Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held In Public

Tuesday 9 March 2021
10.00 am – 12.00 pm

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

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

Agenda

1	**Apologies and welcome**	verbal	Terry Moran - Chair
2	**Declarations of Interest**	verbal	Terry Moran - Chair
	2.1 Changes to Directors' interests since the last meeting		
	2.2 To consider any conflicts of interest arising from this agenda	verbal	Terry Moran - Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 9 February 2021	attached	Terry Moran – Chair
	3.2 Board Reporting Framework	attached	Rebecca Thompson – Corporate Affairs Manager
	3.3 Board Development Framework	attached	
4	**Matters Arising**		
	4.1 Action Tracker	attached	Rebecca Thompson – Corporate Affairs Manager
	4.2 Any other matters arising	verbal	Terry Moran – Chair
5	**Patient Story**	presentation	Makani Purva – Chief Medical Officer
6	**Standing Orders and Governance**		
	6.1 CEO Report and Covid Update	attached/verbal	Chris Long – Chief Executive
	6.2 External Review of Trust's Pandemic Response – Terms of Reference	attached	Chris Long – Chief Executive
	6.3 Governance update	attached	Terry Moran - Chair
	6.4 Board Assurance Framework	attached	Rebecca Thompson – Corporate Affairs Manager
	6.5 Standing Orders	attached	Rebecca Thompson – Corporate Affairs Manager
7	**Our Patient Impacts**		
	7.1 Performance Summary	attached	Margaret Barnaby - Deputy Chief Operating Officer

	7.1.1 Summary from the Performance and Finance Committee	attached	Mike Robson – Chair of Committee
	7.2 Quality Governance Report	attached	Beverley Geary – Chief Nurse
	7.2.1 Summary and minutes from the Quality Committee	attached	Julie Bolus – Chair of Quality Committee
	7.3 Covid-19 Preparedness and Planning	attached	Michelle Kemp – Director of Strategy and Planning
8	**Our People Impacts**		
	8.1 Staff Overview	attached	Simon Nearney – Director of Workforce and OD
9	**Our Finance Impacts**		
	9.1 Finance Summary	attached	Lee Bond – Chief Financial Officer
10	**Board Reports**		
	10.1 Gender Pay Gap	attached	Simon Nearney – Director of Workforce and OD
	10.2 Research and Innovation Strategy Update	attached	James Illingworth – Research and Innovation Manager
	10.3 Trust Strategy Implementation Update	attached	Michelle Kemp – Director of Strategy and Planning
	10.4 Energy and Decarbonisation Report	attached	Duncan Taylor – Director of Estates
11	Questions from the public relating to today's agenda	verbal	Terry Moran – Chair
12	Chairman's Summary of the Meeting	verbal	Terry Moran – Chair
13	Any Other Business	verbal	Terry Moran – Chair

14 Date and time of the next meeting:
Tuesday 11 May 2021
10am – 12pm via Webex

Attendance 2020/21

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

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 9 February 2021

Present:	Mr T Moran CB	Chairman
	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
	Mrs J Bolus	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
	Mrs E Ryabov	Interim Chief Operating Officer
In attendance:	Mr S Nearney	Director of Workforce and OD
	Mrs M Kemp	Interim Director of Strategy and Planning
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No **Item** **Action**

1 Apologies

There were no apologies received.

Mr Moran thanked colleagues and teams for their continued hard work in challenging times. He added that although Covid rates had reduced deaths continued to rise which was a tragedy for all those families impact and was also having a deep impact on those staff most directly dealing with those patients and families. He offered sincere condolences on behalf of the Board to everyone affected.

Mr Moran also reported that the interim governance arrangements continued and that a formal consideration of their extension and amendment would be considered later on the agenda.

2 Declarations of Interest

2.1 Changes to Directors' interests since the last meeting

There were no declarations made.

2.2 To consider any conflicts of interest arising from this agenda

There were no declarations made.

3 Minutes of the previous meeting

3.1 Minutes of the meeting held 12 January 2021

Item 7.1 paragraph 2 – Mrs Ryabov advised that ENT and Plastics had seen decreases in referral rates but increases in Cancer 2 week wait referrals.

Paragraph 4 – The capacity issues in ENT and Plastics was due to a historical backlog.

Item 7.2.2 – Dr Purva advised that harm reviews were not being undertaken on all 52 week breaches.

Item 9.1 – paragraph 7 – Mr Bond clarified that the External Auditors would still be able to offer an opinion regarding the stock taking but there were challenges to be faced.

3.2 Board Reporting Framework
The Board Reporting Framework was received and noted.

3.3 Board Development Framework
The Board Reporting Framework was received and noted.

4 Matters arising

4.1 Catering Improvements Update
Dr Purva presented the paper which positively addressed feedback from patients and provided an action plan of improvements to be made.

Mrs Jackson asked about longer term patients and how the changed menu would impact them, Mr Robson asked about timescales for the actions to be in place and Mr Hall asked whether the increase in variety would result in more waste. Dr Purva agreed to follow up these questions with Neil Woods and provide and email response to Board members. **MP**

Mr Moran thanked Mr Woods for his creative and energetic response to patient feedback. It was really encouraging to see the value placed on patient feedback.

4.2 Action Tracker
The action tracker was received and noted by the Board.

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

5 Patient Story
Dr Purva presented the item that reviewed non Covid backlogs in ENT and how parents had very different experiences with their children's delayed procedures. The video also highlighted one parent happy to wait for their child's procedure and the other one worried about the impact of the delay.

There was a discussion around the longest backlogs being in the Family and Women's Health Group and Mrs Bolus asked whether a deeper examination of the issues would be appropriate. Mrs Jackson asked if the child that was suffering health wise would become priority over the relatively well child and Mr Curry asked if the Trust had a sense of patients that were prepared to wait for their procedures. Mr Moran expressed his concern regarding people happy to wait and what impact this would have on their health.

Dr Purva advised that a new category of patients had been created and this included patients willing to step off the waiting list. These patients would be reviewed by clinicians first.

In response to the question around the longest backlogs being in the Family and Women's Health Group, Dr Purva advised that it was the nature of the specialities and the fact that they had the most elective work, that the backlogs existed.

Mrs Bolus expressed her concern regarding patients not wanting to attend the Trust for their procedures and asked that robust communication around safety was in place.

6 Standing Orders and Governance

6.1 CEO Report and Covid Update

Mr Long reported that the Trust was seeing the number of Covid patients dropping slowly but expected to have the current high levels in the next 2-3 months. He added that the Trust was still 50% above the peak in wave one. There had been 732 deaths to date with 500 deaths in the last 3 months.

Mr Long advised that staff were very tired and traumatised at the number of deaths they were seeing. He expressed his concern that some staff were not getting enough rest and family time and that single staff were not able to socialise which was storing up pressures for the future. Mr Long suggested that the Board took time to consider longer term proposals for staff support in a Board Development Session. Mr Moran added that the need for increased staff support had been discussed at recent regional meetings. Mr Robson added that the Performance and Finance Committee would be reviewing recovery, including staff support at its meeting in February.

Mr Curry asked if there had been any issues with flu cases and Mr Long advised that there had been no cases so far.

Mrs Bolus asked about the patient mentioned in the report and Mr Long assured her that consent had been granted to include the patient's name.

Mr Moran expressed his sadness at the high number of deaths the Trust had seen.

Resolved:
The Board accepted and received the report.

6.2 Governance Update

Mr Moran presented the item which set out the interim Governance arrangements up until 28th February 2021. He advised that any changes would be reviewed at the next Board meeting in March 2021.

Resolved:
The Board received and approved the update.

6.3 Board Assurance Framework

The Board Assurance Framework was presented to the Board. Mr Bond asked that the financial elements be reviewed as the finance targets would be met but the underlying position could deteriorate. Mr Moran suggested that the changes be discussed at the Performance and Finance Committee and then an updated report would be received at the Board in March 2021. **LB**

There was a discussion around the strategic direction of the BAF and it was agreed that this would be discussed further at a Board Development session when the new Director of Quality Governance started with the Trust.

Resolved:
The Board received and accepted the report.

6.4 Audit Committee Summary
Mrs Christmas advised that the date that the Audit Committee and the Trust Board would approve the Annual Accounts had been re-arranged from May to June 2021 due to the External Audit timescales.

Resolved
The Board received and accepted the summary.

7 Our Patient Impacts

7.1 Performance Summary
Mrs Ryabov presented the report and advised that operational performance was still challenged in December and January, however there had been marginal improvements in some areas. She added that the focus would be on Priority 1 and 2 patients, cancer, 52 week waits and recovery of services.

ED had deteriorated marginally but there had been a reasonable improvement in ambulance handovers. Cancer 2 week wait performance had deteriorated but 62 day cancer had improved although the Trust was still not delivering its standards. There were issues with theatre capacity due to staff redeployment and complex patients needing ITU were particularly challenging.

Patients waiting over 52 weeks had increased to 11000 in January. Work was ongoing in the independent sector to reduce the numbers. Mrs Ryabov confirmed that of the 11000, 166 were children which was 1.5%. The bulk of the patients were in the Family and Women's Health Group.

Mrs Ryabov advised that the recovery plan was in place for Q4 and Q1 2021/22 and on review of the activity numbers the Trust was slightly down on activity compared to the previous year but not significantly.

Appendix 2 showed the starting point, what had been delivered and what the Trust was now forecasting. Work was ongoing to increase activity in outpatients, inpatients and day cases. There were still a number of risks the main ones being that there were still 187 covid patients and a number of the workforce were redeployed. However, sickness absence was reducing and outbreaks were being managed well.

Mr Bond asked what the end point looked like for the patients waiting 52 weeks and Mrs Ryabov advised that there was a long way to go to manage workflows and theatre capacity.

Mrs Bolus asked how the Trust compared to others regarding the 50% theatre capacity. Mrs Ryabov advised that a number of theatre nurses were redeployed to manage ITU beds which had impacted on capacity. She added that Day Surgery would be stood up first and then 52 week patients would be managed next.

Prof Macleod asked if there was any help the University could offer reviewing patient flows as there was resource available. Mrs Ryabov

agreed to speak with Prof Macleod outside of the meeting to discuss further support.

Mr Hall commended the excellent performance around 12 hour trolley waits and ambulance handovers.

Mr Robson asked what the scale was of theatre staff being redeployed and Mrs Ryabov advised that it was around a quarter. She added that emergency theatre work was continuing.

Resolved:
The Board received and accepted the report.

7.2 Quality Governance Summary
Mrs Geary advised that December had been a challenging month and this had continued into January. There had been 11 serious incidents declared in December and the Quality Committee had reviewed the look back thematic review relating to maternity incidents. The increase was due to busy staff, redeployment to different areas and skill mix impacts.

Healthcare Infections included 5 cased of C Difficile, 7 cases of e-Coli and 2 pseudomonas. There had been no flu or Norovirus cases.

The Humber Coast and Vale system had seen an increase in falls and pressure damage due to high acuity and high dependency patients. There had been an increase in delayed transfers of care.

Pressure ulcer damage due to device related pressure and other areas was being reviewed and clinical photography was helping with rapid tissue viability support.

Mrs Geary advised that the CQC were focussing on Infection Prevention, ED and Maternity Services. Any outcomes would be shared with the Board.

The Kirkup report was shared as an appendix to the Quality report because of its similarities with the Ockenden Report and the action plan was reviewed by the Quality Committee for assurance.

The Covid Vaccination programme was ongoing and to date 98% of over 80's had been vaccinated. The Trust had vaccinated 22000 patients locally and 8175 staff. Members of staff that had not been vaccinated were being offered support and information to encourage them to have it. The Trust would be starting on second vaccinations very soon.

Resolved:
The Board received and accepted the report.

7.2.1 Summary from the Quality Committee
Mrs Bolus presented the summary and confirmed that the Ockenden and Kirkup reports had been received for clarity and assurance at the Quality Committee. Incidents and Falls were also being reviewed at the Quality Committee.

Mrs Bolus advised that the minutes of the Quality Committee would be received at the next Board meeting after being approved by the Committee first.

Mr Moran asked Mrs Geary about nurses morale during the pandemic. Mrs Geary advised that nurses were tired but in recent visits to Covid wards she had witnessed good morale and staff taking advantage of learning during the pandemic.

Resolved:
The Board received and accepted the summary.

7.3 Covid Preparedness and Planning
Mrs Kemp presented the item and advised that the Trust continued to cope well and have good structures in place to manage the pandemic. The Trust was really busy with acute work and was managing Winter pressures well. She confirmed that the peak was still well above the first wave but was coming down steadily.

The Trust had clear escalation procedures relating to Covid which included bed allocation. Significant changes had been made to create capacity and work was ongoing to step back up some elective resources.

Clear escalation with covid – beds allocated for covid. Made significant changes to capacity – step back up some of our elective resources.

The HUTH critical care team had been receiving patients as part of the national critical care decompression transfer system and continues to contribute as part of the regional critical care network. Between 22 January and 2 February, HUTH received and cared for 6 patients under this arrangement.

Resolved:
The Board received and accepted the report.

8 Our People Impacts
8.1 Staff Overview
Mr Nearney presented the report and advised that staff absences were reducing (343 currently off sick with Covid or self isolating) although this continued to be an issue. Work was ongoing to distribute the Lateral Flow kits and ensure staff used them correctly and reported their results.

The vacancy rate for Registered Nursing and Midwifery is currently 3.4% across the organisation.

There are currently 55 Trainee Nurse Associates (TNA) employed by the Trust in a range of specialities. 17 of these are currently awaiting results and to become a qualified Registered Nurse Associate (RNA) and obtain their PIN by April 2021. The Trust has successfully trained and developed 23 Registered Nurse Associates over the past 2 years who are now part of the registered nursing workforce. The Trust is currently commencing a further recruitment campaign for a further cohort of 25 TNA`s to commence their programme in May or September 2021.

The Trust has 33 Registered Nurse Degree Apprentices (RNDA previously called SNA) in training. In addition, the Trust has 22 Apprentice Health Care Support Worker (AHCSW). In partnership with Hull College and the University of Hull, the Trust has successfully recruited a further 6 Apprentice Health Care Support Workers who will commence their programme in February 2021.

Mr Nearney advised that the National Staff Survey results would be reported soon and the outcomes would be discussed at the next Workforce, Education and Culture Committee.

Mr Nearney reported that there were a number of staff support arrangements in place.

Pattie would be upgraded in April 2021 and a review of usage had taken place. The review had shown that all nurses and consultants used the system.

A national review of HR and OD would take place with NHS Improvement/England looking at what was working well and what the future visions should be. Mr Nearney advised that he would be initiating a survey that he wanted the Board to participate in to shape and influence the future of HR and OD.

Mr Bond asked about the progress on nurse recruitment and asked if the current rate of trainees would result in a surplus of nurses and how this would be funded. Mrs Geary assured him that a review of the workforce plan would take place and that there was unlikely to be a surplus.

Mr Hall asked if the EU Exit had given rise to any unexpected HR issues and Mr Nearney advised that there had been no surprises or issues so far.

Resolved:
The Board received and accepted the report.

9 Our Finance Impacts

9.1 Finance Summary

Mr Bond presented the report that showed the Month 9 position. He reported that the Trust was continuing to underspend due to not doing elective work but was still spending money on Covid costs. There would be a change to the annual leave accrual made at year end but Mr Bond was not yet clear on what this would be but assured the Board it would satisfy external scrutiny.

It had been recognised that the Centre would fund the work being outsourced which would result in income being received. This was offset with the RMO block and Virology Block being demolished and their values written off. The Trust was heading for deficit that was mainly driven by the annual leave accrual, but this was allowable expenditure and the Centre would adjust the position after year end.

Capital works were ongoing with significant money being spent. Mr Bond was confident that the Trust would achieve its year end target. The Front Entrance (HRI) business case had been approved and work was commencing on the Tower Block.

Mr Robson asked about the annual leave provision and how it compared with other Trusts. Mr Bond advised that he was unsure of the actual figures and was working closely with HR regarding the doctors.

Mrs Ryabov asked about the money relating to the vaccine and Mr Bond advised that money was being run through the Trust as it was the Vaccination Hub. The current figure related to the major operating site in York.

Resolved:
The Board received and accepted the report.

9.2 Digital Aspirant Programme
Mr Bond presented the report which set out the Digital Programme for the next 2 years.

Mrs Bolus asked whether there were timescales in place when each phase would be completed and Mr Bond advised that it was an evolving programme but the completion of the Network refresh would be completed this year. That would ensure e-Prescribing, e-Observations and hand held devices could be introduced.

Mr Moran commended the joint working arrangements with North Lincolnshire and Goole Hospitals NHS Foundation Trust and how patient care through digital improvements was at the centre. Mr Bond added that the teams at both Trusts were working together on a weekly and daily basis and having a very positive affect.

Resolved:
The Board received and approved the programme.

10 Questions from the public relating to today's agenda
Jacqui Evans thanked the Board for allowing her to attend the meeting, she had recently moved to the area and was interested in learning more about her local Trust. She added that she had got a sense of being in safe hands from the meeting and was pleased to see a clear direction of travel. She advised that she would email some suggestions that she had due to working in a similar setting previously to Mrs Thompson that could be forwarded to the relevant person/team. Mr Moran thanked her for her independent view of the meeting.

11 Chairman's Summary of the Meeting
Mr Moran extended his sincere thanks to the Executives and their teams and all staff working in incredible circumstances. He added that the work being done to roll out the vaccines was fantastic and that Jacqui Evan's comment about being in safe hands was a great compliment.

12 Any Other Business
There was no other business discussed.

13 Date and time of the next meeting:
Tuesday 9 March 2021
10am – 12pm – via Webex

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	x	x		x	x	x
	Minutes and Escalation from the Performance and Finance Committee	Every Meeting					x																		
	Escalation from Ethical Clinical Policy Prioritisation Committee	As required	x				x																		
	Minutes and Escalation from the Quality Committee	Every Meeting					x																		
Our People Impacts	Staff Overview Report (Including Nurse Staffing)	Every Meeting	x	x	x		x	x	x	x	x	x	x	x		x	x	x	x	x	x		x	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				x	
	National Patient Survey	Annually							x									x							x
	National Staff Survey	Annually											x							x					
	Gender Pay Gap	Annually											x							x					
	Digital Exemplar	Annually							x									x							x
	Scan for Safety	Annually							x									x							x
	Fit and Proper Person Report	Annually					x							x							x				
Strategy and Planning	Operating Framework	As required						x			x								x						
	5 Year Plan	Annually									x								x						
	Trust Strategy Refresh	As required																							
	Operational Planning	Annually									x		x						x	x					
	Financial Planning	Annually			x								x	x						x	x				
	Capital Planning	Annually			x								x	x						x	x				
	Winter Planning	Annually							x										x						x
	Equality, Diversity and Inclusion Strategy	Every 3 Years											x												
	Assurance against Equalities Objectives	Annually						x									x							x	
	People Strategy	Every 3 Years																			x				
	IM&T Strategy	Every 3 Years												x											
	Research and Innovation Strategy	Every 3 Years											x												
	Trust Strategy Implementation Update	Every 6 Months							x				x				x			x				x	
	Estates Strategy inc. Sustainability and backlog maintenance	Annually			x								x	x						x	x				
Governance	Standing Orders	As required	x	x			x	x																	
	Safeguarding Annual Reports	Annually						x								x							x		
	Learning from Deaths Report/Mortality and Morbidity	Quarterly		x	x				x		x			x		x		x	x		x		x		x
	Information Governance Update	Six-Monthly				x					x				x				x			x			
	Health and Safety Annual Report	Annually						x								x							x		
	Director of Infection Prevention and Control Annual Report	Annually						x								x							x		
	Quality Improvement Programme	Six-Monthly			x									x					x		x				
	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 2020-21
Overarching aims:
• The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
• To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Board Development Dates 2021	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great Clinical Sevices	Great specialist services (until March 19)	Partnership and integrated services	Research and Innovation (from March 19)	Financial Sustainability
09-Feb-21			Reforming of the NHS - How we can actively shape what the new world looks like.		**Area 4 BAF 4**: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog				**Area 4 BAF 7:1**: There is a risk that the Trust does not achieve its financial plan for 2019-20
13-Apr-21				**Area 4 BAF 3:** There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating			**Area 4 BAF 5**: That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost		
08-Jun-21	Strategic drivers/balanced scorecare review		**Area 2 BAF 2**: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust					**Area 4 BAF6**: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas.	
10-Aug-21		**Area 1 BAF 1:** Board Leadership and Strategy Development							**Area 2 BAF 7.3**: Estates/Tower Block update

12-Oct-21					**Area 4 BAF 4**: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 20-21 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog				
14-Dec-21				**Area 4 BAF 3:** There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating					**Area 4 BAF 7:1**: There is a risk that the Trust does not achieve its financial plan for 2020/21

plan and capital requirements

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

Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and Integrated Services	Research and Innovation	Financial Sustainability

	BAF1 : There is a risk that staff engagement does not continue to improve The Trust has set a target to increase its engagement score to above the national average and be an employer of choice There is a risk that the Trust's ambition for improvement and for continuous learning is not credible to staff, to want to go on a journey to outstanding with the organisation What could prevent the Trust from achieving this goal? Risk that staff do not continue to support the Trust's open and honest reporting culture Failure to act on new issues and themes from the quarterly staff barometer survey would risk achievement Risk that some staff continue not to engage	BAF 2: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Work on medical engagement and leadership fails to increase staff engagement and satisfaction Lack of affordable five-year plan for 'sufficient' and 'skilled' staff What could prevent the Trust from achieving this goal? Failure to put robust and creative solutions in place to meet each specific need. Failure to analyse available data on turnover, exit interviews, etc, to inform retention plans	BAF 3: Principal risk: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating What could prevent the Trust from achieving this goal? That the Trust does not develop its learning culture That the Trust does not set out clear expectations on patient safety and quality improvement Lack of progress against Quality Improvement Plan That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust does not increase its public, patient and stakeholder engagement, detailed in a strategy	BAF 4: There is a risk that the Trust does not meet contractual performance requirements for ED, RTT, diagnostic and 62-day cancer waiting times in 19-20 with an associated risk of poor patient experience and impact on other areas of performance, such as follow-up backlog What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues A focus on 62-day cancer targets has brought about improvements and a continued focus is required to	BAF 5: Principal risk: That the Humber, Coast and Vale STP does not develop and deliver credible and effective plans to improve the health and care for its population within the resources available and that the Trust is not able to influence this. In particular, that the lack of a mature partnership both at local 'place' and across the STP will hamper the quality of care and services the Trust is able to provide, as it will slow progress in the development of integrated services and access to transformation funds. What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP The effectiveness of STP delivery, of which the Trust is one part	BAF 6:Principal risk: There is a risk that the Trust does not develop and deliver ambitious research and innovation goals and secure good national rankings in key areas. What could prevent the Trust from achieving this goal? Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Increased competition for research funding What could prevent the Trust from achieving this goal? The Trust being enabled, and taking the opportunities to lead as a system partner in the STP	BAF 7.1: There is a risk that the Trust does not achieve its financial plan for 2019-20 What could prevent the Trust from achieving this goal? Planning and achieving an acceptable amount of CRES Failure by Health Groups and corporate services to work within their budgets and increase the risk to the Trust's underlying deficit BAF 7.2 Principal risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year What could prevent the Trust from achieving this goal? Lack of achievement of sufficient recurrent CRES Failure by Health Groups and corporate services to work within their budgets
	Risk that some staff do not acknowledge their role in valuing their colleagues Risk that some staff or putting patient safety first						Failure to put in place 2-3 credible year plan to address the underlying deficit position BAF 7.3 Principal risk: There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability What could prevent the Trust from achieving this goal? Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality

Principles for the Board Development Framework 2017 onwards

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

Overarching aim:

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

Area 1 – High Performing Board

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

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

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

Area 2 – Strategy Development

Strategy refresh commenced

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
February 2020						
COMPLETED						
01.01	Patient Story	Update regarding catering improvements to be received	NW	February 2020		

Actions referred to other Committees

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

Hull University Teaching Hospitals NHS Trust

Trust Board

9 March 2021

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

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	Covid-19 summary, support for cancer patients, organ donation, disability in the workplace	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 9 March 2021

1. Key messages from February 2021

Covid-19

It was extremely encouraging to see that the number of Covid-19 cases in our hospitals began to reduce significantly during February. However, at the start of March there were still more patients in our hospitals with Covid than there were at the height of the first peak in April 2020.

Tragically, we have now confirmed that since 19 March 2020, more than 800 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.

Vaccinations at our hospital hub will now pause for a short period prior to the commencement of second doses. The vaccination team have done an incredible job of vaccinating patients, care home staff and our own workforce in such a short space of time, and our thanks go to everyone who has been involved in what was a very impressive and efficient programme of work.

Concern for Cancer Patients

Our cancer team addressed concerns that the fear of Covid-19 may be deterring cancer patients from receiving vital treatments and tests.

Julie Watson, Macmillan lead cancer nurse at the Trust received some welcome publicity to encourage people who need care to come into hospital. We have been working hard for many months to ensure our departments, wards and treatment rooms are made safe for the people using them, and that we invite people to attend the hospital only where there's an absolute need for them to do so. Many consultations are conducted by phone or video conference where it's safe to do so, which is often more convenient for people in many ways.

This is a very important message for the public and our patients and we were pleased with the response it received.

Rehabilitation for Covid-19 Patients

Patients sick enough to be admitted to hospital with Covid-19 are being helped by a team of our physiotherapists as they recover from the most severe forms of the virus.

The team has developed a rehabilitation guide to help people on their journey back to health after being admitted to Hull Royal Infirmary or Castle Hill Hospital. The guide shows people how to relax and control their breathing better as well as exercises they can do and techniques to try. It also shows people how to lie, sit or stand to reduce breathlessness and the effort of breathing.

People who have been in hospital for some time can also lose muscle strength so the guide encourages people to reintroduce gentle exercises including ankle raises, seated walks and balance work, using the exercises given to them to do at home by the physiotherapists who looked after them while they were in Castle Hill or Hull Royal.

The guide has been published on our website and can be translated into different languages.

Poppy and Bluebell Teams
Two new teams of midwives have been formed to provide more continuity for women throughout pregnancy and birth.

The Poppy and Bluebell Teams are the latest to be established by our Trust to provide consistent, ongoing care for women in different parts of East Yorkshire.

The Bluebell Team is made up of eight midwives and a midwifery assistant supporting families in Brough, Goole and surrounding areas. Meanwhile, the Poppy Team comprises seven midwives and a midwifery support worker covering some of the more rural towns in East Yorkshire including Driffield, Pocklington and Market Weighton.

Each team will provide care for around 250 women, and each midwife will serve as a friendly face and a dedicated point of advice for around 35 women in total, from first appointment right through to antenatal visits, parenting classes, birth and beyond.

Organ Donation -
Our Trust backed a campaign to encourage people to talk to their loved ones about organ donation following research that less than half of adults in England have had the conversation.

The Leave Them Certain campaign aims to highlight the impact not knowing has on the families who are left behind and encourage people talk about their decision. It follows the law change last year in England, which means that all adults are seen as willing to donate their organs, unless they opt out or are in one of the excluded groups.

However, many people don't realise that families will still be approached before any donation goes ahead. Even though 80 per cent of people are willing to donate their organs, only 39 per cent say they have shared their decision.

Disability in the Workplace
As part of our ongoing equality, diversity and inclusion work we have launched an important piece of work to seek the views of staff across the Trust and understand what the lived experiences are of staff who have a physical or mental illness or long-term condition.

A survey has been running for the past week and we are holding focus groups with staff in order that we can support our workforce and better understand the issues faced by staff with a disability as well as their colleagues and managers. This work will form a key element in a concerted drive to improve the health and wellbeing of our workforce.

3. Media activity

There were a total of 43 articles and broadcasts relating to HUTH in December.

- 28 positive (65%)
- 12 factual (28%)
- 2 neutral (5%)
- 1 negative (2%)

<u>Social media</u>
Facebook
Total "reach" for Facebook posts on all Trust pages in February – 337,075

- Hull Women and Children's Hospital – 68,720

- Castle Hill Hospital – 97,442
- HEY Jobs page – 4,340
- Hull Royal Infirmary – 83,703
- Hull University Teaching Hospitals NHS Trust – 82,870

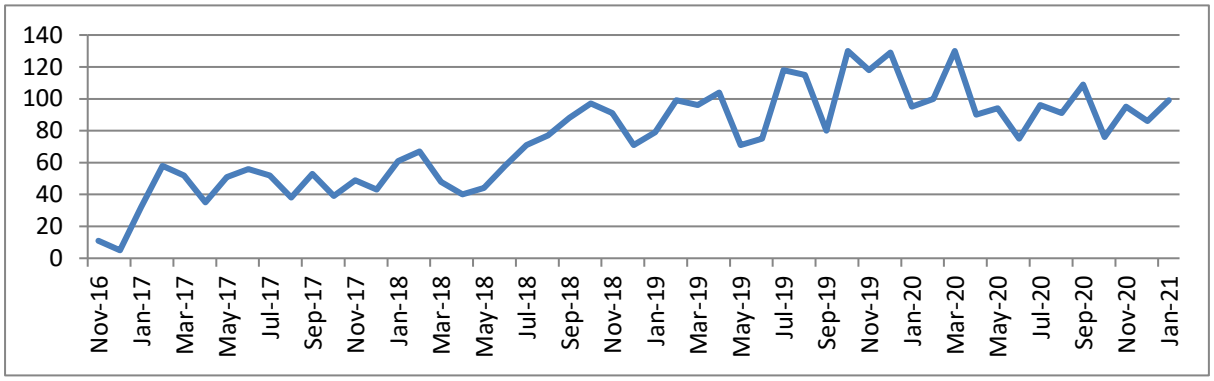
Twitter @HullHospitals
- 281,000 impressions (339,000 impressions January)
- 8,791 followers

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 Nov 2016 – January 2021:



Hull University Teaching Hospitals NHS Trust

Trust Board

Title:	Lessons from HUTH COVID response: A Collaboration with the University of Hull
Responsible Director:	Mr Christopher Long
Author:	Dr Makani Purva

Purpose of the report:	This report is submitted for commissioning purposes	
Strategic Goals:	Honest, caring and accountable culture	**X**
	Valued, skilled and sufficient staff	**X**
	High quality care	**X**
	Great local services	
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	
Summary Key of Issues:	This document recommends to the HUTH Board the commissioning of a report in collaboration with the University of Hull Business School and a newly formed HUTH Advisory Group, specifically for this programme. The report, which is recommended to be commissioned, will explore the response of HUTH to the pandemic during the period between January 2020 to March 2021. It will explore the background, actions taken, aspects of the response performed well, and lessons learned during the pandemic. This will allow for improved planning, particularly around operations management and workforce management, to improve organisational resilience to future service pressures, including potential future pandemics.	

Recommendation:	The Board is asked to receive and review this document, and commission the HUTH and UoH report into the HUTH COVID-19 response.

Aim of the Commission
The aim of the commission is to explore the HUTH response (and previous planning activities) to the COVID-19 pandemic, for actions which were/are directly under the influence of the Trust.

Through an exploration of the response of HUTH to the COVID-19 pandemic, the Commission will make realistic and practical recommendations pertaining to operations and crisis management, service pressure planning, colleague management, leadership and governance issues, in order to improve organisational resilience and responsiveness to pandemics and future service pressures in general.

Scope
The scope will be limited to factors directly under the influence of HUTH.

The requirement for solutions which can be practically undertaken, and the potential short timelines for learning lessons, wider systemic issues or decisions under the control of other organisations (such as by primary care organisations, NHS improvement or the NHS England) will not be considered. Third party actions may, however, provide a context to actions taken by HUTH and may need to be included as part of contextual aspects of the report.

