levels set out in the phase three letter, system-level funding envelopes, to be communicated in due course, will be paid in full.

Where aggregate in-scope activity delivered in the period M6-M12 is below the expected value, 25% (for elective and outpatient procedure activity) and 20% (for outpatient attendance activity) of the shortfall will be deducted from the nationally determined funding envelopes.

Where in-scope activity delivered in this period exceeds the expected value, 75% (for elective and outpatient procedure activity) and 70% (for outpatient attendance activity) of the difference will be added to nationally determined funding envelopes.

3 Progress in relation to the Trust Recovery Plan

3.1 Refresh of activity plans for Phase 3 (within existing resources)

Since the last update to the Trust Board, the clinical and operational teams have refreshed their activity plans for the remainder of the year. We have also undertaken a 'gap analysis' against the activity targets set in the elective incentives letter.

Figures 2, 3 and 4 illustrate the Trust activity actual to July 2020 and plan for the remained for 2020/21 compared to the same months in 2019/20.

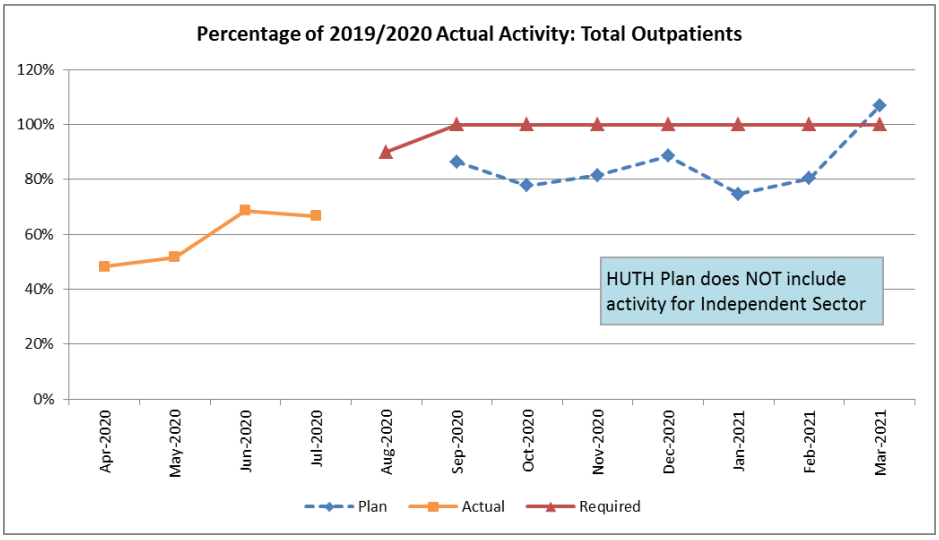


Figure 2: HUTH total outpatients: 2020/21 v 2019/20

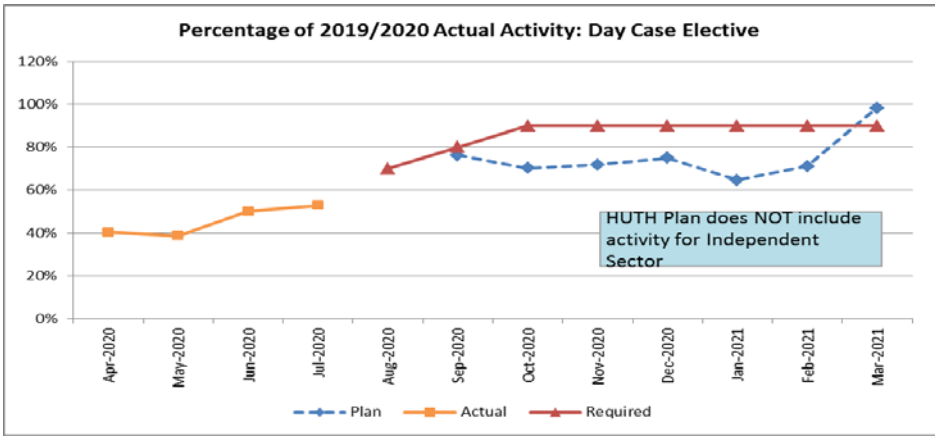


Figure 3: HUTH daycases: 2020/21 v 2019/20

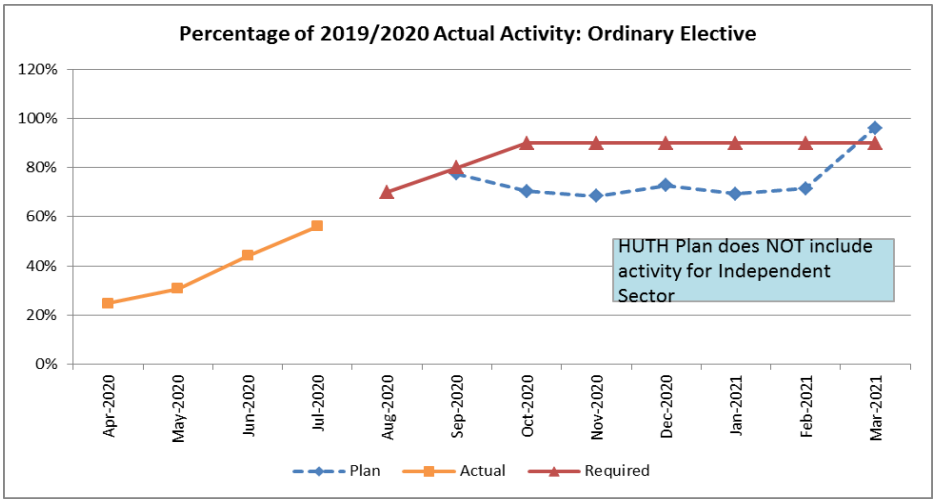


Figure 3: HUTH elective inpatients: 2020/21 v 2019/20

NB. The March to March comparison should be treated with caution as routine elective activity was cancelled part way through March 2020.

As can be seen from figures 2-4, Trust elective activity is climbing steadily from the low point in April and May of 2020, however, we do not currently have a plan to

restore 100% of outpatient activity or 90% of daycase and inpatient procedures. Rather our current plans, which are limited to that which we can achieve within existing resources, achieve 85% of outpatients and 75% of daycase and inpatient procedures in the latter 6 months of 2020/21.

3.2 **Use of the Independent Sector**

In addition to the work undertaken within Trust facilities, there is the opportunity to refer patients for treatment to the local Spire Hospital, under the nationally negotiated NHS Independent Sector (IS) contract, so at no direct cost to the Trust.

This contract was recently extended until the end of December 2020 with some slight changes: 75% of the staffed capacity is available to treat NHS patients, but this must include NHS patients referred directly to the IS providers via 'Choose and Book'.

There are some limitations to the use of this capacity as it does not come with consultant medical cover, so the Trust has to supply this from its own limited supply. Nonetheless the Trust has a plan to undertake 440 outpatient appointments and 140 procedures per month for as long as the contract is in place. We have been given to understand it will be replaced with another contract extended until at least March 2021.

3.3 **Additional activity should resources be made available**

Although the 'Elective Incentive' letter sets out a mechanism for access to funding for additional activity, as at 1 September 2020, the Trust has not had its baseline and Covid funding allocation confirmed for the rest of the year. This is expected imminently.

In anticipation of this, the Trust is working up a range of schemes it could implement if resources allowed to undertake additional activity. Some of this work is being undertaken in collaboration with the other acute trusts in Humber, Coast and Vale. These schemes will be targeted at the specialties with the largest backlogs, e.g.: Ophthalmology, ENT and Plastic Surgery.

4 **Revised Surge Plan and the Winter Plan**

A revised surge plan has been completed. This plan provides for a staged response to any further peaks in Covid 19. The creation of new wards at the back of HRI provides the opportunity to keep the Covid 19 general and enhanced care beds physically separate from the rest of the hospital, unless a future peak exceeds 75% of the cases seen in the first peak.

At that point we would need to start creating Covid 19 beds within the HRI Tower Block and there is a step by step plan to do this if required. At that point we would have to temporarily suspend some elective activity to provide the staff required to support the plan and because we would anticipate such a surge in cases would be associated with increased staff absence.

The Trust is also, as in previous years reviewing and refreshing its Winter Plan.

During September we will be undertaking some workshops to test the Covid 19 Surge Plan and the draft Winter Plan so we can consider various scenarios and how we might best respond to them.

5 Next steps

It is the intention of the Executive Team bring a Recovery Plan to the next Board Meeting
that incorporates the Winter Plan and Covid 19 Surge Plan and elucidates the interdependencies that exist between them.

6 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
8 September 2020

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES)
Trust Submission 2020

Title:	Workforce Race Equality Standard (WRES) Trust Submission
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Sarah Dolby, HR Advisor, Employment Policy and Resourcing

Purpose:	The purpose of this paper is to present for consideration by the Workforce, Education and Culture Committee and Trust Board, the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2019/20 and proposed Action Plan for 2020/21.	
BAF Risk:	Risk 2 – workforce	
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 Key of Issues:	Next steps are identified within the Action Plan 2020/21 (Appendix 2).	

Recommendation:	The Workforce, Education and Culture Committee and Trust Board are requested to note and approve the content of this report prior to it being published on the Trust internet site.

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES)
Trust Submission 2020

1 Purpose

The purpose of this paper is to present the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2019/20 and proposed Action Plan for 2020/21.

2 Background

The NHS Workforce Race Equality Standard (WRES) was commissioned in 2015 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WRES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;
- To produce action plans to close the gaps in workplace experience between White and Black, Asian and Minority Ethnic (BAME) staff; and
- To improve BAME representation at the Board level of the organisation.

By using the WRES, NHS England expects that all NHS organisations will, year on year, improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of the CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

Equality, inclusion and diversity is one of the key strategic workforce themes within the Trust's People Strategy 2019 to 2024, which states "we will continue to develop an organisational culture that encourages every member of staff, whatever their role or background to succeed. A Trust where our staff work hard to make a difference for patients, where staff access opportunities to learn, develop and grow and work in a positive environment free from discrimination."

This report should be read in the context that as at 31 March 2020, the Trust employed 9,562 staff, of which:

- 8,162 (85.36%) identify as White;
- 1,266 (13.24%) identify as BAME; and
- 134 (1.40%) did not declare their ethnicity.

3 WRES Submission 2020

The Trust is required to submit and publish a number of returns. These include:

- Data Template: Contains validated raw technical data from the Trust's Electronic Staff Record (ESR) for staff in post at 31 March 2020. The data is used by NHS England to benchmark the Trust against other NHS organisations. This year, the WRES Implementation Team advised that indicators 5 to 8 (which are taken from the staff survey results) have been excluded from the raw technical data. The deadline for submission is 31 August 2020 (nationally extended due to the COVID-19 pandemic).
- Reporting Template (Appendix 1): Supplementing the Data Template, this provides an overview and 3 year comparison of the organisation's WRES data. To enable a full comparison to be made against the nine WRES indicators; indicators 5 to 8 have been included in this report. The report must be published

on the Trust's website by 31 October 2020 (extended nationally from the normal date of 30 September due to COVID-19).

- WRES Action Plan 2020/21 (Appendix 2): Based on the outcomes from the raw technical data, is intended to address any disparities in the experiences of BAME staff compared to White staff. The Action Plan must be published on the Trust's website by 31 October 2020 (extended from the normal date of 30 September due to COVID-19).

4 Achievements throughout 2019/2020

There have been a number of achievements in the past year, which are detailed in sections 4.1 to 4.6 below.

4.1 BAME Leadership Summit

In October 2019 the Trust ran it's first BAME Leadership Summit with over 45 colleagues from across a wide range of professions attending. The aim of the event was to support, encourage and explore opportunities for BAME colleagues both personally and professionally.

The summit, attended by the Trust's Chief Executive, Chris Long, provided an opportunity to re-energise the Trust's BAME Leadership Network and shape priorities for the future. Bo Escritt, National Diversity Lead, attended as a guest speaker sharing her experiences as a BAME colleague developing BAME Networks across the NHS.

The summit played a fundamental part in raising interest in, and involvement with, the BAME Leadership Network. Following the summit, the Network has grown from 43 to 137 members.

Actions that have taken place since the BAME Leadership Summit include:

- Appointed a BAME Leadership Network Chair and Joint Deputy Chairs.
- Reviewed and re-designed the Trust's in-house leadership development programmes to ensure HUTH leaders role model compassionate and inclusive leadership. The new content, which was piloted in November 2019 with a group of senior managers, has had excellent feedback. Work continues to ensure that inclusion is at the core of all of the Trust's internal leadership programmes.
- The Executive Team received feedback of the lived experiences of BAME colleagues within the Trust. The purpose was to raise awareness of the challenges and obtain support to build upon the excellent feedback received during the BAME Leadership Summit.
- Reviewed and updated the BAME pages on the Trust's intranet to provide an overview of the Summit and provide updated information on the leadership and development opportunities available.
- Held a number of BAME Leadership Network meetings to build upon the feedback from the Summit and shape the purpose and key objectives of the network going forward.

Alongside the Senior Management Team, the BAME Chair and Deputy Chairs have played a fundamental role in supporting BAME staff during the COVID-19 pandemic. Further detail is included in section 4.6.

4.2 Success at the National BAME Awards

The Trust experienced success at the National BAME Awards ceremony held in London. Six staff were shortlisted, of which two went on to win awards for Clinical Champion of the Year and Groundbreaking Researcher.

4.3 Eid al Adha Celebrations

The Eid al Adha Celebrations (also called the "Festival of the Sacrifice") is the second of two Islamic holidays celebrated worldwide each year. The Communication and Catering Teams worked together to acknowledge and raise the awareness of this key period of celebration. The Catering Team created a special menu to mark the occasion and the Communications Team developed branded flyers to go out to all staff. The Lottery Committee also provided funding to purchase Eid banners and decorations for the Trust restaurants.

4.4 Equality, Diversity and Human Rights Training

In 2017 the Trust agreed that Equality Training would become a part of the suite of mandatory and statutory training for staff. As at 31 March 2020, 96.7% of staff were compliant with the requirement to complete this training.

4.5 Training and Awareness Sessions

The Chair of the Trust's Diversity and Inclusion Steering Group worked with Humberside Police to deliver a number of Hate Crime Awareness sessions.

4.6 Support to BAME Staff during the COVID-19 Pandemic

In March 2020 COVID-19 was declared a global pandemic by the World Health Organisation (WHO). Following evidence that the BAME population nationally were more adversely impacted by COVID-19 compared to White people, the Trust introduced a number of proactive measures to support BAME staff.

These included:

- Priority COVID-19 testing for BAME staff and their family members with mild symptoms.
- Development of a BAME specific risk assessment and subsequent feedback sessions for BAME staff and managers to understand how helpful and effective BAME staff have found the risk assessment to be, in order to learn from experience and take further action as required.
- Priority antibody testing.
- The introduction of a panel to support BAME staff for the duration of the pandemic if they have any concerns about the support that they are receiving from line management. The panel will be led by the Trust's Freedom to Speak up Guardian, supported by the BAME Leadership Network Chair and Deputy Chairs.

The Trust will continue to review and explore how to support BAME staff during this unprecedented time.

5 Overview of Key Findings from the 2019/20 Data

- The number of BAME staff employed by the Trust has increased for the third consecutive year. The 2019/20 data shows an increase of 155 BAME employees in the last year.
- BAME candidates are less likely than White candidates to be appointed from shortlisting.
- BAME staff continue to be less likely to enter into the formal disciplinary process than White staff.
- BAME staff are less likely to access non-mandatory training and CPD than White staff (White staff are 1.07 times more likely).
- The number of BAME staff who stated that they had experienced harassment, bullying or abuse from patients, relatives, the public or staff in the last 12 months has increased for the third consecutive year.

- The number of BAME staff who believe they have equal opportunities for career progression or promotion has gone down.
- The staff survey results show that 14.52% of BAME staff state that they have personally experienced discrimination at work compared to 5.46% of White staff.
- Following a successful period of acting into the role of Chief Medical Officer, a Trust BAME colleague was appointed into the role on a permanent base from June 2019.

The outcomes from the Trust's 2019/20 WRES return have been shared with the Trust's BAME Leadership Network.

6 Next Steps

Please see the WRES Action Plan 2020/21 in Appendix 2.

7 Conclusion

Whilst the Trust's 2019/20 WRES data, shown in the Reporting Template (see Appendix 1), highlights that the lived experiences of BAME colleagues within the Trust is different to other groups; working in partnership with the BAME Leadership Network, the Trust is committed to addressing this and areas for improvement have been identified (see WRES Action Plan for 2020/21 in Appendix 2).

The recent appointments of the BAME Leadership Network Chair and Deputy Chairs and the enhanced opportunities that have been given for the Executive Team to engage with BAME staff has re-energised the Network. The Trust now has a strong base from which to develop further.

8 Recommendation

The Workforce, Education and Culture Committee and Trust Board are asked to note and approve the content of this report.

Simon Nearney
Director of Workforce and Organisational Development

August 2020

Appendix 1 - Workforce Race Equality Standard (WRES) 2019/20 Reporting Template

1. Background

To supplement the submission of the Trust's annual Workforce Race Equality Standard (WRES) raw technical data, the Trust is required to produce a reporting template which provides an overview of the Trust's data, accompanied by an Action Plan (see Appendix 2) designed to address the gaps in workplace experience between White and BAME staff.

The report and Action Plan must be published on the Trust's external website by 31 October 2020 (nationally extended from the normal date of 30 September due to the COVID-19 pandemic).

2. Introduction

The Trust employed 9,562 staff at 31 March 2020, which is an increase of 348 staff compared to the previous reporting period.

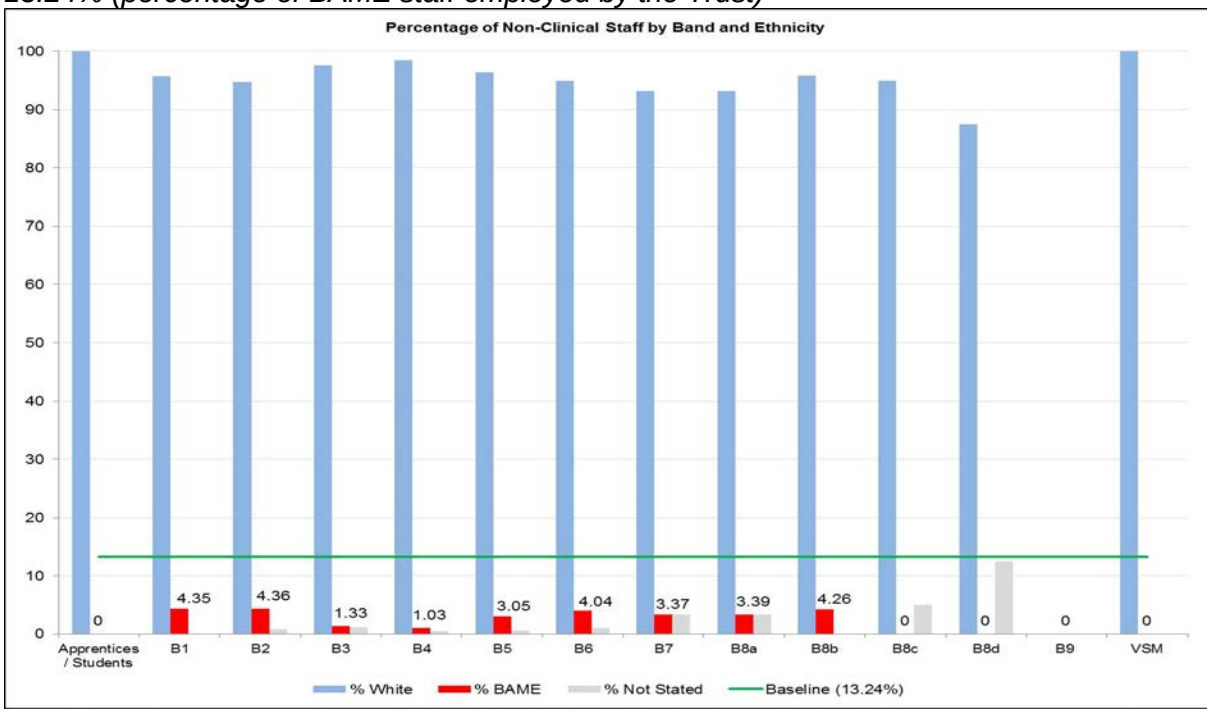
Since the commissioning of the WRES in 2015, the Trust has seen a yearly increase of the number and percentage of BAME staff employed by the Trust:

Ethnicity	31 March 2018	31 March 2019	31 March 2020
White	7755 (87.26%)	7953 (86.31%)	8162 (85.36%)
BAME	988 (11.12%)	1111 (12.06%)	1266 (13.24%)
Not Stated	144 (1.62%)	150 (1.63%)	134 (1.40%)
Grand Total	**8887**	**9214**	**9562**

3. WRES 2019/20 Data

3.1 Indicator 1: Percentage of Staff in each of the AfC Bands 1-9 or Medical and Dental Sub Groups and Very Senior Managers (including Executive Board Members) compared with the Percentage of Staff in the Overall Workforce

Table 1: Percentage of non-clinical staff by band at 31 March 2020 using a baseline of 13.24% (percentage of BAME staff employed by the Trust)



NB: Percentage impacted by the number of BAME staff in each band, see following table.

Table 2: The number and percentage of non-clinical staff in each band over 3 years

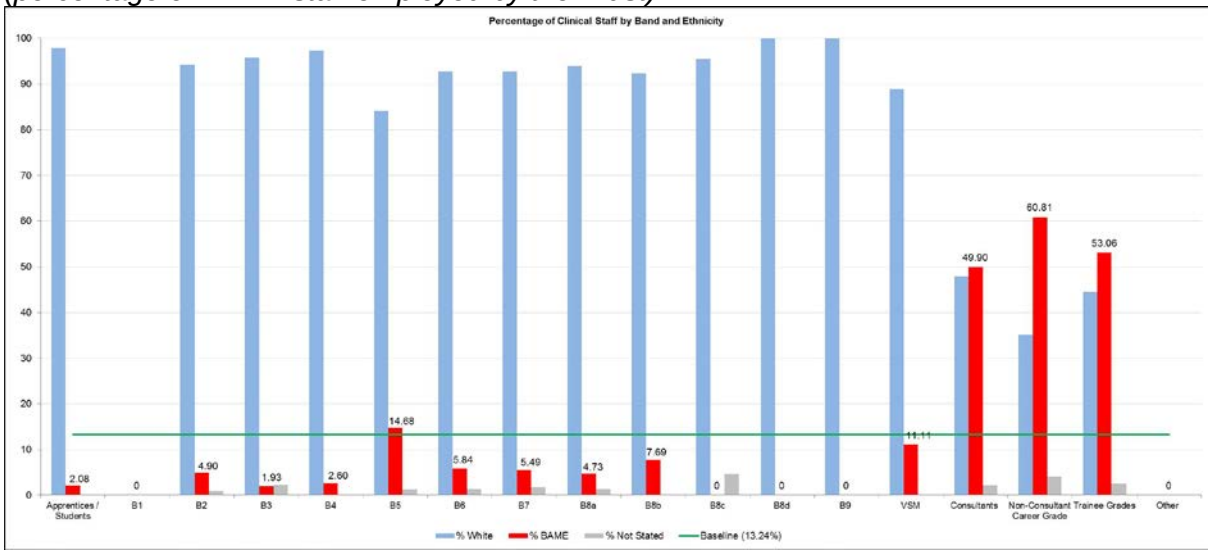
	2017/18 Number and % of Non-Clinical Workforce							2018/19 Number and % of Non-Clinical Workforce							2019/20 Number and % of Non-Clinical Workforce						
	White		BAME		Not Stated		Total No.	White		BAME		Not Stated		Total No.	White		BAME		Not Stated		Total No.
Band	No.	%	No.	%	No.	%		No.	%	No.	%	No.	%		No.	%	No.	%	No.	%	
Under B1	27	100.00%	0	0.00%	0	0.00%	27	28	100.00%	0	0.00%	0	0.00%	28	20	100.00%	0	0.00%	0	0.00%	20
B1	224	91.43%	16	6.53%	5	2.04%	245	238	92.25%	16	6.20%	4	1.55%	258	44	95.65%	2	4.35%	0	0.00%	46
B2	690	97.05%	16	2.25%	5	0.70%	711	748	96.77%	19	2.46%	6	0.78%	773	914	94.81%	42	4.36%	8	0.83%	964
B3	479	97.56%	7	1.43%	5	1.02%	491	522	97.75%	8	1.50%	4	0.75%	534	439	97.56%	6	1.33%	5	1.11%	450
B4	218	98.20%	2	0.90%	2	0.90%	222	225	97.83%	3	1.30%	2	0.87%	230	191	98.45%	2	1.03%	1	0.52%	194
B5	174	97.21%	3	1.68%	2	1.12%	179	165	96.49%	5	2.92%	1	0.58%	171	158	96.34%	5	3.05%	1	0.61%	164
B6	103	97.17%	3	2.83%	0	0.00%	106	103	97.17%	3	2.83%	0	0.00%	106	94	94.95%	4	4.04%	1	1.01%	99
B7	74	92.50%	2	2.50%	4	5.00%	80	86	94.51%	2	2.20%	3	3.30%	91	83	93.26%	3	3.37%	3	3.37%	89
B8a	50	90.91%	3	5.45%	2	3.64%	55	55	91.67%	2	3.33%	3	5.00%	60	55	93.22%	2	3.39%	2	3.39%	59
B8b	41	100.00%	0	0.00%	0	0.00%	41	41	97.62%	1	2.38%	0	0.00%	42	45	95.74%	2	4.26%	0	0.00%	47
B8c	17	100.00%	0	0.00%	0	0.00%	17	19	100.00%	0	0.00%	0	0.00%	19	19	95.00%	0	0.00%	1	5.00%	20
B8d	10	90.91%	0	0.00%	1	9.09%	11	10	90.91%	0	0.00%	1	9.09%	11	7	87.50%	0	0.00%	1	12.50%	8
B9	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0.00%	0	0.00%	0
VSM	12	100.00%	0	0.00%	0	0.00%	12	18	100.00%	0	0.00%	0	0.00%	18	22	100.00%	0	0.00%	0	0.00%	22
Total							2197							2341							2182

Key Findings:

Table 1 and 2 highlight:

- BAME staff are under-represented across all the AfC bands and VSM in the non-clinical workforce, with no BAME staff from 8c upwards.
- The highest number and percentage of BAME staff are employed in band 2 (4.36% / 42 staff).
- There has been a reduction in the number of staff employed at band 1 (from 258 staff at 31 March 2019 to 46 staff at 31 March 2020). This is due to the Agenda for Change Contract Refresh, which resulted in the closure of band 1 to new entrants on 1 December 2018. NHS organisations were encouraged to upskill band 1 roles to band 2 roles. Existing staff (employed prior to 1 December 2018) employed in band 1 roles were given the opportunity to transfer to a band 2 role with effect from 1 April 2019, however they could choose to remain at band 1.
- 2 BAME staff in Estates and Ancillary wished to remain at band 1 following the Agenda for Change Contract Refresh.

Table 3: Percentage of clinical staff by band at 31 March 2020 using a baseline of 13.24% (percentage of BAME staff employed by the Trust)



NB: Percentage impacted by the number of BAME staff in each band, see following table.

Table 4: The number and percentage of clinical staff in each band over 3 years

	2017/18 Number and % of Clinical Workforce							2018/19 Number and % of Clinical Workforce							2019/20 Number and % of Clinical Workforce						
	White		BAME		Not Stated		Total No.	White		BAME		Not Stated		Total No.	White		BAME		Not Stated		Total No.
Band	No.	%	No.	%	No.	%		No.	%	No.	%	No.	%		No.	%	No.	%	No.	%	
Under B1	26	100.00%	0	0.00%	0	0.00%	26	45	95.74%	2	4.26%	0	0.00%	47	47	97.92%	1	2.08%	0	0.00%	48
B1	6	100.00%	0	0.00%	0	0.00%	6	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0.00%	0	0.00%	0
B2	1299	94.75%	58	4.23%	14	1.02%	1371	1257	94.09%	65	4.87%	14	1.05%	1336	1308	94.17%	68	4.90%	13	0.94%	1389
B3	400	96.62%	7	1.69%	7	1.69%	414	405	96.43%	7	1.67%	8	1.90%	420	545	95.78%	11	1.93%	13	2.28%	569
B4	121	94.53%	7	5.47%	0	0.00%	128	116	95.08%	6	4.92%	0	0.00%	122	187	97.40%	5	2.60%	0	0.00%	192
B5	1652	87.32%	215	11.36%	25	1.32%	1892	1619	86.07%	242	12.87%	20	1.06%	1881	1604	84.11%	280	14.68%	23	1.21%	1907
B6	842	93.76%	42	4.68%	14	1.56%	898	891	93.49%	49	5.14%	13	1.36%	953	938	92.78%	59	5.84%	14	1.38%	1011
B7	571	93.45%	25	4.09%	15	2.45%	611	580	93.70%	29	4.68%	10	1.62%	619	591	92.78%	35	5.49%	11	1.73%	637
B8a	102	91.07%	9	8.04%	1	0.89%	112	123	91.79%	9	6.72%	2	1.49%	134	139	93.92%	7	4.73%	2	1.35%	148
B8b	43	97.73%	1	2.27%	0	0.00%	44	48	96.00%	2	4.00%	0	0.00%	50	48	92.31%	4	7.69%	0	0.00%	52
B8c	17	100.00%	0	0.00%	0	0.00%	17	16	100.00%	0	0.00%	0	0.00%	16	21	95.45%	0	0.00%	1	4.55%	22
B8d	4	100.00%	0	0.00%	0	0.00%	4	4	100.00%	0	0.00%	0	0.00%	4	4	100.00%	0	0.00%	0	0.00%	4
B9	3	100.00%	0	0.00%	0	0.00%	3	3	100.00%	0	0.00%	0	0.00%	3	3	100.00%	0	0.00%	0	0.00%	3
VSM	16	100.00%	0	0.00%	0	0.00%	16	9	100.00%	0	0.00%	0	0.00%	9	8	88.89%	1	11.11%	0	0.00%	9
Cons.	215	47.57%	230	50.88%	7	1.55%	452	226	47.98%	234	49.68%	11	2.34%	471	239	47.90%	249	49.90%	11	2.20%	499
Non-Cons. Career Grade	21	34.43%	37	60.66%	3	4.92%	61	24	36.92%	39	60.00%	2	3.08%	65	26	35.14%	45	60.81%	3	4.05%	74
Trainee Grades	298	46.93%	305	48.03%	32	5.04%	635	329	44.28%	368	49.53%	46	6.19%	743	363	44.49%	433	53.06%	20	2.45%	816
Other	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0.00%	0	0.00%	0
Total							6690							6873							7380

Key Findings:

Table 3 and Table 4 highlight that BAME staff equate to:

- 14.68% (280) of the total band 5 clinical staff;
- 49.90% (249) of the total Consultant level;
- 60.81% (45) of the total Non-Consultant Career Grade level; and
- 53.06% (433) of the total Trainee Grade level.

3.2 Indicator 2: Relative Likelihood of Staff being Appointed from Shortlisting across all Posts

Table 5: The percentage of staff shortlisted and appointed over 3 years

Ethnicity	2017/18	2018/19	2019/20
White	21.69%	20.40%	22.13%
BAME	15.77%	23.08%	16.96%
Not Stated	29.41%	23.53%	50.91
Relative likelihood	**1.38**	**0.88**	**1.30**

Key Findings:

- BAME candidates are less likely than White candidates to be appointed from shortlisting.
- Recruitment figures in general have reduced in the past year, from 5011 shortlisted in 2018/19 to 3622 shortlisted in 2019/20 (difference of 1389) and a reduction in those appointed from 1039 in 2018/19 to 794 in 2019/20 (difference of 245). This will partly be due to the COVID-19 pandemic as non-essential recruitment was put on hold in February 2020.
- It is worth noting that due to data retention, TRAC only holds data for 400 days.

3.3 Indicator 3: Relative Likelihood of Staff Entering the Formal Disciplinary Process, as Measured by Entry into a Formal Disciplinary Investigation

Table 6: Percentage of staff who have entered into a formal disciplinary process over 3 years

Ethnicity	2017/18	2018/19	2019/20
White	0.97%	0.92%	1.20%
BAME	0.91%	0.63%	0.79%
Not Stated	2.08%	0.67%	5.97%
Relative likelihood	**0.94**	**0.69**	**0.66**

Key Findings:

- BAME staff continue to be less likely to enter into a formal disciplinary process than White staff.
- The figures include those where the outcome was dealt with through the accepted responsibility route.

3.4 Indicator 4: Relative Likelihood of Staff Accessing Non-Mandatory Training and CPD

Table 7: Percentage of staff who have accessed non-mandatory training and CPD over 3 years

Ethnicity	2017/18	2018/19	2019/20
White	73.23%	85.43%	97.06%
BAME	74.29%	90.10%	90.52%
Not Stated	90.00%	88.67%	94.03%
Relative likelihood	**0.99**	**0.95**	**1.07**

Key Findings:

- Whilst the number of BAME staff who access non-mandatory training and CPD has increased slightly, White staff are 1.07 times more likely to access non-mandatory training and CPD than BAME staff.
- Further work to explore how staff who record training and CPD undertaken outside HEY247 on the HEY247 system can be captured in the reporting data is being undertaken.

3.5 Indicator 5: KF25. Percentage of Staff experiencing Harassment, Bullying or Abuse from Patients, Relatives or the Public in last 12 Months

Table 8: Comparison over 3 years of the percentage of staff who have experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months

Ethnicity	2017/18	2018/19	2019/20
White	25.02%	25.15%	24.72%
BAME	20.95%	24.07%	25.25%

Key Findings:

- The number of BAME staff who stated that they had experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months has increased for the third consecutive year.
- A sub group of the BAME Leadership Network has been formed to tackle bullying and harassment; further details are contained within the Action Plan 2020/21 (see Appendix 2).

3.6 Indicator 6: KF26. Percentage of Staff Experiencing Harassment, Bullying or Abuse from Staff in last 12 Months

Table 9: Comparison over 3 years of the percentage of staff who have experienced harassment, bullying or abuse from staff in the last 12 months

Ethnicity	2017/18	2018/19	2019/20
White	27.59%	28.18%	25.75%
BAME	27.12%	29.59%	30.07%

Key Findings:

- The number of BAME staff who state that they have experienced harassment; bullying or abuse from staff in the last 12 months has increased for the third year running.
- As stated in Indicator 5, a sub group of the BAME Leadership Network has been formed to tackle bullying and harassment; further details are contained within the Action Plan 2020/21 (see Appendix 2).

3.7 Indicator 7: KF21. Percentage Believing that Trust Provides Equal Opportunities for Career Progression or Promotion.

Table 10: Comparison over 3 years of the percentage of staff who believe the Trust provides equal opportunities for career progression or promotion

Ethnicity	2017/18	2018/19	2019/20
White	89.60%	89.59%	88.53%
BAME	80.60%	81.68%	78.88%

Key Findings:

- Both BAME and White staff numbers have decreased in the last year which means that less staff believe they have equal opportunities for career progression or promotion.
- The gap between White and BAME staff has widened.
- A sub group of the BAME Leadership Network has been formed to look at recruitment and promotion; further details are contained within the Action Plan 2020/21 (see Appendix 2).

