Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held In Public

Tuesday 14 September 2021
9.00 am – 12.00 pm

Held via video conference
Appointment details issued by Rebecca Thompson, Head of Corporate Affairs

*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	Stuart Hall – Acting Chair
2	**Declarations of Interest**		
	2.1 Changes to Directors' interests since the last meeting	verbal	Stuart Hall – Acting Chair
	2.2 To consider any conflicts of interest arising from this agenda	verbal	Stuart Hall – Acting Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 13 July 2021	attached	Stuart Hall – Acting Chair
	3.2 Board Reporting Framework	attached	Rebecca Thompson – Head of Corporate Affairs
	3.3 Board Development Framework	attached	
4	**Matters Arising**		
	4.1 Action Tracker	attached	Rebecca Thompson – Head of Corporate Affairs
	4.2 Any other matters arising	verbal	Stuart Hall – Acting Chair
5	**Patient Story**	verbal	Makani Purva – Chief Medical Officer
6	**Standing Orders and Governance**		
	6.1 CEO Report and Covid Update	attached/verbal	Lee Bond – Chief Financial Officer
	6.1.1 Future new hospitals – expression of interest	attached	Lee Bond – Chief Financial Officer
	6.2 Committees in Common Summary	attached	Stuart Hall – Acting Chair
	6.3 Audit Committee Summary	attached	Tracey Christmas – Audit Chair
7	**Performance**		
	7.1 Integrated Performance Report	attached	Ellen Ryabov - Chief Operating Officer/Lee Bond – Chief Financial Officer/Beverley Geary – Chief Nurse/Makani Purva – Chief Medical Officer/Simon Nearney – Director of Workforce and OD
	7.2 Summary and minutes from the Performance and Finance Committee	attached	Mike Robson – Chair of Committee

	7.2.1 PDC Capital Application	attached	Lee Bond – Chief Financial Officer
	7.3 Summary and minutes from the Quality Committee	attached	Stuart Hall – Chair of Quality Committee
	7.3.1 Quality Committee Terms of Reference	attached	Stuart Hall – Chair of Quality Committee
	7.4 Summary and minutes from the Workforce, Education and Culture Committee	attached	Una Macleod – Chair of Committee
	Board Reports		
	8.1 Covid 19 Report	attached	Michelle Kemp – Director of Strategy and Planning
	8.2 EPRR Framework	attached	Michelle Kemp – Director of Strategy and Planning
	8.3 Workforce Race Equality Standards	attached	Simon Nearney – Director of Workforce and OD
	8.4 Workforce Disability Equality Standards	attached	Simon Nearney – Director of Workforce and OD
	8.5 Hospital Standardised Mortality Ratio Report	attached	Makani Purva – Chief Medical Officer
	8.6 Quality Report*	attached	Beverley Geary – Chief Nurse
	8.6.1 Perinatal Quality Surveillance Tool*	attached	Beverley Geary – Chief Nurse
	8.6.2 Perinatal Mortality Review Tool Report for CNST*	attached	Beverley Geary – Chief Nuse
	8.7 Finance Report*	attached	Lee Bond – Chief Financial Officer
	8.8 Performance Report*	attached	Ellen Ryabov – Chief Operating Officer
	8.9 Workforce Report*	attached	Simon Nearney – Director of Workforce and OD
	8.10 Community Paediatrics Report	to follow	Julia Harrison-Mizon – Operations Director, F&W's Health Group
9	Questions from the public relating to today's agenda	verbal	Stuart Hall – Acting Chair
10	Chairman's Summary of the Meeting	verbal	Stuart Hall – Acting Chair
11	Any Other Business	verbal	Stuart Hall – Acting Chair
12	**Date and time of the next meeting:** Tuesday 9 November 2021 9am – 12pm via Webex		

Attendance 2021/22

Name	11/5	10/6	13/7	14/9	9/11	11/1	8/3	Total
T Moran	✓	✓	x					2/3
S Hall	✓	✓	✓					3/3
T Christmas	✓	✓	✓					3/3
T Curry	✓	✓	✓					3/3
U MacLeod	✓	✓	✓					3/3
M Robson	✓	✓	✓					3/3
L Jackson	✓	x	x					1/3
A Pathak	✓	x	✓					2/3
C Long	✓	✓	✓					3/3
L Bond	✓	✓	✓					3/3
M Purva	✓	x	✓					2/3
B Geary	✓	✓	✓					3/3
S Nearney	✓	✓	✓					3/3
E Ryabov	✓	✓	✓					3/3
M Kemp	✓	x	✓					3/2
S Rostron	✓	✓	✓					3/3
R Thompson	✓	✓	✓					3/3

Hull University Teaching Hospitals NHS Trust
Meeting of the Trust Board
13 July 2021

Present:	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
In Attendance:	Mr S Nearney	Director of Workforce and OD
	Ms M Kemp	Director of Strategy and Planning
	Mrs S Rostron	Director of Quality Governance
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No **Item** **Action**

1 Apologies:
Apologies were received from Mr Moran CB,Chair and Mrs L Jackson, Associate Non-Executive Director

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.

3.1 Minutes of the last meeting held on 11 May 2021
Mr Bond advised that on Page 6, 2nd paragraph should read "there was a risk that the Trust would be over established but was working hard to make sure this did not happen".

Page 8 item 9.1 – the surplus was £245,000 and not £147,000. Mr Bond had thanked both the Estates and IT Team for meeting the Capital Plan.

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

3.2 Minutes of the meeting held on 10 June 2021 to approve the accounts
Page 1 item 3, the deficit should read £245,000.

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

4 Matters Arising
Mr Hall, on behalf of the Board, wished Terry Moran all the best for his future recovery and advised that his insight, experience and wisdom would be greatly missed. He added that he would do his best to take over as

Acting Chair in the interim whilst a replacement was found.

4.1 Action Tracker
Mr Long clarified that the Medical Staffing action was relating to medical staffing rotas and the potential growth over the last 2 years. It was agreed that the timescale should be extended for this piece of work.

Mr Long updated the Board relating to the Cancer service and how there had been no volunteers during Covid restrictions. He advised that normal services had now been resumed and the action could be closed down.

4.2 Board Reporting Framework
The Board Reporting Framework was presented to the Board, there were no issues raised.

4.3 Board Development Framework
Mrs Thompson presented the Board Development Framework and advised that she had updated it for 2021/22.

The Board received and accepted the Board Development Framework.

5 Due to technical difficulties the Patient Story was shown later on in the agenda.

6.1 CEO and Covid Update
Mr Long spoke of Terry Moran's departure and how he was a very well regarded Chairman. Mr Long added that he had been a Chief Executive for 25 years and Terry was the best Chairman he had worked with. He wished Terry well with his ongoing health and recovery.

Mr Long reported that there was pressure on the Emergency Department with a high volume of mental health patients at the moment. He also expressed his concern around patients presenting late with cancer after having long waits for treatment.

Mr Long advised that the Trust was using every bit of capacity to recover the backlog situation and how this would tip into elective capacity. He added that the number of Covid patients was increasing. Work was ongoing with system partners to review different ways of working.

Dr Pathak asked about GP services and how partners were helping the Trust in relation to the mental health issues. Mr Long advised that it was a national problem and that the GPs were doing what they could with limitations. Prof Macleod added that Primary Care was pressurised in managing patient expectations.

Mr Long advised that it was really difficult for patients waiting in pain and discomfort for their treatment. He added that all partners were working to manage the situation.

6.1.1. Green Plan
Mr Long presented the Trust's Green Plan and Zero 30 ambition was to reduce the Trust's carbon footprint.

Investment was required but Mr Long advised that the Humber itself had big ambitions and the Trust was also working with the University and other partners across the system. Mr Long suggest a Board Development session to discuss the Green Plan in more detail.

There was a discussion around what was and was not in the Trust's control and the huge agenda and how it would be managed. The Board also discussed the need to reduce gas consumption and the need to understand the alternatives.

Mr Hall suggested a lead NED be appointed to take the proposal forward.

Resolved:
The Trust Board endorsed the proposal and agreed to arrange a Board Development session to discuss the matter in more detail.

6.2 Committees in Common
Mr Hall presented the summary which detailed the initial discussions of the Humber Acute Services Development Committee. The key themes coming out of the meeting were around sharing data and communicating well.

A memorandum of understanding had been agreed and the Terms of Reference adopted by both Trusts.

Resolved:
The Board received and accepted the summary.

6.3 Board Assurance Framework 2021/22
Mrs Thompson presented the full Board Assurance Framework and a summary of the Q1 and Q2 actions to be taken to mitigate the risks.

She added that a new Risk Manager was in place and that the Corporate Risks were now being linked to the BAF.

In May the Performance and Finance Committee had agreed to reduce the target risk rating for BAF 4 to 16 (4 x 4). This still left a high risk but showed that it was being managed and improvements were being made.

Resolved:
The Board received the report and agreed that the risk rating for BAF 4 should be reduced to 16.

6.4 Audit Summary Report
Mrs Christmas presented the report which gave good assurance relating to the Trust's annual accounts. The Audit had been completed with the exception of stock taking and this had been noted in the accounts.

6.4.1 - Approval of the Annual Accounts
The approval of the Annual Accounts had taken place at the Trust Board on 10 June 2021.

Resolved:
The Board received the Annual Accounts in the public Board meeting for transparency purposes.

6.5 Integrated Performance Report – Making Data Count
Mrs Rostron presented the report which highlighted a proposal to use the Making Data Count reporting process and use SPC charts as performance indicators.

Mrs Rostron advised that the Business Intelligence Team were working on this and it was possible to set up. The proposal was to take indicators to each committee to build the report. The aim was to reduce the amount of papers received at the Board and report by exception only.

There was a discussion around the indicators and how the narrative was also important. Dr Purva added her support and suggested using the data across all committees also, refining as necessary.

Mrs Rostron suggested a Board Development session to review the data suggested by the Committees. **RT**

Resolved:
The Board supported the proposal and agreed to a Board Development session in August.

The Board also agreed that reports were sent to Board Committees, Quality, Performance and Finance and Workforce, Education and Culture to discuss their indicators.

7.1 Performance Report
Mrs Ryabov presented the Performance Report and highlighted the pressures on Urgent Care.

Attendances had gone up around 7% in June and Ambulance handovers had increased.

Cancer 62 day performance had reduced but Breast was the most challenged area and with staff pressures. A recruitment plan was in place.

RTT performance was still a way off target but the waiting list volume had dropped in May to 60,000. 52 week waits was also exceeding the plan.

Diagnostics had improved slightly in the last month.

Mr Bond expressed his concern around the increasing stranded patients and how they equated to a number of wards until they were discharged. Mrs Ryabov agreed and advised that there had been a number of patients on complex pathways ready to go to their next place of care yesterday. Work was ongoing with partners to review the options.

Mrs Ryabov also presented the Health Group elective recovery plans.

She advised that the planned trajectories were increasing and was 85% in June and that would increase again in Q2 to 95%. She added that the Trust had done better than anticipated and a huge amount of work was going on to meet the targets.

There was a discussion around colorectal cancer and the long waits for minor procedures that was causing the issues. Mrs Ryabov advised that a new contract had been introduced to help with endoscopy procedures.

Mr Bond asked about the 104+ day cancer performance and Mrs Topliss advised that the Trust was currently at 50 which was an improvement at the end of May.

Resolved:
The Board received and accepted the report.

7.1.1 - Performance and Finance Summary and Minutes
Mr Robson presented the assurance document which showed reasonable assurance but highlighted that a number of performance targets were not being achieved.

Mr Robson added that the Committee had received a presentation from the Emergency Care Health Group Triumvirate who were implementing action plans to improve performance.

7.1.2 - Performance and Finance Terms of Reference
The Performance and Finance Terms of Reference were presented to the Board with minor changes to job titles highlighted.

Resolved:
The Board received and approved the Performance and Finance Terms of Reference.

7.2 Quality Report
Mrs Geary presented the report and advised that the Trust had reported a Never Event in May relating to a wrong site surgery. The investigation had commenced.

There had been 7 serious incidents reported in May 2021. Mrs Geary advised that there was a number of Serious Incidents in the backlog to be cleared. A weekly meeting was being held to review all incidents and they were being signed off at the Serious Incident Committee.

There had been 1 MRSA bacteraemia declared. The patient had complex health needs and an investigation had been completed. The outcome was declared as unavoidable but was a Hospital onset case.

There had been a very low number of D&V in the hospital but the Team was anticipating that this would change during Autumn and Winter as restrictions are lifted. The Trust would be keeping most restrictions to avoid crowding and nosocomial infection rates increasing.

Mrs Geary advised that there had been progress and improvements in the Complaints 40 day standard but there was currently a large backlog of

PALs cases due to staff absence in the department.

Mrs Christmas asked if the Teams were anticipating any problems keeping face masks and social distancing once measures were relaxed nationally. Mrs Geary advised that she was expecting some issues but wanted clear communications to staff and the public to be in place.

Mrs Rostron advised that the HSMR performance had come down in the latest data but Dr Purva and Mr Sedman were leading a detailed piece of work around this. Dr Purva added that a paper would be received at the Quality Committee in August and the Board in September showing the work being carried out and the robust actions in place.

Mr Hall mentioned the new tool being developed in relation to pressure ulcers and the outcomes of this would be reported to the Quality Committee.

Resolved:
The Board received and accepted the report.

7.2.1 Quality Summary and Minutes
Mr Hall presented the summary and highlighted the issues around mental health patients and the impact on patient care and services.

7.2.2 Quality Terms of Reference
The Terms of Reference were presented to the Board with minor changes to job titles highlighted.

Resolved:
The Board approved the Quality Committee Terms of Reference

5 Patient Story
Dr Purva played a video that showed members of the family of patients who had died of Covid in the Trust. They spoke about patient care and how the Trust had supported families during and after the patients had died.

There were tributes paid to the ICU team, Volunteers, Bereavement Team and ward staff. Kindness was shown at every level.

Mr Hall stated that it was a reminder of what staff had gone through during the height of the pandemic and thanked all staff for their care and compassion.

8.1 Our People - Progress Report
Mr Nearney presented the report and expressed his concern regarding the amount of staff absence and how both hospitals were under pressure.

The Emergency Department and Theatre staff were particularly stretched and staff were working long hours to compensate.

Staff absence was up to 5.14% with over 300 staff self-isolating due to Covid and Track and Trace.

The Trust had 382 vacancies currently which was a good position. Mr

Nearney added that there were still some issues in certain hard to staff specialities such as radiology.

The quarterly staff surveys were being reintroduced to the Trust.

A number of cultural leadership briefings had commenced in May to address staff and service recovery.

Each member of staff had been sent a letter giving them an extra day's annual leave in 2021/22 as well as a commemorative coin as a thank you for services during Covid.

Dr Pathak asked how many staff had been vaccinated and Mr Nearney advised that it was 8500+. He advised that work was ongoing to get to as close to 100% as possible. Vaccinations workforce – have all staff been vaccinated.

Resolved:
The Board received and accepted the report.

8.2 Workforce Education and Culture Committee Summary
The summary was received and accepted by the Board.

9.1 Finance Summary Report
Mr Bond presented the report and advised that at month 2 the Trust was reporting a deficit of £1.7m which included elective recovery funding.

Month 2 was showing £200k which was in line with the plan. The Trust was also on target to meet its end of the first 6 months plan.

Mr Bond advised that the gateway criteria for the Elective Recovery Funding had all been met. This was system-wide rather than just HUTH.

Car-parking recovery was above plan and vaccinations and testing expenditure was ongoing.

There were risks around the CRES programme as Health Groups were struggling to find recurrent savings. Mr Bond advised that a small margin had been made on the elective recovery fund but extra pressure would come when the RTT trajectory moved from 85% to 95% in the next few months.

The Capital Programme was underway and the teams were working to bring expenditure into Q3 to release public dividend capital to support the theatre and gamma camera works.

Mr Bond asked the Board to note the deficit and forecast was in line with the plan with costs and income balanced.

Resolved:
The Board received and accepted the report.

10.1 Guardian of Safe Working Annual Report
The Guardian of Safe Working Annual Report had previously been presented to the Quality Committee and was presented at the Board for

noting.

10.2 Director of Infection Prevention and Control Report
The Director of Infection Prevention and Control Annual Report had previously been presented to the Quality Committee and was presented at the Board for noting.

10.3 Learning from Deaths Annual Report
The Learning from Deaths Annual Report had been previously presented to the Quality Committee and was presented at the Board for noting.

10.4 Health and Safety Annual Report
The Health and Safety Annual Report had been previously presented to the Non-Clinical Quality Committee and was presented at the Board for noting.

10.5 Safeguarding Annual Reports
The Safeguarding Annual Reports had been presented previously to the Quality Committee and were presented at the Board for noting.

10.6 NHS Resolution Maternity Scheme
Mrs Geary presented the report and advised that the Trust was now fully compliant in all 10 safety actions. Standard 6 relating to the Saving Babies Lives care bundle and Standard 8 relating to the emergency response to Covid 19 had both been addressed as they were previously partially compliant but were now compliant.

Resolved:
The Board received and accepted the report.

10.7 Minutes from Charitable Funds
The minutes were presented to the Board for noting, there were no issues raised.

10.8 - Charitable Funds Terms of Reference
The Terms of Reference were presented to the Board. Mrs Rostron advised that there had been minor amendments made to job titles only.

Resolved:
The Board approved the Charitable Funds Terms of Reference.

10.9 Freedom to Speak Up Report
Mrs Moverley introduced herself as the new Freedom to Speak up Guardian and advised that she would provide an update quarterly to the Board.

Mrs Moverley advised that she had received 5 concerns since she took over the role. None of the concerns related to Covid.

She was carrying out a gap analysis to aid the Well-Led evidence for the CQC. In section 7 of the report there was some benchmarking scores against other Trusts. The Trust was ranked mid table but was an increasing position.

Mr Hall asked how lessons learned were being conveyed. Mrs Moverley

advised that it was difficult as some of the concerns were confidential but she was reviewing key learning points and reviewing any trends. Mrs Moverley was also working with Workforce and OD in developing the role.

Mr Hall suggested that Mrs Moverley link in with Mrs Christmas the link NED for raising concerns.

Resolved:
The Board received and accepted the report.

10.10 Trade Union Facility Time Reporting
The report had been received at the Workforce, Education and Culture Committee and was presented to the Board for noting.

10.11 Premises Assurance Model
Mr Bond presented the report and highlighted the now statutory self-assessment questions.

He advised that the majority of areas showed good reviews or required minor improvements. The areas of most concern were car-parking, transport and food and drink. Mr Bond added that the new front entrance works would provide good assurance and he commended Mr Taylor and his team for their hard work.

Mr Hall asked which Committee would review this assessment and Mr Bond advised that it would be the Non-Clinical Quality Committee. He added that the range and remit of standards was massive with lots of legislation involved. An action plan was in place and being monitored.

Resolved:
The Board received and accepted the report.

11 Questions from members of the public
There were no questions received from the members of the public attending the meeting.

Mr Hall thanked everyone for attending.

12 Chairman's summary of the meeting
Mr Hall stated that there were many changes and pressures being faced at the moment and it was clear that staff were prepared to adopt and adapt.

Mr Hall wanted to formally recognise the super work and commitments shown by all staff.

13 Any Other Business
There was no other business discussed.

14 Date and time of the next meeting:
Tuesday 14 September 2021, 9am-12pm via Microsoft Teams

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

Hull University Teaching Hospitals NHS Trust
Board Development Programme 2021/22

Overarching aims:

- The Board to focus on the vision, values and goals of the Trust in all that it does
- The Board to provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2022

Board Development Dates 2021/22	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and integrated services	Research and innovation	Financial sustainability	Other
8 June 2021			BAF 2: Equality, diversity and inclusion, Staff Survey, Staff wellbeing	BAF 3.2: Risk of harm to patients due to long waits	BAF 4: Risks to the Recovery Plan				
10 August 2021							BAF 6: Research and Innovation		Board Well-Led self-assessment Making data count training
12 October 2021		BAF 1: Board Leadership/ Leadership and culture				BAF 5: Risk that the HCAV and Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid recovery			CQC – Quality Risk Profile
14 December 2021	Strategic drivers/balanced scorecard review			BAF 3.1: Risk that the Trust is not able to make progress in continuously improving quality					End of Life Care Green Plan IPR Review
8 February 2022					BAF 4: Risks to recovery plan			BAF 7: Financial Sustainability	Estates/IT Strategy Update

Principles for the Board Development Framework

Key framework areas for development (The Healthy NHS Board 2013, NHS Leadership Academy) looks at both the roles and building blocks for a healthy board.

Overarching aim:

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

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?

- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?

- How can we build further resilience, trust and honesty into our relationships?
  Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

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

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?

- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development
Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?

- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (July 2021)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2021						
01.05	Minutes March 2021	Medical Staffing Review plan update to be received	MP/LB	TBC		
COMPLETED						
02.05	Patient Story	Chemotherapy - communication with patients to be reviewed	CL	July 2021		Completed
01.03	External Review of Covid response	Results of the review to be shared with the Board	CL/ER	September 2021		Summary shared

Actions referred to other Committees

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

Hull University Teaching Hospitals NHS Trust

Agenda Item	6.1	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	Chief Executive Officer Report				
Lead Director	Lee Bond – Deputy Chief Executive				
Author	Myles Howell – Director of Communications				
Report previously considered by (date)	The report is received at every Board meeting.				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only	✓	Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	✓
						Financial Sustainability	✓

Key Recommendations to be considered:
That the board note significant news items for the Trust and media performance.

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 14 September 2021

1. Key messages from July/August 2021

Number of deaths after patients test positive for COVID-19
Sadly, we can confirm that since 19 March 2020, over 900 patients have died at Hull University Teaching Hospitals NHS Trust after testing positive for COVID-19.

The families of all patients have been informed and our deepest sympathies are with them at this very difficult time.

This is a sobering milestone, offering a reminder that Covid-19 remains a part of our lives and our communities. Our hospitals continue to see rising numbers of Covid-19 patients and with the return of schools in September we anticipate that community cases and hospitalisations may spike once again.

The pandemic is not over and we must do everything we can to keep ourselves, our workforce, and our loved ones safe.

Hull Royal to refer non-urgent cases to alternative treatment centres
Demand on hospital and community-based healthcare services across East Yorkshire continues to escalate, and attendances at Hull Royal Infirmary's A&E Department have now returned to pre-pandemic levels of around 400 patients per day.

With the pressure on staff and services unrelenting, the Trust has renewed its appeal for patients to seek alternative treatment elsewhere, such as via 111 or their local GP practice, instead of seeking urgent treatment for routine health problems.

We are also referring some patients seeking emergency treatment for non-urgent or routine health problems to alternative treatment centres. Where it is considered safe to do so, those patients will be redirected on arrival either to Story Street Primary Care Centre or one of the four urgent treatment centres across the area (Bransholme, Beverley, Bridlington and Goole).

The increase in the number of people attending A&E, combined with more rigorous cleaning regimes in between patients, means that waiting times in the department are longer than normal, however waits are to be expected in most parts of the health system, and people's patience is appreciated.

Hull's hospitals have declared their intention to be a leader in tackling climate change
Our Trust is setting the ambitious target of becoming the first hospital trust in England to achieve net zero carbon emissions by 2030 and we have outlined our "Zero Thirty" plan.

The NHS has a massive impact on the environment and is responsible for more than five per cent of the UK's total emissions, the same as emissions from 11 coal-fired power stations.

Net zero will be achieved when the amount of carbon emissions produced by the trust is balanced by the amount the organisation removes from the atmosphere.

Emissions from energy use have been reduced by 25 per cent already through energy efficiencies and 20,000 light fittings are currently being replaced by SMART LED lighting at Hull Royal and Castle Hill, as well as other hospital buildings around the city.

We will be working with our staff across the Trust to review how we buy supplies, transport goods, reduce our waste and energy consumption.

Work begins on solar panel field to power Castle Hill Hospital
A key element in our Zero30 plan made great progress in August. Following planning approval from East Riding Council work has started on our solar panel field to generate energy for Castle Hill Hospital. The panels are expected to be generating energy by the end of the year.

Known as “ground mounted solar photovoltaic array”, the development will cover 7.7 hectares, including access roads, on land south of Castle Road in Cottingham.

The Trust will erect almost 11,000 solar panels to generate a third of the total energy requirements of Castle Hill Hospital, meeting all of its daytime requirements in the summer.

Landscaping will be used to screen the development and protect wildlife, with information boards put up around the site to inform people living near the hospital about our environmental plans.

The field is all part of “Zero Thirty,” the trust’s campaign to be a UK leader in tackling the NHS’s impact on climate change by achieving net zero carbon emissions by 2030.

Funding for the project has been possible after the trust received a £12.6m grant from the Department for Business Energy and Industrial Strategy as part of its Public Sector Decarbonisation Scheme to support its new green agenda.

High profile recruitment drive partners with Inner City Sesh
Our national campaign to attract the best talent to vital health and social care roles in Hull and East Yorkshire will be supporting summer music festival Inner City Sesh.

Under the banner, East YorkSHH!re: ‘the secret’s out’, the campaign has had unprecedented success by telling the stories of those people who came to work here, fell in love with it, and now want to spill the beans.

As Humber Street Sesh is a firm favourite with so many who come to the region, the campaign has stepped up and joined forces with the Inner City version – supporting the East YorkSHH!re Silent Disco at the Queen’s Gardens event on Sept 18th.

The “East YorkSHH!re” campaign is an unprecedented recruitment partnership between East Riding of Yorkshire Council, City Health Care Partnership CIC, Hull CCG, East Riding of Yorkshire CCG, Hull University Teaching Hospitals NHS Trust, Humber Teaching NHS Foundation Trust, Humberside Fire and Rescue Services, Humberside Police, Yorkshire Ambulance Service, Hull York Medical School and the University of Hull.

Launched in October 2020, it has built on the success of earlier recruitment campaigns which have succeeded in bringing health care staff to the region.

New service to assess children for Long Covid begins
A new service launched during August to assess children and young people for the long term effects of Covid-19.

From Monday 16 August, the Trust began accepting referrals for our Paediatric Long Covid Assessment Service, serving patients and professionals across the Humber, Coast and Vale Integrated Care System (ICS).

The service reviews children from Hull and the East Riding, as well as those referred in by paediatricians in other parts of the Humber, Coast and Vale region which includes areas such as York, Scarborough, Scunthorpe, Grimsby and Goole.

The establishment of the service follows national announcements made in recent months for multi-million pound investment in services to support those suffering from the effects of Long Covid, including children and young people. It is one of five to operate in the NHS North East and Yorkshire region, and one of just 16 to be set up across the country.

2. Media/social media activity

In July 50 articles and reports were published and broadcast about the Trust:

- 37 positive (74%)
- 8 factual (16%)
- 4 negative (8%)
- 1 neutral (2%)

Social media

Facebook

- Total "reach" for Facebook posts on all Trust pages in July – 248,805
- Hull Women and Children's Hospital – 78,661
- Castle Hill Hospital – 51,778
- HEY Jobs page – 6,960
- Hull Royal Infirmary – 59,628
- Hull University Teaching Hospitals NHS Trust – 51,778

Twitter @HEYNHS

- 158,000 impressions in July 2021
- 9,324 followers
- Tweets with highest number of impressions related to Covid-19 (request for visitors to continue wearing masks beyond 19 July) and liver nurse Dianne Backhouse reaching the finals of the Nursing Times Awards

In July 48 articles and reports were published and broadcast about the Trust:

- 31 positive (65%)
- 9 factual (19%)
- 6 negative (12%)
- 2 neutral (4%)

Social media

Facebook

- Total "reach" for Facebook posts on all Trust pages in July – 297,036
- Hull Women and Children's Hospital – 70,434
- Castle Hill Hospital – 80.845
- HEY Jobs page – 4,291
- Hull Royal Infirmary – 75,508
- Hull University Teaching Hospitals NHS Trust – 65,958

Twitter @HEYNHS

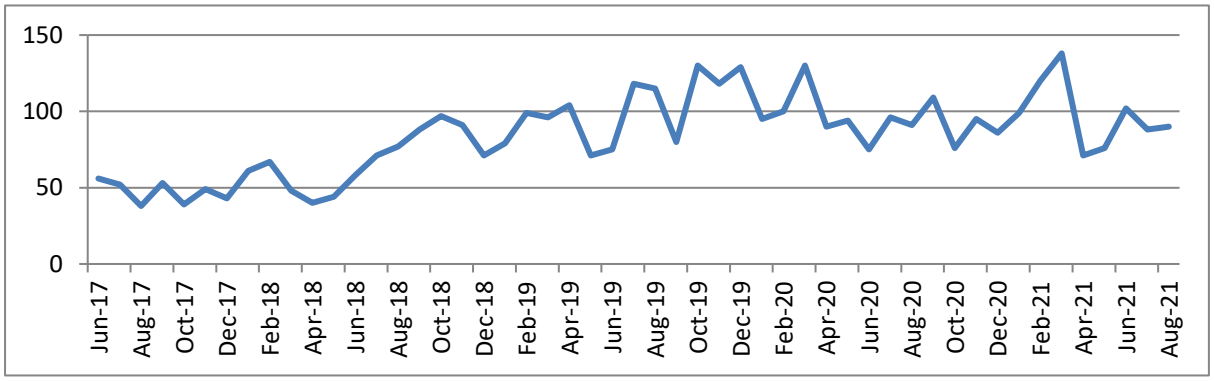
- 142,000 impressions in August 2021
- 9,370 followers
- Tweets with highest number of impressions related to appropriate use of emergency care/A&E and A-level results day – congratulating students embarking on healthcare careers.

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.

Please visit the intranet to read the most recent nominations.

Number of Moments of Magic submitted by month June 2017-August 2021:



Hull University Teaching Hospitals NHS Trust

Agenda Item	6.1.2	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	Health infrastructure plan: future new hospitals – expression of interest template for NHS organisations				
Lead Director	Lee Bond, Chief Financial Officer				
Author	Ivan McConnell, Director HASR				
Report previously considered by (date)	This report has been considered at the Committee in Common, Humber Acute Services Development Committee				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only	✓	Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:

The Board is asked to note the expression of interest attached.

Department of Health & Social Care

Health infrastructure plan: future new hospitals – expression of interest template for NHS organisations

Published 15 July 2021

Guidelines to trusts

Completing the form

Trusts should submit their completed expression of interest form to futurenewhospitals@dhsc.gov.uk by midday on 9 September 2021.

Please note the above mailbox is only for template submissions and/or questions from trusts relating to this stage of the process. Any other queries should be routed to the Department of Health and Social Care (DHSC) correspondence centre and media queries to our press office.

Trusts should submit information in the template proforma and conform to the word limit. Submissions above the word count will not be considered.

No additional information will be accepted or considered as part of this stage of the selection process, outside of this proforma.

No external funding or resource should be used to prepare the case and no additional pre-prepared documentation will be accepted.

Trusts are permitted to submit more than one form (for example for different sites) but must indicate how each proposal affects the trust as a whole and any dependencies between proposals as well as the site-based approach.

Important notes

Cost and savings estimates are only requested to give an early indication of the likely scale of investment required. We appreciate that many schemes will be put forward at the very early stages of development and so precise cost or savings estimates may not be available. We will only use estimates at this stage to understand the broad order of magnitude of costs of potential schemes in the pipeline and any key assumptions being made.

These costs estimates do not equate to a bid for this amount of funding. The ultimate size, scope and cost of shortlisted proposals will be determined in conjunction with the new hospital programme.

Savings estimates could reflect initial assumptions at this stage about efficiency as a result of any investment, for example reductions in backlog maintenance, land disposals, high level floor space and bed data if available.

Please note by submitting this information to the Department of Health and Social Care, you are agreeing that they are permitted to share the form or extracts of it with relevant officials in NHS England and NHS Improvement and their regional teams, and HM Treasury, on an OFFICIAL-SENSITIVE-COMMERCIAL basis.

Next steps

This summary information will form one part of the first stage of the process. It will be combined with evidence from existing national datasets (official data, signed off by provider chief executives) as well as discussions with regional and local NHS leaders. The later stage of the selection process in autumn or winter 2021 will allow for more detailed discussions and further evidence to be provided, if appropriate.

We hope to inform trusts of the outcome of this first stage, including more detail on the later selection process, during autumn 2021. The outcome of the first phase will be a longlist of proposals to continue to stage 2.

We aim to make the final decision on the next 8 hospitals to form part of the national programme by spring 2022.

Expressions of interest – form for completion

New hospital criteria

A whole new hospital site on a new site or current NHS land (either a single service or consolidation of services on a new site).

A major new clinical building on an existing site or a new wing of an existing hospital (provided it contains a whole clinical service, such as maternity or children's services).

Trust type

Acute
Community

Region

North East and Yorkshire

Trust name

Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

Site covered

Scunthorpe General Hospital
Hull Royal Infirmary
Castle Hill Hospital
Diana Princess of Wales Hospital, Grimsby

Indicative cost of scheme [241 words]

Our proposed capital scheme is based upon a portfolio application across two providers/four sites, where we need to rebuild or redevelop our failing infrastructure to implement new models of care and ensure that, as "Anchor" organisations, we fulfil our commitment to local regeneration and economic growth in some of the most deprived areas in the country.

Our portfolio, in priority order, is:

- Rebuild of Scunthorpe General Hospital – on a brown field site with improved access and use of green wire to reduce carbon emissions - £350m
- Redevelopment of medicine and surgery facilities at Hull Royal Infirmary with an aligned Elective/Day Case Hub at Castle Hill Hospital developing it as a specialist elective centre - £250m
- Redevelopment of Diana Princess of Wales Hospital, Grimsby (existing site) – improving access and care quality - £120m

Projected capital costs are based on April 2021 figures. The projected cost (£6,000/m^2) has been benchmarked against outturn costs for a number of our recently completed schemes and includes provisions for Net Zero compliance, enhancement of digital capability and potential changes to the scope of the scheme in the planning period.

Our capital requirements are based upon the detailed work we have undertaken on our Humber Acute Services Transformation Programme, which includes:

- "Left Shift" of activity from hospital to community settings
- Reducing inpatient bed numbers through the use of SDEC and AAU pathways
- Making increased use of community-based diagnostics
- Creating split facilities – Unscheduled Care and Green Elective/Day Case Hubs

Indicative savings of scheme [245 words]

Our proposed service transformation and capital investment programme will achieve an annual revenue cost saving of £36.4m (net of capital charges). Under the 'do minimum' option, the additional revenue cost associated with managing increased acute hospital workloads will be £437.4m/year (at Year 15). Under the proposed approach, the corresponding revenue cost increase would be reduced to £401.0m/year. In determining the overall revenue cost implications, provision has been made for appropriate investment in primary and community care to support service transformation/'left shift'.

	Additional Annual Revenue Costs		
Category	**Do Minimum**	**Proposed**	**Variance**
Service delivery - direct costs	£416.4m	£377.7m	-£38.7m
Equipment maintenance costs	£1.0m	£4.0m	£3.0m
FM costs	£19.9m	£19.2m	-£0.7m
Sub Total	***£437.4m***	***£401.0m***	***-£36.4m***
Cost of capital @3.5% pa	£5.4m	£22.4m	£17.0m
Depreciation costs	£4.7m	£23.1m	£18.4m
Sub Total	***£10.1m***	***£45.5m***	***£35.4m***
Grand Total	**£447.5m**	**£446.5m**	**-£1.0m**

Our proposed service transformation programme requires capital investment of £720m. Under the 'do minimum' scenario significant capital expenditure (£100m) would be required to increase capacity in the acute sector. Further investment would be required to keep our buildings serviceable, including an unavoidable investment of £59m to address known Critical Infrastructure Risks. Addressing all known Backlog Maintenance issues (including CIR), would require an overall investment of £105m.

Hospital Site/Building	**BLM Value**	**CIR Element**
SGH	£60m	£28m
HRI (tower block)	£17m	£12m
DPoW	£28m	£19m
Grand Total	**£105m**	**£59m**

Supported by our Local Authorities and LEPs we have undertaken initial analysis to quantify the wider economic and social impact of our proposed investment. This has shown that the proposed investment will facilitate economic growth and create social value in our local communities, resulting in a net financial benefit of £1.58bn across the Humber.

Status of plans and engagement to date with partners [248 words]

Without capital investment our Humber-wide acute service collaboration and plans for sustainable clinical services will not be deliverable.

Our capital options are based upon the emerging models of care within the Humber Acute Services programme, which will deliver a Pre-Consultation Business Case in December 2021. Formal consultation will be undertaken from May 2022, subject to NHSE/I and Clinical Senate approval. A "pre-SOC document" for capital investment is being developed in parallel ensuring full alignment. This vanguard work on PCBC/SOC alignment, supported by NHSE/I, will inform the development of new national planning guidance.

We have undertaken extensive public, patient and staff engagement:

- What Matters to You (4000 people) – identifies timely access as a priority
- Birthing Choices (1150 people) – identifies co-located maternity units as a priority
- Clinical redesign workshops (700+ primary, community and secondary care staff)
- OSC and representative engagement
- Clinical Senate, GIRFT, College and NHSE/I workshops

We have established a Capital Advisory Board with representatives of Hull and Lincoln Universities, Hull & East Riding and Lincolnshire LEPs, and our Local Authority partners, who all strongly support our proposals. We have also strengthened our provider governance – HUTH and NLaG have established Committees in Common to oversee our collaboration.

Our plans are well advanced, our options for future service delivery are sustainable and reflect what we have heard from our stakeholders. Our proposed programme of capital development has been designed to facilitate a flexible, agile and lean approach to design, procurement and delivery. We are ready to move forward at pace.

Summary of scheme [247 words]

Our proposed capital scheme is a portfolio application across two trusts/four sites. The scheme is critical to delivering clinical transformation across the region and is closely aligned to out-of-hospital developments (specifically, the ICS strategy for the development of community diagnostic services, including new Community Diagnostic Hubs in Scunthorpe, Hull, Grimsby and York) and local regeneration strategies (specifically, the Scunthorpe Towns Deal plan and Hull City Council's master-planning exercise for the Anlaby Road area).

Our portfolio, in priority order, is:

1. Scunthorpe Hospital:
    - Hospital rebuild on a campus site (town centre location identified with North Lincolnshire Council)
    - Development of split emergency and elective/day case hubs

- Optimised digital infrastructure
- "Green wire" providing energy from waste site
- Aligned research/training facilities

2. Hull University Teaching Hospitals:
    - Partial-rebuild and refurbishment of Tower Block
        - Three new-build ward blocks to deliver improved facilities for medicine/surgery
        - Refurbishment of Tower Block as office accommodation (aligned to One Public Estate)
    - New-build day case theatres at Castle Hill Hospital, developing it as a specialist elective centre

3. Diana Princess of Wales Hospital, Grimsby
    - Partial-rebuild of existing site
    - Aligned to Grimsby Town Centre regeneration plans
    - Development of split emergency and elective/day case hubs

Our portfolio application will enable both trusts to increase their levels of clinical collaboration, delivering improved patient experience and a more integrated service offering. By delivering significant clinical service reconfiguration across urgent and emergency care, maternity, paediatric and neonatal services, planned care and diagnostics we will deliver national guidance, whilst also improving patient access and experience.

Expression of interest – statement [750 words]

Improved Outcomes

Our population needs us to change fundamentally the way we provide acute care – our current service configuration is not meeting their needs and our current infrastructure does not support modern models of care. By working collaboratively to make best use of staff, skills, buildings and equipment, our proposed clinical changes will deliver upper decile performance and make it easier for patients to get the care they need.

We will move services that do not need to be in hospital closer to patients' homes, building on successes in Frailty and Cardiology pathways where this "left shift" of activity is already improving access and outcomes for patients and actively addressing health inequalities through provision of proactive or anticipatory care. We will invest in digital technology, implementing interoperable systems, Command Centres, robotics and AI, in line with the ICS Digital Strategy.

These changes will deliver wide-ranging benefits:

	Benefit	**Mechanism**
Urgent and Emergency Care	length of stay ↓ hospital bed numbers ↓	implementation of SDEC and AAU models
	hospital attendances ↓	enhanced use of community assets "hear and see and treat"
	efficiency/productivity ↑	use of Advanced Care Practitioners enhanced use of digital

Maternity, Paediatrics and Neonatal	neonatal capacity in HUTH	↑	repatriating some Northern Lincolnshire cases from Sheffield
	Royal College standards	✓	responding to workforce challenges
	Choice	✓	potential to implement co-located maternity units
Planned Care and Diagnostics	support elective recovery	✓	stand-alone Elective/Day Case Hubs protecting elective theatre time
	efficiency/productivity	↑	improved patient flow
	improved access	✓	pathways aligned with implementation of Community Diagnostic Hubs

Stronger, Greener Buildings

Our proposed investment programme will enable us to provide a hospital estate that is smart, flexible, able to cope with serious outbreaks of infection and the effects of climate change, energy efficient and environmentally sustainable.

Our current infrastructure has not coped well during the Covid-19 pandemic. Infection prevention and control measures have resulted in reduced bed numbers, treating patients in pop-up facilities and other sub-optimal solutions. Backlog maintenance across our sites totals £105m and in some instances over 82% of our infrastructure is at risk of imminent failure or requires major repair or replacement.

Our proposals do not implement a like-for-like hospital build. Instead, they will deliver smarter, more flexible buildings, split unscheduled care from elective/day case work, deliver single rooms, isolation rooms and small bays to optimise patient flow.

Our investment will deliver on our emerging ICS Green Plan delivering carbon reduction, energy efficiency, clean air, and biodiverse local environments. We will capitalise on our unique opportunity to use the academic and commercial expertise in renewable energy that is concentrated in the Humber region. The site identified for the rebuild of Scunthorpe Hospital will utilise “Green Wires” to deliver energy directly from renewables in partnership with the Local Authority. We will use modern methods of construction across the portfolio, resulting in reduced cost and improved environmental sustainability. We will maximise the use of technology in building design and operation, enabling us to reduce bed numbers, reduce staff and patient travel and implement alternatives to admission.

Levelling Up Humber

Our economic and social impact assessment has shown that our investment of £720m in healthcare infrastructure will deliver £1.58 billion in social profit to our local communities. Serving some of the most deprived areas of the country, with lower-than-average life expectancies and some of the worst public health outcomes nationally. This significant social benefit is critical to delivery of our ICS’s ambitious levelling-up commitment.

Our proposed investment is backed by a strong “Anchor Network” across the region and is integral to the delivery of regional regeneration strategies, Local Authority Master Plans and Town Deals. Planning has been undertaken collaboratively with Local Authorities and wider partners (Universities, LEPs), adopting a “One Public Estate” approach, to ensure maximum return on

investment, leveraging wider economic benefits through increased private sector investment in allied industries.

We are working with partners to exploit the benefits of the Humber's forthcoming Freeport status, leveraging investment into MedTech and health research, and developing an innovation collaborative in partnership with the Universities of Hull and Lincoln.

Working with education and skills providers, we are committed to building a skilled local workforce, harnessing apprenticeships, career passports, rotational posts, and shared career pathways. We have strengthened our university relationships and are working on improved strategic workforce planning in partnership with HEE. We will improve health, social and economic wellbeing by supporting the creation of high-quality jobs and improved cross-sectoral career prospects encompassing health and care, construction, engineering, research and innovation.

Working collaboratively, we are seeking to build better places and better prospects for our population.

Declaration

I confirm that the information in this form is accurate at the time of completion and that I have appropriate executive approval from my trusts to submit this expression of interest.

Yes

Name: Ivan McConnell

Role: Director, Humber Acute Services

Email address: ivan.mcconnell@nhs.net

Phone number: 07544 378201

Date approved by trust boards: 26 August 2021

Glossary of terms

AAU	Acute Assessment Unit
AI	Artificial Intelligence
BLM	Back-log Maintenance
CIR	Critical Infrastructure Risk
DPoW	Diana Princess of Wales Hospital, Grimsby
GIRFT	Getting It Right First Time
HEE	Health Education England
HRI	Hull Royal Infirmary
HUTH	Hull University Teaching Hospitals NHS Trust
ICS	Integrated Care System
LEP	Local Enterprise Partnership
NLaG	Northern Lincolnshire and Goole NHS Foundation Trust
OSC	(Local Authority) Overview and Scrutiny Committee
PCBC	Pre-Consultation Business Case
SDEC	Same Day Emergency Care
SGH	Scunthorpe General Hospital
SOC	Strategic Outline Case

Report to the Board in Public
Humber Acute Services Development Committee held on 26 August 2021

Item: Director Overview Report	Level of assurance gained: Good
Ivan McConnell presented the overview and advised that programmes 1 2 and 3 were progressing well with ongoing reviews from the Clinical Senate. NHS E/I were also carrying out formal reviews and providing friendly and critical challenge. From a governance point of view the Committee in Common had agreed its Terms of Reference and received any issues of escalation from the Programme Board or the Executive Committees at both Trusts.	
Item: Capital Expressions of Interest	Level of assurance gained: Good
The proposed submission for the Humber ICS was a full redevelopment of the Scunthorpe hospital, new ward blocks for HRI and CHH and a full redevelopment of Grimsby hospital. This would mean that services could become more flexible for patients. There were 8 schemes available and 30 bids from Trusts had been submitted so far.	
Item: Programme 1 MOU/SLA Update	Level of assurance gained: Good
The wording in the SLA document had been updated to reflect the Clinical Negligence statement of which Trust was liable and this was accepted by the CCG and Capsticks Solicitors. The MOU is also aligned with the SLA.	
Item: Oncology Update	Level of assurance gained: Good
So far the work delivered was Oncology, Haematology, the Lung Health Check and was looking to streamline MDT functions. There was still nervousness about the Oncology move and communications to keep all the wider stakeholders involved was key. The Stakeholder engagement plan would be presented to the next meeting.	

Report to the Board in Public
Quality Committee held on 22 July 2021

Item: Clinical Audit Annual Report	Level of assurance gained: Good
The Clinical Audit Annual Report advised that performance was at 62%. There had been a number of audit extensions due to the pandemic as well as it being difficult to access training. The number of audits being closed was slowly increasing.	
Item: Internal Audit Report	Level of assurance gained: Good
There had been one audit completed which was the Clinical Harm review. The review had gained reasonable assurance. The Clinical Harm review had shown that good risk stratification and procedures were in place. RSM had tested 20 reviews and reporting was consistent.	
Item: Counter Fraud Report	Level of assurance gained: Good
Work was ongoing with finance and procurement and the ABPI declarations data had been released again for review. Mrs Deegan advised that she would present the Single Tender Waiver benchmarking work at the next meeting in October 2021. There were 2 investigations ongoing which had progressed to witness statements and case number 2 had been deemed not a criminal offence. Mrs Deegan also presented a benchmarking report which reviewed the Trust against other acute clients. The report showed that HUTH staff had confidence in reporting fraud as the number of anonymous referrals were fewer.	
Item: External Audit Report	Level of assurance gained: Good
Since the audit of the Accounts had been undertaken Mazars opinion had been submitted and there were no further issues to report.	
Item: Board Assurance Framework	Level of assurance gained: Good
The new version of the BAF was presented to the Committee members. It was reported that the Board were engaged with the risks, risks were now linked to the Corporate Risk Register and that work ongoing in Q1 and Q2 was being highlighted to show how risks were being mitigated.	
Item: Credit Card Expenditure	Level of assurance gained: Good
There was nothing untoward and that recruitment of the international nurses and IT were the biggest expenditures.	
Item: Directors Expenses	Level of assurance gained: Good
Due to the pandemic and meetings being held via video conference, expense levels were low. There were no issues raised.	
Item: Review of debts >£50k and over 3 months old	Level of assurance gained: Good
Mrs Drury presented the report which had been reduced to only 4 invoices remaining. All of these invoices had been settled in June 2021.	
Item: Data Security and Protection Toolkit Report	Level of assurance gained: Good
The report highlighted the Data Security and Protection Toolkit and the Trust's compliance against the indicators. An action plan was being developed to address the areas of concern. Key areas to develop are; training, unsupported systems and IT Protection.	
Item: Single Source Waivers	Level of assurance gained: Reasonable Assurance
50 suppliers that were non-compliant with standing orders were to be reviewed with the Procurement Lead. It was noted that the construction markets were particularly difficult at the moment.	
Item: Legal Fees	Level of assurance gained: Good
the annual contract had been awarded to Capsticks LLP for another year at the same fixed price as last year.	