Appendix 1 outlines the remit for the interim and final reports

In addition, the requirement for practical and realistic solutions within the specialist context of healthcare, the culture and organisation of HUTH, as well as the NHS as a whole, will require specialist input from healthcare professionals. A 'COVID-19 Response Advisory Group' will be founded to provide relevant clinical and specialist input as necessary/needed by the Commission **(Appendix 2)**. Whilst the Group cannot directly steer or influence the conclusions (e.g. due to concern around adverse organisational consequences due to reputational or legal damage) it forms a key role within the production of the report which is to be produced.

The utilisation of HUTH-specific specialist advice through the Group with regards to the actual practicality of the implementation of the recommendations by HUTH is a necessary requirement in order to give credence to the recommendations, gain buy-in from healthcare groups, management and professionals, as well as the document with its associated recommendations, as a whole.

Governance
The COVID-Advisory Group is directly accountable to the Chief Executive Officer of HUTH, via the Group Chair.

The Chief Executive Officer will present the interim and final reports to the Board, in a public Board meeting, upon receipt of the public versions of the interim and final reports.

Timeline
The timeline as follows:

Submission and Approval of TOR for the COVID-Advisory Group: ***10th March 2021***
Submission and Approval of Detailed Report Remit: ***10th March 2021***
Submission to the Board of Interim Report: ***June 2021***
Submission to the Board of Final Report: ***August 2021***

Conclusion
'Great Staff, Great Care, Great Future'; the HUTH values align well with the aims of the commissioned report through an exploration of workforce related issues, an analysis of areas of care and organisational activity during the pandemic and the consideration of future

organisational improvements to enhance the operations management and planning to cope with future service pressures.

Appendix 1
Remit of Report

1. Remit

The remit of the report, in appropriate and logical sections, is provided below.

The order may be altered as required for the quality of the report in its final draft.

1.1. Contextual Information

1.1.1. Environmental Context
1.1.2. Budgetary Context
1.1.3. HUTH organisational performance before COVID-19
1.1.4. Effects of COVID-19 on the work of the Trust
  1.1.4.1. Internal influences
  1.1.4.2. External influences
1.1.5. Appropriateness and usefulness of previous planning activities for pandemics/epidemics/other service pressures at HUTH
1.1.6. Description of actions taken by HUTH to deal with the pandemic
1.1.7. Data interrogation, in combination with an assessment of the veracity of the data and if it is appropriate for utilisation as a form of Quality Assurance for the Trust Board

1.2. Leadership and Governance

1.2.1. Quality of organisational leadership including:
  1.2.1.1. Quality of communication with staff, the general public and external organisations around service disruptions and changes to systems
  1.2.1.2. Quality of motivation of staff through staff benefits, provision of refreshments during shifts etc.
1.2.2. Quality of governance structures focusing on the responsiveness of existing structures, the need for future changes to these during a public health emergency and the planning for the expectation of the need to change these structures in pandemic planning exercises prior to COVID-19

1.3. Preparation for each pandemic wave

1.3.1. The preparation undertaken for the first wave, including how the planning process could have been improved
1.3.2. How lessons were learned from experience during the implementation and planning process from the first wave
1.3.3. How lessons learned from previous waves were applied to the planning and actions taken for subsequent waves

1.4. Operations management

1.4.1. The appropriateness and effectiveness of changes in operations throughout each wave of the pandemic, combined with any changes in the safety or quality of care provided
  1.4.1.1. Elective work
  1.4.1.2. Urgent work
  1.4.1.3. Emergency work
  1.4.1.4. Diagnostics
  1.4.1.5. Outpatients
  1.4.1.6. Theatres

1.4.1.7. Implementation of new patient pathways during the COVID-19 pandemic; their effectiveness, appropriateness, quality and safety
1.4.1.8. Public health programmes (e.g., screening programmes)
1.4.1.9. Additional ward services availability (social work, podiatry etc.)
1.4.1.10. The effectiveness of estates and appropriateness of the estate facilities on each site

1.5. Workforce Issues

1.5.1. Redeployment of staff; process and effectiveness
1.5.2. Sickness process; effects of COVID isolation and other COVID-related illness on the quality and safety of care
1.5.3. Training and development needs
1.5.4. Workforce planning
1.5.5. Avoidance of nosocomial infections
1.5.6. Personal Protective Equipment procurement, availability, appropriateness, ability of HUTH to adhere to government policies and guidance on PPE
1.5.7. Support (mental, physical, social) for staff
1.5.8. Motivational aspects of staff wellbeing

1.6. Future planning

1.6.1. Strategic review following significant environmental, financial and staffing changes after the COVID-19 pandemic; it is likely that the 2019 strategy is now out of date
1.6.2. Assessment of the exercises and planning undertaken for the possibility of a future pandemic/epidemic/other service pressures, and how they may be improved
1.6.3. Assessment of how lessons learned during an ongoing emergency may be captured and the flexibility of the organisation to changing events increased
1.6.4. Consideration of integrated clinical and technological systems to assist with real-time collection of information, data and improved decision making based on evidence

1.7. Conclusions and Recommendations

Appendix 2
Terms of Reference for COVID-19 Advisory Group

1. Formation of the Group

On the recommendation of the Chief Executive of the Hull University Teaching Hospitals NHS Trust (HUTH), the Chief Medical Officer (CMO) has formed a Group to explore the terms of reference (TOR) for a report and analysis of the Trust response to the COVID-19 pandemic.

The Group was be formed on 23rd February 2021 and will dissolve upon submission of the final report submission to the Board.

There is likely to be a requirement, following the report submission, for a further Group (or continuation of this Group) to assist with the implementation, and monitor the implementation of, the recommendations contained in the final version of the report.

The timeline covered by the report shall start from 30th January 2020, when the Director General of the World Health Organisation declared the outbreak of COVID-19 a "Public Health Emergency of International Concern". The period covered will end on the 31st March 2021.

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

2. Role

The Group is responsible for assuring the Board that an ongoing piece of work, by the University of Hull, is being carried out exploring and analysing the organisational response of HUTH during the COVID-19 pandemic.

The purpose of the report is an exploration of what HUTH did well, what could have been improved, and how future pandemics or service pressures could be better prepared for and managed.

The interim and final reports will be presented in a public Board meeting for reasons of transparency, openness and candour.

It is to be noted that there is a balance to be struck between the independence of the Commission and the Group. Whilst the Group cannot directly steer or influence the conclusions (due to concerns of adverse organisational consequences, legal issues or negative consequence to organisational leadership) it forms a key role within the production of the report. The required balance, therefore, between the independence of the report and the actual practicality of the implementation of the recommendations by HUTH is to be seriously considered in order to give credence to the recommendations, as well as the document as a whole.

Therefore, in general terms, the Group are to take an advisory role following the production of the TOR in order to assist in the production of feasible recommendations within the context of HUTH and the wider NHS.

The specific responsibilities of the Advisory Group are outlined below.

Responsibilities:

2.1. To provide the TOR for the report, which is to be led by the University of Hull

2.2. To provide appropriate support for clinical issues raised by the University of Hull as part of their work

2.3. To provide guidance and advice on the practicality of the recommendations which, whilst independent, must be feasibly undertaken within the context of an NHS Trust in accordance with organisational culture, clinical appropriateness, and financial, regulatory and legislative restraints

2.4. To review, with the University of Hull, the final and interim reports, in order to scrutinise the findings and recommendations with respect to the areas raised in 2.3 prior to presentation to the Board

3. Membership of the Group

The Group shall comprise:

- The Chief Medical Officer (Chair)
- Associate Chief Medical Officer (Deputy Chair)
- A senior doctor representative
- A senior nursing representative
- A senior representative of the Allied Health Professions
- A representative from each Healthcare Group
- A representative of patients/service users
- Other stakeholders may be involved either on an ad-hoc or permanent basis at the discretion of the Chair

4. Quorum

The quorum for the Group shall be four individuals, including the Chair (or their Deputy).

The remit of the report, in appropriate and logical sections, is provided below.

The order may be altered as required for the quality of the report in its final draft.

5. Meetings

The Group shall meet on a TBC basis.

The Chair may convene additional meetings at any time to consider business that requires urgent attention

6. Notice of Meetings

Where possible, at least 48 hours notice will be given to Group members to attend meetings. If this is not possible, as much notice as is possible will be provided.

An agenda shall be circulated with a virtual invitation to the meeting if appropriate.

Minutes from meetings shall be provided to Group members within three working days after the occurrence of the meeting

7. Agenda and action points

The agenda and action points of the Group shall be produced in the standard agreed format of the Trust and kept by the Management PA to the CMO within the agreed timeframe.

8. Reporting arrangements

The proceedings of each meeting of the Group shall be reported to the next meeting of the Board following production of the minutes. The Chair shall draw the attention of the Board to any issues that require disclosure or require executive action. The Chair is required to inform the Board of any exceptions to the annual work plan or strategy

9. Duties and Responsibilities of the Group

Relevant decisions and outcomes of discussions from the Group will be communicated and consulted with the health groups and Trust Board if required.

10. Significant Expected Dates

10.1 Delivery of final TOR, approved by the Group: March 2021
10.2 Receipt of interim report: July 2021
10.3 Receipt of final report: August 2021

11 Administration

The Group shall be administered by the Management PA to the CMO.

The Chair will produce the agenda for each meeting.

The administrative support shall be responsible for distribution of the agenda with associated papers, recording of minutes at meetings and keeping a record of matters arising and issues to be carried forward.

Hull University Teaching Hospitals NHS Trust

Trust Board

9 March 2021

Title:	Governance Update
Responsible Director:	Mr C Long - CEO
Author:	Mr T Moran - Chair

Purpose:	The purpose of the report is for the Board to formally ratify the governance arrangements from 1st March 2021 as set out in the report.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	All governance arrangements to be resumed from 1st March 2021.	

Recommendation:	The Board is asked to ratify the decision to resume all governance arrangements from 1st March 2021.

Hull University Teaching Hospitals NHS Trust
Governance Arrangements effective from 1st March 2021

1. **Background**
   The Trust has been operating interim governance arrangements to ensure that the focus was on key priorities during the highest impact of the Covid-19 pandemic and ensure that staff and senior colleagues could focus only on those assurance priorities that would additionally release some capacity to manage the associated extra demands on time.

2. **Governance Arrangements – 1st March 2021**
   It was agreed that the interim arrangements would be reviewed before March 2021. At the CEO/Non-Executive Meeting on Monday 22nd February it was agreed that the time was right to resume full governance arrangements effective from 1st March 2021. This means all sub-committee activity for assurance will be stood up and reporting arrangements reinstated where some of these requirements were temporarily relaxed. None of this should impact negatively the work being done on recovery activity and planning and should be complementary to it.

   In reinstating normal governance it was hoped that teams are able to adopt and apply learning to both the way papers are prepared and meetings structured and timed. So that the benefits of working differently and also proved effective are not lost.

   Chairs of sub-committees to discuss with the relevant lead executive director arrangements for stepping up committees where this has not yet happened and consider what their work plans for 2021/22 should be.

3. **Recommendation**
   The Board is asked to ratify the decision to resume full governance arrangements from 1st March 2021.

T A Moran CB
Chairman
March 2021

Hull University Teaching Hospitals NHS Trust

Trust Board

March 2021

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

Purpose:	The purpose of this report is to present the Board Assurance Framework to the Trust Board for review and to discuss any gaps in assurance or positive assurance that may have an impact on the current risk ratings.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Summary of Key Issues:	Each year, the Trust Board determines the key risks against the achievement of the Trust's strategic objectives. The Board Assurance Framework for 2020-21 is set in the context of the Covid-19 pandemic; in strategy terms, the way that the pandemic has affected business as usual will affect the progress that the Trust will be able to make towards its strategic objectives this year but this will not be the totality of what affects the Trust's ability to make progress on its strategic objectives. The Trust Board approved the Board Assurance Framework at its meeting in July 2020.	

Recommendation:	The Trust Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas for this financial year. The Trust Board is also asked to review and approve the proposed year end risk ratings.

Hull University Teaching Hospitals NHS Trust

Board Assurance Framework

1. Purpose of this report

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

2. Background

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

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

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

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

3. Quarter 4 Board Assurance Framework

As part of the process for signing off the fourth quarter Board Assurance Framework, each of the strategic objectives have been considered.

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

BAF 1 Honest Caring and Accountable Culture

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

The BAME network is now established with events in the diary.
There are capacity issues due to staff absences which were increasing due to Covid-19.

Overall the Trust vacancy position is 3%, recruitment and retention remains a key priority.

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 risk rating = 12
Proposed Q4 risk rating = 12
Year-end target risk rating = 4

BAF 2 Valued, Skilled and Sufficient Staff
Principal Risk: The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust

Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand
There are risks around staff availability and staff absence due to Covid-19.

Health and wellbeing programme to be piloted and evaluated in December 20, Great Leaders management support clinics introduced and the Trust has also received funding to implement Schwartz Round in their virtual shorter format called "Team Time".

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 risk rating = 12
Proposed Q4 risk rating = 12
Year end target risk rating = 4

BAF 3 High Quality Care
Principal Risk: There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating

The ENT Service attended the Quality Committee and presented backlog issues and how these would be addressed in the recovery planning phase.

Falls, pressure damage and nosocomial rates have increased. Work was ongoing to reduce these.

Risk rating at the start of the year = 16
Q1 risk rating = 16
Q2 risk rating = 16
Q3 risk rating = 16
Proposed Q4 risk rating = 16
Year-end target risk rating = 8

BAF 4 Great Clinical Services
Principal Risk: There is a risk to access to Trust services due to the impact of Covid-19
1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19
2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance
3- Planning guidance being released in stages across the year

Recovery planning was ongoing.

ED performance had deteriorated due to swabbing patients and general flow through the hospital.

ENT, Cardiology, Ophthalmology and Plastics specialities were being reviewed as they had the largest waiting lists and backlogs.

Cancer performance and 52 week waits have been impacted by the second and third wave of Covid-19.

Risk rating at the start of the year = 20
Q1 risk rating = 20
Q2 risk rating = 20
Q3 risk rating = 20

Proposed Q4 risk rating = 20
Year-end target risk rating = 8

BAF 5 Partnership and Integrated Services
Principal Risk: That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost

The Trust is working closely with local partners to identify joint working arrangements. The ICS has established a new Acute Provider Collaborative and an ICS level Diagnostics Board to facilitate and strengthen partnership working on a range of key priorities. HUTH/NLAG are progressing the review of service models across 11 clinical specialties with the collective aim of improving service sustainability across the Humber region. There are ongoing developments regarding Frailty pathways, Community Paediatrics and the Outpatient Transformation programme and the Humber group has revised its planned care group as a Strategic Elective Board with the aim of agreeing a programme of work that maximises recovery, particularly around urgent elective access and long waits.

HUTH is the Covid vaccination hub for the Humber Coast and Vale area and continues to successfully lead and operate the vaccination programme.

Risk rating at the start of the year = 9
Q1 risk rating = 9
Q2 risk rating = 9
Q3 risk rating = 9
Proposed Q4 risk rating = 9
Year-end target risk rating = 3

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

Whilst the R&I activities have ben realigned to support a highly successful programme of Urgent Public Health research, there are a number of potential risks that may impact strategic progress if unresolved. These include:

- The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities.
- Loss of commercial research income as well as other income as non-COVID activity was paused, restricting growth and potentially reducing critical mass and capacity.
- Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have burden of additional workload well into 2021-22. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities.
- Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues.

The Trust must continue to risk-assess the balance of investment in R&I capacity against that of other competing priorities, taking into account the reputational momentum that has accrued over the last year in relation to the delivery of a comprehensive and highly effective COVID-19 research programme. Capitalising on this momentum with additional investment should be seen as a priority for the organisation to accelerate the goals of the R&I Strategy namely; increasing research income for reinvestment and growth, supporting clinical service development for high-quality care delivery and the appointment and retention of high-calibre staff. Therefore, the development and implementation of an agreed R&I investment strategy covering the next 3 years (protected research time for staff, providing core budgets for increased admin and other costs) is critical in taking the next step on this journey of development and supporting the research collaborations as a leading partner in the HCV ICS.

Risk rating at the start of the year = 12

Q1 risk rating = 12
Q2 risk rating = 12
Q3 risk rating = 12
Proposed Q4 risk rating = 12
Year-end target risk rating = 6

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

The Trust reported a break-even position for the first 6 months with 'true-up' income of £10.6m.

For the second half of the year the Trust has submitted a plan deficit of £6m based on shortfalls on other income (eg Car parking, catering, private patients) and the expected need to account for an annual leave provision at year end due to the potential difficulty of staff being take to take all their in year due to Covid19.

Due to the financial situation and the forecast to achieve the plan at year end, it is requested that the risk rating be reduced to 4 (4 Severity x 1 likelihood).

Risk rating at the start of the year = 12
Q1 risk rating = 12
Q2 risk rating = 12
Q3 risk rating = 8
Proposed Q4 risk rating = 4
Year-end risk rating = 8

BAF 7.2 Underlying Financial Position
Principal Risk: There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year (year 2)

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

Following discussions at the Performance and Finance Committee it was proposed that the risk rating should increase to 20 (4 severity x 5 likelihood) and an assessment of the underlying issues undertaken.

Risk rating at start of the year = 16
Q1 risk rating = 16
Q2 risk rating = 16
Q3 risk rating = 16
Proposed Q4 risk rating = 20
Year-end risk rating = 4

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

The capital and financial teams are confident that the allocations would be spent by 31 March 2021.

Risk rating at start of the year = 12
Q1 risk rating = 9
Q2 risk rating = 9
Q3 risk rating = 9
Proposed Q4 risk rating = 8
Year-end risk rating = 8

3.2 Corporate Risk Register
An element included in the BAF is the corporate risk register. The updated Corporate Risk Register is reviewed monthly by the Executive Management Committee at operational level. There are currently 16 risks on the corporate risk register.

BAF 1 staff culture = 0 corporate risks
BAF 2 sufficient staff = 8 corporate risks
BAF 3 quality of care = 2 corporate risks
BAF 4 performance = 3 corporate risks
BAF 5 partnership working = 0 corporate risks
BAF 6 research and innovation = 0 corporate risks
BAF 7.1 financial plan = 1 corporate risk
BAF 7.2 financial sustainability = 0 corporate risks
BAF 7.3 capital funding and infrastructure = 0 corporate risks

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

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

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

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

4. Recommendation
The Trust Board is asked to review the BAF, to be aware of the assurance and control needs identified, to inform current and future discussions of these areas for this financial year.

The Trust Board is asked to review and approve the year end risk ratings set out in the report.

Rebecca Thompson
Corporate Affairs Manager

March 2021

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

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

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

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

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

FINANCE
Financial sustainability

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

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

PATIENTS
High quality care
Great clinical services

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

INFRASTRUCTURE
High quality care
Financial sustainability

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

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

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

PARTNERS
Partnership and integrated services

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

BOARD ASSURANCE FRAMEWORK 2020-21 – Version updated 29 December 2020

GOAL 1 – HONEST, CARING AND ACCOUNTABLE CULTURE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating (Imp x likelihood)	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (mitigate gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
1	Chief Executive	From the Trust's strategy: *One of our key priorities is the creation of a positive working culture, because we know that investing in our staff's development, and supporting and caring for them, will enable them to deliver great care; with commitment, compassion and courage.* *Principal Risk*: There is a risk the Trust does not make progress towards further improving a positive working culture this year *What could prevent the Trust from achieving this goal?* Risk that Covid-19 impacts on staff morale, or staff energy to be on a journey of improvement when working in the reality of a pandemic, +/- working in different teams or settings through redeployment Failure to act on	None	**4 (impact major) x 3 likelihood possible = 12**	Establishment of the Workforce, Education and Culture Committee to provide Board-level oversight and accountability for key elements of the People Strategy Refreshed People Strategy focusses on: leadership capacity and capability, empowering staff to lead improvement, equality, diversity and inclusion, employee engagement, communication and recognition Workforce Transformation Committee oversees delivery of the People Strategy, including staff engagement and cultural development; Workforce, Education and Culture Committee set up to seek assurance on progress being made Engagement of Unions via JNCC and LNC on staff survey and associated action plan Board Development Plan will include development of unitary board and leaders by example Leadership Development Programme commenced April 2017 to develop managers to	Action to address identified areas of poor behaviours, as determined by consistently low staff engagements scores in some areas – to be tasked to WECC and Workforce Transformation Committee for service plans to be agreed by close Q2 Consideration of a plan specifically for medical engagement – suggest timescale of end Q2 Need to undertake workforce engagement and transformation as part of Humber Acute Services Review – timescales per HASR progress	**12**	**12**	**12**	**12**	**4 major x 1 rare = 4**	**Positive assurance** Covid-19 has led to daily/regular communications and updates to all staff – level of staff communication has increased positively and can take lessons from this when returning more to business as usual Detailed papers to Trust Board on staffing picture including additional psychological support, access to additional support, risk assessments and support to BAME Leadership Network At the WEC Committee in August the 2020 Staff Survey results showed that the Trust is above average in the following themes: equality, diversity and inclusion, morale, safe environment – bullying & harassment, violence and safety culture. Trust vacancy position 3% excluding Covid. **Further assurance required** Timing and ability to be able to return to specific work on staff engagement, leadership development and other activities that have been impacted by Covid-19 and whether Q2 Is a realistic timescale for this Understanding impact on staff morale, impact of staff moves and redeployment on training and development and bringing organisation on journey of improvement during a sustained period of managing Covid-19 Understanding of impact on staff morale and engagement if/when central financial support for Covid-19 staff support is ended

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

Risk Appetite

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

GOAL 2 – VALUED, SKILLED AND SUFFICIENT STAFF

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 2	Director of Workforce and Organisational Development Support from Chief Medical Officer and Chief Nurse	From the Trust's Strategy: *We will become the employer of choice locally and in the NHS regionally, with staff choosing to start and continue their careers with us. We will also increasingly attract staff to our posts from across the UK and wider world.* *Principal risk:* The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand *What could prevent the Trust from achieving this goal*? National and international shortages Impact of Brexit on availability of EU workers Costs of supporting overseas recruitment Impact on staff health and	F&WHG: anaesthetic cover for under-two's out of hours SHG: registered nurse vacancies Medicine HG: Risk that patient experience is compromised due to an Inability to recruit and retain sufficient nursing staff across the HG F&WHG – inability to access dietetic review of paediatric patients – staffing Medicine HG: multiple junior doctor vacancies F&WHG: Shortage of Breast pathologists F&WHG: Delays in Ophthalmology follow-up service due to capacity F&WHG	**4 (impact major)** **3 (likelihood possible)** **= 12**	Refreshed People Strategy articulates changing workforce requirements Workforce Transformation Committee and WECC assurance – staying ahead to meet changing workforce requirements, international recruitment and the introduction of new roles (such as Nurse Associate, qualified ACP posts etc) Remarkable People, Extraordinary Place campaign – targeted recruitment to specific staff groups/roles Review of international recruitment needs for 2020-21 Golden Hearts – annual awards and monthly Moments of Magic – valued staff Health Group Workforce Plans in place and held to account at monthly performance management meetings on progress to attract and recruit suitable staff and reduce agency spend Improvement in environment and training to junior doctors so that the Trust is a destination of	Need to build in *Developing Workforce Safeguards* for visibility at Trust Board on safe staffing across the Trust and staffing metrics – to be completed by close Q2 Understand impact of Covid-19 on education and training, future timelines for trainees, as well as building up organisational capacity for education, training and supervision – undertake assessment through WECC by end Q3	**12**	**12**	**12**	12	4 x1 = 4	**Positive assurance** Recruitment was in a positive position prior to Covid-19; Covid-19 brought in ability to recruit retired staff and qualifying students quickly Staffing levels subject to daily review during pandemic; risk assessments and support put in place for all staff, staff supported by testing, working from home and ability to shield without affecting pay There are plans to restart virtually the 'Great Leaders' Be Remarkable and Bitesize programmes in October 2020 Introduction of 'virtual classrooms' to ensure medical education can continue during the pressurised Winter months A number of staff support services have been established to help staff through the second wave. These include Psychological, pastoral and occupational health services. Overall vacancies are reducing in line with the long term plan. Health and wellbeing programme commencing in December 2020, Great Leaders support clinics introduced. Schwartz rounds introduced. **Further assurance required** Absence remains 1% above 5 year average due to staff needing to self isolate and have tests due to Covid 19 like symptoms. Board Development Session to review: • staff availability and staff absence should there be a second wave of Covid-19 • Staff morale following environment changes due to the updated Capital plan

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

Risk Appetite

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

GOAL 3 – HIGH, QUALITY CARE

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 3	Chief Medical Officer Chief Nurse	Taken from the Trust's strategy: *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* *Principal risk*: There Is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating *What could prevent the Trust from achieving this goal?* That the Trust does not develop its patient safety culture That Quality Improvement Plan is not designed around moving to good and outstanding That the Trust is too insular to know what outstanding looks like That the Trust	F&WHG – The Breast service reliant on one Pathologist due to long term sickness. Corporate: Time being taken to embed new clinical admin hubs	**4 (impact = major)** **4 – likely = 16**	New Quality Improvement Plan (QIP)I being put in place for 2020-21, focussing on key quality priorities, using project management methodology to set realistic goals to improve. The QIP will run throughout the financial year and monthly updates will be provided to the Quality Committee for confirm and challenge. New CQC action plan being put in place following publication of the partial inspection in June 2020; this will pick up on all 'should do' areas from the CQC, with each HG tasked with setting an action plan to address key points in their own areas Midwifery services have a robust plan to achieve the ambition in Better Births this is overseen at organisational and LMS level The Trust has put in place all requirements to date on Learning from Deaths framework over the last 3 years The Trust regularly monitors quality and safety data to understand quality of care and where further	Need to complete gap analysis against the national Patient Safety Strategy and implement a trust-wide action plan – by end Q2 Need to complete an updated Patient and Public Engagement plan and governance structure by end Q2 Need to assess impact on patient safety and clinical harm due to Covid-19 service delivery and service changes – by end Q1 Need to look at Board-level reporting on patient outcomes – by end Q3	**16**	**16**	**16**	**16**	4 x 2 = 8	**<u>Positive assurance</u>** Covid-19 has required temporarily cessation to some activities such as routine meetings; there is an opportunity to refresh the governance structure around patient safety and high quality care to continue in a lean, patient-focussed way Monthly update to the Trust Board on quality of care, monitored for Covid-19 as well as usual service delivery – no escalating risks on quality of care to report The Trust has undertaken a self-assessment against the NHSE Infection, Prevention and Control Board Assurance Framework. The CQC have reviewed the intelligence and have confirmed that the Trust has effective infection prevention and control measures in place in response to COVID and that the Trust continues to ensure that the health needs of patients and staff are met. 2 Never Events declared in April 2020 (relating to Robinson drains) had been downgraded and were now being investigated as serious incidents. No Never Events declared since April 2020. Covid Fundamental standards audits had commenced. **<u>Further assurance required</u>** Outcome of risk assessments/quality impact assessments on changes to patient pathways and delays to patient care in case these flag risks to patient harm The Trust has seen a slight increase in falls overall. In July 2020, agreement was made to re-focus the purpose of the Falls Prevention Committee. Focus Groups are to be introduced; primarily these will be set up in Elderly Medicine, and Oncology, where the highest numbers of falls are reported. The Elderly Medicine Group will focus on the link between falls and patients with Dementia or Delirium. Review of Ophthalmology eye injection service at the next Quality Committee – Backlog issues. A cluster of Serious Incidents relating to Covid-19 had been declared. The Trust was deciding whether to declare these as a cluster or individually. Reviews of ENT and Plastics have been carried out by

		does not increase its public, patient and stakeholder engagement, detailed in a strategy The impact on harm due to longer waiting times, delayed activity and less capacity from Covid-19 is not carefully managed. Capacity of organisation potentially compromised to be able to make Trust-wide improvements in quality of care			response is required Fundamental standards in nursing care on wards are being adapted for Outpatients. Will be monitored at the Trust Board and Quality Committee Participation in the "Moving to Good" Programme Close relationship with commissioners on clinical quality and improvement; have identified areas of partnership working on post-pandemic harm and patient waiting list management Regarding Falls - A monthly escalation report has been requested from each Health Group which will highlight to the Committee any increase/decrease in falls per ward, narrative around themes and trends, and any areas of concern and actions taken.			the Quality Committee.

Risk Appetite

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

GOAL 4 – GREAT CLINICAL SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 4	Chief Operating Officer	Taken from the Trust's strategy: *The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* *Principal risk:* There is a risk to access to Trust services due to the impact of Covid-19 1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19 2- There is a level of uncertainty regarding the scale and pace of recovery that is	F&WHG – Ophthalmology experiencing significant delays in meeting outpatient appointments F&WHG – Capacity for vitreal injections is limited. Clinical Support - Insufficient capacity in Radiology to accommodate increasing demand	**4 (impact = major)** **5 (likelihood = almost certain)** **= 20**	Quality Impact Assessments being undertaken on changes in service delivery due to Covid-19 Assessment per HG and service for Covid-19 recovery plans Clinical harm reviews process updated; service recovery plans require clinical review and prioritisation of all current patients on an open pathway; this includes reviews of harm if triggered Partnership working during Covid-19 and revised national guidance and emergency legislation reduced significantly Delayed Transfers of Care and hospital patients waiting packages of care Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment		**20**	**20**	**20**	**20**	4 x 2 = 8	**<u>Positive assurance</u>** New ways of service delivery adopted due to Covid-19, resulting in more efficient ways of working and ability to step activity back up in different ways, such as clinical triage of all new referrals, increased availability of advice and guidance, telephone consultations – ability to maintain these more efficient ways of working. This includes work with partners on hospital discharge processes and use of Urgent Care Centres as alternatives to ED Detailed briefing shared with Trust Board Development in July 2020 – Board fully sighted on waiting list position, recovery position, national requirements (as currently published) and the partnership working underway for service restoration COO and CMO meeting monthly with the Medical Directors to discuss ED performance and clinical engagement The Adopt and Adapt work for diagnostics is being progressed with the COO at HUTH being the SRO lead across HCV The triaging of the referrals in the RAS is working well for services. Positive engagement from all services to maintain and increase different ways of working across outpatient services Primary Care Collaborative Group had been established to review non-Covid harm The rapid increase in Covid admissions has impacted on urgent and emergency care and a reduction of the planned care programme to enable the conversion of elective wards to covid wards and mobilisation of the Covid surge staffing redeployment plan.

		possible and the impact of national guidance 3- Planning guidance being released in stages across the year What could prevent the Trust from achieving this goal? ED performance did improve following a period of intensive support and improvement focus but performance requires a Recovery and Improvement Plan to meet contractual requirements In all waiting time areas, diagnostic capacity is a specific limiting factor of being able to reduce waiting times, reduce backlogs and maintain sustainable list sizes; this is compounded by staffing and capital issues Ability to step back up activity following Covid-19 surge has rate-limiting factors on PPE and critical care capacity, as well as staff availability and patient availability			Impacts on waiting lists due to Covid-19 measured and published weekly Capacity and demand work in all pathways Plan to review medical base ward capacity to meet demand Restoration command structure in place						**<u>Further assurance required</u>** Results of Quality Impact Assessments and service plans to determine impact on waiting lists; realistic recovery times may be protracted and adding to already large waiting list Further work required on ED performance as patient numbers start to rise again – new weekly meeting in place between Health Group Medical Directors Following receipt of the Phase 3 planning letter there are risks around the performance expectations set out. Diagnostic performance is improving in July 2020, but there are still issues around endoscopy. Operating plan not meeting the national ask. Waiting list forecast March 2021 – 66000 52 week wait forecast March 2021 – 16500 ENT, Cardiology, Ophthalmology and Plastics were being reviewed due to them accounting for 40% of the backlog/waiting list issues. Cancer and 52 week performance is being impacted by the second and third wave of Covid-19.