3.8 Indicator 8: Q17. In the last 12 Months have you Personally Experienced Discrimination at Work from a Manager/Team Leader or other Colleagues

Table 11: Comparison over 3 years of the percentage of staff who have personally experienced discrimination at work from a manager/team leader or other colleagues

Ethnicity	2017/18	2018/19	2019/20
White	5.32%	6.06%	5.46%
BAME	11.04%	13.19%	14.52%

Key Findings:

- 14.52% of BAME staff state that they have personally experienced discrimination at work from any a manager/team leader or other colleague.
- The figure 14.52% represents a 1.33% increase from the previous reporting period (2018-19).
- The data shows BAME staff are nearly three times more likely to experience discrimination at work from a manager/team leader or other colleagues compared to White staff.

3.9 Indicator 9: Percentage difference between the Organisations' Board Membership and it's Overall Workforce disaggregated by Voting Membership of the Board / by Executive Membership of the Board

Table 12: Comparison over 3 years of the percentage difference between the organisations' Board membership and it's overall workforce

Ethnicity	2017/18	2018/19	2019/20
% difference between White and BAME staff	-11.1%	-5.8%	-6.1%

Key Findings:

- Table 12 shows that the percentage difference between White and BAME staff has increased, as there continues to be a higher representation of White staff at Board level compared to the Trust's overall workforce. Additionally, at 31 March 2020, the Trust had 2 vacancies (a Non-Executive and Associate Non-Executive vacancy).
- Board vacancies specifically reference in the job advert that applications from under-represented groups are welcomed and the Trust Board use their networks to promote the role. However, work to increase BAME representation at Board level needs to continue.
- The last Executive appointment was for the role of Chief Medical Officer which was filled by a BAME colleague, who, following a period of temporarily acting into the role, was successfully appointed on a permanent basis in June 2019.

4. Trust Achievements throughout 2019/2020

There have been a number of achievements in the past year, which are detailed in sections 4.1 to 4.6 below.

4.1 BAME Summit

In October 2019 the Trust ran it's first BAME Leadership Summit with over 45 colleagues from across a wide range of professions attending. The aim of the event was to support, encourage and explore opportunities for BAME colleagues both personally and professionally.

The summit, attended by the Trust's Chief Executive, Chris Long, provided an opportunity to re-energise the Trust's BAME Leadership Network and shape priorities for the future. Bo Escritt, National Diversity Lead, attended as a guest speaker sharing her experiences as a BAME colleague developing BAME Networks across the NHS.

The summit played a fundamental part in raising interest in, and involvement with, the BAME Leadership Network. Following the summit, the Network has grown from 43 to 137 members.

Actions that have taken place since the BAME Leadership Summit include:

- Appointed a BAME Leadership Network Chair and Joint Deputy Chairs.
- Reviewed and re-designed the Trust's in-house leadership development programmes to ensure HUTH leaders role model compassionate and inclusive leadership. The new content, which was piloted in November 2019 with a group of senior managers, has had excellent feedback. Work continues to ensure that inclusion is at the core of all of the Trust's internal leadership programmes.
- The Executive Team received feedback of the lived experiences of BAME colleagues within the Trust. The purpose was to raise awareness of the challenges and obtain support to build upon the excellent feedback received during the BAME Leadership Summit.

- Reviewed and updated the BAME pages on the Trust's intranet to provide an overview of the Summit and provide updated information on the leadership and development opportunities available.
- Held a number of BAME Leadership Network meetings to build upon the feedback from the Summit and shape the purpose and key objectives of the network going forward.

Alongside the Senior Management Team, the BAME Chair and Deputy Chairs have played a fundamental role in supporting BAME staff during the COVID-19 pandemic. Further detail is included in section 4.6.

4.2 Success at the National BAME Awards

The Trust experienced success at the National BAME Awards ceremony held in London. Six staff were shortlisted, of which two went on to win awards for Clinical Champion of the Year and Groundbreaking Researcher.

4.3 Eid al Adha Celebrations

The Eid al Adha Celebrations (also called the "Festival of the Sacrifice") is the second of two Islamic holidays celebrated worldwide each year. The Communication and Catering Teams worked together to acknowledge and raise the awareness of this key period of celebration. The Catering Team created a special menu to mark the occasion and the Communications Team developed branded flyers to go out to all staff. The Lottery Committee also provided funding to purchase Eid banners and decorations for the Trust restaurants.

4.4 Equality, Diversity and Human Rights Training

In 2017 the Trust agreed that Equality Training would become a part of the suite of mandatory and statutory training for staff. As at 31 March 2020, 96.7% of staff were compliant with the requirement to complete this training.

4.5 Training and Awareness Sessions

The Chair of the Trust's Diversity and Inclusion Steering Group worked with Humberside Police to deliver a number of Hate Crime Awareness sessions.

4.6 Support to BAME Staff during the COVID-19 Pandemic

In March 2020 COVID-19 was declared a global pandemic by the World Health Organisation (WHO). Following evidence that the BAME population nationally were more adversely impacted by COVID-19 compared to White people, the Trust introduced a number of proactive measures to support BAME staff.

These included:

- Priority COVID-19 testing for BAME staff and their family members with mild symptoms.
- Development of a BAME specific risk assessment and subsequent feedback sessions for BAME staff and managers to understand how helpful and effective BAME staff have found the risk assessment to be, in order to learn from experience and take further action as required.
- Priority antibody testing.
- The introduction of a panel to support BAME staff for the duration of the pandemic if they have any concerns about the support that they are receiving from line management. The panel will be led by the Trust's Freedom to Speak up Guardian, supported by the BAME Leadership Network Chair and Deputy Chairs.

The Trust will continue to review and explore how to support BAME staff during this unprecedented time.

5. Summary

As shown in section 3, 'WRES 2019/20 Data', improvements have been made across the following indicators:

- The number of BAME staff employed by the Trust has increased for the third consecutive year. The 2019/20 data shows an increase of 155 BAME employees compared to the previous reporting period (2018/19).
- BAME staff continue to be less likely to enter into the formal disciplinary process than White staff.

Further improvements need to be made across the following indicators:

- BAME candidates are less likely than White candidates to be appointed from shortlisting.
- BAME staff are less likely to access non-mandatory training and CPD than White staff.
- The number of BAME staff who stated that they had experienced harassment, bullying or abuse from patients, relatives, the public or staff in the last 12 months has increased for the third consecutive year.
- The number of BAME staff who believe they have equal opportunities for career progression or promotion has gone down.
- The staff survey results show that 14.52% of BAME staff state that they have personally experienced discrimination at work compared to 5.46% of White staff.
- Whilst, following a successful period of acting into the role of Chief Medical Officer, a Trust BAME colleague was appointed into the role on a permanent basis from June 2019, further work to increase BAME representation across the Trust Board needs to continue.

In conclusion, whilst work to improve a number of the WRES indicators needs to continue, the achievements detailed in section 4, 'Trust Achievements throughout 2019/2020', highlights the Trust's commitment to the equality, diversity and inclusion agenda.

The recent appointments of the BAME Leadership Network Chair and Deputy Chairs and the enhanced opportunities that have been given for the Executive Team to engage with BAME staff has re-energised the Network. The Trust now has a strong base from which to develop further.

The Trust continues to be committed to closing the gap between White and BAME worklife experience as shown within the actions detailed within the Action Plan 2020/21 (see Appendix 2).

Appendix 2 - Workforce Race Equality Standard Action Plan 2020/21

The Action Plan 2020/21 has been developed, based on the 2019/20 WRES technical data results, to help close the gaps in workplace experience between White and Black and Ethnic Minority (BAME) staff. A separate detailed workplan supports the Action Plan.

Action	WRES Indicator	Timescale	Lead
Launch an internal and external "Zero Tolerance To Racism" Campaign for staff, patients and visitors.	Indicators 5, 6, 8	End December 2020	Director of Communications/Marketing Manager
Empower BAME staff to speak up, raise concerns and ensure adequate/visible support mechanisms are in place.	Indicators 5, 6, 8	End December 2020	Director of Workforce/BAME Chair and Deputy Chairs
Re-fresh and re-energise mandatory and statutory equality and inclusion training to include powerful, impactful videos to highlight and celebrate contribution of BAME colleagues within the Trust.	All	End March 2021	Head of Education/BAME Network/Equality and Inclusion Lead
Develop mandatory leadership and management development programmes focusing on discrimination, bullying and harassment, unconscious bias, cross-cultural understanding and micro-aggression which develop managers to empower BAME staff to speak up and raise concerns.	Indicators 5, 6, 8	End March 2021	Head of Organisational Development/Senior Organisational Development Practitioner
Review recruitment and selection processes to ensure equal opportunity to employment and career progression.	Indicators 1, 2, 7	End December 2020	Head of HR Services/Equality and Inclusion Lead/BAME Leadership Network
Design a BAME specific induction programme highlighting the Trust's commitment to BAME colleagues as well as signposting to colleagues in the Trust and local BAME community groups/services.	All	End December 2020	Director of Communications/Head of Organisational Development
Develop proposal for achieving proportionate percentage of BAME staff in senior and managerial roles from Band 6 and above across all staffing groups.	Indicators 1, 9	End December 2020	Head of HR Services/Equality and Inclusion Lead/BAME Chair
Review end to end process and outcomes to identify any bias in informal and formal grievance, investigation and disciplinary processes.	Indicator 3	End March 2021	Head of Workforce/BAME Leadership Network

WRES Indicators

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. Compare the data for white and BME staff: Relative likelihood of staff accessing non-mandatory training and CPD
5. KF: 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8. Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues
9. Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce.

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2020

Title:	Workforce Disability Equality Standard (WDES) Trust Submission
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Liz Dearing, HR Manager

Purpose:	The purpose of this paper is to present for consideration by the Executive Management Committee the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2020 and proposed action plan.	
BAF Risk:		
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 Key of Issues:		

Recommendation:	The Executive Management Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WDES return and action plan for submission to the Trust Board for approval.

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2020

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2020 and proposed action plan.

2 Background

The NHS Workforce Disability Equality Standard (WDES) was commissioned in 2019 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WDES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators;
- To produce action plans to close the gaps in workplace experience between disabled and non-disabled staff; and
- To improve disabled representation at the Board level of the organisation.

By using the WDES, NHS England expects that all NHS organisations will, year on year, improve workforce disability equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WDES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

3 WDES Submission 2020

The Trust is required to submit and publish a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2020. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 31 August 2020.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WDES Action Plan which is based on the outcomes from the technical data results and is intended to address any disparities in the experiences of disabled staff compared to non-disabled staff (see Appendix 3).
- This report should be read in the context that only 209 staff self-reported with a disability whereas when completing the Staff Survey (December 2019) a higher number of staff reported themselves as disabled.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 30 September 2020.

4 Key Findings for 2020

The WDES seeks to ask questions in the following areas:

1. The percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce at 31 March 2020.
2. The relative likelihood of Disabled staff compared to Non-disabled staff being appointed from shortlisting across all posts.
3. The relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process.

4. The percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse.
5. The percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. The percentage of Disabled staff compared to Non-disabled staff saying they have felt pressure from their managers to come to work when they have not felt well enough to do their duties.
7. The percentage of Disabled staff compared to Non-disabled staff saying they are satisfied with the extent to which their organisation values their work
8. The percentage of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.
9. A) The staff engagement scores for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.
   B) Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?
10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce at 31 March 2020.

The key findings from the technical data for 2020 are:

- The Trust employed 9,562 staff at 31 March 2020.
- Of the 9,562 staff, 36.63% (3,503) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 41.66% (2019).
- 209 staff have reported as Disabled on ESR; an increase from 183 staff (2019).
- The metric with the highest disparity between Non-disabled staff and Disabled staff is staff saying they are satisfied with the extent to which their organisation values their work (Staff Survey December 2019 data). However this metric has improved for Disabled staff from 35% (2018) to 36.9% (2019).
- The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that said the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months (Staff Survey December 2019 data). This metric has improved for Disabled staff from 40.6% (2018) to 41.1% (2019).

The data for 4 to 9 B) above is from the Staff Survey and inherently more staff report themselves as disabled when completing the staff survey compared to the staff who report themselves as disabled through ESR.

The data shows there are improvements to be made across all of the indicators. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR.

5 WDES Action Plan

The draft WDES Action Plan for 2020/21 is available in Appendix 3.

6 Recommendation

The Executive Management Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WDES return and action plan for submission to the Trust Board for approval.

Simon Nearney
Director of Workforce and Organisational Development
August 2020

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2020
Name and title of Board lead for the Workforce Disability Equality Standard:	Teresa Cope, Chief Operating Officer
Name of lead compiling this report:	Liz Dearing, HR Manager
Names of commissioners this report has been sent to:	Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group
Name of co-ordinating commissioner this report has been sent to:	Hull Clinical Commissioning Group
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however 36.63% of the workforce have not declared as disabled or non-disabled, which represents 3,503 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 9,562

Proportion of disabled staff employed within the Trust at the date of the report: 2.19% of the total staff employed as self-declared through ESR.

3. Self-Reporting

The proportion of total staff who have self-reported disabled/non-disabled: 63.37%

Have any steps been taken to increase declaration rates? All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

Are any steps planned during the current reporting period to improve the level of self-reporting? To improve the quality of data stored within ESR, ESR Self Service continues to be rolled out, highlighting to staff that they can update their personal information, including ethnicity, marital/partnership status and disability status.

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2020 and activity during the financial year 2019/20.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2019/20		Data for previous year 2018/19		Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2020:				In total 63.38% of Trust staff declared themselves as disabled or non-disabled. The highest percentage of disabled employees are within the clinical workforce (non-medical) whilst the lowest percentage of disabled employees are within the clinical workforce (medical and dental)	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
		Non-clinical workforce (Non-disabled) =	12.98%	Non-clinical workforce (Non-disabled) =	13.25%		
		Non-clinical workforce (Disabled) =	0.53%	Non-clinical workforce (Disabled) =	0.59%		
		Clinical workforce (non-medical Non-disabled) =	36.67%	Clinical workforce (non-medical Non-disabled) =	33.01%		
		Clinical workforce (non-medical Disabled) =	1.44%	Clinical workforce (non-medical Disabled) =	1.20%		
		Clinical workforce (medical and dental non-disabled) =	11.54%	Clinical workforce (medical and dental Non-disabled) =	9.72%		
		Clinical workforce (medical and dental Disabled) =	0.21%	Clinical workforce (medical and dental Disabled) =	0.16%		
2	Relative likelihood of Non-disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.22 Disabled: 0.16 Relative likelihood: 1.41		Non-disabled: 0.21 Disabled: 0.14 Relative likelihood: 1.49		The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2019/20	Data for previous year 2018/19	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-disabled staff. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled: 0.00 Non-disabled: 0.00 Relative likelihood: 4.00	Disabled: 0.01 Non-disabled: 0.00 Relative likelihood: 1.67	The numbers of staff entering the formal capability process are low, the relative likelihood of entering the formal capability process is nil for both Disabled and Non-Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Non-disabled: 23.9% Disabled: 27.0% (From Staff Survey December 2019)	Non-disabled: 23.5% Disabled: 32.2% (From Staff Survey December 2018)	The percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months.	Non-disabled:11.9% Disabled: 20.0% (From Staff Survey December 2019)	Non-disabled:12.8% Disabled: 24.6% (From Staff Survey December 2018)	The percentage of Disabled staff experiencing harassment, bullying or abuse from managers has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months.	Non-disabled: 17.8% Disabled: 29.7% (From Staff Survey December 2019)	Non-disabled: 19.8% Disabled: 30.8% (From Staff Survey December 2018)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from other colleagues has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	Non-disabled: 40.8% Disabled: 41.1% (From Staff Survey December 2019)	Non-disabled: 42.1% Disabled: 40.6% (From Staff Survey December 2018)	The percentage of Disabled staff reporting harassment, bullying or abuse at work has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
5	Percentage of staff	Non-disabled: 89.2%	Non-disabled: 90.5%	The percentage of Disabled	Please see action plan.

	Indicator	Data for reporting year 2019/20	Data for previous year 2018/19	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	believing the Trust provides equal opportunities for career progression or promotion.	Disabled: 79.4% (From Staff Survey December 2019)	Disabled: 82.1% (From Staff Survey December 2018)	staff believing the Trust provides equal opportunities for career progression or promotion has decreased.	Actions link to EDS2 goals and the Trust Equality Objectives.
6	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 21.8% Disabled: 29.2% (From Staff Survey December 2019)	Non-disabled: 22.9% Disabled: 32.9% (From Staff Survey December 2018)	The Percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has decreased .	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 50.2% Disabled: 36.9% (From Staff Survey December 2019)	Non-disabled: 51.7% Disabled: 35.0% (From Staff Survey December 2018)	The percentage of Disabled staff saying they are satisfied with the extent to which their organisations values their work has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	74.3% (From Staff Survey December 2019)	75.7% (From Staff Survey December 2018)	The percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the overall score for the organisation.	Non-disabled staff: 7.1 Disabled: 6.6 Organisation: 7.0 (From Staff Survey December 2019)	Non-disabled staff: 7.2 Disabled: 6.6 Organisation: 7.0 (From Staff Survey December 2018)	The staff engagement score for Disabled staff continues to be lower than for Non-disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9b	Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?	No	Yes	The feasibility of an on-line forum has been explored and further discussions will include IT services.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	**Data for reporting year 2019/20**	**Data for previous year 2018/19**	**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	-2.0%	-2.0%	Considering the percentage of staff who have self-reported as Non-disabled and the percentage of staff who have self-reported as Disabled the disaggregated percentage difference would be expected to be very low. The Trust acknowledges that, in respect of disability, the Board is not representative of the population it serves. Within Hull and East Riding the disabled population is 19%.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

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

None

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

The Draft WDES Action plan is attached.

					Snapshot of data as at 31st MARCH 2020						
					Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
METRIC	INDICATOR	DATA ITEM		MEASURE	# DISABLED	% DISABLED	# NON-DISABLED	% NON-DISABLED	# UNKNOWN/NULL	% UNKNOWN/NULL	TOTAL
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.		**1a) Non Clinical Staff**								
		1	Under Band 1	Headcount	1	5.0%	18	90.0%	1	5.0%	20
		2	Bands 1	Headcount	1	2.2%	27	58.7%	18	39.1%	46
		3	Bands 2	Headcount	23	2.4%	584	60.6%	357	37.0%	964
		4	Bands 3	Headcount	12	2.7%	237	52.7%	201	44.7%	450
		5	Bands 4	Headcount	4	2.1%	109	56.2%	81	41.8%	194
		6	Bands 5	Headcount	4	2.4%	94	57.3%	66	40.2%	164
		7	Bands 6	Headcount	0	0.0%	51	51.5%	48	48.5%	99
		8	Bands 7	Headcount	2	2.2%	50	56.2%	37	41.6%	89
		9	Bands 8a	Headcount	1	1.7%	30	50.8%	28	47.5%	59
		10	Bands 8b	Headcount	3	6.4%	17	36.2%	27	57.4%	47
		11	Bands 8c	Headcount	0	0.0%	9	45.0%	11	55.0%	20
		12	Bands 8d	Headcount	0	0.0%	4	50.0%	4	50.0%	8
		13	Bands 9	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0
		14	VSM	Headcount	0	0.0%	11	50.0%	11	50.0%	22
		15	Other	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0
			1b) Clinical Staff								
		20	Under Band 1	Headcount	3	6.25%	43	89.58%	2	4.17%	48
		21	Bands 1	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0
		22	Bands 2	Headcount	31	2.23%	931	67.03%	427	30.74%	1389
		23	Bands 3	Headcount	10	1.76%	287	50.44%	272	47.80%	569
		24	Bands 4	Headcount	3	1.56%	106	55.21%	83	43.23%	192
		25	Bands 5	Headcount	57	2.99%	1265	66.33%	585	30.68%	1907
		26	Bands 6	Headcount	19	1.88%	538	53.21%	454	44.91%	1011
		27	Bands 7	Headcount	12	1.88%	255	40.03%	370	58.08%	637
		28	Bands 8a	Headcount	2	1.35%	58	39.19%	88	59.46%	148
		29	Bands 8b	Headcount	1	1.92%	12	23.08%	39	75.00%	52
		30	Bands 8c	Headcount	0	0.00%	7	30.43%	16	69.57%	23
		31	Bands 8d	Headcount	0	0.00%	2	50.00%	2	50.00%	4
		32	Bands 9	Headcount	0	0.00%	1	33.33%	2	66.67%	3
		33	VSM	Headcount	0	0.00%	1	12.50%	7	87.50%	8
		34	Medical & Dental Staff, Consultants	Headcount	2	0.40%	294	58.92%	203	40.68%	499
		35	Medical & Dental Staff, Non-Consultants career grade	Headcount	1	1.35%	51	68.92%	22	29.73%	74
		36	Medical & Dental Staff, Medical and dental trainee grades	Headcount	17	2.08%	758	92.89%	41	5.02%	816
		37	Other	Headcount	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By Voting membership of the Board • By Executive membership of the Board This is a snapshot as of at 31st March 2020.	54	Total Board members	Headcount	0		0		14		14
		55	*of which: Voting Board members*	Headcount	0		0		11		11
		56	*: Non Voting Board members*	Auto-Calculated	0		0		3		3
		57	Total Board members	Auto-Calculated	0		0		14		14
		58	*of which: Exec Board members*	Headcount	0				5		
		59	*: Non Executive Board members*	Auto-Calculated	0		0		9		9
		60	Number of staff in overall workforce	Auto-Calculated	209		5850		3503		9562
		61	Total Board members - % by Disability	Auto-Calculated		0%		0%		100%	
		62	Voting Board Member - % by Disability	Auto-Calculated		0%		0%		100%	
		63	Non Voting Board Member - % by Disability	Auto-Calculated		0.00%		0%		100%	
		64	Executive Board Member - % by Disability	Auto-Calculated							
		65	Non Executive Board Member - % by Disability	Auto-Calculated		0%		0%		100%	
		66	Overall workforce - % by Disability	Auto-Calculated		2%		61%		37%	
		67	Difference (Total Board - Overall workforce)	Auto-Calculated		-2%		-61%		63%	
		68	Difference (Voting membership - Overall Workforce)	Auto-Calculated		-2%		-61%		63%	
		69	Difference (Executive membership - Overall Workforce)	Auto-Calculated							

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN 2020/2021

The Action Plan has been developed, based on the 2019/20 WDES technical data results, to help close the gaps in workplace experience between Disabled and Non-disabled staff.

Action	Metric	Delivery Timescale	Lead Responsibility
Explore establishing a Disability network.	**All**	**January 2020**	**Head of HR Services/Head of Workforce**
Renew Disability Confident Scheme.	**1, 2**	**October 2020**	**Head of HR Services**
Review Great Leaders Bitesize programme – ensure equality, diversity & inclusion is incorporated to enable and empower staff to be consistently conscious and fair in all decision making.	**All**	**January 2020**	**Head of OD/Head of Education**
Review the Reasonable Adjustment process and raise awareness and knowledge.	**5, 6, 7, 8, 9a**	**December 2020**	**Head of Workforce**
Continue to encourage staff to complete/update personal details on ESR.	**All**	**November 2020**	**Workforce Planning, Intelligence & ESR Systems Manager**
Develop and launch a Differently-Abled Passport	**4, 5, 6, 7, 8, 9a, 9b**	**December 2020**	**Head of Workforce**

Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee / Trust Board

20 August 2020 / 8 September 2020

Title:	Trade Union Facility Time Publication Requirements
Responsible Director:	Simon Nearney, Director of Workforce and OD
Author:	Louise Whiting, Employment Policy and Resourcing Manager

Purpose:	The purpose of this report is to share with and seek the Workforce, Education and Culture Committee and Trust Board's approval for the Trust's Trade Union Facility Time Reporting data for the period 1 April 2019 to 31 March 2020, prior to publication of the data in line with statutory requirements	
BAF Risk:	Risk 2 – workforce	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	
Summary Key of Issues:	Under the Trade Union (Facility Time Publications Requirements) Regulations 2017, all public sector organisations that employ over 49 full time employees are required to publish annually certain data relating to facility time usage within their annual reports, on their organisation website and also through the Governments reporting service. This year reporting needs to be complete by 30 September 2020. The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.	

Recommendation:	The Workforce, Education and Culture Committee and Trust Board are requested to note and approve content of this report. Once approved by the Board, the report will be published on the Trust and Gov.UK websites. It is also referenced in the Trust Annual Report.

Hull University Teaching Hospitals NHS Trust
Trust Board
Trade Union Facility Time Publication Requirements

1 Purpose of this Report

The purpose of this report is to explain the background to the Trust's reporting requirements in relation to Trade Union Facility Time, provide an overview of the specific annual reporting requirements, together with Trust data for the third reporting period.

2 Background

The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

The percentage of the Civil Service pay bill spent on facility time fell after the implementation of similar reforms, from 0.26% in 2012 to just 0.07% for the 1st quarter of 2015.

It is not however expected that it will result in a significant impact on trade union representatives carrying out their trade union duties for which there is a legal entitlement to reasonable paid time off work.

The Government will assess the information published by public sector employers on facility time before deciding whether regulations to introduce limits on the level of facility time that public sector employers provide, in proportion to their total pay bill, are appropriate.

3 Annual Reporting Requirements

The third report (covering the period 1 April 2019 to 31 March 2020) must be published by 30 September 2020 (extended from the normal 31 July 2020 deadline in light of the COVID-19 pandemic) on the Trust's website and referenced in the Trust Annual Report. The information must also be reported via the government portal to the same timescales so that it can be placed on the Gov.UK website.

The reporting requirement applies only where an employer has at least one trade union representative and 50 or more employees for seven months during the reporting period, which is the period of 12 months beginning 1 April each year. As such the Regulations apply to the Trust.

The duty to report covers specific information (set out in detail in Schedule 2 of the Regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation. The Trust's proposed report also contains brief narrative to contextualise the required data (Appendix 1).

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4 Trust Data 2019 – 2020

The Trust's mandatory data for the third reporting period 1 April 2019 to 31 March 2020 (detailed in Appendix 2) highlights that the Trust percentage of total pay bill spent on facility time, at 0.02% is less than the Civil Service 2015 data (0.07%). The percentage is the same as for the two previous reporting periods, 2017 – 2018 and 2018 – 2019.

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017, utilising data submitted from staff side representatives (taken from national NHS Electronic Staff Record, HealthRoster, ABIS, Job Planning systems or paper returns).

Whether in providing support to individual staff members at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (e.g. Job Evaluation Panels, Joint Negotiating and Consultative Committees, Collective Agreements, Policy Sub Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

5 Comparative Data – Using Data from Previous Reporting Period

The reforms encourage public sector employers, including the Trust, to monitor and, where appropriate, evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

As part of this assessment the Trust has used the 2018 – 2019 data published on the Cabinet Office website to compare the percentage of the pay bill it spent on facility time in 2018 – 2019 (0.02%) with comparable NHS organisations both nationally and more geographically based (i.e. with a headcount of 5001 to 9999), as well as with local (non-comparable sized) Trusts.

Analysis of the data of the 48 Trusts nationally who formally reported via the national reporting tool by the July 2019 deadline shows:

- the percentage of the pay bill spent on facility time ranged from 0 to 7.09
- the mode was 0.02% (the percentage value that appears most often),
- the medium was 0.03% (the middle value in the list of numbers),
- data for Trusts more geographically based are shown in Table 1 below.

Table 1: Comparable Sized NHS Trusts (headcount 5001 to 9999) Data 2018 – 2019

Trust Name	**% of Pay Bill Spent on Facility Time**	**Higher/Lower % than the Trust (0.02%)**
Bradford Teaching Hospitals NHS Foundation Trust	0.01	↓
Calderdale and Huddersfield NHS Foundation Trust	0.02	Same
County Durham and Darlington NHS Foundation Trust	0.02	Same
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	0.01	↓
Mid Yorkshire Hospitals NHS Trust	0.02	Same
Nottinghamshire Healthcare NHS Foundation Trust	0.03	↑
South Tees Hospitals NHS Foundation Trust	0.03	↑
York Teaching Hospital NHS Foundation Trust	0.02	Same
United Lincolnshire Hospitals NHS Trust	0.04	↑

A further comparison was also undertaken against other (non-comparable sized) local Trusts.

Table 2: Non-Comparable Local NHS Trusts Data 2018 – 2019

Trust Name	**% of Pay Bill Spent on Facility Time**	**Higher/Lower % than the Trust (0.02%)**
Humber NHS Foundation Trust	0.03%	↑
Northern Lincolnshire and Goole Foundation Trust	0.02%	Same
Leeds Teaching Hospitals NHS Trust	0.02%	Same

The analysis provides assurance that, based on the figures for the last reporting year (2018 – 2019), the data for the Hull University Teaching Hospitals NHS Trust was within reasonable limits.

The Trust will again compare the percentage of pay it has spent on facility time for 2019 – 2020 with other similar sized and local NHS Trusts, once they have submitted their data for this, the third reporting period deadline.

6 The Proposed Report for 2019 – 2020

Attached for the Board's approval (as Appendix 1 and 2), is the proposed report to meet the Trade Union Facility Time Publication Requirements for the third reporting period 1 April 2019 to 31 March 2020.

7 Recommendation.

The Workforce, Education and Culture Committee and Trust Board are asked to note the content of this report.

Finally, the Board are asked to approve the report. Once approved by the Board, the report will be published within the on the Trust website, prior to the 30 September deadline. It will also be placed on the Government portal.

Simon Nearney
Director of Workforce
August 2020

Appendix 1

Hull University Teaching Hospitals NHS Trust

Trade Union Facility Time Publication Requirements
Reporting Period; 1 April 2019 to 31 March 2020 Inclusive

1 Introduction

The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

2 Background to the New Reporting Requirements

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

3 Annual Reporting Requirements

The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation.

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4 Trust Data 2019 – 2020

The Trust's data for the reporting period 1 April 2019 to 31 March 2020 is attached as Appendix 2.

Whether in providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (for example: Joint Negotiating and Consultative Committees, Job Evaluation Panels, Collective Agreements, Policy Sub-Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

The Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

Appendix 2

Hull University Teaching Hospitals NHS Trust

The Trade Union (Facility Time Publication Requirements) Regulations 2017
Reporting Period; 1 April 2019 to 31 March 2020 Inclusive

Table 1: Relevant union officials

Total number of Trust employees who were relevant union officials during the relevant period, 1 April 2019 to 31 March 2020:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number (of trade union representatives)
68	60.27

Table 2: Percentage of time spent on facility time

Hull University Teaching Hospitals NHS Trust's employees, who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	25
1%-50%	43
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time

The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

	Figures
Total cost of facility time	£81,042
Total pay bill	£388,021,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, the number of staff hours spent by employees who were relevant union officials during the relevant period on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	1.02%

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017.

HULL UNIVERSIRT TEACHING HOSPITALS NHS TRUST

TRUST BOARD

8 SEPTEMBER 2020

Title:	Trust Strategy Implementation Midyear Update	
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning	
Author:	Jacqueline Myers, Director of Strategy and Planning	
Purpose:	The purpose of this report is to apprise the Board of progress towards the achievement of the goals set in our Trust Strategy 2019 - 2024	
BAF Risk:	The Strategy is relevant to all of our BAF risks	
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	X
Key Summary of Issues:	• All of the outcome implementation plans have been reviewed by the lead Executive Officer. • A number of milestones set by Directors for 2020/21 have not been met, largely because of the impact of Covid 19. This has resulted in 11 outcome measures having their risk rating increased. • Progress is on track for 37 of the 50 outcome measures. • Progress has improved for 2 of the outcome measures and 1 (achievement of Integrated Care System Status for Humber, Coast and Vale Partnership) has been delivered.	
Recommendation:	1. That Trust Board notes the contents of the paper and indicates any areas where further action or assurance is sought.	