Integrated Performance Report

Hull University Teaching Hospitals NHS Trust

The purpose of this report is to update the Board on the performance of the Trust over a number of key areas and provide analysis in order to support decisions, action or initiate change and also set out out proposed plans and trajectories for performance improvement.

Performance metrics are grouped into domains covering **Caring**, **Effective**, **Responsive** and **Safe**.

The report is presented in the Making Data Count format which intends to provide an exception based reporting presentation through the use of Statistical Process Control (SPC) charts and Icon Based approach to assist in presenting areas of concern, improvement or common cause variation.

The report includes 24 months of data for trend analysis.

Integrated Performance Report | Executive Summary Scorecard

Domain: All | Group: All | Metric: All

July 2021
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- Exec Summary
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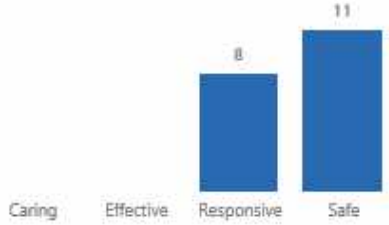
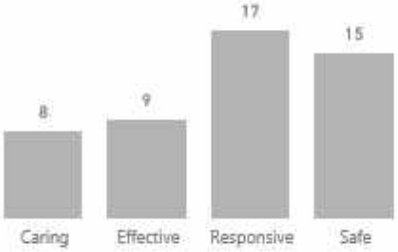
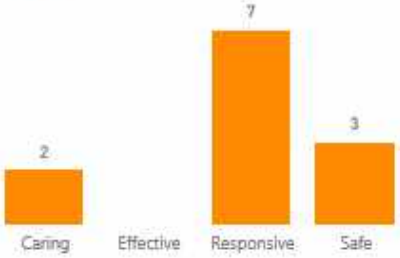
Consistently Passing



Hit and Miss



Consistently Failing



Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Unreliable	Not capable	Capable	N/A
Caring	7			2	1	8	2		
Effective	7	1	1			9			
Responsive	18	6	9		1	17	7	8	2
Safe	26		2		3	15	3	11	2
Total	**58**	**7**	**12**	**2**	**5**	**49**	**12**	**19**	**4**

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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Domain
- [x] Select all
- [x] Caring
- [x] Effective
- [x] Responsive
- [x] Safe

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
58	7	12	2	5
Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
A&E FFT response rate	May 2021	17.8%	Common Cause	Not capable
A&E Monthly Attendance Contract Plan	August 2019	12,478	Common Cause	N/A
A&E Scores from Friends and Family Test - % negative	May 2021	10.0%	Improvement (Low)	Not capable
A&E Scores from Friends and Family Test - % positive	May 2021	82.0%	Common Cause	Unreliable
A&E Type 3 Performance from April 2019	July 2021	95.5%	Concern (High)	Capable
Admission of full term babies to neo-natal care	July 2021	17	Common Cause	Unreliable
Ambulance handovers waiting >60 minutes	July 2021	330	Common Cause	Unreliable
Ambulance handovers waiting 30-60 minutes	July 2021	627	Common Cause	Unreliable
Cancelled op 28 day breaches % (quarterly)	June 2021	0.8%	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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SPC Variation Icons

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SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Cancelled op 28 day breaches number	July 2021	2	Common Cause	Unreliable
Cancelled Operations % of FFCEs (quarterly)	June 2021	22.4%	Common Cause	Unreliable
Cancelled Operations number	July 2021	57	Common Cause	Unreliable
Cancer 104 Day Waits	June 2021	39	Common Cause	Not capable
Cancer 2 week (all cancers)	June 2021	74.6%	Concern (High)	Unreliable
Cancer 2 week (breast symptoms)	June 2021	3.1%	Concern (High)	Not capable
Cancer 31 day wait for second or subsequent treatment - drug treatments	June 2021	100.0%	Common Cause	Capable
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	June 2021	99.3%	Common Cause	Capable
Cancer 31 day wait for second or subsequent treatment - surgery	June 2021	77.6%	Concern (High)	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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Metric Metadata

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- [x] Safe

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
58	7	12	2	5
Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Cancer 31 day wait from diagnosis to first treatment	June 2021	94.1%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	June 2021	44.3%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from urgent GP referral)	June 2021	64.5%	Concern (High)	Not capable
CAS alerts outstanding	July 2021	0	Common Cause	Unreliable
Category 1 Pressure Ulcer	July 2021	0	Common Cause	Capable
Category 2 Pressure Ulcer	July 2021	22	Concern (Low)	Capable
Category 3 Pressure Ulcer	July 2021	0	Common Cause	Capable
Category 4 Pressure Ulcer	July 2021	0	Improvement (Low)	Unreliable
Clostridium Difficile - Infection rate (per 1000 beddays)	July 2021	0.3	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Clostridium Difficile - number	July 2021	9	Common Cause	Capable
Crude Mortality (non-elective admissions)	July 2021	3.5%	Common Cause	Unreliable
Diagnostics: Patients waiting <6 weeks from referral to test	July 2021	37.1%	Concern (Low)	Not capable
E.Coli	July 2021	9	Common Cause	Capable
ED: 12 hour trolley waits	July 2021	0	Common Cause	Unreliable
ED: Attendances Type 1	July 2021	11,734	Common Cause	N/A
ED: Standard Performance Type 1	July 2021	62.8%	Common Cause	Not capable
ED: Standard Performance Type 1 & 3	July 2021	72.8%	Concern (High)	Not capable
Elective c-section rate	July 2021	13.4%	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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SPC Variation Icons

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SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Emergency c-section rate	July 2021	18.8%	Common Cause	Unreliable
Emergency readmissions within 30 days	June 2021	6.8%	Common Cause	Unreliable
Falls (rate per 1,000 bed days)	June 2021	0.2	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - Weekend	May 2021	108.8	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - monthly position	May 2021	86.8	Common Cause	Unreliable
Inpatient FFT response rate	May 2021	100.0%	Improvement (High)	Unreliable
Inpatient Scores from Friends and Family Test - % negative	May 2021	0.0%	Common Cause	Unreliable
Inpatient Scores from Friends and Family Test - % positive	May 2021	98.0%	Common Cause	Unreliable
Klebsiella spp bacteraemia	July 2021	4	Common Cause	Capable
Maternal Deaths	July 2021	0	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Maternity FFT response rate	May 2021	100.0%	Improvement (High)	Unreliable
Maternity Scores from Friends and Family Test - % negative	May 2021	0.0%	Common Cause	Unreliable
Maternity Scores from Friends and Family Test - % positive	May 2021	96.0%	Common Cause	Unreliable
Medication errors causing serious harm	July 2021	0	Improvement (Low)	Unreliable
Midwife to birth ratio	July 2021	1.3	Improvement (Low)	Not capable
Mixed Sex Accommodation Breaches	July 2021	0	Common Cause	Unreliable
MRSA bactaraemias	July 2021	1	Concern (Low)	Unreliable
MSSA	July 2021	8	Common Cause	Capable
Never events - Incidence Rate (per 1000 beddays)	July 2021	0.0	Common Cause	Unreliable
Number of Never Events in month	July 2021	1	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

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Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Number of new Harms	March 2020	1.8%	Common Cause	Unreliable
Number of patients on Admitted Backlog (18+ weeks)	June 2021	13,950	Concern (Low)	Capable
Number of patients on Non Admitted Backlog (18+ weeks)	June 2021	44,526	Concern (Low)	Capable
Number of Serious Incidents in month	July 2021	11	Common Cause	Unreliable
Outpatients: Hospital Cancelled Outpatient Appointments %	July 2021	8.6%	Improvement (Low)	Unreliable
Percentage of new Harms	March 2020	94.6%	Common Cause	Not capable
Potential under-reporting of patient safety incidents	September 2019	0	Common Cause	N/A
Potential under-reporting of patient safety incidents resulting in death or severe harm	September 2019	0	Common Cause	N/A
Pressure ulcers	July 2021	30	Common Cause	Capable

Integrated Performance Report | Metric Summary

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SPC Variation Icons

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58	7	12	2	5
Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Pseudomonas aeruginosa bacteraemia	July 2021	2	Common Cause	Capable
Referral to Treatment Incomplete numbers away from 92%	June 2021	20,237	Concern (Low)	Unreliable
Referral to Treatment Incomplete numbers over 18 weeks	June 2021	24,916	Concern (Low)	Unreliable
RTT 104+ Weeks Waiters	July 2021	269	Concern (Low)	Unreliable
RTT 52+ Week Waiters	July 2021	7,409	Concern (Low)	Capable
RTT 78+ Weeks Waiters	July 2021	3,010	Concern (Low)	Capable
RTT Incomplete Pathways % performance	July 2021	57.1%	Common Cause	Not capable
RTT Total Waiting List	July 2021	57,560	Concern (Low)	Capable
Serious Incidents rate (per 1000 beddays)	July 2021	0.4	Common Cause	Unreliable
ST-Elevation myocardial infarction call to primary percutaneous coronary intervention	June 2021	85.7%	Common Cause	Unreliable

Integrated Performance Report | Metric Summary

Domain: All | Group: All | Metric: All

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SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
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SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
49	12	19	4
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
within 150 minutes				
Stranded Patients at End of Month 21 days	July 2021	98	Common Cause	Unreliable
Stroke 60 mins	June 2021	44.7%	Common Cause	Unreliable
Stroke PTs >90% stay on a Stroke Ward	June 2021	64.5%	Concern (High)	Unreliable
Summary Hospital Mortality Indicator (HSCIC) - (latest data available Sept 18)	February 2021	154	Concern (Low)	Unreliable
Suspected Deep Tissue Injury	July 2021	7	Common Cause	Capable
Unstageable	July 2021	1	Common Cause	Capable
VTE Risk Assessment	June 2021	81.5%	Common Cause	Not capable
WHO Checklist	July 2021	98.7%	Common Cause	Unreliable
Written Complaints - rate (Still annual report) per 1000 beddays	July 2021	1.3	Common Cause	Unreliable

Report to the Board in Public
Performance and Finance Committee held August 2021

Item: Performance Report	Level of assurance gained: Reasonable
The Trust had not achieved its targets, ED, Cancer and Faster Diagnosis. 52 week waits continued to reduce and the waiting list trajectory had been met. There were challenges around the volume of activity particularly in paediatrics and urgent care. The Emergency Care intensive Support Team had been invited to carry out a Missed Opportunities audit. Work was also ongoing to re-direct patients who did not need emergency care to other more appropriate facilities.	
Item: Elective Recovery Report	Level of assurance gained: Reasonable
The 85% trajectory and remainder of the H1 plan had been increased to 95% delivery resulting in the Emergency Recovery Funding not being met. The Trust had achieved the 85% trajectory in month. The Family and Women's Health Group continued to be challenged and were down £500k in month.	
Item: Procurement Strategy and Scan4Safety	Level of assurance gained: Good
Updates were received relating to the Procurement Strategy and the work with the Health Groups to standardise products to help with volume buying and economies of scale. The Scan4Safety update highlighted stock in the system and how easy it was (using barcodes) to identify and locate it.	
Item: Finance Report	Level of assurance gained: Good
The Trust is reporting a surplus of £0.2m at month 4, which is in line with plan. NHSEI have indicated that they will provide further guidance on H2 in September 21 with plans due to be submitted in October 21.	
Item: Underlying Run Rate	Level of assurance gained: Reasonable
The current underlying position of a deficit of £47.8m which is a deterioration of £38.4m from 2019/20	
Item: National Cost Allocation	Level of assurance gained: Good
The report highlighted the systems and procedures in place to support submission of the NCC. Where compliance is not achievable with national requirements NHSEI will be contacted to note any potential shortfall.	
Item: PDC Capital Allocation	Level of assurance gained: Good
The Committee approved the progression of the purchase of the Gamma Camera and the start of the Theatre redevelopment using the Trusts internal cash as a source of funding until the PDC application is approved. This requires Board approval.	

Hull University Teaching Hospitals NHS Trust
Performance and Finance Committee
Held on 26 July 2021

Present:	Mr M Robson	Chair
	Mr T Curry	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mrs E Ryabov	Chief Operating Officer
	Mr L Bond	Chief Financial Officer
	Mrs A Drury	Deputy Finance Director
In Attendance:	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Actions
1	**Apologies:** Apologies were received from Mr S Evans, Deputy Finance Director Mr Robson explained that Mr Hall would be stepping down from the Committee whilst he was Acting Chair.	
2	**Declarations of interest** There were no declarations received.	
3	**Minutes of the meeting held 28 June 2021** The minutes were approved as an accurate record of the meeting.	
4	**Matters Arising** There were no matters arising from the minutes.	
5	**Tracker** Mrs Ryabov explained that the Cardiology Service was down on activity but up overall in income. The Pioneer insourced work had benn superseded by Modality. She added that the elective recovery report included indicated values.	
6	**Workplan 2021/22** The Committee received the workplan.	
7	**7.1 Performance Report** Mrs Ryabov advised that the ED 4 hour performance was at 79.5% and the department had seen an increase in activity. There had been a reduction in majors activity which had dropped by 16% but Children's activity had increased by 11%. Primary Care was up 10% and GPs were also seeing much higher volumes of patients. The Trust was not seeing higher admission rates. Cancer performance was at 74.9% and with the exception of breast, skin, upper GI and Haematology the standards had been met. 62 day performance was at 62%. Diagnostics was still challenging, in particular the Endoscopy service. RTT was improving now that the Trust was doing more elective work and 52 week waits had improved by 1200 patients since May.	

Mr Curry asked if breast turnaround times were causing harm to patients and Mrs Ryabov advised that the issues were at the front end and once the patient was on the pathway they were treated very quickly. She added that waiting was days rather than weeks.

There was a discussion about the long waits for treatments and any harm caused by this. Mrs Ryabov stated that any patients coming to harm would be seen through the majors pathway and this was not increasing. The main area of concern was the increase in children with respiratory type issues. Mrs Ryabov added that 88% of all children are discharged.

Mr Robson expressed his concern about any Winter influxes due to children having low immunity. Mrs Ryabov advised that a new paediatric consultant had been appointed.

Length of stay has gone up and was creating a problem and the cases were related to the elderly and were more complex.

Resolved:
The Committee received and accepted the report.

Elective Recovery
Mrs Ryabov advised that all services had achieved the 80% trajectory target in month.

P2s were under trajectory and had been impacted by trauma coming into the hospital. Diagnostics had delivered within 10% and Outpatients were all delivering.

Clinical Support Health Group had delivered against all areas, Family and Women's were being challenged by the high workload, Medicine didn't deliver on new activity but have delivered above their plan. Follow ups and day case were above plan and Surgery did well on news and follow ups. Orthopaedics were still challenged by the volume of trauma patients. There were also issues due to staffing issues.

Overall the Trust had performed well against its H1 plan.

Mrs Christmas asked if the red areas could recover and turn green and whether plans could be re-forecasted if necessary. Mrs Ryabov advised that the Health Groups were reviewing their plans on a monthly/quarterly basis.

Mr Curry asked about DNA rates relating to Covid swabbing 3 days before coming into hospital. Mrs Ryabov stated that the double vaccinations would help but the Trust was still swabbing and enforcing social distancing at the moment. She added that the changing rules were difficult to keep up with.

Mr Robson asked if it would be useful to have a presentation at the Committee relating to Cancer performance. Mrs Ryabov agreed to bring a presentation to the September 2021 meeting.
Mrs Ryabov expressed her concern about pushing staff to the limit as some staff were working 7 days per week under challenging conditions.

She was being guided by the teams and the Infection Prevention and Control Team to ensure rules were adhered to around social distancing.

Resolved:
The Committee received and accepted the report.

8.1 Finance Report
Mr Bond presented the report and advised that the Trust was making a surplus of £1m in month. The month 6 H1 forecast is £1.7m deficit which is in line with the plan. The Emergency Recovery Fund income for months 1 and 2 was robust and was £1m above plan currently. The Vaccination programme had been covered by external income.

Car parking income has recovered slightly better than expected and is £0.1m above plan. It should be noted that the Trust income plan was reduced by £1.8m in H1 to reflect reduced income in car parking, catering and private patients.

The reported position includes a further expenditure accrual of £2.0m to bring the position to plan levels. The expectation is that this will contribute towards a reserve that can be used in Q2 or even into H2. The change to the ERF threshold is expected to cost the trust £2.3m in Q2 and the expectation of a materially increased efficiency challenge in H2 and the absence of any additional funding for "winter" suggests a much harder second half to the year. Mr Bond advised that the Health Groups were still finding it challenging to achieve any CRES savings.

Mr Bond advised that it was unlikely that the Treasury would make a deal on the money for the 2nd half of the year until the end of September 2021. He speculated that the efficiency ask would be increased and the 3% pay increase would have to be built into the second half of the year.

The Trust's cash position was positive and the debtors over 90 days position was improving. Stock levels were fluctuating.

There was still a lot of Capital to spend and the Capital Resource Allocation Committee were working through the issues.

The Committee discussed the CRES situation and the difficulty in closing the efficiency gap. Mrs Christmas stated that Getting it Right First Time meant that wastage would be prevented and efficiencies would be made. She added that processes that had been changed due to Covid that were successful should be explored further. She gave an example of the costs saved by Directors not travelling and having high expenses claims.

Mr Bond advised that he would present a report to the next Committee detailing the Trust's underlying run rate which would analyse decisions being made and what was driving the cost base. **LB**

ICS Report
Mr Bond presented the report which gave an aggregated ICS position.

Risks to the plan were performance against targets affecting the Elective Recovery Funding, hospital discharge programme and length of stay and capital issues.

The ICS is in a positive position regarding H1 financial delivery. Risks do remain in the system and are being actively managed, however with the potential benefit of ERF the overall position indicates the ICS will achieve at least its breakeven position

YTD £10.7m surplus in the North Yorkshire Strategic Partnership and a YTD surplus of £2.4m in the Humber Strategic Partnership. Driven by assumed income for ERF in the provider sector.

ERF is falling short of planning assumption; however the contribution/surplus on this activity could mean the ICS has some contingencies to support non recurrent transformation schemes over the next few months.

The Capital Plan (ICS CDEL) £72.5m, forecast spend £72.5m, break-even is a subset of the total capital award. It reflects the "operational" capital that the ICS has been allocated, funding mainly replacement items plus DH Loans

- ICS CDEL £4.7m expenditure YTD, variance to plan of £9.8m,with FOT as per plan.

Mrs Christmas asked why the efficiency lines were green and Mr Bond advised that this was due to travel fees offered up in the first half of the year.

Resolved:
The Committee received and accepted the Finance and the ICS Reports.

9.1 Capital Resource Allocation Committee Minutes
Mrs Drury presented the minutes and advised that capital priority areas have been identified and these were highlighted in the minutes.

There had been a debate around the Green Plan being linked to all capital works and the plan to deliver the Carbon Zero earlier than expected.

Mrs Drury advised that there was a review of forecasts being undertaken due to the pressures against the Capital Plan.

Resolved:
The Committee received and accepted the minutes.

11.1 Integrated Performance Report
Mrs Thompson presented the report which detailed the new Making Data Count SPC chart performance indicators for use in the new Integrated Performance Report. At Appendix 1 there was a list of likely indicators linked to performance and finance to include in the report.

There was a discussion around the amount of indicators and what were the key areas the Committee would need to review. Mrs Thompson advised that any indicators not falling within the specified control limits would trigger an exception report. Mr Bond was keen to keep the commentary around the financial performance indicators as the Committee found this useful. Mrs Ryabov added that the parameters may

not be appropriate for all indicators and SPC charts might not work in all areas.

The Committee agreed that more work was to be done in relation to the new IPR and Mr Bond and Mrs Ryabov had a meeting with Mrs Rostron to discuss further. It was the aim to have a draft dashboard ready for the September 2021 Board meeting.

Resolved:
The Committee received and accepted the report.

11.2 Contract Extension for Crown Commercial Non-Clinical Temporary and Fixed Term Staff Framework
Mr Bond presented the contract extension which related to recruitment agencies on the NHS Framework for temporary staff.

Resolved:
The Committee received and approved the contract extension.

11.3 Contract Recommendation for the supply of Neuro Vascular Interventional Radiology Consumables
Mr Bond presented the contract and advised that it was a 3 year contract costing £1m. 31 companies had expressed an interest and the bids were included in the report.

Mrs Christmas asked if it replaced a previous contract and was the Trust out of contract at this time. Mrs Drury advised that the contract expired in August 2021.

Resolved:
The Committee received and approved the contract.

Mr Robson stated that the Procurement Strategy and Scan4Safety updates would be presented at the next meeting. **LB**

12 Date and time of the next meeting:
Monday 23 August 2021, 1.30pm – 4pm, via Teams

Agenda Item	7.2.1	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	**CAPITAL PLANNING 2020/21 – Cash Summary**				
Lead Director	Lee Bond, Chief Financial Officer				
Author	Lee Bond, Chief Financial Officer				
Report previously considered by (date)	The report has previously been presented to the Performance and Finance committee				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	✓	Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	
				Well-led		Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:
The Trust Board is asked to approve the progression of the purchase of the Gamma Camera and the start of the Theatre redevelopment using the Trusts internal cash as a source of funding until the PDC application is approved. The Trust Board is also asked to note the potential risks if the PDC application is not approved and the affect this will have on the Trusts cash balance; working capital balances and the current BPPC ratio.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

CAPITAL PLANNING 2020/21 – Cash Summary

1. INTRODUCTION

The Trust has a Capital Programme for 2021/22 totalling £55.6m. The capital programme has been presented at a previous Board meeting and is discussed and reviewed monthly at the Capital and Resource Allocation Committee (CRAC).

This paper is to update the Board on the progression of specific schemes within the capital programme for which the Trust needs external financial cash support. The paper has previously been discussed, considered and endorsed by the Performance and Finance Committee.

2. CAPITAL PROGRAMME FUNDING

The capital programme is predominantly funded through depreciation with some additional schemes funded from charitable donations; grants and PDC funding.

The Trust has a pre commitment on its depreciation funding, as it must first service the Trusts existing long-term debt commitments (a combination of long-term loans and PFI contracts). This is expected to cost £5.4m in 2021/22. This financing is the first call on the Trust's available cash resources from depreciation.

In addition to depreciation funding, the Trust can utilise any SOCI surplus gained in year for capital expenditure as this should generate the internal cash benefit.

For 2021/22 the Trust has not included any SOCI surplus gain in terms of funding the capital programme as the H1 plan is a deficit plan of £1.7m.

The following table sets out at a summary level the anticipated source and applications of capital for 2021/22. This also shows whether the source of funding is the Trust's internally generated funds or items expected to be funded externally.

	£m	£m	£m
Resources:	**Internal**	**External**	**Total**
Depreciation	18.2		18.2
Donated Assets		0.3	0.3
Grants Salix & NPIC		13.7	13.7
PDC STP Wave 4 UEC		16.4	16.4
PDC Digital Aspirant		1.5	1.5
PDC Theatre Development		5.0	5.0
PDC Gamma Camera		1.5	1.5
ICS Contingency	2.1		2.1
Internal Cash (matched funding balance)	2.3		2.3
	22.6	**38.4**	**61.0**
Less Required Financing Commitments:			
Loan Repayments	(1.3)		(1.3)
PFI Liabilities/Finance Lease Liabilities	(4.1)		(4.1)
Subtotal Capital Resources Available	**17.3**	**38.4**	**55.6**
Capital Programme:			
Grants Salix & NPIC		13.7	13.7
PDC STP Wave 4 UEC		16.4	16.4
PDC Digital Aspirant		1.5	1.5
PDC Theatre Development		5.0	5.0
PDC Gamma Camera		1.5	1.5
Backlog Maintenance & Compliance	2.0		2.0
IM&T	2.0		2.0
Medical & Scientific Equipment	3.3		3.3
Matched funding (Brocklehurst/Robotic/Digestive Suite)	2.3		2.3
CIR HRI Boilers & ICU (precommitments)	2.2		2.2
CHP at CHH (precommitments)	0.6		0.6
Other	5.2	0.3	5.5
ICS Contingency	2.1		2.1
SubTotal Capital Programme	**19.7**	**38.4**	**58.1**
Less IFRS impact of PFI/IFRIC 12	(2.5)		(2.5)
Total Capital Programme	**17.3**	**38.4**	**55.6**

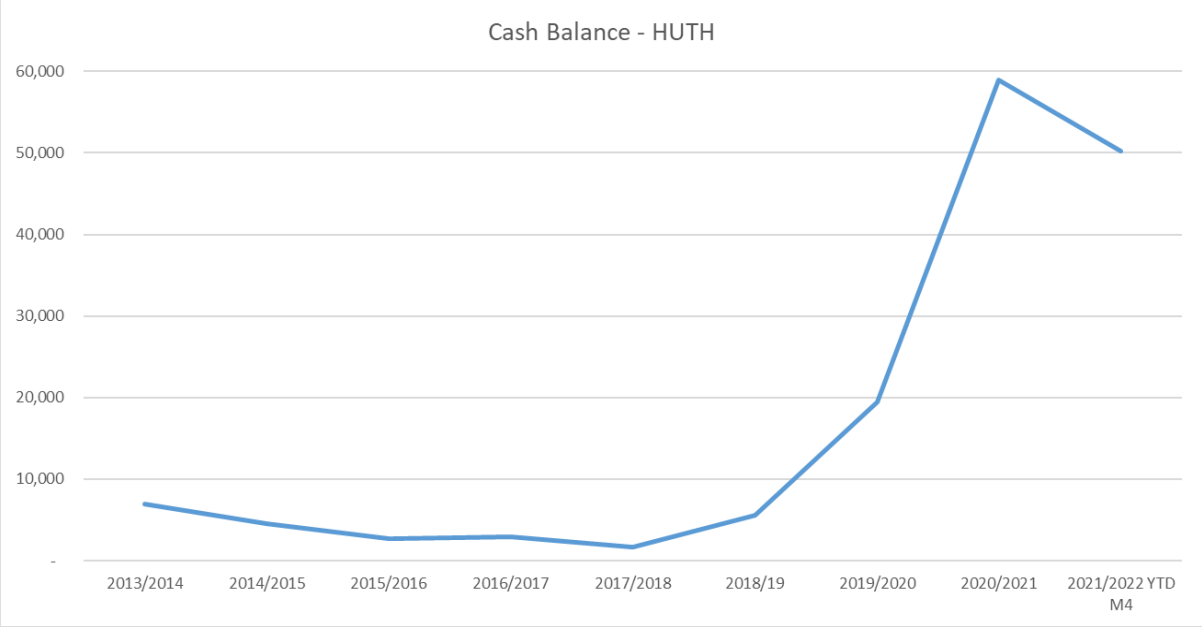
The Trust has included within its overall capital allocation an amount of £6.5m that requires emergency capital PDC funding for the purchase of a Gamma Camera (£1.5m) and Theatre redevelopment (£5m). The Trust has the capital cover (CDEL – Capital Delegated Expenditure Limit) included within the main capital programme as well as ICS approval however we do not have the associated cash cover and must therefore apply for external cash funding.

PDC funding has already been secured for the Digital Aspirant scheme (£1.5m) and the STP Wave 4 UEC scheme (£16.4m) and this cash will flow in to the Trust as costs are incurred.

3. CASH BALANCES

Historically the Trust has had quite low cash balances and as such needed support both in terms of revenue and capital to support the capital programme and working capital balances.

More recently the Trust's cash balances have started to increase and this can be seen from the chart below.



Cash balances have been increasing due to a number of factors. During 2020/2021 Interim revenue loans, including working capital facilities and interim capital debt at 31 March 2020 were written off and funded from external PDC. For the Trust this totalled £35.2m. This means the cash reserves the Trust was building up to repay revenue loans was no longer required and could be used to improve the working capital position.

In addition, the financial regime changed during 2020/21 to support the Trust's cash position during the pandemic and as a result, more payments are made in advance and are not dependent on activity. Consequently our NHS debtors have significantly reduced over the last couple of years.

The following feedback has been received from NHSE/I:

Where providers have assumed emergency capital in plans, and have high cash balances, we would expect these Trusts to be able to proceed with these schemes utilising their internal cash reserves. Given that the majority of these applications relate to immediate and necessary works and systems have the cash and CDEL cover to deliver them we would expect these to be progressed at speed.

In addition, cash payments were received last year for our annual leave provision and provisions for unfinished spells and this contributed over £7m of cash without the corresponding expenditure – although some of this may be incurred as the year

progresses. The Trust was also able to improve its balance sheet position in terms of pensions and bad debt provisions during 2020/21 to ensure the future risks are covered, based on the best and most prudent estimates but the resulting cash payments from these will be in future years hence some of the current cash benefit is more a timing issue.

Whilst the cash balances currently look high, the forecast cash balance for 2021/22 is £32m and this is expected to reduce further during 2022/23 as the Trust improves its working capital balances further in particular around the Better Payment Practice (BPPC) ratio which is currently 91% and mechanism for contract payments may revert to pre-Covid arrangements. To achieve 95% BPPC the Trust needs to pay an additional £6m creditors.

Also the Trust does have an underlying deficit and hence the balances will reduce as the full year impact of our commitments are seen within the expenditure, along with expected income reductions due to higher CRES requirements from October onwards. Nationally, as NHS Trusts are holding large cash balances, NHSI/E are requesting that Trusts use these reserves in the first instance to fund items such as the Emergency Capital funding we require for the Gamma Camera and Theatres. This is to ensure the process is not held up centrally in terms of progressing these emergency schemes. The Trust has had assurance that the PDC application can still be progressed if the Trust can demonstrate the need for the cash cover. The Trust has provided details of the cash requirements needed and is still expecting the PDC application to be approved.

In the meantime, so the purchase of the Gamma Camera and progression of the main Theatre scheme can start, we need to initially fund these from our cash reserves until the PDC funding is approved.

Currently the Trust can manage this in cash terms due to the high level of cash balances held, however if the PDC is not subsequently awarded then working capital balances could potentially suffer and we would risk not improving our BPPC rating to the 95% level. The forecast cash balance would reduce to approximately £26m.
In the scenario where the Trusts cash balances significantly decline, the Trust would have to seek support in the form of Revenue Working Capital loan and the Trust has had assurance from NHSI/E that this would be supported. Ths is not expected to happen during 2021/22.

4. RECOMMENDATION

The Trust Board is asked to approve the progression of the purchase of the Gamma Camera and the start of the Theatre redevelopment using the Trusts internal cash as a source of funding until the PDC application is approved. The Trust Board is also asked to note the potential risks if the PDC application is not approved and the affect this will have on the Trusts cash balance; working capital balances and the current BPPC ratio.

Lee Bond
Chief Financial Officer
12th August 2021

Report to the Board in Public
Quality Committee held on 23 August 2021

Item: Ophthalmology Backlog Update	Level of assurance gained: Good
Mr Vize presented the update and advised that cataract throughput was back under control, 6 eye scanning machines were in place with a strong group of technicians and although there were still waits for eye injections work was ongoing to reduce this backlog. Virtual approaches were being used where possible and e-Referral was being rolled out.	
Item: Quality Report	Level of assurance gained: Reasonable (demand and capacity issues)
The Committee received updates relating to Hospital acquired infections, the backlog of serious incidents, complaints and PALS and issues around sickness in the department, pressure ulcers, falls and the CQC engagement meetings. There was significant pressure in the organisation due to high patient attendances and staff sickness. A missed opportunities audit had taken place and the results would be shared with the Quality Committee.	
Item: Quality Improvement Plan	Level of assurance gained: Good
The QIP was presented and although some projects had been halted due to the pandemic, 3 projects had been completed. Work was ongoing relating to Mental Health patients.	
Item: Enhanced Monitoring Report	Level of assurance gained: Good
Mental Health patients had been added to the monitoring report at the Trust's request. Due to pressure in the system some elective work had been stood down and the national target for recovery had been increased to 95% from 85%. The Trust was not seeing high levels of harm that it had expected due to patients waiting a long time.	
Item: CQC Update	Level of assurance gained: Good
There had been whistleblowing cases due to the staffing levels and comprehensive responses had been sent back to the CQC. There were no open CAS Alerts but there had been a Stroke Mortality Alert. This was being reviewed to understand the issues.	
Item: **HSMR Update**	Level of assurance gained: Good
The report highlighted the task and finish group's work and included the deaths over a 2 year period and the peaks correlating to the pandemic. A case note review had taken place and there were no concerns relating to quality of care.	
Item: **Perinatal Surveillance Tool**	Level of assurance gained: Good
Work was ongoing to review perinatal deaths, ensure Serious Incident actions were monitored and addressed, teaching and training took place and any themes and trends were escalated. Safe staffing was also monitored and assurance was also provided by the matron's handbook compliance.	
Item: **Perinatal Mortality Tool**	Level of assurance gained: Good
Multi-disciplinary meetings were being held with families of babies that died. NHS Resolution had been informed of all cases.	
Item: **Quality Sub-Committee Proposal**	Level of assurance gained: Good
The Committee approved the decision to disestablish the Operational Quality Committee and have a more robust sub-committee structure (including a risk committee) in its place.	

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 26 July 2021

Present:	Mr S Hall	Chair
	Prof U Macleod	Non-Executive Director
	Dr M Purva	Chief Medical Officer
	Mrs J Ledger	Deputy Chief Nurse
	Mr S Gaines	Deputy Chief Pharmacist
	Mrs A Green	Lead Clinical Research Specialist
	Mrs M Stern	Patient Representative
In Attendance:	Mrs L Cooper	Head of Midwifery
	Mr P Sedman	Associate Medical Director
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Dr A Pathak, Associate Non-Executive Director, Mrs S Rostron, Director of Quality Governance, Mrs B Geary, Chief Nurse, Mrs L Jackson, Associate Non-Executive Director	
2	**Declarations of interest** There were no declarations made.	
3	**3.1 Minutes of the meeting held 28 June 2021** Following correction of a typo the minutes were approved as an accurate record of the meeting.	
	3.2 Matters Arising It was agreed that the Director of Research and Innovation be invited to the meeting. Mr Hall advised that Prof Macleod had been appointed as Vice Chair of the Committee.	
	3.3 Action Tracking List The Director of Research and Innovation to be added to the action tracker as well as inviting Fiona Thompson to present the next learning from deaths paper.	
	3.4 Any Other Matters Arising There were no other matters arising.	
	3.5 Workplan 2021/22 The Committee received the workplan, there were no issues raised.	
	4.1 Quality Report Mrs Ledger presented the report and advised that there had been zero MRSA cases, 5 MSSA cases, 1 cdifficile case and 6 e-Coli cases**.** All of these cases were being investigated. There had been no outbreaks of Norovirus but there was a Covid outbreak on ward 11. There were 43 covid patients in the hospital and 5	

in ICU. A piece of work to review the current estate and wards to be used was being undertaken.

Mrs Ledger advised that there had been 6 Serious Incidents and 1 Never Event declared. There were 59 Serious Incidents that were under review and there were actions in place to address this backlog.

Mrs Ledger reported that the number of falls had decreased but the moderate level of harm had increased. A gap analysis was being undertaken following the Kettering Trust CQC report relating to falls. This was being monitored at the Falls Committee.

There was also focus on pressure ulcers and a new assessment process Purpose T had commenced.

The Trust has received two whistleblowing concerns that have been reported to the CQC. The concerns raised direct to the Emergency Department and Urology at CHH. The concerns also relate to low staff morale and delays for patients. The Trust has provided a full response to the ED concerns and is in the process of providing a response to the Urology concerns.

There had been 38 complaints in month, 24 of these related to treatment which was the highest category. The Trust was not complying against the 40 working day turnaround of complaints. There had been 48 PALs received in June 2021.

Mrs Ledger advised that there had been 24 safeguarding children referrals and this had been raised at the Board and in the CQC liaison meeting. The Trust had also requested system support.

Mr Hall asked about the status of the Trust and Mrs Ledger advised that Silver Command meetings had been re-introduced. She advised that the surge plan had been activated but for green activity and not Covid activity. Dr Purva added that there was pressure on the workforce due to many staff self-isolating.

Prof Macleod highlighted the 3 maternity serious incidents and asked if staff had time to review them and embed the learning as well. Mrs Ledger advised that good practice was being shared but there was more work to do to embed the learning.

Resolved:
The Committee received the report and took good assurance that improvement work was ongoing in all areas.

4.2 Patient Safety Annual Report
Mrs Thompson presented the report which highlighted Serious Incident performance for 2020/21.

Mr Hall asked about the increase in the reporting of Serious Incidents and Dr Purva advised that this was in line with Leeds and Hull was not an outlier.

Mr Hall advised that there was a typo on page 5, chocking should read choking.

Mr Hall asked if the training sessions had commenced again following the pandemic. Mrs Thompson agreed to find out and report back to the Committee. **RT**

Resolved:
The Committee received the report and felt that it gave good assurance that the Trust was a good reporter of incidents.

4.3 Enhanced Monitoring Report
Ms Coneyworth presented the report and advised that the key risks were reviewed monthly by the CCGs and NHS E/I. This review was linked to the BAF 3.2 and highlighted what was being done to mitigate the risk around patients waiting and the results of the harm reviews.

Mr Hall asked that improvements and changes where highlighted in the next report.

Resolved:
The Committee took good assurance from the enhanced monitoring arrangements.

5.1 Clinical Audit Report
Mrs Coneyworth advised that 62% of audits had been completed in year, the low take up was due to the pandemic.

National Audits had been undertaken and the outcomes presented to the Clinical Effectiveness Committee. There were some areas where the Trust was performing worse and work was ongoing with the Health Groups to improve compliance.

The Trust was fully compliant with all NICE TAGS.

Mr Hall asked about the Paediatric Diabetes audit and where the action plan was reviewed. Ms Coneyworth advised that the actions were monitored at the Family and Women's Health Group Board meeting.

Dr Purva added that the Trust had been an outlier in this areas for years due to the deprivation of the Hull population. The Laparotomy audit also had an action plan in place with an action to add an out of hours consultant. Dr Purva also mentioned the National Hip Fracture Database and how there was intense pressure at the rising number of hip fractures.

Mr Gaines added that Audits were monitored at the Drug and Therapeutic Committee to ensure compliance.

Resolved:
The Committee received the report and took good assurance from the work ongoing.

5.2 NICE Guidance Report

Ms Coneyworth presented the report and advised that there were no new TAGs that the Trust did not comply with.

The partially compliant TAGs had been outstanding for some time and these would be reviewed separately. There was one area of guidance relating to epilepsy that had been added to the risk register.

Mr Hall asked for some benchmarking and trend analysis to be included in the next report as it was not clear in some instances whether the data was positive or not.

Resolved:
The Committee received the report and took good assurance from the compliance.

5.3 Mortality – Learning from deaths framework

Dr Purva presented the report and advised that the Trust was an outlier relating to HSMR and there was much work being carried out to address the issues.

Dr Purva reported that patient deaths in the first quarter were now at normal pre-pandemic numbers. Junior Doctors provided coding for patient deaths and there were 3 most common conditions.

Structured Judgement Reviews were being carried out and the Trust was well within the 4% target amount of reviews undertaken. Each case requiring escalation is reviewed for good practice as well as any areas of concern. The Trust was particularly good at end of life conversations but needed to work on capturing early deterioration of patients. Documentation was also an area of concern.

The Medical Examiners were now embedded and a review of the RESPECT forms had shown that early conversations in the Community was an example of good practice. Mr Hall commended the teams on the 97% of all patients having RESPECT forms in place.

There had been a task and finish group set up to review HSMR and the team were currently collecting data and carrying out case note reviews. Multi-agency reviews and a general system review was being carried out at the same time.

Key area doing more SJRs and embedding the learning. Also looking at multi-agency reviews. General system review as well
Task and finish group HSMR – collating data, case note reviews – information at the next quality committee.

Mrs Green asked if digitalisation of the service would improve the documentation and Dr Purva agreed it could especially if automatic capture of data could be achieved.

Resolved:
The Committee received the report and took good assurance from the HSMR work and the RESPECT forms in place.

5.4 WHO Checklist - SSIPs

Dr Purva presented the report and advised that performance had improved and was monitored in real time at the Performance and Accountability meetings. The Business Intelligence team had worked to get bespoke reports for services even challenging services such as radiology.

Dr Purva advised that the dashboards gave an overview of the audit compliance, where audits had been carried out and areas where the Trust was failing. She used an example of the Never Event when time out and sign out procedures had failed. This had been highlighted and work was ongoing to embed changes in practice to ensure compliance. She added that the digitalisation programme would also remove the need for paper forms and would become more efficient.

Resolved:
The Committee received the update and took good assurance from the processes and improvements in place.

5.5 Operational Quality Committee Summary

Dr Purva presented the report and advised that VTE compliance and blood transfusion training were discussed. There were still issues around VTE compliance but blood transfusion training was improving.

Dr Purva advised that the new cohort of Junior Doctors were about to start with the Trust.

The Committee had received a presentation relating to Falls and how the Trust was carrying out a gap analysis following the CQC Kettering Report.

Resolved:
The Committee received the summary and took good assurance from the work ongoing around VTE, blood transfusion training and falls.

5.6 Maternity Transformation

Mrs Cooper presented the report and advised that the Trust must have the Continuity of Care pathway in place by March 2023. This would mean that the Birth Rate Plus assessment tool and workforce upskilling would need to be in place. It meant that that the current 4 teams would increase to 16 teams across the city. The transformation would be supported by a robust business case and will enter into a consultation with staff as it would have a huge impact on maternity services.

Mrs Cooper was nervous about the rolling out of the programme as funding and infrastructure was required. It was important to retain staff and safe care whilst working towards the 2023 deadline. Additional workforce had been built in to ensure the Continuity of Care outcomes could be achieved.

Mrs Cooper advised that the report would also be presented to the Trust Board in September 2021.

Mr Hall asked Mrs Thompson to add Continuity of Care to the Committee workplan. **RT**

Resolved:
The Committee received the update and agreed to add it to the workplan for further monitoring.

6.1 Quality Governance Review
Mrs Thompson presented the report which detailed the proposal to dis-establish the Operational Quality Committee have the Patient Safety and Risk Management Committees in its place.

Mr Thompson advised that there had been 4 responses to the survey of 38 members of Operational Quality Committee. Everyone that had responded was in favour of the Committee proposals.

Mrs Ledger stated that the Nutrition Committee should report into the Patient Safety Committee and Dr Purva added that Mortality and Morbidity Committee would also report up to Patient Safety. Dr Purva added that Mrs Rostron had met with Health Group Directors as part of the consultation period.

Resolved:
The Committee received the report and supported the approach being taken.

6.2 Integrated Performance Report
Mrs Thompson presented the report which highlighted the proposal for using the Making Data Count SPC charts to inform the new Integrated Performance Report. She advised that she had also written similar reports capturing the performance, finance and workforce criteria.

Mr Hall reported that NHS Improvement would be presenting a training session on Making Data Count and advised that good examples of this could be found in the Kettering Board papers.

Mrs Thompson advised that any area of concern where the data is outside of the SPC control limits would be covered by an exception report.

Resolved:
The Committee received the report and agreed to review the indicators and email Mrs Thompson any other appropriate areas.

7 Any Other Business
There was no other business discussed.

8 Chairman's Summary
Mr Hall reported that he would escalate the Learning from Deaths approach to the Board as a positive process. He added that the utilisation of the RESPECT forms was outstanding.

9 Date and time of the next meeting:
Monday 23 August 2021, 9am – 11am, via Teams

Hull University Teaching Hospitals NHS Trust

Agenda Item	7.3.1	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	Quality Committee Terms of Reference				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is considered annually at the Quality Committee and is approved by the Trust Board				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	✓	Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	
Committee Agreement	✓	Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Board is asked to approve:

- The nomination of Professor Una Macleod as the Vice Chair of the Quality Committee
- The Associate Non-Executive Directors being counted for quoracy
- The Committees reporting into the Quality Committee following the restructuring

Hull University Teaching Hospitals NHS Trust

Quality Committee

Terms of Reference

1. Formation of this committee

The Board has established a committee, known as the Quality Committee reporting to the Board, in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee shall have terms of reference and powers and be subject to conditions such as reporting back to the Board, as the Board shall decide and shall act in accordance with any legislation, regulation or direction issued by the regulators.

The committee is a committee of the Board and has executive powers delegated specifically in these terms of reference. The Terms of Reference can only be amended with the approval of the Board.

2. Role

The Committee is responsible for providing the Board with assurance concerning all aspects of quality and safety relating to patient care and identifying quality improvement measures. The specific responsibilities are to:

- Monitor delivery of Trust strategies as delegated by the Board to this committee.
- Advise the Board on appropriate quality and safety indicators and benchmarks for inclusion in the Trust's Corporate Performance Report and keep these under regular review.
- Propose Quality Accounts priorities for consideration by the Board and maintain oversight of delivery.
- Scrutinise performance against quality targets, highlighting risks and exceptions to the Board.
- Regularly review compliance with Care Quality Commission requirements and receive assurance that agreed actions are being progressed.
- Regularly review progress with the Trust's Quality Improvement Plan, as the Trust's over-arching plan on driving improvement in quality of care, including any issues highlighted by the Care Quality Commission
- To assure the Board that where there are risk and issues that might jeopardise the Trust's ability to deliver excellent quality care that these are being managed in a controlled and timely way.
- Receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality.
- Monitor the information being received from patient feedback and adverse incidents to demonstrate that the Trust is learning and making improvements.
- Learning and compliance from national and local reviews.
- Regularly review outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths
- To receive regular updates on the delivery of the People Strategy and its link with quality and safety

3. Membership of the Committee

The committee shall comprise:
Non Executive Director (Chair)
Non Executive Director (Vice Chair)

2 x Non-Executive Directors + Associate Non-Executive Director (if determined by the Trust Chairman)
Chief Nurse
Chief Medical Officer
Chief Pharmacist
Director of Quality Governance
Lead Allied Health Professional
Patient Council Representative
Head of Corporate Affairs

It is expected that all members will attend 9 out of 12 committee meetings per financial year. If Directors are unable to attend a meeting they will send a deputy.

An attendance record will be submitted to the committee for information and action at each meeting.

The Trust Board will ensure that the Committee membership is refreshed and that undue reliance is not placed on particular individuals when undertaking the responsibilities of the committee.

The Director of Workforce and Organisational Development will attend on a quarterly basis to present an update on the People Strategy and the links between workforce and patient care, quality and safety.

4. Chairman of the Committee

The Chairman of the Committee shall be a Non Executive Director and the Vice Chairman shall be a Non Executive Director.

5. Quorum

The quorum shall be a minimum of 6 members, to include at least one Executive Director and two Non Executives. Associate Non-Executive Directors will count for quoracy when decisions are made.

6. Meetings

The Quality Committee will meet 12 times per year on a monthly basis. Additional meetings will be called at the request of the Chair of the Committee.

7. Attendance at meetings

Other senior employees may be invited to attend by the chair, particularly when the committee is discussing an issue that is the responsibility of that employee. The following staff will be expected to attend meetings at the invitation of the Chair:

- Chief Operating Officer
- Health Group Triumvirate Directors
- Assistant Director of Information
- R&D Manager

The Committee will be open to all Non Executive Directors to attend as observers.

8. Notice of meetings

Meetings of the committee shall be set prior to the start of the calendar year by the Quality Governance Officer. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the committee not less than five days before the date of the meeting.

9. Agenda and action points

The agenda will be agreed with the Chairman of the committee. The agenda and action points of all meetings of the committee shall be produced in the standard agreed format of the Trust and kept by the Quality Governance Officer.

10. Reporting arrangements

The proceedings of each meeting of the committee shall be reported to next meeting of the Board. The Chairman of the meeting shall draw the attention of the Board to any issues that require disclosure or require executive action. The Chairman is required to inform the Board on any exceptions to the annual work plan.

11. Duties and Responsibilities of the Committee

The committee is required to fulfil the following responsibilities:

11.1 Meet the annual objectives of the committee.

11.2 Produce an annual work plan in the agreed Trust format in line with the objectives.

11.3 Report to the Trust Board any exceptions to the achievement of the annual work plan and resulting risks.

11.4 Produce an annual report setting out the achievements of the committee and any gaps in control, effectiveness of reporting arrangements from sub-committees and to the Board, responding to actions delegated from the Trust Board and achievement of the Terms of Reference.

11.5 Monitor, review and recommend any changes to the terms of reference annually to the Trust Board.

12. Authority

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

The committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust.

13. Relationships with other committees

The committee receives escalation reports from the:

- Patient Safety and Clinical Effectiveness Committee
- Patient Experience Committee
- Operational Risk and Compliance Committee
- Non-Clinical Quality Committee

This committee must escalate any issues to the Trust Board by presenting the minutes following each meeting.