Risk Appetite

A range of plans were put in place to further manage these issues in to 2019-20. The Trust wants to decrease waiting times as the particular concern in this is the anxiety and concern caused to patients having to wait. This concern has increased significantly in light of actions required during the Covid-19 first surge. Whilst there is an opportunity to use technology to a greater extent and make pathways more efficient, the Trust will need to consider how to make improvements in waiting times without compromising quality of care; this will need to fit in to the resource envelope when the financial plan for the year is confirmed. There is an appetite to take risks if this would improve quality of care and use resources more efficiently; this will require innovation as well as consideration of pathway change, some of which may need to be bigger schemes. This will require risk-sharing across system partners, which is yet to strongly emerge in practice.

GOAL 5 – PARTNERSHIP AND INTEGRATED SERVICES

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 5	Director of Strategy and Planning	Taken from the Trust strategy: *In our strategy we have made a powerful commitment to work in a collaborative and proactive way, at all levels, to foster positive relationships with our partners and more closely integrate our services with other providers in primary, community and mental health and social care* *Principal risk:* That the Humber, Coast and Vale Health and Care Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid-19 recovery; momentum on work previously in progress could be lost *What could prevent the Trust from achieving this goal?*	None	**3 (impact = moderate)** **3 (likelihood = possible)** **= 9**	The Trust has key leadership roles in the current ICS governance structure – this has a breadth and depth of span and senior leaders from HUTH involved in all key groups, chairing many HUTH taking role in continued partnership work and asking for momentum on acute service reviews to be picked back up as soon as possible Undertaken detailed stakeholder feedback survey, and formulating action plan following Board discussion Recent discussions and plans on Humber Acute Services Review	Updated ICS framework for post-Covid-19 surge recovery to avoid duplication of work as well as to reflect ICS priorities on planning and delivery that have been interrupted by Covid-19 – timescales will be per ICS but likely to be concluded in Q3 Ongoing discussions on accountability framework at ICS level, the statutory duties of each ICS member organisation and the governance structures underpinning these – require continued discussion in 2020-21	**9**	**9**	**9**	9	3 x 1 = 3	**Positive assurance** The Trust is working closely with local partners to identify joint working arrangements. The ICS has established a new Acute Provider Collaborative and an ICS level Diagnostics Board to facilitate and strengthen partnership working on a range of key priorities. HUTH/NLAG are progressing the review of service models across 11 clinical specialties with the collective aim of improving service sustainability across the Humber region. There are ongoing developments regarding Frailty pathways, Community Paediatrics and the Outpatient Transformation programme and the Humber group has revised its planned care group as a Strategic Elective Board with the aim of agreeing a programme of work that maximises recovery, particularly around urgent elective access and long waits. HUTH is the Covid vaccination hub for the Humber Coast and Vale area and continues to successfully lead and operate the vaccination programme. **Further assurance required**

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

GOAL 6 – RESEARCH AND INNOVATION

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 6	Chief Executive Chief Medical Officer	Taken from Trust strategy: *Our purpose in developing a new long term goal of 'great research and innovation' is to demonstrably improve the lives of the population we serve, by establishing the Trust as a nationally recognised research centre of excellence, with a culture of innovation* *Principal risk:* There is a risk that the Trust does not develop make progress in developing its research capability, capacity and partnerships *What could prevent the Trust from achieving this goal?* Scale of ambition vs. deliverability Current research capacity and capability may be a rate-limiting factor Unknown impact of Covid-19 on partner organisation and	None	**3 (impact = moderate)** **4 (likely)** **= 12**	Strengthened partnership with the University of Hull Trust investment in last 12 months in research capability including jointly funded posts and projects Actions against Strategic Goals within Trust Strategy for Research and Innovation in place – detailed plan in place with milestones and risk assessment Further development of partnership with Sri Ramachandra, India and joint research conference and projects	Understanding impact of Covid-19 in the short- and long-term on Trust's strategy as well as key partners – likely to understand position by close Q3 Understanding relationship and impact on clinical quality and patient outcomes with Trust's R&I and clinical audit activities – to have framework for updating/reporting at high level by end Q3	**12**	**12**	**12**	12	3 x 2 = 6	**Positive assurance** Trust taking part in Covid vaccination trial Trust working with HC&V to identify mutual benefits across the system Successful portfolio of Covid studies managed in 2020 HUTH Hull City Region Vaccine Hub. Funding received to support the delivery of the vaccine trials Non Covid research to commence where possible and safe to do so **Further assurance required** Junior Doctors and Research Fellows research time impacted due to Covid and clinical responsibilities Whilst the R&I activities have ben realigned to support a highly successful programme of Urgent Public Health research, there are a number of potential risks that may impact strategic progress if unresolved. These include: • The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. • Loss of commercial research income as well as other income as non-COVID activity was paused, restricting growth and potentially reducing critical mass and capacity. • Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have burden of additional workload well into 2021-22. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities.

		research funding availability Recovery of Trust research staff redeployed during Covid-19 into front-line roles back in to research work								• Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues.

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

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.1	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *Principal risk:* There is a risk that the Trust does not achieve its financial plan for 2020-21 *What could prevent the Trust from achieving this goal?* Inability of Trust to restrict Covid related expenditure to within nationally prescribed expectations Inability of Trust to	Corporate: Pensions	**4 (impact = major** **3 (likelihood = possible)** **= 12**	HG held to account on financial and performance delivery at monthly Performance reviews; HGs hold own performance meetings Ongoing management of Trust cash balances to ensure no liquidity issues. Process in place to agree level of activity planned for remainder of year. Cannot be concluded until financial envelope known Monthly analysis and interrogation of Covid and non-Covid spend using established accounting processes and develop better understanding of the cost base Review of income generating activities taking place with assumption of charging for all relevant services (except staff car parking) from early September	Need to see financial plan from Centre to be able to frame the degree of risk and action required to achieve Assurance over grip and control of cost base; underlying run-rates increasing pressures Accurate forecasting and control Grip and control of locum and agency spend Delivery of recurrent CRES All above controls need to be addressed by end Q1	**12**	**12**	**8**	4	4 x 2 = 8	**<u>Positive assurance</u>** Monthly block contract arrangement and access to Covid-19 funding reported to Trust Board; Trust continues to monitor capacity and demand, income and cashflow in detail Achieved revised plan for first quarter of the year Financial planning guidance received for month 7 onwards Trust has maintained its break even position in Month 8 Trust has submitted a plan deficit of £6m based on shortfalls on other income such as car parking. The month 7 in month deficit of £0.52m was an improvement to the planned £0.7m Due to the financial situation and the forecast to deliver the year end plan, it is proposed to reduce the risk to 4 (4x1). **<u>Further assurance required</u>** Provider shares of the ICS Covid and growth allocations are still to be determined. ICS plans had been submitted. The risks were being reviewed. The ICS had a £8.9m gap to be addressed.

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

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

GOAL 7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.2	Chief Financial Officer	Taken from the Trust Strategy: *The last 3 years have been a time of significant financial constraint; in the NHS as a whole, for our commissioners and also for the Trust. As at the end of 2018/19, the Trust is carrying a recurrent deficit of circa 5% of its operating budget. The NHS Long Term Plan sets out an approach to returning NHS providers to surplus over the next 5 years; we would expect to achieve a return to surplus early in the 5 year period and go on to sustain this.* *Principal risk:* There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year (year 2) *What could prevent the Trust from achieving this goal?* Lack of achievement of sufficient recurrent	None	**4 (impact = major)** **4 (likely)** **= 16**	Robust financial planning processes in place Covid-19 recovery planning already commenced Covid-19 funding available nationally, on a non-recurrent basis. Unclear what recurrent impact of Covid will be both in terms of income and expenditure	Need to update longer term financial plan – planning assumptions may change as well as ability of ICS to be able to meet all financial pressures of system Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews	**16**	**16**	**16**	20	4 x 1 = 4	**Positive assurance** **Further assurance required** Emerging direction of travel for NHS Finance sees performance being measured at a system (ICS) level. It is not clear just how this evolving picture will impact on the Trusts underlying position.

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

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

GOAL7 – FINANCIAL SUSTAINABILITY

BAF Risk Ref:	Accountable Chief / Director. Responsible Committee	Principal Risk & what could prevent the Trust from achieving this goal?	Corporate risks on Risk Register that relate to this risk	Initial Risk Rating (no controls)	Mitigating Actions		2020/21 risk ratings				Target risk rating	Effectiveness of mitigation as detailed to the Trust Board or one of its Committees
					What is being done to manage the risk? (gaps in controls)	What controls are still needed or not working effectively?	Q1	Q2	Q3	Q4		
BAF 7.3	Chief Financial Officer	*Principal risk:* There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability *What could prevent the Trust from achieving this goal?* Lack of sufficient capital and revenue funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment; capital funding is not available against the Trust's critical priority areas but is available in others, making the capital position look more manageable than operational reality	None	**4 (impact)** **3 (likelihood) Possible = 12**	Risk assessed as part of the capital programme Comprehensive maintenance programme in place and backlog maintenance requirements being updated Ability of Capital Resource Allocation Committee to divert funds Service-level business continuity plans Equipment Management Group in place with delegated budget from Capital Resource Allocation Committee to manage equipment replacement and equipment failure requirements – managing critical and urgent equipment replacement in 18-19 Business case for Wave 4 STP capital completed. This will enable some infrastructure risks in 2020-21 to be addressed Combined Heat and Power Plant capital funding sourced in 2019-20 – CHP being commissioned in 20-21 Critical infrastructure funding of £6m received to help reduce	Insufficient funds to manage the totality of risk at the current time – unable to address internally	**9**	**9**	**9**	**8**	4 x 2 = 8	**Positive assurance** Increased capital plan for 2020-21, successfully application for additional capital funding to address some long-term infrastructure needs The Capital Resource Allocation Committee were informed that the Government has announced an additional £600m capital to address high risk critical infrastructure backlogs. This funding is to improve estates resilience and is expected to deliver maximum reduction in reported critical infrastructure risks (CIR). The HCAV's proportion of this bid is £14.9m for critical care infrastructure, with HUTH's proportion being £6.2m. HCaV Urgent and Emergency Care Business Case Update has progressed to NHSEI and DHSC for evaluation. Difference to the original plan (£18.6m) discussed at the Trust Board meeting in September 2020. Works have started although the MOU is yet to be received. Finance teams are confident that the Trust will spend the capital allocations by 31 March 2021. **Further assurance required** Building works for the updated Capital programme and the impact on services and staff.

					backlog.					

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

Hull University Teaching Hospitals NHS Trust

Trust Board

March 2021

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

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

Recommendation:	The Trust Board is requested to: • Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders March 2021

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since January 2021 as this paper was deferred as non-urgent business until this month. Where the old Trust name is used, it relates to a contract in place under the previous Trust name, which has been updated/amended. As an existing contract, it is correct to retain the name of the organisation under which the original agreement was formed. Each case is double-checked with the Trust solicitors before proceeding.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2021/01	Hull University Teaching Hospitals NHS Trust and East Riding Fertility Services Ltd – Renewal lease by reference to a previous lease at IVF facility at Hull Royal Infirmary site	3 February 2021	Chris Long – CEO Lee Bond - Chief Financial Officer

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Corporate Affairs Manager
March 2021

Hull University Teaching Hospitals NHS Trust

Trust Board

4th March 2021

Title:	Our Patients - Performance Summary	
Responsible Director:	Ellen Ryabov - Chief Operating Officer	
Author:	Mags Barnaby – Acting Chief Operating Officer Louise Topliss – Assistant Director of Operations (Operational Performance)	
Purpose:	The purpose of this paper to provide an Executive Summary of Performance for January 2020 against expected National Standards.	
BAF Risk:	BAF 4 – Performance	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	
	Financial sustainability	
Key Summary of Issues:	• Operational performance has remained challenged in the month of January • Revised Phase 3 Recovery Plan is in the final stages of construction • Plans for Q1 recovery and the longer term strategy to deliver improvements in operational recovery are underway	
Recommendation	That the Trust Board receives and accepts the content of this paper and indicates whether any further assurance is required.	

Performance Report - Executive Summary

4 March 2021

1. Purpose

This paper provides an executive summary of actual delivery towards key performance standards for the month of January 2021 as compared to planned national standards.

Performance attainment against all key 'responsiveness' indicators is monitored at the Performance and Activity Meetings, chaired by the Chief Operating Officer. A Summary of Key Performance Standards achieved in month, and trend data for the previous eleven months is provided for information in ***Appendix 1.***

2. Summary of Key Performance Issues in Month

The operational performance of the Trust remained challenging and this position has continued throughout February 2021.

As a result of the third Covid surge, pressure impacting delivery of our key constitutional standards has continued. Whilst there has been marginal improvement in some areas, the overall operational performance within the Trust has not improved significantly this month, when compared to that seen in the previous month.

Focus for the operational teams is to ensure that we:

- safely accommodate our urgent and emergency patient flows from point of arrival
- have sufficient resources to operate on all P1 and P2 surgical cases
- safely accommodate and manage all cancer cases in a timely manner
- deliver a significant reduction in the number of long waiting patients

Patient flow issues within the urgent and emergency care pathway continued in the month of January .The number of theatre sessions remains well below business as usual. The reason for this is the large volume of theatre staff currently deployed into other roles within the Trust. This is impacting ability to provide sufficient inpatient capacity, resulting in the decrease in activity planned for inpatients as outlined in section 3 below. Elective Day Case theatre activity resumed in February 202.

The significant shortfalls in capacity for breast cancer as seen in October have not yet improved, and work continues to realign theatre and inpatient capacity to address this shortfall, including use of the Independent Sector.

The 2 week wait position For December is 79.4%,. Actual performance for 62 day cancer standard in December was 55.6%.

The 52 week position remains of significant concern, and in January the number of patients waiting in excess of 52 weeks reached 11,044.. We have forecast that this number could reach circa 14K by the end of March, albeit that we do now expect our year end forecast position to improve as a result of the increased activity planned through to the end of March 2021.

The current position on 52 week waits by Health Group, with an overview of the top 10 specialties by point of delivery is outlined in table 1 below:

	52 WEEK WAITS - BY POINT OF DELIVERY @ 31 JAN 21					
HEALTH GROUP	First Activity	Subsequent	Day Case	Elective	Grand Total	% Split
CLINICAL SUPPORT SERVICES	29	7	81	5	122	1.10%
FAMILY & WOMENS HEALTH	4825	113	1889	347	7174	64.96%
MEDICINE	388	219	138	11	756	6.85%
SURGERY	459	58	1785	690	2992	27.09%
	5701	**397**	**3893**	**1053**	**11044**	**100.00%**

		52 WEEK WAITS - BY POINT OF DELIVERY @ 31 JAN 21					
	SPECIALTY TOP 10	First Activity	Subsequent	Day Case	Elective	Grand Total	% Split
Family & Women HG	ENT	2543	27	467	58	3095	33.58%
	Plastic surgery	687	13	728	5	1433	15.55%
	Ophthalmology	999	30	213	3	1245	13.51%
	Gynaecology (including oncology)	124	24	343	190	681	7.39%
	Dermatology	346	10	4		360	3.91%
	Breast surgery	55	4	115	70	244	2.65%
Medicine HG	Cardiology	282	185	110	9	586	6.36%
Surgery HG	Oral surgery	64	5	569	1	639	6.93%
	Urology	27	6	366	82	481	5.22%
	Trauma & orthopaedics	41	7	162	243	453	4.91%
		5168	**311**	**3077**	**661**	**9217**	**100.00%**

Summary Total % Top 10	**90.65%**	**78.34%**	**79.04%**	**62.77%**	**83.46%**

As can be seen from the above, Family & Women's Health account for 65% of the long waiting patients, with the majority awaiting a first outpatient slot. This is then followed by the Surgical Health Group, having responsibility for 27% of those patients waiting in excess of 52 weeks, the majority of whom are awaiting either day case or inpatient treatments.

The recovery plan focus is on the top 10 specialties, which account for over 83% of the total numbers waiting, with first outpatients being the single greatest pressure on service delivery at this time.

3. Phase 3 Recovery Planning

As outlined in the January Trust Board Performance report the national guidance on Phase 3 planning was issued in August 2020 and set out the expectations for the NHS to return to 'near normal' levels of non Covid health services by the end of March 2021.

It is now clear that delivery of "near normal" levels of activity are not yet being delivered and at this stage within HUTH, we are unlikely to see a return to those levels of activity delivered in 2019/20, the last full year of "normal workload".

It is also clear that all points of service delivery have been significantly impacted by the most recent 3rd Covid surge and given that the current surge is not yet over, delivery of the elective recovery plan remains at significant risk.

The main challenge to any potential return to "near normal" levels is the direct impact resulting from the redeployment of both theatre and outpatient staff. Planning to restore some elective services, outpatients and day case is underway. The Trust plans, originally set out in October have now been fully revised and are based on what we now believe can be delivered both in

house, and with additional support externally. Further minor adjustments are planned to include all activity that will be completed in the Independent Sector as part of the National Contract. In addition, we have identified further activity that will be delivered as part of an in-sourcing project which will move us further towards delivery of activity in line with the original plans.

It is possible that this plan could improve, or indeed deteriorate depending on the current Covid numbers and whether or not we see a 4th Covid wave. The Trust plans are being managed through our Elective Recovery Group and monitored via Performance and Activity meetings.

Main risks which continue to impact the delivery of HUTH planned elective recovery programme

- Covid capacity requiring continued use of > 200 beds to accommodate 3rd Covid surge
- Workforce redeployment > 100 theatre staff to accommodate above
- Workforce sickness absence potential to increase
- Critical care capacity/workforce
- High Observation Bed capacity/workforce
- Covid outbreaks on elective wards resulting in a further reduction in available bed

4. Conclusion.

The Trust continues to admit Covid patients throughout January and into February 2021.

The result of the ongoing pandemic is that we are experiencing significant and continued pressures on our urgent and emergency care pathways, which when combined with our normal winter pressures has, and will continue, to reduce our ability to fully recover our elective planned care programme.

We will continue to complete as much work as we can on the elective care programme and in particular to benefit from the opportunity of maximising outpatient and day case capacity and Independent Sector activity, which places less pressure on our inpatient beds, on both the HRI and CHH sites.

5. Recommendation

That the Trust Board receives and accepts the content of this paper and indicates whether any further assurance is required

Mags Barnaby

4th March 2021

Appendix 1

1. Operational Performance – Emergency Department

PaF Key Performance Indicators | Emergency Department

Period: Last 12 Months (Calendar) — 01/02/20 - 31/01/21

Emergency Department	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
ED: Attendances Type 1		10,332	8,819	6,476	8,289	9,133	9,788	10,213	9,880	9,779	8,646	8,604	8,362
ED: Breaches - Type 1		3,818	2,496	870	754	1,147	1,433	1,486	2,221	2,748	2,905	2,758	2,584
ED: Standard Performance Type 1	95%	63.0%	71.7%	86.6%	90.9%	87.4%	85.4%	85.4%	77.5%	71.9%	66.4%	67.9%	69.1%
ED: Attendances Type 1 & 3		19,129	15,244	9,150	11,822	13,583	15,412	16,748	16,253	15,515	13,033	13,269	12,508
ED: Breaches - Type 1&3		3,872	2,536	870	754	1,148	1,434	1,507	2,238	2,763	2,908	2,766	2,596
ED: Standard Performance Type 1 & 3	95%	79.8%	83.4%	90.5%	93.6%	91.5%	90.7%	91.0%	86.2%	82.2%	77.7%	76.9%	79.2%
ED: % of attendees assessed within 30 minutes of arrival		84.6%	88.8%	94.1%	96.6%	94.3%	95.9%	95.6%	93.4%	89.6%	84.1%	89.3%	90.4%
ED: % of attendees seen by doctor within 60 minutes		38.1%	51.1%	80.8%	70.4%	62.7%	55.5%	54.3%	49.0%	50.0%	46.9%	57.6%	58.2%
ED % patients waiting over 6 hours in the departments		21.9%	16.2%	5.8%	3.4%	54.0%	6.0%	5.7%	11.3%	17.3%	21.7%	19.8%	19.1%
ED: Median time between arrival and treatment (minutes)		98	65	25	36	47	57	59	62	64	68	54	51
ED: % of patients who Left Without Being Seen		7.3%	5.1%	2.7%	3.4%	4.4%	5.2%	4.1%	4.4%	4.3%	4.4%	4.1%	3.8%
ED 12 hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0
ED: % of ED attendances subsequently admitted		25.1%	25.6%	28.7%	26.6%	26.6%	26.3%	25.9%	24.9%	25.8%	28.0%	26.3%	27.0%

Emergency Dept

2. Operational Performance – Unplanned Care

PaF Key Performance Indicators | Unplanned Care

Period 01/02/20 - 31/01/21

Last 12 Months (Calendar)

Unplanned Care	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Ambulance handovers waiting 15-30 minutes		997	980	917	1,062	1,084	978	1,019	968	1,049	837	847	827
Ambulance handovers waiting 30-60 minutes	0	641	479	210	156	196	158	227	279	493	601	396	426
Ambulance handovers waiting >60 minutes	0	384	193	19	9	10	1	11	33	171	304	199	211
Non Elective Admissions		5,258	4,719	3,726	4,302	4,741	5,062	5,087	4,986	4,829	4,496	4,407	4,287
Patients with LOS 0 Days (Elective & Non-Elective)		1,365	1,254	807	1,029	1,138	1,235	1,355	1,282	1,292	1,072	1,129	1,057
Patients with a LoS >= 7 Midnights (Elective & Non-Elective)		381	297	188	241	323	297	301	330	321	311	348	319
Stranded Patients at End of Month 14 days		212	206	115	103	133	146	137	155	163	172	180	176
Average Bed Days Occupied by Stranded Patients		48	46	55	51	47	55	55	55	52	50	47	49
Stranded Patients at End of Month 21 days		122	126	72	57	74	82	78	91	100	93	89	101
Average Bed Days Occupied by Super Stranded Patients		84	81	106	97	94	100	97	93	86	92	96	85
Delayed Transfers of Care - Acute Hospitals	1.6%	2.2%											
Emergency readmissions within 30 days	8.1%	7.4%	6.7%	9.6%	9.5%	8.8%	9.3%	10.0%	7.5%	6.7%	7.3%	8.4%	7.5%

3. Operational Performance – Cancer

PaF Key Performance Indicators | Cancer Performance

Period: 01/02/20 - 31/01/21 (Last 12 Months (Calendar))

Cancer	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Cancer 2 week (all cancers)	93%	94.7%	93.9%	93.1%	95.4%	92.3%	87.6%	85.0%	73.8%	81.3%	76.2%	79.4%
Cancer 2 week (breast symptoms)	93%	91.7%	91.8%	80.6%	51.2%	43.9%	59.7%	16.0%	9.7%	5.4%	6.6%	5.6%
Cancer 31 day wait from diagnosis to first treatment	96%	97.4%	95.3%	97.3%	94.0%	90.9%	88.8%	92.4%	93.4%	91.7%	92.5%	88.6%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	83.1%	87.5%	86.5%	91.9%	81.1%	81.4%	88.2%	85.1%	80.0%	95.6%	65.6%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	94%	95.2%	99.1%	95.5%	97.8%	98.1%	98.6%	100.0%	99.1%	99.3%	99.2%	97.4%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	67.1%	69.5%	70.8%	56.4%	70.6%	68.9%	71.3%	61.2%	62.2%	69.9%	55.6%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	39.7%	59.0%	59.4%	40.0%	0.0%	16.7%	0.0%	66.7%	88.9%	71.8%	51.4%
Cancer 28 Day Wait - Faster Diagnosis Standard	75%	86.2%	85.5%	71.8%	84.5%	83.9%	82.7%	80.1%	77.5%	80.9%	78.8%	51.0%

***one month behind due to national reporting timetable*

4. Operational Performance – 18 Weeks Referral to Treatment

PaF Key Performance Indicators | 18 Weeks Referral to Treatment

Period: Last 12 Months (Calendar) — 01/02/20 - 31/01/21

18 Weeks Referral To Treatment	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Diagnostics: Patients waiting <6 weeks from referral to test	1%	11.5%	20.3%	71.3%	72.5%	55.4%	43.6%	36.8%	39.7%	34.2%	34.8%	40.8%	43.8%
RTT Incomplete Pathways % performance	92%	68.1%	65.4%	57.7%	49.9%	40.5%	35.2%	40.6%	46.0%	49.9%	51.8%	50.4%	50.0%
RTT Total Waiting List	58,515	52,997	52,785	52,216	52,746	52,794	55,545	56,560	58,032	58,176	58,697	59,443	59,705
RTT 36+ Week Waiters		2,868	4,056	5,962	7,969	10,202	12,925	15,233	16,519	18,242	19,803	19,094	18,078
RTT 52+ Week Waiters	0	00	86	364	909	1,886	3,307	4,399	5,800	6,820	8,022	9,356	10,873
Number of patients on Admitted Pathway		10,860	10,932	11,213	10,808	11,101	11,892	12,191	12,477	12,241	12,674	13,393	13,860
Number of patients on Non Admitted Pathway		42,137	41,853	41,003	41,938	41,693	43,653	44,369	45,555	45,935	46,023	46,050	45,845
Mean Week Waiting Time - Incomplete Pathways		11.13	11.29	14.69	18.03	20.69	22.92	24.99	23.13	18.04	16.00	17.00	17.00
e-Referrals Service Rejected Requests and Referrals Returned by RAS			10.8%	25.0%	14.8%	15.9%	13.4%	13.0%	13.5%	14.7%	15.7%	14.7%	
Advice & Guidance Volume		1,162	1,398	1,334	1,440	1,934	2,208	1,987	2,214	2,313	2,336	2,164	2,431

5. Operational Performance – Planned Care

PaF Key Performance Indicators | Planned Care

Period 01/02/20 - 31/01/21

Last 12 Months (Calendar)

Planned Care	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Outpatients: All Referral Types		16,766	13,991	6,240	8,008	10,561	13,249	12,716	13,908	14,405	12,848	12,859	13,156
Outpatients: Consultant to Consultant Referrals		3,954	3,352	1,899	1,850	2,235	2,784	2,705	3,319	3,439	3,126	3,192	3,128
Outpatients: GP Referrals		8,158	6,815	2,463	3,561	5,537	6,747	6,396	6,603	7,270	6,652	6,528	6,893
Outpatients: Other Referrals		2,361	1,971	808	972	1,085	1,681	1,637	1,913	1,750	1,602	1,678	1,656
Outpatients: 1st Attendances		18,664	15,808	7,432	8,943	12,511	15,434	14,835	17,882	18,122	17,840	17,143	17,284
Outpatients: Follow Up Attendances		42,434	38,131	23,822	27,284	33,456	36,713	33,024	40,266	44,510	39,327	37,037	40,038
Outpatients: 1st to FU Ratio		2.10	2.30	3.20	301.00	2.60	2.40	2.20	2.30	2.50	2.20	2.20	2.20
Outpatients: DNA rates		8.0%	8.6%	6.2%	5.4%	6.1%	7.1%	8.2%	8.4%	8.4%	9.1%	8.5%	7.6%
Outpatients: Hospital Cancelled Outpatient Appointments %		7,373	22,520	26,524	11,098	7,636	6,836	6,081	7,335	7,537	11,389	8,416	8,282
Outpatients: Patient Cancelled Outpatient Appointments %		9,036	11,198	3,627	1,799	1,961	3,029	3,744	5,440	5,939	6,708	5,418	7,328
Outpatients: Cancelled Clinics < 6 weeks notice		656	2,643	5,709	3,022	2,638	3,153	2,268	2,248	2,687	3,080	3,002	2,720
Elective Admissions		1,229	1,006	304	384	571	754	790	950	1,027	637	582	506
Day Case Admissions		6,040	4,996	2,406	2,406	2,919	3,448	3,347	4,370	5,018	4,221	4,032	3,964
Theatres: Utilisation of planned sessions	85%	86.7%	70.7%	26.9%	37.7%	36.0%	43.2%	50.6%	62.6%	61.4%	66.1%	63.3%	63.3%
Theatres: number of sessions held		1,135	1,004	355	491	520	627	747	978	1,182	797	619	592
Theatres: Cancelled Sessions (due to leave, staffing etc)		110	51	22	0	0	0	0	10	4	0	0	0
Cancelled op 28 day breaches number		5	2	0	2	6	5	2	6	2	1	6	8
Cancelled Operations number		66	61	9	14	20	27	35	52	74	46	34	60
Cancelled Operations % of FFCEs (quarterly)	0.8%		0.8%			18.6%			13.1%			0.0%	
Cancelled op 28 day breaches % (quarterly)	5%		5.1%			0.5%			0.7%			0.0%	

Emergency Dept

Unplanned Care

Cancer

18 weeks RTT

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Performance and Finance Committee

Meeting Date:	22 February 2021	**Chair:**	Mr M Robson	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- The committee received a detailed presentation regarding Covid 19 Recovery
- The Trust would focus on the following:
  Urgent and Emergency Care, Urgent elective care P2, Cancer (this has been ongoing through the pandemic), Longest waits and elective recovery
- The Board Assurance Framework was presented – the committee discussed the financial risks. The proposed ratings would be presented to the Board in March 2021.
- Key performance issues were highlighted as RTT, Cancer and diagnostics.
- Finance report - Month 10 the Trust was reporting a deficit of £500k which was £1.3m better than plan.
- Finance and planning framework – no new guidance had been received
- ICS Finance Reporting – The wider report to be received regularly by the committee.
- Capital Resource Allocation Committee - next year's capital plan was being considered. Risks included backlog maintenance, IT and Infection Control.

Key decisions made:

- The Pentax Equipment contract was presented to the Committee for approval and formed part of the main entrance business case. The committee approved the contract.

Risk and assurance matters to be received by the Board:

- The Trust had not declared any 12 hour trolley waits.

Matters to be escalated to the Board:

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
QUALITY REPORT

PREPARED FOR THE TRUST BOARD
March 2021

Title:	Quality Report: Patient Impacts
Responsible Director:	Beverley Geary - Chief Nurse
Author:	Kate Southgate, Deputy Director of Quality Governance

Purpose:	The purpose of this report is to provide information and assurance to the Trust Board to matters relating to quality governance and patient safety including: • Risk Management • Patient Safety • Patient Experience • Well-led domain	
BAF Risk:	BAF 3 – Quality of Care	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	X
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Summary Key of Issues:	During January 2021 the following have been reported: • No Trust apportioned MRSA bacteraemia cases have been reported from the 1st April 2020 until the 31st December 2020. • There have been 3 Trust apportioned MSSA bacteraemia cases reported. • There has been an increase in reported Covid 19 cases and an increase in the Trust nosocomial infection rates in January. This prompted a visit from NHSI to seek assurance around the actions taken. • One Never Event was declared (wrong site surgery) and a further 5 Serious Incidents were declared. Details of which are provided in the report. • Trustwide overall number of falls and falls per 1,000 bed days has decreased slightly in January 2021, however numbers per 1,000 bed days remain above control limits.	

	• There has been a decrease in the number of incidents with a level of harm of moderate or above • Pressure damage has increased across all catagories with a significant increase from 69 in total in December to 106 in January. • The CQC are currently out to consultation on their new strategy which proposes changes to how the regulation and inspect organisations. They are also out to consultation on their rating processes which proposes a change to how they rate organisations following an inspection and providing one overall rating for Trust's rather than for each domain and an overall rating.
Recommendation:	The Board is asked to receive the report as assurance on the quality of care being delivered in the Trust and that mechanisms are in place to record exceptions and mitigate risks.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD

PATIENT IMPACTS

1. PURPOSE OF THIS REPORT

The purpose of the report is to apprise the Board of the key issues in relation to quality governance, patient safety and regulatory matters.

