**Hull University Teaching Hospitals NHS Trust**

**Trust Board Meeting Held In Public**

**Tuesday 10 November 2020**
**10.00 am – 12.00 pm**

**Held via video conference**
Appointment details issued by Rebecca Thompson, Corporate Affairs Manager

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

## Agenda

| | | | |
|---|---|---|---|
| **1** | **Apologies and welcome** | 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 8 September 2020 | attached | Terry Moran - Chair |
| **4** | **Matters Arising** | | |
| | 4.1 Action Tracker | attached | Rebecca Thompson – Corporate Affairs Manager |
| | 4.2 Any other matters arising | verbal | Terry Moran - Chair |
| **5** | **Standing Orders and Governance** | | |
| | 5.1 Trust Board and Committee Governance | attached | Terry Moran – Chair |
| | 5.2 CEO Report and Covid Update | attached/verbal | Chris Long – Chief Executive |
| | 5.3 Board Assurance Framework Q2 | attached | Rebecca Thompson – Corporate Affairs Manager |
| | 5.4 Standing Orders | attached | Rebecca Thompson – Corporate Affairs Manager |
| **6** | **Our Patient Impacts** | | |
| | 6.1 Performance Summary | attached | Teresa Cope – Chief Operating Officer |
| | 6.2 Quality Governance Summary | attached | Beverley Geary – Chief Nurse |
| | 6.2.1 Quality Improvement Programme | attached | Beverley Geary – Chief Nurse |
| | 6.3 Covid-19 Preparedness and Planning | attached | Jacqueline Myers – Director of Strategy and Planning |

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| **7** | **Our People Impacts** | | |
| | 7.1 Staff Overview | attached | Simon Nearney – Director of Workforce and OD |
| **8** | **Our Finance Impacts** | | |
| | 8.1 Finance Summary | attached | Lee Bond – Chief Financial Officer |
| **9** | **Items to be approved by the Board** | | |
| | 9.1 Ethics Committee Terms of Reference | attached | Stuart Hall – Chair of the Committee |
| | 9.2 Audit Committee Terms of Reference | attached | Tracey Christmas – Chair of the Committee |
| | 9.3 Quality Accounts | attached | Beverley Geary – Chief Nurse |
| | 9.4 Clinical Negligence Scheme for Trusts – Maternity Services | attached | Beverley Geary – Chief Nurse |
| | 9.5 Modern Slavery Statement | attached | Simon Nearney – Director of Workforce and OD |
| **10** | **Reports for noting by the Board** | | |
| | 10.1 Emergency preparedness, resilience and response (EPRR) annual assurance 2020/21* | attached | Jacqueline Myers – Director of Strategy and Planning |
| | 10.2 Freedom to Speak Up Guardian* | attached | Rebecca Thompson – Corporate Affairs Manager |
| **11** | Questions from the public relating to today's agenda | verbal | Terry Moran – Chair |
| **12** | Chairman's Summary of the Meeting | verbal | Terry Moran – Chair |
| **13** | Any Other Business | verbal | Terry Moran – Chair |
| **14** | **Date and time of the next meeting:**<br>Tuesday 8 December 2020<br>10am – 12pm via Webex | | |

**Attendance 2020/21**

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

**Hull University Teaching Hospitals NHS Trust**
**Minutes of the Trust Board held in public**
**8 September 2020**

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| **Present:** | Mr T Moran CB | Chairman |
| | Mr S Hall | Vice Chair |
| | Mrs T Christmas | Non-Executive Director |
| | Prof M Veysey | Non-Executive Director |
| | Mr T Curry | Non-Executive Director |
| | Mr M Robson | Non-Executive Director |
| | Mr C Long | Chief Executive Officer |
| | Mrs T Cope | Chief Operating Officer |
| | Mr L Bond | Chief Financial Officer |
| | Dr M Purva | Chief Medical Officer |
| | Mrs B Geary | Chief Nurse |
| **In Attendance:** | Ms J Myers | Director of Strategy and Planning |
| | Mr S Nearney | Director of Workforce and OD |
| | Mrs G Johnson | Director of Infection Prevention and Control |
| | Mrs R Thompson | Corporate Affairs Manager (Minutes) |

**No** **Item** **Action**

**1 Apologies:**
Apologies were received from Prof U Macleod, Non-Executive Director and Ms C Ramsay, Director of Corporate Affairs

**2 Declarations of Interest**

**2.1 Changes to Directors' interests since the last meeting**
There were no declarations made.

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

**3 Minutes of the previous meeting held on 14 July 2020**
The minutes were approved as an accurate record of the meeting.

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

**4.1 Action Tracker**
Mr Bond agreed to email the front entrance floor plans after the meeting.

It was agreed that the e-Rostering item would be discussed at the Workforce, Education and Culture Committee as there were many changes being implemented.

Mr Long advised that the Trust had identified a lead to ensure lay members were trained and available for consultant appointment panels. Due to Covid there had been no training as yet. Mr Long added that NED availability was much better due to the current online panels.

Dr Purva reported that 7 Day Services had been suspended due to the impact of Covid-19 on operational services and would be deferred until further notice.

**4.2 Board Reporting Framework 2020-21**
The Board Reporting Framework was presented and there were no issues raised.

**4.3 Board Development Framework 2017-21**
The Board Development Framework had been updated until the end of the year. A 12 month rolling programme to be established and presented to the next Board meeting. **RT**

**5 Chair's Opening Remarks**
Mr Moran opened the meeting and advised that there was a lot of media coverage around the number of Covid-19 cases and how infection rates were increasing. He stated that he felt assured that the senior teams had plans in place to respond should there be another spike in cases.

He also reminded colleagues that the majority of the Board reports had already been scrutinised at the Board Committees and therefore we could be assured that detailed oversight had been undertaken. He asked therefore that scrutiny at the Board keep that in mind.

**6 Chief Executive Briefing**
Mr Long presented his report and advised that 10% of staff had responded to the special staff survey seeking views about how the trust had responded to the Covid-19 impact. In general there had been a positive response to how the Trust had managed the pandemic.

He added that the Junior Doctors had responded in a less positive way but their criticism was mainly aimed at issues at a national level. Work was on-going to address the issues relating to Junior Doctors.

Mr Long also reported that ED staff were being subjected to abuse by the public as patients wanted to bring family and friends into the ED for support. He added that the Trust would not tolerate staff being abused in this way and that messages on social media were reinforcing this message.

**7 Patient Story**
Dr Purva presented the item and played a video of 4 patients who gave their accounts about the impact the pandemic had had on them where procedures had been cancelled due to Covid-19 restrictions. The patients were now on the backlog lists waiting to be seen. Dr Purva reported that all of the patients in the video now had their operations scheduled in the next 2 weeks. She added that whilst the Trust reported numbers about people impacted it was, the impacts on individuals was not always visible to us. Dr Purva advised that all 4 patients had given their consent for the videos to be used in the public Board forum.

The videos were very humbling to watch and captured the pain and impact on the lives of the patients that were waiting to be seen.

Mr Long reported that the patients all had routine procedures but that the long waits were making them more vulnerable and that this would also be the case for other procedures such as routine cataract surgery.

Mr Moran added that the NHS England recovery plan was focussed on

waits and waiting times and he supported that approach. Dr Purva stated that some patients would be able to wait longer than others or have alternate remedies, but that reduced theatre sessions could compound the issues.

Mr Moran thanked Dr Purva for bringing the very real impacts on our patients so visibly to the Board. He would write to the four patients to thank them for taking the time to tell us about their experience and for allowing us to share the, at public Board.

**8 Board Assurance Framework**

Mr Moran presented the report which highlighted the proposed quarter 1 risk ratings. Mr Moran brought the Board's attention to the BAF risk topics that would be presented to the Board Development session in 2020/21.

**Resolved:**

The Board received and approved the quarter 1 BAF risk ratings.

**9 Our patient Impacts**

**9.1 Performance Report**

Mrs Cope presented the report and advised that ED performance was 90% for July and that August would be a similar position. The Trust remained mid table for performance although activity was 20% down on last year.

Cancer performance was stable at 70% for June and July.

There was some good news in that the FIT initiative had been implemented and this would reduce the demand for endoscopy. Diagnostic performance as a whole was an improving position and there would be a full theatre timetable available from September 2020 for routine work.

52 week waits had risen to 3300 at the end of July but the waiting list volume was holding with only small increases. Referral centres were working well to ensure all referrals were relevant and patients were being seen at the most appropriate place of care.

Mrs Cope advised that she and Dr Purva had met with every speciality lead to review their recovery and improvement plans. The Phase 3 planning process had highlighted significant expectations and it had been a useful exercise to meet with the leads to work on plans to reduce the backlogs as soon as possible. A full update of the Phase 3 planning submission would be presented to the Performance and Finance Committee at the end of September and then the Board.

Mrs Jackson asked if using the independent sector for some procedures would help achieve the ambitious plans of 90%-100% activity levels. Mrs Cope advised that it would help but there would still be a gap. Ms Myers added that the Centre was relying on Trusts to achieve the plans without relying on the independent sector.

Mr Robson reported that a lot of detail was received at the Performance and Finance Committee for scrutiny and he stated that it was good to see the stabilisation and improvements being made. Mr Hall expressed his concern in relation to the appointment slot issues and asked how the Trust was risk assessing patients if they had not been seen. Mrs Cope advised that the

Trust had implemented the Referral Assessment Services so that all referrals would be clinically assessed and validated by the clinical teams. Clinical assessment had been built into the job plans and was being made a core procedure to follow.

Mrs Cope advised that the patient initiated follow up was being implemented and learning around this was being shared across the Humber Coast and Vale. Dr Puva added that there was a huge amount of work being carried out by the Primary/Secondary Care Recovery Group to reduce the number of referrals and have more work carried out in the Primary Care setting.

**Resolved:**
The Board received and accepted the report.

**9.2 Minutes and Escalation from the Performance and Finance Committee**
Mr Curry presented the minutes and escalation report and advised that the detailed Phase 3 planning incorporating recovery and Winter would be presented to the Performance and Finance Committee in September 2020.

Mr Moran asked Mr Curry if the Committee was appropriately assured and was clear about what was required of the Trust from a performance perspective and Mr Curry stated that there would be increased assurance once the Phase 3 plans had been received.

**Resolved:**
The Board received and accepted the minutes and escalation report and were assured by the work being done and already in hand.

**9.3 Quality Report**
Mrs Geary presented the report and advised that there had been a positive start to the year with no MRSA cases reported to date and MSSA rates were low. There had been a slight increase in MSSA rates in August and this was due to the increase in clinical activity. C-difficile rates were low and within the threshold.

Legionella had been found on a ward and extensive works had taken place and the ward was re-opening today.

There had been 5 Serious Incidents reported in July which included a fall with harm. There had been a slight increase in falls with harm but a Quality Improvement Programme and action plan was in place to address the issues.

There had been an increase in pressure ulcers and this was mainly due to Covid-19 patients in ICU with pressure damage to their faces.

Mrs Geary reported advised that the Trust had submitted the Infection Control Board Assurance Framework which had been requested by NHS Improvement and that all areas were compliant.

Mr Moran asked about the patient with Legionella disease and whether there was any link with the water supply and the Legionella found there. Mrs Johnson advised that the patient had been infected for a week before being admitted and the strain in the water supply was a different one that

would not result in disease.

Prof Veysey asked if all water supplies were being tested and Mrs Johnson advised that the water supply was checked twice yearly with random testing in between. Mrs Geary added that there was a full programme of testing and active flushing for any areas of concern.

There was a discussion around Serious Incident details and Mrs Geary reported that there were detailed discussions held in the Quality Committee and would consider whether further detail should be included in the Quality Report.

**Resolved:**
The Board received and accepted the report.

**9.4 Minutes and Escalation from the Quality Committee**
Prof Veysey reported that the Committee was assured regarding the quality of care and reported that a paper had been received around new ways of ensuring patients with suspect cervical cancer were captured and treated.

Clinical assurance of CRES and the impact on quality had been presented but there had been no CRES schemes raised in recent months since the pandemic started.

Prof Veysey also reported that any Serious Incidents that were of concern were scrutinised fully and further information requested.

Mr Moran took the opportunity to thank Prof Veysey for his time as a NED with the Trust as the meeting was likely to be his last one before his departure at the end of October 2020. He thanked Prof Veysey for his work as a NED and for his leadership as Chair of the Quality Committee. Prof Veysey thanked the Board and added that he had learned a lot and enjoyed his time with the Trust.

**Resolved:**
The Board received and accepted the minutes and escalation from the Quality Committee and were assured.

**9.5 Update from the Ethical and Clinical Prioritisation Policy Committee**
Mr Hall gave the update and advised that an informal meeting had been held to discuss the Committee's future and a revised terms of reference would be presented to the Board in November 2020. There was nothing to report at the current time.

Mr Long asked if the Committee was to be formally constituted as a sub Board Committee and Mr Moran advised that this was his understanding following a conversation with Ms Ramsay. Mr Long agreed to discuss this matter with Ms Ramsay on her return. **CL/CR**

**Resolved:**
The Board received and accepted the update.

**10 Our People Impacts**
**10.1 Staff Overview Report**

Mr Nearney presented the report and advised that sickness absence was at 3.6% which was better than the national average. The Trust still had staff off work self-isolating and on maternity leave. The vacancy level was at 3.46% overall and there were plans in place to reduce this. The figure did not include temporary and locum staff.

Mr Nearney reported that the People Strategy is reviewed in detail at the Workforce, Education and Culture Committee (WEC) and the report was being refined to show positive improvements and any gaps in assurance.

The Workforce Race Equality and Workforce Disability Standards were scrutinised by the WEC Committee and were on the Board agenda for approval.

The Flu Campaign was underway with changes to the administration of the vaccine due to Covid-19. There would be no mass vaccinations for non-clinical staff.

Mr Nearney advised that staff support was on-going although the free meals, childcare and accommodation would be withdrawn from 13th September 2020. He added that free car-parking would remain following national guidance.

Mr Nearney reported that an emergency workforce planning session had been arranged to run through a worst case scenario of 10% of staff being absent due to a pandemic.

Mr Moran asked how the flu vaccinations would be administered if mass vaccinations were not possible. Mr Nearney advised that there would be appointments for drop ins and new areas would be made available on site.

Mr Moran also asked how the return of staff previously shielding had progressed and was viewed. Mr Nearney advised that the HR teams had worked with the members of staff to ensure they felt safe in their workplaces, workplaces that were Covid-19 secure, or staff worked in different locations.

Mr Bond expressed his concern regarding the nurse staffing vacancies. Mr Nearney advised that 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 shortly.

**Resolved:**
The Board received and accepted the report.

**10.2 Escalation and minutes from the Workforce Education and Culture Committee**
Mr Nearney presented the report and highlighted the ratification of the WRES, WDES action plans, the recruitment of an Equality and Diversity manager and the discussion of the results of the Covid-19 survey about how the trust had managed the response.

**Resolved:**
The Board received and accepted the report.

**11 Our Finance Impacts**

**11.1 Finance Summary Report**

Mr Bond presented the report and advised that in the first 4 months of the year the Trust was reporting a deficit of £2.3m. After Covid-19 top up costs the Trust was reporting a break-even position.

The Trust had spent £10.6m on Covid-19 related expenditure year to date. Overspends were around staffing but were offset by underspends in clinical activity.

Mr Bond advised that the financial teams were working with operations to review the increase in activity in months 5 and 6. More sensitive forecasts were being established but there was still uncertainty about finances beyond month 6.

Mr Bond also reported that he was in discussions regarding the financial allocation of the ICS funding and how the money would be split. The final submission for the funding would be 16th September 2020.

Mr Bond advised that the Capital programme was £61m and he was collating all the additional allocations such as ED and Critical Care to review the risks to delivery. A report detailing this would be presented to the Performance and Finance Committee in September 2020.

Mr Robson asked if funding notifications came late in the year would the Trust lose the money if not able to spend it in time and Mr Bond advised that other areas such as replacement equipment could be identified instead to ensure the money was spent. Mr Bond was confident about the timescales agreed. Mrs Cope added that the Trust should be mindful of moving staff around simply to accommodate work to achieve the Capital plan. Staff have had a difficult year and we should be aware of such impacts so that they can be minimised and that the Communications around the moves and operational alignment was key.

Mr Moran requested that he be involved in the early stages of the discussions if Capital expenditure issues related to HUTH and NLAG jointly.

**Resolved:**

The Board received and accepted the report.

**11.2 Operating Plan Guidance and Recovery Planning**

Ms Myers presented the update and advised that Operational planning guidance and supplementary letter received by the Trust were being discussed and plans worked up. There were questions around how activity could be restored to the level expected, could more work be done in the independent sector and the availability of workforce to take on additional sessions out of hours and at the weekend. Ms Myers advised that the Trust had not waited for guidance and was well underway with the recovery. She added that it was difficult to plan the financial package when the Trust was waiting for an announcement regarding this from the Centre. A second Covid-19 surge and likely Winter pressures had been taken into account as part of the plan.

Ms Myers advised that the Trust's activity levels were similar to that of other

Trusts across the country and that improvement and transformational goals had been established with the aim of reaching them.

Ms Myers advised that a paper was being presented to the Performance and Finance Committee at the end of September and a Board Development session would follow and was already in the diary.

**Resolved:**
The Board received and accepted the report.

**12 Items for approval by the Board**

**12.1 Quality Accounts**

Mrs Geary reported that the Quality Accounts would be published in December 2020 and would be presented to the Quality Committee at the end of October 2020. She added that the Quality Improvement Programme made up the Quality Accounts.

**Resolved:**
The Board received and accepted the report.

**12.2 Workforce Race Equality Standards**

Mr Nearney presented the report and advised that 13% of the Trust's staff were BAME. There had been a new BAME network established which had 137 members and a new agenda to address leadership numbers in the A4C structure. He added that the report had been ratified at the Workforce, Education and Culture Committee in August.

Mr Moran stated that the network and activities was very encouraging. He added that more work was needed across a number of important areas being monitored.

**Resolved:**
The Board received and approved the report.

**12.3 Workforce Disability Equality Standards**

Mr Nearney presented the report and advised that the Trust had 2.19% staff that had declared a disability but that there could be potentially another 3000 staff who had so far not declared one way or the other. Mr Nearney reported that there was an action plan in place but it was not owned by disabled staff.

Mrs Cope stated that a number of staff may not have mentioned any mental health challenges they had and it was important to reach out to them. She added that a lot of work had been done during Covid-19 to recognise staff struggling with their mental health.

Mr Moran expressed his concern around one of the statements and how it had been taken as a success because the percentage had improved slightly since last year. The abuse from colleagues for disabled staff was at 30% compared to non-disabled staff at 18%, Mr Moran asked for this to be more reflective of the issue and disparity rather than a modest reduction from the previous year. He suggested that the trust consider some external expertise to promote the establishment of disabled employee networks. He and Mr Nearney would discuss further.

**Resolved:**
The Board received and approved the report.

**12.4 Trade Union Facility Time Reporting Requirements Regulations**
Mr Nearney presented the report and advised that the Trust spent 0.02% on the Trade Union pay bill. He added that a benchmarking exercise had been carried out and the Trust was in line with other Trusts such as Leeds, York and Goole. The Trust's relationship with the Trade Unions was good and constructive. Parties did not always agree but there was an open and honest relationship to allow both parties to have their say in a professional way.

Mr Moran asked what evidence was there to suggest that good relationships were in place. Mr Nearney advised that the management of disciplinary hearings during Covid-19 had gone ahead in different formats and some had to be suspended. The Trade Unions had been involved in the staff benefits agreed during the pandemic and there was a programme of policy developments in place. The two parties also had a heads up policy and met fortnightly to discuss any emerging issues. He was confident that relationships were strong and open and mutually respectful.

**Resolved:**
The Board received and approved the report.

**12.5 Trust Strategy Delivery – 6 Month Update**
Ms Myers presented the update against the framework in place. The scorecard included the milestones, measureable outcomes and executive lead for each criteria. Arrows showing progress had been added to the report. There had been some slippage during the pandemic but the focus on delivery was back on track. One area relating to supporting the STP to a achieve ICS standard had been completed but there was more work to do around the cancer standards.

Mr Hall asked if the standards and their ratings had been sense checked against the objectives since the pandemic and Ms Myers advised that although the route to achieve some standards had changed the objectives were still relevant.

Mr Curry asked whether a narrative for each standard would be useful, but Ms Myers advised that there was lots of detail in many Board reports so it would be a duplication of work.

Mr Moran asked about the staff section of the framework and what progress was being made. Mr Nearney highlighted that the Trust had held its position in relation to the Staff Survey when other Trusts had seen deterioration in their results. It was hoped that the Staff Survey results from the October survey would move the Trust into the top 20%. The BAME network working with the HR Teams were identifying leaders and the leadership courses were now back on track but in virtual formats.

There was a discussion around Serious Incident reporting and the launch of the Stop the Line initiative and Dr Puva advised that this was now included in the Quality Improvement Plan and would be monitored through the Quality Committee.

Mr Moran thanked Ms Myers for her report and stated that it was a helpful and clear way to understand progress against the milestones.

**Resolved:**
The Board received and accepted the report.

**12.6 Emergency Preparedness Statement of Assurance – Update**
Ms Myers presented the report and advised that up to the beginning of the pandemic good progress was being made against the action plan. Ms Myers reported that the emergency planning resources were put into full use during the pandemic and were working 7 days a week to co-ordinate support for the operational teams and frontline staff. Ms Myers added that a number of points on the plan had not been completed but would be by October 2020 and it was expected that the Trust would declare significant assurance.

Mr Bond asked if the 50 additional fridges were Council funded and queried the timescale for installation. Ms Myers agreed to check and let him know.

The Board discussed progress against the plan and Mr Hall asked whether system partners were holding back progress relating to the mass vaccination plan. Ms Myers advised that further guidance was to be published and that this was the reason for the delay.

Mr Hall asked if the Board committees should have oversight of the plan and Ms Myers advised that the plan was monitored at the Resilience Committee and the Non Clinical Quality Committee and the Board.

**Resolved:**
The Board received and accepted the report.

**12.7 – Standing Orders**
The report highlighted the use of the Trust seal, minor changes to the Charitable Funds Committee's terms of reference and the departure and recruitment arrangements of the Director of Corporate Affairs.

Mr Moran thanked Ms Ramsay for her work and commitment to the Board and stated that she was a fountain of knowledge and that her replacement had large shoes to fill.

**Resolved:**
The Board:

- Approved the use of the Trust seal
- Approved the changes to the Charitable Funds Committee's terms of reference
- Noted the departure and recruitment arrangements for the Director of Corporate Affairs

**13 Reports to the Board**

**13.1 Health and Safety Report**
Mrs Geary presented the report and advised that it had been ratified at the Non Clinical Quality Committee previously. Mrs Geary highlighted improvements in areas such as manual handling and slips, trips and falls. Additional training was being put into place for working at height.

Objectives had been agreed for the coming year but the team was currently working to ensure departments (where possible) were Covid-19 secure by carrying out risk assessments.

**Resolved:**
The Board received and accepted the report.

**13.2 Director of Infection Prevention and Control Report**
Mrs Johnson reported that a number of changes within the Infection Control team which included new starters, key consultants retiring and returning and a change in the DIPC.

Mrs Johnson reported that there had been a reduction in CDifficile and MSSA bacteraemia and work was ongoing with partners to improve device management. She added that the report referred to lack of robust evidence for MSSA training, but this was due to lack of paperwork and not actual training. There had also been improvements in surgical site infections as Fracture Neck of Femur infections had reduced. The Trust had been subjected to Norovirus, mainly in the DME wards and this was being closely monitored. Influenza activity was in line with the Southern Hemisphere but had been controlled effectively. Collaboration work with system partners was ongoing to further understand the infections, especially outbreaks.

Work was underway to understand all the competencies across the workforce and Junior Doctors were being encouraged to attend the Infection Reduction Committee and complete a number of audits. Training packs were being created for the Junior Doctors.

Mr Bond asked whether there was adequate resource within the Trust and whether the level of risk was understood by clinical staff. Mrs Johnson suggested that she discussed this with Mr Bond and the Infectious Diseases team outside of the meeting. **LB/GJ**

Mr Moran suggested that the Quality Committee discussed the resource issues in more detail.

**Resolved:**
The Board received and accepted the report.

**13.3 Escalation and minutes from the Charitable Funds Committee**
Mr Curry presented the escalation report and minutes of the meeting. He reported that Corporate Social Responsibility had been discussed and that it should be more widely considered by the Board. Ms Myers suggested that she discussed this further with Mr Curry outside of the meeting. **JM/TC**

Mr Curry also reported that the Committee had reviewed its Terms of Reference and that good assurance was being received regarding the Wishh Charity.

**Resolved:**
The Board received and accepted the escalation report and minutes.

**13.4 Calendar of Board and Committee Meetings**
The forward schedule of meetings (2021/2022/2023) were presented to the Board.

**Resolved:**
The Board received and accepted the timings proposed.

**14 Chairman's Summary of the Meeting**
Mr Moran thanked Board members for their efficient use of time during the meeting. He reminded the Board that much more detail was discussed at the Committees.

**15 Any other business**
There was no other business discussed.

**16 Any questions from Members of the public**
There were no questions received from members of the public.

**17 Date and time of the next meeting:**
Tuesday 10 November 2020, 9am – 12pm via Webex

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

## Actions arising from Board meetings

| Action NO | PAPER | ACTION | LEAD | TARGET DATE | NEW DATE | STATUS/ COMMENT |
|---|---|---|---|---|---|---|
| **September 2020** | | | | | | |
| 01.09 | Board Development Framework | 12 month rolling programme to be established | RT | Nov 2020 | | |
| **COMPLETED** | | | | | | |
| Sept 2020 | Ethics Committee | Ethics Committee TOR to be presented to the Committee | SH | Nov 2020 | | |
| July 2020 | Covid-19 Recovery | ICS Discussion with NLAG to be arranged | CR | TBC | | |
| | UEC Business Case | Mr Bond to share ground floor diagrams with the Board via email | LB | Sept 2020 | | |
| | Guardian of Safe Working | Deadline to be set regarding all clinical staff being on E-Rostering | CL/MP | Sept 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 | | |
| 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 | | |

## Actions referred to other Committees

| Action NO | PAPER | ACTION | LEAD | TARGET DATE | NEW DATE | STATUS/ COMMENT |
|---|---|---|---|---|---|---|
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**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 2020**

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|---|---|
| Title: | Assurance and Governance requirements in Wave 2 of Covid-19 for Board Meetings & Sub-Committees – changes effective from 9 November 2020. |
| Responsible Director: | Mr Terry Moran, Chairman |
| Author: | Mr Terry Moran, Chairman |

| | | |
|---|---|---|
| Purpose: | To agree assurance and governance arrangements in Wave 2 Covid-19 | |
| BAF Risk: | All | |
| 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: | | |

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| Recommendation: | The Trust Board is invited to consider and formally approve the assurance and governance proposals set out in the report and to be affective from Monday 9 November. |

Board Members HUTH From Terry Moran

Date 4 November 2020

**Assurance and Governance requirements in Wave 2 of Covid-19 for Board Meetings & Sub-Committees – <u>changes effective from 9 November 2020</u>.**

1. We now know that Covid-19 cases are rising and that the Humber region has been moved into Tier 2 level restrictions. We are seeing our hospitals impacted more significantly than we did in Wave 1.

2. In the absence of any national or regional guidance about easements to governance I think it important we don't delay considering the issues for ourselves. I have therefore agreed the following arrangements with Chris.

3. As we did during Wave 1 of Covid-19 we need to consider how we continue to discharge our accountabilities as a Board for ensuring appropriate oversight and assurance. We need to do so whilst also being mindful of the pressures on our services and on key individuals. That requires us to be clear about those areas which must remain our focus and priority for assurance and that the associated governance requirements are both reasonable and proportionate.

## FOCUS AND PRIORITIES DURING WAVE 2

4. Our focus and priorities for assurance during Wave 1 remain relevant and I have therefore agreed that our focus should again be as follows:

    a. **Our patients** – the quality and safety issues and relevant priorities and CQC must dos, key risks arising and decisions required of the Board;
    b. **Our people** – well-being/resilience, health & safety, safe staffing, absences; relevant priorities, key risks arising and decisions required of the Board;
    c. **Our money** – what financial impacts and risks are arising, relevant priorities, decisions required of the Board;
    d. **Covid-19 preparedness and planning** - to ensure other issues and risks not captured above are reported e.g. testing, PPE, etc decisions required by the Board; and
    e. **Record of key decisions/investments/risks/deferments** – to be maintained for later scrutiny and/or review/action.

## TRUST BOARD AND SUB-COMMITTEE MEETINGS

5. I propose the following arrangements:

    a. **Trust Board** – should meet monthly and be restricted to 2 hours. This time I don't think it should be in private and we should therefore consider the need for a two part agenda still within the agreed 2 hours to include a private board meeting if required. It should oversee the key

assurance matters and matters for decision normally delegated to sub-committees with the exception of routine matters relating to quality;

b. **Quality Committee** – should meet monthly and prioritise its business as above. I think we learned the importance of keeping this operating after a period of suspension in Wave 1;
c. **Audit Committee** – should continue as scheduled and meet additionally if exceptional circumstances arise;
d. **Other sub-committees of the Board** – should be stood down and only meet on an exception basis to consider urgent and important business that cannot wait, or is inappropriate, for the monthly Trust Board; and
e. **Ethics Committee** – to be stood up and meet as necessary.

6. We should ensure that we actively review the effectiveness of meetings of the Trust Board and Quality Committee with a short follow-up questionnaire to ensure we are satisfied that we are using our time with added value and focussed on the right issues.

7. The CE & colleagues will determine any changes to **Executive committees**.

**REPORTS AND PAPERS FOR TRUST BOARD**

8. As before we should we should ensure papers/reports reflect the priorities outlined above. They should be short (up to 4 pages) and focussed to capture the key points and avoid dense prose. Less will definitely be more in our ability focus on the key issues and also to reduce the work needed to prepare and also to read. This would also allow for papers to be contemporary by being prepared no later than 48 hours before the relevant meeting.

**NED AND CHIEF EXECUTIVE BRIEFINGS**

9. During Wave 1 NEDs met with the CE weekly for up to an hour to be briefed on the latest issues and to fast track any approvals/decisions necessary that may require NED involvement. I believe we should do the same again. They will be minuted but not routinely require papers or an agenda, but will do so only when necessary.

**IMPLEMENTATION AND DURATION**

10. I have discussed with Chris Long and propose these changes are introduced from 9 November 2020 and remain in operation until the pressures have eased. In any event I propose the governance arrangements are reviewed no later than 1 February 2021, sooner if a Board member requests it.

11. You are therefore invited to consider and formally approve these proposals to be affective from Monday 9 November.

T A Moran CB
Chairman

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 2020**

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|---|---|
| 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: | Thank you to staff, communication, doctors' conference, Golden Hearts Awards | |

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|---|---|
| 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 September-October 2020

*Thank you to all staff*
Firstly a thank to everyone at HUTH. We are entering what will certainly be the hardest winter we've ever known in the NHS. Staff are tired both mentally and physically and as well as having to cope with a stressful situation at work they have home lives which have also been impacted upon by this pandemic. Their health and wellbeing remains our main priority.

Over the next few weeks and months many people will be asked to work in unfamiliar areas, some will be working from home. Many will be directly affected by the virus, either themselves or their loved ones. But despite this we know they will be there for each other and for their patients.

Their efforts, their will to provide the best care for patients, their dedication to the NHS is what makes this the greatest organisation in the world.

We must formally acknowledge each and every person at HUTH, thank them for their support and pledge to do everything we can to ensure they are safe and receiving the support and care they need from us at this time.

*Communication*
We have gone to great lengths to communicate our pandemic surge plans to staff and the public. We held a press conference a fortnight ago at which Teresa Cop, Dr Makani Purva and Professor Russell Patmore set out our plans for additional ward capacity and staff redeployment. The event was well attended by the media and has been well received on social media.

Our plans have been regularly updated and issued to staff across the Trust in daily updates and on Pattie.

Furthermore we have taken the decision to provide public updates on the situation in the hospital, with numbers of inpatients updated every two days on social media. This has been very well received by the public and has helped us to impress upon our local population the need to attend appointments but otherwise only come to hospital if it is an emergency.

*Staff Survey*
As ever the National Staff Survey is currently live. We have set ourselves a target of a 50% response rate. The survey closes on the last Friday in November.

Friends and Family test staff surveys are still not running. We are waiting for further guidance from NHS England around whether these will be back online in 2021

*Consultant Conference*
The Consultant Conference took place on Friday 11th September and was held via Webex Events. The virtual event was held in collaboration with NLAG, Chaired by Terry Moran, and our keynote speaker was Professor Michael Holmes who discussed the future of healthcare in light of Covid-19.

The event was attended by over 350 Consultants, which far surpassed any attendance at a physical event in the past (usually around 180), and we are really proud to have engaged with so many of our consultant body. The conference lasted around three hours in total and

included a Q&A session with the Executive Teams from both trusts, to allow consultants to ask any questions or raise concerns.

We are reviewing the feedback we received from attendees which will inform the format for our 2021 event. This will be led and hosted by NLAG.

*Golden Hearts Awards*
In light of recent events, we felt it was important to push ahead with the Golden Hearts awards, albeit in a different format. We received 164 nominations in total, most of which were of a high standard and really highlighted the great work that our staff have been delivering over the last 18 months.

We know our finalists for this year and they have all been notified. An announcement will be taking place on Friday 13th November where we will reveal the nominees to the Trust.

Our intention, and depending on the situation with the pandemic, is to hold a belated event for all nominees in 2021. The format for this is yet to be agreed.

*A&E After Dark*
The documentary series was filmed by Crackit Productions for Channel 5 and the response to the first series was overwhelmingly positive. After Dark generated a huge amount of respect for staff and appreciation for the work that they do. Feedback on social media was extremely positive.

The six-part series peaked with a consolidated audience of over 2.4 million viewers, winning its primetime slot and making it the highest-rating series on Channel 5 in 2020. The programme performed well for a young audience delivering a 12.5% share of audiences in the 16-24 and 25-34 age brackets.

Congratulations and thanks to everyone who helped to make this a success.

## 3. Social media activity

*Twitter*
Current following stands at 8,258. Between August and October we averaged 103 new followers a month.

Overall impressions have risen month on month, from 119,000 in August, 198,000 in September and 244,000 to date in October.

One of the best performing posts was our BAME video (written, filmed and produced by our Digital Communications Team) which achieved 10,800 impressions, 106 likes and 46 retweets.

Several new departmental twitter accounts were approved this quarter including Radiotherapy, Endoscopy and The Cancer Psychological Service.

One of our posts for Clinical Engineering Day was retweeted by Dr Phil Hammond, @drphilhammond with circa 90,000 followers.

*Facebook*
Between August and October 2020, we have produced social media content for multiple awareness days/events including:

- World Mental Health Day
- World Heart Day

- International Day of Older Persons
- World Suicide Prevention Day
- World Sepsis Day
- National Eye Health Week
- Clinical Engineering Day
- Baby Loss Awareness Week
- Black History Month

We also produced a series of still photographs and video shorts to thank our ED staff on Emergency Services Day (9 September) and scheduled a series of 14 facebook posts over seven days for Baby Loss Awareness Week, with the top performing post achieving a reach of 15,600.

Our social media pages also counted down to the launch of the Shh… East Yorkshire recruitment campaign, and aviation featured strongly, with posts on the NHS Spitfire flypast and images from the HRI helipad test landings performing well across all sites.

For a number of months, we have been using the pages to raise awareness of issues relating to Covid-19 and appropriate behaviours (and continue to do so). This includes appropriate and respectful behaviour towards staff as well as adherence to social distancing, hand washing and face covering requirements. This subject matter has accounted for some of the top performing posts in the last three months.

Among the highest performing posts on each page in the past 3 months are:

HRI – Request to be respectful to staff (37,900 reach, 442 shares, 207 reactions)
HUTH – Request to be respectful to staff (18,300 reach, 141 shares, 78 reactions)
WCH – Retirement of Miss Sanja Besarovic (53,000 reach, 262 shares, 743 reactions)
CHH – Request to be respectful to staff (21,600 reach, 196 shares, 103 reactions)
Hull Hospitals Jobs – Post showing how an OT had gone over and above to help a cancer patient's recovery (2,800 reach, 13 shares, 45 reactions)

In the last 28 days, followers for each of our pages have increased as follows:
HRI – 353 (Total = 13,069)
HUTH – 216 (Total = 2,917)
WCH – 315 (Total – 11,955)
CHH- 104 (Total = 5,798)
Hull Hospitals Jobs – 31 (Total = 4,186)

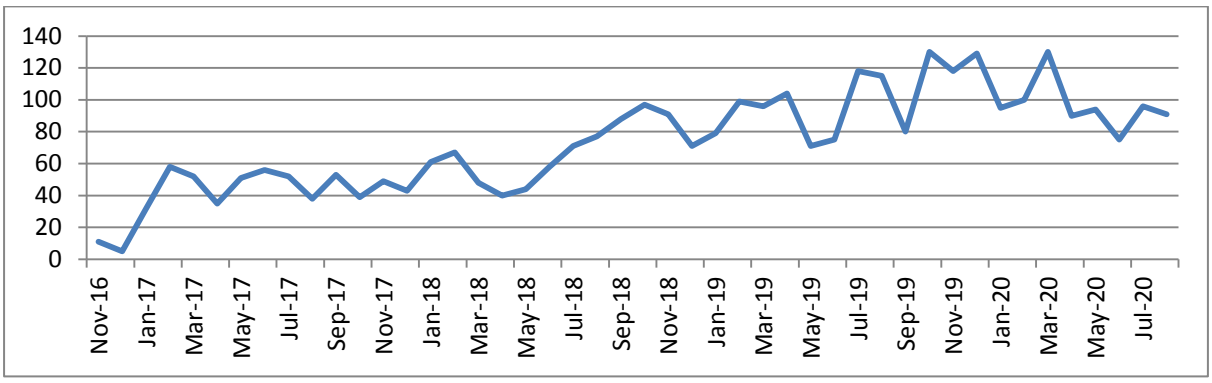
**3. Moments of Magic**

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

Although the numbers of nominations dipped slightly after lockdown we're still routinely receiving over 90 most months.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month 2016-2020:


140
120
100
80
60
40
20
0
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20

**Hull University Teaching Hospitals NHS Trust**

**Monday 26 October 2020**

| | |
|---|---|
| **Title:** | Board Assurance Framework 2020-21 |
| **Responsible Director:** | |
| **Author:** | Rebecca Thompson – Corporate Affairs Manager |

| | | |
|---|---|---|
| **Purpose:** | The purpose of this report is to present the Board Assurance Framework to the Trust Board for review and to discuss any gaps in assurance or positive assurance that may have an impact on the current risk ratings. | |
| **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.<br><br>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.<br><br>The Trust Board approved the Board Assurance Framework at its meeting in July 2020. | |

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| **Recommendation:** | The Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas in this Committee for this financial year.<br><br>The Board is also asked to approve the Q2 risk ratings. |

**Hull University Teaching Hospitals NHS Trust**

**Board Assurance Framework**

## 1. Purpose of this report

The purpose of this report is to present the Board Assurance Framework to the Board for review and to discuss any gaps in assurance or positive assurance that may impact the current risk ratings. The Board is also asked to approve the Q2 risk ratings.

## 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 Q1 risk ratings were approved by the Board at the September 2020 Board meeting. The Q2 proposed risk ratings are highlighted below and in the BAF itself.

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*.The BAME network is now established with events in the diary. There are issues around staff morale, linked to the Capital works and ward and department moves.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Proposed Q2 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 are risks around staff availability and staff absence due to Covid-19. The Trust Board is holding a development session to review potential shortfalls should there be a second wave. The Board will also discuss staff moves due to the fast paced capital works and how this is impacting on staff morale.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Proposed Q2 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*

Further assurance was requested at the Quality Committee relating to the backlog of eye injections due to the pandemic and the impact on the patients waiting for their treatment. The Quality Committee to have a deep dive of this area at its October 2020 meeting.

Risk rating at the start of the year = 16
Q1 risk rating = 16
Proposed Q2 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*

A number of initiatives have been introduced to reduce ED attends such as the 111 service (to be introduced in December 2020), Attend Anywhere and the 12 hour frailty line hosted in the Community. The Adopt and Adapt bid for diagnostics had been submitted which should increase capacity.