Trust Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Great Staff	Staff survey overall result top 20% of Trusts	↓	Staff report able to make improvements top 20% of Trusts	↓
	Staff engagement score top 20% of Trusts	↓	More BME staff in leadership roles	↓
	80% of staff recommend us as a place to work	↓	95% of posts are filled with permanent staff	←
	At least a 92% retention rate	←	Improve the health and wellbeing of our staff	↓
Great Care	Achieve 'Outstanding' overall CQC rating	←	Increase harm free care year on year	←
	Increase the length of time between SIs and NEs	←	Deliver the 4 priority 7 day working standards	←
	Fewer complaints and PALS relating to outpatient services	←	Patient Friends and Family Test score : in top 20% of Trusts	←
	Improve transition from children's to adult services	←	Provide patient electronic access to medical records	←
	Extend access to latest surgical and drug treatments	←	Achieve and sustain 28 day and 6 week diagnostic targets	←
	Deliver 10,000 health prevention interventions	←	Reduce hospital stays for patients in the last year of life	←
	Reduce admissions for patients with long term conditions	←	Deliver year on year reductions in our length of stay	←
	Ensure our integrated teams have access to shared care records	←	Meet the standard for fractured neck of femur	←
	Deliver standards for urgent and emergency care	←	Reduce face to face outpatient appointments	←
	Expand and update our diagnostic capacity	←	Deliver the 'Better Birth' ambitions	←
	Centralise inpatient paediatrics and improve the NICU	←	Deliver the clinical access standards for cancer and electives	↓
	Secure sustainable specialist paediatric service	↓	Continue to improve our major trauma survival rates	←
	Improve timely access to acute and elective cardiac care	←	Improve the cancer stage of presentation and survival rates	←
	Establish a mechanical thrombectomy service	←	Working with partners, support the progression of the HCAV HCP into an ICS	↑
	Establish an ICP that can show measurable improvement to the health of its population	←	Working with partners across the Humber region, secure safe and sustainable acute hospital services	↓
	Support the work to create a sustainable clinical model for hospitals services in Scarborough	←	Establish mature programmes of workforce development and research with our international partners	←
Great future	Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit	←	Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio	←
	Achieve all Department of Health and NIHR research performance metrics	←	Secure three new long-term commercial research partnerships	↓
	Secure 'top 5' national status with our Academic Oncology Research Unit	↓	Working with partners, achieve financial balance across our ICP	←
	Improve the quality of our estate and increase the productivity per square metre	←	Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy	←
	Become greener by reducing our energy consumption and waste	←	Become a digital first organisation; removing paper	↑

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Staff survey overall result top 20% of Trusts		
Exec Owner S Nearney		
Milestone	By When	Progress
4 of the key findings in the top 20% and 6 equal to or better than the national average	March 2020	4 are in the top 20%, 4 are equal to or better than the national average
6 of the key findings in the top 20% and 4 equal to or better than the national average	March 2021	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Staff report able to make improvements top 20% of Trusts		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2020	Slightly decreased by 0.6% (48.4% to 47.8%)
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2021	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.4%	March 2022	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2023	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2024	
Achieve top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Staff engagement score top 20% of Trusts		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey result for staff engagement – 7.1	March 2020	HUTH held its engagement score at 7.0. Nationally this score worsened.
National Staff Survey result for staff engagement – 7.2	March 2021	
National Staff Survey result for staff engagement – 7.3	March 2022	
Achieve top 20% ranking	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

More BME staff in leadership roles		
Exec Owner: S Nearney		
Milestone	By When	Progress
Number of BME staff in leadership roles will increase by 0.5% to 6.25%	March 2020	WRES action plan developed and submitted.
Number of BME staff in leadership roles will increase by 0.75% to 7%	March 2022	
Number of BME staff in leadership roles will increase by 1% to 8%	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

At least 80% of staff recommend us as a place to work		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey question . Staff response will be 67%	March 2020	62.7% of staff would recommend us as a place to work.
National Staff Survey question . Staff response will be 70%	March 2021	
National Staff Survey question . Staff response will be 74%	March 2022	
National Staff Survey question . Staff response will be 77%	March 2023	
National Staff Survey question . Staff response will be 80%	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

95% of posts are filled with permanent staff		
Exec Owner: S Nearney		
Milestone	By When	Progress
94.2% of posts filled with permanent staff	March 2020	As at 31.7.20 96.4% of posts are filled with permanent staff
94.6% of posts filled with permanent staff	March 2021	
95% of posts filled with permanent staff	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

At least a 92% retention rate		
Exec Owner: S Nearney		
Milestone	By When	Progress
91% staff retention rate	March 2020	91% as at 31.7.20
91.5% staff retention rate	March 2021	
92% staff retention rate	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Improve the health and wellbeing of our staff		
Exec Owner: S Nearney		
Milestone	By When	Progress
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2020	Remained the same at 6.8 (out of 10)
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2021	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2022	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2023	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2024	
Achieve 6.4 point score which will deliver a top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Achieve 'Outstanding' overall CQC rating		
Exec Owner: C Long		
Milestone	By When	Progress
Achieve overall 'Good' rating	Mar 2020	Trust rated 'Requires Improvement' overall in March 2020 inspection. 'Good' rating for 'Well Led' retained. Trust joined the NHSE&I 'Moving to Good' Programme, however this has been suspected during the response to Covid 19.
Sustain overall 'Good rating' and achieve 'Outstanding' rating in 2 core services	Mar 2022	The CQC is reviewing their inspection regime and it is not yet clear what the approach or requirements will be.
Sustain overall 'Outstanding' rating	Mar 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Increase harm free care year on year		
Exec Owner: Makani P		
Milestone	By When	Progress
Establish mechanisms to measure harm and establish a baseline	September 2019	Completed
Identify areas of improvement to achieve harm free care	November 2019	Patient safety committee formed
Focus on one area of improvement	January 2020	Near misses
Roll out to wider areas and Embark on further areas of improvement	January 2022	Commenced but stalled due to Covid

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Increase the length of time between SIs and NEs		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Refresh mechanisms to capture and manage SIs	November 2019	Refresh underway
Full launch of Stop the Line Campaign	March 2020	Campaign in development
Develop and deliver projects to address key themes	March 2021	Delayed due to Covid but recommenced in September 2020
Continually capture real time data	March 2021	
Embed proactive safety culture	December 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Achieve compliance with the 4 clinical priority standards for 7 day services by March 2020		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Develop a series of metrics to support reporting of progress against the 7DS standards	July 2019	Complete (actual performance to date 2 of 4 achieved)
Identify those specialties who continue to under-perform against the standards and agree specific actions to address the shortfalls in delivery	August 2019	Complete
Provide six monthly updates on progress to the Trust Board in accordance with the 7DS Board Assurance Framework	Ongoing	On track Program suspended nationally this financial year due to Covid

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Fewer complaints and PALS relating to Outpatient Services		
Exec Owner: B Geary		
Milestone	By When	Progress
Baseline report based on 2018/19 to be completed	June 2019 – completed	Baseline of reported complaints/PALS for 2018/19 36 compliments 957 concerns (PALS) 191 Complaints (Formal) (However not all linked to outpatient activity due to categorisation – this is being addressed) Update 08/2020: XXXXX
Focussed patient engagement to be undertaken	July 2019	Family and Friend continues to be used in OPD's. 2018/19 97.83%.Questionairre to be amended to ask "Did you need to attend today?" NHS Choices reported monthly. All areas act on comments/concern/compliments on a daily basis Update 08/20 : active engagement with patients being undertaken to evaluate new digital approaches
Action plan to be developed and approved by the OP Governance Group	July 2019	Patient stories shared monthly at OPG and datix and discussed. Monthly break down of PALS at Committee since October again future work as not all concerns
Quarterly monitoring to commence against baseline	Oct 2019	Commenced first report received at October committee
Development and deployment of Trust annual outpatient survey	2020/2021	Not yet commenced Update; 08/20 Given the planned significant changes to Outpatients' services which were implemented initially as a result of the Covid-19 pandemic, a rebasing of the work needs to be undertaken to review objectives in light of new ways of working .

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Patient Friends and Family Test score : in top 20% of Trusts		
Exec Owner: B Geary		
Milestone	By When	Progress
Identify themes in F&FT and agree action plan to address	Sept 2019	Wider review of patient and public feedback well underway. Update 08/20 : PESG now identifying themes from patient feedback with a view to identifying areas for improvement
Delivery improvement on 2018/19 baseline	March 2020	Delayed due to Covid 19
Following launch of successor scheme to F&FT, develop and deploy plan to achieve top 20% rank	TBC	Delayed due to Covid_19

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Improve transition from children's to adult services		
Exec Owner: T Cope		
Milestone	By When	Progress
Baseline audit against NICE standards	March 2019	Complete
Broader transition partnerships developed and activated	March 2020	Complete have local links and a member of the Yorkshire and Humber Transition forum
Patient and carer levels of knowledge regarding condition and adult services enhanced	March 2020	Complete in specific areas i.e. diabetes, CF and IBS
Robust patient experience measurement tool developed	March 2021	
Delivery model for transition clinics reviewed and changes implemented as indicated	March 2022	
Tool deployed and shows improved experience	2022 - 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Provide patient electronic access to medical records		
Exec Owner: L Bond		
Milestone	By When	Progress
Go Live with 'Patient Knows Best' system	Jul 2019	Slightly delayed by flow of national funding but will be delivered by March 2020
Rollout, linked to the Yorkshire and Humber Care Record programme	Sept 2020	
Deliver plan to maximise patient take up, with focus on long term conditions	Sept 2021	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Extend access to latest surgical and drug treatments

Exec Owner: Makani P

Milestone	By When	Progress
Increased commercial research activity year on year from 2018/19 baseline.	March 2020 (Yr 1) March 2021 (Yr 2)	Engagement and contribution to Y&H CRN 2020/21 Annual Plan. As at 28.08.20 HUTH (71) has the highest commercial recruitment in Y&H ahead of Leeds (69) and Sheffield (30). Due to Covid-19 vaccine trials (many commercial) this metric will be skewed in Yr 2 by allocation of these trials to sites by Y&H CRN (based on capacity). Commercial activity is not likely to return to normal equitable levels until Yr 3 (2021/23).
Increased research workforce capability to deliver increased activity.	On-going from 2019/20	4 PhD Scholarships awarded (1 AHP). 6 Research Support Funding awards (with HYMS) to support protected time and provide methodological support (activity paused due to Covid-19). 9 Clinical Research Fellows appointed (Infection, Renal, Cardiothoracic, Orthopaedics , Vascular and Gastro). 5 NIHR ACF Posts awarded to start in 2020. 7 new Principal Investigators engaged (Renal, ID, ED, Imaging). 2 posts supported in Pharmacy Trials Team (from September 2019). Lead Research Nurse appointed (Oct 2019) Radiotherapy research nurse appointed. Vaccine Task Force Funding to boost Covid-19 research capacity (2 RNs, I CTA, 1 RA and 0.5 CRF). **Trust priority to establish 'Academic Dept of Infection Research'**
Increased research awareness from Trust visitors, carers and patients.	On-going from 2019/20	Website development on-going with facility for researchers to upload and share stories and promote activities/articles and presentations. Development paused during Covid-19

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Achieve and sustain 28 day and 6 week diagnostic targets

Exec Owner: T Cope

Milestone	By When	Progress
Determine the Capacity requirements in each modality and target	August 2019	Demand on each modality is monitored and discussed vi a Performance and Activity meeting fortnightly.
Understand the impact of referrals from outside HUTH	August 2019	This is reported fortnightly via Performance and Activity Meeting and report on Inter Hospital Transfer are provided to referring Trusts on a monthly basis
Project growth in demand over the next 5 years	August 2019	This work has been completed as part of the Long Term Plan
Factor in changing technologies or therapies over the next five years	August 2019	This work has been completed as part of the Long Term Plan
Develop staged milestones required to achieve the targets	Sept 2019	In place
Breach percentage against the 6 week standard reduced to 2%	March 2020	**This milestone was not achieved due to high levels of demand for Endoscopy throughout 2019/2020 and then further Impacted by Covid from March 2020. Performance at the end of Q1 20/21 was 55% of patients seen within 6 weeks with 4618 patients over 6 weeks. Recovery Plans are in place as part of Phase 3 planning .**
6 week standard achieved	March 2021	**This milestone is unlikely to be achieved due to the impact of Covid and reduced efficiency in diagnostics as a result of Infection Prevention and Control requirements .**
28 day standard achieved	September 2021	**Achieved. The 28 day Faster Diagnostic Standard has been set at 75% from April 2020. The standard was achieved for Q4 2019/20 and has been achieved for May and June 2020.**

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Deliver 10,000 health prevention interventions		
Exec Owner: Makani P		
Milestone	By When	Progress
Establish baseline levels of delivery	March 2020	Delayed due to Covid 19. Will be picked up in 2021/22
Develop a programme plan to increase level of health prevention activity delivered by the Trust, based on brief intervention and sign posting to smoking cessation, healthy weight and alcohol services	March 2020	Delayed due to Covid 19. Will be picked up in 2021/22
Deliver a minimum of 10,000 interventions	March 2024	Should still be able to achieve this

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Reduce hospital stays for patients in the last year of life

Exec Owner: T Cope

Milestone	By When	Progress
Embed SAFER principles across the organisation, with Home First as a priority.	1st July 2019	Achieved: SAFER has been re-launched across the organisation with agreed metrics in place which are monitored by the Emergency Performance and Flow Performance and Activity Meeting.
Use Red2Green days to reduce any unnecessary waiting.	1st July 2019	see above
Work with the Discharge Hub to support advanced care planning.	1st June 2019	A review of the Discharge Hub has been undertaken in Q1 and a work programme for the Hub has been agreed to improve interface with the wards and Out of Hospital partners. This is monitored via the Unplanned Care Delivery Group.
Ensure all RESPECT forms are appropriate and up to date.	1st July 2019	**Achieved: As part of the system wide response to Covid work was undertaken across the local system to support the Frail Elderly population and increase support to Care Homes to prevent any unnecessary conveyances to hospital . These arrangements are being supported to continue across the system.**
Develop and implement an improvement plan, for the above.	1st June 2019	See above
Develop and implement an	1st July 2019	See above

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Reduce admissions for patients with long term conditions

Exec Owner: T Cope

Milestone	By When	Progress
Introduce Hospital at Home for COPD patients.	December 2019	Programme plan in place and on track to begin in December 2019
Work with the ICC/ED/ Care homes to prevent Frailty patients being admitted.	December 2019	Care Home workstream in place
Increase access to ACU/MDCU to prevent in-patient admissions.	July 2019	Plan for expansion of AMU/MCDU on track
Audit with a multidisciplinary team x 60 sets of case notes to establish if all patients needed admission or could they have gone elsewhere. Evaluate and present to partner organisations.	June 2019	
Work with partner organisation to identify alternatives to hospital i.e. social care/ see & treat/ step up beds.	December 2019	
Identify the highest cohort of long term conditions, working with the speciality teams to help prevent hospital admission.	June 2019	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Deliver year on year reductions in our length of stay

Exec Owner: T Cope

Milestone	By When	Progress
Deliver 40% reduction in number of occupied bed days of patient with a length of stay of 21 days or greater. Baseline 126 patients Target 77 patients	March 2020	This target was achieved at the end of March 2020.
Make year on year reductions in length of stay of patients who are in hospital 7 days or longer.	March 2022 - 24	The Target for 20/21 is for there to be no more than 66 patients in hospital over 21 days by March 2021. At the end of Q1, there were 74 patients with a LOS of 21 days or greater.
Work collaboratively with out of hospital partners to reduce delays in the transfer of care for patients with a length of stay of 7 days or greater. Baseline – 15%	March 2020	As a result of Covid a number of changes has been implemented across the local system have been put in place which has reduced the number of Delayed Transfer of Care. Via the Unplanned Care Delivery Group and the A&E Delivery Board programmes are in place to ensure these benefits are sustained going forward.
Improve pre-operative length of stay in Surgery	March 2020	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Ensure our integrated teams have access to shared care records		
Exec Owner: L Bond		
Milestone	By When	Progress
Agree benefits case for the Yorkshire and Humber Care Record Programme (YHCR), ensuring it achieves functional shared care records for Humber, Coast and Vale (HCAV)	March 2020	Benefits case agreed
Develop and agree investment plan for the YHCR	March 2020	Complete
Complete YHCR rollout in HCAV	March 2021	Implementation under way

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Meet the standard of fractured neck of femur		
Exec Owner: T Cope		
Milestone	By When	Progress
Hull & East Yorkshire NHS Trust to have a designated NOF Theatre (9) and 10 established theatre sessions. Recruit Neck of Femur Specialist Nurse	July 2020 November 2020	**Achieved: All 10 sessions to start 06.07.20** **Achieved: NOF Specialist Nurse trial commenced July 2020 for 12 weeks**
Recruit to vacant Ortho-geriatrics post.	April 2020	**Achieved Ortho - geriatric consultant recruited start date to be confirmed. Project group established.**
Fractured NOF bed to be available at all times on the 12th floor at HRI to accommodate all confirmed NOFS within the 4 hour target.	December 2019	**Complete**
Neck of Femur MDT to be established weekly.	May 2019	**Complete**
Deliver target of surgical treatment within 36 hours of arrival in ED	September 2020	**Monitoring compliance and all breaches discussed in the monthly NOF Governance Meeting.**

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Deliver standards for urgent and emergency care

Exec Owner: T Cope

Milestone	By When	Progress
Develop ED recovery and improvement plan linked to agreed performance standards trajectory	10th May 19	Complete. System Wide ED Recovery Plan in place and monitored via the Unplanned Care Delivery Group and the A&E Delivery Board
Sign off of ED recovery and improvement plan via UCDG	1st June 19	Complete
Primary Care Streaming (PCS) service specification developed and signed off by CCGs and HUTH	1st June	Complete. Primary Care Streaming Service commences from mid December following capital investment and estates reconfiguration works
PCS Implementation plan developed and signed off by UCDG	1st June	Complete
Develop and implement ACU improvement plan	1st July	Complete. ACU will be expanded to provide a Multi-specialty ACU with effect from mid December.
Develop and implement AMU improvement plan	1st August	In progress. AMU will be expanded to provide an Initial Assessment and Triage Zone from mid December to support effective flow.
Develop and implement Discharge Lounge improvement plan	1st September	Complete

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Reduce face to face outpatient appointments		
Exec Owner: T Cope		
Milestone	By When	Progress
Programme for reducing the number of face to face outpatient follow-ups agreed by the Out-Patient Improvement Board.	April 2019	Approach agreed via the OPD Improvement Board.
Phase 1 specialties for the reduction programme, support by the Trust Improvement Team, identified.	April 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 2 specialties for the reduction programme, supported by the Trust Improvement Team, identified	September 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 3 specialties for the reduction programme, supported by the Trust Improvement Team, identified	April 2020	
Out-patient follow-up volume reduced by 50% from baseline at 31/3/19.	June 2020	Progress at M6 2019/20 has been assessed and reported to PAF.
Phase 4 specialities for the reduction programme, supported by the Trust Improvement Team, identified	September 2020	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Expand and update our diagnostic capacity		
Exec Owner: L Bond		
Milestone	By When	Progress
Replace oldest CT and Gamma Camera	March 2020	CT replaced and Gamma Camera installation under way
Explore options for accelerating access to Wave 4 capital	March 2020	Complete
Agree business case for expanded endoscopy capacity	March 2020	Allam funded development in train. Additional kit funded as part of Wave 4 case
Install additional MRI and CT and commission additional endoscopy capacity	No later than March 2022	Funding secured for additional MRI and CT, plus replacement of Radiotherapy CTs with diagnostic capable machines
Agree demand requirements across the STP for key modalities through to 2024	March 2020	Initial demand and capacity work completed. To be refreshed in 2021
Agree and deliver further diagnostic capacity that meets forecast demand	March 2023	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Deliver the 'Better Birth' ambitions

Exec Owner: B Geary

Milestone	By when	Progress
Continuity of Carer	35% of women to be on a pathway for CoC by March 2020. 51% by March 2021	12 fixed term secondments have been recruited to CoC implementation Lead Diabetes Specialist Midwife, Midwifery Assistants x 4 for each CoC team. Primrose the 2nd Caseloading team launched June2019, linked to area of high depravation. Ivy team in place 1 year , 190 births and achieving 85% births attended by team member FABC model commenced July 2019. Currently 15.1% CoC, demonstrating the full pathway Update 08/20 due to Covid -19 this has been amended to 35% CoC by March 2021. Plan on-going
All women to have access to digital personalised care plan	March 2021	Work on-going with IS to develop personalised care plan
Maternity Voices Partnership to be in place	MVP to be in place by March 2019	MVP's in place for Hull and the East Riding of Yorkshire. Meetings set up and Hull MVP will be 'walking the patch' in the next couple of months
Prevention of Cerebral Palsy in pre-term infants Avoiding Term Admissions to neonatal units Reducing smoking (to 6% nationally)	Reducing stillbirths and morbidity by 2025	All midwives have undertaken ATAIN training, recent submission of ATAIN audit indicates decrease of term admissions. LMS Prevention Lead recruitment in progress. HUTH have declared compliance with CNST SafetyAction6 including SIP elements. Mat Neo Collaborative project; 'Increasing the Proportion of Smoke-Free Homes' with the Primrose team. Update 08/20 Action plans updated to meet Mat Neo objectives, managed through the LMS and W&C HG
Improved safety systems and culture, working with the Local Maternity System	March 2021	HUTH actively contributes to the Y&H safety learning network.
Workforce development – agree STP wide recruitment strategy and training standards	March 2021	Scoping Maternity Support Worker roles B3 with Hull College Engagement with Hull University addressing increase midwifery placements Culture survey feedback on-going Potential for LMS wide recruitment Update 08/20 HUTH engagement with the soon to be developed regional People Board to increase Nursing and Midwives by 50,000 by 2025

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Centralise inpatient paediatrics and improve the NICU		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree plan for future configuration of paediatrics	Mar 2020	Plan agreed
Agree funding stream for plan	Mar 2021	Wave 4 capital bid approved
Agree plan for improvement of NICU	Mar 2020	Minor works completed. Awaiting outcome of the HASR work.
Complete implementation of plans	Mar 2022	On track

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Deliver the clinical access standards for cancer and electives

Exec Owner: T Cope

Milestone	By When	Progress
Deliver Improvement in the 62 day Cancer performance to 85% (adjusted)	March 2020	This milestone was not achieved and has been further adversely impacted by Covid. Performance at end of Q1 was 67%. Improvement plans by Tumour site are in place and are monitored by the Performance and Activity Meetings and by the Humber Cancer Board.
Deliver 62 day cancer performance standard (unadjusted)	September 2021	See above
Reduce ASI / Holding by 50% from baseline position (31/3/19)	March 2020	The cessation of all routine OPD appointments during Covid resulted in the ASI and Holding increasing by 16,000 from the 31/1/20 baseline position. Plans to address the backlog are being developed as part of Phase 3 planning however the March 2021 target to eliminate ASI and Holding will not be achieved.
Eliminate ASI / Holding	March 2021	See above
Improve RTT performance to 84.5%	March 2020	RTT has been significantly impacted by Covid and at the end of Q1 RTT performance was 40.5% with 1886 patients waiting over 52 weeks for treatment. Recovery Plans are place as part of Phase 3 planning.
Reduce total waiting list volume by 3,000 from baseline 31/3/19)	March 2020	Stock take review at month 6 2019/20 has been conducted and reported to PAF 7th November. The Trust anticipates reducing its WLV in 19/20 but not by the stretch target of 3,000. The Trust reduced its WLV as at 31/1/20 against the baseline position and has continued to hold its WLV position through Q4 and Q1 20/21.
Improve RTT performance to 92%	December 2021	This is not expected to be achieved given the impact of Covid.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Secure sustainable specialist paediatric service		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree an approach to the service review with NHSE Specialist Commissioners	Mar 2020	Discussions in progress with both the specialised commissioners and as part of the Humber Acute Services Review
Undertake review and agree recommendations	Mar 2021	Review paused as part of Covid 19 response, but now restarting under umbrella of Humber Acute Services Review
Fully implement agreed revised service model	Mar 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Continue to improve our major trauma survival rates

Exec Owner: T Cope

2016 - 94.7%
2017 - 95.9%
2018 - 98.2%
2019 -98.54%

Milestone	By When	Progress
Maintain accuracy of TARN data collection, monitoring and outcomes.	Annually	**Review and validate quarterly dashboards on coding accuracy and escalate actions through the Major Trauma Board.**
Structured judgement review completed for all reportable deaths for the past 12 months.	June 2020	**1ST Mortality and Morbidity meeting held June 2020 now scheduled bi-monthly.**
5 year strategy to increase Major Trauma Consultant presence	April 2024	**Major trauma consultant presence increased from 5 to 10 hours Monday to Friday from October 6th 2020**
Maintain performance of 2018 baseline performance levels	Annually	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Improve timely access to acute and elective cardiac care

Exec Owner: T Cope

Milestone	By When	Progress
Work with peripheral Trusts to ensure optimisation undertaken prior to transfer, reduce pre-op LOS	April 2020	Achieved. Work has been undertaken across the ICS by the Clinical Team to ensure that all patients are optimised prior to transfer to HUTH.
Revised referral form to confirm readiness for elective procedure and prevent delays in patient pathway	October 2019	Achieved. There is a criteria led referral form in place. Referral forms have to be fully completed and all test results reviewed and documented prior to patients being accepted.
Scope the benefit of implementing a Cardio-thoracic Surgical Admissions Ward	Sept 2019	The scoping for this facility has been undertaken. This would require an additional 6 beds but would improve LOS and efficiency and reduce cancellations.
Implement day of surgery admissions	October 2020	A protocol has been developed to enable day of surgery admissions, however this requires some beds to be ring-fenced and additional nursing hours. The service is developing a business case for the additional nurse staffing.
Introduce one stop clinic to include pre- assessment for thoracic patients to improve patient pathway and experience	Dec 2019	Achieved; This was Implemented in February 2020 however for temporarily suspended in March due to Covid and redeployment of staff. The One Stop Clinic is expected to recommence from October 2020.
Achieve timely access: Acute inpatients operated on within 7 days of being fit for surgery. Elective patient wait to under 30 week waits.	March 2021	During Q1 – all Acute Inpatients have been operated on within 7 days as the Service has been able to Implement a Consultant of the Week model during Covid. The service is currently looking at how it can Implement a Consultant of the Week Model on a permanent basis. Prior to Covid, the Trust had 22 patients over 30 weeks. This has increased as a result of Covid to 84 patients over 30 weeks. Of these patients have dates for their Surgery. The service is still operating a reduced theatre timetable however a full theatre timetable is expected to be in place from September 2020.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Improve the cancer stage of presentation and survival rates

Exec Owner: Makani P

Milestone	By When	Progress
Supporting research programmes that focus on local and national issues for cancer stage of presentation.	On-going	The Trust supports and facilitates research undertaken with HYMS and UoH as part of £5m YCR funding. Recent example projects – 'Cancer Diagnosis via Emergency Presentation Study' (EMPRESS) and a range of patient reported outcomes surveys (PROMS) across multiple tumour sites. Work streams and new projects are likely to be delayed due to national mandate to pause non Urgent Public Health Research during Covid-19 pandemic. Restart activities commencing from August 2020.
Development of a research programme around PET CT and cyclotron facilities at CHH	On-going	Current work has focussed on non-cancer. Cancer research is likely to develop further in 2020-21. HUTH and HYMS Research Support Funding made available from September 2019 to provide seed money to support projects in PET-CT. Progress delayed with start up due to Covid-19 pause of non-urgent research activity.
Establish and maintain support for the Daisy Tumour Bank and collection of human samples to aid research in this area.	On-going	The bank is established in the Daisy Building at CHH with R&D Manager as liaison officer on behalf of the Trust. Review of future of Daisy Tumour Bank required by March 2021.
Support research programmes around tumour microenvironment (microfluidics).	On-going	The work of Professor John Greenman and colleagues in the University of Hull Daisy Laboratories has continued to expand with a focus on the utilisation of samples across colorectal, lung, head and neck, brain and thyroid cancers. Around 70 tumour samples have been used in various microfluidic devices and the work is part of that for 3 PhD students and 1 MD student. This work is also now expanding internationally following successful collaboration events in Chennai, India.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Establish a mechanical thrombectomy service

Exec Owner: T Cope

Milestone	By When	Progress
Develop a 9-5pm Monday-Friday mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2018	Current service is Monday-Friday 9-5pm and ad hoc dependant upon availability of skilled Neurointerventionists & Vascular Radiologists.
Develop a 24/7 mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2017-27	The Service continues to work towards this ambition however there is a national shortage of skilled clinicians to meet the NHSE ambition to deliver a 24/7 service by March 2021. This is being discussed via Regional and HCV Stroke Network meetings
Develop HASU & Stroke unit which will fully support mechanical thrombectomy. Providing the correct bed base for stroke services.	2018/19	HASU originally had 4 x speciality beds this has now moved to x 8, with a view to moving to x 12 as the tertiary service develops & expands. In April 2020 the HASU at Scarborough Hospital closed with patients now being received in HUTH. This has been accommodated within the current bed base however a business case is being developed to meet this additional demand in the longer term.
Staff & resource HASU & Stroke unit to fully support mechanical thrombectomy. Specialist staff required for supporting patients post mechanical thrombectomy.	2018/19	The service has some workforce challenges and has struggled to recruit to Consultant vacancies however continues to deliver the service outlined in the 2017 business case.
Monitor mechanical thrombectomy outcomes through the SSNAP data collection.	Ongoing	The service has continued to deliver the MT service during Covid and input full datasets for SSNAP over this period maintaining our current high standard of care

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Working with partners, support the progression of the HCAV HCP into an ICS		
Exec Owner: J Myers		
Milestone	By When	Progress
Support STP team to complete the system 5 year plan	Dec 2019	Plan completed and submitted
ICS established in shadow form	Mar 2021	Full ICS status achieved from April 2020
ICS fully established	Mar 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Establish an ICP that can show measurable improvement to the health of its population		
Exec Owner: J Myers		
Milestone	By When	Progress
Working with partners, establish a governance structure to develop the ICP	Oct 2019	ICP arrangements progressed well until March 2020, but now being reviewed in light of decision to create 'Humber' system
Support creation of ICP infrastructure and work programme	Mar 2020	Humber system governance agreed and programmes being transitioned into new set up
Support the development of ICP population health capability and agree improvement targets	Mar 2021	Holderness Primary Care Network is participating in the national support programme as a pilot for the ICS
Demonstrate improved population health in target areas	Mar 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Working with partners across the Humber region, secure safe and sustainable acute hospital services		
Exec Owner: J Myers		
Milestone	By When	Progress
Agree with all partners the approach and method for the review of acute services	Jun 2019	Complete
Ensure effective participation and leadership from HUTH teams and reps	Mar 2020	In progress – excellent HUTH engagement in development of the options for Urgent and Emergency Care and Maternity and Paediatrics.
Ensure effective scrutiny, and review of all service proposals for alignment to both Trust and review goals	Mar 2020	In progress
Working with colleagues and partners, oversee timely and effective implementation of service changes.	Mar 2022	In progress, some delays due to Covid 19, however, Interim Clinical Plan for most fragile services now agreed and service changes expected to be agreed and implemented within 12 months

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Support the work to create a sustainable clinical model for hospitals services in Scarborough		
Exec Owner: J Myers		
Milestone	By When	Progress
Ensure effective participation in the review by all relevant Trust teams	Mar 2020	Trust has a seat on the Steering Group for the Board
Represent HUTH on the review steering group and ensure active support for solutions and alignment to HUTH strategy	Mar 2020	Plan for sustainable oncology services agreed and implemented. Transfer of Hyper-acute stroke services to York, HUTH and South Tees Trusts agreed and implemented

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Establish mature programmes of workforce development and research with our international partners

Exec Owner: Makani P

Milestone	By When	Progress
Exchange programme for doctors in key specialities.	August 2019 - sustained on-going programme over the next few years	
Development of educational resources facilitated by an exchange programme of staff and resources.	May 2019 and on-going	Overseas simulation fellowship opportunities-to commence the first fellowship by May 2019 and follow up with others by May 2020 –on hold till Covid ends
Development of joint research opportunities and projects and Joint Research Conference.	December 2021	Sri Ramachandra Research Institute (Microfluidics, Infectious Disease, Geriatrics, Rehabilitation, Renal, Orthopaedics, Simulation research) – very successful collaborative research conference held in Chennai (India)February 2020. Reciprocal arrangements for a second conference held in Hull on hold due to Covid-19. Individual research collaborations to continue remotely (most advanced currently is Microfluidics).

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit

Exec Owner: Makani P

Milestone	By When	Progress
Be an active and influential voice as part of the HHTU Advisory Board.	On-going	R&D Manager invited to review HHTU provisional accreditation application that was submitted in August 2019. Provisional Accreditation received by UKCRC in September 2019.
Provide access to Trust expertise and staffing (i.e. Quality Assurance Team) as a formal contribution to the HHTU core staffing infrastructure.	On-going	R&D QA support provided as part of development activities of HHTU including complex drug study setup. Trial Manager invited to spend some time in the Trust R&D QA Team. Continuous support provided as required.
Provide a clear pathway allowing efficient and easy access to the HHTU and UoH research methods support.	March 2019 and on-going.	Supported the HHTU and UoH ICAHR launch in March 2019: ICAHR R&D Manager supporting seminar events for researchers. Research Support Funding allocations (from Sept-19) made to multiple applicants who are utilising the money to engage in services from HHTU/ICAHR.
Maximise the exploitation of Hull Health Trials Unit facilities (i.e. outsourcing skills and expertise to external partners).	On-going	HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU. Research Support Funding bids utilising HHTU expertise to further increase successful NIHR and other grant applications. Current research work on Alcohol Services linking up HUTH, HHTU and NLAG.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio

Exec Owner: Makani P

Milestone	By When	Progress
Ensuring equity of access to research for our patients - increasing the number of patients recruited into NIHR Portfolio studies.	March 2020 (Yr 1) March 2021 (Yr 2)	Yr 2: Nearly all non-Covid-19 research was paused in March 2020 (in line with national priorities). Target for 2020/21 is still 6,000 participants but focus from Y&H CRN in 2020/21 will be in ensuring equity of access to Covid-19 research rather than the pre-covid-19 performance metrics. Focus for remainder of the year is Covid-19 Vaccine Trials. A 'Hull City Region Vaccine Hub' is developing to support this work.
Embracing Y&H CRN systematic early review processes to encourage all clinicians to regularly look for opportunities to participate in research.	On-going from April 2019	Expression of interest monitored by Y&H CRN monthly. HUTH R&D to assess barriers and capacity issues. Pharmacy SLA signed to help unblock issues. On hold until August 2020 and will resume as part of the national NIHR 'research restart'.
Proactive and realistic feasibility and assessment of capability and capacity (C&C).	On-going from April 2019	All Covid -19 research prioritised and approved with a week of receipt of documents. Non-covid-19 work to resume fully from September 2020.
Maximising resource utilisation - improved flexibility and responsiveness in our agreed priority areas.	March 2021	Lead Research Nurse appointed. Additional Senior Research nurse to be appointed (Nov 2020). Review of priority areas required again in light of post-covid-19 landscape.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Achieve all Department of Health and NIHR research performance metrics		
Exec Owner: Makani P		
Milestone	By When	Progress
Provide enhanced performance management data to research teams and Health Groups on all local and national metrics (NIHR High Level Objectives (HLOs)).	April 2019	Power BI research performance dashboards developed and available on Pattie. Dashboards will be refreshed and reviewed by March 2021.
Provide quarterly performance report for Trust Board.	July 2019 and quarterly thereafter	Executive summary info graphic available on Power BI (Pattie) by end of Oct. Plans to report to Trust Quality Committee and feed up to Trust Board – first report received by QC in June 2020.
Focus on Recruitment to Time and Target (RTT) metrics (80% compliance for commercial and non-commercial studies).	Achieve 12 month rolling target for closed studies by March 2020.	Commercial RTT = 100% (all 7 closed studies) Non-commercial RTT = 40% (3 of 8 studies closed). Metric for 2020-21 will be monitored but affected significantly by national pause of studies.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Secure three new long-term commercial research partnerships		
Exec Owner: C Long		
Milestone	By When	Progress
Working with our university colleagues, identify potential partners that align to Trust Research and Innovation Strategy goals and undertake initial discussions	Mar 2020	Discussions delayed due to Covid 19, will recommence in Q3 2020/21
Set goals for shortlisted partnerships and broker arrangements	Mar 2021	
Agreements in place with 3 new commercial research partners	Mar 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Secure 'top 5' national status with our Academic Oncology Research Unit		
Exec Owner: Makani P		
Milestone	By When	Progress
Consider Y&H CRN/ NIHR 'peer-review' of the Oncology/Haematology research unit infrastructure and delivery models.	June 2021	National pause of research activity will require a significant period of time to focus on the 'restart' of Oncology research. Proposed that review of position no later than June 2021.
Establish baseline position on NIHR KPIs for Oncology.	June 2021	Proposed that review of position no later than June 2021 in light of paused activities and redefining of priorities post Covid-19.
Define objectives to achieve KPIs for Oncology.	June 2021	Need to re-establish these post Covid-19. Focus is TYA and radiotherapy SABRE trials.
Establish commercial 'preferred site' status for Oncology/Haematology.	June 2021	This has slipped due to competing pressure for resources. Development of industry engagement document to be developed by June 2021.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Working with partners, achieve financial balance across ICP		
Exec Owner: L Bond		
Milestone	By When	Progress
Deliver HUTH contribution to Hull and East Riding system financial plan for 2019/20	March 2020	Complete and achieved
Agree Hull and East Riding system plan for 2020/21 that eliminates recurrent deficits	April 2020	In progress but some uncertainty due to change in financial regime due to Covid 19. Further guidance awaited.
Deliver HUTH contribution to Hull and East Riding system financial plan for 2020/21	March 2021	See above
Working with NLAG, development and delivery of the financial plan to support the output of the Humber Acute Services Review	March 2021	In development
Working with York Trust, development and delivery of the financial impact of the Pathology collaboration	March 2021	Business case to Trust Board November 2020

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Improve the quality of our estate and increase the productivity per square metre		
Exec Owner: D Taylor		
Milestone	By When	Progress
Delivery of Estates Rationalisation Programme Phase 2	Late 2019	Complete
Carter Metric - Non-clinical space <35% (under utilised space at 0%, Carter Metric 2.5%)	Late 2019 onwards	Achieved
Implement office accommodation strategy including flexible and agile working.	Summer 2019	Suite 36 and rationalisation of Staff Res/Admin Block at implementation stage. Refresh of office accommodation strategy progressing as a result of Covid 19, with significant increase in home working.
Upgrade vacant old cardiac theatres to robotic theatres	Dec 2019	Complete
Reprovide staff accommodation both sites	Late 2020/2021	Some junior doctor accommodation moved to university.