Actions escalated to the committee must be recorded within the minutes/report to the Quality Committee and highlighted to the committee.

The committee shall have a standing agenda item for matters delegated from the Trust Board.

14. Administration

The committee shall be supported administratively by the Quality Governance Officer who will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the committee.

Date previous approved by Trust Board: July 2021
Date updates received by Trust Board: July 2021
Review date: July 2022

Report to the Board in Public
Workforce Education and Culture Committee
August 2021

Item: Talent Management	Level of assurance gained: Good
Talent management is to be incorporated into non-clinical staff appraisals along with health and wellbeing. Mrs Vere to attend the Junior Doctor forum to review development.	
Item: Occupational Health Report	Level of assurance gained: Good
Occupational Health referrals had increased by 12% in year. The flu vaccination programme had achieved 87% take up and the new programme for 2021/22 was being planned. 200 vaccinators had been trained. The vaccination take up amongst doctors was highlighted as an area of concern.	
Item: Medical Education Report	Level of assurance gained: Reasonable
The report highlighted Junior Doctor disengagement due to clinical leadership, Covid preparedness and communication. A recovery training programme was in place and each trainee had an action plan in place. This was despite high pressures within the Trust.	
Item: Guardian of Safe Working Report	Level of assurance gained: Reasonable
A roadmap for all grades of junior doctors was in place to ensure rotas were available. E-Rostering was at 37% and work was ongoing to improve compliance by engagement of clinical supervisors, medical directors and expansion of the medical staffing team.	
Item: Workforce Race Equality Standard	Level of assurance gained: Good
The report highlighted work ongoing to support the WRES such as a diversity recruitment scheme, Board diversity, appointment of the BAME Network Chair and collaborating with GPs to build a network of allies.	
Item: Workforce Disability Equality Standards	Level of assurance gained: Good
A new enabled network had been established and the Trust was promoting external programmes and Occupational Health to work with disabled staff.	
Item: Modern Slavery Statement	Level of assurance gained: Good
The Modern Slavery statement was approved by the Committee. The statement would be received at the Board meeting in September 2021.	
Item: People Performance Report	Level of assurance gained: Good
The Trust vacancy position was good but staff Covid absence had gone up. Statutory and Mandatory training rates were improving.	
Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Good
CHPPD for June 2021 remained higher than the time period prior to COVID -19, but it had significantly reduced in comparison to previous months. Mrs Geary added that it would reduce further in the next report due to staff sickness over the recent weeks. The `Let's Get Started` induction programme for the new registrants has been reformatted.	
Item: Variable Pay Report	Level of assurance gained: Good
The Trust had spent £7.4m in Quarter 1 on Variable Pay. This was compared to the same period of time in 2019/20 and the cost was £200k less.	

Hull University Teaching Hospitals NHS Trust
Minutes of the Workforce Education and Culture Committee
Held on 14 June 2021

Present:	Prof U Macleod	Chair
	Dr A Pathak	Non-Executive
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
	Mr S Nearney	Director of Workforce and OD
	Miss H Cattermole	Director of Medical Education
	Prof M Loubani	Guardian of Safe Working
	Mrs S Rostron	Director of Quality Governance
	Mrs H Knowles	Head of HR
	Mrs F Moverley	Head of Freedom to Speak Up
In Attendance:	Mr D Hepburn	Director of Undergraduate Medical Education
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies and welcome:** Apologies were received from Mr M Howell, Director of Communications Prof Macleod welcomed Dr Pathak, Associate Non-Executive Director and Mrs Moverley, Head of Freedom to Speak Up to the Committee.	
2	**Declarations of Interest** Prof Macleod declared her interest in item 8.2 – Medical Undergraduate Progress Report.	
3	**Minutes of the meeting held on 12 April 2021** Page 7 - Miss Cattermole asked about the breakdown of staff so that she could determine whether the staff support for junior doctors was being accessed appropriately. Mrs Vere agreed to send her a breakdown. Page 8 - Miss Cattermole also advised that Junior Doctors were losing learning opportunities due to pressure in the Phlebotomy service. Dr Carradice was reviewing this area. Page 8 - She added that self-development time has been in the contract since 2016 but was specified for Foundation Doctors in 2020 and work was ongoing to ensure this is introduced evenly. Following these corrections the minutes were approved as an accurate record of the meeting.	
4	**Matters Arising** There were no matters arising from the minutes.	
5	**Action Tracker** The Committee reviewed the action tracker. All items were covered in the papers, were not yet due or had been completed.	

6 Workplan

Mr Nearney asked if the quarterly staff survey could be added to the workplan.

The agenda was taken out of order at this point

10.2 Guardian of Safe Working

Prof Loubani presented the report and highlighted 4 main issues:

- The roll out of e roster in all departments in the Trust
- Support and recommendations to be provided to resolve the phlebotomy issue in the Trust
- Support the introduction of Self Development Time to all trainees in the Trust
- Support discussions with the Medical directors to improve Supervisors responsiveness to exception reports

Prof Loubani advised that some medical departments were not using e-Rostering and were working with other systems so breaches were not being picked up.

There was a discussion around the 31 reports that were submitted within this quarter for missed self-development time. This issue has also been raised at the Junior Doctors Forum. Trainees are expected to receive this time within their working week to complete the requirements of their ARCP. SDT has been in place for GP and the majority of higher trainees for some time and was implemented for Foundation Doctors in August 2020. There has been some confusion regarding SDT and consistency across all departments is important. Dr Purva advised that she was working with the clinical leads, had identified the gaps and was working with the finance teams. She added that the Trust was above average compared with other Trusts.

Mr Nearney advised that the HR team was working on the e-Rostering issues and resource was required to work with the services. Dr Purva agreed to meet with Prof Loubani to review the areas that were not using the e-Rostering system. Miss Cattermole added that some systems were consultant driven and managed on spreadsheets which meant that they could not be managed as part of the e-Rostering system.

Resolved:

The Committee received and accepted the report. Prof Macleod asked that the next report have a review of the e-Rostering system and how services were progressing.

8.2 Medical Undergraduate Progress Report

Dr Hepburn presented the report and highlighted the partnership with the Medical School and the increase in students from 47 to 76 in year 3. Additional consultants and tutors were scoping out programmes to incorporate the increase.

There were no problems with the expansion in year 3 and year 4 would be womens health in 2022/23 which was in line with other secondary care providers. There were 2 posts awaiting financial approval to support the expansion which would impact on the clinical skills department. Dr

Hepburn advised that there was enough money in the budget to support the posts. Mr Nearney agreed to review the posts and discuss further with the finance teams.

Prof Macleod thanked Dr Hepburn for the Trust's support for the University Students through the pandemic and the considerable achievement and engagement from his team.

Resolved:
The Committee received and accepted the report.

7.1 People Performance Report
Mr Nearney presented the report and advised that the vacancy position was 6.9% which was reasonable although there were some challenges in some specialities.

The SAS vacancy position was 35% and a data cleanse was being carried out.

Turnover was 11.4% and this included the temporary workforce. If this was removed the figure was 9.2% against the target of 9.3%.

The Trust is currently meeting the Trust target and when compared with the percentage sickness in Acute Teaching Hospitals is ranked 14th out of 38 Trusts (NHS Digital). Additional Clinical Services (5.37%), Estates and Ancillary (4.76%), Medical & Dental – SAS (4.85%) and Nursing and Midwifery Registered (4.31%) are above the Trust target.

The Trust is 10.4% below the target for AfCstaff appraisals and 54.2% below the target for Cons/SAS appraisals. The Trusts performance in the appraisal targets has been impacted by the Covid 19 pandemic.

The Trust is 3.6% below the Trust target for mandatory training. The Trusts performance in the training target has been impacted by the Covid 19 pandemic.

The Staff Survey results had been discussed at the June 2021 Board Development session. Mrs Vere advised that extra training sessions were being added due to social distancing for training such as fire safety and resuscitation.

Dr Purva advised that consultant job planning was underway and that she was meeting with clinical leads to ensure that compliance was sustained.

Resolved:
The Committee received and accepted the report.

7.2 Board Assurance Framework
Mrs Thompson presented the new look report and advised that the BAF for each Committee would be presented with a quarterly update on what had been achieved and what was in the plan for the next quarter. Risk ratings would be reviewed quarterly and meetings with the executive leads to discuss action plans would take place.

Miss Cattermole had a number of sources of assurance and some issues with training recovery post Covid, so Mrs Thompson agreed to have a catch up with Miss Cattermole outside of the meeting to update the BAF.

Miss Cattermole asked if Dr Pathak would like to attend the Annual Senior Leaders engagement meeting planned for October 2021. This would be arranged, diary permitting.

Resolved:
The committee received and accepted the report.

8.1 Nursing and Midwifery Staffing Report
Mrs Geary advised that there were 107 Registered Nurse vacancies but the Trust had 126 student nurses registering in the Autumn. The Trust would be in a good establishment position going into Winter and a piece of work around bed modelling was ongoing to ensure the staffing levels were appropriate.

The vast majority of Registered Nurse vacancies were in theatres (9.54%) and there were plans in place to address this. The Safety Brief was still being carried out 6 times per day where a review of acuity and staffing numbers were discussed.

Mrs Geary advised that from the perspective of newly qualified Registered Nurses, members of the Practice Development Team have been requested by NHSE/I, to present the research project the Trust has been involved in with the University of Hull in relation to the STaRs Programme (Supporting Transition and Retention of newly qualified nurse) at a Masterclass event hosted by Mark Radford in July 2021.

Dr Pathak congratulated Mrs Geary on the recruitment campaign and asked if the Pilipino nurses were compliant with the language and the nursing standards of the UK. Mrs Geary advised that the Pilipino nurses had to take national exams to ensure they were at the appropriate standard. She added that their rates of pay were the same and followed the Agenda for Change pay scale.

Dr Pathak thanked Mrs Geary and the Nursing Teams for the excellent work they had done around recruitment of registered nurses.

Resolved:
The Committee received and accepted the report.

9.1 Staff Support during Covid
Mrs Vere presented the report and advised that a multi-disciplinary team was being created to support staff which included: occupational health, pastoral team, the psychologist and the practice nursing team.

She added that the Trust had a strong training and education programme as well as good governance arrangements.

Miss Cattermole suggested having a Junior Doctor representative on the multi-disciplinary team and Mrs Vere agreed to attend the Junior Doctor forum to discuss this further as well as how the health and wellbeing opportunities were working for the Junior Doctors.

Mrs Vere advised that the Great Leaders course was still popular and managers were also using the 1:1 support offered. Wellbeing conversations would be added into the appraisal process and this would be launched officially on 5 July 2021.

The Schwartz Rounds steering group has been running successful for 3 months and has supported the operationalisation of Team Time at HUTH. We now have 9 facilitators trained and the first session has been completed with the Steering Group being its guinea pigs on the subject of working in the pandemic. We also have a new facilitators group which will provide specific guidance and support to all new Team Time Facilitators.

Resolved:
The Committee received and accepted the report.

10.1 Freedom to Speak up Report
Mrs Moverley attended the meeting as the new Freedom to Speak up Guardian. She reported that 2020/21 cases were similar in number to the previous year with bullying being the main theme.

Mrs Moverley advised that she was in the process of raising the profile of the service through the Communications Department and the intranet. She was also presenting to the Junior Doctors in August and would be appointing Freedom to Speak up Champions.

Mr Nearney welcomed Mrs Moverley to the meeting and suggested having a discussion outside of the meeting to discuss relevant networks and the new ways of working.

Resolved:
The Committee received and accepted the update.

11 Trade Union Facility Time Reporting Arrangements
Mr Nearney reported that the Trade Union pay was 0.01% of the overall Trust pay. Some investigations had been put on hold due to the pandemic, but the Trust had good relationships with its Trade Unions.

Mr Nearney advised that the report would be published on the Trust's website following this meeting.

Resolved:
The Committee received and accepted the report.

12 National Committees
Mr Nearney advised that he would be reviewing the Trust's People Strategy and the 7 themes at the next committee. He advised that this would capture the 4 themes highlighted in the National People Plan.

Mrs Geary advised that the National work related to the Ockenden Reprot was showing a gap of 1000 midwives. Additional funding had been arranged and Trusts had been invited to bid for funds. She added that the Trust was covered at the moment.

13 Any Other Business

Prof Macleod asked the Committee members how they thought the Committee was working and whether members were assured about what it was like to work and be trained at the Trust.

Mr Nearney advised that the quarterly staff surveys had been suspended and these would be restarting in July, so feedback would be presented to the Committee in due course.

Mrs Rostron advised that the Barratts value work and the latest management briefings would also give good feedback and assurance to the Committee.

There was a discussion about the meeting length and Mr Nearney expressed his concern at the challenging August agenda. Prof Macleod suggested that papers concentrated on any issues making a difference (good or bad).

Date and time of the next committee:
Monday 9th August 2021, 10am – 12pm, via Webex

Hull University Teaching Hospitals NHS Trust Quality Report Trust Board
August 2021

Agenda Item	8.1	**Meeting**	Trust Board	**Meeting Date**	14/09/21
Title	Update on the Trust's response to the Covid-19 pandemic				
Lead Director	Michelle Kemp, Director Strategy & Planning				
Author	David Roney, Head of Emergency Planning				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	x	Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only	x	Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led		Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
For Trust Board to note the contents of the report.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

Update on the Trust's response to the Covid19 pandemic

1. Purpose

This report provides an update on the Trust's ongoing response to the Covid-19 pandemic.

2. Summary of Covid-19 activity in the Trust up to 12th August 2021

The initial HUTH Covid-19 command structure was formally stood down in May 2021 when the impact of Covid-19 was sufficiently low to be managed as business as usual through existing corporate and health group structures.

The Elective Recovery Group retained responsibility for managing current and developing elective backlog and a Winter Planning Delivery Group was established from 22nd June 2021 to plan for pressures during the winter 2021/22.

The gradual easing of lockdown restrictions in May 2021 and June 2021 saw a rise in infection rates across the country and locally. National Coronavirus restrictions were stood down on Monday 19th July 2021 and the Trust set up a Silver Group to plan for and manage an increase in Covid-19 activity following the easing of restrictions and subsequent potential impact on the Trust. The Group was chaired by the Director of Strategy and Planning and reported directly to the Trust Executive Directors Group. The first meeting was held on Friday 9th July 2021 and weekly thereafter.

The Covid Silver Group managed six urgent work streams as follows;

- Surge /Bed Capacity Development /escalation sequence
- Staff Testing/Isolation SOP
- Fit Testing/PPE of staff
- Infection Prevention & Control Measures
- Workforce to support surge and business as usual activity
- Protecting elective activity/UEC

Each work stream was managed by a lead who was responsible for reporting progress to Silver.

On 3rd August 2021, the Covid Silver Group formally amalgamated with the Winter Planning Delivery Group and operates as the Silver Tactical Command for Covid-19 and Winter 2021/ 2022. Silver Command is chaired by Director of Strategy and Planning.

Four additional urgent work streams have been established by the Silver Command Covid-19/ Winter as follows;

- Estates work re ventilation and IPC controls/adjustments
- Non-clinical space risk assessments (using HSE guidance)
- Clinical space risk assessments (using HSE guidance)

- Covid virtual wards
- Vaccination Programme (Covid-19 and Seasonal Influenza)
- Response to paediatric RSV

The Silver Command meetings are held on a weekly basis at 08:00 – 10:00 every Tuesday, and reports directly to the Trust Executive Directors Group

3. Impact of Covid-19 on the Trust

The NHSE Reasonable Worst Case Scenario for winter planning has been set as 50% of Covid activity at the April 2020 peak. This equates to 55 patients with Covid-19.

On 9th July 2021, the Trust had 13 patients with Covid-19, one of whom was being treated in ICU.

The number of Covid positive patients peaked on 10th August 2021 at 53 patients, with 6 being treated in ICU. These are a mix of patients who have been admitted for treatment for other conditions, but who have tested positive for Covid-19, and patients admitted primarily because they require treatment for Covid-19

On 9th July 2021, there were 13 patients with Covid-19, since then, 159 new patients have been admitted, of which 91 patients have been discharged, and 16 patients have died within 28 days of a positive Covid-19 test. As at 12th August 2021 the trust has 57 patients with Covid-19.

The surge plan proposed sequence was approved by Silver Command on 10th august 2021 has been implemented. Currently H37 and designated bays on H38 make up the Covid bed base. The surge plan has been agreed with the objective to maintain the safety of patients and staff and to, as far as practicable, preserve Castle Hill Hospital as a non-Covid site to support the elective recovery.

The Trust has started to experience the predicted increase in Adult and Paediatric RSV, which is mirrored across the rest of the North East and Yorkshire region. MHG and FWHG have agreed measures as part of winter planning to safely manage adult and Paediatric RSV going into winter.

Reinforcement of the visitor policy and the requirement for patients and visitors to wear masks have been prioritised as part of outbreak prevention and a means of reducing healthcare acquired Covid-19 infection.

4. Winter Funding Priorities

Winter funding priorities, totalling £1,948,000 have been agreed by Health Group Triumvirates and signed off by Silver Command. The funding priorities have been shared with and noted by the Executive Directors Group. These are as follows;

- Additional ED nursing staff to provide care to the PED due to the anticipated surge in attends forecasted.

- ED Nursing to maintain staffing levels.
- Increased transfer nurse and portering resources (B2) in the ED department
- Progress chaser support in paediatrics
- PEM Locum Consultants
- Winter locum – Paediatrics
- Paediatrics PHDU - staffing for 6 beds
- 2nd Tier registrar overnight on the 6th floor
- Winter Ward
- increased hours for respiratory virus testing to maintain the service until 10:00pm
- POCT analyser, consumables and staffing to support flow in PED and within the paediatric wards.

5. Work stream Progress

Work stream progress as at August 2021 is summarised in the below table;

Work Stream	Current Position
Surge /Bed Capacity Development /escalation sequence	Surge plan sequence beyond H37 and H38 has been agreed and signed off for publishing to the Staff Intranet. Joint HG plan for next steps and a long term plan fort the medicine and surgical bed base into winter is being developed.
Staff Testing/Isolation SOP	Staff contact and return to work guidance signed off and published 30th July 2021
Fit Testing/PPE of staff	Action plan led by the Health and Safety Team and IPC in place.
Inpatient Testing	Speciality proposals for point of care testing resources to be considered as part of winter planning.
Infection Prevention & Control Measures	Ongoing comms and guidance re-circulated. Increase in adult and paediatric RSV is being monitored for impact.
Workforce to support surge and business as usual activity	The trust is managing high levels of absence across all staff groups. Covid-19 related absence has started to stablise.
Protecting elective activity/UEC	Health Groups are managing impact all services as business as usual to maintain patient flow and to mitigate impact on elective activity.
Estates work re ventilation and IPC controls/adjustments	Ventilation review ongoing
Non-clinical space risk assessments (using HSE guidance)	HSE self-assessment checklist signed off and paper signed off by H&S Committee.
Clinical space risk assessments (using HSE guidance)	HSE self-assessment checklist signed off and paper signed off by H&S Committee.
Covid virtual wards	MHG developing business case to go to EMC
Vaccine Programme	Covid-19 Booster programme will commence Autumn 2021. Vaccine hubs to be set up at HRI and CHH. Flu vaccine programme to run concurrently.
Paediatric RSV	Plan in place, being considered with CHCP and CCG.

6. Staffing Issues

There has been an increase in staff absence since 9th July 2021 comparable to the January 2021 peak . The themes and trends identified are:

Self-isolating following Test and Trace alerts
Staff cohabiting with a person with Covid-19
Isolating as symptomatic for Covid-19 and/ or testing positive for Covid-19.

The peak absence level was 3rd August 2021, with 515 staff absent. Staff absence rates have stablished in the last 2 weeks. However, absence due to cohabiting with a person positive with Covid-19 and/or staff symptomatic or positive themselves remain high.

High absence levels are having an impact across the trust in all services and will affect the ability to implement effective surge capacity and maintain the elective recovery programme.

The staff isolation policy has been reviewed with a view to allowing some critical staff who are absent because of test and trace alerts to return to work supported by a testing regime.

The LAMP testing programme has had a very low take-up and a group to consider how we can improve the uptake and provide staff with an effective asymptomatic testing programme has been established.

Staff from Surgery and Medicine Health Groups continue to support the Covid bed base.

7. Recommendation

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

David Roney
Head of Emergency Planning

Rachel Hugman
Administrator
Covid-19/Winter ICC

Hull University Teaching Hospitals NHS Trust

Agenda Item	8.2	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2021/22				
Lead Director	Michelle Kemp, Director of Strategy and Planning and Accountable Emergency Officer (AEO)				
Author	Jackie Railton, Assistant Director, Strategy and Planning/Trust Lead for EPRR				
Report previously considered by (date)	The purpose of this document is to present to the Trust Board the outcome of the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2021/22				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	✓	Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance	✓	Staff Confidentiality		Caring		High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

- As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. This is undertaken through the annual EPRR assurance process.
- 2021/22 assurance findings - A total of 46 EPRR standards were applicable to the Trust as an acute provider. Of the 46 standards, the Trust was felt to be fully compliant with 44 standards and partially compliant with 2 standards, resulting in an overall assessment of 'substantially compliant'.
- The areas of partial compliance were in relation to:
    - Mass Casualty – Patient Identification. The Trust does not have a non-sequential numbering system in place for major incident patients. A work-around is being implemented pending an upgrade to Lorenzo,
    - Business Continuity – Data Protection and Security Toolkit (DPST):
- An EPRR action plan has been developed to address areas where attention is required and to strengthen areas where the Trust is already compliant.
- Progress against the actions identified will be monitored through the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.

The Trust Board is asked to:

- Endorse the findings of the 2021/22 EPRR assurance process and the assurance rating of 'Substantially Compliant'.
- Endorse the Trust's EPRR action plan and monitoring arrangements.
- Endorse the establishment of a Task and Finish Group to take forward the work in relation to medical gases and oxygen supply.

Hull University Teaching Hospitals NHS Trust

Trust Board

Emergency Preparedness, Resilience and Response (EPRR)
Annual Assurance Process for 2021/22

1. Purpose

The purpose of this document is to present to the Trust Board the outcome of the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2021/22.

2. Background

2.1 NHS Core Standards for EPRR

As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this NHS England (NHSE) and NHS Improvement (NHSI) ask commissioners and providers of NHS funded care to complete an annual EPRR assurance process. This process incorporates four stages:

- Organisational self-assessment against NHS Core Standards for EPRR
- Local Health Resilience Partnership (LHRP) confirm and challenge
- NHSE and NHSI regional EPRR confirm and challenge
- NHSE and NHSI national EPRR confirm and challenge.

The process in 2020 was much reduced and focused on learning from the first Covid-19 wave and the preparation for future waves and Winter 2020. In 2021 the EPRR assurance process aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the challenging landscape of the NHS.

The EPRR assurance process usually uses the NHS Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. NHSE have therefore removed a small number of standards to accommodate this year's assurance process, until NHSE undertakes a full review.

Organisations have been asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each, as follows:

- Non-compliant — Not compliant with the core standard
  The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.

- Partially compliant — Not compliant with the core standard
  However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.

- Fully compliant — Fully compliant with core standard.

An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation has assessed itself as being 'fully compliant' with. The thresholds for each assurance rating are indicated below:

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve
Non-compliant	The organisation is compliant with 76% or less of the core standards they are required to achieve.

2.2 Deep Dive Review

In addition to the self-assessment against the NHS Core Standards for EPRR, each year NHS organisations are asked to undertake a deep dive review to gain additional assurance in a specific area. Previous years have covered such topics as business continuity, governance, pandemic flu, command and control arrangements, severe weather responsiveness and climate adaptation.

Through the response to the Covid-19 pandemic NHSE have identified a number of factors that inhibit our ability to increase inpatient capacity. One of these factors is internal piped oxygen system capacity, which have a number of interdependent components to increasing volume and flow roles. In order to better understand the resilience of our internal piped oxygen system, the 2021/22 EPRR annual deep dive focuses on this area.

The self-assessment against the deep dive standards does not contribute to the organisation's overall EPRR assurance rating.

2.3 Timescales for Submission

Assurance returns are to be submitted by 29 October 2021 and will be subject to confirm and challenge by the Local Health Resilience Partnership (LHRP) and NHSE/I.

3. Trust EPRR Assurance Self-Assessment

A total of 46 EPRR standards are applicable to the Trust as an acute provider. The detail of each standard and the Trust's self-assessment rating is available in the embedded document below.

RWA Hull University Teaching 2021-Core

The Trust achieved full compliance against 44 of the 46 standards, and is therefore reporting a 95.7% compliance rate, resulting in an overall assessment of 'substantially compliant'. A summary of the compliance against the core standards is provided overleaf.

Hull University Teaching Hospitals NHS Trust

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	8	1	0
Command and control	1	1	0	0
Response	5	5	0	0
Warning and Informing	3	3	0	0
Co-operation	2	2	0	0
Business continuity	7	6	1	0
CBRN	12	12	0	0
Total	**46**	**44**	**2**	**0**

The areas of partial compliance were in relation to:

- **Mass Casualty – Patient Identification**
  The standard requires that the Trust has arrangements in place to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient gender.

  The system employed by the Trust is a manual system and based on sequential numbering. As the suppliers are unable to confirm when the Trust's Electronic Patient Record - Lorenzo - can be updated, Patient Admin are adopting a system where each MI patient is identified by a 'Frogger' number. The 'Frogger' is non-sequential and links to NHS/Hey numbers. This is preferable to a fully paper-based system.

- **Data Protection and Security Toolkit (DPST)**
  The Trust is required to issue a statement of compliance with the DPST on an annual basis. The Trust's DPST submission will be made in October 2021, with a decision on the level of compliance expected in December 2021.

An EPRR action plan has been developed to address areas where attention is required and to strengthen areas where the Trust is already compliant (see Appendix).

Progress against the actions identified will be monitored through the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.

4. Outcome of Deep Dive

As outlined in Section 2.2 above, the Trust is required to undertake a Deep Dive into the resilience of our internal piped oxygen system. The domains included governance, business continuity plans, system supply, skills and competencies, escalation plan and processes, technical details and risk assessment. The self-assessment identified that the Trust was fully compliant with 3 out of the 7 domains and partially compliant with the remaining 4 domains. These are summarised overleaf.

Oxygen Supply - Deep Dive Domain	Level of compliance
Medical gases – Governance: Medical Gas Committee	Full
Medical gases – Planning: Business Continuity Plans	Partial
Medical gases – Planning: Cryogenic liquid system supply	Full
Medical gases – Workforce: Skills and competencies	Partial
Oxygen systems – Escalation Plan and process	Partial
Oxygen systems – Technical File	Full
Oxygen systems – Risk Assessment	Partial

Whilst the Deep Dive does not contribute to the Trust's overall EPRR assurance rating, it has highlighted a number of areas where further work needs to be undertaken to ensure that robust systems and processes are in place and fully documented. These include the development of Standard Operating Procedures for staff regarding the use, storage and operation of medical gas cylinders that meet safety and security policies; evidence of nursing staff training in the use, storage and operation of medical gas cylinders; and the development of SOPs for the 'stand up' of weekly/ daily multi-disciplinary oxygen rounds where appropriate.

It is therefore proposed to establish an EPRR Medical Gases Task and Finish Group led by the Head of Emergency Planning which will undertake a gap analysis against the domains in the EPRR Deep Dive self-assessment, gather evidence and develop an action plan to address any areas of concern. The work will be reported to the Trust Resilience Committee and Medical Gas Committee, both of whom report to the Non Clinical Quality Committee.

5. Next Steps

Following endorsement by the Trust Board, the EPRR self-assessment will be submitted to the North East and Yorkshire Regional EPRR team (by 29th October 2021). The Trust's self-assessment will be subject to a confirm and challenge process by the Local Health Resilience Partnership and NHSE/I during November 2021.

5. Recommendation

The Trust Board is asked to:

- Endorse the findings of the 2021/22 EPRR assurance process and the assurance rating of 'Substantially Compliant'.
- Endorse the Trust's EPRR action plan and monitoring arrangements.
- Endorse the establishment of a Task and Finish Group to take forward the work in relation to medical gases and oxygen supply as outlined in Section 4.

Michelle Kemp
Director of Strategy and Planning
Accountable Emergency Officer
06 September 2021

Hull University Teaching Hospitals NHS Trust

2021/22 EPRR Annual Assurance Action Plan

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
Mass Casualty – Patient Identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	**Partially compliant** - The Trust's mass casualty patient identification system was signed off by Trust Patient Administration / Care Record Service teams and tested during the June 2017 Live Exercise. However, the system is a manual one and based on sequential numbering. As the suppliers are unable to confirm when the Trust's Electronic Patient Record - Lorenzo - can be updated, Patient Admin are adopting a system where each MI patient is identified by a 'Frogger' number which identifies them as a major incident patient and allows quick identification as such. The 'Frogger' is non-sequential and links to NHS/Hey numbers, This is preferable to a fully paper-based system.	Testing of Frogger system Continued dialogue with Hdigital regarding future scope to upgrade to electronic non-sequential numbering in ED.	June 2022 March 2023	Head of Emergency Planning in conjunction with Head of Patient Administration and Deputy Director of IT and Innovation
Data Protection and Security Toolkit	The Trust is required to issue a statement of compliance with DPST on an annual basis.	**Partially compliant** – Standards not fully met. Work continues to achieve compliance with significant progress now being made. Systems disaster recovery plans updated August 2021 and linked to HUTH Overarching Business Continuity Plan. Overarching BCP now includes prioritisation of clinical IT systems, which are reflected in HDigital BCP and individual BCPs as appropriate. Move to Windows 10 finalised in July 2021 which improved data security. Exercise Gascoigne in February 2021 tested IT resilience and demonstrated robustness of IT BC management and response to infrastructure, cyber crime and data corruption issues. Actions from the exercise all completed. After action	The Trust's DPST submission will be made in October 2021, with a decision on level of compliance expected in December 2021.	December 2021	Deputy Director of IT and Innovation

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
		reviews have taken place in respect of system and telephony issues in past year and actioned accordingly by HDigital Team.			
Major Incident Plan	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	**Fully Compliant** - The Trust has a Major Incident Plan, which conforms to the requirements of the Civil Contingencies Act 2004, the NHS Act 2006 (as amended) and the NHSE EPRR Framework 2015. The Major Incident Plan would cover the response to a major incident. The Major Incident Plan was approved by the EMC in November 2019. It has been periodically updated since then. A programme of table top exercises has taken place through the last year to test the Major Incident and Trust Business Continuity plans. The major incident plan is undergoing a substantial review and the new plan will be published in autumn 2021 supported by a communications plan, training and exercising to embed it.	Continued testing of the MIP through the use of table top exercises. Test of MIP via a live exercise planned for 14th May 2022 in conjunction with partner agencies, in particular Yorkshire Ambulance Service and Hull College. Ongoing review of the MIP to ensure is still fit for purpose.	Ongoing May 2022 Ongoing	Head of Emergency Planning Head of Emergency Planning Head of Emergency Planning
CBRN – Staff Training	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	**Fully Compliant** – The Trust has certified CBRN trainers and decontamination training takes place throughout the year in line with current guidance. Staff trained in decontamination are the Emergency Department medical and nursing staff and portering staff. However, recent training events have identified a need to raise awareness of the CBRN plan and organisational response amongst members of the site team, on call managers and senior management team.	Awareness training programme to be developed and implemented for those managers who are not directly involved in the decontamination of patients, but who need to understand the organisational response required in the event of a CBRN incident.	March 2022	Head of Emergency Planning

Please consider the environment before printing this report. However, if printing is absolutely necessary, it may be helpful to print in colour.

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES) Trust Submission 2020/21

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

Purpose:	The purpose of this paper is to present for consideration by the Workforce, Education and Culture Committee and Trust Board, the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2020/21 and proposed Action Plan for 2021/22.	
BAF Risk:	Risk 2 – workforce	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	
Summary Key of Issues:	Next steps are identified within the Action Plan 2021/22 (Appendix 2).	

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

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES)
Trust Submission 2020/21

1 Purpose

The purpose of this paper is to present the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2020/21 and proposed Action Plan for 2021/22.

2 Background

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

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

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

Equality, diversity and inclusion is one of the key strategic workforce themes within the Trust's People Strategy 2019 to 2024, which states:

"we will continue to develop an organisational culture that encourages every member of staff, whatever their role or background to succeed. A Trust where our staff work hard to make a difference for patients, where staff access opportunities to learn, develop and grow and work in a positive environment free from discrimination."

This report should be read in the context that as at 31 March 2021, the Trust employed 10,256 staff, of which:

- 8,627 (84.12%) identify as White;
- 1,428 (13.92%) identify as BAME; and
- 201 (1.96%) did not declare their ethnicity.

3 WRES Submission 2020/21

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

- Raw Technical Data: Contains validated raw technical data from the Trust's Electronic Staff Record (ESR) for staff in post at 31 March 2021. The data is used by NHS England to benchmark the Trust against other NHS organisations. The WRES Implementation Team have continued to exclude indicators 5 to 8 (which are taken from the staff survey results) from the raw technical data. The deadline to submit this data to NHS England and NHS Improvement is 31 August 2021.
- Report (Appendix 1): Supplementing the Data Template, this provides an overview and 2-year comparison of the organisation's WRES data. To enable a full comparison to be made against the nine WRES indicators; indicators 5

to 8 have been included in this report. The report must be published on the Trust's website by 27 September 2021.

- WRES Action Plan 2021/22 (Appendix 2): Based on the outcomes from the raw technical data, the Action Plan is intended to address any disparities in the experiences of BAME staff compared to White staff. The Action Plan must be published on the Trust's website by 27 September 2021.

4 Achievements throughout 2020/21

There have been a number of achievements in the past year, which are detailed below:

4.1 Appointment to EDI Roles

To embed the Trust's commitment to equality, diversity and inclusion, funding has been secured to make appointments to dedicated equality, diversity and inclusion posts, who will cover all the protected characteristics. The Trust's Senior OD Facilitator also continues to support the equality, diversity and inclusion agenda, particularly linked to issues which underpin the WRES.

4.2 BAME Leadership Network

With the successful appointments of the BAME Leadership Network Chair and Joint Deputy Chairs in 2020, the Network has continued to go from strength to strength, in what has been a challenging year due to the COVID-19 pandemic.

The Network meetings have continued during the pandemic via WebEx to enable members to stay connected and to enable important work to continue.

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

Following evidence that the BAME population nationally were more adversely impacted by COVID-19 compared to White people, the Trust introduced a number of proactive measures to support BAME staff. These included:

- Priority COVID-19 testing for BAME staff and their family members with mild symptoms.
- Priority antibody testing.
- Promoted avenues of support to BAME staff if they have any concerns about the support that they are receiving from line management during the pandemic.

The Trust continues to work with the BAME Leadership Network and BAME colleagues across the organisation to review any additional support measures that are required as a result of the pandemic.

4.3 Success at the National BAME Health and Care Awards 2021

The Trust was very proud to have the work of three staff recognised as part of the National BAME Health and Care Awards 2020. These successes were in the Workforce Innovator of the Year, Compassionate and Inclusive Leader/Initiative and Outstanding Corporate Achievement categories.

4.4 Training

The Trust continues to be committed to developing BAME staff, with leadership development opportunities being promoted on a regular basis. These include BAME Leadership Programmes 20/21, Great Leaders Coaching Network, Great Leaders Leadership Programmes, Reverse mentoring and the NHS Leadership Academy.

A series of management clinics were held to support Trust leaders and staff to take an inclusive approach and explore how they can better become allies to staff from a BAME, LGBTQ+, disabled or other protected characteristics background. The clinics focused on self-reflection and how to take proactive action to support colleagues. Over 80 members of staff attended these sessions in 2020/21.

'Let's talk about discrimination – Become an Ally' sessions were provided for staff across the Trust in October 2020 during Black History Month. These sessions focused on the importance of fostering an inclusive culture where all staff feel they belong and can progress at work, regardless of their identity. Further sessions will continue throughout 2021.

4.5 Our Voices Project

In September 2020, an exciting six-month project, 'Our Voices', launched to inform the Trust's Equality, Diversity and Inclusion Strategy and work going forward.

The project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey/ feedback forums.

Understanding the lived experience of staff from all backgrounds will enable the Trust to meaningfully work towards a culture where, both in employment and service provision, no individual is discriminated against or treated less favourably due to age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010) and the vision as set out in the Trust's Equality, Diversity and Inclusion Strategy.

5 Overview of Key Findings from the 2020/21 Data

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 162 (from 1266 to 1428) which is a positive, however further work to provide career progression opportunities to BAME colleagues needs to continue (in line with the national WRES Model Employer goals).
- BAME staff continue to be less likely to enter into the formal disciplinary process compared to White staff.
- BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff, although as noted in the WRES 2020/21 Report (see Appendix 1, section 3.4), the 2019/20 WRES data audit concluded that the data for this indicator needs to be improved.

Further improvements need to be made across the following indicators:

- Although the percentage of BAME staff being appointed from shortlisting increased in the last 12 months, the relative likelihood of White staff being appointed from shortlisting compared to BAME staff has increased.
- Further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue.
- Work to improve the diversity of the Trust Board needs to continue.

The Trust continues to be committed to closing the gap between White and BAME worklife experience as detailed within the Action Plan 2021/22 (see Appendix 2).

The outcomes from the Trust's 2020/21 WRES return will be shared with the Trust's BAME Leadership Network.

6 Next Steps

The WRES Action Plan 2021/22 (in Appendix 2) details the Trust's next steps.

7 Conclusion

The Trust's 2020/21 WRES data, shown in the WRES 2020/21 Report (see Appendix 1), continues to highlight that the lived experiences of BAME colleagues within the Trust is different to other groups.

However, the Trust is committed to addressing this and will continue to work with the BAME Leadership Network and BAME colleagues across the Trust to close the gap between the lived experience for BAME colleagues and other staff groups. Areas for improvement have been identified in the WRES Action Plan for 2021/22 (see Appendix 2).

8 Recommendation

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

Simon Nearney
Director of Workforce and Organisational Development

August 2021

Appendix 1 - Workforce Race Equality Standard (WRES) 2020/21 Report

1. Background

This report details the Trust's 2020/21 Workforce Race Equality Standard (WRES) technical data, and key findings from this data. An Action Plan, designed to address the gaps in workplace experience between White and BAME staff, is available in Appendix 2.

This report and Action Plan must be published on the Trust's external website by 27 September 2021.

2. Introduction

The Trust employed 10,256 staff at 31 March 2021. This is an increase of 694 staff in total compared to the previous reporting period (9562 staff as at 31 March 2020).

As the Trust is the lead employer for the Humber, Coast and Vale (HCV) vaccination programme, this in itself will have had a significant impact on headcount.

The number and percentage of staff by ethnicity is as follows:

Ethnicity	31 March 2020	31 March 2021
White	8162 (85.36%)	8627 (84.12%)
BAME	1266 (13.24%)	1428 (13.92%) (+162)
Not Stated	134 (1.40%)	201 (1.96%)
Grand Total	**9562**	**10,256**

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

3 WRES 2020/21 Data

3.1 Indicator 1: Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and Very Senior Managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Non-Clinical Staff

In the non-clinical category, there has been a total increase of 93 staff across all ethnicities (from 2182 to 2275). Of this there has been an increase of BAME staff by 7 (from 68 to 75).

Table 1: The number and percentage of ***NON-CLINICAL*** staff at 31 March 2021

	White		BAME		Unknown	
	Headcount	**%**	**Headcount**	**%**	**Headcount**	**%**
Under B1	8	100%	**0**	**0%**	0	0%
B1	38	90.48%	**3 (+1)**	**7.14%**	1	2.38%
B2	962	94.50%	**46 (+4)**	**4.52%**	10	0.98%
B3	469	97.51%	**7 (+1)**	**1.46%**	5	1.04%
B4	185	97.37%	**3 (+1)**	**1.58%**	2	1.05%
B5	172	97.18%	**4 (-1)**	**2.26%**	1	0.56%
B6	94	95.92%	**3 (-1)**	**3.06%**	1	1.02%
B7	91	91%	**5 (+2)**	**5%**	4	4%
B8a	60	95.24%	**1 (-1)**	**1.59%**	2	3.17%
B8b	42	95.45%	**2**	**4.55%**	0	0%
B8c	19	100%	**0**	**0%**	0	0%
B8d	7	87.50%	**0**	**0%**	1	12.50%
B9	0	0%	**0**	**0%**	0	0%
VSM	26	96.30%	**1 (+1)**	**3.70%**	0	0%
Total	**2173**		**75 (+7)**		**27**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

Clinical Non-Medical Staff

In the clinical non-medical category, there has been a total increase of 577 staff across all ethnicities (from 5991 to 6568). Of this, there has been an increase of BAME staff by 142 (from 471 to 613).

The increase in headcount is likely to be due to the Trust's ongoing international Nurse recruitment programme and the additional recruitment required as a direct impact of the COVID-19 pandemic.

As lead provider for the Covid-19 Vaccination Programme for the HCV ICS, the Trust set up a bank of Vaccinators. Recruitment routes were via NHS Providers, the Bring Back Staff Campaign and local recruitment drives. Roles included band 6 Vaccination Clinical Supervisors, band 5 Registered Healthcare Professional Vaccinators and band 3 Vaccinators/Vaccination Support Workers. The available resource totalled approximately 500 casual workers (which are included in the total Trust headcount of 10,256 above). Requests for staff have come from across the ICS, including mass vaccination centres, Primary Care Networks and Community Pharmacists.

Table 2: The number/percentage of ***CLINICAL NON-MEDICAL*** staff at 31 March 2021

	White		BAME		Unknown	
	Headcount	**%**	**Headcount**	**%**	**Headcount**	**%**
Under B1	66	94.29%	**4 (+3)**	**5.71%**	0	0%
B1	6	100%	**0**	**0%**	0	0%
B2	1314	93.59%	**71 (+3)**	**5.06%**	19	1.35%
B3	643	95.54%	**19 (+8)**	**2.82%**	11	1.63%
B4	282	90.10%	**16 (+11)**	**5.11%**	15	4.79%
B5	1709	81.15%	**371 (+91)**	**17.62%**	26	1.23%
B6	978	90.81%	**84 (+25)**	**7.80%**	15	1.39%
B7	623	93.83%	**30 (-5)**	**4.52%**	11	1.66%
B8a	150	89.82%	**14 (+7)**	**8.38%**	3	1.80%
B8b	47	94%	**3 (-1)**	**6%**	0	0%
B8c	21	95.45%	**0**	**0%**	1	4.55%
B8d	4	100%	**0**	**0%**	0	0%
B9	2	100%	**0**	**0%**	0	0%
VSM	9	90%	**1**	**10%**	0	0%
Total	**5854**		**613 (+142)**		**101**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

Medical and Dental Staff

There has been a total increase of medical and dental staff across all ethnicities by 24 (from 1389 to 1413). Of this, there has been an increase of BAME staff by 13 (from 727 to 740).