There was concern raised regarding the Operating Plan not meeting the national requirements and the forecasted increase in the waiting list and 52 week waits by March 2021. The risks are being managed but clinical priority remains the main focus.

Risk rating at the start of the year = 20
Q1 risk rating = 20
Proposed Q2 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*

The Trust is working closely with local partners to identify joint working arrangements. HUTH/NLAG are reviewing service models to improve services across the Humber region. There are further developments regarding Frailty pathways, Community Paediatrics and the Outpatient Transformation programme.

Risk rating at the start of the year = 9
Q1 risk rating = 9
Proposed Q2 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*

An update was received at the September Quality Committee. The Trust is taking part in the Covid vaccination trail with 1200 participants included so far.

The Trust was working closely with the Humber Coast and Vale to identify mutual benefits across the system.

Concern was raised regarding the reduced research time that Junior Doctors and Research Fellows had due to the pandemic and clinical responsibilities.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Proposed Q2 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 financial planning guidance had been received for month 7 onwards. The Trust had maintained its break even position in month.

Provider shares of the ICS Covid and growth allocations are still to be determined.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Proposed Q2 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
Q1 risk rating = 16
Proposed Q2 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*

There had been funding adjustments made to the original Capital Plan of £18.6m. There had been a number of works commenced although the Memorandum of Understanding had not yet been received. The Performance and Finance Committee had discussed the adjusted programme and how this would impact on services. The increase in funding included £5.9m for critical infrastructure risks, £4.3m for Covid related items and an Adopt and Adapt bid to increase capacity in diagnostics of £1.4m.

Risk rating at start of the year = 12
Q1 risk rating = 9
Proposed Q2 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 16 risks on the corporate risk register.

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 = 3 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= 1 corporate risk (pension risk shared with BAF 2)
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 0 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 the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas for this financial year.

The Committee is also asked to approve the Q2 risk ratings.

**Rebecca Thompson**
Corporate Affairs Manager

November 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 21 September 2020 following the September Board meeting

## 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:<br>*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.*<br><br>*Principal Risk*: There is a risk the Trust does not make progress towards further improving a positive working culture this year<br><br>*What could prevent the Trust from achieving this goal?*<br><br>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<br><br>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<br><br>Refreshed People Strategy focusses on: leadership capacity and capability, empowering staff to lead improvement, equality, diversity and inclusion, employee engagement, communication and recognition<br><br>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<br><br>Engagement of Unions via JNCC and LNC on staff survey and associated action plan<br><br>Board Development Plan will include development of unitary board and leaders by example<br><br>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<br><br>Consideration of a plan specifically for medical engagement – suggest timescale of end Q2<br><br>Need to undertake workforce engagement and transformation as part of Humber Acute Services Review – timescales per HASR progress | **12** | **12** | | | **4 major x 1 rare = 4** | **Positive assurance**<br>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<br><br>Detailed papers to Trust Board on staffing picture including additional psychological support, access to additional support, risk assessments and support to BAME Leadership Network<br><br>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.<br><br>**Further assurance required**<br>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<br><br>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<br><br>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<br><br>Risk that some staff continue not to engage<br><br>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<br><br>Trust acknowledged by commissioners and regulator to be open and honest regarding patient safety and staffing numbers<br><br>Regular reports to the Trust Board on the People Strategy<br><br>Significant staff support put in place for Covid-19 including 24/7 psychological first aid support<br><br>Daily/regular messages to staff on Covid-19 activity, Trust Surge plan, PPE, staff support, staff testing<br><br>Board-level leadership in HASR and maintaining momentum on progress<br><br>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 |
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| | | | | | 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<br><br>Support from Chief Medical Officer and Chief Nurse | From the Trust's Strategy:<br>*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.*<br><br>*Principal risk:*<br>The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust<br><br>Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand<br><br>*What could prevent the Trust from achieving this goal*?<br><br>National and international shortages<br><br>Impact of Brexit on availability of EU workers<br><br>Costs of supporting overseas recruitment<br><br>Impact on staff health and | F&WHG: anaesthetic cover for under-two's out of hours<br><br>SHG: registered nurse vacancies<br><br>Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG<br><br>F&WHG – inability to access dietetic review of paediatric patients – staffing<br><br>Medicine HG: multiple junior doctor vacancies<br><br>F&WHG: Shortage of Breast pathologists<br><br>F&WHG: Delays in Ophthalmology follow-up service due to capacity<br><br>F&WHG | **4 (impact major)**<br><br>**3 (likelihood possible)**<br><br>**= 12** | Refreshed People Strategy articulates changing workforce requirements<br><br>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)<br><br>Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles<br><br>Review of international recruitment needs for 2020-21<br><br>Golden Hearts – annual awards and monthly Moments of Magic – valued staff<br><br>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<br><br>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<br><br>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 | **12** | **12** | | | 4 x1 = 4 | **<u>Positive assurance</u>**<br>Recruitment was in a positive position prior to Covid-19; Covid-19 brought in ability to recruit retired staff and qualifying students quickly<br><br>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<br><br>There are plans to restart virtually the 'Great Leaders' Be Remarkable and Bitesize programmes in October 2020<br><br>Introduction of 'virtual classrooms' to ensure medical education can continue during the pressurised Winter months<br><br>**<u>Further assurance required</u>**<br><br>Absence remains 1% above 5 year average due to staff needing to self isolate and have tests due to Covid 19 like symptoms.<br><br>Board Development Session to review:<br>• staff availability and staff absence should there be a second wave of Covid-19<br>• Staff morale following environment changes due to the updated Capital plan |

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| | | availability due to Covid-19 including long-term trauma and burn-out<br><br>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<br><br>Nursing safety brief several times daily to ensure safe staffing numbers on each day<br><br>Employment of additional junior doctor staff to fill junior doctor gaps<br><br>Regular reports to the Trust Board from the Guardian of Safe Working<br><br>Particular focus and investment in staff support during Covid-19 including mental health support<br><br>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 |
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| | | | | | 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<br>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*<br><br>*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<br><br>*What could prevent the Trust from achieving this goal?*<br><br>That the Trust does not develop its patient safety culture<br><br>That Quality Improvement Plan is not designed around moving to good and outstanding<br><br>That the Trust is too insular to know what outstanding looks like<br><br>That the Trust | CCSHG: lack of compliance with blood transfusion competency assessments<br><br>CCSHG: Pathology results reviewed by requesting clinicians<br><br>CCSHG: Risk to patient safety involving discharge medicines | **4 (impact = major)**<br><br>**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.<br><br>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<br><br>Midwifery services have a robust plan to achieve the ambition in Better Births this is overseen at organisational and LMS level<br><br>The Trust has put in place all requirements to date on Learning from Deaths framework over the last 3 years<br><br>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<br><br>Need to complete an updated Patient and Public Engagement plan and governance structure by end Q2<br><br>Need to assess impact on patient safety and clinical harm due to Covid-19 service delivery and service changes – by end Q1<br><br>Need to look at Board-level reporting on patient outcomes – by end Q3 | **16** | **16** | | | 4 x 2 = 8 | **Positive assurance**<br>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<br><br>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<br><br>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.<br><br>2 Never Events declared in April 2020 (relating to Robinson drains) had been downgraded and were now being investigated as serious incidents.<br><br>**Further assurance required**<br><br>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<br><br>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.<br><br>Review of Ophthalmology eye injection service at the next Quality Committee – Backlog issues. |

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| | | does not increase its public, patient and stakeholder engagement, detailed in a strategy<br><br>The impact on harm due to longer waiting times, delayed activity and less capacity from Covid-19 is not carefully managed.<br><br>Capacity of organisation potentially compromised to be able to make Trust-wide improvements in quality of care | | | response is required<br><br>Fundamental standards in nursing care on wards are being adapted for Outpatients. Will be monitored at the Trust Board and Quality Committee<br><br>Participation in the "Moving to Good" Programme<br><br>Close relationship with commissioners on clinical quality and improvement; have identified areas of partnership working on post-pandemic harm and patient waiting list management<br><br>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 |
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| | | | | | 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.*<br><br>*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<br><br>ECHG: crowding (space) in ED leading to inefficient patient flows and delays impacting 4 hour target<br><br>Corporate: pensions<br><br>Corporate: availability of pressure relieving mattresses | **4 (impact = major)**<br><br>**5 (likelihood = almost certain)**<br><br>**= 20** | Quality Impact Assessments being undertaken on changes in service delivery due to Covid-19<br><br>Assessment per HG and service for Covid-19 recovery plans<br><br>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<br><br>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<br><br>Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance | | **20** | **20** | | | 4 x 2 = 8 | **<u>Positive assurance</u>**<br>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<br><br>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<br><br>COO and CMO meeting monthly with the Medical Directors to discuss ED performance and clinical engagement<br><br>The Adopt and Adapt work for diagnostics is being progressed with the COO at HUTH being the SRO lead across HCV<br><br>The triaging of the referrals in the RAS is working well for services.<br><br>Positive engagement from all services to maintain and increase different ways of working across outpatient services<br><br>Primary Care Collaborative Group had been established to review non-Covid harm |

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| | | 2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance<br>3- Planning guidance being released in stages across the year<br><br>What could prevent the Trust from achieving this goal?<br><br>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<br><br>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<br><br>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<br><br>Impacts on waiting lists due to Covid-19 measured and published weekly<br><br>Capacity and demand work in all pathways<br><br>Plan to review medical base ward capacity to meet demand<br><br>Restoration command structure in place | | | | | | | **<u>Further assurance required</u>**<br>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<br><br>Further work required on ED performance as patient numbers start to rise again – new weekly meeting in place between Health Group Medical Directors<br><br>Following receipt of the Phase 3 planning letter there are risks around the performance expectations set out.<br><br>Diagnostic performance is improving in July 2020, but there are still issues around endoscopy.<br><br>Operating plan not meeting the national ask.<br><br>Waiting list forecast March 2021 – 66000<br>52 week wait forecast March 2021 - 16500 |

**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 |
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| | | | | | 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:<br>*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*<br><br>*Principal risk:*<br>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<br><br>*What could prevent the Trust from achieving this goal?* | None | **3 (impact = moderate)**<br><br>**3 (likelihood = possible)**<br><br>**= 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<br><br>HUTH taking role in continued partnership work and asking for momentum on acute service reviews to be picked back up as soon as possible<br><br>Undertaken detailed stakeholder feedback survey, and formulating action plan following Board discussion<br><br>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<br><br>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** | **9** | | | 3 x 1 = 3 | **Positive assurance**<br>Output of Humber Acute Services Review Interim Clinical Plan will move forward partnership working<br><br>ICS status and new meetings bringing together acute providers to work more collaboratively<br><br>HUTH/NLAG reviewing service models to improve services across the Humber region<br><br>**Further assurance required** |

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

## GOAL 6 – RESEARCH AND INNOVATION

| BAF Risk Ref: | Accountable Chief / Director. Responsible Committee | Principal Risk & what could prevent the Trust from achieving this goal? | Corporate risks on Risk Register that relate to this risk | Initial Risk Rating (no controls) | Mitigating Actions | | 2020/21 risk ratings | | | | Target risk rating | Effectiveness of mitigation as detailed to the Trust Board or one of its Committees |
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| | | | | | 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:<br>*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*<br><br>*Principal risk:* There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships<br><br>*What could prevent the Trust from achieving this goal?*<br><br>Scale of ambition vs. deliverability<br><br>Current research capacity and capability may be a rate-limiting factor<br><br>Unknown impact of Covid-19 on partner organisation and | None | **3 (impact = moderate)**<br><br>**4 (likely)**<br><br>**= 12** | Strengthened partnership with the University of Hull<br><br>Trust investment in last 12 months in research capability including jointly funded posts and projects<br><br>Actions against Strategic Goals within Trust Strategy for Research and Innovation in place – detailed plan in place with milestones and risk assessment<br><br>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<br><br>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** | **12** | | | 3 x 2 = 6 | **Positive assurance**<br>Trust taking part in Covid vaccination trial<br><br>Trust working with HC&V to identify mutual benefits across the system<br><br>**Further assurance required**<br><br>Junior Doctors and Research Fellows research time impacted due to Covid and clinical responsibilities |

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| | | research funding availability<br><br>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 |
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| | | | | | 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:<br>*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.*<br><br>*Principal risk:*<br>There is a risk that the Trust does not achieve its financial plan for 2020-21<br><br>*What could prevent the Trust from achieving this goal?*<br><br>Inability of Trust to restrict Covid related expenditure to within nationally prescribed expectations<br><br>Inability of Trust to | Corporate: Pensions | **4 (impact = major**<br><br>**3 (likelihood = possible)**<br><br>**= 12** | HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings<br><br>Ongoing management of Trust cash balances to ensure no liquidity issues.<br><br>Process in place to agree level of activity planned for remainder of year. Cannot be concluded until financial envelope known<br><br>Monthly analysis and interrogation of Covid and non-Covid spend using established accounting processes and develop better understanding of the cost base<br><br>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<br><br>Assurance over grip and control of cost base; underlying run-rates increasing pressures<br><br>Accurate forecasting and control<br><br>Grip and control of locum and agency spend<br><br>Delivery of recurrent CRES<br><br>All above controls need to be addressed by end Q1 | **12** | **12** | | | 4 x 2 = 8 | **<u>Positive assurance</u>**<br>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<br><br>Achieved revised plan for first quarter of the year<br><br>Financial planning guidance received for month 7 onwards<br><br>Trust has maintained its break even position in Month 8<br><br>**<u>Further assurance required</u>**<br><br>Provider shares of the ICS Covid and growth allocations are still to be determined. |

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| | | generate income from non-clinical activities to pre-Covid levels<br><br>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<br><br>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 |
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| | | | | | 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:<br>*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.*<br><br>*Principal risk:*<br>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)<br><br>*What could prevent the Trust from achieving this goal?*<br><br>Lack of achievement of sufficient recurrent | None | **4 (impact = major)**<br><br>**4 (likely)**<br><br>**= 16** | Robust financial planning processes in place<br><br>Covid-19 recovery planning already commenced<br><br>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<br><br>Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution<br><br>Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews | **16** | **16** | | | 4 x 1 = 4 | **Positive assurance**<br><br>**Further assurance required**<br>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. |

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| | | CRES or make efficiencies<br><br>Unknown impact of Covid-19 finances and recovery planning<br><br>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<br><br>*What could prevent the Trust from achieving this goal?*<br><br>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)**<br><br>**3 (likelihood) Possible = 12** | Risk assessed as part of the capital programme<br><br>Comprehensive maintenance programme in place and backlog maintenance requirements being updated<br><br>Ability of Capital Resource Allocation Committee to divert funds<br><br>Service-level business continuity plans<br><br>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<br><br>Business case for Wave 4 STP capital completed. This will enable some infrastructure risks in 2020-21 to be addressed<br><br>Combined Heat and Power Plant capital funding sourced in 2019-20 – CHP being commissioned in 20-21<br><br>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** | **9** | | | 4 x 2 = 8 | **<u>Positive assurance</u>**<br>Increased capital plan for 2020-21, successfully application for additional capital funding to address some long-term infrastructure needs<br><br>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.<br><br>HCaV Urgent and Emergency Care Business Case Update has progressed to NHSEI and DHSC for evaluation.<br><br>Difference to the original plan (£18.6m) discussed at the Trust Board meeting in September 2020. Works have started although the MOU is yet to be received.<br><br>**<u>Further assurance required</u>**<br><br>Building works for the updated Capital programme and the impact on services and staff. |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 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
February 2021 Board Development (Board leadership and strategy 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 and October 2020 Board Development
June 2021 Board Development

**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
April 2021 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
April 2021 Board Development

**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
August 2021 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
February 2021 Board Development

**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
February 2021 Board Development
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.
April 2021 Board Development

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 2020**

| | |
|---|---|
| **Title:** | Standing Orders |
| **Responsible Director:** | |
| **Author:** | Rebecca Thompson, Corporate Affairs Manager |

| | | |
|---|---|---|
| **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.<br><br>The paper contains recommendations for 3 changes to the Terms of Reference for the Charitable Funds Committee. | |

| | |
|---|---|
| **Recommendation:** | The Trust Board is requested to:<br>• Authorise the use of the Trust's seal<br>• Note the changes to the Scheme of Delegation |

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Standing Orders November 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 |
|---|---|---|---|
| 2020/25 | Hull University Teaching Hospitals NHS Trust – DSI form – land on the west side of Willerby Low Road, Cottingham – Date of change 3 July 2020 | 5/10/20 | Signed and sealed by: Lee Bond, Chief Financial Officer and Chris Long, CEO |
| 2020/26 | City Healthcare Partnership Limited and Hull University Teaching Hospitals NHS Trust – Hull NHS lift underlease for part of the third floor at the Wilberforce Health Centre, 10 Story Street, Hull, HU1 3SA | 4/11/20 | Signed and sealed by: Lee Bond, Chief Financial Officer and Chris Long, CEO |

## 3 Scheme of Delegation amendment

The Scheme of Delegation has been amended to allow the Chief Executive to sign orders for NHS Blood and Transplant up to the value of £2,500,000. The amendment was reviewed by the Audit Committee in October 2020 and no issues were raised. The Board is asked to note the change and following the meeting it will be added to the current Standing Orders and published on the Trust's intranet and website.

## 4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Note the changes to the Scheme of Delegation

Rebecca Thompson
**Corporate Affairs Manager**
**October 2020**

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**September 2020**

| | | |
|---|---|---|
| Title: | Our Patients - Performance Summary | |
| Responsible Director: | Teresa Cope - Chief Operating Officer | |
| Author: | Teresa Cope - Chief Operating Officer | |
| Purpose: | The purpose of this paper to provide an Executive Summary of Performance for July 2020 against national standards. | |
| BAF Risk: | BAF 4 – Performance | |
| Strategic Goals: | Honest, caring and accountable culture | |
| | Valued, skilled and sufficient staff | |
| | High quality care | X |
| | Great local services | X |
| | Great specialist services | X |
| | Partnership and integrated services | |
| | Financial sustainability | |
| Key Summary of Issues: | ED Performance for the month of September was 84.2% (combined) which was a 5.7% reduction on Augusts performance.<br><br>There was a slight improvement in Cancer 62 day performance for August and the Faster Diagnostic Standard continues to be was achieved. 2 WW referrals into the Trust during September was in excess of the pre-covid levels of referrals and this has continued throughout October.<br><br>September saw an Improvement in RTT performance and a reduction in ASI / Holding levels compared with August. The Trust reported were 5800 patients waiting over 52 weeks at the end of September. | |
| Recommendation | That the Trust Board receives and accepts the content of this paper and indicates whether any further assurance is required. | |

**Performance Report - Executive Summary**

**September 2020**

## 1. Purpose

The purpose of this paper to provide an executive summary on performance for September 2020 against the national standards. Performance against all 'responsiveness' indicators is monitored by weekly Performance and Activity Meetings, chaired by the Chief Operating Officer. A Summary of Performance Standards is shown at Appendix 1.

## 2. Phase 3 Planning

The national guidance on Phase 3 planning was issued on the 7th August and set out the expectations for the NHS to return to 'near normal' levels of non covid health services. In summary those expectation were;

- **Day Case and Electives**: That for September, Trusts should deliver 80% of last year's activity rising to 90% in October.
- **Diagnostics**: That Trusts (and system's) achieve 90% of last years activity for MRI, CT and Endoscopy with a goal of reaching 100% by October 2020.
- **Outpatients**: That Trusts deliver 100% of last year activity for first outpatient attendances and follow-ups from September and for the remainder of the year.

The Trust plans identified that for the period September to March the Trust would deliver 83% electives against the 90% requirement; 88% for diagnostics against the 100% target and 92% Outpatient activity against the 100% target.

The table below shows the position for September against the plan and the provisional position for October.

Current month activity is projected for whole month using working days

| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New Outpatients | Actual | 7,327 | 7,840 | 9,821 | 11,553 | 11,126 | 14,802 | 16,973 | | | | | |
| | Plan | | | | | | 15,639 | 16,318 | 15,161 | 13,772 | 15,047 | 14,737 | 16,211 |
| | Variance from Plan | | | | | | -837 | 655 | | | | | |
| | % of 2019/2020 | 41% | 45% | 58% | 63% | 75% | 83% | 92% | | | | | |
| Follow Up Outpatients | Actual | 18,912 | 21,971 | 27,254 | 28,980 | 26,877 | 33,066 | 30,945 | | | | | |
| | Plan | | | | | | 31,637 | 35,925 | 32,607 | 28,089 | 34,674 | 31,129 | 34,242 |
| | Variance from Plan | | | | | | 1,429 | -4,981 | | | | | |
| | % of 2019/2020 | 56% | 59% | 77% | 73% | 81% | 92% | 76% | | | | | |
| Total Outpatients | Actual | 26,239 | 29,811 | 37,075 | 40,533 | 38,003 | 47,868 | 47,918 | | | | | |
| | Plan | | | | | | 47,276 | 52,243 | 47,767 | 41,861 | 49,721 | 45,866 | 50,453 |
| | Variance from Plan | | | | | | 592 | -4,325 | | | | | |
| | % of 2019/2020 | | | | | 79% | 89% | 81% | | | | | |
| Day Cases | Actual | 2,456 | 2,405 | 2,919 | 3,448 | 3,347 | 4,369 | 4,733 | | | | | |
| | Plan | | | | | | 4,627 | 5,015 | 4,683 | 4,280 | 4,948 | 4,529 | 4,982 |
| | Variance from Plan | | | | | | -258 | -281 | | | | | |
| | % of 2019/2020 | 40% | 39% | 50% | 53% | 56% | 71% | 71% | | | | | |
| Ordinary Elective | Actual | 304 | 384 | 571 | 753 | 790 | 950 | 1,223 | | | | | |
| | Plan | | | | | | 983 | 1,058 | 1,023 | 879 | 1,036 | 920 | 1,012 |
| | Variance from Plan | | | | | | -33 | 165 | | | | | |
| | % of 2019/2020 | 25% | 31% | 44% | 55% | 70% | 72% | 87% | | | | | |
| Diagnostics | Actual | 5,054 | 7,214 | 10,245 | 10,087 | 8,361 | 10,254 | | | | | | |
| Specified Tests Only | Plan | | | | | | 10,491 | 11,537 | 10,811 | 9,840 | 11,267 | 10,345 | 11,380 |
| MRI, CT, Non-obs US | Variance from Plan | | | | | | -237 | | | | | | |
| Colon, Flexi, Gastro | % of 2019/2020 | 43% | 59% | 85% | 77% | 66% | 83% | | | | | | |

During October, the number of Covid admissions has increased which has started to impact on the elective plan. Through the Trust Command Structure arrangements a formal reduction in the elective programme has been agreed from w/c 2nd November

which will impact on the delivery of the phase 3 plan. Further details on this will be provided in the separate update to the Board on the Trust response to Covid 19.

## 3. Unplanned Care

3.1 ED performance for September 2020 was 84.2% (combined), a 5.7% reduction on performance for August 2020. Type 1 ED attendances for September were 19% below the levels of attendances for the same period last year. System wide performance (YTD) is 89%.

3.2 For September, 58% of ambulance handover were achieved within the 15 minute standard which is a slight deterioration on Augusts performance. There were 33 occasions during the month where ambulance handover exceeded 60 minutes (1% of all ambulance conveyances).

3.3 The Trust continues to report Zero 12 hour trolley waits.

3.4 The Trust monitors the overall time that patients spend within the Emergency Department as this is a key quality metric recommended by Getting it Right First Time (GIRFT) and the Royal College of Emergency Medicine. For September, 11.3% of patients spent longer than 6 hours in the ED, a deterioration on the previous 5 months recorded levels. Overall length of stay in the ED is monitored via the Emergency Department and Flow Performance and Activity meeting.

## 4. Planned Care

4.1 The Trust reported an RTT performance position of 46.4% for September, an improvement of 5.46% on the previous month. The waiting list volume at the end of September was 58032 which is achieving against the revised phase 3 trajectory. The average wait for a first OPD appointment in September 23 weeks against a 7 week standard.

4.2 Four specialties account for 40% of the Trusts waiting list volumes; ENT, Cardiology, Ophthalmology and Plastics and therefore focussed solutions have been put in place for these specialties including outsourcing of activity to Independent Sector providers and additional internal activity. ASI and Holding at the end of September was 26,452 which is an improvement of 3200 on the August position. The Referral Assessment Services (RAS) continue to operate effectively across all specialties with 14% (n=1086) of referrals rejected or converted to Advice and Guidance during September. 36% of all out-patient were conducted as non face to face appointments during September. Patient initiated follow ups (PIFU) rather than traditional outpatient follow up at a clinically identified time are being implemented through the Optimise programme.

4.3 The number of 52 week breaches reported as at the end of September was 5800 which is an increase of 1401 on Augusts position. 42% of the breaches are on admitted pathway and 58% on non admitted pathways. Surgical prioritisation using

the Royal College guidelines is fully embedded and used to prioritise access to theatre capacity via the Theatre Control Meetings.

## 5. Diagnostics

5.1 Performance against the diagnostic 6 week standard was 39.8% (against the 1% standard) which is a slight deterioration on the August position. 52% of all breaches are within the Endoscopy Service. Against the diagnostic standard, the Trust was ranked 65th of 125 Trusts nationally. The Trust has contributed to the Adopt and Adapt programme of work across the Humber Coast and Value ICS to accelerate recovery across Endoscopy, MRI and CT and has been awarded £1.16m of capital investment which will be used to fund additional equipment.

## 6. Cancer Standards

6.1 From July, 2WW referrals returned to the levels seen pre-covid, however during September and October, the weekly 2WW referrals are higher than the pre-covid baseline levels.

6.2 The Trust did not achieve the 2WW standard for August with 85% of patients seen within 14 days against the 93% standard. The standard was achieved in all tumour sites except lower GI, Upper GI and Breast. Non compliance against the standard in upper and lower GI was due to reduced capacity for endoscopy and non compliance against the standard for Breast is due to increased demand across and reduced clinic capacity due to social distancing requirements.

6.3 Performance against 62 day standard was 71.3% for August, a slight improvement of previous months with 37 patients treated outside of the 62 days. The Trust continues to achieve the Faster Diagnostic Standard, achieving 79.6% for August and provisional performance of 76.3% for September.

## 7. Conclusion.

During September, the Trust continued to recover from the Impact of ceasing planned activity during Covid -19. Restoration continued to be managed via the weekly Covid Steering Group and the Trust had actively been engaged within the national Adopt and Adapt Programmes across diagnostics, OPDs and Theatre.

The final phase 3 planning submission for the Trust identified that the Trust could not fully meet all of the requirement as outlined in the phase 3 plan, but has demonstrated improving levels of Elective activity during September as increased restoration of services was achieved.

There however remain continued risks to planned care delivery as a result of the increase in number of Covid 19 admissions during October 2020 which will adversely impact on the elective programme.

**Weekly Scorecard**

NHS Hull University Teaching Hospitals NHS Trust

| Group | Measure | Notes | 19/20 Avg. (where appropriate) Baseline | 07 Sep | 14 Sep | 21 Sep | 28 Sep | 05 Oct | 12 Oct | 19 Oct | Trend (7/52) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| RF | GP referrals (Volume) | GP or GP with Special Interest | 2,398 | 1,631 | 1,575 | 1,563 | 1,516 | 1,497 | 1,535 | 1,301 |  |
| RF | GP referrals (Rate) | GP Referrals / OP Referrals | 55% | 45% | 44% | 44% | 46% | 47% | 47% | 44% |  |
| RF | A&G Requests | Referrals to A&G Team | 207 | 480 | 525 | 591 | 517 | 518 | 504 | 382 |  |
| RF | 2ww Referrals | All referrals as 2ww priority from a GP | 371 | 416 | 423 | 427 | 378 | 428 | 447 | 463 |  |
| RF | 2ww seen within 14 days | Cancer Performance | 93% | 65% | 79% | 65% | 78% | 73% | 78% | 70% |  |
| ED | 4hr Performance | Type 1 | 70% | 77% | 76% | 76% | 76% | 72% | 80% | 69% |  |
| ED | Number of attendances | Type 1 | 2,644 | 2,308 | 2,399 | 2,290 | 2,144 | 2,303 | 2,215 | 2,259 |  |
| ED | 4hr Performance | Type 1&3 combined | 81% | 86% | 85% | 85% | 85% | 82% | 87% | 81% |  |
| ED | Number of attendances | Type 1&3 combined | 4,188 | 3,819 | 3,942 | 3,669 | 3,500 | 3,649 | 3,503 | 3,611 |  |
| OP | New outpatient attendances | All mediums | 5,001 | 4,530 | 4,604 | 4,318 | 4,535 | 4,265 | 4,217 | 4,285 |  |
| OP | Follow up outpatient attendances | All mediums | 10,573 | 9,591 | 10,052 | 10,069 | 10,113 | 10,445 | 10,588 | 9,665 |  |
| OP | 2ww Appointment attendances | Appointment Priority of 2ww | 439 | 462 | 492 | 458 | 460 | 476 | 426 | 521 |  |
| OP | 62 day RTT Cancer Performance | | 67% | 73% | 56% | 49% | 51% | 59% | 56% | 65% |  |
| OP | 31 day DTT Cancer Performance | | 93% | 90% | 90% | 96% | 95% | 89% | 89% | 90% |  |
| OP | Number of hospital cancellations | Due to COVID-19 | - | 207 | 258 | 216 | 212 | 75 | 85 | 52 |  |
| OP | Number of patient cancellations | Due to COVID-19 | - | 53 | 76 | 73 | 94 | 124 | 140 | 150 |  |
| OP | Rate % OP hospital cancellations (all) | Hosp Cancel / Hosp Cancel + Patient Cancel + DNA + Attend | 10% | 9% | 9% | 8% | 8% | 9% | 10% | 9% |  |
| OP | Rate % OP patient cancellations (all) | Patient Cancel / Hosp Cancel + Pat Cancel + DNA + Attend | 12% | 7% | 7% | 7% | 7% | 7% | 7% | 8% |  |

**Weekly Scorecard**

NHS
Hull University Teaching Hospitals
NHS Trust

| Group | Measure | Notes | 19/20 Avg. (where appropriate) Baseline | 07 Sep | 14 Sep | 21 Sep | 28 Sep | 05 Oct | 12 Oct | 19 Oct | Trend (7/52) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IP | Elective admissions | | 1,661 | 1,144 | 1,253 | 1,324 | 1,309 | 1,365 | 1,441 | 1,473 | |
| IP | Emergency admissions | | 1,010 | 883 | 880 | 875 | 836 | 883 | 860 | 862 | |
| IP | Elective cancellations | Due to COVID-19 | - | 4 | 14 | 5 | 8 | 10 | 10 | 14 | |
| RT | RTT list size | Against baseline March 19 | 52,808 | 58,967 | 59,237 | 59,626 | 59,947 | 59,612 | 59,163 | 59,276 | |
| RT | Follow up backlog (over 3 months) | Against baseline March 19 | 18,761 | 34,880 | 34,880 | 34,298 | 34,044 | 34,044 | 33,284 | 33,284 | |
| RT | ASI / Holding | Against baseline March 19 | 16,357 | 28,886 | 28,278 | 27,753 | 27,034 | 26,074 | 12,948 | 24,892 | |
| RT | 52 week breaches (Unvalidated) | Against baseline 2018/19 | 2 | 5,196 | 5,488 | 5,841 | 6,127 | 6,402 | 6,553 | 6,753 | |
| RR | Total number swabbed | | - | 2,024 | 2,274 | 2,360 | 2,269 | 2,483 | 2,645 | 2,680 | |
| RR | Total number confirmed | | - | 4 | 12 | 9 | 23 | 26 | 45 | 86 | |
| BD | Current inpatients as at 08:00 Monday | | - | 901 | 879 | 895 | 913 | 955 | 934 | 925 | |
| BD | Total G&A Open | Based on yesterday's Monday vs previous Monday | - | 974 | 979 | 989 | 989 | 972 | 989 | 982 | |
| BD | Total G&A Occupied | Based on yesterday's Monday vs previous Monday | - | 807 | 824 | 852 | 852 | 851 | 863 | 783 | |
| 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 | - | 37 | 32 | 23 | 31 | 29 | 29 | 31 | |
| BD | G&A Bed Occupancy Rate | Based on yesterday's Monday vs previous Monday | - | 83% | 84% | 86% | 86% | 88% | 87% | 80% | |
| BD | CC Bed Occupancy Rate | Based on yesterday's Monday vs previous Monday | - | 53% | 46% | 33% | 44% | 41% | 41% | 44% | |
| BD | Trust Bed Occupancy Rate | Based on yesterday's Monday vs previous Monday | - | 81% | 82% | 83% | 83% | 84% | 84% | 77% | |
| DG | Diagnostics Over 6 weeks | | 1,075 | 3,493 | 3,943 | 4,014 | 3,920 | 3,894 | 3,798 | 3,753 | |
| IP | Medical Beds Avg LoS (Trimmed) | | 3.8 | 3.5 | 4.0 | 4.1 | 4.3 | 4.4 | 3.5 | 4.2 | |
| CN | Cancer 62 Day PTL (104+ days) | | 128 | 125 | 109 | 103 | 96 | 94 | 89 | | |

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

**PREPARED FOR THE TRUST BOARD**
**November 2020**

| | |
|---|---|
| Title: | Quality Report: Patient Impacts |
| 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 a briefing and assurance to the Trust Board in matters relating to quality governance and patient safety including:<br>• Infection Prevention and Control<br>• Serious Incidents<br>• Incidents<br>• Harm Free Care – Including Falls & Pressure Ulcers<br>• Patient Experience<br>• 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 a briefing on key quality indicators. Exceptions are noted in more detail in the report in relation to:<br>• There have been 0 Trust apportioned MRSA bacteraemia between 1st April and 30th September 2020.<br>• There have been 3 Trust apportioned MSSA bacteraemia cases reported in September (27 year to date). A deep dive has identified that 42% of cases were linked to peripheral vascular devices.<br>• 2 Hospital onset healthcare associated (HOHA) *Clostridium difficile* cases were reported along with two community onset healthcare associated cases (COHA). Outcomes of early RCA processes during Quarter 1 highlighted challenges associated with the pandemic, including infectious diseases in reach and appropriate antimicrobial prescribing and treatment regimens for COVID-19.<br>• 7 Trust apportioned E.coli bacteraemia 949 cases to date). The trends and sources of infection are identified to be biliary, urinary and respiratory.11 Serious Incidents were declared in September 2020<br>• Incidents in Ophthalmology continue to be noted with a recovery plan being developed and presented to the October 2020 Quality | |

| | |
|---|---|
| | Committee<br><br>• Whilst falls per 1,000 bed days remain within control limits, an increase has been noted in the Clinical Support Health Group, which requires further investigation.<br>• 34 complaints and 155 PALS were recorded in September 2020. Of the 22 complaints closed in this time period, 71% were completed to the 40 day target<br>• A gap analysis has been undertaken in ED following the CQC publication of the report into the Covid outbreak at Hillingdon<br><br>Detailed reports on all aspects of quality and patient safety are received by the Quality Committee. |
| Recommendation: | The Board is asked to receive and accept this report as assurance of the quality of care being provided in the Trust; that mechanisms are in place to record exceptions, and that appropriate actions are taken to mitigate risk. |

**Hull University Teaching Hospitals NHS Trust**
**Trust Board**
**Quality Governance Update Report**

## 1. Purpose of this report

The purpose of the report is to brief the Board of the key issues in relation to quality governance matters.

## 2. Risk Management

### 2.1 Never Events and Serious Incidents

During September 2020, there were 0 Never Events and 11 serious incidents declared. It is noted that this is the highest number of SI's declared in month for over 18 months. The Duty of Candour process has been initiated in all cases.

The incidents were:

- An inappropriate discharge from paediatrics
- A treatment and care incident in gynaecology with a delay in diagnosis involving a minor.
- 2 falls where patients sustained fractured neck of femur
- A treatment and care incident where a patient sustained an extravasation injury to their hand whilst undergoing chemotherapy
- A treatment and care incident where a patient received the incorrect medication
- A delayed diagnosis incident where a malignancy was not detected in a timely manner
- A delayed diagnosis in radiology where a bone (tibia) tumour was not detected when an x-ray was reported
- A delayed diagnosis in radiology where a bone tumour was not detected
- A treatment delay in ophthalmology
- A treatment and care incident where a patient did not receive a follow up appointment

A review of themes and trend took place at the October SI Committee and the following areas were identified: the number of SIs declared in the Emergency Department in recent months has increased and the number of cases linked to Radiology / Test Results has increased. Whilst there appear to be no clear themes apparent; further analysis is being undertaken and a report is due to be tabled the November SI Committee. Updates will be providing by exception following the analysis in the November Quality Report. In addition, the SI Committee commissioned a piece of work to be undertaken of further examination of SIs with potential links to the Covid-19 Pandemic in order to provide assurance or to identify areas for action.

### 2.2 Incident Reporting

During the last month we have seen a continued level of 'moderate and above' incidents per 1,000 bed days peaking above the control limits. When reviewed Ophthalmology Speciality remains a higher than normal reporter of incidents, some relating to a reduction in vision of patients with degenerative eye conditions. The Family and Women's Health Group have a recovery plan in place to address this and the Medical Director of the Health Group attended Quality Committee in October to present the context, impact and plans as assurance.

## 3. Patient Safety

### 3.1 Healthcare Associated Infections

During Quarter 1 and Quarter 2 there have been 0 Trust apportioned MRSA bacteraemia cases. During September 2020 r 3 Trust apportioned MSSA bacteraemia cases were reported (27 year to date). A deep dive has identified that 42% of cases were linked to peripheral vascular devices, an improvement programme is ongoing to address the themes from the incidents

During September 2020, 2 hospital onset healthcare associated (HOHA) *Clostridium difficile* cases were reported along with two community onset healthcare associated cases (COHA). Outcomes of early RCA processes during Quarter 1 highlighted challenges associated with the pandemic, including infectious diseases in reach and appropriate antimicrobial prescribing and treatment regimens for COVID-19. Quarter 2 demonstrated a marked reduction in hospital onset cases which is encouraging with a high number deemed no lapses in practice. Quarter 1 & 2 HOHA cases are awaiting review and sign off by the commissioner led HCAI review group which is expected to recommence.

In addition, in September 2020, seven Trust apportioned E.coli bacteraemia (949 cases in Q1 and Q2). The trends and sources of infection are identified to be biliary, urinary and respiratory.

On the 12th October 2020, the Care Quality Commission (CQC) published the findings of a focused inspection of The Hillingdon Hospital NHS Foundation Trust in response to concerns around the trusts' infection prevention & control (IPC) practices. The inspection was prompted by a significant outbreak of COVID-19 amongst staff. The staff worked in the Emergency Department (ED) and due to the number affected resulted in the ED department being closed to admissions; with emergencies being diverted to neighbouring Trusts. A gap analysis of the findings of the CQC has been completed by the IPT within our own department with positive results, the detail will be presented to the Infection Reduction Committee.

**3.2 Falls**
In September 2020, there was a slight increase in the number of falls declared within the Trust, as well as slight increase in moderate and above incidents of falls per 1,000 bed days. It should be noted however, that the numbers remain within expected control limits. Of note however, is the increase in the Clinical Support Health Group. Whilst the Health Group only sees small numbers of moderate and above falls, the increase has been noted and escalated for review at the October Falls Prevention Committee. Further updates will be provided in the November Quality Report.

**3.2 Pressure Damage**
The Trust has had zero grade 4 or grade 3 pressure damage in September 2020.

**4. Patient Experience**

34 complaints were opened in September 2020, the majority of which (23) were linked to treatment and care recieved. The numbers received remain below the figures recorded for the same time period in 2018-19 and 2019-20. Of the complaints that were closed in September 2020, 22 (71%) were closed within the 40 day target. Individual Health Groups have been asked to develop an improvement plan to improve this performace.

155 PALS were received within September 2020. The primary subjects were : patients not satisfied with care plan, waiting times in outpatients, delays in care plan, delays in notification of results and communication issues.

**5. Care Quality Commission**
As per our regulatory obligations an engagement meeting was held between the Trust and CQC in September 2020. The CQC were provided with updates on performance, details of how we plan to manage the backlog as a result of the cancellation of elective work during Covid, winter planning and returning to normal business. The CQC accepted the progress made against the action plan.

As the Board are aware the CQC are currently developing virtual well-led inspections. Given HUTH did not have a well-led inspection in March 2020 due to COVID-19, we may expect a virtual well-led assessment towards the end of 2020.