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy		
Exec Owner: L Bond		
Milestone	By When	Progress
Complete and sign off the refresh of the Development Control Plan for HRI	Oct 2020	Agreed, but being deployed flexibly in response to capital availability. HRI artists impression complete
Complete and sign off the refresh of the Development Control Plan for CHH	March 2021	In development
Agree approach to business case(s) for capital funding	Oct 2021	ICS Major Capital Group established £60m capital secured for 2020/21
Achieve business case(s) approval and secure capital funding stream(s)	March 2023	

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Become greener by reducing our energy consumption and waste		
Exec Owner: D Taylor		
Install new Combined Heat and Power system in HRI, reducing waste heat	March 2020	Complete
Replace HRI main boilers, increasing efficiency from 55% - >85%	March 2021	On track
Install new Combined Heat and Power system in CHH, reducing waste heat	June 2021	On track
Reduce Trust carbon consumption in line with UK government aim to achieve carbon neutrality by 2050	Year on year reduction	On track

Strategy Implementation Scorecard 2019-2024
2020/21 half year update

Become a digital first organisation; removing paper		
Exec Owner: L Bond		
Milestone	By When	Progress
Agree capital financing for the Trust Digital Strategy	Sept 2019	£5m secured (£10m joint with NLAG) for development of Lorenzo.
Agree plan for e-casenotes	March 2021	Use of paper case notes reducing. Plan for removal of paper record needed
Complete network upgrade	March 2021	Will complete main sites by end of 2020/21 with residual sites in 2021/22
Complete rollout of e-prescribing	March 2021 (CHH) March 2021 (HRI)	Will complete in 2021/22 following completion of the network upgrade
Complete rollout of e-observations	March 2022	Will complete in 2021/22 following completion of the network upgrade
Deploy e-casenotes solution	March 2023	See above

Strategy Implementation Scorecard 2019-24 progress report colour rating key

Colour Rating	Definition
	Delivered
	On track to be fully delivered by deadline
	Not currently on track but confidence in plans to recover and deliver by deadline
	Not on track and low or moderate risk to delivery by deadline
	Not on track and high risk to delivery by deadline

Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

8 September 2020

Title:	Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21
Responsible Director:	Jacqueline Myers, Director of Strategy and Planning/Accountable Emergency Officer
Author:	Jackie Railton, Assistant Director of Strategy and Planning

Purpose:	The purpose of this paper is to provide the Trust Board with an update on the Emergency Preparedness, Resilience and Response (EPRR) process for 2020/21 and to seek approval for the Accountable Emergency Officer to submit the Trust's assurance update to the Regional EPRR team prior to 31st October 2020 in line with the NHS EPRR assurance process timetable.	
BAF Risk:		
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 Key of Issues:	For the EPRR assurance process this year, NHS organisations are required to provide assurance on three areas: 1. Progress made by organisations who had previously reported partial or non-compliance in the 2019/20 process. Trusts are required to provide an updated assurance level following review and delivery of their ongoing action plans. 2. Assurance that organisations have undertaken, or plan to undertake, a formal review process on their response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of their ongoing EPRR work programme; and 3. That organisations have reviewed their response to the COVID-19 pandemic and taken steps to embed key lessons and actions in their planning for winter and associated system response arrangements. The Trust has an action plan in place which will see it move to 'substantially compliant' by 31st October 2020 and has undertaken a formal review of its Covid-19 response which is informing its future planning for a potential second wave and also its planning for winter.	

Recommendation:	The Trust Board is asked to note the contents of this paper and authorize the Accountable Emergency Officer to submit the Trust's statement of assurance on 31st October 2020.

Hull University Teaching Hospitals NHS Trust

Trust Board

Emergency Preparedness, Resilience and Response (EPRR)
Annual Assurance Process 2020/21

1. Purpose of Paper

The purpose of this paper is to provide the Trust Board with an update on the Emergency Preparedness, Resilience and Response (EPRR) process for 2020/21 and to seek approval for the Accountable Emergency Officer to submit the Trust's assurance update to the Regional EPRR team prior to 31st October 2020 in line with the NHS EPRR assurance process timetable.

2. Background

As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. The NHS Core Standards for EPRR are the minimum requirements commissioners and providers must meet. They cover ten core domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical, Biological, Radiological, Nuclear (CBRN).

The applicability of each core standard is dependent on the organisation's function and statutory requirements. Each organisation type (eg acute provider, commissioner), has a different number of core standards to assure itself against.

Participating organisations are asked to rate their compliance as follows:

- Non-compliant — Not compliant with the core standard
  The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.

- Partially compliant — Not compliant with the core standard
  However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.

- Fully compliant — Fully compliant with core standard.

An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with. The thresholds for each assurance rating are indicated below:

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve
Non-compliant	The organisation is compliant with 76% or less of the core standards they are required to achieve.

A total of 64 EPRR standards are applicable to the Trust as an acute provider. In 2019/20, the Trust's self-assessment was that overall we are 'partially compliant'. Of the 64 standards, the Trust was fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	8	6	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	2	1	1
Business Continuity	9	6	3	0
CBRN	14	14	0	0
Total	64	50	13	1

An action plan was developed to address the areas of partial and non-compliance during the remainder of 2019/20 and 2020/21.

3. EPRR Annual Assurance Process 2020/21

On 20 August 2020 NHS England/Improvement (NHSE/I) published a letter outlining the EPRR Annual Assurance Process for 2020/21. It acknowledged that the detailed and granular process of previous years would be excessive while the NHS prepares for a potential further wave of Covid-19, as well as the upcoming seasonal pressures and the operational demands of restoring services and therefore set out an amended process for 2020/21 which instead focuses on three areas:

- Progress made by organisations who had previously reported partial or non-compliance in the 2019/20 process. Trusts are required to provide an updated assurance level following review and delivery of their ongoing action plans.

- Assurance that organisations have undertaken, or plan to undertake, a formal review process on their response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of their ongoing EPRR work programme; and

- That organisations have reviewed their response to the COVID-19 pandemic and taken steps to embed key lessons and actions in their planning for winter and associated system response arrangements.

4. Trust Progress Against the 2019/20 EPRR Assurance Action Plan

The table below shows the areas where the Trust was not fully compliant with the EPRR standards in 2019/20 and the progress to date.

Standard	Issue in 2019/20	Progress to date
17 - Mass Countermeasures	This is related to the distribution of mass prophylaxis or vaccination. We have not previously had a written policy as this is led by the community providers. A written procedure is to be put in place following liaison with partner agencies.	A number of key partners are yet to prepare plans themselves which is preventing the HUTH plan from being completed. *Partial compliance rating remains*
19 – Mass Casualty – Patient ID	There is a new requirement for the patient ID system to be non-sequential. Process in ED to be updated (we are also awaiting an e-solution)	Module available within Lorenzo. Work ongoing with DXC and CRS team to enable module *Partial compliance rating remains pending implementation*
20 – Whole site evacuation plan	The Trust did not have this in place for HRI or CHH.	Draft Full and Partial Evacuation Plan in place. Internal testing was via a table top exercise on 30th July 2020. A further table top exercise is planned for 22nd September with Partner agencies. This will inform the final version of the Plan with sign off expected in October 2020. *Remains partial compliance until sign off. Anticipate full compliance by 31st October 2020.*
21 - Lockdown procedure	This was covered in the Major Incident Plan and an annotated site map but needed to be strengthened with traffic flow plans and tested.	Draft Lockdown Plan in place. Internal testing was via a table top exercise on 30th July 2020. A further table top exercise is planned for 22nd September with Partner agencies. This will inform the final version of the Plan with sign off expected in October 2020. *Remains partial compliance until sign off. Anticipate full compliance by 31st October 2020.*
22 – VIP policy	The policy is overdue review	The policy was reviewed and approved by the Workforce Transformation Committee, Local Negotiating Committee (Medical staff) and Joint Negotiating and Consultative Committee (JNCC). Approved version of policy uploaded to Pattie on 07.02.20. *Rating is now: Fully compliant*
23 – Excess deaths arrangements	The Trust has some arrangements in place but needs to review the capacity and agree mutual aid arrangements	50 additional fridges to be installed at HRI. New fridges at HRI will meet Trust needs for business as usual during worst case scenario. Temporary mortuary at CHH for 36 additional fridges until March 2021 as part of Covid-19 response. Local authority temporary mortuary until March 2021. LRF Excess Death plan tried and tested during Covid-19 pandemic and no issues. Excess death worst case scenario planning assumption for second spike of Covid-19 is worst week for winter times six weeks. The arrangements above will cope with that planning assumption. *Rating is now: Fully compliant*
27 – Exercise and	The Trust has some training and a	Exercise and testing calendar in place for

Standard	Issue in 2019/20	Progress to date
training programme	programme of testing in place. Needs to be strengthened with an annual training plan and a single action tracker for learning from tests	2020/21 and being developed for 2021/22. 20/21 includes outbreak management TTXs, EU transition TTXs, Covid-19/winter incident concurrent TTX and TTXs linked to command training. Covid-19 classified as live exercise for purposes of 3 year testing requirements. 21/22 includes potential for a live exercise in June 2021 and Humber flood exercise in October 2021 (LRF leading) For 2021/22 all TTXs across the Trust will, where possible, have linked themes. Lessons learned from previous exercises and incidents reviewed and outstanding actions followed up. Information stored on shared drive. *Rating is now: Fully compliant*
30 – Incident Co-ordination Centre (ICC)	The Trust needs to test its fall back ICC	ICC fallback at HRI = Committee Room, Alderson House ICC fallback at CHH = IT Training Room on Suite 22 Both rooms are being equipped in event of Major Incident and to be tested by end of September 2020 Covid-19 Silver hub to be retained until March 2021 whilst options considered re control room and ICC. ICC functions being included in considerations of work with Cloud2 in respect of digital command centre (Control Room and ICC). *Remains partial compliance until testing complete. Anticipate full compliance October 2020.*
32 - Business Continuity Plans (BCPs)	Overarching Plan to be set out that includes Trust level response to Trust wide incidents.	BCP Policy completed. Draft Trust overarching BCP circulated to members of Resilience Committee 28th July. Currently being updated following feedback and will then to ratified at appropriate committees in September/October 2020. *Remains partial compliance until BCP approved. Anticipate full compliance October 2020.*
40 – Attendance of the Accountable Emergency Officer at the Local Health Resilience Partnership (75%) meetings	Diary had not allowed this. HUTH had been represented at all meetings.	AEO attendance at LHRP (Nov 2019) LHRP meetings did not take place during the Covid-19 pandemic. HCAV Health Strategic Co-ordination Group meetings attended by Assistant Director of Strategy and Planning *In line with other Trusts, this rating has been changed to partial compliance.*
42 – Mutual aid arrangements	This is covered in the Major Incident plan, but needs to be strengthened to include a range of other types of mutual aid	Mutual aid effective (eg PPE) during Covid-19 MACA references will be updated as part of September 2020 refresh of MIP *Remains partial compliance until September MIP refresh, when will become fully compliant.*
49 - Business Impact Assessment	This is contained within the Trust process for development of business continuity plans, however, the approach needs to be	New BCP template has BIA module within it. Draft Trust overarching BCP circulated to members of Resilience Committee 28th July. Currently being updated following feedback

Standard	Issue in 2019/20	Progress to date
	articulated in the overarching Business Continuity Plan	and will then to ratified at appropriate committees in September/October 2020. *Remains partial compliance until BCP approved. Anticipate full compliance October 2020.*
50 – Data Protection and Security Toolkit	This is a new standard – the toolkit was published in March 2019. Deadline of March 2020 was extended due to Covid-19	Work ongoing to achieve compliance by March 2021. *Remains partially compliant*
51 – Business Continuity Plans	Same issue as standard 32, need overarching Trust level BCP	*Remains partial compliance until BCP approved. Anticipate full compliance October 2020.*

With the work undertaken to date and a number of other actions due to be concluded in September/October 2020, the Trust is anticipating a forecast position of full compliance against 60 of the 64 standards by 31st October 2020. This would improve the Trust's overall compliance rating from 'partially compliant' to 'substantially compliant'.

Compliance with EPRR Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
2019/20	64	50	13	1
2020/21 to 1 September 2020	64	53	11	0
Forecast position at 31 October 2020	64	60	5	0

4. Lessons Learned from the Covid-19 Pandemic First Wave

In order to coordinate and manage all lessons learned from the Trust's response (January to May 2020) to the Covid-19 pandemic, a structured debrief was undertaken with staff who played a key role in the response. Feedback was provided through e-surveys, Health Group Recovery Planning presentations and one to one meetings with Silver Command leads and a cross section of staff from corporate Directorates and the Health Groups. The resulting report was presented to the Covid-19 Steering Group in July 2020 and a number of recommendations have been incorporated into the planning for a second wave, including:

- A smaller Gold Command group aided by a Clinical Advisory Group (this has been successful in other Trusts)
- A lead Silver Commander to chair Silver meetings during the operational phase and be the final arbiter on decisions (other than those requiring escalation to Gold Command)
- A review of Silver roles to reflect the tactical requirements of managing the Covid-19 response.
- Earlier planning for recovery from a second wave
- Identification of potentially 'at risk' staff groups
- Embracing the 'can do' attitude to problem solving displayed during the first wave and maintaining the solution-focused approach used at that time
- Effective collaboration with system partners.

5. Incorporation of Lessons Learned into Winter Planning

The Trust is facing a challenging winter with the potential of a second wave of Covid-19 infection on top of the usual pressures, including increased respiratory infections and influenza. This will necessitate careful planning to ensure sufficient bed capacity to manage the expected increase in emergency admissions, whilst ensuring effective separation of

suspected and positive Covid-19 patients from negative Covid-19 patients, and the maintenance of elective services. Using the lessons learned from earlier this year, the following measures have been put in place:

- Weekly Winter Planning Group established and Winter Work Plan under development
- Winter Planning Group and Covid-19 Steering Group to merge in October 2020 to ensure integrated response to winter pressures and potential second wave of Covid-19 admissions
- Continuing to build on what worked well last winter
- Covid-19 Surge Plan being revised in event of second wave
- Capacity Escalation Plan and Full Capacity Protocol in place based on Operational Pressures Escalation (OPEL) Framework. OPEL checklist used to determine OPEL level and actions required to respond to peaks in demand eg Emergency Department attendances, level of unplanned admissions, bed capacity.
- Refurbishment and reconfiguration of acute services on the ground floor of the Tower Block (due for completion Dec 2020) leading to improved acute patient pathways
- Flu vaccination programme
- EU Exit planning in case no comprehensive trade agreement in place by 31st December 2020 which may impact on the supply of medicines, medical devices, clinical and non-clinical consumables.

As part of its EPRR work plan, the Trust is conducting a series of table top exercises to test and refine its winter, Covid-19 and EU exit plans to ensure that it is able to identify risks to delivery of services and put the actions in place to mitigate against those risks.

6. Next Steps

The Trust's Accountable Emergency Officer is required to submit a statement of assurance to the Regional EPRR team on the Trust's progress against the 2019/20 EPRR Assurance action plan by 31st October 2020. For this year only there is no requirement for the statement to be signed off by the Trust Board, however the Accountable Emergency Officer is seeking the Board's authorization to submit the statement on the Trust's behalf. A full report on the final statement and the Trust's level of compliance against the EPRR standards will be given at the November Trust Board.

7. Recommendation

The Trust Board is asked to note the contents of this paper and authorize the Accountable Emergency Officer to submit the Trust's statement of assurance on 31st October 2020.

Jacqueline Myers
Accountable Emergency Officer
Director of Strategy and Planning

1st September 2020

Hull University Teaching Hospitals NHS Trust

Trust Board

8 September 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. The paper contains recommendations for 3 changes to the Terms of Reference for the Charitable Funds Committee. The paper includes an update on the Director of Corporate Affairs role.	

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal • Approve changes to the Charitable Funds Committee Terms of Reference, including that corporate social responsibility is no longer delegated to the Committee and reverts to the Trust Board • Receive the update regarding the Director of Corporate Affairs

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders September 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	DIRECTORS
2020/23	Permission Homes Ltd and Hull University Teaching Hospitals NHS Trust – legal charge relating to land at Castle Lane, Cottingham	13 August 2020	Teresa Cope – Chief Operating Officer Carla Ramsay – Director of Corporate Affairs
2020/24	Hull University Teaching Hospitals NHS Trust and the University of Hull and UPP (Hull) Limited – agreement relating to the nomination of student accommodation at Westfield Court, Hull	26 August 2020	Lee Bond – Chief Finance Officer Carla Ramsay – Director of Corporate Affairs

3 Changes to Charitable Funds Committee Terms of Reference

In keeping with good governance, the Terms of Reference of Board Committees are periodically reviewed. All Board Committee Terms of Reference are set by the Trust Board, therefore any amendments require Board approval.

At the most recent review of the Charitable Funds Committee Terms of Reference, two minor amendments have been identified for Board approval. There are both in Section 14 of the Terms of Reference, to amend one job title and one team name. The changes are highlighted in grey as follows:

14. Administration
The Committee is supported administratively by the Deputy Director of Finance and the Corporate Affairs Team. The Corporate Affairs team will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the committee.

As part of this discussion, Committee members also discussed paragraph 2.9, which currently reads:

2.9 To oversee the Trust's broader Corporate Social Responsibility role, in particular the Trust's role to support the well-being of the local community, which may be supported through charitable funds.

CSR was originally adopted by the Charitable Funds Committee because of the special interest of previous membership in this area. The Committee felt that the remit of CSR should be more widely considered and that more recent work by the Trust, particularly the range of partnership working in train at present, demonstrates this in practice. It was agreed that this should be referred back to the Trust Board as it was deemed that this was no longer an appropriate delegated item for this Committee.

This was originally delegated by the Board to the Charitable Funds Committee under the Scheme of Delegation, therefore the Charitable Funds Committee recommend that this delegation is rescinded, as Charitable Funds will only be one part of consideration and acting on the role the Trust in the wider community.

4 Director of Corporate Affairs

The Director of Corporate Affairs will be taking up a different role in the organisation imminently. Recruitment for a new postholder is underway, during which an interim arrangement is being put in place to cover the statutory/mandated elements of the role (Trust Secretary, Freedom to Speak Up Guardian, Data Protection Officer).

5 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve changes to the Charitable Funds Committee Terms of Reference, including that corporate social responsibility is no longer delegated to the Committee and reverts to the Trust Board
- Receive the update regarding the Director of Corporate Affairs

Carla Ramsay
Director of Corporate Affairs
September 2020

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Safety Team Annual Report 2019/20

Title:	Safety Team Annual Report 2019/20
Responsible Director:	Executive Chief Nurse
Author:	David Bovill, Trust Safety Manager

Purpose	The purpose of this report is to provide information and assurance to the Trust Board and others, in relation to matters relating to the management of Safety within the Trust.	
BAF Risk	N/A	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	Information is provided in the report on the following topics: • Safety Dept. KPI's • General RIDDOR Reportable Incidents • RIDDOR: Occupational Health • Annual incidents by Health Group • Non-reportable slip trip falls • Timeliness of reporting of incidents to the HSE • Site inspections • Staff incidents reported by severity • Quarterly Physical Inspections • EL / PL Claims • Manual Handling • Objectives for 2020/21	

SUMMARY

- The Trust's excellent record with the Health and Safety regulator, the HSE, continued in 2019/20, with again no enforcement activity (nor any communication) recorded against the Trust.

- Reportable Incidents: The Trust's Safety Team reported 10 incidents to the HSE under the requirements of the RIDDOR regulations in 2019/20. This is a dramatic decrease from the previous year (which was 27) and is the lowest total on record. Manual handling RIDDOR injuries decreased from nine to four in 2019/20. Similarly, reportable slips, trips and falls injuries reduced from 10 to just one.

- The incidence of less serious cases of slips, trips and falls (non-RIDDOR reportable incidents) has decreased in 2019/20 with 47 compared to 54 the year before and 102 the year before that.

- In terms of timeliness of reporting to the HSE, just one of the 10 incidents were reported after the 15 day target: a significant reduction from previous years.

- The Trust's Occupational Health Team reported six incidents to HSE, again a big reduction from the previous year (20). These comprised five needle-sticks and one case of other exposure to blood borne viruses. There were no reported cases of work-related dermatitis for the fourth year running.

- Claims: The number of new staff claims against the Trust was 10 in 2019/20. This is a reduction of four compared with the previous year.

- Link Staff: Following increasing the available training for new departmental Safety Link Staff and Moving and Handling Link Trainers, the Trust has increased these numbers by 31 and 35 respectively. These staff volunteer to be the 'eyes and ears' for safety in their work areas, and so are given extra training to fulfil this important role.

- Key areas of safety management focus in 2019/20 included working at height and slips, trips and falls prevention. . In the area of manual handling, additional training is also now being provided on induction, increasing practical knowledge and skills for new starters.

- Quarterly site inspections: Safety identified a combined total of 101 defects between CHH and HRI with a shared total of 50 defects having since been acted upon.

    - At HRI there were 68 defects (58 Medium and 10 Low risks) with 25 (23 Medium and 2 Low risks) of those since acted upon leaving a deficit of 43 defects.

    - At CHH there were 33 defects identified (1 High - 30 Medium – 1 Low and 1 Very low risk) with 25 of those since acted upon (24 Medium and 1 Low risk).

- The number of departmental quarterly physical inspection checklists performed on the wards and departments and sent to the Safety Team was 365 in 2019/20 with a deficit of 210.

Safety Department Annual Report, 2019 / 2020.

Contents:

1. KPI's

Key Performance Indicators (KPI's) – Monitored quarterly - and covering the following topics:

- **Number (and rate – No. / employees x 100) of RIDDOR reportable incidents.** This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses. The target for RIDDOR reportable incidents should always be as few as possible, though an organisation as large and complex as HEYT would certainly alert the regulator (HSE) if no such incidents were reported.

- **Total staff slips, trips and falls incident rate (not just RIDDOR).** The justification for this choice of KPI is that it is the single biggest cause of staff injury. The target improvement here would be a steady decrease, though with caution regarding incident reporting rates generally – less is not necessarily better (depending upon severity – see below).

- **EL / PL Claims –** new employees' / public liability claims received (non-clinical).

- **Numbers of hazards identified by site quarterly inspections** by the Safety Team; a pro-active measure. We would want to see a reduction in the number of hazards identified in any given area upon subsequent inspections if the corrective actions have been taken.

- **Staff accidents reported by severity**. Numbers of those classed as either severe or catastrophic. A good reporting culture in the organisation would have staff recording high numbers of near misses, no harm or minor harm incidents. For this reason, an increase in overall staff incidents should not necessarily be seen as a negative outcome. However, we would want to see low numbers of those incidents classed as major or catastrophic, as such incidents are unlikely to go unreported.

2. General RIDDOR reportable accidents

Table 1: Annual by quarters

RIDDOR Apr 2019 - Mar 2020	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total	RIDDOR 2018 - 2019
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Slip- trip fall	-	-	-	-	-	-	-	1	-	-	-	-	1	10
Manual handling	-	-	-	-	-	-	1	1	-	1	1	-	4	9
Struck by or against something	-	-	-	-	-	-	-	-	-	-	1	-	1	1
Contact with hot/cold, object/liquid, electric or machinery	-	-	-	-	-	-	-	-	-	1	-	-	1	1
Contact with sharp material or object non medical	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Other personal accident	-	1	-	-	-	1	-	-	-	-	-	-	2	4
Contact other medical sharps	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Exposure to harmful agent e.g. radiation, substance, bio agent,	-	-	-	-	-	-	-	-	-	1	-	-	1	-
Total	-	1	-	-	-	1	1	2	-	3	2	-	10	27
		1			**1**			**3**			**5**			

Table 2: Three Year Comparison

Incident Category	FTE 7175 2017 - 2018 Total	Rate		FTE 7175 2018 - 2019 Total	Rate		FTE 7430 2019 - 2020 Total	Rate		Total
Slip, trip or fall	5	0.06	▽	10	0.13	△	1	0.01	▽	**16**
Moving and handling	8	0.11	▽	9	0.12	△	4	0.05	▽	**21**
Struck by or against something	2	0.02	▽	1	0.01	▽	1	0.01	-	**4**
Contact with hot/cold object/liquid, machinery or electricity	-	-	▽	1	0.01	△	1	0.01	-	**2**
Contact with sharp material or object, non-medical	-	-	▽	2	0.02	△	-	-	▽	**2**
Other Personal Accident	1	0.01	▽	4	0.05	△	2	0.02	▽	**7**
Contact with other medical sharps	1	0.01	△	-	-	▽	-	-	-	**1**
Exposure to harmful agent e.g. radiation, substance, bio agent	1	0.01	-	-	-	▽	1	0.01	△	**2**
Total	**18**		▽	**27**		△	**10**		▽	**55**

The annual total for reportable incidents shows an all-time low of just 10 reportable incidents. This is a decrease on the previous year by 17, and when compared to the total of two years ago **32** this is a decrease of 22.

There has been a decrease in the slips, trips and falls category over the past year (one) when compared to the previous year 10 and moving handling has also seen a decrease over the past year 4 when compared to the previous year 9 (see later for analysis).

Table 3: General and Occupational Health reported Incidents Year on Year Comparison – 2011 – 2020

Decrease ▽ No change - Increase △

	2011 - 2012	2012 - 2013	2013 -2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 -2018	2018 - 2019	2019 - 2020	Total
Slip- trip fall	16	18 △	13 ▽	18 △	10 ▽	10 -	5 ▽	10 △	1 ▽	**101**
Manual handling	15	8 ▽	10 △	14 △	5 ▽	9 △	8 ▽	9 △	4 ▽	**82**
Struck by or against something	4	4 -	2 ▽	5 △	5 -	4 ▽	2 ▽	1 ▽	1 -	**28**
Contact with hot/cold, object/liquid, electric or machinery	3	2 ▽	2 -	- ▽	- -	1 △	- ▽	1 △	1 -	**10**
Contact with sharp material or object non medical	6	5 ▽	4 ▽	1 ▽	1 -	1 -	- ▽	2 △	- ▽	**20**
Other personal accident	9	5 ▽	2 ▽	2 -	6 △	6 -	1 ▽	4 △	2 ▽	**37**
Contact other medical sharps	-	- -	2 △	- ▽	2 △	- ▽	1 △	- -	- -	**5**
Exposure to harmful agent e.g. radiation, substance, bio agent,	1	- ▽	- -	- -	4 △	1 ▽	1 -	- -	1 △	**8**
Total	**54**	**42** ▽	**35** ▽	**40** △	**33** ▽	**32** ▽	**18** ▽	**27** △	**10** ▽	**291**
Needl stick	6	5 △	9 △	10 △	5 ▽	9 △	7 ▽	12 △	5 ▽	**68**
Exsposure to blood born viruses	2	1 △	7 △	7 -	7 -	7 -	7 -	8 △	1 ▽	**47**
Work related dermatitis	-	4 △	7 △	- ▽	2 △	- ▽	- -	- -	- -	**13**
Total	**8**	**10** △	**23** △	**17** ▽	**14** ▽	**16** △	**14** ▽	**20** △	**6** ▽	**128**

Figure 1: General Incidents – 2011 - 2020

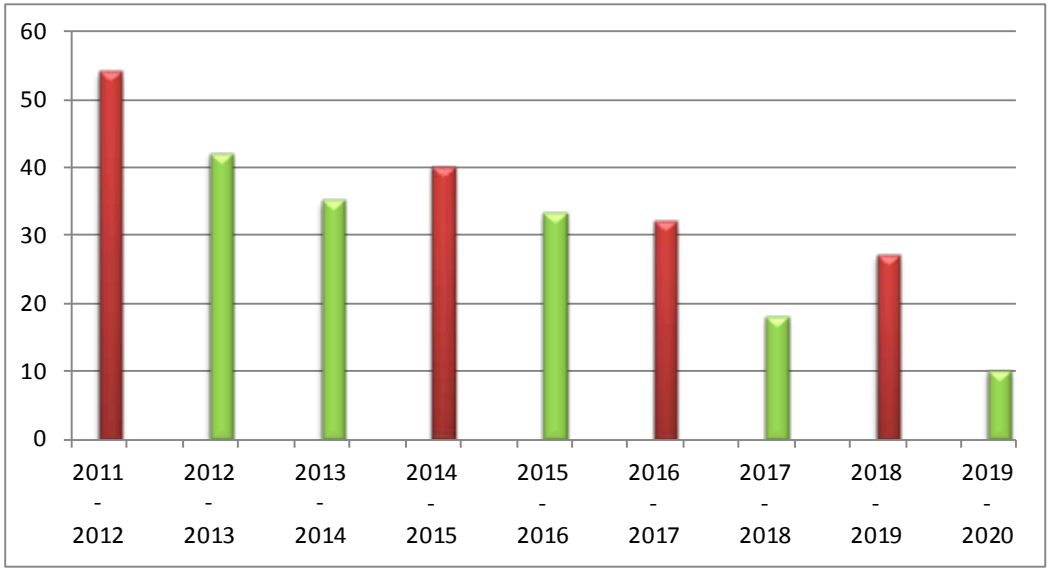
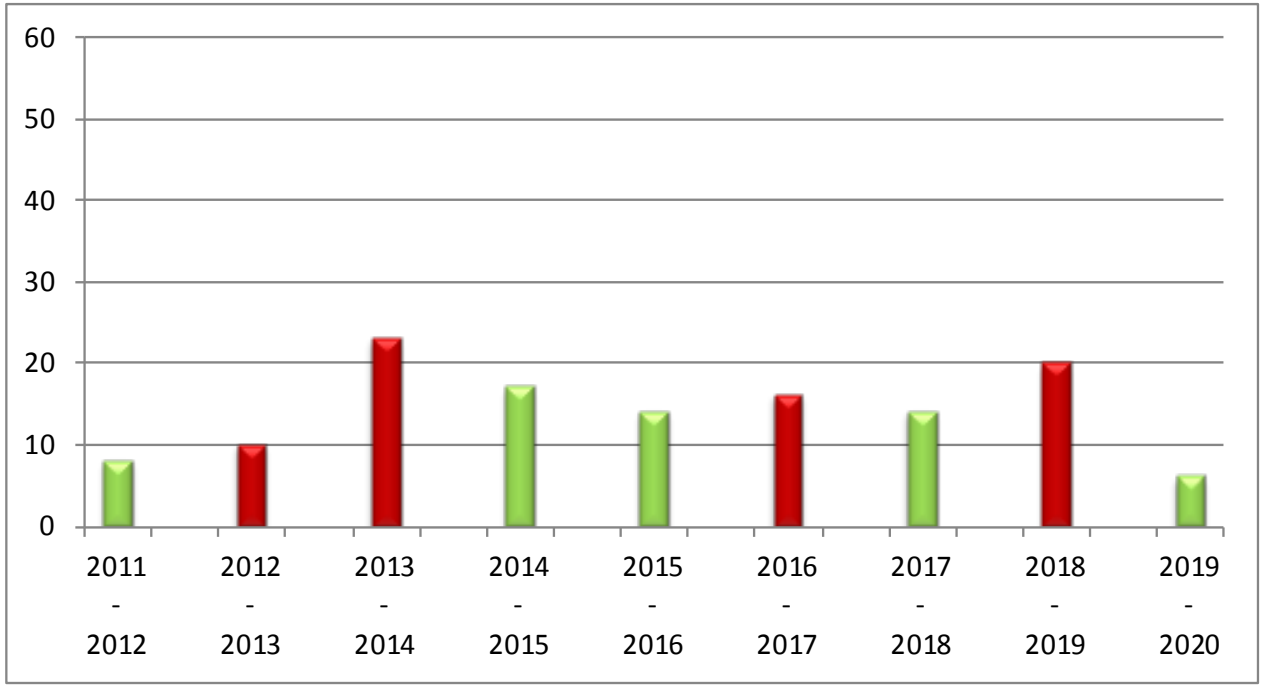


Figure 2: Occ Health reported Incidents – 2011 – 2020:



Since 2011, Slips, trips and falls have been the most commonly reported category with a total of 101 incidents followed by Manual handling with a total of 82 incidents.

This past year we have witnessed a significant reduction in both of these categories with slip trip falls showing only 1 incident against its highest point in 2014/15 whereby we witnessed 18 incidents.

Moving handling showing only 4 incidents during the past twelve months which again is a significant decrease when compared to its highest point in 2011/12 where we witnessed 15 reportable incidents.

Needle sticks is the highest category for Occupational Health incidents with a total of 68 incidents since 2011, followed by Exposure to blood born viruses with a total of 47 and we have witnessed 13 reportable Dermatitis incidents with the last being reported in 2015/16.

3. Annual RIDDOR incidents by Health Group:

Table 4: Annual RIDDOR incidents by HG:

Health Group	FTE	Q1	Rate		Q 2	Rate		Q 3	Rate		Q4	Rate		Total
Clinical Support	1702	-	-	-	-	-	-	1	0.05	▲	1	0.05	-	**2**
Family and Women's Health	1111	-	-	-	-	-	-	1	0.09	▲	-	-	▽	**1**
Surgery	1863	1	0.05	▽	-	-	▽	-	-	-	2	0.11	▲	**3**
Corporate Directorates	1502	-	-	-	1	0.06	▲	1	0.06	-	-	-	▽	**2**
Medicine	1252	-	-	-	-	-	-	-	-	-	2	0.15	▲	**2**
Total:	**7430**	**1**		▲	**1**		-	**3**		▲	**5**		▲	**10**

Surgery had the most incidents for the year with three, whereas Medicine, Corporate and Clinical Support had two and Family Women's Health had one.

Table 5: Three Year Comparison – HG's

Health	FTE 7175 2017 - 2018 Total	Rate		FTE 7175 2018 - 2019 Total	Rate		FTE 7430 2019 - 2020 Total	Rate		Total
Clinical Support	2	0.02	-	3	0.04	▲	2	0.05	▽	**7**
Family and Women's Health	3	0.04	-	2	0.02	▽	1	0.01	▽	**6**
Surgery	4	0.05	▽	8	0.11	▲	3	0.04	▽	**15**
Corporate Directorates	4	0.05	▽	5	0.06	▲	2	0.02	▽	**11**
Medicine	5	0.06	▽	9	0.12	▲	2	0.02	▽	**16**
Total:	**18**		▽	**27**		▲	**10**		▽	**55**

Over the last three years, Medicine has had the most incidents with 16 and Surgery had the second most incidents with 15 followed by Corporate with 11 incidents then Clinical Support with 7 incidents and finally Family and Women's Health with 6.

4. RIDDOR Reportable slip trip falls:

Table 6: Annual by quarter:

FTE 7430	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Incidents	-	-	1	-
Rate	-	-	0.01	-

There has been only one Slip trip fall during this past year this is a significant decrease when compared to the previous year of 10 incidents.

Table 7: Three Year Comparison:

	FTE 7175	FTE 7175	FTE 7430	
Date	2017 - 2018	2018 - 2019	2019 - 2020	Total
Incidents	5	10	1	**16**
Rate	0.6	0.13	0.01	

Table 8: Three Year Quarterly Comparison:

	2017 - 2018	2018 - 2019	2019 - 2020
Quarter 1	2	-	-
Quarter 2	1	2	-
Quarter 3	1	6	1
Quarter 4	1	2	-
Total	5	10	1

The past year is an all-time low for reportable slip trip falls with just one reportable incident.