Table 3: The number/percentage of ***MEDICAL AND DENTAL*** staff at 31 March 2021

2020/21	White		BAME		Unknown	
	Headcount	**%**	**Headcount**	**%**	**Headcount**	**%**
Consultants	241	46.08%	**263 (+14)**	**50.29%**	19	3.63%
Non-Consultant Career Grade	22	30.14%	**48 (+3)**	**65.75%**	3	4.11%
Trainee Grades	337	41.25%	**429 (-4)**	**52.51%**	51	6.24%
Other	0	0%	**0**	**0%**	0	0%
Total	**600**		**740 (+13)**		**73**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

Table 4: The number and percentage of ***NON-CLINICAL*** staff by band at 31 March 2021 using a baseline of 13.92% (% of BAME staff)

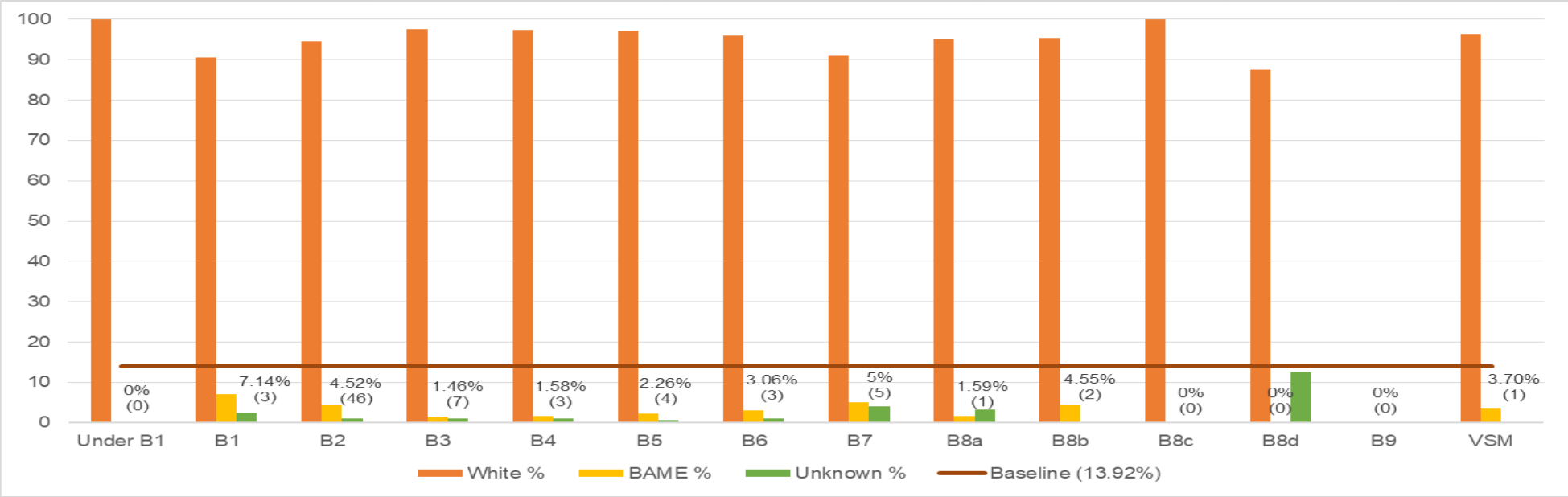


Table 5: The number and percentage of ***NON-CLINICAL*** staff in each band over 2 years

	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	20	100%	8	100%	**0**	**0%**	**0**	**0%**	0	0%	0	0%
B1	44	95.65%	38	90.48%	**2**	**4.35%**	**3 (+1)**	**7.14%**	0	0%	1	2.38%
B2	914	94.81%	962	94.50%	**42**	**4.36%**	**46 (+4)**	**4.52%**	8	0.83%	10	0.98%
B3	439	97.56%	469	97.51%	**6**	**1.33%**	**7 (+1)**	**1.46%**	5	1.11%	5	1.04%
B4	191	98.45%	185	97.37%	**2**	**1.03%**	**3 (+1)**	**1.58%**	1	0.52%	2	1.05%
B5	158	96.34%	172	97.18%	**5**	**3.05%**	**4 (-1)**	**2.26%**	1	0.61%	1	0.56%
B6	94	94.95%	94	95.92%	**4**	**4.04%**	**3 (-1)**	**3.06%**	1	1.01%	1	1.02%
B7	83	93.26%	91	91%	**3**	**3.37%**	**5 (+2)**	**5%**	3	3.37%	4	4%
B8a	55	93.22%	60	95.24%	**2**	**3.39%**	**1 (-1)**	**1.59%**	2	3.39%	2	3.17%
B8b	45	95.74%	42	95.45%	**2**	**4.26%**	**2**	**4.55%**	0	0%	0	0%
B8c	19	95%	19	100%	**0**	**0%**	**0**	**0%**	1	5%	0	0%
B8d	7	87.50%	7	87.50%	**0**	**0%**	**0**	**0%**	1	12.50%	1	12.50%
B9	0	0%	0	0%	**0**	**0%**	**0**	**0%**	0	0%	0	0%
VSM	22	100%	26	96.30%	**0**	**0%**	**1 (+1)**	**3.70%**	0	0%	0	0%
Total	**2091**		**2173**		**68**		**75 (+7)**		**23**		**27**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

Table 6: The number and percentage of ***CLINICAL NON-MEDICAL*** staff by band at 31 March 2021 using a baseline of 13.92% (% of BAME staff)

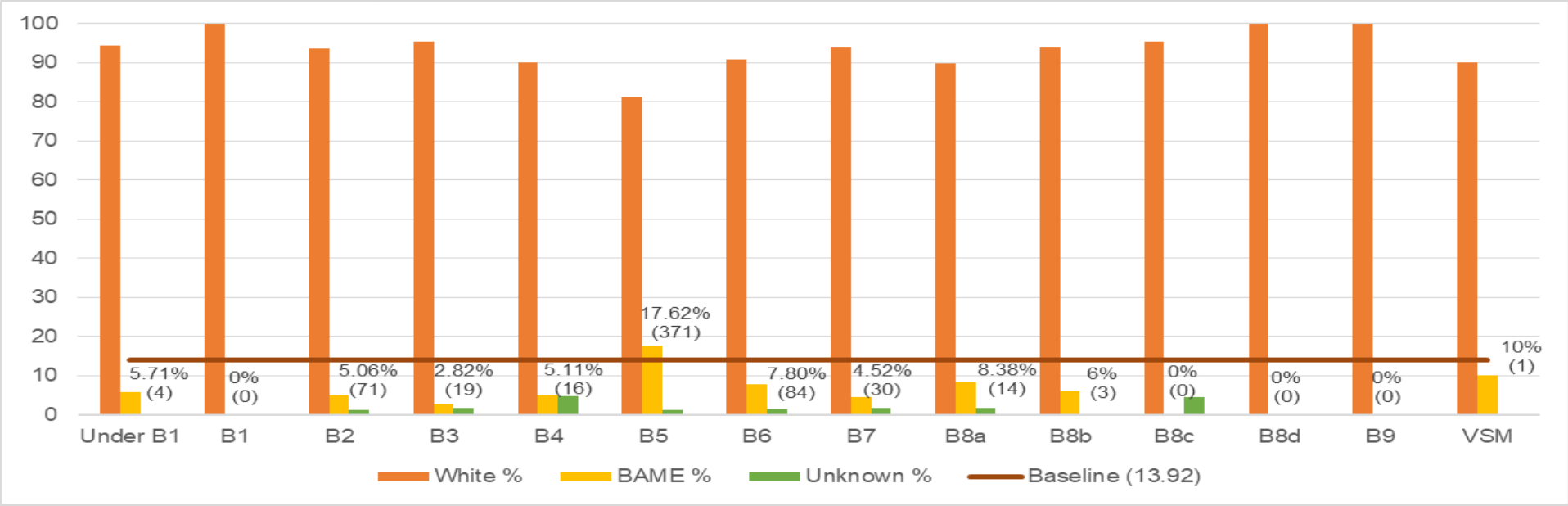


Table 7: The number and percentage of ***CLINICAL NON-MEDICAL*** staff in each band over 2 years

2020/21	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	47	97.92%	66	94.29%	**1**	**2.08%**	**4 (+3)**	**5.71%**	0.00	0%	0	0%
B1	0	0%	6	100%	**0**	**0%**	**0**	**0%**	0	0%	0	0%
B2	1308	94.17%	1314	93.59%	**68**	**4.90%**	**71 (+3)**	**5.06%**	13	0.94%	19	1.35%
B3	545	95.78%	643	95.54%	**11**	**1.93%**	**19 (+8)**	**2.82%**	13	2.28%	11	1.63%
B4	187	97.40%	282	90.10%	**5**	**2.60%**	**16 (+11)**	**5.11%**	0	0%	15	4.79%
B5	1604	84.11%	1709	81.15%	**280**	**14.68%**	**371 (+91)**	**17.62%**	23	1.21%	26	1.23%
B6	938	92.78%	978	90.81%	**59**	**5.84%**	**84 (+25)**	**7.80%**	14	1.38%	15	1.39%
B7	591	92.78%	623	93.83%	**35**	**5.49%**	**30 (-5)**	**4.52%**	11	1.73%	11	1.66%
B8a	139	93.92%	150	89.82%	**7**	**4.73%**	**14 (+7)**	**8.38%**	2	1.35%	3	1.80%
B8b	48	92.31%	47	94%	**4**	**7.69%**	**3 (-1)**	**6%**	0	0%	0	0%
B8c	21	95.45%	21	95.45%	**0**	**0%**	**0**	**0%**	1	4.55%	1	4.55%
B8d	4	100%	4	100%	**0**	**0%**	**0**	**0%**	0	0%	0	0%
B9	3	100%	2	100%	**0**	**0%**	**0**	**0%**	0	0%	0	0%
VSM	8	88.89%	9	90%	**1**	**11.11%**	**1**	**10%**	0	0%	0	0%
Total	**5443**		**5854**		**471**		**613 (+142)**		**77**		**101**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

Table 8: The number and percentage of ***MEDICAL AND DENTAL*** staff by band at 31 March 2021 using a baseline of 13.92% (% of BAME staff)

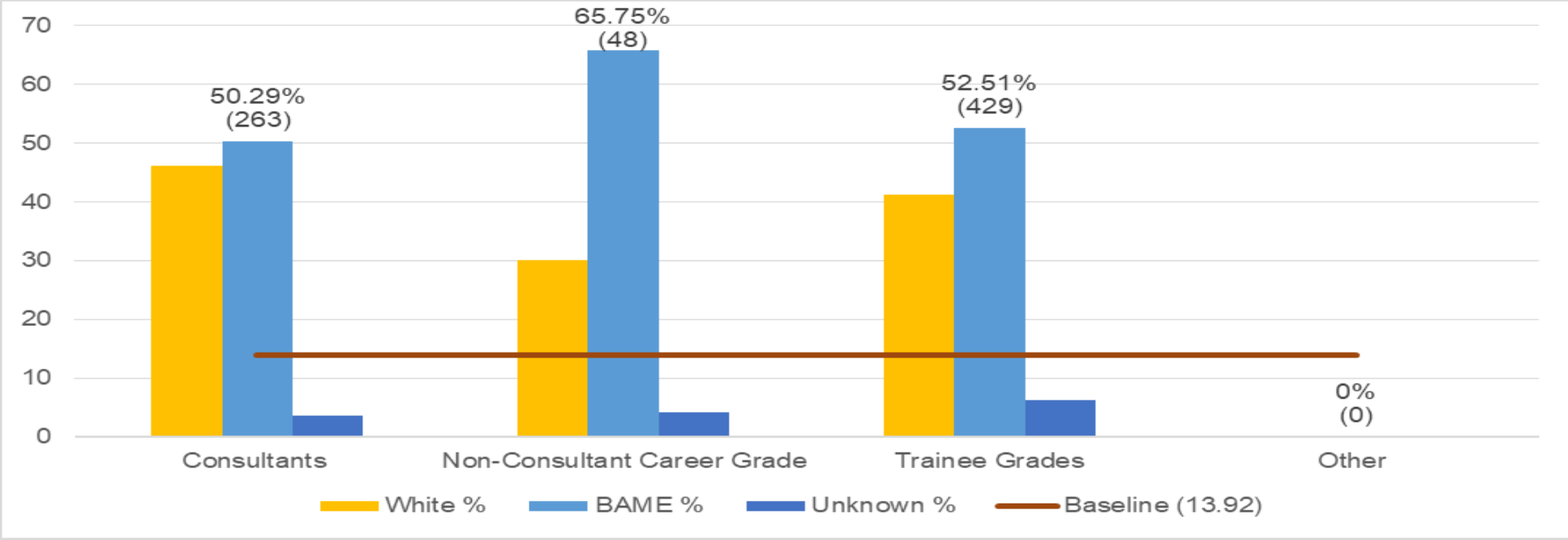


Table 9: The number and percentage of ***MEDICAL AND DENTAL*** staff in each band over 2 years

	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Consultants	239	47.90%	241	46.08%	**249**	**49.90%**	**263 (+14)**	**50.29%**	11	2.20	19	3.63%
Non-Consultant Career Grade	26	35.14%	22	30.14%	**45**	**60.81%**	**48 (+3)**	**65.75%**	3	4.05	3	4.11%
Trainee Grades	363	44.49%	337	41.25%	**433**	**53.06%**	**429 (-4)**	**52.51%**	20	2.45	51	6.24%
Other	0	0%	0	0%	**0**	**0%**	**0**	**0%**	0	0.00	0	0%
Total	**628**		**600**		**727**		**740 (+13)**		**34**		**73**	

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

3.2 Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

In comparison to the 2019/20 WRES data, this year's data shows:

- 614 BAME applicants were shortlisted and 105 appointed compared to last year (which showed 454 BAME applicants were shortlisted and 77 appointed).
- The percentage of BAME staff being appointed from shortlisting has slightly improved. This however, is not enough of a change to affect the relative likelihood in a positive way. The relative likelihood is that White staff are 1.43 times more likely to be appointed from shortlisting compared to BAME colleagues.

Table 10: The percentage of staff ***SHORTLISTED*** and ***APPOINTED*** over 2 years

Ethnicity	2019/20	2020/21
White	22.13%	24.46%
BAME	16.96%	17.10%
Not Stated	50.91%	25%
Relative likelihood	**1.30**	**1.43**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.3 Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator takes into account staff who have been through the formal disciplinary process by ethnicity. Where a collective disciplinary has occurred, multiple ethnicities are not recorded. During the reporting timeframe, there has been 1 collective disciplinary, which for the purposes of the WRES, has been included in the 'Not Stated' figures.

In comparison to the 2019/20 WRES data, the 2020/21 data shows:

- BAME staff are less likely to enter into the disciplinary process than White staff.
- The number of disciplinaries in total across all ethnicities from 1 April 2020 to 31 March 2021 has increased by 1 (from 116 to 117).
- However, the number of BAME staff entering the formal disciplinary process has decreased by 1 (from 10 to 9) in total over the last year.

Table 11: Percentage of staff who entered into a ***FORMAL DISCIPLINARY PROCESS***

Ethnicity	2019/20	2020/21
White	1.20%	1.21%
BAME	0.79%	0.63%
Not Stated	5.97%	1.99%
Relative likelihood	**0.66**	**0.52**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.4 Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

In comparison to the 2019/20 WRES data, this year's data shows:

- The number of BAME staff accessing training has increased by 299 employees (from 1146 to 1445).
- Within the Trust, the relative likelihood shows that BAME staff are more likely to access non-mandatory training and CPD than to White staff.

NB: An outcome from the recent 2019/20 WRES data audit was to improve the data for this indicator. Therefore, in conjunction with the Head of Learning and Organisational Development, this will be reviewed to enable improvements to be made in next year's report.

Table 12: Percentage of staff who accessed ***NON-MANDATORY TRAINING*** and ***CPD***

Ethnicity	2019/20	2020/21
White	97.06%	99.86%
BAME	90.52%	101.26%
Not Stated	94.03%	72.14%
Relative likelihood	**1.07**	**0.99**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.5 Indicator 5-8 Staff Survey Results

The 2020/21 Staff Survey results show in comparison to the 2019/20 data:

- Bullying and harassment from patients, relatives or the public has increased for BAME staff, but has fallen for White staff.
- Bullying and harassment from staff has increased for both White and BAME staff, however it has increased more for BAME staff (by over 3%).
- The number of staff who feel that the Trust provides equal opportunities for career progression or promotion has reduced by over 1% for both White and BAME staff.
- The number of BAME staff who stated that they personally experienced discrimination at work from a manager/team leader or other colleagues has increased by over 1%.

With the launch of the Policy for Staff Conflict Resolution and Professionalism in the Workplace in May 2021, there is hope that this may have a positive impact on bullying and harassment figures in the future.

The policy (which replaces the Bullying and Harassment Policy) aims to address behaviours at the lowest possible level, when behaviours can often be identified as a minor disagreement or conflict between staff rather than a default claim of bullying and harassment.

An 'Unacceptable Behaviour Scale' has been included as a guide to categorising the behaviour being experienced to understand the potential avenues for resolution.

Identifying behaviours, particularly in the lower categories may help staff to determine the behaviours they are experiencing are unacceptable and there is a mechanism for this to be addressed/resolved.

Table 13: Data for Indicators 5 to 8

Staff Survey Indicators	White %		BAME %	
	2019/20	2020/21	2019/20	2020/21
Indicator 5: KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24.72%	23.5%	25.25%	26.5%
Indicator 6: KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25.75%	26.8%	30.07%	34.1%
Indicator 7: KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	88.53%	87.2%	78.88%	77.0%
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues	5.46%	5.6%	14.52%	15.9%

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.6 Indicator 9: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

As at 31 March 2021, the Trust has 16 Board members in total, of which:

- 15 (93.8%) are of White ethnicity compared to 13 in the previous year.
- 1 (6.3%) is a BAME staff member which is the same as the previous year.

Table 14: Percentage difference between the ***BOARD MEMBERSHIP VS. OVERALL WORKFORCE***

Ethnicity	2019/20	2020/21
Difference (total Board – overall workforce)	-6.1%	-7.7%

4 Achievements throughout 2020/21

There have been a number of achievements in the past year as detailed below:

4.1 Appointment to EDI Roles

To embed the Trust's commitment to equality, diversity and inclusion, funding has been secured to make appointments to dedicated equality, diversity and inclusion posts, who will cover all the protected characteristics. The Trust's Senior OD Facilitator also continues to support the equality, diversity and inclusion agenda, particularly linked to issues which underpin the WRES.

4.2 BAME Leadership Network

With the successful appointments of the BAME Leadership Network Chair and Joint Deputy Chairs in 2020, the Network has continued to go from strength to strength, in what has been a challenging year due to the COVID-19 pandemic.

The Network meetings have continued during the pandemic via WebEx to enable members to stay connected and to enable important work to continue.

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

Following evidence that the BAME population nationally were more adversely impacted by COVID-19 compared to White people, the Trust introduced a number of proactive measures to support BAME staff. These included:

- Priority COVID-19 testing for BAME staff and their family members with mild symptoms.
- Priority antibody testing.
- Promoted avenues of support to BAME staff if they have any concerns about the support that they are receiving from line management during the pandemic.

The Trust continues to work with the BAME Leadership Network and BAME colleagues to review any additional support measures that are required as a result of the pandemic.

4.3 Success at the National BAME Health and Care Awards 2021

The Trust was very proud to have the work of three staff recognised as part of the National BAME Health and Care Awards 2020. These successes were in the Workforce Innovator of the Year, Compassionate and Inclusive Leader/Initiative and Outstanding Corporate Achievement categories.

4.4 Training

The Trust continues to be committed to developing BAME staff, with leadership development opportunities being promoted on a regular basis. These include BAME Leadership

Programmes 20/21, Great Leaders Coaching Network, Great Leaders Leadership Programmes, Reverse mentoring and the NHS Leadership Academy.

A series of management clinics were held to support Trust leaders and staff to take an inclusive approach and explore how they can better become allies to staff from a BAME, LGBTQ+, disabled or other protected characteristics background. The clinics focused on self-reflection and how to take proactive action to support colleagues. Over 80 members of staff attended these sessions in 2020/21.

'Let's talk about discrimination – Become an Ally' sessions were provided for staff across the Trust in October 2020 during Black History Month. These sessions focused on the importance of fostering an inclusive culture where all staff feel they belong and can progress at work, regardless of their identity. Further sessions will continue throughout 2021.

4.5 Our Voices Project

In September 2020, an exciting six-month project, 'Our Voices', launched to inform the Trust's Equality, Diversity and Inclusion Strategy and work going forward.

The project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey/feedback forums.

Understanding the lived experience of staff from all backgrounds will enable the Trust to meaningfully work towards a culture where, both in employment and service provision, no individual is discriminated against or treated less favourably due to age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010) and the vision as set out in the Trust's Equality, Diversity and Inclusion Strategy.

5 Summary

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 162 (from 1266 to 1428) which is a positive, however further work to provide career progression opportunities to BAME colleagues (in line with the national WRES Model Employer goals) needs to continue.
- BAME staff continue to be less likely to enter into the formal disciplinary process compared to White staff.
- BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff, although as noted in section 3.4, the 2019/20 WRES data audit concluded that the data for this indicator needs to be improved.

Further improvements need to be made across the following indicators:

- Although the percentage of BAME staff being appointed from shortlisting increased in the last 12 months, the relative likelihood of White staff being appointed from shortlisting compared to BAME staff continues to increase.
- Further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue.
- Work to improve the diversity of the Trust Board needs to continue.

The Trust continues to be committed to closing the gap between White and BAME worklife experience as detailed within the Action Plan 2021/22 (see Appendix 2).

Appendix 2 - Workforce Race Equality Standard Action Plan 2021/22

The Action Plan 2021/22 has been developed, based on the 2020/21 WRES technical data results, to help close the gaps in workplace experience between White and Black and Ethnic Minority (BAME) staff. A separate detailed workplan supports the Action Plan.

Action	WRES Indicator	Timescale	Lead
Launch an internal and external "Zero Tolerance To Racism" Campaign for staff, patients and visitors.	Indicators 5, 6, 8	December 2021	Director of Communications / Marketing Manager
Continue to empower BAME staff to speak up, raise concerns and ensure adequate/visible support mechanisms are in place.	Indicators 5, 6, 8	December 2021	Director of Workforce/ BAME Chair and Deputy Chairs
Continue to re-fresh and re-energise mandatory and statutory equality and inclusion training to include powerful, impactful videos to highlight and celebrate contribution of BAME colleagues within the Trust.	All	October 2021	Senior OD Practitioner / EDI Leads
Continue to develop mandatory leadership and management development programmes focusing on discrimination, bullying and harassment, unconscious bias, cross-cultural understanding and micro-aggression which develop managers to empower BAME staff to speak up and raise concerns.	Indicators 5, 6, 8	March 2022	Head of Learning and Organisational Development / Senior OD Practitioner
Design and launch a 'Diversity in Recruitment' scheme underpinned by diversity in recruitment specialists (pilot within nursing for band 6 and above role)	Indicators 1, 2, 7	Review pilot November 2021	Head of HR Services / EDI Leads / Senior OD Practitioner
Design a BAME specific induction programme highlighting the Trust's commitment to BAME colleagues as well as signposting to colleagues in the Trust and local BAME community groups/services.	All	December 2021	Director of Communications / Head of Learning and Organisational Development
Review end to end process and outcomes to identify any bias in informal and formal grievance, investigation and disciplinary processes.	Indicator 3	March 2022	Head of Workforce / Chair of BAME Leadership Network

WRES Indicators

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

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2021

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

Purpose:	The purpose of this paper is to present for consideration by the Executive Management Committee the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2021 and proposed action plan.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great local services	
	Great specialist services	✓
	Partnership and integrated services	✓
	Financial sustainability	
Summary Key of Issues:		

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

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2021

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2021 and proposed action plan.

2 Background

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

The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES aims to help inform year on year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities and implementing long lasting change for Disabled people.

The WDES enables NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators and to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff.

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

3 WDES Submission 2021

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

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2021. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 31 August 2021.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WDES Action Plan which is based on the outcomes from the technical data results and is intended to address disparities in the experiences of disabled staff compared to non-disabled staff (see Appendix 3).
- This report should be read in the context that only 282 staff self-reported with a disability whereas when completing the Staff Survey (December 2020) a higher number of staff reported themselves as disabled.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 31 October 2021.

4 Key Findings for 2021

The WDES seeks to ask questions in the following areas:

1. The percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce at 31 March 2021.

2. The relative likelihood of Disabled staff compared to Non-disabled staff being appointed from shortlisting across all posts.
3. The relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process.
4. The percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse.
5. The percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. The percentage of Disabled staff compared to Non-disabled staff saying they have felt pressure from their managers to come to work when they have not felt well enough to do their duties.
7. The percentage of Disabled staff compared to Non-disabled staff saying they are satisfied with the extent to which their organisation values their work.
8. The percentage of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.
9. A) The staff engagement scores for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.
   B) Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?
10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce at 31 March 2021.

The key findings from the technical data for 2021 are:

- The Trust employed 10,256 staff at 31 March 2021.
- Of the 10,256 staff, 29.47% (3,022) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 36.63% (2020).
- 282 staff have reported as Disabled on ESR; an increase from 209 staff (2020).
- The metric with the highest disparity between Non-disabled staff and Disabled staff is staff saying they are satisfied with the extent to which their organisation values their work (Staff Survey December 2020 data). However, this metric has marginally improved for Disabled staff from 36.9% (2019) to 37.1% (2020).
- The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that said the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months (Staff Survey December 2020 data). This metric has decreased for Disabled staff from 41.1% (2019) to 39.7% (2020).

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

The data shows there are improvements to be made across all of the indicators and the disparity between the experience of Disabled staff measured against Non-disabled staff remains a challenge for the Trust. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR.

5 WDES Action Plan

The draft WDES Action Plan for 2021/2022 is available in Appendix 3.

6 WDES Innovation Fund Award

The Trust won a WDES Innovation Fund Award in December 2020. The successful bid was submitted on behalf of the Trust and the Trust was awarded £20,000. This funding has enabled a programme of work to be planned and undertaken which has included the following:

- A Trust wide in depth survey – Perspectives on Inclusion and Disability Staff Survey.
- Facilitated Focus Groups have been held with our disabled staff.
- Development of an Enabled Staff Support Network; the first meeting was held on 18 May 2021.
- An Enabled Staff Support Network Conference was held on 25 June 2021.

The information gathered through the Survey, Focus Groups, the Enabled Staff Support Network and Conference has informed the development of the actions in the Draft WDES Action Plan.

7 Recommendation

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

Simon Nearney
Director of Workforce and Organisational Development
August 2021

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2021
Name and title of Board lead for the Workforce Disability Equality Standard:	Ellen Ryabov, Chief Operating Officer
Name of lead compiling this report:	Liz Dearing, HR Manager
Names of commissioners this report has been sent to:	Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group
Name of co-ordinating commissioner this report has been sent to:	Hull Clinical Commissioning Group
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however 29.47% of the workforce have not declared as disabled or non-disabled, which represents 3,022 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 10,256

Proportion of disabled staff employed within the Trust at the date of the report: 2.75% of the total staff employed as self-declared through ESR.

3. Self-Reporting

The proportion of total staff who have self-reported disabled/non-disabled: 70.53%

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

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

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2021 and activity during the financial year 2020/21.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2020/21		Data for previous year 2019/20		Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2021:				In total 70.53% of Trust staff declared themselves as disabled or non-disabled. The highest percentage of disabled employees are within the clinical workforce (non-medical) whilst the lowest percentage of disabled employees are within the clinical workforce (medical and dental)	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
		Non-clinical workforce (Non-disabled) =	13.98%	Non-clinical workforce (Non-disabled) =	12.98%		
		Non-clinical workforce (Disabled) =	0.69%	Non-clinical workforce (Disabled) =	0.53%		
		Clinical workforce (non-medical Non-disabled) =	42.71%	Clinical workforce (non-medical Non-disabled) =	36.67%		
		Clinical workforce (non-medical Disabled) =	1.76%	Clinical workforce (non-medical Disabled) =	1.44%		
		Clinical workforce (medical and dental non-disabled) =	11.10%	Clinical workforce (medical and dental Non-disabled) =	11.54%		
		Clinical workforce (medical and dental Disabled) =	0.30%	Clinical workforce (medical and dental Disabled) =	0.21%		
2	Relative likelihood of Non-disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.24 Disabled: 0.18 Relative likelihood: 1.31		Non-disabled: 0.22 Disabled: 0.16 Relative likelihood: 1.41		The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2020/21	Data for previous year 2019/20	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-disabled staff. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled: 0.00 Non-disabled: 0.00 Relative likelihood: 6.16	Disabled: 0.00 Non-disabled: 0.00 Relative likelihood: 4.00	The numbers of staff entering the formal capability process are low, the relative likelihood of entering the formal capability process is nil for both Disabled and Non-Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Non-disabled: 22.5% Disabled: 29.6% (From Staff Survey December 2020)	Non-disabled: 23.9% Disabled: 27.0% (From Staff Survey December 2019)	The percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months.	Non-disabled:12.2% Disabled: 17.7% (From Staff Survey December 2020)	Non-disabled:11.9% Disabled: 20.0% (From Staff Survey December 2019)	The percentage of Disabled staff experiencing harassment, bullying or abuse from managers has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months.	Non-disabled: 18.8% Disabled: 30.9% (From Staff Survey December 2020)	Non-disabled: 17.8% Disabled: 29.7% (From Staff Survey December 2019)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from other colleagues has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they experienced harassment, bullying or abuse at work, they or a colleague	Non-disabled: 43.7% Disabled: 39.7% (From Staff Survey December 2020)	Non-disabled: 40.8% Disabled: 41.1% (From Staff Survey December 2019)	The percentage of Disabled staff reporting harassment, bullying or abuse at work has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2020/21	Data for previous year 2019/20	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	reported it in the last 12 months.				
5	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 87.1% Disabled: 82.0% (From Staff Survey December 2020)	Non-disabled: 89.2% Disabled: 79.4% (From Staff Survey December 2019)	The percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
6	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 24.9% Disabled: 31.3% (From Staff Survey December 2020)	Non-disabled: 21.8% Disabled: 29.2% (From Staff Survey December 2019)	The Percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has increased .	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 52.2% Disabled: 37.1% (From Staff Survey December 2020)	Non-disabled: 50.2% Disabled: 36.9% (From Staff Survey December 2019)	The percentage of Disabled staff saying they are satisfied with the extent to which their organisations values their work has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	81.4% (From Staff Survey December 2020)	74.3% (From Staff Survey December 2019)	The percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the overall score for the organisation.	Non-disabled staff: 7.2 Disabled: 6.7 Organisation: 7.1 (From Staff Survey December 2020)	Non-disabled staff: 7.1 Disabled: 6.6 Organisation: 7.0 (From Staff Survey December 2019)	The staff engagement score for Disabled staff continues to be lower than for Non-disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2020/21	Data for previous year 2019/20	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
9b	Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?	Yes	No	The Trust has developed an Enabled Staff Support Network and held a Network Conference. An in-depth survey has been completed and the analysis of the data has fed into the Trust's Action Plan.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	5.0%	-2.0%	Considering the percentage of staff who have self-reported as Non-disabled and the percentage of staff who have self-reported as Disabled the disaggregated percentage difference would be expected to be very low. The Trust acknowledges that, in respect of disability, the Board is not representative of the population it serves. Within Hull and East Riding the disabled population is 19%.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

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

During the pandemic Trust staff with underlying health conditions were advised to shield by the Government and therefore a significant number of the Trust's disabled staff were unable to undertake their roles within the hospital sites for prolonged periods of time.

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

The Draft WDES Action plan is attached.

				Snapshot of data as at 31st MARCH 2021						
				Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall
Metric	Indicator		Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/ Null	% Unknown/ Null	Total
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	**1a) Non Clinical Staff**								
		Under Band 1	Headcount	1	12.5%	7	87.5%	0	0.0%	8
		Bands 1	Headcount	1	2.4%	25	59.5%	16	38.1%	42
		Bands 2	Headcount	28	2.8%	663	65.1%	327	32.1%	1018
		Bands 3	Headcount	16	3.3%	299	62.2%	166	34.5%	481
		Bands 4	Headcount	6	3.2%	119	62.6%	65	34.2%	190
		Bands 5	Headcount	9	5.1%	117	66.1%	51	28.8%	177
		Bands 6	Headcount	1	1.0%	55	56.1%	42	42.9%	98
		Bands 7	Headcount	3	3.0%	68	68.0%	29	29.0%	100
		Bands 8a	Headcount	1	1.6%	34	54.0%	28	44.4%	63
		Bands 8b	Headcount	3	6.8%	16	36.4%	25	56.8%	44
		Bands 8c	Headcount	1	5.3%	9	47.4%	9	47.4%	19
		Bands 8d	Headcount	0	0.0%	5	62.5%	3	37.5%	8
		Bands 9	Headcount	0		0		0		0
		VSM	Headcount	1	3.7%	17	63.0%	9	33.3%	27
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0
		1b) Clinical Staff								
		Under Band 1	Headcount	4	5.71%	61	87.14%	5	7.14%	70
		Bands 1	Headcount	0	0.00%	4	66.67%	2	33.33%	6
		Bands 2	Headcount	32	2.28%	1011	72.01%	361	25.71%	1404
		Bands 3	Headcount	14	2.08%	431	64.04%	228	33.88%	673
		Bands 4	Headcount	16	5.11%	211	67.41%	86	27.48%	313
		Bands 5	Headcount	65	3.09%	1544	73.31%	497	23.60%	2106
		Bands 6	Headcount	31	2.88%	679	63.05%	367	34.08%	1077
		Bands 7	Headcount	14	2.11%	325	48.95%	325	48.95%	664
		Bands 8a	Headcount	4	2.40%	80	47.90%	83	49.70%	167
		Bands 8b	Headcount	0	0.00%	20	40.00%	30	60.00%	50
		Bands 8c	Headcount	0	0.00%	9	40.91%	13	59.09%	22
		Bands 8d	Headcount	0	0.00%	2	50.00%	2	50.00%	4
		Bands 9	Headcount	0	0.00%	0	0.00%	2	100.00%	2
		VSM	Headcount	0	0.00%	3	30.00%	7	70.00%	10
		Medical & Dental Staff, Consultants	Headcount	4	0.76%	331	63.29%	188	35.95%	523
		Medical & Dental Staff, Non-Consultants career grade	Headcount	1	1.37%	55	75.34%	17	23.29%	73
		Medical & Dental Staff, Medical and dental trainee grades	Headcount	26	3.18%	752	92.04%	39	4.77%	817
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** • By Voting membership of the Board • By Executive membership of the Board This is a snapshot as of at 31st March 2020.	Total Board members	Headcount	1	6.25%	0	0.00%	15	93.75%	16
		of which: Voting Board members	Headcount	1	7.69%	0	0.00%	12	92.31%	13
		: Non Voting Board members	Auto-Calculated	0	0.00%	0	0.00%	3	100.00%	3
		of which: Exec Board members	Headcount	1	12.50%	0	0.00%	7	87.50%	8
		: Non Executive Board members	Auto-Calculated	0	0.00%	0	0.00%	8	100.00%	8
		Difference (Total Board - Overall workforce)	Auto-Calculated		4%		-68%		64%	
		Difference (Voting membership - Overall Workforce)	Auto-Calculated		5%		-68%		63%	
		Difference (Executive membership - Overall Workforce)	Auto-Calculated		10%		-68%		58%	

Appendix 3

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN 2020/2021

The Action Plan has been developed, based on the 20/21 WDES technical data results, to help close the gaps in workplace experience between Disabled & Non-disabled staff.

Action	Metric	Delivery Timescale	Lead Responsibility
1. Development of a pathway to ensure disabled staff have an input into infrastructure and estate development and projects • Attendance of network members at future projects meeting to assist with consultation of accessibility considerations for new builds. • Attendance of Director of Estates, Facilities and Development at Enabled Staff Support Network meetings. • Ensure EF&D colleagues actively use the Equality Impact Assessment process as part of capital and estate development projects as well as when considering changes to services which directly impact on staff.	**9a**	**March 2022**	**Workforce & OD EDI Team**
2. Development of a secure support forum on Pattie (Trust intranet) • Creation of an administered secure online forum for disabled members of staff to use as a social networking space to post questions and ask for support and guidance. • Explore the creation of an administered 'questions area' for non-disabled members of staff on Pattie to offer guidance and support on disability issues.	**9a**	**March 2022**	**Workforce & OD EDI Team**
3. Development of a signposted area for disabled staff on Pattie containing information regarding career progression, accessibility assistance, information on Access to Work, educational tools and disability awareness information. • The online resource hub will support all HUTH staff and line managers. • Explore the possibility of developing the current wellbeing champions to incorporate disability awareness.	**9a, 7**	**March 2022**	**Workforce & OD EDI Team**
4. Review the reasonable adjustment process and raise awareness and knowledge • Develop a managerial education package and management clinics to offer support and guidance to managers in supporting and enabling their disabled staff members. • Update the existing reasonable adjustment process to make it more accessible to managers and staff with a disability.	**8, 6**	**February 2022**	**Workforce & OD EDI Team and Head of Workforce**

Action	Metric	Delivery Timescale	Lead Responsibility
5. Review existing recruitment process and raise awareness and knowledge • Support the development of the Diversity in recruitment Scheme by promoting the opportunity for disabled staff to become Diversity in Recruitment Specialists, • Continuation of the 'Disability Confident Scheme' to guarantee an interview for disabled applicants, who meet the shortlist criteria.	**2**	**October 2021**	**Workforce & OD EDI Team**
6. Continue to encourage staff to complete/update personal information details relating to disability on ESR, through increasing disability confidence • Emphasis on disability education to encourage the creation of a more disability confident culture within HUTH.	**All**	**March 2022**	**Workforce & OD EDI Team**
7. Continue to update disability awareness element of the Trust mandatory inclusion training • Creation of updated learning modules focusing on 'Disability awareness and inclusion' which will become an integral part of the Trust's revamped Equality, Diversity and Inclusion training. • Content of disability modules to be monitored to ensure that all the government and Trust policy information remains up to date.	**7, 9a**	**March 2022**	**Workforce & OD EDI Team**
8. Continue promotion of the Enabled Staff Support Network through disability confidence campaigns. • Promotion of the staff film created by Craig Lazenby in a targeted Trust wide disability awareness campaign	**7, 9a**	**March 2022**	**Workforce & OD EDI Team**
9. Develop a leadership programme to support leaders at all levels to develop their understanding and gain practical skills in relation to EDI • Programme to run alongside the update of the existing mandatory training package and will be specifically aimed at staff with a disability • Implementation of complimentary learning opportunities throughout the year including: 'Lunch and Learn@ session, which would provide short bursts of learning and development. • Promotion of existing leadership programmes targeted at the recruitment of staff with a disability.	**5, 7, 9a**	**March 2022**	**Workforce & OD EDI Team**

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item	8.5	**Meeting**	Trust Board	**Meeting Date**	14 September 2021
Title	Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH				
Lead Director	Dr Purva, Chief Medical Officer				
Author	Leah Coneyworth, Head of Effectiveness and Improvement				
Report previously considered by (date)	08 September 2021 at the Mortality and Morbidity Committee				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Trust Board is recommended to:

- Receive the final 'Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH' and to note the agreed improvement work and the improved HSMR status
- Receive the information from the Telstra Health UK review of the Trust's HSMR outlier status and receive assurance that it mostly supports the Trusts findings also
- Decide whether any further action is required aside from the Mortality Improvement steps as detailed in the Next Steps' section of the 'Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH' report

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
UNDERSTANDING AND IMPROVING HOSPITAL STANDARDISED MORTALITY RATIO (HSMR) AT HUTH

1. PURPOSE

The purpose of this report is to provide the Trust Board with the final report from the investigation into the Trust's HSMR outlier status and to provide assurance that the HSMR ratio is reducing and returning back within the control limits.

2. INTERNAL INVESTIGATION

In May and July 2021, the CQC highlighted that Hull University Teaching Hospitals NHS Trust was an outlier against HSMR (monthly) ratio and was rated as performing 'Much Worse' than the national average. A score over 100 is considered to exceed the "expected" mortality rate. The Trust has performed over the national average for 2018/19 and 2019/20.

CQC Insight Report – May and July 2021

Indicator	National Average	Previous Performance	Current Performance	National Comparison
Hospital Standardised Mortality Ratio (HSMR) Dr Foster - Dr Foster - HSMR (29 Mar 2021)	100.0	102.9 Oct 18 - Sep 19	109.5 Oct 19 - Sep 20	Much Worse

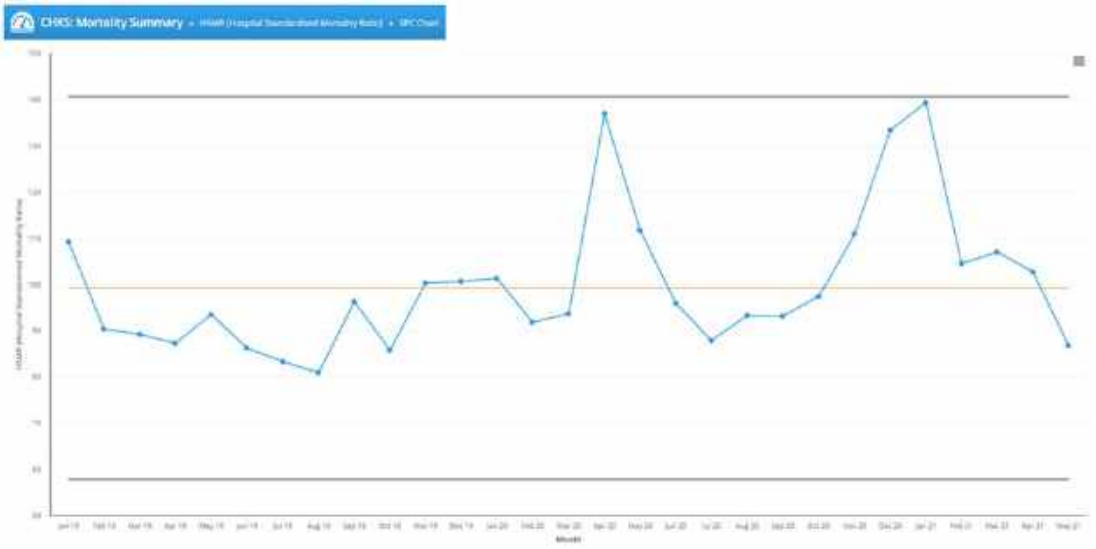
In response to this, the Chief Medical Officer established a Mortality and Morbidity Task and Finish Group to undertake some more in-depth mortality analysis work. The Task and Finish group was multidisciplinary and consisted of members from Hull University Teaching Hospitals NHS Trust and East Riding of Yorkshire CCG. It also pulled on all relevant expertise as the review evolved. The task and finish group analysed HSMR, weekend mortality, SHMI and undertook a case note review of deaths during the period leading to the outlier status.

It is the judgement of the Task and Finish Group that whilst the outlier status was a concern there has been no discernible drop in the standard of care provided by HUTH nor evidence to suggest failing standards by hospital staff.

The "increased" deaths" that were observed during the period of the outlier status happened in a number of different specialities and on a variety of (mostly COVID-19) wards under different specialist teams. They occurred, in the majority of circumstances in patients who were admitted with acute medical problems, mostly of infective origin and most obviously during the peaks of the COVID-19 pandemic. This reflects the nature of the patients presenting to our Emergency Department during the pandemic. The periods of concern highlighted by the HSMR data were during the peaks of the pandemic and there is evidence that this has not adequately been accounted for in the HSMR data. National adjustments to raw data to cleanse the consequences of COVID-19 are only partially effective and outside the peaks of the pandemic our HSMR rating does not trigger alerts.

There were no concerns raised from case note review other than the observation that the majority of patients whose notes were reviewed were highly unlikely to have survived whatever intervention had been offered and that the quality of care provided was considered generally good.

Early indicators suggest that our HSMR status is returning to more typical levels and have continued to decrease from March 2021 to July 2021 now being 80.6; within the Trust control limit and below the national average.



The task and finish group have identified a number of recommendations for improvement as detailed in the 'Next Steps' section of the report. The group will continue to meet to continually monitor HSMR and SHMI data on a monthly basis for at least the next year. The Task and Finish Group will also monitor the delivery and impact of the Mortality Improvement Plan.

The 'Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH' report is attached at Appendix A for information and assurance.

3. EXTERNAL SCRUTINY

As part of the investigation into the Trust's HSMR outlier status the Trust requested Telstra Health UK to undertake an external investigation into the increased HSMR for the same time period to seek external scrutiny to assist with our understanding of why this happened. The key objectives of this review was to:

1) How did the HSMR for Hull University Teaching Hospitals NHS Trust change over time?
2) Why did the HSMR for Hull University Teaching Hospitals NHS Trust change over time?
3) Are there changes that occurred at the Hull University Teaching Hospitals NHS Trust and nationally that could explain the changes in the HSMR?

The final report from this investigation was received on 07 September 2021 in line with the agreed timescales. A summary of this report is attached at Appendix B for information, which mostly supports the Trusts findings and that COVID-19 has been a significant contributory factor in the increased HSMR. This provides a good level of assurance to the Trust Board on how the Trust is managing and aiming to improve its HSMR.

4. RECOMMENDATIONS

The Trust Board is recommended to:

- Receive the final ‘Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH’ and to note the agreed improvement work and the improved HSMR status
- Receive the information from the Telstra Health UK review of the Trust’s HSMR outlier status and receive assurance that it mostly supports the Trusts findings also
- Decide whether any further action is required aside from the Mortality Improvement steps as detailed in the Next Steps’ section of the ‘Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH’ report

Leah Coneyworth
Head of Effectiveness and Improvement
September 2021

APPENDIX A

UNDERSTANDING AND IMPROVING HOSPITAL STANDARDISED MORTALITY RATIO (HSMR) AT HUTH

AUGUST 2021

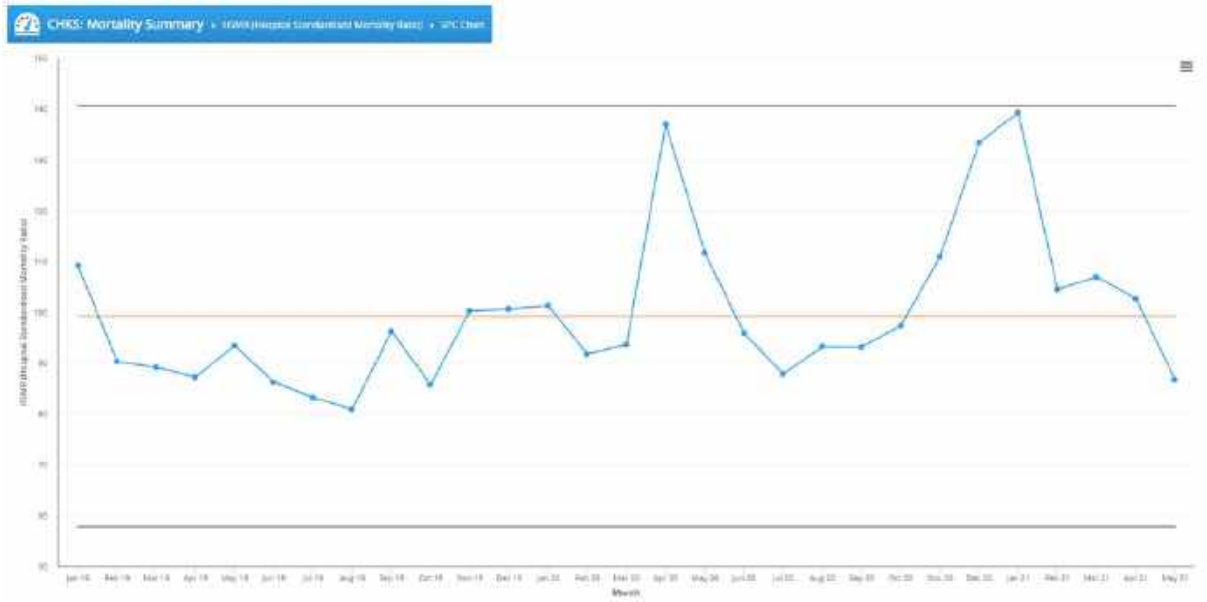
CONTENTS

EXECUTIVE SUMMARY

Hull University Teaching Hospitals NHS Trust (HUTH) has been identified as an outlier in its Hospital Standardised Mortality Ratio (HSMR) and also by a similar marker, the Standardised Hospital Mortality Index (SHMI) over a 12-month period during 2020 and 2021. This was a finding of concern and, in response to this, a Mortality and Morbidity Task and Finish Group was established to investigate possible explanations for these observations. The Group met weekly between June and August 2021, to examine Business Intelligence information and in parallel a case note review of a sample of patients who died was undertaken to identify trends and areas of improvement from learning.

It is the judgement of the Task and Finish Group that whilst the outlier status is a concern there has been no discernible drop in the standard of care provided by HUTH nor evidence to suggest failing standards by hospital staff.

For most of the 12 month period the data suggests that HUTH's clinical performance was in close alignment with comparator Trusts but for five months, (all of which correlated with the peaks of the waves of the COVID-19 pandemic), the Trust's performance appeared to fare less favourably. There is strong evidence that the effects of COVID-19 have not been fully cleansed from the data analysis and this has affected the data in both subtle and overt ways. At the time of presentation of this report the HSMR statistics have returned to levels within the Trust control limits and below the National Average, indicating that the Trust is no longer an outlier in comparison with other similar Trusts.



The Task and Finish Group are satisfied that the quality of the clinical coding provided by the clinical coding department is to a high standard but considers that there is room for improvement in the clinical record keeping upon which the coders rely on. Coders can only code on the basis of the information recorded in the clinical notes and frequently the record of most importance is the initial record on admission when, in the case of emergencies the diagnosis is still unclear to the admitting doctors. However, this situation might be similar in other Trusts (who share a similar Junior Doctor workforce) and so this alone cannot explain the differences.

During the months of most concern Hull experienced significantly high levels of COVID-19 and its population was particularly susceptible to the effects of this. Care of the COVID-19

patient, once diagnosed, was to a high standard but HUTH experienced a higher rate of nosocomial infections than its peers and the methodology used to “cleanse” the effects of COVID-19 from data analysis (by the National Team) will not have picked up most of this group of patients.

There is also evidence that during the peaks of the pandemic, emergency patients in Hull were in general, presenting later in the course of their disease than normal and this increased acuity is not recognised or compensated for in the HSMR methodology.

Further, Hull has higher levels of social deprivation than most of our peer group and the numbers of GP’s serving this population are chronically, and significantly, low by national standards. It is likely therefore, that there is a significant level of undiagnosed and untreated co-morbidities in our patient group which will chronically adversely impact HSMR figures.

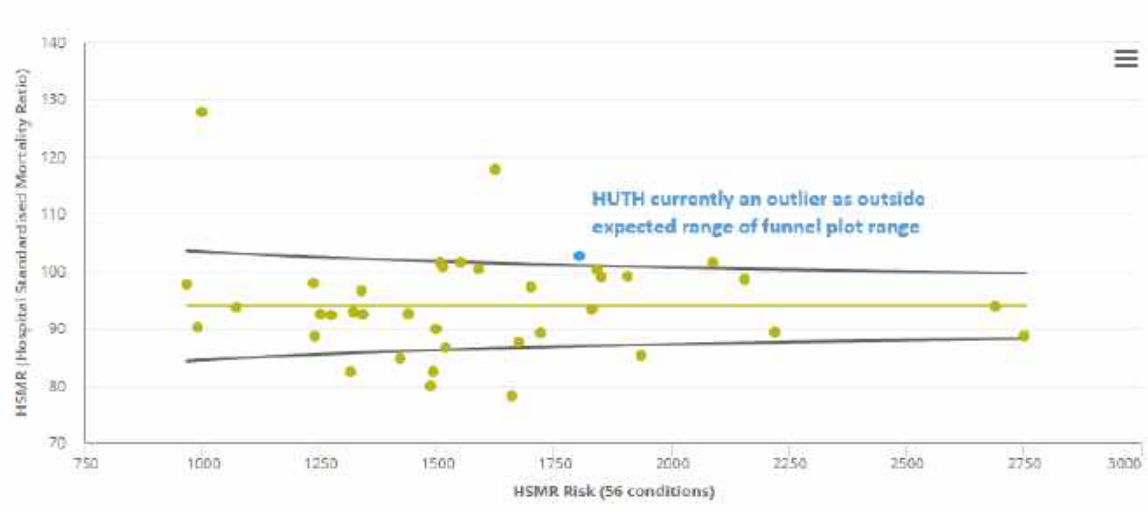
In normal times these challenges are managed and the HSMR is within the expected range. However, during the pandemic the HSMR rose, as alongside the expected challenges, the higher nosocomial COVID-19 infection rate (as occurred in HUTH during the second wave) tipped the HSMR into the outlier level that required investigation.

The findings of the Task and Finish group are presented but in addition to this an independent external report from the Dr Foster team has been commissioned for simultaneous presentation to the Board in September 2021.

1. BACKGROUND

Hospital Standardised Mortality Ratio (HSMR) is an indicator of hospital mortality developed by Dr Foster Intelligence (DFI). It is an indicator that measures whether the number of deaths in hospital is higher or lower than expected. It is a nationally benchmarked indicator, released on a monthly basis. Like all statistical indicators, it is not perfect, but can be both a measure of safe, high-quality care and a warning sign that things are going wrong. It is recognised that increased mortality, as measured by HSMR and SHMI, does not automatically imply that there were avoidable deaths but high figure should promote enquiry.