The CQC are in the process of developing their next strategy and are seeking views from healthcare organisations over the coming months. The new strategy is built on four central and interdependent

themes that determine the changes they want to make to regulation. Running throughout each theme is the CQC ambition to improve people's care by looking at health and care systems and how they're working together to reduce inequalities. The four key themes are People, Smart, Safe, Improve.

A quarterly review of progress against the 'Must' and 'Should' do actions has been undertaken with Medicine, Emergency Care, Surgery and Critical Care. Good progress is being made against the delivery of the overall action plan with action being already taken against the majority of actions to ensure the deadline dates are achieved. Nine sub-actions have also been closed. The detail of the action plan has oversight by the Quality Committee.

**5. Recommendation**

The Trust Board is recommended to receive and accept the updates provided in this report.

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**QUALITY IMPROVEMENT PLAN (QIP) 2020-21 UPDATE**

**Trust Board**
**November 2020**

| | | |
|---|---|---|
| Title: | Quality Improvement Plan (QIP) 2020-21 | |
| Responsible Director: | Beverley Geary Executive Chief Nurse | |
| Author: | Jo Ledger, Deputy Chief Nurse and Kate Southgate, Deputy Director of Quality Governance | |
| Purpose: | The purpose of this report is to provide the Trust Board with an update against the QIP projects for 2020. | |
| BAF Risk: | BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care. | |
| Strategic Goals: | Honest, caring and accountable culture | Y |
| | Valued, skilled and sufficient staff | Y |
| | High quality care | Y |
| | Great clinical services | Y |
| | Partnership and integrated services | Y |
| | Research and Innovation | |
| | Financial sustainability | |
| Summary Key of Issues: | The 2020-21 QIP currently has 8 projects open. All projects commenced in July 2020 this was due to a delay as a result of Covid. Each QIP was required to produce a project initiation document that outlined the background, aims and quarterly objectives. These were agreed by the July 2020 Quality Committee.<br><br>This report provides the Board with progress to date.<br><br>All projects, with the exception of the Stop the Line project have initiated task and finish groups. The Stop the Line project is due to be reviewed with the leads to narrow down the scope of the project in the coming weeks. | |
| Recommendation: | The Trust Board is asked to review the progress made and determine if further assurance is required. | |

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**
**QUALITY IMPROVEMENT PLAN (QIP) 2020-2021 UPDATE**

## 1.0 PURPOSE OF THE REPORT

To provide the Trust Board with an overview of progress to date against each of the individual QIPs for information.

## 2.0 QIP 2020-21

The 2020-21 QIP currently has 8 projects open. As a result of covid the commencement of the projects was delayed and they began in July 2020. Each QIP was required to undertake detailed planning and to produce a project initiation document that outlined the background, aims and quarterly objectives. These were agreed by the July 2020 Quality Committee.

All projects, with the exception of the Stop the Line project have initiated task and finish groups of clinical teams, these feed into the steering group which is chaired by the Deputy Chief Nurse.
The Stop the Line project is due to be reviewed with the leads to narrow down the scope of the project in the coming weeks.

As a result of the current pressures due to Covid the governance, oversight and assurance of the QIP will via the Patient Engagement, Effectiveness and Safety Committee with immediate effect.

The updates by project are provided as per the table below:

| QIP | AIM FOR Q1 | UPDATE |
|---|---|---|
| **Safety Brief** | • Set Up Project Team<br>• Scoping of existing local and national safety brief frameworks | The task and finish group has been established, meetings have commenced with further meetings have been scheduled for the remainder of the year.<br><br>All Band 7 nurse leads have been requested to send their current Safety Brief / Safety Huddle template for a review to be undertaken by the task and finish group of methods used across the organisation. |
| **Falls in Dementia Patents** | • Set Up Project Team | The first meeting of the task and finish group has been held and further meetings have been scheduled for the remainder of the year. Terms of referenced have been agreed.<br><br>Individual tasks have been scoped and assigned including a review of the Datix form |
| **Mental Health Triage in the Emergency Department** | • Set Up Project Team<br>• Scoping of existing local and | The first meeting of the task and finish group has been held and further meetings have been scheduled for the remainder of the year. |

| QIP | AIM FOR Q1 | UPDATE |
|---|---|---|
| | national mental health triage assessments | The first two meetings have been held with Humber FT, further meetings are scheduled.<br><br>Scoping work has commenced. |
| **Preceptorship** | • Set Up Project Team<br>• Scoping of project plan | Terms of Reference including membership for the task and finish group have been agreed. Meetings have been scheduled for the remainder of the year.<br><br>The Practice Learning Facilitators |
| **Patient and Public Involvement** | • Scoping exercise of internal processes<br>• Development of internal database for patient groups<br>• Patient Council review and recruitment campaign | The first meeting of the task and finish group has been held and further meetings have been scheduled for the remainder of the year.<br><br>Work with NHSI to identify areas of improvement has almost completed, this will result in a detailed work plan that will have oversight by the Patient Experience Steering Group and the QIP steering group. |
| **Surgery Health Group – Line Infections** | • Set Up Project Team<br>• Scoping of existing local and national guidance for Line Management | Meetings of the task and finish group have commenced.<br><br>Audits are currently being undertaken and information is being gathered and analysed. A review of the data is currently being undertaken to determine which clinical areas would most benefit from the project.<br><br>A review had commenced of the discrepancies identified between the number of RCAs being completed as per the Trust wide figures in comparison to local (ie Health Group) figures). |
| **Stop The Line** | • Set Up Project Team,<br>• Scope project plan<br>• Identify trial surgical team<br>• Introduce QIP to the trial team | Scope of the project has been discussed, workstream and feeds into the Patient Safety Committee. |
| **Tissue Viability** | • Set Up Project Team<br>• Scoping of other organisations with non-registered workforce in leadership roles | The first task and finish group has been scheduled and would take place across both sites.<br><br>An external scoping exercise has commenced with initial discussions being held with Bradford. |

## 3.0 RECOMMENDATIONS

The Trust Board is asked to receive the progress made against the QIP and accept the new governance and reporting arrangements.

**Jo Ledger**
**Deputy Chief Nurse**

**Kate Southgate**
**Deputy Director of Quality Governance**

**November 2020**

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

# TRUST BOARD

## 10 NOVEMBER 2020

| | | |
|---|---|---|
| Title: | Covid Preparedness Report | |
| Responsible Director: | Jacqueline Myers, Director of Strategy and Planning | |
| Author: | Jacqueline Myers, Director of Strategy and Planning | |
| Purpose: | The purpose of this document to provide the Trust Board with a briefing on the arrangements for the next phase response to Covid 19. | |
| BAF Risk: | | |
| Strategic Goals: | Honest, caring and accountable culture | |
| | Valued, skilled and sufficient staff | X |
| | High quality care | X |
| | Great local services | X |
| | Great specialist services | X |
| | Partnership and integrated services | |
| | Financial sustainability | |
| Key Summary of Issues: | • The Trust is experiencing a further surge of Covid 19 Cases<br>• The Command and Control Structure has been stood back up to daily Executive led Gold Command Meetings<br>• The 2nd surge response plan is agreed and in action | |
| 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**

**Update on the arrangements to respond to Covid 19**

1 **Purpose**

The purpose of this document to provide the Trust Board with a further update on the arrangements for the next phase response to Covid 19.

**2 Update on Covid 19 activity in the Trust as at 5 November 2020**

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

As at 5 November 2020, the Trust has 121 confirmed inpatient cases of Covid-19 in the general bed base and 24 suspected cases. Additionally there are 19 confirmed cases in critical care and 1 suspected case. As such activity has now exceeded the 1st peak in April-May 2020.

**3 Command and control arrangements**

The Trust has stood up daily (7 days per week) Gold Command meetings, which are chaired by a member of the Executive Team. These are supported by daily Silver (operational) command meetings and 7 day a week corporate management and administrative support is being provided, to ensure that any national directives are reviewed upon receipt and acted upon as required.

The Trust has a Covid dashboard that reports key metrics in relation to patients, staff, testing and PPE on a daily basis. We also receive daily public health and regional critical care utilisation intelligence.

4 **Covid Response plan update**

4.1 Revised bed model and configuration

The revised bed configuration reported at the last Trust Board has now been implemented; the Acute Medical and Elderly Assessment Units remain in temporary accommodation pending the completion of the capital works on the ground floor; this is not impeding the delivery of the surge or winter plan as we now have access to the new wards at the back of the HRI site (H37 and H38) but has unfortunately halted the work to upgrade the wifi in the Tower Block, which will need to recommence later in the year when the ground floor works are complete.

The critical care surge plan has been revisited and revised, taking into account learning from the care of patients to date and also the wish to as far as is practicable maintain elective activity. As part of this we are undertaking some further work on the provision of high flow oxygen therapy to ensure we optimise the capacity to provide this, across both critical care and respiratory medicine, again learning from experience.

4.2 Revised staff deployment plan

A revised workforce plan has been drafted for all key staff groups, which aligns to the revised bed configuration model and is in action. The deployment of each stage of the surge plan and associated staff redeployment plan is handled by Silver

Command with oversight by Gold Command, ensuring we have enough headroom at each stage. Given the acuity and complexity of Covid 19 patients, the staffing model is relatively rich, so we needed more than 3 dedicated Covid wards it became necessary to reduce elective services to release staff for redeployment. Silver Command is also having to take into account the higher than usual rates of staff absence as a result of Covid-19 in implementing the redeployment of staff.

**5 Delivery of capital plans**

The further capital works to Wards H36, H37 and H38, which enhance the facilities to isolate suspected Covid 19 cases and to undertake aerosol generating procedures, have been completed.

As reported above, the improvement works to the acute assessment units are progressing, with the Adult Medical Unit due to complete in December 2020 and the elderly assessment area in March 2021.

Capital has been secured to support the building of a new 30 bedded critical care unit at HRI, on the site of the RMO Block, this is due to complete in March 2021.

The outstanding 'Wave 4' capital schemes, including the new front entrance to the Tower Block and the creation of a new paediatric department are due to commence on site imminently.

**6 The Covid Vaccination Programme**

The Trust has been asked to act as the Hub for the Humber, Coast and Vale area for the Covid mass vaccination programme. The Chief Nurse, Beverley Geary is leading this work. Arrangements are being put in place to commence the vaccination of NHS staff and the elderly and vulnerable population, from 1 December 2020, subject to one or more of the vaccinations in development securing a licence.

5 **Delivery of elective work and recovery planning**

5.1 Approach to clinical prioritisation

The Health Groups have continued to review their patient tracking lists, identifying the clinical prioritisation of the patients waiting for treatment and ensuring patients of the higher risk categories continue to be booked. The Theatre Resource Allocation Panel has been stepped back up to facilitate this process.

The Trust is also working with the other acute providers within the Humber, Coast and Vale Integrated Care System to consider how working together may offer opportunities to mitigate clinical risk and also with primary care and the voluntary sector, to ensure oversight and support is provided in the community to lower priority patients, who are experiencing long waits for treatment.

5.2 Revised activity plan

Revised elective activity plans were agreed for the remainder of the year, based on their understanding of the capacity available to the Trust for this work and the constraints on productivity imposed by the Covid 19 related enhanced infection control measures. These plans are being performance managed via the 'PANDA' group.

It should be noted, however, that in the last week the Trust has regrettably had to curtail some elective work to release workforce to support the response to Covid 19 and it is anticipated there will be a further surge of Covid activity and further losses

of elective activity before the impact of the national restrictions to public interaction are felt. There has not been a blanket cancellation of routine electives and the Trust is striving to maintain elective activity where possible, including moving some additional work to the independent sector.

The Trust's activity plans include continued use of the Independent Sector for daycase surgery and some outpatients and diagnostics. The national contract between the NHS and a range of independent sector hospitals has been extended to run until the end of December 2020 and NHS England is currently out to tender for a replacement arrangement, with potentially a wider range of independent sector providers, that will run until at least 31 March 2021.

**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**

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 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. | |
| **BAF Risk:** | Goal 1 – Organisational Culture, Staff Engagement<br><br>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 3.1%. Staff absence overall is currently 10.14% which includes Covid-19 related, other absences and maternity leave. The Trust flu programme continues at pace. 4,300 staff have been vaccinated and staff wellbeing and support arrangements continue to work well. | |

| | |
|---|---|
| **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**

**10 November 2020**

**Our People**

## 1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues.

## 2. Background

The Trust has put in place a surge plan for the pandemic second wave. On Saturday 31st October Hull and East Riding moved into "High Risk" tier 2 lockdown measures in response to a rapid increase in the rate of infection locally, with over 8,000 confirmed cases, which we are seeing reflected in the numbers of Covid-19 positive cases in our hospitals.

Trusts around HUTH remain inundated with Covid-19 patients and most have risen beyond the highest level that they saw during the first wave. We are expecting a further increase in Covid-19 positive patients, which if the rate of increase continues, could double from 65 (as at 29.10.20) to 130 over the next 10 days. Gold Command will, in accordance with the surge plan, make timely and appropriate decisions and reduce elective activity as required. A key challenge will be staff redeployment. Staff are exhausted and some were redeployed in the first wave. Staff understand we are in a pandemic and will move, but care and attention must be taken to support and provide additional supervision to those staff to make the experience as positive 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 465 staff absent due to Covid-19 which is 4.78% of the workforce. Total absence including maternity leave and all other reasons for absence is 10.14%. This is a significant increase from 6.10% as at the last Board meeting (8th September, 2020).

Staff absence usually runs at 3.6%, so the Trust is well above its normal absence levels which means staffing is a significant risk to the provision of services.

## 4. Staff Testing

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

Antibody testing
Antibody testing: HUTH staff were offered antibody testing during the month of June and July 2020: 8,868 tests were completed at this stage with a Covid-19 antibody positive rate of 13.21%.

Repeat antibody tests were then offered for a short period of time prior to the commencement of the SIREN study.

Social care antibody testing: the Trust supported antibody testing for Hull and ER social care staff during the month of September 2020. In total 1,353 tests were undertaken with a positivity rate of 14.63%

Antigen testing
Staff Covid antigen testing via a drive through has been available since April 2020. Between April-October, we have tested 6159 HUTH staff or family members, 634 (10.3%) of which were positive.

From September 2020, demand for the service has increased. 2,625 HUTH staff or family members were tested between 1 September and 31 October. The positivity rate has changed dramatically in October increasing from 2% in September to 12% in October.

The Trust also tests staff from CHCP, Yorkshire Ambulance Service, Humber FT and others, which are additional to the figures above.

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 292 staff to self-isolate as a result of a 'contact' within their workplace. In August the figure was 8, which increased to 32 in September and increased significantly in October to 192.

**5. Staff Vacancies**
The Trusts overall vacancy position as at 30th September, 2020 is as follows:

| Staff Group | Establishment WTE | Staff in Post WTE | Temp Workforce WTE | Vacancies WTE | Vacancy Rate % |
|---|---|---|---|---|---|
| **Additional Clinical Services** | 1457.5 | 1409.5 | 53.0 | -5.0 | 0.0% |
| **Add Prof Scientific and Technical** | 351.0 | 291.8 | 4.5 | 54.7 | 15.6% |
| **Administrative and Clerical Staff** | 1557.9 | 1550.6 | 8.1 | -0.8 | -0.1% |
| **Allied Health Professionals** | 482.2 | 457.0 | 8.1 | 17.1 | 3.5% |
| **Estates and Ancillary** | 574.3 | 535.0 | 4.3 | 35.0 | 6.1% |
| **Healthcare Scientists** | 303.2 | 286.3 | 3.7 | 13.2 | 4.4% |
| **Medical & Dental - Consultant** | 488.5 | 444.8 | 17.5 | 26.2 | 5.4% |
| **Medical & Dental - SAS** | 65.7 | 50.6 | 0.0 | 15.1 | 23.0% |
| **Medical & Dental – Trainee Grades** | 636.4 | 653.5 | 13.8 | -30.9 | 0.0% |
| **Nursing and Midwifery Registered** | 2387.6 | 2190.9 | 63.5 | 133.2 | 5.6% |
| **Trust Total** | 8304.2 | 7869.9 | 176.5 | 257.8 | 3.1% |

Overall the Trust vacancy position is 3.1%. The Consultant vacancy rate is 5.4%. Whilst our vacancy situation remains in a healthy position the Trusts recruitment plans have been somewhat interrupted, but recruitment and retention remains a key priority.

Registered Nurse and Midwifery
The vacancy rate for Registered Nursing and Midwifery is currently 5.6% across the Organisation. The wards, ED and ICU have 21.93wte vacancies. This includes the newly appointed Aspirant Nurses.

There are currently 69 Trainee Nurse Associates (TNA) employed by the Trust. The September, 2018 cohort (10 in total) are due to complete their programme in October, 2020 following completion of their end-point assessment.

The Trust has 33 Student Nurse Apprentices in training. 12 of those commenced the programme in September, 2020. In addition, the Trust has 25 Health Care Support Worker apprentices, 12 of which commenced the programme in September, 2020. In partnership with Hull College and the

University of Hull the Trust is seeking to recruit a further 9 Health Care Support Workers to begin the programme in November.

The Trust has recruited 103 international nurses since the beginning of 2018 with an attrition rate of 3% overall.

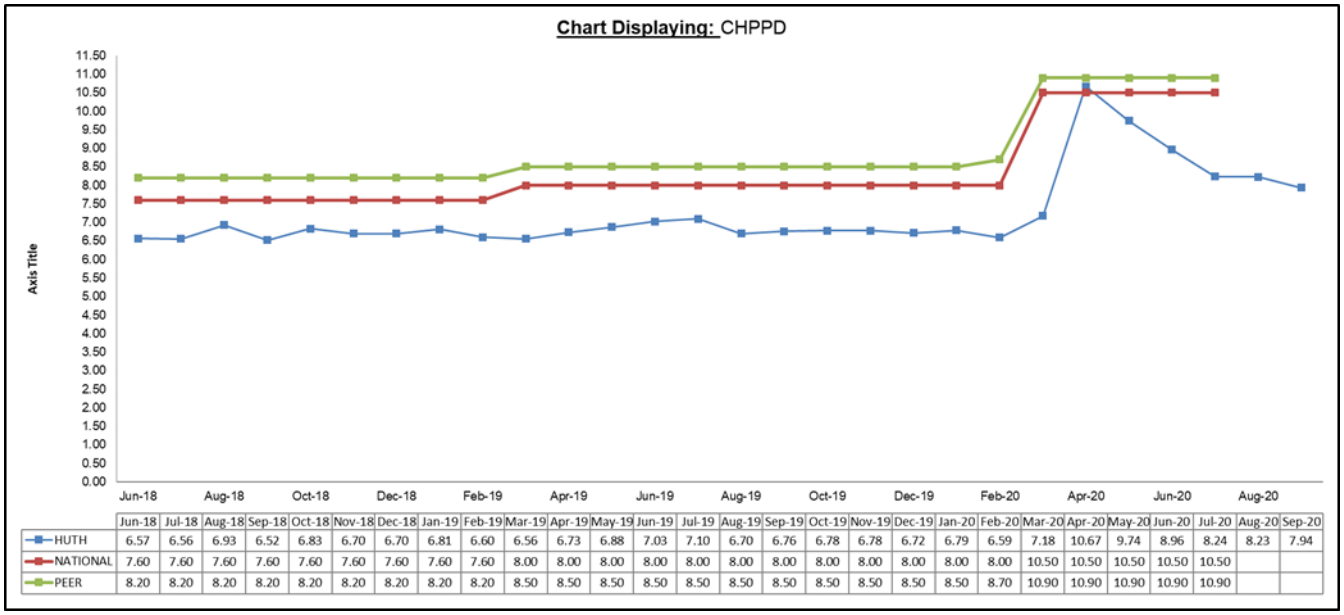
Prior to Covid-19 the Trust was pursuing a further 25 international nurses, 6 arrived prior to the enforced travel restrictions and are currently preparing for their OSCE. The remaining 19 have also commenced with the Trust and will be taking their OSCE on 10th November. In order to support the Trusts winter plan and surge capacity for Covid-19 funding was approved to recruit a further 23 international nurses (21 for Medicine and 2 for Ophthalmology theatres) who will commence employment with the Trust in November. Finally 10 theatre nurses will be recruited to support and improve the current 52 week position across surgical specialities.

In addition, there are currently 10 non-registered overseas staff employed at the Trust who currently work in unregistered nursing roles, but are qualified and will be supported to complete their OSCE and become a registered nurse.

## 6. Care Hours per Patient Days

### Care Hours Per Patient Day (CHPPD)

As illustrated below the CHPPD for September is 7.94. This has reduced from 8.23 from the previous month because patient activity increased during September. The Aspirant Nurses (second year students) also resumed their academic studies in September, 2020 and therefore are not included in the CHPPD submission for September.




| | 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 | Jul-20 | Aug-20 | Sep-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 | 8.24 | 8.23 | 7.94 |
| 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 | 10.50 | 10.50 | 10.50 | 10.50 | 10.50 | | |
| 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 | 10.90 | 10.90 | 10.90 | 10.90 | 10.90 | | |

## 7. Staff Flu Campaign

The Trust has a Board agreed action plan which commenced in October, 2020. As at 29th October the Trust has vaccinated 4,300 staff and are awaiting the next delivery of vaccines which are scheduled for 9th November. The Trust has a good track record of delivering the flu vaccine and will ensure over 80% of staff receive the vaccine.

## 8. Working from home

In order to minimise the spread of infection in the workplace we are encouraging as many staff as possible to work from home. Guidance and risk assessments are available for managers and their teams on the intranet. At the start of lockdown in March we invested in more bandwidth to enable larger numbers of staff to access our remote Pulse connection as well as hundreds of laptops to enable home working.

**9. National Staff Survey**
The National Staff Survey has been launched across all NHS Trusts to understand the current levels of staff engagement as well as other key indicators. As at 29th October 27% of our staff have completed it. The national average completion rate is currently 29%. Our aim is to achieve over 50% completion, however this will be difficult considering the challenging environment our staff are currently working in. The survey closes on 26th November, 2020

**10. Staff Support Arrangements**
The Staff Psychosocial Support service which is a partnership of our Psychological Services, Pastoral and Spiritual Care, Occupational Health and Organisational Development teams continues to support staff at whatever level of intervention is required. Health and wellbeing of our staff throughout the pandemic has and will always be a priority.

**11. Communication and engagement**
We have invested a lot of time in communication and engagement with staff over the past 9 months. Daily emails have been sent to all staff and to wards with urgent and important updates, we have restructured the intranet site, Pattie to make it easier for staff to access information and we have assigned one member of the communications team to work on Covid-19 information on a full-time basis.

In order to ensure staff feel valued we have been promoting the profiles of individuals and teams on social media, and in particular focusing on our BAME colleagues. This has been well received by the public and staff.

In our July Covid-19 staff survey over 30% of staff told us that communication was the most effective aspect of our Covid-19 response.

**12. Conclusion**
During the pandemic first wave the Trust maintained a focus on its recruitment, health and wellbeing of staff and equalities and inclusion programme and we will seek to do the same during the second wave. The Trust has tried to ensure 'staff experience' is also maintained and continue the improvement over past years, but considering the working environment and the difficult decisions that will be made, the National Staff Survey result will let us know how well we have done. The staff flu vaccination plan is robust and will achieve its goal.

**13. 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

**TRUST BOARD: TUESDAY 10th NOVEMBER**

**FINANCE UPDATE**

## 1. Purpose of Paper

To inform the Trust Board on the month 6 reported financial position, update on the level of expenditure committed in managing Covid19 and provide guidance on the Financial system that will operate in months 7-12.

## 2. Month 6 Reported Position

The Trust has reported a break-even position for the year to date at month 6 with the expected receipt of £10.6m of 'True-up' income to be received from NHSEI.

The Trust has committed £14.6m on managing the impact of covid in the first 6 months. These costs have been partially offset by underspends against the plan due to reduced clinical activity with £5.2m less being spent on theatre implants and other consumables, £1.9m less being spent on Wet AMD drugs and there have also been reductions in establishment expenses (-£1.0m)

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 £0.9m below the average monthly spend. This reflects the reduction in additional waiting lists and reduced agency costs.

The Trust has seen a reduction in "other" income across health group budgets with the main shortfalls being in Car parking (-£850k), Catering (-£562k), private patients & overseas patients (-£190k) and injury compensation scheme (-£211k). This is in line with expectations given the reduction in clinical activity along with the on-going free staff car parking and the free staff meals on offer during the first quarter.

Overall the month 6 variances, with and without Covid pressures, are summarised below:

| | Pay | Non-Pay | Income | TOTAL |
|---|---|---|---|---|
| | £'000s | £'000s | £'000s | £'000s |
| Variance non-covid | 950 | 6,789 | **(3,661)** | 4,078 |
| Covid pressures | (6,625) | (8,007) | | (14,632) |
| **TOTAL** | **(5,675)** | **(1,218)** | **(3,661)** | **(10,554)** |
| True-up | | | 10,554 | **10,554** |
| **NET POSITION** | **(5,675)** | **(1,218)** | **6,893** | **0** |

The Financial position of the first 6 months is now closed and the plan is to report the position for month 7-12 as a separate financial period. No over or under spends from the first 6 months will be carried over in to the second half of the year.

## 3. Summary Revenue Position – Months 7-12

NHSEI have now issued the financial framework that will operate for the final 6 months of the year, months 7-12. The Key principles include:

- Integrated Care Systems (ICSs) are issued with fixed funding envelopes for the second half of the year with sufficient top-up funding to bring the system to a breakeven position, using an updated version of the methodology applied in the month 1-6 financial framework.

- Block contracts will continue with commissioners with a centrally calculated deficit top up funding payment. HUTH will receive £7.7m as part of the block arrangements to enable it to break even. This is £2.0m more than the top up payment the Trust received in the first 6 months.

- High cost drugs with specialist commissioners revert back to a pass through basis. This includes Cancer Drug Fund and Hepatitis C. High cost drugs with CCG commissioners remain part of the block. This is being reviewed to determine if it will cause any pressure.

- Unlike the first half of the year, costs incurred related to covid-19 will not be covered through the retrospective top up arrangement that brought Providers into financial balance. The ICS has received funding for covid in the last 6 months and work is underway to assess the level of covid spend in each organisation.

- The Humber system has received growth funding of £5.6m based on anticipated 20/21 CCG allocation growth rates. This has been utilised within the system to offset shortfalls in CCG allocations.

- System funding envelopes are based on the expectation that organisations will return non NHS income to the levels seen in 2019/20. Recognising that this may be challenging for some, the national team will review the impact of non NHS income when assessing system and organisational performance and continue to discuss with the government the treatment of income shortfalls against the recovery expectation. The Trust has calculated that the Trust is likely to be £3.3m short of the expected level.

- The costs of covid testing will be funded from a separate income pot from the centre. The Trust currently estimates that it will spend £3.5m and that this will be fully funded.

- An elective incentive scheme has been put in place from 1st September 2020 (M6) to 31st March 2021 (M12). The scheme is designed to support the delivery of the elective ambitions set out in the phase 3 letter of July 20. Trusts will incur penalties if they do not reach the target activity volumes. The Trust submission for phase 3 did not meet the EIS targets and it is likely that the Trust will receive penalties. A crude calculation indicated that this could be around £3.5m but the Trust is still awaiting details of the scheme and the baseline. Health Groups non-pay budgets have been top sliced to create a reserve to offset this potential penalty. The top slice is based on current health group forecasts of non-pay underspends based on the activity levels that are being projected to be undertaken.

- The baseline assumes that independent sector spending will remain as per 19/20 month 8-10 average. Any variation to this level will see funding envelopes either increased or decreased accordingly.

- There is no explicit efficiency requirement set out in the planning guidance. However, there is an expectation that organisations deliver a level of efficiency to live within financial envelopes. This will be required as the Trust has received no growth funding so increases to the cost base will all need offsetting, for example ED streaming, Capital Charges, Oncology Workforce,

MRI/CT scanners. Also if covid spending continues at month 1-5 average that will also create pressures.

- Annual Leave provision. Trusts were required to include an estimated costs for a potential annual leave provision as part of their system submissions. This is estimated to be an increase of £2.7m although NHSEI will be reviewing methodologies for estimation to ensure that there is consistency across the sector. The Trust policy remains that it expects staff to take all annual leave within the leave year.

- The Trust has submitted a plan to NHSEI that has a £6.0m deficit. This is driven by 2 items:

| | |
|---|---|
| £3.3m | Other Income Shortfall |
| £2.7m | Annual leave Accrual* |
| £6.0m | Total Forecast Deficit |

## 4. Capital and cash

The reported capital position at month 6 shows gross capital expenditure of £10.7m. The main areas of expenditure relate to Capital COVID (£2.6m), Backlog maintenance (£1.4m) and Robotic Scheme (£1.2m).

The forecast position for capital expenditure (incl PFI/IFRIC12 impact) is £61.3m; this includes assumptions on the Trust receiving PDC allocations relating to emergency PDC (£4.9m); Capital Covid (£2.6m); ED Covid UEC (£4.3m); Critical Infrastructure (£5.9m); ICU (£3m). In addition the Trust has also recently been notified of additional PDC relating to Radiotherapy CTs (£1.2m) and potential funding for Adapt & Adopt (£1.2m) and Digital Aspirant (£2.5m). The Trust is waiting for confirmation of these allocations. We are confident these allocations will be spent by 31 March 2020 and the forecast reflects this. Forecasts have been reviewed in detail and the main change from last month is £2m slippage on our internal schemes funded via prior year matched funding.

The Trust has also recently had approval of the Wave 4 Urgent & Emergency care Business Case (£10.5m), however due to delays in approval and to ensure an accurate forecast is included at M6, the Trust has slipped £6m into 21/22.

The Trust received the final receipt from the sale of land at CHH (£3m) in October.

The Trust's liquidity position remains relatively healthy and very little change from last month, with a cash balance of £78.7m and this continues to be driven mainly from the payment of the 2 months of contract income during April. The forecast cash position assumes that there are 12 block payments in the year and therefore that the current cash gain from an additional block payment is neutralised by year-end. Indicative forecasts suggest a cash balance of circa £20m by year- end but this is heavily dependent on the timings of payments associated with the capital programme and the finalisation of the plans associated with the financial framework from month 7 onwards.

## 5. Summary

Subject to the final sign off on 'tru-up' income the Trust has achieved its break-even financial plan for the first 6 months of the year. The budget position for the first 6 months is now frozen. No over or under spends will be carried forward into the second 6 months.

The Financial framework for the second 6 months has now being set by NHSEI. The top up system no longer exists. The Trust has been given a financial envelope in which it is expected to achieve break-even. The Trust has submitted a plan that says it will be £6.0m overspent in the final 6 months due to reduced other income and the potential for an annual leave accrual.

## 6. Recommendation

Trust Board is asked to approve the following:

a) Retrospective approval of the submitted financial plan of £6.0m deficit linked to reduced income and potential requirement for an annual leave accrual

**Stephen Evans**
Deputy Director of Finance
October 2020

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Tuesday 10 November 2020**

| | |
|---|---|
| **Title:** | Ethics Committee Terms of Reference Annual Review |
| **Responsible Director:** | |
| **Author:** | Stuart Hall, Vice Chair |

| | | |
|---|---|---|
| **Purpose:** | To present the current terms of reference for approval | |
| **BAF Risk:** | N/A | |
| **Strategic Goals:** | Honest, caring and accountable culture | ✓ |
| | Valued, skilled and sufficient staff | |
| | High quality care | |
| | Great local services | |
| | Great specialist services | |
| | Partnership and integrated services | |
| | Financial sustainability | |
| **Summary of Key Issues:** | The Terms of Reference remain current and no amendments are proposed. | |

| | |
|---|---|
| **Recommendation:** | The Trust Board is asked to approve the current terms of reference already reviewed by the Ethics Committee in October 2020 |

**Hull University Teaching Hospitals NHS Trust**

**Ethics Committee**

## 1. Formation of this Committee

This committee was originally convened during the Covid-19 pandemic in early 2020. It is considered there is a continued role for the Trust to retain an Ethics Committee at Board sub-committee level to provide an ethical consideration of **developments** in the Trust. It retains one of the original aims of the committee, which is to promote the highest standards of ethical and clinically responsible conduct and decision-making, monitor compliance with organisational conduct with this regard and identify good practice and opportunity for improvement.

The continued role of the Ethics Committee is to provide ethical consideration of Trust decision-making, to ensure the organisation continues to progress on the basis of sound ethical considerations and that looking at decision through an ethical lens demonstrates positive consideration by the Trust of the ethics involved in the Trust's plans and service delivery.

The authority of the Ethics Committee is derived from being a sub-committee of the Trust Board. It will formally report to each Trust Board meeting to record decisions and issues arising. In exceptional circumstances it will escalate any significant matters that the Ethics Committee deems of such importance to the Trust Chairman and Chief Executive.

## 2. Role of the Committee

## 2.1 Committee Objectives

### 2.1.1 Organisational Decision-Making

- Receive by referral Trust plans and decisions being taken on future strategy, direction of travel, service developments and partnerships, to provide consideration and feedback of proposed decisions from an ethical point of view

### 2.1.2 Clinical Policy

- Agree any new guidance or Trust-wide policy on urgent clinical decision-making from an ethical point of view.
- Agree any changes or new system for clinical prioritisation of patients during major events, such as pandemic or similar critical situations
- Design a system for supporting clinicians at the time of making these difficult decisions.
- Design a system for reviewing the process and outcomes when difficult decisions have been made
- Rapidly review and circulate national guidance as this becomes available, taking local decisions on behalf of the Trust as to how to apply new guidance
- Endorse and circulate good practice already in use that provides valuable guidance to clinicians on clinical prioritisation based on clinical need

## 3. Membership

The membership will be:
Non-Executive Director of the Trust
Chief Medical Officer and/or Associate Chief Medical Officer
Chief Nurse or Deputy Chief Nurse
Nominated clinical representation

Director of Corporate Governance and/or Deputy Director of Quality Governance and Assurance
Chaplaincy
Patient Representative
Clinical Commissioning Group representative

**4. Chair of the group**
The chair of the group shall be the Non-Executive Director; in their absence, the Chair is to nominate a meeting chair.

**5. Quorum**
It is anticipated that all members will be present at all meetings, however a meeting will be considered quorate with the minimum presence of a chair or nominated meeting chair, one of the Chief Medical Officer/Associate Chief Medical Officer/Chief Nurse/Deputy Chief Nurse, one panel representative and a governance representative

**6. Meetings**
The Committee shall meet quarterly and meetings stepped down if not needed. A meeting will be held as soon as possible following establishment.

Urgent meetings can be convened through the chair at any time and through the published process.

Meetings will be held remotely and may involve the use of telephone, and electronic messaging and conferencing facilities. Patient identifiable material will not be disclosed directly to the committee unless necessary and if so will be circulated to the necessary members securely following Information Governance protocols.

**7. Attendance at meetings**
Other stakeholders and employees will be invited to attend by the chair as required.

**8. Notice of meetings**
Meetings of the Committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Group not less than 1 working day before the date of the meeting.

**9. Agenda and action points**
The agenda and action points of all meetings of the Committee/Group shall be produced in the standard agreed format of the Trust and kept by the Committee administrative support. Where significant difference of opinion is expressed in the meeting about a key decision the dissenting voice opinion shall also be recorded if the member requests it. If, exceptionally, a member of the ECPPC has a serious concern with either the conduct of the Committee or of the outcome agreed by the Committee the member has the right to raise it directly with the Chief Executive or, in their absence, the Chair of the Trust Board.

The decisions of the Committee and agreed guidance will be published by the administrative support on Pattie as well as through the Trust's Gold Command circulation.

The decisions made by the Committee will be reported to the next available Trust Board meeting.

**10. Reporting arrangements**
The proceedings/minutes of each meeting of the Committee/Group shall be shared with Gold Command and be circulated to members of the Trust's Executive Management

Committee as well as to the Trust Board as set out above in section 1. The absence of any meetings should also be reported formally.

**11. Authority**

The Group is authorised by the Trust Board through the Executive team to plan and deliver actions within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are required to co-operate with any request made by the Committee.

Date terms of reference agreed by the Trust Board:
Date terms of reference due for review:

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Tuesday 10 November 2020**

| | |
|---|---|
| **Title:** | Audit Committee Terms of Reference Annual Review |
| **Responsible Director:** | |
| **Author:** | Rebecca Thompson – Corporate Affairs Manager |

| | | |
|---|---|---|
| **Purpose:** | To present the current terms of reference for approval; the Terms of Reference were last reviewed in May 2019. | |
| **BAF Risk:** | N/A | |
| **Strategic Goals:** | Honest, caring and accountable culture | ✓ |
| | Valued, skilled and sufficient staff | |
| | High quality care | |
| | Great local services | |
| | Great specialist services | |
| | Partnership and integrated services | |
| | Financial sustainability | |
| **Summary of Key Issues:** | The Terms of Reference remain current and no amendments are proposed. | |

| | |
|---|---|
| **Recommendation:** | The Trust Board is asked to approve the current terms of reference already reviewed by the Audit Committee in October 2020 |

**Hull University Teaching Hospitals NHS Trust**

**Audit Committee**

**Terms of Reference**

## 1 Constitution

### 1.1 Establishment

The Trust Board has established an Audit Committee (The Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. This committee reports directly to the Board.

### 1.2 Membership

The Committee shall be appointed by the Board from amongst the Non Executive Directors of Hull University Teaching Hospitals NHS Trust ("the Trust") and shall consist of not less than three members. The Chairman of the Trust shall not be a member of the Audit Committee. Appointments to this Committee shall be made by the Board in consultation with the Audit Committee Chairman. Appointments to be for an initial period of up to 3 years, extendable by no more than one additional 3 year period.

### 1.3 Quoracy

A quorum shall be two members.

### 1.4 Attendance

(a) The Chief Financial Officer, Director of Corporate Affairs, Head of Internal Audit, the Trust's nominated Local Counter Fraud Specialist and representatives of the External Auditors shall normally attend meetings advising the Committee on pertinent issues / areas. The Committee will meet in private with External and Internal Auditors without any Executive Directors or members of the Trust staff present at least once a year.

(b) The Chief Executive, other Directors or lead officers may be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that individual.

(c) The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

(d) The Trust Secretary, or assistant, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair of Committee and its members.

### 1.5 Meetings

Meetings shall be held not less than five times a year. The Chair of the Committee can call additional meetings as required to discuss urgent business. Members are expected to attend at least 75% of meetings per year.

## 2 Authority

### 2.1 Authority to investigate and seek information

(a) The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

(b) The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant expertise if it considers this necessary.

## 3 Role and Purpose of the Audit Committee

The duties of the Committee are:

### 3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:-

(a) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board.

(b) The structures, processes and responsibilities for identifying and managing key risks facing the organisation in particular the Board Assurance Framework -including the link with the corporate risk register.

(c) The underlying control and assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements.

(d) The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

(e) Consider and review the Annual Information Governance Toolkit (or replacement requirements) and the Data Quality Reports.

(f) Trust arrangements to meet the requirements of the General Data Protection Regulations that apply from 25 May 2018.

### 3.2 Power to seek reports and assurances

In carrying out this work the Committee will primarily utilise the work of Internal Audit, Counter fraud**,** External Audit and other assurance functions, but will not be limited to these audit functions. It may also seek reports and assurances from Directors and managers as appropriate, concentrating on the over arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The Committee will receive the

minutes of the Board's Performance and Finance Committee, Quality Committee and Charitable Funds Committee to inform its assurance work.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.3 **Internal Audit**

The Committee shall ensure that there is an effective internal audit function established by management; that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee.

It will:-

(a) Recommend the appointment of the Internal Auditors to the Board, approve the annual fee and consider any questions of resignation and dismissal.

(b) Review and approve the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework and Strategic Plans.

(c) Consider the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

(d) To review progress on implementing internal audit recommendations.

(e) Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

(f) Monitor the effectiveness of internal audit through their annual review

3.4 **External Audit**

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

This will be achieved by:-

(a) Recommending to the Trust Board the appointment of the External Auditor.

(b) Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.

(c) Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

(d) Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission

to the Board and any work undertaken alongside the annual audit plan together with the appropriateness of management responses.

(e) Review and monitor the external auditor's independence and objectivity, taking into account relevant UK professional and regulatory requirements.

3.5 **Financial Reporting**

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focussing particularly on:-

(a) The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

(b) Changes in, and compliance with, accounting policies, practices and estimation techniques.

(c) Unadjusted mis-statements in the financial statements.

(d) Letter of Representation.

(e) Significant judgements in preparation of the financial statements.

(f) Significant adjustments resulting from the audit.

3.6 **Other Assurance Functions**

3.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Improvement, NHS Litigation Authority etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

3.6.2 In addition, the Committee will consider the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This Committee also needs to be review the assurances gained from clinical audit activities in the organisation.

3.6.3 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.6.4 The Committee will seek annual assurance that a current, clear and effective Whistleblowing or Protected Disclosures Policy is in place and that all Trust staff have access to this policy. One Non Executive Director under the current policy (reference CP169) will be one of a number of internal contacts available to consult and be the "Whistleblowing Champion" of the Trust.

3.7 **Reporting**

3.7.1 The minutes of the Audit Committee meetings shall be approved by the Chairman of the Audit Committee and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.7.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and effectiveness of risk management in the organisation, the integration of governance arrangements and produce an annual work plan.

3.8 **Other Matters**

The Committee shall undertake reviews of:

- Risk register
- Write offs and compensations
- Outstanding debtors over £50,000 and 90 days or more outstanding.
- Fraud register
- Decision to waive tender procedures
- Offers of hospitality/gifts and sponsorship
- Review of Standing Orders and Standing Financial Instructions and approval of proposed changes
- Waiver of Standing Orders
- Going Concern Reviews
- Corporate credit card expenditure
- Legal expenditure

3.9 **Administration**

The Committee shall be supported administratively by the Trust Secretary, or assistant and the Deputy Director of Accounting and Treasury. Their duties in this respect will include:

- Agreement of each agenda with the Chairman and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues
- Enabling the development and training of Committee members

**4 Monitoring Compliance with these Terms of Reference**

The Trust Secretary and the Chairman of the Committee have a joint responsibility for ensuring compliance with these Terms of Reference. Any member or person in attendance who considers compliance with these Terms of Reference is at risk should bring their concerns to the attention of the Trust Secretary.

Date previously ratified by Trust Board: May 2019

Review date: October 2020

Date ratified by Trust Board:

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 2020**

| | |
|---|---|
| Title: | Quality Accounts 2019/20 |
| Responsible Director: | Beverley Geary – Chief Nurse |
| Author: | |

| | | |
|---|---|---|
| Purpose: | To provide an updated position to the Board regarding the Quality Accounts process. | |
| BAF Risk: | BAF Risk 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 Quality Accounts attached are currently out with stakeholders for their statements, which are due by 12 November 2020. The Quality Accounts are due to be finalised, approved and published by 15 December 2020. | |

| | |
|---|---|
| Recommendation: | The Board is asked to delegate authorisation of the Quality Accounts to the Quality Committee. |

Hull University Teaching Hospitals NHS Trust

# HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST QUALITY ACCOUNT 2019/20

Remarkable people.
Extraordinary place.

# Contents

# Part 1: Introducing Our Quality Account

This section includes:

# Statement on Quality from the Chief Executive

## Welcome to Hull University Teaching Hospitals NHS Trust's 2019/20 Quality Account…

I am pleased to present Hull University Teaching Hospitals NHS Trust's Quality Account. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2020/21. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.

In Part 3 of this report we set out the quality and safety improvement priorities for 2020/21. These priorities were identified through consultation with staff, Trust members, Health & Wellbeing Boards, Healthwatch, Clinical Commissioning Groups and the local community. As a result, the following quality and safety improvement priorities were identified:

### Safer Care (Patient Safety)

1. Reduction of inpatient falls of patients who have a diagnosis of Dementia and have an inpatient fall within the Department of Elderly Medicine
2. Development of a standardised safety brief framework
3. Reduction in line infections in our surgical specialities
4. Increase "stop the line" reporting and improve staff engagement and satisfaction with the new reporting process and increase measurable actions

### Better Outcomes (Clinical Effectiveness)

1. Improve mental health triage in the Emergency Department
2. Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

### Improved Experience (Patient and Staff Experience)

1. Improved framework of preceptorship for new registrants to ensure they are supported and develop in to confident and competent practitioners
2. Improve patient and public involvement across the Trust

Many staff and our stakeholders have been involved in the development of the Quality Account. Comments from the stakeholders on the content of the Quality Account are included in full in the Annex of this report.

We welcome involvement and engagement from all staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2019/20 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

**Chris Long**
**Chief Executive**

# What is a Quality Account?

## What is a Quality Account?

The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

## What should a Quality Account look like?

Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). This toolkit can be accessed via https://www.gov.uk/government/news/quality-accounts-toolkit.

The Quality Account must include:

### Part 1 (Introduction)

- A statement from the Board (or equivalent) of the organisation summarising the quality of NHS services provided

### Part 2 (Looking back at the previous financial year's performance)

- Organisation priorities for quality improvement for the previous financial year
- A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

### Part 3 (Looking forward at the priorities for the coming financial year)

- A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience
- A series of statements from Stakeholders on the content of the Quality Account

## What does it mean for Hull University Teaching Hospitals NHS Trust?

The Quality Account allows NHS healthcare organisations such as Hull University Teaching Hospitals NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas e.g. service delivery and to inform the public of its future quality plans and priorities.

## What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare organisation it is scrutinising each and every one of its services, providing particular focus on those areas that requires the most attention.

## How will the Quality Account be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically on the NHS Choices website by 15 December 2020*. Hull University Teaching Hospitals NHS Trust also makes its Quality Account available on the website: http://www.hey.nhs.uk/about-us/corporate-documents/

**Due to the National COVID-19 Pandemic Response, work on the annual Quality Accounts was temporarily stopped and the timeframe for publication set out in regulation was deferred.*

If you require any further information about the 2019/2020 Quality Account, please contact the Compliance Team on: 01482 482352 or e-mail us at: quality.accounts@hey.nhs.uk

# About Us

We employ just over **7,000 whole time equivalent staff** and are supported by **300 volunteers**

We have **two** main hospital sites: **Hull Royal Infirmary** and **Castle Hill Hospital**

We have an **annual income** of circa **£560 million**

Secondary care services are provided to a to a catchment population of approximately **600,000** in the **Hull and East Riding of Yorkshire** area

The Trust also provides specialist and tertiary services to a catchment population of between **1.05 million and 1.25 million** extending from **Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire** respectively

We saw over **134,000** patients in our **Emergency Department** last year

We admitted over **160,000** patients into our **wards** last year

Over **780,000** patients attended an **Outpatient Department** last year

We delivered over **4700** babies in our **Women's and Children's Hospital** last year and over **500** of these in our **Fatima Allam Birth Centre**

The **vision** of the Trust is:
**'Great Staff, Great Care, Great Future'**

We have a set of **organisational values**:
**'Care, Honesty, Accountability'**

# What Our Patients Said in 2019/20

"Being my first pregnancy I was really scared. The team there really helped me stay calm and relaxed"

"A ward where I felt my dad was safe and surrounded with professionalism"

"…took the time to reassure him and explain carefully his options…"

"…doing a fantastic job of providing quality care. We couldn't have felt more looked after at a difficult time…"

"The level of care received was of high quality and dignity was maintained throughout"

"Since arriving I have been treated with respect and excellent care. Thank you to all concerned"

"The staff members we met were so kind and it was so reassuring to get immediate answers to my questions. It's obvious how much care and pride they take in their work."

"…it was great to be cared for by such empathetic, conscientious and friendly staff…"

"The treatment my father received was timely, thorough, profession and kind."

"The whole team were responsive to not only my dad's medical needs but made a terrifying experience for him bearable and positive within their levels of care shown"

# Celebrating Success in 2019/20

## Greatix – Positive learning

Excellence in healthcare is everywhere; we believe that capturing excellence creates opportunities for learning and can improve our resilience and morale. It is important that we learn from things that do not go so well, but we can also learn when they do. So when a member of our staff sees some great teamwork, a new way around a problem, or want to tell us about someone who's been really helpful, they can fill out a Greatix excellence report. The person or team they have nominated are contacted to thank them and the Greatix will be disseminated to celebrate and to discuss what we can learn, both individually and as an organisation.

Almost 200 Greatix reports have been submitted over the last year. Below are some examples:

*"I have just finished my Nurse Training. My last placement as a 3rd year student was on Ward 30 at CHH with **Robert Holmes** as my mentor. Rob encouraged me to believe in myself when at times I doubted my abilities and knowledge as a soon to be qualified nurse. Alongside this the whole of Ward 30 made me feel like I had always been part of their team and treated me like one of their own; valuing my opinions and recognising me as a team member and not just as a student who was only there for a short time."*

*"Our housekeeper, **Michelle Baron**, on ward one is one in a million. She goes well above and beyond to help all staff especially when we are short staffed. She is there to sort out any problems we may have"*

## Moments of Magic

The Moments of Magic is a Trust established recognition scheme, which acknowledges staff who go above and beyond to provide great care to patients, staff and visitors. Whether it is a friendly gesture, an act of kindness or simply a way of putting people at ease when they may be anxious or upset, these are the kinds of thing which can make a big difference to people in our care, and which make us all proud of our local hospitals and the wider NHS. Below is a sample of some of the over 900 'moments of magic' that were recognised within the last year:

*"**Maggie Moran**, Senior Physiotherapist was on our ward talking to a patient and their relative. The relative was concerned if the patient would receive some medication before discharge which had previously been discussed with them by the medical staff. Even though she was really busy Maggie went down to pharmacy to make sure the medication was available and the issue was quickly resolved. Her help was especially appreciated on this occasion by both patient and staff"*

*"**Emma Chaffer** went above and beyond her role to recover a patient's medical records. Without her help the patient would have missed the slot for the combined procedure they required"*

*"**Jamie MacGregor** was working a run of night shifts and a patient deteriorated on his first night quite rapidly, he accompanied them to Cardiothoracic (CT) and did not leave the patients side all night long, he was fantastic with the family members and sacrificed having a break in order to make sure the patients care came first. His quick recognition of the patient deteriorating ensured that family could be called to the hospital in order to be with their family member. Following this the same happened on the next night shift in a similar situation. In this particular case he accompanied the patient down to the Intensive Care Unit (ICU) even though it was after his shift had finished in the morning."*

## Innovation and Good News

### Patient Safety Campaign 'Stop the Line' launched to mark World Patient Safety Day


The campaign aims to encourage, empower and support every member of staff, regardless of job title, to speak out when they see something unsafe to prevent patient harm.

### Success at Black, Asian and Minority Ethnic (BAME) Health awards

At the national BAME Health and Care Awards consultant obstetrician Uma Rajesh was named Clinical Champion of the Year and consultant gastroenterologist and Prof Shaji Sebastian won the award for 'Ground-breaking Researcher'. Also shortlisted for awards were Head of Patient Experience, Louise Beedle, Midwife Melanie Lee, Consultant Interventional Radiologist Raghuram Lakshminarayan, and Chief Executive Chris Long.

### Bereavement midwife nominated by families wins prestigious national award

Specialist Bereavement Midwife Sue Cooper won the award from the Charlies-Angels-Centre Foundation after she was nominated by some of the families she has cared for when their babies have died. As well as her hard work and dedication in helping families whose children have died, Sue has also developed the Bereavement Service to ensure families in Hull and the East Riding get the best possible support. At a regional and national level, she has developed links with the Yorkshire Clinical Network and has played a major role after the Trust was chosen as a pilot site for the development of a National Bereavement Care pathway.

### Justin achieves his nursing dream in Hull after seven years in a refugee camp, he's now been nominated for a national award for his outstanding contribution

Justin spent seven years in a refugee camp, watching the sick and dying suffer with little access to nursing or medical help. Justin Mwange fled to Zambia from the war-torn Democratic Republic of Congo as a teenager with his family and spent seven years living in abject poverty and deprivation. What he saw in the camp fuelled his passion to help the sick and vulnerable. Despite his lack of formal education or access to financial support to further his studies, he was determined to become a nurse. Justin has now been nominated for a Chief Nursing Officer's award in the category of BAME Student Diversity by Vicky Needler, Practice Learning Facilitator at the Trust after achieving his dream of becoming a nurse and impressing staff throughout his placements at Hull Royal Infirmary and Castle Hill Hospital.

### First flight touches down on hospital's new £500,000 helipad

A five-person crew from Lincolnshire and Nottinghamshire Air Ambulance was the first to fly in and step foot on the completed helipad to the rear of Hull Royal Infirmary in August 2019. The Trust has undertaken a major construction project so patients seriously hurt in accidents across East and North Yorkshire and parts of Lincolnshire can be flown into the hospital grounds, the Major Trauma Centre (MTC) for the area. The helipad, situated behind Hull Royal Infirmary's £12m Emergency Department, has been funded entirely by the HELP (Helicopter Emergency Landing Pads) Appeal.

### Radiotherapy Physics MPACE accreditation

The Radiotherapy Physics Team at the Queen's Centre at Castle Hill Hospital have become the first such team in

the country to achieve a new standard which assures cancer patients of quality care. The Medical Physics and Clinical Engineering (MPACE) accreditation scheme independently reviews all aspects of healthcare science which underpin the radiotherapy treatment provided to patients, including safety, treatment planning and equipment maintenance.

### Emergency Department (ED) staff from Hull have inspired a new nationwide promotional campaign centred on patients with a learning disability


The Learning Disability (LD) pledge was promoted by the Makaton Charity as part of Learning Disability Awareness Week in June 2019. The pledge is based on a piece of work authored by Consultant, Dr Liz Herrieven and play specialist, Laura Burton. Their ED Pledge laid the foundations for the LD Pledge, a national movement which seeks to raise awareness of the needs and rights of people with a learning disability in accessing equitable health care.

### Trust receives a share of £500K to create Changing Places for disabled visitors

Following a successful bid for capital funding, the Trust will receive £105,000 of Government money to create four new 'Changing Places' facilities across both Hull Royal Infirmary and Castle Hill Hospital. Hull is one of ten NHS Trusts to receive a share of half a million pounds for this purpose.

### Shining bright at city's Health and Care awards

At the Hull Daily Mail Health and Care Awards, Hull University Teaching Hospitals NHS Trust (HUTH) teams claimed some of the most notable awards going after a total of seven teams and individuals were nominated. Storming to victory as 'Team of the Year' was our Neonatal Team. Outstanding Health Professional of the Year was awarded to Consultant in Rehabilitation Dr Abayomi Salawu, while Day Surgery Nurse Gilly Macleod was named Outstanding Nurse of the Year. John Drury, a familiar face at the front of the HRI tower block reception, was also named Volunteer of the Year.

### Unused hospital wheelchairs to help landmine victims in Africa

deso
Disabled Equipment Sent Overseas

Old wheelchairs no longer required by hospital patients were sent to Africa to help children and adults who have had limbs blown off by landmines. The Trust transported 34 wheelchairs, once destined for recycling as scrap metal, to Disabled Equipment Sent Overseas (DESO). Environmental Support Officer Gavin Lee discovered the charity's work as he searched for a solution to prevent still-usable equipment being sent for scrap metal. Gavin is also sourcing crutches and walking frames which are no longer required by the NHS to add to the collection.

### A member of the Facilities Team has been awarded the MBE for his services to the environment

Dawda Jatta joined the Trust as a monitoring officer, ensuring the hospitals meet environmental and hygiene standards and in 2019 celebrated after he was awarded the MBE in the Queen's Birthday Honours for Recycling and Energy Saving. Dawda founded BAMEEN (Black and Minority Ethnic Environment Network), a community organisation promoting recycling, energy saving, local food production and environmental educational training programmes to BAME groups in Hull and the East Riding.

health expo
hull and east riding

# Performance against Priorities 2019/20 – summary

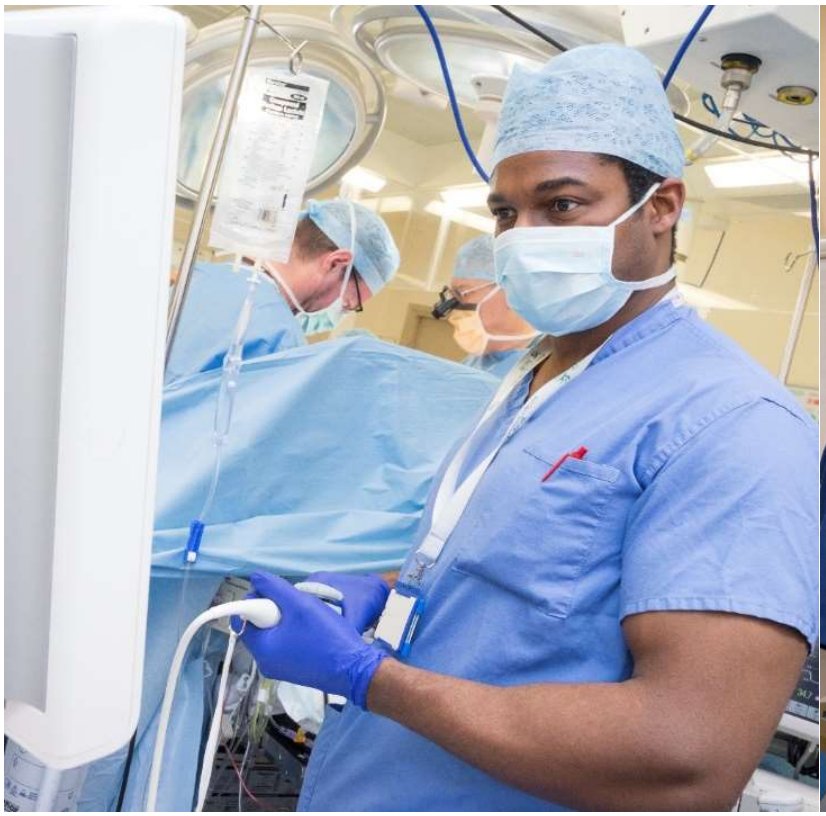
The Quality Improvement Plan (QIP) is a high-level plan which defines the improvement goals the Trust is working towards for improving quality and safety across the organisation. The plan includes the 'must do' and 'should do' actions from any Care Quality Commission (CQC) inspections alongside areas of work the Trust is pursuing to improve, quality and safety priorities as detailed in the Quality Account. This year the QIP had projects in place, all of which were linked to the 10 Quality and Safety Priorities as set out in the 2018/19 Quality Account, with the exception of VTE. The achievements of the VTE priority are detailed in section 2.1.

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |

| | Project | Indicator | Achieved |
|---|---|---|---|
| ▲Safer Care | Nutrition and Hydration | 95% of patients weighed within 24hrs of admission | ↗ |
| | | 90% of patients weighed every 72hrs | ↗ |
| | | 95% of weighs plotted on weight graph | ↗ |
| | | 90% of weight recorded on Drug Chart | ✓ |
| | | 95% of daily Nutrition Risk Assessments | ↗ |
| | | 95% of appropriate referral to Dietician | X |
| | | 95% of care plan states "low, Medium or High Risk" | ↗ |
| | | 80% of hydration charts completed | ↗ |
| | Medicine Optimisation | 70% of dispensing discharge prescriptions within an hour for patient lounge by March 2020 | ✓ |
| | | 50% increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020 | ✓ |
| | Deteriorating Patient | 90% of patients that have a NEWS Score above 1 have evaluation which states actions taken or escalation documented | ↗ |
| | Pressure Ulcers | Completion of Root Cause Analysis (RCA) in 14 days | X |
| | Acute Kidney Injury (AKI) | Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition. | ↗ |
| | | Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored. | ↗ |
| | | Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected. | ↗ |

| | Priority | Indicator | Achieved |
|---|---|---|---|
| ▲Better Outcomes | VTE | 0 VTE Serious Incidents | ✓ |
| | | 95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital | ↗ |
| | Dementia | 75% dementia / delirium screening pathway completed in the medical document | ✓ |
| | | 75% of online dementia/delirium screening tool completed | ✓ |
| | | 75% of dementia diagnosis documented in the medical notes | ✓ |
| | | 75% of Butterfly displayed at the bedside | ↗ |
| | | 75% of the Butterfly icon in place on Cayder | ✓ |
| | | 75% of Reach Out To Me document at the bedside | ↗ |
| | | 75% compliance with two members of staff able to articulate the meaning of Johns Campaign & Butterfly Scheme on each ward | ✓ |
| | | 75% of clinical areas displaying poster regarding Johns Campaign | ✓ |
| | | 75% of clinical areas displaying poster regarding Butterfly Scheme | ✓ |
| | Mental Health | 95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm | ✓ |
| | | Established bi-monthly Mental Health Committee | ↗ |
| ▲Improved Experience | Outpatient Services | 90% of OP areas rated green or blue Patient Experience Fundamental Standard | ✓ |
| | | 90% of OP areas rated green or blue Staff Experience Fundamental Standard | ✓ |
| | | Outpatient Governance Committee held | ✓ |
| | | 98% Friends and Family Test Scores for Outpatients | ✓ |
| | | Increase in positive compliments or comments on NHS Choices | X |
| | | Improved waiting times at clinics | ↗ |
| | Patient Experience | Reduce the number of reopened complaints due to dissatisfaction by 10% | X |

# Part 2: Priorities for Improvement and Statements of Assurance from the Board



This section includes:

# 2.1 Performance Against Priorities 2019/20:

This section covers:

- Safer care
- Better outcomes
- Improved experience

# Safer Care: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To improve nutrition and hydration

#### Why was this important?

The provision and administration of nutritious food is essential to patient care; effective nutritional care is paramount to recovery and improved patient outcomes. Improving hydration brings well-being and better quality of life for patients. Being well-hydrated also helps medicines to work more effectively. The completion of nutrition and hydration risk assessments was identified as an area requiring improvement by the CQC in February 2018.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aims of this project were:

- To ensure patient's nutrition and hydration needs are risk assessed in accordance with Trust Nutrition and Hydration Policy (CP335)
- To ensure patients are weighed in accordance with Trust Policy (CP335)
- To ensure that patients are fasted pre-operatively in accordance with Trust Policy (CP335)

#### How did we perform?

The project completed a number of actions including:

*To ensure patient's nutrition and hydration needs are risk assessed:* The performance indicator for '95% of care plan states "Low, Medium or High Risk"' was not achieved in the year; however, a good improvement has been demonstrated from 79.7% in April 2019 to 85.3% in March 2020 and the average performance for the year was 82%. Therefore, progress is being made. It is expected that the rollout later in 2020 of electronic documentation will have a positive impact on the completion of forms.

*Ensure that patients are weighed in accordance to Trust Policy (CP335):* Compliance with has been less than optimum against target. The compliance against the targets have seen significant fluctuations, therefore, further improvements are required.

*Ensure that patients are fasted pre-operatively in accordance with Trust Policy (CP335):* This aim was linked to an action from the 2018 CQC inspection which found that a consistent and agreed approach to fasting was required. This remains on the work plan of the Surgery Health Group and a re-audit was completed in January 2020. The audit lead was able to provide some comparison against the 2018, 2019 and 2020 audits which suggested that there was an increase of 11.16% of patients fasting between 0-2 hours which is the optimum time for fasting. In addition, reductions were demonstrated in fasting over 4 hours by 20.6%. Therefore, further improvements are required.

*Implementation of Monthly Ward Based Nutrition and Hydration Auditing:* In 2019, the Trust continued to rollout a program of ward based monthly auditing, called the Matron's Handbooks. These audits include a range of key topics, including hydration and nutrition. The completion of the handbooks was a particular drive for nursing staff over the year, as completion of these audits provides up-to-date and accurate compliance data with a number of topics relating to the Quality and Safety Priorities, including the ones detailed in the following performance table.

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| 95% of patients weighed within 24hrs of admission | 84.5% | 87.2% average ↗ |
| 90% of patients weighed every 72hrs | 74.3% | 80.2% average ↗ |
| 95% of weighs plotted on weight graph | 74.4% | 84.2% average ↗ |
| 90% of weight recorded on Drug Chart | 88.3% | 91.5% average ✓ |
| 95% of daily Nutrition Risk Assessments | 92.4% | 94.4% average ↗ |
| 95% of appropriate referral to Dietician | 92.6% | 88.1% average X |
| 95% of care plan states "Low, Medium or High Risk" | 77.4% | 82% average ↗ |
| 80% of hydration charts completed | 45.8% | 69.6% average ↗ |

*Assisted Feeding:*

The Trust has an assisted feeding process, which has been in place for a number of years. This has been strengthened in 2019/20 by the use of red trays and lids to identify those who need assistance with feeding and drinking and ward personnel designated to support those patients at mealtimes. Family members are encouraged to support their relations at mealtimes and mealtimes are protected from ward rounds, nursing interventions or other medical or clinical care whilst patients eat. The Trust also introduced staggered ward services to allow more staff to be available to help those patients who need support at mealtimes.

*'Cake and Shake' Rounds:*

A 'Cake and Shake' round was introduced in 2019 on those wards with a high proportion of elderly and frail patients. Staff give patients a piece of cake and choice of milkshake every day. The cakes and milkshakes are provided to patients to increase their calorie intake, to aid their recovery and help improve their mental health. Some patients are often unable to finish meals and prefer to eat in a different frequency to those set out for the majority of patients, and this additional round helps increase essential high-calorie intake for those patients most in need. The project success was measured by the monitoring of several key indicators. These are detailed below along with how the Trust performed:

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

As the performance table demonstrates, not all the targets were achieved. It must be noted that all targets with the exception of one has made improvement demonstrating good progress achieved overall.

## Going forward

This priority will be carried forward for further action and monitoring.

The delivery of optimum Nutrition and Hydration for our patients continues to have a high profile within the Trust and we are committed to finding new ways to improve patient's nutritional care whilst in hospital. Monitoring of the key indicators will continue as part of the Matron's Handbook audits as will the annual Nutrition Census and Fasting / Nil-by-mouth audit.

All residual actions will be monitored by the Trusts Nutritional and Hydration Steering Committee.

# Safer Care: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

## Priority: To improve medicine optimisation

### Why was this important?

Medicines optimisation is defined by the National Institute for Health and Care Excellence (NICE) as 'a person-centred approach to safe and effective medicine use, to ensure people obtain the best possible outcomes from their medicines.

### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aims of this project were:

- To improve key aspects of the medicines management discharge process by increasing referrals to the 'Transfer of Care around Medicines Scheme'
- Improve turnaround times of dispensing discharge prescriptions for the patient lounge
- Improved timeliness of Immediate Discharge Summary (IDS) from the Boots Pharmacy to the Queen's Centre wards
- Improved accessibility of oral nutritional supplements (SIP feeds) on wards

### How did we perform?

The project completed a number of actions including:

*Increasing the Number of Referrals to the 'Transfer of Care around Medicines Scheme':*

The scheme focuses on patients in hospital who have been identified as requiring additional support with their essential medication. These patients are then referred through a secure digital system, to their local community pharmacy at the point of discharge.

This improves integration between care settings. It was first implemented in 2019 on the Cardiology Wards at Castle Hill Hospital before being rolled out to 17 wards in total across both sites. 100% of rotational pharmacists and pharmacy assistants have been trained following a launch event held in June 2019.

A user guide for community pharmacists and a Patient Information Leaflet was developed to provide guidance and information to support the delivery of the scheme. The target for the year was to improve the number of referrals to the scheme by 50%, from 84 to >126. This target has been met and the number of referrals increased exponentially to over 500.

*Improving the percentage of Discharge Prescription Dispensed within One Hour with the Discharge Lounge:*

Discharging patients from hospital can be a time consuming process and often results in patients waiting for their medicines. The Discharge Lounge is a safe place for patients to wait for transport to their home address or for medications. The Trust wanted to improve the length of time people were waiting for medications in the Discharge Lounge, so the aim to have 70% of mediations dispensed within one hour for those patients waiting in the lounge was agreed.

In June 2019 a Medicine's Management Assistant was placed in the Discharge Lounge to help facilitate this aim. A tracking system was also introduced to help identify not only the time taken to dispense the prescription but any issues that make the prescriptions take longer. The baseline figures showed 53% of prescriptions were dispensed within an hour.

Between May 2019 and March 2020 performance against this target achieved 72% of prescriptions were dispensed within one hour, demonstrating an improvement against the baseline and achievement of the target.

*Improving Discharge for Queen's Centre Patients:*
The third aim for this project was to complete a trial at the Queen's Centre in conjunction with the Boots Pharmacy based there. Currently, all prescriptions from the Oncology wards at the Queen's Centre at Castle Hill Hospital are sent electronically to the Boots Pharmacy on site.

In order to reduce delays for patients waiting in public areas at the Queen's Centre, the trial was established for a designated Trust Pharmacy staff member carrying a bleep, which would be used by the Boots Pharmacy staff to inform them that a patient's prescription was ready to collect. The Trust Pharmacy staff would then deliver the prescription directly to the patient thereby improving the patients discharge experience. This reduced the time patients were waiting. Further work and analysis is being completed to scope a future process where this can be in place permanently.

*Improved availability of 'Sip Feeds' on Wards:*
Oral Nutritional Supplements or 'sip feeds' are prescribed drinks that provide extra nourishment in an easy to take form. They can be prescribed for certain conditions for example, disease related malnutrition. They are frequently used in hospitals to support recovery and prevent further weight loss. These types of feed can be prescribed on discharge to patients.

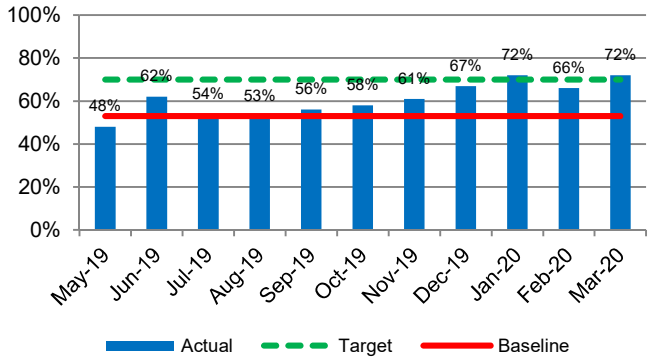
A project was commenced to review the number of feeds held 'in stock' on wards to see whether these can be increased and all relevant wards to hold a level of feeds that can be given to the patient at the point of discharge, rather than waiting for the feeds from pharmacy. An educational poster has been developed for wards and pharmacy staff to support the rollout of this amended process. Further work is required and therefore this will be carried forward.

The project success was measured by the monitoring of two key indicators. These are detailed below along with how the Trust performed:

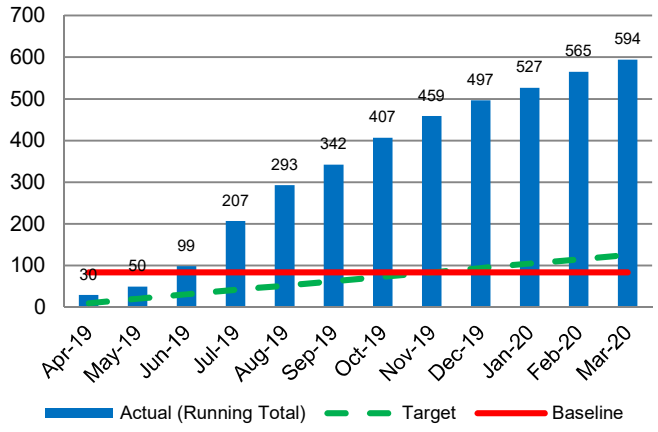
| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| 70% of dispensing discharge perceptions within an hour for patient lounge by March 2020 | 53% (annual) | 72% (end of March 2020) ✓ |
| 50% (>126) increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020 | 84 (annual) | 594 ✓ |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

**Achieve 70% of dispensing discharge prescriptions within an hour for the Patient Lounge:**




**Achieve 50% increase (>126) in referrals to the 'Transfer of Care around Medicines Scheme':**



## Going forward

This priority will be carried forward for further action and monitoring.

The delivery of all aspects of Medicines Management and Optimisation for our patients continues to have a high profile within the Trust and we are committed to finding new ways to improve our pharmacy service. Monitoring of the key indicators will continue as part of our Pharmacy Team's work plan and will be monitored by the Safer Medication Practice Committee.

# Safer Care: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To improve care, management, detection and treatment of the deteriorating patient

#### Why was this important?

Early identification of a patient's deterioration, enabling rapid targeted management, can help reduce the need for transfer to higher acuity units, reduce hospital lengths of stay and improve survival rates.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to ensure all patients with an elevated National Early Warning Score (NEWs) to be escalated in line with Trust Recognition of the Deteriorating Patient Policy (which incorporates NEWS2).

#### How did we perform?

The project completed a number of actions including:

*Embedding and Monitoring of NEWS2 across the Trust:*

National Early Warning Score (NEWS) is based on a scoring system in which a score is allocated to six physiological measurements – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS). Following the publication of NEWS2, the Trust focused on embedding this tool into practice.

During 2018 and early 2019 a revised Recognition of the Deteriorating Patient Policy was developed, which is compliant with NEWS2 guidance, along with clinical guidance from the National Institute for Health and Care Excellence (NICE). The NICE CG50: Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration is published national guidance with the aim to improve the recognition and response to the physical deterioration of patients with the objective to improve physical health provision and outcomes for patients. Following this policy revision, the corresponding deteriorating patient care bundle was devised for use with appropriate patients and allowed staff to record, monitor and escalate patients appropriately. To support this, a rollout of newly developed training package for staff to ensure full competency with the new processes.

The focus for the Trust this year has been to establish a robust audit process, which has been achieved through the establishment of a 'Recognise and Respond' Fundamental Standard Inspection programme and the Matron's Handbook audits. The Trust monitors on a monthly basis, the percentage of patients that have a NEWS Score above 1 and the actions taken or escalation documented.

The Trust identified the target of 90% of all patients to meet the aim; there was not a baseline from the previous year to compare it to. Performance has been varied throughout the year with three months achieving over 80% compliance and one month achieving over 90%, the average performance for this target was 76.8%. This has been identified as a continuing area of improvement for the Trust to focus on in 2020/21.

*Development of a 'Recognise and Respond' Fundamental Standard Inspection programme:*

The Fundamental Standard Inspections are a formal review process, which reviews objectively the quality of care delivered by our clinical teams.

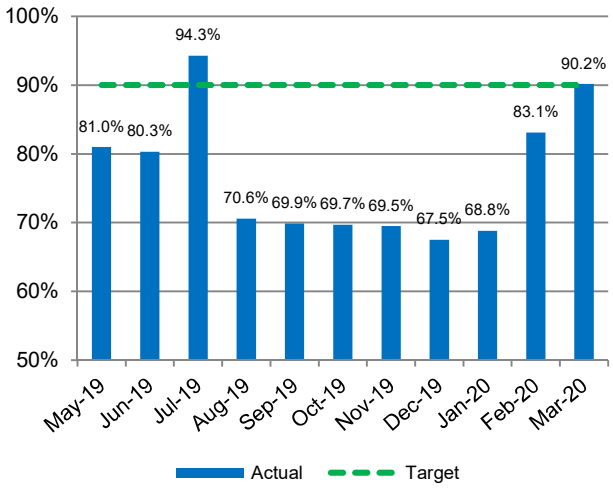
It is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care and are influenced by the CQC key lines of enquiry prompts used during inspections. The Recognise and Respond criteria includes questions for staff about their knowledge on fluid balance recording, sepsis screening and escalation. It also reviews the quality of the documentation for the Deteriorating Patient bundles, the sepsis pathway, fluid balance chart and ReSPECT forms (Recommended Summary Plan for Emergency Care and Treatment forms).

Ward oxygen cylinder storage and resuscitation boxes and trolleys are also checked to ensure they are in date and have been audited regularly. 39 wards across both Castle Hill Hospital and Hull Royal Infirmary have been audited at least once using the Recognise and Respond audit tool and over half of the wards have been rated either blue or green, which indicates outstanding and good performance and can be audited again within a 9 to 12-month period.

*Rollout of Electronic Observations (e-obs):*
During 2019 and 2020, the Trust commenced a rollout programme to use Electronic Observations (e-obs) for the electronic capture, calculations of Early Warning Scores and automated cascading escalations to ensure recognition is followed by appropriate and timely action. The system provides the electronic capture of patient information, via handheld devices, at the bedside, enabling timely and accurate data collection. This system includes automatic calculations and alerts for those patients who display concerning observations, as well as due and overdue reminders.

The project success was measured by the monitoring of the key indicator. The Trust target was to achieve 90% of patients that have a NEWS Score above 1 and the evaluation states actions taken or escalation documented monthly. The source of this indicator is the Trust's internal nursing auditing programme, called the Matron's Handbook.

As the graph demonstrates, compliance was not always achieved. The average for 2019/20 is 76.8% and therefore, this remains an area of improvement for next year. This will be used as the baseline for future monitoring against this target.




## Going forward

This priority will be carried forward for further action and monitoring.

The care of deteriorating patients is and will always be important to the Trust. The continued rollout of e-obs across all wards and the monitoring of the 'Recognise and Respond' Fundamental Standard audit will be monitored throughout the coming year to ensure all patients with an elevated NEWS to be escalated in line with Trust Recognition of the Deteriorating Patient Policy.

# Safer Care: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To reduce avoidable hospital acquired pressure ulcers

#### Why was this important?

The National Institute for Health and Care Excellence (NICE) Quality Standard for Pressure Ulcers states: "Pressure ulcers are caused when an area of skin and/or the tissues below are damaged as a result of being placed under pressure for long periods of time. All people are potentially at risk of developing a pressure ulcer. They are, however, more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, poor posture or a deformity, compromised skin or who are malnourished. Pressure ulcers are graded with increasing severity from category 1–4.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to be open and transparent skin damage reporters, improving safety and patient experience through robust assessment, care planning and evaluation by sharing best practice from areas with low reported incidents and to improve understanding of key themes and trends from all reported incidents.

#### How did we perform?

The project completed a number of actions including:

*Compliance with the NHSI Recommendations:*
NHS Improvement (NHSI) said "Our national 'Stop the Pressure' programme has developed a guide to support nurses and other healthcare professionals in preventing pressure ulcers. The recommendations in our guide will support an organisation's ability to learn from reported incidents and looks at ways to improve the prevention of pressure damage."
As part of this, Trusts were required to amend their reporting criteria and recommendations via their incident reporting tool, (Datix) which would in turn standardise the findings, themes and trends and allow Trusts to be benchmarked against each other. NHSI expected all Trusts to implement these recommendations from April 2019.

This year, following the publication of the recommendations, the Trust updated all training, policies and guidance related to the management of pressure ulcers and developed a communication strategy to ensure all staff were aware of the changes. Datix reporting criteria were amended as per the recommendations. From April 2020 the Trust will be able to review themes and trends from each month, along with the numbers of reported pressure ulcers or moisture damage against the performance during 2019.

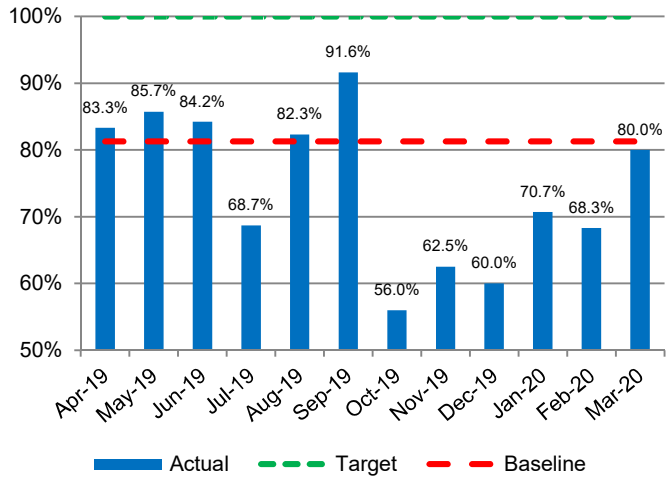
*Review of SSKIN Care Bundle:*
SSKIN is a five-element approach to preventing and treating pressure ulcers which includes:

- **S**urface,
- **S**kin inspection,
- **K**eep moving,
- **I**ncontinence/moisture,
- **N**utrition/hydration

The SSKIN Care Bundle was previously part of the Trust's 'Intentional Rounding' documentation. Intentional Rounding is a process where nursing staff conduct regular checks on patients throughout the day to ensure their fundamental care needs including pain, comfort/positioning, toileting, water, temperate etc. are being addressed.

This year the Trust planned to develop a specific care bundle, with SSKIN as the basis, for the identification and management of pressure and moisture damage. Having a specific care bundle would mean that all staff who input into a patient's care, such as physiotherapist and dieticians, can contribute to the care bundle thereby ensuring a truly multidisciplinary tool. The Trust's Tissue Viability Matron invited all therapies staff to be involved in the development of the care bundle and the bundle is now in the testing stage.
A pilot is in underway in all Medical Elderly wards within Hull Royal Infirmary. Full rollout will be completed once the final tested care bundle has been agreed.