5. Non-RIDDOR reportable slip trip falls:

Table 9: Annual by HG / Quarter:

Health Group	FTE	Q1		Rate	Q2		Rate	Q3		Rate	Q4		Rate	Total
Clinical Support	1702	3	▲	0.17	3	-	0.17	2	▼	0.11	-	▼	-	**8**
Family and Women's Health	1111	2	▲	0.18	1	▼	0.09	3	▲	0.27	1	▼	0.09	**7**
Surgery	1863	2	▲	0.1	3	▲	0.16	6	▲	0.32	2	▼	0.01	**13**
Corporate Directorates	1502	1	▼	0.06	5	▲	0.33	6	▲	0.39	1	▼	0.06	**13**
Medicine	1252	2	▲	0.15	3	▲	0.15	1	▼	0.07	-	▼	-	**6**
Total:	**7430**	**10**	▲		**15**	▲		**18**	▲		**4**	▼		**47**

There have been 47 non-reportable staff slips trip falls over the past twelve months.

Table 10: Three Year Comparison:

Health Group	FTE 7175 2017 - 2018 Total	Rate		FTE 7175 2018 - 2019 Total	Rate		FTE 7430 2019 - 2020 Total	Rate	Total
Clinical Support	10	0.13	▼	5	0.06	▲	8	0.1	**23**
Family and Women's Health	20	0.27	▼	7	0.09	-	7	0.09	**34**
Surgery	24	0.33	▼	22	0.31	▼	13	0.17	**59**
Corporate Directorates	32	0.44	▼	14	0.19	▼	13	0.17	**59**
Medicine	16	0.22	▼	6	0.08	-	6	0.08	**24**
Total:	**102**	-		**54**	▼		**47**	▼	**199**

We have witnessed a slight decrease over the past 12 months when compared to the previous year.

6. RIDDOR – reported by the Occupational Health Department:

RIDDOR – reported by Occupational Health – by category:

Table 11: Annual by quarter:

Incident by Category	FTE	Q1	Rate		Q2	Rate		Q3	Rate		Q4	Rate	Total
Needle Stick Injuries	7430	2	0.02	▼	1	0.01	▲	2	0.02	▼	-	-	**5**
Exposure To Blood Born Viruses		-	-	▲	1	0.01	-	-	-	-	-	-	**1**
Work Related Dermatitis		-	-	-	-	-	-	-	-	-	-	-	**-**
Total		**2**			**2**			**2**			**0**		**6**

Table 12: Three Year Comparison

	FTE 7175			FTE 7175			FTE 7430			**Total**
Incident by Category	2017 - 2018		Rate	2018 - 2019		Rate	2019 - 2020		Rate	
Needle Stick Injuries	7		0.09	12	▲	0.16	5	▼	0.06	**24**
Exposure To Blood Born Viruses	7	-	0.09	8	▲	0.11	1	▼	0.01	**16**
Work Related Dermatitis	-	-	-	-	-	-	-	-	-	**-**
Total	**14**	▼		**20**	▲		**6**	▲		**40**

When compared to the previous 12 months, we have witnessed a decrease of 14 when compared to the previous year and we have had no reportable cases of Work Related Dermatitis for the past five years.

7. Timeliness of Reporting of incidents to the HSE:

The reporting of incidents in accordance to regulation 4.2 of the RIDDOR Regulations 2013: **within 15 days** (NB: The following information does *not* include Occupational Health reportable incidents)

Timeliness of Reporting of incidents to the HSE during 2018 – 2019:

Table 13: Annual

Reported	Reported on time	Reported late	Total
Quarter 1	1	-	**1**
Rate	0.01	-	
Quarter 2	1	-	**1**
Rate	0.01	-	
Quarter 3	2	1	**3**
Rate	0.02	0.01	
Quarter 4	5	-	**5**
Rate	0.06	-	

We have witnessed only one late reporting of an incident to the HSE during the past twelve months. The late reporting of the incident was due to the incident being reported late to the Trust Safety department.

Table 14: Three Year Comparison:

Reported	Reported on time	Reported late	Total
2017 - 2018	13	5	**18**
2018 - 2019	24	3	**27**
2019 - 2020	9	1	**10**
Total	**46**	**9**	**55**

We have seen a year on year improvement in the timeliness of reporting of incidents to the HSE: the proportion of those reported late has reduced for the third consecutive year. (It should be noted that the HSE has never contacted the Trust regarding late reporting).

8. Quarterly Site Inspections:

Hull Royal Infirmary:

Table 15: Area inspected on a quarterly basis over the past three years:

	Area 1	Area 2	Area 3	Total
2017 - 2018	7	26	5	**38**
2018 - 2019	18	8	9	**35**
2019 - 2020	22	36	10	**68**
Overal total	**47**	**70**	**24**	141

When compared to the previous year, we have seen an increase in the total number of defects found.

Table 16: Defects found and acted upon at the HRI Estate.

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	16	6	20	16	**58**
Low	2	4	2	2	**10**
Very low	-	-	-	-	**-**
Overal total	**18**	**10**	**22**	**18**	**68**

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	**-**
Moderate	14	-	7	2	**23**
Low	2	-	-	-	**2**
Very low	-	-	-	-	**-**
Overal total	**16**	**-**	**7**	**2**	**25**

Castle Hill Hospital:

Table 17: Area inspected on a quarterly basis over the past three years:

	Area 1	Area 2	Area 3	Total
2017 - 2018	10	2	14	**26**
2018 - 2019	6	6	6	**18**
2019 - 2020	8	6	19	**33**
Overal total	**24**	**14**	**39**	77

When compared to the previous year we have witnessed an increase in the number of defects found across the site however, for the first time known we have witnessed no reportable slip trip falls on the external grounds of this site.

Table 18: Defects found at the CHH Estate, by quarter and severity:

Defects found					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	1	-	-	**1**
Moderate	7	3	8	12	**30**
Low	-	1	-	-	**1**
Very low	-	1	-	-	**1**
Overal total	**7**	**6**	**8**	**12**	33

Defects acted upon					
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
High	-	-	-	-	
Moderate	3	1	8	12	**24**
Low	-	1	-	-	**1**
Very low	-	-	-	-	
Overal total	**3**	**2**	**8**	**12**	25

When compared to the previous year, we have seen an increase of defects 33 across the site, however, 25 of those defects have since been acted upon.

9. Staff incidents reported by severity

Table 19: Annual by quarter:

Risk Rating	Q1		Rate	Q2		Rate	Q3		Rate	Q4		Rate	Total
FTE 7430													
No harm	32	▼	0.37	28	▼	0.37	33	▲	0.44	24	▲	0.32	**117**
Minor	57	▼	0.84	63	▲	0.84	40	▼	0.53	64	▲	0.86	**224**
Moderate	3	▲	0.01	4	▲	0.01	3	▼	0.04	1	▼	0.01	**11**
Major	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Catastrophic	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Total:	**92**	▼		**95**	▲		**76**	▼		**89**	▲		**352**

Table 20: Three Year Comparison:

Risk Rating	2017 - 2018		2018 - 2019		2019 - 2020		Total
No harm	127	▼	271	▲	117	▼	**515**
Minor	348	▼	387	▲	224	▼	**959**
Moderate	19	▼	17	▼	11	▼	**47**
Major	-		-	-	-	-	**-**
Catastrophic	-		-	-	-	-	**-**
Total:	**494**	-	**675**	▼	**352**	▼	**1521**

The above pattern is seen as encouraging. The fact that we have seen a continued decrease in the moderate category, combined with zero incidents classified as either major or catastrophic, is welcomed.

10. Quarterly Physical Inspections

Quarterly Physical Inspections performed by wards and departments

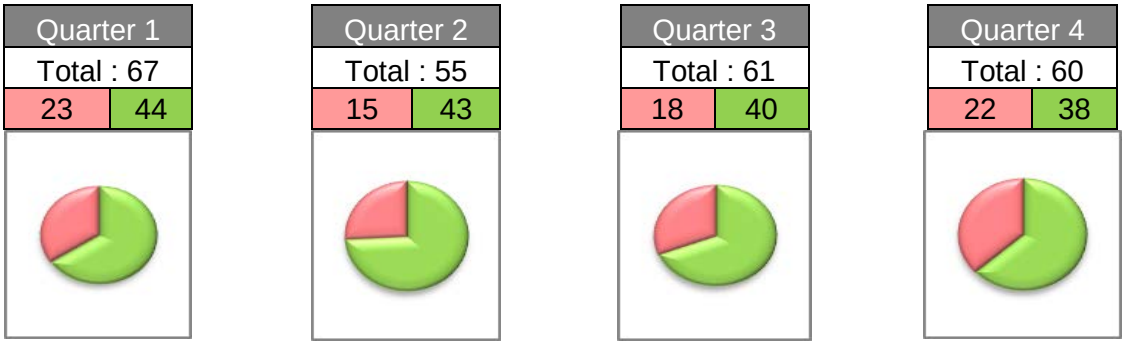
(a)Hull Royal Infirmary:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total : 80	Total : 82	Total : 84	Total : 91
24 / 56	31 / 51	41 / 43	41 / 50

Inspections not received	137	Inspections received	200

(b)Castle Hill Hospital:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total : 67	Total : 55	Total : 61	Total : 60
23 / 44	15 / 43	18 / 40	22 / 38



Inspections not received	78	Inspections received	165

NB: Please be aware that the overall numbers of areas vary between the two sites, and due to infrastructural changes within the organisation the number of areas will continue to vary quarter on quarter making it difficult to give a definitive overall number for each site each quarter.

11. Safety Focal Persons, (SFP's):

The Safety department identified a gap in the training of new Safety Focal Persons (SFP) and as a result have taken charge of providing the necessary training needed for staff to become an SFP.

The new revised training course has been reduce from its original three days to just one day thus reducing the time staff spend away from the workplace while still managing to maintain and keep all of the key elements and cores skills needed for a staff member to become an SFP.

Since advertising the new revised course there has been a keen interest from staff across the Trust with 78 new SFP's 47 last year and 31 in 2019/20.
Staff who have undertaken the training course in the past 12 months have provided excellent feedback.

12. Employers Liability / Public Liability Claims

EL Claims 2019/2020:

Ten Employee Liability Claims were opened within the financial year 2019/2020. **This is a reduction in 8 from the previous financial year.**

The common theme remains incidents relating to slips, trips and falls.

Table 30: Summaries Below

Clerical worker crossed through external courtyard in Queens Centre to use a photocopier and on returning to the building allegedly slipped due to wet shoes and absence of a mat and sustained facial/dental injuries.
Observation monitor (Philips Intellivoe MX 800 OBs Screen) fell on to right shoulder of staff member while cleaning causing soft tissue injuries.
Slipped on spillage resulting in injury to ligament in right knee. Spillage caused by MITIE employee decanting waste bags into a waste container. CCTV shows that employee noted spillage and left the area without attempting to rectify it. Liability denied. Claim to be referred to MITIE.
The Claimant was moving orange clinical waste bags and sustained a needle stick injury to his left palm. Claimant is employed by MITIE who operate a waste management contract for the Trust. Although the Claimant was wearing gloves they were not suitable for the handling of this type of waste and this had been expressed previously to MITIE by the Trust.
Curtain rail collapsed when curtain opened falling on to head and causing alleged concussion, headaches, neck, shoulder and back pain.
The Claimant, a staff nurse, allegedly suffered a sprained back whilst trying to move a patient in their bed in order to fit a catheter
Psychological injury as a result of disclosure of personal information at Trust meeting
Alleged psychiatric illness as a result of conduct of the Trust and/or Trust staff in respect of alleged allegation of harm caused to partner who was a patient.
Alleged that took evasive action to prevent a patient, who had tripped, from hitting his head on a desk in a corridor of the ward and in doing so sustained a sprain to his shoulder
Alleged trip over door stop attached to the floor resulting in fall to floor sustaining fracture to left scaphoid, swelling and bruising to hand and knee and lump to left side of head with headaches, dizziness and nausea.

Table 31: PL Claims 2019/2020

11 Public Liability Claims were opened in the financial year 2019/2020. This is an increase from the previous financial year.

Claimant fell from wheelchair in patient lounge at HRI shortly after being discharged, sustaining a fracture of the left tibia and fibula. It is alleged that the auxiliary nurse who accompanied the Claimant failed to apply the brakes on the wheelchair causing the fall.
On attempting to open gate to waste compound that was pushed inward and stuck, trapped little finger in gate resulting in fracture requiring surgical fixation.
Sustained injury to back when fell 4-5 feet whilst being hoisted from bed to commode as a result of hoist becoming loose whilst being operated by one member of staff.
Alleged slip on substance on entering anaesthetic room in day surgery unit causing collision with fire extinguisher, loss of consciousness and sustaining injuries to face including damage to four teeth and lacerations to lips and chin.
Sustained bruising, swelling and contusion when struck face on the bottom edge of a car parking sign positioned on a post on the footpath. Root cause: Sign positioned at a height which was hazardous to pedestrians and the grey colour was inconspicuous to pedestrians crossing the footpath towards the car park from the rear of the sign. All signage assessed and repositioned following incident.
Fall on uneven ground in argyle street car park sustaining fracture to cheek bone and bruising to face and arm.
Agency security guard alleged that slipped on water in staff toilet on ward 40 sustaining fracture dislocation of left shoulder
Alleged that sustained severe bruising to leg and subsequent burst haematoma requiring attendances for dressings and antibiotics as a result of a thermometer holder dropping on to the claimant's leg.
Alleged slip on wet leaves whilst walking up to hospital, resulting in dislocation of right ring finger and facial injuries including two black eyes.
Sustained penetrating injury to right index finger from needle discarded in bin. Claim for psychological injury due to risk of infection.
Alleged that suffered irritation and blisters to face, skin infection and swollen glands after waste water splashed on to face whilst cleaning the restaurant after a flood from the main waste pipe.

Closed Claims

There were 15 claims closed in the financial year 2019/2020. 8 of which were settled, one case was dismissed by the Courts and the remaining 6 were denied. No Public liability claims were closed within the same period.

13. Manual Handling

Executive Summary of Activity for 2019/20

Phase 1 of the 'Patients with Obesity – Access to Services' group concluded. This piece of work helped identify where areas of assurance could be provided as well as where additional work is required in order to future-proof services. Work in this area is still ongoing.

A review of the hoist provision was carried out and funding for high priority replacement pieces was obtained. Risk 1726 relating to hoist provision was reviewed and downgraded to Low as the needs of the Trust are currently being met.

A total of 35 new Link Trainers have been trained this year helping to maintain a strong and healthy network across the organisation.

Practical patient handling training compliance is now being monitored and has already shown improvement. Practical patient handling is now a mandatory element on the induction programme for new clinical starters. ClinicalSkills.net has been brought online for all clinical staff as an alternative way to gain practical patient handling compliance.

Out of hours access to information relating to manual handling issues and equipment has improved with updated Pattie pages.

Manual Handling incidents, including those reported under RIDDOR, are at the lowest in 5 years.

A Humber Coast and Vale regional group of Manual Handling Advisors has been set up to review patient handling practice and equipment currently used across various Trusts. The aim of the group is to promote best practice and work towards transferable training. The group has representation from HUTH, NLaG, University of Hull, Humber Teaching Trust, Hull CCG, CHCP as well as Social Services from the North and South banks.

Summary of KPI Performance Indicators for 2019/20

Manual Handling RIDDORs
Four incidents in total were reported to the HSE under RIDDOR during 2019/20 for incidents on Datix logged as manual handling activities. These were split evenly between patient handling and inanimate load handling incidents and all incidents were reported as Minor severity.

Link Trainers
There are currently 139 active Link Trainers across the organisation helping to promote safe manual handling practice and improve patient and staff safety.

Patient Handling Assessments
90% of patient care records reviewed had comprehensive handling assessments completed had been reviewed and updated appropriately. Feedback on the others was provided to help improve future compliance.

Key Activity

Link Trainers

Work continues to update Pattie with new pages and information to assist the Link Trainers in their roles and ensure that staff are able to access information relating to manual handling easily.

A total of 35 new Link Trainers have been trained in 2019/20. They will now be able to sign off staff for the practical element of the manual handling training and ensure important information and standards are maintained in their departments.

In Q4 21 Link Trainers attended an update to refresh their knowledge and skills. This brings the total who have attended an annual update to 76 for the year. The low number is due to several courses having to be cancelled due to unforeseen circumstances. Additional places are to be offered once face to face training is reinstated to ensure those Link Trainers who are due or overdue for an update can attend as soon as possible.

The 'Back Issue' newsletter is being distributed to Link Trainers. This is created by the Manual Handling Lead and includes updates on equipment, training and practical skills. This acts as an additional resource to keep them up to date with current issues in between their annual face to face updates.

Equipment – Access and provision

A new quick access equipment library for bariatric beds and specialist mattresses called 'Medstrom Now' has been activated at HRI. This system is already used at CHH and has proven invaluable when staff require specialist equipment at short notice. This system aims to take pressure off staff by having appropriate equipment onsite. This also saves money on delivery and collection charges.

A quick reference page has been created on Pattie to help staff obtain order codes and important information for manual handling equipment quickly.

Networking

The HCaV Manual Handling Group reviewed frequency and content of training and agreed some core information that they all delivered. The group also reviewed what slide sheets were used and the pros and cons of using a single preferred product patch-wide.

Risks

Risk 1726 – Hoist provision

This risk remains Low as the hoist stock is healthy and meets the current needs of the organisation. Monitoring of this continues and projected purchasing requirements have been submitted to the Equipment Management Committee.

Risk 3316 - Inability to flat-lift safely from the floor.

Preferred product options have been chosen and work continues to bring this to conclusion in order to improve patient and staff safety.
The poor use of slide sheets continues to be a concern. Preferred product options have been selected and promoted. In order to support the audit of slide sheets that has already been carried out, a follow up audit is planned for later in 2020.

M/H Incidents

Table 1: ALL Manual Handling Incidents by HG 2019/20

	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
Corporate Functions	3	4	8	4	2	18
Clinical Support - Health Group	3	6	7	3	3	19
Emergency Medicine - Health Group	1	1	0	0	0	1
Family and Women's Health - Health Group	3	1	3	2	2	8
Medicine - Health Group	3	2	5	3	4	14
Surgery - Health Group	2	6	3	4	7	20
Total	15	20	26	16	18	80

N.B. *The reporting of high incident numbers of low severity should not be seen as a negative but seen as healthy reporting culture and encouraged.*

Action taken – The Tissue Viability Matrons and the Manual Handling Lead have already been collaborating to highlight the intrinsic links between manual handling activities and tissue viability problems. Presentations have been delivered to the Link Trainers of both services encouraging joint working especially when dealing with patients with complex issues.

Chart 1: Five Year Run Chart – All Manual Handling Incidents

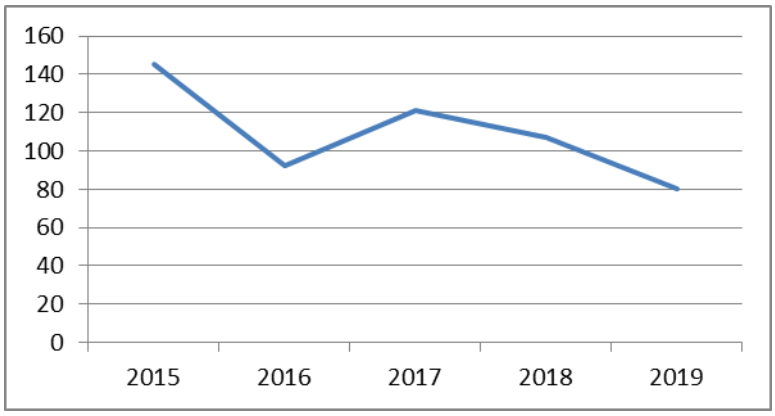
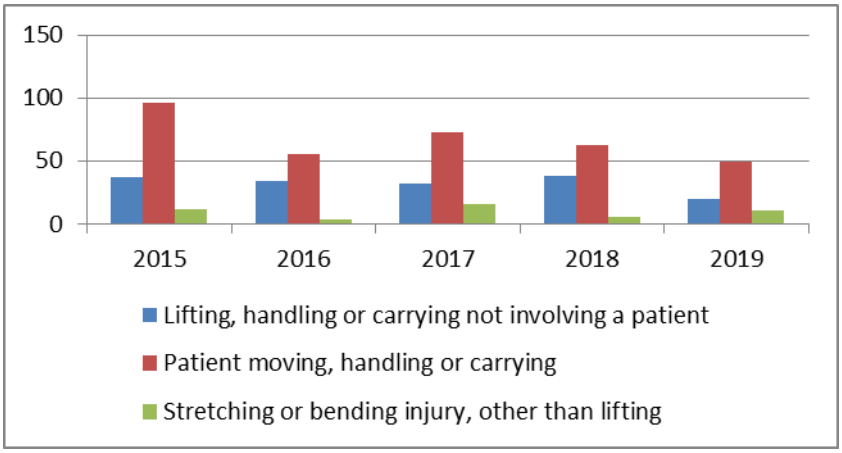


Chart 2: Five Year Comparison by Sub-category



The chart above shows a five year comparison of manual handling incidents. There has been an overall downward trend seen across the five years with patient handling and inanimate load handling incidents. Those incidents reported as 'stretching or bending injury, other than lifting' has seen more of a plateau.

In 2019/20 patient handling incidents accounted for 61% of all manual handling incidents submitted and remains the highest sub-category reported.

In 2019/20 Incidents relating to manual handling activities only accounted for 2% of all personal accident incidents reported and is the 6th highest (out of 12) reported category within 'Personal Accidents'.

Chart 3: Percentage of Manual Handling Incidents against All Personal Accident - 5 Year Run

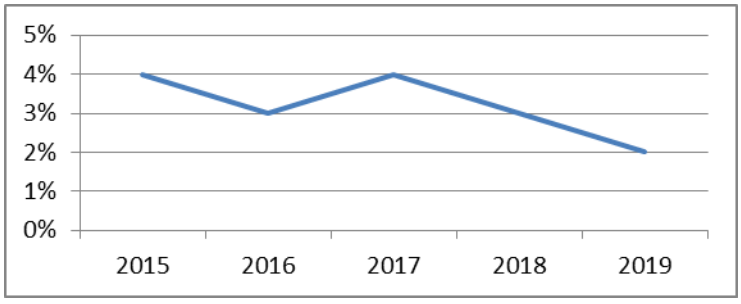
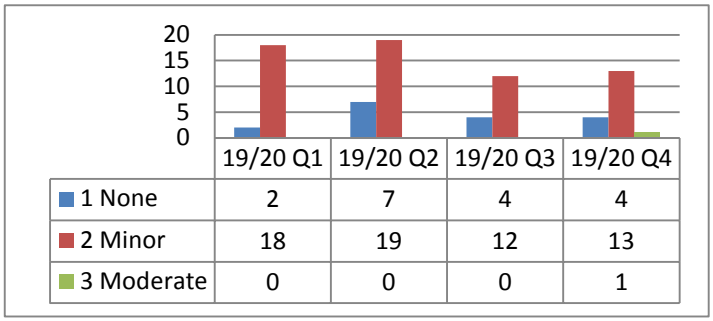
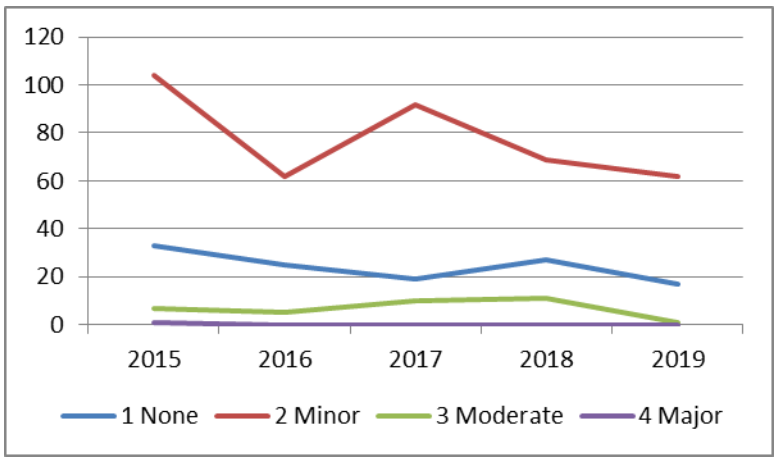


Chart 4: All Manual Handling Incidents by Severity 2019/20



	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4
1 None	2	7	4	4
2 Minor	18	19	12	13
3 Moderate	0	0	0	1

Chart 5: 5 Year Run Chart by Severity



For the whole of 2019/20 Minor incidents account for 78% of the manual handling incidents reported and 21% was reported as No Harm.

In 2019/20 31% of the Minor incidents reported resulted in staff sustaining musculoskeletal injuries due to unexpected movement of the patient, 29% related to injuries to staff sustained whilst moving inanimate objects and 21% resulted in skin damage to the patient.

Staff M/H incidents

Chart 6: Staff Manual Handling Incidents by Sub-category.

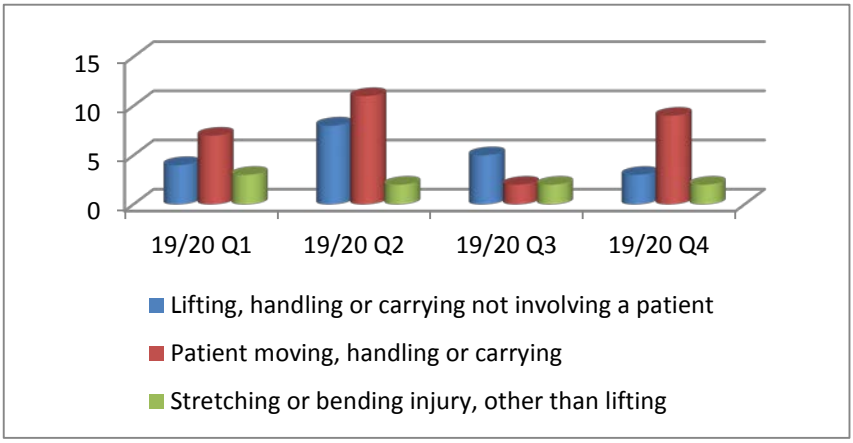
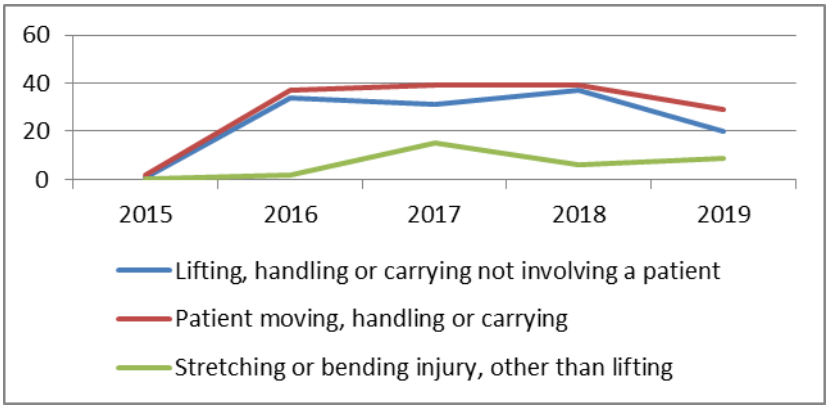


Chart 7: Staff Manual Handling Incidents by Sub-category – 5 Year Run



73% of the total manual handling incidents reported in 2019/20 were to staff.

Injuries sustained during patient handling activities remains the highest reported sub-category accounting for 50% of staff manual handling incidents over the year.

All staff incidents reported in 2019/20 relating to patient handling activities were reported as Minor severity with the exception of one No Harm.

RIDDOR

Incidents Reported under RIDDOR.
The total for 2019/20 is four which is the lowest number for five years. However, RIDDOR incidents relating to manual handling activities is the highest category reported by the Trust's Safety Team.

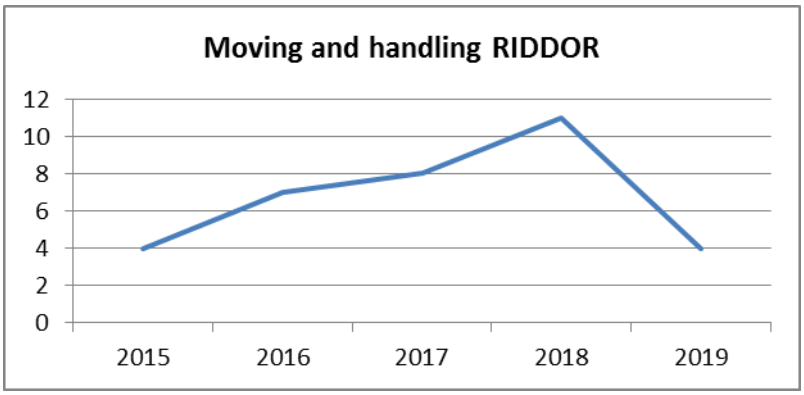
Root causes identified for the RIDDOR incidents include; poor communication when team handling, poor planning of activity and unpredictable movement of a patient.

Actions taken:
The community midwifery service carried out an in-depth review and an agreement was reached to reduce the equipment needed to be transported and smaller carry bags have been purchased.

Additional support such as Occupational Health and Physiotherapy referrals have been provided as well as the offer of one to one support from the Manual Handling Lead upon return to work.

All manual handling incidents that were reported under RIDDOR were reported for staff being off work for more than 7 days (not including the day of incident) as a result of the incident.

Chart 8: 5 Year Run of RIDDOR Incidents



Training

The Manual Handling module of ClinicalSkills.net has now been brought on line for all staff who carry out patient handling activities to access. Successful completion of all four assessments will count as their practical update.

Throughout the year the uptake of places for practical training on induction has improved significantly and this training is now mandatory for all new clinical starters that move and handle patients as part of their role.

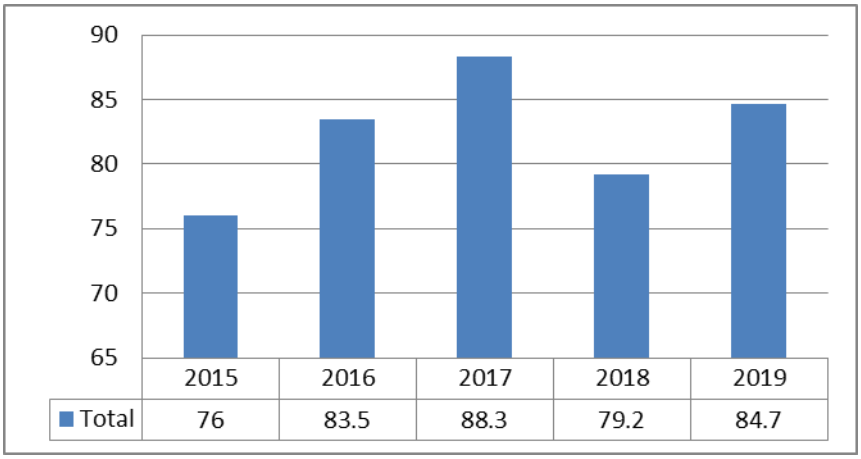
Table 2: 2019/20 Training Compliance Across All Health Groups (HG)

Health Group	E/O Q1 2019/20	E/O Q2 2019/20	E/O Q3 2019/20	E/O Q4 2019/20
Clinical Support Services	90.2	89.3	91.6	87.5
Corporate Directorates	90.5	91.9	91.3	86.5
Infrastructure & Development	97.0	95.0	96.4	93.1

Family & Women's Health	88.7	87.0	91.5	88.5
Medicine	84.7	81.2	84.2	82.6
Emergency and Acute Medicine	89.8	84.4	86.2	87.5
Surgery	86.8	85.5	86.7	84.7
Total	**89.0**	**87.9**	**89.6**	**86.5**

Chart 9: Total Training Compliance – 5 Year Run

The chart below shows the overall annual compliance for manual handling training.



From January 1st the practical patient handling updates (which should be undertaken every three years for clinical staff who move and handling patients) are now being monitored and are being reported as a separate KPI.

Figures below show that the 90% compliance target for this practical training may take some time to achieve however there has already been a marked improvement in the first quarter of monitoring despite restrictions encountered by the Covid-19 pandemic.

Table 3: Practical Patient Handling Training Compliance

Row Labels	January	E/O Q4
356 Level 1 Clinical Support Services	**46.3%**	**53.6**
356 Level 1 Corporate Directorates	**35.7%**	**42.9**
356 Level 1 Emergency Care	**23.6%**	**50.7**
356 Level 1 Estates, Facilities and Development	**29.8%**	**59.3**
356 Level 1 Family & Women's Health	**40.0%**	**51.8**
356 Level 1 Medicine	**49.2%**	**55.5**
356 Level 1 Surgery	**35.7%**	**48.4**
Grand Total	**40.6%**	**51.0%**

Practical patient handling update training should be carried out by the Manual Handling Link Trainers however staff can now access ClinicalSkills.net and complete all four assessments to gain compliance as well.

14 Objectives for 2020/21[1]

(a) Complete the work at height risk assessments

(b) Finalise new permit choice for work at height

(c) Undertake audits of all permit to work activity

(d) Audit and update of Estates' risk assessments and safe working procedures

(e) Redouble efforts regarding ward / department quarterly inspections

(f) Manual handling:

Seating A combined project with the MHL, Tissue Viability and the Falls Group will be to carry out a full audit and review of patient seating. This will be to identify the condition and suitability of our current stock and to make recommendations to future proof purchasing.

Beds

A risk has been placed on the risk register as a significant number of electric and hydraulic beds require replacement. Data is being collated to identify the needs of the Trust and a head-to-head trail of the market leaders is to be set up. Additional work is also to be carried out to identify if this can be used as an opportunity to introduce some specialist equipment which will aid recovery and patient experience.

[1] Accepted that COVID-19 activity will place additional pressures in certain areas – Safety Team to offer assistance with statutory compliance

Hull University Teaching Hospitals NHS Trust

Trust Board

8th September 2020

Title:	Director of Infection Prevention and Control (DIPC) Annual Report 2019-20
Responsible Director:	Beverley Geary – Chief Nurse
Author:	Greta Johnson – DIPC/Lead Infection Control Nurse

Purpose:	This report provides an overview of the work done in accordance with the Infection Prevention and Control Strategy during the financial year 2019-20. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases more generally. It also describes areas where improvement is needed.	
BAF Risk:	BAF 3 – High Quality Care	
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:	Internal and external reviews have confirmed that the Trust has appropriate systems and processes in place for the prevention and control of healthcare associated infection. Performance against mandatory local and national targets has been satisfactory, with the exception of a continued increase in MSSA bacteraemia and an increase in gram negative bloodstream infections (GNBSIs). There have been consistent improvements in some specific aspects of infection prevention and control (e.g. management of *Clostridium difficile*, clinical engagement in root cause analysis, completion of ward level audits and increased partnership working). The Trust has a strong antimicrobial stewardship programme, and there has been documented improvement in antimicrobial prescribing. The Antibiotic Pattie page has been reviewed and improved during 2019-20 so that each speciality has their own section and they are currently being updated with involvement of the clinical specialities. There are weaknesses in the Trust estate and facilities for managing patients with infections, with COVID-19 and enacting a corresponding	

	surge plan bringing it sharply in focus: - limited number of single rooms - inadequate isolation facilities in paediatrics Solutions to these estate issues are being considered as part of a wider Trust strategy. There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections. There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship. It is worth noting these latter key issues have appeared on previous DIPC Annual Reports and it beyond the power of the Department of Infection to address them without support.

Recommendation:	The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)

ANNUAL REPORT 2019-20

1 PURPOSE OF THE REPORT

This report provides an overview of the work done in accordance with the Infection Prevention and Control Plan during the financial year 2019-20. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases more generally. It also describes areas where improvement is needed.