The HSMR data reflected has been collected over the last 12 to 18 months and there have been fluctuations but overall there has been a trend towards worsening data and this can no longer be assumed to be as a result of natural fluctuations. It therefore required in depth analysis. The funnel plot below (based on HSMR data) demonstrates our outlier status and that is unlikely to be the result of chance alone. The outlier status is also reported in the CQC Insights Report and is closely monitored by the CQC.



The CQC use Insight reporting to bring together the information they have gathered about Trust services using a number of indicators they monitor. This informs the CQC where Trusts are performing 'better than', 'same as' or 'worse than' nationally. This helps the CQC decide who, where and when to inspect. In May and July 2021, the CQC highlighted that Hull University Teaching Hospitals NHS Trust was an outlier against HSMR (monthly) ratio and was rated as performing 'Much Worse' than the national average. The Trust has performed over the national average for 2018/19 and 2019/20.

2. TASK AND FINISH GROUP

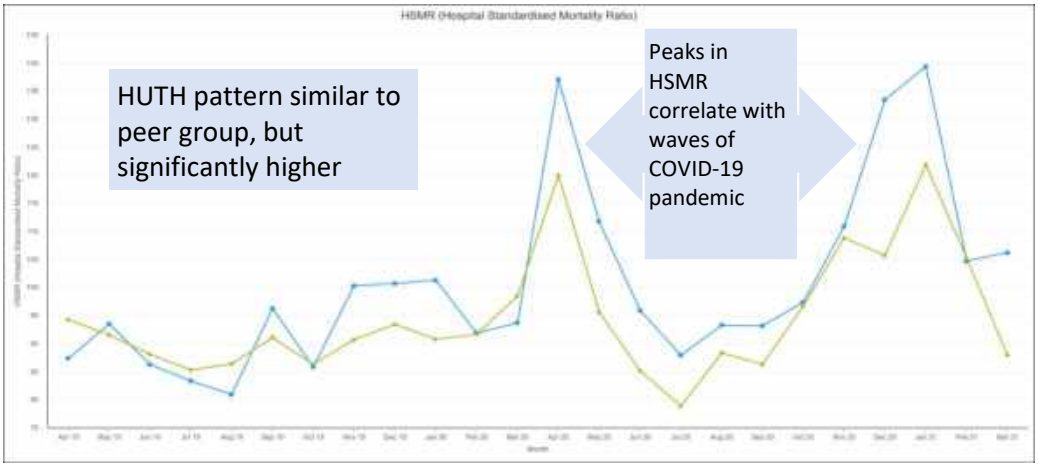
A Mortality and Morbidity Task and Finish Group chaired by the Deputy Chief Medical Officer with support from the Head of Effectiveness and Improvement was established in June 2021. The Task and Finish group was multidisciplinary and consisted of members from Hull University Teaching Hospitals NHS Trust and East Riding of Yorkshire CCG. It also pulled on all relevant expertise as the review evolved. The task and finish group analysed HSMR, weekend mortality and SHMI, reviewed a number of possible factors (Appendix B) and undertook a case note review of deaths during the period leading to the outlier status against the top clinical conditions (CCS) (Appendix C)

3. CAUSES OF INCREASED HSMR

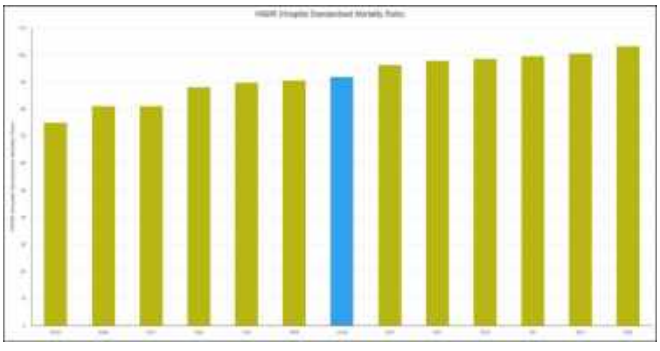
3.1 HUTH HSMR and Peer Group Comparison

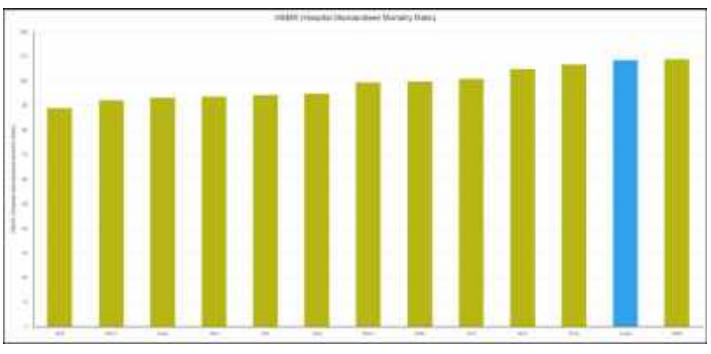
Chart 1 provides the Trust HSMR between April 2019 and March 2021 compared with the mortality peer group (Appendix A). It demonstrates, that the HSMR rate spiked in March and April 2020 and began to increase again from October 2020. This links with the data in the CQC Insight Report for the outlier status and correlates with the waves of the COVID-19 pandemic for 2020/21. All Trusts in the peer group had similar patterns, but not as significant as HUTH. Charts 2 and 3 demonstrate the changes to the Trust's HSMR position between 2019/20 and 2020/21 compared with the mortality peer group as a result of the pandemic.

Chart 1: Monthly Trend in HSMR April 2019 - March 2021 Compared to Mortality Peer Group



Charts 2 and 3: HUTH HSMR Position in 2019/20 and 2020/21 compared to Mortality Peer Group

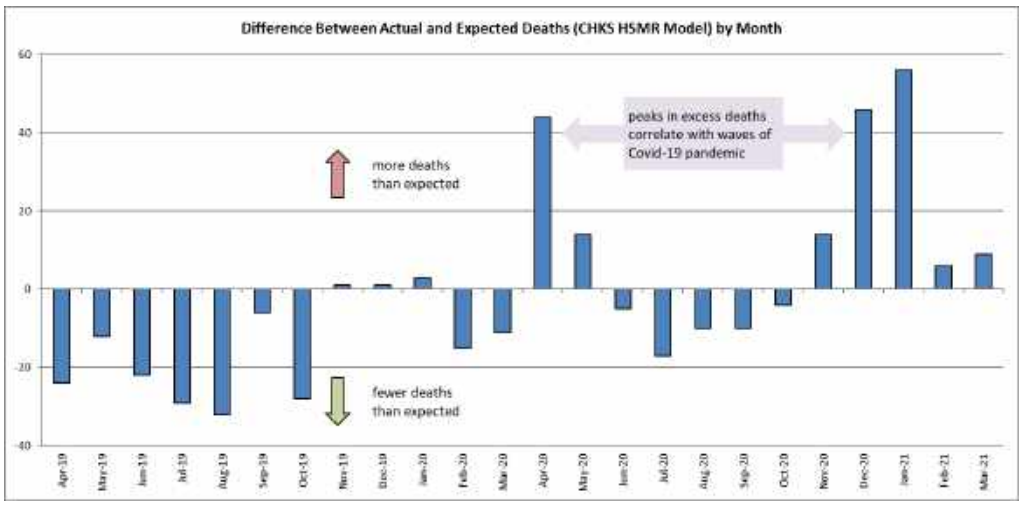




3.2 HSMR and Activity

Between April 2019 and March 2020, the Trust was mainly experiencing fewer than expected deaths. Chart 4 demonstrates, there was a significant spike in deaths in April and May 2020 and then again from November 2020, which correlate with the waves of the COVID-19 pandemic and with the increase in the HSMR ratio in the chart above.

Chart 4: Actual and Expected Deaths between April 2019 and March 2021



3.3 HSMR and COVID-19

3.3.1 Methodology

HSMR methodology was not designed to be used in a pandemic a number of corrections were made in the data at national level to compensate and allow for this. Initial analysis of our HSMR data showed that peaks in the number of excess deaths coincided with the 'waves' of the COVID-19 pandemic. It was suspected that the effects of COVID-19 had not been adequately corrected. A deeper dive into the methodology revealed that COVID-19 was only excluded from analysis if it was expressly documented in the first two episodes of care in a pateints pathway and was not excluded otherwise.

Analysis of HUTH data using the CHKS 'icompare' tool shows that of 1794 observed deaths included in the HSMR calculation for financial year 2020/21, 261 had been coded as having been diagnosed with COVID-19 at some point during their admission. A breakdown of COVID-19 deaths per the Trust's clinical conditions is attached at Appendix C. If the HSMR is re-calculated excluding **all spells** where a diagnosis of COVID-19 is coded as present at any point during the admission, the calculated ratio reduces to 95.59 (from 108.64) for the financial year.

3.3.2 Nosocomial Infections

To further understand hospital acquired infections in HUTH for this time period an internal investigation into the hospital onset, hospital acquired (HOHA) COVID-19 infection and mortality was undertaken in March 2021. This identified that:

- Between November 2020 and February 2021, 512 patients had tested positive for COVID-19 eight or more days into their inpatient stay.
- 358 probably and 154 definitely acquired this infection in the hospital environment.
- A quarter of these patients (132) died within 30 days of testing positive.
- Between November 2020 and February 2021 the Trust had high rates of HOHA (above national average) and this was associated with an increase in the Trust's mortality rate. It is difficult to determine to what extent the infection contributed towards each death, but it is likely that there was some contribution as shown in the table below.

Month	Probable HOHA 8-14 d		Definite HOHA >14 d		Total HOHA COVID-19		Mortality rate following HOHA
	Cases	Deaths	Cases	Deaths	Cases	Deaths	
Nov	42	11	20	9	62	20	32.3%
Dec	111	30	39	6	150	36	24.0%
Jan	154	36	65	13	219	49	22.4%
Feb	51	19*	30	8*	81	27*	33.3%*
Total	358	96*	154	36*	512	132*	25.8%*

* Data incomplete, figures may have increased from that period

As of March 2021, HUTH was identified as being among the 10 worst performing Trusts in the country regarding hospital acquired COVID-19 cases. Rates had increased from October 2020, peaking in late January 2021, and despite falling subsequently, the proportion of HOHA cases (compared to the total cases in the Trust) remained high. The pandemic offered many challenges to the Trust; during the autumn and winter surges in 2020 the Trust endeavoured to maintain as many normal services as it safely could, whilst balancing multiple, sometimes competing clinical priorities. Wards commonly ran at over 85% occupancy and emergency admissions continued at normal rates. A very noticeable split between which clinical areas had high rates of HOHA cases and those wards which did not was noted. In general, those wards with high turnovers or located in older estate fared less well than those newer wards which were well ventilated or lower turnover and thus better compliance with preadmission SARS Cov-2 screening.

Further, the Lead Medical Examiner (ME) also reviewed the deaths associated with COVID-19 to determine whether they had received the medical care in compliance with local and national guidance. 242 deaths within 30 days of COVID-19 infection between November 2020 and February 2021 were examined. 43% (104) were defined as probable or definite HOHA with the remaining 57% of in-hospital deaths were due to community-acquired infection. This sample reflects 79% of HOHA deaths during this period.

COVID-19 was considered the primary cause of death (listed in part 1 of the Medical Certificate for Cause of Death - MCCD) in 80% of these cases and a contributing factor in 17% cases. COVID-19 was not mentioned on the MCCD in seven cases who had been COVID-19 positive.

3.4 Deaths and Crude Mortality by COVID-19 and Non-COVID-19

Crude mortality is calculated as the number of deaths as a percentage of all discharges (excluding well babies).

Charts 5, 6 and 7 all demonstrate that the crude mortality rates are significantly impacted on by the waves in the COVID-19 pandemic and the increase in COVID-19 deaths. The number of Non-COVID-19 deaths did not increase during the period under consideration. The increase in crude mortality was due to deaths of COVID-19 positive patients and a decrease in activity (the denominator for the crude mortality rate) during the pandemic. The drop in activity levels was due to both a suspension of elective activity in the spring of 2020 and reduced non-elective demand (fewer emergency patients presenting to hospital).

Chart 5: Overall Deaths compared with the Crude Mortality Rates

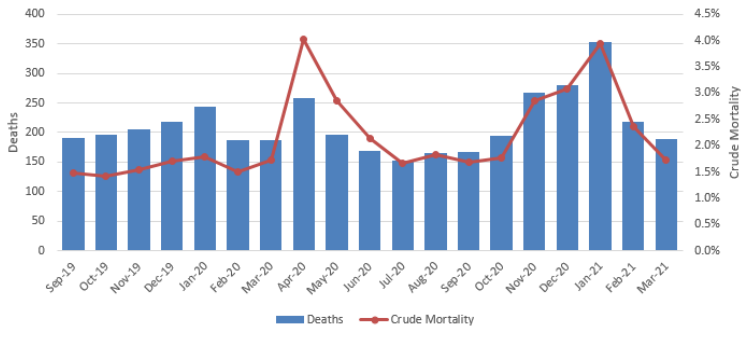


Chart 6: Deaths by COVID-19 and Non-COVID-19

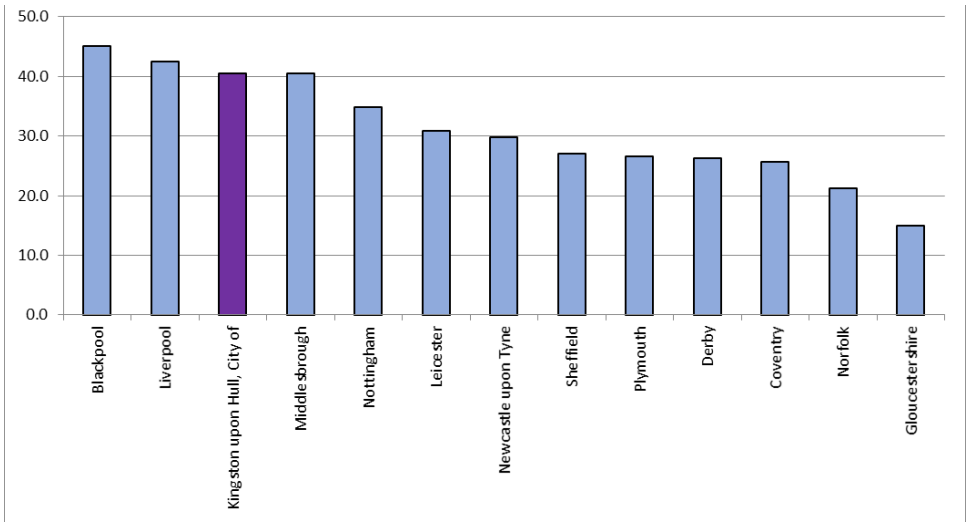
Chart 7: Crude Mortality by COVID-19 and Non-COVID-19

3.5 HSMR and Deprivation

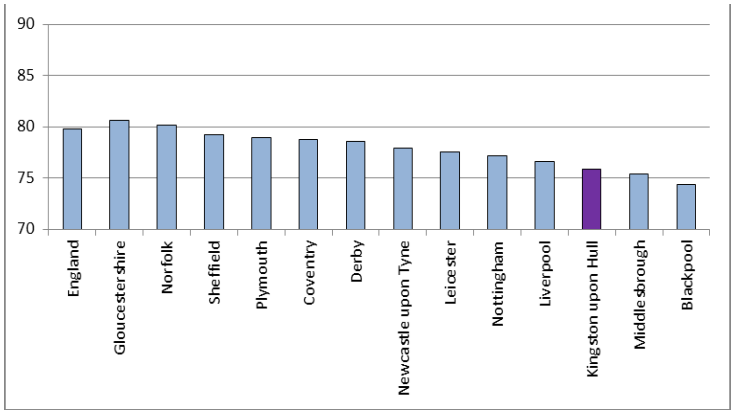
Researchers, as reported in the Lancet Regional Health-Europe, June 2021, found that nationally, during the pandemic three quarters of excess deaths during the pandemic were attributed to respiratory causes, (although not all were diagnosed as from the virus). Excess deaths were noted to be 'unequally distributed' regionally and socio-economically, with the highest rates of excess mortality were in the West Midlands, the North East and the North West. This observation is mirrored by the NHS Digital report on SHMI data between March 2020 and February 2021 as detailed on the map in section 5 of this report.

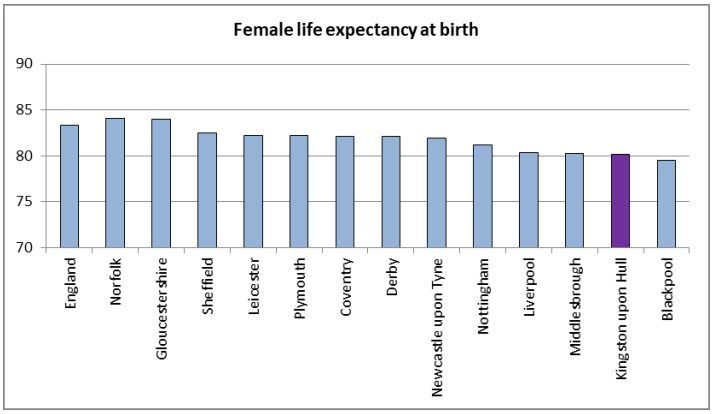
Hull is the 3rd most deprived local authority in England in 2017. The health of people in Hull is generally worse than the England average and life expectancy for both men and women is lower than the England average. 28% (14,300) of children in Hull live in low income families and the health and wellbeing of children is worse than the England average.

Chart 8: Multiple Deprivation Average Score 2019 by Local Authority



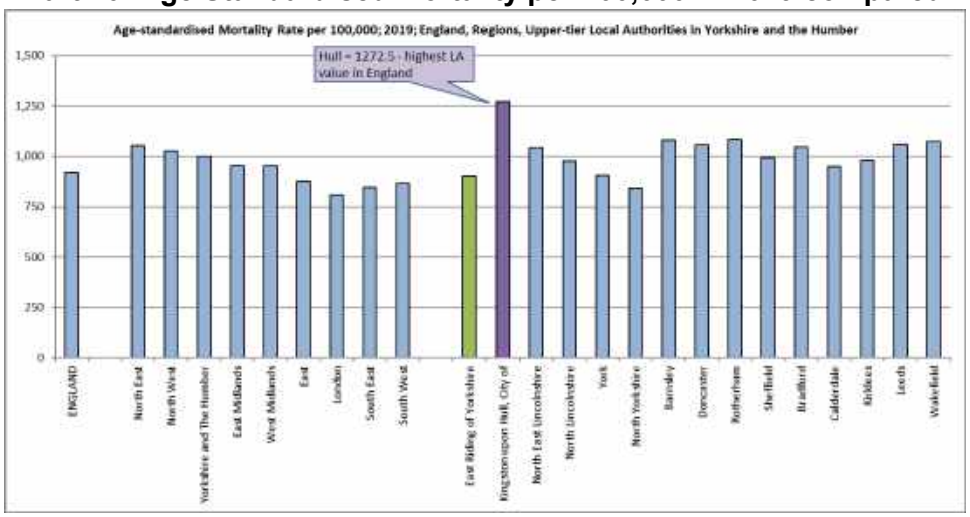
Charts 9: Male and Female Life Expectancy at Birth in Hull between 2017 and 2019





Life expectancy in Hull has remained static over the last decade unlike the national picture where life expectancy has risen progressively and the Age Standardised Mortality Rate (ASMR) is the highest of any upper-tier local authority in England.

Chart 10: Age Standardised Mortality per 100,000 in 2019 compared with peer group

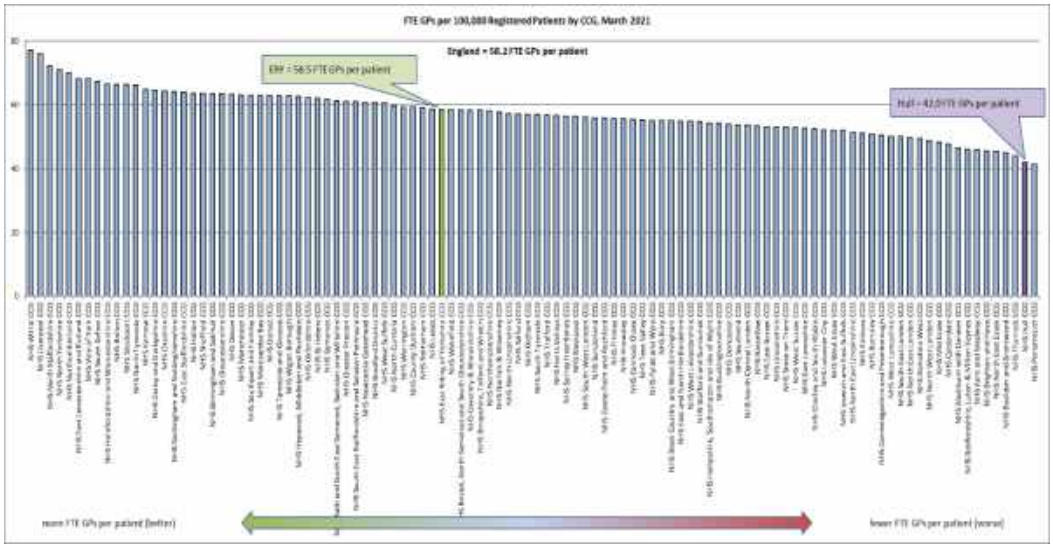


Compared to the national average we have a higher burden of admissions for arteriosclerotic disease (stroke, myocardial infarction) and a much higher burden of admissions for pulmonary disease. We have the second highest prevalence of smoking and smoking attributable conditions in the country (after Blackpool) and the highest number of emergency hospital admissions for Chronic Obstructive Pulmonary disease and smoking attributable mortality in England.

Under 75 mortality rates for Respiratory Disease, Cardiovascular Disease and Cancer, which are all already identified as the Trust's top presenting clinical conditions, are identified as those with excess deaths in the current HSMR analysis.

Access to primary care is likely to play a significant role in health care outcomes including mortality. It is therefore noteworthy reflect upon Hull Clinical Commissioning Group's (CCGs) longstanding status as the second most under General Practiced area in England. This is despite the best and sustained efforts of Hull's PCT and later CCG to attract GPs to the area. Hull has too few GPs and has had for over 25 years.

Chart 11: FTE GPs per 100,000 Registered Patients by CCG



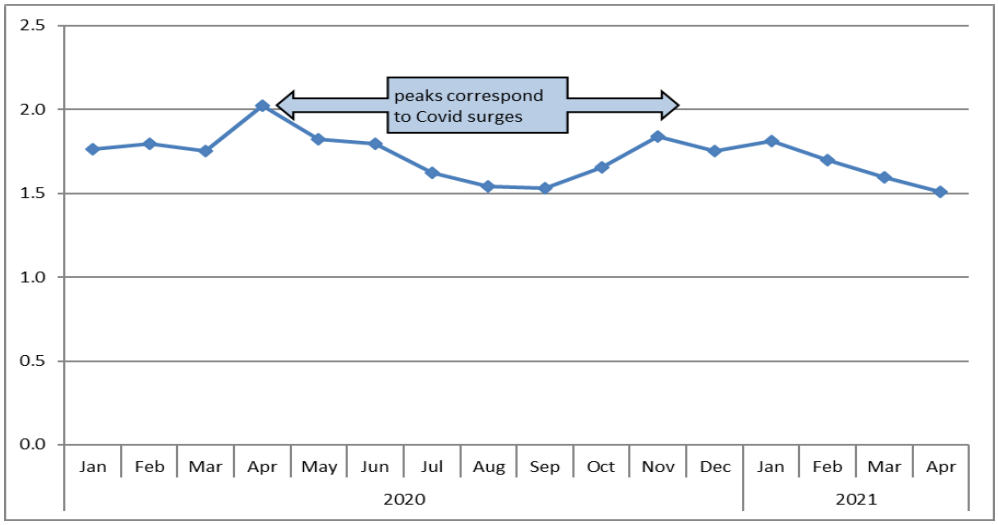
The expected implications of long term poor access to General Practice may include that disease is not diagnosed early or sometimes not diagnosed at all. Several markers (such as the high number of new diagnoses of cancer picked up through the Emergency Department may support this hypothesis. The shortage of numbers of General Practitioners in Hull is unfortunate, especially given that the City has one of the highest mortality rates in England.

It seems likely therefore, that Hull has a large burden of undiagnosed disease in the population. Patients attending hospital do so with undiagnosed conditions, which means that they are more complicated than they first appear and so are more likely to die. When not otherwise stressed HUTH copes with these unexpectedly complex cases. With COVID-19 as well, the system became overstressed. The need to treat COVID-19 was common to many Trusts across the country and HUTH performed well in this.

3.6 HSMR and NEWS Score

The review into the Trust's HSMR identified that during the pandemic patients appeared to be presenting to the Trust at a (sometimes much) later stage in their symptoms. In an attempt to demonstrate this objectively the task and finish group evaluated the NEWS (National Early Warning Score) score on attendance to the Emergency Department or admission. The chart below do not demonstrate unsafe or poor care provided by HUTH; however; it does show higher NEWS scores for the patients in the department on admission

Chart 12: Average NEWS Score on Attendance / Admission between January 2020 and April 2021



3.7 Sepsis and HSMR

Sepsis is defined as a life threatening organ dysfunction due to dysregulated host immune response to infection, which in severe infection kills patients, which also naturally has an impact of the Trust mortality.

The Consultant in Infectious Diseases presented to the Trust Mortality and Morbidity Committee in May 2021 against Sepsis and Mortality at HUTH. The presentation confirmed the mortality rate from all comers of Sepsis at HUTH, which demonstrates that between 23% and 28% of deaths at HUTH are as a result of Sepsis.

On review of the Sepsis cases within the Trust during 2020/21, the key points are summarised as follows:

- Majority of cases coming through the door in the last year with high NEW scores had COVID-19 pneumonia; however, some will have been coded as Sepsis and as a result of their condition, late attendance and high NEWS score had led to death. This outcome is already reflected in this report.
- Less patients overall attending the hospital with bacterial infections and traditional Sepsis increasing the apparent *rate* (as the denominator was lessened)
- Hull has areas of high deprivation and can be poorly served by primary care = patients present late with severe infection that is beyond salvage
- East Riding has a population with a slightly different demographic who also tend to present late for all things including infections
- In 2020 / 2021 we know that these problems were exacerbated by fear of COVID-19 and therefore even more people were presenting late

4. HSMR CASE NOTE REVIEW

In the period of April 2020 to March 2021 there were 143 excess deaths in the Trust above that which would be expected if the Trust had performed to an HSMR of 100.

Of the 55 clinical coding groups studied, as detailed in Appendix C, 31 had an HSMR of >100 and 24 had HSMR lower than 100. Nine clinical coding groups collectively had 151 “higher than anticipated deaths” (of a total of 929 deaths observed in these groups over the 12 month period) and were selected for the case note review.

CCS	Notes Reviewed	High	Likely	Probable	Possible	Unlikely	Highly Unlikely
Pneumonia							
Acute Bronchitis	41	0	0	1	0	7	23
Aspiration							
Cardiology	3	0	0	1	0	1	1
Sepsis	14	0	0	1	1	1	11
Head Injury	3	0	0	1	1	0	1
Renal	5	0	0	0	0	5	0
Stroke	8	0	0	0	1	2	5
Total	**74**	**0**	**0**	**4**	**3**	**16**	**41**

The key observations to note from this case note audit review are:

- There is no discernible evidence of a Cluster or a “Shipman” effect
- Overall there were no major failings of care identified
- In no cases reviewed was CPR recorded as having been performed. It would be the normal default position to begin CPR in patients who collapse suddenly or inexplicitly and

the absence of this therefore implies forewarning and fore planning for the Deaths investigated

- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) plans were completed in the vast majority of patients
- Five patients had COVID-19 as a significant diagnosis. The data is not therefore fully cleansed from the effects of COVID-19
- Patients appeared to be presenting at a later stage than might be expected. This was anecdotal and will not be reflected in the HSMR algorithm which does not categorise for severity of illness on arrival.
- Many patients (especially in the "sepsis" group) were considered to be in the process of dying on admission.
- Approximately 20 - 30% would have been re-categorised into a different coding group if a senior clinician had reviewed the primary coding analysis
- Of the (only) three patients who would have been considered likely to have survived their illness when admitted to hospital but who subsequently died; two were patients whose discharge was delayed and they subsequently acquired COVID-19 as a nosocomial infection. The third had a rare but recognised fatal complication from their presenting disease (a fatal bowel infarction whilst recovering from sepsis)

5. INCREASED HSMR (WEEKEND)

Weekend mortality increased from 102.4 in February 2021 to 159.1 in March 2021. The task and finish group examined mortality by day of admission and by day of death. In keeping with all NHS Trusts HSMR weekend mortality statistics rise by day of death but the reasons are multifactorial and depend on discharge possibilities for patients returning home with discharge packages or being admitted to residential homes etc. This work is ongoing but for the purpose of this report it is concluded that for the majority of weekend deaths are in line with the national average and was outside control limits in only one month from a continuous 24 month period.

Chart 13 shows that the actual deaths which occur throughout the week were relatively steady and chart 14 suggests the weekend effect is less pronounced in HUTH than in our peer group hospitals. Work is ongoing locally and nationally to try to understand the "weekend effect" and is respectfully deferred from further comment here.

Chart 13: Actual Deaths at HUTH on Weekends and Weekdays between April 2019 and May 2021

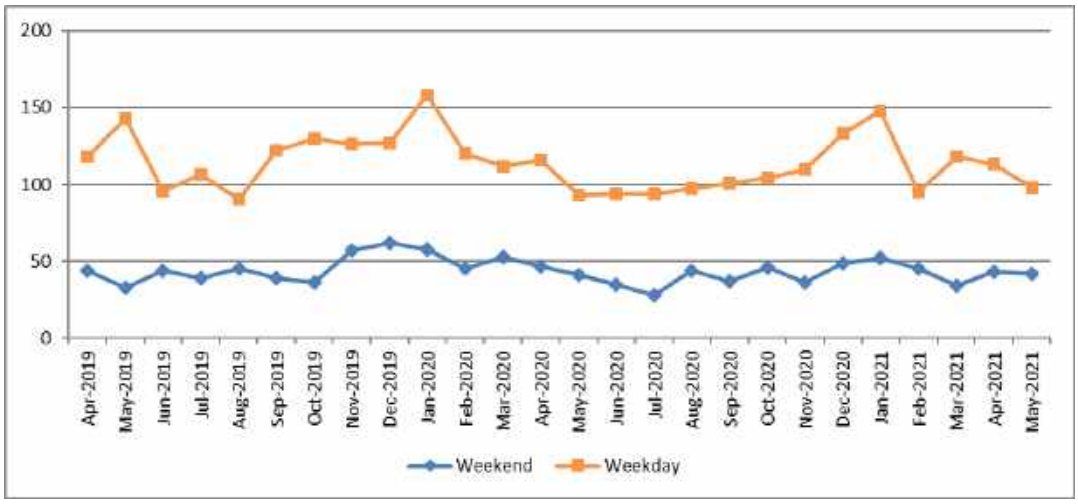
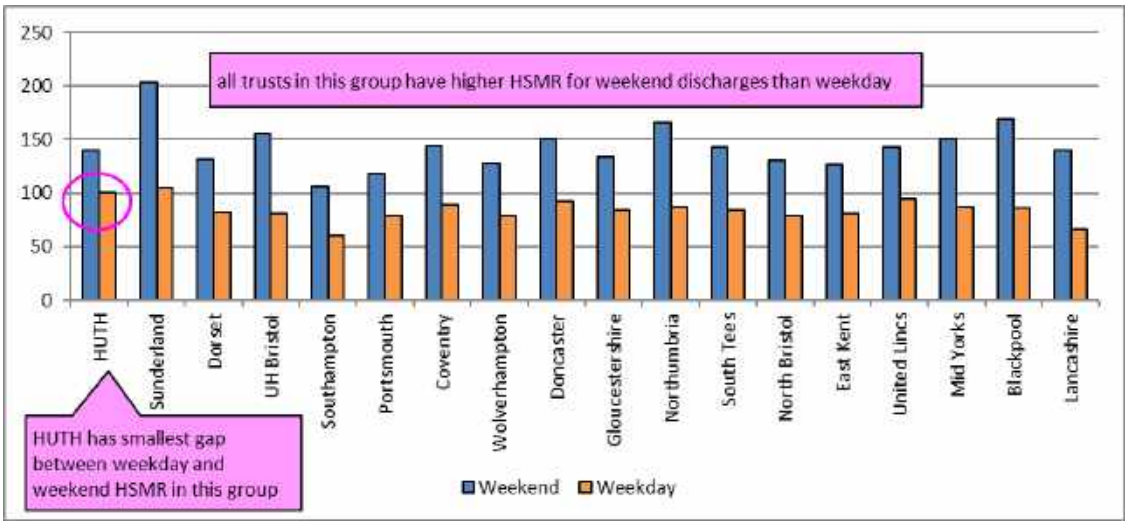


Chart 14: Weekend and Weekday HSMR for HUTH and Peers 2020/21



6. SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust and is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die Unlike HSMR it includes deaths in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline. Reporting is annualised (smoothed over a 12 month period to reduce peaks and troughs) and lags behing HSMR reporting.

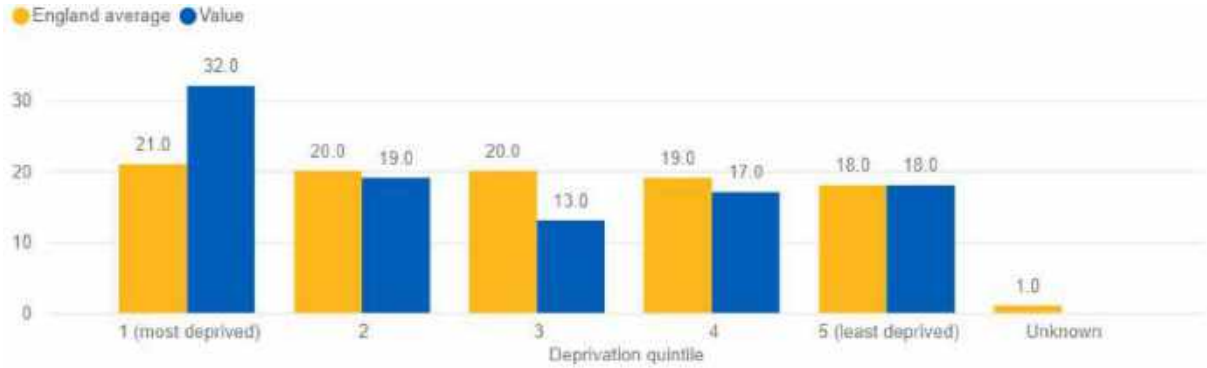
Chart 15: Public View HUTH SHMI Performance to March 2021

The SHMI chart from public view clearly also demonstrates that there is an increase which starts from April 2020 at the start of the pandemic. This will continue to be monitored by the Trust Mortality and Morbidity Committee.

The SHMI methodology does not make any adjustments for deprivation. This is because adjusting for deprivation might create the impression that a higher death rate for those who are more deprived is acceptable; however, it is a very clear indicator that areas of deprivation do have more deaths as demonstrated in the charts below for HUTH and there is no indication that the Trust is providing unsafe or poor care to patients.

Similarly to the HSMR the geographical distribution is also linked to deaths that are higher or lower than expected. The NHS Digital Summary Hospital-Level Mortality Indicator (SHMI) Report for England between February 2020 and January 2021 demonstrates that there are some regional patterns in the distribution of Trusts with SHMI values which are higher and lower than expected. In particular, the majority of Trusts with lower than expected SHMI are located in the south east of England as displayed in the map below (in light blue). NHS Digital have stated that further investigation is required to understand the reasons for this pattern; however, it does demonstrate that the Trusts with a higher than expected SHMI are mostly in the North (navy blue).

Chart 16: Percentage of deaths reported in the SHMI belonging to each deprivation quintile between February 2020 and January 2021



7. CONCLUSION

The primary driver for studying HSMR and hospital mortality figures is to identify poor care at an early stage and to improve this.

The accuracy, validity and meaning of HSMR and SHMI data is the subject of respectable challenge and is the best benchmark available and deserves analysis.

The Mortality and Morbidity Task and Finish Group have concluded and are very confident in several conclusions.

Firstly there is no evidence of nefarious behaviour. The “increased” deaths” that were observed during this period happened in a number of different specialities and on a variety of (mostly COVID-19) wards under different specialist teams. They occurred, in the majority of circumstances in patients who were admitted with acute medical problems, mostly of infective origin and most obviously during the peaks of the COVID-19 pandemic. This reflects the nature of the patients presenting to our Emergency Department during the pandemic.

The periods of concern highlighted by the HSMR data were during the peaks of the pandemic and these is evidence that this has not adequately been accounted for.

Hull had a problematic period of nosocomial infection during the peak pandemic and this is highly relevant to the analysis. This is covered in more detail in a separate report.

National adjustments to raw data to cleanse the consequences of COVID-19 are only partially effective and outside the peaks of the pandemic our HSMR rating does not trigger alerts.

Early indicators suggest that our HSMR status is returning to more typical levels and have continued to decrease from March 2021 to July 2021 now being 80.6; within the Trust control limit and below the national average.

There were no concerns raised from case note review other than the observation that the majority of patients whose notes were reviewed were highly unlikely to have survived whatever intervention had been offered and that the quality of care provided was considered generally good.

There have been no anecdotal concerns raised or challenges voiced about the overall quality of care provided during this period of extreme stress and there is no evidence of unsafe or poor care to our patients during this time. Complaints have not risen nor have there been concerns raised by the Medical Examiner or Coroner about deteriorating standards of care.

The pandemic has stressed the system in an unprecedented way and many centres have seen similar patterns in their HSMR data. The problems in Hull are compounded by an already overstressed system with high indices of social deprivation, high smoking rates and a chronically understaffed community healthcare system. Patients presented late in their illness when options were much more limited.

8. NEXT STEPS

- We propose to maintain the Task and Finish group membership to continually monitor HSMR and SHMI data on a monthly basis for at least the next year. The Task and Finish Group will also monitor the delivery and impact of the Mortality Improvement Plan
- An independent analysis of the available data has been commissioned from the healthcare analytic group Dr Foster. This is in progress and will be available at the time of presentation of this paper to the Trust Board in September 2021 and the Mortality and Morbidity Committee in October 2021. Any recommendations from this report will be added to the Mortality Improvement Plan.
- There will be ongoing and increasing scrutiny of all in-hospital deaths at HUTH bolstered by an expansion of the Medical Examiner Office

- Improve the Stroke 30-day Mortality following on from the Sentinel Stroke National Audit Programme (SSNAP)
- Implement methodologies to improve the accuracy of the information available to coders and implementing sustainable processes to facilitate this especially in acute medical care. This will include
    - Providing dedicated time within job plans for consultants to undertake timely case note review in collaboration with the coding team and junior doctors
    - Ensuring accurate clinical diagnosis
    - Train and support clinical leads and quality colleagues in the SJR process and learning from deaths
    - Identification and monitoring of any other mortality markers to align with the Mortality Improvement Plan and to help identify any quality issues that require further attention
- Restore an education process for the junior doctors highlighting the importance and significance of coding and their influence on this
- Undertake an improvement project with NHSEI regarding Sepsis mortality, identify improvement actions and learn lessons

APPENDICES

Appendix A – Mortality Peer Group
Appendix B – Potential explanations for increased HSMR
Appendix C - HSMR Relevant Deaths with COVID-19
Appendix D – Clinical Coding Information

The Mortality and Morbidity Task and Finish Group
August 2021

APPENDIX A - MORTALITY PEER GROUP

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHSFT

UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST

APPENDIX B - POTENTIAL EXPLANATIONS FOR INCREASED HSMR

Possible explanations include:

Higher than anticipated numbers of actual deaths: possible explanations for further consideration and analysis:

Possible Explanations	Considered and referenced in the report
Poorer care of COVID-19 patients in hospital	✓
Higher rates of hospital acquired COVID-19 infection in higher risk groups	✓
Poorer care of Non-COVID-19 patients in hospital	✓
Delays in the treatment of Non-COVID-19 disease	✓
Poorer care of COVID-19 patients in the community	✓
Poorer care of Non-COVID-19 patients in the community	✓
Later presentation or referral of COVID-19 disease to hospital	✓
Later presentation or referral of Non-COVID-19 disease to hospital	✓
Higher admissions of terminally ill patients	✓
Lower discharges of terminally ill patients	✓

Lower expected deaths: possible explanations for further consideration and analysis:

Possible Explanations	Considered and referenced in the report
Imperfect baseline model for estimation of mortality in the local population	✓
Local population more vulnerable to COVID-19 related mortality	✓
Local population more vulnerable to reduction in healthcare for Non-COVID-19 conditions	✓
Lower depth of coding	✓
Greater management of lower risk patients as outpatients during pandemic	×
Greater impact of pandemic on planned admissions	✓

APPENDIX C - HSMR RELEVANT DEATHS WITH COVID-19

CCS Condition	Deaths Observed	Expected Deaths	HUTH Value	Alert	Excess Deaths	Deaths Covid+	% Deaths Covid+
HSMR (Hospital Standardised Mortality Ratio)	**1794**	**1651.0**	**108.64**	**Red**	**143.0**	**261**	**14.5%**
2 - Septicemia (except in labor)	143	93.0	153.56	Red	50.0	12	8.4%
122 - Pneumonia (except that caused by tuberculosis or sex	261	233.0	112.24	Amber	28.0	20	7.7%
109 - Acute cerebrovascular disease	175	159.0	110.05	Amber	16.0	17	9.7%
157 - Acute and unspecified renal failure	92	78.0	117.25	Amber	14.0	27	29.3%
159 - Urinary tract infections	41	29.0	141.40	Amber	12.0	17	41.5%
233 - Intracranial injury	45	33.0	135.99	Amber	12.0	6	13.3%
108 - Congestive heart failure; nonhypertensive	83	72.0	114.54	Amber	11.0	21	25.3%
129 - Aspiration pneumonitis; food/vomitus	69	58.0	118.02	Amber	11.0	6	8.7%
125 - Acute bronchitis	20	13.3	150.35	Amber	6.7	5	25.0%
38 - Non-Hodgkin`s lymphoma	24	17.5	136.79	Amber	6.5	3	12.5%
145 - Intestinal obstruction without hernia	27	21.6	124.82	Amber	5.4	4	14.8%
101 - Coronary atherosclerosis and other heart disease	21	16.2	129.75	-	4.8	4	19.0%
199 - Chronic ulcer of skin	11	6.2	176.26	Amber	4.8	2	18.2%
197 - Skin and subcutaneous tissue infections	21	16.9	124.21	-	4.1	9	42.9%
127 - Chronic obstructive pulmonary disease and bronchiect	47	43.0	108.85	Amber	4.0	7	14.9%
68 - Senility and organic mental disorders	19	15.4	123.68	Amber	3.6	10	52.6%
149 - Biliary tract disease	18	14.7	122.37	-	3.3	5	27.8%
151 - Other liver diseases	20	16.7	119.88	Amber	3.3	2	10.0%
17 - Cancer of pancreas	25	21.8	114.78	Amber	3.2	1	4.0%
32 - Cancer of bladder	10	7.0	143.21	Amber	3.0		0.0%
115 - Aortic; peripheral; and visceral artery aneurysms	28	25.0	112.04	-	3.0	1	3.6%
155 - Other gastrointestinal disorders	27	24.0	112.60	-	3.0	3	11.1%
153 - Gastrointestinal hemorrhage	33	30.2	109.39	Amber	2.8	6	18.2%
14 - Cancer of colon	18	15.5	116.45	Amber	2.5		0.0%
15 - Cancer of rectum and anus	10	8.1	123.44	Amber	1.9	2	20.0%
117 - Other circulatory disease	10	8.2	121.53	Amber	1.8	4	40.0%
231 - Other fractures	18	16.2	111.07	-	1.8	2	11.1%
245 - Syncope	3	1.4	216.48	Amber	1.6	1	33.3%
27 - Cancer of ovary	6	4.8	125.72	Amber	1.2		0.0%
24 - Cancer of breast	5	3.9	127.92	Amber	1.1		0.0%
133 - Other lower respiratory disease	6	5.4	111.34	Amber	0.6		0.0%
134 - Other upper respiratory disease	2	1.7	120.29	-	0.3	1	50.0%
13 - Cancer of stomach	9	8.8	102.51	-	0.2	3	33.3%
19 - Cancer of bronchus; lung	51	51.0	99.89	Amber	0.0	3	5.9%
158 - Chronic renal failure	3	3.1	96.01	Amber	-0.1		0.0%
29 - Cancer of prostate	9	9.3	96.39	-	-0.3		0.0%
55 - Fluid and electrolyte disorders	20	20.3	98.42	-	-0.3	5	25.0%
103 - Pulmonary heart disease	18	18.3	98.42	-	-0.3	3	16.7%
12 - Cancer of esophagus	15	15.5	96.54	Amber	-0.5	1	6.7%
237 - Complication of device; implant or graft	10	10.7	93.08	-	-0.7	3	30.0%
107 - Cardiac arrest and ventricular fibrillation	27	27.8	97.22	-	-0.8	2	7.4%
131 - Respiratory failure; insufficiency; arrest (adult)	6	7.1	84.85	-	-1.1	1	16.7%
106 - Cardiac dysrhythmias	10	11.2	88.99	-	-1.2	2	20.0%
148 - Peritonitis and intestinal abscess	2	3.2	62.99	-	-1.2		0.0%
150 - Liver disease; alcohol-related	22	24.8	88.72	-	-2.8	4	18.2%
43 - Malignant neoplasm without specification of site	12	15.4	77.96	-	-3.4	2	16.7%
226 - Fracture of neck of femur (hip)	34	38.0	89.29	-	-4.0	9	26.5%
39 - Leukemias	13	18.4	70.53	-	-5.4		0.0%
130 - Pleurisy; pneumothorax; pulmonary collapse	16	21.4	74.89	-	-5.4	2	12.5%
59 - Deficiency and other anemia	10	16.6	60.27	-	-6.6	3	30.0%
114 - Peripheral and visceral atherosclerosis	39	47.0	83.39	-	-8.0	8	20.5%
224 - Other perinatal conditions	15	23.8	63.00	-	-8.8		0.0%
100 - Acute myocardial infarction	62	73.0	84.85	-	-11.0	4	6.5%
42 - Secondary malignancies	53	71.0	75.00	-	-18.0	8	15.1%

APPENDIX D – CLINICAL CODING INFORMATION

The Clinical Coding Department at Hull University Teaching Hospitals NHS Trust (HUTH) is responsible for coding all admitted hospital provider spells. A spell is the total continuous stay of a patient from admission to discharge, typically spells are broken down into periods of time in the continuous care of one consultant, known as Finished Consultant Episodes or FCEs.

During the review period, 2020/21, the Trust had 138,659 FCEs. This was a drop compared with the previous financial year by 25.6% (source CHKS).

The Coding Department begins the coding process once the patient is discharged, depending on the date of discharge and the availability of documentation the coding will be completed between 1 day and up to a maximum of 8 weeks following discharge.
In accordance with national coding standards the coded record is completed episodically, meaning only conditions treated or investigated during the relevant FCE are coded. A condition may arise in patients 4th FCE, for example, and continue to be treated until the patient is discharged. This condition will only be coded in episode 4 and any subsequent episodes, and not in episodes 1 to 3.

To provide as complete an accurate coded record the coders look at a variety of information sources. Case notes are the primary information source for most admitted patient care; the exceptions are Endoscopy, Maternity and Acute Assessment wards, which are coded exclusively from electronic sources. For all other areas coders will routinely review any letters and doctors written notes relevant to the current admission. The Trust's PAS is used to support the case notes and the coders will access operation notes, clinic letters, referral letters, histology results and any other relevant documentation.

National Clinical Coding Standards ICD10 2021 p5
Hospital provider spell and consultant episode
A clinical coder must assign ICD-10 codes to the diagnoses recorded in the medical record for each consultant episode (hospital provider) within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (which includes day cases).
A hospital provider spell may contain a number of consultant episodes (hospital provider) and the definitions for these terms are found in the NHS Data Model and Dictionary at: http://www.datadictionary.nhs.uk/

The NHS Data Model and Dictionary is the source for assured information standards to support health care activities within the NHS in England. It is aimed at everyone who is actively involved in the collection of data and the management of information in the NHS. The concept of a finished consultant episode, commonly abbreviated to "FCE" is widely used in the NHS and has been used in previous clinical coding guidance.