The project success was measured by the monitoring of one key indicator. The Trust monitored on a monthly basis, the percentage of Root Cause Analysis (RCA) completion within 14 days of all finally approved Hospital Acquired Pressure Ulcers (HAPU). The target was to achieve 100% of RCAs completed within 14 days. As the graph below demonstrates, the target was not achieved within the year. The average performance for the year was 74.4%, which is also deterioration from the baseline of 81.3% from 2018/19.




In addition, the number of pressure ulcers in each category was reported and monitored. The Trust was unable to compare these numbers against previous years due to the categorisation revision recommendations by NHS Improvement (NHSI) in June 2018 as part of their national Stop the Pressure programme for implementation in April 2019.

| Indicator | 2019/20 |
|---|---|
| Category 2 Hospital Acquired Pressure Ulcers | 162 |
| Category 3 Hospital Acquired Pressure Ulcers | 4 |
| Category 4 Hospital Acquired Pressure Ulcers | 1 |
| Unstageable Hospital Acquired Pressure Ulcers | 22 |
| Deep Tissue Injury (DTI) Hospital Acquired Pressure Ulcers | 70 |

## Going forward

This priority will be carried forward for further action and monitoring.

The management and identification of pressure ulcers and moisture damage is a key factor of patient care for the Trust and will remain high on the monitoring and improvement agenda for the coming year.

Completion of RCA's as well as understanding themes and trends will continue to be monitored and actioned by all of the Health Groups within the Trust as well as the Wound Management Committee.

# Safer Care: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To reduce avoidable acute kidney injury

#### Why was this important?

The National Institute for Health and Care Excellence (NICE) clinical guideline 169 states that: "Acute Kidney Injury (AKI) encompasses a wide spectrum of injury to the kidneys, not just kidney failure". Acute kidney injury is seen in 13–18% of all people admitted to hospital, with older adults being particularly affected. The number of inpatients affected by acute kidney injury means that it has a major impact on healthcare resources.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to increase compliance, specifically, with NICE Quality Standard 76; Acute Kidney Injury. This sets out the following aim for the standard: "This quality standard covers preventing, detecting and managing acute kidney injury in adults, young people and children". The aim of this project was to become compliant with the following three quality statements from the quality statement:

- **Quality statement 2:**
  People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition (baseline: not compliant)
- **Quality statement 3:**
  People in hospital who are at risk of acute kidney injury have their serum creatinine level monitored (baseline: not compliant)
- **Quality statement 4:**
  People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected (baseline: partially compliant)

#### How did we perform?

The project was designed to be a short-term project to support the completion of an audit against compliance with the above Quality Statements.

A number of actions were completed within the 2018/19 project to increase compliance with the three quality statements, including delivery of focussed kidney injury training in elected clinical groups within key areas of the Trust and an acute kidney injury toolkit was developed and implemented for use on the acute medical unit.

The audit that was completed at the end of the 2018/19 project and into the 2019/20 project evidenced some improvements, with quality statement two and three increasing from not compliant to partially compliant. Quality statement four remained partially compliant.

The lead identified two key areas for improvement. The first was the introduction of online and face to face mandatory training for the diagnosis and management of AKI for both junior and senior medical staff. From this, an excellent online training package has been made available. Secondly, the audit found that the introduction of an AKI care bundle in the initial patient clerking sheet would increase compliance with the three quality statements.

As the Trust is currently in the midst of a large-scale project to transfer all paper patient documentation onto electronic clinical systems, it was agreed that this will be taken forward as part of this wider project in the following year.

The project success was measured by the monitoring of three indicators as described in the aim.

These are detailed below along with how the Trust performed:

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| Compliant with Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition. | Not compliant | Partially compliant ↗ |
| Compliant with Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level monitored. | Not compliant | Partially compliant ↗ |
| Compliant with Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected. | Partially compliant | Partially compliant ↗ |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

## Going forward

The management and identification of acute kidney injury remains an important issue for the Trust and further work has been identified for the following year. This work will be led by the AKI Consultant and monitored at the Trust's Clinical Effectiveness, Policies and Practice Development Committee.

# Safer Care: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To ensure all appropriate patients are risk assessed for Venous Thromboembolism (VTE)

#### Why was this important?

VTE is an important cause of death in hospitalised patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with a considerable cost to the health service. In 2005, VTE was registered as the underlying cause of death in more than 6,500 patients, although this figure is likely to be an underestimate of the true incidence. The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted and on any predisposing risk factors (such as age, obesity and concomitant conditions).

#### What did we aim to achieve?

The aim of this priority was to ensure all appropriate patients are risk assessed for VTE and where necessary receive the correct treatment.

#### How did we perform?

The project completed a number of actions including

- Detailed monthly reporting alongside completing the NHS Safety Thermometer audits. This ensures that the Trust is prescribing the right patients the right DVT (Deep Vein Thrombosis) treatment.
- Quality Improvement projects undertaken by junior doctors on surgical wards to improve compliance
- A sustained follow up of non-compliant areas through clinical leads-followed up at the Trust's Performance and Accountability Committee
- A monthly accountability meeting every month with Health Group Medical Directors

The project success was measured by the monitoring of two key indicators. These are detailed below along with how the Trust performed:

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| 0 VTE Serious Incidents | 1 | 0 ✓ |
| 95% compliance with assessment of all relevant patients to identify the risk of VTE no later than 24 hours following admission to hospital | 88.5% | 92.2% ↗ |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

We have had a sustained 92% compliance through the year with some areas achieving the 95% compliance. Further analysis of the data revealed that when the patients who stayed less than 24 hours are removed from the non-compliant group it improved compliance to 95%.

#### Going forward

The aim of 95% of all relevant patients to be assessed for the risk of VTE no later than 24 hours following admission to hospital remains part of the performance measures in place by the Trust for patient safety requirements and will continue to be reported throughout the committee structures within the organisation.

# Better Outcomes: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

## Priority: To improve the care of people with Dementia within the Trust

### Why was this important?

Dementia is a progressive and usually irreversible syndrome, characterised by a widespread impairment of cognition. People with dementia can experience one or a combination of the following: Memory loss, Language impairment, Changes in personality, Disorientation and Self-neglect. There are 3 main types: Alzheimer's disease, Vascular Dementia and Dementia with Lewy Bodies. There are over 850,000 people with dementia in the UK according to Alzheimer's Research UK and an estimated 25% of acute hospital beds are occupied by people with dementia who often have a longer length of stay and poorer outcomes during their hospital admission. At Hull University Teaching Hospitals, a Trust-wide screening tool for all acute admissions over the age of 75years is used.

For patients with either confirmed or suspected dementia, or delirium (acute confusion) the Butterfly Scheme is used. The Butterfly Scheme is a system that enables staff to provide person centred care to patients with dementia. A butterfly symbol is placed above the patient's bed to act as a discreet reminder to staff that this patient has dementia. The scheme delivers skills based education to key staff based on a five-point response (REACH response - a summary of the skills the scheme teaches to staff) and also involves the use of a carer sheet to empower patients and their carers to personalise the care they receive. Every ward in the Trust now has a dedicated member of staff appointed as a Butterfly Champion who will promote the scheme and support staff in its use.

As an organisation, the Trust recognises the key role that relatives and carers have in helping staff to plan and to deliver person-centred safe and effective care and the Trust encourages their input at every point of the patient's journey. John's campaign establishes the right of partners/carers of people with a diagnosis of dementia, to remain in hospital with their loved one outside of regular visiting hours.

### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and the dementia documentation is consistently completed to the appropriate level.

### How did we perform?

The project completed a number of actions including:

*Dementia Bundle:*

The first aim of this project was to ensure that the dementia bundle was embedded across the Trust. The dementia care bundle is a set of interventions that, when used together, significantly improve patient outcomes and when multi-disciplinary and multi-agency teams work together there are proven benefits to patients and their carers. A significant amount of work has been completed in order to achieve this and the bundle has been reviewed, updated and tested. As the Trust is working towards a minimal paper patient records system, the bundle has been transferred into a compatible format for these electronic systems and is planned for launch in 2020.

*Review and Development of Revised Dementia Training:*

It was identified that in order to increase the consistency of completion of dementia related documentation, the existing dementia training would need to be updated and made available to a wider range of staff.

In 2019, a Training Needs Analysis (TNA) was completed to identify which staff members should be trained in dementia as part of a mandatory programme. This analysis identified 'tiers' of training, for different levels of staff. The training programmes for each staff tier has been completed and the revised training programmes are currently being approved by the relevant structures within the organisation.

In addition, there is an agreed list of 'Dementia Champions' across the organisation. These are members of staff with additional training in dementia who have the responsibility to promote the care and wellbeing of dementia patients and support the training and development of other staff members in dementia and cascade any new learning across the Trust.

*Dementia Documentation Is Consistently Completed:*

A series of performance indicators were agreed to monitor the completion of Dementia documentation as detailed in the table below. Whilst the monthly data fluctuated throughout the year, compliance was achieved against the targets for all except two; however, performance improved from the baseline from 2018/19 demonstrating further improvements made.

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| 75% of dementia / delirium screening pathway completed in the medical document | 85.7% | 81.6% average ✓ |
| 75% of online dementia / delirium screening tool completed | 76.2% | 78.6% average ✓ |
| 75% of dementia diagnosis documented in the medical notes | 100% | 94.6% average ✓ |
| 75% of Butterfly Icon displayed at the bedside | 66.7% | 73.1% average ↗ |
| 75% of Butterfly Icon in place on Cayder board | 100% | 97.5% average ✓ |
| 75% of Reach Out To Me document at the bedside | 40.9% | 44.7% average ↗ |
| 75% compliance with two members of staff able to articulate the meaning of Johns Campaign & Butterfly Scheme on each ward | 77.8% | 88.3% average ✓ |
| 75% of clinical areas displaying poster for Johns Campaign | 63.6% | 77.8% average ✓ |
| 75% of clinical areas displaying poster for Butterfly Scheme | 72.7% | 78.4% average ✓ |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

Part way through the project term, the following training indicators were discontinued due to the postponement of a revised Dementia Training Programme of which the indictors were linked.

- 30% of Trust Tier 1 staff have completed the relevant dementia
- 30% of Trust Tier 2 staff have completed the relevant dementia
- 30% of Trust Tier 3 staff have completed the relevant dementia

In addition, the indicators below were amended in June 2019 to reflect the new way of auditing dementia documentation that was introduced by the Trust part-way through the year. The indicators below were superseded:

- 75% compliance with dementia/delirium screening assessments undertaken
- 75% compliance on H8, H9, H90 and EAU with the use of the Butterfly Scheme which focuses on Butterfly Symbol and the Reach Form

- 75% staff awareness of John's campaign
- 75% relative/carer awareness of Johns campaign

## Going forward

This priority will be carried forward for further action and monitoring.

The Trust has a Dementia Strategy in place and is being updated in 2020. The strategy covers all aspects of care for patients living with dementia during their care within the Acute Trust, whether inpatient or outpatient and also recognises the needs of their relatives and carers. This will continue to be delivered following its revision.

# Better Outcomes: Performance against Priorities 2019/20

►Safer Care ►Better Outcomes ►Improved Experience

## Priority: To improve the governance of children and adult patients requiring Mental Health care within the Trust

### Why was this important?

To provide appropriate care the Trust should document how the mental health needs of patients are met, including how the Trust works with other specialist agencies in the provision of mental health support and how staff are trained in mental health conditions.

### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was:

- to improve the sharing of patient information between the Acute Trust and Mental Health services;
- to ensure that all children with Mental Health needs have an individual care plan appropriate to their needs, including risk assessments undertaken to eliminate potential self-harm;
- to ensure that all mental health training is recorded centrally and to ensure the Service Level Agreement for Adults with Humber Teaching NHS Foundation Trust is monitored and delivered via the specific Mental Health Committee.

### How did we perform?

The project completed a number of actions including:

*Improve the sharing of patient information between the Acute Trust and Mental Health services:*

The Trust's senior Paediatric Nursing Team, including the Nurse Director of the Family and Women's Health Group and the Paediatrics Matron meet with senior managers from Humber NHS Trust on a regular basis to discuss the mental health provision within the Trust and other relevant issues pertinent to CAMHS (Child and Adolescent Mental Health Services) provision within the Trust. In addition, CAMHS is an important feature in the patch wide Safeguarding Children's Board where CAMHS waiting times, service delivery and risks are all escalated and discussed.

The Trust's internal Safeguarding Committee manages, escalates and disseminates issues, risks and actions in relation to Mental Health and CAMHS across the organisation and facilitates the approval of policies and guidelines in relation to CAMHS.

*All children with Mental Health needs have an individual care plan appropriate to their needs, including risk assessments undertaken to eliminate potential self-harm:*

In 2016 the CQC instructed the Trust to put actions in place in relation to the completion of risk assessments for children with mental health concerns whilst in hospital. In 2018 and 2019 several audits were completed to review the quality of these risk assessments.

The audits undertaken during 2018/19 demonstrated a good level of performance; Q2 100%, Q2 85.5% and Q4 100%. The audit was undertaken again during Q1 of 2019/20 and it demonstrated 96.6% compliance. It was therefore agreed that these audits were not required to be completed every quarter and they would be transferred to an annual audit programme.

*All mental health training is recorded centrally:*
The teacher practitioners for Paediatrics records all the training, visits and ad hoc sessions delivered by the local CAMHS teams or Humber Mental Health NHS Trust to paediatric staff. This ensures there is a robust record of training.

*The Service Level Agreement for adult Mental Health with Humber Mental Health Trust is monitored and delivered via the specific Mental Health Committee:*
The first Mental Health, Learning Disabilities and Autism Committee was held in February 2020 and are scheduled to take place on a bi-monthly basis. The committee has a remit of assuring the Trust's Operational Quality Committee on the oversight and management of all matters relating to the care and treatment of patients with Mental Health Illness, Learning Disabilities and Autism. This also includes Perinatal Mental Health, Mental Health Liaison, and Dementia, CAMHS, Suicide Prevention and Acute care. The committee is also responsible for ensuring the delivery of the National and Local strategy for Mental Health, Learning Disabilities and Autism.

The indicators below were the measure for success for this aim, along with the other achievements detailed in this report:

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| 95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm | 100% | 96.6% ✓ |
| Established bi-monthly Mental Health Committee | Held | Complete ↗ |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

The following indicators were discontinued throughout the year as it was agreed that they were not required to provide assurance that the aim had been met:

- Quarterly operational working group with Child and Adolescent Mental Health Services leads and HUTH Children's Service held from August 2019
- 95% compliance with paediatric relevant staff trained in Child and Adolescent Mental Health Services (CAMHS)

## Going forward

This priority will be carried forward for further action and monitoring.

The remit of the Mental Health, Learning Disabilities and Autism Committee will ensure that all of the aims detailed above will be monitored and re-visited if required.

# Improved Experience: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To improve the experience of staff working in the Trust's outpatient areas

#### Why was this important?

NHS Employers says "How staff feel when they are at work is key to the successful delivery of high quality patient care. Evidence shows us that having engaged, healthy staff leads to increased productivity and an overall happier workforce". The Trust understands how important staff are and this is therefore reflected in the Trust's vision of 'Great Staff, Great Care, Great Future'.

NHS England's 'The Patient Experience Book' states that "Patient experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care." Therefore, the staff and patient experience within the Trust's outpatient areas are of specifically importance. In addition, following the 2018 CQC inspection the CQC instructed the Trust to put actions in place to ensure there were mechanisms in place to monitor patient waiting times in clinics.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to use learning tools such as staff and patient complaint and survey data to improve the outpatient service and improve the availability of data on wait times in clinics.

#### How did we perform?

The project completed a number of actions including:

*Clinic Waiting Times Audit*:

At the Trust's CQC inspection in February 2018, the Trust was issued an action to ensure that there was a mechanism in place to monitor clinic waiting times. An audit was implemented to monitor the percentage of outpatient clinics that were on time, early or late. The results of the audits were reported to the Outpatient Governance Committee for information and further action, where required.

Two clinic waiting times audits were undertaken in 2019, the first in May 2019 and the second in November 2019. The results indicate that over 70% of clinics start on time or early. The second audit showed a further increase from 71.6% to 74.8%. Although the target to achieve 85% improved clinic waiting times was not achieved, the results from these two audits demonstrate a good rate of progress and therefore, this will now be transferred to the organisation's annual audit plan.

*Staff and Patient Experience:*

Outpatient staff have taken part in a number of Trust and national surveys. The provisional results prompted the inclusion of several clinic staff attending the Trust's 'Great Leaders' programme. A more targeted staff survey will be completed next year to follow on from the initial survey and to identify additional actions to further improve staff experience within the Outpatient areas.

The results of the Patient Experience and Staff Experience Fundamental Standards for Outpatients were very positive, with consistent scores of between 95-100% wards rated green and blue (which are the highest pass ratings). This is supported by the Friends and Family scores over the year for outpatient services (98%). A patient representative is an active member of the Outpatient Governance Committee and remains a progressive link between our outpatient services and our patient council. Attendees of the committee

are encouraged to share positive or negative patient stories and complaints, to provide examples of good care or areas for improvements. This provides an excellent opportunity for processes to be updated and learning shared.

The project success was measured by the monitoring of a number of key indicators. These are detailed below along with how the Trust performed:

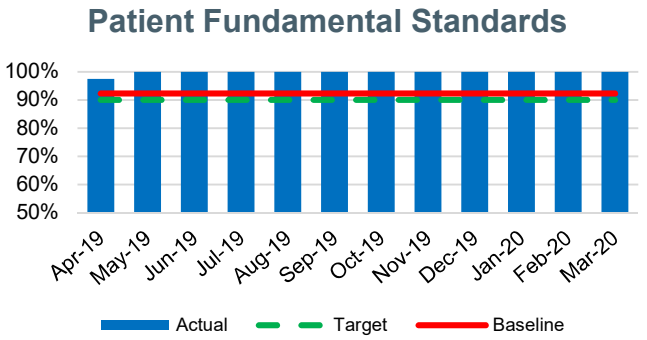
| Indicator | Baseline 2018/19 | Performance 2019/20 | |
|---|---|---|---|
| 90% of OP areas rated green or blue Patient Experience Fundamental Standard | 92.3% | 99.8% average | ✓ |
| 90% of OP areas rated green or blue Staff Experience Fundamental Standard | 92.5% | 96.7% average | ✓ |
| Outpatient Governance Committee held monthly | Achieved | Achieved | ✓ |
| 98% Friends and Family Test Scores for Outpatients | 98% | 98% average | ✓ |
| Increase in positive compliments or comments on NHS Choices | 41 | 31 | X |
| 75% of clinics on time or early | No baseline | 73.2% average | ↗ |

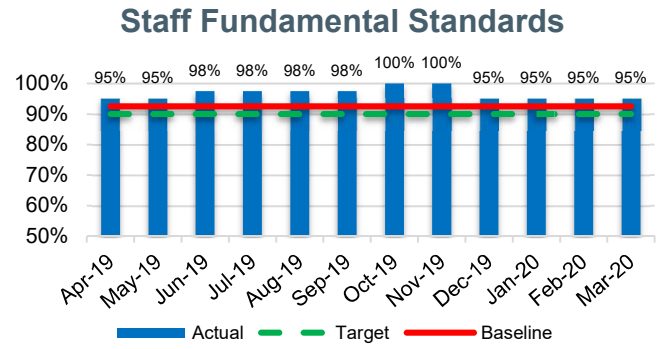
| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

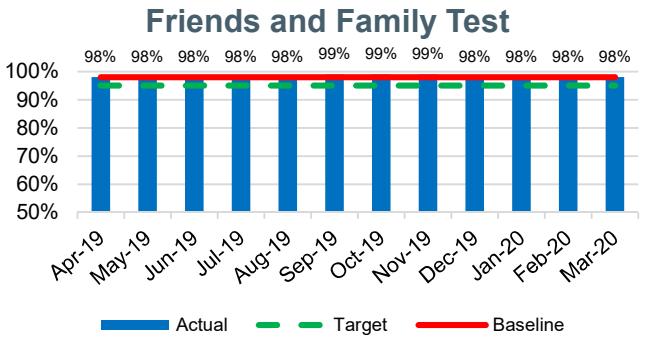
## Going forward

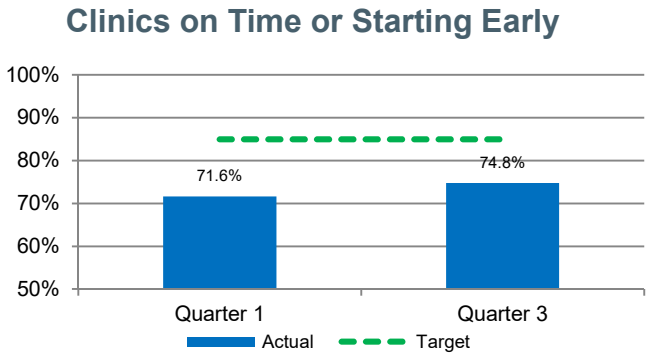
This priority will be carried forward for further action and monitoring.

The Trust's Outpatient Governance Committee will ensure this priority is taken forward throughout the coming year and be further developed as required.



# Improved Experience: Performance against Priorities 2019/20

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority: To listen to and act on patient experience to improve services

#### Why was this important?

The Trust welcomes all compliments, comments, concerns and complaints from users of the services provided, as this is essential to contribute to the highest standards of care for patients. Feedback, both positive and negative is valued, as this gives the Trust opportunity to review and implement changes to continually improve the delivery of care. In accordance with the NHS Constitution, the Trust is committed to providing a high quality of care, listening to the feedback received and learning from any mistakes made. All of this links to the Trusts vision of 'Great Staff, Great Care, Great Future' which is supported by the organisational values of 'Care, Honesty, Accountability'.

#### What did we aim to achieve?

This priority was developed into a project in the organisations Quality Improvement Plan. The aim of this project was to reduce the number of re-opened complaints due to dissatisfaction and to facilitate a process to address all recommendations from the NHS Patient Survey 2018 and the Mersey Internal Audit Agency Complaints Management Review.

#### How did we perform?

The project completed a number of actions including:

*Reducing the number of re-opened complaints due to dissatisfaction*:
The Patient Experience Forum was disbanded and a formal Patient Experience and Engagement Committee was established. Its first meeting took place in January 2020.

*NHS Patient Survey 2018:*
A working group was established to address any actions from the NHS Patient Survey 2018. The results were received in June 2019, they were reviewed and an action plan was put into place to address the areas for further improvement. This is monitored by the Patient Experience and Engagement Committee. HUTH was rated 33 out of the 77 Trusts for positive feedback by Picker. The top five positive scores were linked to patients were able to discuss their concerns with staff, they did not wait for beds during admission, no noise at night, discharge arrangements and delayed discharge. The top five negative scores were linked to planned admissions, information received from staff within ED, hospital food, overall views and information regarding concerns.

*Mersey Internal Audit Review:*
The actions from the Mersey Internal Audit Agency Complaints Management Review are included in reporting at senior level committees against the Trust's targets for responding to complaints, lessons learnt and complaints outcomes. During 2019 these were included in the regular patient experience reports to the Trust Board.

The project also completed a number of additional actions including:

- The Patient Experience Team have recorded a significant reduction on Interpreter spend, particular from the introduction of remote interpreter services. The Electronic Video Link Interpreter system was nominated for an award with HSJ for Technology.

- The numbers of volunteers within the Trust continue to increase, with a number of projects established or gaining pace through the year. This includes; dining companions, which is a

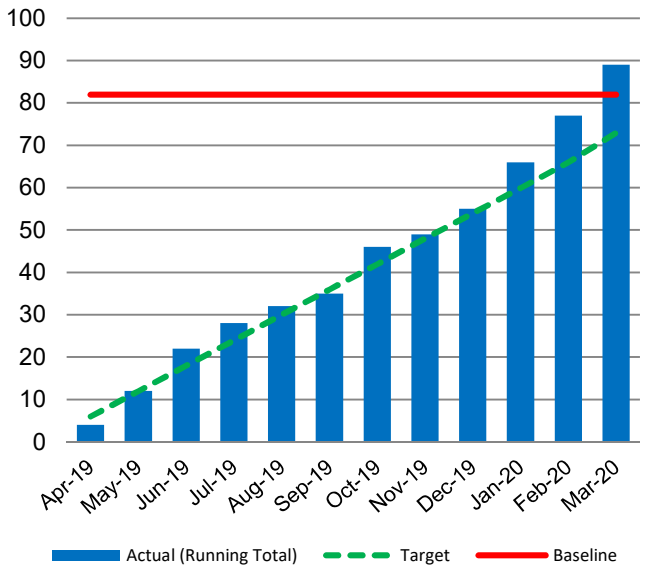
cohort of volunteers with a specific remit for nutritional support of patients, Reading Room volunteers to provide stimulation to patients and the re-distribution of volunteers to high risk areas across the Trust in busy times such as winter pressures to provide additional support.

The project success was measured by the monitoring of one key indicator

| Indicator | Baseline 2018/19 | Performance 2019/20 |
|---|---|---|
| Reduce the number of reopened complaints due to dissatisfaction by 10% from the baseline (73.8) | 82 | 89 X |

| Key | | | |
|---|---|---|---|
| Achieved | ✓ | Did not Achieve | X |
| Improvements made against baseline | ↗ | Discontinued | |
| All baselines were taken from March 2019 or as stated annually | | | |

The Trust reported 89 complaints re-opened due to dissatisfaction which was over the target of no more than 73. The target was not achieved and demonstrated deterioration from the baseline.




## Going forward

This priority will be carried forward for further action and monitoring.

The experience and engagement of our patients is of utmost importance to us and all work undertaken within 2019/20 will continue to be built upon and expanded, along with other new actions to improve patient experience and engagement over the coming year.

This will be monitored by the Patient Experience and Engagement Committee.

# 2.2 Performance Against Other Quality and Safety Indicators

This section covers:

- Seven day services within the NHS
- Patient Safety Incidents
- Serious Incidents and Never Events
- Patient Safety Alert compliance
- NHS staff survey results
- Whistleblowing and freedom to speak up
- Duty of Candour

# Seven Day Services in the NHS

## What does it mean to provide seven-day services?

Seven-day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. The seven-day services programme is designed to improve hospital care with the introduction of seven-day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are the four standards that all NHS Trusts must adopt and implement by 2020. Implementation of these standards is monitored by NHS Improvement.

The four standards are:

- **Standard 2** – Time to first consultant review
- **Standard 5** – Access to diagnostic tests
- **Standard 6** – Access to consultant-directed interventions
- **Standard 8** – On-going review by consultant twice daily if high dependency patients, daily for others

## What do seven-day services mean to patients?

Implementation of the four priority clinical standards will ensure patients:

- Do not wait longer than 14 hours to initial consultant review
- Get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- Get access to specialist, consultant-directed interventions
- With high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

## Monitoring of the Clinical Standards at Hull University Teaching Hospitals NHS Trust

The Trust has undertaken a stocktake of progress against compliance with the four priority clinical standards and is working to achieve full compliance.

| Standard | Compliance | Actions to address |
|---|---|---|
| Standard 2 - Time to First Consultant Review | Non-compliant | • Explore opportunities to strengthen the electronic recording of consultant reviews through further development of Lorenzo. *It is noted that this action is on the roadmap for future upgrades to Lorenzo, but is not likely to take place within the next 1-2 years.*<br>• Communicate to clinical staff the need to ensure accurate and contemporaneous recording of consultant review activity. *This action was undertaken following the March* |

| Standard | Compliance | Actions to address |
|---|---|---|
| | | *2019 audit and report and was reiterated prior to the most recent audit.*<br>• Undertake specific work with each specialty to address shortfalls in delivery. *It is proposed to target the Acute Medical Unit and General Surgery (H6/H60) during December with a service specific audit focusing on the patient pathway and documentation over a weekend (Friday to Sunday).*<br>• Adoption of standardised model for the identification of those patients requiring/not requiring a consultant review. *The model was circulated to the Health Groups for adoption. The August 2019 audit has demonstrated a need for the delegation of daily reviews to be formally recorded in the patient record to enable the auditors to take the delegated review into account.* |
| Standard 5 - Diagnostic Services | Compliant | The latest results demonstrate a significant improvement on the previous position and reflect the work that has been done to increase CT and MRI capacity and reporting turnaround times, no further actions required. |
| Standard 6 - Consultant-directed interventions | Compliant | No actions required |
| Standard 8 - On-going review | Non-compliant | Actions are reported above in standard 2 |

# Patient Safety Incidents

The Trust encourages incident reporting and believes that a strong incident reporting culture (i.e. a high level of incident reporting), is a sign of a good patient safety culture.

**Figure 1** is taken from the latest NHS England National Reporting and Learning Service (NRLS) data report published March 2020. This shows our incident reporting rates compared to other acute Trusts of a similar size. Our Trust is highlighted below and shows no evidence for potential under-reporting of incidents.

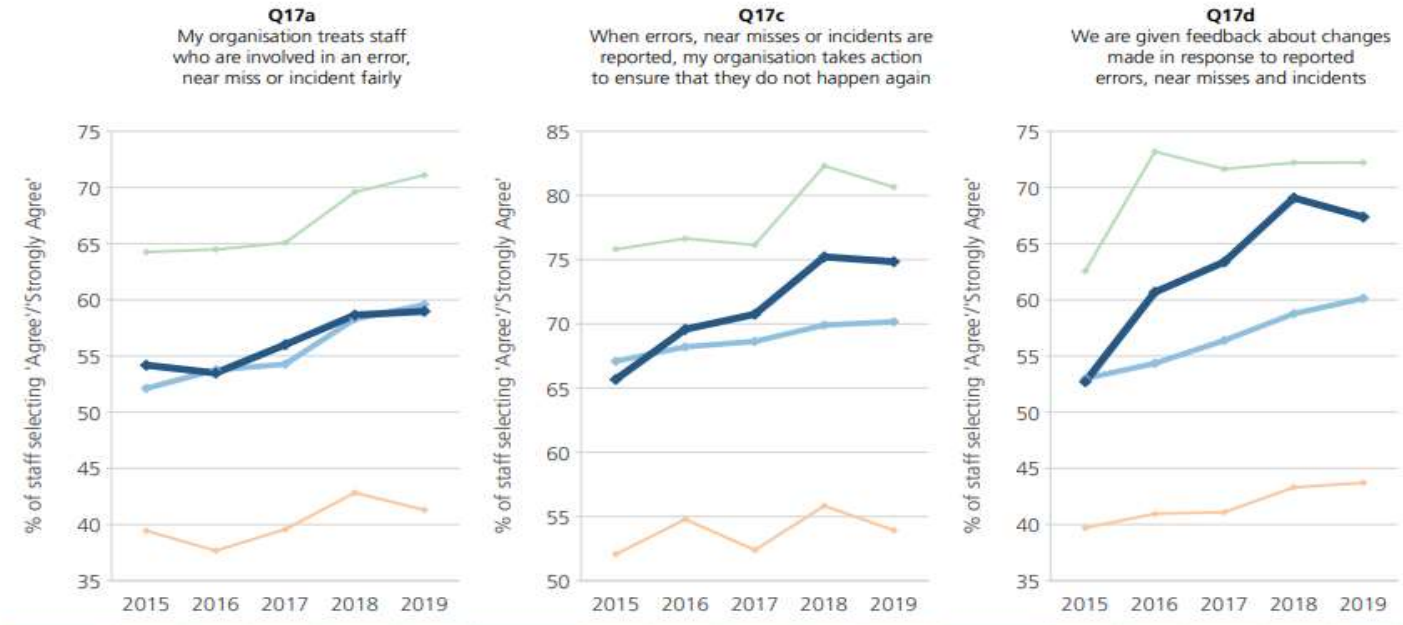

The NRLS report states that incident reporting patterns should be interpreted alongside other information such as the NHS Staff Survey results on reporting culture and practice.

The Trust's 2019 NHS Staff Survey results, again published in March 2020, has shown a slight deterioration in how staff feel about the Trust's patient safety culture, however the Trust is in line with national results and remains above national average.

The results continue to show that:

- ✓ ***We treat staff involved in an error, near miss or incident fairly***
- ✓ ***When errors, near misses or incidents are reported, we take action to ensure that they do not happen again***
- ✓ ***Staff are given feedback about changes made in response to reported errors, near misses and incidents***

**Figure 2**; extract from 2019 Staff Survey Results




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Best | 64.3% | 64.5% | 65.1% | 69.6% | 71.1% |
| Your org | 54.2% | 53.5% | 56.0% | 58.6% | 59.0% |
| Average | 52.1% | 53.8% | 54.3% | 58.3% | 59.6% |
| Worst | 39.4% | 37.7% | 39.6% | 42.8% | 41.3% |

| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Best | 75.8% | 76.7% | 76.2% | 82.3% | 80.7% |
| Your org | 65.7% | 69.6% | 70.8% | 75.2% | 74.8% |
| Average | 67.1% | 68.2% | 68.6% | 69.9% | 70.2% |
| Worst | 52.1% | 54.8% | 52.4% | 55.8% | 53.9% |

| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| Best | 62.6% | 73.2% | 71.6% | 72.2% | 72.2% |
| Your org | 52.7% | 60.7% | 63.4% | 69.1% | 67.4% |
| Average | 53.0% | 54.3% | 56.4% | 58.8% | 60.1% |
| Worst | 39.7% | 41.0% | 41.1% | 43.3% | 43.7% |

# Serious Incidents and Never Events

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Some Serious Incidents are called Never Events (NE). Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

**Total number of Never Events and Serious Incidents (SIs) declared 2017/18, 2018/19 and 2019/20:**

| | 2017 / 18 | 2018 / 19 | 2019 / 20 |
|---|---|---|---|
| Total Never Events declared | 6 | 0 | 8 |
| Total Serious Incidents declared | 60 | 71 | 58 |
| **Total*** | **66** | **72*** | **66** |

** Excludes any which have been de-escalated from Serious Incident status*

The Trust declared 7 Never Events in 2019/20; more than in any other previous reporting period. During 2018/19 the Trust did not declare any Never Events. The way the Trust investigates Never Events has evolved this year with the introduction of simulation events. The simulation events allow for a scenario based investigation with the staff involved in the incident to re-enact the event and gain an understanding of why the incident happened. This allows staff to identify contributory factors and to establish what could be learned and actioned to prevent such Never Event's occurring again. Simulation events utilise the '5 whys' technique and cause and effect (fishbone diagram) to analyse the findings of the simulation and discussion.

One of the ways the Trust is improving its patient safety culture is by adopting the 'Just Culture' approach to staff involved in incidents. Just Culture is a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. The Trust wants to ensure that staff feel supported when mistakes do happen, which will allow for lessons to be learned to prevent the same errors being repeated.

The Trusts approach to Serious Incident investigations continues to evolve, with this year a focus being on how patients and families are involved in the investigation process. Patients and their representatives are regularly invited to ask questions to the investigation panel, the answers to which are incorporated into the final report. Meetings are often held with patients and their representatives during and following investigations to allow them to be part of the investigation.

The Trust will continue to be open and honest when Serious Incidents, and Never Events, do occur, to ensure that these are fully investigated, with appropriate actions taken as a result. The Trust is committed to providing the best care to our patients and our responses to the Serious Incidents and Never Events are much improved and the learning and actions arising from the investigations is helping to improve the patient safety within the organisation.

## Types of Serious Incident (SI) and ever Events declared during 2017/18, 2018/19 and 2019/20

| Serious Incident type | 2017 / 18 | 2018 / 19 | 2019 / 20 |
|---|---|---|---|
| Treatment Delay | 11 | 13 | 2 |
| Treatment Delay – lost to follow up | 8 | 0 | 0 |
| Patient Fall | 2 | 3 | 3 |
| Delayed Diagnosis | 1 | 8 | 16 |
| Pressure Ulcer | 8 | 7 | 7 |
| Surgical/Invasive Procedure incident | 7 | 3 | 4 |
| Sub-optimal care of the deteriorating patient | 3 | 6 | 2 |
| 12 hour Emergency Department trolley breaches | 0 | 0 | 0 |
| Drug Incident | 1 | 4 | 3 |
| Unexpected Death | 10 | 8 | 11 |
| Health Care Associated Infection (HCAI)/Infection Control Incident | 1 | 0 | 0 |
| Never Event – Retained Foreign Object | 0 | 0 | 1 |
| Never Event – Wrong Site Surgery | 3 | 0 | 4 |
| Never Event – Misplaced Naso-gastric Tube | 0 | 0 | 1 |
| Never Event – Wrong Implant | 1 | 0 | 0 |
| Never Event – Surgical Invasive Procedure | 1 | 0 | 0 |
| Never Event – Medication Incident | 1 | 0 | 0 |
| Never Event – Unintentional Connection to Air Flow meter | 0 | 0 | 1 |
| Retained dressing (not a Never Event) | 0 | 0 | 1 |
| Retained foreign object (not a Never Event) | 0 | 1 | 0 |
| Wrong Site Surgery (not a Never Event) | 0 | 1 | 0 |
| Unplanned NICU admission | 4 | 1 | 0 |
| Absconded Patient | 0 | 0 | 0 |
| Maternity/Obstetric Incident *(prior to 17/18 these SI's were reported under different categories)* | 5 | 8 | 5 |
| Others | 0 | 9 | 4 |
| **Totals** | **66** | **72** | **66** |

2019/20 has seen an increase in the number of delayed diagnosis Serious Incidents declared and a reduction in the number of treatment delays. Some of the delayed diagnosis incidents then led to the patient not receiving timely treatment and therefore the incidents could fall into either category type. There is also a theme amongst the delayed diagnoses where test results were not acted upon in a timely manner, again resulting in treatment being provided as well as an increase in the number of wrong site surgery Never Events. A significant amount of improvement work has been undertaken as a result of the Never Events including re-enactments of the incidents with all staff members involved as a larger learning exercise, lessons learned have also been disseminated to all other areas via the Trust learning lessons newsletter.

# Patient Safety Alerts Compliance

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the National Reporting and Learning System (NRLS) and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

NHS Improvement issue three types of alert, Warning Alerts issued in response to new or under-recognised patient safety issues which ask healthcare providers to take constructive action to reduce the risk of harm occurring; Resource Alerts issued in response to already well-known issues which ask health care providers to plan implementation of new resources and Directive Alerts, issued because a specific, defined action to reduce harm has been developed which can be widely adopted through standardisation of practice or equipment.