2 BACKGROUND

This report is required by the Code of Practice for the Prevention and Control of Healthcare Associated Infection contained in the Health and Social Care Act 2008.

3 INFECTION PREVENTION & CONTROL ARRANGEMENTS

Dr Peter Moss, who was the Trust **Director of Infection Prevention and Control (DIPC)**, for part of this period, was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan, the role transferred to Greta Johnson, Lead Nurse for the Department of Infection during the summer of 2019. Dr Makani Purva, Chief Medical Officer, had executive responsibility for infection prevention and control during 2019-20. During 2019-20 the role of **Infection Control Doctor** was facilitated by Dr Debbie Wearmouth (HUTH Consultant Microbiologist), with additional support by Dr Neil Todd (York FT Consultant Microbiologist). During 2019-20, the Trust was successful in recruiting an additional Infectious Diseases Consultant and a Consultant Microbiologist along with a trainee Consultant Clinical Scientist in Medical Microbiology. The **Lead Nurse for the Department of Infection** is responsible for the infection prevention & control team and Infectious Diseases specialist nurse teams.

The **Infection Reduction Committee (IRC**) meets monthly, under the chairmanship of the DIPC. The IRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate.

The **Infection Prevention and Control Committee (IPCC)** meet bimonthly. During 2019-20 this committee has been chaired by either the DIPC or Infection Control Doctor. The IPCC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, from the Department of

Infection, from Occupational Health, from the Estates & Facilities Directorate, from the Sterilisation and Decontamination Unit, and from Pharmacy. It reports to the IRC. The IPCC has responsibility for guiding Infection Prevention and Control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment.

The **clinical IPC team** is composed of an Infection Prevention and Control Doctor, specialist Infection Prevention and Control nurses, and supporting secretarial and administrative staff. The nursing team is managed by the Lead Nurse for the Department of Infection and for the period covered by this report consisted of 2.0 WTE band 7's, 3.0 WTE band 6 and 1 WTE band 5 IPC Nurses, supported by a secretary and a part-time administrative assistant. The national recommendation is for 1 nurse per 250 acute beds (as part of a fully supported team); 83% of English NHS Trusts achieve this figure. Advertisement of IPC posts and recruitment during 2019-20 continued, which at times was challenging, a theme experienced by other organisations over the same time period. A further 1.0 WTE band 5 nurse was recruited during 2019-20. Further recruitment into the remaining post in line with the IPC team structure is being planned for 2020/21. Continuing to delivering an effective IPC proactive and reactive service has developed further during 2019-20 with support from the Infection Control Doctor, Consultant Microbiologist, Infectious Diseases Consultants, Corporate Nursing team and site team. There is currently no system analyst, data manager, or epidemiological support for the team.

The **Department of Infection clinical team** includes 8 (5 WTE) Consultant Infectious Disease physicians, 2 Consultant Microbiologists (2 WTE), 1 Virology Consultant Clinical Scientist and 1 trainee Consultant Clinical Scientist in Medical Microbiology. The nursing team consists of Specialist Nurses in HIV (1.8 WTE), viral hepatitis (4.0 WTE), sepsis (2.0 WTE), and Outpatient Antibiotic Therapy (3.2 WTE), as well as a team of ward-based nurses managing the infectious disease ward at Castle Hill Hospital.

4 OTHER RELEVANT COMMITTEES

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the IPCC, and report to IRC. There have been concerns about frequency of some meetings but attendance has improved during the past year. The chair of the Water Safety Committee, which is a mandatory institution, saw an improvement in attendance by Health Groups and Fresenius Renal Unit. The Water Safety Committee has also benefitted from the continuation of input from an Authorising Engineer for water safety. Water safety issues are also reviewed regularly by IRC.

The Trust's designated Board level **Decontamination Lead** (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development supported by the Surgical Health Group Medical & Nursing Directors.

5 THE WIDER INFECTION PREVENTION TEAM

In addition to the core clinical IPC team (DIPC, Infection Control Doctor, IPC nurses, etc.) an increasing number of other clinicians are being recruited to support the Trust's efforts.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Study days, which are facilitated by the Infection Prevention and Control Team, are held twice a year to disseminate new information and guidance. The Link Practitioners are then supported by the Infection Prevention and Control Team to be proactive in implementing this guidance within their workplace.

Access to infection prevention and control information can also be obtained from the Trust Pattie page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required.

6 SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

Public Health England Fingertips data

PHE produce regularly-updated information on a variety of IPC parameters, benchmarking NHS Trusts against other organisations in England (https://fingertips.phe.org.uk/profile/amr-local-indicators/data). The huge amount of information available can be grouped in various ways: the appendices contain spine plots of the performance of the Trust against all other acute NHS trusts in England in overall performance on all HAI targets (Appendix 1), in antimicrobial prescribing data (Appendix 2) and in other IPC measured initiatives (Appendix 3). This information represents both 2017/18 and 2018-19 data (depending on availability of information) against the NHS initiative targets, HUTH has performed at or better than the benchmark in all cases. For the wider range of HAI targets the Trust generally falls between the 25th and 75th centile, but was a significant negative outlier for Trust-attributed Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections (BSI). Performance was excellent for the antimicrobial prescribing targets: the Trust was better than the benchmark value in all criteria, and was a significant (positive) outlier in some areas.

i Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

The Trust had achieved a year on year reduction in cases of MRSA BSI since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA BSI by the Department of Health, and the Trust met its target for 2011-12 (8 cases against a threshold of 9), and 2012-13 (6 cases against a threshold of 7).

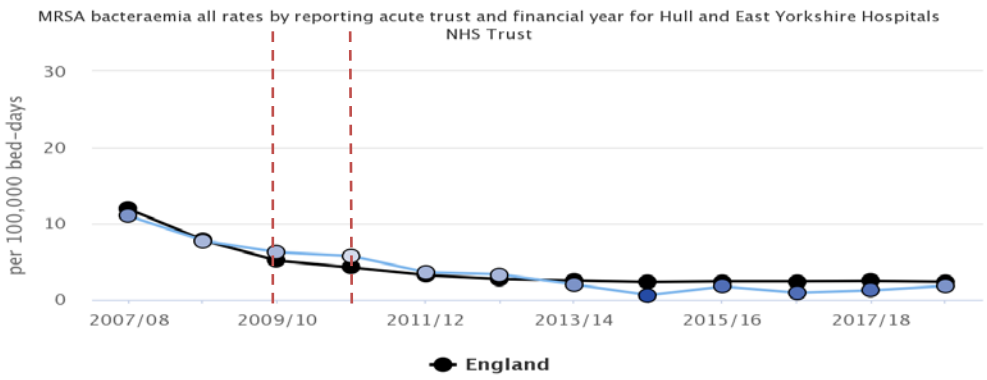


Figure 1. MRSA BSI rates in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)

From 2013-14 the Department of Health moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figure 1). The numbers of total and Trust-attributed MRSA BSI diagnosed in the Trust for the last 6 years are shown in Table 1.

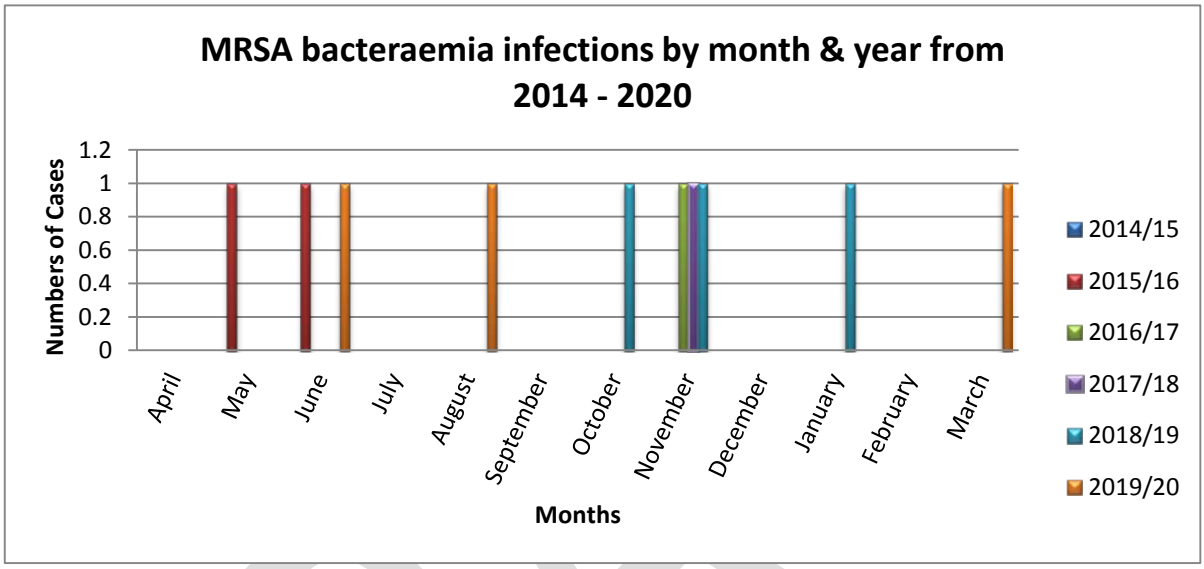


Table 1. MRSA bloodstream infection diagnosed in HUTHT 2014-20

During 2019-20 a continued trend was noted with an increase in both Trust and Community apportioned cases – in total 3 Trust apportioned and 3 Community apportioned cases were detected, the same number detected the previous financial year.

On the 3rd June 2019 a hospital apportioned MRSA bacteraemia case was detected in a patient nursed on C28, the patient was admitted with a late presentation NSTEMI, they were screened on admission and found to be nasally positive although this was initially a presumptive result, causing a slight delay in confirming colonisation. The patient had numerous peripheral cannulas inserted, mainly by medical staff which were not always documented; in addition there were inconsistencies in documentation and VIP scoring. The patient complained of pain and swelling around a cannula on his RT arm on the 3rd June 2019, phlebitis was noted and the cannula removed - on the same day the patient became pyrexial and blood cultures collected. The cause of the pyrexia was initially thought to be related to removal of a urinary catheter but this was dismissed and the cause of the bacteraemia identified as the cannula, with a pus swab from the cannula site confirming MRSA. Unfortunately, the patient was cannulated in the same arm but distal to the area of thrombophlebitis/ cellulitis for IV fluids and antibiotics resulting in widespread swelling and cellulitis of the RT arm. A Post Infection Review meeting was held on the 31st July 2019 and

concluded the case was avoidable. The patient and family have been an active part of the investigation, are grateful for the thorough investigation and accept the findings of the PIR.

A MRSA bacteraemia was detected in a patient nursed on C15 on the 31st August 2019. The patient had extensive abdominal and urological surgery 12 days before the MRSA bacteraemia was detected, with a stay on ICU and had multiple devices. The bacteraemia was investigated via a Post Investigation Review and a PIR meeting held with the clinicians, senior nurses and commissioners – the case was deemed unavoidable due to the complexities of the case. The clinician responsible for the patient's care provided feedback to the patient of the investigation and outcome.

The third Trust apportioned MRSA bacteraemia was reported in March 2020. The case was determined as Trust apportioned due to the timing of the sample but following review by the Infectious Diseases team, the patient was diagnosed with a deep seated infection thought to be present on and the reason for the admission e.g. discitis requiring prolonged antimicrobial therapy. The patient had a previous history of spinal surgery performed in Romania in 2015 and this was the site of the current infection. Patient was managed conservatively with antibiotics. Outcome of the PIR following discussion with Public Health England (PHE) and Commissioners concluded that there were no lapses of practice by both the Trust and Primary Care and the case was deemed unavoidable.

Of the three Community apportioned cases, one represented a patient recently admitted to the Trust therefore the PIR reflected the care the patient received whilst in hospital. Outcome of the PIRs following discussion with Public Health England (PHE) and Commissioners concluded that two were deemed unavoidable and the remaining case avoidable due to lapses of care identified whilst the patient received care at Castle Hill Hospital. Opportunities to identify and act upon previous positive MRSA decolonisation results had not been taken in a timely manner by the Trust. Although review by the Infectious Diseases team suggests the source of the bacteraemia is an implanted longstanding cardiac device which cannot be explanted but treated with lifelong antibiotics.

Among other measures to try to reduce the number of MRSA BSI, the Department of Health in 2010 mandated that all patients admitted to hospital in England must be screened for MRSA skin colonisation. This has proved difficult to implement in practice, and the efficacy of such universal screening (as opposed to testing patients at higher risk) has always been debated. In 2014 the DH Expert Advisory Group on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) reviewed the available evidence, and recommended that all Trusts move from a policy of universal screening to one of selective screening of high risk patients. However many Trusts have been reluctant to make this change for fear of a reversal in the downward trend in MRSA BSI, and only one organisation in Yorkshire has fully implemented the ARHAI recommendation. On the advice of previous ICDs HUTH continued to attempt universal screening for MRSA colonisation. However, during 2018/19 the DIPC presented an options appraisal to the Executive Team in July 2018, setting out a number of screening options. Option 4 was the preferred option - combine the national recommendation with local policies and procedures to improve practice in preventing a range of Healthcare Associated Infections (HAI). These would include reviewing past screening results to identify any additional areas which might qualify as 'high risk', and development of a checklist for transfers from other healthcare facilities to ensure

appropriate screening for a panel of HAIs (including MRSA). A proforma was developed to assist clinical areas with identifying which patients, which areas and when HCAI screening will be completed. To date this has not been formally adopted, especially with a continued increase in MRSA bacteraemia cases experienced during 2019-20 and the Trust continues to screen all admissions for MRSA on admission. It was hoped that the proforma and preferred option would be launched during 2019-20, however, there were impending changes nationally again with regards to MRSA screening which at the time of writing this report remain outstanding. Opportunities to screen for other HCAI's, including *Clostridium difficile* and Carbapenemase producing Enterobacteriaceae (CPE) are taken in line with the drafted proforma which the IPCT continue to monitor.

ii *Clostridium difficile* Associated Diarrhoea (CDAD)

The Trust has participated in the mandatory surveillance of *Clostridium difficile* since 2004. In 2011-12 the Trust performed particularly poorly in preventing hospital acquired C difficile infection. In this period there were 105 cases of CDAD attributed to the Trust, against a maximum threshold of 60 set by the Department of Health. Following a number of interventions the number of cases in 2012-13 fell to 58, and the Trust has maintained a steady improvement in performance since then (*Figure 2*).

In 2019, the Department of Health and PHE introduced updated CDAD objectives based on using CDAD data from 1 April 2018 to 31 December 2018. The changes to the CDI reporting algorithm for financial year 2019-20 included adding a prior healthcare exposure element for community onset cases, reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission. For 2019-20 cases reported were assigned as follows:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)
- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)
- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA)

Acute provider objectives for 2019-20 were set using these two categories:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

In 2019-2020 there were 44 HOHA and 14 COHA cases reported, taking the total of CDAD cases to 58, against a threshold of 80 cases.

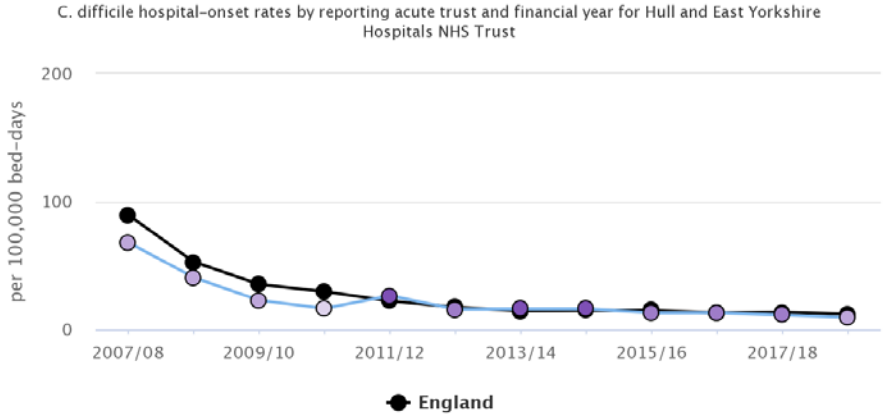


Figure 2. C. difficile rates in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

From 2015-16 there was an opportunity for cases of *C difficile* for which the commissioners agreed that there had been no lapses of care (and the infection was therefore unavoidable) would be highlighted and removed from any financial penalty, although still included in the total. The Trust agreed a very strict definition with the commissioners, whereby any deviation from Trust or national guidance (even if not necessarily contributory to the development of infection) was classed as a lapse of care. Meetings with the Commissioners to review CDAD cases continued up to and including January 2020, but due to COVID-19 these were postponed but of the 22 cases reviewed 77% of the reported cases were agreed to have been unavoidable through a robust consultation process with the IPC representatives of the commissioners. The continuing reduction in the number of Trust-attributed cases is a reflection of improved infection control processes on the general wards, and dramatically improved antibiotic prescribing practices across the Trust.

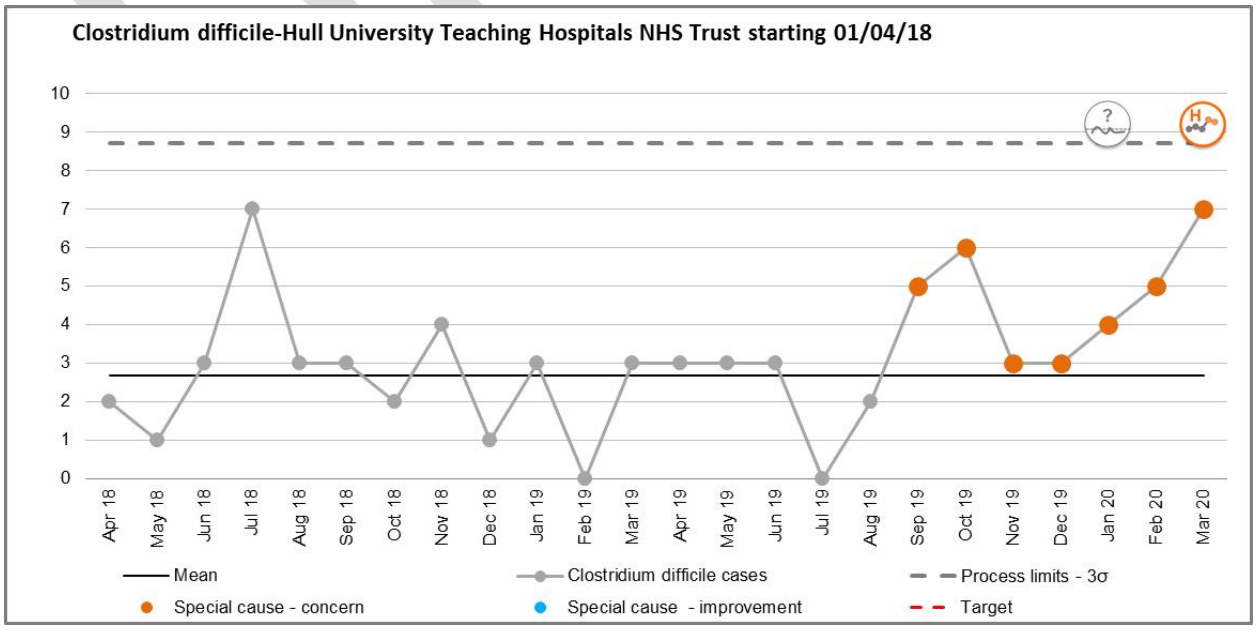


Table 2. Hospital onset Clostridium difficile infections diagnosed in HUTHT 2018-20

All cases of *C difficile* infection are subject to a Root Cause Analysis (RCA). The RCA process is led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPC team. Summary outcomes are presented to the IRC. In most cases there were no significant failures of care apparent that had led to the development of CDAD. One key identified issue for improvement related to antimicrobial stewardship and adhering to the Trust antimicrobial prescribing guidance.

Of note is a marked increase in cases at year end which is multifactorial and currently under review at the time of writing this report but early indications suggest the use of high risk antibiotics such as Cephalosporin's and Quinolones used to treat patients with COVID-19 has clearly impacted on acquisition of CDAD. Another aspect is reduced 'in reach' by the Infectious Diseases team to wards and departments, especially at the peak of the pandemic in the Trust, providing advice on prudent antimicrobial prescribing.

Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. Root cause analysis of MSSA BSI cases are completed and reported via the IRC. There have been year to year fluctuations, but during 2019-20 HUTH reported a continued increase in the rate of MSSA BSI, and it remains the one major HAI indicator for which we are significantly worse than the national benchmark.

From a national perspective, rates of Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia continued to increase moderately from 2011/12 when the PHE HCAI surveillance was introduced. These increases are primarily driven by the increase in community-onset cases. Between January 2011 and January to March 2020, the count and the incidence rate of community-onset cases increased by 41.9% and 33.9% respectively from 1,464 to 2,078 cases and from 11.2 to 15.0 cases per 100,000 population. Over the same period, the count of hospital-onset cases increased by 2.0% from 735 to 750 cases, while the incidence rate increased 2.7% from 8.4 to 8.6 cases per 100,000 bed-days.

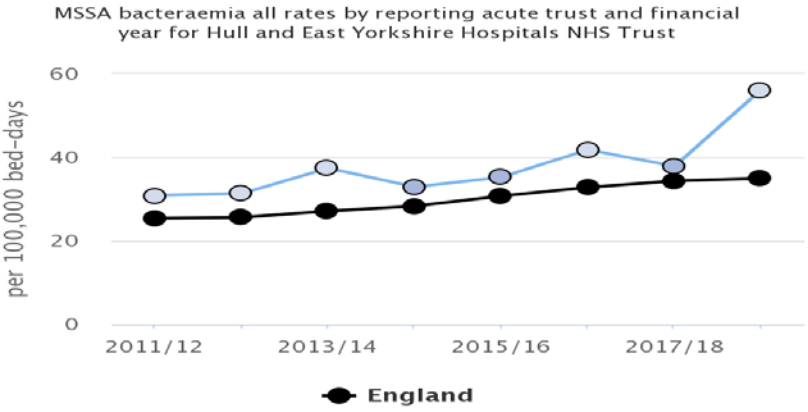


Figure 3. MSSA BSI rates in England 2011 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

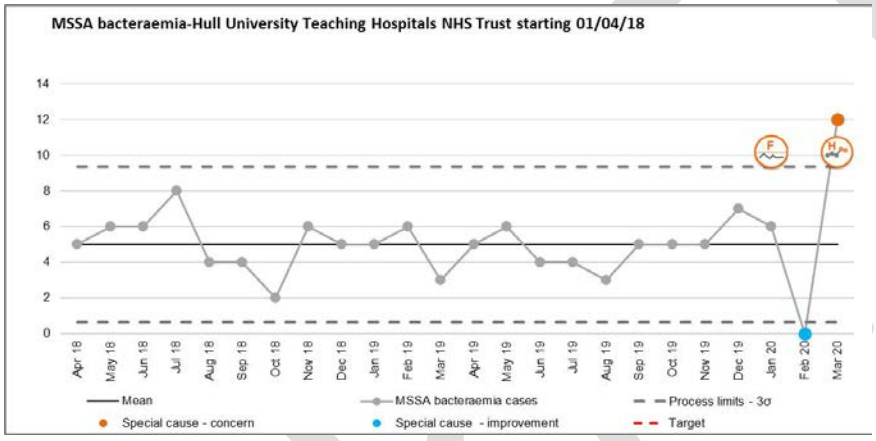


Table 3. MSSA bloodstream infection diagnosed in HUTHT 2018-20

Reasons for the continued relatively high rate of MSSA BSI during 2019-20 relate predominantly to poor intravascular line insertion and care, specifically peripheral vascular devices and these should be avoidable. During 2019-20, in response to the number of MSSA bacteraemia reported and outcomes of RCAs, a Device Task, Challenge & Finish Group continued with attendance from Consultants, Senior Nurses across all Health Groups, along with Nurse Educators and Supplies. The purpose of the group is to understand the systems, processes, products and human factors responsible for increasing the risk of infection and mitigating those risks by making it easier for clinical staff to do the right thing. Other cases associated with intravenous drug use and chronic ulcers are more difficult to address, but further work is needed to investigate why such a high proportion of our overall MSSA BSI cases are hospital-apportioned. During 2019-20, focus has primarily been working alongside the Surgical Health Group to address concerns with regards a number of surgical wards with higher than average MSSA bacteraemia rates. Initial findings suggest a correlation with regards the use of central venous access devices and a lack of robust evidence to support staff competencies. Additional training was being provided along with a Trust wide roll out updated care bundles to improve documentation. Of interest is an associated continued increase in Community Apportioned MSSA bacteraemia cases across

Hull & East Riding of Yorkshire during 2019-20 of which some are linked to intravenous recreational drug abuse and warrant System wide additional investigation.

Escherichia coli bacteraemia

Mandatory surveillance of *E coli* bacteraemia was introduced in 2011. This organism is the commonest cause of bacteraemia in hospital (43,242 cases reported in 2018-19), and numbers are increasing year on year. There is also a steady increase in the proportion of these organisms which produce Extended Spectrum Beta Lactamase (ESBL), an enzyme which makes them highly antibiotic-resistant. These facts have led PHE, NHSI, and ARHAI to focus on reducing the rate of Gram negative bacteraemia, and especially blood stream infection due to *E coli*. The Department of Health had announced a formal intention to reduce the incidence of *E coli* bacteraemia by 50% by 2020; this was subsequently reviewed and updated on the 24th January 2019 on the Department of Health publication of 'Tackling antimicrobial resistance 2019–2024. The UK's five-year national action plan'. This publication acknowledged the complexity of reducing gram negative bloodstream infections but reiterated the need to continue work to halve healthcare associated Gram negative BSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024

National benchmark data show a total of 43,242 cases of E. coli bacteraemia were reported by NHS Trusts in England between 1 April 2018 and 31 March 2019. Of the 43,242 E. coli cases, 7,632 (17.6%) were hospital-onset. National benchmark data show that HUTH is above the national mean rate of hospital-attributed E coli BSI (33.7/100 000 bed days), compared to a mean of 22.1 in 2018-19 (Figure 4). The HUTH figure for 2018-19, remains the same as of 2017-18, at 33.7/100 000 bed days.

The majority of *E coli* BSI diagnosed in HUTH are the cause of admission rather than being hospital-acquired (usually related to urine or gall bladder infections), and are therefore considered as 'non-attributable' to the Trust. However a proportion of *E coli* bloodstream infections continue to be acquired in hospital, associated with urinary catheters, wound infections, vascular devices, and ventilator-associated pneumonia. Even for the 'community-attributable' bacteraemia the situation is not as straightforward as it may seem, as infections developing in the community may be related to a previous admission to hospital. Although surveillance of cases is reported, it is difficult to determine which infections were potentially avoidable without robust investigation. Each hospital apportioned case is subject to a review by the Infection Prevention & Control Team (IPCT) and if identified lapses in practice are identified then a root cause analysis (RCA) is completed. Of the cases reviewed for 2019-20, 47% were deemed avoidable, mainly related to urinary tract infections and patients with indwelling urinary catheters, a feature of previous reviews of Trust apportioned E.coli bacteraemia cases. Concerns remain with reducing the burden of community apportioned cases which challenges efforts to address the continuing rise in cases in the community and meet the required thresholds of a reduction of 25% reduction of Gram Negative Bloodstream Infections (GNSBSIs) by 2021-2022 with the full 50% by 2023-2024.

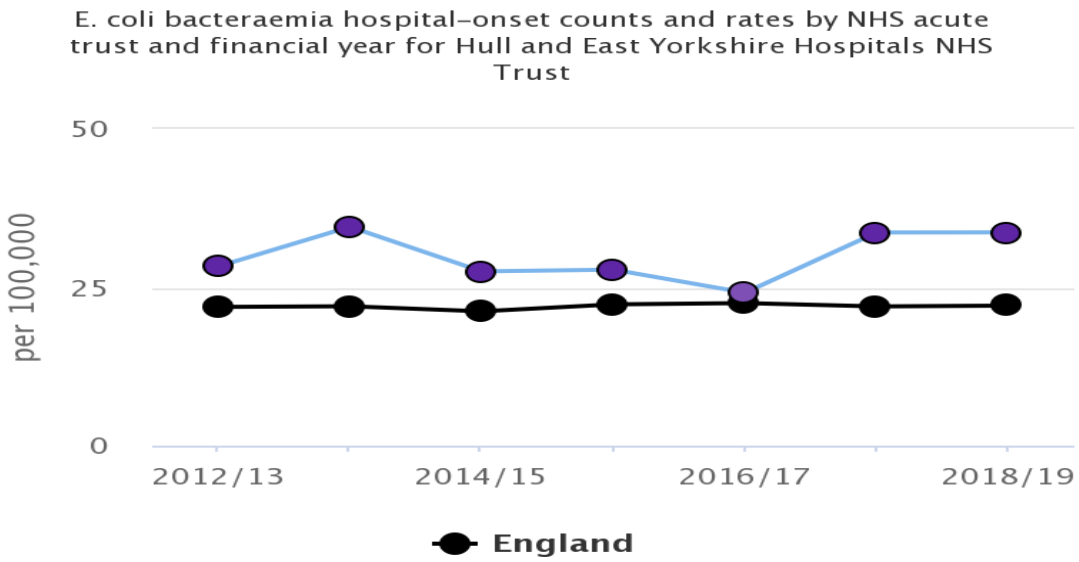


Figure 4. E.coli BSI rates in England 2012 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

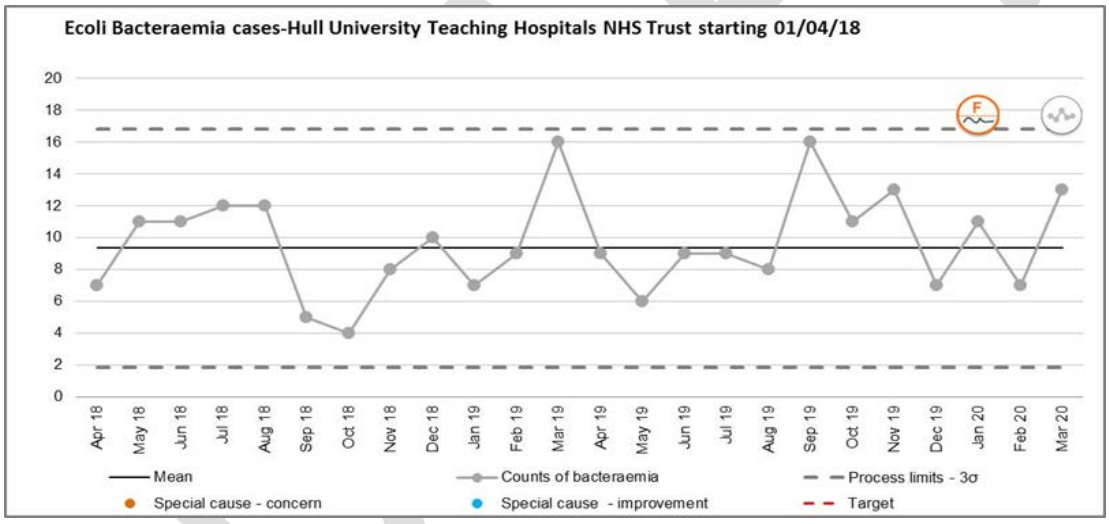


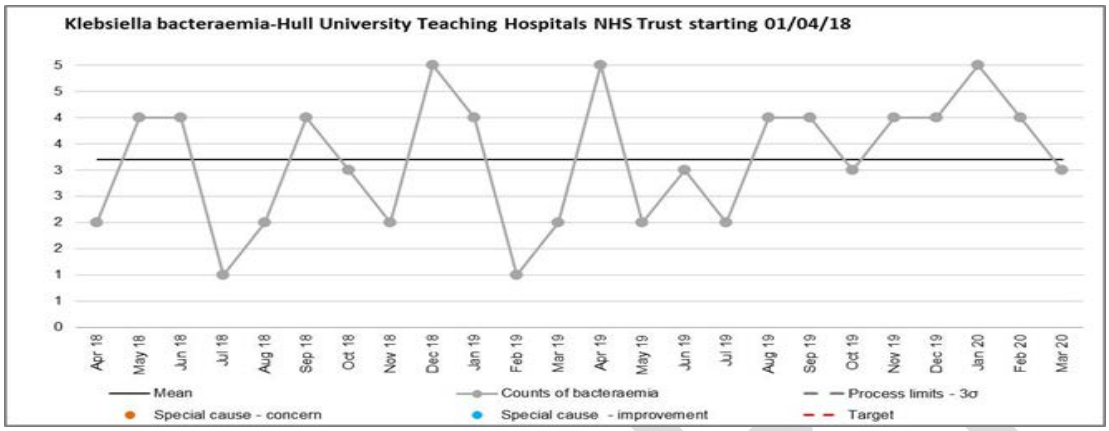
Table 4. E. coli bloodstream infection diagnosed in HUTHT 2018-20

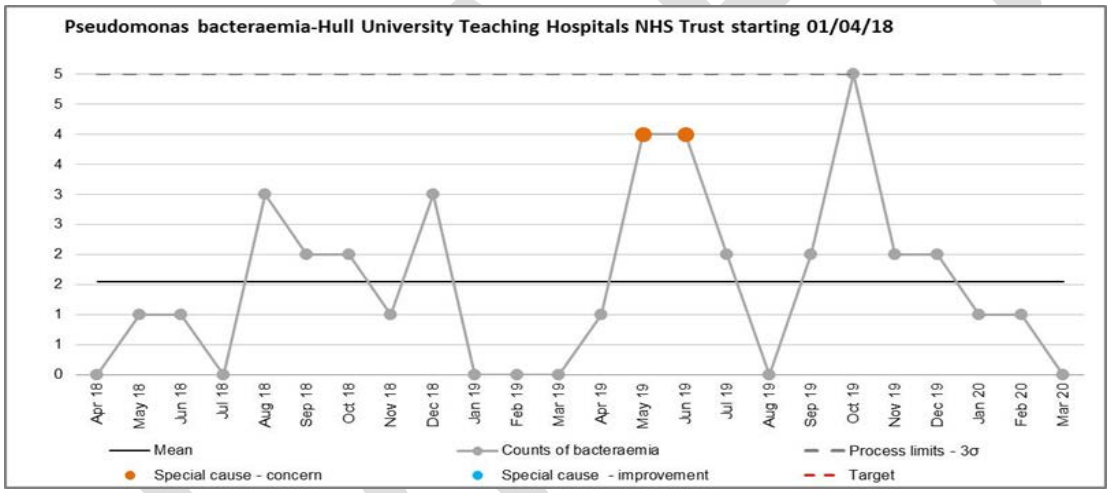
Klebsiella and Pseudomonas Aeruginosa bacteraemia

For the operational period 1st April 2019 to 31st March 2020, PHE and NHS England required 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, inclusive of E.coli, Klebsiella and Pseudomonas Aeruginosa bacteraemia. Klebsiella and Pseudomonas Aeruginosa bacteraemia demonstrate similar risk factors as those found with E.coli bacteraemia, with both reported for cases of respiratory and urinary tract infections.

During 2019-20 an increase in both Klebsiella and Pseudomonas Aeruginosa bacteraemia were noted, with a significant number demonstrating resistance to Carbapenems which was monitored and managed by both the Infectious Diseases team and IPCT. By year end case numbers levelled off to within normal limits.