See the NHS Data Model and Dictionary frequently asked questions for more information at: https://webarchive.nationalarchives.gov.uk/20160921150518/http://systems.digital.nhs.uk/data/nhsdmds/faqs

National Clinical Coding Standards ICD10 2021 p9
Coding uniformity
Uniformity means that whenever a given condition or reason for a consultant episode is coded, the same code is always used to represent that condition or reason for the encounter.

Uniformity is essential if the information is to be useful and comparable. General rules for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient's condition during the consultant episode.
- Code every condition or reason for encounter which affects the care, or influences health status, during the consultant episode, which is available in the classification and supported by the medical record.
- Code each problem to the furthest level of specificity, i.e. third, fourth or fifth
- Character, which is available in the classification and supported by the medical record.
- Do not code background information or chronic problems which are no longer active and which do not influence the health care being provided in the relevant consultant episode. It is not always intended that symptoms or history be coded. Just because a condition can be coded does not mean it should be coded each time the patient is admitted. Any uncertainty around issues of relevance or inactive problems should be discussed with the responsible consultant.

APPENDIX B

SUMMARY OF THE TELSTRA HEALTH UK REVIEW OF THE TRUST HSMR OUTLIER STATUS

1. BACKGROUND

Hull University Teaching Hospitals NHS Trust contacted Telstra Health UK as they have seen an increase in their HSMR over the last year and wanted to obtain a better understanding of why this has happened. In order to do this Telstra Health UK have put together this report to investigate and analyse recent changes at the trust in comparison to a select peer group as well as a comparison to the national picture.

The key objectives agreed for the external review were to address the following three questions:

1) How did the HSMR for Hull University Teaching Hospitals NHS Trust change over time?
2) Why did the HSMR for Hull University Teaching Hospitals NHS Trust change over time?
3) Are there changes that occurred at the Hull University Teaching Hospitals NHS Trust and nationally that could explain the changes in the HSMR?

To do this the investigation looked at changes in the HSMR over the time period (April 2019 to March 2021), reviewing observed and expected deaths against spells and the impact the COVID-19 pandemic had on these. It then looked at changes in the parameters contributing to the HSMR over time this included admission profiles, deprivation, emergency admissions, end of life coding and comorbidity profiles including the average Charlson scores. Finally, it analysed the coding at HUTH compared with the peer group, which was also used as part of the internal investigation by the Task and Finish Group. The final report was received and is broken down into these sections.

2. EXECUTIVE SUMMARY

Section 1: Changes in the HSMR

This section investigated how the HSMR and SMR at Hull University Teaching Hospitals NHS Trust has changed over time. Spell volumes dropped at the trust from April 2020 and have only returned to pre-pandemic levels in March 2021. Even when spells with a secondary diagnosis of Covid were removed, spell volumes were still reduced from April 2020. The observed mortality rate was much higher than expected, with peaks in April 2020 and January 2021. Until April 2020 the observed mortality rate was similar to the expected rate but from April 2020 it has been consistently higher than expected. The observed mortality rate peaked in April 2020 but the peak in observed mortality that happened between November 2020 and January 2021 was not seen when secondary Covid spells were removed.

Finally, the HSMR was within the expected range between April 2019 and March 2020, however it was significantly higher than expected in April and May 2020 and November 2020 to January 2021. The HSMR has returned to expected levels from February 2021. With Covid spells removed, the HSMR still peaks to be significantly higher than expected in April 2020 however it then remains similar to expected for the rest of the time period.

Section 2: Changes to the HSMR casemix variables

Casemix analysis showed that most casemix variables remained similar over the two-year time period. The trust does serve a more deprived patient casemix compared to the peer group and nationally, with the trust having the highest proportion of most deprived patients.

There was a sudden increase in observed deaths for the most deprived patients in April and May 2020 and again in January 2021. This also corresponded to a significant increase in relative risk for those patients in those months.

Over the two-year period, the average Charlson score has increased, with a jump in score seen in April and May 2020. During the time period assessed, the average Charlson score for the trust was consistently higher than the peer group and national scores.

We also investigate different diagnosis groups that were seeing a significant increase in relative risk during the pandemic. Pneumonia was one of the diagnosis groups investigated and saw increases in relative risk during the same time as the trust saw an overall increase in the HSMR.

Section 3: Depth of coding analysis
The depth of coding analysis shows that the trust has a lower proportion of spells with an invalid age or sex code and a lower proportion of spells with a primary diagnosis of a sign or symptom compared to the peer group. The trust did have a higher average number of secondary diagnoses, but this could be due to the trust being better at recording and coding secondary diagnosis compared to the peer group.

3. CONCLUSIONS

The HSMR for Hull University Teaching Hospitals NHS trust was above expected in April and May 2020 and again between November 2020 and January 2021. These peaks occurred during the first and second wave of the pandemic and are most likely attributed to the pandemic. Spell volumes dropped during this time period and observed death rates spiked much higher than expected. The 12-month rolling HSMR has increased over time, with the increases most likely driven by the spikes in the monthly HSMR values.
The HSMR was also calculated with the spells with covid as a secondary diagnosis removed. The peak in relative risk was still seen in April 2020, however the second peak was not observed, with the relative risk remaining within an expected range from May 2020 onwards.

A depth of coding analysis showed that the trust's coding is of a high quality. The trust had a lower proportion of spells with invalid age or sex coding as well as coding a lower proportion of spells with a sign or symptom as the primary diagnosis. The trust recorded a higher average number of secondary diagnoses, which likely reflects coding quality rather than case mix factors and is reflected in the higher Charlson score seen at the trust.

The trust has seen an increase in patients with higher Charlson scores during the pandemic and the increase in treating more seriously ill patients has led to a change in the patients seen during the pandemic which may affect the HSMR. The diagnosis groups investigated showed how these could be impacting the HSMR, with the groups observing increases in relative risk during the pandemic. Even with Covid spells removed, these groups still observed increases in relative risk during the pandemic. These diagnosis groups could be areas for further investigation.

Overall, the HSMR has been impacted by the pandemic. The two peaks in observed deaths between April and May 2020 and again between November 2020 and January 2021 are likely to be the main cause of the monthly HSMR increase. Removing the spells with a secondary diagnosis of Covid removes the second peak in the observed deaths as well as the second peak in the HSMR which indicates that Covid was a significant contributory factor in the elevated risks seen during those months. The first peak may also be driven by Covid, but with limited coding and testing of patients at the start of the pandemic, it may not be obvious within the data that this was the case. We would recommend further investigation into deaths occurring during the first peak of the pandemic to unpick the increase in observed deaths.

QUALITY REPORT

LEAD: Beverley Geary, Chief Nurse

PURPOSE OF THE REPORT

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

ITEMS FOR ESCALATION IN MONTH (July 2021)

Safe:

- The Trust has had no apportioned MRSA bacteraemia cases reported for July 2021. There have been 8 MSSA bacteraemia cases reported, 9 Trust apportioned C.difficile and 2 Community apportioned cases and 9 E.coli bacteraemia cases in month. In addition, 3 Klebsiella bacteraemia cases and 1 pseudomonas aeruginosa bacteraemia cases reported in month. There has been 1 outbreak of diarrhoea and vomiting. 474 patients screened positive for Covid-19 in month.
- 14 Serious Incidents and 1 Never Event declared.
- Patient Incident numbers have shown a decrease from last month and remain within control limits.
- The total number of falls per 1000 bed days has shown another decrease, severity of harm caused by these falls has also reduced.
- Pressure damage has decreased across all categories in July 2021. However, Category 2 Pressure Ulcers has seen 68% increase since March 2021.

Effective:

- No areas for upward escalation

Caring

- The Trust has received 61 complaints in July 2021. 32 complaints closed in June 2021, 14 (73.6%) were closed within 40 working days.
  84 contacts were made with the PALs team in July 2021.

Responsive:

- No areas for upward escalation

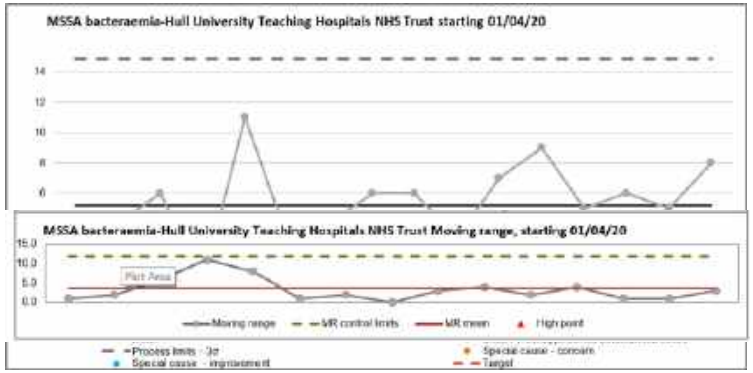
Well-led:

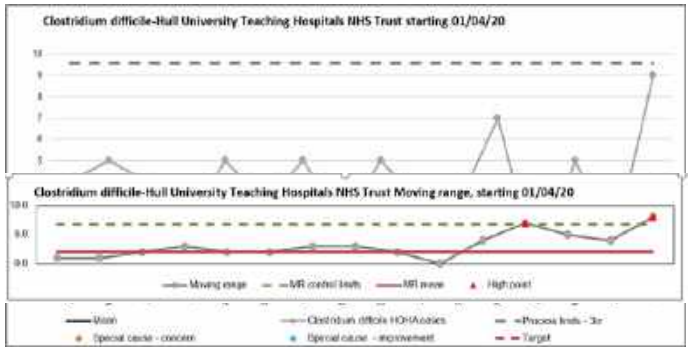
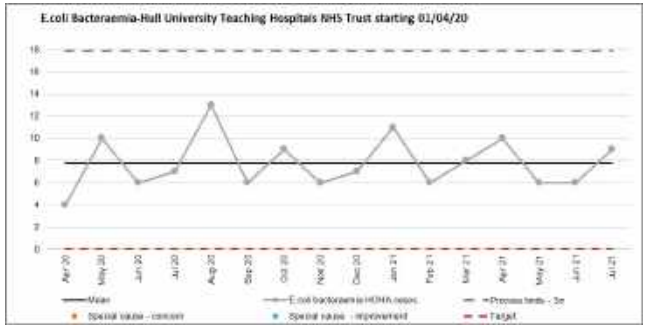
- Trust has received two whistleblowing concerns that have been reported to the CQC. The Trust has provided a full response.
- The Trust is undertaking a number of learning from others gap analysis reviews in some key areas for assurance and to inform any relevant improvement plans. The areas currently under review are Maternity in response to Ockenden, Children and Young People and Emergency Care in response to mental health and Medical Care in response to falls.
- A Trust level well-led self-assessment is in progress and will be presented to the Board Development Session in August 2021. This self-assessment will then be used to assess the core service well-led domains to continue to work towards improve the quality and safety of the services for patients and achieve outstanding services.

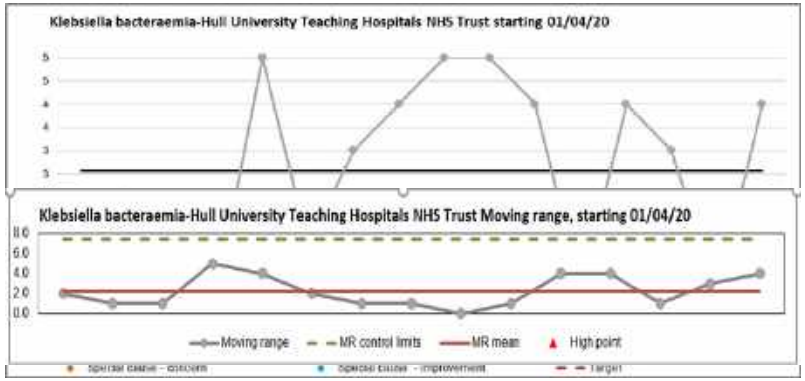
RISKS TO DELIVERY

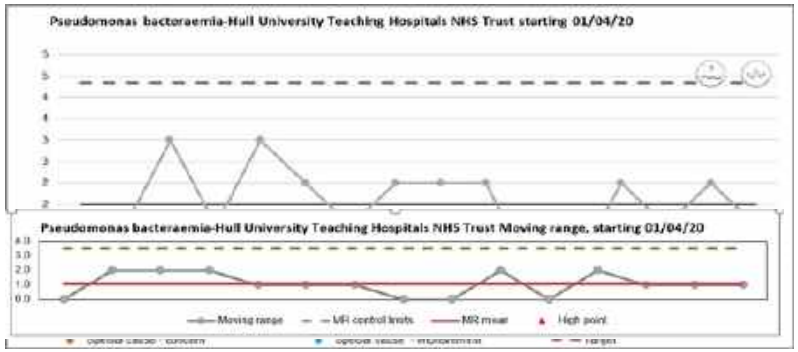
- *None noted*

Healthcare Associated Infections Report

The purpose of this report is to provide information and assurance on matters relating to the prevention and control of healthcare associated infections (HCAIs) and opportunistic infections		
Items for Escalation at close of June 2021		
MRSA Bacteraemia	No hospital or community onset cases reported for July 2021.	**Health Group Reported Cases 2021/22** 1 Trust apportioned cases reported, deemed unavoidable 0 Community apportioned cases reported
MSSA Bacteraemia	During July 2021, 6 Trust apportioned MSSA bacteraemia cases were reported, 6 of these were identified in the Surgical Health Group, likely source of the bacteraemia is associated with intravenous cannula, warranting further investigation by the team. All Trust apportioned cases are investigated using a root cause analysis (RCA) process with final RCAs expected for these reported cases – early indications suggest two MSSA bacteraemia cases are deemed lapses in practice linked to cannula and CVC (central line) management.  	HOHA cases: Medicine Health Group - 10 cases Surgical Health Group - 11 cases Clinical Support Health Group – 3 cases Families & Women's Health Group - 0 cases COHA cases: Medicine Health Group - 4 cases Surgical Health Group - 0 cases Clinical Support Health Group – 2 cases Families & Women's Health Group - 0 cases

***Clostridium Difficile* (*Clostridioides difficile*)**	During July 2021, 9 Trust apportioned (HOHA) and two community apportioned (COHA) *C difficile* cases were reported, this is a marked increase in C.difficile cases which is of concern. Of the 9 cases, 3 were reported in the Clinical Support Healthcare Group, all cases were linked to time and place but ribotyping did not find any linked cases in this cluster. 3 cases reported in the Medicine Health Group and the remaining three in the Surgical Health Group on wards. A review of reporting and assurance around the investigation of Clostridium difficile by both the IPCT and HGs is underway however, RCAs are required for all HOHA and COHA cases, work will commence to identify themes from previous RCA findings. 	HOHA cases: Medicine Health Group – 5 cases Surgery Health Group – 4 cases Clinical Support Health Group – 6 cases Families & Women's Health Group - 0 cases COHA cases: Medicine Health Group – 2 cases Surgery Health Group – 5 cases Clinical Support Health Group – 2 cases Families & Women's Health Group - 0 cases
E.coli Bacteraemia	During July 2021, 9 Trust apportioned E. coli bacteraemia were reported, demonstrating a continued improvement in incidence. Each case is subject to a review by the IPCT and if lapses in practice are identified and an RCA required. The same trends and sources of infection continue to be identified, these being biliary, urinary and respiratory. From the 1st July 2021, the IPCT will focus on E. coli and undertake a deeper dive of bacteraemias linked to urinary catheter related infections – outcomes of this deeper dive will be available to report once completed. 	HOHA cases: Medicine Health Group – 15 cases Surgery Health Group – 11 cases Clinical Support Health Group – 4 cases Families & Women's Health Group – 1 case COHA cases: Medicine Health Group – 8 cases Surgery Health Group – 6 cases Clinical Support Health Group – 12 cases Families & Women's Health Group – 1 case

Klebsiella Bacteraemia	During July 2021, 3 Trust apportioned cases were identified, these were cases reported on wards Surgery Health Group, clinical Support Health Group and two in Medicine Health Group. Each case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required. The same trends and sources of infection continue to be identified, being urinary, respiratory and intra-abdominal. From the 1st July 2021, the IPCT will focus on GNBSI, including Klebsiella and undertake a deeper dive especially regarding bacteraemia linked to urinary catheter related infections and those deemed antibiotic resistant – outcomes of this deeper dive will be available to report once completed.  	HOHA cases: Medicine Health Group – 4 cases Surgery Health Group – 6 cases Clinical Support Health Group – 1 cases Families & Women's Health Group – 0 cases COHA cases: Medicine Health Group – 2 cases Surgery Health Group – 0 cases Clinical Support Health Group – 4 cases Families & Women's Health Group – 1 cases

Pseudomonas aeruginosa Bacteraemia	During July 2021, 1 Trust apportioned Pseudomonas aeruginosa bacteraemia case was reported in the Surgical HG. This was reported as hospital onset pneumonia but with multiple samples including urine culturing Pseudomonas aeruginosa. The same trends and sources of infection continue to be identified, being soft tissue, respiratory and intra-abdominal.  	HOHA cases: Medicine Health Group – 4 cases Surgery Health Group - 2 case Clinical Support Health Group - 0 cases Families & Women's Health Group - 0 case COCA cases: Medicine Health Group – 1 case Surgery Health Group - 0 cases Clinical Support Health Group - 0 cases Families & Women's Health Group - 0 cases
Outbreaks / Incidents of Infection	During July 2021 1 outbreak of diarrhoea was reported on H12 which was contained and affected one bay only. The 4 bedded area was closed as a precaution on the 1st July 2021 and reopened on the 3rd July 2021. No causative organism was detected.	
Neonatal Intensive Care Unit (NICU)	No additional Pseudomonas aeruginosa cases were identified on NICU during July 2021. Weekly screening continues for all neonates on the unit.	
COVID-19	During July 2021, 474 patients screened positive for COVID-19; the majority were patients screened with a decision to admit and/or in OPD settings a marked increase from the 53 reported during June 2021. There was 1 reported COVID-19 outbreak, resulting in 13 positive cases, of which eight were definite hospital onset cases reported at >15days, 4 were probable hospital onset cases reported at days 8-14 and the remaining 2 identified from screening taken at days 5-7. Mass staff screening was undertaken and 1 member was found to be positive. The ward was closed on the 16th July 2021 and reopened on the 2nd August with the IPCT input until 23rd August 2021 (28 days from the last reported positive case). Root causes included placement of index patients following POCT negative admission result in 4 bedded rooms prior to day 3 and days 5-7 screen. Of interest, of the 13 positive cases the predominant strain was a VOC P681R, a variant associated with the Delta variant. In addition, continued screening and monitoring of inpatients identified a further 4 isolated hospital onset cases, three at days 8-14 (probable hospital onset) and one at >15 days (definite hospital onset). These patients were not linked to other cases and were reported upon routine screening, one of which had missed screening at days 3 and days 5-7 because of a current TB diagnosis.	
Other relevant information	On the 16th August 2021 PHE/NHSE updated thresholds for Clostridioides difficile and Gram Negative Bloodstream Infections (GNBSIs), basing thresholds on 2019 HCAI figures. Of note is the marked reduction in the threshold for Clostridioides difficile with the threshold set at 53 reported	

	cases inclusive of HOHA and COHA cases – up to 31st July 2021 22 HOHA & COHA cases have been reported. This has prompted a review of pathways for the reporting, investigation and assurance sought following the identification of Cdifficile cases. Further information and updates will be reported in future reports. Therefore, the Trust will continue to strive for a continued decline in hospital onset cases and especially those which resulted in a contributory lapse in practice. As previously a deeper dive into Trust apportioned MSSA bacteraemia cases will continue during 2021/22.

SERIOUS INCIDENTS (Including Never Events)
AREAS FOR ESCALATION
In July 2021, 14 SIs and one Never Event were declared. Details of which are contained below.

KEY UPDATES IN MONTH

Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that result in moderate harm, severe harm or death. It is a statutory requirement for the Trust to be open and transparent, ensuring patients / their families are informed about patient safety incidents that affect them receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences.
In July 2021, 14 SIs and one Never Event were declared. The Duty of Candour process has been initiated in all cases.
These were:

1. Never Event: A patient had an incorrect contraceptive device fitted.
2. A patient was admitted to ED and received an incorrect diagnosis
3. Patient misdiagnosis
4. A patient had an unwitnessed fall resulting in fracture
5. A patient with a chest drain and a lack of appropriate observations.
6. A patient presented to ED and diagnosed with complete heart block, the patient died before they were reviewed by Cardiology.
7. A patient was transferred from ICU, rapidly deteriorated
8. Unwitnessed fall resulting in a fractured left hip
9. An external reporting company incorrected interpreted the results of a CT
10. PPH and unplanned admission to ICU
11. A patient had an unwitnessed fall resulting in a fracture
12. Patient detained under MHA with a serious attempt of deliberate self-harm
13. A patient received an injury during surgery. An independent review is being undertaken into this incident.
14. A patient slipped through the bedrails of a trolley
15. A patient attended the ED after having a fall. There was a delayed diagnosis resulting in a requirement for emergency surgery.

RISKS TO DELIVERY

Currently there are 57 open SI investigations which is placing considerable pressure on the investigations team and the panels chairs. Mitigation has been put in place with support being received from QSMs and a wider range of panel chairs Additional resource to clear the ‘backlog’ of investigations (those overdue the 3 month investigation timescale has been in place since May 2021.

INCIDENT REPORTING RATES

AREAS FOR ESCALATION

Patient Incident numbers have shown a decrease from last month and remain within control limits.

KEY UPDATES IN MONTH

Patient Incident numbers have shown a decrease (11.44%) from last month, and remain within control limits. 'Suspected Slips/Trips/Falls (un-witnessed)' (-19.46%), 'Administration of care' (43.21%) and 'Community acquired Pressure Ulcer' (-8.75%) accounted for the majority of the decrease among Type.

In the Clinical Support Health Group, 1 moderate or above incidents were declared in month. The health group has seen an 9.13% decrease in reporting of incidents.

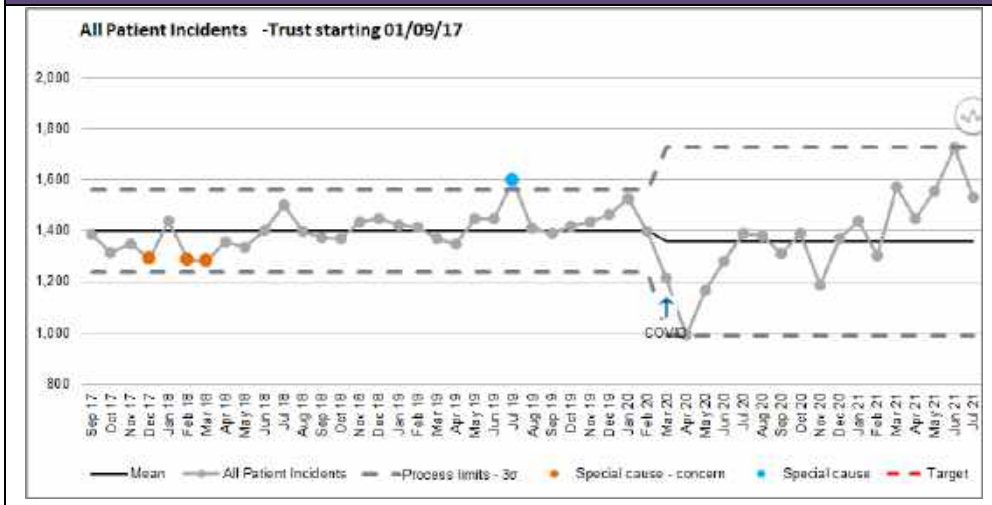
In the Emergency Care Health Group, 1 moderate and 1 Catastrophic were declared. The health group has seen an 18.29% decrease in reporting of incidents.

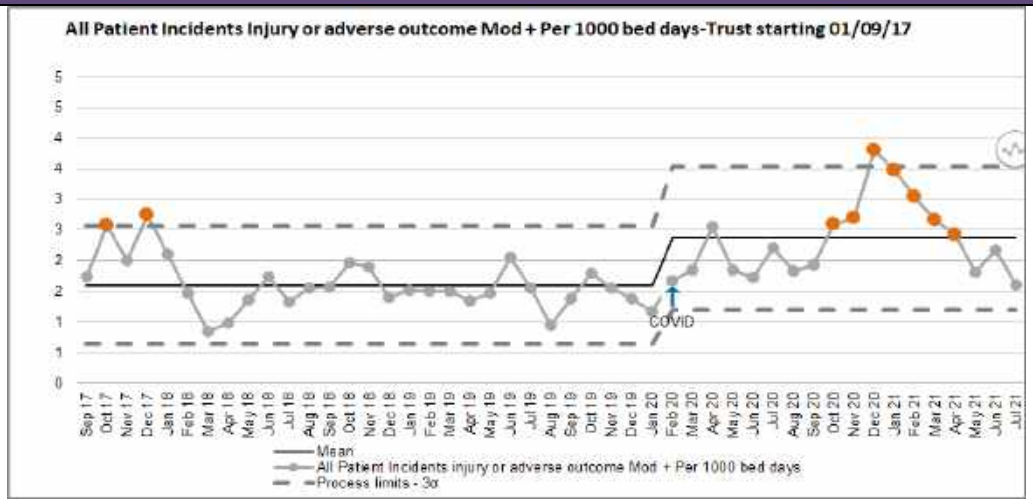
In Family and Women's Health Group, there were 6 moderate incidents declared.

In Medicine Health Group, 21 moderate and 1 Major incident have been declared in month. The health group has seen an 7.74% decrease in reporting of incidents.

In Surgery Health Group, 17 moderate, 1 Major and 1 Catastrophic incident have been declared. The Health Group has seen a 13.91% decrease in reporting of incidents in month.

INCIDENT REPORTING RATES





RISKS TO DELIVERY

None noted

FALLS

AREAS FOR ESCALATION

The total number of falls per 1000 bed days has shown a decrease in July, the severity of harm reported by these falls has also shown a decrease.

KEY UPDATES IN MONTH

The overall numbers of falls per 1000 bed days across the trust has fallen again for the 4th consecutive month and at our lowest number since October 2018

The number of falls moderate and above falls show a significant reduction from June's numbers. There were two moderate falls in July, both head injuries, one managed conservatively and the other one it is unable to definitely say that the fall caused increased bleeding as the patient already had pre-existing haemorrhagic brain metastasis.

The falls prevention committee now meets bi-monthly so there are no reports from each health group this month, however the data shows :

Family & women's HG
A slight reduction on the overall numbers of falls from June and no moderate or above this month (since February 2021)

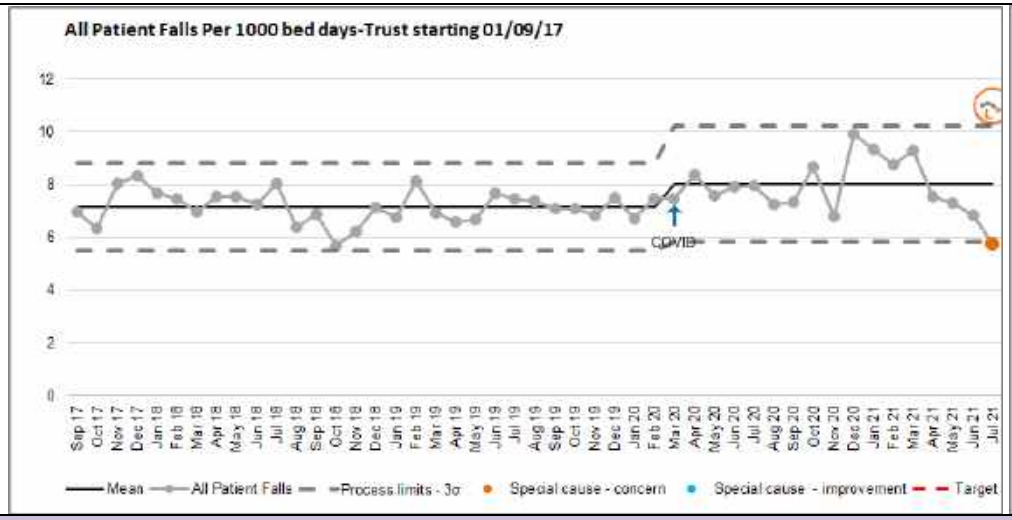
Medicine HG
Overall numbers show a reduction in falls, there was also a reduction in the number of moderate or above this month, however both the moderate falls occurred within this HG

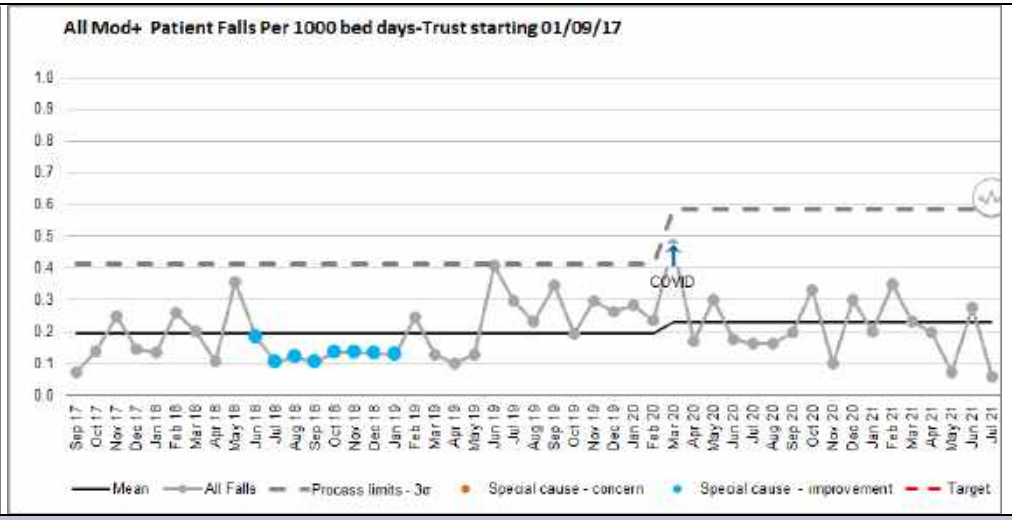
Surgery HG
A very slight increase in the overall numbers of falls, but no moderate or above occurred in July

Clinical Support HG
The HG shows a very slight decrease in the number of falls with no moderate or above this month (since March 2021)

Emergency medicine HG
Overall there has been a reduction in the number of falls (please note this is not per 1000 beds days) with no moderate or above this month (since March 2021)

The Falls Committee is now meeting bi-monthly on the alternate months; but are also meeting as an MDT o provide greater quality to the Serious Incident Decision forms reviews and work together on other quality issues. This month the Falls Prevention Policy was reviewed.





RISKS TO DELIVERY

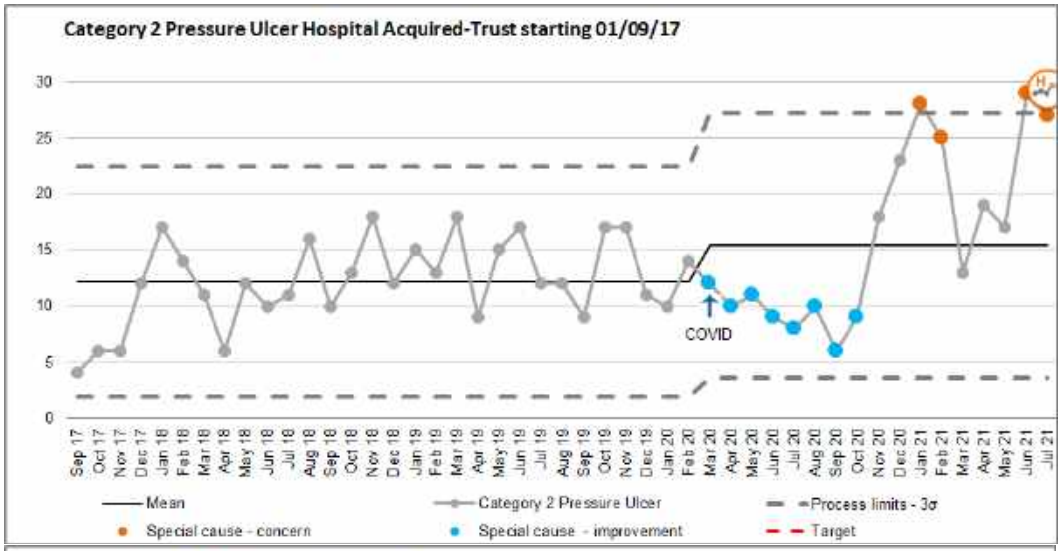
None noted

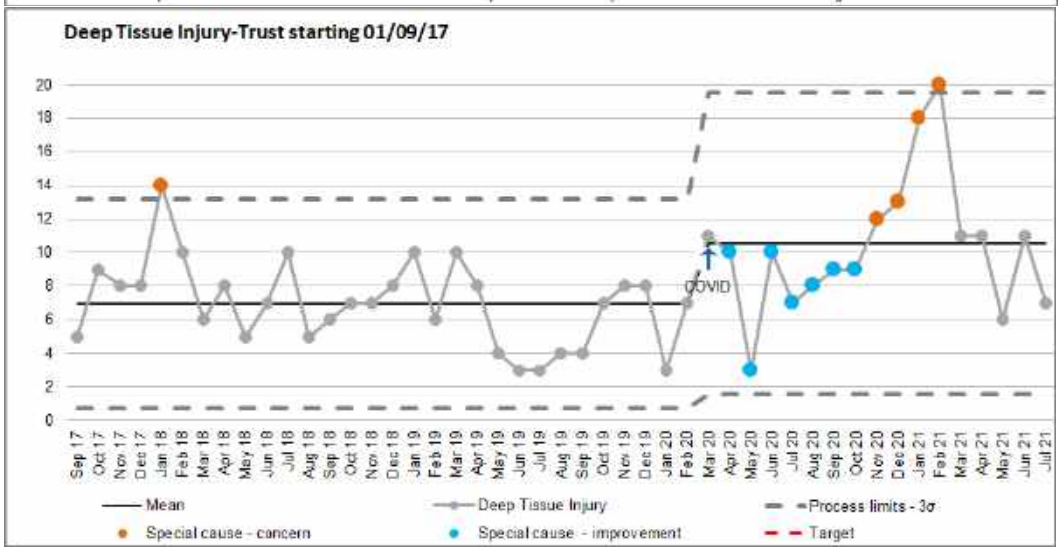
PRESSURE ULCERS

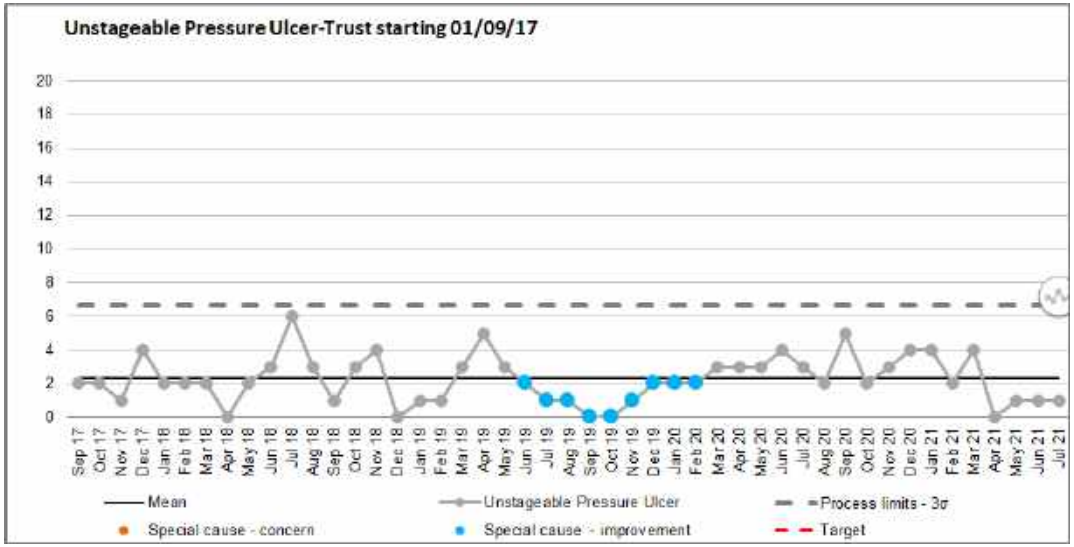
AREAS FOR ESCALATION

Pressure damage has decreased across all categories in July 2021. However Category 2 Pressure ulcers has seen an increase since March 2021.

KEY UPDATES IN MONTH







WELL-LED

AREAS FOR ESCALATION

- The Trust has received two whistleblowing concerns that have been reported to the CQC. The Trust has provided a full response to one of the concerns and is in the process of providing a response into the second..
- The Trust is undertaking a number of learning from others gap analysis reviews in some key areas for assurance and to inform any relevant improvement plans. The key areas currently under review are Maternity in response to Ockenden, Children and Young People and Emergency Care in response to mental health and Medical Care in response to falls.
- A Trust level well-led self-assessment is in progress and will be presented to the Board Development Session in August 2021. This self-assessment will then be used to assess the core service well-led domains to continue to work towards improve the quality and safety of the services for patients and achieve outstanding services.

KEY UPDATES

CARE QUALITY COMMISSION – INTERNAL ACTIVITY UPDATES

1. CQC ACTION PLAN – MARCH 2020 INSPECTION

The Q1 update against the action plan is been gathered between the Compliance Team and the leads for Medicine, Surgery, Critical Care and the Emergency Department. 19 actions remain open, 16 have been closed and 4 are partially closed. A further evaluation of all closed actions is also required to demonstrate the actual improvements has been achieved and the outcomes for patients have improved.

The Trust is anticipating that the Emergency Department, Maternity, Children and Young People and Outpatients will be inspected at the next CQC inspection. This is in line with the service previous ratings and the areas the CQC are currently focusing on. There is also a potential for Medical Care due to other Trust inspections with concerns around in-patient falls. Preparedness work is underway in these areas.

2. INTERNAL CORE SERVICE REVIEWS

The Compliance Team has an agreed programme of internal core services reviews. These reviews are an in-depth assessment in conjunction with the relevant leads against the CQC Key Lines of Enquiries (KLOEs) and inspection frameworks specific to those core services. It includes a gap analysis against the framework, evidence gathering and assessment of robustness, ward inspections and discussions with staff and patients. The reviews also consider other Trust inspections to inform any potential learning from others. A report is provided to inform improvement plans to improve the outcomes for patients and in turn improve compliance with regulatory requirements and service ratings.

To date internal core service reviews have been completed in Maternity, Children and Young People, the Emergency Department and Critical Care. Improvement work with these areas continues. Outpatients and Diagnostics are currently under review.

3. LEARNING FROM OTHER TRUST CQC INSPECTION REVIEWS

The Compliance Team undertake a monthly review of all other Trust inspection reports published. The aim of this review is to inform learning from others, emerging themes in the CQC approach to the key lines of enquiry for their inspections and potential risks. It also provides the Trust with the opportunity to assess whether this 'Outstanding' or 'Inadequate' practice is happening at HUTH and what improvement plans are required to prevent the issues at HUTH and to celebrate the outstanding services. Currently the Compliance Team are using reports where services have deteriorated to 'Inadequate' at other Trust's to assess practice within the Emergency Department, Children and Young People Services, Maternity and Medicine regarding falls in particular. All of which are likely to be included in the Trust's next inspection and link to concerns the Trust has in relation to mental health and the Trust's recent response to the Ockenden Report. Further information is provided below.

3.1 Children and Young People Mental Health

Because of the pandemic, mental health cases are increasing significantly with no appropriate beds in mental health services for patients to be admitted to. This means that this group of patients being cared for in the wrong environment, potentially being at more risk and not necessarily having staff who are trained and experienced enough to meet their needs. Many of these patients have no physical health needs and ordinarily should not be admitted to an acute provider, but local systems are struggling with both capacity and decision making in where these patients would be safest if home is not safe and the only beds available are in acute healthcare.

This is a key area of risk and focus for the CQC now and they are assessing organisations against this. In February 2021, the CQC inspected the Children and Young People Services located at The Princess Royal Hospital, which forms part of Shrewsbury and Telford Hospital NHS Trust. This was because the CQC had concerns about the safety and quality of the provision of the assessment and treatment of children and young people who presented to the service with acute mental health needs and/or learning disabilities. This inspection resulted in the hospital receiving a rating of 'Inadequate' across all domains.

Since their last inspection in 2016, the Children and Young People Services at HUTH have undertaken a significant amount of improvement work against the mental health processes, risk assessments, ligature risks, staff training and engagement with external mental health providers. The Head of Effectiveness and Improvement is working with the Children and Young People's Service to undertake an up to date assessment against the inadequate findings at The Princess Royal Hospital. The gap analysis is partially complete, the draft report is underway, the interim analysis has shown an increased level of assurance from the improvement work undertaken within the service, and there are some areas of improvement required around some of the Trust guidelines.

3.2 Maternity Services

In March 2021, the CQC inspected the Jessop Wing at Sheffield Teaching Hospitals NHS Foundation Trust. The Maternity Service received a rating of 'Inadequate' following this inspection. In 2016, the Jessop Wing was previously rated Outstanding, which is a significant deterioration and will include a huge amount of learning. A gap analysis against the findings from this review has commenced against the Trust's Maternity Service for assurances and for the identification of further improvement work. The outcomes from the Ockenden Report will be included in this review to ensure a joined up improvement plan.

3.3 Mental Health in the Emergency Department

Between August 2020 and April 2021, the CQC had published 11 inspection reports specifically relating to Emergency Departments and as part of their winter pressures programme. As part of the ongoing learning from others work a review of the 11 inspection reports as well as the Hillingdon Hospital inspection from 2020 was undertaken. With the exception of the Hillingdon Hospital inspection, which inspected all five domains, all other inspections focused on the Safe, Responsive and Well-led domains, which were mainly rated as 'Inadequate' or 'Requires Improvement'. In the reports reviewed, the CQC found a number of breaches of the Health and Social Care Act 2014 requiring action that must be addressed and areas with minor breaches but did not require regulatory action. Some of these breaches were also linked to enforcement action and warning notices. It is apparent that the CQC are increasing the use of their enforcement powers and as a result issuing and reporting more Section 29A Warning Notices and Section 31 Letters of Intent to providers because of their lack of improvement and level of risks associated with the regulatory breaches following inspections.

As part of the Emergency Care quality improvement work, the Head of Effectiveness and Improvement is working with the Emergency Department to undertake a gap analysis against the findings from the other Trust inspections to identify learning and improvement work for HUTH, alongside the implementation of the Patient FIRST tool. The information gathered to date has demonstrated a 30% increase in the number of patients arriving with mental health needs, and the significant length of time these patient are waiting for further management and beds. It is recognised by the service that this is a causative stress factor amongst the team and the patients themselves. The Trust has requested support in the form of a dedicated workforce from Humber Mental Health Foundation Trust to support this increased demand of patents and to provide care to theses patient whilst waiting. The Trust has also escalated these concerns due to the significant risk to patients and staff to the system for support and it has been discussed with our CQC inspectors.

3.4 Falls within Medical Care

In July 2021, the CQC inspected Kettering General Hospital, which forms part of Kettering General Hospital NHS Foundation Trust. This was an unannounced focused inspection because the CQC had concerns about the quality of services in response to patient safety incidents relating to falls. During this inspection, the CQC inspected the Medical Care core service using their focused inspection methodology. They did not cover all key lines of enquiry; however, the CQC did still rated this service in accordance with their enforcement policy in response to their concerns. The rating of the service went down to 'inadequate' and have taken enforcement action because of this inspection to promote

patient safety. The CQC also served a warning notice to the Trust requiring Kettering to make improvements in the assessment and management of risk, implementation of falls prevention actions and improvements in learning from Serious Incidents. The inspection report has been shared with the Trust Falls Lead who has reviewed and pulled out a number of actions in the interim. The Head of Effectiveness and Improvement to undertake a full gap analysis against the findings at Kettering against HUTH for assurances and for the identification of further improvement work will support the Trust Falls Lead. The outcomes from the Falls QIP will be included in this review to ensure a joined up improvement plan for Falls.

4. WELL-LED SELF ASSESSMENT
A self-assessment against the overall Trust well-led domain. Due to COVID-19, the CQC were unable to complete the Trust's well-led assessment; therefore, the Trust remained rated as 'Requires Improvement' overall for Well-led.

The Head of Effectiveness and Improvement and the Head of Corporate Affairs is undertaking an assessment against the well-led domain, using the CQC well-led Key Lines of Enquiries (KLOEs) and the CQC outstanding rating characteristics. The self-assessment will identify the evidence that demonstrates outstanding or good, current challenges, what works well but would be better if. The outcome of the self-assessment will be reported to the Trust Board and will inform the Board Development Session in August 2021. This self-assessment will then be used to assess the core service well-led domains to continue to work towards improve the quality and safety of the services for patients and achieve outstanding services.

5. BE PREPARED, BE HONEST, BE PROUD
All services are asked to identity all of the positive changes that have happened since the last inspection, to celebrate success and what you are all proud of. The Trust must improve its celebrating of success and its remarkable people. This is something that has not previously been celebrated, as it should be with the CQC and our patients. We want to change this.

6. WHISTLEBLOWING CONCERNS
The Trust has received two whistleblowing concerns that have been reported to the CQC. The concerns raised direct to the Emergency Department and Urology at CHH. The concerns also relate to low staff morale and delays for patients. The Trust has provided a full response to the ED concerns and is in the process of providing a response to the Urology concerns.

CARE QUALITY COMMISSION – EXTERNAL ACTIVITY UPDATES

7. MONITORING APPROACH
In March 2020, the CQC suspended all routine inspections in response to COVID-19 and developed their ability to monitor services using a mix of on-site and off-site methods. During this time, the CQC have made real progress in this area. The introduction of the emergency support framework gave them a structured way to have conversations with providers as part of the routine engagement meeting arrangements to help monitor risk and provide support. They then built on this with the introduction of their transitional monitoring approach. The CQC are now in a position to evolve their monitoring approach further, to ensure the public have assurance about the safety and quality of the care they receive, while still focusing on risk. The continued development of the monitoring approach still focuses on the following three key areas identified by the CQC on how they monitor services:

- Improving their ability to monitor risk to help them to be more targeted in their regulatory activity
- Bringing information together in one place for inspection teams, presented in a way that supports inspectors with their decision making
- Testing elements of how they want to work in the future, including how they provide a more up-to-date view of risk for people who use services

A number of pilot areas were undertaken in July 2021, with the CQC wanting to roll out to more services from July 2021, although it is worth noting that the dates for roll out in NHS Acute Trusts are not yet confirmed. However, it is a change the Trust must be aware of.

The CQC plan to carry out monthly reviews that will help support their ability to monitor risk. Where the information does not find evidence that tells them that they need to re-

assess the rating or quality at a service, they will publish a short statement on the provider profile page on the CQC website for those services. This will inform the public and people who use services, that this review has taken place and that there are concerns based on the information held at that time. The CQC will also communicate this with the provider by email prior to the public statement being published. This will also enable the teams to target their resources where they are most needed.

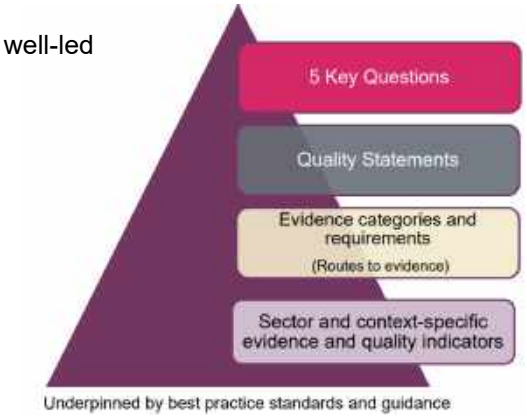
Until these changes are rolled out the NHS Trusts, the CQC will continue to:

- Focus on safety and how effectively a service is led
- Have structured conversations with providers, with a focus on safety and leadership
- Use our specific existing key lines of enquiry (KLOEs) to monitor a service
- Use digital methods and our local relationships to have better direct contact with people who are using services, their families and staff in services
- Target inspection activity where we have concerns.