Coordination of patient safety alerts is carried out by the Quality Team who work with various Trust departments and Health Groups to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

## NHS England NPSAS alerts issued 2019/20 and the Trust's progress

| Reference | Alert Title | Issue Date | Deadline | Trust Response |
|---|---|---|---|---|
| NATPSA/2019/001/NHSPS | Depleted batteries in intraosseous injectors | 05-Nov-19 | 05-May-20 | Action not required |
| NATPSA/2019/002/NHSPS | Risk of death and severe harm from ingesting superabsorbent polymer gel granules | 28-Nov-19 | 01-Jun-20 | Action underway |
| NATPSA/2019/003/NHSPS | Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices | 13-Dec-20 | 11-Sep-20 | Action complete and matter resolved |
| NATPSA/2020/001/NHSPS | Ligature and ligature point risk assessment tools and policies | 03-Mar-20 | 23-Jun-20 | Action underway |

# NHS Staff Survey Results

## NHS Staff Survey Results

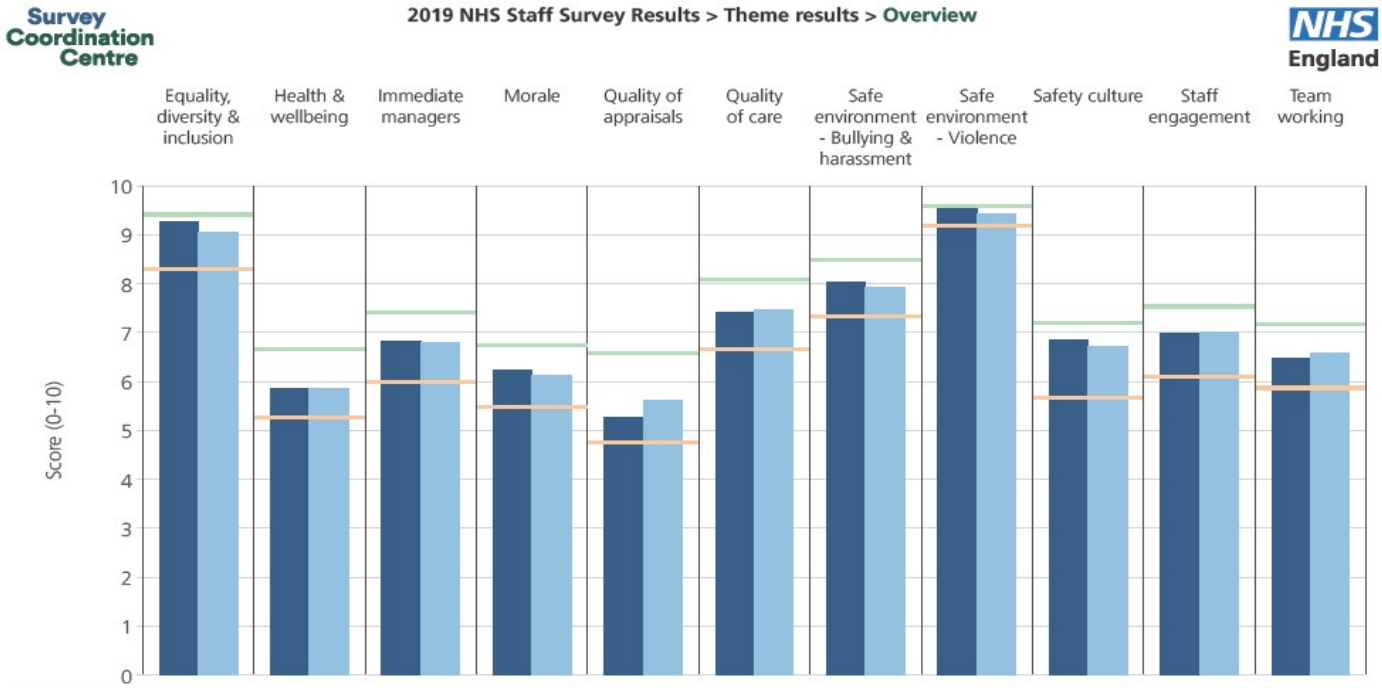
The 2019 NHS National Staff Survey ran during October and November 2019. This was a full census survey in which 3101 staff returned a survey, equating to 37% of the workforce. The response rate for the staff survey has decreased year on year since 2016 and the 2019 response rate was below the national average. An action plan is in place to further increase the response rate and engagement with the staff survey which is being monitored through the monitored via the Workforce Transformation Committee.

In the previous national staff surveys, 10 key themes were identified. This has been increased to 11 in the 2019 survey, with Team Working the new theme, the 11 themes are as follows:

- Staff Engagement
- Safety Culture
- Equality, Diversity and Inclusion
- Health and Wellbeing
- Immediate Managers
- Morale
- Quality of Appraisals
- Quality of Care
- Safe Environment – Bullying
- Safe Environment – Violence
- Team working

For each of the key themes, organisations receive a score out of ten.

Overall the Trust is better than or equal to the national average for eight of the eleven key themes in the National Staff Survey. Quality of Care, Team Working and Quality of Appraisals are worse scores than the national average. The following section of the report provides the Trust's performance compared with the national average, best score in the NHS and worst score in the NHS for each of the eleven key themes.




| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of appraisals | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.4 | 6.7 | 7.4 | 6.7 | 6.6 | 8.1 | 8.5 | 9.6 | 7.2 | 7.5 | 7.2 |
| Your org | 9.3 | 5.9 | 6.8 | 6.2 | 5.3 | 7.4 | 8.0 | 9.5 | 6.8 | 7.0 | 6.5 |
| Average | 9.0 | 5.9 | 6.8 | 6.1 | 5.6 | 7.5 | 7.9 | 9.4 | 6.7 | 7.0 | 6.6 |
| Worst | 8.3 | 5.3 | 6.0 | 5.5 | 4.8 | 6.7 | 7.3 | 9.2 | 5.7 | 6.1 | 5.9 |
| Responses | 3,089 | 3,098 | 3,094 | 3,088 | 2,669 | 2,757 | 3,076 | 3,090 | 3,091 | 3,101 | 3,073 |

### Staff engagement:

This is a key indicator for the Trust which aspires to be in the top 20% of organisations in 2020 for staff engagement. The Trust has sustained a score of 7.0 in terms of engagement, while both the best and worst scores in the country have deteriorated.

### Safety Culture:

While the Trust remains ahead of the national average for Safety Culture our score of 6.8 has deteriorated while the national average has improved.

### Equality, Diversity and Inclusion:

For Equality, Diversity and Inclusion, the Trust's score of 9.3 has remained static since the 2017 survey. For the theme as a whole however, the Trust is performing better than the national average, and almost as well as the best performing Trusts in the country.

### Health and Wellbeing:

For the Health and Wellbeing theme, the Trust is performing at the level of the national average, with a score of 5.9.

### Immediate Managers:

The Trust score of 6.8 has remained the same and due to an improving national picture we are performing at the level of the national average.

### Morale:

2019 is the second year that a theme for morale has featured in the staff survey. The Trust is ahead of the national average for this theme, with a score of 6.2, although our score has deteriorated slightly since 2018.

### Quality of appraisals:

Overall the Trust is behind the national average for this theme, with a score of 5.3.

### Quality of Care:

For the theme of quality of care, the Trust is performing slightly below the national average of 7.5, with a score of 7.4.

### Bullying and harassment:

For the theme of bullying and harassment, the Trust has a score of 8.0, which is just slightly above the national average of 7.9, however both Trust and national performance has deteriorated slightly in the last year, although this is not a significant deterioration.

### Violence:

For the theme of violence, the Trust is performing as well as the best organisations in the country with scores improving significantly in the last three years.

The National Staff Survey 2019 offers a clear indication of where the Trust needs to focus attention in the coming year. The following broad actions are included, amongst other, in the Trust's action plan which is monitored at the Workforce Transformation Committee:

- A number of waves of the Remarkable People Leadership Programme to be delivered in year
- Focus groups to be held with staff who identify themselves as having a disability or long-term condition
- Task and finish group established to address issues of concern regarding the quality of appraisals
- Review of staff networks for feeding back information to staff
- Register of networks to be established and a process for cascading information agreed
- Task and finish group established to address issues of bureaucracy and the difficulty staff have in delivering ideas for improvement

# Whistleblowing and Freedom to Speak Up

## Whistleblowing

In line with the NHS Constitution and Trust values, the Trust is committed to achieving the highest possible standards of quality, honesty, openness and accountability in all of our practices.

An important aspect of accountability and openness is a mechanism to enable employees, workers and volunteers to voice their concerns in a responsible and effective manner and for them to feel valued for doing so. Confidentiality is a fundamental term of every contract of employment, however, where an individual discovers information which they believe shows serious malpractice or wrongdoing within the Trust, this information should be disclosed without fear of reprisal.

Whistleblowing occurs 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' (Public Concern at Work). A 'protected disclosure' is one where a worker must have a reasonable belief that their disclosure is in the public interest.

To qualify for the protection (a 'qualified disclosure') afforded by The Public Interest Disclosure Act 1998, staff must have a reasonable belief that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

- a criminal offence
- the breach of a legal obligation
- a miscarriage of justice
- a danger to the health and safety of any individual
- damage to the environment
- deliberate attempt to conceal any of the above

In addition to the legal framework, in 2010 the NHS Staff Council agreed that 'Employees in the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest'. This change has been incorporated into the Terms and Conditions of Service Handbook for staff employees.

The Francis Report 'Freedom to Speak Up – A review of whistleblowing in the NHS' published in February 2015, clearly indicated that NHS staff did not feel safe raising their concerns about patient care that was being delivered. A key theme of the report was the requirement for openness, transparency and candour about matters of concern; the need for a 'just culture' as opposed to a 'no blame culture'.

Following on from the Francis Report, in April 2016 NHS England introduced 'The Freedom to speak up: raising concerns (whistleblowing) policy.' This policy was one of the recommendations from the Francis review and it aimed at improving the whistleblowing experience in the NHS.

The Trust's Raising Concerns policy incorporates the recommendations from the Francis Review stating that all staff are able to raise concerns at an any level, in the right way, and with the assurance that they will be dealt with properly. The Trust's Raising Concerns policy and governance arrangements are reviewed periodically by the Trust's Audit Committee to ensure the Trust continues to meet national requirements and expectations on supporting staff to speak up. Likewise, the Trust's policy has been subject to an internal audit review, which gave positive assurance that the Trust has effective arrangements in place to support staff to speak up.

Concerns may be raised via internal reporting processes, for example:

- DATIX (Incident Reporting tool)
- Line Manager
- Lead Clinician
- Matron
- Staff Side Representative
- Human Resources

- Occupational Health
- Chaplains
- Director of Corporate Affairs (Freedom to Speak Up Guardian)
- Staff Advice Liaison Service (SALS)
- Safeguarding Team

Concerns may be raised to the next level of management; for example:

- A member of a Health Group Triumvirate
- A Deputy/Assistant Director
- A Divisional General Manager/Divisional Nurse/Clinical Director
- Heads of Service
- Wellbeing Champions

Concerns may be raised to the most senior level of management; for example:

- A Chief/Director
- The Chief Executive
- A Non-Executive Director (NED) – the Senior Independent Director in particular has a role to support staff who need to blow the whistle
- The Director of Corporate Affairs (Freedom to Speak Up Guardian)

If the member of staff feels unable to report at any of these levels for any reason, or feels their concerns have not been addressed adequately at an earlier level, they may choose to report their concerns externally.

Concerns may be raised with an external regulatory body (which includes prescribed bodies or persons). The Trust would urge staff to allow the Trust the opportunity to investigate and resolve the concerns prior to reporting externally if at all possible. If the investigation finds the allegation is unsubstantiated and all internal procedures have been exhausted, but the member of staff is not satisfied with the outcome, the Trust recognises the lawful rights of employees to make disclosures to prescribed persons. In order to maintain the protection afforded by the Act, disclosure other than to the Trust must be made to prescribed bodies or persons and the Trust encourages staff to notify the Chief Executive of their intention to disclose their concerns externally. The Trust also encourages staff considering this course of action to seek advice from the Trust's Freedom to Speak up Guardian.

## Freedom to Speak Up

In 2017, the Trust appointed Carla Ramsay as the Freedom to Speak up Guardian. Carla has worked for the Trust since 2016 and is the role of Director of Corporate Affairs. Carla in her role as the Freedom to Speak up Guardian is available to support any colleague who is concerned about an issue that affects patient care, and if they are not sure about how to raise this issue in the organisation.

Speaking up about colleagues' behaviours can be very difficult. Likewise, raising questions about patient safety can also be intimidating, as staff may be worried about the reaction from colleagues. If staff find themselves in this position, they are encouraged to contact the guardian, or the Staff Advice and Liaison Service (SALS), in confidence to talk through the issue and to receive support.

The Freedom to Speak up Guardian reports directly to the Trust Board on their work on a quarterly basis. This includes the types of concerns being raised through this role and through SALS, so that the Trust Board is sighted on the issues being raised up in the organisation. This information is published with the Trust's public Board papers and a full-year review is included in the Trust's Annual Report.

Freedom to Speak up Guardians is supported by the National Guardian's Office (NGO). The NGO's office undertakes Trust reviews of the culture of speaking up in individual Trusts and publishes these reviews as case studies for cross-NHS learning. These are reviewed by the Trust's Freedom to Speak up Guardian and included in the updates to the Trust Board. In addition, the NGO publishes a 'speaking up index', which measures positive speaking up cultures in each NHS organisation. Hull University Teaching Hospital NHS Trust's current index shows a positive speaking up culture and that staff know how to, and feel able to raise concerns.

# Duty of Candour

## What is Duty of Candour?

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing patients about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

## How is the Trust Implementing Duty of Candour?

The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature. This requirement is detailed within the Trust's Being Open when Patients are Harmed Policy (Duty of Candour) for staff to follow, which states that the ten principles of Being Open must be applied to any incident, complaint or claim occurring as a result of healthcare treatment within the Trust resulting in harm to the patient. This policy is also supported by the Datix incident investigation training which is available for all staff to complete.

Duty of Candour is monitored within the Trust's Quality Governance and Assurance Department, who ensures that response to patients and their representatives, is sent in a timely manner, and to check the quality and content of letters, to ensure that information sent to the patient and their representatives is open and honest. Compliance is monitored and reported to the Health Groups and Operational Quality Committee for assurance and action.

## What is the Trust's compliance with Duty of Candour with the CQC?

The CQC assessed the Trust in June 2016, February 2018 and March 2020 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements and that the Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust expects that a verbal and written apology is given within 10 days of the incident occurring, and that a written explanation of the incident is sent within 10 days of the completion of the incident investigation. This compliance is monitored against a target of 90% compliance, allowing for those incidents which require more time to provide an open and honest apology and response.

## Duty of Candour compliance rates

From April 2019 to March 2020 537 incident investigations were completed that required Duty of Candour. This is because they were rated moderate or above and fit the Duty of Candour requirements.

**Verbal apology**

A verbal apology was offered for 516 (96.1%) of the 537 incidents. Of the 516 apologies that were offered, 491 (95.2%) were within 10 working days.

**Written apology**

On 208 occasions, when offered verbal apologies the patient's/families expressed they did not a written apology or feedback letter. Of the 329 incident investigations that required a written apology, 305 (92.7%) were sent. Although written apologies are sent, when requested, many of these are not within the 10 working days' timeframe. Of the 305 written apologies sent, 188 (61.6%) were sent within 10 working days. On average the remainder were sent within one month of the incident occurring.

Further work is being undertaken during 2020/21 to ensure apologies are received within reasonable timescales.

**Written feedback on completion of investigation**
Although feedback letters are sent, many of these are not within the 10 working days of the investigation being concluded. Of the 329 incident investigations that required a written feedback, 279 (84.8%) were sent. Of the 279 written feedback letters sent, 257 (92.1%) were within 10 working days.

Overall monthly 10 working day compliance for April 2019 to March 2020 is detailed in the table below:

| Duty of Candour | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Verbal | 95.5% | 94.8% | 98.1% | 91.8% | 97.0% | 90.6% | 95.7% | 97.5% | 95.1% | 96.7% | 95.3% | 94.4% |
| Written | 70.0% | 73.7% | 60.0% | 67.4% | 68.2% | 55.0% | 64.0% | 55.6% | 60.9% | 52.6% | 46.9% | 53.3% |
| Feedback | 85.7% | 93.3% | 84.0% | 95.1% | 100.0% | 63.2% | 95.8% | 100.0% | 95.0% | 100.0% | 93.1% | 100.0% |

# 2.3 Statements of Assurance From the Board

This section covers:

- Review of services
- Participation in clinical audits
- Participation in clinical research
- Goals agreed with our commissioners: use of the CQUIN payment framework
- What others say about the Trust: CQC
- Secondary Uses Service: NHS number and general practice code validity
- Information Governance
- Payment By Results Clinical Coding Audit
- Data Quality Improvements
- Learning from Deaths Update
- Reporting against core indicators - NHS Digital

# Review Services

During 2019/20 the Hull University Teaching Hospitals NHS Trust provided and/or sub-contracted 40 NHS services within 5 Health Groups and 14 Divisions.

The Hull University Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 40 of these NHS services.

The income generated by the NHS services reviewed in 2019/20 represents 100% of the total income generated from the provision of NHS services by the Hull University Teaching Hospitals NHS Trust for 2019/20.

# Clinical Audits – Participation

During 2019/20, 55 national clinical audits and 5 national confidential enquiries covered NHS services that Hull University Teaching Hospitals NHS provides.

During that period Hull University Teaching Hospitals NHS Trust participated in 96% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust was eligible to, and participate in during 2019/20 are listed below.

The national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is listed in the last column.

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| **Peri- and Neonatal** | | |
| National Neonatal Audit Programme (NNAP) | ✓ | 100% |
| National Maternity and Perinatal Audit (NMPA) | ✓ | 100% |
| **Children** | | |
| Care of Children in Emergency Departments - College of Emergency Medicine) | ✓ | 100% |
| National Paediatric Diabetes Audit (NPDA) | ✓ | 100% |
| National Audit of Seizures and Epilepsies in Children and Young People | ✓ | 100% |
| **Acute care** | | |
| Mental Health – Care in Emergency Departments | ✓ | 100% |
| National Emergency Laparotomy Audit (NELA) | ✓ | 93% |
| Society for Acute Medicine's Benchmarking Audit (SAMBA) | ✓ | 100% |
| Adult Critical Care (Case Mix Programme – ICNARC) | ✓ | 100% |
| National Asthma and COPD Audit Programme | ✓ | 100% |
| National Audit of Seizure Management in Hospitals (NASH3) | ✓ | 100% |
| National Audit of Care at the End of Life (NACEL) | ✓ | 66% |
| **Long term conditions** | | |
| Diabetes (National Adult Diabetes Audit) | ✓ | 100% |
| Diabetes in Pregnancy Audit | ✓ | 83% |
| Diabetes Footcare Audit | ✓ | 100% |
| National Diabetes Inpatient Audit (NADIA) | ✓ | 100% |
| NaDIA-Harms (Diabetic Inpatient Harms in England) | ✓ | 100% |
| Inflammatory Bowel Disease Programme / IBD Registry | ✓ | Approval is waiting from the IT Programme Board. Once this has been granted, procurement of the system will take place. It is hoped the Registry will be up and running |

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| | | later this year |
| National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis | ✓ | 100% |
| British Association of Urological Surgeons (BAUS) Urology Audit – Female Stress Urinary Incontinence | ✓ | 100% |
| UK Cystic Fibrosis Registry | ✓ | 100% |
| National Smoking Cessation Audit | ✓ | 100% |
| Neurosurgical National Audit Programme | ✓ | 100% |
| National Audit of Dementia | ✓ | 100% |
| UK Parkinson's Audit | ✓ | 100% |
| National Ophthalmology Audit | X | The Trust does not have the relevant software but runs its own independent Departmental Cataract Surgery outcomes audit. Getting It Right First Time (GIRFT) was happy with this approach. The Trust is aiming to integrate the software and take part in the audit later in the year |
| **Elective procedures** | | |
| National Joint Registry (NJR) | ✓ | 100% |
| National Audit of Percutaneous Coronary Interventions (PCI) | ✓ | 100% |
| National Vascular Registry | ✓ | 99% |
| BAUS Urology Audit - Nephrectomy | ✓ | 100% |
| BAUS Urology Audit – Radical Prostatectomy | ✓ | 100% |
| BAUS Urology Audit - Cystectomy | ✓ | 100% |
| BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL) | ✓ | 100% |
| Perioperative Quality Improvement Programme (PQIP) | ✓ | 100% |
| Adult Cardiac Surgery Audit (ACS) | ✓ | 100% |
| National Bariatric Surgery Registry (NBSR) | ✓ | 66% |
| **Heart** | | |
| Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP) | ✓ | 100% |
| National Heart Failure Audit | ✓ | 69% |
| Cardiac Rhythm Management (CRM) | ✓ | 100% |
| National Cardiac Arrest Audit (NCCA) | ✓ | 100% |
| **Cancer** | | |
| Lung Cancer (National Lung Cancer Audit) | ✓ | 100% |
| Bowel Cancer (National Bowel Cancer Audit Programme) | ✓ | 100% |
| Oesophago-gastric Cancer (National O-G Cancer Audit) | ✓ | 100% |
| National Prostate Cancer Audit | ✓ | 100% |
| Head and Neck Audit (HANA) | ✓ | 100% |
| **Trauma** | | |
| Major Trauma (Trauma and Audit Research Network) | ✓ | 100% |

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| **Older People** | | |
| Falls and Fragility Fractures Audit Programme (FFFAP) | ✓ | 100% |
| National Audit of Breast Cancer in Older People (NABCOP) | ✓ | 100% |
| Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP) | ✓ | 100% |
| Assessing Cognitive Impairment in Older People / Care in Emergency Departments | ✓ | 100% |
| **Infection** | | |
| Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) | ✓ | Data entry closes 30 April |
| Surgical Site Infection Surveillance Service | ✓ | Data entry closes 30 April |
| **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study** | | |
| Long Term Ventilation | ✓ | 50% |
| Acute Bowel Obstruction | ✓ | 75% |
| Dysphagia in Parkinson's Disease | ✓ | Ongoing |
| Out-of-Hospital Cardiac Arrest | ✓ | Ongoing |
| **Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)** | | |
| Maternal Infant and Perinatal Programme (MBBRACE-UK) | ✓ | 100% |

# Clinical Audits – Actions

The reports of 23 national clinical audits were reviewed by Hull University Teaching Hospitals NHS Trust in 2019/20 and Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

| Audit | Proposed Actions |
|---|---|
| **National audit** | |
| Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP) | • To undertake a local audit on Bronchopulmonary Dysplasia<br>• Monthly breastfeeding statistics, including any learning points to be emailed out to all NICU staff |
| National Chronic Obstructive Pulmonary Disease Audit (COPD) | • To review current performance against the standard for oxygen performance (through the NACAP online tool |
| Lung Cancer (National Lung Cancer Audit) | • To contact the Multi-Disciplinary Team (MDT) Co-Ordinators to establish how Forced Expiratory Volume (FEV) is collected and recorded, in order to establish how data submission rates for this indicator can be improved. |
| Heart Failure (Heart Failure Audit) | • No further action required |
| National Diabetes Footcare Audit (NDFA) | • To share the results of the audit with Vascular Surgery, particularly in relation to the amputation rate. |
| National Diabetes Inpatient Audit (NaDIA) | • Implement a NaDIA Harms section on Datix (Incident Reporting Software) to ensure a more robust collection of diabetes-related harms data<br>• To carry out a Trust-wide review on staff training relating to diabetes, as part of the Getting It Right First Time (GIRFT) programme<br>• To implement the foot risk assessment tool<br>• To continue with the development of a business case in order to provide 7-day cover by Diabetes Inpatient Specialist Nurses |
| Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit) | • To implement a proforma to be completed by ward staff to ensure patients are screened for coeliac disease and carb counting on admission<br>• To put together a business case to employ a dedicated paediatric diabetic dietician<br>• To continue to work closely with patients with high HbA1c levels. Continuing one to one sessions in clinic and drop in sessions in schools. To review the high HbA1c policy with the MDT<br>• To continue to do microalbumin tests at the time of the clinic appointment in paediatrics. This action was first implemented in 2018 and has already proven to be successful seeing figures rise from 49.1% in 2017/18 to 61.8% in 18/19 |
| National Audit of Dementia – Spotlight Audit on Delirium Assessment | • To introduce the '4AT' test as part of the Trust wide delirium assessment<br>• To include the '4AT' test in the medical clerking booklet alongside the 'SQiD' (Single Question in Delirium)<br>• To introduce new dementia training across the Trust, for all staff members (including externally contracted staff).<br>• To develop and distribute a dementia and delirium information leaflet for patients and carers<br>• To raise awareness that finger food is available for dementia patients across the Trust<br>• To establish a formalised network of Dementia Champions within the Trust<br>• To establish a direct referral route to the Dementia Lead Nurse in order to provide support to patients/ carers and staff |
| National Cardiac Arrest Audit (NCAA) | • Continue to share learning from the NCAA dataset including ceilings of care and the prescription of appropriate resuscitation in the Consultant mandatory update training |
| Vital Signs in Adults (RCEM) | • No further action required |
| VTE Risk in Lower Limb Immobilisation (RCEM) | • To implement the VTE and Bleeding Risk Assessments<br>• To review the content of the relevant Patient Information Leaflet |
| **National audit** | |
| Feverish Children (RCEM) | • To include various aspects of the sepsis tool and completion of observations within the mandatory sections of the new Electronic Patient Record through Lorenzo, to improve documentation |

| Audit | Proposed Actions |
|---|---|
| | • To raise awareness of the need to document wherever patients are provided with Patient Information Leaflets<br>• To carry out an audit focused on paediatric patients that definitively require blood pressure monitoring, to establish compliance with the standards for these patients<br>• To review the escalation processes in place for triage nurses, to provide quicker senior reviews where required |
| Myocardial Ischaemia National Audit Project (MINAP) | • To raise the issue of delays with both the Cardiac Network and the relevant Ambulance Services, particularly in relation to patients transferred into Castle Hill Hospital from other hospitals in the region |
| National Audit of Percutaneous Coronary Interventions (PCI) | • No further action required |
| Sentinel Stroke National Audit Programme (SSNAP) | • To explore potential opportunities for raising stroke awareness within the local GPs (e.g. through recorded lectures and posters to guide GP referrals) and communities<br>• To ensure the attendance of the audit co-ordinator at the Multi-Disciplinary Team meetings, to ensure that rehabilitation goals are recorded for all patients<br>• To carry out a patient survey seeking patient / carer views on stroke services<br>• To gain agreement from MRI to provide a number of slots for use by Stroke Medicine, so that clinic attenders are able to access these tests in a timely fashion |
| National Prostate Cancer Audit (NPCA) | • To ensure all theatre notes are typed up onto Lorenzo. Each of the 6 key data items are to be recorded on typed operation notes or clinic letters for all new patients<br>• To discuss with colleagues the potential over treatment of men with low-risk localised disease at the Urology Performance Meeting, however treatment received is down to patient choice |
| National Hip Fracture Database | • To establish a multidisciplinary group (including representatives from Orthopaedics, Orthogeriatrics, Elderly Medicine, Anaesthetics, Emergency Department, Nursing and Therapies), to ensure service improvements across all aspects of care for patients with hip fractures<br>• To increase theatre capacity in order to improve the time to theatre for patients with hip fractures<br>• To recruit and allocate increased resource to the collection of data for the National Hip Fracture Database, to improve overall data quality<br>• To investigate the use of Sliding Hip Screw (SHS) in patients with intertrochanteric hip fractures<br>• To investigate potential alternatives for reviewing patients 120 days post-surgery (e.g. telephone clinics)<br>• To recruit further Orthogeriatric specialists<br>• To ensure that physiotherapists record data on patient mobilisation in both physical and digital copies of the patient record<br>• To discuss the use of nerve blocks in addition to general anaesthetic with the Neck of Femur group, to establish why HUTH use differs from the national data |
| National Oesophago-Gastric Cancer Audit | • To increase the proportion of patients that are managed endoscopically<br>• To implement the guidance set out by NHS England in the 'Implementing a timed oesophago-gastric cancer diagnostic pathway' handbook |
| National Audit of Breast Cancer in Older People (NABCOP) | • No further action required |
| **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study** | |
| Mental Healthcare in Young People and Young Adults | • Gap analysis to be presented at the CEPPD committee in October 2020 |
| Pulmonary Embolism | • Gap analysis currently underway |
| **Other Enquiries/Reviews** | |
| MBRRACE-UK Perinatal Mortality Surveillance | • To introduce delayed cord clamping as standard practice<br>• To increase compliance with antenatal steroids given before birth<br>• To introduce the MBRRACE Perinatal Review Tool |
| Saving Lives, Improving Mothers' Care | • To develop a referral flowchart for the care of pregnant women with breast cancer and cardiovascular disease |

# Clinical Audits – Action Progress

An update regarding the implementation of the actions identified as a result of a national clinical audit report published in 2018/19 has been provided below. Actions taken in response to reports published in 2019/20 will be included in the Quality Accounts for 2020/21.

| Proposed actions | Progress |
|---|---|
| **Pain in Children (College of Emergency Medicine)** | |
| To educate staff on carrying out and documenting pain scoring. | Training has been undertaken both face-to-face and via email. Posters have also been displayed |
| To educate staff on the documentation of analgesia given, and the importance of recording a reason wherever analgesia is not given. | |
| To amend the Casualty Card (CAS) card to include a section for documenting reasons for why analgesia has not been given | Action complete |
| To discuss the possibility of having pain scoring and analgesia added to the triage section of the patient's Lorenzo record | The pain score is part of the Lorenzo electronic system and will be on electronic observations when it is implemented in the Paediatric Emergency Department |
| To implement a system of patient-led evaluation of pain after analgesia. This will include education of nursing staff on the new system and the creation of posters to be shown in patient waiting areas to ensure that patients are aware of the system. | Action complete. Leaflets are given to patients at reception and at triage |
| To develop a business case for improved nursing cover, in order to improve triage times | Ongoing |
| To disseminate results to all Emergency Department staff, to raise awareness of the issues and key learning points | The results have been disseminated via email and presented at the senior staff executive forum |
| To undertake a re-audit and present the results to the Clinical Effectiveness, Policies and Practice Development Committee | This has been delayed until the new electronic observations system is in place |
| **Procedural Sedation in Adults (College of Emergency Medicine)** | |
| To introduce a proforma for patients undergoing sedation in the Emergency Department to ensure all relevant data is recorded | An electronic sedation proforma is now in use |
| **National Diabetes Inpatient Audit (NaDIA)** | |
| To explore the possibility of setting up a mandatory training module for all clinical staff on the subject of diabetes. | Ongoing |
| To communicate the importance of insulin timing and treatment to staff across the Trust (through Lessons Learned / Newsletter/ Pattie). | An insulin safety walk around the Trust was undertaken in December 2019 promoting correct injection technique and not omitting basal insulin. A Diabetes Safety Group has been set up to promote safe high quality care for in patients with diabetes. A quarterly newsletter will be launched in April 2020 |
| To send a copy of the outcome form / report to the Trust Catering Services Manager, to ensure that the patient feedback included within the report (in relation to catering) is passed on. | Action complete |
| **National Audit of Dementia (NAD)** | |
| To carry out a Trust wide teaching session on delirium and dementia | Action complete |
| To re-audit the delirium screen and assessment | To be completed post phase 2 Lorenzo Digital Exemplar (LDE) switchover (digital/paperless working) |
| To arrange a meeting with the Lorenzo team to introduce a section on cognition on the Immediate Discharge Letter to enable transfer of information | Action complete. This work forms part of phase 2 LDE pathway |
| To undertake a junior doctor teaching session on delirium recognition and assessment (including history taking) | This has been completed as part of DME teaching, junior doctor induction and grand rounds |
| To provide a teaching session on the importance of filling out the dementia and delirium care bundle | This has been completed at numerous meetings including the nurse conference |
| **National Hip Fracture Database (NHFD)** | |

| Proposed actions | Progress |
|---|---|
| Theatre space will be increased as of February 2019. A further 7 theatre lists a week are to be available to the trauma service, including a dedicated hip fracture list every day. A new trauma consultant has also been employed. | The Trust now has an extra 7 trauma theatre lists and has appointed two substantive trauma consultants (starting June and August 2020). Two locums are currently in post |
| To speak to anaesthetic lead to determine whether the number of nerve blocks given during a General Anaesthetic (GA) can be increased. | Action complete |
| To remind the orthopaedic team that intertrochanteric fractures should be treated with a SHS as this is more cost efficient. | Action complete |
| To hold 'Time out' sessions to involving the various disciplines contributing to hip fracture care to review patient pathways. | A working group now meets monthly to develop the pathways |
| **National Paediatric Diabetes Audit (NPDA)** | |
| To liaise with HICOM and HEY IT Services to agree the pathology interface license for Twinkle system to improve data collection from Lorenzo to Twinkle. | IT Services have linked the systems and the new system will be up and running by Summer 2020 |
| To ensure Micro albumin tests are now being done at the time of clinic appointment in the Paediatrics Department | The results of the most recent audit show that this figure has increased by 9% to 53% |
| To undertake a casenote audit to understand if there are any variances in practice between Hull CCG and East Riding CCG patient cohorts. | To be undertaken in Summer 2020 |
| **National Chronic Obstructive Pulmonary Disease Audit (COPD)** | |
| To update the Trust Oxygen Policy, in line with RCP Guidance | The policy has been updated |
| To introduce a new Oxygen training package, in line with the new policy | This has been introduced and is mandatory for all clinical staff |
| A proforma for the initiation of non-invasive ventilation (NIV) in the Emergency Department has been introduced, featuring the NIV criteria, ceiling of care, time of initiation and other key information. | The proforma has been introduced in the Emergency Department |
| For the Acute Respiratory Assessment Service (ARAS) nurses to state clearly during reviews that follow-up arrangements should be clearly documented in the Immediate Discharge Letter (IDL), in order to improve data quality. | Action complete. ARAS initiate and arrange all follow up appointments to ensure patients are not missed |
| To explore the feasibility of visiting GP practices to assist in identifying patients that are receiving suboptimal care, in order to improve readmission rates | A pilot programme outreaching into GP practices to support asthma management has been undertaken. The results of this have been presented to the CCG |
| To pursue the possibility of Respiratory Medicine being able to have a protected bed base for Chronic Obstructive Pulmonary Disorder (COPD) patients | There is no protected bed base but COPD patients are admitted to respiratory where possible and if not, ARAS endeavour to review them |
| All spirometry results are now accessible from all desktop computers in the organisation. Further work is being carried out to ensure that spirometry results from tests carried out anywhere in the Trust are accessible via Lorenzo | Spirometry performed in Castle Hill clinics are available on Lorenzo, however this is not the case for spirometry performed in the chest clinic at Hull Royal Infirmary due to the equipment being used |
| **Heart failure (Heart Failure Audit)** | |
| To investigate the causes for low referral rate to Heart Failure Nurse follow up – particularly in patients with Left Ventricular Systolic Dysfunction (LVSD) patients | Patients are more frequently followed up by cardiology than by the Heart Failure nurses (this includes LVSD patients) |
| **Sentinel Stroke National Audit Programme (SSNAP)** | |
| To review cases where an eligible patient (according to the Royal College of Physicians guideline minimum threshold) is not thrombolysed | The Trust usually meets the standard for 100% of patients. However, there is a fortnightly meeting where patients who are not thrombolysed are discussed |
| To download Trust data prior to the submission deadlines, in order to review and ensure the quality of the thrombolysis data | This is routinely undertaken |
| To undertake an audit of swallow screening on the Stroke ward | An audit has been undertaken |
| To communicate with the Stroke Co-ordinators to highlight the need to refer all patients to Speech and Language Therapy that are marked as suffering dysarthria on the NIHSS (National Institutes of Health Stroke Scale) | Action complete |

The reports of 114 local clinical audits were reviewed by the provider in 2019/20 and Hull

University Teaching Hospitals NHS Trust. For a full list of the proposed actions Hull University Teaching Hospitals NHS Trust intends to take following local audits reviewed during 2019/20, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: quality.accounts@hey.nhs.uk or online via https://www.hey.nhs.uk/about-us/corporate-documents/#quality-account

# Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was 3,137.

## Commitment to research as a driver for improving the quality of care and patient experience

The Trust is committed to providing the best possible care to patients and recognises the value of high quality peer-review research as a fundamental tool in the successful promotion of health and well-being for the population it serves. To achieve this, the Trust has focused on research activities which addresses NHS priorities, is of national and international quality and is cost-effective.

Every study the Trust participates in will, in some way, have a direct or indirect benefit to institutions, staff, patients, carers, policy makers and academics. The collective benefits for our population of participating in research include more personalised, protocol driven care with often more frequent oversight of clinical outcomes and safety assessments. Frequently, research participation allows for increased interactions between clinical staff and patients, providing more time to make assessments of patients' needs and anxieties and therefore supporting a trusting relationship to flourish.

## Research portfolio and activity

The Trust was involved in processing 103 new clinical research studies of which 84 commenced during the reporting period 2019/20. This compares with 127 new submissions and 73 commencing in 2018/19. Of the studies given permission to start, 94 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 143 studies actively reporting patient recruitment under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 142 portfolio studies reporting accruals for the period 2018/19.

The number of recruits into the Trust portfolio studies for the periods 2019/20 and 2018/19 was 2,493 and 4,210 respectively. The largest topic area of portfolio adopted studies across 2019/20 was Oncology (Cancer) and Haematology with 41 studies between them. The top five therapeutic areas of Trust research in 2019-20 (based on portfolio recruiting studies) were:

1) Oncology and Haematology (41)
2) Cardiovascular (26) (Cardiology Intervention + Academic, Cardiothoracic, Diabetes, Vascular, Respiratory)
3) Gastroenterology and Hepatology (16)
4) Musculoskeletal (7)
5) Trauma and Emergency Care (6); Surgery (6)

89% of commercial portfolio studies completed in 2019/20 recruited on time and to an agreed target. This has helped the Trust maintain a strong relationship with pharmaceutical and medical device companies that allows the Trust to be part of offering novel technologies and treatment to patients in more and more therapeutic areas.

## Research Strategy

The Research and Innovation Strategy 2018-23 was approved by the Trust Board in July 2018. The Trust Research and Innovation Strategy will be delivered through three key priority themes:

### A Research Aware Organisation

***Achievements:***

- Year 1 has focussed on generating institutional research awareness through metrics. The development of performance dashboards available on Pattie provides all staff with access to interactive, visually appealing reports that give

real-time data intelligence for planning and forecasting purposes.
- The dashboards have been operational from April 2019 with development work on-going to ensure they are robust and effective.
- Focus has been on involving Patient Research Ambassadors (PRAs) in co-design and review (via Trans-Humber Consumer Research Panel – hosted by HUTH).
- Excellent feedback in annual external Trust Research and Development R&D website review (2019).
- Patient Research Experience Survey (PRES) 2019 – Yorkshire and Humber (Y&H) CRN target reached.

## Positive, Proactive Partnerships

### *Achievements:*

- 'Cluster Arrangements' (clinical Synergies) for multi-morbidity research: Diabetes + Renal, ICU + Infectious Diseases, Cardiology + Interventional Cardiology + Cardiothoracic Surgery.
- 'Provisional' accreditation status for the Hull Health Trails Unit (HHTU) confirmed by the UK Clinical Research Collaboration (UKCRC). Full accreditation expected within 3 years.
- Formal contribution of R&D quality assurance support provided as part of development activities of HHTU including complex drug study setup.
- Supported the HHTU and University of Hull (UoH) Institute for Clinical and Applied Health Research (ICAHR) launch in March 2019
- HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU.
- UoH acknowledged as core academic partner with Trust name change in March 2019.
- Strategic and operational support for HHTU and ICAHR.
- Aligned research focus (PET-CT, Palliative/Respiratory, Rehabilitation, Gastroenterology, Infectious Diseases supported as part of jointly funded 'Research Support Funding' initiative).
- Addictions Research Collaborative –support for development of alcohol addiction research (first joint study to be undertaken in Q4 2019/20).
- Y&H Academic Health Science Network (AHSN): (Innovate UK grant with Entia - medtech company (Renal Point of Care/telehealth/app), adoption of Accelerated Access Collaborative products (HeartFlow)).
- Y&N CRN - Strong focus in 'research relevant' specialties (Cardiovascular, Diabetes, Oncology, Respiratory and Renal).
- International Partnerships - HUTH signed an 'Agreement for Academic Exchange and co-operation' with Sri Ramachandra Institute of Higher Education and Research (SRIHER) Chennai, India in May 2019. This agreement has already yielded the following returns:
  - Overseas Simulation Fellow programme commenced in May 2019 with one SRIHER colleague visiting HUTH in May and June 2019.
  - Identification of 14 potential areas of research collaboration between the Trust and SRIHER (of which Microfluidics, Therapies/Rehabilitation, Infectious Diseases, Diabetes, Renal and clinical skills/simulation have already established strong links).
  - A Joint Research Conference in Chennai in February 2020. A delegation representing HUTH and UoH attended.

## Reputation through Research

### *Achievements:*

- 4 PhD Scholarships awarded in conjunction with UoH (2 Allied Health Professionals).
- 6 areas and individuals supported with protected time or methodological support following the award of 'Research Support Funding' from HUTH/UoH and Hull York Medical School (HYMS).
- 2 R&D Funded Clinical Research Fellows appointed (Renal and Cardiothoracic Surgery).
- 4 further Clinical Research Fellows (funded from NIHR RCF or other external sources – 2 in Orthopaedics, 1 in Gastroenterology (IBD)), 1 in Renal).
- Lead Research Nurse appointed October 2019.
- Vascular Allied Health Professional (AHP) leading an NIHR grant.
- Secured 1 NIHR Senior Investigator Award (Prof Chetter, Vascular Surgery)

- Secured multiple Academic Clinical Fellows (ACFs) in key clinical and academic areas for appointment in 2020.
- The Trust has continued to build capability and capacity with a number of new early career researchers and Principal Investigators. The NIHR have awarded the Trust with the following 5 ACF posts, for appointment in 2020:
  - ACF Clinical Oncology or Medical Oncology, under the Platform Science and Bioinformatics theme. To work under their supervision on molecular pathways of pancreatic cancer carcinogenesis from pancreatic cystic neoplasms to adenocarcinoma.
  - ACF Haematology, ST3 entry under the Therapeutics or Clinical Pharmacology theme. To work on targeted re-purposing of diabetes medicines to reduce thrombosis in patients with myeloproliferative neoplasms.
  - ACF Vascular Surgery, under the Older People and Complex Health Needs theme. To work on identifying changes in vascular inflammation associated with improved patient outcomes in peripheral arterial disease following structured exercise.
  - ACF General Surgery or Vascular Surgery (formula post, therefore, no theme and research plans not proposed in advance).
  - ACF Palliative Medicine (formula post therefore, no theme, and research plans not proposed in advance).

# Goals Agreed With Our Commissioners: Use of the CQUIN Payment Framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

## Use of the CQUIN payment framework

A proportion of Hull University Teaching Hospitals NHS Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Hull University Teaching Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

There are no local Clinical Commissioning Group (CCG) schemes as there are several national CQUIN schemes mandated to all Trust's to deliver in 2019/20.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value.

**National CQUIN schemes** 2019/20 for CCGs include:

- Staff Flu Vaccinations
- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery
- Alcohol and Tobacco – Screening and brief advice
- Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

### NHS England Specialised Services (NHSE):

The Trust receives a CQUIN value of 1.25%. The CQUIN payment will be based on actual contract expenditure; however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Tariff Payment System and all other expenditure contracted on a "pass through" basis. CQUIN funding for the Hepatitis C Operational Delivery Network previously paid via a top up of 0.65%.

The NHSE specialised schemes of 2019/20 include:

- Hepatitis C Operational Delivery Network (ODN)
- Rethinking Conversations
- Medicines optimisation
- Enabling Thrombectomy
- Immunoglobulin stewardship

Public Health England (PHE) has used the national CQUINs for 2019/20.

Due to the COVID-19 pandemic, national guidance was produced advising Commissioners and Trusts to take a pragmatic approach to the agreement of the final payments amounts for the 2019/20 CQUIN schemes based on available data. There were no formal requirements for the Quarter 4 (Q4) 19/20 reports to be submitted and therefore, the Trust received its Q4 19/20 payments in full. With no data available for Q4 19/20, there was an assumption that schemes that had previously failed would also fail in Q4 19/20. The following table details the CQUIN's for 2019/20.

## 2019/20 National Achievement:

| CQUIN Indicator / No. | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Expected £ 4,402,978 | Under Achieved £ |
|---|---|---|---|---|---|---|
| 1a AMR Older People | Failed | Failed | Failed | Failed | 550,407 | 550,407 |
| 1b AMR Colorectal Surgery | Failed | Achieved | Achieved | Achieved | 550,352 | 137,602 |
| 2 Improving the uptake of flu vaccinations for frontline clinical staff **Annual target** | Not required | Not required | Not required | Achieved | 1,100,813 | |
| 3a Alcohol and Tobacco Screen | Failed | Failed | Failed | Failed | 366,901 | 366,901 |
| 3b Tobacco Advice | Achieved | Achieved | Achieved | Achieved | 366,901 | |
| 3c Alcohol advice | Failed | Failed | Failed | Failed | 366,901 | 366,901 |
| 11aSDEC pulmonary Embolism | Achieved | Achieved | Achieved | Achieved | 366,901 | |
| 11b SDEC AF | Achieved | Achieved | Achieved | Achieved | 366,901 | |
| 11c SDEC Pneumonia | Achieved | Achieved | Achieved | Achieved | 366,901 | |
| | | | | **Total** | **4,036,077** | **1,421,811** |

## 2019/20 NHS England Specialised Achievements:

| CQUIN Indicator / No. | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Expected £ 2,114,573 | Under Achieved £ |
|---|---|---|---|---|---|---|
| PSS1 Medicines Optimisations Trigger 1 | Not Required | Achieved | Achieved | Achieved | 115,001 | |
| PSS1 Medicines Optimisations Trigger 2 | Achieved | Achieved | Achieved | Achieved | 92,000 | |
| PSS1 Medicines Optimisations Trigger 3 | Achieved | Achieved | Failed | Failed | 161,001 | 80,500 |
| PSS1 Medicines Optimisations Trigger 4 | Not Required | Achieved | Achieved | Achieved | 92,000 | |
| PSS2 Hepatitis C Trigger 1 | Partially Achieved | Partially Achieved | Partially Achieved | Partially Achieved | 528,501 | 84,560 |
| PSS2 Hepatitis C Trigger 2 | Achieved | Achieved | Achieved | Achieved | 75,000 | |
| PSS2 Hepatitis C Trigger 3 | Achieved | Achieved | Achieved | Achieved | 151,000 | |
| PSS2 Hepatitis C Governance | Achieved | Achieved | Achieved | Achieved | 150,000 | |
| PSS9 Immunoglobulin Stewardship Trigger 1 | Achieved | Achieved | Achieved | Achieved | 141,001 | |
| PSS9 Immunoglobulin Stewardship Trigger 2 | Achieved | Achieved | Achieved | Achieved | 23,500 | |
| PSS9 Immunoglobulin Stewardship Trigger 3 | Achieved | Achieved | Achieved | Achieved | 58,751 | |
| PSS9 Immunoglobulin Stewardship Trigger 4 | Achieved | Achieved | Achieved | Achieved | 11,750 | |
| PSS9 Immunoglobulin Stewardship Trigger 5 | Achieved | Achieved | Achieved | Achieved | 0 | |
| PSS12 Enabling Mechanical Thrombectomy Trigger 1 | Achieved | Achieved | Achieved | Achieved | 37,501 | |
| PSS12 Enabling Mechanical Thrombectomy Trigger 2 | Achieved | Achieved | Achieved | Achieved | 37,501 | |
| PSS12 Enabling Mechanical Thrombectomy Trigger 3 | Achieved | Achieved | Achieved | Achieved | 37,501 | |
| PSS12 Enabling Mechanical Thrombectomy Trigger 4 | Achieved | Achieved | Achieved | Achieved | 37,501 | |
| PSS13 Rethinking Conversations Trigger 1 | Achieved | Achieved | Achieved | Achieved | 40,001 | |
| PSS13 Rethinking Conversations Trigger 2 | Achieved | Achieved | Achieved | Achieved | 40,001 | |
| PSS13 Rethinking Conversations Trigger 3 | Achieved | Achieved | Achieved | Achieved | 60,001 | |
| PSS13 Rethinking Conversations Trigger 4 | Achieved | Achieved | Achieved | Achieved | 60,001 | |
| | | | | Total | 1,949,513 | 165,060 |

Further details of the agreed goals for 2019/20 and for the following 12 month period are available on request from the following email address: quality.accounts@hey.nhs.uk

# Care Quality Commission

## About the Care Quality Commission

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services. The CQC Operating Model was revised and in June 2017 the CQC confirmed they will focus on eight core services and four additional services. The additional services may be inspected depending on the level of activity and risk.

The eight core services are:

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients

The four additional services are:

- Gynaecology
- Diagnostic Imaging
- Rehabilitation
- Spinal Injuries

When inspecting these eight core services, the CQC will focus on the following five key questions:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well-led?

The CQC continue to use the ratings as detailed in their Operating Model; they are an important element of the CQC approach to inspection and regulation. The ratings are outstanding, good, requires improvement and inadequate. You can find more about the CQC and the standards here: www.cqc.org.uk

## Statement of compliance with the Care Quality Commission

Hull University Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has taken enforcement action against Hull University Teaching Hospitals NHS Trust during 2019/20.

Hull University Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

## Sexual Assault and Referral Centre Inspection

The CQC undertook a Sexual Assault and Referral Centre (SARC) inspection of the Trust's Child Sexual Assault Assessment Service (CSAAS) during the reporting period. The inspection was undertaken on 29 and 30 January 2020 in the Anlaby Suite at Hull Royal Infirmary.

The Trust received a Section 29a Warning Notice following this inspection because the systems and processes the Trust had in place did not ensure the effectiveness of decontamination procedures.

The Trust took immediate actions to address the concerns raised in the Section 29a Warning Notice and an action plan was developed to evidence this. A full response on actions taken and planned actions were submitted to the CQC in line within the agreed timescales and assurance was provided.

In March 2020, the CQC published the final report from the January 2020 SARC inspection.

The CQC reported that the service was providing safe, effective, caring and responsive care in accordance to the relevant regulations. However, the CQC reported that the service was not providing well-led care in accordance with the relevant regulations and as a result they have taken enforcement action in relation to the regulatory breaches. Regulation breach 17 – Good Governance was breached due to effectiveness of the decontamination procedures.

The Trust reviewed the published report and included the additional areas for improvement to the original action plan, which again was shared with the CQC for assurance on actions taken.

In May 2020, the SARC lead inspector completed a desk top review of the delivery against the Trust action plan, supporting evidence and additional photographic evidence to demonstrate improvements to the environment as the inspector was unable to re-visit the site due to the COVID-19 pandemic. The CQC have published an additional inspection report following the desk top review, which confirms the required improvements have been made and the breaches have been addressed. The CQC reported that the service was now providing safe, effective, caring, responsive and well-led care in accordance to the relevant regulations.

## Trust Comprehensive Inspection; Current CQC Ratings

The CQC commenced the Trust's comprehensive inspection during the reporting period. The CQC undertook the unannounced element of the inspection process between 03 and 05 March 2020 across both Hull Royal Infirmary and the Castle Hill Hospital. The inspection covered the Emergency Department, Medical Care, Surgery and Critical Care. Due to the Covid-19 pandemic the CQC was not able to complete the well-led element of the inspection and therefore the comprehensive inspection was partially completed.
Following the inspection, the Trust received a Section 31 Initial Letter of Intent from the CQC in relation to nurse and medical staffing within the Paediatric Emergency Department. The Trust was required to provide an action plan to demonstrate how it would address the areas of concern and to submit a weekly information update to the CQC on medical and nurse staffing rotas and any actions taken to address any gaps. The Trust provided the information as required. A further letter was received in April 2020, stating that the CQC was satisfied that their concerns and mitigates patient safety risks highlighted. However, they do still have a duty to ensure patient safety is maintained and in response to the COVID-19 pandemic they changed the frequency of reporting to monthly. The Trust has also complied with this.

The Section 31 action plan is currently being implemented, which again was shared with the CQC for assurance on actions taken. This will continue to be monitored until fully delivered and the CQC have the relevant assurance and evidence that improvements have been made.

The CQC confirmed that they would still produce an inspection report of findings and ratings for the services inspected in March 2020; Emergency Department, Medical Care, Surgery and Critical Care. The inspection report and evidence appendix were published on 23 June 2020. The full inspection reports can be accessed via https://www.cqc.org.uk/provider/RWA

The Trust's overall rating remains as 'Requires Improvement' due to the non-completion of the

**Ratings for the whole trust**

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement Jun 2018 | Good Jun 2018 | Good Jun 2018 | Requires improvement Jun 2018 | Good Jun 2018 | Requires improvement Jun 2018 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services
Ratings for other key questions are from combining ratings for services and using our professional judgement.

**Rating for acute services/acute trust**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Hull Royal Infirmary | Requires improvement 2020 | Good 2020 | Good 2020 | Requires improvement 2020 | Requires improvement 2020 | Requires improvement 2020 |
| Castle Hill Hospital | Good 2020 | Good 2020 | Good 2020 | Good 2020 | Good 2020 | Good 2020 |
| **Overall trust** | Requires improvement 2020 | Good 2020 | Good 2020 | Requires improvement 2020 | Good 2020 | Requires improvement 2020 |

Trust well-led inspection. Although the overall rating for the Trust did not change, there were a number of improved ratings for the core services and domains across HRI and CHH. These are detailed in the rating tables on the next page.

## Ratings for Castle Hill Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 |
| Surgery | Good ↑ 2020 | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good ↑ 2020 |
| Critical care | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Requires improvement →← 2020 | Good ↑ 2020 |
| End of life care | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 |
| Outpatients | Good Jun 2018 | Not rated | Good Jun 2018 | Requires improvement Jun 2018 | Good Jun 2018 | Good Jun 2018 |
| **Overall*** | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 |

## Ratings for Hull Royal Infirmary

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement ↓ 2020 | Good →← 2020 | Good →← 2020 | Requires improvement →← 2020 | Requires improvement ↓ 2020 | Requires improvement ↓ 2020 |
| Medical care (including older people's care) | Requires improvement →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 |
| Surgery | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 |
| Critical care | Good ↑ 2020 | Good →← 2020 | Good →← 2020 | Good →← 2020 | Requires improvement →← 2020 | Good ↑ 2020 |
| Maternity | Good Jun 2018 | Good Jun 2018 | Good Jun 2018 | Good Jun 2018 | Good Jun 2018 | Good Jun 2018 |
| Services for children and young people | Requires improvement Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 |
| End of life care | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 | Good Feb 2017 |
| Outpatients | Good Jun 2018 | Not rated | Good Jun 2018 | Requires improvement Jun 2018 | Good Jun 2018 | Good Jun 2018 |
| **Overall*** | Requires improvement →← 2020 | Good →← 2020 | Good →← 2020 | Requires improvement →← 2020 | Requires improvement ↓ 2020 | Requires improvement →← 2020 |

The CQC found areas of improvement including 11 areas of legal requirements. This translated into 8 must do actions in urgent and emergency services, 1 must do in medical care and 2 in critical care.

The Trust was also issued with a number of minor breaches which resulted in should do actions for medical care, surgery and critical care. The must do actions and that the Trust must address are as follows:

### *Urgent and Emergency Care*

- The service must ensure the right care is received promptly when people access the service
- The service must ensure steps are taken urgently to facilitate the flow of patients through the emergency department
- The service must ensure initial assessment of paediatric patients includes the completion of a paediatric early warning score for each patient
- The service must ensure staff have the skills, competence and experience to provide safe care and treatment for children
- The service must ensure care and treatment is safe and timely for patients with mental health needs including children
- The service must ensure patient records are completed fully and consistently and include basic nursing tasks and assessments undertaken and on-going care of patients lodging in the department
- The service must ensure governance processes are operated which ensure the performance of the service is monitored and managed effectively
- The service must ensure governance processes are operated which ensure risks are monitored and mitigated effectively

### *Medical Care*

- The service must ensure that all patients who trigger an alert using the National Early Warning Score (NEWS2) to show signs of deterioration are appropriately escalated for a medical review in line with the trust policy and this must be documented in the patient's record at HRI

### *Critical Care*

- The service must ensure robust governance processes are introduced to maintain oversight of all of the key risks to the units and ensure actions are put in place to mitigate these risks effectively at HRI and CHH

The Trust has developed an action plan to address all areas of must and should do actions and corresponding regulatory breaches.

## Outstanding practice

The CQC also identified a number of outstanding practices including:

### *Surgery*

- Staff working and volunteering in neurosurgery on ward 40 clearly treated patients with outstanding compassion and kindness, taking into account each patients' individual needs. The specialist care, treatment and emotional support they provided to patients, families and carers to minimise their distress was exceptional, from writing cards to relatives of patients who had passed away, to developing new ways of providing services and encouraging working with volunteer organisations they were clearly committed to delivering high standards of care.

### *Critical Care*

- Staff in the unit told the CQC about a number of initiatives they had in place for the families of patients who were receiving end of life care. This included providing moulds or hand prints, locks of hair, forget me not and poppy seeds. In addition, the unit had memory boxes for children which included trinkets and a teddy.
- The specialist nurses for organ donation explained they would be involved in the care of patients at the end of their life, regardless of the organ donation decision. This included being involved in conversations with the patients loved ones to determine any final wishes, for example if they wanted any specific music played, or the presence of a chaplain.
- The unit also had a lead for care at the end of life. This member of staff said the unit was striving to ensure patients and their families received a positive experience of the care

provided at end of life. A number of initiatives were in place, for example, completing Respect documentation to ensure patient's wishes were carried out, arranging visits to a local hospice if applicable, and ensuring patients preferred place of care was established and documented.

- The specialist staff also told the CQC that they would stay with family members throughout the withdrawal of treatment for organ donors or any patient who was at the end of their life.

# NHS Number and General Medical Practice Code

Hull University Teaching Hospitals NHS Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:
Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care
- 99.86% for admitted patient care;
- 99.95% for outpatient care; and
- 99.07% for accident and emergency care

# Information Governance

The Information Governance Data Security and Protection Toolkit (DSP Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance. It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisation and between external organisations.

The Information Governance Assurance Statement is a required element of the DSP Toolkit and is re-affirmed by the annual submission to demonstrate that the organisation has robust and effective systems in place to meet statutory obligations on data protection and data security.

Hull University Teaching Hospitals NHS Trust's Information Governance Assessment Report overall score for 2019/20 was % unknown, (rated unknown). *

**The Trust is unable to complete this statement at this time (May 2020). Due to the National COVID-19 Pandemic Response, the Information Commissioner's Office (ICO) has announced that the 2019/20 DSP Toolkit Assessment submission deadline has been extended to 30 September 2020. The assessment can be accessed via the NHS Digital website https://www.dsptoolkit.nhs.uk/OrganisationSearch/RWA*

# Payment by Results Clinical Coding Audit

Hull University Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

# Data Quality Improvements

Hull University Teaching Hospitals NHS Trust will be taking the following actions to improve data quality. The actions have been taking from recommendations from specialty audits undertaken throughout 2019/20.

| Recommendation | Priority | Progress update | Status |
|---|---|---|---|
| R1 – Engagement should be encouraged with clinicians across all specialities with examples of good and bad coding to highlight where any problems are occurring and why, and the impact this has on coding outcomes. | High | The number of validation sessions has increased. In addition to previous areas; Vascular, Oral Surgery and Paediatric Surgery have been keen to be involved in validations. | Improved, on-going |
| R2 - Achieve Mandatory level in all internal speciality audits. | High | An on-going audit and spot check programme is in place. Internal audits have shown a requirement for on-going training, a need for coders to spend more time reading documentation and better documentation. | Programme complete 2019/20. New programme commenced April 2020. |
| R3 – Ensure coders are maintaining standards and receive regular audit/spot check feedback. | Medium | Regular post audit/spot check feedback. | Feedback complete 2019/20 |
| R4 – Ensure documentation is consistent and adequate for coding purposes. | Medium | Reviewed through audits and spot checks and when identified by individual coders. Some areas still to investigate and remedy. | On-going |
| R5 – Streamline coding processes to allow more time to review documentation | Medium | Continually assessing viability of electronic sources over case notes. Changes made where practicable. | On-going |

# Learning from Deaths Update

This section provides an update against the NHS England and NHS Improvement prescribed information for learning from deaths, as well as an update on other key areas of work that have taken place to identify quality improvement both within the Trust and across the wider, more complex system of health care providers.

During 2019/20, 2317 of Hull University Teaching Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 552 in the first quarter
- 516 in the second quarter
- 626 in the third quarter
- 623 in the fourth quarter

By 01 April 2020, 105 Structured Judgement case note reviews and 9 investigations have been carried out in relation to 2317 deaths. In addition to the Structured Judgement Review, a number of other case-note review methodologies are also implemented, for which we do not currently record figures for. All deaths discussed within a Speciality Morbidity and Mortality meeting receive a form of case-note review.

Any Serious Incident investigation where the patient has died incorporates a full case note review.

In 9 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 2 in the first quarter
- 3 in the second quarter
- 0 in the third quarter
- 4 in the fourth quarter

9 deaths, representing 0.39% of the total patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- representing 0.36% for the first quarter
- representing 0.58 % for the second quarter
- None for the third quarter
- representing 0.64% for the fourth quarter

These numbers have been estimated by consideration of all Serious Incidents that occurred within the reporting period, where patient death was deemed potentially due to problems in the care provided.

The following themes were identified from case reviews and investigations, where problems in care were more likely than not to have contributed to the patient's death:

- Delay in the administration of antibiotics
- Lack of compliance with Surgical checklists
- Issues relating to not repeating checks, e.g. ''stop before you block''

The Trust has taken a number of actions to contribute to the resolution of the themes identified, these include:

- Roll out of a Sepsis awareness campaign
- Introduction and completion of a monthly Surgery checklist audit to monitor improvement actions implanted from the themes and an external peer review
- Multi-agency reviews are undertaken with Clinical Commissioners and the Yorkshire Ambulance Service to ensure improved partnership working and shared learning
- Introduction of a 'Stop the Line' campaign to ensure an open and honest safety culture and empowering all staff to be able to 'stop' when they see something wrong

All actions that are implemented and shared learning, including the actions noted above, are assessed and reported on the Trust's monthly Shared Learning Report which is presented to the

Trust Board for assurance. The Trust Board papers can be accessed via https://www.hey.nhs.uk/about-us/trust-board-meetings/. Particular actions e.g. Safer Surgery and Stop the Line are reported to other committees within the Trust committee structure including the Operational Quality Committee and the Quality Committee.

There were 0 case record reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of 2019/20.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

# NHS Digital: Core Set of Indicators

Since 2012/13 Hull University Hospitals NHS Trust has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

The Hull University Teaching Hospitals NHS Trust considers that this data is as described because performance information is consistently gathered and data quality assurance checks made as described in the next section.

**The table below details performance against the Summary Hospital-level Mortality Indicator (SHMI):**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The value of the SHMI for the Trust for the reporting period* | 1.08 | 1.0430 | 1.00 | 0.691 | 1.268 |
| The banding of the SHMI for the Trust for the reporting period* | 2 | 2 | 2 | 1 | 3 |
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period* | 27.9% | 35% | 37% | 58% | 9% |

*Most recent data on NHS Digital for period April 2019 – March 2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Mortality and Morbidity Committee.

**The table below details performance against the Patient Reported Outcome Measures (PROMs):**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| • hip replacement surgery EQ-5D Average health gain (Primary)* | 0.448 | 0.42 | 0.468 | 0.731 | 0.104 |
| • hip replacement surgery EQ-5D Average health gain (Revision)* | -- Insufficient records | -- Insufficient records | 0.305 | 1.286 | -0.175 |
| • hip replacement surgery Oxford Hip score Average health gain (Primary)* | 22.566 | 23.195 | 22.8 | 29.833 | 14.095 |
| • hip replacement surgery Oxford Hip score Average health gain(Revision)* | 7.853 | 9.667 | 14.3 | 39 | -2 |
| • knee replacement surgery EQ-5D Average health gain (Primary)* | 0.35 | 0.324 | 0.342 | 0.59 | -0.431 |
| • knee replacement surgery Oxford Knee score Average health gain (Primary)* | 18.138 | 17.172 | 17.4 | 24.4 | -6 |
| • knee replacement surgery EQ-5D Average health gain (Revision)* | 0.35 | 0.324 | 0.314 | 0.945 | -0.393 |
| • knee replacement surgery Oxford Knee Score Average health gain (Revision)* | -- Insufficient records | -- Insufficient records | 14.4 | 33.3 | -4.5 |

*Most recent data on NHS Digital for period April 2018 – March 2019 Published February 2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Patient Experience and Engagement Committee.

**The table below details performance against the Readmission rate into hospital within 28 days of discharge**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period* | 9.0% | 11.4 | 12.5 | 1.8 | 69.2 |
| The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period* | 7.6% | 12.9 | 14.6 | 2.1 | 57.5 |

*Most recent data on NHS Digital for period 01/04/2018 to 31/03/2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Health Group and Executive Performance and Accountability Meetings.

**The table below details performance against the Trust's responsiveness to the personal needs of our patients**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The Trust's responsiveness to the personal needs of its patients during the reporting period* | 68.5 | 64.4% | 66.7% | 84.2% | 59.5% |

*Most recent data on NHS Digital for period Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2019 to 31/01/2020

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Health Group and Executive Performance and Accountability Meetings.

**The table below details performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends* | 84% | 70.6% | 71.4% | 90% | 41% |

*Most recent data on NHS Digital for period Hospital stay: 01/07/2018 to 31/07/2018; Survey collected 01/08/2018 to 31/01/2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Workforce and Transformation Committee.

**The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period* | 92.04% | 92.12% | 95.33% | 100% | 71.59% |

*Most recent data on NHS Digital for period October to December 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Thrombosis Committee.

**The table below details performance against the C.Difficile infection rate, per 100,000 bed days**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The rate per 100,000 bed days of cases of C Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period* | 11.4 | Data not available | Data not available | Data not available | Data not available |

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Infection, Prevention and Control Committee.

**The table below details performance against the number of patient safety incidents reported and the level of harm**

| Prescribed Information | 2018/19 | 2019/20 | National Average | Best performer | Worst performer |
|---|---|---|---|---|---|
| The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,* | 51.3 | 50.7 | 0.38 | 14.9 | 2.63 |
| The number and percentage of such patient safety incidents that resulted in severe harm or death* | 0.56 | 0.12 | 0.38 | 0 | 140.6 |

*Most recent data on NHS Digital for period October 2018 to March 2019

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services, by continually monitoring performance at the Trust Operational Quality Committee.

# Part 3: Our Plans for the Future; Priorities for Improvement

This section includes:

- Our plans for the future – Consultation
- Quality and Safety Improvement Priorities 2020/21

# Our Plans for the future – Consultation

## Quality and Safety Improvement Priorities 2020/21 Consultation

For 2020/21 the Trust put together a list of potential quality improvement priorities by:

- Evaluating performance against the quality and safety priorities for 2019/20
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2019/20
- Looking at national priorities and local priorities that have been agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN)
- Looking at what our regulators have identified as priorities, such as compliance with the CQC Fundamental Standards
- Areas we have identified as requiring improvement from incidents and patient feedback

In order to seek the views of our staff, Trust patient members, stakeholders and our local community on what they thought the priorities should be for 2020/21, the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff, patient members and stakeholders to consult on the 2020/21 priorities in February and March 2020
- Relevant committees were also asked for their comments and ideas:
  - Operational Quality Committee for consultation on all priorities and approval of the 2020/21 priorities
  - Trust Board for ratification of the 2020/21 priorities
  - Quality Committee for approval of the 2020/21 priorities

## Our chosen priorities

The Trust has identified these quality improvement priorities for 2020/21 because they are important to our staff, patients and stakeholders:

### Safer Care (Patient Safety)

- Reduction of inpatient falls of patients who have a diagnosis of Dementia and have an inpatient fall within the Department of Elderly Medicine
- Development of a standardised safety brief framework
- Reduction in line infections
- Increase stop the line reporting and improve staff engagement and satisfaction with the new reporting process and increase measurable actions

### Better Outcomes (Clinical Effectiveness)

- Improve mental health triage in the Emergency Department
- Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

### Improved Experience (Patient and Staff Experience)

- Improved framework of preceptorship for new registrants to ensure they are supported and develop in to confident and competent practitioners
- Improve patient and public involvement across the Trust

# Quality and Safety Improvement Priorities 2020/21 – Safer Care

## ►Safer Care ►Better Outcomes ►Improved Experience

### Priority One: Reduction of inpatient falls of patients who have a diagnosis of Dementia within the Department of Elderly Medicine (DEM)

#### Aim:

To develop a Multi-Disciplinary Task and Finish group to complete an in-depth review of patients who have a diagnosis of Dementia and have an inpatient fall within DME.

#### Objectives:

- To understand the barriers that prevents the escalation of care for this group of patients.
- To develop a structured framework for the assessment and interventional care for this group of patients.
- To review the nursing documentation for both the Falls Prevention and Dementia/Delirium care (including IT options)
- To share finding across the organisation and plan a roll out of good practice
- To improve situational awareness of safety concerns.

#### Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Staff Benefits - Provision of high quality care, improved education. Organisational Benefits – Supports the patient safety strategy and reduces patient harm

#### Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Governance Team. Delivery of the project will be monitored by the DME Task and Finish Group with reporting and escalation to the Falls Committee for support and Trust Quality Committee for assurance.

### Priority two: Reduction in line infections

#### Aim:

To reduce the number of Methicillin-sensitive Staphylococcus Aureus (MSSA) line infections.

#### Objectives:

- To review the range of cases linked to line infections
- To identify one area to be used as a pilot
- To develop specialised training for the pilot area
- To learn lessons from the pilot and shared for up scaling

#### Planned outcomes:

- Patient Experience - improved length of stay
- Quality Experience - timely interventions / treatment will be implemented by appropriate staff member
- Staff Benefits - peer support, enhanced training and clinical supervision
- Organisational Benefits - Supports the patient safety strategy and reduces patient harm. Supports Ward to Board communication.

#### Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Infection, Prevention and Control Team. Delivery of the project will be monitored by the Surgery Health Group (SHG) Line Infection Task and Finish Group with reporting and escalation to the Device Committee for support and Trust Quality Committee for assurance.

## Priority three: Increased stop the line reporting and improved staff reporting and satisfaction with the new reporting process and increase measurable actions

### Aim:

By providing clear guidance on actions and process when a stop the line is called, reporting and investigating procedures and learning from the events we will see an increase in stop the lines reported, increase in staff engagement and satisfaction with the process, and an increase in measurable actions from stop the lines

### Objectives:

- Increase stop the lines by 50% in a 6-month period
- Increase documented actions from stop the line investigations to a minimum of 2 a month

### Planned outcomes:

- Patient Safety – By promoting an environment where staff can take steps to limit preventable harm and learn from those near misses, we will see a reduction in avoidable harm
- Quality Experience - Staff should feel more engaged with the policy and procedures around incident reporting and stop the line
- Staff Benefits - Improved moral and satisfaction with stop the line reporting and action feedback
- Organisational Benefits – reduction in avoidable harm

### Monitoring arrangements:

The project will be led by the Chief Medical Officer, supported by the Governance Team. Delivery of the project will be monitored by the Operational Quality Committee with reporting and escalation to the Trust Quality Committee for assurance.

## Priority four: Development of a standardised safety brief framework

### Aim:

To develop a standardized safety brief framework to be used by ward areas and departments

### Objectives:

- To develop a common language for the escalation of patients
- To develop a structured mechanism for effective communication
- To enhance teamwork through communication and co-operative problem-solving
- To share understanding of the focus and priorities of the day by all team member
- To improve situational awareness of safety concerns

### Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Staff Benefits - Mechanism for escalation, peer support and clinical supervision
- Organisational Benefits – Supports the patient safety strategy and reduces patient harm. Supports Ward to Board communication

### Monitoring arrangements:

The project will be led by the Assistant Chief Nurse, supported by the Practice Development Matrons. Delivery of the project will be monitored by the Operational Quality Committee with reporting and escalation to the Trust Quality Committee for assurance.

# Quality and Safety Improvement Priorities 2020/21 – Better Outcomes

►Safer Care ►Better Outcomes ►Improved Experience

## Priority five: Improve mental health triage in the Emergency Department

### Aim:

All adult patients attending ED will have a mental health triage by an ED nurse on arrival.

### Objectives:

- To develop a comprehensive triage assessment
- To ensure all staff are educated in the use of the assessment with the relevant underpinning knowledge (Mental Health)
- To ensure the triage assessment is on a digital platform

### Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented
- Staff Benefits - Improved knowledge of the assessments required for this patient group
- Organisational Benefits – Stratification of the number of patients accessing the Emergency Department with a Mental Health issue. The information gained will support the organisation to work with mental health services to improve patient pathways

### Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Governance Team. Delivery of the project will be monitored by the Mental Health in ED Task and Finish Group with reporting and escalation to Mental Health, Learning Disability and Autism Committee for support and Trust Quality Committee for assurance.

## Priority six: Empowerment of the non-registered workforce to improve the delivery of the SSKIN care bundle

### Aim:

The aim of this project is to focus improvement in the delivery of the SSKIN care bundle.

### Objectives:

- This project aims to empower the non-registered workforce to lead on the implementation, decision-making and communication to improve the quality of care and the safety of the patient.

### Planned outcomes:

- Patient Experience - Identification of high risk patients in a timely manner
- Quality Experience - Timely interventions/treatment will be implemented by the appropriate member of staff
- Organisational Benefits – Supports the patient safety strategy and reduces patient harm.

### Monitoring arrangements:

The project will be led by a Nurse Director, supported by the Tissue Viability Team. Delivery of the project will be monitored by the Wound Management Committee with reporting and escalation to the Trust Quality Committee for assurance.

# Quality and Safety Improvement Priorities 2020/21 – Improved Experience

►Safer Care ►Better Outcomes ►Improved Experience

## Priority seven: Improved preceptorship

### Aim:

To provide a consistent framework of preceptorship for all of our new registrants, where they feel supported and are enabled to develop into confident and competent practitioners.

### Objectives:

- To define preceptorship as an organisation
- To share the definition through an updated policy for preceptorship
- Work with key stakeholders to provide an educational package to support preceptors and to develop a more robust approach to preceptorship
- To reduce staff turnover rates
- To reduce clinical incidents/ SI's involving new registrants
- To improve the quality of care patients, receive.
- Improved staff experience/satisfaction which is shown with improved staff survey results for Registered Nurses (RNs) and newly qualified RNs
- Progression to consider wellbeing study and improved wellbeing for staff in this group for newly qualified staff

### Planned outcomes:

- Seamless progression from preceptorship to clinical supervision

### Monitoring arrangements:

The project will be led by a Nurse Director, supported by a Practice Development Nurse.

Delivery of the project will be monitored by the Preceptorship Task and Finish Group with reporting and escalation to the Nursing Workforce Committee for support and Trust Quality Committee for assurance.

## Priority eight: Improved patient and staff experience

### Aim:

To develop and implement a Public and Public Involvement (PPI) Strategy

### Objectives:

- To scope existing PPI structures and processes internally and externally presenting a report on this with recommendations in line with National and Regulatory requirements and standards
- To develop a PPI strategy and action plan to deliver the strategy utilising the Trust Patient Experience and Engagement Committee
- To commence delivery and monitoring of the actions

### Planned outcomes:

- Patient Experience – Using PPI to improve services and patient experience
- Quality Experience - Improve Trust services by having a robust strategy and action for PPI
- Staff Benefits - Improved knowledge of PPI and how to utilise for patient/service developments/assessments
- Organisational Benefits – Compliance with CQC and national standards and improved reputation with external stakeholders and the public

### Monitoring arrangements:

The project will be led by the Head of Patient Experience and Engagement supported by the Governance Team.

Delivery of the project will be monitored by the Patient Experience and Engagement Committee with reporting and escalation to the Trust Quality Committee for assurance.

# ANNEXES

This section includes:

- Annex 1:
  - Statements from Key Stakeholders
  - Trust response to Stakeholder Statements

- Annex 2:
  - Statement of Directors' Responsibility
  - Independent auditor's report

- Annex 3
  - Abbreviations and definitions
  - How to provide feedback
  - Other formats

# Annex 1

This section includes:

- Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group
- Healthwatch Kingston upon Hull
- Healthwatch East Riding of Yorkshire
- Hull City Council Overview and Scrutiny Committee
- East Riding of Yorkshire Overview and Scrutiny Committee
- Trust response to Stakeholder Statement

# Statements from Key Stakeholders

## Joint Statement from NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group

*Pending*

## Healthwatch Kingston upon Hull

*Pending*

## Healthwatch East Riding of Yorkshire

*Pending*

## Hull City Council Overview and Scrutiny Committee

*Pending*

## East Riding of Yorkshire Overview and Scrutiny Committee

*Pending*

## Trust response to Stakeholder Statement

*Pending*

**Due to the National COVID-19 Pandemic Response work on the annual Quality Accounts was temporarily stopped and the timeframe for publication set out in regulation was deferred. Therefore, the draft Quality Accounts was shared with Stakeholders in May 2020 as in previous years for them to review and provide a statement. The first draft will now be shared with Stakeholders by 15 October 2020 for publication by 15 December 2020.*

# Annex 2:

This section includes:

# Statement of Directors' Responsibility

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

# Independent Auditor's Report

Due to the National COVID-19 Pandemic Response, the Quality Accounts has been able to undergo an independent review and NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20.

Please see https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements/ for further information.

# Annex 3:

This section includes:

# Abbreviations and Definitions

| | |
|---|---|
| **Acute Kidney Injury (AKI)** | Acute Kidney Injury is caused by reduced blood flow to the kidneys, usually in someone who is already unwell with another health condition. This reduced blood flow could be caused by: low blood volume after bleeding, excessive vomiting or diarrhoea, or as seen with severe dehydration. |
| **Audit** | An audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. |
| **Butterfly Scheme** | The Butterfly Scheme is a system that enables staff to provide person centred care to patients with dementia. |
| **C.Difficile** | Clostridium difficile infection is a type of bacteria which may live in the bowel and can produce a toxin that can affect the digestive system. |
| **Care Bundle** | Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections. |
| **Care Quality Commission (CQC)** | The organisation that regulates and monitors the Trust's standards of quality and Safety. |
| **Cayder** | Cayder is an electronic system monitoring and tracking patient flow in and out of the Trust. |
| **CHH** | Castle Hill Hospital |
| **Chronic Obstructive Pulmonary Disease (COPD)** | COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease. |
| **Clinical Audit** | This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done. |
| **Clinical Outcomes** | A clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions. |
| **Clinical Research** | Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease. |
| **Commissioning for Quality & Innovation (CQUIN)** | A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets |
| **Data Quality** | Ensuring that the data used by the organisation is accurate, timely and informative. |
| **DATIX** | DATIX is the Trust wide incident reporting system |
| **Duty Of Candour** | Involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. |
| **ED** | The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year. |
| **Engagement** | This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care. |
| **eObservations** | Electronic observation and decision support system designed to improve patient safety and outcomes, allows patient vitals to be viewed from any connected device. |
| **ePrescribing** | Electronic prescribing system |

| | |
|---|---|
| **Friends and Family Test** | The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. |
| **Fundamental Standard Inspections** | A formal review process, which reviews objectively the quality of care delivered by our clinical teams, is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care. |
| **Greatix** | Opportunity for staff to report where things have gone well and to share positive learning outcomes. |
| **Health Groups** | Health Groups are the areas of the Trust delivering care to our patients. There are four Health Groups; Clinical Support, Family and Women's, Medicine, and Surgery. These four Health Groups are headed by a Consultant (Medical Directors) who is the Accountable Officer. They are supported in their role by a Director of Nursing and an Operations Director. |
| **HUTH** | Hull University Teaching Hospitals NHS Trust |
| **HRI** | Hull Royal Infirmary Hospital |
| **Intentional rounding** | Intentional rounding is a process where nursing staff conduct regular checks on patients throughout the day to ensure their fundamental care needs including pain, comfort/positioning, toileting, water, temperate etc. are being addressed. |
| **Johns Campaign** | Johns Campaign is a national campaign with the aim to give the carers of those living with dementia the right to stay with them in hospital, in the same way that parents stay with their sick children. |
| **Just culture** | A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. |
| **Lorenzo** | The Trust's electronic patient record system |
| **MSSA** | Methicillin-sensitive Staphylococcus Aureus (MSSA) is a type of bacteria (germ) which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised. |
| **National Patient Safety Agency Alerts** | Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices. |
| **Never Event** | A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. |
| **NEWS2** | National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness. |
| **NHS** | National Health Service |
| **NHS England** | NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system. |
| **NHSI** | NHS Improvement (NHSI) is a non-departmental body in England, responsible for overseeing the National Health Service's foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. |
| **NHS Safety Thermometer** | The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. |
| **NICE** | The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient. |

| | |
|---|---|
| **NIHR** | The National Institute for Health Research commissions and funds research in the NHS and in social care. |
| **NRLS** | National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. |
| **Pressure Ulcer** | Open wounds that form when prolonged pressure is applied to the skin. Patients who spend prolonged periods of time in a bed are prone to such ulcers. A pressure ulcer can be avoided if the appropriate preventative actions are taken. |
| **QIP** | Quality Improvement Plan (QIP) - The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey HEY is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts. |
| **Root Cause Analysis (RCA)** | RCA is a method of problem solving that tries to identify the root causes of faults or problems. |
| **Sepsis** | Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection. |
| **Serious Incident (SI)** | An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. |
| **SHMI** | Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations. |
| **SSKIN** | SSKIN is a five step approach to preventing and treating pressure ulcers. The five steps are: 1) **S**urface: make sure your patients have the right support, 2) **S**kin inspection: early inspection means early detection - show patients and carers what to look for, 3) **K**eep your patients moving, 4) **I**ncontinence/moisture: your patients need to be clean and dry and, 5) **N**utrition/hydration: help patients have the right diet and plenty of fluids |
| **Stakeholders** | A group of people who have a vested interest in the way Hull University Teaching Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care. |
| **Tissue viability** | Tissue viability is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration. |
| **Transfer of Care Around Medicines Scheme** | The scheme focuses on patients in hospital who have been identified as requiring additional support with their essential medication. These patients are then referred through a secure digital system, to their local community pharmacy at the point of discharge. |
| **Trust Board** | The Trust's Board of Directors, made up of Executive and Non-Executive Directors. |
| **VTE** | Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE). |

# How to provide Feedback

## We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information which is meaningful to you and reflects, in part, the aspects of quality that matter most to you.

If you have any feedback regarding the 2019/20 Quality Account please e-mail your comments to: quality.accounts@hey.nhs.uk

However, if you prefer pen and paper, your comments are welcome at the following address:

**The Compliance Team**
**Quality Governance and Assurance Department**
Medical Education Centre
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

# Other formats

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information, you can contact Rebecca Thompson:

**Call:** (01482) 674828

**Email:** rebecca.thompson@hey.nhs.uk

**Write to:** Rebecca Thompson
Corporate Affairs
Alderson House
Hull Royal Infirmary
Hull
HU3 2JZ

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**10 November 2020**

| | |
|---|---|
| Title: | Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 3 -<br>Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool |
| Responsible Director: | Beverley Geary – Chief Nurse |
| Author: | Jan Cairns – Head of Midwifery |

| | | |
|---|---|---|
| Purpose: | The purpose of this report is to provide assurance to the Trust Board that the national Perinatal Review Tool is being completed by a multidisciplinary team, to the standard required by the Clinical Negligence Scheme for Trusts (CNST). | |
| BAF Risk: | BAF Risk 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: | Maternity services are meeting the required standard as per year 3 CNST incentive scheme, with 100% compliance with all the standards. All reviews are on target to be completed in the timeframes required. | |

| | |
|---|---|
| Recommendation: | The Trust Board is requested to:<br>• Receive the report outlining the details of the deaths reviewed and the action plans.<br>• Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met<br>• Decide if any further information and/or assurance are required |

**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**

**Maternity Services**
**Family and Women's Health Group**

**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 3 - Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool**

**1. Purpose of the Report**

The purpose of this report is to provide assurance to the Trust Board that the national Perinatal Review Tool is being completed by a multidisciplinary team, to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

**2. Introduction**

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will also receive a share of any unallocated funds. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon Thursday 20 May 2021. Trust submissions will be subject to a range of external verification points including cross checking with: MBRRACE-UK data (safety action 1 point a, b, c).

**3. Requirements for Safety Action 1** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? **Appendix 1, 2 & 3**

**a)**

i. All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where care was provided by your Trust staff and the baby died.

iii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 will have been started within four months of each death. This includes deaths after home births where care was provided by your Trust staff and the baby died.

**b)**

i. At least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool by Thursday 31 December 2020.

ii. At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Saturday 1 August 2020 to Thursday 31 December 2020 will have been reviewed using the PMRT, by a multidisciplinary review

team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.

**c)** For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

**d)** Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

## 4. Perinatal Mortality Review Tool (PMRT)

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The PMRT has been designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth
- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report which should be shared with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

## 5. Summary

Maternity services are meeting the required standard as per year 3 CNST incentive scheme, with 100% compliance with all the standards. All reviews are on target to be completed in the timeframes required.

## 6. Recommendations

The Trust Board is requested to:

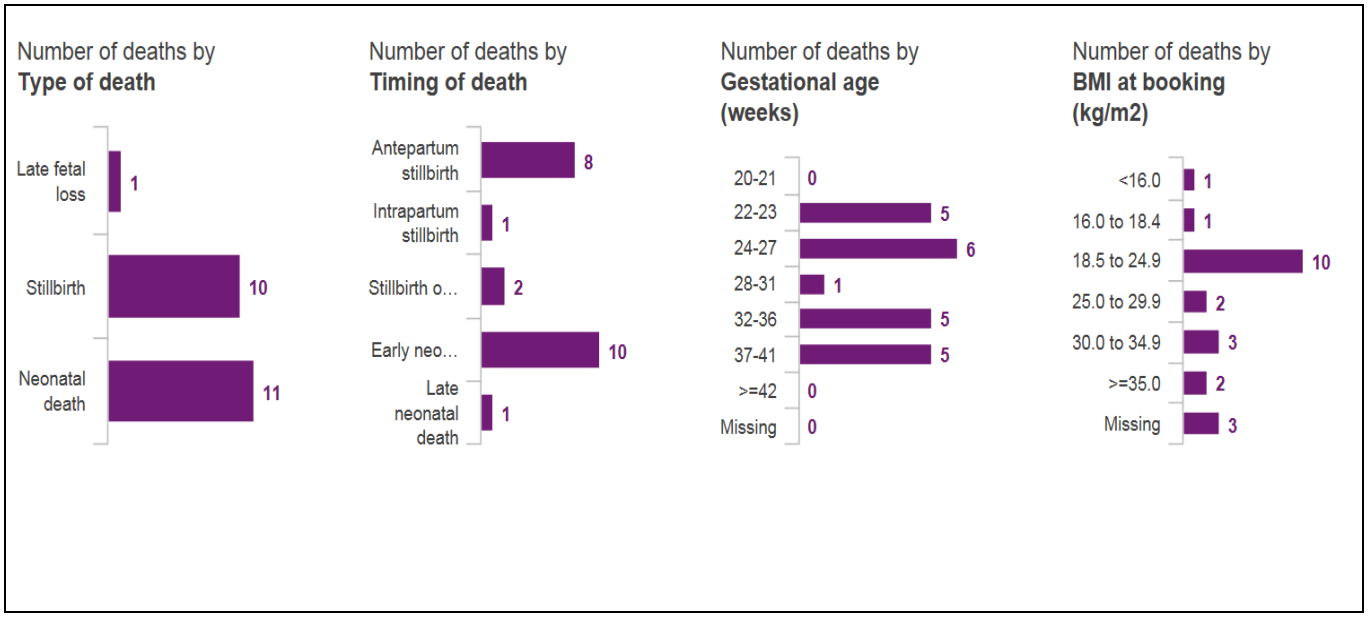
- Receive the report outlining the details of the deaths reviewed and the action plans.
- Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met
- Decide if any further information and/or assurance are required

**Janet Cairns**

**Head of Midwifery October 30 2020**

**Appendix 1**

HUTH DATA - The organisation has had 22 deaths between 23 April 2020 and 23 October 2020



## Appendix 2

Perinatal Mortality Review Update October 2020

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Hull University Teaching Hospitals NHS Trust<br>Perinatal Mortality Review Tool Review update Oct 2020 | | | | | | | |
| | Outstanding and completed Neonatal cases upto Oct 2020 | | | | | | | |
| | | MBRRACE ID | Stillbirth/ Neonatal Death | Date of death | PMRT commenced | Target for completion | PMRT Completed | Grading | Actions / Good practice |
| | 1 | | NND 33 weeks Unbooked | | 29/04/2020 | 22/06/2020 | | | Neonatal team to complete |
| | 2 | | NND 24+4 weeks | | 10/05/2020 | 10/09/2020 | 15/09/2020 | B/A/B | Reminder to staff on Labour ward to call for the neonatal team in a timely manner, Ensure parents are aware of PMRT , introduce new process for informing all staff following a bereavement, |
| | 3 | | NND 40+6 weeks | | 15/06/2020 | 15/10/2020 | 14/09/2020 | B/B/A | Review local guidance in line with SBLV 2 scanning recommendation, Reminder to staff to consider Curosef for babies with meconium aspiration and PPHN |
| | 4 | | NND 27 weeks | | | | | | Ex utero transfer from another Trust- no HEY maternity input required |
| | 5 | | NND 39 weeks @ 5 days old | | 31/07/2020 | 17/11/2020 | | ?/A/A | Discuss grading to complete |
| | 6 | | NND 35 weeks | | 23/09/2020 | 07/12/2020 | | | For review 30/10/20 - known cardiac abnormality |
| | 7 | | NND 26 weeks | | 01/10/2020 | 31/12/2020 | | | Review November meeting |
| | 8 | | NND 22 weeks | | 15/10/2020 | 14/01/2021 | | | Review November meeting |
| | 9 | | NND 22+6 weeks | | 17/10/2020 | 17/01/2021 | | | declared as SI |
| | 10 | | NND 23+6 weeks ( Twin) @ 6 days | | | | | | Review November meeting |
| | 11 | | NND 9 weeks old | | | 02/02/2021 | | | ? To be reviewed ? Only upto 28 days olds |
| | 12 | | NND 38 weeks @ 1 day old | | | 04/02/2021 | | | Review December meeting coronors PM |
| | 13 | | NND 23+2 @ 1 day old | | 17/10/2020 | 08/02/2021 | | | Review December meeting |
| | | MBRRACE ID | Stillbirth/ Neonatal Death | Date of death | PMRT commenced | Target for completion | PMRT Completed | Grading | Actions / Good practice |
| | Maternity cases July - Sept 2020 (Q2) Commenced / completed | | | | | | | | |
| | 11 | | Twin SB 29 weeks | | 10/07/2020 | 09/09/2020 | 03/09/2020 | B/B | Feedback re PN investigations |
| | 12 | | Stillbirth 36 weeks fetal anom | | 26/06/2020 | 25/09/2020 | 25/09/2020 | A/A | No issues identified |
| | 13 | | Unbooked Term Stillbirth | | 24/06/2020 | 28/09/2020 | 03/08/2020 | A/A | No issues identified |
| | 14 | | Stillbirth 36 weeks | | 26/06/2020 | 17/10/2020 | | | Discuss grading to complete |
| | 15 | | Stillbirth 36+2 weeks | | 26/06/2020 | 22/10/2020 | 28/08/2020 | B/A | Review local guidance in line with SBLV 2 scanning recommendation, Reminder to staff to consider Curosef for babies with meconium aspiration and PPHN |
| | 16 | | Stillbirth 27 weeks | | 03/08/2020 | 30/11/2020 | | | For review 30/10/20 |
| | 17 | | Stillbirth 35 weeks | | 17/08/2020 | 07/12/2020 | | | For review 30/10/20 |
| | 18 | | Stillbirth 24 weeks | | 02/10/2020 | 27/01/2021 | | | Review November |

**Appendix 3**

## PMRT Action Plan October 2020

| Case | Actions | Lead | Due date | Status |
|---|---|---|---|---|
| 66832 | Individual reflection with the midwife and appropriate learning identified To review the process for communication between the consultant and community midwives after receiving a guidance letter and length of time to undertake actions | LC | 30/04/20 | Completed |
| | Individual reflection with the midwife and appropriate learning identified Email to all midwifery staff to remind them of the need to undertake a full risk assessment when women attend with reduced fetal movements | LC | 30/04/20 | Completed |
| 67316 | Individual reflection with the staff providing intrapartum care with regard to issues identified with risk assessment, escalation and CTG interpretation.<br>Individual reflection with regard to the predicted presence of the neonatal team being required | AR | 31/08/20 | Completed |
| 67900 | Smoking cessation training for all midwives on mandatory training | CC | 31/12/20 | |
| | Feedback to all midwives to emphasise the importance of ensuring all women receive written information with regard to fetal movements | JG | 31/07/20 | Completed |
| | To look at the evidence and ensure a local guideline is agreed on the process for monitoring fetal growth when the women has significant weight gain in pregnancy | KS | 31/08/20 | Completed |
| 68178 | Individual reflection with the practitioners involved with regard to pregnancy induced hypertension | LC | 31/07/20 | Completed |
| | Individual reflection with the practitioners involved undertaking a CTG prior to IOL | | | |
| | Individual reflection with the practitioners involved with making plans for delivery | KS | 31/07/20 | Completed |
| 68094 | Postnatal appointment with the consultant to give preconception advice and make a plan for future pregnancies | | | |
| 68754 | The Latent phase guidance to be reviewed | JG | 30/11/20 | |
| | Individual feedback and training needs to be identified with midwives from the continuity of care team | JM | 30/11/20 | |
| | Review partogram document | SG/SC | 30/11/20 | |
| | Individual feedback to midwives re completion of partogram | SC | 30/11/20 | |
| 68756<br>09/07/20 | Individual feedback to midwife undertaking the booking appointment<br>re requirement for Aspirin and risk assessment | JM | 30/11/20 | |
| 68835<br>25/09/20 | Reminder to all staff to inform the neonatal team when active pushing<br>commenced in the 2nd stage of labour in pre- term births | AR | 30/11/20 | |
| | Implement new neonatal bereavement checklist to informed parents<br>informed of PMRT and on-going bereavement care | AM | 02/12/20 | |
| 68890<br>02/10/20 | Scans to be reviewed by senior consultant radiographer | KS | 30/09/20 | Completed |
| | Individual feedback to the midwife providing intrapartum care re observations | LC | 30/11/20 | |
| | Individual feedback to the midwife with regard to postnatal investigations following a loss | LC | 30/11/20 | |
| | Introduce a robust process for informing parents with regard to the<br>PMRT and obtaining feedback | SC | 01/09/20 | Completed |

**Hull University Teaching Hospitals NHS Trust**

**Modern Slavery Statement**
**Trust Submission 2020**

| | |
|---|---|
| Title: | Modern Slavery Statement |
| 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 Modern Slavery Statement 2019/20. The statement outlines the steps the Trust has taken, and will continue to take, to ensure slavery and human trafficking is not taking place in any of its supply chains or business. | |
| BAF Risk: | Risk 2 – workforce | |
| Strategic Goals: | Honest, caring and accountable culture | ✓ |
| | Valued, skilled and sufficient workforce | ✓ |
| | High quality care | ✓ |
| | Great clinical services | |
| | Partnership and integrated services | ✓ |
| | Research and Innovation | ✓ |
| | Financial sustainability | |
| Summary Key of Issues: | Following the introduction of the Modern Slavery Act in 2015, there is a statutory requirement for the Trust to produce an annual statement describing what steps have or are being taken to tackle modern slavery (or state that no action has been taken, if this is the case).<br><br>In normal circumstances, the requirement is for organisations to publish their formal statement within six months of the end of their financial year (i.e. 30 September for HUTH).<br><br>However, in April 2020, the Government announced that businesses would not be penalised, should they need to delay the publication of their modern slavery statement by up to 6 months due to COVID-19 related pressures.<br><br>The Trust's annual Modern Slavery Statement has not been unduly delayed due to the COVID-19 pandemic and will be published on the Trust internet site by the end of November 2020. | |

| | |
|---|---|
| Recommendation: | The Workforce, Education and Culture Committee and Trust Board are asked to approve the attached Modern Slavery Statement for 2019/20. This will then be published on the Trust's website. |

**Hull University Teaching Hospitals NHS Trust**

**Modern Slavery Statement**
**Trust Submission 2019/20**

## 1 Purpose

The purpose of this paper is to share the Trust's Modern Slavery Statement for the financial year 1 April 2019 to 31 March 2020.

## 2 Background

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.

Section 54 of the Act recommends that organisations report on the following:

1. organisational structure, business and supply chains;
2. its policies in relation to slavery and human trafficking;
3. due diligence processes in its business and supply chains;
4. parts of its business/supply chains where there is a risk of slavery and human trafficking taking place, and steps taken to assess and manage that risk;
5. effectiveness in ensuring that slavery/human trafficking is not taking place in its business or supply chains, measured against performance indicators;
6. the training about slavery and human trafficking available to its staff.

The Act requires organisations to publish a Modern Slavery Statement on their website and include a link in a prominent place on it's homepage within six months of the end of the financial year. However, in April 2020, the Government announced that businesses would not be penalised, should they need to delay the publication of their statement by up to 6 months, due to COVID-19 related pressures.

## 3 The Trust's Proposed Statement for 2019/2020

The Statement contained within Appendix 1 has been produced in partnership with the Modern Slavery Working Group:

- Bank Nurses/Casual Workers: Julie Bonewell
- Corporate Affairs: Carla Ramsay
- Education and Development: Ben Greenwood
- Estates, Facilities and Development: Kim Butcher / Zara Ridge
- Human Resources: Sarah Dolby
- Patient Experience: Lou Beedle
- Procurement, Supplies: Julie Lumb
- Safeguarding: Jayne Wilson

## 4 Recommendation

The Trust's annual Modern Slavery Statement has not been unduly delayed due to the COVID-19 pandemic.

The Workforce, Education and Culture Committee and Board are asked to note the content of the Statement. The Act requires the statement to be approved and signed by the Trust Board. The Statement will then be published on the Trust's website by the end of November 2020.

Simon Nearney, Director of Workforce and Organisational Development
October 2020

**Hull University Teaching Hospitals NHS Trust**

**Modern Slavery Statement**
**1 April 2019 to 31 March 2020**

## 1. Introduction

The Modern Slavery Act 2015 requires organisations to publish an annual Modern Slavery Statement on their website within six months of the end of the financial year (i.e. for the Trust this would require the statement to be published by 30 September). The Trust also, in normal circumstances, includes the annual Modern Slavery Statement in the Annual Report.

However, in April 2020 the Government advised that, due to the COVID-19 pandemic, organisations would not be penalised if they needed to delay the publication of Modern Slavery Statements if they were, for example, facing staffing challenges.

Therefore due to workforce pressures relating to the pandemic, the Trust has delayed the publication of the statement by two months and only included a reference (rather than the full statement) in the Trust Annual Report.

The Trust is committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking. Whilst this statement has been delayed, the organisation has continued to adhere to the requirements of the Act during this time.

## 2. Background

Modern slavery continues to be prevalent across the UK, with the number of people identified as victims of modern slavery rising year on year. In March 2020, the Office for National Statistics[1] reported:

- The national Modern Slavery Helpline received a 68% increase in calls and submissions in the year ending December 2018, compared with the previous year.
- There were 5,144 modern slavery offences recorded by the police in England and Wales in the year ending March 2019, an increase of 51% from the previous year.
- The number of potential victims referred through the UK National Referral Mechanism (NRM) increased by 36% to 6,985 in the year ending December 2018.

It is therefore important that organisations continue to support the Government's Modern Slavery Strategy, by taking steps to ensure that modern slavery (i.e. slavery and human trafficking) is not taking place in any part of its own business or supply chains.

## 3. Statement

This statement sets out the steps that Hull University Teaching Hospitals NHS Trust has taken over the financial year 1 April 2019 to 31 March 2020 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains.

The statement covers the following:

- Organisational structure, business and supply chains
- Policies in relation to slavery and human trafficking
- Due diligence in our business and supply chains
- Assessing and managing risks in our business and supply chains
- Performance indicators
- Training in slavery and human trafficking

[1] Office for National Statistics
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/modernslaveryintheuk/march2020

## 3.1 Organisational Structure, Business and Supply Chains

### *3.1.1 Organisational Structure and Business*

Hull University Teaching Hospital NHS Trust is a large acute NHS Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs just over 7,000 whole time equivalent staff, has an annual income of circa £639m million and has two main sites; Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

The Trust's organisational structures are available on the Trust's internet site https://www.hey.nhs.uk/downloads/structure/.

Further details regarding the Trust's business is provided in the Annual Report and Accounts 2019/20 which is available on the Trust's internet site https://www.hey.nhs.uk/about-us/corporate-documents/.

### *3.1.2 Supply Chains*

The Trust's Procurement and Supplies Department is responsible for spending £120m non-pay which includes:

- £19m through the Supply Chain (compared to £28m in the previous statement);
- £65m from goods ordered directly (not Supply Chain) through goods and service maintenance contracts (compared to £55m in the previous statement);
- £37m on other contracts, for example; car park and security, transport and all other service type contracts (which remains the same as the previous reporting period).

It must be noted that these figures are approximate and will fluctuate year on year.

The Trust does not enter into business with any organisation, in the UK or abroad, which knowingly supports or is found to be involved in slavery, servitude and forced or compulsory labour.

## 3.2 Policies in Relation to Slavery and Human Trafficking

Trust policies, for both service users and staff, are subject to a thorough consultation and ratification process with input from staff side and management representatives, prior to being published on the Trust's intranet site.

Trust policies in relation to the Modern Slavery Act 2015 (which include the Raising Concerns at Work (Whistleblowing) Policy, Equality, Diversity and Inclusion in Employment Policy and Bully and Harassment Policy, etc.) are available to staff via the Trust's intranet site and to the public through a Freedom of Information request. The Trust continues to be committed to reviewing policies on a regular basis and in line with changes to legislation.

### *3.2.1 Safeguarding Policies*

The Trust continues to publish a broad range of safeguarding policies and factsheets, for both service users and staff, on the Trust intranet which are reviewed as required.

New factsheets published on the Trust intranet during the last financial year include:

- Key contacts and support in Humberside
- Exploitation, spotting the signs

## 3.3 Due Diligence Processes in the Trust's Business and Supply Chains

### *3.3.1 Due Diligence in Business*

The Trust is committed to preventing slavery and human trafficking in it's corporate activities, and to ensuring that it's supply chains are free from slavery and human trafficking. The Trust also has a responsibility to ensure that workers are not being exploited, that they are safe

and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

The Trust's recruitment and people management processes are designed to ensure that all prospective employees are legally entitled to work in the UK and to safeguard employees from abuse or coercion.

All active agencies who supply staff to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.

*3.3.2 Due Diligence in Supply Chains*

The Trust continues to expect that the supply chains it works with have suitable anti-slavery and human trafficking policies and processes in place.

Within the Procurement Department, all of the Trust tenderers continue to be expected to respond to the question within the Selected Questionnaire document, tender document and quotation document to provide assurance that they adhere to the Modern Slavery Act. A central database has been set up to record this assurance from tenderers.

The Facilities Department (who manage the supply of some of the Trust's key contracts e.g. cleaners etc.) has also continued to monitor which of their suppliers are compliant with the Modern Slavery Act 2015 during the last financial year.

47 suppliers within the Facilities Department were identified, and out of these:

- 37 organisations have shared their modern slavery statement with the Trust
- 6 organisations do not meet the requirement to produce an annual modern slavery statement (i.e. annual turnover is below £36m)
- 4 organisations have not yet provided their statement; however the Facilities Team will continue to try and obtain these.

Over the next year, the Facilities Department is planning to review how they continue to monitor which of their suppliers is compliant with the Modern Slavery Act 2015 in order to streamline the process.

### 3.4 Assessing and Managing Risks in our Business/Supply Chains

Within the Trust's business the following will continue to safeguard the Trust against slavery and human trafficking:

- All staff are employed on employment contracts which comply with UK law.
- All employees including those transferred into the Trust and doctors in training; volunteers (including students and trainees on work experience); agency staff, contracted out staff and other people accessing the Trust in an official capacity, e.g. those involved in the Patient Advocacy and Liaison Service (PALS), and those subject to an honorary contract undergo pre-employment checks.
- All staff undertake mandatory safeguarding training, which covers modern slavery.
- The Trust is considering a new model to replace the Safeguarding Champion role which provides individuals with an understanding of the fundamentals for good safeguarding (which includes modern slavery and human trafficking). To improve dissemination of safeguarding updates and information, proposals for a new model are to be presented to the Safeguarding Committee meeting in November 2020.
- A comprehensive range of modern slavery and safeguarding information for service users and staff is available for staff on the Trust intranet.
- As an equal opportunities employer, the Trust is committed to creating an inclusive working environment for all staff, which enables staff to feel confident that they can

raise concerns without any risk to themselves via a number of avenues, e.g. via the Freedom to Speak up Guardian etc.

- The Trust continues to have strong links with the Humber Modern Day Slavery Partnership, with representatives from both the Safeguarding Children's Team and Safeguarding Adult's Team sitting as part of a strategic group within the partnership.
- The Trust will continue to evolve and learn and develop new processes to safeguard the organisation and the population it serves against modern slavery. Following a scoping meeting held in January 2020, in response to two cases in which the patients needed a place of safety following discharge, there is now a multi-agency agreement to hold an emergency/short notice strategy meeting with key partner representatives. In addition to the Trust's Safeguarding Adults Team, key partners include: The Local Authority Safeguarding Adults Team, Independent Domestic Violence Advocate/Hull DAP, Domestic Abuse Team and PVP Unit/Humberside Police, the Hospital Social Work Team and the Mental Health Team.
- The Trust, in collaboration with the local CCGs (Hull and East Riding), Humber Teaching Foundation Trust and City Health Care Partnership, developed and held a Safeguarding Adults Conference (Level 3) 'The Voice of the Person'. Several key topics were covered, which included modern slavery 'A Local Perspective', delivered by a representative from one of the local Safeguarding Adults Board. Following evaluation and positive feedback received, particularly around the theme of modern slavery, the Trust will plan to develop a Safeguarding Adults Conference annually.

The Trust continues to reduce the risk of modern day slavery occurring within the organisation's supply chains by ensuring the Selected Questionnaire document, tender document and quotation document are up-to-date and continue to request tenderers to provide assurance that they adhere to the Modern Slavery Act 2015.

Whilst there is more of a risk for non-compliance when goods and services are procured outside of the tendering process, there continues to be robust processes in place to mitigate these risks. All goods purchased outside the tendering process must adhere to the Trust's Standing Financial Instructions and are subject to the Purchase Order Version of the Terms and Conditions for both goods and services (January 2018) which references modern slavery. Also, purchases of £10k or more must have 3 official quotations.

The Trust will continue to review it's major suppliers, with a view to obtaining their ongoing commitment to compliance with the Act.

### 3.5 Performance Indicators

Compliance with the Trust's modern slavery agenda is measured via the following:

- All staff are required to complete mandatory safeguarding training (which includes modern slavery). As of March 2020, in excess of 90% of Trust staff are compliant with the required training, which is consistent with previous years.
- Relevant departments (e.g. Procurement, Facilities etc.) ask suppliers to provide assurance that they are compliant with the Modern Slavery Act 2015.
- All staff undergo the relevant pre-employment checks.
- Any modern slavery concerns are raised through the Trust's incident reporting system (DATIX) and referred to the Safeguarding Team for investigation.

### 3.6 Training in Modern Slavery and Human Trafficking

The Trust provides training to staff on modern slavery via the following courses/eLearning packages:

- Safeguarding Adults (mandatory for all staff)
- Modern Slavery and Human Trafficking
- Introduction to Migration

Modern Slavery is also embedded into other relevant training programmes including Recruitment and Selection.

Throughout 2020 all midwives within the Trust are required to undertake additional training around modern day slavery as part of their mandatory training day. The training was delivered face to face in January 2020 but, due to the COVID-19 pandemic, is now being undertaken as e-learning for the remainder of the year. The eLearning utilised is hosted on the Trust's learning platform HEY247, and is entitled 'Modern Slavery and Human Trafficking'.

The Safeguarding Teams provide additional ad-hoc training and day to day support around modern slavery when requested.

## 4. Summary

Since the requirement for organisations to produce an annual Modern Slavery Statement, the Trust has continued to demonstrate an ongoing commitment to preventing slavery and human trafficking in any part of our business or supply chains.

The Trust is committed to:

- Continuing to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.
- Monitor and review ongoing modern slavery legislation and best practice.
- Obtain assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015 and ensure these are recorded and monitored within the relevant department
- Review Trust corporate policies and include references to modern slavery where appropriate.
- Consider whether an Awareness Raising Programme can be held remotely.

The Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed _____
Mr Terry Moran
Chairman

Dated

Signed _____
Mr Chris Long
Chief Executive

Dated

**Hull University Teaching Hospitals NHS Trust**

**Trust Board Meeting**

**10 November 2020**

| | |
|---|---|
| Title: | Emergency preparedness, resilience and response (EPRR) annual assurance 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 outcome of the Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance process for 2020/21 | |
| 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: | In 2019/20, the Trust's self-assessment was that overall we were 'partially compliant' with the NHS Core EPRR standards. Of the 64 standards applicable to Acute Trusts, the Trust was fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard. An action plan was developed to address the areas of partial and non-compliance during the remainder of 2019/20 and 2020/21.<br><br>As a result of the work undertaken, the Trust is now fully compliant with 60 of the core standards and partially compliant with four, providing the Trust with a 'substantially compliant' rating.<br><br>Lessons learned from the Covid-19 Pandemic First Wave have been incorporated into the planning for the Second Wave.<br><br>Lessons learned from Winter 2019/20, identified a number of measures that have been put in place to assist in addressing the challenges of winter, together with the second wave of Covid-19 infection, seasonal influenza, increased respiratory infections and the potential disruption as a result of the EU transition. | |

| | |
|---|---|
| Recommendation: | The Trust Board is asked to note the content of this paper and the improvement in the Trust's rating from 'partially compliant' to 'substantially compliant' against the NHS Core Standards for Emergency Preparedness, Resilience and Response. |

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Emergency Preparedness, Resilience and Response (EPRR)**
**Annual Assurance 2020/21**

## 1. Purpose of Paper

The purpose of this paper is to provide the Trust Board with an update on the outcome of the Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance process for 2020/21

## 2. Background

In September 2020 the Board was advised of the arrangements for the annual assurance process in relation to Emergency Preparedness, Resilience and Response.

NHS England and NHS Improvement had acknowledged that the detailed and granular process of previous years would be excessive while the NHS prepared for a further wave of Covid-19, as well as the upcoming seasonal pressures, and the operational demands of restoring services. They had therefore indicated that Trusts should instead focus on three areas:

- Progress made by organisations who had previously reported partial or non-compliance in the 2019/20 process. Trusts were 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.

For this year only the Trust's Accountable Emergency Officer was 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. This was submitted on 22 October 2020.

## 3. Compliance with EPRR Core Standards

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. |

In 2019/20, the Trust's self-assessment was that overall we were 'partially compliant' with the NHS Core EPRR standards. Of the 64 standards applicable to Acute Trusts, the Trust was fully compliant with 50 standards, partially compliant with 13 standards and non-compliant with 1 standard. An action plan was developed to address the areas of partial and non-compliance during the remainder of 2019/20 and 2020/21.

As a result of the work undertaken, the Trust is now fully compliant with 60 of the core standards and partially compliant with four, providing the Trust with a 'substantially compliant' rating.

| Compliance with EPRR Core Standards | Total standards applicable | Fully compliant | Partially compliant | Non-compliant |
|---|---|---|---|---|
| 2019/20 | 64 | 50 | 13 | 1 |
| Position at 31 October 2020 | 64 | 60 | 4 | 0 |

A summary of the work undertaken against each of the core standards with which the Trust was not fully compliant in 2019/20 is attached as an Appendix.

**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**

Using the lessons learned from earlier this year, the following measures have been put in place to assist the Trust is addressing the challenges of winter, together with the second wave of Covid-19 infection, seasonal influenza, increased respiratory infections and the potential disruption as a result of the EU transition:

- Weekly Winter Planning and Delivery Group was established during the summer and a Winter Work Plan developed to ensure an integrated response to winter pressures and the second wave of Covid-19 admissions. Winter planning has now been absorbed into the Covid command structure.
- Continuing to build on what worked well last winter
- Covid-19 Surge Plan revised to address second wave requirements

- 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 Transition planning in case no comprehensive trade agreement is in place by 31st December 2020 which may impact on the supply of medicines, medical devices, clinical and non-clinical consumables.

In addition to the above, 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**

Work is ongoing to address the four areas of partial compliance with the NHS core EPRR standards and to ensure that the Trust retains its fully compliant status with all other standards. A programme of education and training has been established for the rest of 2020/21 and for 2021/22, together with the ongoing review of the Major Incident Plan and associated documentation.

**7. Recommendation**

The Trust Board is asked to note the content of this paper and the improvement in the Trust's rating from 'partially compliant' to 'substantially compliant' against the NHS Core Standards for Emergency Preparedness, Resilience and Response.

**Jacqueline Myers**
**Accountable Emergency Officer**
**Director of Strategy and Planning**

**2 November 2020**

## EPRR Annual Assurance Process 2020/21

| 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. | *Draft plan in place. Awaiting input from System partners.*<br>*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) | *Partial compliance rating remains pending implementation* |
| 20 – Whole site evacuation plan | The Trust did not have this in place for HRI or CHH. | Site Evacuation Plan in place<br>*Fully Compliant* |
| 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. | Lockdown Plan in place<br>*Fully Compliant* |
| 22 – VIP policy | The policy is overdue review | Policy in place<br>*Fully compliant* |
| 23 – Excess deaths arrangements | The Trust has some arrangements in place but needs to review the capacity and agree mutual aid arrangements | Mutual aid arrangements agreed<br>*Fully compliant* |
| 27 – Exercise and training programme | The Trust has some training and a programme of testing in place. Needs to be strengthened with an annual training plan and a single action tracker for learning from tests | Annual training plan in place and tested<br>Action tracker for learning in place<br>*Fully compliant* |
| 30 – Incident Co-ordination Centre (ICC) | The Trust needs to test its fall back ICC | ICC and fall back ICC tested<br>*Full compliance* |
| 32 - Business Continuity Plans (BCPs) | Overarching Plan to be set out that includes Trust level response to Trust wide incidents. | Trust BCP in place<br>*Fully compliant* |
| 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. | *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 | Other types of mutual aid reflected in updated MIP<br>*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 articulated in the overarching Business Continuity Plan | BIA process reviewed and updated. Approach articulated in Trust BCP<br>*Fully compliant* |
| 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<br>Deadline extended to March 2021 due to Covid-19<br>*Remains partially compliant* |
| 51 – Business Continuity Plans | Same issue as standard 32, need overarching Trust level BCP | Trust BCP in place<br>*Fully compliant* |

**Hull University Teaching Hospitals NHS Trust**

**Trust Board**

**Tuesday 10 November 2020**

| | |
|---|---|
| **Title:** | Freedom to Speak Up Guardian update |
| **Responsible Director:** | Carla Ramsay – Interim Director of Operations Surgery Health Group and Freedom to Speak Up Guardian |
| **Author:** | Carla Ramsay – Interim Director of Operations Surgery Health Group and Freedom to Speak Up Guardian |

| | | |
|---|---|---|
| **Purpose:** | To provide an update from the Freedom to Speak Up Guardian for Q2 2020-21 data and reflections | |
| **BAF Risk:** | BAF 1 | |
| **Strategic Goals:** | Honest, caring and accountable culture | ✓ |
| | Valued, skilled and sufficient staff | |
| | High quality care | |
| | Great local services | |
| | Great specialist services | |
| | Partnership and integrated services | |
| | Financial sustainability | |
| **Summary of Key Issues:** | The Trust Board receives a regular report from the Freedom to Speak Up Guardian on the issues being raised by staff and a 'read-across' of issues raised through other routes.<br><br>The key concern raised by staff, consistent with previous quarters, is individual examples of poor behaviours and/or bullying behaviours between colleagues.<br><br>All issues have action taken, as far as the individual who is raising concerns is comfortable with. The intelligence is also used to feed in to wider Trust organisational development programmes. | |

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

**Hull University Teaching Hospitals NHS Trust**

**Freedom to Speak Up Guardian report**

## 1. Purpose of the paper

To provide an update from the Freedom to Speak Up Guardian for Q2 2020-21 data and reflections.

## 2. Introduction

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

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

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

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

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

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

## 3. Freedom to Speak Up Guardian

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

### 3.1 Freedom to Speak Up Guardian – Trust Contacts

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

The Trust's figures are as follows:

From 1 July 2020 – 30 September 2020 the FTSUG has been contacted as follows:

| **Route of contact** | **Number of contacts** |
|---|---|
| Contacted via anti-bullying Tsar | 0 |
| Contacted directly by the member of staff | 11 |
| Requesting advice for a colleague | 0 |
| Contacted via SALS | 1 |
| Signposted by manager | 0 |
| Signposted by Occupational Health | 0 |
| Signposted by a FTSUG in another Trust | 0 |
| Signpost by Trust's Guardian of Safe Working Hours | 0 |
| Signposted by Trade Union contact | 0 |
| **Total** | **12** |

The following types of concern were raised 1 July 2020 – 30 September 2020

| **Type of concern** | **Number of contacts** |
|---|---|
| Concerns about bullying behaviour | 5 |
| Concerns about HR process involving the member of staff – concerns about fair treatment | 0 |
| Concern about patient safety | 1 |
| Concerns about workload | 0 |
| Concerns about inappropriate behaviour | 0 |
| Concerned about role within the Trust | 0 |
| Concerned about issues directly relating to Covid-19 | 0 |
| Concerns about service delivery | 0 |
| Concerned about poor working relationships within team | 5 |
| Unspecified – contacted for general support | 1 |
| **Total** | **12** |

For comparison purposes, from 1 April 2020 – 30 July 2020, the FTSUG was contacted as follows:

| **Route of contact** | **Number of contacts** |
|---|---|
| Contacted via anti-bullying Tsar | 0 |
| Contacted directly by the member of staff | 7 |
| Requesting advice for a colleague | 0 |
| Contacted via SALS | 0 |
| Signposted by manager | 0 |
| Signposted by Occupational Health | 0 |
| Signposted by a FTSUG in another Trust | 0 |
| Signpost by Trust's Guardian of Safe Working Hours | 1 |
| Signposted by Trade Union contact | 0 |
| **Total** | **8** |

The following types of concern were raised 1 April 2020 – 30 June 2020 were as follows:

| **Type of concern** | **Number of contacts** |
|---|---|
| Concerns about bullying behaviour | 1 |
| Concerns about HR process involving the member of staff – concerns about fair treatment | 0 |
| Concern about patient safety | 0 |
| Concerns about workload | 0 |
| Concerns about inappropriate behaviour | 0 |
| Concerned about role within the Trust | 0 |
| Concerned about issues directly relating to Covid-19 | 4 |
| Concerns about service delivery | 0 |
| Concerned about poor working relationships within team | 3 |
| Unspecified – contacted for general support | 0 |
| **Total** | **8** |

**3.2 Making a difference**

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

Board members will note the increased number of concerns about poor working relationships within a team in Quarter 2 (5 contacts, compared with 3 in Q1). Four of the five contacts came from within the same team, one of whom had also made contact in Q1. This was escalated to the Executive team, who took specific actions in respect of this situation. Whilst not being able to give further information in a public board paper, I wish to record my thanks for the supportive and decisive actions from the Executive team as a result of staff speaking up, and being supported to do so, particularly in light of the difficulties these colleagues were having to describe within their team.

**3.2 National Guardian's Office**
The National Guardian's Office (NGO) has published a detailed review of cases raised in 2019-20. Broadly, more staff in the NHS speak up about poor behaviours, bullying or unprofessional behaviours than patient safety concerns, which broadly mirrors this Trust's position. The NGO took up feedback via FTSUGs from staff who have spoken up about an issue and whether they would do so again – nationally, over 85% of staff would raise an issue again if they needed to, and cited the role of the FTSUG as being helpful support in the speaking up process.

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

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

On this basis, the Guardian has reviewed the following:
- Each Quality report to the Trust Board from January 2017
- The detail of all whistleblowing cases – role and grade of staff member and department working in
- The headline National Staff Survey data and the quarterly cultural/staff friends and family test

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

Previous Board reports have contained a summary of whistleblowing cases received at the Trust since 2015. There have been no new cases forwarded for the Trust's central file since November 2019.

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

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

prioritised dealing with the pandemic situation first. This may happen again at the Trust moves in to second wave with Covid-19.

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

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

### 4.3.1 Staff Behaviours

In the last 18 months, the issues being raised about staff behaviours with the FTSUG and also through other routes reflect perhaps a changing dynamic. Many of the issues are about poor working relationships and how these are affecting service delivery and/or the health and wellbeing of staff involved. This appears to be a changing dynamic away from bullying behaviours, which have been the predominant issue raised with the FTSUG and through the staff survey; it reflects perhaps more of the frustration expressed in the staff survey about the culture of the organisation about having 'permission' to make positive changes within a team for service improvement as well as the culture of the organisation needing to reduce feelings of bureaucracy and focus more on positive relationships and accountability.

### 4.3.2 Covid-19 specific issues

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

- Concerns about staff social distancing when in public areas
- Staff adherence to changes in the uniform policy and wearing face coverings
- Fair treatment in respect of the Covid-19 risk management process

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

## 5. Conclusion

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

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

- Most members of staff making direct contact with the Freedom to Speak Up Guardian have been isolated cases – in terms of each coming from a different part of the Trust and being individual cases, with the below exception
- One issue from within the same team has been raised this quarter and managed at senior level as a team issue
- There are some cases where staff have contacted more than one area for advice and support, such as the Guardian of Safe Working and FTSUG – this is encouraged so that staff know there is support available

- The link between speaking up and organisational/team culture is one that the FTSUG will be seeking to support current work within the Trust, including support and training to Trust managers, as the recent staff management clinics have shown that managers are keen to learn best practice as well as share their own management experiences to encourage others

**6. Recommendation**

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

**Carla Ramsay**
Interim Director of Operations Surgery Health Group and Freedom to Speak Up Guardian
November 2020