2. RISK MANAGEMENT

2.1 Never Events and Serious Incidents

In January 2021, one Never Event was declared (wrong site surgery) and a further 5 serious incidents were declared. The Duty of Candour process has been initiated in all cases.

They were:

- A patient fall resulting in an inter-cerebral haemorrhage
- 3 obstetric incidents
- A negative pressure wound
- A wrong site surgery Never Event

Themes and trends from Serious Incident and Near Misses are routinely reviewed at the SI Committee. Trend analysis is undertaken and reported to the appropriate committee, most recently; a pressure damage and a nosocomial infection rate review has been commissioned by the SI Committee.

2.2 Incident Reporting

Patient Incident numbers have shown a 5% increase from last month, of note is the increase above control limits of moderate and above patient safety incidents per 1,000 bed days for consecutive months.

In the Emergency Care Health Group, 0 moderate, major and catastrophic incidents were reported.

In the Clinical Support Health Group, 8 moderate incidents were declared with no themes or trends noted. Zero Major and catastrophic incidents were declared.

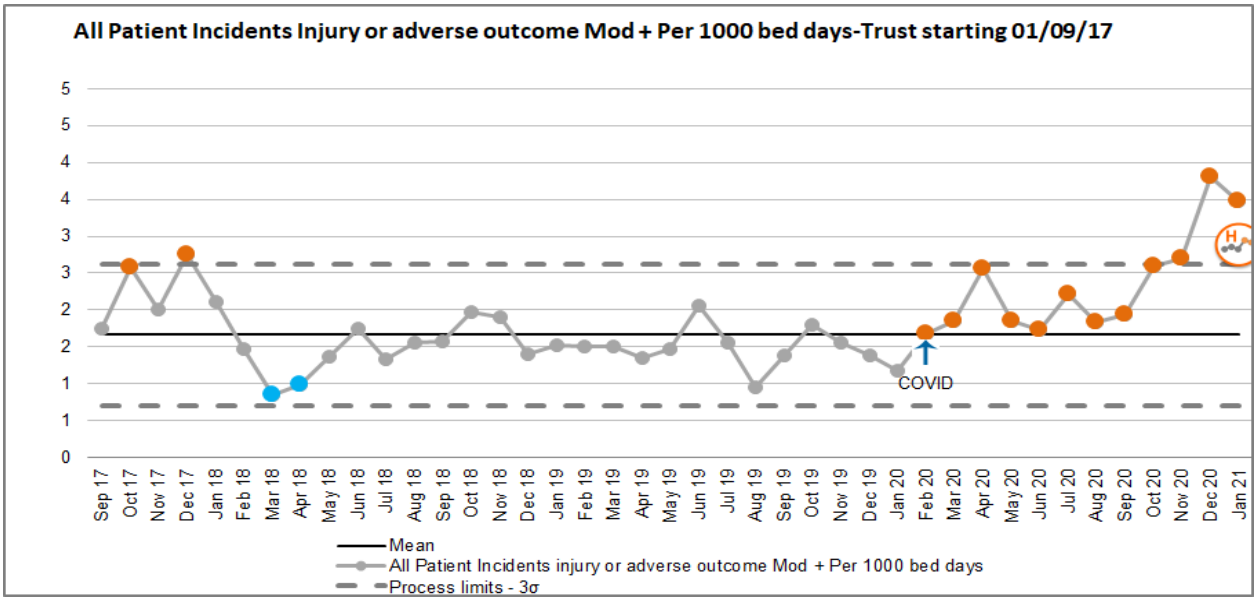
In Medicine Health Group, 26 moderate incidents were declared, 2 majors and no catastrophic. One incident has been escalated as an SI which is a Pressure Ulcer on H90. Pressure Ulcers and Falls remain the highest report incident. The Tissue Viability Nurse continues to work closely with the Ward Sisters and Charge Nurses.

In Surgery Health Group, 22 moderate incidents were reported, 15 of which were pressure ulcers. Zero majors and catastrophic incidents were declared. Falls and pressure ulcers remain at higher than normal levels as well as an increase in patient documentation incidents relating to the mortuary.

In Family and Women's Health Group, there were 24 moderate incidents declared, 2 of which have been declared as SIs (A Never Event, wrong site surgery and a maternity incident relating to a CTG machine). One catastrophic incident was declared which has become an SI in relation to an unexpected baby death. The Health Group has seen an increase in administration incidents with Ophthalmology, mitigation is being put in place to expedite the appointment of a failsafe office and a

risk has been added to the risk register. The Health Group have seen a rise in pressure damage and falls, mainly on their Covid ward, this continues to alter the figures of baseline for the Health Group.

Figure 1: All patient incidents, injury or adverse outcome – Moderate and above per 1,000 bed days



3. PATIENT SAFETY

3.1 Healthcare Associated Infections

MRSA
No Trust apportioned MRSA bacteraemia cases have been reported from the 1st April 2020 until the 31st December 2020. On the 22nd June 2020, a community apportioned case was reported and investigated via a Post Infection Review; the PIR remains with the Commissioners for review and outcome decision.

MSSA
There have been 3 Trust apportioned MSSA bacteraemia cases reported during January 2021. By the end of January 2021, 46 Trust apportioned MSSA bacteraemia cases have been reported. These cases represent a mixture of causes including deep seated infections, skin and soft tissue infections, ventilator association pneumonia, often secondary to COVID-19 infections and also still some device related cases.

A previous review of MSSA bacteraemia cases by the IPCT up to and including August 2020 identified that 42% were associated with vascular devices. A further review of MSSA bacteraemia cases due in January 2021 has been delayed due to rising COVID-19 numbers but will be rescheduled by the team. All Trust apportioned cases are investigated using a root cause analysis (RCA) process.

Additional information
During January 2021, 3 Hospital onset healthcare associated *Clostridium difficile* cases were reported but no community onset healthcare associated cases which reported. During January 2021, 10 Trust apportioned E.coli bacteraemia were reported, demonstrating a slight increase in reported cases. 5 Trust apportioned Klebsiella bacteraemia cases were reported during January 2021. 2 Pseudomonas aeruginosa bacteraemia cases were reported – one associated with relapsed acute myeloid leukaemia,

neutropenic sepsis and axillary abscess and one associated with sepsis in a patient who developed COVID-19 during the course of their admission.

Covid 19 Incidence

From the 1st December – 31st December 2020, the Trust piloted the introduction of day 3 COVID-19 screening for inpatients, this resulted in a significant increase of COVID-19 cases being detected and reported. This was rolled out during as standard practice across the Trust along with regular repeat screening for inpatients.

During January 2021, 1,369 patients were screened positive for COVID-19; the vast majority of these patients were screened with a decision to admit. This increased activity has posed significant pressure on the organisation and impacted on patient flow. the Trust reported its highest inpatient rate of COVID-19 of 264 inpatients with COVID-19 in January

A marked increase in hospital onset COVID-19 infections was noted across the Surgical Health Group, incident meetings are held for each outbreak Public Health England representatives are invited to attend. Actions following the outbreaks included screening of all ward patients and facing staff. RCA's for all outbreaks and mortality reviews are undertaken of patient deaths associated with COVID-19.

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Due to increasing hospital onset rates of COVID-19, NHSE/I contacted the Trust to gain some assurances as to the increase in nosocomial infection rates. A visit from the NHSI IP lead was carried out on 4.2.21 with a number of recommendations being made at the visit. These were reinforced in a follow up letter, a number of actions have been undertaken, namely:

- Nurse Directors' have undertaken a risk assessment in the 6 bedded bays in HRI
- Ventilation options are being explored
- Signage at ward entrances have been reviewed
- Ready rooms trial to begin in surgery – orders have been raised.
- A number of beds have been removed from ward 5, 7 and 9 to reduce overcrowding
- Thematic review of outbreaks has been commissioned and report into IRC and Quality Committee

An action plan addressing all of the areas in the NHSI feedback will be agreed oversight and delivery will be monitored at the Infection Reduction Committee.

A report highlighting all hospital acquired COVID-19 cases, outbreaks and the impact of these during the second and current peaks of the pandemic, along with contributory factors and subsequent recommendations and national guidance was presented to the Trust Board as part of a development session

3.2 Falls

The Trustwide overall number of falls and falls per 1,000 bed days has decreased slightly in January 2021, and the number of incidents with a level of harm of moderate or above has seen a decrease however numbers per 1,000 bed days remains above control limits.

Medicine Health Group - The number of falls, and falls resulting in moderate harm or above have both fallen in January. 1 major incident was reported on EAU, this was escalated as a potential SI but deemed unavoidable. The SID will be reviewed by the Falls Committee for completeness. H8 and H80 and EAU were the highest reporter of falls incidents.

Family and Women's Health Group - had 20 falls reported, 18 to Ward 10, CHH (Covid ward) of which 15 were no harm and 3 were minor harm. 1 x fall offsite (member of staff) fell from the Retinal

screening stairs. Minor harm and Safety Team alerted. 1 x patient fell on the stairs outside the Clinical skills building. No harm

Clinical Support Health Group – had 29 falls reported, 24 x unwitnessed (16 no harm / 8 minor) and 5 x witnessed (4 x no harm / 1 x minor)

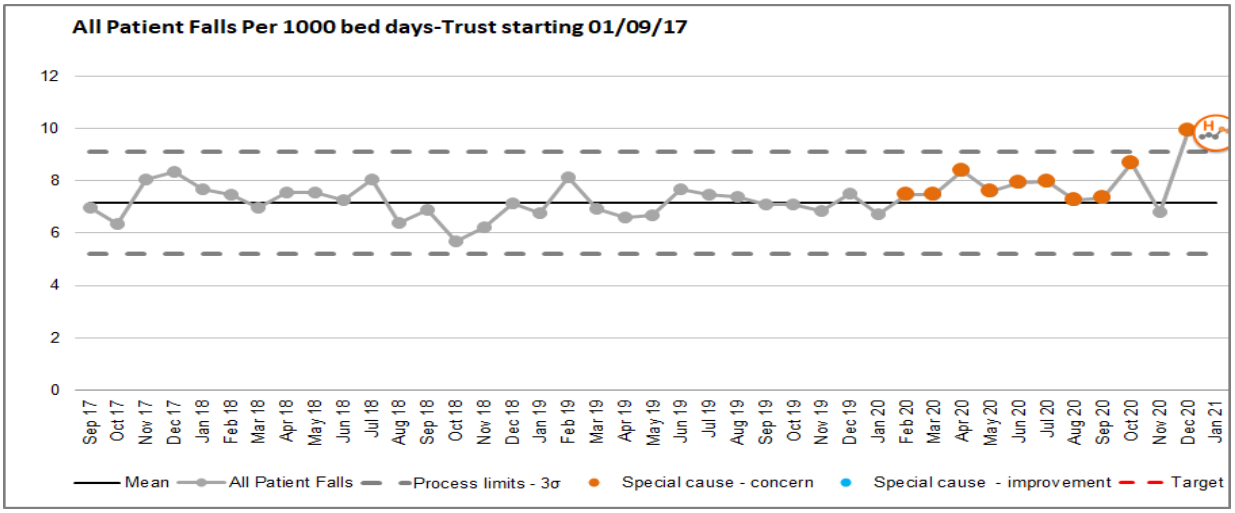
Surgery Health Group - have seen an increase to 57 incidents, although 49 of them are reported as no harm and the remaining 8 are reported as a minor harm. On from that 48 of them are reported as "with manual assistance from staff". The majority of falls occurred in Orthopaedics Trauma (21) and on Ward H10 which held a cohort of a mixture of patients due to the pandemic and Elective (10) which were all on Ward C9.

Emergency Health Group – have had 9 falls reported, 6 x unwitnessed (5 no harm, 1 minor), 3 x witnessed (all no harm).

An audit of the high incidence areas has been undertaken, the results, themes and actions will be reported to Quality Committee in March 2021.

	September 2020	October 2020	November 2020	December 2020	January 2021
Minor	29	50	32	46	46
Moderate	1	1	1	3	3
Major	5	6	2	3	1
Catastrophic	0	0	0	0	0

Figure 2: All patient falls per 1,000 bed days



3.3 Pressure Damage

Pressure damage has increased across all categories in Januray 2021, with a significant increase from 69 in total in December to 106 in January.

A thematic review into pressure damage has been commissioned by the Chief Nurse, terms of reference and scope will be agreed with findings and reccomendations being shared with quality committee. In addtion, fundamental stadnards audits are planned to recomence and a change of focus on intential rounding and focus on skin integrity with additional training in high inciden areas if required.

As noted from the table below, pressure damage has increased across all categories in January 2021, with a significant increase from 69 in total in December to 106 in January:

	October	November	December	January
Pressure Ulcer	18	33	46	52
Device Related Pressure Ulcers	8	11	9	17
Moisture Associated Skin Damage	27	26	14	37
Total:	54	70	69	106

4. PATIENT EXPERIENCE

100 complaints were made between November and January 2021. Treatment continues to be the subject receiving the highest number of complaints, making up over 50% of the numbers. 46% of complaints were closed within the 40 working days' timescales which is a reduction from 62% in December 2020. Of note is the NHSI directive regarding extension of response times for complaints response, some of the Health Groups are working to a 6 months' time frame but it is anticipated that this will revert back to the original 40 days in April 2021.

5. WELL-LED

5.1 CQC engagement

The CQC are currently not conducting routine comprehensive and well-led inspections due to COVID. The CQC have had to change the way they monitor and inspection organisations and these have become more risk focused based on the identification of any significant quality and safety concerns that have not been able to be resolved through routine engagement activities between the CQC and the provider and through information requests. A number of risk based inspections have been undertaken during the pandemic; however, the CQC are routinely monitoring and assessing quality and safety through engagement activities with providers. An example of this is the CQC Engagement Meeting feedback provided below. These meetings have been happening between every two to four weeks with the CQC for updates and assurance.

6. RECOMMENDATION

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

Kate Southgate
Deputy Director of Quality Governance
January 2021

Hull University Teaching Hospitals NHS Trust

Committee Summary Report to the Board

Quality Committee

Meeting Date:	22 February 2021	**Chair:**	Mrs J Bolus	**Quorate (Y/N)**	**Y**

Key items discussed where actions initiated:

- Board Assurance Framework – the committee discussed BAF 3 and BAF 6 and agreed that the risk ratings should remain the same. BAF 6 would be discussed further at the March committee.
- Dr Pearson attended the committee to discuss issues around ENT backlogs and what their recovery strategy was.
- Quality report – healthcare associated infections, falls, pressure damage, patient experience and the vaccination programme was discussed.
- CQC and safeguarding updates were received.
- The Quality Improvement Programme update was received. Most projects had carried on despite the pandemic
- A summary from the Operational Quality Committee was received and mandatory training was the key issue raised.
- An update was received from the Ethics Committee.

Key decisions made:

Risk and assurance matters to be received by the Board:

Matters to be escalated to the Board:

- One Never Event declared (wrong site surgery)
- 2 maternity serious incidents declared

Hull University Teaching Hospitals NHS Trust
Minutes of the Quality Committee
Held on 25 January 2021

Present:	Mrs J Bolus	Chair/Non-Executive Director
	Mr S Hall	Vice Chair
	Prof U Macleod	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
	Mr D Corral	Chief Pharmacist
	Mrs K Southgate	Deputy Director of Quality Governance and Assurance
	Mrs M Stern	Patient Representative
In Attendance:	Mrs C Hughes	Head of Speech and Language
	Dr D Carradice	Associate Medical Director
	Mrs R Thompson	Corporate Affairs Manager (Minutes)

No	Item	Action
1	**Apologies** Apologies were received from Mrs A Green, Lead Clinical Research Therapist. Introductions were made and Mrs Hughes (attending on behalf of Mrs Green) welcomed to the meeting.	
2	**Declarations of Interest** There were no declarations made.	
3	**Minutes** **3.1 Minutes of the meeting held 21 December 2020** The minutes were approved as an accurate record of the meeting.	
	3.2 Matters Arising Mrs Geary agreed to prepare a falls update to be presented at the meeting. Mr Hall asked about cancer referrals and the work ongoing with the CCGs to reject any referrals without an image. Dr Purva advised that the Cancer Network was now involved and work was ongoing to standardise the pathway.	
	3.3 Action Tracking List All items on the tracking list were either on the agenda or covered off within the meeting.	
	3.4 Any other matters arising There were no other matters arising.	

3.5 Workplan
A review of the workplan before 2021 to take place to ensure alignment with the Board and other Committees.

3.6 Board Assurance Framework
The BAF was presented to the Committee.

It was agreed that the BAF would be discussed in more detail with the new Director of Quality Governance, who was due to start in March 2021.

Resolved:
A meeting to discuss the BAF and in particular BAF 3 to be arranged. **RT**

The agenda was taken out of order at this point.

4.3 Learning from Deaths Report
Dr Carradice presented the report which highlighted available mortality data from NHS England and from a Trust perspective. The Trust's graphs showed the pattern of the pandemic so far which was similar to the national figures.

Dr Carradice advised that the report showed the number of deaths relating to patients who had tested positive within the last 30 days. It also highlighted the number of patients that had been admitted to the Trust for a different reason, but had contracted Covid and died. Patients being reluctant to come into the Trust due to the pandemic was impacting on non-covid conditions.

More patients were surviving in the second surge compared with the first and the teams were more confident treating patients with Covid.

Dr Carradice advised that there had been 67 more deaths in November 2020 than in November 2019.

Dr Carradice stated that age, gender (male), mixed ethnicity and having co-morbidities were the main risks of dying with Covid. 57% of all deaths were in the over 80s.

The Committee discussed community mortality rates and Dr Carradice advised that the number of deaths in the second surge was not as large as the first.

Mr Hall asked about the impact of Flu on the Trust and whether the Covid restrictions had meant a reduction in patient numbers. Dr Carradice advised that work was ongoing to encourage non-Covid patients to attend if necessary and recovery planning was being implemented. He expected to see a reduction in mortality rates in all other areas as Covid had brought forward frail patient's deaths. Dr Purva added that there was a reduction in Flu cases due to isolating, hand hygiene and social distancing.

Dr Carradice expressed his concern about the new variants and how they were associated with a higher mortality rate. He added that despite this the Trust was still managing to reduce mortality rates.

Mrs Jackson asked why COPD was not particularly mentioned as a risk and Dr Carradice advised that usually patients with COPD were still quite well and did not have organ failure.

There was a discussion around NHS capital disinvestment and how wards were configured, which made it difficult to manage infection rates. Dr Carradice reported that more isolation cubicles were required. Dr Purva advised that the Trust was looking at patient capsules (ready rooms) which the North Lincolnshire and Goole NHS Foundation Trust were trialling. She added that the Infectious Diseases Doctor was attending the Board Development session in February to review Infection Control.

Resolved:
The Committee received and accepted the report.

The agenda returned to order at this point

4 Increase the rate of harm-free care each year

4.1 Quality Report

Mrs Geary presented the report and advised that in December 2020 there had been no MRSA cases to date, there have been 6 MSSA bacteraemia cases and 5 C Difficile cases along with 2 community onset healthcare associated cases.

During December 2020, 7 Trust apportioned E.coli bacteraemia, 5 Trust apportioned Klebsiella bacteraemia and 2 Pseudomonas aeruginosa bacteraemia cases were reported during December 2020.

There had been very small numbers of Norovirus cases but increasing numbers of Covid infection outbreaks. This was mainly due to patients coming into the hospital asymptomatic but incubating the infection. Increased swabbing was being carried out and this was resulting in more outbreaks.

There had been 11 Serious Incidents reported in December and the Duty of Candour process had been followed in all cases. Some incidents had been linked to a significant increase in acuity with patients requiring more support and care.

There had been an increase in Falls, both in number and severity and an increase in pressure damage and skin related injuries. The vast majority had were Community acquired although some related to patients being put into the prone position and device related damage.

27 complaints had been reported in December which was a slight reduction and in addition to this there had been 18 compliments received.

Mrs Geary advised work was ongoing to ensure the Ockenden Report recommendations were in place and compliant and the Team was collecting data relating to the perinatal surveillance tool and an update would be presented to the Board in March 2021.

Mrs Geary reported that 7122 staff had been vaccinated to date and the Hub was working 7 days a week to ensure as many people as possible

were vaccinated. She added that new vaccination sites in Hull and York would be commencing next week. Mrs Geary commended Mr Jessop and Mrs Hoyle for their continuing work in the Hub. Staff and patient feedback was very positive about the vaccination process and flow through the department. Mrs Stern had received her vaccination and also complimented the service.

Mr Hall asked about the Falls Committee and why it was not meeting when there was a clear increase in patient falls. Mrs Geary assured the members that falls were being reviewed by the Patient Experience Committee and any themes and learning discussed at that meeting. Mrs Geary was content with the Governance arrangements around falls and added that Mrs Ledger, Deputy Chief Nurse chaired the meeting.

Mr Hall asked about staff absence and how the care hours per patient per day were being covered. Mrs Geary advised that nurse staffing was reviewed shift by shift and monitored at the Gold Command meeting. Mrs Geary added that the staff symptom and isolation policy was being reviewed in line with national guidance.

Dr Purva added any Junior Doctor shortages were managed through Silver Command and ultimately by Health Education England.

Mrs Bolus reported that she would discuss any Serious Incidents that were classed as moderate or above with Mrs Southgate as well as reviewing falls.

Mrs Bolus also raised the amount of complaints not being managed within the 40 day turnaround time by the Family and Women's Health Group. Mrs Geary advised that the main issues were workload and complexity of the services.

Resolved:
The Committee received and accepted the report.

4.2 Maternity Serious Incidents – Thematic Review
Mrs Geary presented the review which pre-dated the Ockenden Report. The review was a look-back exercise over maternity Serious Incidents dating back to 2018/19. The Regional Serious Incident Committee and the CCGs had also seen the review. Work was ongoing to implement the action plan and recommendations agreed.

There was a discussion around maternity guidelines and issues around staff failing to follow them. Mrs Geary advised that the guidelines were clear and explicit and that there were some issues with staff deviating from them. She added that HR processes were in place to address this. Dr Purva added that some staff have to make very rapid decisions that could impact on the patient's outcome and it was important to take the human factors approach to support staff. Mrs Bolus added that investigations should be just and fair and the learning should be widespread.

Mrs Jackson asked whether any benchmarking would help give assurance and asked if any themes had been identified as part of the exercise. Mrs Geary advised that there had been no big surprises and

since the review was undertaken there had been significant changes in personnel. Safety walkabouts, safety champions and cultures changes had also been implemented to improve the service and environment.

The Committee also discussed the Board development session due to take place in February, staff attitudes and the views of patients regarding their delivery experience.

Resolved:
The Committee received and approved the recommendations and approach being taken.

5 Reports received for assurance

5.1 Kirkup Benchmarking Report

Mrs Geary presented the benchmarking report which had been refreshed in light of the Ockenden Report. The Head of Midwifery was reviewing the services priorities and a look back exercise was being undertaken to see if the Trust was delivering the recommendations.

Mr Hall asked to what extent the Ockenden Report repeat the Kirkup Report and how could the Trust ensure that the recommendations were being implemented and lessons learned. Mrs Geary reported that there was evidence in place to support the recommendations and there was oversight by the LMS. She added that the Board would have an opportunity to scrutinise the service further at the Board Development session in February 2021.

Mrs Bolus expressed her concern around the delay in complaint responses as in some cases these were over the 40 day turnaround time.

Resolved:
The Committee received and accepted the report.

5.2 Quality Improvement Programme

Mrs Southgate verbally updated the Committee regarding the Quality Improvement Programme.

Safety Brief Project – a checklist was being developed for wards but this was proving difficult due to the complexities of patient and staff movements during the pandemic.

Stop the line – There had been slippage with this project due to the pandemic but a pilot in H4 and H131 would be implemented as soon as possible.

Inpatient falls reduction programme – The assessment framework development and education programme had been established but this had been delayed due to the second surge.

Line infection reduction programme – The training booklet was being developed along with educational tools. This project was also on hold due to the pandemic.

Mental health project – An assessment tool had been agreed and discussions were ongoing regarding digital capacity. Further training for the Band 7s was being implemented.

Pressure ulcers project – A second safety culture survey had been carried out.

Preceptorship project – the number of preceptors was being reviewed but it was proving difficult to hold meetings due to the pandemic.

PPI – the initial scoping had been carried out to undertake greater patient engagement. The project was on hold due to Covid.

Mrs Bolus suggested that the next report could detail the projects to be prioritised and the key things that needed to happen.

Resolved:
The Committee received and accepted the report.

6 Any other business

6.1 Operational Quality Committee Summary

Dr Purva advised that the Committee was stood down due to operational pressures. She added that the Health Group challenge was being covered by Gold and Silver Command and the Mortality Committee still met monthly.

7 Chairman's summary to the Board

7.1 Key opportunities, risks and successes

Opportunities included the standardisation of Cancer pathways relating to receiving images, alignment of Committee workplans, and CQC focus areas.

Risk areas were under-investment in estates, access to the vaccine and increased staff sickness.

Mrs Bolus also suggested that the Quality Improvement Programme focussed on key areas to prioritise workloads.

Successes included the vaccination programme and the positive feedback from staff and the public.

7.2 What went well

Mrs Bolus stated that the Kirkup Report received along with the Serious Incident look back report reinforced the work ongoing around the Ockenden Report compliance. She added that the Learning from Deaths report had been extremely informative and interesting.

Mr Hall reflected that the quality of the papers received had ensured that good discussions had taken place and the process had run smoothly.

7.3 Even more effective if

Mrs Bolus to discuss the Quality minutes being ratified by the Committee before being presented at the Board for information, with the Chairman.

8 Date and time of the next meeting:
Monday 22 February 2021, 10am – 12pm, by Webex

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

9 March 2021

Title:	Covid Preparedness Report	
Responsible Director:	Michelle Kemp, Director of Strategy and Planning	
Author:	Michelle Kemp, Director of Strategy and Planning	
Purpose:	The purpose of this document is to provide the Trust Board with an update on the ongoing response to the Covid 19 pandemic and recovery programme.	
BAF Risk:		
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	
Key Summary of Issues:	• The Trust is seeing a steady reduction in the number of patients requiring inpatient treatment due to covid illness. • A Covid Virtual Ward has been established in line with the national requirements and services are being developed to address the emerging post-covid long-term health issues. • The Trust's Elective Recovery Group continues to develop and is implementing a programme to support delivery of agreed recovery objectives. A full briefing was provided for PAF on 22 February 2021. • The Trust's operational planning cycle for 2021/22 has been restarted based on key planning assumptions but will be finalised based on the new planning guidance and confirmation of financial allocations for 2021/22. • A review of the Trust's response to the pandemic will be undertaken as part of good EPRR practice and also to derive maximum learning and feedback on the Trust's response to the pandemic.	
Recommendation	That the Trust Board notes the content of this paper and indicates whether any further assurance is required.	

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

Update on the Trust's response to the covid 19 pandemic

1 Purpose

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

2 Summary timeline of Covid 19 activity in the Trust up to 2 March 2021

The first period of national lockdown started on 23 March 2020 and ended on 15 May 2020. The peak experienced by the Trust as part of the first wave of the pandemic occurred on 21 April 2020, with 110 confirmed Covid 19 inpatient cases. Critical care case numbers peaked 11 days later on 2 May with 20 confirmed cases.

National lockdown period 2 started on 5th November and ended on 3 December 2020. The second wave peak occurred on 16 November 2020, with Covid 19 inpatient numbers reaching 183. Critical care inpatient numbers reached their wave 2 peak 8 days later at 20 patients on 24 November 2020.

At the end of the second period of national lockdown on 3 December 2020, the Trust had 152 confirmed inpatient cases of Covid-19, and 15 of these patients were in critical care.

During January 2021, the Trust entered the third wave of the pandemic and saw a rapid increase in the volume of patients with covid illness, the wave 3 peak for HUTH (to date) was reached on 25th January, with 267 confirmed cases with 14 patients in critical care and a further 13 patients receiving higher acuity respiratory care.

The position as at 2 March is that we have 105 patients with confirmed covid illness (67 at HRI and 58 at CHH), 9 of these are in ICU at HRI and a further 12 patients are receiving respiratory HDU level care at HRI.

In line with national requirements (NHSE letter C1041 January 2021), the Trust has now established a Covid Virtual Ward (CVW). The CVW will allow some patients to be discharged from hospital for ongoing monitoring at home using pulse oximetry equipment and with regular telephone calls from specialist hospital staff and access to advice. The multi-professional Respiratory team is working to set up services that support patients with emerging post-covid long term health issues. The Respiratory and Emergency Medicine teams are also currently exploring the possible use of the CVW to avoid admission by supporting some patients at home with pulse oximetry monitoring and access to specialised advice and support. It should be noted that patients have to meet stringent clinical safety and home circumstances criteria in order to be considered for admission to the CVW.

The pandemic surge plan continues to be used flexibly to achieve the best possible balance between provision of covid and non-covid bed capacity across the two hospital sites. We continue to work with system partners across Hull and East Riding on a daily basis to progress hospital discharges to community and social care provider settings.

3 Command structure update

The Trust's command structure remains in place and continues to operate as a regular point of contact, communication and decision making supported by the EPRR/ICC team. From the first week of March, the frequency of Gold and Silver meetings has been reduced to a pattern of 1 Gold and 2 Silver meetings per week with Bronze Command meetings taking place at frequencies that meet service needs.

The command structure will retain the flexibility to respond to the pandemic as long as is needed, but as we continue to see reductions in the number of patients who need hospital care for covid illness. HUTH senior teams have been asked to start planning for what the post pandemic 'business as usual' models will look like. In particular how the care and treatment of patients with covid illness will be managed in the longer term as we transition away from the higher levels of national escalation and incident management and into the recovery phase.

4 Recovery planning

The Trust's ability to deliver its usual volume of elective and diagnostic activity has been impaired by several factors since the start of the pandemic back in March 2020.

To mitigate the impact on elective and diagnostic delivery, the Trust has been actively working with Independent Sector Providers (ISPs) since April 2020 as part of a national policy initiative to support elective delivery during the pandemic response. For Q4 we have a comprehensive programme of additional ISP capacity in place secured via this initiative. We are also planning for additional elective capacity via this route for Q1 subject to confirmation of financial allocations and commissioning priorities for 2021/22.

A Trust level Elective Recovery Group (ERG) is now fully established and is responsible for the development and implementation of a range of work streams intended to deliver an agreed set of recovery objectives. The objectives closely reflect our clinical prioritisation system as well as addressing our longest elective waits, they also set out our longer term aims of achieving a maximum waiting list volume of 36k and an average RTT clearance time of 11 weeks.

Current activity monitoring is measured against the national Phase 3 activity plans submitted in September 2020 and the Trust is doing well overall but with specific challenges around inpatient elective capacity which is expected to improve as the elective beds and workforce are restored. A full briefing on elective recovery was provided to PAF on 22nd February 2021.

New operational planning guidance for 2021/22 is expected mid to late March 2021, and the Trust has restarted its operational planning cycle for 2021/22 based on known planning assumptions at this stage. Plans will be refined in response to the planning guidance and confirmation of the financial allocations for 2021/22.

The ERG works closely with the operational and performance leadership teams to support delivery of our recovery objectives, it also monitors and works in partnership with the Humber and ICS level recovery programmes. Some of the Improvement Team resources have been refocused to support the recovery programme.

5 The Covid Vaccination Programme

The Trust continues to operate the Vaccination Hub for the Humber, Coast and Vale area for the Covid mass vaccination programme on a 7 day basis. The Chief Nursing Officer continues to lead this work.

6 Review and learning from our response to the pandemic

As a standard element of EPRR practice, all significant incidents or events would be reviewed in order to identify the learning and to invite feedback from stakeholders involved in the response.