Tables 5&6. Klebsiella and Pseudomonas aeruginosa bloodstream infections diagnosed in HUTHT 2018-2020





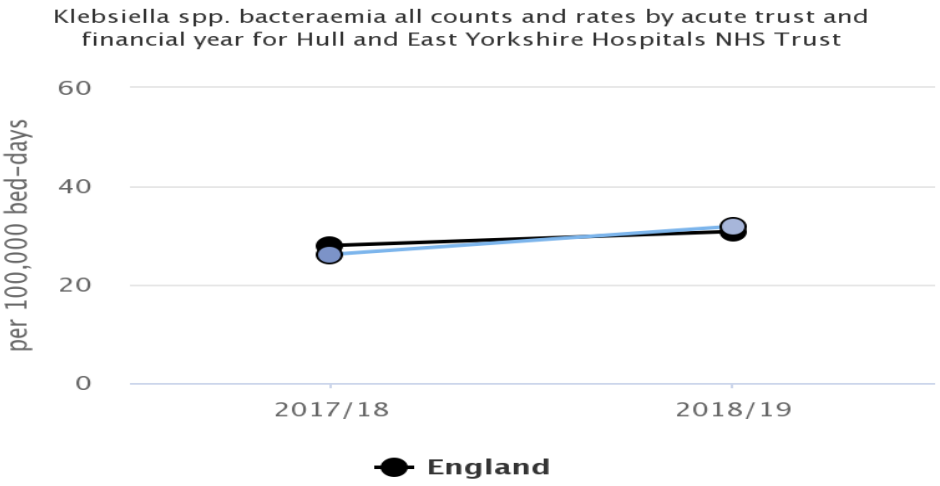


Figure 4. Klebsiella BSI rates in England 2017 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

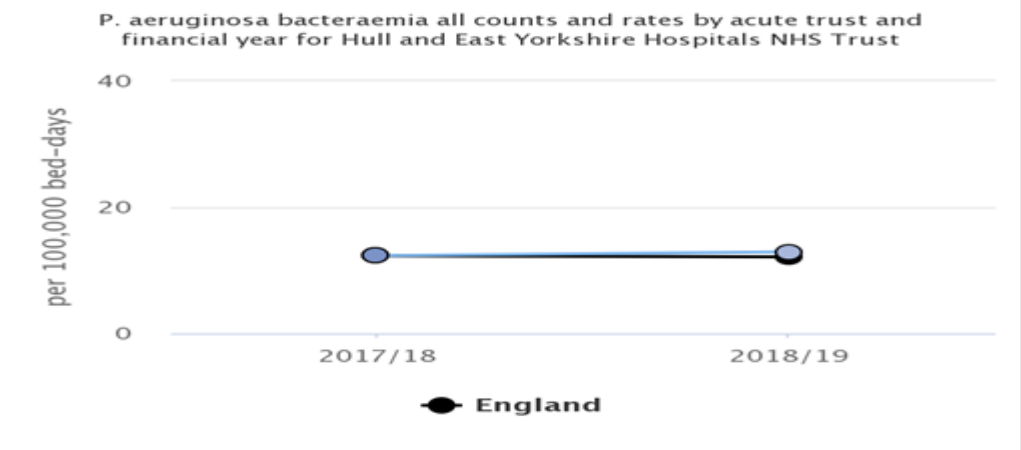


Figure 5. Pseudomonas aeruginosa BSI rates in England 2017 - 2019 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2019-20 this included orthopaedic surveillance (knee replacements) and was undertaken during October to December 2019; in addition, from January 2020 to March 2020 because of concerns raised regarding perceived increase in wound infections amongst fractured neck of femur patients, repair of neck of femur fracture surveillance was once again undertaken, providing the opportunity to compare year on year figures.

With regards knee replacement surveillance, during October – December 2019, seventy seven knee replacement operations were surveyed, 1 patient was reported to have a superficial wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 1.3% which is slightly higher than the national hospital SSI rate of 1.2%. However, stratifying results from all knee replacement surveillance completed over the last 5 years demonstrates a lower Trust percentage of 0.6%.

With regards repair of neck of femur fracture surveillance, during January – March 2020, eighty eight repair of neck of femur operations were surveyed, 1 patient was reported to have a superficial wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 1.1%, in line with the national hospital SSI rate. This is a significant improvement from the same quarter in 2019 which demonstrated a SSI rate of 2.8% and is associated with measures to improve practice for patients with a fractured neck of femurs pre, peri-operatively and post operatively and the respective trauma and orthopaedic teams working closely with the IPCT and ID physicians.

8 OUTBREAKS AND RESISTANT ORGANISMS

The Trust's policy on outbreaks and incidents of infection has been followed by the IPC team and respective Health Groups. Incident and Outbreak Control Group meetings have been

held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patient safety and preventing onward transmission.

Confirmed Measles case

During April 2019 an incident meeting was held to discuss a case of confirmed measles reported in a patient who presented to the Emergency Department. Although there was a delay in diagnosis – possibly partially attributed to the delayed serology sample from AAU reaching Virology but more likely due to the clinical presentation, which was atypical and MMR history, the patient was managed appropriately and transferred to the Infectious Diseases ward. The Trust was commended by Public Health England for active management by ID and early intervention reducing any potential transmission events by enforcing side-room, droplet precautions and ultimately transferring care to ID unit along with rapid management and review of all contacts – mostly undertaken at the weekend by the on call Infectious Diseases Consultant and Lead Nurse and rapid review of staff by the OH department.

MRSA incident on Neonatal Intensive Care Unit (NICU)

During January and February 2020, five neonates were colonised with MRSA in a variety of sites, including nasal/axilla and groin. Initially, the first two cases were not thought to be linked because the isolates demonstrated different antibiograms, however with a cluster of a 4 further cases in rapid succession occurring on the unit in early February 2020, a decision was made to send all 6 isolates for typing to PHE, Colindale. Results from typing identified the first 2 cases were linked because the index case had 2 different strains of MRSA and the second case shared one of the strains, whereas, the 4 remaining isolates did not match the first two yet all 4 cases were indistinguishable. This demonstrates there were 2 distinct clusters of MRSA colonisation occurring on the unit, related to time and place, further investigation demonstrated a correlation with neonates being nursed in the ‘red room’. Action to date included closure to the network for 1 week to ensure control measures were put in place, deep cleaning of the unit – the ‘red room’ was deep cleaned on 2 separate occasions, reinforcing the importance of hand hygiene and correct use of PPE with both staff and parents and an increase in screening frequency to twice weekly during the incident. Incident meetings were held with representation from PHE and the commissioners were informed of the incident. To date, no clinical infections caused by MRSA were identified on the unit. Additional actions included the use wipes designed specifically for cleaning and disinfecting hand held devices, including mobile phones, IPODS and IPADS which has proved beneficial for patients and staff.

Norovirus

The majority of Incident/Outbreak Control meetings were called because of Norovirus, facilitated by liaison following bed meetings which were attended by members of the Infection Prevention & Control Team. The overall number of Norovirus cases locally and nationally over the year was below nationally expected numbers and the local situation was in line with national epidemiology.

During 2019-20, outbreaks of diarrhoea & vomiting, mainly affecting medical elderly wards were reported. The majority of these were identified as being caused by Norovirus.

In April 2019, a full ward closure on H11 was required; the ward was affected with an abrupt outbreak of diarrhoea and vomiting, confirmed as Norovirus. There were concerns raised regarding whether this was as a consequence of a previous outbreak, reported the month before and that either suboptimal cleaning prior to the ward being reopened, during the outbreak and/or suboptimal standard precautions contributed to the April 2019 outbreak. The outbreak was extremely protracted due to patients displaying symptoms for an extended period – one patient had multiple positive results which was extremely unusual. The ward and affected bays were eventually cleaned and reopened on the 30th April 2019. Education on outbreak management for ward H11's team was organised to mitigate any further confusion regarding application of standard precautions.

In accordance with national guidance hospital outbreaks of Norovirus were managed with partial restrictions but some complete ward closures were necessary, as in keeping with trends associated with 2018-19.

Of note during 2019-20 there were protracted outbreaks of diarrhoea and vomiting / Norovirus on both H9 and H90. Both these clinical areas nurse medical elderly patients who are more prone to acquiring infections such as Norovirus, often presenting with symptoms, and a day to two days following admission so therefore incubating infection on admission. Outbreaks of diarrhoea and vomiting / Norovirus can also occur in care homes, resulting in patients being admitted over concerns of dehydration. Patients with dementia and with symptoms of diarrhoea and vomiting, who wander around the ward can increase transmission rates too.

However, following investigation, the implications of no floor to ceiling partitions, poor compliance with utilising personal protective equipment (PPE) and suboptimal deep cleaning following a ward closure all potentially contributed to the protracted nature of the outbreaks.

All areas affected by Norovirus were closed and cleaned in full accordance with IPC guidance. Opportunities to review existing policies, procedures and communication strategies with internal and external partners continued throughout 2019-20 with the embedding of a discharge policy, to facilitate safe discharge from affected wards, although remained a challenge during 2019-20.

Carbapenemase producing Enterobacteriaceae (CPE)

Infections with multi-drug resistant Gram negative bacteria are becoming increasingly common in Britain, and there have been a number of healthcare associated outbreaks (including some in other acute trusts in Yorkshire). During 2019-20 Hull University Teaching Hospitals NHS Trust continued to experience increases in imported infected and/or colonized patients, all of whom brought the organism in from elsewhere. The Trust continues to identify and respond as per the national toolkit on prevention and management of CPE and during 2019-20 met the requirements of the toolkit e.g. identifying, screening and managing at risk patients and those with active infection. During 2019-20 in response to an increase in admissions and transfers of patients with CPE and a concern regarding the propensity for CPE to survive in healthcare environments, reactive cleaning of ward/department areas using Hydrogen Peroxide Vapours (HPV) was conducted where patients had been nursed and/or treated. This was invariably needed out of normal working

hours and conducted by an external company who specialise in HPV decontamination. This represents a cost burden to the Trust in the long term with HPV decontamination out of hours costing the Trust £53,640.00 excluding VAT for 2019-20.

Influenza

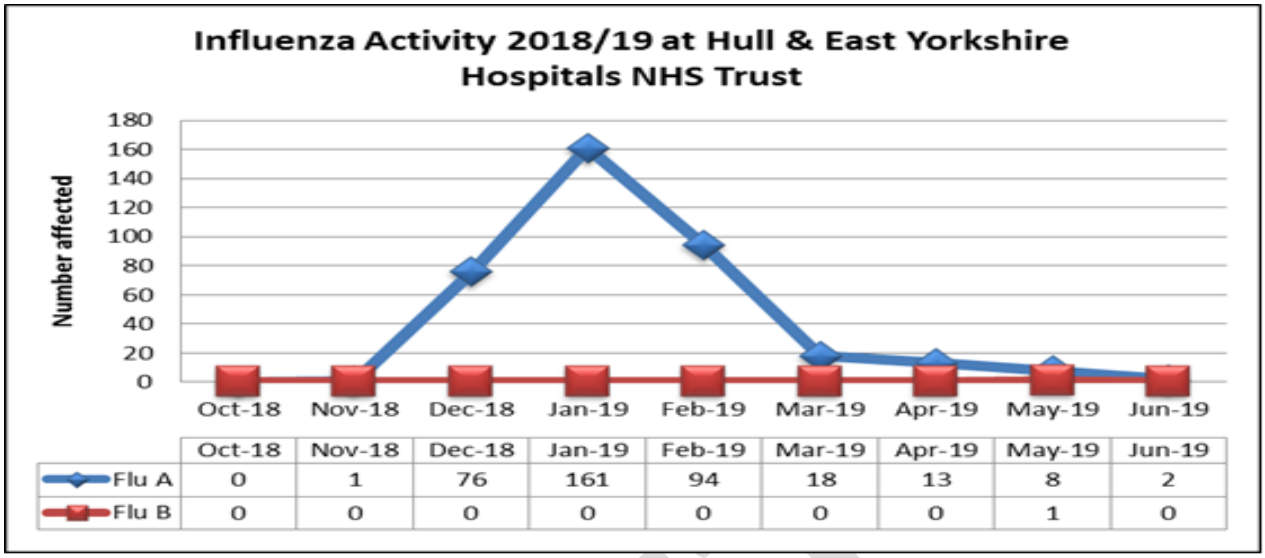
Influenza activity continued during quarter one of 2019 which was unusual. During April 2019, thirteen cases of Influenza A were reported, reducing to eight cases in May 2019 and two in June 2019, only one influenza B case was reported in that timeframe.

The influenza vaccination campaign for 2019-20 commenced on the 25th September 2019 and at year end, 83% of Trust staff involved in providing direct patient care had taken up the influenza vaccine.

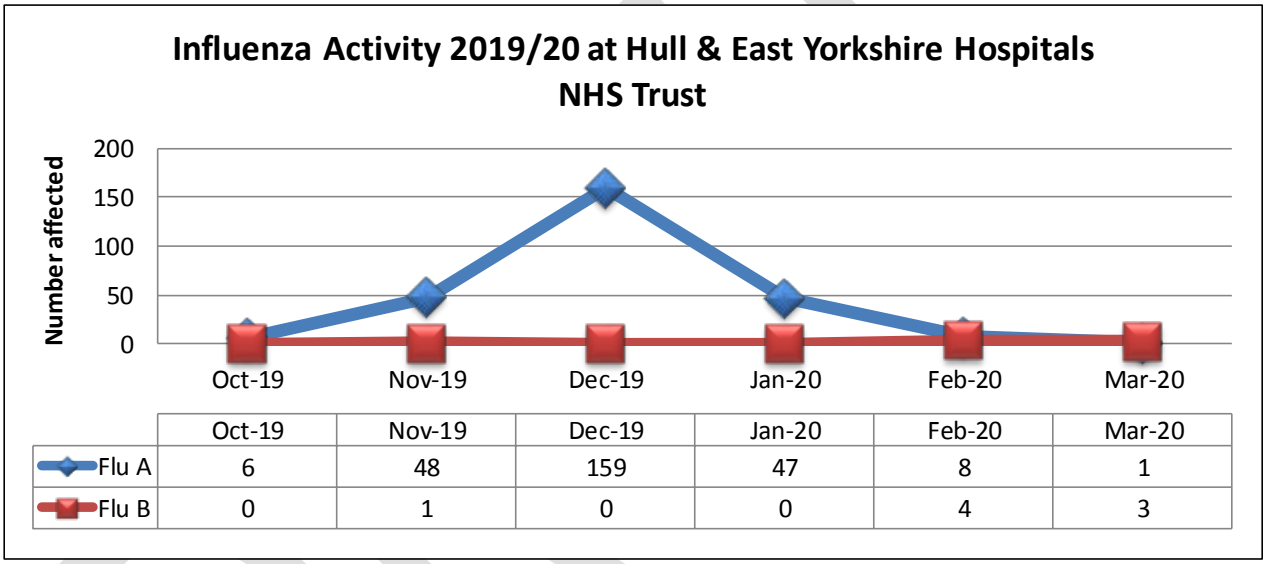
Cases of Influenza in patients admitted to the Trust were first noted during October 2019, a month earlier than normal but in keeping with experiences reported in the Southern Hemisphere with an early onset of influenza. A marked peak in cases occurred during December 2019, with 159 reported cases which reduced to 47 in January 2020, 12 in February 2020 and 4 in March 2020. In spite of the earlier onset and the significant increase, these cases represented normal seasonal flu activity; the majority of cases were detected with Influenza A, however in response to COVID19 and increased screening, eleven Influenza B cases were detected and likely to have been imported from Italy following foreign travel. Patients were screened, isolated, treated and managed appropriately. During October 2019 – March 2020, 12 patient deaths occurred in the organisation associated with Influenza.
Patients were proactively screened for influenza during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety.

During 2019-20, the Microbiology laboratory continued to use molecular testing (Biofire film array multiplex PCR system). This provided rapid respiratory panel testing including influenza, enabling prudent management and treatment of respiratory viral infections and improving patient flow.

The following two graphs show the distribution of Influenza strains for FY 18-19 and 19-20.

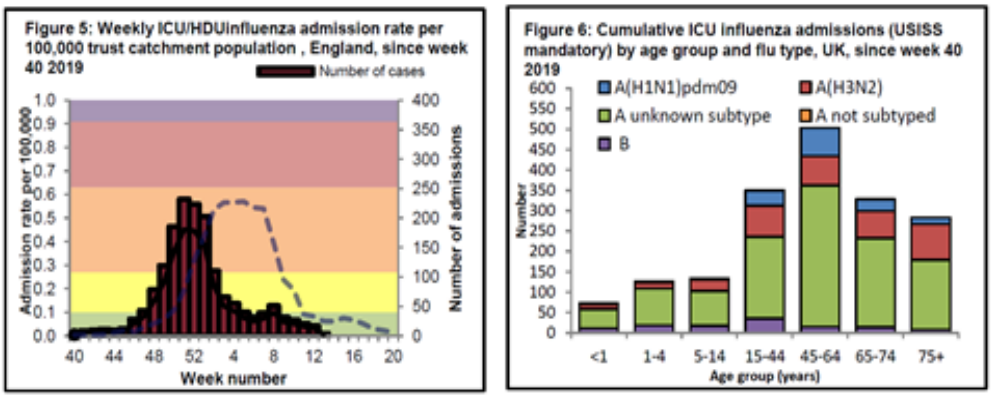


	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Flu A	0	1	76	161	94	18	13	8	2
Flu B	0	0	0	0	0	0	0	1	0



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Flu A	6	48	159	47	8	1
Flu B	0	1	0	0	4	3

Table 9. Represents influenza activity at the Trust since October 2019 until the end of March 2020



**The Moving Epidemic Method (MEM) has been adopted by the European Centre for Disease Prevention and Control to calculate thresholds for ICU/HDU admission rates for the start of influenza activity (based on 7 seasons) in a standardised approach across Europe. For MEM threshold values, please visit: https://www.gov.uk/guidance/sources-of-uk-flu-data-influenza-surveillance-in-the-uk#disease-severity-and-mortality-data*

Table 10. England Flu Activity PHE Weekly National Influenza Report

COVID-19

With the onset of COVID19, the Infectious Diseases team/ IPCT remained vigilant as to the risks and impact of a high consequence infectious disease on the Trust and on the 31st January 2020 detected two patients nursed on C7 with COVID19; these represented the first UK reported cases. Ward C7 continued to accept patients with symptoms associated with COVID19 increasing the need to utilise Ward C16 and also assist the 111 service with the screening of patients presenting with symptoms. On the 12th March 2020, COVID19 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. The Trust continued to screen and identify COVID19 positive patients, increase critical care capacity to accept those patients with severe life threatening infections/ complications and also work closely with System Partners to understand the impact on the local health economy. No additional cases were detected during February 2020, but sixty eight cases of COVID-19 were detected during March 2020 – these cases mainly represented local residents across Yorkshire & the Humber who had developed symptoms and had returned following foreign travel to areas such as Europe, United States of America and Asia where COVID-19 was circulating.

The Infectious Diseases team/ IPCT provided training and support with regards donning and doffing of PPE, fit test training for respirator face masks (FFP3s), advice on isolation and management of patients with a high consequence infectious disease. On the 27th March 2020 the WHO reclassified COVID-19 as an infectious disease transmitted via contact and droplet route (rather than airborne) but the need for vigilance remained.

9 ISOLATION FACILITIES

There have been, for many years, concerns about the Trust's isolation facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.

The opening of ward C7 has had a positive impact on patient management, particularly those patients with difficult to treat infections and infectious diseases requiring specialist isolation facilities. It also means that we can manage several patients at once with conditions requiring long term isolation, for example multidrug resistant tuberculosis.

There remain concerns about the organisation's ability to isolate children, especially those with airborne infections. Although plans are discussed and implemented to minimise the risk of infections, especially during winter with risk assessments and liaison with IPCT - there have been, and will continue to be, cases of hospital transmitted influenza and respiratory syncytial virus (RSV) until more suitable facilities for isolating children with these infections are provided. It is hoped during 2020-21 suitable facilities will be provided to minimise the risk associated with the transmission of infections.

Due to a number of reported outbreaks on the Neonatal Intensive Care Unit over the last 5 years which cited the environment as being a contributory factor, significant work has been undertaken on the unit to mitigate risks. These included reconfiguring the 'red room' and the adjacent cubicles, enabling safer nurse to neonate staffing ratios. In addition the bed

capacity in the ‘blue room’ was reduced by one cot space. Further plans have been drafted to reconfigure the ‘blue room’ with a recommendation from the Department of Infection for this to be addressed as soon as is practicable given the tertiary nature of this level 3 unit.

10 ANTIMICROBIAL STEWARDSHIP

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control plan. This is useful in reducing the development of *C difficile* infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship.

The World Health Organisation created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship and to reduce antimicrobial resistance. The three AWaRe categories divide antibiotics as follows:

• Reserve – antibiotics that need to be reserved due to antimicrobial resistance

• Watch – second-line agents

• Access – key antibiotics which are narrow spectrum and used as first-line treatment options.

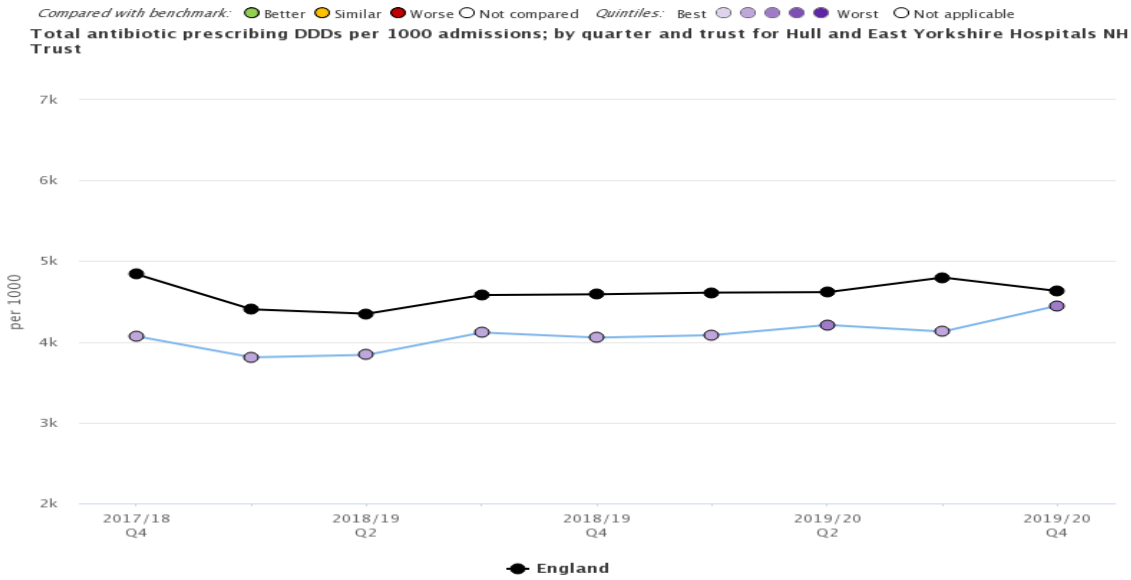
During 2019-20, the Trust made progress with regards the assigned CQUINS - the antimicrobial resistance CQUIN 2019/20 Part CCG1a assesses the appropriate diagnosis and management of lower urinary tract infection (UTI) in older people (patients over the age of 65 years). This quality improvement initiative was underpinned by recent NICE guidance on the management of UTI as well as Public Health England’s diagnostic guidance. Overall compliance with the CQUIN, including antimicrobial prescribing improved from 9% in Q1 to 47% in Q3. Trend was upwards for Q4. The improvement, although it didn’t reach the target of 60% was significant.

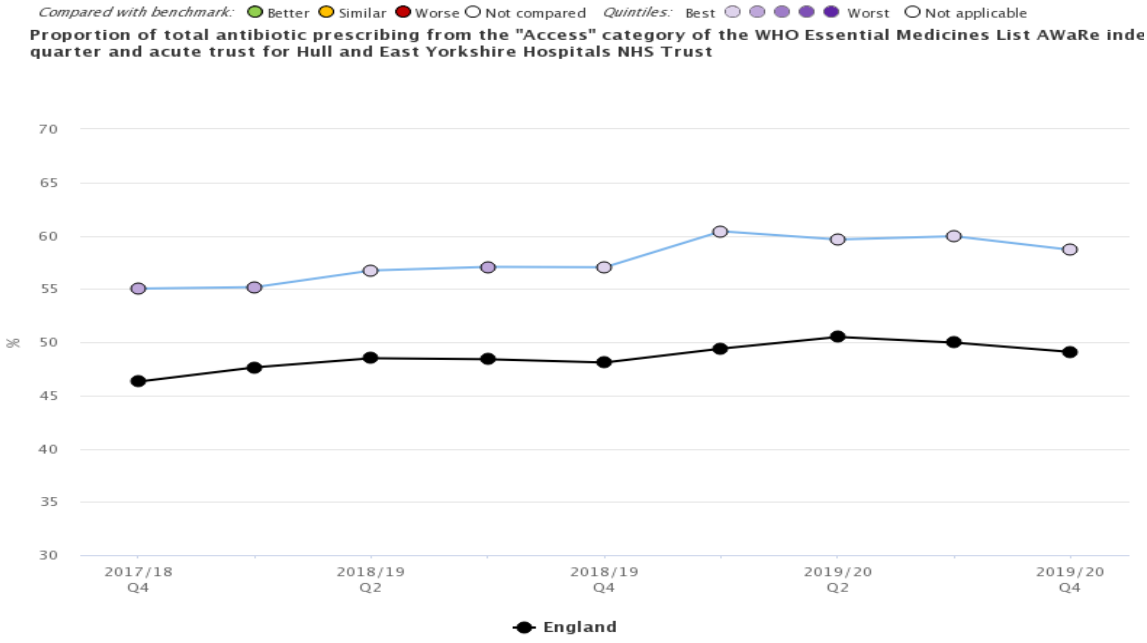
Part CCG1b: Improving surgical prophylaxis in elective colorectal surgery, achieved 56% compliance in Q1 due in part to individual prescribers but exceeded maximum target of 90% in Q2 and Q3.

Although the CQUIN did change the Trust continued to monitor Carbapenem usage throughout 2019/2020 and the proportion of ACCESS agents. By the end of 2019/2020:

- Carbapenem use was up by 12.1% (as was total antibiotic use) compared to 2018-19, which is concerning,

However, ACCESS agents accounted for 55.6% (58.7% according to Fingertips and considered one of the best for the region) of Trust total antibiotic use at the end of 2019-20 which implies that although the Trust antibiotic consumption has increased, probably largely due to using specific antibiotics such as Doxycycline it has included the ACCESS list agents and not just broad spectrum antibiotics.





The Antibiotic Control Advisory Team (ACAT continues to work on improving antibiotic usage within the Trust. Advice on the use of antibiotics is included in consultants' mandatory training day and junior doctor's induction. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on Pattie. The Antibiotic Pattie page has been reviewed and improved during 2019-20 so that each speciality has their own section and they are currently being updated. Closer links with the specialities concerned is integral to the development of the updates which will hopefully encourage guideline adherence.

On the Pattie homepage there is a direct link to the Antibiotic page and it is accessible on mobile devices via Pattie links.

The Empiric Guidance has been updated during 2019-20 with new chart (Blue person) soon to be available on the wards. The focus is moving to intranet and mobile device access rather than hard copies with the exception of the new posters. ACAT meets regularly to review antibiotic usage, and reports to IRC. ACAT and pharmacy have altered the reports that are reviewed at IRC and ACAT, tabling the updated reports towards the end of the financial year, these include quarterly Health Group reports looking at antibiotic consumption, I&D reporting, antibiotic related incident reporting via DATIX and bi-annual speciality reports.

During 2019-20 electronic prescribing and medicines administration (EPMA) continued across the Clinical Support Health Group. There were continued issues regarding the documentation of indication and duration on the electronic system affecting the overall Trust position when audited by Pharmacy teams. This was addressed by training, prompts and escalation by the respective consultants, along with changes to the EPMA interface with improvement noted.

Along with conventional antimicrobial stewardship, the benefit of an outpatient parenteral antimicrobial therapy (OPAT) service to manage the delivery of intravenous and complex oral antibiotics to patients who are medically stable, within an outpatient setting eliminates the need to either admit or keep in hospital patients whose only reason to stay in hospital is to receive IV / complex oral antibiotic therapy. All OPAT patients continue to have their medical condition and therapy closely supervised by a multidisciplinary team with a proven record that this service contributes to reducing a patient's length of stay in hospital, promotes early discharges and improves patient experiences. It improves quality of life for patients and reduces the risk of hospital-acquired infection. Feedback from OPAT patients is overwhelmingly positive, citing the benefits of receiving treatment as an outpatient, the ability to return to work, and the care, support and expertise of the OPAT team. At the start of the COVID19 pandemic in February / March 2020 the OPAT service provided an invaluable means of discharging numerous patients out of hospital safely while still maintaining their treatment.

The OPAT service continues to make significant savings for the Trust. These have previously been calculated as being in the region of £608,824 - £803,205 per 6 months (based on in depth calculations by the OPAT team for the months of April to September 2018). In the same time period the service saved the Trust 2845 bed days of which 662 bed days were from complete admission avoidance as they went straight on to OPAT rather than being an inpatient first.

11. SEPSIS

The Trust Sepsis service was started in September 2015 and now consists of 1PA of Infectious Diseases consultant time as the clinical lead for the service and 2 Sepsis specialist nurses. From the beginning the Sepsis team have had the dual aim of fulfilling the national CQUIN requirements and more importantly improving the care of patients with Sepsis in HUTH. To this end there have been notable improvements in the measured parameters (amount of patients screened for sepsis on admission and time from admission to giving the first dose of IV antibiotics). This improvement was recognised by NHS Improvement in 2018 as being amongst the best in the country. Since the beginning of April

2019, the Sepsis CQUIN has no longer been in place and the targets from the CQUIN have now been written in to the local contract. Up until the beginning of March 2020 the Sepsis team continued to audit practice within the Trust and report these audit figures to the local commissioners. This was temporarily suspended at the beginning of March 2020 due to the impact of the Covid19 pandemic but has now restarted. The Sepsis team ran a full teaching programme throughout 2019 / 20 with regular teaching sessions for nurses (including student nurses), midwives (including student midwives) and junior doctors. There is also a combined session on Sepsis and antimicrobial stewardship in the consultant's mandatory training. An innovative wrap around review service for patients with Sepsis was designed and due to be introduced in February 2020. Unfortunately the introduction of this had to be postponed due to the pandemic and the impact of a shielding member of the nursing team on the service and the inability of doing any meaningful face to face patient contact, compounded by the consultant lead and other specialist nurse supporting wards managing patients with COVID-19 but it is hoped that it will start during 2020/21. The team anticipate a further improvement in the care and patient experience for patients with Sepsis once this is introduced.

11 DECONTAMINATION

The Trust Decontamination Committee was previously chaired by the Director of Estates, Facilities & Development but responsibility for chairing the meeting during 2019-20 was transferred to the Surgical Health Group. The committee meets quarterly and covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. The Trust endoscopy users, sterile services department and theatre report into this group. This committee reports to the IRC.

The frequency of the Trust Decontamination Committee meeting on a quarterly basis improved during 2019-20, due in part to the involvement of the Surgical Health Group, the meetings, however, scheduled towards the end of the financial year were impacted by COVID-19.

Central Sterile Services Department (CSSD) continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008. For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only).

During 2019/20 embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued.

12 WATER SAFETY

The Water Safety Group (WSG) continues to work to raise awareness of water safety issues throughout the Trust and continues to take steps to improve arrangements for water safety and governance. During 2019-20 attendance at the WSG from respective Health Groups was noted, better and continued clinical representation is needed to effectively assess and respond to risks to patient safety and translate the work of the WSG to the clinical

environment. Attendance of an appointed authorising engineer for water safety during 2019-20 provided assurance to Estates, Health Groups and the IPCT of the adopted systems/ processes but also the challenge to change and improve practice.

Flushing on both Trust sites is now firmly established, with improved compliance now seen. The Estates department utilise a software database to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The new system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system. The system continues to be embedded by the Estates Department and respective Health Groups and is reliant on contemporaneous contact details of key team members, in some cases wards and departments use both the electronic system and paper records to record flushing compliance.

Any positive water samples culturing both Legionella and/or Pseudomonas are reported by Public Health England to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

13 CLEANING SERVICES

Hull University Teaching Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2019-20, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for Hull University Teaching Hospitals NHS Trust. Following their inception and mobilisation into the organisation in June 2018, OCS have utilised 2019-20 to reassess Trust requirements, embed systems/ processes and streamline services but maintain quality of service to patients, staff and visitors. During the financial year the IPCT attended operational meetings to share information with regards risk and/or issues related to HCAIs and outbreaks but also to acquire assurance that hospital cleanliness remained a priority.

Standards of cleanliness were monitored and maintained during the transition with ongoing monitoring from both Facilities and the infection prevention and control team to ensure the contract is being delivered to the required standards and Trust expectations.

14 PLACE INSPECTIONS

The annual Patient Led Assessment of the Environment (PLACE) inspection of the Trust sites this year achieved an overall score of 97.30% for cleanliness; this is a reduction from the score achieved in 2018-19 and slightly lower than the national average. Work is ongoing to improve the domestic cleaning element, predominately relating to the standards of floors and washroom facilities which has potentially resulted in the lower score. Following the implementation of the cleaning responsibility matrix an improvement on medical equipment cleaning has been seen from the previous year.

15 AUDIT

An annual programme of audit is agreed as part of the annual IPC/ Fundamental Standards programme. The audit programme is a combination of policy audits and general IPC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are also undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2019-20 audits were presented to the IPCC/IRC, summarising all of the audit activity and high level findings.

16 POLICIES

The Trust has a programme for review and revision of core infection prevention and control policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on PATTIE and many are also available to the public on the main internet web page. In addition, policies and procedures on COVID-19 were added during January – March 2020, with a dedicated COVID-19 PATTIE page.

17 TRAINING AND EDUCATION

Education and training are essential to the plan to limit healthcare associated infections (HCAI) in the Trust. They form part of every staff job description, and an integral part of the appraisal process.

Infection prevention & control education forms part of the mandatory induction programme for all staff. Additionally infection prevention and control is included in junior doctor orientation and as part of the consultants' mandatory training programme. Staff attendance at mandatory infection control updates is recorded centrally.

The infection prevention and control team conduct ad hoc education sessions to staff groups which have included security, volunteers and Estates staff.

At the start of 2020, COVID-19 provided the opportunity for the IPCT to deliver bespoke training on donning and doffing of personal protective equipment and also to deliver fit test training to staff required to wear FFP3 masks. Training was also underpinned by visual cues such as posters and guidance available to staff on Pattie.

18 OTHER ACHIEVEMENTS IN 2019-20

The Trust has always worked in collaboration with commissioners and other partners in reducing avoidable infections. Although some national targets and CQUINs divide healthcare associated infections into 'acute-attributed' and 'community-attributed' these are artificial distinctions. Many infections diagnosed in the community have their origins in hospital, and vice versa. It is therefore essential that a 'whole system' approach is taken to tackling healthcare associated infections. The Trust continues to meet regularly with partners in a number of forums, and during 2019/20 successful collaboration continued with the investigation of HCAIs.

During 2019-20, the Department of Infection successfully recruited a further Consultant Microbiologist and ID consultant, along with a trainee Consultant clinical scientist in

microbiology. This enabled the ability to phone through results to clinical teams, provide advice on treatment options and for significant laboratory results (such as positive blood cultures) to be followed up by a bedside visit from an ID physician, this has resulted in continued positive feedback from some clinical teams. Regular infection in reach ward rounds took place during 2019-20 in a number of areas (e.g. orthopaedics, vascular surgery, diabetes, neurosurgery, cardiology/cardiothoracic), in addition to telephone advice and specific visits, clinical teams can also request advice and pose questions through 'Ask Infection'.

19 OTHER RISKS IN 2019-20

During 2019-20, a number of incidences have occurred involving the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients. The infection prevention and control team have worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and Public Health England to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local commissioners.

During 2019-20, clinical infections associated with Pseudomonas Aeruginosa were detected in two neonates nursed on the Neonatal Intensive Care Unit; this was in addition to colonised babies additionally found on weekly screening. No bacteraemia cases have been detected on the unit since August 2018. Extensive investigation regarding a possible source related to the environment has taken place with no known source found. Measures to improve water safety and mitigate environmental contamination have taken place during 2019/20 as has liaison with other Trusts with similar issues. Prudent communication with Public Health England and local commissioners via incident meetings has taken place as has ongoing screening. During 2019/20, a decision was made to increase screening to twice weekly to enable prompt intervention and action should colonised cases be reported. Cases and environmental data to date have been shared with PHE to identify and/or exclude epidemiological links. All samples are submitted to PHE for variable number tandem repeats (VNTR) profiling to enable links to be identified – on at least three occasions linked VNTR profiles have been reported but these represent commonly found strains both in humans and the environment so it was difficult to elicit clinical relevance. Environmental sampling of sinks identified a significant burden of Pseudomonas aeruginosa on the unit. A pilot of a novel cleaning agent used to clean and decontaminate hand wash basins commenced during August 2019 on the unit and lasted 2 weeks, pre and post pilot swabs were taken, yielding a 50% reduction in pseudomonas contamination. A longer pilot of the product was planned on the unit but delayed due to commercial issues and then supply issues at the start of the COVID-19 pandemic.

During 2019-20, the IPCT continued to work closely with the cardiac perfusion team to mitigate the risks associated with Mycobacterium chimaera. In 2016, following a worldwide rise in patients developing this infection following cardiac bypass surgery, the Medicines & Healthcare products Regulatory Agency (MHRA) published a medical device alert with

regards cardiac perfusion machines and the risks associated with this organism. The issue was compounded in that the majority of cardiac perfusion machines were contaminated during manufacture which was only identified once a rise in cases was noted. Since 2016, the Infectious Diseases team and IPCT have worked alongside the perfusion team and cardiac surgeons to safeguard patients, undertaken water sampling from the machines and acting on positive results, removing affected machines from use, following PHE and manufacturers guidance and if required contact tracing patients, alerting GPs and providing a follow up service to patients. When required incident meetings have been held with the Surgical Health Group and with involvement of PHE. During 2019-20 the opportunity to improve systems and processes including the physical decontamination and cleaning of the perfusion machines has been taken with the creation of a dedicated cleaning facility within cardiac theatres.

20 EXTERNAL INSPECTIONS

The Trust had a formal CQC inspection from the 3rd to 5th March 2020, a follow up visit would have been undertaken by the CQC to audit the well led domain but this was not possible due to the restrictions COVID-19 imposed on both the Trust and CQC. No concerns were raised at the time of the audit with regards infection prevention and control. The subsequent report was published on the 24th June 2020; the overall trust quality rating remains requires improvement.

21 KEY POINTS AND RECOMMENDATIONS

- Internal and external reviews have confirmed that in the Trust has appropriate systems and processes in place for the prevention and control of healthcare associated infection.

- Performance against mandatory local and national targets has been satisfactory, with the exception of a continued increase in MSSA bacteraemia.

- The Trust has a strong antimicrobial stewardship programme, and continues to monitor improvements in antimicrobial prescribing.

- There have been consistent improvements in some specific aspects of infection prevention and control (e.g. management of *C difficile*, clinical engagement in root cause analysis, completion of ward level audits and increased partnership working).

- There are weaknesses in the Trust estate and facilities for managing patients with infections:

  - limited number of single rooms
  - inadequate isolation facilities in paediatrics

Solutions to these estate issues are being considered as part of a wider Trust strategy

- There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections.

- There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.

The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

Greta Johnson
Director of Infection Prevention and Control
August 2020

Appendix 1. HCAI benchmarking data via PHE Fingertips 2019-20

Quintiles: Low High Not applicable

Export table as image

Export table as CSV file

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
E. coli bacteraemia all rates by reporting acute trust and financial year	2018/19	481	144.6	115.8*	125.2*	0.0		211.5
E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year	2018/19	112	33.7	25.0*	22.1*	0.0		69.3
E. coli bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	May 2020	357	105.6	84.6	98.1	0.0		180.9
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	120	35.5	24.4	21.2	0.0		62.9
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	477	141.2	109.0	119.3	0.0		212.8
E. coli completion of risk factor information, by NHS acute trust New data	May 2020	0	0.0%	41.8%	52.9%	0.0%		100.0%
E. coli known risk factor information, by NHS acute trust New data	May 2020	0	-	61.8%	69.5%	0.0%		100.0%
E. coli completion of antibiotic information, by NHS acute trust New data	May 2020	0	0.0%	37.7%	47.9%	0.0%		100.0%
E. coli known antibiotic information, by NHS acute trust New data	May 2020	0	-	70.5%	68.9%	0.0%		100.0%
Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year	2018/19	106	31.9	32.0*	30.8*	0.0		55.4
Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year	2018/19	38	11.4	11.9*	9.2*	0.0		36.4
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	116	34.3	32.4	31.4	0.0		83.3
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	38	11.2	12.2	9.3	0.0		42.5
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	May 2020	78	23.1	20.3	22.1	0.0		40.8
P. aeruginosa bacteraemia all counts and rates by acute trust and financial year	2018/19	43	12.9	13.2*	12.1*	0.0		53.7
P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year	2018/19	13	3.9	6.2*	4.4*	0.0		38.1
P. aeruginosa bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	May 2020	26	7.7	6.9	7.9	0.0		23.8
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	21	6.2	6.1	4.4	0.0		28.8
P. aeruginosa bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	47	13.9	13.0	12.3	0.0		40.8
MRSA bacteraemia all rates by reporting acute trust and financial year	2018/19	6	1.8	2.1*	2.3*	0.0		8.2
MRSA hospital-onset counts and rates by reporting acute trust and financial year	2018/19	3	0.9	0.8*	0.8*	0.0		6.8

MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month New data	May 2020	5	1.5	2.3	2.3	0.0		8.2
MRSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	May 2020	2	0.6	1.5	1.6	0.0		6.3
MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	May 2020	3	0.9	0.8	0.8	0.0		4.1
MSSA bacteraemia all rates by reporting acute trust and financial year	2018/19	187	56.2	35.7*	35.0*	0.0		68.3
MSSA hospital-onset rates by reporting acute trust and financial year	2018/19	59	17.7	11.1*	9.6*	0.0		23.4
MSSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	May 2020	92	27.2	23.6	25.5	0.0		51.9
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	May 2020	58	17.2	10.0	8.9	0.0		25.6
MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month New data	May 2020	150	44.4	33.6	34.4	0.0		73.9
C. difficile all rates by reporting acute trust and financial year	2018/19	111	33.4	35.3*	35.6*	0.0		168.0
C. difficile hospital-onset rates by reporting acute trust and financial year	2018/19	32	9.6	14.3*	12.2*	0.0		79.7
C. difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month New data	May 2020	89	26.3	36.4	37.3	0.0		130.9
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month New data	May 2020	47	13.9	17.3	15.0	0.0		61.2
C. difficile infection counts and 12-month rolling rates of community onset-healthcare associated, by reporting acute trust and month New data	May 2020	12	3.6	6.3	6.8	0.0		34.7
C. difficile infection Hospital-Onset Healthcare Associated (HOHA) counts and rates, by acute trust and financial year	2018/19	38	11.4	16.3*	14.1*	0.0		90.0
C. difficile infection community-Onset Healthcare Associated (COHA) counts and rates, by acute trust and financial year	2018/19	35	10.5	6.2*	6.6*	0.0		18.0
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute trust and quarter	2019/20 Q2	1,136	13.9	0.0*	16.5	-	*insufficient number of values for a spine chart*	-
Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter	2019/20 Q2	5,404	65.9	76.3*	65.9	-	*insufficient number of values for a spine chart*	-
Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year	2018/19	0	0.0	0.4	0.5	0.0		3.1
Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year	2018/19	0	0.0	0.4	0.5	0.0		3.1

Appendix 2. Antimicrobial prescribing data via PHE Fingertips 2019-20

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust	2019/20 Q4	182,716	4,449.8	4795.0	4629.6	12,301.8		2,391.8
Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust	2019/20 Q4	1,783	43.4	83.8	66.4	669.1		1.0
Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust	2019/20 Q4	107,181	58.7%	48.1%	49.1%	17.8%		74.9%
Percentage of antibiotic prescriptions for lower UTI in older people meeting NICE NG109 guidance and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment; by quarter <60% 60% to 90% ≥90%	2019/20 Q4	-	*	47%	56%	16%		100%
Percentage of single dose surgical antibiotic prophylaxis prescriptions that meet the NICE NG125 guidance regarding the choice of antibiotic for patients who have undergone elective colorectal surgery; by quarter <60% 60% to 90% ≥90%	2019/20 Q4	0	-	91%	90%	60%		100%

Appendix 3. Infection Prevention & Control Metrics via PHE Fingertips

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion of single rooms available within NHS Acute Trusts by financial year	2017/18	342	31.3%	31.7%*	29.9%	11.7%		90.7%
Proportion of single rooms with ensuite available within NHS Acute Trusts by financial year	2017/18	190	17.4%	21.8%*	20.7%	4.6%		82.7%
PLACE Cleanliness Scores; by NHS Acute Trust	2018	-	0.99	-	0.98	0.92		1.00
Percentage of frontline healthcare workers vaccinated with the seasonal influenza vaccine by NHS Acute Trust <60% 60% to 70% ≥70%	2018/19	5,476	82.8%	73.0%*	72.6%*	49.4%		95.4%

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Meeting:

Meeting Date:	4 June 2020	**Chair:**	Mr T Curry	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:
[Please summarise key points which resulted in actions being directed by the Committee.]

- Memorandum of Understanding had been reviewed by Trustees of the WISHH charity and some minor change made.
- Financial Report was received which included income and expenditure along with details of donations and legacies received.
- A Covid-19 fundraising appeal had been launched which had raised £203k at the time of this meeting.
- Fundraising and donations to the Trust during the Covid-19 pandemic appeal was discussed. A separate register would be maintained relating to financial donations to the Charity's Covid-19 pandemic appeal.
- Administration Charge for 20/21 was discussed and approved.
- The Committee Terms of Reference had been reviewed and approved.
- There was a discussion regarding section 2.9 of the Terms of Reference which related to the Trust corporate social responsibility (CSR) role. CSR was originally adopted by the committee because of the special interest of previous Committee membership in this area. The Committee felt that the remit of CSR should be more widely considered. It was agreed that this should be referred back to the Trust Board as it was deemed that this was no longer an appropriate delegated Committee for this to remain under and remains core Board business.

Key decisions made:
[Please record all decisions approved.]

- The Memorandum of Understanding was approved.
- The Committee members approved the Administration Charge for 20/21
- Committee Terms of Reference had been reviewed and ratified.

Risk and assurance matters to be received by the Board:
[Please record anything not captured above.]

Matters to be escalated to the Board:
[Please itemise matters that require the Board to: be aware/take action/make a decision and specify urgency, e.g. can it wait until the Board meeting or does it need attention sooner?]

- Updates to Committee Terms of Reference for formal approval at the Trust Board.
- Corporate social responsibility role to be referred back to the Trust Board from the Charitable Funds Committee.

Hull University Teaching Hospitals NHS Trust

Charitable Funds Committee

Held on Thursday 4 June 2020

Via WebEx

Present:
Mr T Curry, Non-Executive Director (Chair)
Mr D Haire, Project Director, Fundraising
Mr L Bond, Chief Financial Officer
Mr M Robson, Non-Executive Director

In Attendance:
Mr S Evans, Deputy Director of Finance
Ms C Ramsay, Director of Corporate Affairs
Mrs L Roberts, Personal Assistant (Minutes)

1 Apologies for Absence
There were no apologies received for the meeting.

2 Declarations of Interest
Mr Robson advised that he was a Non-Executive Director for Hull Truck Theatre.

An overview of the WISHH charity was given by Mr Bond which included the formation of the independent charity, the proactive fundraising that had taken place over the past 12-18 months and the winding down of the Trust charitable funds which would be redirected through WISHH.

Mr Bond informed the Committee that he was a Trustee of the WISHH charity and a Trustee of Healthcare Financial Management Association. It was added that Mr Haire was also a Trustee of the WISHH charity.

3 Minutes of the previous meeting / Matters Arising
The minutes were approved as an accurate record of the meeting held on 10 March 2020.

4 Action Tracker
It was advised that the Committee Effectiveness review findings would be presented to the Committee at the November 2020 meeting.

5 Project Director's Report
The paper was presented to the Committee by Mr Haire who highlighted the key points below.

It was reported that the WISHH charity now had an operational bank account.

The Memorandum of Understanding had been reviewed by the Trustees of the WISHH Charity; the content was agreed with some minor changes which were highlighted in red in the document which had been circulated with the meeting papers. The Charitable Funds Committee were asked to approve the changes and once the Memorandum of Understanding had been signed by both parties the remaining funds would be transferred over to the WISHH Charity. It was envisaged that this would be completed by the end of July 2020.

The Memorandum of Understanding would be reviewed again prior to 30 September 2021.

There was a discussion regarding WISHH solely raising funds for the benefit of the Trust and the membership of the WISHH Charity. It was added that the Trust had no concerns over money being raised by WISHH. Ms Ramsay added that the charity was registered with Companies House and the information could be viewed on their website. https://beta.companieshouse.gov.uk/company/09594274

A Covid-19 fundraising appeal had been launched which had raised £195k at the time of writing this report and was £203k at the time of this meeting. It was envisaged that the appeal would raise circa £250k, with half of the funding being from NHS Charities Together. Some of the monies had been spent on water bottles, toiletries and other benefits to staff. It was added that people could also donate to this appeal for the benefit of patients if they so wish.

Mr Haire advised that a bid would be submitted next week to NHSCT for a legacy project for WISHH to support the Trust in providing a mental health / wellbeing facility post Covid-19.

The benefactor projects had been delayed due to Covid-19. Work had recommenced on the diabetes centre this week, the endoscopy/digestive diseases development would be towards the end of July 2020, the robotic theatre is expected to be completed by mid-June, however there was a teleconference scheduled next week to arrange training of the staff that would be using the equipment. The Molecular Research Centre had been delayed, although the overall completion date is now expected to be by December 2020, although it was noted that the equipment would be coming from Italy and Sweden.

The Arts Strategy had also encountered issues with limited people being on site, it was added that there were a number of projected nearly completed.

The Committee thanked Mr Haire and Mr Evans for their work in relation to the WISHH charity and other fundraising projects.

Resolved
The Committee:

- Received the report and accepted the contents.
- Approved the Memorandum of Understanding.

6 Financial Report Including Fund Balances

Mr Evans presented the Financial Report to the Committee and advised on the financial position of the charitable funds as at 31 March 2020.

Total income received was £480k (excluding WISHH) and dividend income and interest was £6k.

There had been £362k of income received which was held in the WISHH holding account, available as part of the transfer to the WISHH accounts.

A £200k donation was made by a benefactor for the refractive laser suite and a final donation of £95k was received for the Helipad at Hull Royal Infirmary. £72k related to legacies received that were notified prior to October 2018.

Total expenditure including fees and management charges was £577k which included £53k for WISHH supporting costs. Committed expenditure was £414k which included £200k for the Refractive Laser Suite.

IT was advised that the balances were reducing in preparation for the transfer of funds to WISHH by the end of July 2020.

There was a discussion regarding the Blackburn Legacy and it was reiterated that any plans for expenditure must meet the conditions and purpose of the legacy.

Concerns were raised regarding the charitable funds investments and exposure risks in light of the Covid-19 pandemic. It was agreed to wait and see if the investment market recovers. A COIF update would be presented at the August 2020 Committee meeting.

Mr Robson asked for clarification on restricted funds, Mr Bond advised that some of the funds are restricted and that reviews are undertaken. Mr Evans could provide Mr Robson with further information if required.

It was noted that future reports would contain more information.

Resolved
The Committee:

- Received the report and accepted the contents.
- Agreed to receive a COIF update at the August 2020 Committee meeting. **SE**

7 Fundraising Register

Mr Haire presented the Fundraising Registers report to the Committee and gave an overview of the numerous fundraising activities that had been undertaken on behalf of the Trust.

The registers hold a record of the fundraising undertaken by staff, businesses and members of the public since December 2018.

A separate register would be maintained relating to financial donations to the Charity's Covid-19 pandemic appeal.

National guidance suggested that the Trust keep a record of all "gifts" in kind received, along with estimated values as a result of the Covid-19 pandemic for annual account purposes. This information would be shared with Mr Evans for accounting purposes.

Resolved
The Committee received the report and accepted the contents.

8 Administration Charge

Mr Evans presented the Administration Charge 20/21 to the Committee and advised that the costings of £60k were similar to the last financial year.

The values of the charitable funds would reduce and with the transfer over to WISHH the admin charge would be reduced and ultimately cease by the end of March 2021.

It was highlighted that the administration charge would be reviewed on a quarterly basis.

The majority of the costs were in relation to ELFS and auditing purposes and it was added that the WISHH charity uses ELFS.

Ms Ramsay advised that the Trust has a legal duty to hold and maintain a charitable trust.

Resolved
The Committee received the report and approved the Administration Charge 20/21.

9 Terms of Reference

The Committee Terms of Reference review was presented by Ms Ramsay who highlighted the amendments. It was advised that there were amendments to a job title and a team name and that these were for accuracy and not changes to the roles.

There was a discussion regarding section 2.9 of the Terms of Reference which related to the Trust Corporate Social Responsibility role. It was agreed that this would be referred back to the Trust Board as it was deemed that this was no longer an appropriate Committee for this to remain under.

Resolved

The Committee:

- Received the report and approved the revised Terms of Reference.
- Agreed that the Terms of Reference would be presented at the July 2020 Trust Board meeting for formal ratification. **TC**
- Agreed that the Trust Corporate Social Responsibility role should be mentioned at the Trust Board meeting. **TC**

10 Chairs Summary of the Meeting

Mr Curry summarised the meeting and highlighted the key points:

- Approved the Memorandum of Understanding
- Approved the Administration Charge
- Fundraising Registers
- Proceed with transition over to WISHH by end of July 2020

11 Any Other Business

There was no other business discussed.

12 Date and Time of Next Meeting

Thursday 27 August 2020
10:30am – 1:00pm
Via WebEx

Hull University Teaching Hospitals NHS Trust

Trust Board

7 September 2020

Title:	Board and Committee Meeting Dates 2021 2022 2023
Responsible Director:	Carla Ramsay, Director of Corporate Affairs
Author:	Rebecca Thompson, Corporate Affairs Manager

Purpose:	To inform the Trust Board of the proposed Board and Committee dates up until December 2023.	
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 Key of Issues:	The Board and Committee dates have been set in line with the current arrangements, following the same timings and have only been altered slightly when meetings fall on Bank Holidays.	

Recommendation:	The Board is asked to note the Board and Committee dates up until December 2023.

MEETING	DATE 2021	PAPERS DUE 2021	TIME	LOCATION
Trust Board	12-Jan	05-Jan	9am - 12pm	The Boardroom, HRI
Trust Board	09-Mar	02-Mar	9am - 12pm	The Boardroom, HRI
Trust Board	11-May	04-May	9am - 12pm	The Boardroom, HRI
Trust Board	13-Jul	06-Jul	9am - 12pm	The Boardroom, HRI
Trust Board	14-Sep	07-Sep	9am - 12pm	The Boardroom, HRI
Trust Board	09-Nov	02-Nov	9am - 12pm	The Boardroom, HRI
Extra Ordinary Board Accounts approval	27-May	21-May	11am - 12pm	The Boardroom, HRI
AGM	12-Jul	09-Jul	12pm - 2pm	The Lecture Theatre, HRI
Board Development	09-Feb	02-Feb	9am - 12pm	The Boardroom, HRI
Board Development	13-Apr	06-Apr	9am - 12pm	The Boardroom, HRI
Board Development	08-Jun	01-Jun	9am - 12pm	The Boardroom, HRI
Board Development	10-Aug	03-Aug	9am - 12pm	The Boardroom, HRI
Board Development	12-Oct	05-Oct	9am - 12pm	The Boardroom, HRI
Board Development	14-Dec	07-Dec	9am - 12pm	The Boardroom, HRI
Performance and Finance	25-Jan	18-Jan	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	22-Feb	15-Feb	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	29-Mar	22-Mar	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Apr	19-Apr	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	24-May	17-May	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Jun	21-Jun	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Jul	19-Jul	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	23-Aug	16-Aug	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Sep	20-Sep	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Oct	18-Oct	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	29-Nov	22-Nov	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	20-Dec	13-Dec	1.30pm - 4.30pm	The Committee Room, HRI
Quality	25-Jan	18-Jan	9am - 11am	The Committee Room, HRI
Quality	22-Feb	15-Feb	9am - 11am	The Committee Room, HRI
Quality	29-Mar	22-Mar	9am - 11am	The Committee Room, HRI
Quality	26-Apr	19-Apr	9am - 11am	The Committee Room, HRI
Quality	24-May	17-May	9am - 11am	The Committee Room, HRI
Quality	28-Jun	21-Jun	9am - 11am	The Committee Room, HRI
Quality	26-Jul	19-Jul	9am - 11am	The Committee Room, HRI
Quality	23-Aug	16-Aug	9am - 11am	The Committee Room, HRI
Quality	27-Sep	20-Sep	9am - 11am	The Committee Room, HRI
Quality	25-Oct	18-Oct	9am - 11am	The Committee Room, HRI
Quality	29-Nov	22-Nov	9am - 11am	The Committee Room, HRI
Quality	20-Dec	13-Dec	9am - 11am	The Committee Room, HRI
Remuneration	25-Feb	18-Feb	12pm - 1.30pm	The Committee Room, HRI
Remuneration	27-May	20-May	12pm - 1.30pm	The Committee Room, HRI
Remuneration	26-Aug	19-Aug	12pm - 1.30pm	The Committee Room, HRI
Remuneration	25-Nov	18-Nov	12pm - 1.30pm	The Committee Room, HRI
Audit	26-Jan	19-Jan	9am - 12pm	The Committee Room, HRI
Audit	29-Apr	29-Apr	9am - 12pm	The Committee Room, HRI
Audit Extra Ordinary Accounts	27-May	21-May	9am - 10am	The Committee Room, HRI
Audit	22-Jul	15-Jul	9am - 10am	The Committee Room, HRI
Audit	28-Oct	21-Oct	9am - 10am	The Committee Room, HRI
Charitable Funds Committee	18-Feb	11-Feb	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	20-May	13-May	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	19-Aug	12-Aug	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	18-Nov	11-Nov	2pm - 4pm	The Committee Room, HRI
NED	25-Jan	18-Jan	11.30am - 1pm	The Committee Room, HRI
NED	22-Feb	15-Feb	11.30am - 1pm	The Committee Room, HRI
NED	29-Mar	22-Mar	11.30am - 1pm	The Committee Room, HRI
NED	26-Apr	19-Apr	11.30am - 1pm	The Committee Room, HRI
NED	24-May	17-May	11.30am - 1pm	The Committee Room, HRI
NED	28-Jun	21-Jun	11.30am - 1pm	The Committee Room, HRI
NED	26-Jul	19-Jul	11.30am - 1pm	The Committee Room, HRI
NED	23-Aug	16-Aug	11.30am - 1pm	The Committee Room, HRI
NED	27-Sep	20-Sep	11.30am - 1pm	The Committee Room, HRI
NED	25-Oct	18-Oct	11.30am - 1pm	The Committee Room, HRI
NED	29-Nov	22-Nov	11.30am - 1pm	The Committee Room, HRI
NED	20-Dec	13-Dec	11.30am - 1pm	The Committee Room, HRI

Workforce Education and Culture Committee	08-Feb	01-Feb	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	12-Apr	05-Apr	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	14-Jun	07-Jun	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	09-Aug	02-Aug	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	11-Oct	04-Oct	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	13-Dec	06-Dec	10am - 12pm	The Boardroom, HRI

Ethical Clinical Prioritisation Policy Committee	16-Feb	09-Feb	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	18-May	11-May	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	17-Aug	10-Aug	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	16-Nov	09-Nov	4pm - 5pm	The Committee Room, HRI

MEETING	DATE 2022	PAPERS DUE 2022	TIME	LOCATION
Trust Board	11-Jan	04-Jan	9am - 12pm	The Boardroom, HRI
Trust Board	08-Mar	01-Mar	9am - 12pm	The Boardroom, HRI
Trust Board	10-May	03-May	9am - 12pm	The Boardroom, HRI
Trust Board	12-Jul	05-Jul	9am - 12pm	The Boardroom, HRI
Trust Board	13-Sep	06-Sep	9am - 12pm	The Boardroom, HRI
Trust Board	08-Nov	01-Nov	9am - 12pm	The Boardroom, HRI
Extra Ordinary Board Accounts approval	26-May	19-May	11am - 12pm	The Boardroom, HRI
AGM	11-Jul	08-Jul	12pm - 2pm	The Lecture Theatre, HRI
Board Development	08-Feb	01-Feb	9am - 12pm	The Boardroom, HRI
Board Development	12-Apr	05-Apr	9am - 12pm	The Boardroom, HRI
Board Development	14-Jun	07-Jun	9am - 12pm	The Boardroom, HRI
Board Development	09-Aug	02-Aug	9am - 12pm	The Boardroom, HRI
Board Development	11-Oct	04-Oct	9am - 12pm	The Boardroom, HRI
Board Development	13-Dec	06-Dec	9am - 12pm	The Boardroom, HRI
Performance and Finance	31-Jan	24-Jan	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Feb	21-Feb	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Mar	21-Mar	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Apr	18-Apr	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	23-May	16-May	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Jun	20-Jun	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Jul	18-Jul	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	22-Aug	15-Aug	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Sep	19-Sep	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	31-Oct	24-Oct	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Nov	21-Nov	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	19-Dec	12-Dec	1.30pm - 4.30pm	The Committee Room, HRI
Quality	31-Jan	24-Jan	9am - 11am	The Committee Room, HRI
Quality	28-Feb	21-Feb	9am - 11am	The Committee Room, HRI
Quality	28-Mar	21-Mar	9am - 11am	The Committee Room, HRI
Quality	25-Apr	18-Apr	9am - 11am	The Committee Room, HRI
Quality	23-May	16-May	9am - 11am	The Committee Room, HRI
Quality	27-Jun	20-Jun	9am - 11am	The Committee Room, HRI
Quality	25-Jul	18-Jul	9am - 11am	The Committee Room, HRI
Quality	22-Aug	15-Aug	9am - 11am	The Committee Room, HRI
Quality	26-Sep	19-Sep	9am - 11am	The Committee Room, HRI
Quality	31-Oct	24-Oct	9am - 11am	The Committee Room, HRI
Quality	28-Nov	21-Nov	9am - 11am	The Committee Room, HRI
Quality	19-Dec	12-Dec	9am - 11am	The Committee Room, HRI
Remuneration	24-Feb	17-Feb	12pm - 1.30pm	The Committee Room, HRI
Remuneration	26-May	19-May	12pm - 1.30pm	The Committee Room, HRI
Remuneration	25-Aug	18-Aug	12pm - 1.30pm	The Committee Room, HRI
Remuneration	24-Nov	17-Nov	12pm - 1.30pm	The Committee Room, HRI
Audit	27-Jan	20-Jan	9am - 12pm	The Committee Room, HRI
Audit	28-Apr	21-Apr	9am - 12pm	The Committee Room, HRI
Audit Extra Ordinary Accounts	26-May	29-May	9am - 10am	The Committee Room, HRI
Audit	28-Jul	21-Jul	9am - 10am	The Committee Room, HRI
Audit	24-Nov	17-Nov	9am - 10am	The Committee Room, HRI
Charitable Funds Committee	17-Feb	10-Feb	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	19-May	12-May	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	18-Aug	11-Aug	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	17-Nov	10-Nov	2pm - 4pm	The Committee Room, HRI
NED	31-Jan	24-Jan	11.30am - 1pm	The Committee Room, HRI
NED	28-Feb	21-Feb	11.30am - 1pm	The Committee Room, HRI
NED	28-Mar	21-Mar	11.30am - 1pm	The Committee Room, HRI
NED	25-Apr	18-Apr	11.30am - 1pm	The Committee Room, HRI
NED	23-May	16-May	11.30am - 1pm	The Committee Room, HRI
NED	27-Jun	20-Jun	11.30am - 1pm	The Committee Room, HRI
NED	25-Jul	18-Jul	11.30am - 1pm	The Committee Room, HRI
NED	22-Aug	15-Aug	11.30am - 1pm	The Committee Room, HRI
NED	26-Sep	19-Sep	11.30am - 1pm	The Committee Room, HRI
NED	31-Oct	24-Oct	11.30am - 1pm	The Committee Room, HRI
NED	28-Nov	21-Nov	11.30am - 1pm	The Committee Room, HRI
NED	19-Dec	12-Dec	11.30am - 1pm	The Committee Room, HRI

Workforce Education and Culture Committee	14-Feb	07-Feb	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	11-Apr	04-Apr	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	13-Jun	06-Jun	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	08-Aug	01-Aug	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	10-Oct	03-Oct	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	12-Dec	05-Dec	10am - 12pm	The Boardroom, HRI

Ethical Clinical Prioritisation Policy Committee	15-Feb	08-Feb	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	17-May	10-May	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	16-Aug	09-Aug	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	15-Nov	08-Nov	4pm - 5pm	The Committee Room, HRI

MEETING	DATE 2023	PAPERS DUE 2023	TIME	LOCATION
Trust Board	10-Jan	03-Jan	9am - 12pm	The Boardroom, HRI
Trust Board	14-Mar	07-Mar	9am - 12pm	The Boardroom, HRI
Trust Board	09-May	02-May	9am - 12pm	The Boardroom, HRI
Trust Board	11-Jul	04-Jul	9am - 12pm	The Boardroom, HRI
Trust Board	12-Sep	05-Sep	9am - 12pm	The Boardroom, HRI
Trust Board	14-Nov	07-Nov	9am - 12pm	The Boardroom, HRI
Extra Ordinary Board Accounts approval	25-May	19-May	11am - 12pm	The Boardroom, HRI
AGM	10-Jul	07-Jul	12pm - 2pm	The Lecture Theatre, HRI
Board Development	14-Feb	07-Feb	9am - 12pm	The Boardroom, HRI
Board Development	11-Apr	04-Apr	9am - 12pm	The Boardroom, HRI
Board Development	13-Jun	06-Jun	9am - 12pm	The Boardroom, HRI
Board Development	08-Aug	01-Aug	9am - 12pm	The Boardroom, HRI
Board Development	10-Oct	03-Oct	9am - 12pm	The Boardroom, HRI
Board Development	12-Dec	05-Dec	9am - 12pm	The Boardroom, HRI
Performance and Finance	30-Jan	23-Jan	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Feb	20-Feb	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Mar	20-Mar	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	24-Apr	17-Apr	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	22-May	15-May	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Jun	19-Jun	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	31-Jul	24-Jul	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	21-Aug	21-Aug	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Sep	18-Sep	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	30-Oct	23-Oct	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Nov	20-Nov	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	18-Dec	11-Dec	1.30pm - 4.30pm	The Committee Room, HRI
Quality	30-Jan	23-Jan	9am - 11am	The Committee Room, HRI
Quality	27-Feb	20-Feb	9am - 11am	The Committee Room, HRI
Quality	27-Mar	20-Mar	9am - 11am	The Committee Room, HRI
Quality	24-Apr	17-Apr	9am - 11am	The Committee Room, HRI
Quality	22-May	15-May	9am - 11am	The Committee Room, HRI
Quality	26-Jun	19-Jun	9am - 11am	The Committee Room, HRI
Quality	31-Jul	24-Jul	9am - 11am	The Committee Room, HRI
Quality	21-Aug	21-Aug	9am - 11am	The Committee Room, HRI
Quality	25-Sep	18-Sep	9am - 11am	The Committee Room, HRI
Quality	30-Oct	23-Oct	9am - 11am	The Committee Room, HRI
Quality	27-Nov	20-Nov	9am - 11am	The Committee Room, HRI
Quality	18-Dec	11-Dec	9am - 11am	The Committee Room, HRI
Remuneration	23-Feb	18-Feb	12pm - 1.30pm	The Committee Room, HRI
Remuneration	25-May	18-May	12pm - 1.30pm	The Committee Room, HRI
Remuneration	24-Aug	17-Aug	12pm - 1.30pm	The Committee Room, HRI
Remuneration	23-Nov	16-Nov	12pm - 1.30pm	The Committee Room, HRI
Audit	24-Jan	17-Jan	9am - 12pm	The Committee Room, HRI
Audit	18-Apr	11-Apr	9am - 12pm	The Committee Room, HRI
Audit Extra Ordinary Accounts	25-May	19-May	9am - 10am	The Committee Room, HRI
Audit	20-Jul	13-Jul	9am - 10am	The Committee Room, HRI
Audit	26-Oct	19-Oct	9am - 10am	The Committee Room, HRI
Charitable Funds Committee	16-Feb	09-Feb	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	18-May	11-May	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	17-Aug	10-Aug	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	16-Nov	09-Nov	2pm - 4pm	The Committee Room, HRI
NED	30-Jan	23-Jan	11.30am - 1pm	The Committee Room, HRI
NED	27-Feb	20-Feb	11.30am - 1pm	The Committee Room, HRI
NED	27-Mar	20-Mar	11.30am - 1pm	The Committee Room, HRI
NED	24-Apr	17-Apr	11.30am - 1pm	The Committee Room, HRI
NED	22-May	15-May	11.30am - 1pm	The Committee Room, HRI
NED	26-Jun	19-Jun	11.30am - 1pm	The Committee Room, HRI
NED	31-Jul	24-Jul	11.30am - 1pm	The Committee Room, HRI
NED	21-Aug	21-Aug	11.30am - 1pm	The Committee Room, HRI
NED	25-Sep	18-Sep	11.30am - 1pm	The Committee Room, HRI
NED	30-Oct	23-Oct	11.30am - 1pm	The Committee Room, HRI
NED	27-Nov	20-Nov	11.30am - 1pm	The Committee Room, HRI
NED	18-Dec	11-Dec	11.30am - 1pm	The Committee Room, HRI
Workforce Education and Culture Committee	13-Feb	06-Feb	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	10-Apr	03-Apr	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	12-Jun	05-Jun	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	14-Aug	07-Aug	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	09-Oct	02-Oct	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	11-Dec	04-Dec	10am - 12pm	The Boardroom, HRI
Ethical Clinical Prioritisation Policy Committee	14-Feb	07-Feb	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	09-May	02-May	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	15-Aug	08-Aug	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	14-Nov	07-Nov	4pm - 5pm	The Committee Room, HRI