8. ASSESSMENT FRAMEWORKS

Following consultation, the CQC launched their new Strategy, which outlines how they plan to change and transform to deliver regulation that is more effective. To ensure effective delivery of this strategy, the CQC are also requesting feedback from providers on how they can implement it in partnership. The CQC have shared the potential changes to their assessment frameworks on their digital engagement platform. The current assessment frameworks are the Key Lines of Enquiry (KLOEs). Feedback received against the current KLOES was they are hard to understand, had lots of duplication, did not reflect the current outside work and needed a system and provider view. The CQC want their new assessment frameworks to:

- Have the same 5 key questions; safe, effective, caring, responsive and well-led
- Set out what good care looks like for people, in their terms
- Apply to health and social care
- Work at provider, local authority and system level
- Clear expectations of quality and legal obligations
- Identify minimum sources of evidence
- Support more up to date view of quality based on changes in data
- Support provider benchmarking
- Structured in a way that accelerates improvement



The survey on the digital engagement platform remains open and the Trust will review the presentation which sets out their changes and what they want them to achieve as well as how they aim to bring the key questions to life by using the 'Think Local Act Personal (TLAP)' – Making it Real Framework'. The suggested statements in the Safe domain will also be reviewed and feedback will provided accordingly.

9. CQC COVID-19 INSIGHT REPORT – ISSUE 11

Issue 11 of the COVID-19 Insight Report focuses on care for patients with a learning disability. Support and services for people with a learning disability are often not good enough. For too long, people and their families have faced significant and ongoing challenges in getting care at the right time that meets their individual needs. We have seen how this can lead to people staying for long periods in inappropriate environments, being cared for by people who do not know them and who do not have the skills or knowledge to support them well.

To further explore people's experiences and how services have worked together for people with a learning disability during the COVID-19 pandemic, the CQC carried out a Provider Collaboration Review (PCR) across seven local areas in England. Hull University Teaching Hospitals was included in this review as part of the Humber, Coast and Vale

Health and Care Partnership in March 2021. At that time, it was estimated that the report would be received in July 2021; however, there have been some delays and the report is due in July 2021. Many of the issues emerging from the provider collaboration review are not new. In many cases, the pandemic has simply served to shine a light on pre-existing challenges, gaps and poor-quality care. In particular, how well services work together, or collaborated, to share information and ensure that people receive the right care at the right time and issues with transitioning from the support of children's services to adult services, and how, when things go wrong, people can end up in inappropriate environments.

The Trust will review the findings of the PCR review on receipt of the final report and improvement work will be identified as required.

RISKS TO DELIVERY

None noted

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Title:	PERINATAL QUALITY SURVEILLANCE TOOL JULY 2021
Responsible Director:	Beverley Geary - Executive Chief Nurse
Author:	Beverley Geary, Executive Chief Nurse Lorraine Cooper, Head of Midwifery Julia Chambers, Lead Midwife

Purpose	The purpose of this report is to provide information to the Quality Committee and Trust Board for oversight of perinatal safety within maternity and neonatal services.	
BAF Risk	BAF Risk 3: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	The service reviews all essential key elements of Perinatal Quality surveillance in line with current national guidance. The report provides the Trust Board with oversight of • Perinatal Mortality • Serious Incident Investigations • HSIB referrals • Training compliance • Evidence of Coproduction • !0 CNST Safety Actions	

Recommendation	The Quality committee is requested to: • Review the contents of the paper. • Review how frequently the committee wishes to receive the paper. • Decide if any further information and/or assurance are required.

PERINATAL QUALITY SURVEILLANCE TOOL

July 2021

1.0 INTRODUCTION

The following document provides a monthly update on key measurements, as detailed in the NHSI/E report on the revised requirements for perinatal quality surveillance tool.

2.0 CQC MATERNITY RATINGS

	Safe	Effective	Caring	Responsive	Well Led	Overall
Maternity	Good	Good	Good	Good	Good	Good

In June 2018, the CQC undertook a full inspection of both the Castle Hill Hospital & Hull Royal Infirmary sites and achieved an overall rating of 'Requires Improvement'. Within this inspection, Maternity Services received an award of 'Good' against the five domains – safe, effective, caring, responsive and well led.

In March 2020, the CQC returned to repeat their inspection however due to the COVID-19 pandemic this inspection was suspended to relieve pressure on the healthcare systems. Maternity Services had not been inspected by this point, and therefore the rating of 'Good' remains in place. With an overall trust rating of 'Requires Improvement'.

3.0 REVIEW OF PERINATAL DEATHS

The following provides numbers of perinatal deaths using the real time data-monitoring tool.

Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
2	2	4	1	5	1	3					

In July we reported three cases

76028	NND 23 weeks
76086	Twins – Twin 1 stillbirth, Twin 2 livebirth
76348	Stillbirth 24 weeks

The PMRT meeting discussed and graded 5 cases at the July meeting

- 23 week miscarriage, Graded B/A – re-opened and amended in July
- Stillbirth 36+4 weeks, Graded D/A – SI investigation
- Stillbirth 40+2 weeks, Graded C/A – HSIB investigation
- Stillbirth 38+6 weeks, Graded C/B – SI investigation
- Late miscarriage 23 weeks, Graded B/C – late booker

4.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
0	0	2	2	0	1	0					

There are no completed reports from July.

5.0 INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
Moderate	4	0	2	1	1	3	0					
Major	0	0	0	0	0	0	0					
Catastrophic	0	0	0	0	0	0	0					

There were no moderate or above incidents reported in July 2021.

Themes & Actions

There are no overriding themes from the moderate incidents reported.

There was one Serious Incidents

Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
3	0	1	0	1	0	2					

6.0 TRAINING COMPLIANCE

Obstetric Emergencies (PROMPT)

Staff Group	No of Staff	Total % Perf	
Obstetric Cons, Ass Spec	13	100%	**100%**
Obstetric Registrar	15	100%	**96%**
Obstetric SHO	11	91%	
Gynae Theatre Nurses	15	100%	**97%**
ODA's	28	93%	
Anaesthetic Consultant	8	100%	**100%**
Anaesthetists	16	100%	**100%**
Labour & Del. MW	52	97%	
Community	47	95%	

Senior Midwives	21	100%	
Maple & Rowan Ward Midwives	42	97%	**97%**
MLU Midwives	24	95%	
Bank Midwives	9	100%	
ANC - W&C Midwives	17	97%	
Labour & Del. MW Assist	9	91%	
Community MW Assistants	3	100%	
Maple & Rowan Ward Midwifery Assistant	25	92%	**95%**
MLU MW Assistant	10	87%	
Bank Midwife Assistant	2	100%	
ANC - W&C Midwives Assistant	8	100%	

CTG Training

Following the cancellation of face-to-face teaching in March 2020 CTG training was changed to a complete online package for the remainder of 2020. Staff had to complete K2 competency assessments in Fetal Physiology, Intrapartum CTG & Intrapartum Intermittent Auscultation with a pass mark of >85%. Compliance is as below for completion of the competency assessment.

Moving forward into 2021, there is now 1 hour CTG training as part of the PROMPT ½ day face to face and competency assessment and online requirements are being set.

ACTUAL PERFORMANCE TO DATE

Area	No of Staff	In date	% Perf
Obstetric Cons, Ass Spec	13		
	12	11	92%
Obstetric Registrar	21	19	
Obstetric SHO	11	11	
	32	30	94%
Labour & Del. MW	50	50	100%
MLU Midwives	24	23	95%
Community	47	43	91%
Specialist Snr Midwives	18	18	100%
Maple & Rowan Midwives	42	40	95%
Bank Midwives	10	9	90%
ANC Midwives	24	22	92%
	215	204	95%

Neonatal Resuscitation

It is a mandatory requirement for all Midwifery staff to complete the Newborn Life Support (NLS) Course at least once and to undertake a neonatal resuscitation update annually (delivered by an NLS trained instructor).

ACTUAL PERFORMANCE TO DATE

Area	No of Staff	DAY 1 - REMINDER (10 MTHS)	Expired - Review (1 yr)	In date	% Perf
Neonatal Consultant	9	6	6		
	9	6	6	9	100%
Neonatal Registrar ANNP	10	1	1	9	
Neonatal SHO	9	0	0	9	
	19	1	1	18	95%
Specialist Snr NICU Nurses	7	0	0	7	
NICU Nurses	89	4	4	85	
NICU Bank Nurses	0	0	0	0	
	96	4	4	92	96%
Labour & Del. MW	38	10	4	36	
MLU Midwives	38	12	7	34	
Community	48	14	8	45	
Specialist Snr Midwives	24	7	4	21	
Maple & Rowan Midwives	26	8	2	26	
Bank Midwives	8	1	1	8	
ANC Midwives	34	7	4	31	
	216	59	30	201	93%

7.0 MINIMUM SAFE STAFFING LEVELS

The service is currently running at a Birth Rate Plus ratio of 1:30

A service review of all rota tools has recently taken place with the Assistant Chief Nurse that has demonstrated that all clinical areas in Maternity Services are covered and safe.

A Birth Rate Plus Assessment has commenced and data collection is underway.

Birth Rate Plus Red Flags

Maple Ward – 0 red flags were reported in July

Rowan Ward – 0 red flags were reported in July

Fatima Allen Birth Centre – 0 red flags were reported in July

Labour ward – 5 red flags reported in July, 4 of these were missed / delayed care and 1 delay between admission and induction of labour

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool** **COMPLIANT**	The PMRT group has been able to sustain reporting during the Covid-19 restrictions. The Trust Board will receive quarterly reports between September 2020 and September 2021. The report will evidence compliance with the required standards.
2	**COMPLIANT**	Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1 April 2020 that the Digital Maternity Record Standard (DMRS) compliance date had been delayed from Monday 30 November 2020 to Sunday 28 February 2021. The majority of the requirements for safety action two will be assessed on the trusts' MSDS submission for December 2020 made by 28 February 2021.
3	**COMPLIANT**	Monthly audit of transitional care pathways has recommenced as these ceased in March, and further audit of avoidable admissions of term babies to Neonatal Unit to be undertaken for 20/21
4	**COMPLIANT**	**Obstetric medical workforce** The review of the GMC national trainee survey to be completed and presented to the Trust Board in February 2021. **Anaesthetic medical workforce** Review of the action plan agreed by the trust Board in 2019, to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 **Neonatal medical workforce** Formal recording in trust Board minutes that the neonatal unit meets the British Association of Perinatal Medicine BAPM national standards of junior medical staffing **Neonatal nursing workforce** Action plan in place agreed at trust Board level to meet the recommendations of the service specifications for neonatal nursing standards
5	**COMPLIANT**	Bi Annual Chief Nurse staffing report to Trust Board outlining: • Birth-rate Plus® outcomes • Planned versus actual staffing levels • Midwife: Birth ratio • Compliance with supernumerary status and 1:1 care in labour • Actions to demonstrate progress with Birthrate Plus® recommendations
6	**COMPLIANT**	During the covid-19 pandemic it has been difficult to implement some element of Saving Babies Lives Care Bundle V2, and in particular element one as carbon monoxide testing of women was suspended which has recommenced in November. Restrictions on the provision of the Growth Assessment Protocol for scanning will also impact on the ability to report accurately. The service is not currently compliant with Uterine Artery Doppler scanning as recommended in the Saving Babies Lives Care Bundle V2 – Appendix-D. The maternity service is working with ultrasonography and clinical support on a case of need to increase scanning capacity, delivery of training, increased physical space, procurement of capital equipment and recruitment of staff. A business case has been approved and a paper prepared for the clinical network.
7	**COMPLIANT**	Although face-to-face patient involvement has been suspended, the Maternity Voices Partnership is active and has completed an online survey of women across the LMS – Lockdown Babies. The report is available to the Trust Board via the Head of Midwifery
8	**COMPLIANT**	Multi-professional training has not been possible during the emergency response due to Covid-19. Training in this unit restarted in June 2020 however, the restrictions still affected our ability to provide full face-to-face, or 'hands on skills drills' training. The service has developed a package of multidisciplinary training provided as a half-day virtual/on-line training package as an alternative. With a number of skills drills at the start of the pandemic preparations in key areas such as theatres and labour ward.

		All clinical groups are on board with this and we are monitoring attendance.
9	**COMPLIANT**	Safety Champion meetings were suspended but have now recommenced with dates for Chief Nurse to be agreed.
10	**COMPLIANT**	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and number reported to NHS Resolution

8.0 SERVICE USER VOICE FEEDBACK

The Group B Streptoccocus Support team have recently issued the information below:

"We've been able to translate the *"Group B Streptococcus (GBS) in pregnancy and newborn babies"* leaflet from English into 14 new languages They are:

Arabic, Bengali, Chinese, French, Hebrew, Latvian, Lithuanian, Polish, Portuguese, Punjabi, Romanian, Somali, Urdu and Welsh.

These translations will make a real difference to those for whom English is not their first language – they're free to download and print from https://gbss.org.uk/professional-resources/free-resources/gbs-information-in-your-own-language/.

We co-wrote this leaflet with the Royal College of Obstetricians and Gynaecologists (RCOG) to reflect their 2017 Green top Guideline to prevent early-onset neonatal group B Strep disease."

9.0 STAFF FEEDBACK

A Senior Midwife's Assurance Handbook was undertaken in June. Part of this assurance handbook will explore staff experience in relation to culture, communication, support, incidents and learning lessons.

Action Plan:

Required Actions / Improvements				
Improvement required	**Action**	**Time Frame**	**Accountable Person**	**Completed**
Labour ward board to be updated	All B7's to be reminded to update the board at the beginning of each shift	End of August	Angi Rymer / Sandi Marshall	
Completion of Drug cards	Reminder to all staff regarding correct completion of drug card	End of August	Managers	
Action of out of range fridge temperatures	Education to those staff completing fridge checks	End of August	All Managers	

Boxes off the floor in Labour Ward Store Room	To enquire about more shelving	End of August	Sarah Hames	

10.0 EXTERNAL CONCERNS OR QUERIES

11.0 CORONERS

The Trust was issued with no Coroners Regulation 28 in relation to maternity:

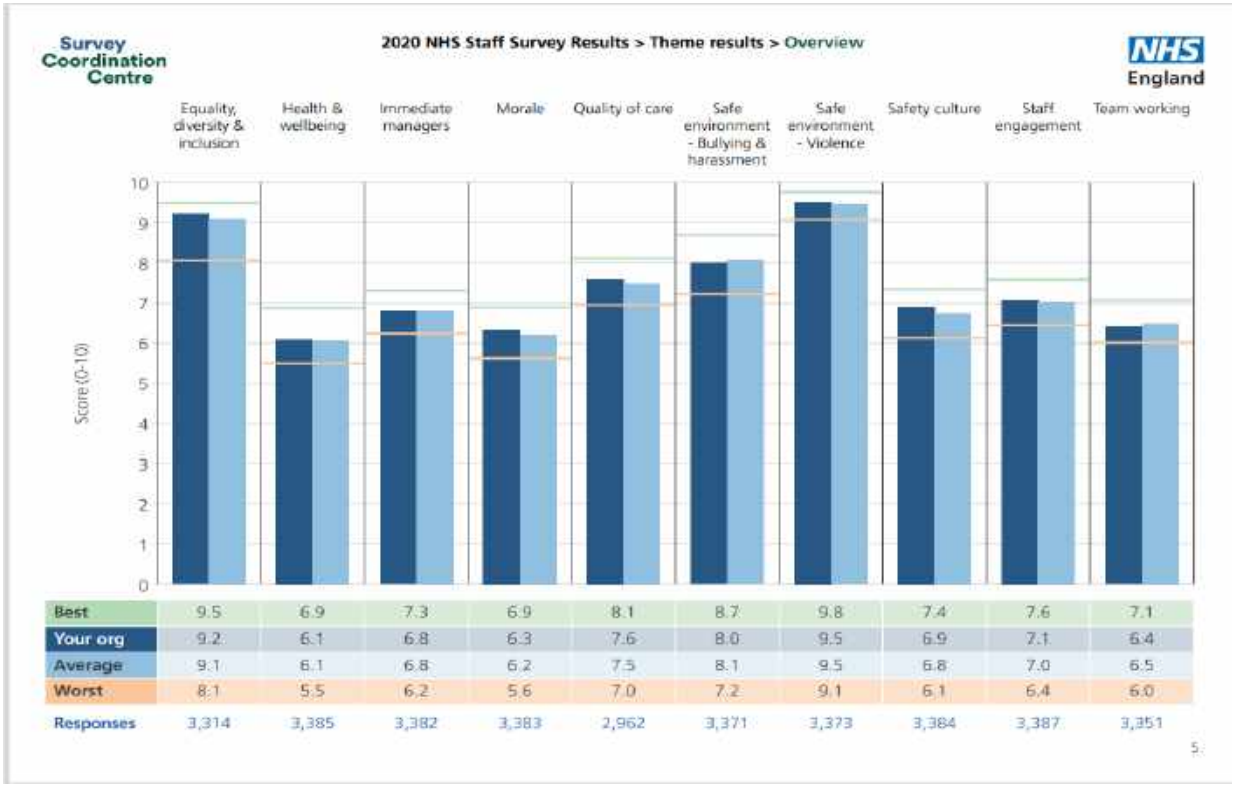
Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021
0	0	0	0	0	2						

12.0 CNST

The section of the report provides details on the Trust's progress against compliance with the 10 CNST Standards.

13.0 NATIONAL SURVEY RESULTS

The national staff survey was undertaken in 2020. Overview results for the Trust are highlighted below:



Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	3089	**9.2**	3314	Not significant
Health & wellbeing	**5.9**	3098	**6.1**	3385	↑
Immediate managers †	**6.8**	3094	**6.8**	3382	Not significant
Morale	**6.2**	3088	**6.3**	3383	↑
Quality of care	**7.4**	2757	**7.6**	2962	↑
Safe environment - Bullying & harassment	**8.0**	3076	**8.0**	3371	Not significant
Safe environment - Violence	**9.5**	3090	**9.5**	3373	Not significant
Safety culture	**6.8**	3091	**6.9**	3384	Not significant
Staff engagement	**7.0**	3101	**7.1**	3387	Not significant
Team working	**6.5**	3073	**6.4**	3351	Not significant

Appendix 1 - Humber Coast and Vale Regional Quality Oversight Group Highlight Report

NE&Y Regional Perinatal Quality Oversight Group Highlight Report

LMS: Humber, Coast and Vale

Reporting period: July 2021

Overall System RAG: TBC
(Please refer to key next slide)

	MW to birth ratio : BR+ recommendation	Vacancy rate (MW)	LW co-ordinator supernumerary (%)
HUTH	1:30	18 WTE	100
NLaG			
YTHFT			

NHS

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

CQC DOMAINS

Maternity unit	HUTH						NLaG						YTHFT					
Date of last inspection: C-caring R-responsive E-effective W-well-led S-safe	C	R	E	W	S	June 2018 Action Plan Status: Completed	C	R	E	W	S	Action Plan Status: To commence Progressing Completed	C	R	E	W	S	Action Plan Status: To commence Progressing Completed

KPI (see slide 4)	Measurement / Target		Trust Rate (current reporting period)			Combined Trust
			HUTH	NLaG	YTHFT	LMS
Caesarean Section rate	Elective	13%	13.49%	13.3%	14.6%	13.7%
	Emergency	17%	18.8%	15.6%	16%	16.4%
Preterm birth rate	≤26+6 weeks	6% annual rolling rate	0.46%			
	≤36+6 weeks		4.8%			
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	3.28%			
Term admissions to NICU		<6%	3.9%			
3rd & 4th degree tear	SVD (unassist'd)	<3.5 overall rate	1.0 %	1.0 %	1.4 %	1.3 %
	Instrumental (assisted)					
Right place of birth		95%	100%	99.4%	98.9%	99.3%
Smoking at time of delivery		6%	21%	17.3%	12.8%	15.3%
Percentage of women placed on CoC pathway		35% (March 21)	65	36.2	43.3	38.3%
Percentage of women on CoC pathway: BAME / areas of deprivation	BAME	75%	BAME 13% / Total	75.7%	50 %	47.5%
	Area of deprivation		AGD 16% / Total			

		Incident Reporting 0				LMS confirmation of SI oversight (evidenced through governance & safety meetings) Yes											
		Unactioned Datix / Open > 30 days		Serious Incidents	Maternity Never Events	HSIB cases	Still Births (All / Term / Intrapartum)			HIE cases (2 or3)	Neonatal Deaths (Early / Late)		Notification to ENS	Maternal Mortality (direct / indirect)	
H	Qu1	0	18	2	0	2	4	3	1	0	0	0	0	0	0
	Qu2	0	23	2	0	3	2	1	1	2	2	1	1	0	0
	Qu3														
	Qu4														
	Total														
N	Qu1														
	Qu2														
	Qu3														
	Qu4														
	Total														
Y	Qu1														
	Qu2														
	Qu3														
	Qu4														
	Total														

Assessed compliance with10 Steps-to-Safety

	Please identify unit	HUTH	NLaG	YTHFT
1	Perinatal review tool	Compliant	Compliant	Compliant
2	MSDS	Compliant	Compliant	Compliant
3	ATAIN	Compliant	Compliant	Compliant
4	Medical Workforce	Compliant		
5	Midwifery Workforce	Compliant		
6	SBLCB V2	Compliant	Compliant	Compliant
7	Patient Feedback	Compliant		
8	Multi-professional training	Compliant	Compliant	Compliant
9	Safety Champions	Compliant	Compliant	Compliant
10	Early notification scheme (HSIB)	Compliant	Compliant	Compliant

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance

	Please identify unit	HUTH	NLaG	YTHFT
1	Reducing smoking	Compliant	Non-compliant	Non-compliant
2	Fetal Growth Restriction	Non-compliant	Non-compliant	Non-compliant
3	Reduced Fetal Movements	Compliant	Compliant	Compliant
4	Fetal monitoring during labour	Compliant	Compliant	Compliant
5	Reducing pre-term birth	Non-compliant	Non-compliant	Non-compliant

Assessment against Ockenden Immediate and Essential Action (IEA)

Please identify unit	HUTH	NLaG	YTHFT
Audit of **consultant led labour ward rounds** twice daily	Yes	Yes	Yes
Audit of **Named Consultant** lead for complex pregnancies	Yes	Yes	Yes
Audit of **risk assessment** at each antenatal visit	Partial	Partial	Partial
Lead **CTG Midwife and Obstetrician** in post	Yes	Yes	Partial
Non Exec and Exec Director identified for Perinatal Safety	Partial	Yes	Yes
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	On track	No	Nil return
Plan in place to meet **birth rate plus** standard (please include target date for compliance)	Assessment commenced	Partial	Partial
Flowing accurate data to **MSDS**	Yes	Yes	Yes
Maternity SIs shared with trust Board	Yes	Partial	Partial

Maternity unit	HUTH	NLaG	YTHFT	LMS
Freedom to speak up / Whistle blowing themes	None			
Themes from Datix (to include top 5 reported incidents/ frequently occurring)	PPH > 1.5 litres Delay to treatment (antenatal) GAP – missed IUGR 2nd stage LSCS In-utero transfer			
Themes from Maternity Serious Incidents (Sis)	No completed SI's in July			Peer review and learning shared via SWG
Themes arising from Perinatal Mortality Review Tool	No themes			
Themes / main areas from complaints	Communication,			
Listening to women (sources, engagement / activities undertaken) CQC Women's Experience	**Matron's Handbook** – includes talking to women about their experiences **Maternity Voices Partnership**			
Evidence of co-production	**Hull & ERY Maternity & Primary Care Meeting** – working together with the CCG to address issues arising and ensure correct care for women e.g. production of 6-8 week PN check leaflet to give to women as theme identified that women did not know what to expect during COVID times			BAME champions identified, working group includes MVP
Listening to staff (eg activities undertaken, surveys and actions taken as a result)	**Matron's Handbook** undertaken monthly includes discussion with staff Newly created **Maternity Staff Network** – led by two Midwives, arena for open discussions about all aspects of maternity to support and encourage cross area working & collaboration			
Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	Safety Bulletin circulated Maternity Case Review lessons circulated			Safety bulletin circulated with links

KPIs: Targets & Thresholds

Ref	KPI	Measurement	Target	Green Range	Amber Range	Red Range	Source
S1	**Caesarean section rate** (Caesarean section targets are based on England HES data for 2019/20)	% Caesarean sections: elective & emergency	29% EL 13% EM 17%	<30% <13% <17%	NA	> 33% > 15% > 19%	Trust / MSDSv2
S2	**Preterm birth rate** (Denominator = all births over 24 weeks gestation)	% Preterm birthrate: <27 weeks & <36 weeks	<6%	< 6% achieved in 12 months	N/A	> 6 achieved in 12 months	Trust
S3	**Massive obstetric haemorrhage** (Based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	NA	>2.9%	Trust / MSDSv2
S4	**Term admissions to NICU** ((from all sources eg Labour ward, postnatal ward / community but not transitional care babies)	% Terms admissions to NICU	<6%	<6%	NA	>6%	Trust / Badgernet
S5	**3rd & 4th degree tear** (3rd/ 4th degree tears are based on NMPA data for 2017/17 for women who give birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6)	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (denominator total singleton cephalic SVD / total Instrumental births / total vaginal births)	NMPA SVD: 2.8% Instrumental: 6.8% Overall: 3.5%	< 3.5%	NA	>5%	Trust / MSDSv2
S6	**Right Place of Birth** (denominator = no of women birthing under 27, 28 with multiple or <800g)	% Right Place of Birth: <27 weeks or <28 weeks multiple & EFW <800g born in tertiary centre	95%	>90%	80% – 90%	<80%	Trust / Badgernet
S7	**Smoking at time of delivery**	% women smoking at time of delivery	6%	4% – 6%	6% - 8%	>8%	Trust / MSDSv2
S8	**Percentage of women placed on Continuity of Carer pathway** denominator = all women reaching 29 weeks gestation within the month	% women placed on continuity of carer pathway at 29 weeks gestation	35%	25% - 35%	15%-25%	<15%	Trust / MSDSv2
S9	**Percentage of BAME women or from areas of deprivation placed on Continuity of Carer pathway** (denominator as above)	% BAME women placed on continuity of carer pathway at 29 weeks gestation	75%	65% - 75%	55% - 65%	<55%	Trust / MSDSv2

Appendix 2 – HUTH Maternity Dashboard

Maternity Dashboard	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Activity													
Number of Births per month		428	395	397	391								
Number of Bookings per month		506	457	461	461								
Direct Access before 12+6		88%	88.0%	96.0%	89.0%								
Booking over 13 weeks within 2 weeks	95.0%	98%	92.0%	100.0%	100.0%								
Caesarian Section	26.2%	32.7%	33.9%	32.9%	32.2%								
Elective Caesarean Section	13.9%	15.2%	14.4%	14.9%	13.4%								
Emergency Caesarean Section	12.1%	17.5%	19.5%	18.0%	18.8%								
Instrumental Birth	12.8%	8.1%	8.5%	6.3%	6.2%								
Normal Birth	61.0%	58.0%	56.4%	55.8%	57.3%								
Home Birth		1.4%	2.0%	2.0%	1.7%								
MLU Births		15.4%	11.1%	12.5%	10.2%								
Induction of Labour		32.0%	26.8%	36.0%	39.4%								
Epidural		28%	33.0%	37.0%	35.0%								
Workforce													
Weekly hours of Consultant cover on LW	98	95	95	95	95								
Midwife/Birth Ratio	1:32	1:30	1.30	1.30	1.30								
Provision of 1:1 Care in Labour	100.0%	100.0%	100.0%	100.0%	100.0%								
Supernumary status of Labour Ward Coordinator	100.0%	100.0%	100.0%	100.0%	100.0%								
Maternal Morbidity													
Eclampsia		1	0	0	0								
ICU/HDU Admissiona in Obstetrics		1	0	1	1								
Blood Transfusion (>4 units)		1	1	0	2								
Post-Partum Hysterectomies		1	1	0	1								
Neo-Natal Morbidity													
Number of cases of meconium aspiration		0	0	0	0								
Number of cases of hypoxic encephalopathy (grades 2 & 3)		1	1	0	0								
Referrals to NHSR		0	1	0	0								
Total Stillbirths		0	2	2	1								
Stillbirths at Term (after 37 weeks)		0	1	1	0								
Risk Management													
Failed Instrumental Delivery	< 1%	0.0%	0.0%	0.2%	0.1%								
Maternal Death	0	0	0	0	0								
Massive PPH > 2 litres	10	8	7	7	4								
Shoulder Dystocia	6	0	0	2	1								
3rd/4th degree Tear	20	6	4	4	1								
Complaints													
Number of Complaints		4	0	1	0								

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total	Average per month
TOTAL BIRTHS 2021/22	**428**	**395**	**397**	**391**										
TOTAL BIRTHS 2020/21	**405**	**394**	**454**	**438**	**409**	**437**	**426**	**401**	**380**	**393**	**353**	**379**	2963	423
TOTAL BIRTHS 2019/20	**391**	**465**	**414**	**455**	**469**	**405**	**423**	**390**	**444**	**420**	**364**	**414**	5054	421
TOTAL BIRTHS 2018/19	**422**	**439**	**458**	**445**	**432**	**480**	**442**	**429**	**419**	**420**	**367**	**404**	5157	430
TOTAL BIRTHS 2017/18	**434**	**433**	**458**	**414**	**462**	**474**	**467**	**484**	**448**	**407**	**370**	**434**	5285	440
TOTAL BIRTHS 2016/17	**432**	**461**	**453**	**520**	**481**	**463**	**459**	**454**	**467**	**444**	**420**	**451**	5505	459
TOTAL BIRTHS 2015/16	**419**	**466**	**483**	**492**	**501**	**486**	**488**	**468**	**459**	**464**	**450**	**448**	5624	472
TOTAL BIRTHS 2014/15	**461**	**486**	**485**	**468**	**438**	**529**	**485**	**492**	**457**	**458**	**432**	**462**	5653	478

Appendix 3 – Abbreviations

- ATAIN – Avoiding Term Admissions to Neonatal Unit
- BBA – Born Before Arrival to Hospital
- CTG – Cardiotocograph
- HSIB – Health Safety Investigation Branch
- IUD – Intra Uterine Death
- LSCS – Lower Segment Caesarean Section
- NND - Neonatal Death
- PMRT – Perinatal Mortality Review Tool
- PPH – Postpartum Haemorrhage
- PSROM – Prolonged Spontaneous Rupture of Membranes
- PROMPT – Practical Obstetric Multi-Professional Training
- SB – Stillbirth

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Title:	Perinatal Mortality Review Tool Report for CNST
Responsible Director:	Beverley Geary - Executive Chief Nurse
Author:	Beverley Geary, Executive Chief Nurse Lorraine Cooper, 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: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	The service reviews all elements of the PMRT tool and the aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.	

Recommend ation	The Quality committee and 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 have been met and a plan introduced to ensure standard c) is achieved has improved the standard from the previous quarter. • 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, which was revised in March 2021 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 (MIS@resolution.nhs.uk) by 12
noon on Thursday 15 July 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 and 2**

a)

i. All perinatal deaths eligible to be notified to MBRRACEUK from Monday 11 January 2021 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 15 March 2021, will have been started before 15 July 2021.

b) At least 50% 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 Monday 15 March 2021 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 before 15 July 2021.

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. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

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

a) i. **All** perinatal deaths in the Trust from Monday 11 January 2021 have been notified to MBRRACE-UK within 7 working days.
ii.**100%** of all deaths of babies suitable for review using the perinatal mortality review tool, have been commenced from 20th December 2020 until the present time.

b) **91%** of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 have been reviewed using the PMRT, by a multidisciplinary review team as required by CNST. These cases have been completed to the point that at least the tool has generated a PMRT draft report. **Two** cases in the period remain under review

c) In **94.7%** of all deaths of babies who were born and died in the Trust from Friday 20 December 2019 until 30 June 2021 the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT process and in the outstanding cases; the perspective has been sought, increasing the total to **95.6%** fulfilling the CNST standard.

d) Quarterly reports are submitted as per standard and discussed with the Trust safety champion

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 have been met and a plan introduced to ensure standard c) is achieved has improved the standard from the previous quarter.
- Decide if any further information and/or assurance are required

Lorraine Cooper

Head of Midwifery July 2021

APPENDIX 1 June 2021 PMRT Update

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review update June 2021								
Outstanding and completed Neonatal cases upto June 2021								
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**Target for completion**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	**67679**	NND 33 weeks Unbooked	28/02/2020	**29/04/2020**	22/06/2020	**08/06/2021**	**C/C/A**	SI involving onocolgy
2	**72889**	NND 29+5 weeks	02/01/2021	**15/03/2021**	02/05/2021	**28/05/2021**	**A/A/A**	Delayed as Coroners PM , no issues identified
3	**73630**	NND @ 9 days 24+5 weeks	13/02/2021	**15/03/2021**	13/06/2021			SI investigation -awaiting completion
4	**73719**	NND 23+4 weeks	18/02/2021	**15/03/2021**	18/06/2021	**28/05/2021**	**A/A/A**	Unbooked - no issues identified
5	**73958**	NND 23 weeks	05/03/2021	**24/03/2021**	05/07/2021	**17/06/2021**	**B/A/B**	Writing report - Management of the prevention of preterm labour. Need for preterm clinic
6	**73968**	NND @ 17 days 30 weeks	06/03/2021	**24/03/2021**	06/07/2021			Delayed as Coroners PM - review maternity element
7	**74352**	NND @ 4 weeks 37+3 weeks	16/03/2021	**24/03/2021**	16/07/2021			Delayed as Coroners PM - review maternity element
8	**74488**	NND 22+2 weeks	17/03/2021	**30/03/2021**	17/07/2021			To agree and complete
9	**75197**	NND 24+3 week Twin	09/05/2021	**11/05/2021**	09/09/2021			York transfer to NICU - maternity care all in York
10	**75315**	NND 22+3 weeks	17/05/2021	**09/06/2021**	17/09/2021			Review maternity care followig transfer from Grimsby
11	**75708**	NND @ 4 months	07/06/2021	**11/06/2021**	07/10/2021			
	MBRRACE ID	***Stillbirth/ Neonatal Death***	***Date of death***	***PMRT commenced***	***Target for completion***	***PMRT Completed***	***Grading***	***Actions / Good practice***
Outstanding and completed Maternity Cases upto June 2021								
1	**74709**	SB 30 weeks unbooked	07/04/2021	**23/04/2021**	07/08/2021	**28/05/2021**	**A/B**	Completion of the partogram in labour - new document introduced
2	**75266**	SB 36+4 weeks	14/05/2021	**17/05/2021**	14/09/2021			SI briefing paper
3	**75364**	Term SB 40+2 weeks	19/05/2021	**21/05/2021**	19/09/2021			SI briefing paper - HSIB
4	**75416**	Term SB 38+6 weeks	22/05/2021	**26/05/2021**	22/09/2021			
5	**75484**	SB 36+6 weeks	26/05/2021	**17/06/2021**	26/09/2021			
6	**75490**	Late miscarriage 23 weeks	28/05/2021	**11/06/2021**	28/09/2021			Late booker

APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION TRACKER JUNE 2021

MBRRACE ID	ACTIONS	Lead	Due date	RAG
71385	Development of a specialist preterm clinic			
	Review bereavement guideline to ensure postnatal investigations needed are clear	SC	30/04/21	
71405	Feedback to midwife providing intrapartum care	JC	28/05/21	
	Review pre-term guideline to ensure it is clear what observations are required from 22 weeks gestation	JG	28/05/21	
71426	Update neonatal bereavement checklist	AM	30/06/21	
71568	Update bereavement checklist to capture information on informing parents where their baby is being taken	SC	28/05/21	
71823	Update bereavement checklist to capture information on informing parents where their baby is being taken	SC	28/05/21	
71861	Implement improved communication with reference to plans of care and follow from scans in ADU	WMc	28/05/21	
	Update bereavement checklist to capture information on informing parents where their baby is being taken	SC	28/05/21	
	To review process for women DNA growth scans	WMc	30/06/21	
	Review and amend if required use of oxytocin with women with an IUD who have had a previous LSCS	JG	30/06/21	
	Individual feedback and reflection with regard to the management of the 2nd stage of labour	KS	30/06/21	
	Review current support for women who do not access care in the AN period during the pandemic	JM	30/06/21	
73229	Review the current process in place for reviewing growth scans and documenting plans of care in ADU	WMc	30/06/21	
	Update bereavement checklist to capture information on informing parents where their baby is being taken	SC	28/05/21	
74709	Reminder to staff on monthly newsletter re completion of partograms	SC	30/07/21	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

RAG rating

Red – off track and overdue
Amber- off track but recoverable
Green – complete
No colour – not yet commenced

Agenda Item	8.1	**Meeting**	Performance and Finance Committee	**Meeting Date**	23.08.21
Title	Finance Report – month 4				
Lead Director	Lee Bond				
Author	Stephen Evans				
Report previously considered by (date)					

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	√	Valued, Skilled and Sufficient Staff	
Assurance	√	Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	√	Great Clinical Services	
				Well-led	√	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	√

Key Recommendations to be considered:

Performance and Finance is asked to note the following:

a) The year to date surplus of £0.2m in line with plan.
b) The struggle to identify efficiency schemes.
c) The H1 forecast deficit of £1.7m in line with plan.
d) The current underlying position of a deficit of £47.8m which is a deterioration of £38.4m from 2019/20

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE: MONDAY 23rd AUGUST 2021

FINANCIAL UPDATE - 2021/22 MONTH 4

1. Purpose of Paper

To inform the Performance and Finance Committee on the month 4 reported financial position and forecast to end of September 21 (H1).

2. Background

NHSEI has issued official planning guidance that sets out the details of the finance and contracting arrangements for the 6-month period from April 21 to September 21.

The Trust has set a target plan of a deficit of £1.7m for the H1 period. The overall Humber, Coast and Vale ICS position is break-even. This includes the £7.5m expected income to be received from the Elective Recovery Fund (ERF) and the associated expenditure. The threshold for delivery in Q2 has been increased from 85% to 95%. This may reduce the expected income for H1 by £2.3m.

3. Month 4 Reported Position

The table in appendix 1 shows the month 4 reported position against the NHSI plan, at health group level, with a high-level commentary on the variance. The Trust is reporting a surplus of £0.2m at month 4, which is in line plan. Appendix 2 shows the same position but at SOCI level, therefore showing the gross income and expenditure at Trust level.

4. Income Variances

Overall Trust income is £13.6m above the initial plan.

£6.4m of this relates to additional income to offset costs of vaccination programme (£5.2m), testing (£0.9m) and deployment of final year nursing students (£0.3m). All these items were excluded from the initial plan.

£5.4m relates to cost of additional pass through drugs and devices from NHSEI.

£3.0m relates to additional income above plan from the Elective Recovery Fund in the first quarter. £8.7m has been assumed delivered to date. This is above the full plan for H1 (£7.5m) but based on the centre increasing the baseline delivery for Q2 to 95% the Trust is not expecting to receive any additional income above the £8.7m.

£0.7m mainly relates to improved car parking income (£0.2m) and Income generation schemes (£0.4m). The level of income from Injury Compensation scheme is £0.15m below plan.

The income relating to donations and grant income is £2.0m below plan. This relates to the receipt of income from the Salix grant and is a phasing issue. The full income from the grant is expected to be received.

5. Expenditure Variances

Health Groups are showing as £1.0m above plan at Month 4, an increase of £0.5m in month.

£0.2m of the increase relates to high cost drugs that are covered within the block contracts. July saw a large increase in Home Delivery drugs which can fluctuate from month to month but will be kept under review. Surgery Health Group was £0.2m overspent with pressure on anaesthetic agency costs and junior doctors. Family and Women's Health overspend increased by £0.1m with pressure on continuity of carer in midwifery and continued use of Pioneer for Paediatric Gastroenterology. Remaining Health Groups were close to plan in month 4.

The Trust has identified £2.1m of expenditure to date in dealing with Covid19 and spend is fairly consistent at £0.5m per month. This does not include further costs including admin that have resulted as a result of the impact of Covi19 on waiting lists. The Trust is spending very little on additional PPE now as majority is sourced through national procurement routes and covered centrally.
The main headings of current spending are:

	Year to Date £000	H1 Forecast £000
Expand NHS Workforce	827	1,486
Decontamination	471	651
Segregation of Pathways	319	466
Remote Management of Patients	269	482
PPE Associated Costs	87	162
Other	95	110
Total	2,068	3,357

All health groups are struggling to identify recurrent CRES schemes and this remains a challenge for the Trust. The Trust plan for H1 included delivery of £1,2m savings from the Elective Recovery Scheme and this has been achieved in the first quarter. The Trust is able to cover the projected spend on elective recovery in Q2 from the income earned during Q1 and is therefore able to cover the impact of the increased threshold from 85% to 95%.

The reported position includes expenditure accruals of a further £2.0m to show the Trust being on plan. The expectation is that this will contribute towards a reserve that can be used in H2 if there are any funding issues in the second half of the year. Cost pressures are likely to increase in H2 as winter kicks-in and the Trust is being prudent.

6. Forecast Outturn (Months 1-6)

The Trust is currently forecasting that it will achieve its plan of £1.7m deficit for H1. The expectation is that this will also include a reserve of £2m to support H2.

Health Group and Corporate forecast positions are as follows:

	£000
Surgery	-286
Medicine	-657
Emergency Care Health Group	481
Clinical Support Services	-482
Clinical Support Services - pass through drugs	-726
Family + Womens Health	-440
Corporate Directorates	-34
Estates Facilities & Developmt	7
Other Expenditure	-13
Reserves	2150
Total	0

The above position assumes that the recently announced pay award of 3% or agenda for change staff and consultants that will be back-dated to 1st April 21 will be fully funded.

7. Underlying Run Rate

NHSEI have indicated that they will provide further guidance on H2 in September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there may a reduction in the level of Covid19 funding available. Elective Recovery Funding is expected to continue but there will also be an increased efficiency requirement of up to 3% required from October 21. This is now being classed as 'waste reduction.'

The Trust has been working through what its underlying financial position will look like when it moves forward into 2022/23.

The latest position is shown in Appendix 3 with the build up from the 19/20 outturn of £9.5m deficit as reported at previous Performance and Finance Committee meetings.

It should be noted that the planning rules around 2022/23 remain unclear with no guidance yet on what mechanisms will be in place and what the Trusts baseline level of income will be.

The current position is reported as a deficit of £47.8m. This is based on the following assumptions.

a) Costs are full year impact for 2020/23
b) CCG income from 2019/20 is only uplifted for 1.4% plus specific CNST funding (2.5% inflation less 1.1% efficiency target)
c) CCG income from 2020/21 is only uplifted by 0.5% plus CNST funding (0.78% inflation less 0.28% efficiency target)
d) No growth funding for 2020/21 and 2021/22 from CCGs included.
e) Specialist Commissioning income is increased in line with the inflation above plus for cost of pass through drugs as per current agreements. No other growth funding included.
f) Cancer Alliance funding for Lung Health Check, Rapid Diagnostics and Director post included but other commissioner funding excluded.
g) 2021/22 Pay Award of 3% is fully funded.
h) Only recurrent CRES schemes for 2020/21 and 2021/22 included at this point.
i) MRET funding and NCA funding remains in the system even if the flow changes.
j) Private patient income and Injury compensation income return to previous levels.

The Underlying deficit has increased by £38.4m. The main drivers of this are as follows and relate to expenditure growth for which no income source has been identified due to the delays in planning guidance and the delay to CRES identification and delivery.

	£000
Cost of Capital	3,574
Lung Health Check	2,500
MRI/CT Development	2,390
Flowers	1,200
Other 20/21 Pressures & Developments (Appendix 4)	5,143
Other 21/22 Pressures & Developments (Appendix 4)	6,089
Recurrent Covid19 pressures	8,940
Lost Income	2,319
20/21 & 21/22 CRES Shortfall	2,900
High Cost Drugs in Block	3,334
Total	38,379

There are also likely to be further pressures on top of the above which still need to be quantified and signed off.

Some of the shortfall will be met by additional income from commissioner growth and potential ongoing support funding for Covid19. This will include items such as Lung Health Check and MRI/CT development. Until the full extent of what funding will be available is known there remains a large potential deficit in the Trust without further action.

A 3% CRES target would be around £20m but based on historic delivery and the national agreement on deliverable targets, the maximum achievable may only be between 1 and 2% so between £7m – £14m. Planning guidance on the likely efficiency ask is expected by end of August 21.

This section on the underlying position will continue in each monthly report from now on so that the committee have full sight of any movements going forward.

8. Statement of Financial Position (SOFP) and Statement of Cash flow (SOCF)

The SOFP and SOCF for month 3 are reported in appendices 5 and 6.

Capital

The reported capital position at month 4 shows gross capital expenditure of £10.3m. The main areas of expenditure relate to the Salix Energy Efficient scheme, PFI lifecycle costs and Brocklehurst scheme and Urgent and Emergency Care.

The Trust is £4.6m below plan. £2.0m relates to capital donations and grants with the other £2.6m relating to the applications made for emergency PDC to support schemes agreed within the ICS CDEL limit. Expenditure on these will not be committed until the PDC funding is confirmed.

The forecast capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £58.1m and is in line with plan; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m).

The PDC Applications for Theatres and the Gamma Camera have been submitted for approval following some initial queries.

Cash

The Trust's liquidity position remains healthy with a cash balance of £50m at the end of July. The forecast cash balance by the end of March 22 at £35m will be reviewed regularly to reflect any changes in financial arrangements in H2 and the timings of capital spend along with costs and income associated with elective recovery.

To date the Trust has paid 96% by volume and 90% by value of non-NHS invoices within best practice terms. In July, the figures were 97% by volume and 86% by value. The shortfall on value largely related to 3 large Boots Pharmacy invoices totalling £2.2m and 4 capital invoices totalling £600k which had issues with processing. Discussions have been held with Pharmacy to ensure invoices are processed speedily. If these invoices had been paid on time the Trust would have been at 95% by value.

Debtors

The Trust currently has £2.8m of debt which is over 90 days. This has increased by £0.2m in month. The main debtors been as follows

Debtors over 90 Days	July 21	June 21	Change
	£	£	£
York & Scarborough Teaching Hospitals Nhs Ft	578,656	582,987	-4,331
City Health Care Partnership	211,626	170,192	41,434
University Of Hull	149,922	155,862	-5,940
Get Aid	92,900	-	92,900
Humber Teaching Nhs Foundation Trust	89,230	91,430	-2,200
Fresenius Medical Care Renal Services Ltd	89,043	75,054	13,989
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
Hull York Medical School	52,690	-	52,690
Ge Healthcare	51,962	51,962	0
Others	1,450,048	1,448,501	1,547
Total	2,836,397	2,646,308	190,090

Discussions continue with York to make mutual payments to reduce outstanding balances but is taking longer than expected. The Get Aid invoice has been raised with the company and it is now expected to be paid imminently. Balances on CHCP, University of Hull and Humber will be kept under review to ensure they do not start to grow again.

Stocks

Stock levels are at £15.5m, a drop of £0.1m in month and £0.5m higher than the year-end figures.

Health Group	Mar 21 £000	Jun 21 £000	Jul 21 £000	Change from Year-End £000
Clinical Support	7,460	7,500	7,246	(214)
Surgery	4,247	4,226	4,255	8
Medicine	1,026	1,756	1,831	805
F & WH	1,174	1,010	1,079	(95)
Other	439	437	438	(1)
PPE Stock	635	635	635	0
Total	14,982	15,565	15,485	503

Stock levels in medicine have been increased in the Cardiology area mainly to reflect increased levels of activity in the Cath labs and also to mitigate against delays in deliveries of supplies due to leaving the EU and the pandemic.

9. Recommendations

The Performance and Finance Committee is asked to note the following:

a) The year to date surplus of £0.2m in line with plan.

b) The struggle to identify new efficiency schemes which is a concern given the potential increase in target from October 21.

c) The H1 forecast of a deficit of £1.7m in line with plan.

d) The updated underlying deficit position of £47.8m and the need to clarify recurrent income and efficiency savings to offset this. This is a deterioration of £38.4m since 2019/20.