To supplement this and to benefit from an independent perspective; a review led by the University of Hull team will be undertaken to ensure expert independent evaluation of the Trust's response to the pandemic.

7 Recommendation

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

Michelle Kemp

Director of Strategy and Planning

Hull University Teaching Hospitals NHS Trust

Trust Board

9th March 2021

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

Purpose:	The purpose of the report is to provide the Board with an overview of the key people issues.	
BAF Risk:	Goal 1 – Organisational Culture, Staff Engagement Goal 2 – Valued, skilled and sufficient staff	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	✓
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	✓
Key Summary of Issues:	The Trust staff vacancy rate is currently 3.6%. Staff absence overall is currently 7.18% which includes Covid-19 related, other absences and maternity leave. The Trust flu programme has now finished. 7,412 staff have been vaccinated. Staff wellbeing and support arrangements continue to work well. The staff Covid-19 vaccine has been rolled out at pace and 8,293 staff have received their 1st dose of the vaccine.	

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

Hull University Teaching Hospitals NHS Trust

Trust Board

9th March 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 February the Trust had 211 Covid-19 inpatients. As at 3rd March, 2021 the Trust has 104 Covid-19 inpatients. This is a significant reduction over the past month which has reduced the severe pressure the Trust has been under. The surge has been managed via our Gold Command infrastructure and they are also managing the transition to resume normal business as safely and effectively as possible. Service recovery is extremely important and that will be underpinned by a robust people recovery plan to ensure our transition is effective and our people are well and cared for. With the reduction of Covid-19 patients some wards have already been reconfigured back to surgical areas and that redeployment plan will continue. It goes without saying that our people have been truly remarkable throughout the pandemic and the national lockdown has been a major factor in the reduction of Covid-19 community infection rates and subsequent reduction in Covid-19 patient admissions into our Trust. The national lockdown arrangements are being slowly lifted over the next 3 months commencing on 8th March, 2021. Its imperative local communities take up their Covid-19 vaccine as the roll-out programme continues and people maintain their discipline with regard to space, face and hands.

3. Key Issues

Staff Absence

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

The Trust currently has 221 staff absent due to Covid-19 which is 2.15% of the workforce. Total absence including maternity leave and all other reasons for absence is 7.18%. This is a reduction from 9.50% as at the last Board meeting in February.

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

4. Staff Testing

PCR Test

The Trust continues to test staff and family members for Covid-19 via a drive through facility which has been in operation since April 2020. Between April-February, 2021, we have tested 12,496 HUTH staff or family members, 1,867 (14.9%) of which were positive.

During February 810 HUTH staff or family members were tested. 124 HUTH staff or family members tested positive. The positivity rate for February, 2021 was 15.3% (This includes staff referred to the drive through as a result of a positive lateral flow test). The positivity rate for December was 26.6% and January, 2021 was 22.4%.

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

Asymptomatic Staff Test (Lateral Flow)

Patient facing staff are being asked to test themselves for Covid-19 twice weekly effective from Monday 30th November 2020. This will enable the Trust to identify staff who have no symptoms, but who might be positive and should be self-isolating. Staff test themselves the night before their shift, allowing 30 minutes for the result. Approximately 7,000 test kits have been distributed to staff in the first wave and second kits have started to be distributed to those that had recorded their results on Pattie. Since implementation, the Trust has received 42,308 test results back with 311 positive results. All these staff had a subsequent PCR test and 288 were confirmed as positive cases (approx. 0.68%)

Test and Trace
The NHS Test and Trace programme launched on Friday 5th June 2020. To date the Trust has requested 925 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 and 25 in February.

5. Staff Vacancies
The Trusts overall vacancy position as at 31st January 2021 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1450.9	1358.3	34.7	57.9	4.0%
Add Prof Scientific and Technical	353.4	296.9	0.0	56.5	16.0%
Administrative and Clerical Staff	1567.9	1559.5	8.3	0.1	0.0%
Allied Health Professionals	503.1	458.5	9.7	34.9	6.9%
Estates and Ancillary	575.3	537.4	0.0	37.9	6.6%
Healthcare Scientists	303.3	302.1	1.0	0.2	0.1%
Medical & Dental - Consultant	497.5	444.2	23.9	29.4	5.9%
Medical & Dental - SAS	65.7	53.5	0.0	12.2	18.6%
Medical & Dental – Trainee Grades	650.6	678.5	6.8	0.0	0.0%
Nursing and Midwifery Registered	2397.7	2258.2	67.6	71.9	3.0%
Trust Total	8402.5	7947.1	152.0	303.4	3.6%

Overall the Trust vacancy position is 3.6%. The Consultant vacancy rate is 5.9%. Whilst our vacancy situation remains in a healthy position the Trusts recruitment plans during this financial year have been somewhat interrupted, but recruitment and retention remains a key priority.

The vacancy rate for Registered Nursing and Midwifery is currently 3.0% across the organisation.

There are currently 55 Trainee Nurse Associates (TNA) employed by the Trust in a range of specialities, 17 of which are currently awaiting results and if successful will obtain their PIN to become Registered Nurse Associates (RNA) by April 2021. The Trust has successfully trained and developed 23 Registered Nurse Associates over the past 2 years who are now part of the registered nursing workforce. The Trust is currently commencing a further recruitment campaign for a further cohort of 25 TNA`s to commence their programme in September 2021.

The Trust has 33 Registered Nurse Degree Apprentices (RNDA previously called SNA) in training. In addition, the Trust has 28 Apprentice Health Care Support Worker (AHCSW).

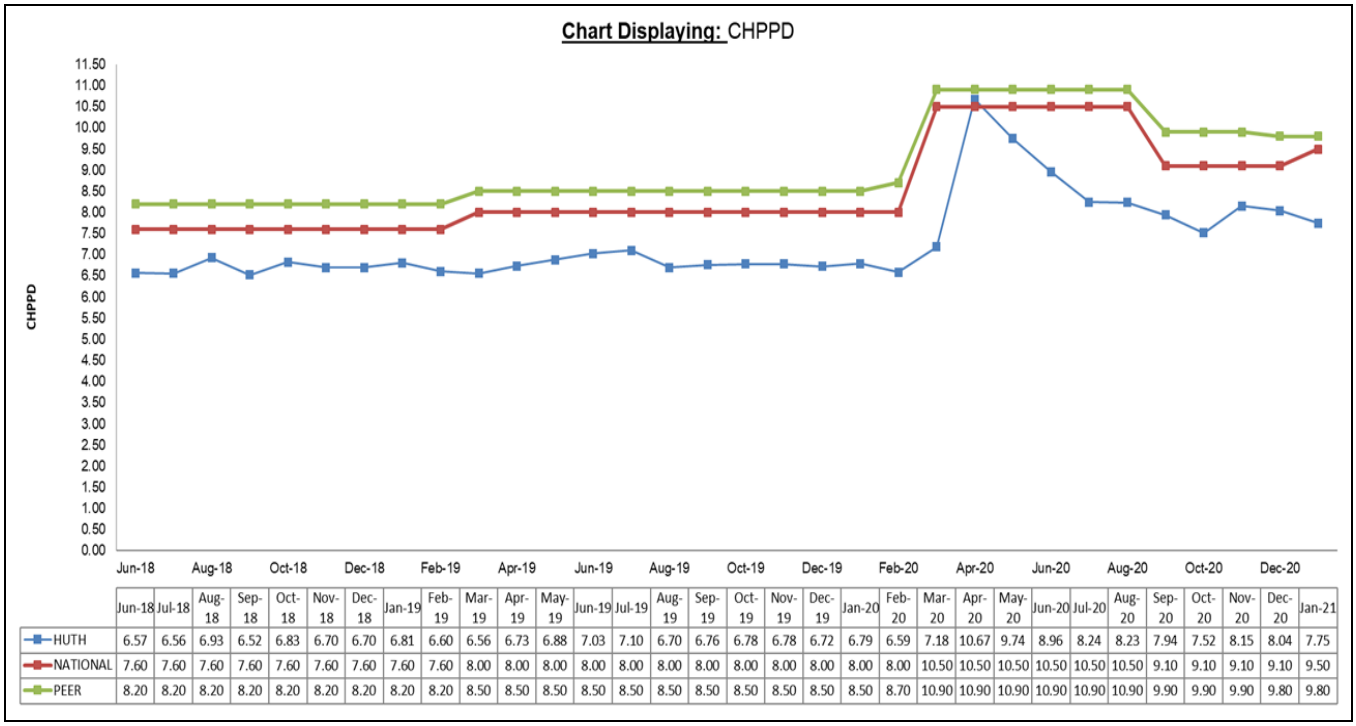
From an international nurse perspective, the Trust has 127 internationally trained nurses, who have all passed the NMC OSCE. There are a further 10 who commenced in February 2021, for theatres and are planned for their OSCE exam in April 2021.

In response to the financial support offered by NHSI/E in relation to recruiting additional international nurses, the Trust was successful in securing the funding for an additional 45 international nurses. The first cohort of 15 are planned to arrive on 3rd March 2021 and are booked for OSCE in May 2021. A further cohort of 15 are planned to arrive on 30th March 2021 and are booked for OSCE in May and June 2021. The last 15 are due to arrive in April 2021 and OSCE's have provisionally been booked for the end of June 2021.

The Trust has submitted a further NHSI/E bid for a further 75 international nurses to be planned to arrive during the 2021/2022 financial year.

With regard to more local recruitment the Trust has interviewed and offered 146 student nurses predominantly from the University of Hull this includes 13 in paediatrics; all applicants to commence later in 2021.

6. Care Hours per Patient Days
Care Hours Per Patient Day (CHPPD)
As illustrated below the CHPPD for January 2021 is 8.75 this has reduced slightly from 8.04 from the previous month.



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
HUTH	6.57	6.56	6.93	6.52	6.83	6.70	6.70	6.81	6.60	6.56	6.73	6.88	7.03	7.10	6.70	6.76	6.78	6.78	6.72	6.79	6.59	7.18	10.67	9.74	8.96	8.24	8.23	7.94	7.52	8.15	8.04	7.75
NATIONAL	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	7.60	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00	10.50	10.50	10.50	10.50	10.50	10.50	9.10	9.10	9.10	9.10	9.50
PEER	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.20	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.50	8.70	10.90	10.90	10.90	10.90	10.90	10.90	9.90	9.90	9.90	9.80	9.80

7. Staff Flu Campaign
The Trust has a Board agreed action plan which commenced in October 2020. At the 29th February, 2021 the Trust has vaccinated 7,412 staff of which 87% are frontline healthcare staff.

8. Covid-19 Vaccination programme.
HUTH has been designated the Lead Agency to deliver the ICS Covid-19 vaccination programme. Led by Beverley Geary, Chief Nurse a population and health and care staff vaccine programme and plan has been developed and is being implemented at pace. 8,293 staff have received their first vaccine dose. The 2nd dose, as per JCVI guidance will be administered after 10 weeks. The Castle Hill Hospital hub has administered a total of 27,121 vaccines to local residents over the age

of 70, people in residential homes and health and care staff. (25,556 1st dose and 1,565 2nd dose).

9. National Staff Survey

The National Staff Survey is embargoed until 12 March 2021. Internal reports have been circulated within Health Groups and discussions are underway at business meeting level to understand how we can deliver improvements in both our most challenged areas and areas where staff are well-led, engaged and motivated to improve.

Overall the survey indicates an improvement including against our key measure of staff engagement when compared with the national average of acute trusts.

10. Staff Support Arrangements

A new Humber Coast and Vale Resilience Hub has now been launched, providing wellbeing screening and support service for staff who work in the NHS frontline clinical services, care home staff and other emergency services. The Hub will support people in scope adversely affected by the Covid-19 pandemic to access timely confidential, culturally-competent, trauma-informed care. The Hub is a central electronic Hub with a screen/triage model and provides low level psychological interventions and then uses existing services for more extensive treatment. Pathway development is underway to ensure great communication both ways and that if needed staff can be clearly signposted back to Trust services.

The Resilience Hub will be advertised widely in the Trust and used to signpost staff who need to access support. Self-referral will be encouraged or if they come via the staff.support@hey.nhs.uk requesting 1:1 support we will include the resilience hub offer alongside Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team. A clinical psychology service for staff will be available from the end of April via occupational health. Coaching services will now be accessed via the usual 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 staff.support@hey.nhs.uk email address.

The Quick Guide to Staff Support during Covid-19 will continue to be available and updated to reflect the current changes in services available.

The plans are now beginning to be in place for our first virtual Schwartz Rounds “Team Time” session to run. There will be 9 facilitators trained by mid-March 2021 with a plan to commence April 2021 for our first session.

11. Learning and Organisational Development

The continuation and development of online provision of services across all Learning and OD programmes continues. The deployment of the Big Blue Button is supporting all educators within the Trust to provide both clinical and non-clinical development for our staff. There are 7 mini-virtual classrooms available to be booked within Suite 22 and a further 3 available with our Medical Education Centre. These are allowing a wide range of facilitators to deliver great training and has significantly increased our “classroom capacity”. More training sessions for educators are now being made available to support people to translate their learning into a virtual format. This is an opportunity for us not to just return back to the “normal classroom environment” unless it has a value added benefit or an essential need.

Leadership Development Programmes are now being planned to come back in their new redesigned and virtual format from May/June 2021 as the demand for Covid support begins to reduce. We continue to offer our Leading with COVID-19 programme and this will convert back to our usual Great Leaders Bitesize offer from June 2021 onwards. Management Clinics continue to

be a popular source of support for leaders and will continue every 2 weeks until the demand decreases. Also offered currently, is targeted support to ward leaders alongside a drop in session for staff to compliment the staff support offer already available.

A new level 3 Leadership Apprenticeship is being launched in the next 2 weeks with 20 places available for our new and mid-level leaders to gain experience and a leadership qualification. This is pilot cohort and if successful will be re-commissioned.

12. National review of HR and OD

The Chief People Officer at NHSI/E has commissioned a national review of HR and OD at Trust, ICS, regional and national level. Inspired by the ambitions set out in the NHS People Plan, HR & OD professionals across the NHS are setting their sights on 2030 and working together with partners to create a vision for the future of the function and determine how HR & OD within the NHS will continue to make a positive impact upon our colleagues and patients.

As part of the programme, NHSI/E are partnering with the CIPD, the professional body for HR, L&D and OD to develop the HR & OD function across the country and to support continuous professional development.

The review will gather feedback from key stakeholders from this organisation and all other NHS providers to ensure there is a broad range of views on the current work of HR and OD, its impact, and any areas we need to prioritise for development. Stakeholders can join the debate at ournhspeopleprofession.org

13. Conclusion

With the significant reduction in Covid-19 inpatients, the pressure placed upon services and staff has lifted. The next phase of recovery and restoration is important and at the heart of that is the support and wellbeing of our people. The Executive team are finalising the people recovery plan.

14. 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

TRUST BOARD: TUESDAY 9th MARCH 2021

FINANCE UPDATE – MONTH 10

1. Purpose of Paper

To inform the Trust Board on the month 10 reported financial position, update on the level of expenditure committed in managing Covid19 and financial potential risk for year-end.

2. Background

NHSEI have split financial reporting for 2020/21 into 2 periods. For the second six months the Trust submitted a plan deficit of £6.0m based on shortfalls on other income, £3.3m (eg Car parking, catering, private patients) and the expected need to account for an annual leave provision at year-end due to the potential difficulty of staff being take to take all their in year due to Covid19, £2.7m.

3. Month 10 Reported Position

The Trust is reporting a £0.5m deficit, which is £1.3m better than plan.

4. Income

As noted above the Trust is £1.3m better than plan driven by two income sources:

The Trust has a plan deficit based chiefly on non-contract income levels being below pre-Covid19 levels. Other income in several areas has fallen further than the planned shortfall. Injury Recovery Scheme (£0.12m), Catering income (£0.19m) and car parking (£0.05m) are all below the reduced planned levels due to the impact of the second wave of Covid19. Offsetting this, the Trust has received additional income from Health Education England, reversing previous shortfalls (£0.4m). In total, other income is £0.3m above the planned level.

The position also includes £1.0m of expected income from NHSEI to support the level of independent sector activity done in months 7 to 10 above the baseline. The amount is still to be signed-off by NHSEI and therefore remains a risk.

The Trust is also expecting to receive £1.1m from NHSEI to offset the cost of additional pass through drugs costs.

5. Expenditure

In month 10 the Trust reported net marginal spending of £1.0m in responding to Covid19, bringing the total marginal spend for the 4 months (months 7-10) to £4.2m. This includes £0.9m on testing. The biggest areas of expenditure in month were testing (£0.1m), ICU Capacity (£0.2m) and Decontamination (£0.1m). The table below summarises the spend for the 4 months by NHSEI category with forecast for last 2 months. The Trust is expecting to spend £6.7m by year-end. The gross cost of managing Covid19 is higher than this as it does not reflect the opportunity costs of moving staff internally from other areas to Covid19 areas.

	M7	M8	M9	M10	To Date		Forecast
NHSEI Category	£000	£000	£000	£000	£000		£000
Expanding NHS Workforce	48	71	70	76	265		916
Aspirant Nurses	5	-	-	-	5		5
Testing not included in Outside Envelope categories	-	34	64	26	125		177
Testing included in Outside Envelope categories	185	144	319	123	771		1,288
Decontamination	66	78	165	100	410		579
Increased ITU capacity	75	282	203	174	733		1,024
Segregation of patient pathways	115	403	65	27	611		749
Existing workforce - additional shifts	33	34	124	65	256		298
Backfill for higher sickness absence	-	16	21	53	90		141
Remote working for non-clinical staff	30	0	-	-	31		73
Support for stay at home models	-	46	7	8	61		98
Remote Management of Patients	0	70	42	52	163		284
Plans to Release Bed capacity	2	-	-	4	7		7
PPE Locally procured	-	-	-	-	-		251
Other categories	107	114	148	321	690		828
Total Additional Covid Costs	667	1,292	1,228	1,029	4,216		6,716

The Trust has spent £0.3m in month 10 on the vaccination programme with a year-end forecast of £4.8m. The costs of this will be fully funded through NHSEI. Funding will flow monthly in arrears. As lead provider for the ICS the contractual documentation is agreed with NHSEI, as well as the associated sub-contracts with other providers within the ICS.

Pay budgets in total are £0.9m below plan at month 10. There are pressures on Medical staffing budgets at month 10 but these have been offset by underspends on nurse staffing support, allied health professionals and non-clinical staff.

£1.2m has been spent above plan on purchase of healthcare from independent sector. As per NHSEI guidance, the Trust is expecting to receive income to cover this. NHSEI have now confirmed that there will be no penalties imposed for not delivering the elective recovery targets for the six month period.

The position also includes a £1.2m provision for an impairment relating to buildings that are to be demolished to accommodate improvements to the estate at HRI and the Virology move from CHH to HRI, which are schemes within the Trust's capital programme.

6. Forecast Outturn (Months 7-12)

The Trust is currently forecasting that it will have a year-end deficit of £8.4m, which is £2.4m worse than plan.

The increase is due to the Trust reviewing its provision for annual leave outstanding at year-end in line with guidance from NHSEI. The forecast provision has increased to £7m to include all staff and to increase the potential number of days outstanding to 5 days. This is an increase of £4.3m. Further work continues to refine the calculation for year-end. This is a provision only and is not cash backed.

The Trust is forecasting receiving £1.4m income for independent sector work above baseline on non-framework contracts.

The Trust has committed £2.3m to support elective recovery in the last quarter with additional insourcing and additional internal capacity /waiting list activity.

The Trust is forecasting other income will be £0.5m above plan at year-end. This would mean that other income would be £2.8m lower than the base period from 2019/20, rather than the £3.3m built into plan. NHSEI have now indicated they will fund part, or all of this, cash shortfall in February 21.

The Trust has also increased the year-end forecast depreciation by £0.5 to reflect the additional capital spent in year due to Covid19.

The movement from plan to forecast outturn can be summarised as follows:

	Plan £000	Forecast £000
Annual Leave Provision	(£2.7m)	(£7.0m)
Other Income Shortfall	(£3.3m)	(£2.8m)
Increased Depreciation		(£0.5m)
Elective Recovery		(£2.3m)
Impairment		(£1.2m)
Use of Covid19 funds		£4.0m
Total	(£6.0m)	(£9.8m)
IS (pre-framework contracts)		£1.4m
Current Trust Forecast		**(£8.4m)**

The Trust has flagged a potential risk of £3m relating to the Flowers case (a legal case revolving around the payment of additional annual leave based on overtime worked). It is expected national guidance will be published shortly directing Trusts as to how they should account for this issue. Our latest assessments of value suggest a recurrent cost of between £0.7m and £1.0m per year with £1.8m to £2.5m in back pay for previous years.

7. Capital

The reported capital position at month 10 shows gross capital expenditure of £27.4m. The main areas of expenditure relate to Capital COVID (£3.2m), Backlog maintenance (£4.0m); IM&T (£3.5m); Expansion of Acute bed base (£2.3m); Medical Equipment (£4.8m) and Robotic Scheme (£1.6m).

The forecast position for capital expenditure (incl PFI/IFRIC12 impact) is £63.2m; this includes assumptions on the Trust receiving PDC allocations relating to Backlog Maintenance (£4.9m); Capital Covid (£3.2m); ED UEC (£4.3m); Critical Infrastructure (£5.9m); ICU (£3m); Radiotherapy CTs (£1.2m); Adopt & Adapt (£1.4m) and more recently Breast Screening (£0.3m). In addition, the Trust is also anticipating additional PDC relating to Digital Aspirant (£2.3m) and HSLI (£0.8m).

The Trust is confident these allocations will be spent by 31 March 2020 but there remains some risk in ensuring the full allocation is committed.

The Trust has also had approval of the Urgent & Emergency care Business Case (£10.5m). However due to delays in approval and to ensure an accurate forecast, the Trust has slipped £8m into 21/22. The revised expenditure profile has been agreed by NHSEI and the cash will be moved into next year with no loss of spending power.

As part of managing the ICS CDEL total, the Trust has agreed to additional CDEL coverage from within the ICS of £1.8m. Internal cash balances will cover this.

8. Cash

The Trust's liquidity position remains healthy with a cash balance of £78.6m. The block payments for March will be reduced to reflect the additional month's cash the Trust received in April 20. The current forecast is that the Trust will have a cash balance of circa £40m by year- end but this is heavily dependent on the timings of payments associated with the capital programme, the vaccination & testing programmes and further decisions form NHSEI regarding central cash funding.

9. Recommendations

Trust Board is asked to note the following:

a) The year to date deficit of £0.5m. This is £1.3m better than plan.

b) The forecast deficit of £8.4m due to the increased provision for annual leave. The deficit may be reduced if additional income is received from NHSEI.

c) The current capital spend of £27.4m with a forecast outturn of £63.2m

Stephen Evans
Deputy Director of Finance
March 2021

Hull University Teaching Hospitals NHS Trust

Trust Board 9th March 2021

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

Purpose:	The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2020, prior to publication of the data in line with statutory requirements.	
BAF Risk:	Risk 2 – workforce	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient workforce	✓
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	
Key Summary of Issues:	New regulations that took effect on 31 March 2017 (The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017) require all public sector organisations in England employing 250 or more staff to publish gender pay gap information. These form part of the Trust's public sector equality duty under the Equality Act 2010. The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2021*) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format. *On 23rd February 2021, the Equalities and Human Rights Commission (EHRC) announced that, due to the continuing impact of the Coronavirus (COVID-19) pandemic, employers would have until 5 October 2021 to report their gender pay gap information and no enforcement action will be taken if they report by then. The Trust however intends to report to the original deadline.	

Recommendation:	The Trust Board is asked to note and approve content of this report. Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines (by 30 March 2021*).

Hull University Teaching Hospitals NHS Trust

Trust Board

Gender Pay Gap Reporting

1 PURPOSE OF THIS REPORT

The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2020, prior to publication of the data in line with statutory requirements.

2 BACKGROUND

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

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

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

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

3 REPORTING REQUIREMENTS

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

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

- **Pay distribution by gender** – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands

The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2020. The figures must be calculated using the mechanisms set out in the gender pay gap reporting legislation.

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2021*) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

*On 23rd February 2021, the Equalities and Human Rights Commission (EHRC) announced that, due to the continuing impact of the Coronavirus (COVID-19) pandemic, employers would have until 5 October 2021 to report their gender pay gap information and no enforcement action will be taken if they report by then. The Trust however intends to report to the original deadline.

4 THE PROPOSED GENDER PAY GAP REPORT FOR 2020

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

5 RECOMMENDATION

The Trust Board is requested to note and approve the contents of this report,

Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines (by 30 March 2021*).

Simon Nearney
Director of Workforce & OD
March 2021

APPENDIX 1

Hull University Teaching Hospitals NHS Trust

Gender Pay Gap Reporting

1 BACKGROUND

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

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

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

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

2 NHS PAY STRUCTURE

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

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

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

3 GENDER PAY GAP DATA 2020

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

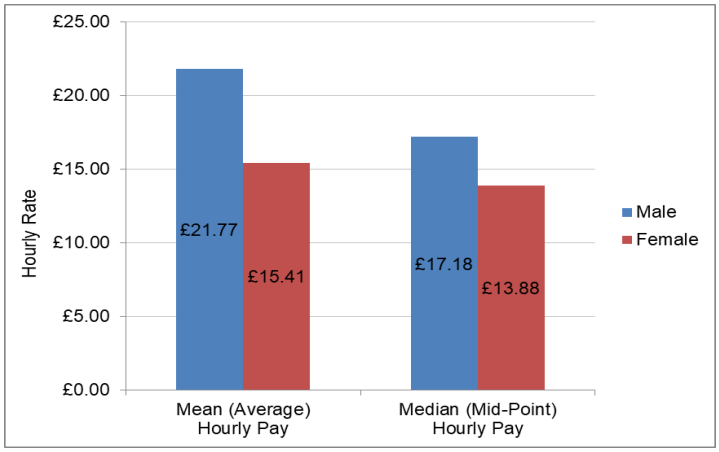
The analysis does not look at whether there are differences in pay for men and women in equivalent posts. Therefore, the results will be affected by differences in the gender composition across the Trust's various professional groups and job grades.

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

Hull University Teaching Hospitals NHS Trust's Gender Pay Gap Data for the snapshot date of 31 March 2020 is as follows;

3.1 Mean and Median Gender Pay Gap

Gender	Mean (Average) Hourly Pay	Median (Mid-Point) Hourly Pay
Male	£21.77	£17.18
Female	£15.41	£13.88
£s difference	£6.36	£3.30
% difference	29.21% ***(29.2%)***	19.21% ***(19.2%)***



- The mean gender pay gap is 29.21% (i.e. this means that women's average earnings are 29.21% less than men's).
- The median gender pay gap is 19.21% (i.e. this means that women's average median earnings are 19.21% less than men's).

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

3.1.1 Key Findings

- The Trust has an overall gender split of 76.60% female and 23.40% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 23.40% of the workforce, there are a disproportionate number of males, 39.90% in the highest paid (upper) quartile, (predominantly medical staff) with 60.10% being female.

- The mean gender pay gap for the whole economy, based on April 2020 data, (according to the Office for National Statistics Annual Survey of Hours and Earnings figures. N.B. the ONS felt that coronavirus factors did not have a notable impact on the gender pay gap for 2020 as the impact of the pandemic was not fully reflected) is 14.6% while the Trust's mean gender pay gap is 29.21% in favour of males. The median gender pay gap for the whole economy is 15.5%, compared to the Trust average of 19.21%.
- Medical staff pay has a strong impact on the mean and median data. If Medical staff were excluded from the data above, the mean (average) hourly pay gap is 3.80% or £0.57, and the median (mid-point) hourly pay is 0.30% or £0.04. Nationally the Consultant workforce is predominately male.
- The percentage of males in the upper pay quartile has risen. Contributing to the Trust slight increase in mean and median pay gap data this year are changes to the composition and pay of the female versus male medical workforce. The Trust has seen it's net female medical workforce increase by 54 and it's male medical workforce increase by 22. The majority of this increase is in the upper pay quartile (this quartile has increased by 36 females and 23 males) however, for the highest paid grade of Consultant the increase in females was 3, compared with an increase of 7 male Consultants. Therefore although there has been a bigger increase in the female workforce within the Medical and Dental staff group and in the medical upper pay quartile, the majority of this increase has been for the trainee (lower paid) grades.
- In the current reporting period (2020) the male mean pay (£21.77) falls in the upper quartile, and the female mean pay (£15.41) falls in the upper middle quartile.
- The median pay for males (£17.18) falls in the upper middle pay quartile and female median pay (£13.88) falls in the lower middle quartile.
- The Trust operates a number of salary sacrifice schemes. Given 80.23% of those who pay into salary sacrifice schemes are female staff (compared to 19.77% of male staff) this has a significant impact on the Trust's gender pay gap data, including the mean and median female averages and also where females fall in pay quartiles (i.e. they might otherwise fall into a higher quartile).

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

  The disproportionate impact on female pay is highlighted in the salary sacrifice data detailed in tables 1 and 2 below.

Table 1 – All Salary Sacrifice Schemes by Quartile and Gender (Cycle, Childcare, Car Lease, Home Electronics)

2020 Trust Gender split 76.60% female, 23.40% male

Quartile	2020 Male	2020 Female	2020 Total
Lower	61 (16.85%↑)	301 (83.15%↓)	362
Lower Middle	65 (14.81%↓)	374 (85.19%↑)	439
Upper Middle	56 (13.05%↓)	373 (86.95%↑)	429
Upper	131 (37.11%↑)	222 (62.89%↓)	353
Total	**313 (19.77%↓)**	**1270 (80.23%↑)**	**1583↓**

NB; Arrows indicate an increase or decrease from 2019 return

Although there is a slightly lower number of staff paying into salary sacrifice schemes in this reporting period, the percentage of females paying into the schemes has increased by 1.12% (79.11% in the 2019 return). The largest shift has been an additional 3.19% (83.76% in the 2019 return) of females paying into schemes from within the upper middle quartile.

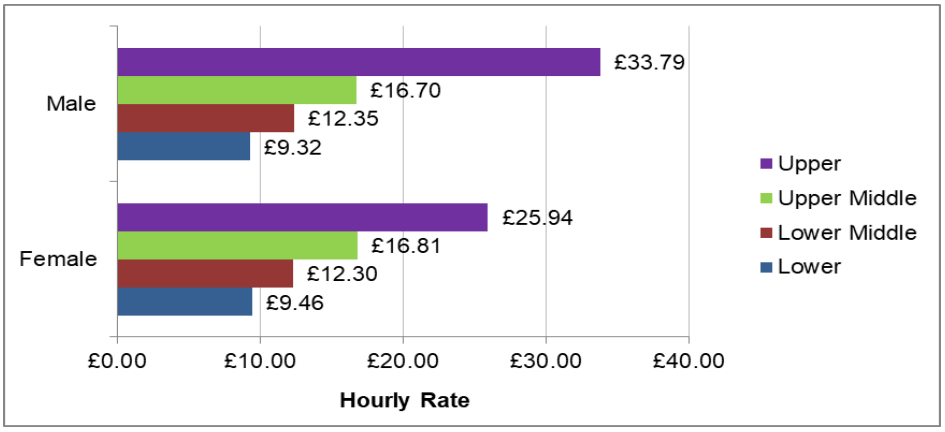
More female staff pay into the high value salary sacrifice schemes than male staff, as highlighted in table 2 below. Across the high value schemes 139 staff (119 female/20 male) pay into more than one schemes. Of these, 134 staff pay into 2 high value schemes (114 female/20 male), 5 staff pay into three of the high value schemes (5 female/0 male).

Table 2 – 2020 Data of High Value Salary Sacrifice Schemes by Gender (Childcare, Car Lease, Home Electronics)

Salary Sacrifice Schemes	Headcount and % of Staff in Scheme			Average Sacrifice per Month		Range	
	Female	Male	Total	Female	Male	Female	Male
Childcare Vouchers	187 (73.33%)	68 (26.67%)	255	£283.92	£115.62	£15 – £243	£15 – £243
Home Electronics	811 (84.22%)	152 (15.78%)	963	£59.86	£65.45	£2.62 – £272.82	£4.51 – £357.33
Lease Car Scheme	237 (76.45%)	73 (23.55%)	310	£394.26	£506.36	£252.64 – £800.87	£267.53 – £1820.20
Total	**1235** ↑	**293** ↓	**1528**	**£136.58** ↓	**£186.94** ↓	**£2.62 – £800.87**	**£4.51 – £1820.20**

3.2 Pay Quartiles by Gender

Quartile	Male			Female			Total
	Headcount	% Headcount	Mean (Average) Hourly Pay	Headcount	% Headcount	Mean (Average) Hourly Pay	
Lower	381	17.33% ***(17.3%)***	£9.32	1817	82.67% ***(82.7%)***	£9.46	2198
Lower Middle	400	18.19% ***(18.2%)***	£12.35	1799	81.81% ***(81.8%)***	£12.30	2199
Upper Middle	400	18.19% ***(18.2%)***	£16.70	1799	81.81% ***(81.8%)***	£16.81	2199
Upper	877	39.90% ***(39.9%)***	£33.79	1321	60.10% ***(60.1%)***	£25.94	2198
Total	**2058**	**23.40% *(23.4%)***	**£21.77**	**6736**	**76.60% *(76.6%)***	**£15.41**	**8794**

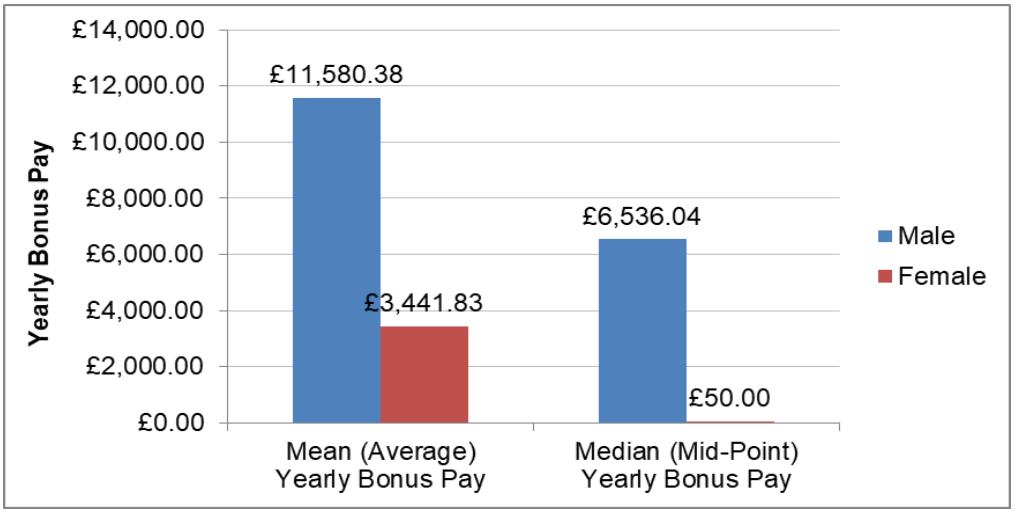


3.2.1 Key Findings

- Based on the Trust's overall gender split (76.60% female and 23.40% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. There are a disproportionate number of males, 39.90%, in the upper quartile compared to 60.10% being female. This accounts for the mean gender pay gap of 23.23% and £7.85 in the upper quartile. Despite the slight 0.41 increase in the percentage of males in the upper quartile, the gender pay gap in the upper quartile has within this narrowed by 1.08% and £0.24 on the previous reporting period.
- Within the Medical staff group there is a disproportionate gender split (37.89% females and 62.11% male). In the Upper Quartile for Medical staff the split is 35.90% female and 64.10% male. Medical staff account for the majority of the Trust's highest earners.
- The Trust has a split of 58.74% full time and 41.26% part time staff. 92.56% of part time staff are female. The majority of part time staff are in the lower quartiles (57.77% are in the lower and lower middle).
- Only 28.25% of staff in the upper quartile are part time, 87.12% of whom are female. This is disproportionate when compared with the Trust wide figure of 41.26% of staff being part time.

3.3 Mean and Median Gender Bonus Gap including Long Service Awards

Gender	Mean (Average) Yearly Bonus Pay	Median (Mid-Point) Yearly Bonus Pay
Male	£11,580.38	£6,536.04
Female	£3,441.83	£50
£s Difference	£8,138.55	£6,486.04
% Difference	70.28% ***(70.3%)***	99.24% ***(99.2%)***



3.3.1 Key Findings

- The mean gender bonus gap is 32.54% when long service awards[1] are excluded from the data, rising to 70.28% when they are included in line with national guidance. This represents a significant improvement on the 2019 report when the gender bonus gap was 37.43% (excluding long service awards) and 78.69% (including long service awards). The 8.41% improvement is largely due to a shift in the proportion of males v females receiving Clinical Excellence Awards, together with a larger percentage reduction in females receiving long service awards.
- The median gender bonus gap is 33.33% (£3,016 per year) – the same as 2019 when long service awards are excluded from the data, rising to 99.24% when they are included (a slight reduction from 99.45% in 2019).

3.4 Bonus Distribution by Gender including Long Service Awards

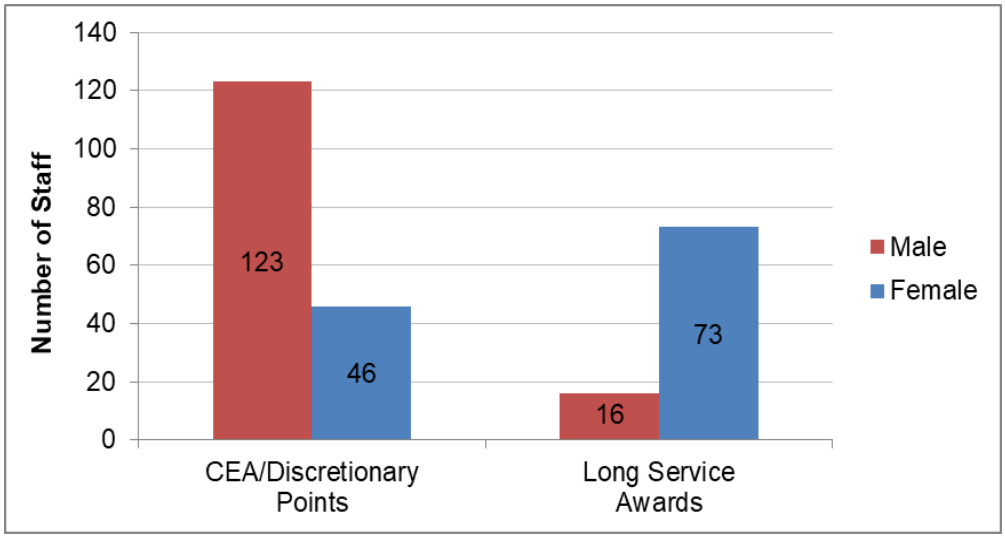
Gender	% Receiving Bonus
Male	6.32% ***(6.3%)***
Female	1.77% ***(1.8%)***

- The proportion of male employees receiving a bonus is 5.98% excluding long service awards (6.32% when included) and the proportion of female employees receiving a bonus is 0.68% excluding long service awards (1.77% when included).

3.5 Bonus Type by Gender

Bonus Type	Male		Female		Total Headcount
	Headcount	%	Headcount	%	
CEA/Discretionary	123	72.78%	46	27.22%	169
Long Service Awards	16	17.98%	73	82.02%	89
Total	139	53.88%	119	46.12%	258

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



3.5.1 Key Findings

- This year the Trust has two types of bonus that meet reporting requirements – Long Service Awards and Clinical Excellence Awards (CEAs – which are awarded based on the performance of Consultant Medical staff subject to national and local eligibility criteria in recognition of excellent practice over and above contractual requirements).
- The Trust's gender bonus data is significantly distorted by the Trust's Long Service Award scheme as, given the gender makeup of our workforce, more females receive an award. Calculations have therefore been made both including and excluding this data. Including long service awards, the median bonus pay for females is £50 and £6,536.04 for men. Excluding long service awards, the median bonus pay for females is £6,032.00. This compares to £9,048.00 for males.
- The gender split for all bonus pay is 46.12% female and 53.88% male, however as 61.34% of female bonus pay is the £50 long service award and only 11.51% for men, this results negatively on mean bonus pay.
- If long service awards are excluded, the mean bonus pay gap reduces from 70.28% (£8,138.55) to 32.54% (£4,255.73) and the median bonus pay gap reduces from 99.24% (£6,486.04) to 33.33% (£3,016.00).
- Nationally agreed changes to the local Clinical Excellence Awards scheme effective from 1 April 2018 are starting to gradually impact on the Trust Gender Pay Gap data, commencing from the previous (2019) Gender Pay Gap report, as awards are made retrospectively.
- *Existing* local awards awarded prior to April 2018 will remain consolidated and pensionable and the associated payments will remain protected until at least 31st March 2021.
- *New* local awards post-April 2018 (including new awards to existing award holders) are: time limited, (payable for up to two years within Hull University Teaching Hospitals NHS Trust), paid as a lump sum, non-consolidated, non-pensionable and do not include uplifts for Consultants undertaking Additional Programmed Activities.
- CEA and Discretionary points account for 65.50% of all bonuses awarded.
- The difference in bonus pay is also driven by the payment of higher (accumulated) bonuses for Consultant Medical staff where there is a greater proportion of men.
- The proportion of male medical staff currently receiving accumulated CEAs (i.e. including both old and new style CEAs) is higher than females (the gender split of

those receiving a CEA/Discretionary award is 72.78% male compared to 27.22% female). N. B. This is an improvement from 76.00% male and 24.00% female in the last reporting period. This 3.22% shift is pivotal in the reduction in the mean gender bonus gap.

- Of the CEAs held under the old pre-April 2018 CEA scheme, 76.4% are held by male staff compared to 23.6% by female staff, an improvement compared to 77.8% and 22.2% respectively in the previous reporting period.
- Under the new post-April 2018, CEA scheme 56.0% of awards are held by male staff, 44.0% by female staff, an improvement compared to 63.6% and 36.4% in the previous reporting period.
- Eligibility for the new CEA/Discretionary points (28.68% female, 71.32% male) was broadly consistent with the Consultant gender split (26.86% female and 73.14% male), however, when it came to applying, of those eligible, a slightly higher percentage of females (30.43%) applied compared to males (69.57%).
- Within the 12 months up to 31 March 2020 the percentage of applications resulting in a successful new CEA award was 0% for male medical staff, and for females this was 57.14%.
- A greater number of the Trust's female Consultants work flexibly on a part-time basis (9.88% male, 28.81% female). This distorts both the mean and median bonus pay as CEA bonus payments are pro-rated for part-time employees. This part-time split is broadly reflected in those with CEAs (5.69% of male CEAs are for part-time Consultants, 28.89% of female CEAs are for part-time Consultants).
- The number of applications for Clinical Excellence Awards significantly decreased this year, by 52.08%. This may be due to the changes in the local award scheme from April 2018 as well as the changes in the pension scheme for Consultants and the annual allowance.

4 NATIONAL PICTURE

The government has announced it will establish an implementation panel to help address the structural barriers outlined in 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England', published by the Department of Health and Social Care (DHSC) on 15 December 2020. The report, commissioned by the Department of Health and Social Care in 2017 to examine the structural and cultural barriers affecting the female medical workforce, was chaired by Professor Dame Jane Dacre and led by Professor Carol Woodhams, an expert in gender pay.

The report outlines a range of recommendations to make senior roles more accessible to women and help close the gender pay gap. These include;

- reducing pay points within pay scales, so it takes less time for people to reach the top, and encourage greater transparency in general practice
- promoting flexible working, with jobs advertised as flexible unless there is a strong justification not to, helping to improve work-life balance and make the NHS the best place to work
- restructuring part-time training to focus on competency rather than time served, reducing disproportionate long-term penalties for women who are more likely to go part-time

The 47 recommendations support measures set out in the NHS People Plan, to improve recruitment and retention, including ensuring equal opportunity and access to flexible working for both men and women. Further information can be found in Appendix 2.

The NHS People Plan 2020/21 (which embodies the 'Our People Promise') and the Trust's Local People Plan encompass the actions the Trust will work towards over the coming months. The nine strands; health and wellbeing, flexible working, equality and diversity, culture and leadership, new ways of delivering care, growing the workforce, recruitment, retaining staff, recruitment and deployment across systems will all contribute to improving the experience of working in the NHS for everyone. Importantly, they embrace actions that will help support improvements to the gender pay gap.

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

5 SUMMARY OF RESULTS AND ACTIONS

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

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

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

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

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

The Trust's mean gender pay gap at 29.21% and median gender pay gap at 19.21% have increased slightly since the previous reporting period, and are above the national averages of 14.6% (mean) and 15.50% (median). Excluding medical and dental staff the Trust figures would be 3.80% and 0.30% respectively.

The mean and median data has been impacted by changes to the composition and pay of medical staff.

This year's gender pay gap data has again been impacted by the disproportionate percentage of females (80.23%) that pay into salary sacrifice schemes, compared to male staff (19.77%). It has significantly impacted on the mean and median female averages and also where females fall in pay quartiles (i.e. they might otherwise fall into a higher quartile).

Although there is a slightly lower number of staff paying into salary sacrifice schemes in this reporting period, the percentage of females paying into the schemes has increased by 1.12% (79.11% in the 2019 return). The largest shift has been an additional 3.19% (83.76% in the 2019 return) of females paying into schemes from within the upper middle quartile. In addition, more female staff pay into the high value salary sacrifice schemes than male staff.

The mean gender bonus gap has improved by 8.41%, largely due to a shift in the proportion of males and females receiving Clinical Excellence awards within both the old and new CEA schemes, together with a larger percentage reduction in females receiving long service awards.

5.1 What Have We Done to Date?

- Consolidated the Trust's approach to talent management. This ensures that the talent of all individuals in Hull University Teaching Hospitals NHS Trust are maximised. This includes extending work to open up professions to under-represented groups, particularly through apprenticeships.
- Embedded the Trust's commitment to developing a comprehensive 'grow our own' approach across all staff groups and promoted development opportunities for non-stereotypical male/female roles.
- Continued the development and extension of new roles including; Consultant Sonographers, Radiographers, reporting Radiographers and Nursing Associates.
- Enshrined career pathways, which clearly map out opportunities for career advancement in a number of areas including Physiotherapy, Radiology, Occupational Therapy, Speech and Language Therapy.
- Extended roll out of medical workforce roles and medical associate professions including Advanced Clinical Practitioners, Physicians Associates, Advanced Critical Care Practitioners, Anaesthetic Associates, Surgical Care Practitioners which provide career development opportunities at a more senior, higher paid level.
- The Trust continues to deliver the Equality, Diversity and Inclusion training programme which forms part of the Trust's Recruitment and Selection training. The Equality, Diversity and Inclusion training forms part of the Trust's mandatory training programme.
- To support our leaders to fully model a compassionate, inclusive leadership approach, a range of leadership programmes for both medical and non-medical leaders (including Trust Board) have been delivered including; Great Leaders – Be Remarkable, a Supervisors+ programme, a Rise and Shine programme, Rising Up programme and Great Leaders Bitesize.
- A Coaching and Mentoring Network, with over 30 accredited coaches in place within the Trust. Three senior coaches have attended a National Leadership Academy programme on Coaching for Inclusion.
- Continued to review output of exit data to better understand blocks to gender pay progression, to help identify and implement actions to improve this. Specific retention surveys have been undertaken in areas of high turnover to address any concerns, including equality concerns that may be raised.
- A range of flexible working options are available for all Trust staff to better cater for work-life balance. This includes part-time working, job-sharing, flexi-time, annual hours contracts, flexible rostering, term-time working, fixed work patterns, flexible retirement and homeworking. All employees who have a flexible working arrangement in place have equal access to training, development and promotion opportunities.
- The benefits of providing flexible working options for Doctors in Training are well documented. The Trust's SuppoRRT Champion (Medical Consultant) continues to provide advice and guidance to medical trainees who are returning to work after a lengthy period of absence (for example maternity leave or returning from out of programme) as well as supporting trainers with this process.
- The Trust's quarterly forum for those doctors already working, and those considering working, less than full-time, run in partnership with the BMA is firmly established. Successes include a comprehensive induction package for those doctors returning to training or returning from, for example, family friendly leave. This incorporates, for example, details of roster changes, what has changed in their medical training, what they need to refresh.

- Embedded further the Pay Group which considers elevated starting salary requests for Agenda for Change staff and casual workers, to ensure fairness and equity of application, particularly in light of the new pay structure.
- During Covid-19 the Trust has appreciated the impact this has had on a number of individuals including those with childcare commitments, caring commitments and those that have found they have not been able to return to the UK from abroad. The Trust has provided additional access to time off and support mechanisms for individuals, such as home working where possible.

5.2 Next Steps

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

- Further developing the evidence base of data to ensure effective gender monitoring is in place.
- Consider the findings and take action in light of the 'Mend the Gap, The Independent Review into Gender Pay Gaps in Medicine in England' report published on 15 December 2020.
- Continue to review and update appropriate policies and practices, for example, flexible working, in partnership with staff side representatives and managers. The enforced working from home put in place for some staff as a result of the COVID-19 pandemic has highlighted the opportunity to further review flexible working practices, and the benefits of the increased use of technology.
- Continue to encourage female participation in leadership development programmes and review career and talent development opportunities so that capable employees of both genders can progress.
- The Trust will continue to introduce secondment roles in order to provide more personal and professional development opportunities for staff. For example, two secondments within Organisational Development have been created in order to focus on inclusion and increasing the engagement of staff with protected characteristics.
- The Black, Asian and Minority Ethnic Staff Network is well established and supports female membership by signposting personal and professional developmental opportunities internally and also within the NHS Leadership Academy. It has and will continue to provide ad hoc engagement sessions with BAME nurses in order to understand their experiences at work.
- *'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 focus 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.
- The Executive and Non-Executive team will participate in an Inclusion Programme of work which will partially explore barriers to career progression for staff.
- A number of Interviewing Skills workshops have been offered quarterly to staff who conduct interviews. These workshops aim to support staff to either refresh or upskill their interviewing technique and explore strategies to challenge any unconscious bias, in order to improve hiring decisions. These sessions will continue on a quarterly basis.
- Interviewing Skills Training for applicants will be scheduled in order to provide staff support in their preparation before interviews. This is currently offered on an ad-hoc basis.
- Inclusion Bitesize Development workshops will be offered to all staff on a quarterly basis.

- The Coaching and Mentoring Network will continue to offer opportunities to staff to explore their professional and career development, including the introduction of a formal Reverse Mentoring Programme.
- Secure funding and make appointment to Equality, Diversity and Inclusion Lead (Workforce) post (appointment made with post-holder commencing January 2021).
- Within the Medicine and Emergency Medicine Health Group set up a Workforce Committee to review all aspects of the workforce, including all aspects of the Equality Agenda. An aim is to continue to develop career progression frameworks for all specialties and roles (already in place for the Neurophysiology, nursing and medical workforce which makes up the majority of the workforce within both Health Groups), so that career pathways are clearly mapped out with opportunities for career advancement and defined pathways.

Solutions to the gender pay gap lie in culture changes both in society and organisations. Closing the gap will take time, and progress will not be linear.

Nationally most of the issues driving gender pay gaps require a longer term view.

The Trust believes, however, that over time, its commitment to fostering inclusion, fairness and flexibility will be reflected in its gender pay gap figures, building a strong foundation for individual and organisational growth.

The Trust will continue to take steps to reduce its pay gap and continue to explore best practise across the sector and beyond.

APPENDIX 2

Hull University Teaching Hospitals NHS Trust

Gender Pay Gap in Medicine Report

1 INTRODUCTION

'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England', was published by the Department of Health and Social Care (DHSC) on 15 December 2020.

The report, was commissioned by the Department of Health and Social Care in 2017 to examine the structural and cultural barriers affecting the female medical workforce, and was chaired by Professor Dame Jane Dacre and led by Professor Carol Woodhams, an expert in gender pay, alongside a team of analysts and researchers from the University of Surrey.

2 FINDINGS

The gender pay gap for medics is significant, being 24.4% for hospital and community healthcare (mostly hospital) doctors, 33.5% for GPs and 21.4% for clinical academics.

The report, which considered the records of 86,000 Trust doctors over a 10 year period, 16,000 GPs and 4,500 clinical academics, finds that careers in medicine were designed for a predominantly male workforce and retains a male dominated culture.

As a result, the reward package for doctors inadvertently creates a glass ceiling for women based on an expectation of full-time work, with no breaks in service for family reasons.

2.1 Explanations for the Pay Gap

The report identifies the following reasons for the medical gender pay gap:

- Hours: Women are more likely to work less than full-time (LTFT), which helps to explain why their pay is lower. However, men report working more unpaid overtime, which means that their effective pay is overstated. When these factors are taken into account, the gender wage gap is smaller.
- Grade and experience: Male doctors are more likely to be older, have more experience and hold more senior positions – all of these characteristics lead to higher pay. Periods of LTFT working have long-term implications for women's career and pay trajectories as they reduce their experience and slow down or stall their progress to senior positions.
- Additional payments: Among hospital doctors, gaps in total pay, which include Clinical Excellence Awards (CEAs), allowances and money from additional work, are larger than gaps in basic pay alone.
- Women are more likely to work less than full time (LTFT), and many never catch up with their male peers even after a return to full-time working. The report also suggests that there may be an unconscious bias amongst peers, recruiters, and even the wider health and care community, that those on LTFT contracts lack the same levels of skill and experience as their full-time counterparts, and urges the NHS to "put a value on individual talent and ability, not hours on the clock".

2.2 Key Recommendations

Key recommendations of the review include:

- Review pay-setting arrangements, using fewer scale points (so it takes less time for people to reach the top) and greater use of job evaluation for hospital doctors, and more structure and greater transparency for GPs.
- Give greater attention to the distribution of additional work and extra payments, by increasing transparency around additional allowances and individually negotiated pay (for example, for locums or waiting list initiatives), monitoring the gender split of applications for CEAs and encouraging more applications from women.
- Promote flexible working for both men and women, by advertising all jobs as available for LTFT, reconsidering the structure of LTFT training, so that it focuses on competency not time served, and reducing disproportionate long-term career penalties for women who are more likely to go part time. This would help to improve work-life balance and make the NHS the best place to work

The report outlines a range of recommendations to make senior roles more accessible to women and help close the gap. These include:

- Address structural barriers to the career and pay progression of women
- Make senior jobs more accessible to women
- Introduce increased transparency on gender pay gaps
- Mandate changes to policy on gender pay gaps
- Promote behaviour and cultural change
- Review clinical excellence and performance payments and change accordingly
- Implement a programme of continuing and robust analysis of gender pay gaps

2.3 <u>Aim of Recommendations</u>

- Address the structural barriers to the progression of women in the medical workforce
- Prioritise retention and promotion of more women to more senior levels in the workforce
- Eliminate the pay and career penalty for those doctors working less than full time.

These recommendations support measures set out in the NHS People Plan, to improve recruitment and retention, including ensuring equal opportunity and access to flexible working for both men and women.

3 NEXT STEPS

The Government has confirmed that it is to establish an Implementation Panel to tackle the barriers outlined in the report.

4 FURTHER INFORMATION

The full report for the 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England' is available on the Government website[2].

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

Hull University Teaching Hospitals NHS Trust

TRUST BOARD

9th March 2021

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

Purpose:	The purpose of this paper is to provide the Trust Board with an update on progress with the Trust Research and Innovation Strategy 2018-23 in the context of COVID-19.	
BAF Risk:	BAF 6 – Research and Innovation	
Strategic Goals:	Honest, caring and accountable culture	
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	X
	Financial sustainability	
Summary of Key Issues:	1. Our HUTH response to the COVID-19 pandemic has demonstrated our capabilities to deliver clinical research at pace and scale and we have now enrolled over 2,500 participants across 27 COVID-19 studies since April 2020 (see ***Appendix 1*** for HUTH COVID-19 research achievements). 2. HUTH has made a significant contribution to the development of a COVID-19 vaccine. 3. The recovery of non-COVID research activity will be gradual and must be aligned to the recovery of clinical services. 4. The Trust has set out its ambition to create a multi-disciplinary Infection Research Group (IRG) that links the strengths of both clinical and academic partners in our locality. 5. The Trust wishes to lead the establishment of a Humber, Coast and Vale Integrated Care System 'Research Collaborative' in 2021-22. 6. There are a number of potential challenges and risks that may impact strategic progress if unresolved. 7. Capitalising on this momentum with additional investment should be seen as a priority for the organisation to accelerate the goals of the R&I Strategy.	

Recommendation:	The Trust Board is asked to acknowledge the limited progress made against the R&I Strategy in parallel to the delivery of a comprehensive and successful COVID-19 portfolio of research. Furthermore, the Trust Board is asked to acknowledge the potential risks associated with the ongoing strategy development in light of challenges presented by the pandemic.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESEARCH AND INNOVATION STRATEGY UPDATE

1. PURPOSE OF PAPER

The purpose of this paper is to provide the Trust Board with a Research and Innovation (R&I) Strategy update in the context of COVID-19.

2. BACKGROUND

The Research and Innovation Strategy 2018-23 was approved by the Trust Board in July 2018. The strategy will be delivered through three key priority themes:

(1) A Research Aware Organisation
(2) Positive, Proactive Partnerships
(3) Reputation through Research

Over the last 11 months, healthcare organisations across the world have continued to turn to research for answers in the fight against the COVID-19 pandemic. Our Trust is no exception. This strategy update is provided within this context.

3. PROGRESS TO DATE ON KEY STRATEGIC PRIORITIES

It should be acknowledged that the last 11 months focus has centred on the delivery of the National Institute for Health Research (NIHR) Urgent Public Health research portfolio in response to the Government's co-ordinated COVID-19 action plan: (1) Contain (2) Delay **(3) Research** (4) Mitigate.

The NIHR 'Urgent Public Health Research' agenda was rapidly established to address numerous pressing questions such as: "Who is susceptible, and why?", "What are the mechanisms of severe / critical disease?", "What are the sites and dynamics of virus replication?", "How can early cases be identified and triaged?", "Use and validation of innovative diagnostic tests?" and "What treatments work?".

The support of all NHS organisations in this aspect of the UK action plan is critical. In this situation research is able to immediately impact and also inform effective national policy responses. It also helps to make available and responsibly manage drug therapies that currently lack regulatory approval in this context, develop vaccines and vaccine strategies and enable new diagnostic testing.

The UK is a leading nation for the delivery of clinical trials. Our HUTH response to the COVID-19 pandemic has demonstrated our capabilities to deliver clinical research at pace and scale and we have now enrolled over 2,500 participants across 27 COVID-19 studies since April 2020 (with approximately 2,900 COVID-19 admissions since 17/03/20).

In 2020-21 the three core pillars of the R&I Strategy were aligned to the central requirements of the NIHR:

a) Reputation through Research - Urgent Public Health Research (Covid-19):

The COVID-19 portfolio of research continued to grow daily. The Trust continued to seek opportunities for participation being mindful of staffing restrictions, the need to bring new and paused non-COVID research back on line as soon as is safe to do so and the caseload of COVID-19 cases in our hospitals.

Strategically, all NHS R&D Offices were asked to prioritise NIHR Urgent Public Health research and the national priority COVID-19 trials (including vaccine work) as well as longer-term research in areas such as rehabilitation post-hospitalisation and recovery strategies for patients.

In parallel with the delivery arm of our research teams, the Trust R&D Office continuously sought external investment in infrastructure to support the rapid uptake of research in the event of multiple COVID-19 'waves' or similar pandemic situations in the future.

(See ***Appendix 1*** for HUTH COVID-19 research achievements).

Impact on quality care: HUTH has successfully managed an intensive portfolio of COVID-19 research as well as ensuring studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient can continue with appropriate safeguards. This achievement has been formally recognised by the Clinical Director of the Yorkshire and Humber CRN as well as the CEO of the NIHR.

b) Reputation through Research - COVID-19 Vaccine Research:

HUTH represents the Hull City Region Vaccine Hub and is one of 7 hubs in Yorkshire and Humber. To date HUTH has received £116,000 dedicated Vaccine Task Force funding to support the delivery of covid-19 vaccine trials.

Locally, 494 participants were enrolled into the Oxford trial being led at HUTH by Dr Patrick Lillie. This means that 1 in every 40 of the participants in the trial globally came from the Hull and East Yorkshire region.

It is important to note that COVID-19 vaccine research will be on-going for a significant period of 2021/22 as follow-up of participants continues. In addition, research to enable licensed vaccines in other populations and cohorts is also on-going with 4 known vaccine trials still being setup nationally. HUTH is currently in discussions with the University of Oxford with a view to supporting further COVID-19 vaccine work from next month.

Impact on quality care: HUTH has made a significant contribution to the development of a COVID-19 vaccine. This experience and momentum must be galvanised and used as a catalyst to grow vaccine and other infectious diseases research portfolios.

c) Research Aware Organisation - NIHR 'Restart' of non-COVID-19 research:

Back in the summer of 2020, the Trust embarked upon the national NIHR 'Restart' initiative with around 90% of non-COVID-19 research activity reinstated in line with appropriate risk assessments and the clinical strategy across the Trust. However, the second wave and our local position required a different approach in Q3.

Nationally, the three levels of prioritisation set out within the Restart Framework still apply, with some further prioritisation within Level 1 to identify the highest priority COVID-19 UPH studies:

- Level 1a (Top Priority) - COVID-19 UPH vaccine and prophylactic studies (as prioritised by the Vaccines Task Force and agreed by Jonathan Van-Tam, NIHR Deputy CMO) and platform therapeutics trials (currently RECOVERY/RECOVERY+).
- Level 1b - Other COVID-19 UPH studies
- Level 2 - Studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm. These might be studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient.
- Level 3 - All other studies (including COVID-19 studies not in Level 1a or 1b).

A focus on level 1 (a and b) combined with a reduction in level 3 activity has allowed resources to be maneuvered to support the most critical research and it is likely this strategy will continue into Q1 of 2021/22.

As at 01.03.21, HUTH had resumed 83% of all research activity (207 studies) with 84 studies registering recruits. The recovery of non-COVID research activity will be gradual and must be aligned to the recovery of clinical services. In these challenging times it is critical that our research activities are viewed as a complimentary, rather than prohibitive, asset in providing high quality clinical care for our patients.

Impact on quality care: HUTH will continue to provide equitable access for patients and staff to both Urgent Public Health Research and non-COVID-19 research where it is possible and safe to do so.

d) Research Aware Organisation - BAME COVID-19 Project:

HUTH is working with colleagues from Yorkshire and Humber CRN on a strategic project to help manage misinformation on COVID-19 research, specifically the COVID-19 vaccine, within local communities ensuring that those of Black Asian and Minority Ethnic groups are able to make informed decisions in a safe environment.

The project hopes to link up with the HUTH BAME Network with dedicated funded support to allow the delivery of co-ordinated workshops in Q4 of 2021/22.

HUTH has also participated in the Yorkshire and Humber CRN BAME Network Leads Survey. Our network has provided some insightful feedback informing engagement with communities, fears and concerns and media and social media guidance.

e) ***Positive Proactive Partnerships - Infection Research Group (IRG):***

The Trust has set out its ambition to create a multi-disciplinary Infection Research Group (IRG) that links the strengths of both clinical and academic partners in our locality.

Building on the successes of the delivery of COVID-19 research, an opportunity to grow and harness a sustainable, agile and dedicated talent-pool would undoubtedly leverage a highly valuable return on investment (clinically and academically).

The potential longevity of disruption that new diseases such as COVID-19 brings will necessitate a forward thinking, long-term institution-wide strategy. A focused and supported research group that has academic identity and backing should be viewed as one of the cornerstones of our clinical research.

Impact on quality care: The development of the IRG is allowing the creation of capability and capacity to offer an increase in both COVID and non-COVID-19 research opportunities. Its development is being considered in tandem with routine service delivery so that it becomes a truly integrated service. Initially, this work will be underpinned by COVID-19 vaccine work and associated DHSC funding with plans to integrate into OPAT and other Infectious Diseases services. Institutional support will be required longer-term.

f) ***Positive Proactive Partnerships - Humber Coast and Vale ICS*****:**

The Trust wishes to lead the establishment of a Humber, Coast and Vale Integrated Care System 'Research Collaborative' initially of the Acute Providers in the patch; Harrogate, HUTH, NLAG and York.

Informal work has begun with a focus of COVID-19 research delivery. A formal framework will be embedded in 2021-22 to try and set the terms of this collaboration and to try and identify areas of work that would lend themselves to the development of a mutually beneficial ICS Research Strategy.

The timing of these discussions fits well with the likelihood of future Y&H Clinical Research Network funding destined (in some shape or form) to be contingent upon demonstrating strong research themes and collaboration in each ICS.

Impact on quality care: This collaboration, starting with Acute Trusts and moving to all providers and commissioners within the ICS footprint, will allow a unified research strategy picking up perhaps two or three mutually beneficial themes to be explored with a view that joining of resources and expertise can greater serve the needs of our geographic areas. It is anticipated (but not assumed) that a focus on mental health, community services and social care will provide a backbone to these initial scoping of themes.

4. IMPACT

HUTH continues to make a significant contribution to the Urgent Public Health research agenda, maximising opportunities for our patients to participate in trials looking at therapeutic treatment options for those severely ill with COVID-19 as well as post-hospitalisation rehabilitation.

It should be acknowledged that COVID-19 research activity will continue to be prioritised well into 2021/22 and plans for ensuring an agile and resilient workforce are being enacted. Our ability to deliver the COVID-19 research agenda at pace and scale has been testament to the dedication of our staff. We need to acknowledge the immense efforts of our research and non-research colleagues who have worked hand-in-hand in often challenging environments to ensure patients get access to treatment options. Staff have embraced new ways of working and the sense of community that this situation brings.

5. CHALLENGES AND RISKS

Whilst the R&I activities have ben realigned to support a highly successful programme of Urgent Public Health Research, there are a number of potential challenges and risks that may impact strategic progress if unresolved.

a) Risks:

- The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities.
- Loss of commercial research income as well as other income as non-COVID activity was paused, restricting growth and potentially reducing critical mass and capacity.
- Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload well into 2021/22. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities.
- Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues.

b) Challenges/Risk Appetite:

The Trust must continue to risk-assess the balance of investment in R&I capacity against that of other competing priorities, taking into account the reputational momentum that has accrued over the last year in relation to the delivery of a comprehensive and highly effective COVID-19 research programme. Capitalising on this momentum with additional investment should be seen as a priority for the organisation to accelerate the goals of the R&I Strategy, namely; ***increasing research income for reinvestment and growth***, ***supporting clinical service development for high-quality care delivery*** and ***the appointment and retention of high-calibre staff***.

Consideration of the development and implementation of an agreed R&I investment strategy covering the next 3 years (protected research time for staff, providing core budgets for increased admin and other costs) is critical in taking the next step on this journey of development and supporting the research collaborations as a leading partner in the HCV ICS.

6. RECOMMENDATION

The Trust Board is asked to acknowledge the perseverance and resilience of the R&I workforce in continuing to develop operationally in response to the pandemic and in turn, the ability to consolidate and prioritise strategically in this challenging year.

Furthermore, the Trust Board is asked to acknowledge the Trust's tremendous contribution to COVID-19 research to date including the tireless efforts of all staff (research and non-research) in ensuring all possible opportunities to participate have been made available for our patients, staff and carers.

The Trust will recognise that research teams will continue with efforts being made to ensure non-COVID-19 research activity can resume as quickly and as safety as feasibility assessments allow, providing safe opportunities for the Trust to offer high quality care through research participation.

James Illingworth
R&D Manager
Hull University Teaching Hospitals NHS Trust

March 2021

Appendix 1: HUTH COVID-19 Research Achievements

✓	Recruiting over 2,500 participants to COVID-19 research in 11 months
✓	Opening 27 COVID-19 studies (18 currently open and badged as Urgent Public Health).
✓	Strategically supporting interventional UPH research that offers therapeutic options for all pathways and severity of COVID-19 disease.
✓	The significant contribution to the collection of large cohort data to better understand the nature and impact of the disease (PRIEST and ISARIC studies).
✓	One of the top recruiters nationally to the SIREN study investigating the nature of antibody protection against COVID-19
✓	494 participants enrolled into the Oxford/AstraZeneca COVID-19 vaccine Trial (accounting for 1 in every 40 participants globally).
✓	180 (and counting) recruits to the RECOVERY study (NIHR Platform study) rapidly identifying therapeutic treatments for hospitalised patients (including the use of Dexamethasone).
✓	Being one of the first trial sites in the UK to be able to offer the drug Remdesivir to those admitted to hospital with both severe and moderate COVID-19 disease.
✓	Recruiting 25% of the global recruits to the Synairgen commercial COVID-19 study offering another therapy for our severely ill patients.
✓	Recruiting the first global participant to the sister Synairgen commercial COVID-19 study.
✓	Top recruiter nationally in the CLARITY-IBD study looking at the development of antibodies to SARS-CoV-2 in UK patients with Crohn's and Colitis.
✓	Leading work focussed on the management of acute diseases in shielding groups (i.e. IBD: PREPARE-IBD, PROTECT ASUC) and surgical outcomes studies for impacts (i.e. Vascular: COVER study).
✓	Undertaking studies looking at the post-hospital rehabilitation of COVID-19 patients (PHOSP-COVID and COVID-19 Tele-Rehab studies).
✓	83% of non-COVID-19 activity issued continuing Capability and Capacity as part of the NIHR ‘Restart’ initiative allowing recruitment to studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm.
✓	Achieving the NIHR Clinical Research Target of at least 80% of COVID-19 commercial research recruiting on time and to target (RTT).
✓	Third highest open and recruiting portfolio studies (84) in Yorkshire & Humber (Behind Leeds and Sheffield) as part of recovery of non-COVID-19 research.
✓	Using opportunities for collaborative working with local stakeholders within HCV ICS (Humber Foundation Trust support for vaccine study delivery, CHCP for PHOSP-COVID study).

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD

9 MARCH 2021

Title:	Trust Strategy Implementation End of Year Update 2020/21	
Responsible Director:	Michelle Kemp, Director of Strategy and Planning	
Author:	Michelle Kemp, Director of Strategy and Planning	
Purpose:	The purpose of this report is to apprise the Board of progress towards the achievement of the goals set in our Trust Strategy 2019 - 2024	
BAF Risk:	The Strategy is relevant to all of our BAF risks	
Strategic Goals:	Honest, caring and accountable culture	X
	Valued, skilled and sufficient staff	X
	High quality care	X
	Great local services	X
	Great specialist services	X
	Partnership and integrated services	X
	Financial sustainability	X
Key Summary of Issues:	• All of the outcome implementation plans have been reviewed by the lead Executive Officer. • A number of milestones set by Directors for 2020/21 have not been met and at the end of year review, there are 19 scorecards where progress has been adversely affected by the pandemic. • 28 of the 50 outcome measures remain on track for delivery. • Progress has improved for 1 of the outcome measures (delivery of the outcomes that support urgent and emergency care). • 1 of the outcome measures (delivery of cancer and elective access standards) remains at high risk of not being delivered due to the impact of the pandemic.	
Recommendation:	That Trust Board notes the contents of the paper and indicates any areas where further action or assurance is sought.	

Trust Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

Great Staff	1. Staff survey overall result top 20% of Trusts	↓	2. Staff report able to make improvements top 20% of Trusts	←
	3. Staff engagement score top 20% of Trusts	↓	4. More BME staff in leadership roles	↓
	5. 80% of staff recommend us as a place to work	↓	6. 95% of posts are filled with permanent staff	←
	7. At least a 92% retention rate	↓	8. Improve the health and wellbeing of our staff	↓
Great Care	9. Achieve 'Outstanding' overall CQC rating	←	10. Increase harm free care year on year	←
	11. Increase the length of time between SIs and NEs	←	12. Deliver the 4 priority 7 day working standards	←
	13. Fewer complaints and PALS relating to outpatient services	←	14. Patient Friends and Family Test score : in top 20% of Trusts	←
	15. Improve transition from children's to adult services	←	16. Provide patient electronic access to medical records	←
	17. Extend access to latest surgical and drug treatments	←	18. Achieve and sustain 28 day and 6 week diagnostic targets	←
	19. Deliver 10,000 health prevention interventions	←	20. Reduce hospital stays for patients in the last year of life	←
	21. Reduce admissions for patients with long term conditions	←	22. Deliver year on year reductions in our length of stay	←
	23. Ensure our integrated teams have access to shared care records	←	24. Meet the standard for fractured neck of femur	←
	25. Deliver standards for urgent and emergency care	←	26. Reduce face to face outpatient appointments	←
	27. Expand and update our diagnostic capacity	←	28. Deliver the 'Better Birth' ambitions	←
	29. Centralise inpatient paediatrics and improve the NICU	←	30. Deliver the clinical access standards for cancer and electives	↓
	31. Secure sustainable specialist paediatric service	↓	32. Continue to improve our major trauma survival rates	←
	33. Improve timely access to acute and elective cardiac care	←	34. Improve the cancer stage of presentation and survival rates	←
	35. Establish a mechanical thrombectomy service	←	36. Working with partners, support the progression of the HCAV HCP into an ICS	↑
	37. Establish an ICP that can show measurable improvement to the health of its population	←	38. Working with partners across the Humber region, secure safe and sustainable acute hospital services	↓
	39. Support the work to create a sustainable clinical model for hospitals services in Scarborough	←	40. Establish mature programmes of workforce development and research with our international partners	←
Great future	41. Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit	←	42. Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio	←
	43. Achieve all Department of Health and NIHR research performance metrics	←	44. Secure three new long-term commercial research partnerships	↓
	45. Secure 'top 5' national status with our Academic Oncology Research Unit	↓	46. Working with partners, achieve financial balance across our ICP	←
	47. Improve the quality of our estate and increase the productivity per square metre	←	48. Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy	←
	49. Become greener by reducing our energy consumption and waste	←	50. Become a digital first organisation; removing paper	↑

Strategy Implementation Scorecard 2019-24 progress report summary

Key	Definition	2020/21 half year update (count)	2020/21 end of year update (count)
	Delivered	1	1
	On track to be fully delivered by deadline	27	28
	Not currently on track but confidence in plans to recover and deliver by deadline	2	2
	Not on track and low or moderate risk to delivery by deadline	19	18
	Not on track and high risk to delivery by deadline	1	1
Total		50	50

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

1. Staff survey overall result top 20% of Trusts		
Exec Owner: Simon Nearney		
Milestone	By When	Progress
4 of the key findings in the top 20% and 6 equal to or better than the national average	March 2020	4 are in the top 20%, 4 are equal to or better than the national average
6 of the key findings in the top 20% and 4 equal to or better than the national average	March 2021	0 are in the top 20%. 8 are equal to or better than national average.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

2. Staff report able to make improvements top 20% of Trusts

Exec Owner: Simon Nearney

Milestone	By When	Progress
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2020	Slightly decreased by 0.6% (48.4% to 47.8%)
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1%	March 2021	Increase by 1% (55.9%)
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.4%	March 2022	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2023	
National Staff Survey response – 'I am able to make improvements happen in my area of work' increase by 1.5%	March 2024	
Achieve top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

3. Staff engagement score top 20% of Trusts		
Exec Owner: Simon Nearney		
Milestone	By When	Progress
National Staff Survey result for staff engagement – 7.1	March 2020	HUTH held its engagement score at 7.0. Nationally this score worsened.
National Staff Survey result for staff engagement – 7.2	March 2021	Increased to 7.1 above national average (7.0)
National Staff Survey result for staff engagement – 7.3	March 2022	
Achieve top 20% ranking	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

4. More BME staff in leadership roles		
Exec Owner: Simon Nearney		
Milestone	By When	Progress
Number of BME staff in leadership roles will increase by 0.5% to 6.25%	March 2020	WRES action plan developed and submitted.
Number of BME staff in leadership roles will increase by 0.75% to 7%	March 2022	
Number of BME staff in leadership roles will increase by 1% to 8%	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

5. At least 80% of staff recommend us as a place to work

Exec Owner: Simon Nearney

Milestone	By When	Progress
National Staff Survey question . Staff response will be 67%	March 2020	62.7% of staff would recommend us as a place to work.
National Staff Survey question . Staff response will be 70%	March 2021	Increase of 4.1% (67%)
National Staff Survey question . Staff response will be 74%	March 2022	
National Staff Survey question . Staff response will be 77%	March 2023	
National Staff Survey question . Staff response will be 80%	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

6. 95% of posts are filled with permanent staff		
Exec Owner: Simon Nearney		
Milestone	By When	Progress
94.2% of posts filled with permanent staff	March 2020	As at 31.7.20 96.4% of posts are filled with permanent staff
94.6% of posts filled with permanent staff	March 2021	94.6% as at 31/01/21
95% of posts filled with permanent staff	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

7. At least a 92% retention rate		
Exec Owner: Simon Nearney		
Milestone	By When	Progress
91% staff retention rate	March 2020	91% as at 31.7.20
91.5% staff retention rate	March 2021	88.9% as at 31/01/21
92% staff retention rate	March 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

8. Improve the health and wellbeing of our staff

Exec Owner: Simon Nearney

Milestone	By When	Progress
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2020	Remained the same at 6.8 (out of 10)
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2021	Increased by two points (6.1)
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2022	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2023	
National Staff Survey key finding – Health and Wellbeing increases by 1 point	March 2024	
Achieve 6.4 point score which will deliver a top 20% ranking	March 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

9. Achieve 'Outstanding' overall CQC rating		
Exec Owner: Chris Long		
Milestone	By When	Progress
Achieve overall 'Good' rating	Mar 2020	Trust rated 'Requires Improvement' overall in March 2020 inspection. 'Good' rating for 'Well Led' retained. Trust joined the NHSE&I 'Moving to Good' Programme, however this has been suspected during the response to Covid 19.
Sustain overall 'Good rating' and achieve 'Outstanding' rating in 2 core services	Mar 2022	The CQC is reviewing their inspection regime and it is not yet clear what the approach or requirements will be.
Sustain overall 'Outstanding' rating	Mar 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

10. Increase harm free care year on year		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Establish mechanisms to measure harm and establish a baseline	September 2019	Completed
Identify areas of improvement to achieve harm free care	November 2019	Patient safety committee formed
Focus on one area of improvement	January 2020	Near misses
Roll out to wider areas and Embark on further areas of improvement	January 2022	Commenced but stalled due to Covid

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

11. Increase the length of time between SIs and NEs		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Refresh mechanisms to capture and manage SIs	November 2019	Refresh underway
Full launch of Stop the Line Campaign	March 2020	Campaign in development
Develop and deliver projects to address key themes	March 2021	Delayed due to Covid but recommenced in September 2020
Continually capture real time data	March 2021	
Embed proactive safety culture	December 2022	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

12. Achieve compliance with the 4 clinical priority standards for 7 day services by March 2020		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Develop a series of metrics to support reporting of progress against the 7DS standards	July 2019	Complete (actual performance to date 2 of 4 achieved)
Identify those specialties who continue to under-perform against the standards and agree specific actions to address the shortfalls in delivery	August 2019	Complete
Provide six monthly updates on progress to the Trust Board in accordance with the 7DS Board Assurance Framework	Ongoing	On track Program suspended nationally this financial year due to Covid

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

13. Fewer complaints and PALS relating to Outpatient Services (1 of 2)

Exec Owner: Beverley Geary

Milestone	By When	Progress
Baseline report based on 2018/19 to be completed	June 2019 – completed	Baseline of reported complaints/PALS for 2018/19 36 compliments 957 concerns (PALS) 191 Complaints (Formal) (However not all linked to outpatient activity due to categorisation – this is being addressed) Update 08/2020: The Trust has developed and produces a monthly report for complaints and PALs that is submitted to the Trust Board Quality Committee. The data is compared with NHS Digital information with regards to where the Trust is nationally and compared to other acute providers for complaints and PALs.
Focussed patient engagement to be undertaken	July 2019	Family and Friend continues to be used in OPD's. 2018/19 97.83%.Questionairre to be amended to ask "Did you need to attend today?" NHS Choices reported monthly. All areas act on comments/concern/compliments on a daily basis Update 08/20: Active engagement with patients being undertaken to evaluate new digital approaches We have introduced the Attend Anytime feedback for the outpatients departments and seen an increase in response rates since starting this in August 2020 patients are now able to leave their feedback via the web or by scanning a QR code on the feedback form. The Optimise2 improvement programme has patient engagement events and these have continued during 2020 and into 2021 with key areas and themes to review.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

13. Fewer complaints and PALS relating to Outpatient Services (2 of 2)

Exec Owner: Beverley Geary

Milestone	By When	Progress
Action plan to be developed and approved by the OP Governance Group	July 2019	Patient stories shared monthly at OPG and datix and discussed. Monthly break down of PALS at Committee since October again future work as not all concerns
Quarterly monitoring to commence against baseline	Oct 2019	Commenced first report received at October committee All patient feedback is reported to the Patient Experience and Engagement committee and themes and trends identified as part of these reports.
Development and deployment of Trust annual outpatient survey	2020/2021	Not yet commenced Update; 08/20 Given the planned significant changes to Outpatients' services which were implemented initially as a result of the Covid-19 pandemic, a rebasing of the work needs to be undertaken to review objectives in light of new ways of working .

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

14. Patient Friends and Family Test score : in top 20% of Trusts

Exec Owner: Beverley Geary

Milestone	By When	Progress
Identify themes in F&FT and agree action plan to address	Sept 2019	Wider review of patient and public feedback well underway. Update 08/20 : PESG now identifying themes from patient feedback with a view to identifying areas for improvement
Delivery improvement on 2018/19 baseline	March 2020	Delayed due to Covid 19. Improvements to the Friends and Family Test are continually being reviewed at the Trusts Patient Experience and Engagement committee. The committee has made improvements to individual services and are focusing on learning lessons from patient feedback throughout the organisation.
Following launch of successor scheme to F&FT, develop and deploy plan to achieve top 20% rank	TBC	Delayed due to Covid_19 The mandatory response rate requirements were removed in 2015. NHS England will publish the number of responses collected and the number of eligible patients. If the number of responses falls too low we will focus on the specialty area or a trigger point to promote the FFT. The Trust is confident that the response rate will meet the requirements set out by NHS England when the national statistics are released in February 2021 although there is indication that this will be delayed due to Covid 19.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

15. Improve transition from children's to adult services

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Baseline audit against NICE standards	March 2019	Complete
Broader transition partnerships developed and activated	March 2020	Complete have local links and a member of the Yorkshire and Humber Transition forum
Patient and carer levels of knowledge regarding condition and adult services enhanced	March 2020	Complete in specific areas i.e. diabetes, CF and IBS
Robust patient experience measurement tool developed	March 2021	Delayed due to Covid-19 response - programme to be revised in April 2021
Delivery model for transition clinics reviewed and changes implemented as indicated	March 2022	On-track – subject to programme review identified above
Tool deployed and shows improved experience	2022 - 2024	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

16. Provide patient electronic access to medical records		
Exec Owner: Lee Bond		
Milestone	By When	Progress
Go Live with 'Patient Knows Best' system	Jul 2019	Slightly delayed by flow of national funding but will be delivered by March 2020
Rollout, linked to the Yorkshire and Humber Care Record programme	Sept 2020	
Deliver plan to maximise patient take up, with focus on long term conditions	Sept 2021	

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

17. Extend access to latest surgical and drug treatments

Exec Owner: Makani Purva

Milestone	By When	Progress
Increased commercial research activity year on year from 2018/19 baseline.	March 2020 (Yr 1) March 2021 (Yr 2)	Engagement and contribution to Y&H CRN 2020/21 Annual Plan. As at 28.08.20 HUTH (71) has the highest commercial recruitment in Y&H ahead of Leeds (69) and Sheffield (30). Due to Covid-19 vaccine trials (many commercial) this metric will be skewed in Yr 2 by allocation of these trials to sites by Y&H CRN (based on capacity). Commercial activity is not likely to return to normal equitable levels until Yr 3 (2021/23).
Increased research workforce capability to deliver increased activity.	On-going from 2019/20	4 PhD Scholarships awarded (1 AHP). 6 Research Support Funding awards (with HYMS) to support protected time and provide methodological support (activity paused due to Covid-19). 9 Clinical Research Fellows appointed (Infection, Renal, Cardiothoracic, Orthopaedics , Vascular and Gastro). 5 NIHR ACF Posts awarded to start in 2020. 7 new Principal Investigators engaged (Renal, ID, ED, Imaging). 2 posts supported in Pharmacy Trials Team (from September 2019). Lead Research Nurse appointed (Oct 2019) Radiotherapy research nurse appointed. Vaccine Task Force Funding to boost Covid-19 research capacity (2 RNs, I CTA, 1 RA and 0.5 CRF). **Trust priority to establish 'Academic Dept of Infection Research'**
Increased research awareness from Trust visitors, carers and patients.	On-going from 2019/20	Website development on-going with facility for researchers to upload and share stories and promote activities/articles and presentations. Development paused during Covid-19

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

18. Achieve and sustain 28 day and 6 week diagnostic targets		
Exec Owner: Ellen Ryabov		
Milestone	By When	Progress
Determine the Capacity requirements in each modality and target	August 2019	Demand on each modality is monitored and discussed vi a Performance and Activity meeting fortnightly.
Understand the impact of referrals from outside HUTH	August 2019	This is reported fortnightly via Performance and Activity Meeting and report on Inter Hospital Transfer are provided to referring Trusts on a monthly basis
Project growth in demand over the next 5 years	August 2019	This work has been completed as part of the Long Term Plan
Factor in changing technologies or therapies over the next five years	August 2019	This work has been completed as part of the Long Term Plan
Develop staged milestones required to achieve the targets	Sept 2019	In place
Breach percentage against the 6 week standard reduced to 2%	March 2020	This milestone was not achieved due to high levels of demand for Endoscopy throughout 2019/2020 and then further Impacted by Covid from March 2020. Performance at the end of Q1 20/21 was 55% of patients seen within 6 weeks with 4618 patients over 6 weeks. Recovery Plans are in place as part of Phase 3 planning .
6 week standard achieved	March 2021	This milestone is unlikely to be achieved due to the impact of Covid and reduced efficiency in diagnostics as a result of Infection Prevention and Control requirements .
28 day standard achieved	September 2021	Achieved. The 28 day Faster Diagnostic Standard has been set at 75% from April 2020. The standard was achieved for Q4 2019/20 and has been achieved for May and June 2020.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

19. Deliver 10,000 health prevention interventions		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Establish baseline levels of delivery	March 2020	Delayed due to Covid 19. Will be picked up in 2021/22
Develop a programme plan to increase level of health prevention activity delivered by the Trust, based on brief intervention and sign posting to smoking cessation, healthy weight and alcohol services	March 2020	Delayed due to Covid 19. Will be picked up in 2021/22
Deliver a minimum of 10,000 interventions	March 2024	Should still be able to achieve this

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

20. Reduce hospital stays for patients in the last year of life		
Exec Owner: Ellen Ryabov		
Milestone	By When	Progress
Embed SAFER principles across the organisation, with Home First as a priority.	1st July 2019	Achieved: SAFER has been re-launched across the organisation with agreed metrics in place which are monitored by the Emergency Performance and Flow Performance and Activity Meeting.
Use Red2Green days to reduce any unnecessary waiting.	1st July 2019	see above
Work with the Discharge Hub to support advanced care planning.	1st June 2019	A review of the Discharge Hub has been undertaken in Q1 and a work programme for the Hub has been agreed to improve interface with the wards and Out of Hospital partners. This is monitored via the Unplanned Care Delivery Group.
Ensure all RESPECT forms are appropriate and up to date.	1st July 2019	Achieved: As part of the system wide response to Covid work was undertaken across the local system to support the Frail Elderly population and increase support to Care Homes to prevent any unnecessary conveyances to hospital . These arrangements are being supported to continue across the system.
Develop and implement an improvement plan, for the above.	1st June 2019	See above
Develop and implement an improvement plan for diagnostics, equipment and treatments/medications to allow patients to leave hospital sooner.	1st July 2019	See above

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

21. Reduce admissions for patients with long term conditions

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Introduce Hospital at Home for COPD patients.	December 2019	Completed December 2019
Work with the ICC/ED/ Care homes to prevent Frailty patients being admitted.	December 2019	Care Home work stream in place. FIT Model operating daily with ED.
Increase access to ACU/MDCU to prevent in-patient admissions.	July 2019	AMU and MCDU redesign complete.
Audit with a multidisciplinary team x 60 sets of case notes to establish if all patients needed admission or could they have gone elsewhere. Evaluate and present to partner organisations.	June 2019	
Work with partner organisation to identify alternatives to hospital i.e. social care/ see & treat/ step up beds.	March 2021	Action complete, system partner calls in place and options progressed daily through the DLT. System wide 'falls' pathways review involving HUTH and community partners underway. D2A work commenced. Streaming Hub in place.
Identify the highest cohort of long term conditions, working with the speciality teams to help prevent hospital admission.	March 2021	Work delayed due to Covid. Neurology has a front door admission avoidance model with daily hot clinics. PIFU running in cardiology, respiratory and neurology in support of reducing acute attendances and therefore admissions. Other MHG specialities progressing with PIFU. Neurology headache teams working with PKB to develop a structured education programme to prevent acute attendances.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

22. Deliver year on year reductions in our length of stay

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Deliver 40% reduction in number of occupied bed days of patient with a length of stay of 21 days or greater. Baseline 126 patients Target 77 patients	March 2020	This target was achieved at the end of March 2020.
Make year on year reductions in length of stay of patients who are in hospital 7 days or longer.	March 2022 - 24	The Target for 20/21 is for there to be no more than 66 patients in hospital over 21 days by March 2021. At the end of Q1, there were 74 patients with a LOS of 21 days or greater.
Work collaboratively with out of hospital partners to reduce delays in the transfer of care for patients with a length of stay of 7 days or greater. Baseline – 15%	March 2020	As a result of Covid a number of changes has been implemented across the local system have been put in place which has reduced the number of Delayed Transfer of Care. Via the Unplanned Care Delivery Group and the A&E Delivery Board programmes are in place to ensure these benefits are sustained going forward.
Improve pre-operative length of stay in Surgery	March 2021	Due to the impact of the Covid pandemic multiple surgical pathways have changed and patients have been accommodated outside of their normal bed base. It is therefore been difficult for specialties to focus on delivering reductions against this metric. Further work is needed to address this issue moving into 2021/22.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

23. Ensure our integrated teams have access to shared care records		
Exec Owner: Lee Bond		
Milestone	By When	Progress
Agree benefits case for the Yorkshire and Humber Care Record Programme (YHCR), ensuring it achieves functional shared care records for Humber, Coast and Vale (HCAV)	March 2020	Benefits case agreed
Develop and agree investment plan for the YHCR	March 2020	Complete
Complete YHCR rollout in HCAV	March 2021	Implementation under way

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

24. Meet the standard of fractured neck of femur

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Hull & East Yorkshire NHS Trust to have a designated NOF Theatre (9) and 10 established theatre sessions. Recruit Neck of Femur Specialist Nurse	July 2020 November 2020	Achieved: All 10 sessions to start 06.07.20 Achieved: NOF Specialist Nurse trial commenced July 2020 for 12 weeks
Recruit to vacant Ortho-geriatrics post.	April 2020	Achieved Ortho - geriatric consultant recruited start date to be confirmed. Project group established.
Fractured NOF bed to be available at all times on the 12th floor at HRI to accommodate all confirmed NOFS within the 4 hour target.	December 2019	Complete
Neck of Femur MDT to be established weekly.	May 2019	Complete
Deliver target of surgical treatment within 36 hours of arrival in ED	September 2020	Monitoring compliance and all breaches discussed in the monthly NOF Governance Meeting.

Strategy Implementation Scorecard 2019-2024
2020/21 end of year update

25. Deliver standards for urgent and emergency care

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Develop ED recovery and improvement plan linked to agreed performance standards trajectory	10th May 19	Complete. System Wide ED Recovery Plan in place and monitored via the Unplanned Care Delivery Group and the A&E Delivery Board
Sign off of ED recovery and improvement plan via UCDG	1st June 19	Complete
Primary Care Streaming (PCS) service specification developed and signed off by CCGs and HUTH	1st June	Complete. Primary Care Streaming Service commences from mid December following capital investment and estates reconfiguration works
PCS Implementation plan developed and signed off by UCDG	1st June	Complete
Develop and implement ACU improvement plan	1st July	Complete. ACU will be expanded to provide a Multi-specialty ACU with effect from mid December.
Develop and implement AMU improvement plan	1st August	In progress. AMU will be expanded to provide an Initial Assessment and Triage Zone from mid December to support effective flow.
Develop and implement Discharge Lounge improvement plan	1st September	Complete

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26. Reduce face to face outpatient appointments

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Programme for reducing the number of face to face outpatient follow-ups agreed by the Out-Patient Improvement Board.	April 2019	Approach agreed via the OPD Improvement Board.
Phase 1 specialties for the reduction programme, support by the Trust Improvement Team, identified.	April 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 2 specialties for the reduction programme, supported by the Trust Improvement Team, identified	September 2019	In Progress. Health Group Programmes in place supported by the HIP team. Stock Take review undertaken in October 2019 which has reported to PAF
Phase 3 specialties for the reduction programme, supported by the Trust Improvement Team, identified	April 2020	
Out-patient follow-up volume reduced by 50% from baseline at 31/3/19.	June 2020	Progress at M6 2019/20 has been assessed and reported to PAF.
Phase 4 specialities for the reduction programme, supported by the Trust Improvement Team, identified	September 2020	Optimise2 was paused due to the pandemic

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27. Expand and update our diagnostic capacity

Exec Owner: Lee Bond

Milestone	By When	Progress
Replace oldest CT and Gamma Camera	March 2020	CT replaced and Gamma Camera installation under way
Explore options for accelerating access to Wave 4 capital	March 2020	Complete
Agree business case for expanded endoscopy capacity	March 2020	Allam funded development in train. Additional kit funded as part of Wave 4 case
Install additional MRI and CT and commission additional endoscopy capacity	No later than March 2022	Funding secured for additional MRI and CT, plus replacement of Radiotherapy CTs with diagnostic capable machines
Agree demand requirements across the STP for key modalities through to 2024	March 2020	Initial demand and capacity work completed. To be refreshed in 2021
Agree and deliver further diagnostic capacity that meets forecast demand	March 2023	

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28. Deliver the 'Better Birth' ambitions (page 1 of 2)

Exec Owner: Beverley Geary

Milestone	By when	Progress
Continuity of Carer	35% of women to be on a pathway for CoC by March 2020. 51% by March 2021 **MARCH 2021** 35% of women to be booked onto a pathway for CoC by March 2021. Of which 35% of BAME and 35% from the most deprived area. **MARCH 2022** 51% of women in receipt of CoC 55% of BAME in receipt of and 55% in receipt of from the most deprived area **MARCH 2023** 51% of women in receipt of CoC 65% of BAME in receipt of and 65% in receipt of from the most deprived area. **MARCH 2024** 51% of women in receipt of CoC 75% of BAME in receipt of and 75% in receipt of from the most deprived area.	**CURRENT POSITION** There are currently three different models of care operating within maternity services; the traditional midwifery model, caseloading continuity of carer teams and high risk continuity of carer teams. There are current nine CoC teams at HUTH - **Projected position in March 2021 is 38% (Target 35%)** Team Name / Model / Criteria / Annual Caseload (approx) Ivy / Caseloading / Geographical HU17 / 280 Primrose / Caseloading / Geographical HU9 (part) / 270 Poppy / Caseloading / Geographical YO25 YO42 YO43 / 250 Bluebell / Caseloading / Geographical HU15 DN14 / 250 Linnaea / High risk / Multiple pregnancy / 60 Fern / High risk / Gestational diabetes / 500 Fetal Medicine / High risk / Fetal medicine obstetric care / 100 Lavender / High risk / Vulnerable women / 100 Forget Me Not / High risk / Previous pregnancy or neonatal bereavement / 100 **Plans** - HUTH should aim to introduce continuity of carer pathways for approximately 640 more women, focusing particularly on women from a BAME background and in areas of high deprivation **Further planned teams:** Snowdrop Team (Preterm birth- SBL recommendation, pending US support) – 43% Two further geographical teams focused on HU3/HU19 (BAME/deprivation) – 55% In addition, as the ambition shifts from 'booked on' to 'in receipt of' the high risk models needs to be adjusted to ensure women are in receipt of continuity of carer (in particular intrapartum & community care)

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28. Deliver the 'Better Birth' ambitions (page 2 of 2)

Exec Owner: Beverley Geary

<table>
<tr><th>Milestone</th><th>By when</th><th>Progress</th></tr>
<tr><td>All women to have access to digital personalised care plan</td><td>March 2021</td><td>Work on-going with is to develop personalised care plans and the local Humber Coast and Vale LMS are currently working with providers move towards a single IT system. A working group has been established in line with achieving the digital national ambition.</td></tr>
<tr><td>Prevention of Cerebral Palsy in pre-term infants
Avoiding Term Admissions to neonatal units
Reducing smoking (to 6% nationally)</td><td>Reducing stillbirths and morbidity by 2025</td><td>All midwives have undertaken ATAIN training, recent submission of ATAIN audit indicates decrease of term admissions. Mat Neo Collaborative project; 'Increasing the Proportion of Smoke-Free Homes' with the Primrose team. Update 08/20 Action plans updated to meet Mat Neo objectives, managed through the LMS and W&C HG

The National target for term admissions into a NNU per 1000 birth is < 5 % with the previous target aimed to reduce the number of term admissions into a NNU per total admissions by 20% by 2020. The table below demonstrates the reducing numbers of Term Admissions to HUTH neonatal unit.

<table><tr><th>Year</th><th>In born term admissions</th><th>% of Term admissions to NNU</th></tr><tr><td>2016</td><td>191</td><td>4.1%</td></tr><tr><td>2017</td><td>186</td><td>3.9%</td></tr><tr><td>2018</td><td>154</td><td>3.3%</td></tr><tr><td>2019</td><td>175</td><td>3.1%</td></tr><tr><td>2020</td><td>159</td><td>3.2%</td></tr></table></td></tr>
<tr><td>Improved safety systems and culture, working with the Local Maternity System</td><td>March 2021</td><td>HUTH actively contributes to the Y&H safety learning network.</td></tr>
<tr><td>Workforce development – agree STP wide recruitment strategy and training standards</td><td>March 2021</td><td>Scoping Maternity Support Worker roles B3 within the Humber Coast and Vale LMS.
Engagement with Hull University and NHS England to scope a midwifery expansion project addressing increase midwifery placements.
Potential for LMS wide recruitment process</td></tr>
</table>

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29. Centralise inpatient paediatrics and improve the NICU		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Agree plan for future configuration of paediatrics	Mar 2020	Plan agreed
Agree funding stream for plan	Mar 2021	Wave 4 capital bid approved
Agree plan for improvement of NICU	Mar 2020	Minor works completed. Awaiting outcome of the HASR Programme 2 work.
Complete implementation of plans	Mar 2022	

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30. Deliver the clinical access standards for cancer and electives

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Deliver Improvement in the 62 day Cancer performance to 85% (adjusted)	March 2020	This milestone was not achieved and has been further adversely impacted by Covid. Performance at end of Q1 was 67%. Improvement plans by Tumour site are in place and are monitored by the Performance and Activity Meetings and by the Humber Cancer Board.
Deliver 62 day cancer performance standard (unadjusted)	September 2021	See above
Reduce ASI / Holding by 50% from baseline position (31/3/19)	March 2020	The cessation of all routine OPD appointments during Covid resulted in the ASI and Holding increasing by 16,000 from the 31/1/20 baseline position. Plans to address the backlog are being developed as part of Phase 3 planning however the March 2021 target to eliminate ASI and Holding will not be achieved.
Eliminate ASI / Holding	March 2021	See above
Improve RTT performance to 84.5%	March 2020	RTT has been significantly impacted by Covid and at the end of Q1 RTT performance was 40.5% with 1886 patients waiting over 52 weeks for treatment. Recovery Plans are place as part of Phase 3 planning.
Reduce total waiting list volume by 3,000 from baseline 31/3/19)	March 2020	Stock take review at month 6 2019/20 has been conducted and reported to PAF 7th November. The Trust anticipates reducing its WLV in 19/20 but not by the stretch target of 3,000. The Trust reduced its WLV as at 31/1/20 against the baseline position and has continued to hold its WLV position through Q4 and Q1 20/21.
Improve RTT performance to 92%	December 2021	This is not expected to be achieved given the impact of Covid.

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31. Secure sustainable specialist paediatric service		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Agree an approach to the service review with NHSE Specialist Commissioners	Mar 2020	Discussions in progress with both the specialised commissioners and as part of the Humber Acute Services Review
Undertake review and agree recommendations	Mar 2021	Review paused as part of Covid 19 response, but now restarting under umbrella of HASR Programmes 1 and 2
Fully implement agreed revised service model	Mar 2022	

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32. Continue to improve our major trauma survival rates

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Maintain accuracy of TARN data collection, monitoring and outcomes. Structured judgement review completed for all reportable deaths for the past 12 months. 5 year strategy to increase Major Trauma Consultant presence	Annually June 2020 April 2024	Review and validate quarterly dashboards on coding accuracy and escalate actions through the Major Trauma Board. 1ST Mortality and Morbidity meeting held June 2020 now scheduled bi-monthly. Major trauma consultant presence increased from 5 to 10 hours Monday to Friday from October 6th 2020 New TARN team leader started in Trust 1 March 2021; data collection vacancies being recruited to Major Trauma Governance and M&M meetings now in place, including new governance process of "Major Trauma of the Month" presented by the treating clinician to share practice and learn lessons – shared with MT network and well welcomed
Maintain performance of 2018 baseline performance levels	Annually	2016 - 94.7% 2017 - 95.9% 2018 - 98.2% 2019 - 98.54% 2020 - 93.8%

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33. Improve timely access to acute and elective cardiac care

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Work with peripheral Trusts to ensure optimisation undertaken prior to transfer, reduce pre-op LOS	April 2020	Achieved. Work has been undertaken across the ICS by the Clinical Team to ensure that all patients are optimised prior to transfer to HUTH.
Revised referral form to confirm readiness for elective procedure and prevent delays in patient pathway	October 2019	Achieved. There is a criteria led referral form in place. Referral forms have to be fully completed and all test results reviewed and documented prior to patients being accepted.
Scope the benefit of implementing a Cardio-thoracic Surgical Admissions Ward	Sept 2019	The scoping for this facility has been undertaken. This would require an additional 6 beds but would improve LOS and efficiency and reduce cancellations.
Implement day of surgery admissions	October 2020	A protocol has been developed to enable day of surgery admissions, however this requires some beds to be ring-fenced and additional nursing hours. The service is developing a business case for the additional nurse staffing.
Introduce one stop clinic to include pre- assessment for thoracic patients to improve patient pathway and experience	Dec 2019	Achieved; This was Implemented in February 2020 however for temporarily suspended in March due to Covid and redeployment of staff. The One Stop Clinic is expected to recommence from October 2020.
Achieve timely access: Acute inpatients operated on within 7 days of being fit for surgery. Elective patient wait to under 30 week waits.	March 2021	During Q1 – all Acute Inpatients have been operated on within 7 days as the Service has been able to Implement a Consultant of the Week model during Covid. The service is currently looking at how it can Implement a Consultant of the Week Model on a permanent basis. Prior to Covid, the Trust had 22 patients over 30 weeks. This has increased as a result of Covid to 84 patients over 30 weeks. Of these patients have dates for their Surgery. The service is still operating a reduced theatre timetable and the duration of this was extended due to the third wave of the pandemic. A full theatre timetable will be restored as part of the recovery phase.

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34. Improve the cancer stage of presentation and survival rates

Exec Owner: Makani Purva

Milestone	By When	Progress
Supporting research programmes that focus on local and national issues for cancer stage of presentation.	On-going	The Trust supports and facilitates research undertaken with HYMS and UoH as part of £5m YCR funding. Recent example projects – 'Cancer Diagnosis via Emergency Presentation Study' (EMPRESS) and a range of patient reported outcomes surveys (PROMS) across multiple tumour sites. Work streams and new projects are likely to be delayed due to national mandate to pause non Urgent Public Health Research during Covid-19 pandemic. Restart activities commencing from August 2020.
Development of a research programme around PET CT and cyclotron facilities at CHH	On-going	Current work has focussed on non-cancer. Cancer research is likely to develop further in 2020-21. HUTH and HYMS Research Support Funding made available from September 2019 to provide seed money to support projects in PET-CT. Progress delayed with start up due to Covid-19 pause of non-urgent research activity.
Establish and maintain support for the Daisy Tumour Bank and collection of human samples to aid research in this area.	On-going	The bank is established in the Daisy Building at CHH with R&D Manager as liaison officer on behalf of the Trust. Review of future of Daisy Tumour Bank required by March 2021.
Support research programmes around tumour microenvironment (microfluidics).	On-going	The work of Professor John Greenman and colleagues in the University of Hull Daisy Laboratories has continued to expand with a focus on the utilisation of samples across colorectal, lung, head and neck, brain and thyroid cancers. Around 70 tumour samples have been used in various microfluidic devices and the work is part of that for 3 PhD students and 1 MD student. This work is also now expanding internationally following successful collaboration events in Chennai, India.

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35. Establish a mechanical thrombectomy service

Exec Owner: Ellen Ryabov

Milestone	By When	Progress
Develop a 9-5pm Monday-Friday mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2018	Current service is Monday-Friday 9-5pm and ad hoc dependant upon availability of skilled Neurointerventionists & Vascular Radiologists.
Develop a 24/7 mechanical thrombectomy business case, which supports clot retrieval within 6 hours of stroke symptoms onset.	2017-27	The Service continues to work towards this ambition however there is a national shortage of skilled clinicians to meet the NHSE ambition to deliver a 24/7 service by March 2021. This is being discussed via Regional and HCV Stroke Network meetings
Develop HASU & Stroke unit which will fully support mechanical thrombectomy. Providing the correct bed base for stroke services.	2018/19	HASU originally had 4 x speciality beds this has now moved to x 8, with a view to moving to x 12 as the tertiary service develops & expands. In April 2020 the HASU at Scarborough Hospital closed with patients now being received in HUTH. This has been accommodated within the current bed base however a business case is being developed to meet this additional demand in the longer term.
Staff & resource HASU & Stroke unit to fully support mechanical thrombectomy. Specialist staff required for supporting patients post mechanical thrombectomy.	2018/19	The service has some workforce challenges and has struggled to recruit to Consultant vacancies however continues to deliver the service outlined in the 2017 business case.
Monitor mechanical thrombectomy outcomes through the SSNAP data collection.	Ongoing	The service has continued to deliver the MT service during Covid and input full datasets for SSNAP over this period maintaining our current high standard of care

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36. Working with partners, support the progression of the HCAV HCP into an ICS		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Support STP team to complete the system 5 year plan	Dec 2019	Plan completed and submitted
ICS established in shadow form	Mar 2021	Full ICS status achieved from April 2020
ICS fully established	Mar 2022	

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37. Establish an ICP that can show measurable improvement to the health of its population		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Working with partners, establish a governance structure to develop the ICP	Oct 2019	ICP arrangements progressed well until March 2020, but now being reviewed in light of decision to create 'Humber' system
Support creation of ICP infrastructure and work programme	Mar 2020	Humber system governance agreed and programmes being transitioned into new set up
Support the development of ICP population health capability and agree improvement targets	Mar 2021	Holderness Primary Care Network is participating in the national support programme as a pilot for the ICS
Demonstrate improved population health in target areas	Mar 2024	

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38. Working with partners across the Humber region, secure safe and sustainable acute hospital services		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Agree with all partners the approach and method for the review of acute services	Jun 2019	Complete
Ensure effective participation and leadership from HUTH teams and reps	Mar 2020	In progress – excellent HUTH engagement in development of the options for Urgent and Emergency Care and Maternity and Paediatrics.
Ensure effective scrutiny, and review of all service proposals for alignment to both Trust and review goals	Mar 2020	In progress
Working with colleagues and partners, oversee timely and effective implementation of service changes.	Mar 2021	In progress, some delays due to Covid 19, however, Interim Clinical Plan for 11 most fragile services now agreed and service changes expected to be agreed and implemented within 12 months

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39. Support the work to create a sustainable clinical model for hospitals services in Scarborough		
Exec Owner: Michelle Kemp		
Milestone	By When	Progress
Ensure effective participation in the review by all relevant Trust teams	Mar 2020	Trust has a seat on the Steering Group for the Board
Represent HUTH on the review steering group and ensure active support for solutions and alignment to HUTH strategy	Mar 2020	Plan for sustainable oncology services agreed and implemented. Transfer of Hyper-acute stroke services to York, HUTH and South Tees Trusts agreed and implemented

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40. Establish mature programmes of workforce development and research with our international partners		
Exec Owner: Makani Purva		
Milestone	By When	Progress
Exchange programme for doctors in key specialities.	August 2019 - sustained on-going programme over the next few years	
Development of educational resources facilitated by an exchange programme of staff and resources.	May 2019 and on-going	Overseas simulation fellowship opportunities-to commence the first fellowship by May 2019 and follow up with others by May 2020 –on hold till Covid ends
Development of joint research opportunities and projects and Joint Research Conference.	December 2021	Sri Ramachandra Research Institute (Microfluidics, Infectious Disease, Geriatrics, Rehabilitation, Renal, Orthopaedics, Simulation research) – very successful collaborative research conference held in Chennai (India)February 2020. Reciprocal arrangements for a second conference held in Hull on hold due to Covid-19. Individual research collaborations to continue remotely (most advanced currently is Microfluidics).

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41. Support the university in securing UKCRC accreditation status for the Hull Health Trials Unit

Exec Owner: Makani Purva

Milestone	By When	Progress
Be an active and influential voice as part of the HHTU Advisory Board.	On-going	R&D Manager invited to review HHTU provisional accreditation application that was submitted in August 2019. Provisional Accreditation received by UKCRC in September 2019.
Provide access to Trust expertise and staffing (i.e. Quality Assurance Team) as a formal contribution to the HHTU core staffing infrastructure.	On-going	R&D QA support provided as part of development activities of HHTU including complex drug study setup. Trial Manager invited to spend some time in the Trust R&D QA Team. Continuous support provided as required.
Provide a clear pathway allowing efficient and easy access to the HHTU and UoH research methods support.	March 2019 and on-going.	Supported the HHTU and UoH ICAHR launch in March 2019: ICAHR R&D Manager supporting seminar events for researchers. Research Support Funding allocations (from Sept-19) made to multiple applicants who are utilising the money to engage in services from HHTU/ICAHR.
Maximise the exploitation of Hull Health Trials Unit facilities (i.e. outsourcing skills and expertise to external partners).	On-going	HUTH currently sponsoring multiple NIHR grants with delegated management to HHTU. Research Support Funding bids utilising HHTU expertise to further increase successful NIHR and other grant applications. Current research work on Alcohol Services linking up HUTH, HHTU and NLAG.

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42. Secure a 'top 20' national ranking for recruited to studies in the NIHR Clinical Research Network (CRN) portfolio

Exec Owner: Makani Purva

Milestone	By When	Progress
Ensuring equity of access to research for our patients - increasing the number of patients recruited into NIHR Portfolio studies.	March 2020 (Yr 1) March 2021 (Yr 2)	Yr 2: Nearly all non-Covid-19 research was paused in March 2020 (in line with national priorities). Target for 2020/21 is still 6,000 participants but focus from Y&H CRN in 2020/21 will be in ensuring equity of access to Covid-19 research rather than the pre-covid-19 performance metrics. Focus for remainder of the year is Covid-19 Vaccine Trials. A 'Hull City Region Vaccine Hub' is developing to support this work.
Embracing Y&H CRN systematic early review processes to encourage all clinicians to regularly look for opportunities to participate in research.	On-going from April 2019	Expression of interest monitored by Y&H CRN monthly. HUTH R&D to assess barriers and capacity issues. Pharmacy SLA signed to help unblock issues. On hold until August 2020 and will resume as part of the national NIHR 'research restart'.
Proactive and realistic feasibility and assessment of capability and capacity (C&C).	On-going from April 2019	All Covid -19 research prioritised and approved with a week of receipt of documents. Non-covid-19 work to resume fully from September 2020.
Maximising resource utilisation - improved flexibility and responsiveness in our agreed priority areas.	March 2021	Lead Research Nurse appointed. Additional Senior Research nurse to be appointed (Nov 2020). Review of priority areas required again in light of post-covid-19 landscape.

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43. Achieve all Department of Health and NIHR research performance metrics

Exec Owner: Makani Purva

Milestone	By When	Progress
Provide enhanced performance management data to research teams and Health Groups on all local and national metrics (NIHR High Level Objectives (HLOs)).	April 2019	Power BI research performance dashboards developed and available on Pattie. Dashboards will be refreshed and reviewed by March 2021.
Provide quarterly performance report for Trust Board.	July 2019 and quarterly thereafter	Executive summary info graphic available on Power BI (Pattie) by end of Oct. Plans to report to Trust Quality Committee and feed up to Trust Board – first report received by QC in June 2020.
Focus on Recruitment to Time and Target (RTT) metrics (80% compliance for commercial and non-commercial studies).	Achieve 12 month rolling target for closed studies by March 2020.	Commercial RTT = 100% (all 7 closed studies) Non-commercial RTT = 40% (3 of 8 studies closed). Metric for 2020-21 will be monitored but affected significantly by national pause of studies.

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44. Secure three new long-term commercial research partnerships

Exec Owner: Chris Long

Milestone	By When	Progress
Working with our university colleagues, identify potential partners that align to Trust Research and Innovation Strategy goals and undertake initial discussions	Mar 2020	Discussions delayed due to Covid 19, will recommence in Q1 2021/22
Set goals for shortlisted partnerships and broker arrangements	Mar 2021	Delayed by Covid and time taken to appoint new Dean. Q2 2021/22
Agreements in place with 3 new commercial research partners	Mar 2022	

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45. Secure 'top 5' national status with our Academic Oncology Research Unit

Exec Owner: Makani Purva

Milestone	By When	Progress
Consider Y&H CRN/ NIHR 'peer-review' of the Oncology/Haematology research unit infrastructure and delivery models.	June 2021	National pause of research activity will require a significant period of time to focus on the 'restart' of Oncology research. Proposed that review of position no later than June 2021.
Establish baseline position on NIHR KPIs for Oncology.	June 2021	Proposed that review of position no later than June 2021 in light of paused activities and redefining of priorities post Covid-19.
Define objectives to achieve KPIs for Oncology.	June 2021	Need to re-establish these post Covid-19. Focus is TYA and radiotherapy SABRE trials.
Establish commercial 'preferred site' status for Oncology/Haematology.	June 2021	This has slipped due to competing pressure for resources. Development of industry engagement document to be developed by June 2021.

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46. Working with partners, achieve financial balance across ICP

Exec Owner: Lee Bond

Milestone	By When	Progress
Deliver HUTH contribution to Hull and East Riding system financial plan for 2019/20	March 2020	Complete and achieved
Agree Hull and East Riding system plan for 2020/21 that eliminates recurrent deficits	April 2020	In progress but some uncertainty due to change in financial regime due to Covid 19. Further guidance awaited.
Deliver HUTH contribution to Hull and East Riding system financial plan for 2020/21	March 2021	See above
Working with NLAG, development and delivery of the financial plan to support the output of the Humber Acute Services Review	March 2021	In development
Working with York Trust, development and delivery of the financial impact of the Pathology collaboration	March 2021	Business case to Trust Board November 2020

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47. Improve the quality of our estate and increase the productivity per square metre

Exec Owner: Duncan Taylor

Milestone	By When	Progress
Delivery of Estates Rationalisation Programme Phase 2	Late 2019	Complete
Carter Metric - Non-clinical space <35% (under utilised space at 0%, Carter Metric 2.5%)	Late 2019 onwards	Achieved
Implement office accommodation strategy including flexible and agile working.	Summer 2019	Suite 36 and rationalisation of Staff Res/Admin Block at implementation stage. Refresh of office accommodation strategy progressing as a result of Covid 19, with significant increase in home working.
Upgrade vacant old cardiac theatres to robotic theatres	Dec 2019	Complete
Reprovide staff accommodation both sites	Late 2020/2021	Some junior doctor accommodation moved to university.

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48. Agree capital plans for renewal of the HRI site and delivery of our clinical service strategy

Exec Owner: Lee Bond

Milestone	By When	Progress
Complete and sign off the refresh of the Development Control Plan for HRI	Oct 2020	Agreed, but being deployed flexibly in response to capital availability. HRI artists impression complete
Complete and sign off the refresh of the Development Control Plan for CHH	March 2021	In development
Agree approach to business case(s) for capital funding	Oct 2021	ICS Major Capital Group established £60m capital secured for 2020/21
Achieve business case(s) approval and secure capital funding stream(s)	March 2023	

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49. Become greener by reducing our energy consumption and waste		
Exec Owner: Duncan Taylor		
Install new Combined Heat and Power system in HRI, reducing waste heat	March 2020	Complete
Replace HRI main boilers, increasing efficiency from 55% - >85%	March 2021	On track
Install new Combined Heat and Power system in CHH, reducing waste heat	June 2021	On track
Reduce Trust carbon consumption in line with UK government aim to achieve carbon neutrality by 2050	Year on year reduction	On track

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50. Become a digital first organisation; removing paper		
Exec Owner: Lee Bond		
Milestone	By When	Progress
Agree capital financing for the Trust Digital Strategy	Sept 2019	£5m secured (£10m joint with NLAG) for development of Lorenzo.
Agree plan for e-casenotes	March 2021	Use of paper case notes reducing. Plan for removal of paper record needed
Complete network upgrade	March 2021	Will complete main sites by end of 2020/21 with residual sites in 2021/22
Complete rollout of e-prescribing	March 2021 (CHH) March 2021 (HRI)	Will complete in 2021/22 following completion of the network upgrade
Complete rollout of e-observations	March 2022	Will complete in 2021/22 following completion of the network upgrade
Deploy e-casenotes solution	March 2023	See above

Strategy Implementation Scorecard 2019-24 progress report colour rating key

Colour Rating	Definition
	Delivered
	On track to be fully delivered by deadline
	Not currently on track but confidence in plans to recover and deliver by deadline
	Not on track and low or moderate risk to delivery by deadline
	Not on track and high risk to delivery by deadline

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

ENERGY AND DECARBONISATION BOARD
TRUST BOARD REPORT

1. PURPOSE OF PAPER

The purpose of this paper is to provide an update to the Trust board of the progress made to date with the delivery of the Combined Heat and Power (CHP) Unit installations at Hull Royal Infirmary (HRI), Sterile Services Unit (SSU) and Castle Hill Hospital (CHH) respectively and to provide an update on the £12.64M funding the Trust received for Decarbonisation from BEIS being administered by Salix. The Trust is also replacing its main Steam generating plant at HRI which will be covered further below. This report will cover the following:

- Combined Heat and Power Units and Onsite generation
- Boiler House Works HRI
- Public Sector Decarbonisation Schemes

2. COMBINED HEAT AND POWER AND ONSITE GENERATION

The Trust utilises and is planning to utilise Combined Heat and Power (CHP) units to provide the base power load for each respective site. Both our main sites have a base load of circa 1.5MWe which is equivalent to the market town of Pocklington. Combined Heat and Power (CHP) typically uses a single fuel to generate both electricity and heat which in the Trusts case is natural gas. This is different from traditional, power station-generated electricity, which uses gas, coal, oil or nuclear to generate heat, which produces steam to power the turbines that produce electricity. Typically, the heat produced in the process must be rejected, since power stations are usually located in rural locations without access to heat consumers. CHP is more efficient and cost-effective, since both heat and power can be utilised on any site that has a suitable heat load and heating infrastructure.

HULL ROYAL INFIRMARY (HRI)

At Hull Royal the Trust installed a 1.5MWe CHP in March 2020. The resultant waste heat is utilised for a steam raising waste heat boiler which contributes around 1000 kg/hr of steam to the trust network and 700kW of low grade waste heat ($90^{O}C$), this is currently utilised in H36/37/38 and within the main boiler house for a number of preheating applications. In late March the Trust will be installing a Control Phase Cycle (CPC) which essentially converts waste heat into additional electricity, this is particularly useful in the summer months when the heating load is lower and there typically, isn't the load which normally results in dumping the heat to atmosphere. The financial savings for the Trust operating a CHP on this site is circa £800K per annum as opposed to importing electric from the grid. This will further increase when the waste heat is fully utilised. There is an indirect carbon saving or scope 3 saving from not contributing emissions at a power station such as Drax but the technology still contributes significant carbon emissions.

STERILE SERVICES UNIT (SSU)

At SSU the Trust installed a 100kW CHP in February 2020 to support the site base load. Waste heat is utilised on this site in the Medical records department. The financial savings for the Trust operating a CHP on this site is circa £75K per annum as opposed to importing electric from the grid. This will further increase when the waste heat is fully utilised. There is an indirect carbon saving or scope 3 saving from not contributing emissions at a power station such as Drax but the technology still contributes significant carbon emissions.

CASTLE HILL HOSPITAL (CHH)

Orders have been placed for a 1.5MWe CHP, WHB, new HV supply point from County Road South, modular plant room and substation. Construction works begin in March 2021 and is anticipated to be complete in late summer 2021. Waste heat will be utilised in block 04/05 and the new Allam Digestive diseases building. The financial savings for the Trust operating a CHP on this site is circa £850K per annum as opposed to importing electric from the grid

FUTURE PROOFING

Whilst there is an indirect carbon saving to the Trust for adding to or contributing to emissions at a power station such as Drax, technology such as Combined heat and power unit being that they are gas driven still submit substantial carbon emissions.

In line with the future Trust Green agenda and Net zero 30 target the Trust will need to look to alternative fuel sources such as hydrogen for the CHP's. The alternative is to consider utilising more renewable technology such as PV arrays or Wind power some of which the Trust will be doing as part of the PSDS works. However, to generate the equivalent amount of electrical output from a PV array requires a significant area of land and battery storage for storing electrical power throughout the dark hours and winter period.

3. HULL ROYAL INFIRMARY STEAM GENERATING BOILERS

The main domestic hot water and heating for HRI is provided by the steam raising boiler plant in the main boiler house. The trust has a combined capacity to deliver 12MW of heat distributed by Steam across the HRI site to the main tower block, W&CH, Eye hospital and rear service buildings. The steam is generated by four boilers in a duty standby arrangement from boilers dating back to the original hospital construction in 1960. The Boilers are critical assets which are circa 50 years old, a typical lifespan for boilers is 25 years. As part of critical infrastructure funding from NHSI the boilers are being replaced from Feb –Apr with 14MW capacity of new steam raising boilers, flue installations and exterior cladding with a combined investment of £1.8M.

4. BEIS (SALIX) PSDS DECARBONISATION FUND

The Department for Business, Energy & Industrial Strategy (BEIS) released a £1 Billion grant funding pot for the delivery of decarbonisation schemes aimed at Public sector agencies decarbonising their respective estates in Oct 2021. The Trust submitted an initial Public Sector Decarbonisation Scheme (PSDS) grant funding application of £12.9M and subsequently a further bid for de-steaming the CHH site. The trust was awarded £12.64M in late Dec 2020 for its initial application. The funding came with a number of conditions with the major one being all schemes completed by Sep 21 and is administered by Salix on behalf of BEIS.

The Significant investment is a real positive for the Trust which will deliver financial savings of circa £1.4M which in comparison to CHP's is low considering the investment, however it is worth noting that some of the schemes increase the electrical consumption on site for example a heat pump reduces gas consumption but increases electrical consumption. The real saving is the amount of carbon that is reduced which is over 1000 tonnes per annum.

The PSDS schemes can also be considered as the pre-cursers to the enabling the Trust Green agenda being realised, the majority of the PSDS schemes are the short term energy reduction or carbon reduction schemes which form part of the Green agenda. The formal Green agenda is a spate policy which will be issued for approval in the new financial year.

The Trust will be delivering the following schemes over the next 8 months:

- 4MWe Photovoltaic Power Station on land adjacent to CHH, which in combination with an operational CHP will mean the Castle Hill site site is net zero for electrical consumption at all times, in the summer peak months the Trust will also be able to export offsetting some of its electrical demands at HRI.
- Replacement of all Fluorescent Lighting to LED lighting totalling over 20,000 light fittings in over 140 buildings on all four sites.
  - Replacement of 5 Medical Air compressor sets at CHH and HRI with energy saving air compressors. Typically, generation of compressed air is one of if not the most energy intensive and subsequently carbon emitting of all medial gas production.
  - Upgrade of various Building Management Systems (BMS) to Building Energy Management Systems (BEMS) with replacement of operating systems, smart technologies which allow buildings to be actively monitored and controlled, replacement of drives and pump systems.
  - Replacement of over 10 gas fired boilers with air source heat pumps to decarbonise the production of heating and hot water generation.
  - Additional building insulation in roofs and cavities in various buildings at HRI and CHH to improve the thermal efficiency of our building stocks.
  - Installation of free cooling to main air conditioning chillers at HRI and CHH which utilises additional fans to utilise ambient air conditions to generate more cooling capacity rather than using mechanically driven systems such as chillers.
  - Installation of a control phase cycle which convert waste heat from the HRI CHP predominately in the summer months when there typically isn't a demand into additional electricity.
  - Replacement of aged Calorifiers which provide demands for hot water and heating water in Block 04 Neurosurgery at Castle Hill Hospital with new plate heat Exchangers.
  - Additional funding for Metering to allow more monitoring and subsequent usage assessment of buildings
- New 7km long supply cable from County Road South to CHH to enable the Photovoltaic power station adjacent to Castle Hill to be electrically connected t the Northern Power Grid network and enable future onsite generation from CHP's or more Photovoltaic cells or wind turbines.

5. RISK

The following are currently the top risks associated with Energy and Decarbonisation works on both sites which all have mitigation plans in place:

- Access to all buildings for Lighting replacement, roof insulation.
- Planning consent for Photovoltaic power station.
- Availability of contractors and relevant technology such as heat pumps.
- Planning consent for Castle Hill CHP.
- Timescale for delivery of schemes which is currently September.

Alex Best
Head of Capital
3rd March 2021