Stephen Evans
Deputy Director of Finance
August 2021

APPENDIX 1

Month 4 2021/22	Budget £000	Actual £000	Variance £000	Comments
Nhs Contract Income	211,072	211,174	102	
Education + Training Income	6,916	6,916	0	
Donated and Grant Income	6,059	4,019	(2,040)	Change in profile of Salix grant income
Other Income	826	676	(150)	Reduced number of Injury Compensation claims
Total Income	**224,873**	**222,785**	**-2,088**	
Surgery	(45,505)	(45,720)	(215)	
Medicine	(28,219)	(28,604)	(385)	Nursing costs in Elderly Medicine, Agency Stroke Consultant and pressure on Rheumatology ward medical staffing.
Emergency Care Health Group	(5,969)	(5,592)	377	Vacancies in Medical and Nursing staffing and underspend on drugs.
Clinical Support Services	(34,767)	(34,917)	(150)	Agency spend in Oncology and Heamatology.
Clinical Support Services - pass through drugs	(22,467)	(22,976)	(509)	Increased Drugs under Block Contract
Family + Womens Health	(27,641)	(27,782)	(141)	Continuity of Care, Paediatric Gastro outsourcing, Gynaecology medical staffing
Corporate Directorates	(25,190)	(25,122)	68	
Estates Facilities & Developmt	(15,333)	(15,345)	(12)	
Other Operating Expenditure	(2,628)	(2,610)	18	Agency Nursing
Reserves	(443)	554	997	Release of reserves to offset Expenditure
Total Operating Expenditure	**(208,162)**	**(208,114)**	**48**	
EBITDA	**16,711**	**14,671**	**(2,040)**	
Total Non Operating Expenditure	**(10,684)**	**(10,684)**	**0**	
Net Surplus/Deficit	**6,027**	**3,987**	**(2,040)**	
Donated and Grant Assets/Gains on Disposals Adjustment	(5,859)	(3,819)	2,040	Technical Adjustments related to donated assets excluded from performance position
Adjusted Financial Performance Surplus/Deficit	**168**	**168**	**0**	

APPENDIX 2

Month 4 2021/22

	Budget £000	Actual £000	Variance £000	Comments
Income from Patient Care Acrivities	213,159	218,568	5,409	Pass Through Drugs & Devices
ERF Income	5,706	8,722	3,016	Over delivered in Q1
Covid19 Income outside Envelope	0	6,417	6,417	Reimbursement for costs incurred
Education + Training Income	10,333	10,391	58	
Donated and Grant Income	6,059	4,019	(2,040)	Change in profile of Salix grant income
Other Income	6,379	7,079	700	Gains in Car Parking, Income generation and income to offset pay costs
Total Income	**241,636**	**255,196**	**13,560**	
Pay	(139,163)	(137,646)	1,517	Vacancies in Nursing and non clinical staff
Non Pay	(85,762)	(96,462)	(10,700)	Pass Through drugs and devices, purchase of non NHS healthcare. Clinical supplies for Elective Recovery
Covid19 Expenditure outside Envelpe	0	(6,417)	(6,417)	Costs Covered by Income
Total Operating Expenditure	**(224,925)**	**(240,525)**	**(15,600)**	
EBITDA	**16,711**	**14,671**	**(2,040)**	
Total Non Operating Expenditure	**(10,684)**	**(10,684)**	**0**	
Net Surplus/Deficit	**6,027**	**3,987**	**(2,040)**	
Donated and Grant Assets/Gains on Disposals Adjustment	(5,859)	(3,819)	2,040	Technical Adjustments related to donated assets excluded from performance position
Adjusted Financial Performance Surplus/Deficit	**168**	**168**	**0**	

					APPENDIX 3
HULL UNIVERSITY HOSPITALS NHS TRUST					
2019/20 TO 21/22 UNDERLYING FINANCIAL POSITION					
	£000				
2019/20 Outturn	-1,011				
Full year Effects	-8,452				
2019/20 Underlying Position	**-9,463**				
2020/21 Expenditure					
Inflation	-14,770				
Cost of Capital	-200				
Pass Through Drugs Growth	-9,800				
20/21 Pressures and Developments	-13,317				
CRES Delivery	3,783				
20/21 Additional Income					
Inflation	9,003				
NHSE (Pass Through Drugs)	7,900				
Education Income	788				
Cancer Alliance (LHC & RDC & Director)	1,890				
East Riding (Alfred Bean)	350				
Net 20/21 Underlying Position	**-23,836**				
2021/22 Expenditure					
Inflation	-17,430				
Cost of Capital	-3,574				
Pass Through Drugs Growth	-9,434				
20/21 Pressures and Developments	-6,245				
ICS	-4,267				
CRES Delivery	930				
21/22 Additional Income					
Inflation	15,007				
NHSE (Pass Through Drugs)	8,000				
ICS	4,267				
21/22 Underlying (Excluding Impact of Covid)	**-36,583**				
Recurrent Covid Costs	-8,940				
Lost Income Due to Covid	-2,319				
Net 21/22 Underlying Position (Including Covid)	**-47,842**				

					APPENDIX 4
20/21 PRESSURES AND DEVELOPMENTS			**21/22 PRESSURES AND DEVELOPMENTS**		
Lead Cancer Clinician	16		Peri-Operative Diabetes	44	
Ops Director ED	108		Cardiology Clinical Director	68	
Hugh Steeper Contract	100		New WLI Rates	68	
Helipad	62		Paediatrics Project Delivery Manager	58	
Security Contract	345		Radiology P2P	96	
NLAG Immunology Service	37		Medical Director Sessions	33	
Medical Examiner	6		TNA Nursing	23	
Scarborough Oncology Service	110		F&WH Business Manager	20	
Paediatric Gastroenterology	240		Junior Doctor Fill Rates	500	
Physicians Associates	59		Neuro MRI Reporting	96	
Cedar Ward	300		Radiology Outsourcing Contract Review	25	
H70 Junior Doctors	200		Nuclear Medicine New Drug	66	
LIMS	275		IT Network Costs	310	
ED Streaming	373		Cardiology Establishment	120	
TAVI	66		HASR Posts	95	
SACU	22		OP Dispensing Boots	575	
Paediatrics Facing the Future 1st Post	125		Paediatrics Facing the Future 2nd Post	125	
Imaging Maintenance	108		Lorenzo Contract	789	
Linear Accererator Warranty	150		Paediatric Surgery 5th Registrar	70	
SACU/ED/AMU Facilities	213		Colposcopy	227	
E-Rostering	91		Breast Surgery	480	
2nd Robot	120		Saving Babies Lives	35	
Lorenzo Digital Exemplar	400		Junior Doctor Rota Alignment	80	
Varian Contract	153		Radiology On-Call	759	
Oncology Workforce	500		H80 Change of Use	300	
AMU 12 Beds	468		Oncology Workforce Strategy	380	
Robotic Suite Funding	153		Cancer Assessment Unit	582	
9th Urology Consultant	114		ED Matron	65	
Ultrasound Hub	230				
Total	5,143			6,089	

APPENDIX 5

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2021 2020/21 £000	Actual 31/06/2021 YTD £000	Actual 31/07/2021 YTD £000	Movement from 31/03/21 £000
Non-current assets				
Intangible assets	5,980	5,602	7,166	1,186
Property, plant and equipment: on-SoFP IFRIC 12 assets	59,606	59,224	59,606	0
Property, plant and equipment: other	274,732	275,459	277,786	3,054
Investment property	100	100	100	0
Investments in joint ventures and associates				0
Other investments / financial assets	392	392	392	0
Receivables: due from NHS and DHSC group bodies	1,469	1,469	1,469	0
Receivables: due from non-NHS/DHSC group bodies	2,253	2,253	2,253	0
Other assets				
Total non-current assets	**344,532**	**344,499**	**348,772**	**4,240**
Current assets				
Inventories	14,982	15,565	15,485	503
Receivables: due from NHS and DHSC group bodies	8,871	19,978	25,191	16,320
Receivables: due from non-NHS/DHSC group bodies	10,298	11,406	12,435	2,137
Other investments / financial assets	0	0	0	0
Other assets	0	0	0	0
Non-current assets for sale and assets in disposal groups	0	0	0	0
Cash and cash equivalents: GBS/NLF	58,915	55,170	50,212	(8,703)
Cash and cash equivalents: commercial / in hand / other	12	12	16	4
Total current assets	**93,078**	**102,131**	**103,339**	**10,261**
Current liabilities				
Trade and other payables: capital	(26,808)	(6,708)	(9,570)	17,238
Trade and other payables: non-capital	(70,087)	(96,971)	(99,018)	(28,931)
Borrowings	(2,917)	(3,035)	(3,074)	(157)
Other financial liabilities	0	0	0	0
Provisions	(202)	(170)	(170)	32
Other liabilities: deferred income including contract liabili	(730)	0	0	730
Liabilities in disposal groups	0	0	0	0
Total current liabilities	**(100,744)**	**(106,884)**	**(111,832)**	**(11,088)**
Total assets less current liabilities	**336,866**	**339,746**	**340,279**	**3,413**
Non-current liabilities				
Trade and other payables	0	0	0	0
Borrowings	(54,350)	(53,920)	(53,774)	576
Other financial liabilities	0			0
Provisions	(5,683)	(5,683)	(5,683)	0
Other liabilities	0	0	0	0
Total non-current liabilities	**(60,033)**	**(59,603)**	**(59,457)**	**576**
Total assets employed	**276,833**	**280,143**	**280,822**	**3,989**
Financed by				
Taxpayers' equity				
Public dividend capital	292,247	292,247	292,247	0
Revaluation reserve	21,556	21,556	21,556	0
Financial assets at FV through OCI reserve	392	392	392	0
Other reserves	0	0	0	0
Merger reserve	0	0	0	0
Income and expenditure reserve	(37,362)	(34,052)	(33,373)	3,989
Others' equity				
Non-controlling Interest	0	0	0	0
Charitable fund reserves	0	0	0	0
Total taxpayers' and others' equity	**276,833**	**280,143**	**280,822**	**3,989**

APPENDIX 6

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2021 2020/21 £000	Actual 31/07/2021 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	1,304	8,610
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**1,304**	**8,610**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	16,506	6,068
Impairments and reversals	15,258	0
Income recognised in respect of capital donations (cash and non-cash)	(2,608)	(4,019)
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	0	
(Increase)/decrease in receivables	20,205	(18,457)
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(382)	(503)
Increase/(decrease) in trade and other payables	14,244	22,109
Increase/(decrease) in other liabilities	219	(730)
Increase/(decrease) in provisions	1,026	(33)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows		
Net cash generated from / (used in) operations	**65,772**	**13,045**
Cash flows from investing activities		
Interest received	8	0
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(1,569)	0
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(42,225)	(23,253)
Proceeds from sales of property, plant and equipment and investment property	3,069	0
Receipt of cash donations to purchase capital assets	807	4,019
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	**(39,910)**	**(19,234)**
Cash flows from financing activities		
Public dividend capital received	65,464	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(36,555)	0
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(22)
Capital element of PFI, LIFT and other service concession payments	(1,929)	(530)
Interest on DHSC loans	(512)	0
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(1)
Interest element of PFI, LIFT and other service concession obligations	(5,783)	(1,957)
PDC dividend (paid)/refunded	(6,994)	0
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	**13,631**	**(2,510)**
Increase/(decrease) in cash and cash equivalents	**39,493**	**(8,699)**
Cash and cash equivalents at 1 April - brought forward	19,434	58,927
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**19,434**	**58,927**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**58,927**	**50,228**

Meeting: Performance and Finance Committee

Date: 23rd August 2021

Agenda Item		**Meeting**	**Performance and Finance Committee**	**Meeting Date**	**23rd August 2021**
Title	Elective Recovery Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)					

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring		High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led		Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:

Urgent and Emergency Care

- Performance against the 4-hour standard was 72.8% for July.
- A revised 4-hour delivery action plan has been developed, alongside a review and update of the Ambulance Handover Improvement Plan.

Cancer

- The Trust did not achieve the 2 week wait target in month at 75.9%. With the exception of Breast, Head & Neck, Paediatric, Skin, UGI and Urology most other services achieved, or exceeded the 93% standard.
- Performance against the 62-day Cancer standard was 61.5% for June.
- The Faster Diagnostics Standard was not achieved in June, at 69.2%.

Diagnostics

- 37.1% of patients on the waiting list for diagnostics have waited over 6 weeks which is a slight deterioration on the June position.

Referral to Treatment Elective Standards

- The Trust had 7,409 52 Week breaches at the end of July which is a 657 improvement on the June position of 8,066.
- Both Trust Total Waiting List Volume (WLV) and 52 week trajectories were met in full.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		**Meeting**	**Performance and Finance Committee**	**Meeting Date**	**23rd August 2021**
Title	Elective Recovery Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)					

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Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring		High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led		Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:

Activity
All PODs were below the required delivery to achieve the revised 95% ERF trajectory for July in terms of activity volumes. The ERF has increased from the original 85% trajectory up to a 95% trajectory in month with limited notice or ability to increase the plans to achieve, especially as July is a key period of staff leave and our theatre capacity was reduced by circa 10% to reflect this.

Finance
Financial value delivered was 92%, only slightly under the revised 95% requirement despite the many challenges the increased ERF added to the system.

RTT
WLV and 52 week trajectories both delivered. P2 was 11% under the trajectory at 51.9%.

Cancer
2ww attendances were -48 patients below trajectory. 31 day treatments achieved the trajectory. 63+ day breaches did not achieve the trajectory at 186 (+37 to trajectory of 149).

Diagnostics
MRI and Colonoscopy were within 10% of their H1 activity plan. Flexible Sigmoidoscopy was significantly below both their plan and 19/20 baseline. Gastroscopy delivered 87% of their plan and Echocardiography 86%.

Outpatient Transformation
Advice and Guidance and PIFU metrics delivered against the trajectory. Virtual outpatient attendances was below plan at 21.5%.

The Performance and Finance Committee is asked to receive, discuss and note the content of the report. Where appropriate, identify and agree any areas of concern that are necessary for onward referral to the Trust Board.

Performance and Finance Committee

Elective Recovery Report

1. Purpose

To update the Performance and Finance Committee on the in-month delivery of the H1 Elective Recovery Plan with regards to the submitted activity/value thresholds and agreed Trust performance trajectories.

2. Background

The Trust submitted the draft H1 operational plan on 27th April 2021. This plan identifies both activity (in numbers) and also total value of activity against the agreed National thresholds. Receipt of income via the Elective Recovery Fund (ERF) is based on activity values, when comparing those achieved in 2019/20 against the current 2021/22 plan.

The agreed thresholds set a trajectory of expected activity achievement from April (70%) through to the end of September (85%) which recognises the impact of transition back to more normal levels of activity post Covid surge. The final plan was submitted on 20th May 2021 with some slight adjustments to activity and the P2 trajectory.

On 9th July 21 all Trust's received updated guidance C1344 – *Elective Recovery: Funding and Reform Letter* setting out a significant change to the original trajectory figures which were to be implemented with immediate effect in the month of July. This change saw the original in month trajectory increase from 85% as a minimum up to a minimum delivery of 95% of 2019/20 activity from July through to September 2021.

The ERF tariff thresholds were also changed from July, meaning that we will be paid at 100% of tariff above the 95% threshold, and at 120% of tariff above 100% of 2019/20 activity.

The ERF funding will continue to be earned on a system basis to encourage systems to continue to use their capacity and resources as flexibly as possible across organisations to maximise recovery activity.

3. Summary

The summary of the submitted Trust H1 Plans and actual delivery in July are outlined below.

Recovery Summary @ 160821

Key

			* Provisional data at 2.8.21	On Target	Within 10% of Plan	Not Met	
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	ERF Activity Trajectory	70%	75%	80%	95%	95%	95%
Activity (Activity as % of 19/20)	Outpatient New	94%	92%	106%	94%		
	Outpatient FUP	99%	90%	107%	86%		
	Day Case	85%	88%	108%	92%		
	Elective Ordinary	71%	80%	80%	84%		
Activity (Activity as % of H1 Plan)	Outpatient New	105%	106%	109%	108%		
	Outpatient FUP	101%	102%	110%	95%		
	Day Case	105%	97%	109%	96%		
	Elective Ordinary	97%	95%	90%	100%		
Trajectories (Internal & ICS)	RTT WLV Trajectory	61,611	61,031	59,050	57,576	56,917	55,803
	RTT WLV	60,422	59,993	58,476	57,560		
	52 week Trajectory	11,157	9,618	8,610	7,902	7,455	6,964
	52 weeks	10,750	9,268	8,066	7,409		
	P2 Trajectory	47%	55%	60%	63.3%	66.7%	70%
	P2 waits <4 weeks	47.3%	55.1%	50.2%	51.9%		
Cancer (H1 Op Plan)	Cancer 2ww Attends Trajectory	2,053	2,009	1,989	2,039	2,115	1,961
	Cancer 2ww Attends	1,745	1,863	2,116	1,991		
	Cancer Treatments Trajectory	343	369	397	409	380	356
	Cancer Treatments	355	294	340	432		
	Cancer 63+ days Trajectory	174	165	158	149	140	130
	Cancer 63+ days	171	186	163	186		
Diagnostics (Activity as % of 19/20)	Magnetic Resonance Imaging	109%	108%	114%	111%		
	Computed Tomography	105%	111%	114%	109%		
	Non-Obstetric Ultrasound	86%	90%	88%	80%		
	Colonoscopy	91%	71%	85%	83%		
	Flexi Sigmoidoscopy	65%	64%	46%	52%		
	Gastroscopy	97%	79%	81%	76%		
	Echocardiography	63%	69%	102%	73%		
Diagnostics (Activity as % of H1 Plan)	Magnetic Resonance Imaging	97%	103%	98%	96%		
	Computed Tomography	111%	118%	121%	124%		
	Non-Obstetric Ultrasound	110%	113%	113%	115%		
	Colonoscopy	101%	90%	90%	92%		
	Flexi Sigmoidoscopy	86%	73%	55%	53%		
	Gastroscopy	108%	91%	94%	87%		
	Echocardiography	90%	93%	128%	86%		
Outpatient Transformation (H1 Op Plan)	Non F2F Trajectory	25%	25%	25%	25%	25%	25%
	Non F2F Actual	19.5%	23.1%	21.6%	21.5%		
	A&G Requests Trajectory	2,537	2,537	2,537	2,537	2,537	2,537
	A&G Requests	2,640	2,474	2,823	2,784		
	PIFU Trajectory	132	132	132	132	132	132
	PIFU Additions	123	230	253	269		

For each area outlined above that are behind planned activity numbers in month, these will require further attention by the Health Groups, specifically the total number of Cancer treatments in month, 63+ day Cancer breaches, Flexi Sigmoidoscopy, Gastroscopy and Endoscopy modalities, P2 performance and virtual outpatient consultations.

It is to note that methodology for virtual (non-face to face attendances) has changed to include all outpatient attendances reported through SUS. Prior to this change, the number of patients was derived from the Trust's internal monitoring of those attendances without an outpatient procedure.

4. Elective Activity Plan

The Trust has not achieved the ERF threshold of 95% of 19/20 baseline activity in July at all Points of Delivery (PODs).

- Outpatient new although above the H1 plan by +1,283 (108%) we remained below the 95% by 140.
- Outpatient follow up was 5% below the H1 plan and 86% of baseline (-3,297 to 95%)
- Day case procedures delivered 96% of the H1 plan and 92% of baseline (-184 to 95%)
- Ordinary Elective delivered 100% of H1 plan and 84% of baseline (-149 to 95%)

It is also worth to note that the July 2019 baseline activity was significantly higher than that seen in previous months.

In addition, we may still increase the total activity numbers outlined above, as there is an element of lag in terms of reporting and therefore recording until the SUS freeze date.

In addition to the Trust levels summary shown below, the Health Group activity summaries outlining actual activity at POD level and applicable finances for each HG are shown for information in Appendix 1.

Further detail and specific commentary received from Health Group Operations Directors (for the top 12 specialties) are detailed in Appendix 2.

TRUST Level Activity at POD

Activity data up to	09/08/2021		Apr	May	Jun	Jul
			*Actual activity for current month is projected using working da			
Elective Recovery Fund Threshold:			70%	75%	80%	95%
						ERF thresholds Ju
TRUST TOTAL	New	Baseline	17,631	17,087	16,627	18,381
		Plan	14,332	14,710	16,084	16,039
		Actual*	14,749	15,347	17,200	17,322
		H1 Plan %	103%	104%	107%	108%
		19/20 Baseline %	84%	90%	103%	94%
	Follow Up	Baseline	32,415	36,173	34,175	38,080
		Plan	31,681	31,919	33,178	34,620
		Actual*	32,968	32,584	37,445	32,879
		H1 Plan %	104%	102%	113%	95%
		19/20 Baseline %	102%	90%	110%	86%
	Day Case	Baseline	6,080	6,198	5,817	6,488
		Plan	4,948	5,607	5,776	6,231
		Actual*	5,213	5,456	6,297	5,980
		H1 Plan %	105%	97%	109%	96%
		19/20 Baseline %	86%	88%	108%	92%
	Ord Elect	Baseline	1,203	1,276	1,296	1,341
		Plan	881	1,073	1,155	1,122
		Actual*	856	1,019	1,049	1,125
		H1 Plan %	97%	95%	91%	100%
		19/20 Baseline %	71%	80%	81%	84%

As can be seen above, planned delivery levels of activity were not achieved and were below the revised (and increased) National Threshold of 95% in month of July for all PODs. The financial ERF likewise was not achieved at a Trust level reaching only 88%; it should be noted however that access to the ERF funding is reliant on all Trust in the ICS meeting the national threshold of 95% of 2019/20 financial values, and overall position for the ICS is not yet confirmed.

5. Diagnostic Activity Plan

The H1 operational plan requirement for diagnostics is to deliver "Recovery of the **highest possible** diagnostic activity volumes will be particularly critical to support elective recovery".

MRI (-89), Colonoscopy (-27), Flexi-sigmoidoscopy (-85), Gastroscopy (-65) and Echocardiography (-71) did not deliver their H1 plans.

Flexi-sigmoidoscopy delivered 52% of 19/20 activity and 53% of their H1 plan.

Appendix 3 details the activity against the Trust H1 plan for the top 7 diagnostic modalities.

6. RTT Trajectories

The Trust exceeded both the WLV and 52 week trajectories at the end of July 2021.

7. Priority 2 Trajectory

The trajectory for July was not delivered although slightly improved on June at 51.9% of the P2 waiting list <4 weeks. The main specialties driving the under-delivery of the trajectory are Cardiology, Pain Management, Vascular, Plastic Surgery, Colorectal Surgery and Orthopaedics and each area will review the cause of this drop in performance, which resulted in this plan not being delivered.

8. Cancer Trajectory

The submitted plan for 63+ day cancer breaches was above the planned trajectory with 37 more than the planned trajectory of 149. The Trust level trajectory has been allocated down to each tumour site in order to monitor delivery. 6 of 9 tumour sites were above their trajectories with only Gynaecology, Upper GI and Colorectal achieving their trajectories.

In constructing the submitted Cancer plan, an expectation of "bounce back" for referrals and treatments not received during 20/21 was included. The H1 plan is based on 2 week wait attendances which were below the "bounce-back" plan by 48. The expectation is that primary care will undertake active case finding to identify patients who may require an urgent cancer referral.

Although each tumour site has agreed a trajectory for 2ww attendances, it should be noted that delivery against this is subject to actual referrals being received, which is outside of the Trust's control.

The total numbers of cancer treatments in month were above the submitted plan by 23.

9. Outpatient Transformation

The H1 plan has 3 key areas for outpatient transformation. Increasing non-face to face outpatient activity with a minimum of 25%, was not achieved in July, we reached 21.5% (see earlier note of change in methodology for this indicator). Use of Advice and Guidance with a monthly trajectory based on 20/21 baseline, which was above plan.

Implementation of Patient Initiated Follow Up (PIFU) in at least 3 main specialties with a monthly additions trajectory, of which the Trust delivered above the plan with 269 (+137 on plan). The 3 main specialty are that of Cardiology, Dermatology and Neurology.

10. Financial Summary

The overall financial summary shows non-achievement of the ERF trajectories in July 2021 at all Points of Delivery except Ordinary Elective. However, it is to note that the delivery remains above the original 85% requirement originally set in all PODs. Appendix 1 has the breakdown by Health Group.

		TARGET	70%	75%	80%	95%
HG	**POD**	**Data**	**April**	**May**	**June**	**July**
TRUST	01 Day Case	Baseline 2019-20	3,639,987	3,464,075	3,970,856	3,799,012
		Actual 2021-22	2,992,961	3,356,817	3,876,396	3,472,287
		Baseline %	82%	97%	98%	91%
		Indicative income gain	***444,970***	***841,231***	***799,945***	***-136,774***
	02 Elective	Baseline 2019-20	4,938,120	4,747,625	5,979,783	5,104,469
		Actual 2021-22	3,818,856	4,813,142	4,914,172	5,006,304
		Baseline %	77%	101%	82%	98%
		Indicative income gain	***362,172***	***1,407,955***	***130,346***	***157,059***
	05 Outpatient Firsts	Baseline 2019-20	3,211,203	3,054,088	3,518,003	3,428,518
		Actual 2021-22	2,735,695	2,972,459	3,320,813	3,100,280
		Baseline %	85%	97%	94%	90%
		Indicative income gain	***489,087***	***757,190***	***572,513***	***-156,812***
	06 Outpatient Followups	Baseline 2019-20	3,129,962	3,084,372	3,515,090	3,469,481
		Actual 2021-22	2,984,331	2,943,596	3,371,053	3,011,198
		Baseline %	95%	95%	96%	87%
		Indicative income gain	***858,130***	***694,693***	***635,626***	***-284,809***
TRUST Overall		Baseline 2019-20	**14,919,272**	**14,350,159**	**16,983,732**	**15,801,479**
		Actual 2021-22	**12,531,843**	**14,086,013**	**15,482,434**	**14,590,069**
		Baseline %	**84%**	**98%**	**91%**	**92%**
		Income gain	**2,154,359**	**3,701,069**	**2,138,430**	**-421,337**
Included in financial position		**ICS Calc**	**2,906,102**	**3,681,189**		
		ICS Plan assumed at M3			**2,134,320**	**0**

11. Conclusion

The Trust made excellent progress in delivering the planned activity in Quarter 1, however with the extremely late change in the national trajectory requirement to 95%, plus July 2019 activity baseline being significantly higher than other months, alongside non-elective demand displacing some elective activity the July 2021 ERF trajectory has not been met. The financial value delivered 92% of 19/20 activity; -£420k below the baseline and therefore there is a risk to the ICS in relation to the receipt of additional recovery funding in the month of July.

Regular exception reporting has been implemented within each Health Group where the agreed activity plan is more than 10% below the H1 plan at POD level. The exception report will also cover where the specialty is: -

- above the RTT WLV
- above the 52-week trajectory
- below the trajectory for P2 patients waiting less than 4 weeks
- below the trajectory for 2ww attendances
- below the plan for cancer 31 day treatments
- above the 63+ day wait trajectory

- **Issue: Why has the plan not been delivered in month**
- **Action: What actions will be taken to address the shortfall and is it recoverable**
- **Outcome: When can we expect the plan to recover, rectification timeline**

12. Recommendation

That the Performance and Finance Committee receive, discuss and accept the report and confirm or otherwise indicate assurance of the Committee in relation to our Elective Recovery Plan progress.

Hull University Teaching Hospitals NHS Trust

Trust Board and Committee Front Sheet

Agenda Item	8.1	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	✓
						Financial Sustainability	✓

Key Recommendations to be considered:
The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

14th September 2021

Our People

1. Purpose

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

2. Background

At the previous Board meeting in July the Trust had 10 Covid-19 inpatients. As at 7th September, 2021 the Trust has 70 Covid-19 inpatients. A significant increase. Community infection rates have also significantly risen and the Trust is once again under extreme pressure continuing to fight the pandemic whilst attending to the high demands on our Emergency Department and continuing to reduce our overall waiting lists. The current pressures are exacerbated as staff continue to self-isolate if symptomatic. The guidance on self-isolation has changed late August, so more staff isolating are only absent for 2 or 3 days not 10 as they can return to work following a risk assessment. Staff are exhausted. Silver command and Executive team are monitoring and managing the position on a daily basis.

3. Key Issues

Staff Absence

The total staff sickness absence for the financial year 2020-21 was 3.51%. The total absence including sickness and Covid-19 for 2020-21 was 7.20%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 208 staff absent due to Covid-19 which is 1.91% of the workforce. Total sickness and Covid-19 absence is currently 5.69%. This is a slight increase from 5.41% as at the last Board meeting in July.

4. Staff Testing

Symptomatic Testing (PCR)

The Trust continues to test symptomatic staff and family members for Covid-19 via a drive through facility which has been in operation since April 2020. Between April 2020-June 2021, we have tested 15,446 HUTH staff or family members (15.5%) of which were positive.

During August, 881 HUTH staff or family members were tested. 229 HUTH staff or family members tested positive. In June, 2020 459 HUTH staff or family members were tested and 34 were positive. The positivity rate for Aug 2021 was 26%. The staff positivity rate over the past few months is as follows –

December 2020	26.6%
January 2021	22.4%
February	15.3%
March	10.9%
April	2.2%
May	2.9%
June	7.4%
July	29.0%

Asymptomatic Staff Testing (LAMP)

On Tuesday 1 June 2021, the Trust commenced LAMP testing via a partnership with the University of York and Capita. LAMP testing has been offered to all staff, clinical and non-clinical and will replace lateral flow testing for most staff.

Uptake has been below expected levels and is reducing from a peak in June of 12.3% to just 7.4 % at the end of August. This means the vast majority of our staff are not currently undertaking any routine asymptomatic testing. Informal feedback is that the lamp test is more problematic / difficult to undertake than LFT and staff do not like 'to spit'. A meeting has been arranged to discuss this in September with a view to increasing the uptake to a level that represents a robust asymptomatic testing programme.

Test and Trace

The NHS Test and Trace programme launched on Friday 5th June 2020. To date the Trust has requested 1284 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, 192 in October, 236 in November, 137 in December, 121 in January, 2021, 25 in February, 34 in March, 12 in April, 19 in May, 121 in June, 118 in July and 229 in August.

5. Staff Vacancies

The Trusts overall vacancy position as at 31st July 2021 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1407.1	1371.0	73.2	0.0	0.0%
Add Prof Scientific and Technical	368.2	307.0	4.3	57.0	15.5%
Administrative and Clerical Staff	1639.3	1554.9	13.2	71.1	4.3%
Allied Health Professionals	487.0	462.8	11.0	13.2	2.7%
Estates and Ancillary	601.2	519.4	2.4	79.4	13.2%
Healthcare Scientists	330.5	307.1	0.0	23.4	7.1%
Medical & Dental - Consultant	499.5	451.2	13.7	34.6	6.9%
Medical & Dental - SAS	64.6	48.4	0.7	15.5	23.9%
Medical & Dental – Trainee Grades	655.3	634.9	17.3	3.1	0.5%
Nursing and Midwifery Registered	2385.6	2257.0	39.2	89.4	3.7%
Trust Total	8438.3	7913.9	175.0	349.5	4.1%

Overall the Trust vacancy position is 4.1%. The Consultant vacancy rate is 6.9%. Whilst our vacancy situation remains in a healthy position the Trusts recruitment plans during this financial year have been interrupted, but recruitment and retention remains a key priority.

The vacancy rate for Registered Nursing and Midwifery is currently 3.7% across the organisation.

The Trust is currently pursuing 117 adult and paediatric student nurses predominately from the University of Hull.

There are currently 39 Registered Nursing Associates (RNA) and 5 more who have completed the programme but are just awaiting their PIN. There are 36 Trainee Nursing Associates (TNA`s) employed by the Trust. The Trust has successfully recruited a further 25 TNA`s who will commence the programme in September 2021.

From the perspective of the Registered Nurse Degree Apprentices (RDNA) there are currently 33 in training, with 13 of the 2018 cohort due to qualify as Registered Nurses this month. More RDNA's will be recruited to the programme this month as well.

In relation to the Health Care Support Worker Apprentices, there are currently 26 in training, 9 of whom will complete their apprenticeship this month. It is envisaged that potentially 7 of these apprentices will transfer onto the RDNA programme with the remaining 2 onto the TNA programme. In conjunction with Hull College and the University of Hull the Trust plans to recruit a further 15 HCSW to commence their programme in September 2021.

From an international perspective, the Trust has successfully recruited 208 international nurses mainly from the Philippines since October 2017. Of those 5 have left the Trust which is a retention rate of 97.5%. Of those that left 4 have relocated to be with family in the UK (3 in London and 1 in Brighton) and the other left for a promotional opportunity in Leeds.

In response to the financial support offered by NHSI/E, the Trust plans to recruit a further 30 international nurses, by December 2021. There are also 9 existing Trust HCSW`s currently being supported through the OSCE process.

6. Vaccination programme.

HUTH is the Lead Agency to deliver the ICS Covid-19 vaccination programme. Led by Beverley Geary Chief Nurse, a population and health and care staff vaccination programme has been rolled out. A total of 56,000 vaccines have been administered from the centre. Over 8,500 HUTH staff have been vaccinated. The vaccination centre has now reduced its operating times to 1 clinic per week.

The Covid-19 boosters and seasonal flu vaccination programme is jointly managed by Carole Hunter, Head of Occupational Health and Steve Jessop, Chief Nurse Information Officer. Trusts were instructed to have plans in place to start offering Covid-19 booster doses to staff from the 6th September however the Joint Committee on Vaccination and Immunisation is still awaiting the outcome of trials before issuing further guidance. The flu vaccine programme will commence 14th September. It had been anticipated that the Covid-19 booster and the flu vaccine could be given at the same time however this has not yet been approved. Trusts have been advised not to delay starting the flu vaccine programme whilst awaiting further guidance. Vaccination hubs at HRI and CHH have been set up as reporting and storage requirements dictate that it is not feasible for the vaccines to be administered in wards or departments by peer vaccinators as in previous years.

7. Communications and engagement

Staff Surveys

From Quarter 2 (July-September) all NHS organisations were required to run a quarterly staff engagement survey based on the nine engagement questions in the national survey – Q3 will be the national survey itself. A quarterly staff engagement score for the trust will be submitted to NHSE/I from Q4 2021/2022 onwards.

The Trust ran a successful pilot version of this with our new provider, Picker, for quarter 2. The national staff survey will be running during October/November as usual.

The Q2 engagement score for HUTH was 6.85, compared with an average of 6.76 for all organisations currently using Picker as their survey provider.

A detailed report will be presented to WEC.

8. Staff Support Arrangements

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work.

The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for

general mental wellbeing support. An internal clinical Psychology service for staff is now available via Occupational Health. We also now have an in situ Staff Support Clinical Psychologist in ICU. Coaching services are now being accessed via the coaching referral form available on Pattie.

The 24/7 staff support hotline will continue to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address. As Covid-19 number continue to rise the Staff Support MDT will adapt services to be flexible and line with the needs of staff.

The OD team are working with a number of wards to hold team development and support sessions, which are designed to allow reflection, restoration and a look to the future. This is coupled with in-reach by the Staff Support Psychologists and a Senior OD Practitioner.

The Quick Guide to Staff Support is available and updated regularly on Pattie to effectively signpost our staff to local and national services.

Wellbeing Conversation Roll Out
A new version of MyAppraisal was launched on 7th July 2021 which now includes a more comprehensive Wellbeing Conversation tool that prompts the appraiser and records the outcome of the conversation. It makes sure that at least once a year that these conversations will be happening to support our staff.

Alongside this a new training session is available to support managers to make these conversations as effective and meaningful as possible. Since launch 66 managers have completed this training. Of those that completed a conversation 83% found it very helpful. From a managers side most completed this section of the appraisal although out of the 91 completed since the launch 22 had this as a blank section. As awareness grows of the importance of the conversation we expect this number to reduce. It will be monitored over the coming months.

The Schwartz round initiative “Team Time” programme continues and we have now signed up to the full Schwartz round programme, which allows us more freedom on the sessions we can run. Those attending find them useful but there is still a need to create more awareness about the benefits they can bring. Three more sessions are planned with ‘Disability, HUTH and a flipping pandemic’ (14th September 3pm), ‘Rudeness at work’ (October) and an ‘Empty seat at the table’ (December). We plan to engage with senior leaders and clinicians to encourage them to become storytellers and relaunch the programme under the Schwartz Round banner. We hope that Team Time will continue grow in demand and continue to have a positive impact upon our people.

9. Learning and Organisational Development

Despite the challenges of Covid-19, apprenticeships have continued to thrive in the Trust. Of the 226 learners currently on programme, only 13 are on a break in their learning.
Since the introduction of the apprenticeship levy in 2017, the Trust has:

- committed to over £5.8m of learning activity
- supported over 500 colleagues onto apprenticeships (both existing and new staff)
- 199 colleagues have now achieved their full apprenticeship
- 76 colleagues have withdrawn from their apprenticeships (the bulk of which were substantive staff – 52)[1]

Currently, the Trust is supporting the following apprenticeship activity:

- 226 colleagues (both substantive and apprentices) on apprenticeship programmes worth approx. £3.3m

[1] To note, this equates to £559,000 for substantive staff and £113,000 for apprentices we would have spent if remained on programme

- Agenda for Change profiles for substantive staff on apprenticeships range from Band 2 through to consultant
- 49 colleagues awaiting apprenticeship programme starts this autumn (of which 20 are new employees to the Trust), this equates to a further £630,000 of learning

The apprenticeship team is also working closely with departments across the Trust to identify opportunities to expand apprenticeships to support their career pathways. This includes:

- Nuclear Medicine (with 2 x HEE salary supported apprentices starting in September 2021)
- Radiation Engineering and Radiotherapy Physics (again, with a post each being salary supported by HEE to start in September 2021)
- Dietetics
- Speech and Language Therapy
- Nursing teams for Enhanced Clinical Apprenticeships (as well as Advanced Clinical Apprenticeships)
- Voluntary services support team
- Medical Engineering

To meet these increasing needs on capacity, the apprenticeship team is working with Salisbury Managed Procurement Services (SMPS) - Salisbury NHS Foundation Trust - to identify and procure HEE approved provision that meets quality standards (for example Ofsted).

The apprenticeship team is also continuing to work with local providers to sustain wider education provision in the region in line with our social responsibility.

Key Challenge: Expiring levy

Levy funds continue to expire on a monthly basis (these are unused funds that are taken from the digital account after 24 months if unspent). To address this, the apprenticeship team are taking the following steps;

- Enabling swifter commissioning and commencement of apprenticeships through using approved HEE providers identified on the SMPS
- Working with Humber, Coast and Vale Health and Care Partnership to identify opportunities to transfer funds before expiry to other NHS/affiliated organisations who are either non-levy payers (ie, GP practices) or smaller levy-payers where internal funds are limited
    - Currently we are looking to transfer up to £86,000 of our allowance to NHS providers in the HCV region, pending approval
    - This would be in addition to the £32,000 of levy previously transferred

Nursing and Allied Health Professionals Education Funding

Health Education England have changed the way they fund continuing professional development (CPD) and specialist post registration skills for our nursing and AHP staff. Previously all funding would go directly to higher education institutes and while this continues at a smaller rate of funding, a new CPD fund has been created and is directly allocated to Trusts. We are in year 2 of a 3-year funding promise and this year our allocation was £1,010,333. Our spending plan has now been approved by HEE and half of the allocation has now arrived at the Trust.

The money will be spent in a variety of ways from internal clinical educator roles to maximise funding and bring education to the teams across NICU, ED, Tissue Viability, Falls and even a new Lead Nurse Associate role. These roles will also directly support the digital roll out programme alongside embedding quality improvement approaches and a clinical supervision service. We also have a process for staff to apply for funding for everything from conferences to university accredited modules. A CPD Advisory Board meets monthly to allocate funding and align personal

development goals with Trust and Health Group roles. This funding is open to all non-medical registered staff within the Trust.

Great Leaders Programmes Restarting

Managers at all levels within our Trust are needed more than ever to create outstanding work environments for our people, so we have focussed our efforts to restart our leadership programmes. Supporting and developing our managers to become truly compassionate and transformational leaders is a key priority for HUTH.

Be Remarkable

This is a programme designed for existing leaders and leadership teams to stretch their skills and knowledge to make a difference in their workplace and ultimately patient care. 3 cohorts starting this autumn (Sept, Oct, and Nov) from Jan 2022, there will be cohorts every 2 months. They will complete module 1 as a cohort, they can then access units in module 3 to fit operational needs as these will be repeated every two months, before coming together as a group in module 3 to complete the programme. So far 26 leaders have signed up for the first 3 cohorts.

Rise and Shine

Rise and Shine is for new and emerging leaders to hone their leadership and management skills. This programme runs for 11 months. We have 2 cohorts running over the next year one starting in September and one in March next year. Both cohorts are booked with 24 people in total.

Supervisors +

This programme is for leaders that are not yet line managers but take on leadership responsibilities within their team. It is a 6-month programme with 2 cohorts advertised one in September which has 12 people booked on it and one in March next year that already has bookings.

10. Recommendations

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

Officer to contact:

Simon Nearney
Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust

Agenda Item	8.10	**Meeting**	Trust Board	**Meeting Date**	14.09.21
Title	**CLINICAL REVIEW OF ISSUES ARISING FROM THE TRANSFER OF COMMUNITY PAEDIATRIC MEDICAL SERVICE OF CITY HEALTHCARE PARTNERSHIP TO HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST AND HUMBER TEACHING NHS FOUNDATION TRUST**				
Lead Director	Beverley Geary, Chief Nurse				
Author	Julia Harrison-Mizon, Director of Operations – Family and Women's Health Group				
Report previously considered by (date)	The report has been considered at the July 2021 Board meeting, in the private part of the meeting				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only	✓	Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
The Board is asked to note the contents of the report.

CLINICAL REVIEW OF ISSUES ARISING FROM THE TRANSFER OF COMMUNITY PAEDIATRIC MEDICAL SERVICE OF CITY HEALTHCARE PARTNERSHIP TO HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST AND HUMBER TEACHING NHS FOUNDATION TRUST

SEPTEMBER 2021

1. INTRODUCTION

The purpose of this paper and attached report is to update the Trust Board the outcome of the clinical review of the issues arising from the transfer of Community Paediatric Medical Services from City Healthcare Partnership CIC.

2. BACKGROUND

The contractual commissioning of the Community Paediatric Medical Service was transferred from City Health Care Partnership to both Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust on 1 April 2019.

On transfer, following clinical review of each of the circa 2,400 patients (transferred to HUTH), it was found that there were delays in patient referrals and out-patient reviews, which impacted on the assessment and treatment pathways for these children, and may have caused harm.

This report outlines the findings of the inquiry into issues arising upon the transfer of Community Paediatrics Medical Service provision in Hull and the East Riding of Yorkshire and aims to give a detailed understanding of what happened, the nature of any harm suffered by patients, the action taken to mitigate any harm, a review of the reconfigured Community Paediatric Services and a summary of lessons learnt.

The work described in the report has been overseen by the Community Paediatric Oversight Group, a system wide partnership, inclusive of NHE England/Improvement, NHS Hull Clinical Commissioning Group (HCCG), NHS East Riding of Yorkshire Clinical Commissioning Group (ERYCCG), Hull University Teaching Hospitals NHS Trust (HUTH), City Health Care Partnership (CHCP) and Humber Teaching NHS Foundation Trust (HTFT).

The Oversight Group and resulting report was led by Professor Andrew Cant (Consultant Paediatrician and Chair of the Northern England Clinical Senate) with input from an independent Consultant Paediatrician (with a specialist interest in neurodisability), Dr Alistair Morris. The Terms of Reference for the review can be found in Appendix 1 of the report.

The Trust Board reviewed the report in the private part of its July 2021 meeting. The report will be placed in the public domain today and can be found at: https://www.eastridingofyorkshireccg.nhs.uk/cpms-clinical-review

3. METHODOLOGY AND SUMMARY OF FINDINGS

3.1 Methodology

The external independent clinical review was undertaken by Dr Alistair Morris, MBBS, MRCPCH, MSc Child Health, PGDip Neurodisability Consultant Paediatrician with a special interest in Neurodisability from Calderdale and Huddersfield NHS Foundation Trust.

The focus of review was to:

(i) Review a random selection of 'No Harm' cases to provide assurance of appropriate assessment

(ii) Review cases identified as having suffered harm and with Dr Sandhya Jose and Dr Chris Wood, decide on level of harm and actions taken to mitigate this harm

(iii) Identify any common themes resulting in this harm

(iv) Appraise the service design for new *(HUTH)* Community Paediatric service.

3.2 Findings in relation to individual patients

The findings of external review were submitted to the Community Paediatrics Oversight Group in March 2020. In terms of the HUTH approach to the transfer of patients, Dr Morris found that:

- 2,427 cases were transferred from CHCP to HUTH. Of these 46.2% were discharged after the desk-top of the clinical records. The remaining 53.8% were triaged and reviewed through a face to face or telephone appointment by HUTH.

- Of these 68 were identified as having suffered potential harm by the HUTH clinicians on first review. On second review 28 were classified as having suffered no harm and 40 were classified as having suffered potential or actual harm.

- Of these remaining 40, 11 cases had been transferred to HTFT and therefore no up to date clinical information was available to Dr Morris to make an assessment, however from the information provided there was potential for harm due to non-timely medication review in these cases which is well recognised.

Of these 29 cases, Dr Morris considered that:

- 17 suffered No Harm
- 3 Mild Harm (minimal harm – patient(s) required extra observation or minor treatment).
- 8 Moderate Harm (short term harm – patient(s) required further treatment, or procedure) (7 confirmed, 1 potential).
- 1 Severe Harm - this was the SI already investigated by HUTH (permanent or long term harm).

All of these incidents have been logged through the HUTH Datix system.

The parents/carers of the 11 children/young people have been contacted with a view to authorising access to the HUTH held records by CHCP to enable them to understand what, if anything, they could have done better and so that the local health partners can fulfil the Duty of Candour, and make any apology needed should the Community Paediatric Medical Service (prior to April 2019) have fallen short of the expected experience of this service. Consent has been provided by the parents of 6 of the children for this to take place.

A further letter has been sent to the parents/carers of these 11 children by the Trust, on behalf of the CCGs, to inform them that the review will be in the public domain from the 14 September 2021. This letter also offers the opportunity to discuss the report and any concerns they may have.

3.2 Findings in relation to Community Paediatric Medical Service prior to April 2019

The common themes presented to the Community Paediatrics Oversight Group by Dr Morris were:

(i) Delay in timely follow-up of patients – this was both planned (i.e. decision to follow up patient in 2 years when needed earlier review) but mostly unplanned (i.e. decision to follow up in 1 year but not seen for 3 years). In Dr Morris's opinion the latter was due to lack of capacity resulting in a decision between CHCP and CCGs in October 2016 to prioritise statutory work.

(ii) Lack of understanding of roles/responsibilities – this was particularly obvious in management of spasticity. Dr Morris considered this to be the role of the Community Paediatrician to commence antispasmodic treatments such as Baclofen before onward referral. There was a lack of continuity of care and there appeared to be a belief that the Orthopaedic Surgeons would do this (outside their remit) or requests for the GP to refer onto Neurology or tertiary Neurology without the commencement of basic management.

(iii) Lack of clear patient management pathways and MDT working – there are clear guidelines for the management of spasticity (NICE CG145 2012) and hip monitoring in cerebral palsy. There is no evidence that these were followed.

(iv) High dependency on locums – this resulted in patients seen by multiple practitioners with no oversight for their investigations or care. There was a lack of understanding of local services/processes and a passive approach to management and investigation of these children – often brought back for review without commencement of therapy.

(v) Mitigation by other services – in a number of the no harm cases there was a lack of timely review by Community Paediatrics, however this was mitigated by other clinicians and therapists.

4. CONCLUSION

Professor Cant concludes that report as follows*: "Reviews of services failing to meet patients' needs always make sad reading, especially when set against a background of immense difficulties of staff recruitment and retention. This review is no exception, and the impact on children, young people and their families is a matter of deep regret.*

This report also highlights the honest and open appraisal of what happened, the "whole system" willingness to invite independent external review, and the prompt and most energetic action in the light of the lessons learnt. Despite workforce challenges, the reconfigured Community Paediatric Service should be much better placed to care for this vulnerable group of patients and to be an exemplar of good paediatric practice."

5. RECOMMENDATION

The Trust Board is asked to note:

- The final report and findings
- That there are potentially 11 children/young people deemed to have suffered harm prior to April 2019 which will need to be further investigated
- Access to the full medical records was requested from the 11 parents of the children/young people who have been identified as being harmed. Six consented and the information for these children has been provided to CHCP

- Note that the Community Paediatric Medical Service provided by HUTH with effect from April 2019 is praised within the report

Julia Harrison Mizon
Operations Director
Family and Women's Health Group

27 June 2021

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 the next available 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 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

2.2 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 not meet unless the chair deems it necessary and there are ethical decisions to be made that are outside of business as usual and not encompassed within clinical decision making protocols.

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

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 in accordance with item 6 above ~~quarterly~~ and set by the Corporate Team. The Chair can call an urgent meeting at any time if necessary. ~~outside of the usual meeting dates~~. Notice of urgent meetings, 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 Ethics Committee 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: