Hull University Teaching Hospitals NHS Trust
Trust Board Meeting Held in Public
Tuesday 8th March 2022

Agenda

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

1	**Apologies and welcome**	verbal	Sean Lyons, Chairman
	Chair's Opening Remarks	verbal	Sean Lyons, Chairman
2	**Declarations of Interest**		
	2.1 Changes to Directors' interests since the last meeting	verbal	Sean Lyons, Chairman
	2.2 To consider any conflicts of interest arising from this agenda	verbal	Sean Lyons, Chairman
3	**Minutes of the previous meeting** held on Tuesday 9 November 2021	attached	Sean Lyons, Chairman
	3.1 Board Reporting Framework	attached	Rebecca Thompson, Head of Corporate Affairs
	3.2 Board Development Framework	attached	Rebecca Thompson, Head of Corporate Affairs
4	**Matters Arising**	attached	Sean Lyons - Chair
	4.1 Acton Tracker	attached	Rebecca Thompson, Head of Corporate Affairs
	4.2 Any Other Matters Arising	attached	Sean Lyons - Chair
5	**Patient Story**	verbal	Makani Purva, Chief Medical Officer
6	**Standing Orders and Governance**		
	6.1 CEO Report/Covid Update	attached	Chris Long, Chief Executive Officer
	6.1.1 Collaboration of Acute Providers Board update	attached	Chris Long, Chief Executive Officer
	6.2 Committees in Common Summary	attached	Sean Lyons, Chairman
	6.3 Standing Orders	attached	Rebecca Thompson, Head of Corporate Affairs
	6.4 Audit Committee Summary	attached	Tracey Christmas, Audit Chair

7	**Strategy**		
	7.1 Refreshed Trust Strategy 2022 – 25	attached	Michelle Cady, Director of Strategy and Planning
	7.2 Quality Strategy	attached	Suzanne Rostron, Director of Quality Governance
	7.3 Risk Management Strategy	attached	Suzanne Rostron, Director of Quality Governance
	7.4 Board Assurance Framework Q3 Update	attached	Rebecca Thompson, Head of Corporate Affairs
8	**Quality**		
	8.1 Integrated Performance Report including: 8.2 Quality Update	attached	Beverley Geary, Chief Nurse, Suzanne Rostron, Director of Quality Governance
	8.3 Minutes from the Quality Committee	verbal/attached	David Hughes, Chair of Quality Committee
	8.4 Hull University Covid Report	attached	Makani Purva, Chief Medical Officer
9	**Maternity Services**		
	9.1 Ockenden Report	attached	Beverley Geary, Chief Nurse
	9.2 Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme Year	attached	Beverley Geary, Chief Nurse
	9.3 Perinatal Mortality Review Tool	attached	Beverley Geary, Chief Nurse
	9.4 Midwifery Staffing Report	attached	Beverley Geary, Chief Nurse
10	**Performance**		
	10.1 Performance Update	attached	Ellen Ryabov, Chief Operating Officer
	10.2 Finance Update	attached	Lee Bond, Chief Financial Officer
	10.3 Minutes from the Performance and Finance Committee	attached	Mike Robson, Chair of Committee
11	**Workforce**		
	11.1 Workforce Update	attached	Simon Nearney, Director of Workforce and OD
	11.2 Minutes from the Workforce, Education and Culture Committee	attached	Una Macleod, Chair of Committee
	11.3 Freedom to Speak Up Guardian Report	attached	Fran Moverley, Head of Freedom to Speak Up

	11.4 Gender Pay Gap Report	attached	Simon Nearney, Director of Workforce and OD
12	**Questions from the public relating to today's agenda**	verbal	Sean Lyons, Chairman
13	**Chairman's summary of the meeting**	verbal	Sean Lyons, Chairman
14	**Any Other Business**	verbal	Sean Lyons, Chairman
15	**Date and time of the next meeting:** Tuesday 10 May 2022, 9am – 12pm		

Attendance 2021/22

Name	11/5	10/6	13/7	14/9	9/11	11/1	8/3	Total
Sean Lyons	-	-	-	-	-	Stood down		
T Moran	✓	✓	x	-	-	Stood down		2/3
S Hall	✓	✓	✓	✓	✓	Stood down		5/5
T Christmas	✓	✓	✓	x	✓	Stood down		4/5
T Curry	✓	✓	✓	✓	✓	Stood down		5/5
U MacLeod	✓	✓	✓	✓	✓	Stood down		5/5
M Robson	✓	✓	✓	✓	✓	Stood down		5/5
L Jackson	✓	x	x	✓	✓	Stood down		3/5
A Pathak	✓	x	✓	✓	✓	Stood down		4/5
David Hughes	-	-	-	-	-	Stood down		
C Long	✓	✓	✓	x	✓	Stood down		4/5
L Bond	✓	✓	✓	✓	✓	Stood down		5/5
M Purva	✓	x	✓	✓	✓	Stood down		4/5
B Geary	✓	✓	✓	✓	✓	Stood down		5/5
S Nearney	✓	✓	✓	✓	✓	Stood down		5/5
E Ryabov	✓	✓	✓	✓	✓	Stood down		5/5
M Cady	✓	x	✓	✓	✓	Stood down		4/5
S Rostron	✓	✓	✓	✓	✓	Stood down		5/5
R Thompson	✓	✓	✓	✓	✓	Stood down		5/5

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

Present:	Mr S Hall	Acting Chair
	Mr M Robson	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mr S Nearney	Director of Workforce and OD
	Mrs M Cady	Director of Strategy and Planning
	Mrs S Rostron	Director of Quality Governance
In Attendance:	Mr A Pickering	Chief Information Officer
	Mrs F Moverley	Head of Freedom to Speak Up
	Mr E Quider	Associate Director of Quality
	Mrs G Johnson	Director of Infection Prevention and Control
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies and welcome** Mr Hall welcomed all participants to the last Board meeting of the calendar year. There were no apologies received.	
2	**Declarations of Interest** **2.1 Changes to Directors' interests since the last meeting** There were no declarations received. **2.2 To consider any conflicts of interest arising from this agenda.** There were no conflicts of interest raised.	
3	**Minutes from the previous meeting** **3.1 Minutes of the meeting held 14 September 2021** Page 2 item 1.1 Mr Bond clarified that there had been well over 100 expressions of interest submitted. Page 7 HSMR report. Dr Purva clarified that this had been an internally commissioned report. Item 8.6 Mrs Geary advised that although fines could be possible for Trusts not achieving their CDifficile threshold this had not yet been determined. Mr Nearney clarified that the Trust had supported over 500 staff on the Apprenticeship programme, but presently there were 230 staff on the programme.	

Item 8.9 paragraph 6 – Dr Purva advised that the word ailments should be changed to symptoms.

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

3.2 Board Reporting Framework
Mrs Thompson presented the updated framework which included why reports were received at the Trust Board.

3.3 Board Development Framework
Mrs Thompson presented the Board Development Framework and advised that a minor changes had been made to ensure current matters were discussed.

4 Matters Arising
4.1 Action Tracker
There were no items to discuss on the Tracker.

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

5 Patient Story
Dr Purva presented a patient story of a lady who had suffered rapid blood loss during her C Section due to having Asherman's Syndrome and the lack of communication from clinical staff leading her to feel unsafe. The patient also spoke of a quick discharge being overwhelming.

The patient had contacted the Head of Midwifery, Lorraine Cooper who had provided a follow up package which the patient said was fantastic. She also commended Mrs Cooper as an amazing asset to the hospital. She added that the staff overall were exemplary and the quick decisions they made meant that she was alive today.

Dr Purva advised that a new Birth Afterthoughts clinic and guideline had been implemented and weekly case review meetings were being held to improve clinical management of births.

Mr Hall added that as the Maternity Safety Champion he was pleased to see the learning and actions being implemented since the incident.

6 Standing Orders and Governance
6.1 CEO Report and Covid Update
Mr Long advised that there were 45 patients with Covid in the hospital at the moment. This was impacting on Intensive Care and Cancer work in particular.

Mr Long expressed his concern around the lodged patients in ED waiting to be allocated a bed and the general flow through the hospital. He advised that partners were working to help but there were real challenges in the social care sector and this would get worse in the winter months. A review of the bed base was being carried out. Mr

Long added that he would be taking a shift with an Ambulance Crew to witness their challenges also.

He advised that staff were very tired and nurturing them was very important. Dr Pathak asked how the Trust was nurturing staff and Mr Long advised that demonstrating that they were valued, supported and removing obstacles to enable staff to deliver their job was key.

6.2 – Ambulance Handovers
Mr Ryabov presented the report which highlighted the Trust and partner action plan in response to the NHS E/I letter sent in October 2021.

Mrs Ryabov advised that the actions also aligned with the Emergency Care Intensive Support Team outcomes following their Missed Opportunities Audit. She added that the lack of Community Care and access to GP services meant that this was a system wide problem.

The Board discussed length of stay due to social care issues, crowding in the hospital and how access to alternative pathways rather than ED was key. Mrs Ryabov advised that at the moment there was no clear way out of the problem.

Mr Curry asked if the data was available to review how many community beds were required and Mr Long advised that the data was there but the Trust did not have the workforce or capacity to achieve the results.

Prof Macleod asked if the Trust could influence the social care pay terms and Mr Long advised that CEOs across the Humber Coast and Vale and the ICS were discussing this.

Mrs Rostron advised that from a quality perspective there had been no Serious Incidents declared as a result of the teams being under immense pressure and this was credit to them doing all they could to keep patients safe under challenging circumstances.

Mr Hall advised that the item would be monitored at the Performance and Finance Committee.

6.3 Committees in Common Summary
Mr Hall presented the summary and there were no issues raised.

6.4 Audit Committee Summary
Mrs Christmas presented the summary and advised that the Committee had received a reports detailing Single Source Waivers and had gained substantial assurance.

6.5 Standing Orders
Mrs Thompson presented the report which highlighted the use of the Trust's seal. Retrospective approval was required from the Board.

Resolved:
The Board approved the use of the Trust's seal.

6.6 Board Assurance Framework

Mrs Thompson presented the Quarter 2 Board Assurance Framework and advised that the document had been reviewed at each of the Board Committees and updated monthly following the discussions and reports.

She advised that the actions in Appendix 2 now had assurance ratings so that the Committees could review the risks of achieving the target end of year ratings.

Mrs Thompson stated that there were no proposals to change any of the risk ratings for Quarter 2.

Resolved:
The Board approved the risk ratings and noted the changes to the report.

7.1 Integrated Performance Report
Mrs Ryabov presented the performance section of the report and advised that the 4 hour performance continues to be a challenge. The region ratings show the Trust in the bottom 25% but compared with major trauma centres the Trust's performance is average.

There had been 5 12 hour trolley waits. One of the patients was waiting for a speciality bed and one waited for a mental health bed. The Trust had been commended on its patient safety by the ECIST.

Mrs Ryabov advised that the Trust had been given a target of having no patients waiting over 104 weeks by the end of March 2022.

Cancer had improved slightly and 52 week waits had seen significant improvement. Overall the waiting list volume had increased but one of the reasons was due to the transfer of patients from NLAG to Neurology.

7.2 Summary and minutes from the Performance and Finance Committee
Mr Robson presented the summary and advised that reasonable assurance was received as although the Trust was not meeting all of its targets there was a lot of work going on to mitigate the risks and keep patients safe. He added that the Committee had received good assurance for the Finance elements although the underlying deficit was challenging.

Mr Bond asked about 4 areas; stranded, super stranded, Advice and Guidance and Breast 2 week waits.

Mrs Ryabov advised that length of stay and more complex delays was impacting on the stranded and super stranded indicators. There had been more virtual and telephone follow ups which had impacted on the Advice and Guidance indicator and Breast 2 week wait was improving but the number of patients was very large.

7.2.1 Finance Report
Mr Bond presented the report and advised that the Trust was reporting a deficit of £1.7m which was in line with plan.

There were a number of pressure points including medical workforce issues in Clinical Support, the Continuity of Care programme and outsourcing of support services in gastroenterology.

The efficiency programme was still challenging.

Mr Bond advised that the underlying financial position was being challenged further by the agreement to support the recruitment of Obstetric consultants that would cost £400k and was not supported by any income arrangement.

The new H2 framework was now in place and the Trust was working with its Humber Partners to achieve the 95% recovery target. The Humber ICS had been awarded £20 and work was ongoing to ensure it was utilised effectively.

Capital
The Trust had spent £23m of the planned £27m so far and it was hoped that the new ICU and Elderly Assessment units would be completed by the end of November. The new Diabetes Centre was also due to be completed by the end of December. Work had slipped slightly on the main entrance due to supply issues.

Mr Bond advised that the Trust had plenty of cash and was paying its bills on time.

Dr Pathak asked if any money had been saved during Covid by the reduction in elective work and Mr Bond advised that the Trust's cost base was of a fixed nature and the wards remained even during Covid. He added that nursing staff were moved to support other services so little savings were made.

Work was ongoing to understand the recurrent impact of the Covid funding being removed.

Resolved:
The Board received and accepted the reports, summaries and minutes from the Performance and Finance Committee.

7.3.1 Summary and minutes of the Quality Committee
Mr Hall presented the summary and minutes. Mrs Rostron highlighted the Cardiology Report and disagreed that the assurance should be limited. She advised that much work and improvements had been implemented so felt that the assurance should be reasonable rather than limited. The Board agreed that this should be the case.

Mr Hall added that following the mortuary issues currently in the media had resulted in a comprehensive report providing substantial compliance and assurance to the Committee.

7.3.1 Quality Report
Mrs Geary reported that there had been 2 Never Events reported in September one had resulted in no harm and the other in moderate

harm. Both of these investigations would be scrutinised at the Serious Incident Committee.

Mrs Geary advised that the Quality Delivery Group had received a presentation from the ED team highlighting their risks of overcrowding, ambulance handovers and lodged patients. They had also presented their mitigating actions and good assurance was received.

There was work ongoing to address the mental health patient issues.

Mrs Geary advised that there had been good results back from the Friends and Family tests and 70% of patients in ED would recommend the Trust. Staff were under extreme pressure so these results were to be congratulated.

7.3.2 IPC BAF Report
Mrs Geary presented the IPC BAF which now included the improvement work carried out during the Summer.

There were 3 red rated goals and Mrs Geary advised that some could easily be addressed but others, such as ventilation would be more difficult. A Task and Finish Group had been established and a good overview of the risks was now in place.

Mr Bond asked why triage at the front door was red as this was now happening and Mrs Johnson advised that the key questions determining contact history were being reviewed.

IPC - 6 month update report
Mrs Johnson presented the report and advised that there had been limited MRSA cases and although there was no threshold for MSSA infections the Trust had a locally agreed threshold.

The Cdifficile threshold had been reduced to 53 and work was ongoing with partners to ensure everything was being done to avoid any cases.

There was a steady increase in ground negative blood stream infections and the IPC team were reviewing cases. Some of the cases were unavoidable and linked to sepsis.

There had been no Norovirus outbreaks so far and the Covid surge during the summer had now reduced. Cases had increased in the 15-25 year olds who were socialising more and it was thought that during the winter months cases would increase further.

Resolved:
The Board received and accepted the Quality reports and summary documents.

7.4 Summary and minutes from Workforce, Education and Culture Committee
Prof. Macleod presented the summary and minutes. There were no issues raised.

7.4.1 Workforce Report

Mr Nearney presented the report and advised that there were currently 145 staff off work due to Covid or self-isolation. The majority of these staff would only be off for a few days as they could return to work following a negative PCR test.

Staff absence was overall at 3.9% and staff vacancies were reducing and at 3.3% currently.

57% of staff had received their Covid booster and 52% of staff had received the flu vaccination. There was an issue with the supply of flu vaccinations but the programme would carry on once received.

The Staff Survey has a completion rate of 36% and the closing date was 26 November 2021. The results would be published late January.

Resolved:
The Board received and accepted the workforce reports.

Board Reports
8.1 Freedom to Speak Up Report
Mrs Moverley presented the quarter 2 summary and advised that the number of cases were increasing and would be higher again for quarter 3.

She advised that there were no over-riding themes but poor working relationships featured in some cases.

Mrs Moverley advised that she was attending HR meetings, staff networks and doctor training sessions to raise the profile of the guardian role. She was also working with Primary Care regarding anti-racism. Updates on Pattie were also raising the profile of the role. Mrs Christmas was liaising with Mrs Moverley as the NED champion for speaking up.

Resolved:
The Board received and accepted the update.

8.2 Digital Strategy Report
Mr Pickering attended the Board and presented the Digital Strategy update.

He reported that the strategy was aligned with the changes due to the Integrated Care System and post-covid responses and recovery.

Work was ongoing with partners to ensure that patient record systems were compatible, the Humber Acute Services were supported and there was a focus on Patients Knows Best and the different pathways available. The Digital Team had supported remote consultations during the pandemic and Community diagnostics support.

The Strategy supported more resilient staff systems, faster and more secure systems, simpler interfaces, easy collection and sharing of data as well as supporting mobile and flexible working.

Future plans included; supporting ED, NLAG collaborations, the Humber Acute Services and the capital investment in Phase 3. All future plans will be aligned with the Integrated Care System.

Mr Hall stated that the digital progress was one of the Trust's top 3 enablers and change should be transformational.

Resolved:
The Trust Board received and accepted the update.

8.3 Responsible Officer Report
Dr Purva presented the report as the Trust's Responsible Officer. She advised that appraisals had been suspended last year due to the pandemic but had resumed in April 2021 and the Trust was on course to complete them. Dr Purva commended Oliver Miskin on his work to ensure compliance.

Dr Purva advised that she was appointing a Super Appraiser to ensure appraisals were taking place during the pressurised winter months.

Resolved:
The Board received and accepted the report.

8.4 Cardiology Report
Dr Purva presented the report and advised that a review was instigated in August 2020 following concerns raised by the Freedom to Speak Up Guardian at the time. The Royal College terms of reference included a review of clinical cases, service design and a cultural review.

The final report was received by the Trust in August 2021 and no patient safety concerns had been raised. An action plan was developed and the changes are being implemented. The amount of work that has been carried out is significant and the service has been deemed safe and fit for purpose.

Dr Purva advised that there has been as change in the leadership team and there was now a joint with NLAG Associate Medical Director in place as well as 2 new clinical leads being appointed.

Government arrangements had been strengthened and incident management improved. A service strategy has been developed.

The cultural issues have been addressed and trainees have suggested the working environment is much better.

There is to be a Cardiology presence on the HRI site and this will operate Monday – Friday. A new echo machine is in place to provide cardiology input when required.

Prof Macloed advised that a detailed discussion had been undertaken at the Quality Committee and she commended Dr Purva for initiating the review. She added that the discussion around the actions was reassuring.

Dr Pathak asked what happened on a weekend at HRI as cover was only Monday to Friday. Dr Purva advised that out of hours cover would be provided on the weekend.

Mr Long stated that the behaviours of a small number of consultants was disappointing but the actions since the review were encouraging.

Mr Hall stated that he was due to visit the service to see the changes and that he would be interviewing a number of staff to get their views since the review.

Resolved:
The Board received and accepted the report.

8.5 EPRR Annual Report
Mrs Cady presented the Annual Report which included a statement of assurance.

The report gave an overview of the EPRR function and much work had been carried out updating key plans and ensuring training was in place.

Mrs Cady added that the next steps were to ensure that EPRR was aligned with the ICS for future developments.

Mr Hall thanked the team and commended the amount of work and testing evidence that had been done.

8.6 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme
Mrs Geary presented the report and advised that work was ongoing to achieve all of the standards including investment in obstetrics, releasing staff to complete training and the new Continuity of Care programme.

The risks moving from LMS to HCAV were being worked through with the ICS. The Ockenden report was due before December with increasingly challenging actions for Trusts.

Mr Hall stated that the Board could take assurance from the scrutiny the report was given in the Quality Committee.

8.7 Perinatal Mortality Review Tool
Mrs Geary presented the report and advised that the Trust was meeting all of the standards. The Trust reviews 73% of all deaths which is above the target. This report is regularly scrutinised at the Quality Committee.

8.8 Research and Innovation Update
The Research and Innovation update was received for information.

9 Questions from the public relating to today's agenda
There were no questions received.

10 Chairman's summary of the meeting

Mr Hall stated that the Trust was working towards maintaining recovery progress, refocussing ED and working with ambulance partners to improve turnaround times.

He thanked staff for their hard work and asked that the support systems continued.

11 Any Other Business

There was no other business discussed.

12 Date and time of the next meeting:

Tuesday 11 January 2021, 9am – 12pm

Item	Sponsor	Lead	Jan	Mar	May	EO June	Jul	Sept	Nov	Fequency	Purpose of the report	Considered by another Committee	Why is this report required to go to Trust Board	Action
Opening Items														
Declarations of Interest	Chair	Chair	✓	✓	✓	✓	✓	✓	✓	Every Board Meeting	To declare any interests the Board may have	No	Statutory	Nothing
Minutes of the last meeting	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure an accurate record of the meeting is kept	No	Statutory	Nothing
Action Tracker	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure actions are completed	No	Statutory	Nothing
Trust Board work programme	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure all statutory items are received	No	Statutory	Nothing
Trust Board Development Framework	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To aprise the Board of future Development sessions	No	Statutory	Nothing
Chief Executive Briefing	Chief Executive	Chief Executive	✓	✓	✓		✓	✓	✓	Every Board Meeting	To update Board members on Trustwide matters	No	The report covers a wider remit of what is happening around the Trust and the wider health economy	Nothing
Regulatory, Compliance and Corporate Governance														
Board Assurance Framework and Corporate Risk Register	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Three times per year	To receive assurance in relation to the management and mitigation of the risks as approapriate and that the BAF remains reflective of the current risks to the achievement of the strategic objectives	Quality/Workforce, Education and Culture/Performance and Finance on a quarterly basis		
Trust Annual Report including Annual Governance Statement and Quality Accounts	Director of Quality Governance	Head of Corporate Affairs				✓				Annually	To seek approval of the Annual Report	Audit Committee	The Trust is required to publish an Annual Report	Approval
Trust Annual Accounts including Going Concern Review and Audit Letter	Chief Financial Officer	Deputy Director of Finance				✓				Annually	To adopt the Annual Accounts	Audit Committee	The Trust is required to adopt and publish the Annual Accounts	Approval
Audit Committee Annual Report	Audit Chair	Head of Corporate Affairs			✓					Annually	To provide assurance to the Trust Board tha the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Audit Committee	In line with the requirements of the Audit Committee Handbook and contributes to the Annual Governance Statement	Approval
Audit Committee summary and minutes	Director of Quality Governance	Head of Corporate Affairs		✓	✓			✓	✓	4 times per year	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Standing Orders	Director of Quality Governance	Head of Corporate Affairs					✓			Every Board Meeting	The report sets out the usage of the common seal of the Trust during the year and is provided for noting	No	Affixation is governed by the Trust's Standing Orders which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board	Noting
Care Quality Commission Registration Report	Director of Quality Governance	Head of Effectiveness and Improvement						✓		Annually	To provide and update on the Trusts current CQC Registration status and outline changes proposed to the system of statutory regulation	Executive Team Meeting	Compliance with the proposed fundamental standards of safety and quality	Assurance
Code of Business Conduct	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To seek commitment from the Trust Board on an individual and collective basis to comply with the provision of the Code of Conduct and Statement of Responsibilities for the Board of Directors	No	The document demonstrates the Trust's commitment to embedding world class governance and compliance with statutory requirements	Approval
Forward Work Programme	Director of Quality Governance	Head of Corporate Affairs		✓						Annually	To review and support the annual programme of work	No	To approve the annual programme of work	Approval

Timetable of Board and Committee Meetings	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To approve the annual timetable of Board and Committee meetings for the year ahead	No	As part of the overall governance structure for the organisation	Approval
EPRR Self-Assessment Assurance and Annual Report	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To identify the current status of EPRR within the Trust and present the workplan to ensure full compliance within the year	Emergency Planning Steering Group	It is a requirement that the report received executive support and is approved by the Trust Board	Approval
Health and Safety Annual Report and work programme	Director of Quality Governance	Head of Health and Safety			✓					Annually	To provide assurance given the overall responsibility of the Trust Board for Health and Safety and the potential individual and corporate consequences of health and safety breaches	Health and Safety Committee	The Trust Board has overall responsibiity for Health and Safety	Approval
Information Governance Toolkit Submission	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	For the Trust Board to approve the annual submission of the Information Governance Toolkit	IG Committee	IG is a key component of the Trust's governance framework	Approval
Register of Gifts and Interests Annual Update	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	To present the register of interests and gifts and hospitality to the Board for approval	Audit Committee	The Trust is required to hold and maintain a register of Interests and a register of gifts and hospitality for public inspection	Approval
Freedom to Speak Up	Director of Quality Governance	Head of Freedom to Speak Up	✓				✓			Twice per year	To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG	Workforce, Education and Culture Committee	Expectation for all Boards to have a FTSUG following the Francis report.	Assurance
Trust Self-Certification	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To receive assurance	No	To receive assurance	Assurance
Fit and Proper Persons Test	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards	No	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5	Assurance
Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Director of Quality Governance	Head of Corporate Affairs					✓			Annually	To present proposed amendments to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Audit Committee	The document is the Trust's core corporate governance and describes how the Trust Board will conduct its business	Approval
Statement of Elimination of Mixed Sex Accommodation	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that there have been no MSA breaches	No	To provide assurance to the Board	Assurance
Patient Experience														
Patient Experience Quarterly Report	Chief Nurse	Assistant Chief Nurse	✓		✓		✓		✓	Quarterly	To highlight compliments, complaints, PALs, patient feedback and involvement	Patient Experience	Ensures the Trust Board has oversight of good practice and improvement areas	Assurance
Safeguarding Children and Vulnerable Adults Report	Chief Nurse	Assistant Chief Nurse						✓		Twice per year	To update the Board on Safeguarding activity, issues and risks	Safeguarding	To provide assurance to the Board	Assurance
National Patient Survey	Chief Nurse	Assistant Chief Nurse								Annually	To update the Board of patients views of healthcare experiences	Patient Experience	To provide assurance to the Board	Assurance
Patient Story	Chief Medical Officer	Chief Medical Officer	✓	✓	✓		✓	✓	✓	Every Board Meeting	To highlight patient experience from the patient	No	To align the Trust's values and behaviours	Nothing
Performance														
Integrated Performance Report	Director of Quality Governance	All	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Quality/Workforce, Education and Culture/Performance and Finance on a monthly basis	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Performance Report	Chief Operating Officer	AD of Operations	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Peformance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance

Finance Report	Chief Financial Officer	Deputy Director of Finance	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Peformance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Covid-19 Recovery Report	Director of Strategy and Planning	AD Strategy and Planning	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on Covid-19 recovery plans	No	To update the Board regarding Covid-19 planning and activity	Assurance
Summary and minutes from the Performance and Finance Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Peformance and Finance Committee	As part of overall governance of the Trust	Assurance
Quality														
Quality Report	Chief Nurse/Chief Medical Officer/Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key quality indicators	Quality Committee	The Trust has an obligation to meet operational, financial and contractual targets, including SI s and Never Events	Assurance
Summary and minutes from the Quality Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Quality Committee	As part of overall governance of the Trust	Assurance
Infection Prevention and Control Annual Report and workplan	Chief Nurse	Director of Infection Prevention and Control					✓			Annually	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Infection Reduction Committee	To provide assurance to the Board	Assurance
Medical Revalidation and Appraisal Update	Chief Medical Officer	Senior E-Medical Workforce Officer						✓		Annually	Provides an update on Medical Appraisal and Revalidation within the Trust		Statutory obligation	Assurance
Mortality (SHMI and HSMR) update	Chief Medical Officer	Associate Chief Medical Officer			✓			✓		Twice per year	To monitor the Trust's mortality performance	Mortality and Morbidity Committee/Quality Committee	National Requirement to report mortality to the Trust Board	Assurance
End of Life Care Annual Report	Chief Nurse						✓			Annually	To update the Board on End of Life Care	End of Life Committee	To provide assurance around progress	Assurance
Complaints Annual Report	Chief Nurse	Assistant Chief Nurse						✓		Annually	To provide assurance on key work undertaken by the Patient Experience Team around the management of complaints	Quality Committee	To provide the Board with oversight of the Complaints	Assurance
Cancer Services Annual Report	Chief Operating Officer	Cancer Manager							✓	Annually	To provide assurance of the actions that have been taken to demonstrate improved performance against delivery of the cancer standards to improve patient outcomes and provide a positive experience	Cancer Board	To provide assurance regarding Cancer Services and performance	Assurance
Midwife Staffing Annual Report	Chief Nurse	Head of Midwifery					✓			Annually	To advise the board of the work undertaken over the year and measures in place to ensure safe midwifery staffing	Quality Committee	To provide assurance to the Board that measures are in place to ensure safe staffing for midwifery	Assurance
Guardian of Safe Working Annual Report	Chief Medical Officer	Guardian of Safe Working					✓			Annually	To demonstrate the work carried out to manage safe working hours for doctors	Workforce, Education and Culture Committee	To provide assurance around safe working compliance	Assurance
Summary and minutes from the Ethics Committee	Chair of Committee	Head of Corporate Affairs								If the Committee meets	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Workforce														
Staff Overview Report (Including Nurse Staffing)	Director of Workforce and OD	Deputy Chief Nurse	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key workforce indicators	No	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Summary and minutes from the Workforce, Education and Culture Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Equality and Diversity Annual Report	Director of Workforce and OD	Head of HR					✓	✓		Annually	To inform the Board of the work of Equality and Diversity throughout the Trust	Workforce, Education and Culture Committee	Equality Act 2010 - progress against eliminating discrimination	Assurance
Staff Survey	Director of Workforce and OD	Director of Communications								Annually	To inform the Board of the Staff Survey results	Workforce, Education and Culture Committee		Assurance

Modern Slavery Statement	Director of Workforce and OD	Head of HR						✓		Annually	The Board to approve the Modern Slavery Statement for publication on the Trust's website	Workforce, Education and Culture Committee	As part of overall governance of the Trust	Assurance
Workforce Disability Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WDES reporting template	Workforce, Education and Culture Committee	To ensure disabled staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance
Workforce Race Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WRES reporting template	Workforce, Education and Culture Committee	To ensure BAME staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance
Strategy and Planning														
Trust Strategy	Director of Strategy and Planning	AD of Strategy and Planning												
Update Digital Strategy	Chief Financial Officer	Director of IM&T			✓					Annually	To provide and update to the Board regarding improvements within the IM&T infrastructure	Non-Clinical Quality Committee	Efficient IT infrastructure is critical to delivereing high quality clinical care, patient safety and experience and staff acces to essential information	Assurance
Operating Framework - Performance and Finance	Director of Strategy and Planning	AD of Strategy and Planning		✓						Annually	To approve the strategy and updates	Performance and Finance	The framework sets out the Trust's performance and finance targets	None
Capital Planning	Chief Financial Officer	Deputy Director of Finance		✓						Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual capital plan	Approval
Winter Planning	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual winter plan	Approval
Equality, Diversity and Inclusion Strategy	Director of Workforce and OD	Head of HR						✓		Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates the Trust's commitment to Equality, Diversity and Inclusion	Approval
People Strategy	Director of Workforce and OD	Head of HR					✓			Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates investment in the workforce, through training and development to improve the quality of leaders	Approval
Estates Strategy	Director of Estates and Facilities	Director of Estates and Facilities					✓			Annually	To approve the strategy and updates	Performance and Finance Committee	The Strategy sets out the Trust plans for the estates, facilities and IM&T services	Approval
Clinical Strategy	ICS	Director of Strategy and Planning								Annually	To approve the strategy and updates	Quality Committee	The Clinical Strategy articulates the organisational vision and aims and the desired model of delivery of healthcare	Approval
Quality Strategy	Director of Quality Governance	Associate Director of Quality	✓							Annually	To approve the strategy and updates	Quality Committee	The Quality Strategy sets out the Quality Improvements to ensure high quality care for patients	Approval
Risk Management Strategy	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To approve the strategy and updates	Operational Risk and Compliance	The Risk Strategy sets out the Risk Management Improvements to ensure risk management is embedded across the organisation	Approval
Research and Innovation														

Research and Innovation Strategy	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To approve the strategy and updates	Quality Committee	The Research and Innovation strategy sets out how the service will increase research activities, attract talent, integrate with clinical care and increase collaboration with partners	Approval
Research and Innovation Annual Report	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To provide annual assurance to the Board of the work carried out relating to Research and Innovation	Quality Committee	To inform the Board of the work carried out by the Research and Innovation Team	Assurance

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

Overarching aims:

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

Board Development Dates 2021/22	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and integrated services	Research and innovation	Financial sustainability	Other
10 August 2021							BAF 6: Research and Innovation		Board Well-Led self-assessment Making data count training
12 October 2021		BAF 1: Board Leadership/ Leadership and culture				BAF 5: Risk that the HCAV and Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid recovery			CQC – Quality Risk Profile
14 December 2021	Strategic drivers/balanced scorecard review			BAF 3.1: Risk that the Trust is not able to make progress in continuously improving quality					Patient Safety
8 February 2022					BAF 4: Risks to recovery plan			BAF 7: Financial Sustainability	IPC End of Life Care
12 April 2022	Trust Strategy Update								Board Assurance Framework

Principles for the Board Development Framework

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

Overarching aim:

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

Area 1 – High Performing Board

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

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

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

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

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

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

Area 2 – Strategy Development
Strategy refresh commenced

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

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (March 2022)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
November 2021						
COMPLETED						

Actions referred to other Committees

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

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	Chief Executive Report				
Lead Director	Chris Long – Chief Executive Officer				
Author	Chris Long – Chief Executive Officer				
Report previously considered by (date)	This report is presented at the Board meetings				

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

Key Recommendations to be considered:

Key issues:
Allam building opens,
visitor restrictions lifted,
Omicron vaccine trial
Halcyon Linac

Recommendation:
The Board is asked to note significant news items for the Trust and media performance.

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 9 NOVEMBER 2021

1. Key messages from January/February 2022

COMPASSIONATE CARE

State-of-the-art Allam Building Opens to Patients

The new Allam Diabetes Centre is the latest building to open on the Hull Royal Infirmary site and has been generously supported by local businessman and philanthropist, Dr Assem Allam, with a donation of £3m. The balance has been provided by the trust, with the overall cost of the building development amounting to some £7.5 million.

This new centre of excellence is serving as a hub to treat more than 9,000 people every year for diabetes and metabolic bone diseases such as osteoporosis. In addition, it is providing a significantly expanded range of accommodation for world-class diabetes and endocrinology research and other research teams.

On the ground floor there is a large open waiting area leading to clinical facilities for all of the trust's diabetes and endocrinology outpatient services. Expanded diabetic eye screening facilities are now housed here and there is dedicated space for diabetic foot care.

The entire first floor has been given over to diabetes and endocrinology research and the staff supporting this work. Their cutting-edge research facilities now include dedicated laboratories, a sports science laboratory, ultrasound, ECG and consulting rooms plus day case facilities for complex clinical trials. The team currently has over 200 people involved in 12 active clinical trials right now, the findings of which will go on to benefit people with long-term conditions by significantly advancing treatment options and medical knowledge.

Patient education sessions are already being delivered on the second floor, and further research teams, including those specialising in vascular surgery and neurology, are due to move in there over the next few weeks.

The bone densitometry service, which helps to identify and manage bone conditions such as osteoporosis and which regularly performs in excess of 5,000 bone scans each year, also has a base here. This service has been on the receiving end of another generous donation from the Osprey Charity recently, having been gifted a further two bone scanners valued at £75,000 each to expand its diagnostic capacity.

We are incredibly grateful to Dr Allam and his family for their continued generosity in supporting our hospitals, our patients and our wider city.

Radiotherapy First Team In The Country To Secure Accreditation For Patient Care

The radiotherapy department at Hull University Teaching Hospitals (HUTH) has received national accreditation for its work using CT imaging to target cancer cells with radiation.

Based at the Queen's Centre at Castle Hill Hospital, the team is the first radiotherapy service to be awarded BS70000:2017 (MPACE) accreditation for its CT localisation process, the beginning of radiotherapy planning which is a specialist treatment minimising damage to healthy tissue and organs in patients with cancer.

Radiotherapy had to meet exacting challenges in technical competence to prove the treatment was "fit for purpose" when a Therapeutic Radiographer, acting as a technical

assessor, and a lay assessor, considering the service from a patient's perspective, carried out the audit in July.

Staff were praised for being welcoming, open, honest and professional during the audit as they provided evidence and explained why processes were designed in specific ways.

Many congratulations to the team for this achievement.

3D Tour of New ICU Now Available

A 3D tour of our new £8m Intensive Care Unit (ICU) has been created to give people a chance to see some of the best critical care facilities in the country.

We opened our new 24-bed unit at Hull Royal Infirmary, just before Christmas.

Critically ill and injured patients from across Yorkshire and Northern Lincolnshire can be brought to the unit for life-saving treatment as part of the trust's role as a major trauma centre for the area.

Now, the virtual tour has been produced for the trust's Capital Development team to support families and patients and to assist in the training and recruitment of staff to the department.

The 3D tour allows viewers to explore some of the three-storey unit, next to Hull Royal Infirmary's Emergency Department. They can take a look inside one of the 12 glass-fronted cubicles where patients receive specialist one-to-one care from the highly skilled and dedicated clinical team.

The tour enables people to "walk along" corridors, taking in views of the central observation area for staff, the donning and doffing lobbies used by staff caring for patients with Covid-19 and other infectious diseases and the "quiet room" for relatives of patients.

Visiting Restrictions Lifted

Visiting restrictions have been eased in our hospitals next week as the number of people infected with Covid-19 continues to fall.

Visiting slots of up to one hour must be booked in advance with the ward sister or charge nurse and the visitor must be the same person for the duration of the patient's stay in hospital.

The named visitor must also carry out a lateral flow test to prevent people with the virus coming to hospital and spreading the potentially deadly virus to already sick and injured patients. Visiting arrangements for children's wards, Intensive Care Units and maternity services remain unchanged and people attending the trust's Emergency Department must come on their own.

RESEARCH, DEVELOPMENT AND INNOVATION

Omicron Vaccine trial

Our hospitals have been selected to take part in a new vaccine trial targeting the Omicron variant of Covid-19.

Around 150 staff working at Hull Royal Infirmary and Castle Hill Hospital and members of the public who are in good health and over the age of 16 are being asked to volunteer for the trial. It will help answer questions around fourth doses of vaccines, in particular do they need to be adapted to Omicron or if the original vaccines give good responses still.

As part of the mRNA-1273-P305 clinical trial, participants will be given one injection in the upper arm, receiving either the investigational booster vaccine, mRNA-1273.529, or the already authorized booster, Spikevax.

Researchers will measure the immune response to the investigational vaccine by collecting blood samples, testing them for antibodies to understand if the investigational vaccine is working.

Hull's Infectious Diseases team, who identified and treated the first patients confirmed with the virus at Castle Hill Hospital in January 2020, have participated in a serious of ground-breaking trials to protect people against Covid-19. The trust played a major part in the development of the Oxford Astra Zeneca vaccine in the first year of the pandemic, when one in every 45 participants was recruited by the Hull team. They are currently involved in a trial to understand the effects of receiving different forms of the vaccine.

ZERO30

#WearTheBear
Staff from across our trust who have pledged to cut their environmental impact are being invited to #WearTheBear

We recently published our Zero30 strategy and Green Plan, ambitious documents designed to support the Trust's aim to become carbon neutral by 2030 – a full 15 years ahead of targets set by the Department of Health.

At the same time, hospital staff have been invited to share their own ideas and examples of steps they have taken to cut their personal carbon emissions or promote sustainability, either at home or at work.

Scores of staff have already made a pledge and are now receiving specially designed Bear badges, made of sustainable bamboo, to wear as an outward show of their commitment.

Pledges already made by staff include more frequent use of public transport, using the correct waste streams at work, and supporting the roll-out of digital nursing within the hospitals, which in turn reduces the need for paper and cross-site travel.

Halcyon Linac Helping with our Zero30 Ambitions
A team of health scientists at Castle Hill Hospital is showing that better care for cancer patients doesn't have to cost the earth.

The routine replacement of a linear accelerator (linac) last year, used in radiotherapy treatment for cancer patients, with a new Varian Halcyon generated more than just improvements in throughput. The Radiotherapy Physics Team, based at the Queen's Centre, found that not only were the therapeutic radiographers able to treat around 20% more patients each month, but that power consumption in Bunker 4, where the Halcyon is now sited, dropped by 70 per cent.

Energy consumption in Bunker 4, dropped from 4,500kWh per month to just 1,200kWh, which equates to quarterly cost savings of over £2,000.

Our patients have told us the Halcyon also delivers a better experience for them - it's quicker, it's quieter and it generates much higher quality images for the therapeutic radiographers to use. In turn, this enables our radiotherapy team to target patients' cancer cells with much more accuracy and avoid damaging healthy tissue.

Vote Leaves
As part of our ongoing commitment to achieving net zero by 2030, we're voting leaves.

That is, we're currently working on plans to plant 1,000 trees across our hospital estate as just one way of helping to offset our carbon emissions.

We've recently received funding for 1,000 saplings courtesy of the Centre for Sustainable Healthcare and NHS Forest, and we're looking to have sites identified and roots in the ground by the end of March this year.

Recognising that this is an investment in not only the hospital estate but in the local area and environment more widely, we've asked our local community to help us and we will be engaging with local schools to help us plant the first of our 1,000 saplings.

2. Media/social media activity

In January there were 66 articles published about the Trust:

- 26 positive (39%)
- 7 factual (11%)
- 21 negative (32%)
- 12 neutral (18%)

Most negative coverage related to the NMC hearing for former employee Paul Johnson.

Social media

Facebook

Total "reach" for Facebook posts on all Trust pages in January – 233,362

- Hull Women and Children's Hospital – 54,474
- Castle Hill Hospital – 58,465
- HEY Jobs page – 29,233
- Hull Royal Infirmary – 43,097
- Hull University Teaching Hospitals NHS Trust – 48,093

Twitter @HullHospitals

- 127,000 impressions in January 2022
- 9,786 followers
- Tweets with highest number of impressions related to walk in sessions for the public to receive Covid vaccinations/boosters at HRI.

In February there were 61 articles written about the trust:

- 39 positive (64%)
- 0 neutral (0%)
- 21 negative (34%)
- 1 factual (2%)

Social media

Facebook

Total "reach" for Facebook posts on all Trust pages in February – 268,534

- Hull Women and Children's Hospital – 53,829
- Castle Hill Hospital – 91,051
- HEY Jobs page – 11,777
- Hull Royal Infirmary – 63,537
- Hull University Teaching Hospitals NHS Trust – 48,340

Twitter @HullHospitals

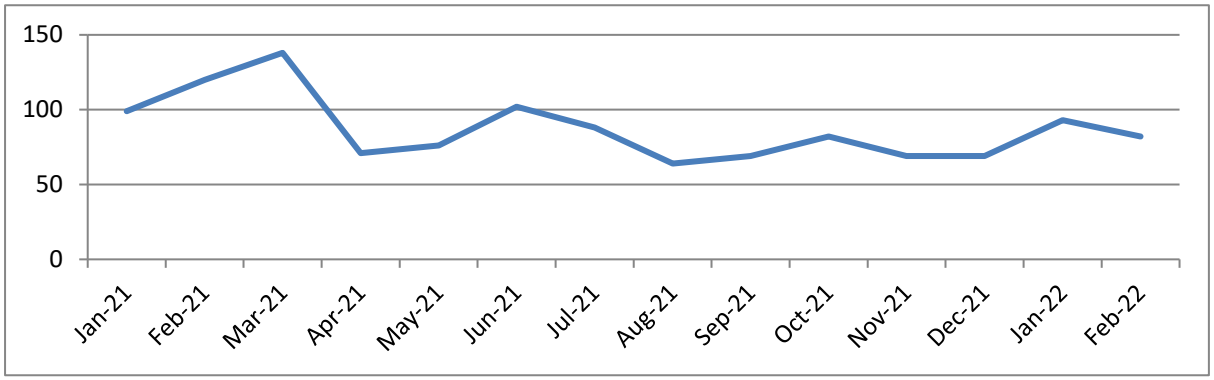
- 92,200 impressions in February 2022
- 9,868 followers
- Tweets with highest number of impressions related to National Apprenticeship Week and the return of hospital docuseries A&E After Dark to Channel 5

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 January 2021-February 2022:



BRIEFING PAPER FOR TRUST BOARDS

JANUARY 2022

EXECUTIVE SUMMARY

The purpose of this paper is to provide the acute provider Trust Boards with an overview of the Humber, Coast and Vale Collaboration of Acute Providers (HCV CAP), including a summary of the national and local context, its work programme for 2022/12 and progress to date, current governance arrangements and the proposed next steps for its further development.

NHS England and Improvement have issued guidance and a toolkit to support systems in establishing and running effective provider collaborative arrangements. All acute providers are required to be members of an at scale (ICS wide) provider collaborative.

The new Health and Social Care Act, if brought into law, will introduce a new duty on providers to collaborate and new mechanisms to facilitate joint working arrangements between providers. ICBs will be encouraged and able to delegate roles and functions to provider collaboratives.

The HCV CAP was formed in January 2021 and its members are the four acute providers in the patch:

- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust.

The proposed next steps for the CAP are summarised as:

1. Agree with the ICS roles and functions to be delegated to the CAP, together with the associated resources to support their delivery
2. Agree to set up a governance task and finish group to make recommendations to the Board regarding the next phase governance arrangements for the CAP

3. Commence the CAP Development Programme

In addition, continue to deliver the existing work around operational planning, elective recovery and leadership of the strategic programmes

Trust Boards are asked to consider the briefing provided and indicate their willingness to support the proposed next steps

BRIEFING PAPER FOR TRUST BOARDS

JANUARY 2022

1 PURPOSE

The purpose of this paper is to provide the acute provider trust boards with an overview of the Humber, Coast and Vale Collaboration of Acute Providers (HCV CAP), including a summary of the national and local context, its work programme for 2022/12 and progress to date, current governance arrangements and the next steps for its further development.

2 NATIONAL POLICY CONTEXT

The statutory changes currently progressing through the legislative system, which will reshape the health system in England, are widely known to include the dissolution of Clinical Commissioning Groups (CCGs) and the creation of new statutory bodies, Integrated Care Boards (ICBs). The 'go live' date for the change recently moved back to 1 July 2022.

ICBs will replace Integrated Care Systems (ICSs) but will carry into their new arrangements some of the features of ICSs, in particular, closer involvement of providers within their patch in their leadership and operation. The way in which this will work in practice is still in development, but we do know that ICBs will have at least 1 provider leader on their Board and that all acute and mental health providers are required to be members of a provider collaborative.

In August 2021, NHE England and Improvement published 'Working together at scale: guidance on provider collaboratives'[1]. The key points of the guidance were articulated as:

- Provider collaboratives will be a key component of system working, being one way in which providers work together to plan, deliver and transform services
- By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities
- Significant scope to deliver these benefits already exists within current legislation and, subject to its passage through Parliament, we expect the Health and Care Bill will provide new options for trusts to make joint decisions

The guidance outlines a number of areas provider collaboratives can consider

undertaking work:

- Reductions in unwarranted variation in outcomes and access to services Providers can work together to develop new evidence-based models of care and standardise protocols
- Common processes and procedures ensure that staff can more easily move between sites.
- Reductions in health inequalities: Provider collaboratives have an opportunity to embed joint accountability, improve equity of access to appropriate and timely health services, to better meet the needs of underserved communities
- Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures
- Members can support each other to implement improvements in quality of care, and can develop combined capacity and capability if a need for enhanced support arises.
- Strong leadership teams can help other providers stabilise and improve quality or navigate complex change.
- Staff may be able to work more flexibly between sites across a wider footprint through aligned contracts, processes and cultures. This could reduce agency spend, improve patient experience and make it easier to respond to demand changes in real time across the footprint.
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans:
- Consolidation of low-volume or specialised services: Where clinically beneficial providers can improve outcomes and enable a greater degree of sub-specialisation by agreeing how and where to consolidate specialised services.
- Efficiencies and economies of scale: Members can find savings by joining up certain clinical support and corporate services, or leveraging joint purchasing power in procurement of, for example, clinically appropriate and safe medicines.

The guidance notes that provider collaboratives are distinct from ‘place based

partnerships' and that in addition to being part of an ICS wide provider collaborative, providers will also be part of one or more place based partnerships, which will be multi-sectoral and cover smaller geographical footprints, often aligned to local authority boundaries.

3 LOCAL CONTEXT

Within HCV, it was determined that four sector based provider collaboratives would be established, covering acute, mental health, community and primary care providers.

The HCV Collaborative of Acute Providers launched in January 2021, replacing the previously existing Hospital Partnership Board and including Harrogate and District Foundation NHS Trust, which had moved over from the West Yorkshire to the HCV ICS in April 2020.

The members of the HCV CAP are:

- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust.

From its inception, the CAP agreed to take a lead role in operational planning for the acute sector, where this was required on a system footprint. During 2021/22, NHS operational planning guidance included a number of asks that had to be fulfilled collectively by the acute sector across the ICS footprint, in order to access some financial allocations, for example the target activity levels for elective care. In addition, there was a requirement to prioritise bids for elective capital funding across the ICS.

At the request of the ICS leadership team, the CAP agreed to take on the leadership of a number of existing ICS wide strategic programmes and clinical networks.

The strategic programmes are:

- The Elective Programme
- The Urgent and Emergency Care Programme
- The Local Maternity System
- The Diagnostic Programme
-

The clinical networks are:

- The Cancer Alliance
- The Major Trauma Network
- The Critical Care Network

- The Cardiac Network
- The Stroke Network
- The Imaging Network
- The Hull/Scarborough/York Pathology Network

4 2021/22 CAP WORK PROGRAMME

The early meetings of the CAP Board agreed to get on with some key shared projects from the off, rather than spend the first year working only on building relationships and governance systems and processes.

In building the work programme, the CAP agreed to focus on identifying areas of joint work that would be additive to all of the activity already going on within individual trusts and where working together at scale or in partnership offered the hope of solutions that were not possible for individual providers to deliver.

The key areas of the work programme and a summary of key achievements to date are set out below:

4.1 Elective Recovery

Elective Recovery has been a key area of focus for the CAP.

Aim: To reduce the maximum waiting times and the overall number of patients waiting for elective care, with the longest waiting times to reduce most.

Collaborative work undertaken to date

- Agreement of common planning assumptions and improvement targets (incorporating national requirements)
- Development of an shared 18 week referral to treatment (RTT) report which brought together the overall ICS position and highlighted relative waiting times by trust and collective and individual progress again our agreed aims
- Development and agreement of an overarching recovery plan, bringing both the Trust plans and the shared plans together
- Joint planning for additional elective capacity including securing £22m of capital investment
- Joint engagement with the Getting It Right First Time Team to access their data, best practice pathways and clinical leadership resources
- Support to local outpatient transformation programmes, successfully bidding for digital investments to support new ways of working
- Development of an approach to supporting patients on the waiting list Multiple examples of provision of mutual aid, to reduce the longest waiting times in services where patient are at risk of waiting or have waited over 104 weeks
- The work on the elective recovery programme has highlighted the need to undertake a piece of clinical strategy work to provide the basis for

further bids for elective recovery capital and this work has been agreed and launched by the CAP Board. Building on the work undertaken within the Humber Acute Services Review Planned Care work and taking account of the national policy drive towards more elective activity taking place on Covid minimal protected cold sites, the project is aiming to provide a framework within which shorter-term plans are made.

Measures of success:

- Elimination of >4 week waits for Priority 2 patients
- Reduction in the overall number of patients on the active 18 week RTT PTL
- Elimination of >52 week waits
- Reduction in the number of patients waiting over 40 weeks
- Reduction in the number of follow up patients waiting over 3 months beyond their due date
- Reduction in the range of waiting times on the 18 week RTT PTL ('the tail'), with improvement in every provider and place

Progress to date:

The CAP's aims in relation to the RTT were clearly ambitious, especially in the light of the level of acute pressure and the Omicron Covid 19 variant. There is some notable progress to date; in particular, in relation reducing over 52 week waits. Despite growth in the overall list size, all Trusts have reduced the numbers of patients waiting over 52 weeks, with the numbers in HUTH, which had by far the largest number, reducing the most, as shown in figure 1 below.

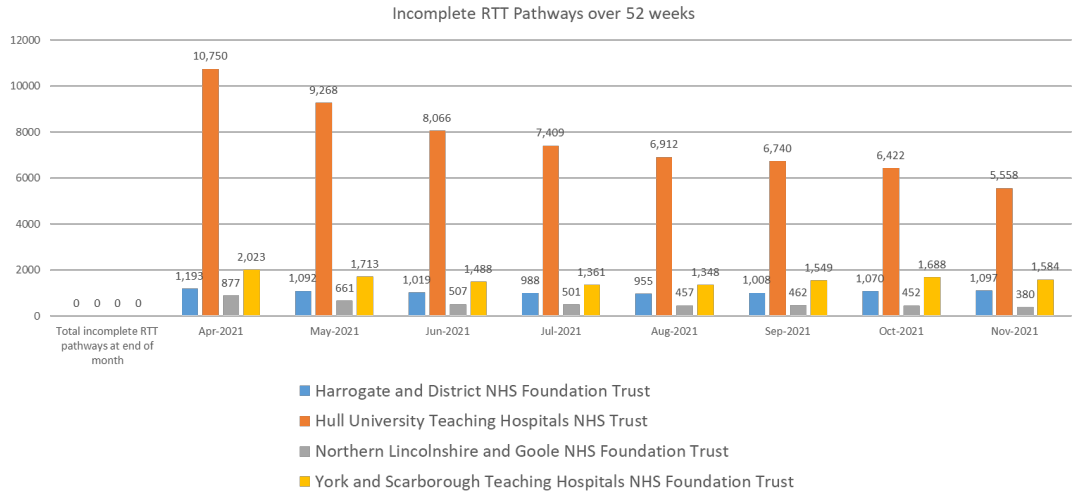


Figure 1: Incomplete >53 week RTT pathways by Trust Apr – Nov 2021

Overall, the incomplete RTT waiting list had grown from £134k at the end of March 2021, to over £152k by the end of December 2021 and there has been a growing problem with a number of patients exceeding 104 weeks in some

Trusts. As mentioned above, the Trusts have worked together to manage this issue, delivering significant mutual aid involving all 4 providers.

Efforts to progress specialty networking and pathway redesign work have been less successful than hoped. This is because there is such pressure on front line clinical staff and managers that attendance at groups has been patchy, support resources from regional and GIRFT Team have been intermittently redeployed to Covid response tasks and the ability to progress actions is being hampered by the short-term focus of the 2021/22 planning processes. The CAP Executive Planning and Operations Group is reviewing this work to consider how to take it forward.

4.2 Cancer

Aim: To enhance the provider and clinical input into the Cancer Alliance and develop a work programme that drives the delivery of improved outcomes and equality of outcomes

Collaborative work undertaken to date:

- An acute Provider CEO has become joint chair of the Cancer Alliance Board
- The Lung Health Check Programme has secured two sources of funding to support its extension to a wider population
- Data packs for Primary Care Networks highlighting their referral rates for cancer pathways have been developed, to address areas of under and over referral
- Investment in Rapid Diagnostic Centres has been extended

Measures of success:

- Improved clinical and provider involvement and engagement in the Cancer Alliance at Board, programme and tumour site groups
- Agreed pathways and action plans in priority specialties of lung and urology
- Improved performance against the 62-day urgent suspected cancer referral to treatment standard
- Regular provision of cancer outcomes intelligence to the Alliance Board and groups and agreement of a work programme to deliver improvements
- Improved performance against the 28-day diagnostic standard

Progress to date:

The main success to date has been in terms of improved performance against the 28-day faster diagnosis standard. The standard became a live performance measure in October 2021 with the required performance being 75%. Two of the 4 Trusts are meeting it and the overall performance across the ICS for November 2021 was 74.3%.

Again, there has been limited progress on the pathway redesign process, for the reasons outlined above. As the Cancer Alliance sets its work programme for the coming year, there will be the opportunity for it to refocus its efforts in relation to this work.

Due to the enduring challenges in relation to non-surgical oncology services, which are very significant in HCV, the Cancer Alliance is working with the NEY Regional Team and the other 3 cancer alliances in the patch to call for an expert review into the future provision of these services.

4.3 Diagnostics

Aim: To develop the diagnostic capability and capacity across the ICS

Collaborative work undertaken to date:

- Development of the ICS approach to Community Diagnostic Centres (CDCs)
- Securing significant Year 1 funding for the CDC programme: £5m capital and £3.7m revenue to support the purchase of diagnostic equipment and the rental of staffed MRI and CT mobile scanners.
- Creation of the HCV Imaging Network, securing programme resource for the next 2 years
- Agreement of workforce development priorities actions to address them, including close work with Hull University to establish a local undergraduate training programme for radiographers

Measures of success:

- First CDH in train (completion date will be effected by national timetable for funding)
- Signed off diagnostic strategy and action plan
- Signed off workforce plan and progress on actions identified
- Updated demand and capacity modelling and asset register
- Improvement in performance against the 28-day faster diagnosis and 6 week diagnostic standards

Progress to date:

This is a new strategic programme established in March 2021. Overall, there has been good progress. In addition to securing the largest Year 1 investment in community diagnostics in the Region, the programme is on track to submit year 2-5 plans for the development of community diagnostic centres in Q1 of 2022/23, based on a hub and spoke model.

We have received £2m capital investment to support the digital connectivity of diagnostic services and for small pieces of equipment and staffing to support

backlog clearance.

Hull University have confirmed they are planning to commence a radiography undergraduate programme in September 2023.

4.4 Urgent and Emergency Care

Aim: To improve the experience and outcomes of urgent and emergency care for patients

Collaborative work undertaken to date:

- Development of the enhanced clinical assessment service for 111 calls disposed to ED or an urgent GP response
- Work with the for Urgent Treatment Centres (UTCs) to increase capacity and the range of patients they can take, based upon implementation of the national enhanced specification
- Roll out of the national ED streaming tool in progress
- Development of the anywhere to anywhere booking system
- Work with YAS to understand why conveyance rates remain high

- **Measures of success:**
- Increase in the percentage of UEC patients 'seen' and treated (including virtually) outside acute hospital settings
- Reduction in ED attendances
- Increase in SDEC activity
- Increase in SDEC 7-day service coverage for key specialties
- Agreed plan for UTCs, with progress on implementation and timelines for full completion
- Programme measures in place with regular and timely access to data to update progress

Progress to date:

As all trusts are acutely aware, pressure in the urgent care system remains extremely high and ED attends are exceeding pre-pandemic levels in most departments. The ICS wide UEC programme is cognisant of this and of all the improvement work that Trusts are leading with their partners in their local systems and so seeks to facilitate developments that are additive to this as they improve the connectivity within the system.

4.5 System Development

Aim: To develop the Collaborative of Acute Providers into an effective vehicle for the improvement of acute services within Humber, Coast and Vale

Collaborative work undertaken to date:

- Establishment of the CAP Board and Executive Planning and Operations Group
- Implementation of standardised programme reporting and oversight for

the strategic programmes
- Initial Board Development session undertaken
- Structured CAP development programme offer developed in collaboration with the NHS Regional and National Teams
- Formal offer made to the ICS Leadership Team regarding the roles and functions that the CAP is willing and able to undertake on behalf of the ICB, when it is established.
- Links made with the key ICS enabling programmes so that the Collaborative led programmes of work have access to expertise and resources, for workforce development, digital and population health

Measures of success:

- Progress against the Provider Collaborative Development Matrix (currently in development by national team)
- Sign off of overarching clinical service strategy
- Feedback from participants in the OD work
- 'Commissioning'/ service redesign function in place
- Revised clinical network portfolio, support team, clinical lead and chair arrangements in place and work programmes agreed
- Delivery plans for workforce, digital and population health priorities agreed and in action

Progress to date:

Work is ongoing to develop the governance, relationships and functionality of the CAP and there are some proposals for the next steps for the CAP in terms of the governance arrangements in section 7 of this paper.

The CAP Board held an initial development session following its December 2021 Board meeting. CEOs each made a presentation on their organisations' key goals and challenges and some initial discussion took place around ways of working together and the need to expose the differing views and expectations about the role of CAP. It was agreed that further development work was a critical component of the CAP work programme.

A more formal CAP development programme offer has been created, following discussions between the CAP and the North East and Yorkshire Regional Team CEO lead for provider collaborative development. A summary of the approach is set out in Appendix 1 of this paper. It is proposed that this programme is commenced within the next few months, once the incoming Trust Chairs are all in post.

In September 2021, the CAP set out an offer to the ICS Leadership Team in relation to the roles and functions it is willing to undertake on behalf of the ICB. This proposal received very positive feedback, indeed the other provider

collaboratives within the ICS were asked to adopt the CAP approach and it is being used as the basis for provider collaborative discussions with ICSs in three other patches.

We are awaiting the further implementation of the ICS transition to progress to finalise the arrangements, we are advised this is still expected to be completed by the end of March 2022, despite the move back of the formal establishment of the ICBs to 1 July 2022.

5 OPERATIONAL PLANNING

In order to ensure that the H1 and H2 system plans for HCV met all of the requirements for the acute provider sector, the CAP Director facilitated a weekly acute planning call during the plan development phase and linked in with the wider HCV planning process.

The 2022/23 NHS Operational Planning Guidance again includes a large number of expectations for the acute sector and sets targets that are measured at system level. The CAP will therefore continue to take the lead on operational planning for the acute sector on behalf of the ICS.

In support of this work, a lead Chief Finance Officer (CFO) has been agreed for the CAP (Andrew Bertram from York and Scarborough Teaching Hospitals) Two key pieces of work have been identified to support operational planning:

- Development of an understanding the underlying financial position across the acute sector to support the financial allocation process.
- Development of some agreed principles to support the allocation of any discreet additional funds made available to the ICS for use by the acute providers, where there is insufficient time to undertake a full prioritisation process.

6 CAP PROPOSAL TO THE ICS ON FUTURE ROLE AND FUNCTIONS

As referenced above, the CAP has made an offer to the ICS Leadership Team regarding the roles and functions the CAP could undertake on behalf of the ICB. Taking close account of the guidance published so far, the offer addresses the following key roles:

1. Development of collaboration and system leadership capability and capacity
2. Strategic and operational planning for acute services
3. Improving outcomes, equity and productivity
4. Clinical service sustainability

The ways in which the CAP is already active have been set out in this briefing paper. The offer set out a plan to build on the work done to date by crystalising the strategic programmes into service domain and improvement teams, which

will be the vehicle and resource to facilitate acute provider leadership of the strategic and operational planning of acute services.

The proposed teams are:

- Cancer
- Elective
- Urgent and Emergency Care
- Diagnostics
- Maternity and Paediatrics

These teams would pick up the acute service commissioning functions that are currently the responsibility of the CCGs and for specialised services, NHSE/I. Specifically

- Develop intelligence on patient need, through use of population health data
- Respond to clinical developments and nationally issued service specifications and requirements
- Work with teams to reduce unwarranted variation and to promote equity of access, particularly for underserved populations
- Facilitate the spread of new service models and evidence based pathways, drawing in support from regional and nation expert teams
- Make a link with the wider system in relation to services and pathways and support local place innovation and integration where it touches acute services and co deliver ICS priorities
- Building on the work already done in the acute service reviews, take forward actions to improve clinical service sustainability

It is understood that the offer was well received. Next steps are tied to the national and local timetables for the transition of the health systems to the new arrangements; a confirmation of the role and functions of the provider collaboratives is expected by the end of March 2022.

7 GOVERNANCE ARRANGEMENTS

7.1 Current Arrangements

During its first year of existence, a largely pragmatic approach was taken to the development of the CAP. In recognition of the coming national guidance, a barebones governance structure was stood up, with the expected next steps set out, but an agreement to hold off standing up a fuller set of committees until the national position was clearer and there were sufficiently meaty work programmes in play to require a more fulsome set of joint working arrangements.

The new groups established were a CAP Board, chaired by Chris Long, CEO of HUTH, and an Exec Planning and Operational Group, chaired by Shaun Stacey, COO of NLAG. Together these groups developed and signed off a work programme for 2021/22.

Figure 2 is the current governance structure, with the live elements in blue and the groups/committees yet to be established in grey.

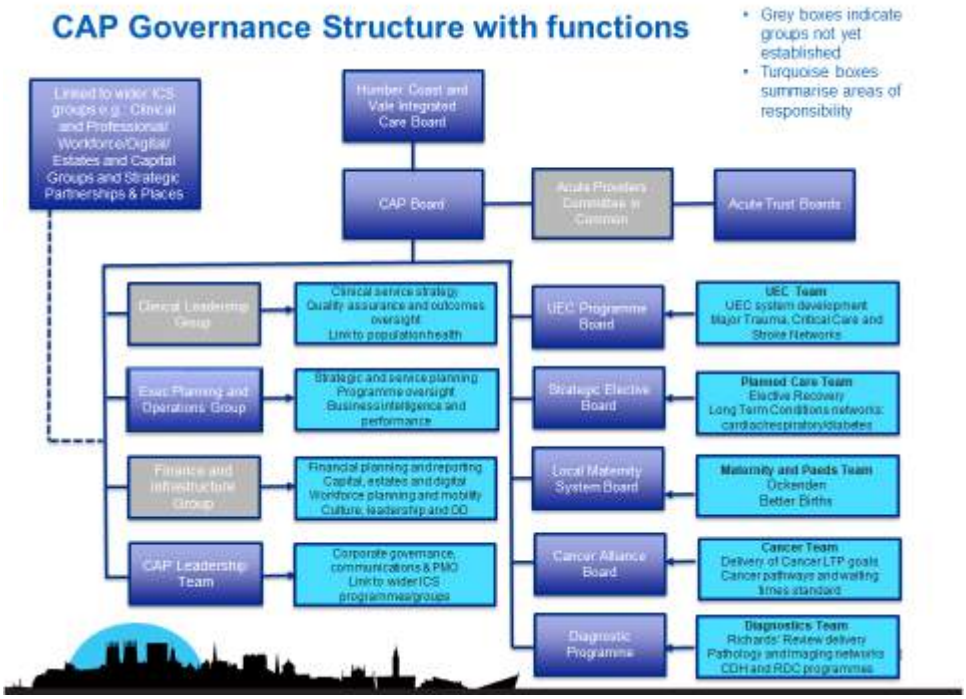


Figure 2: CAP governance structure as at Jan 2022

7.2 Governance arrangements next steps

In 18 January 2022, NHSE/I issued a toolkit designed to help systems set up provider collaborative arrangements. The toolkit provides a wide range of resources to support the initial engagement prior to setting up a provider collaborative, to facilitate the ongoing development of those ventures and for the development of appropriate governance arrangements.

The toolkit posits 3 possible forms for provider collaboratives, these are:

- **Provider leadership board –** Chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards, in line with their schemes of delegation. This model can make use of **committees in common**, where committees of each organisation meet at the same time in the same place and take aligned decision

- **Lead provider -** A single trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required

- **Shared leadership -** Each collaborative member has a defined leadership structure in which the same person or people lead each of the trusts involved. Generally, this has been achieved with, at a minimum, the same person filling the chief executive posts at the trusts involved in the collaborative, and may also include chairs and other executive posts

The CAP was founded on the provider leadership board model and it is proposed that the next phase governance model is progressed within this archetype.

The toolkit segments governance into five areas:

1. Boards, committees and other partner links
2. Decision making arrangements
3. Written agreements
4. Risk management and sharing
5. People and roles

7.21 Boards, committees and other partner links

A review of the previously outlined governance structure (Fig 2) against the NHSE/I toolkit suggests that it incorporates all of the recommended elements.

To date the CAP has not established a committee in common to oversee its activities. It has The toolkit outlines the purpose of committees in common as a way for organisations to take aligned decisions about how to deliver benefits of scale.

If the Health and Care Bill is enacted, NHS Foundation Trusts and NHS Trusts will be able to delegate decision-making functions to joint committees. This may mean that governance arrangements will look different from committees in common, but the results – taking decisions together – are the same.

An **NHS foundation trust** board may delegate some or all its powers to a committee of its own directors (or one executive director) to exercise (take decisions) on behalf of the organisation. A wide range of responsibilities can be delegated, but they must be in line with a board's scheme of delegation. Committee members remain accountable to their respective trust boards.

An **NHS trust** may take a similar approach, but an NHS trust can delegate functions to non-directors who can exercise those functions on committees

that include others who are not employees of the NHS trust.

These committees with delegated authority meet at a common time and place where decisions can be taken on behalf of each participating trust. These committees in common should each work according to the same agenda and consider the same papers. A single discussion can take place, considering the matters of common concern to the trusts but also addressing issues of specific concern to one or more of the trusts involved. Commissioning contracts remain with the respective providers. Trust boards remain accountable for the decisions taken in committees in common and so often will want to maintain a monitoring role.

The CAP has also to date not stood up its Finance or Clinical Groups. In part, this is because both of these professional groups are members of a relevant ICS group. It is therefore envisaged that these groups will be stood up over the next few weeks, once an agreement is finalised with the ICS and their specific remit be defined in consultation with the relevant ICS group chairs as well as the CAP Board.

In addition to the meetings outlined on the structure, a number of other supporting groups have formed, which can be incorporated into the structure, for example, the Business Intelligence Leads Group meets informally once a week and is an invaluable touch point for the CAP.

7.22 Decision making arrangements

Provider collaboratives may consider adopting an agreed approach to decision making. The toolkit suggests that the following questions are considered:

- Under each trust's governance, can individual trust boards delegate decision-making to their representative on the collaborative? Or do decisions of the collaborative need to be ratified by the boards?
- How will decisions be taken? Will unanimity be required or will trusts agree that they will each provider take the decision that a majority of providers have agreed to take?
- Are there different types of decisions that may be taken and do all members need to be involved in all decisions?
- How will the collaborative resolve any disagreements among members? Or otherwise ensure that disagreements do not derail progress?

Further work needs to be undertaken on this matter and it is proposed that the CAP Director works with the trusts' directors of corporate affairs/governance to

develop a proposal for the next phase governance arrangements for the CAP. It will be important to consider for example, if the CAP is to take in responsibility for the allocation of resources how the agreed mechanisms deal with a failure to reach a consensus agreement.

7.23 Written agreements

The toolkit suggests that it is good practice for members of the collaborative enter into a written partnership agreement or memorandum of understanding (MOU) setting out their shared visions, terms of reference, how they will work together and take decisions, how they will hold each other to account, and any risk or gain sharing arrangements.

Such a written agreement is not yet in place. It is recommended that the development of one forms part of the considerations of the directors of corporate affairs/governance.

Some of the Trusts already have MOUs in place between them and the CAP partnership agreement will need to take account of and build on these.

7.24 Risk management and sharing

The toolkit recommends that collaboratives agree and set out in their written agreements their approach to risk management and sharing, taking into account the following question:

- How will risks to delivery be identified, reported and managed?
- How will financial risks be managed and shared across collaborative members?
- How will any financial savings be managed and/or reinvested? How will this be decided?

The collaborative already has in place a risk and issue management process for all of its programmes of work.

In relation to financial risk and benefit sharing, a separate piece of work needs to be undertaken to support the delegation of any financial management responsibilities to the CAP and this needs to link with the wider risk and benefit sharing arrangements for the ICB. It is not expected that this work needs to be completed before the end of 2022/23.

7.25 People and roles

The CAP is organised and run by the providers to support them to work together for the benefit of the patients and populations they serve. As such, key leadership roles will be fulfilled by senior leaders from the Trusts,

supported by a small, dedicated team under the direction of the CAP SRO and Board. The CAP Board is chaired by the CEO of HUTH and each of the other CAP groups will be chaired by an appropriate Trust Exec or in the case of any committees in common or joint committee a Trust Chair.

The CAP is currently supported by one full time member of staff, the CAP Director, who is a director seconded from HUTH. There are a number of members of staff attached to the clinical networks and strategic programmes, who are managed by the director, via a programme structure These staff work for a number of different organisations within the system.

To support the proposal regarding the future role of the CAP and the functions it proposes be delegated to it by the ICB, a resource plan was developed. This is depicted in figure 3 below. The request was for a relatively small core team of 3 (CAP Director, CAP deputy director, planning and CAP Finance Lead) plus a bolstering of the existing programme team roles, responsibilities and capacity to replace the acute commissioning functions that have sat with CCGs and NHSE/I for specialist services.

At the request of the ICS, mapping of existing resource to the new structure has been undertaken.

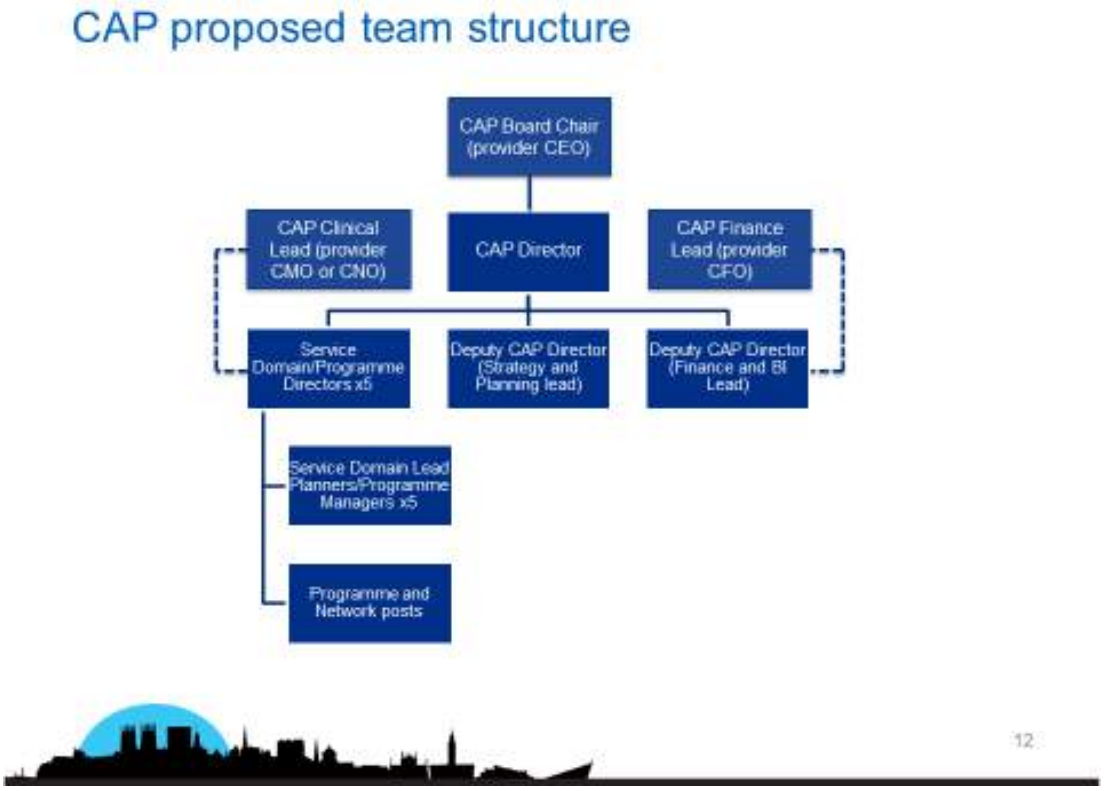


Figure 3: Proposed team structure for the CAP post formation of the ICB

8 SUMMARY OF PROPOSED NEXT STEPS

To summarise, the proposed next steps are as follows:

1. Agree with the ICS roles and functions to be delegated to the CAP, together with the associated resources to support their delivery
2. Agree to set up a governance task and finish group to make recommendations to the Board regarding the next phase governance arrangements for the CAP
3. Commence the CAP Development Programme

In addition, continue to deliver the existing work around operational planning, elective recovery and leadership of the strategic programmes

9 CONCLUSION AND RECOMMENDATIONS

Trust Boards are asked to consider the briefing provided and indicate their willingness to support the next steps as outlined in section 8.

10 REFERENCES

1 *Working together at scale: guidance on provider collaboratives. Published by NHSE/I August 2021 ref PAR754*

2 *Provider collaboratives. Toolkit for setting up collaborative arrangements. Published by NHSE/I*

Jacqueline Myers
Director, HCV CAP
31 January 2022

APPENDIX 1 – OUTLINE OF PROPOSED EXTERNALLY FACILITATED cap DEVELOPMENT PROGRAMME

Building on the initial development session held by the CAP Board in December 2021, the CAP Director and Board Chair have been working with the North East and Yorkshire Regional Improvement Hub and the National Improvement Team to develop a bespoke development programme for the HCV CAP. This is a 5-stage offer, which is currently being delivered in both South Yorkshire and Bassetlaw Acute Federation and the South Cumbria and Lancashire Provider Collaborative, in each case shaped to meet the stage of development and areas of focus for each one and referring to NHS North Provider Collaborative Development Framework.

The offer for the CAP is built from an evidence-based leadership development model already in place through NHS England and NHS Improvement that has been used effectively in several areas. This is a 'framework for reflection and action' tool, which will garner views on the current position and working relationships of the CAP to help inform your further development needs.

Prior to formal commencement of the 5-stage programme, informal contact will take place with Trust Chairs to discuss and finalise the shape of the programme.

Stage 1- A short morning or afternoon session with the key leaders CAP (members of the CAP Board, plus Trust Chairs) to gauge shared understanding of the purpose of the Collaborative within the context of your Integrated Care System (ICS). Using an evidence-based structure, develop the shared narrative of purpose as the basis for furthering discussions about the development of the CAP.

In advance of the stage 1 session a confidential, non-attributable electronic survey of the attendees of the session. The survey will be analysed, confidentially, by the facilitator team only, with the results being fed back to leaders at the first formal development session.

Stage 2 – this will involve the circulation of a co-designed confidential and nonattributable electronic survey to the wider leadership groups (clinical and managerial) in your provider trusts so that this group can also reflect on where they think the CAP needs to make the most progress. This would be used as a form of 'check and challenge' to the SYBAF Board.

The results from the survey will be used to prompt conversations and inform the production of a development plan meeting the specific needs of the CAP.

In short, this stage is to identify or reinforce 'the what' that needs to be done to help deliver the agreed purpose.

Stage 3 – A second facilitated development session with the leaders of the CAP Board, Trust Chairs and identified senior clinical and managerial staff in order to present the analysed survey results from Stage 2, with opportunity for reflection, discussion and group work to identify development themes that the CAP would wish to work on as a priority.

In short, this stage is to provide a check and challenge on 'the what' to stimulate further thinking and identify other possible development opportunities.

Stage 4 – A third development session, should it be required. This will focus on developing a more detailed response to the priorities, preparing a high-level development and delivery plan with identification of outcomes required, actions to deliver the outcomes, a measurement framework that tells us when we have achieved the outcomes

With support, this plan would then be tested with various stakeholders, as agreed with the CAP Board, as part of your communications approach, to provide both a sense check on direction and be used as part of a wider communications plan signalling intent and direction in alignment with the ICS.

In short, this stage is to identify 'the how' the development plan will be delivered.

Stage 5 – Supporting the CAP to move into delivery of the development plan utilising resources and approaches as agreed. Support from NHS England and NHS Improvement can be available to support specific development needs, should this be required.

Report to the Board in Public
Humber Acute Services Development Committee held on 15 February 2022

Item: Director Overview Report P2 and P3	Level of assurance gained: Substantial
P2 and P3 engagement plans had been agreed with NHS E/I. 5 Overview and Scrutiny Committees had approved the engagement approach and given positive feedback. Future milestones were discussed along with risks to the delivery of the programme and capital funding. Any delays in the programme could be impacted by the dis-establishment of the CCGs. Communications support to be sought.	
Item: P1 Handover Plan	Level of assurance gained: Substantial
The plan would conclude 31 March 2022. An interim clinical plan has been established for the vulnerable services reviewing workforce and delivery of service. Each specialty had carried out a waiting list stock take, impact assessments, risk assessments and had process mapped their service. Clinical strategies and Lorenzo interface to be aligned with the programme.	
Item: Joint Development Board	Level of assurance gained: Substantial
Work was ongoing with nuclear medicine and the vascular pathways and there were discussions around the Breast Imaging Team joining forces due to the challenging workforce position. MC added that a number of non-clinical areas such as digital, finance, information governance and clinical coding were also working together on strategy development. Linda Jackson and Stuart Hall would oversee the establishment of the 10 key areas.	
Summary by the Chair • A high level risk register to be developed – MC to review with RT • Internal Communications to be increased. Both Boards to be briefed routinely but specifically before the 7th March MP meeting. • Important not to link P1 and P2 programmes for consultation purposes. • PCBC comments to be submitted to IMc by mid March 2022	

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	Standing Orders				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report was previously considered at the November 2021 Trust Board				

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

Key Recommendations to be considered:

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders March 2022

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since March 2021.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2022/01	Hull University Teaching Hospitals NHS Trust and the Hull and East Yorkshire Medical Research Centre – Variation agreement relating to a development for lease and under-lease in respect of the construction and letting of premises known as the new Cyclotron and Radio-pharmacy facility at Castle Hill Hospital	21/01/22	Chris Long – Chief Executive Officer Lee Bond – Chief Financial Officer
2022/02	Hull University Teaching Hospitals NHS Trust and Integrated Utility Services Ltd, Lloyds Court – Installation of the 11kv works associated with the provision of the SMWe Solar PV ground mounted arrays at Castle Hill Hospital and connection to the site private HV network	01/02/22	Chris Long – Chief Executive Officer Lee Bond – Chief Financial Officer

3 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
March 2022

Report to the Board in Public
Audit Committee 24 February 2022

Item: Information Governance Update	Level of assurance gained: Reasonable
Area of concern around Information Governance Training compliance impacting on Data Security and Protection Toolkit. It was agreed to escalate this to the Board.	
Item: Internal Audit Infection Control Audit Report	Level of assurance gained: Partial
A number of management actions in place to ensure the current processes run more effectively.	
Item: Doctor's leave Audit Report	Level of assurance gained: Minimal
The Committee were not assured in relation to the Doctor's leave audit. Some Health Groups and services were performing better than others. It was agreed to escalate the issue and further scrutiny be carried out at the Workforce, Education and Culture Committee.	
Item: Theatre Utilisation Audit Report	Level of assurance gained: Reasonable
Management actions in place to address the data quality concerns relating to the transfer of data from Ormis to Lorenzo.	
Item: New Starters Audit Report	Level of assurance gained: Partial
Management actions in place to address communication and end to end document flow relating to new starters.	
Item: Asset Management Audit Report	Level of assurance gained: Partial
Medium actions in place to ensure the asset register was updated and any losses reported.	
Item: Counter Fraud Progress Report	Level of assurance gained: Good
Key messages had been communicated to staff during Fraud Awareness week. There had been a good response to the Gifts and Hospitality survey. Cyber alert information was being communicated across the Trust.	
Item: External Audit Plan and Fees	Level of assurance gained: Good
Mazars presented their Audit plan for 2022/23. Fees remained the same as last year.	
Item: Credit Card Expenditure	Level of assurance gained: Good
No issues to report regarding the use of the Credit Card. Robust processes were in place. IT purchases and overseas nurse recruitment were the main areas of expenditure.	
Item: Director's Expenses	Level of assurance gained: Good
There were no issues raised. It was agreed that this would be removed from the workplan and built into the Internal Audit plan to be reviewed every 2 years.	
Item: Debts >£50k and over 3 months old	Level of assurance gained: Good
Good progress had been made to reduce the number of invoices. There were no issues raised.	
Item: Register of Gifts and Hospitality and Declarations of Interest	Level of assurance gained: Good
Registers received by the Committee. No areas of concern. Quarterly emails being sent out to all staff to remind them to declare. Improvements in staff giving estimated costs to conferences/receiving gifts etc.	

Item: Legal fees	Level of assurance gained: Good
Fixed fee contract in place although the Trust had gone over its allocated time due to a number of inquests and the front entrance build.	
Item: Accounting Policies and Going Concern Status	Level of assurance gained: Good
The Trust's 2021/22 Accounts would be prepared using the Going Concern basis due to 'anticipated continued provision of the service'.	
Item: Audit Committee Effectiveness	Level of assurance gained: Good
The Committee is performing at a high level of Effectiveness following the results of the survey.	
Item: Fraud Policy	Level of assurance gained: Good
The Fraud Policy was approved by the Committee.	
Item: AOB	Level of assurance gained: Minimal
Radiographers set up own business to provide training to overseas trainees. The Trust to be charged for each trainee recruited with this training. The Committee had requested further information from HR regarding the business and when and how it would be conducted.	

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item	7.1	**Meeting**	Trust Board	**Meeting Date**	8.3.22
Title	Refreshed Trust Strategy 2022-25				
Lead Director	Michelle Cady, Director of Strategy and Planning				
Author	Michelle Cady, Director of Strategy and Planning				

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

Key points to be considered:

The Trust Strategy has been refreshed for 2022-25.

The process of refreshing and updating the strategy has involved the draft content being shared and feedback received from the individuals, groups and organisations who are members of or are represented by the following:

- Executive Team
- Non-Executive Directors
- Executive Management Committee
- Strategic Development Group
- Hull Health and Care Partnership
- East Riding Health and Care Partnership
- Healthwatch Hull and East Riding

The proposed final version of the refreshed Trust Strategy 2022-25 is presented today with a request for the Trust Board to:

- Approve the content of the refreshed Trust Strategy 2022-25 (final draft v14 dated 28.2.22)

- Note that the main risks to delivery of the ambitions set out within the Trust Strategy are around workforce and finance

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

- Approve the move to the implementation and monitoring phase
- Note that implementation, monitoring and evidence based reporting will be supported by the Trust's Strategic Development Group (SDG)
- Note that a Strategic Delivery Framework (SDF) has been developed to accompany the refreshed Trust Strategy 2022-25 and this sets out specific objectives for each of the twenty seven strategic ambitions along with the measures and indicators that will be used to monitor progress and delivery
- Note that once approved, the content will be used to develop a digital brochure containing graphics and images that present the strategy in accordance with the Trust's agreed branding and presentation approach
- To advise if any further changes to the document are required

Michelle Cady
28.2.22

Trust Strategy

Hull University Teaching Hospitals NHS Trust Strategy 2022-2025	
Version:	Final draft V14 dated 28.02.22
Lead Director:	Director of Strategy and Planning
Document Managed by Name:	Michelle Cady

Introduction

Welcome to our refreshed HUTH strategy, which we will be using to guide our priorities and decisions over the next three years.

At HUTH, we are proud to be the largest teaching hospital trust in the Humber Coast and Vale Integrated Care System, with circa 9,900 staff providing safe and high quality care through over one million patient contacts each year.

We provide a range of acute and specialist services to the people of Hull, the East Riding of Yorkshire, the Humber Coast and Vale area and beyond, and we have ambitious plans for the development of our organisation.

Our key ambitions include:

- Provision of outstanding quality of care and better access to our services for all of our patients
- Developing and supporting our remarkable workforce
- Development of our specialist service portfolio
- Delivery of our environmental sustainability programme
- To build and sustain partnerships
- To build on our exciting research and innovation programme

Why we need a refreshed strategy for 2022-2025

- More than ever we have to work in partnership and use our resources in innovative ways to ensure we can design, organise and deliver services to our patients and give them the best possible outcomes. There are growing opportunities for collaboration and partnerships within our geographical partnership, our Integrated Care System (ICS), other sectors and beyond. We intend to develop sustainable, long term partnerships and to work in collaboration with others in order to deliver our mission.

- We have refreshed and updated our ambitions around the development of our specialist service portfolio. Significant advances in specialised clinical service provision and medical technologies, coupled with population growth and ageing, mean that it is more important than ever for us to prioritise the development of our specialised clinical services. This is so that we can play our part in ensuring equitable access to these services and the best possible outcomes for those patients who require specialised care and treatments.

- The pandemic has changed the way we work and has presented new challenges around our productivity. It has also created significant challenges around waiting times and access to services for some of our patients.

- The workforce challenges across the NHS and wider health and care systems mean that we must find innovative ways of attracting people to work with us. We must also train, develop and support our staff to work in different ways.

- The development of digital, artificial intelligence (AI) and robotic technologies are creating new ways of working that will bring opportunities to transform the way we work and deliver services.

- To deliver the NHS Long Term Plan, NHS People Plan and Humber Coast and Vale five year plan we must align our strategic objectives and ambitions to the wider NHS context and play a key role in driving reform and a lead role in building and strengthening collaborative work and long term partnerships.

Foreword

As we emerge from one of the most challenging periods the NHS and the country have ever experienced; it is important to recognise and applaud the contribution, commitment and achievements of our staff and partners during the Covid-19 pandemic.

During 2020 and 2021 we faced major disruption to the delivery of our usual services and we have cared for many members of our community affected by the virus, including some of our own colleagues. There has been a terrible impact on so many families, friends and loved ones, and for so many people touched by the pandemic this impact will also be long term.

We rose to those challenges, we did our best, we adapted our ways of working and together we found innovative solutions to problems. We worked differently and we built and strengthened our partnerships across the wider health and social care systems to do our very best for the communities we serve and for each other.

It is this spirit, this tenacity, our important togetherness and the capability of our extraordinary organisation that will not only take us through the post-pandemic recovery period over the next few years, but will also take our organisation to the next level in terms of our future development as we further strengthen our place as a key member of the Humber Coast and Vale Integrated Care System, Humber Partnership, Hull and East Riding Place Partnerships and the wider region.

At the centre of our strategy is outstanding care, safety and quality for our patients, delivered by a skilled and diverse workforce in a culture of equality, inclusion and civility.

We will need to work together within our organisation and with our partners to deliver our mission, which is to lead the provision of outstanding care and contribute to improved population health, by being a great employer and partner, living our values and spending money wisely.

Our strategy sets out our ambitions and commitments for the next three years and we will bear these in mind in our decision making and in our prioritisation. We want this strategy to bring together and align the whole organisation and we want the whole organisation to work together in the delivery of this strategy and its supporting plans. We hope that every member of the team, every service, every department and every part of the organisation will fully engage with the ambitions set out here, and will develop plans that align with and drive us forward to the future we aspire to.

We commend the commitments and ambitions set out in this strategy and invite every person, team and service within our organisation to engage with our refreshed strategy for 2022-2025 so that our organisation's strategic ambitions are reflected in all future plans.

We are Hull University Teaching Hospitals NHS Trust

We are extraordinary people working together in a remarkable place with a clear mission.

We are proud to present this refreshed Trust strategy for 2022 to 2025.

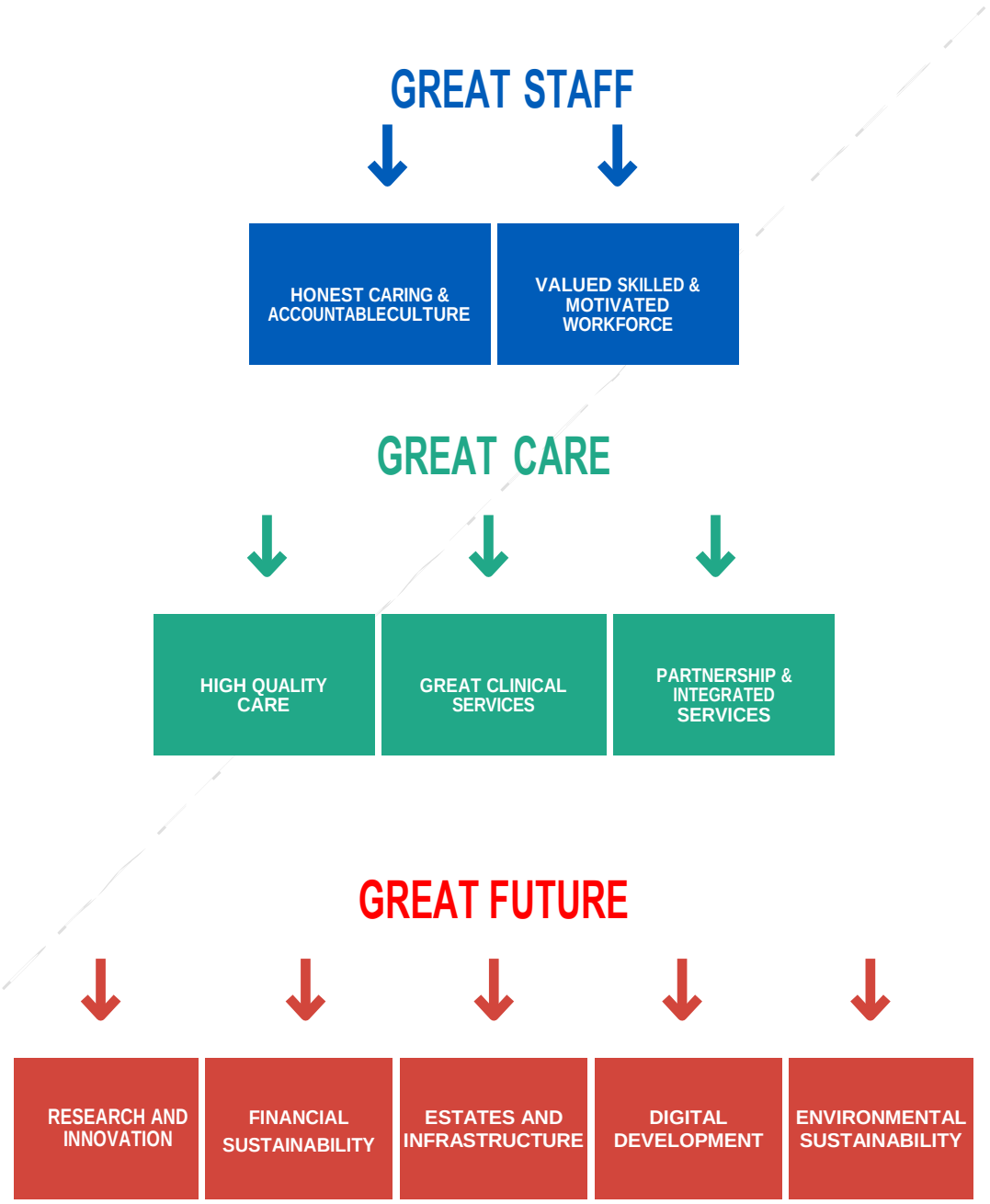
Chris Long	Sean Lyons
Chief Executive Officer	Chairman

Our Vision and long term goals

Our people are at the heart of our vision for the future of the organisation. We will deliver outstanding care to our patients and service users through the skill, expertise, commitment and innovation of our workforce.

We recognise our responsibilities as a large employer and service provider and we will become a highly sustainable and greener organisation.

We will be a leading partner working in a range of important collaborations, networks, programmes and partnerships with improving population health and development of our organisation as our central principles.



Our Mission

Our mission is to lead the provision of outstanding treatment and care and contribute to improved population health, by being a great employer and partner, living our values and using resources wisely.

Our Values

Care

We are polite and courteous, welcoming and friendly. We smile and we make time to listen to our patients and staff. We consider the impact our actions have on patients and colleagues. We take pride in our appearance and our hospitals and we try to remain positive.

Honesty

We tell the truth compassionately. We involve patients in decisions about their care and we are honest when things go wrong. We always report errors and raise concerns we have about care. Our decisions and actions are based on facts not stories and opinions.

Accountability

We are all responsible for our decisions and actions and the impact these have on care. All staff are responsible for maintaining high standards of practice and we take every opportunity to continuously learn. Everyone is encouraged to speak up and contribute their ideas to improve the care we provide.

Purpose of the Strategy

The purpose of this strategy is to state our vision, mission and long term goals and then set out how we plan to achieve them.

The strategy aims to align and bind the whole organisation together in terms of our future development and vision. All enabling strategies and plans should use the Trust strategy for inspiration, purpose and direction.

We will work to make sure that this strategy is effectively deployed to every part and level of the organisation. We hope that every team and function will be informed of and engaged in these refreshed strategic ambitions, and will formulate their own specific plans in line with our strategic goals for 2022-2025.

Our Context

In February 2021 the Health and Social Care secretary, with the support of NHS England, set out new proposals to bring health and care services closer together to build back better from the impact of the Covid-19 pandemic by improving care and tackling health inequalities. The measures set out in the Government's White Paper: *'Integration and Innovation: Working together to improve health and social care for all'* seek to modernise the legal framework to make

the health and care system fit for the future and put in place targeted improvements for the delivery of public health and social care. It will support local health and care systems to deliver higher quality care to their communities, in a way that is less legally bureaucratic, more accountable and more joined up, by bringing together the NHS, local government and partners to tackle the needs of their communities as a whole.

The proposals build on the NHS' recommendations for legislative change in the NHS Long Term Plan.

During 2021/22 measures were put in place to create statutory Integrated Care Systems (ICSs). These will comprise an ICS Health and Care Partnership and an ICS NHS Body. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the local health, public health, and social care needs. These statutory bodies will come into effect on 1st July 2022.

As part of the progressive development of ICSs, place-based and provider collaboration arrangements, including Primary Care Networks (PCNs), are playing an increasingly important role in the co-ordination and delivery of joined-up care across local populations.

Hull and East Riding of Yorkshire Place Partnerships

The Trust is a key member of two place based Health and Care Partnerships, Hull Health and Care Partnership and East Riding of Yorkshire Health and Care Partnership. As we embark upon this refreshed strategic period, and as part of the formation of the ICS arrangements; these partnerships are in development along with the Health and Well Being Boards for each Place. We will play a key role in the development of the new arrangements and will work to build and strengthen collaborative working with all partners around our shared priorities for the health of the communities we serve.

Humber Coast and Vale Integrated Health and Care Partnership

The Trust sits within the Humber, Coast and Vale Health and Care Partnership (HCAV HCP). There are a number of different organisations from across the health and social care sector which are formal members of the Partnership. These include four acute hospital Trusts - Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG), York and Scarborough Teaching Hospitals NHS Foundation Trust, Harrogate and District NHS Foundation Trust and this Trust - three mental health providers, six Clinical Commissioning Groups (CCGs), six local Councils, three community services providers and two ambulance Trusts.

These organisations only represent part of the health and care system across our area. Across Humber, Coast and Vale there are around 230 GP practices, 550 residential care homes, 10 hospices, 180 home care companies and thousands of voluntary and community sector organisations all helping to keep our local people well. We need to *all* work together in order to provide the best services for our local people.

The HCAV HCP Long Term Plan 2019-2024 sets out the Partnership's ambition to 'Start Well, Live Well and Age Well'.

This means shifting the focus of our work from picking people up when they fall to helping to prevent them from becoming unwell in the first place and supporting more people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

Humber Acute Services Programme

The Humber Acute Services Programme is about designing hospital services for the future that are safe, accessible and meet the needs of our people. To achieve this, we have to change what we do and how we do it – both in our hospitals and in the healthcare provided out of hospital.

That change started with a clinically led review of hospital services based on evidence, taking into account local health needs and looking at what has worked, and what hasn't, from similar changes in other parts of the UK.

This review has led to three inter-linked work streams which will enable us to change how we do things:

1. Stabilising vulnerable services (Interim Clinical Plan) over the next 1-2 years.
2. Redesign core hospital services to design a future model for hospital care to implement in 2-5 years.
3. Redevelop and rebuild our hospitals (Building Better Places) over a 5-10 years period.

The programme will deliver significant changes in how we deliver hospital services across the Humber in collaboration with Northern Lincolnshire and Goole NHS Foundation Trust, community, primary care and mental health partners.

Our strategic ambitions

This section sets out a summary of our strategic ambitions, organised using the themes for our vision and long term goals. These statements set out the areas we will prioritise and develop over the next three years.

Great Staff

An honest, caring and accountable culture is our priority. We will strive to build on our work to date and further develop inclusion, equality and diversity in our organisation. We will have a strong focus on the well-being of our staff as well as working to improve the experience and satisfaction of working at HUTH. Our aim is to have a skilled, motivated and engaged workforce and to be an employer of choice who can play a lead role as an anchor institution in our local communities as well as our wider system.

We will measure our progress towards our Great Staff ambitions by using the results of staff surveys as well as absence rates, the take up of well-being support services, engagement with our new improvement methodology and the results we achieve via our team-led continuous improvement programme. We will also monitor our appraisal rates and the number of staff accessing development and research activities.

Great Care

By delivering outstanding, safe, equitable and high quality care to our patients, improving outcomes and access to our services and developing our specialist services, we will deliver great care and treatment to the communities we serve, including those with complex or long term health care needs. We will seek to reduce the waiting times that have built up as a result of the Covid-19 pandemic and to ensure that no one is waiting longer than 18 weeks from referral to treatment.

We will develop a new Quality Strategy. By using technology well and supporting our patients to initiate their follow up care, we will optimise the use of our outpatient services.

We will play a key role in the development of our system and we will develop partnerships and design integrated services to reduce inequity and variation.

We will measure and monitor our progress on our Great Care ambitions by using the results of patient and staff surveys, the proportion of clinical specialties using digital consultation technology and patient led models to optimise outpatient delivery and by monitoring and benchmarking our performance against a range of quality, safety and access standards. We will take care to do this without creating inequity of access and by working as part of the wider collaborative, place and ICS structures.

Great Future

We will secure the long term financial health of the Trust and work with partners towards securing the financial health of the wider system in line with our ICS plans. We will evaluate and monitor our progress on our financial sustainability ambitions by monitoring our financial performance and how that contributes to the wider system's financial plan.

Sustainability in the form of transforming our environmental, waste and energy impact will be a top priority for us as an organisation and as part of a wider system and the places we work in. We will have a comprehensive and ambitious Green Plan and we will monitor our progress against all relevant standards and indicators around our green plan and sustainability programmes.

We will build on our local, national and international partnerships to develop our research portfolio and capability and we will strive to increase our research activity and maximise our contribution to the wider knowledge base. We will have an ambitious Research and Innovation Strategy and to measure our progress we will monitor the output of our partnerships as well as our overall research activity using a range of measures.

We will develop an ambitious estates plan to replace our oldest clinical facilities, reflect our ambitious clinical service development programme and to work as part of a wider system to offer the best possible clinical and non-clinical space to carry out our work and that of our partners. We will join forces with our local partners to maximise the use of clinical and non-clinical space.

Our ambition is to be a digital first and digital exemplar organisation and to maximise our opportunities to transform and optimise the way we work through use of digital technologies. We will do this by having a clear and ambitious Digital Strategy and we will play a key part in the system and place level plans for digital development and build on our work with our partner organisations to develop and streamline our digital capability.

Addressing Health Inequalities

HUTH recognises that the population we serve suffers from significant health inequalities. Health inequalities lead to a reduction in both the quality and duration of people's lives and impact on the type and level of services that the Trust needs to provide. It is likely that interventions that help to address these inequalities will lead to a much greater improvement in public health than any new treatments that medical advances may deliver. We will work with our partners across health and social care to reduce inequalities. We will use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes. We will use the data collected on the patients that we treat to:

- Improve access to care for those who need it most.

- Identify where it may be beneficial to provide additional health education and support to people to aid prevention and self-management, improve the uptake of care and compliance with treatment, so that we can improve health outcomes.
- Help our partners provide information to our population to help people recognise the inequalities that exist and support them to take responsibility for their own health and that of their families.
- Work with our partners to demonstrate a reduction in health inequalities across our population over the next 10 years.
- Demonstrate through our actions and information that we take as much responsibility for the health of our population as we do for the delivery of individuals' specific health care needs.

Summary of our strategic ambitions

The table below sets out a high level summary of our strategic ambitions for 2022-2025.

	Goal	Element	Strategic ambition
1	Great staff	Honest, caring and accountable culture	We will have a strong culture of inclusion, diversity and equality
2			We will have a strong culture of learning and team led continuous improvement
3		Valued, skilled and motivated workforce	We will have a strong focus on the well-being of our staff
4			We will have one of the most engaged and motivated staff in the NHS
5			We will have fewer vacancies and lower turnover
6	Great Care	High Quality Care	We will receive an outstanding rating by our quality regulator
7			We will increase harm free care
8			We will improve patient experience and outcomes
9		Great Clinical Services	We will improve access to our urgent and emergency care services
10			We will improve our outpatient services, using technology to enable better access
11			We will develop our specialist clinical services portfolio
12			We will recover and improve access to elective services as part of our pandemic recovery programme
13		Partnership and integrated services	We will develop effective partnerships with other providers
14			We will play a key role in the reform of health and care systems and provision of services closer to home
15			We will support the developing ICS structure and play a lead role in the Collaborative of Acute Providers and Place Partnerships
16	Great Future	Financial sustainability	We will secure the long term financial health of the Trust
17			We will work with partners across the system in the aim of financial balance at system and ICS level
18		Environmental sustainability	We will further reduce our energy consumption and waste
19			We will become a greener organisation
20		Research and innovation	We will create a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities
21			We will lead collaborative partnerships in the region to realise the full potential of research and innovation
22			We will create a positive reputation through our research, increasing R&I capability and demonstrably improving patient care and experience
23		Estates and infrastructure	We will agree an ambitious estates plan that delivers our clinical strategy and replaces our oldest clinical facilities
24		Digital development	We will become a digital first organisation
25			We will play a key role in the development and delivery of the Humber and ICS Digital strategy and plans
26			We will work in partnership with neighbouring organisations and systems to develop more streamlined digital capability
27			We will become a digitally mature, secure and resilient organisation

Delivery and monitoring of the strategy

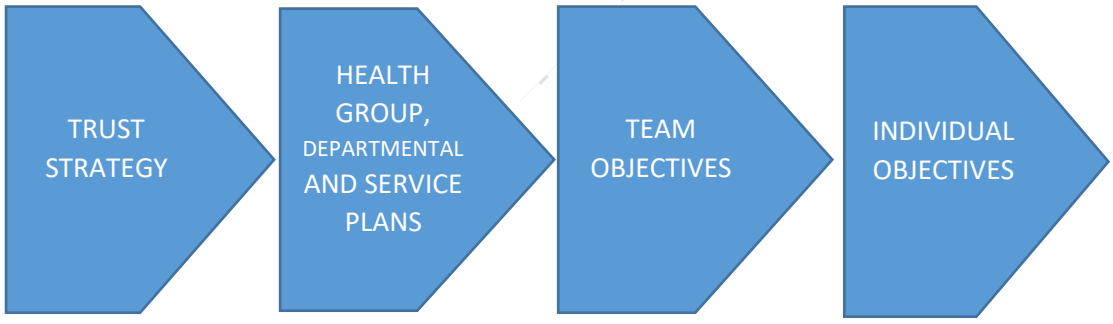
We will support, co-ordinate and monitor progress via a new strategic development group and strategic delivery framework, which will provide a strong basis for evidence based reports based on agreed measures of progress, and the impact they are having, to the Executive Management Committee, with the Trust Board maintaining formal oversight via regular progress reviews.

Our new strategic delivery framework sets out specific development objectives over three years to ensure a systematic and consistent approach to the realisation of our ambitions, and effective oversight of our overall development as a large acute provider organisation.

For each of our strategic ambitions we will set out the measures we will use to monitor how we are progressing towards the achievement of each of our twenty seven strategic ambitions. A key part of this will be monitoring and mitigating as far as possible the risks to delivery.

We launch the new strategy with key objectives for each of the three years covered by the 2022-2025 strategy.

For each of these objectives there will be a comprehensive action plan overseen and supported by an accountable executive officer (AEO). These action plans will be reviewed regularly with the named leads via the strategic development group and they will be dynamic in nature, with adjustment of actions and addition of new actions to drive progress towards achievement of the objectives during the three year period of this Trust Strategy.



To deliver the Trust Strategy, we have a number of specific projects and a group of supporting strategies and delivery plans including:

- The People Strategy 2019-2024 (to be refreshed in 2022)
- The Research and Innovation Strategy 2018-2023
- The Estates Strategy 2017-2022
- The Digital Strategy 2018-2023
- The Zero Thirty Plan, launched in July 2021
- The Quality Strategy (in development during 2021/22)
- The Nursing Strategy (in development during 2021/22)
- The Clinical Strategy, including our Cancer Centre Strategy (in development tbc)
- The Finance Strategy (in development tbc)
- The Equality Strategy (in development during 2021/22)
- The Risk Management Strategy (in development during 2021/22)

Our Health Groups and Corporate Services Teams will develop or refresh their strategic plans to reflect the commitments set out in the new Trust Strategy. The new Strategic Development Group will hold a central register of all supporting strategies and plans, and will maintain a calendar system to ensure the ongoing currency of active plans as well as the closure of completed plans.

There are some potential risks to our ability to deliver our strategy and these are centred around being able to secure and sustain the workforce and funding required for development.

The Strategic Development Group will work with the executive owners and delivery leads to co-ordinate evidence of progress for each of our strategic commitments and will formally report progress to the Trust Board twice a year.

Michelle Cady

HUTH Director of Strategy and Planning

FINAL DRAFT v14 dated 28.02.22

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
QUALITY STRATEGY

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8th March 2022
Title	Quality Strategy 2022-2025				
Lead Directors	Suzanne Rostron, Director of Quality Governance				
Author	Ernesto N. Quider, Associate Director of Quality				
Report previously considered by (date)	This report has been previously considered at the Quality Committee.				

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

Key Recommendations to be considered:
The Trust Board is recommended to approve the proposed Quality Strategy for this meeting. The attached Quality Strategy was presented and shared for consultation at the Quality Committee, Patient and Public Council, CCG Quality Delivery Group and at CQC engagement meeting.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
DEVELOPMENT OF QUALITY STRATEGY 2022-2025

1. PURPOSE

The purpose of this report is to provide the Board the update on the development of Quality Strategy for 2022-2025 after key engagement and consultation meetings were held with partners, patient council and external stakeholders.

2. BACKGROUND

The Quality Strategy provides key quality and safety objectives on how our Trust will take forward its vision to deliver Great Care, Great Staff and Great Future, through the implementation of our Trust's QUEST (Quality Effective Safe Trust) towards delivering high quality care for our patients.

This strategy builds on our improvements and successes for the past few years to achieve an outstanding CQC overall rating. This Quality Strategy will set out the approach and help shape the direction of improvement in achieving our ambitions for both of our patients and their families, our staff and other stakeholders.

3. QUALITY PRIORITIES OVERVIEW

The Quality Strategy sets out a quality management system (QMS) approach, which aims to put high quality care for our patients at the centre of every quality process and embedding a culture of continual quality improvement (CQI) and learning. All of our quality ambitions have a series of quality indicators to enable effective monitoring of high-level deliverables and work streams with measurable outcomes. The priorities within this strategy will go through a regular consultation process and will be used to inform the annual Quality Accounts.

The priorities of our Quality Strategy are set out across four main quality domains with the acronym, 'S.E.L.F.'- ***s**afety, **e**ffectiveness, **l**earning (experience) and **f**ocussed (person-centred car**e**)*. Our quality strategy is aimed to establish and achieve these priorities and its associated objectives that are owned *('SELF')* by every staff member-clinical or non-clinical who will all contribute to delivering high quality patient care outcomes and work together with our remarkable staff, patients, service users alongside our partners in the Integrated Care System (ICS).

4. RECOMMENDATIONS

The Board is recommended to approve the proposed Quality Strategy at this meeting.

Ernesto N. Quider
Associate Director of Quality

March 2022

NHS
Hull University Teaching Hospitals
NHS Trust

QUALITY STRATEGY 2022-2025

When this document is viewed as a paper copy, it is the reader's responsibility to ensure that it is the most current version.

BETTER
BRIGHTER
GREENER
FAIRER

Remarkable people.
Extraordinary place.

EXECUTIVE SUMMARY

As a major teaching and University hospital, Hull University Teaching Hospitals NHS Trust is committed to delivering high quality patient care and safety, which sits at the heart of this Quality Strategy. Our Quality Strategy defines the overarching quality management system framework and our quality ambitions that we will focus on over the next four years. This strategy provides key quality and safety objectives on how our Trust will take forward its vision to deliver Great Care, Great Staff and Great Future, through the implementation of our Trust's QUEST (Quality Effective Safe Trust) towards high quality care and builds on our improvements and successes for the past few years to achieve an outstanding CQC overall rating.

The Trust is in an extraordinary challenging time during this pandemic period. However, we pride ourselves with initiatives including the implementation of quality priorities and measures, Schwartz rounds, our ongoing compliance to national accreditations, quality rounds, executive-led weekly patient safety summit and quality deep dives, Getting It Right First Time and other quality projects, which all contribute to the delivery of this new Quality Strategy.

The objectives of our Quality Strategy are set out across four main quality domains- safety, effective, learning (experience) and focussed (person-centred care)
(i.e. 'SELF'), which are aimed for our Trust to work together with our remarkable staff, patients, service users alongside our partners in the Integrated Care System (ICS).

FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

We are delighted to present Hull University Teaching Hospitals NHS Trust first Quality Strategy, which sets out our quality and safety ambitions for 2022 to 2025 and linked with our Big Ambitions detailed in the Trust Strategy 2019 to 2024. Patient care and safety sit at the heart of this strategy, with our aims for outstanding quality of care, staff experience and clinical services.

The Trust employs 9,900 people and has a comprehensive care portfolio covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area. The Trust provides specialist services to a catchment population of between 1.05 million and 1.8 million extending from York and Scarborough in North Yorkshire to Grimsby and Scunthorpe in Northern Lincolnshire. Providing outstanding care to our patients is our vision and is reflected in our ambitions and commitment to improving services and outcomes for our patients.

The Trust is on a journey to achieve an overall rating of 'Outstanding' with the CQC, whilst increasing harm free care, implementing a strong culture of team led continuous improvement and having one of the most engaged and satisfied staff in the NHS. This Quality Strategy will set out the approach and help shape the direction of improvement in achieving our ambitions.

This strategy has been developed in consultation with our staff and stakeholders who have shared their views and indicated what they believe our priority areas for improvement are. We have taken into account their views and that of our commissioners and regulators in developing this strategy.

We will lead by example through high-visible compassionate leadership and promote a culture of quality improvement by supporting our staff to make quality their priority and remove barriers to ensure that change and improvement is sustainable and really makes a difference to the patients using our services.

Mr Sean Lyons
Chairman
(Joint Chair with NLAG)

Chris Long
Trust Chief Executive

GREAT STAFF

- HONEST CARING & ACCOUNTABLE CULTURE
- VALUED, SKILLED & SUFFICIENT WORKFORCE

GREAT CARE

- HIGH QUALITY CARE
- GREAT CLINICAL SERVICES
- PARTNERSHIP & INTEGRATED SERVICES

GREAT FUTURE

- RESEARCH & INNOVATION
- FINANCIAL SUSTAINABILITY
- ESTATES & INFRASTRUCTURE
- DIGITAL DEVELOPMENT
- ENVIRONMENTAL SUSTAINABILITY

INTRODUCTION

Our Quality Strategy's QUEST to achieving high quality care describes how we at Hull University Teaching Hospitals NHS Trust are delivering our vision of Great Staff, Great Care, and Great Future together with our remarkable staff, patients, stakeholders and partners in the region. Core to our delivery of our quality agenda are our strong beliefs in our Trust values and related behaviours, notably in becoming a learning organisation with our just culture and compassionate leadership across all levels.

Our approach of collaborative working with multidisciplinary teams and embedding a culture of shared learning and continuous improvement are keys to delivering our quality agenda, which means that we value our staff development and their wellbeing in order to put every patient and their families who needs our care, expertise and support at the heart of everything we do. In order to improve patient pathways across the Humber, our Quality Strategy is also a demonstration of our commitment to working in partnership with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and other regional partners.

This Strategy sets out a quality management system approach, which aims to put high quality care at the centre of every quality process. All of our quality ambitions have a series of quality indicators to enable effective monitoring of high-level deliverables and work streams with measurable outcomes. The priorities within this strategy have been selected by our patients, staff, commissioners and the public through a regular consultation process and will be used to inform the annual Quality Accounts.

ENABLING QUALITY MANAGEMENT SYSTEM

Diagram 1. Quality Management System approach to deliver our overarching Quality Aim.

STRATEGIC CONTEXT AND OBJECTIVES

Through implementing this strategy, we WILL:

KEY EXTERNAL CONTEXT

- NHS long term plan
- National patient safety strategy
- Integrated care systems / partnerships i.e. HASR
- Regulatory and accreditation standards

Diagram 2. Our Strategic Context that influences the development of this Quality Strategy.

STRATEGIC CONTEXT

Our Quality Strategy builds on the accomplishments and steady improvements of the previous years including our learnings during this unprecedented time and having attained a 'Good' rating in the 'Well Led' domain (2018) from the Care Quality Commission (CQC) with a 'Good' rating for the majority of its services, although the overall rating remained 'Requires Improvement'.

This strategy provides a quality framework to develop, standardise and innovate in order to achieve our QUEST to high quality care and an outstanding overall CQC rating in the next four years. The external context that outlines our quality journey has also transformed with our Trust to work as integrated care system alongside our regional partners to deliver safe and effective care whilst continuously striving to meet expanding demands on improving population health and developing our remarkable staff.

Our Quality Strategy replicates this overarching contextual framework, 'Quadruple Aim' in line with our continued pursuits (QUEST) to deliver high quality care whilst continually responding to relentless demands brought about by the pandemic: reset and recovery programme; improving population health within our integrated care systems, achieving value and financial sustainability and improving patient experience and staff well-being.

QUALITY PRIORITIES

Our quality ambition to be a regional centre of excellence as one of the leading major teaching hospitals in the country will see us provide evidence-based, efficient and cohesive healthcare pathways. Our Quality Strategy alongside the Clinical Services Strategy outline the drivers for the Trust in our QUEST of providing high quality care. Thus, it defines our Quality Priorities as follows:

QUALITY PRIORITIES *('SELF')*

SAFETY
— Harm free care
— Learning from events

EFFECTIVE
— Right patient, right place, right time
— Best clinical outcomes

LEARNING
— Listenning from patients and staff experience
— Improve engagement with staff, patients, and the public

FOCUSSED
— Person centered care
— End of life care
— Mental health
— Dementia care

In order for us to deliver our Quality Priorities (i.e. 'SELF') we have defined our strategic ambitions with corresponding high-level deliverables to measure effectively our ongoing progress in meeting our quality aim. In line with our aim for effective implementation and regular evaluation of improvements achieved, each quality priority will have its corresponding improvement plans by the accountable leads and reporting committees based on their designated work streams to ensure that they are as robust as possible.

SAFE CARE

STRATEGIC AMBITION

All patients receiving harm-free care as measured by the following six harms:

1. Hospital acquired pressure ulcers
2. Catheter associated UTI
3. Avoidable venous thromboembolism (VTE)
4. Harm from falls
5. Hospital acquired infection
6. Medication errors

HIGH-LEVEL MEASURES / DELIVERABLES

— Reduction in trsut preventable infections and complications e.g. sepsis, acute kidney infection, pressure sores, VTE
— Accelerate rollout of trust PSIRP and patient safety improvement programmes
— Reduction in patient falls and other identified major incident categories
— Develop safety culture / learning from events e.g. safety huddles, compliance with medication reviews / controlled drug checks, ward accreditation programme

EFFECTIVE CARE

STRATEGIC AMBITIONS

1. Develop outcome measures for each speciality and used for clinical improvement (best clinical outcomes)
2. Establish and embed actionable local audits with clear improvement and monitoring programme for clinical departments
3. Deliver consistent high evidence based quality care; right patient, right place, right time

HIGH-LEVEL MEASURES / DELIVERABLES

— Utilise quality measurement tools e.g. Hospital Standardised Mortality Ratios (HSMR), Summary Hospital Level Mortality Indicators (SHMI), to inform and improve the provision of services effectively
— Develop and implement improvement plans for clinical indicators
— Improve partnership working to reduce Delayed Transfers of Care
— Ensure compliance with NICE guidance and other best practices appropriate to HUTH

EXPERIENCE

STRATEGIC AMBITIONS

1. Develop and enhance public and patient engagement strategy (learning from experience)
2. Work in partnership with patients and public to develop and improve services
3. Develop staff health and well-being

HIGH-LEVEL MEASURES / DELIVERABLES

— Reduction in formal complaints, particularly in trust top categories e.g. staff attitude, dignity and respect, and communication
— Increase Friends and Family response rates for all departments / service areas
— Implement YOUnique (staff as patients QI programme) to listen, learn and act from patients' perspectives - patients and staff feedback forum
— Improve implementation of Schwartz rounds, including improving medical engagement in well-being programmes

PERSON-CENTERED CARE

STRATEGIC AMBITION

1. Develop End of Life Care Strategy aimed at improving the quality of care for patients and their families at the end of life with clear priorities and work programmes
2. Develop improvements in dementia care and mental health at all levels within the organisation
3. Develop specialist services focused on continuity of care in all care settings - maternity and neonatal care, vascular, cardiology services

HIGH-LEVEL MEASURES / DELIVERABLES

— Establish QI programme in line with NHSEI's End of Life collaboration
— Redcuation in formal cmoplaints relating to End of Life Care
— Improve compliance with specialist service specifications and national standards relevant to HUTHT
— Improve implementation of Better Births programme - rollout of 'Always Events' QI initiative (focused on the things we should always aim to do well)

STRATEGY TARGETS AND MILESTONES

YEAR 1 : 2022/23

SAFETY, EXPERIENCE
- Increase in proportion of harm-free incidents
- Become accredited QSIR faculty / academy

YEAR 2: 2023/24

ENCOMPASSES ALL PRIORITIES
- Establish training programme for QI
- Improve self-assessment ratings against CQC KLOE and standards

YEAR 3: 2024/25

EFFECTIVE, EXPERIENCE, PERSON-CENTERED CARE
- Year on year improvements in Clinical Outcome indicators;
- GIRFT, SSNAP, NNAP, NPDA, ACS, MINAP, FFFAP and other national audits programme
- Increase positive patient and staff experience, feedback and review outcomes

YEAR 4: 2025/26

ENCOMPASSES ALL PRIORITIES
- Deliver best practice more consistently
- Acheive Outstanding overall CQC Rating

QUALITY IMPROVEMENT FRAMEWORK

In order to achieve our quality ambitions and embed a culture of learning and continuous improvement, we are embarking on an ambitious training and development programme for staff, which will equip them with the skills to undertake quality improvement projects. This Trust's QI programme called **Quality, Service, Improvement and Redesign (QSIR)** is a quality programme that has been delivered over many years to various staff- both clinical and non-clinical, which is led by NHS England and NHS Improvement. We involve regional strategic partners to help train our staff directly and to 'train the trainer' so that at the end of the QSIR programme, our Trust can be self-sustaining. In collaboration with our ICS partners and NHSE/I regional system improvement leaders, we will develop also a joint QI celebration or learning events that cultivates shared learning of our improvements and best practices.

Our Trust will focus on the consistent use of robust quality improvement methodologies to drive measurable and sustained quality improvement. These methodologies will support the delivery of the programmes of work outlined in this Quality Strategy.

Quality, Service Improvement and Redesign (QSIR) curriculum

—Leading improvement

—Project management

—Measurement for improvement

—Sustainability of improvement

—Engaging and understanding others

—Creativity in improvement

—Process mapping

—Demand and capacity

—Trust-wide QSIR Programme sponsored by EMC

—Quality Governance and Clinical / Nonclinical Team as QSIR Accredited Faculty

—Quality Priorities and QI Training Needs defined in each Division and Health Group

—Frontline staff members training and involvement of CQI projects

Diagram 3. Enabling systematic quality improvement approach through QSIR programme.

QI Capacity and Capability Development:

This Strategy will provide more focus on the development of our systematic approach to delivering Trust wide Quality Improvement with the executive-led quality improvement enablers as shown on diagram 4. Over the next four years, our Trust's Quality Improvement Programme will focus on the following key areas of work outlined in this strategy, which will address current systems challenges we are facing and build on the ongoing improvement priorities and accomplishments already made so far:

1. Introduce a new QI academy programme based on QSIR tools for our team leaders, frontline staff and non-clinical staff members in line with their QI training needs and quality priorities in each health group;
2. Focus on the systematic scaling up and spreading of interventions, which have been shown to work in one service area and which are applicable to other service areas or health groups;
3. Evaluate different ways to expand the involvement of patients, their representatives and other service users in our QI work within the Trust;
4. Promote the wider application of QI within corporate services and engage our commissioners with our QI approach.
5. Remodel our information systems so that our staff have better access to the data they need to understand quality, performance and accountability and to support their QI projects with meaningful data and measurable outcomes;
6. Continue to build will and build improvement capability across the organisation, integrating the programme into our governance systems and operational delivery;
7. Develop learning framework across the quality management system in line with our continuous quality improvement (CQI) monitoring and evaluation processes towards achieving our strategic ambitions on our quality priorities.

SUMMARY OF CQI FRAMEWORK

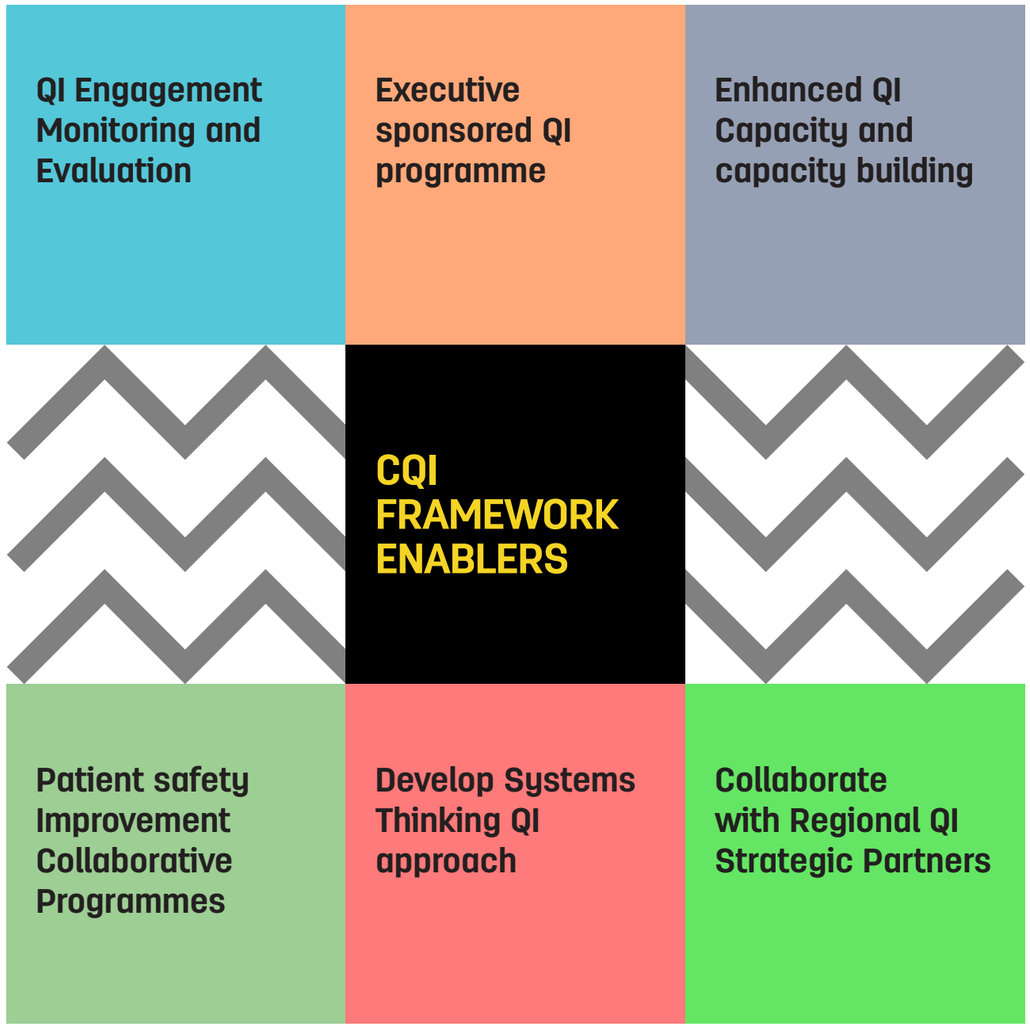


Diagram 4. Summary of CQI Framework Enablers to support systematic approach to Trust wide Quality Improvement programme.

PATIENT SAFETY FRAMEWORK

Following the launch in July 2019 of the NHS Patient Safety Strategy (Safer Culture, Safer Systems, Safer Patients) by NHS England and NHS Improvement, which describes how the NHS will continually improve patient safety over the next 5-10 years. The three strategic aims focus on insight, involvement and improvement. Our Quality Strategy supports our local delivery of the NHS patient safety strategy and the implementation framework through developing our Trust's patient safety incident response plan (PSIRP).

MONITORING, EVALUATION AND REVIEW

The implementation of this Strategy will be monitored with defined performance measures and actionable results through various work streams with corresponding committees and assigned accountable areas of leadership (Executive and Operational). The Quality Committee will be the Board Committee with responsibility for seeking assurance on the delivery of the Quality Strategy.

DIVISIONAL AND HEALTH GROUP ACCOUNTABILITY:

To ensure that all staff are committed to the success of our Quality Strategy, there will be various levels of monitoring and reporting starting from individual division and health group. Each Health Group should ensure to effectively monitor their elements of the quality strategy implementation plan, which will be monitored and evaluated at the Performance and Accountability meetings. This will enable lessons to be learned from successes in some areas and additional support or intervention to be provided in areas who are not demonstrating quality improvement through the identified indicators.

Each quality priority detailed within this strategy has an accountable leads (executive and operational) as detailed in the appendix section, table 1. The Trust Board will hold this named leads to account on the delivery of the work streams and outcomes for the quality priority. A Non-Executive Director sponsor will also provide additional challenge and support to the delivery of each priority. As outlined in table 1 of the appendix section, the Trust has a number of committees that will be able to provide expertise, support or monitoring of the agreed quality priorities. Each quality priority states which reporting committee is aligned to, which serves as a Trust-wide monitoring process (see appendix section, table 1).

LINK WITH ANNUAL QUALITY ACCOUNTS:

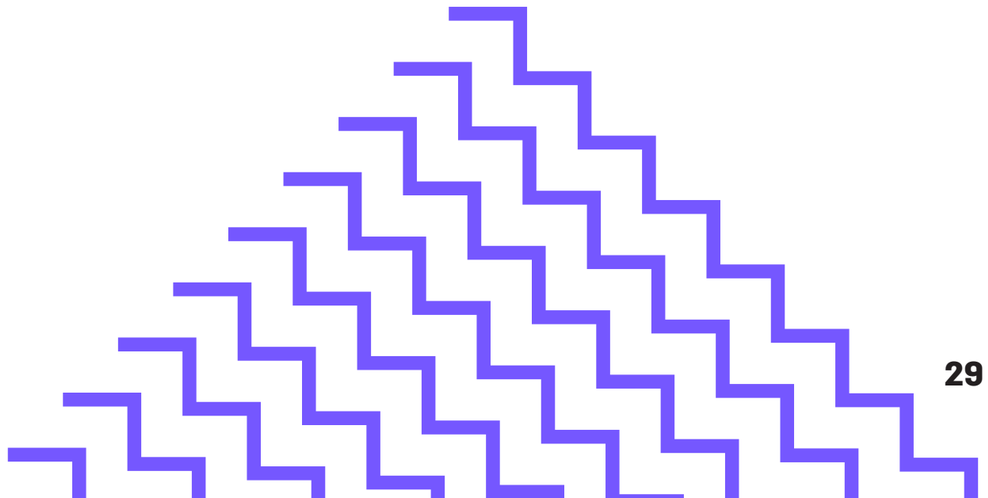
The Trust will continue to update its Quality Account in our public facing website and hold stakeholder events to ensure that progress is reported as one of our mechanisms for prioritising and reporting publicly as widely as possible. The Trust's Quality Accounts, and the process that accompanies them, is the key tool for delivering this strategy and maintaining stakeholder involvement.

TRUST BOARD

QUALITY COMMITTEE
Seeks assurance of the delivery

SUB-COMMITTEES
Monitor specific work streams

STRATEGIC DEVELOPMENT GROUP
Provide progress reports



EQUALITY IMPACT ASSESSMENT

In order to ensure compliance with equality legislation, it is important that an Equality Impact Assessment is undertaken to ensure that the strategy under development does not impact negatively on different communities or groups.

ENABLING STRATEGIES AND POLICIES

Our Quality Strategy is also supported through other key strategies and associated policies:

— Clinical Services Strategy
— People Strategy
— Risk Management Strategy
— Nursing, Midwifery and AHP Strategy
— Patient Safety incident Response Plan (PSIRP)
— Digital Strategy
— Research and Development Strategy
— Mental Health Strategy
— Dementia & Delirium Strategy

APPENDIX

Table 1. Accountability Monitoring and Evaluation of Quality Priorities

QUALITY PRIORITY 1: SAFE CARE

STRATEGIC AMBITIONS

All patients receiving harm-free care as measured by the following six harms:

1. Hospital acquired pressure ulcers
2. Catheter associated UTI
3. Avoidable venous thromboembolism (VTE)
4. Harm from falls
5. Hospital acquired infection
6. Medication errors

ACCOUNTABLE EXECUTIVE LEAD(S)

— Chief Medical Officer
— Chief Nurse

ACCOUNTABLE OPERATIONAL LEAD(S)

— Deputy CMO
— Deputy Chief Nurse
— HG Triumvirates
— Chief Pharmacist
— Head of Patient Safety and Improvement
— Medical QI Lead

MONITORING COMMITTEE

— Patient Safety and Clinical Effectiveness Sub-Committee

QUALITY PRIORITY 2: EFFECTIVE CARE

STRATEGIC AMBITIONS

1. Develop outcome measures for each specialty and used for clinical improvement (best clinical outcomes)
2. Establish and embed actionable local audits with clear improvement and monitoring programme for clinical departments
3. Deliver consistent high evidence based quality care **- right patient, right place, right time**

ACCOUNTABLE EXECUTIVE LEAD(S)

— Chief Medical Officer
— Chief Nurse
— Director of Quality Governance

ACCOUNTABLE OPERATIONAL LEAD(S)

— Deputy CMO
— Deputy Chief Nurse
— HG Triumvirates
— Head of Patient Safety and Improvement
— Medical QI Lead

MONITORING COMMITTEE

— Patient Safety and Clinical Effectiveness Sub-Committee

QUALITY PRIORITY 3: LEARNING (EXPERIENCE)

STRATEGIC AMBITIONS

1. Develop and enhance public and patient engagement strategy **- learning from experience**
2. Work in partnership with patients and public to develop and improve services
3. Develop staff health and well-being

ACCOUNTABLE EXECUTIVE LEAD(S)

— Chief Medical Officer
— Chief Nurse
— Director of Quality Governance
— Director of Workforce

ACCOUNTABLE OPERATIONAL LEAD(S)

— Deputy CMO
— Deputy Chief Nurse
— Associate Director of Quality
— HG Triumvirates
— Head of Patient Experience and Engagement
— Medical QI Lead

MONITORING COMMITTEE

— Patient Experience Sub-Committee

QUALITY PRIORITY 4: FOCUSSED (PERSON-CENTRED CARE)

STRATEGIC AMBITIONS

1. Develop End of Life Care framework aimed at improving the quality of care for patients and their families at the end of life with clear priorities and work programmes
2. Develop improvements in dementia care and mental health at all levels within the organisation
3. Develop specialist services focused on continuity of care in all care settings- maternity and neonatal care, vascular, cardiology services.

ACCOUNTABLE EXECUTIVE LEAD(S)

— Chief Medical Officer
— Chief Nurse

ACCOUNTABLE OPERATIONAL LEAD(S)

— Deputy CMO
— Deputy Chief Nurse
— Assistant Chief Nurse
— HG Triumvirates
— Head of Midwifery
— Head of Patient Experience and Engagement
— Medical QI Lead

MONITORING COMMITTEE

— Patient Experience Sub-Committee

NHS
Hull University
Teaching Hospitals
NHS Trust

BETTER
BRIGHTER
GREENER
FAIRER

Remarkable people.
Extraordinary place.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	Risk Management Strategy				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Strategy has been received at the Quality Committee and approved by the Board				

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

Key Recommendations to be considered:

The Board is asked to note that the content of the Risk Management Strategy will not change but the pictures are currently being updated and refreshed.

The Board is asked to receive the report for information only.

Hull University Teaching Hospitals
NHS Trust

RISK MANAGEMENT STRATEGY

NOVEMBER 2021

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1. INTRODUCTION

1.1 Purpose

This document sets out the strategic direction for risk management for Hull University Teaching Hospitals NHS Trust for the next three years. It has been developed to comply with legal and statutory requirements, assist in compliance with national standards, promote proactive risk management and to improve the safety and quality of patient care.

1.2 Aim of Risk Management

Risk management is a central part of the Trust's strategic and operational management. It is the process whereby the Trust identifies, assesses and analyses the risks inherent to and arising from its activities, and puts in place robust and effective controls to mitigate those risks. The aim of risk management is to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operational objectives.

This strategy describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide reasonable assurance that risks are managed and an effective control system is in place. The strategy is a trust-wide document, and is applicable to all employees, as well as sub-contracted staff at all levels of the organisation.

For the purpose of this strategy risk is defined as **'a circumstance, situation, action or event, which prevents** Hull University Teaching Hospitals NHS Trust **from achieving its objectives or meeting regulatory compliance requirements.'**

1.3 Scope

This strategy covers the range of risks that Hull University Teaching Hospitals NHS Trust may be exposed to such as clinical, financial, operational and reputational risks.

1.3.1 Strategic Risks

Those business risks that, if realised, would fundamentally affect the way in which the organisation exists or conducts its business. These risks may have a detrimental effect on the organisations Annual Business Plan and thus achievement of its key business objectives. This risk realisation could lead to material failure, loss or lost opportunity. Strategic risks are detailed in the Trust's Board Assurance Framework (BAF) and mapped against the Trust's strategic objectives.

1.3.2 Corporate Risks

The risks associated with the key business processes within the Corporate departments such as IT, Estates and HR. The issues arising from these will be considered at department level in the first instance and then escalated to the Operational Risk and Compliance Committee, Clinical and Non-Clinical Quality Committees and the Executive Management Committee if required.

The Risk Management Team will work closely with the Corporate functions in the same way as the Health Groups.

1.3.3 Operational Risks

The risks associated with the key business processes at speciality, department, divisional and Health Group/Directorate level. The issues arising from these will be considered at Department/ Divisional / Health Group/Directorate level in the first instance, and then escalated to the Operational Risk and Compliance Committee, Clinical and Non-Clinical Quality Committees and the Executive Management Committee if required, (i.e. if the risk cannot be resolved at Health Group/Corporate Directorate level or if the central Quality Governance and Assurance Team observe trends). This approach will ensure effective use of key business processes, streamlining information and risks towards the Trusts Strategic aims.

The Risk Management Team will work closely with the Health Groups to identify risks, standardise the approach to risk management and manage any risk clusters and themes emerging.

All risks are categorised using the same matrix and framework. This can be found within CP362 Risk Policy and Procedures.

1.4 Overarching Goal

We at HUTHT aspire to develop a cohesive and integrated risk management system that aligns strategically with Trust's objectives by adopting best practices in the identification, evaluation and control of both clinical and non-clinical risks in order to deliver an effective, safe and high quality care to our patients and stakeholders.

The Trust is committed to the management of risk in order to:

- Monitor continuously and seek to improve the quality of care provided in partnership with patients, carers, staff and the public.
- Provide a safe environment for the benefit of patients, staff and visitors by reducing and, where possible, eliminating the risk of loss / harm.
- Protect its assets and reputation.

The Trust is committed to mitigating those risks within its control and preparing contingencies for risks beyond its control. As the Trust seeks to manage risks according to the appetite for those risks, it recognises the need to balance the costs and benefits of measures to reduce risk levels.

In order to succeed, risk management must be embedded at all levels within the organisation.
To this end, the following components are critical:

- Clear and effective governance arrangements
- Strong, respected and impactful leadership with accountability
- Explicit strategic objectives
- Appropriate resource allocation
- Integrated planning arrangements
- Effective stakeholder involvement
- Education and training strategies
- Recognising the value of innovation that all staff can contribute to the overall management of risk
- A system of risk identification, recording and action planning (Risk Register)
- Learning lessons and changing practice both within the Health Groups and organisation wide
- Sharing lessons to learn with the wider health community

2. TRUST STRATEGIC OBJECTIVES AND RISK MANAGEMENT

2.1 Strategic Objectives

This strategy aims to support the Trust in achieving its Strategic Objectives, which are:

OUR VISION (and long term goals)

Our people are at the heart of our vision for the future of the organisation. We will deliver outstanding care to our patients and service users through the skill, expertise, commitment and innovation of our workforce.

We recognise our responsibilities as a large employer and service provider and we will become a highly sustainable and greener organisation.

We will be a leading partner working in a range of important collaborations, networks, programmes and partnerships with improving population health and development of our organisation as our central principles.

OUR MISSION

Our mission is to lead the provision of outstanding treatment and care and contribute to improved population health, by being a great employer and partner, living our values and using resources wisely.

GREAT STAFF

- HONEST CARING & ACCOUNTABLE CULTURE
- VALUED, SKILLED & SUFFICIENT WORKFORCE

GREAT CARE

- HIGH QUALITY CARE
- GREAT CLINICAL SERVICES
- PARTNERSHIP & INTEGRATED SERVICES

GREAT FUTURE

- RESEARCH & INNOVATION
- FINANCIAL SUSTAINABILITY
- ESTATES & INFRASTRUCTURE
- DIGITAL DEVELOPMENT
- ENVIRONMENTAL SUSTAINABILITY

OUR VALUES

CARE

We are polite and courteous, welcoming & friendly. We smile and we make time to listen to our patients and staff. We consider the impact our actions have on patients and colleagues. We take pride in our appearance and our hospitals and we try to remain positive.

We do not treat anyone unfairly. We do not let our mood affect the way we treat people. We don't talk negatively about colleagues or other teams. Offensive language, shouting, bullying and spreading rumours are unacceptable.

HONESTY

We tell the truth compassionately. We involve patients in decisions about their care and we are honest when things go wrong. We always report errors and raise concerns we have about care. Our decisions and actions are based on facts not stories and opinions.

We do not withhold information from colleagues or patients. We never discourage staff from reporting concerns. We are not careless with confidential information. We do not present myths as facts.

ACCOUNTABILITY

We are all responsible for our decisions and actions and the impact these have on care. All staff are responsible for maintaining high standards of practice and we take every opportunity to continuously learn. Everyone is encouraged to speak up and contribute their ideas to improve the care we provide.

We do not unfairly blame people. We positively embrace change and we don't discourage people from having opinions. Controlling behaviours and silo working should not be exhibited in our trust.

RISK MANAGEMENT OBJECTIVES

This Risk Management Strategy has been developed to support the delivery of Hull University Teaching Hospitals NHS Trust's Strategic Objectives. The Risk Management Strategy priorities are:

- To ensure that risks that could prevent objectives being achieved are proactively identified, quantified and managed to an acceptable level and in doing so provide a robust risk management framework with appropriate reporting arrangements and individual responsibilities clearly identified.
- For all strategic risks to be managed in line with the Trust Board's risk appetite.
- To improve organisational risk maturity, at all levels of the Trust.

CURRENT POSITION

— All Health Groups use the risk register and include it in their governance meetings

— There is good evidence within the governance meeting minutes that risks to patient safety are being managed; whether these risks are recorded on the register or not

— The quality of risk registers is variable across the organisation; some registers are limited to Health and Safety risks and do not identify all residual risks to the service

— Risk descriptions do not always identify the condition, cause and consequence of the risk

— Inconsistency in risk ratings with risk ratings not always applied using the matrix in the Risk Management Policy

— Corporate risks are not aligned to the Board Assurance Framework

— Corporate risks have appropriate controls identified

— Ineffective action plans with some risks being >3 years old and little challenge applied at risk reviews

— Risks not being closed when managed to the lowest level practicable

PLANNED POSITION

— All key risks should be identified, assessed and managed in accordance with the Risk Management Policy

— Risk descriptions should clearly articulate the condition, cause and consequence of the risk

— All risks, when entered onto the DATIX risk management system, should have clearly detailed existing controls in place.

— The action plan to achieve the 'target risk' for operational risks should be uploaded to DATIX at the time of entering the risk

— All risks to be aligned with the Board Assurance Framework

— Training to be given to ensure all risk managers understand inherent risk and target risk ratings

— Good risk management practices to be shared Trustwide

— All high risks (≥15) should have a review date of no longer than 1 month from the time of entry.

— All moderate risks (8-12) should have a review date of no longer than 3 months.

— All low risks (<8) should have a review date of no longer than 6 months

3. HOW RISKS ARE MANAGED

For further information on how risks are managed locally including the Risk Register and Risk Assessment process, please refer to CP362 Risk Policy and Procedures.

3.1 Strategic Risks - Board Assurance Framework

3.1.1 Purpose of the Board Assurance Framework

A Board Assurance Framework is 'a structure within Boards which identifies the principal risks to the organisation meeting its principal objectives and maps out both the key controls in place to manage them and also how they have gained sufficient assurance about their effectiveness'.

3.2 Target risk ratings

Target risk ratings should be set for all risks. The target risk rating is a means of expressing the lowest acceptable (tolerated) level for that risk.

3.3 Operational Risks

Any risks within Health Groups are operational risks and any risks within Corporate Functions are Corporate risks. Both are recorded on the Trust's risk register, DATIX.

Examples of these risks are;

- Patient Safety
- Financial
- Reputational
- Health and Safety

These risks can be identified at any level within the Trust, and should use the Trust management structures to facilitate these risks being entered onto the Trust risk register.

3.3.1 Management of operational and corporate risks

Each Health Group has members of staff responsible for the management of their risk registers. These people are not the only people who identify risks, as any staff member can do so, they are the nominated persons to access DATIX to record and update the risk registers.

These risks should be reviewed by Health Group Committee structures as per the timescales set out in CP362 Risk Policy and Procedures.

4. IMPLEMENTATION OF THE RISK MANAGEMENT STRATEGY

The implementation of this strategy will be achieved through:

— The identification of all significant risks and thei associated controls to the achievement of the strategic objectives.

— The recording and on-going review of those risks and associated action plans on the Trust's risk register to ensure they are managed and appropriate

— On-going assessment of risk using a common methodology in all Health Groups and Directorates to identify, control and minimise risks;

— The regular review of all identified and recorded risks to ensure they are managed and valid;

— Providing a comprehensive programme of risk management training and support to senior managers to enable them to manage risk as part of normal line management responsibilities;

— Providing risk management awareness sessions and various training packages to ensure all staff are aware of their responsibilities for risk management systems and processes;

— Using the Systems Engineering Initiative for Patient Safety (SEIPS) tools to investigate incidents, identify contributory factors and root causes;

— Using the Weekly Patient Safety Summit to flag high and moderate risks, particularly cluster risks and emerging themes.

— Working with the Estates Team to manage risks through routine maintenance programmes and risk assessments of facilities and equipment.

— Ensuring Information Governance Risks are managed in line with the Data Security and Protection Toolkit standards.

— Ensuring that systems are in place to allow organisational learning from both individual incidents, risk, complaints, PALS and claims and trends from aggregated data for any of these sources;

— Continuing to implement the recommendations from NHS England/Improvement and Central Alerts Safety Broadcasting System;

— Ensuring that lessons learned from all of the above are shared and disseminated Trust-wide to promote organisational development.

— Government Functional Standards – Counter fraud specifies that organisations have to carry out fraud risk assessments to identify fraud, bribery and corruption risks. This analysis has to be conducted in line with the Government Counter Fraud Profession (GCFP) fraud risk assessment methodology, recorded in line with the organisations' risk management policy and included on the appropriate risk registers.

5. MONITORING AND REVIEW OF THIS STRATEGY

The outcomes below will demonstrate progress in the implementation of this strategy:

- The Trust's progress against its strategic and corporate objectives;
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented.
- An overall rating of 'good' from the CQC and at least 'good' for Well-led
- Improved risk maturity rating at all levels of the organisation (from 22/23 following baseline)

The monitoring of compliance with this strategy will be undertaken through:

- A bi-monthly risk management report to the Operational Risk and Compliance Committee and Non-clinical Quality Committee of the risks relevant to each committee. This will include monitoring the effective management of risks within the Health Groups, directorates and escalation processes
- A bi-monthly Summary High Risk Report to the Executive Management Committee (to focus on trends, themes and a summary of risk activity)
- A half-yearly Risk Management Strategy Indicator report to the Operational Risk and Compliance Committee and Quality Committee, including analysis of the high risks alongside the Board Assurance Framework. The Quality Committee will escalate any areas of concern to Trust Board.
- Quarterly oversight by the Audit Committee of risk management processes.

The strategy will be reviewed annually via the Quality Committee. Earlier review may be required in response to exceptional circumstances, organisation change or relevant changes in legislation or guidance.

Risk Maturity

Working with the Internal Auditors the Trust will take a risk maturity self-assessment and benchmark how in line the current risk management practices are with Risk Maturity indicators. Once completed the Trust will have a maturity score which measures effectiveness of key risk management activities, how proactive teams are to risk management and how much coverage of risk management there is in the organisation.

6. STRATEGY COMMUNICATION AND DISSEMINATION

The Risk Management Strategy will be disseminated to staff / volunteers through:

— Health Group Boards
— The Trust Committee Structure
— Corporate induction
— Mandatory training

The Strategy will be made available via the Trust Intranet to ensure ease of access.

Through the usual information cascade process, managers will be responsible for
communicating this Strategy to all staff, in a manner appropriate to their area.

The Risk Team will give guidance and clarity relating to the strategy for all staff if required.

7. ASSOCIATED STRATEGIES, POLICIES AND PROCEDURES

Other key related documents include:

— Trust Strategy 2019-2024
— Quality Strategy
— Estates Strategy 2017-2022
— Risk Management Policy CP362
— Incidents Policy CP379
— Health & Safety at Work Policy CP137
— Raising Concerns at Work (Whistleblowing Policy) CP169
— Infection Control Outbreak and Incident Policy CP204
— Critical Incident Stress Management for Staff (CISM) Policy (Supporting Staff Involved in an Incident, Complaint or Claim) CP205
— Communications Policy CP385
— Management of Clinical Negligence, Personal Injury, and Property Expenses Claims CP213
— Major Incident Plan
— Being Open when Patients are Harmed Policy and Procedure CP259
— Confidentiality and Information Security Policy CP134
— Information Governance Policy CP29

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Agenda Item		Meeting	Trust Board	Meeting Date	8 March 2022
Title	Board Assurance Framework				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Board Assurance Framework is received quarterly at the Board Committees and the Trust Board				

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

Executive Summary and Update

The Q3 Board Assurance Framework (Appendix 1) was shared virtually in January 2022 with the Board for approval. Board members approved the report and it was agreed that it would be presented for information at the March 2022 Board meeting.

The year-end Board Assurance Framework will be presented to the Board Committees in March 2022 to discuss whether the target risk ratings have been met.

The year-end BAF and the new 2022/23 BAF will form part of the Board Development session in April 2022 and will have facilitated workshops for each BAF risk. This will determine whether we can close any risks off, need to re-scope any risks or add any new risks to the BAF.

The 2021/22 BAF and the new approved 2022/23 BAF will be presented to the May 2022 Board.

Agenda Item		Meeting	Trust Board	Meeting Date	11.01.22
Title	Board Assurance Framework				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Board Assurance Framework is received quarterly at the Board Committees and the Trust Board				

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

Key Recommendations to be considered:

The Committee is asked to consider the risk ratings and decide:

- Are the target risk ratings and assurance ratings correct
- Are there any risk ratings that should change
- Has sufficient assurance been received and are any further actions or information required

Hull University Teaching Hospitals NHS Trust
Trust Board
Board Assurance Framework Q3 2021/22

1. Purpose of the Report

The purpose of the report is to present the Q3 Board Assurance Framework to the Trust Board. The Board is asked to consider the proposals regarding the Q4 target risk ratings.

2. Background

The Board held a development session on 8 April 2021 to consider progress against the Trust Strategy and consider the risks to achieving the associated strategic objectives to inform the BAF for 21/22. Inherent (risks without any controls in place), current and target risk ratings were considered and risk appetite levels were set. The Board discussed and approved these at its meeting in April 2021.

3. Current Status of the Board Assurance Framework

An overview of all BAF risks is provided in the table below. The risks are considered, discussed and challenged at the appropriate Board Committees with meetings held between the Head of Corporate Affairs and the named Executive lead.

3.1 – Proposed risks, ratings and risk appetite 2021/22

The table below shows all risks and risk ratings with the performance and finance risks highlighted for discussion.

Risk	Inherent Risk Rating (Lxl)	Current Risk Rating (Lxl)	Target Risk Rating (Lxl)	Risk Appetite Score
Honest Caring Accountable Culture				
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year.	4x4=16	4x3=12	3x3=9	Moderate
Well-Led, Skilled and Sufficient Workforce				
BAF 2 - The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand	5x5=25	4x3=12	3x3=9	Moderate
High Quality Care				
BAF 3.1 - 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	4x4=16	3x4=12	2x4=8	Moderate
*New BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm. Causes – access to services/waiting lists, patient flow, human error, clinical guidance not adhered to, poor compliance with fundamental standards.	5x5=25	4x4=16	3x3=9	Low

Great Clinical Services				
BAF 4 - There is a risk to access to Trust services due to the impact of Covid-19 1- There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19 2- There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance 3- Planning guidance being released in stages across the year	5x5=25	4x5=20	4x4=16	Low
Partnership and Integrated Services				
BAF 5 - That the Trust will not be able to fully contribute to the development of the Integrated Care Service review due to recovery constraints	3x3=9	2x3=6	2x3=6	High
Research and Innovation				
BAF 6 - That the Trust does not make progress in developing its research capability, capacity and partnerships and that the Trust does not deliver the Non-Covid research during the recovery phase due to capacity issues.	4x4=16	3x4=12	3x4=12	High
Financial Sustainability				
BAF 7.1 - There is a risk that the Trust does not achieve its financial plan for 2021/22	4x4=16	4x3=12	4x2=8	Moderate
BAF 7.2 - There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year	4x5=20	4x5=20	3x5=15	Low
BAF 7.3 - There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x4=16	4x3=12	4x2=8	Moderate

4. Actions Update

The Board will receive updates on the actions taken in quarter with a plan for the following quarter. A number of actions have been taken in Quarter 3 and these are shown at Appendix 2. The planned actions for Quarter 4 are also included in this table.

5. Risk ratings

There are no proposed changes to the risk ratings in quarter 3. The Board is asked to consider if the actions taken in quarter 3 has an impact on the current risk rating or changes the ability to achieve the target risk rating. All proposals for changes in risk ratings require Board approval. The risk matrix is attached at Appendix 3.

Robust discussions were held at each of the Board Committees with the following decisions being made for each BAF risk:

BAF 1 – Honest, caring and accountable culture

Following discussions at the Workforce, Education and Culture Committee it was agreed that the assurance rating of green was correct and that the risk was likely to achieve its target risk rating in Q4.

BAF 2 – Valued, skilled and sufficient staff
The Workforce, Education and Culture Committee discussed the leadership and development programmes in place and how they were aligned with the People Strategy. It was also agreed that the risk was likely to achieve its target risk rating in Q4.

However, the increasing staff absence due to rising infection rates was highlighted as an issue outside of the Trust's control.

BAF 3.1 – High Quality Care
The Quality Committee have reviewed the Q3 and Q4 actions in place and with the sign off of the Quality Strategy in January 2022 believe that the risk will achieve its target risk rating.

BAF 3.2 – Harm Free Care
The assurance rating for this risk is still amber and the target risk may not be met. However the Quality Committee discussed the possibility of the Trust no longer being monitored against the enhanced risks and this would impact positively on the assurance rating. The Committee also commented on the realistic plans in pace to aid the recovery of specialty back logs. The target risk rating to be reviewed in Q4.

BAF 4 – Great Clinical Services
The Performance and Finance Committee discussed performance and the measures in place to mitigate this risk. It was felt that despite the amount of actions in place, issues outside of the Trust's control would prevent the risk from achieving its target in Q4.

BAF 5 – Partnerships
The Humber Acute Services Review and ICS work is moving at pace and the Trust is fully engaged with the process. The Committees in Common and Development Board have been established and are overseeing the work programmes. The assurance rating is green and the risk is on track to achieve its target.

BAF 6 – Research and Innovation
A celebration event is being hosted by the Trust in February 2022 to showcase the remarkable research and innovation work that is being carried out. The target risk rating has already been achieved with the mitigating actions in place.

BAF 7.1 – Finance
The Performance and Finance committee discussed the assurance rating for this risk and considered whether it should be green as it was forecasted that the financial targets would be met in Q4. It was decided, however, that due to the uncertainty of the pandemic, staff absence and uncertainty about recovery funding that the assurance level should remain amber. The target risk rating would be reviewed again in Q4.

BAF 7.2 – Underlying Financial Position
It was agreed at the Performance and Finance Committee that the amber assurance rating should remain. The underlying financial position will be reviewed in 2022/23 as a system wide issue. The target risk rating would be reviewed again in Q4.

BAF 7.3 – Capital and Infrastructure
The assurance rating for this risk is green and following discussions at the Performance and Finance Committee the general view was that it would achieve its target risk rating. Factors outside of the Trust's control, such as supply issues are being closely monitored.

6. Assurance Ratings

Draft assurance ratings have been assigned to inform the quarter 3 discussions and the Quality Committee is asked to decide whether sufficient actions are being taken to achieve the target risk ratings by the end of quarter 4. Escalation to the Board should be made formally if it considered target risk ratings will not be achieved along with the reasons why.

The ratings are as follows:

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

7. Links to the Risk Register

The BAF is supported by operational and corporate risks and the references for these are shown on the BAF. DATIX has been updated to include the strategic objectives, which enables all operational and corporate risks to align to a BAF risk. To strengthen this further the new Operational Risk and Compliance Subcommittee will be routinely sharing the BAF and asking operational teams to consider any risks in their areas that could prevent the Trust from meeting its strategic objectives.

New risks or risk themes will also be escalated from Non-Clinical Quality Subcommittee and the Operational Risk and Compliance Subcommittee via the Quality Committee if there is sufficient evidence to support requesting a new risk is entered on the BAF in year or that impacts on risk ratings for existing strategic risks.

8. Timetable

The end of year BAF will be presented to the April 2022 Board Committees and the May 2022 Board meeting for approval and review of the year.

The 2022/23 BAF will be developed at a workshop at the April Board Development Session and presented at the May 2022 Board meeting for approval.

9. Recommendations

The Board is asked to consider the risk ratings and decide:

- Are the target risk ratings and assurance ratings correct
- Are there any risk ratings that should change
- Has sufficient assurance been received and are any further actions or information required

Rebecca Thompson
Head of Corporate Affairs
January 2022

Strategic Theme: Strategy
Risk Appetite: Moderate
Risk: Failure to improve a positive working culture

Strategic Objective: Honest Caring and Accountable Culture | **Assurance Committee: Workforce, Education and Culture**
Executive Lead: Chris Long
CQC Domain: Well Led | **Enabling Plan: People Strategy**

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: **Improving Culture** **Condition:** The Trust does not make progress towards further improving a positive working culture this year. **Cause:** Staff behaviours Low staff engagement Workforce engagement with ICS/HASR **Consequence:** Trust unable to achieve Outstanding CQC rating and Well Led domain	Trust People Plan 2019/22 approved and in place Work being carried out around recruitment and retention Nursing establishment investment Staff Development programmes Leadership Development programmes Staff wellbeing services during the recovery phase Positive relationships with JNCC and LNC (Trade Unions) Monthly Health Group Performance and Accountability meetings to ensure workforce targets are being met Health Group and Directorate management manage workforce KPIs Wellbeing Centre opened at CHH – September 2021 Freedom to Speak up Month	Delays in delivering the People Plan due to the pandemic Face to face Leadership courses have not taken place due to the pandemic Emergency Medicine Staff Survey results Staff survey – engagement scores have reduced	**Management assurance:** Workforce, Education and Culture Committee Workforce Transformation Committee Andrea Glover Consulting has been commissioned to support HUTH with completing a talent management and succession planning diagnostic Staff Survey 2020 - The Trust is above average in the following themes: • Equality, Diversity & Inclusion • Morale • Quality of Care • Safety Culture • Staff Engagement Rise and Shine programme – emerging leaders to commence Q3	**Gaps:** Possibility that staff may leave the Trust following the pandemic Long term effects of Covid Recovery processes – returning to business as usual Flexible working must be embedded (work/life balance) Junior Doctor Training Line managers creating the right environment – culture issues Trust is not meeting its target for Turnover Staff Survey 2020 - The Trust is below average in the following themes: • Safe Environment – Bullying & Harassment • Team Working	People plan (action plan) Health Group/Directorate Staff Survey action plans Leadership Programmes – online learning courses established BAME Network Conference Disabilities Network established Wellbeing champions to be appointed Talent Management Plan to be established in October 2021 Inclusion programme for senior leaders commenced Secured additional funding to support and progress the EDI agenda Promote the work of BAME colleagues internally and externally / Awards / Exec blogs and emails Update employment framework (Zero Tolerance policy to be launched) BAME network currently reviewing Trust Inclusion training for managers and staff Allyship programme – l50 people attended so far Interview skills training / coaching and reverse mentoring / resilience training Leadership programmes Diversity in recruitment programme / NHSI/E – Disparity in management posts HUTH / York Non-Executive Board Development Programme Level 3 Apprenticeship – Bitesize learning for nursing staff has commenced.	Q1 – Update to the Workforce, Education and Culture Committee Board Development Deep Dive in Q2 – Equality, Diversity and Inclusion, Wellbeing of staff and Staff Survey Results Management Briefing sessions relating to staff recovery in Q2 Q2 Management Briefings A Trust level well-led self-assessment is in progress and will be presented to the Board Development Session in August 2021. This self-assessment will then be used to assess the core service well-led domains to continue to work towards improve the quality and safety of the services for patients and achieve outstanding services. Q3 Talent Management plan to be established in October 2021 Inclusion programme for senior leaders Additional funding secured to support Equality, Diversity and Inclusion agenda BAME Network promotion continues Allyship Programme has commenced and will continue in Q3 Diversity in recruitment programme to be progressed HUTH/YORK Non-
Risks from Risk Register:			**Metrics** Performance against People Strategy Quarterly and National Staff Survey Results People Report monitoring/ Board and Workforce committees **Independent / semi-independent:** NHSE/I CQC Internal Audits – WRES standards Doctors Annual Leave Cardiology Report and action plan	**Outcomes:** Established BAME network Diversity in recruitment implemented		

							Executive Board Development Programme Q4 Be Remarkable: This is a programme designed for existing leaders and leadership teams to stretch their skills and knowledge to make a difference in their workplace and ultimately patient care. There are three cohorts starting this autumn (Sept, Oct, and Nov) from Jan 2022 and then there will be cohorts every 2 months. They will complete module 1 as a cohort, they can then access units in module 2 to fit operational needs as these will be repeated every two months, before coming together as a group in module 3 to complete the programme. Seven participants started module one in September, with a further twelve starting in October and fourteen in November. We have already started recruiting for the January and March cohorts.

Inherent risk			**Risk as at 30.09.21 (Q3)**			**Target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	3	12	3	3	9

Strategic Theme: Workforce Risk Appetite: Moderate Risk: Managing staffing levels

Strategic Objective: Valued, skilled and sufficient staff **Executive Lead:** Simon Nearney **CQC Domain:** Safe, Effective, Well-Led			**Assurance Committee: Workforce Education and Culture** **Enabling Plan: People Strategy**			
Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**
Strategic risk: Sufficient staffing **Condition:** The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across the Trust **Cause:** National and international shortages Impact of Brexit on availability of international workers Covid impact on staff health including long term trauma and burnout **Consequence:** Insufficient staff to deliver services	People plan in place which sets out the changing workforce requirements Remarkable People, Extraordinary Place brand – targeted recruitment Golden Hearts, Moments of Magic rewards in place Monthly monitoring of Health Group plans – Performance and Accountability meetings Nurse safety brief to ensure safe staffing Guardian of Safe Working reports to the Workforce Committee and Board Focus on staff wellbeing Workforce planning forms part of business plan to understand and predict workforce trends New nurse intake in November 2021	Freedom to speak up champions Medical staffing levels including Junior Doctors Variable (agency and overtime) pay - At Month 3 the Trust position is £887km overspent on pay budgets. The Health Groups reporting the majority of the overspend are Clinical Support (£889k) and Surgery (£444k). Emergency Care continue to show an underspend. Absence of WiFi in educational buildings Maintenance of time for training for both trainees and trainers in the light of service recovery and a possible third pandemic surge Absence of transferability of statutory and mandatory training records; risk of training not being completed Physical loss of departmental teaching spaces to allow social distancing Nursing levels/sickness – out of hours	**Management assurance:** Monitoring of Workforce assurances through the Workforce Transformation Committee and Workforce Education and Culture Committee Vacancy position reported in every Board meeting The Trust CHPPD for May 2021 is 7.87 and June 2021 is 7.05. Although the CHPPD for June 2021 remains higher than the time period prior to COVID-19, it has significantly reduced in comparison to previous months. The Trust is currently pursuing 117 adult and paediatric student nurses predominately from the University of Hull.	**Gaps:** Impact of Covid relating to training, education, retention of staff Certain medical specialities struggle to recruit due to national/international shortages Managers thinking innovatively about new roles to new ways of working (ACP/PA) The Trust currently has 101.42 RN vacancies which equates to 4.16% of the established RN workforce. From the perspective of the wards, ED and ICU, there are 50.66 vacancies (4.01%).	People Plan Health Group Directorate action plans address challenging areas Management Briefing sessions – staff recovery The `Let's Get Started` induction programme for the new registrants has been reformatted this year based on the feedback from previous cohorts. The Healthcare Support Worker Development Programme will have a number of facets and will be underpinned by the *Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England*.	Q1 Disabled Network established BAME conference Q2 – Board Development deep dive: • Equality, Diversity and Inclusion • Staff Wellbeing • Staff Survey Q3 The 'Lets Get Started' induction programme for the new Nurse registrants has been reformatted this year based on the feedback from the previous cohort The Healthcare Support Worker Development Programme to be established Health Groups to monitor annual leave and review loss of capacity. Additional sessions being offered to staff. Use of the Independent Sector continues. Q4 Mary Seacole Programme We are currently advertising funded places to the Mary Seacole Leadership Programme run by the Leadership Academy. Hull University is also becoming an accredited delivery centre for Mary Seacole and we hope to access this from March 2022 onwards. The National Review of HR and OD report shared with the
Risks from Risk Register: 3460 – Radiology Staffing 2817 – Dietetic Staffing 3125 – JD vacancies 3990 – Cardiothoracic staffing 3044 – Consultant Pathologist			**Metrics** Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits WRES Doctors annual leave	**Outcomes:** The vacancy rate for the Trust is 371.4 WTE (4.4%) and this reduces to 205.7 WTE (2.4%) when adjusted for temporary staffing usage. • Nursing and Midwifery Registered Staff have 121.1 WTE (5.1%) vacancies, which reduces to 82.1 WTE (3.4%) when adjusted for temporary staffing usage. • Medical and Dental Consultants have 47.0 WTE (9.4%) vacancies. This reduces to 27.0 WTE (5.4%) when adjusted for temporary staffing usage.		

							Workforce Education and Culture Committee Work will now be undertaken by the Director of Workforce and OD and team to align actions in the report to ongoing work to deliver the Trust's People Strategy.

Inherent risk			**Risk as at 30.09.21 (Q3)**			**Target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	3	12	3	3	9

Strategic Objective: We will achieve a rating of 'Outstanding' in the next 5 years (2019-2024) **Assurance Committee: Quality Committee**

Executive Lead: CMO/CN/DQG
CQC Domain: All/Well-led **Enabling Strategies/Plans: Quality, Patient Safety, Improvement**

Strategic Theme: High quality care
Risk Appetite: Moderate
Risk: 3.1

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: 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* **Condition:** 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 **Cause:** 1. The Trust does not develop its patient safety culture and become a learning organisation. 2. Insufficient focus, resource and capacity for continuous quality improvement for quality and safety matters. 3. Poor governance arrangements. 4. That Quality Improvement Plan is not designed around moving to good and outstanding 5. That the Trust is too insular to know what outstanding looks like **Consequence:** Patients do not receive the level of care and clinical outcomes that we strive to provide.	Quality committee structure & work-plans Health Group Governance Performance Management Meetings Patient Safety Specialist role IPC arrangements Safeguarding processes Fundamental Standards programme Quality Improvement Plan Serious Incident Management Clinical Audit programme CQC improvement plans External agency register and process Horizon scanning Integrated Performance Report – BI Reporting Urgent Treatment Centre opened 1st December 2021 Support has been provided by the Quality and Patient Safety Lead at Hull CCG to take a proactive approach to review all open serious incidents to determine which can be undertaken as a concise review and which require a comprehensive review Support from the Health Groups via the Weekly Patient Safety Summit (WPSS) in the support of timely completion of Rapid Review Reports (RRR) and early identification of statement providers/memory capture and immediate	External report 20/21 highlighted a review of assurance/performance committees could be beneficial Patient Safety Specialist role new, needing time to embed Greater scrutiny required for clinical audits, improvement plans and outlier reports VTE Compliance Mental Health Services Ambulance turnaround times and the impact on patients ED Crowding – risk being monitored through EMC 7.65% increase in Patient Incidents compared to September 2021. '	**Management assurance:** Reports to Quality Committee Quality/outcome data Self-assessments Infection Control Annual Report Quality Accounts Associate Director of Quality appointed OQC has been disestablished and a new sub-committee structure established to incorporate the Operational Risk and Compliance Committee Enhanced Monitoring Process Ophthalmology presentation to the Quality Committee outlining backlog improvements HSMR update Report. Task and finish group established and case note reviews undertaken - no evidence of unsafe or poor care highlighted – the Trust is no longer an outlier New Chief Pharmacist appointed Purpose T Pressure Ulcer risk assessment tool introduced at Castle Hill Hospital – roll out February 2022	**Gaps:** Quality Risk Profile – Patient flow and the Trust's waiting list **Assurance:** There are currently 34 Registered Nursing Associates (RNA) and 43 Trainee Nursing Associates (TNA`s) employed by the Trust. The Trust has successfully recruited a further 25 TNA`s who will commence employment with the Trust in September 2021. Quality Governance restructure in place. Risk management, effectiveness and patient safety strengthened as part of the process. Family and Women's risk pilot underway	1. Develop Quality Strategy and supporting implementation plan 2. Develop Continuous Improvement programme in line with 'Be Remarkable' 3. Develop Patient Safety Strategy 4. Strengthen Patient Safety Committee and work-plan 5. Undertake review of quality related committees using WWW/EBI 6. Introduce further forums and mechanisms for recognising and celebrating exceptional practice 7. Undertake Well-led self-assessment, developing and implementing plan as an outcome. 8. Implement assurance visits to core services 9. Ensure suitable structure and personnel for quality improvement and governance requirements 10. Review quality data and measuring for improvement. 11. Mental Health triage in ED for high risk patients 12. Quality Strategy presented to the Quality Committee 13. Continuity of Care planning	Q1 Re-structuring of the Quality Governance Team and consultation has taken place following the NHS E/I Governance report Q2 OQC disestablished Q2 New Quality Committee sub-committee structure in place Q2 First Patient Safety Conference held showcasing work in Patient Safety. Posters submitted to National congress. Q2 Well-led Self-assessment undertaken at Board level. Q2 'Making data count' training provided to Board. Draft IPR prepared. Q3 Quality Strategy presented to the Quality Committee Risk Management Strategy presented to the Board Development Session Patient Safety Improvements to be presented at the December Trust Board Development Day Q4 Quality and Risk Strategies presented to the Board for approval
Risks from Risk Register: 3460 - Availability of Radiology Support for Paediatric & Neonatal Services.			**Metrics** National Audit Benchmarking Harm Free Care Patient Experience Survey	**Outcomes:** No Never Events – 2 Never Events to date (no harm caused)		

	3282 - Failure in the Trust systems to ensure requested test results, pathology and radiology, are reviewed & actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses	actions/learning points. A focussed falls trial of the TAG nursing approach to be incorporated in the QIP framework and trialled within the DME		**Independent / semi-independent:** CQC inspections Internal audits – QI scheduled External reviews (e.g. NHSEI)	No Regulation 28 reports – None received to date Top quartile for patient safety incident reporting		

Inherent risk			**Risk as at 30.09.21 (Q3)**			**Target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Strategic Theme: High quality care/Great clinical services
Risk Appetite: Low
Risk: 3.2

Strategic Objective: We will increase harm free care
Executive Lead: CMO/CN
CQC Domain: Safe

Assurance Committee: Quality Committee

Enabling Strategies/Plans: Recovery Plan & Work-streams, Patient Safety

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: 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.* **Condition:** There is a risk that patients suffer unintended or avoidable harm. **Cause:** Delayed access to services due to the increased waiting lists as part of the pandemic, patient flow, human error, clinical guidance not adhered to, poor compliance with fundamental standards. **Consequence:** Deterioration of conditions for patients, poor quality of life, loss of sight. Patient experience, clinical outcomes, timely access to treatment and regulatory action.	• Clinical harm review process • Prioritisation of P1 patients • Fundamental Standards programme • The Trust's Elective Recovery Group is responsible for the co-ordinated oversight of the agreed elective recovery plans in line with the Trust's and system level recovery objectives. This work is underpinned by 14 Task and Finish Groups which will focus on different aspects of recovery 1. Independent Sector 2. Evidence Based Interventions 3. Day Case Capacity Development 4. Productivity, Benchmarking and Demand and Capacity 5. Outpatient Transformation 6. Data Quality and Validation 7. Theatre Capacity Hull University Teaching Hospitals NHS Trust 24 Assurance Framework Responsive 8. Diagnostics Capacity 9. Therapies Capacity 10. Critical Care Capacity for Elective Post-op care 11. Pre-operative Assessment Capacity 12. Outpatient Capacity 13. Partial Booking 14. Job Planning for Recovery. The trajectory for the Elective Recovery Plan continues to be 95%. Performance against this has improved in a number areas with 13 out of 22 indicators achieving above 95% Clinical harm reviews continue to be undertaken	Reduction of beds in Medicine Radiology capacity issues There were 268 breaches of the 2ww standard with the majority in Breast at 223, then Skin at 22. 2ww suspected cancer referrals are now back to pre-Covid levels of demand. The Trust is in the median quartile nationally for 2week wait performance at 82nd out of 124. 26% of the 52 ww breaches are in ENT (2,857) – of which 81% are on a non-admitted pathway Ophthalmology experiencing a delay in meeting outpatient appointments 7 extreme risks being monitored via the Quality Risk Profile: • Core Patient Safety 14 - Discharges and Patient Flow with impact on quality and safety • Core Patient Safety 52 - Significant waiting list Issues including access to screening and follow-up programmes. • Core Patient Safety 74 - Significant Reputational Risk Issues • Acute Patient Safety 6 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E. • Acute Patient	**Management assurance:** • Reports to Quality Committee • Clinical harm data and reports • 52 week reports • Humber Acute Strategic Development Committee joint review of P1/P2 patients • 1.2% improvement in RTT performance in April Ophthalmology validation of follow ups is undertaken weekly to ensure capacity is utilised appropriately Funding in place to source 2 additional Glaucoma Consultants and 2 additional MR consultants MRI Issue: 59 MRI procedures behind plan due to unexpected equipment issues at the end of Q3 and into the start of Q1. This led to reduced capacity and the loss of approximately 27 slots. The H1 plan at Point of Delivery was achieved in May above the Elective Recovery Fund trajectory of 80% of 19/20 baseline Overall treatments for cancer were above the enhanced bounce-back trajectory. Reduction of the 52 week waits are performing well, there continues to be a significant reduction since March 2021, achieving the trajectories month on month	**Gaps:** Diagnostic waiting times GP Capacity and increased referrals Assurance Glaucoma virtual review sessions in place The Cardiology service continues to work with the Independent Sector (IS) for Heart Failure and Intervention backlogs which remain challenged. IS also supporting with Echo delivery which will further help reduce the O/D Follow Up backlog. Two serious incidents in the Gynaecology service were identified during clinical harm reviews; the patients did not receive timely follow-ups/dates for surgery and subsequently received cancer diagnoses CS completed 7 Clinical Harm reviews in July 21 F&Ws completed 15 Clinical Harm reviews in July 21 Surgery completed 14 Clinical Harm reviews in July 21 The RTT trajectory of 55,803 was not achieved for September. Achieved 58,795 The September 2021, the total WLV baseline was 58,795; the October 2021 position is higher at 62,439, there are 2 main factors for the increase. Firstly, the Neurology service was transferred from NLAG to HUTH on 1st October 2021 as part of the Humber Acute	Improvement meetings with Family and Women's Health Group to target specific specialities Diagnostics: • Currently looking at 'delays' from D1S to ordering CTs and x-rays. These aren't high in number but do show significant wait times when they occur • Radiographers start to approve to review and sign-off of the more common, simple CT requests – at present this is only the Radiologists who are multi-tasking with reporting scans and reviewing ordered ones • Reviews have shown few delays once ordered – with the exception of laboratory system or testing machine breakdowns • Approval and funding has been given for the replacement of the RIS – expected complete late Q2/early Q3 21/22 Incomplete list size trajectory to be achieved – aim to reduce to 55,803 by end of September 2021 The Elective Recovery Group/In-hospital Delivery Group are monitoring the delivery of the improvement plan. These have representation from all Health Groups. ED quality issues and performance, all Health Groups are contributing to the improvement plans. There is a weekly meeting with the Chief Operating Officer to monitor both the delivery of actions and outcomes of this.	Q1 Review of bed base due to activity levels H1 plan in place which covers the first 6 months of the year Increase Elective Capacity Framework – independent sector providers included Updates received at the Performance and Finance Committee regarding waiting list initiatives for Breast surgery, cardiology, dermatology, ENT, Gynaecology, Interventional Radiology,Ophthalmology, Oral Surgery and Plastic Surgery St Hughs was still being used for Trauma and Orthopaedics activity Urology working with external provider in Q1 Q2 Replacement of the Radiology Information System Breast - Under 40s and over 40s clinics to be introduced (under 40s do not require mammograms) Health Group recovery actions detailed in Appendix 2. Q3 H2 Plan Q4 The Trust submitted the final H2 operational plan on 8 th November 2021. This plan identified activity to be delivered each month in the second half of 2021/22 (H2). The Elective Recovery Fund (ERF) requirement has changed in H2 and is now based upon RTT monthly clock stops comparing those achieved in 2019/20 against the monthly

			Safety 7 -Quality issues identified due to handover delays. • Acute Patient Safety 13 - > 52 week waiters Acute Patient Safety 16 - All cancers – maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral The Trust is still experiencing too many cancer patients waiting over 63 days, this is working progress 3 The P2 actual performance was 55.4% against a target of 70% for September 2021 Outpatients remains below the trajectory of 25%, achieving 20.4% Slight increase in the number of Incidents, PALS and Complaints received in response to delays in treatment The ED targets and the ambulance handover times were not achieved		Services Programme 1, which increased the WLV by circa 500 patients. Secondly, a counting change to include the patients awaiting referral triage (Referral Assessment Service – RAS) was implemented from 1 October 2021, this increased the WLV by a further circa 2,400 patients.	Key elements of the ED and patient flow programme are to be implemented at the beginning of July. Work is currently underway to engage with all relevant staff to maximise the benefit of this. The Executive Team include monitoring of all of these risks and the monthly Health Group performance and accountability review meetings (chaired by the CEO) Incomplete list size trajectory to be achieved – aim to reduce to 55,803 by end of September 2021	delivery in 2021/22. The ERF threshold trajectory of expected monthly clock stops has been set at a minimum of 89% of 19/20 baseline. For clock stops delivered between 89-94% the Trust will receive 100% of tariff; for delivery over 94% the Trust will achieve 120% of tariff. The value is based on the H1 SUS submissions at Treatment Function level and split between admitted and non-admitted clock stops. The regional team is providing an indicative ERF Ready Reckoner for Trust to be able to forecast potential ERF income. The ERF funding will continue to be earned on a system basis to encourage systems to continue to use their capacity and resources as flexibly as possible across organisations to maximise recovery activity
	Risks from Risk Register: 2675 - Insufficient capacity within Radiology to accommodate increasing demand			**Metrics** Patient Safety incidents Waiting list numbers **Independent / semi-independent:** CQC inspections Internal audits – Waiting lists, recovery included in schedule	**Outcomes:** RTT list size for April was under the trajectory at 60,422 RTT list size for July was under the trajectory at 57,560 RTT list size for October was over trajectory at 62,439		

Inherent risk			Risk as at 30.09.21 (Q3)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	4	16	3	3	9

Strategic Objective: Great Clinical Services | **Assurance Committee:** Performance and Finance Committee

Executive Lead: Ellen Ryabov – Chief Operating Officer

CQC Domain: Effective | **Enabling Plan:** Operating Plan

Strategic Theme: Performance Risk Appetite: Low Risk: to access Trust services due to Covid-19

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: BAF 4 - There is a risk to access to Trust services due to the impact of Covid-19 **Condition:** 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 There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance Planning guidance being released in stages across the year **Cause:** Delayed access to services **Consequence:** **Deterioration of conditions for patients**	Performance and Accountability meetings Clinical harm reviews taking place Partnership working with ICS/HASR Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment Trust Escalation Policy The 4-hour delivery action plan continues to be further developed, and associated service change will be implemented rolled out alongside an implementation plan for an UTC type facility on the HRI site.	Mismatch between demand and capacity Flow through the ED department Exit blocking Using locums to optimise staffing levels Performance against the 4 hour ED standard – September PAF 29.1% patients waiting longer than 6 hours Cancer performance: 2 week wait target at 75.9% in July Breast, Head and Neck, Paediatric, Skin, UGI and Urology did not achieve the 93% target in July The faster diagnosis standard was not achieved in June 69.2% 37.1% of patients on the waiting list for diagnostics have waited over 6 weeks which is a deteriorating positon Timely discharge deterioration due to nursing home closures Staffing issues in histopathology, anaesthetics and oncology Ambulance Handover Times – letter from NHS E/I Performance against the 4-hour standard was 63.7% for September. The Trust did not achieve the 2-week wait cancer target in the month of August delivering 82.6%. With the exception of Breast, Colorectal, Head and Neck, Skin, Urology and UGI all other tumour sites achieved,	**Management assurance:** Monthly performance report to the Performance and Finance Committee which includes a recovery plan for each of the 12 specialties with the largest waiting lists Bi-monthly Board Report Health Group Performance and Accountability meetings monitor recovery plans in place Both Trust total waiting list volumes and 52 week trajectories were met in June 2021 Advice and Guidance and PIFU metrics delivered against the trajectory. Systemwide Ambulance handover action plan in place 28/10/21 The Faster Diagnostics Standard achieved in August at 76.5%. **Diagnostics** 39.3% of patients on the waiting list for diagnostics have waited over 6 weeks in the month of September, which is an improvement on the August position. Q3 Flexible Sigmoidoscopy (88%) and Gastroscopy (84%) were below H2 plan and 19/20 baseline.	**Gaps:** Capacity in some specialties Use of ambulatory care The cancer transformation programme is making some progress to improve the patient pathways and increase the number of patients with a diagnosis within 28 days from receipt of referral. The main pathways being, head and neck, lung and upper GI with process mapping, gap analysis against the national optimal FDS pathways and use of the IST pathway analyser to identify delays that can be resolved and those areas that require more radical attention. MRI and Colonoscopy were within 10% of their H1 activity plan. Flexible Sigmoidoscopy was significantly below both their plan and 19/20 baseline. Gastroscopy delivered 87% of their plan and Echocardiography 86%. Delivery of the 4-Hour National Standard in October was not achieved. Actual performance was 55.8% for Type 1 activity and for both Type 1&3 combined 4-Hour performance was 70%, an improvement of performance of 6.3% when compared to the September position. Type 1 ED attendances for the month of October were 11,185, which is broadly similar to the previous month. The Trust had 2 x 12-hour trolley waits on 11th and	Diversionary pathways for admissions away from ED Regular Board rounds within ED to provide senior input and decision making Site team to facilitate flow Additional capacity requirements identified and additional scanning sessions arranged in Radiology. Extension of working hour, additional reporting sessions, reporting outsourcing and alternative providers utilised. The Trust received a visit from the Emergency Care Intensive Support Team who undertook a "Missed Opportunities" Audit reviewing all patients who arrived in ED within a 24-hour period. The initial output of this work was shared with the Executive and Senior Team and the Humber CEOs Group. This review highlighted and confirmed many of the areas of concern, primarily volume of non-ED activity coming into the hospital that should realistically be seen in another setting. The This audit was then followed up by a "Front Door" review of ED, AMU and Frailty all of which identified several areas of learning and potential support going forward, a summary report of the outputs is expected. The last review element of this work is scheduled to take place the week of the 6 September following which a collated report outlining all themes will be received and shared with all system partners as part of a plan to agree specific elements of work that will be in place to support winter.	Q1 – Update Board Streaming implemented which has had a significant impact. MRI Van sessions increased Meetings with each of the challenged specialities will take place during April and will look to find additional means of support to address the significant backlogs within our top 10, now expanded to top 12 with the inclusion of Gastro and Interventional Radiology. Q2 – Humber Acute Strategic Committee meeting in June 2021 to review joint services and working ED Triumvirate presenting performance issues to the Performance and Finance Committee in June 2021 Waiting list recovery plans in place for all of the 12 worst performing specialities. Q3 - A revised 4-hour delivery action plan has been developed, alongside a review and update of the Ambulance Handover Improvement Plan. UTC opened 1st December 2021

			or exceeded the 93% standard. Performance against the 62-day Cancer standard was 55.8% for August. **Referral to Treatment Elective Standards** The Trust had 6,740 x 52 Week breaches at the end of September, which is a 172 improvement on the August position. The H1 planning trajectory was delivered. Total waiting list volume did not achieve the recovery trajectory of 55,803 with 58,795 reported month end position. Although in the main the requirements of the October 2021 plan were delivered, it was lower than the 19/20 baseline activity and RTT clock stops were 83.5% of baseline. There are a number of risks on the Risk Log for the Elective Recovery Group which will be shared as an appendix at the next meeting, following further review and revision of the risk scores.		26 th October. A rapid review has been undertaken; duty of candour was completed along with an apology to the patient for their wait for transfer to another provider. Both were due to Mental Health breaches. Ambulance conveyances in October were fewer than in the previous month with 2,611 ambulance arrivals in month or an average of 84 per day. Handover times in October were 28.6% of handovers within 15 minutes (average handover time was 34 minutes). There were 340 handover delays in October >60 minutes which is a reduction to September. The handover times remain a significant problem as a direct result of our ongoing flow issues across the system.		
	Risks from Risk Register Crowding in the Emergency Department Insufficient capacity within Radiology to accommodate increasing demand			**Metrics** Health Group recovery plan trajectories **Independent / semi-independent:** 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit	**Outcomes:**		

Inherent risk			Risk as at 30.06.21 (Q3)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	4	20	4	4	16

Strategic Objective: Partnerships and Integrated Services | **Assurance Committee:** Trust Board

Executive Lead: Michelle Kemp

CQC Domain: Well Led/Effective/Safe | **Enabling Plan:** Trust Strategy

Strategic Theme: Strategy
Risk Appetite: Cautious (2)
Risk: Contribute to ICS Services

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: **Partnerships and Integrated Services** **Condition:** **That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery constraints** **Cause:** The recovery programme slows down the progress to become an Integrated Care System **Consequence:** **Reputational damage** **Relationships with other care providers are not forged**	The Trust has key leadership roles in the current ICS governance structure HUTH leading on continued partnership work and driving momentum on acute service reviews HUTH driving the wider Acute Provider Collaborative programme Humber Acute Services Development Committee has been established and has met in June and August 2021. The Humber Acute Services Programme is now moving at pace across all elements of the Programme. • Programme 1: Interim Clinical Plan • Programme 2: Core Service Change • Programme 3: Strategic Capital Investment Each of the core elements of the Programme are underpinned by a comprehensive workplan which is supported by a resource plan, an engagement plan and a comprehensive risks and issues log. ICS Chair has been appointed	Uncertainty with the national policy approach around the Independent sector programme Uncertainty around allocation of recovery funding HUTH Workforce recovery following Covid is at an early stage Limited feasibility around delivery of the mutual aid model in the context of possible reliance on the wider system to deliver Alignment of HASR programme service resilience into performance recovery is at an early stage ICS Chair recruitment is underway with Gatenby Sanderson Cardiology Humber-wide – single governance process to be considered HASR workforce plan to be developed – focussed session to be arranged	**Management assurance:** Programme 1 will be governed through the Joint Development Board. Staff briefing sessions are on-going to capture all staff groups (evenings and weekends included to cover shifts) with sessions planned around all aspects of HASR programme • Staff survey results are under review • Overarching slides describing HASR are under review following feedback to ensure they are more descriptive • Joint P1 & P2 report being taken to OSC Sept/Oct to update on progress/current position/challenges • Joint working with Planned care programme within HASR for specialities which are across both P1 and P2	**Gaps:** Urgent and Emergency Care: The requirement to improve and implement out of hospital models of care to divert activity from the hospital front door The potential for changes to service provision The potential for the displacement of activity to DRI and HUTH depending upon any potential future option implemented Neonatal: The impact of the neo natal review The impact of low births rates on the South Bank on emerging options Planned Care: The critical links to the implementation of community diagnostics	Humber Acute Services Programme - The 10 specialties included in the Interim Clinical Plan are: Haematology, Oncology, Neurology and Dermatology, Cardiology, ENT and Ophthalmology, Gastroenterology, Urology and Respiratory The review of the specialties is happening in three stages during 2021/22: – Phase 1 – haematology, oncology, neurology and dermatology (Q2) – Phase 2 – cardiology, ENT and ophthalmology (Q3) – Phase 3 – respiratory, gastroenterology and urology (Q4) Expression of Interest relating to HASR has been submitted - £720m capital projects HASR Board Development session held in October 2021	Q1 – Phase 1,2 and 3 of the HASR programme initiated Q2 - Phase 1 – haematology, oncology, neurology and dermatology (Q3) – Phase 3 – respiratory, gastroenterology and urology
Risks from Risk Register:			**Metrics** Recovery rate Outcomes of Service Reviews **Independent / semi-independent:** NHS E/I CQC ICS HASR Acute Collaborative	**Outcomes:** Achieve an Integrated Care System		

Inherent risk			Risk as at 30.06.21 (Q1)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
3	3	9	2	3	6	2	3	6

Strategic Objective: Research and Innovation
Executive Lead: Dr M Purva
CQC Domain: Safe

Assurance Committee: Quality Committee

Enabling Plan: Research and Innovation Strategy

Strategic Theme: Quality
Risk Appetite: High
Risk: Research and Innovation development

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: **Research and Innovation** **Condition:** That the Trust does not make progress in developing its research capability, capacity and partnerships and that the Trust does not deliver the Non-Covid research during the recovery phase due to capacity issues. **Cause:** Additional activity due to the recovery phase could mean less capacity for Research and Innovation **Consequence:** Impact on R&I Investment Impact on R&I capacity	Strengthened partnership with the University of Hull Infection Research Group established ICS Research Strategy	The impact of Covid-19 in the short and long term. The impact of Covid-19 with key partners. Reduction in support services due to activity delivery Loss of commercial research income as well as other income as non-Covid activity was paused Additional research due to Covid without additional investment in staff Social distancing impacting on research projects 20% of consultants should have 20% protected R&I time. The inability to secure dedicated resource to deliver an ambitious R&I Communications and Engagement Strategy. • 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. • Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload into early 2022-23. 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	**Management assurance:** Successful portfolio of Covid studies managed in 2020 Recruitment above target 2316 patients involved in clinical research as at August 2021 464 ongoing projects Continuing working with HYMS and the ICS	**Gaps:** Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan External funding availability 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.	(1) A Research Aware Organisation (2) Positive, Proactive Partnerships (3) Reputation through Research 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. Build Research and Innovation capacity into consultants protected time. Fund dedicated research time into job roles, especially difficult to recruit areas. Launch R&D Branding, website, newsletter and social media	Q1 – Update 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. 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 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.
Risks from Risk Register: No risks highlighted			**Metrics** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Outcomes:** 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).		

			accommodation issues				

Inherent risk			Risk as at 30.09.21 (Q3)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	3	4	12

Strategic Theme: FINANCIAL
Risk Appetite:
Risk: Failure to achieve financial plan for 2021/22

Strategic Objective: Financial Sustainability | **Assurance Committee: Performance and Finance Committee**
Executive Lead: Chief Financial Officer
CQC Domain: Effective | **Enabling Strategy: Financial Plan 2021/22**

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Financial Sustainability **Condition:** Expenditure incurred exceeds income by greater than agreed control total **Cause:** Health Groups and Corporate Departments do not deliver services within agreed budgets and do not achieve Cash Releasing Efficiency Savings Capped and block contract arrangements limit scope for payment Additional activity delivered may not result in increased income; due to levels of activity or coding issues **Consequence:** Impact on investment in quality Inability to meet regulatory requirements Reputational damage Impact upon recruitment	Health Group Budgets in place 2021/22 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Block contractual arrangements remain in place for Q1 Cost reduction and expenditure controls in place but with lack of consistent application within Heath Groups and corporate functions Gap in identified CRES schemes and required level Delivery of the additional Emergency Recovery Fund - The Trust activity plan has been modelled by NHSEI through its 'ready reckoner' and indications are that the Trust will receive £1.6m of ERF based on the plans. Health Groups are being asked to deliver 2/3rds of the increased efficiency target The main areas of expenditure growth are in Surgery, Family & Women's and Clinical Support and are mainly in areas of pay. This will reflect the increased profile spend, for example, increment movements from 1st October. The new nursing starters from university recruitment will now be included in the numbers with nursing numbers (registered and unregistered) higher in month 7 by 74 wtes	**Management assurance:** Performance Committee and Boards Finance Performance Reviews with Health Groups Additional income can be earned by delivering income above baseline national targets to access the Elective Recovery Fund. This requires delivery across the ICS and is not just dependent upon Trust performance. Plans across the ICS assume that baselines will be exceeded and additional income received. **Metrics** 1. Run rate 2. I&E position 3. CRES position 4. Activity performance against plan 5. Cash flow **Independent / semi-independent:** 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit 5. Local Counter Fraud Specialist	**Gaps:** Divisional awareness of spend within new structures as budget centres have shifted Clarity of ownership of schemes Pace of delivery The struggle to identify efficiency schemes. **Outcomes:** 1. Achieve Board approved financial plan 2. Achieve financial control total at Trust and system level	The NHSEI indicative plan position for the period for HUTH was a deficit of £1.1m within an overall Humber Coast & Vale ICS (HC&V) target of break-even. Following discussions across all organisations within the ICS, based on forecast income and expenditure plans across the patch, the Trust has set a target plan of a deficit of £1.7m. The overall ICS position remains at break-even.	Q1 – Update NHSEI has issued official planning guidance that sets out the details of the finance and contracting arrangements for the six-month period from 1st April 2021 to 30th September 2021 (H1). The year to date surplus of £0.2m in line with plan. The H1 forecast deficit of £1.7m in line with plan. Q3 - NHSEI have indicated that they will provide further guidance on H2 in September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there may a reduction in the level of Covid19 funding available. Elective Recovery Funding is expected to continue but there will also be an increased efficiency requirement of up to 3% required from October 21. This is now being classed as 'waste reduction.'
Risks from Risk Register: RDC Funding not yet agreed						

Inherent risk			Risk as at 30.09.21 (Q3)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Strategic Theme: FINANCIAL Risk Appetite: Risk: Failure to achieve financial plan for 2021/22

Strategic Objective: Financial Sustainability | **Assurance Committee: Performance and Finance Committee**
Executive Lead: Chief Financial Officer
CQC Domain: Effective | **Enabling Strategy: Financial Plan 2021/22**

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Financial Sustainability **Condition:** Expenditure incurred exceeds income by greater than agreed control total **Cause:** Health Groups and Corporate Departments do not deliver services within agreed budgets and do not achieve Cash Releasing Efficiency Savings Capped and block contract arrangements limit scope for payment Additional activity delivered may not result in increased income; due to levels of activity or coding issues **Consequence:** Impact on investment in quality Inability to meet regulatory requirements Reputational damage Impact upon recruitment	Health Group Budgets in place 2021/22 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Block contractual arrangements remain in place for Q1 Cost reduction and expenditure controls in place but with lack of consistent application within Heath Groups and corporate functions Gap in identified CRES schemes and required level The current position is reported as a deficit of £47.8m. **Assumptions** Costs are full year impact for 2020/23 CCG income from 2019/20 is only uplifted for 1.4% plus specific CNST funding (2.5% inflation less 1.1% efficiency target) CCG income from 2020/21 is only uplifted by 0.5% plus CNST funding (0.78% inflation less 0.28% efficiency target) No growth funding for 2020/21 and 2021/22 from CCGs included. Specialist Commissioning income is increased in line with the inflation above plus for cost of pass through drugs as per current agreements. No othergrowth funding included. Cancer Alliance funding for Lung HealthCheck, Rapid Diagnostics and Director post includedbut other	**Management assurance:** Performance Committee and Boards Finance Performance Reviews with Health Groups Additional income can be earned by delivering income above baseline national targets to access the Elective Recovery Fund. This requires delivery across the ICS and is not just dependent upon Trust performance. Plans across the ICS assume that baselines will be exceeded and additional income received.	**Gaps:** Divisional awareness of spend within new structures as budget centres have shifted Clarity of ownership of schemes Pace of delivery The Underlying deficit has increased by £38.4m. The main drivers of this relate to expenditure growth for which no income source has been identified due to the delays in planning guidance and the delay to CRES identification and delivery.	The NHSEI indicative plan position for the period for HUTH was a deficit of £1.1m within an overall Humber Coast & Vale ICS (HC&V) target of break-even. Following discussions across all organisations within the ICS, based on forecast income and expenditure plans across the patch, the Trust has set a target plan of a deficit of £1.7m. The overall ICS position remains at break-even.	Q1 – Update NHSEI has issued official planning guidance that sets out the details of the finance and contracting arrangements for the six-month period from 1st April 2021 to 30th September 2021 (H1). Q3 H2 Plan expected Q4 The Humber Coast and Vale ICS submitted a balance plan for H2 on 18th November. The ICS plan encompasses a level of risk to delivery. Specifically there remains an uncovered risk of £1.5m. Due to the size of the risk outstanding, it was felt that it would be inappropriate to submit a deficit plan at ICS level, but that actions would be developed during the period to manage the risk. This would include a review of the ICS management budget and the potential to earn additional Elective Recovery Fund (ERF) Income. For presentational purposes, this additional risk sits within the financial position of HUTH. Within the ICS break-even plan, HUTH is required to deliver a surplus of £1.7m. This will enable the Trust to achieve break-even across the full financial year.
Risks from Risk Register: RDC Funding not yet agreed			**Metrics** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Achieve Board approved financial plan Achieve financial control total at Trust and system level		

			commissioner funding excluded. 2021/22 Pay Award of 3% is fully funded. Only recurrent CRES schemes for2020/21 and 2021/22 included at this point. MRET funding and NCA funding remains in the system even if the flow changes. Private patient income and Injury compensation income return to previous levels.				

Inherent risk			Risk as at 30.09.21 (Q3)			Target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Strategic Theme: Finance
Risk Appetite: Moderate
Risk: Failure of critical infrastructure

Strategic Objective: Financial Sustainability **Executive Lead:** Lee Bond **CQC Domain:** Effective			**Assurance Committee: Performance and Finance** **Enabling Plan: Capital Plan**			
Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**
Strategic risk: **Financial Sustainability – Capital Programme** **Condition:** There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **Cause:** Lack of sufficient capital and revenue for funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment. **Consequence:** Lack of capital funding impacting on services Lack of investment impacting on patient and staff safety	Capital programme in place and risk assessed Comprehensive maintenance programme in place Capital Resource Allocation Committee in place to allocate funds Service level business continuity plans in place The Trust is expecting capital grant income totalling £13.7m relating to the Decarbonisation schemes and NPIC (pathology). £9.6m of this is expected in the first 6 months The reported capital position at month 7 shows gross capital expenditure of £26.3m against a plan of £31.2m. The schemes which are currently below plan mainly relate to a profiling issue within the emergency PDC application schemes. The main areas of expenditure relate to the Salix Energy Efficient scheme; Backlog Maintenance & Compliance and Urgent & Emergency Care.	Supplier price increases and delays to building works to be managed Since the last Capital Resource Allocation Committee (CRAC) in April a number of risks are emerging in terms of schemes that are not currently accommodated within the capital programme. These include the need for accommodation for the OPAT service, equipment requests associated with elective recovery and risks that there will be additional IT hardware requirements associated with some of the planned capital developments. The planned capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £80m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m).	**Management assurance:** Monthly updates to the Performance and Finance Committee Regular updates to the Board	**Gaps:** Building works impacting on patients and staff Approval of the Urgent & Emergency care Business Case, however due to delays in approval the Trust has slipped £8m into 21/22. It is expected the PDC funding will be moved to match this. The Trust has been working with ICS colleagues to agree an overall ICS capital programme for 2021/22. It should be noted, however, that partner organisations within the ICS remain legally responsible for maintaining their estate and for setting and implementing capital investment plans at organisational level.	Capital Plan Approved at the Board last month, the planned capital expenditure for the full year 2021/22 (incl PFI/IFRIC12 impact) is £58.1m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m). The PDC Applications for Theatres and the Gamma Camera have been submitted for approval following some initial queries.	Q1 – Update to the Performance and Finance Committee and the Board The reported capital position at month 4 shows gross capital expenditure of £10.3m. The main areas of expenditure relate to the Salix Energy Efficient scheme, PFI lifecycle costs and Brocklehurst scheme and Urgent and Emergency Care. The Trust is £4.6m below plan. £2.0m relates to capital donations and grants with the other £2.6m relating to the applications made for emergency PDC to support schemes agreed within the ICS CDEL limit. Expenditure on these will not be committed until the PDC funding is confirmed. The forecast capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £58.1m and is in line with plan; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m).
Risks from Risk Register:			**Metrics** Capital performance and expenditure against the plan **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:**		

Inherent risk			**Risk as at 30.09.21 (Q3)**			**Target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	3	12	4	2	8

Appendix 2 – Actions taken, planned and draft assurance ratings

	Honest Caring and Accountable Culture The Trust does not make progress towards further improving a positive working culture this year. Inherent Risk: 4 x 4 = 16 Current Risk: 4 x 3 =12 Target Risk: 3 x 3 = 9			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Risks approved at the Board in May 2021 BAME Network conference Disability Network established	Board Development deep dive: Equality, Diversity and Inclusion, Wellbeing of staff and the Staff Survey results Wellbeing champions to be appointed Mediation Service and support Roll out of wellbeing conversation programme via appraisal	Talent Management plan established in October 2021 Inclusion programme for senior leaders established Additional funding secured to support Equality, Diversity and Inclusion agenda BAME Network promotion continues Allyship Programme has commenced and continued in Q3 Diversity in recruitment programme established	Be Remarkable: This is a programme designed for existing leaders and leadership teams to stretch their skills and knowledge to make a difference in their workplace and ultimately patient care. There are three cohorts starting this autumn (Sept, Oct, and Nov) from Jan 2022 and then there will be cohorts every 2 months. They will complete module 1 as a cohort, they can then access units in module 2	

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

		HUTH/YORK Non-Executive Board Development Programme	to fit operational needs as these will be repeated every two months, before coming together as a group in module 3 to complete the programme. Seven participants started module one in September, with a further twelve starting in October and fourteen in November. We have already started recruiting for the January and March cohorts.	

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Valued, skilled and sufficient staff The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across Trust Inherent Risk: 5 x 5 = 25 Current Risk: 4 x 3 =12 Target Risk: 3 x 3 = 9

Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Risks approved at the Board in May 2021	Board Development deep dive: Equality, Diversity and Inclusion, Wellbeing of staff and the Staff Survey results Management Briefing Sessions relating to staff recovery commenced – Approximately 100 managers reached so far over 4 sessions Personal Coaching service for home and work wellbeing challenges Great Leaders Management Clinics & Leading through Covid Bitesize Coordination of Schwartz Rounds and Team Time	The 'Lets Get Started' induction programme for the new Nurse registrants has been reformatted this year based on the feedback from the previous cohort The Healthcare Support Worker Development Programme established Health Groups to monitor annual leave and review loss of capacity. Additional sessions being offered to staff. Use of the Independent Sector continues.	Mary Seacole Programme We are currently advertising funded places to the Mary Seacole Leadership Programme run by the Leadership Academy. Hull University is also becoming an accredited delivery centre for Mary Seacole and we hope to access this from March 2022 onwards. The National Review of HR and OD report shared with the Workforce Education and Culture Committee Work will now be undertaken by the Director of Workforce	

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

			and OD and team to align actions in the report to ongoing work to deliver the Trust's People Strategy.	

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	High Quality Care **We will achieve a rating of 'Outstanding' in the next 5 years (2019-2024)** Inherent Risk: 4 x 4 = 16 Current Risk: 3 x 4 =12 Target Risk: 2 x 4 = 8			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Q1 Patient Safety Specialist role established Pressure Ulcer review – action plan being developed Re-modelling of the bed base due to increased activity New Head of Patient Experience in post Quality Governance restructure in place. Risk management, effectiveness and patient safety strengthened as part of the	Q2 Mental Health discussions with CCGs to review the issues with mental health capacity and support Ongoing international recruitment campaign. In response to the financial support offered by NHSI/E, the Trust plans to recruit a further 60 international nurses, between June and December 2021. There are also 9 existing Trust HCSW`s currently being supported through the OSCE process. HASR joint governance arrangements agreed Review Youth and Adult patient council and develop a forward plan	National NHSE feedback used to strengthen the Trust's IPC BAF. The Associate Director of Quality has chaired a task and finish group to progress improvement actions, the IPC BAF and IRC risk register. The Falls committee are now meeting bi-monthly and are also meeting as a MDT to provide greater quality to the patient reviews. Gap analysis undertaken with the Falls lead following the publication of the Kettering Report Gap analysis of the Emergency Department undertaken alongside the	Purpose T Pressure Ulcer assessment tool to be rolled out in February 2022 Quality Strategy to be approved by the Board January 2022 Risk Management Strategy to be approved by the Board January 2022 Continuity of Care plan implementation Inpatient Survey Results – Task and Finish Group to be established	

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

process. Family and Women's risk management pilot underway Weekly patient safety summit and weekly SI Committee commenced.	CAS Alert look back exercise carried out to ensure all alerts are seen by the relevant teams and any actions completed. External Agencies report presented quarterly to the HG Boards to ensure all visits are highlighted and any actions recorded. A review of Klebsiella bacteraemia cases is underway to monitor any learning from Trust apportioned cases HSMR review of deaths completed and reported to the Board. Structured Judgement Reviews - Training seminar is currently being planned to be delivered to senior nurses. Learning from Morbidity and Mortality now takes place across several different departments across the Trust, in varying ways. This includes the Medical Examiner's Office, in addition to SJR and Speciality M&M. The aim going forward is to have a single, robust reporting	implementation of the Patient FIRST tool Re-deployed nurse support in Patient Experience to help with the PALs backlog The patient experience team are working with the information analytics and business intelligence team to set up the new Friends and Family test which will be provided by Healthcare Communications and will go live on the 13th of September 2021 Quality Strategy endorsed by Quality Committee. Patient Safety Incident Response Plan drafted – awaiting National templates in Spring 22 to complete fully. Patient Safety Board Development session held in December 2021. Health Group Governance Frameworks to be completed and signed up to by December 2021 – not yet completed.	Assurance Programme for 22/23 to be presented to Operational Risk and Compliance Sub-committee in January 2022.	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	channel to ensure that the Trust learns lessons, shares lessons and takes positive action to embed positive change. This will allow for good practices to also be identified and shared and will allow for efficient monitoring. QSIR model for improvement approved at EMC. First cohort of training commenced September 2021. Trust Board development session on 'Making Data Count' First Patient Safety Congress held September 2021 with posters submitted to National Congress. Board level Well-led self-assessment completed.	Fundamental standards assurance days held. Assurance process, including unannounced visits, commenced in Maternity and Children and Young People. Risk Management Strategy presented to the Quality Committee in December 2021. First cohort of QSIR trainees completed Practitioner training successfully, which is the first step in the process to become an accredited faculty. Lessons Learned Framework approved by Quality Committee in November 2022.		

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	High Quality Care **We will increase harm free care** Inherent Risk: 5 x 5 = 25 Current Risk: 4 x 4 =16 Target Risk: 3 x 3 = 9				
Q1 Actions		**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Q1 Review of bed base due to activity levels H1 plan in place which covers the first 6 months of the year Increase Elective Capacity Framework – independent sector providers included Updates received at the Performance and Finance Committee regarding waiting list initiatives for Breast surgery, cardiology, dermatology, ENT, Gynaecology, Interventional Radiology,Ophthalmology, Oral		Replacement of the Radiology Information System **Breast** - Under 40s and over 40s clinics to be introduced (under 40s do not require mammograms) Weekend working initiatives included in the plan for Q1 & Q2 • Stratified Breast cancer follow up pathway supported by PIFU & PKB **Cardiology** - Working with clinical support (bi weekly	Provided a deep dive presentation to the 06 September 2021 Quality Delivery Group meeting on the Trust's Clinical Harm Review (CHR) process. Confirmation that significant assurance received. Presentation on management of patient safety and quality risks in ED to QDG (1 Nov 22). Presentation on Missed Opportunities Audit and actions and Ambulance Handover Delays to QDG (6 Dec 22). Confirmation that significant assurance received.	Start process to exit Enhanced Monitoring process. All clinicians in Cardiology have a PIFU access plan target Increase to day case activity to deliver H2 planned levels ENT making good progress in relation to 52 week clearance	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

Surgery and Plastic Surgery St Hughs still being used for Trauma and Orthopaedics activity Urology working with external provider in Q1	meetings in diary) additional weekend sessions secured for June and July. Cardiology registrars are supporting on WLI basis as well additional support for Consultant Cardiologists **Dermatology** - Implement image with referral for the skin pathway – approved for May 2021 go-live and assess impact on 2WW clinic throughput and waiting times for routine referrals **ENT** - Weekend working initiatives to be developed for Q1 & Q2 – including impact of 1st OP backlogs • Recruitment to vacant consultant post – over-recruitment approval to be developed • Develop specialist nursing roles to support/improve capacity and pathways **Gynae** - Cedar maintained as a 7-day ward; increased bed/trolley base (nearly pre-Covid) with screens. Aspiration	Corporate risk register updated to allocate these risks to the Deputy Chief Operating Officers. Breast – increase clinics following the end of consultant paternity leave Cardiology – Utilise Modality and Pioneer to establish additional capacity Greater focus on 45-51 week patients to prevent growth Dermatology – Additional sessions being worked and further outsourcing supported. ENT – Insourced capacity from September 2021 following financial approval Gynaecology – Clinic templates to be reviewed and reinstated to pre-Covid capacity Agency and/or locums to be recruited from WLIs expenditure	Gynae – secured day case sessions Finalise the 'Right Sizing Gynaecology' business case to demonstrate the gap in workforce (consultant & nursing) and theatres within the service. If successful this will provide the capacity required to manage demand and backlog along with the reduction in total WLV. Trauma – Increased follow up clinics to achieve plan Trauma is delivering 90% of pre Covid timetable Urology – P2 performance 67.4% against trajectory of 70%. Only 69 patients undated.	

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Blue	Target risk rating achieved.

	to review of hot/cold configuration supported by POCT • Continued use of Pioneer to support theatres/7-day working • Theatre timetable to return to pre-Covid levels – confirmed for 10 May 2021 for planned theatres; acute provision to be confirmed • Improved access to day case theatres required, potentially at CHH – Day Case T&F Group **Interventional Radiology** - Consideration to be given to introduce Radiographer led sessions in September which will reduce reliance on consultants and improve flexibility in capacity • Mobile CT scanner secured until end of Q3 – will assist with expected increase in demand and reduction of cardiac CT backlog • 4 x Rheumatology led US WLI sessions have been completed in April & May to reduce backlog • CTVC waiting times/backlog reduced and are now being	Interventional Radiology – continue to validate Waiting Lists and appoint long waiters as quickly as possible Ophthalmology – Urgent follow up activity prioritised Locums and substantive staff being secured. Trauma and Orthopaedics – Registrars sessions have been relocated to have the ability to increase the follow up capacity Independent sector use to continue Review of theatre schedule to take place Diagnostics – Continue to progress with the plans for Medinet		

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Blue	Target risk rating achieved.

	completed under 3 week **Ophthalmology** - Continued use of Pioneer to support theatres activity (theatre nurse, technical and consultant vacancies) at weekends for cataracts – releases sub-speciality resource for weekday working • Continued use of locum consultants to manage the sub-speciality demand/backlogs – Glaucoma and Medical Retina • Theatre staff recruitment and training • Further expansion to a 7-day working model for non-medical staff to provide sufficient capacity and/or development of community imaging hubs • Continued use of overtime for optometrists and orthoptists **Oral Surgery** - Significant weekend lists in Oral surgery has started to improve the 52-week position for patients awaiting follow up and treatments – looking to continue weekend lists where teams are			

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	able to support this **Plastic Surgery** - Centenary Theatre capacity to 3 lists per day from May 2021 • Continue to outsource activity to Spire (Hesslewood), St Hughs and Winterton • Continue to deliver WLIs • Consultant recruitment to vacant posts completed in May 2021 with further offer of locum post as over-recruitment approval. Right-sizing business case to be finalised. • Seek improvement in virtual clinic – additional IT support to patients to improve efficiency • Implement image with referral for the skin pathway – go-live 1 May 2021 and assess impact on 2WW clinic throughput and waiting times for routine referrals • Theatre timetable to identify x2 ortho/plastics lists per week • Assess the impact of joint case demand from other specialities as part of the right-sizing business case			

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Blue	Target risk rating achieved.

	Trauma and Orthopaedics - St Hugh's capacity still being utilised – circa 50 cases in April 2021 • C9 bed capacity increased to 19 beds – this enables theatre capacity to be used through case mix as far as possible; further increase in bed capacity likely in June/July 2021 when Complex Rehab unit opens – this provides capacity for long-waiting orthopaedics and neurosurgery patients • ASI/Holding position for new outpatients now back at sustainable position; key area of pressure is new foot/ankle referrals but routine/other sub-specialties do not have new outpatient waiting list issues • Part of ICS project to utilise capacity at Bridlington Hospital at weekends; patients identified who wish to transfer treatment – contractual, financial and patient pathway work being completed at present			

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Great Clinical Services There is a risk to access to Trust services due to the impact of Covid-19 Inherent Risk: 5 x 5 = 25 Current Risk: 4 x 5 = 20 Target Risk: 4 x 4 = 16			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Streaming implemented in ED which has had a significant impact MRI Van sessions increased Meetings with each of the challenged specialities will take place during April and will look to find additional means of support to address the significant backlogs within our top 10, now expanded to top 12 with the inclusion of Gastro and Interventional Radiology.	Humber Acute Strategic Committee meeting in June 2021 to review joint services and working ED Triumvirate presenting performance issues to the Performance and Finance Committee in June 2021 Waiting list recovery plans in place for all of the 12 worst performing specialities.	The Trust received a visit from the Emergency Care Intensive Support Team who undertook a "Missed Opportunities" Audit reviewing all patients who arrived in ED within a 24-hour period. The initial output of this work was shared with the Executive and Senior Team and the Humber CEOs Group. This review highlighted and confirmed many of the areas of concern, primarily volume of non-ED activity coming into the hospital that should realistically be seen in another setting. This audit was then followed up by a "Front Door" review of ED, AMU and Frailty all of which identified several	The H2 requirements in respect of RTT are to:- • Maintain the total WLV at or below the September 2021 baseline • Continue to reduce 52 week+ breaches • Achieve zero 104 week waits by end of March 2022. The H2 requirements in respect of RTT clock stops are to:- • Deliver a minimum of 89% of clock stops to the 19/20 baseline	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

		areas of learning and potential support going forward, a summary report of the outputs is expected shortly The last review element of this work is scheduled to take place the week of the 6 September following which a collated report outlining all themes will be received and shared with all system partners as part of a plan to agree specific elements of work that will be in place to support winter Intense and targeted management of the cancer PTLs continues at weekly meetings between the services and the cancer manager's team. The cancer transformation programme is making some progress to improve the patient pathways and increase the number of patients with a diagnosis within 28 days from receipt of referral. The main pathways being, head and neck, lung and upper GI with process mapping, gap analysis against the national optimal FDS pathways and use of the IST pathway analyser to identify	The H2 requirements for Cancer are to:- • Reduce the number of 63+ day breaches to the February 2020 baseline of 130 by March 2022 • Achieve 31 day treatment numbers monthly to trajectory • Achieve 2ww seen numbers monthly to trajectory The H2 requirements for Outpatients are to:- • Deliver A&G requests per 12/100 outpatient attendances including those through RAS triage models • Implement PIFU (Patient Initiated Follow up) pathways in 5 main specialties • Move 1.5% of outpatient attendances to a PIFU pathway by December 2021, increasing to 2% by March 2022	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

		delays that can be resolved and those areas that require more radical attention. Elective Recovery Group The Elective Recovery Group meet weekly and oversee the recovery programme and delivery of the outputs of the Task and Finish Groups. A separate Elective Recovery Report is provided for the Performance and Finance Committee which outlines delivery of the H1 plan with exception reports for the Top 12 specialties. Urgent Treatment Centre to be built on site Missed Opportunities Audit by the ECIST Team in ED. Presentation to the Performance and Finance Committee outlining the actions.	• Deliver a minimum of 25% virtual attendances per month as a total of all outpatient activity	

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Partnerships and Integrated Services There is a risk that the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery constraints Inherent Risk: 3 x 3 = 9 Current Risk: 2 x 3 = 6 Target Risk: 2 x 3 = 6			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q2)**
Phase 1, 2 and 3 of the HASR programme initiated	Phase 1 – haematology, oncology, neurology and dermatology Humber Acute Services Development Committee has been established and has met in June and August 2021. MOU/SLA agreed with HUTH and NLAG	Phase 2 – cardiology, ENT and Ophthalmology Joint working with Planned care programme within HASR for specialities which are across both P1 and P2 Expression of Interest for capital funding to be submitted to NHSE/I Senate Desk Top reviews and workshops for UEC/Maternity/Paeds and Neonates GIRFT support for planned care Engagement events: Overview and Scrutiny Committee CCGs/PCNs LA Partners	The Pre-Consultation Business Case will be produced by the end of December. Key elements of the document will then be socialised with stakeholder groups during January and February 2022 to gather additional information which may influence the options presented in the Statutory Consultation during 2022. Work continues with the CCG, Primary Care, Community, Mental Health and ODN representatives to work on the key enablers that	

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Blue	Target risk rating achieved.

		VCSE JNCC/LNC Capital pre-SOC workshops OOH and Primary care transformation alignment Service Vision and Clinical Strategy in place for the following services by Nov 2021; Dermatology, Haematology, Neurology and Cardiology Committees in Common meeting held in October highlighted the engagement and communications plan Expression of Interest – capital investment bid has been submitted to the Centre.	need to be in place to ensure successful delivery of the emerging models of care. A plan will be developed in Q4.	

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Research and Innovation **We will develop research capability, capacity and partnerships** Inherent Risk: 4 x 4 = 16 Current Risk: 3 x 4 =12 Target Risk: 3 x 4 = 12			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Q1 – Update 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. 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	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.	AMS – 20% of consultants should have 20% research time • Dedicated research time for early career consultants • Attract talent to our Trust by advertising jobs with dedicated research time • Especially in difficult to recruit areas • Potentially reduce locum spends, waiting list R&D structure is aligned to clinical research network structure - not necessarily with health groups	Success in securing externally funded grant income from the NIHR Lead for multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology. • Expanding research capability - Continuing from the vital COVID-19 vaccine research, the Infection Research Group are in the process of applying for a Genetically Modified Organisms (GMO - Contained Use) license from the Health and Safety Executive. • The Hull Lung Health Study builds on the work of the HCV ICS Hull Lung Health checks. This data collection study will generate a	

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

vaccine and other infectious diseases research portfolios		University – HYMS (Clinical sciences group), Innovation hub, HHTU STP – barrier free research across the Humber Coast and Vale ICS Launching of R&D branding • Research and innovation as one of the four pillars • Website, research newsletter, social media • Improving the profile of Trust • Recruiting high profile clinicians	highly valuable cohort dataset that can help determine future research and influence the direction of service provision in this area. • Increasing research capacity in our workforce – The Trust must continue to support the need to make research and innovation a part of everyone's duty in order to deliver high quality care. In 2022-23, we envisage the start of an ambitious journey to ensure 20% of our Consultant workforce have 20% protected research time. This will start with plans to award the first cohort of 10 Consultant PAs subject to an investment agreement from the Trust. Research communications and engagement strategy Research 'Celebration' Event – in order to showcase the remarkable work of our staff that deliver and facilitate research, we plan to hold this celebration event in late February 2022.	

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Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

			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. Over the remainder of this financial year, plans to cement our research relationships with our immediate neighbours (NLAG and Humber) will take shape, culminating in an agreed Memorandum of Understanding.	

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Financial Sustainability Expenditure incurred exceeds income by greater than agreed control total Inherent Risk: 4 x 4 = 16 Current Risk: 3 x 4 = 12 Target Risk: 2 x 4 = 8				
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**	
NHSEI has issued official planning guidance that sets out the details of the finance and contracting arrangements for the six-month period from 1st April 2021 to 30th September 2021 (H1).	The NHSEI indicative plan position for the period for HUTH was a deficit of £1.1m within an overall Humber Coast & Vale ICS (HC&V) target of break-even. Following discussions across all organisations within the ICS, based on forecast income and expenditure plans across the patch, the Trust has set a target plan of a deficit of £1.7m. The overall ICS position remains at break-even.	The Trust is currently forecasting that it will achieve its plan of £1.7m deficit for H1. The expectation is that this will also include a reserve of £2m to support H2. H2 Indications are that the guidance will be issued week commencing 20th September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there will a 5% reduction in the level of Covid19 funding available at ICS level. There will also be reduced support to offset the loss of other income. Elective Recovery Funding will continue but it is not yet known if there will be any further	1) The Trust has received 'smoothing' funding totalling £3.4m to move from £1.7m deficit to £1.7m surplus 2) The profile of the Trust expenditure budgets shows greater expenditure in H2 compared to H1, for example, utilities costs 3) Pressure due to savings made in H1 on consumable budgets due to the level of baseline for ERF funding at 70% to 85%. 4) Savings made from ERF in H1 are unlikely to be repeated		

Red	Target risk unlikely to be met – insufficient actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

		changes to the threshold. There will also be an increased efficiency requirement from October 21. This will be a minimum of 1.1% (up from 0.28% in H1) for all organisations but additional targets will be allocated to ICS patches. This could be an additional 1% to 2%. This is now being classed as 'waste reduction.' The Trust has now received guidance on the financial framework for H2. Block contracts from H1 will be rolled over with an inflation uplift to cover the agreed 3% pay award plus non-pay uplift. There is an increased efficiency requirement from October 21. This will be a minimum of 1.1% (up from 0.28% in H1) for all organisations	in H2 due to the higher ERF threshold. 5) Committed expenditure in H2 from IS for insourcing and outsourcing. 6) Winter expenditure plan (secured funding for the top 6 priority areas). 7) Reduction in Covid19 funding for H2 8) Reduced support to offset income loss in H2. The national expectation is that non-patient care income will start to recover (Free car parking for staff continues). 9) National CRES target for H2 has been set at 1.1%, 0.82% higher than H1. 10) The ICS has been given an additional efficiency ask above the 1.1% target. This has been shared across all organisations based on levels of expenditure.	

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			11) Remaining System risk The above pressures total £16.0m and without mitigation would leave the Trust reporting a £14.4m deficit. The following items detail the mitigating actions to deliver the control total: 12) Winter funding from system allocation 13) The Trust activity plan has been modelled by NHSEI through its 'ready reckoner' and indications are that the Trust will receive £1.6m of ERF based on the plans. 14) NHSEI has allocated additional funding from the targeted investment fund to enable the Trust to maintain activity levels. 15) Health Groups asked to deliver 2/3rds of the increased efficiency target	

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Blue	Target risk rating achieved.

			16) Additional income from Health Education England 17) Forecast slippage on expenditure plans in H2. 18) System management to offset balancing risk. This may include a review of the ICS management budget and further delivery of ERF. The main risks in the mitigating actions are the delivery of additional ERF (13 above) and the Health Group CRES delivery target (15 above).	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	Financial Sustainability The Trust does not plan or make progress against addressing its underlying financial position over the next 3 years Inherent Risk: 4 x 5 = 20 Current Risk: 4 x 5 = 20 Target Risk: 3 x 5 = 15

Q1 Actions	Q2 Actions	Q3 Actions	Q4 Actions	Assurance Rating (Draft for Q4)
	A 3% CRES target would be around £20m but based on historic delivery and the national agreement on deliverable targets, the maximum achievable may only be between 1 and 2% so between £7m – £14m. Planning guidance on the likely efficiency ask is expected by end of August 21.	H2 Indications are that the guidance will be issued week commencing 20th September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there will a 5% reduction in the level of Covid19 funding available at ICS level. There will also be reduced support to offset the loss of other income. Elective Recovery Funding will continue but it is not yet known if there will be any further changes to the threshold. There will also be an increased efficiency requirement from October 21. This will be a minimum of 1.1% (up from 0.28% in H1) for all organisations but	The Humber Coast and Vale ICS submitted a balance plan for H2 on 18th November. The ICS plan encompasses a level of risk to delivery. Specifically there remains an uncovered risk of £1.5m. Due to the size of the risk outstanding, it was felt that it would be inappropriate to submit a deficit plan at ICS level, but that actions would be developed during the period to manage the risk. This would include a review of the ICS management budget and the potential to earn additional Elective Recovery Fund (ERF)	

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		additional targets will be allocated to ICS patches. This could be an additional 1% to 2%. This is now being classed as 'waste reduction.' There will be an elective recovery scheme in H2. The requirement will be to deliver over 89% of the number of clock stops achieved in the same month of 2019/20. Activity above this will be funded at 100% of tariff up to 94% delivery and at 120% of tariff above this. This will be at ICS level and early indications based on submitted plans are that the ICS would receive around £5m in H2. Work is ongoing to look at how this looks at Trust level. Health Groups are reviewing the H2 activity plan for final submission	Income. For presentational purposes, this additional risk sits within the financial position of HUTH. Within the ICS break-even plan, HUTH is required to deliver a surplus of £1.7m. This will enable the Trust to achieve break-even across the full financial year.	

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Blue	Target risk rating achieved.

	Financial Sustainability Failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability Inherent Risk: 4 x 4 = 16 Current Risk: 4 x 3 = 12 Target Risk: 2 x 4 = 8			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Assurance Rating (Draft for Q4)**
Approved at the Board, the planned capital expenditure for the full year 2021/22 (incl PFI/IFRIC12 impact) is £58.1m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m).	The reported capital position at month 4 shows gross capital expenditure of £10.3m. The main areas of expenditure relate to the Salix Energy Efficient scheme, PFI lifecycle costs and Brocklehurst scheme and Urgent and Emergency Care. The Trust is £4.6m below plan. £2.0m relates to capital donations and grants with the other £2.6m relating to the applications made for emergency PDC to support schemes agreed within the ICS	The PDC Applications for Theatres and the Gamma Camera have been submitted for approval following some initial queries. The forecast capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £58.1m in line with plan; this includes assumptions on the Trust receiving PDC allocations for Urgent & Emergency care Business Case (£16.4m) and Digital The reported capital position at month 6 shows gross capital expenditure of £23.4m against a plan of £27.0m. The main areas of expenditure relate to the Salix Energy Efficient scheme, Brocklehurst scheme and	The reported capital position at month 7 shows gross capital expenditure of £26.3m against a plan of £31.2m. The schemes which are currently below plan mainly relate to a profiling issue within the emergency PDC application schemes. The main areas of expenditure relate to the Salix Energy Efficient scheme; Backlog	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

	CDEL limit. Expenditure on these will not be committed until the PDC funding is confirmed.	Urgent & Emergency Care. The schemes, which are currently below plan, are mainly related to the PDC Capital schemes, which were behind profile due to the approvals process but have since commenced. The planned capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £70.1m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m). The PDC Applications for Theatres and the Gamma Camera have been submitted to the local ICS Finance team for review and approval. Until approval is given, the Trust is commencing these two schemes using internal cash resources.	Maintenance & Compliance and Urgent & Emergency Care. The planned capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £80m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m). The PDC Applications for Theatres and the Gamma Camera have been submitted to the local ICS Finance team for review and approval. Until approval is given, the Trust	

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Blue	Target risk rating achieved.

			is commencing these two schemes using internal cash resources. The Trust has recently submitted an application for Targeted Investment Funds of £10m relating to a Day Surgery Facility. This funding has now been agreed	

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Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

Appendix 3

		Impact Score				
		1	2	3	4	5
Likelihood Score	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Likelihood Descriptions		Score
Rare	This will probably never happen / recur. Not expected to occur for years.	**1**
Unlikely	Do not expect it to happen / recur but it is possible it may do so. Expected to occur at least annually.	**2**
Possible	Might happen or recur occasionally. Expected to occur at least monthly.	**3**
Likely	Will probably happen / recur but it is not a persisting issue. Expected to occur at least weekly.	**4**
Almost Certain	Will undoubtedly happen / recur, possibly frequently. Expected to occur at least daily.	**5**

Impact Domains	Impact Score and Examples of Descriptions				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / Equality / Complaints / Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory Duty / Inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business Objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including Claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / Business Interruption / Environmental Impact	Loss/interruption of >1 hour Minimal or no impact on the environment No impact on other services	Loss/interruption of >8 hours Minor impact on environment Impact on other services within the Division	Loss/interruption of >1 day Moderate impact on environment Impact on services within other Divisions	Loss/interruption of >1 week Major impact on environment Impact on all Divisions	Permanent loss of service or facility Catastrophic impact on environment Impact on services external to the Trust
Information Security / Data Protection	Potential breach of confidentiality with less than 5 people affected Encrypted files	Serious potential breach of confidentiality with 6 – 20 people affected Unencrypted clinical records lost	Serious breach of confidentiality with 21 – 100 people affected Inadequately protected PCs, laptops and remote device	Serious breach of confidentiality with 101 – 1000 people affected Particularly sensitive details (i.e. sexual health)	Serious breach of confidentiality with over 1001 people affected Potential for ID theft

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	Integrated Performance Report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report is currently under review and will be presented to the Board Committees and the Board once completed				

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

Key Recommendations to be considered:

The Board is asked to review the attached report.

The IPR review is ongoing and the Governance Team are reviewing how SPC charts can be applied at all levels of the organisation supported through QSIR training and Quality Improvement projects to provide themed reports for the Health Groups and directorates.

Work is ongoing with North Lincolnshire and Goole Hospital Foundation Trust to share learning around the Integrated Performance Report and adopt good practice.

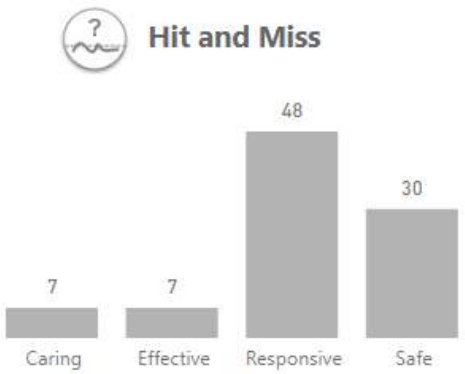
Recommendation:
The Board is asked to review the progress of the IPR and approve the approach being taken.

Integrated Performance Report

Author: Business Intelligence Analytics Team

Contact: Karen Ferguson – Information Manager

Executive Summary



Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)	Unreliable	Not capable	Capable	N/A
Caring	8	1	1					7	1	2	
Effective	8	1			2			7	2	2	
Responsive	28	25	7	5	10	7	1	48	15	8	12
Safe	36	15	4	5	9			30	20	15	4
Total	80	42	12	10	21	7	1	92	38	27	16

Scorecard – Caring

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
8	1	1	0	0	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
7	1	2	0
Hit and miss target	Consistently fail target	Consistently hit target	

Domain	Metric	Month	Result	Variation	Assurance
Caring	A&E FFT response rate	November 2021	17.6%		
Caring	A&E Scores FFT (% negative)	November 2021	19.0%		
Caring	A&E Scores FFT (% positive)	November 2021	79.0%		
Caring	Inpatient FFT response rate	November 2021	4.3%		
Caring	Inpatient Scores FFT - % negative	November 2021	0.0%		
Caring	Inpatient Scores FFT - % positive	November 2021	99.0%		
Caring	Maternity FFT response rate	November 2021	17.5%		
Caring	Maternity Scores FFT - % negative	November 2021	0.0%		
Caring	Maternity Scores FFT - % positive	November 2021	100.0%		
Caring	Mixed Sex Accommodation Breaches	December 2021	0		

Scorecard - Effective

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
8	1	0	0	2	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
7	2	2	0
Hit and miss target	Consistently fail target	Consistently hit target	

Domain	Metric	Month	Result	Variation	Assurance
Effective	Complaints received	January 2022	518		
Effective	Complaints reopened	January 2022	62		
Effective	Crude Mortality (non-elective admissions)	January 2022	4.6%		
Effective	Emergency c-section rate	January 2022	20.3%		
Effective	Emergency readmissions within 30 days	December 2021	6.8%		
Effective	Hospital Standardised Mortality Ratio - Weekend	October 2021	109.20		
Effective	Hospital Standardised Mortality Ratio - monthly position	October 2021	97.89		
Effective	PPCI within 150 minutes	December 2021	73.9%		
Effective	Stroke 60 mins	December 2021	52.3%		
Effective	Stroke PTs >90% stay on a Stroke Ward	December 2021	93.9%		
Effective	Summary Hospital Mortality Indicator (HSCIC)	August 2021	115.37		

Scorecard – Responsive (1 of 6)

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
28	25	7	5	10	7	1
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
48	15	8	12
Hit and miss target	Consistently fail target	Consistently hit target	

Domain	Metric	Month	Result	Variation	Assurance
Responsive	% Ambulance handovers waiting >60 minutes	January 2022	15.3%		
Responsive	% Ambulance handovers waiting 15-30 minutes	January 2022	29.0%		
Responsive	% Ambulance handovers waiting 30-60 minutes	January 2022	20.8%		
Responsive	A&E Monthly Attendance Contract Plan	January 2022	11,768		
Responsive	Admitted Backlog (18+ weeks)	January 2022	14,037		
Responsive	Advice & Guidance Volume	January 2022	2,707		
Responsive	Ambulance handovers waiting <15 minutes (number)	February 2022	1,214		
Responsive	Ambulance handovers waiting >60 minutes (number)	January 2022	392		
Responsive	Ambulance handovers waiting 15-30 minutes (number)	January 2022	740		
Responsive	Ambulance handovers waiting 30-60 minutes (number)	January 2022	531		
Responsive	Average Bed Days Occupied by Stranded Patients	January 2022	10,690		
Responsive	Average Bed Days Occupied by Super Stranded Patients	January 2022	8,597		

Scorecard – Responsive (2 of 6)

Domain	Metric	Month	Result	Variation	Assurance
Responsive	Cancelled op 28 day breaches % (quarterly)	December 2021	1.1%		
Responsive	Cancelled op 28 day breaches number	January 2022	12		
Responsive	Cancelled Operations % of FFCEs (quarterly)	December 2021	12.2%		
Responsive	Cancelled Operations number	January 2022	56		
Responsive	Cancer 104 Day Waits	December 2021	53		
Responsive	Cancer 2 week (all cancers)	December 2021	74.2%		
Responsive	Cancer 2 week (breast symptoms)	December 2021	14.5%		
Responsive	Cancer 28 Day Wait - Faster Diagnosis Standard	December 2021	78.6%		
Responsive	Cancer 31 day wait for second or subsequent treatment - drug treatments	December 2021	100.0%		
Responsive	Cancer 31 day wait for second or subsequent treatment - Radiotherapy	December 2021	96.9%		
Responsive	Cancer 31 day wait for second or subsequent treatment - surgery	December 2021	63.5%		
Responsive	Cancer 31 day wait from diagnosis to first treatment	December 2021	94.3%		
Responsive	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	December 2021	73.9%		
Responsive	Cancer 62 Day Waits for first treatment (from urgent GP referral)	December 2021	66.9%		
Responsive	Capital forecast against plan	January 2022	(20,483)		
Responsive	Complaints: Received rate per 1000 bed days	January 2022	0.87		

Scorecard – Responsive (3 of 6)

Domain	Metric	Month	Result	Variation	Assurance
Responsive	Day Case Admissions	January 2022	4,772		
Responsive	Diagnostics: Patients waiting 6 weeks or more from referral to test	January 2022	37.9%		
Responsive	ED: % of attendees assessed within 30 minutes of arrival	January 2022	88.5%		
Responsive	ED: % patients waiting over 6 hours in the departments	January 2022	35.3%		
Responsive	ED: 12 hour trolley waits	January 2022	4		
Responsive	ED: Attendances Type 1	January 2022	8,788		
Responsive	ED: Attendances Type 1 & 3	January 2022	10,755		
Responsive	ED: Breaches - Type 1	January 2022	4,427		
Responsive	ED: Breaches - Type 1&3	January 2022	4,500		
Responsive	ED: Conversion Rate	January 2022	26.4%		
Responsive	ED: Median time between arrival and treatment (minutes)	January 2022	109		
Responsive	ED: Percentage of patients who Left Without Being Seen (LWBS)	January 2022	7.8%		
Responsive	ED: Standard Performance Type 1	January 2022	49.6%		
Responsive	ED: Standard Performance Type 1 & 3	January 2022	58.2%		
Responsive	ED: Standard Performance Type 3	January 2022	96.3%		
Responsive	Elective Admissions	January 2022	605		
Responsive	e-Referrals Service (Rejects and Returns)	January 2022	14.3%		

Scorecard – Responsive (4 of 6)

Domain	Metric	Month	Result	Variation	Assurance
Responsive	Forecast outturn compared to plan	January 2022	0		
Responsive	Forecast underlying surplus/deficit compared to plan	January 2022	(47,800)		
Responsive	Mean Week Waiting Time - Incomplete Pathways	January 2022	14		
Responsive	Non Elective Admissions	January 2022	4,947		
Responsive	NonAdmitted Backlog (18+ weeks)	January 2022	49,177		
Responsive	Outpatients: 1st Attendances	January 2022	18,187		
Responsive	Outpatients: 1st to FU Ratio	January 2022	2.29		
Responsive	Outpatients: All Referral Types	January 2022	17,318		
Responsive	Outpatients: Cancelled Clinics 6 weeks notice	January 2022	2,395		
Responsive	Outpatients: Consultant to Consultant Referrals	January 2022	3,774		
Responsive	Outpatients: DNA Rates	January 2022	9.2%		
Responsive	Outpatients: Follow-up Attendances	January 2022	41,573		
Responsive	Outpatients: GP Referrals	January 2022	8,665		
Responsive	Outpatients: Hospital Cancelled Outpatient Appointments %	January 2022	14.4%		
Responsive	Outpatients: Other Referrals	January 2022	2,897		
Responsive	Outpatients: Patient Cancelled Outpatient Appointments %	January 2022	8.4%		
Responsive	PALS Complaints	January 2022	1,836		

Scorecard – Responsive (5 of 6)

Domain	Metric	Month	Result	Variation	Assurance
Responsive	Performance against 40 day compliance	January 2022	53.5%		
Responsive	PHSO Referrals	January 2022	4		
Responsive	Priority 2 patients waiting 12+ weeks	January 2022	672		
Responsive	Recurrent efficiencies YTD compared to plan	January 2022	0		
Responsive	RTT 104+ Weeks Waiters	January 2022	613		
Responsive	RTT 18+ weeks waiters	December 2021	25,798		
Responsive	RTT 36+ Week Waiters	January 2022	11,572		
Responsive	RTT 52+ Week Waiters	January 2022	5,292		
Responsive	RTT 78+ Weeks Waiters	January 2022	1,781		
Responsive	RTT away from 92% traj.	December 2021	20,867		
Responsive	RTT Incomplete Pathways % performance	January 2022	57.6%		
Responsive	RTT Total Waiting List	January 2022	63,214		
Responsive	Spells with LoS 0 days	January 2022	1,305		
Responsive	Spells with LoS 7+ days	January 2022	454		
Responsive	Stranded Patients at End of Month 14 days	January 2022	259		
Responsive	Stranded Patients at End of Month 21 days	January 2022	159		
Responsive	Theatres: Cancelled Sessions (due to leave, staffing etc.)	November 2021	0		

Scorecard – Responsive (6 of 6)

Domain	Metric	Month	Result	Variation	Assurance
Responsive	Theatres: Cancelled Sessions (due to leave, staffing etc.)	November 2021	0		
Responsive	Theatres: number of sessions held	January 2022	465		
Responsive	Theatres: Utilisation of planned sessions	January 2022	64.7%		
Responsive	Total efficiencies YTD compared to plan	January 2022	0		
Responsive	YTD actual compared to plan	January 2022	0		

Scorecard – Safe (1 of 5)

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
36	16	4	5	9	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
31	20	15	4
Hit and miss target	Consistently fail target	Consistently hit target	

Domain	Metric	Month	Result	Variation	Assurance
Safe	% of audits overdue	October 2021	35.0%		
Safe	% of NICE interventional procedures that the Trust is compliant with	October 2021	97.1%		
Safe	% of NICE technology appraisals that the Trust is compliant with	October 2021	97.3%		
Safe	% of staff who have a completed Covid 19 Risk Assessment	January 2022	78.8%		
Safe	% Trust participation in national audits	January 2021	94.0%		
Safe	Absence	December 2021	6.4%		
Safe	Adjusted Vacancies WTE	November 2021	230		
Safe	Adjusted Vacancy Rate WTE	December 2021	3.1%		
Safe	Admission of full term babies to neo-natal care	January 2022	9		
Safe	Agency WTE	December 2021	36		

Scorecard – Safe (2 of 5)

Domain	Metric	Month	Result	Variation	Assurance
Safe	Appraisal complete % (AFC)	December 2021	71.3%		
Safe	Appraisal complete % (Consultant)	December 2021	82.8%		
Safe	Bank WTE	December 2021	111		
Safe	CAS alerts outstanding	December 2021	1		
Safe	Category 1 Pressure Ulcer	January 2022	25		
Safe	Category 2 Pressure Ulcer	January 2022	221		
Safe	Category 3 Pressure Ulcer	January 2022	0		
Safe	Category 4 Pressure Ulcer	January 2022	0		
Safe	Clinical harm reviews - Cancer 104 day wait	January 2022	332		
Safe	Clinical harm reviews - 104 week waits RTT	January 2022	372		
Safe	Clostridium Difficile - infection rate (per 1000 bed days)	November 2021	0.10		
Safe	Clostridium Difficile - number	December 2021	41		
Safe	Consultant and SAS – Signed off Job Plans %	December 2021	65.9%		
Safe	COVID - Positive Tests	January 2022	132		
Safe	Covid Absence - Positive and Staff Isolation	December 2021	2.5%		
Safe	Duty of Candour; investigation compliance	January 2022	95.9%		
Safe	Duty of Candour; verbal apology	January 2022	86.1%		

Scorecard – Safe (3 of 5)

Domain	Metric	Month	Result	Variation	Assurance
Safe	Duty of Candour; written apology	January 2022	50.0%		
Safe	E.Coli	December 2021	97		
Safe	Elective c-section rate	January 2022	14.5%		
Safe	Establishment WTE	December 2021	8,259		
Safe	Falls recorded as servere harm or death - rate per 1000 bed days	January 2022	8.76		
Safe	Klebsiella spp bacteraemia	December 2021	41		
Safe	Mandatory Training (% completed)	December 2021	84.9%		
Safe	Maternal Deaths	November 2021	0		
Safe	Medication errors causing moderate harm	January 2022	15		
Safe	Medication errors causing serious harm	January 2022	0		
Safe	Midwife to birth ratio	January 2022	1.30		
Safe	MRSA bactaraemias	December 2021	3		
Safe	MSSA	December 2021	64		
Safe	National audit outlier alerts	October 2021	5		
Safe	Never Events (MAT)	January 2022	5		
Safe	Never events: Incidence Rate (per 1000 bed days)	January 2022	0.03		
Safe	NEWS Compliance	January 2022	100.0%		

Scorecard – Safe (4 of 5)

Domain	Metric	Month	Result	Variation	Assurance
Safe	Patient Incidents	January 2022	1,430		
Safe	Patient incidents recorded as moderate and above - rate per 1000 beddays	January 2022	2.53		
Safe	Patient Incidents: Falls	January 2022	263		
Safe	Patient Incidents: Falls resulting in serious/harm or death	January 2022	31		
Safe	Patient Safety Incidents (Catastrophic)	January 2022	26		
Safe	Patient Safety Incidents (Major)	January 2022	49		
Safe	Patient Safety Incidents (Minor)	January 2022	1,846		
Safe	Patient Safety Incidents (Moderate)	January 2022	661		
Safe	Patient Safety Incidents (No Harm)	January 2022	15,413		
Safe	Patient safety incidents that are harmful	January 2022	4.1%		
Safe	Percentage of harm free care	January 2022	95.9%		
Safe	Percentage of new Harms	October 2021	6.4%		
Safe	Pressure Ulcers (Hospital acquired)	January 2022	383		
Safe	Pseudomonas aeruginosa bacteraemia	December 2021	23		
Safe	Serious Incidents	January 2022	130		
Safe	Serious Incidents investigated within 60 days	January 2022	0.0%		
Safe	Serious Incidents rate (per 1000 bed days)	January 2022	0.53		

Scorecard – Safe (5 of 5)

Domain	Metric	Month	Result	Variation	Assurance
Safe	Serious Incidents report within 48 hours	January 2022	100.0%		
Safe	Sickness – Excluding Covid by Health Group and Staff Group	December 2021	3.8%		
Safe	Staff in Post WTE	December 2021	7,860		
Safe	Suspected Deep Tissue Injury	January 2022	113		
Safe	Turnover by Health Group and Staff Group	December 2021	11.1%		
Safe	Unstageable	January 2022	24		
Safe	Vacancy Rate %	December 2021	4.8%		
Safe	VTE Risk Assessment	December 2021	86.0%		
Safe	WHO Checklist	January 2022	99.0%		

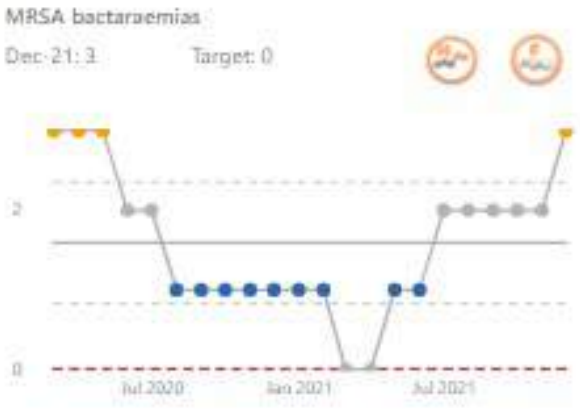
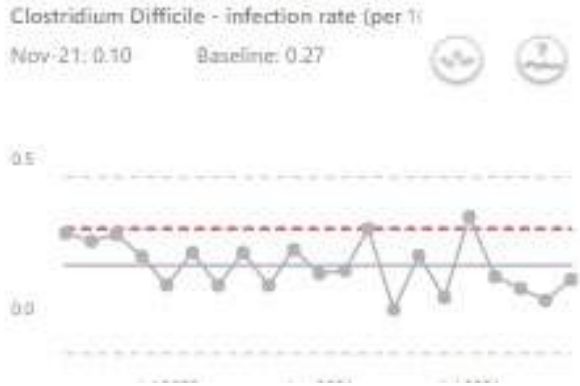
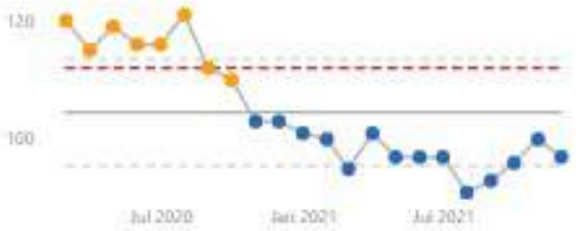


Chart Says	One hospital onset MRSA case was reported in December 2021. There have been 2 cases reported year to date;. The Trust reported 3 C.difficile cases in December 2021;. There were 5 hospital onset MSSA bacteraemia cases reported in December 2021. The graph shows the moving annual total
Issues	; ; There were 3 MSSA cases reported in Surgery Health Group, 1 case reported in Medicine Health Group and 1 in Clinical Support Health Group.
Actions	; MRSA - Patient found to have discitis during course of admission. PIR investigated and meeting being convened; All reported C.difficile samples are sent automatically for ribotyping. All three HOHA cases identified in December 2021 were reported in the Surgery Health Group
Mitigations	; ;



E.Coli

Dec-21: 97 Baseline: 112



Klebsiella spp bacteraemia

Dec-21: 41 Baseline: 38

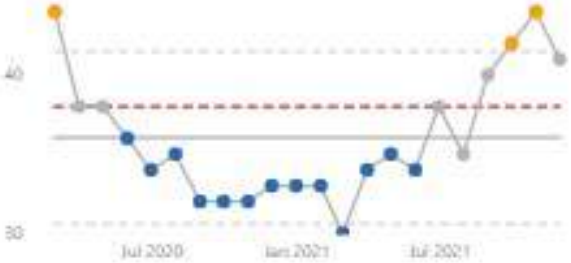


Chart Says

Issues

Actions

Mitigations

Pseudomonas aeruginosa bacteraemia

Dec-21: 23 Baseline: 13

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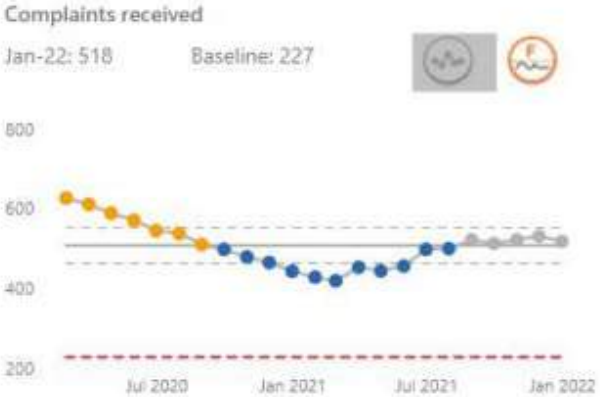

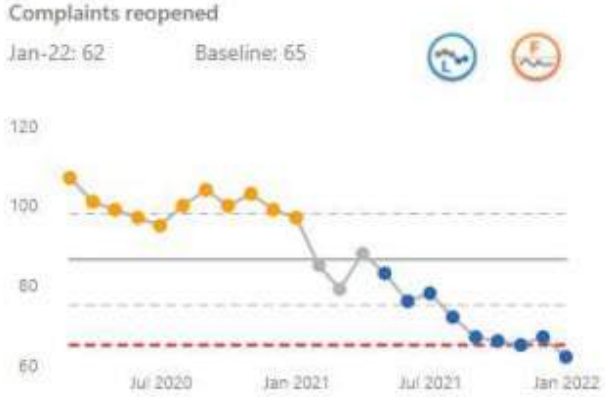

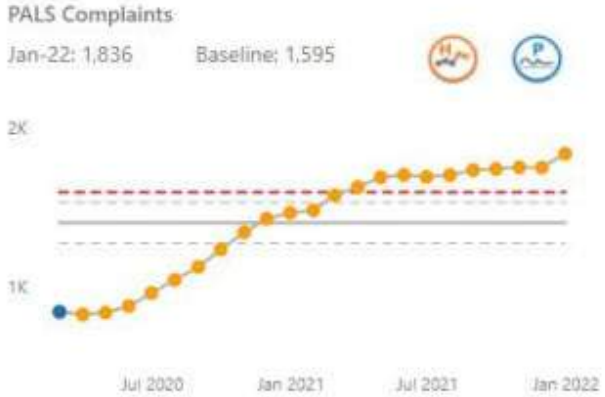

Chart Says	Complaints - The table indicates the number of complaints by subject received by each Health Group during the month of January 2022. Treatment continues to be the subject receiving the highest number of complaints with 15 of the 36 complaints received this month being for this subject. 6 of these were regarding the patient not being satisfied with the treatment plan and 5 re the outcome of surgery. Currently there are 139 complaints open (as of 3 February 2022). PALS - Contact with PALS during January 2022 was the highest received in the past 3 years. The table below indicates the total number of PALS concerns by subject received by each Health Group during the month of January 2022 (230). Delays waiting times and cancellations was the subject with the highest number received (76); of these, 16 were regarding a delay in the notification of results, 13 not satisfied with plan and 12 waiting times for elective surgery.
Issues	In addition to the 230 concerns raised, there were 10 compliments and 22 general advice issues received by the team during January 2022. 231 cases have been closed this month and there are currently (as of 2 February), 83 cases open
Actions	The complaints process is under review in line with the proposed PHSO Complaints Standards Framework (for implementation in 2022). A report as to the Trust's position on compliance to the new standards has been prepared and plans for its implementation are in progress.
Mitigations	

Integrated Performance Report – Quality & Safety

Chart Says	The Trust declared one Never Event in January 2022 in relation to a retained foreign object.
Issues	A patient underwent a procedure involving a dilation balloon; it appears that the sheath of the balloon was retained inadvertently unbeknown to staff. The patient later presented with a perforated duodenum which required surgical intervention.
Actions	A simulation of events is to be undertaken lead by the CMO to identify the root cause of the most recent Never Event and to identify learning to be shared with the wider Trust to prevent a similar recurrence in the future
Mitigations	There has been a total of 5 never events declared in 2021/22 with the most recent declared in January 2022

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Chart Says	Overall there has been a reduction in the number of hospital acquired pressure ulcers this month along with a reduction in Device Related Pressure Ulcers.
Issues	The DRPU continue to be from a variety of specialities not just critical care environments.
Actions	MINIMISE Awareness is a campaign to reduce MASD, the first national awareness day is planned for the 17th March. This will be advertised, in the next TV newsletter with the TV team raising awareness across the organisation.
Mitigations	Purpose T a new Pressure Ulcer Risk Assessment tool has been implemented across CHH in line with the digital roll out. The Tissue Viability Team will work with the Digital Team to roll out of Purpose T at HRI.

Integrated Performance Report – Quality & Safety

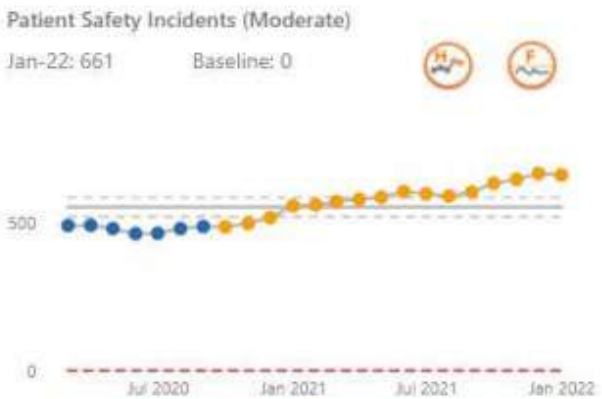
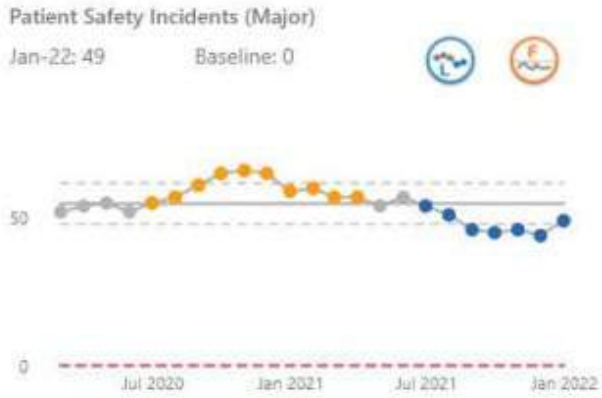
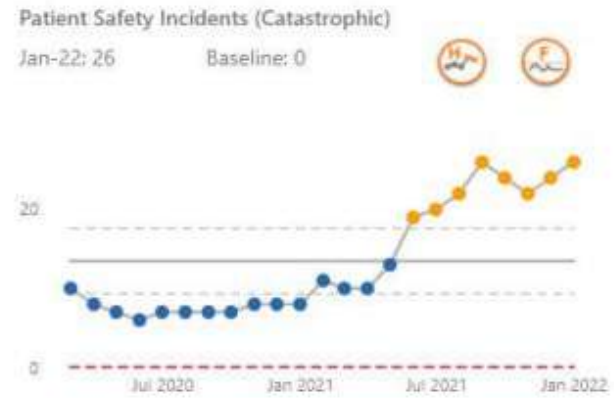
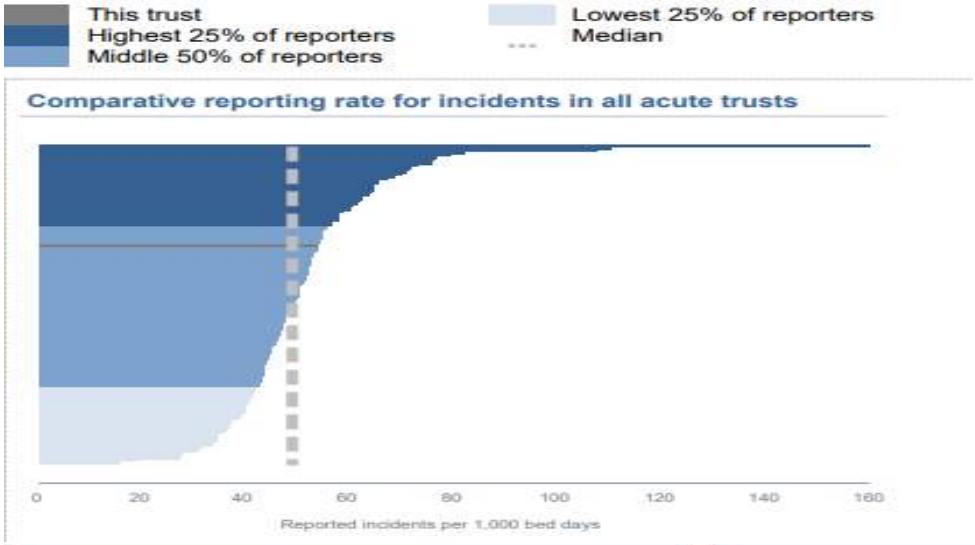


Chart Says	The charts show the reporting rates of all incidents and moderate and above harms by 1,000 bed days on a monthly basis over the past 2 years. The data shows that there was an increase in the numbers reported however this correlates with fewer bed occupancy in the Trust. Bed occupancy has increased and the number of incidents have reported have returned in line with the mean of approx. 39 incidents. The last 5 months has shown a shift run in the percentage reported increasing however the data is within control limits
Issues	The Trust has a positive patient safety reporting culture (high volume, low harm). The NRLS data shows that the Trust is shown to be in the top quartile of the middle 50% of reporters, above the median reporting rate The actual figures calculated by the HoPS&I for a harm review indicates that the mean is approx. 1.5 per 1000 bed days with 2 per 1000 bed days reported in Jan 2022
Actions	
Mitigations	





Patient Safety Incidents



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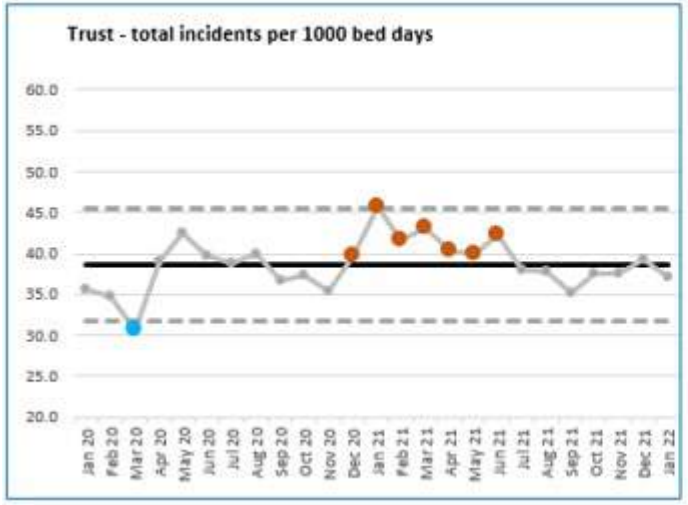
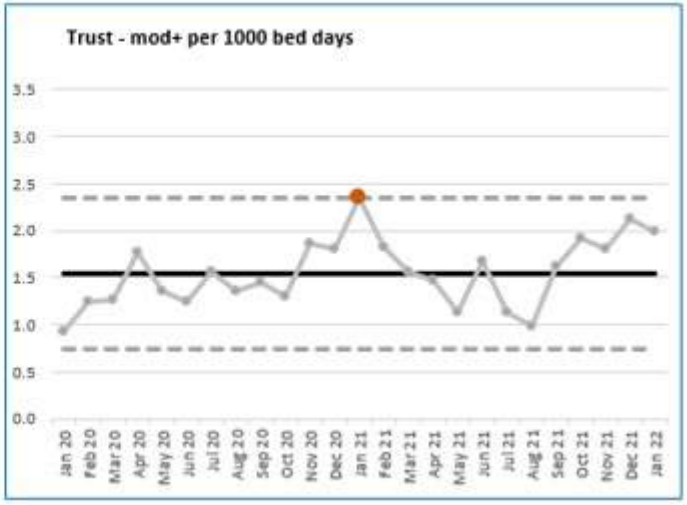
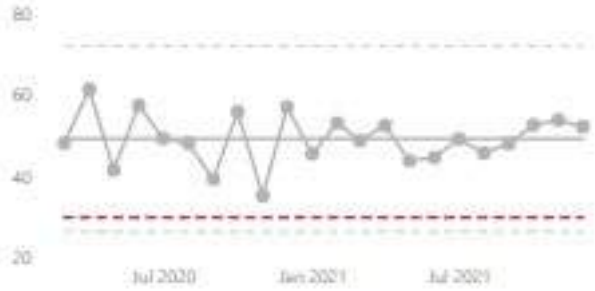




Stroke 60 mins

Dec-21: 52.3% Target: 30.0%



Stroke PTs >90% stay on a Stroke Ward

Dec-21: 93.9% Target: 80.0%

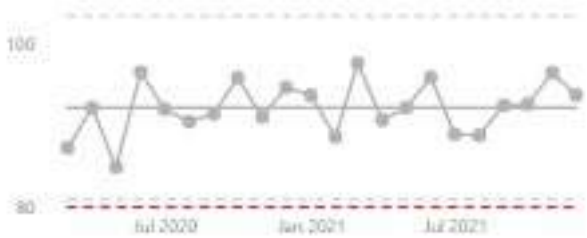


Chart Says

Issues

Actions

Mitigations

PPCI within 150 minutes

Dec-21: 73.9% Target: 90.0%

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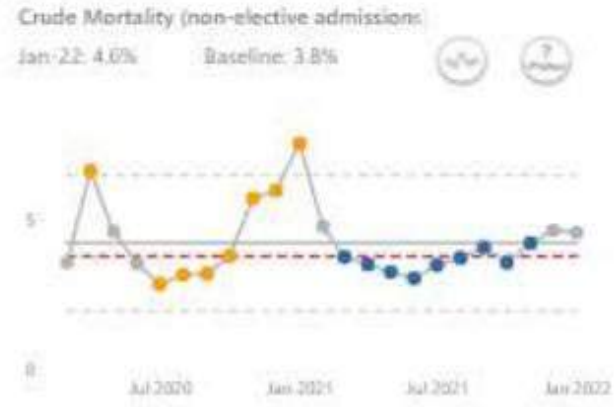

Chart Says	The monthly HSMR demonstrates that the Trust continues to remain within the control limits and below the England average of 100.0. Although the weekend mortality ration is within the Trust's control limits it is actually above the England average of 100.0 at 109.2 as of October 2021, which could potentially trigger outlier status. The SHMI continues to increase and is significantly above the England average of 100.0 at 115.57 for the last twelve months as of August 2021. This is highlighted as a high cause for concern. The Crude Mortality for Non elective admissions has been increasing since July 2021 and has now been reported at 4.6% in January 2022 compared against the England average of 3.2%.
Issues	The Trust continues to be reported as an outlier in the CQC Insight Report for HSMR and SHMI, however, the HSMR data is out of date and the Trust's data, as demonstrated in the graphs shows that the HSMR did return within the control limits and below the England average. SHMI continues to raise and is under investigation to understand the reasons.
Actions	The Mortality Task and Finish Group led by the Chief Medical Officer continues to undertake in depth analysis and improvement work on the high risk areas highlighted in the HSMR and SHMI data. Current areas of focus are Septicaemia, Lung Cancer, Stroke, crude mortality for non-elective admissions and the CHKS rebasing of HSMR and SHMI data.
Mitigations	The group continues to meet twice weekly to deliver the Mortality Improvement Plan following the internal HSMR review, which was also supported by external scrutiny by Dr Foster to address the Trust's Mortality Outlier status. The groups also reviews the HSMR and SHMI data in more detail to undertake improvement work in the key areas. This is being informed and supported by the development of an in house Mortality dashboard and the completion of SJRs as well as other improvement actions as agreed by the group.

Integrated Performance Report – Responsive

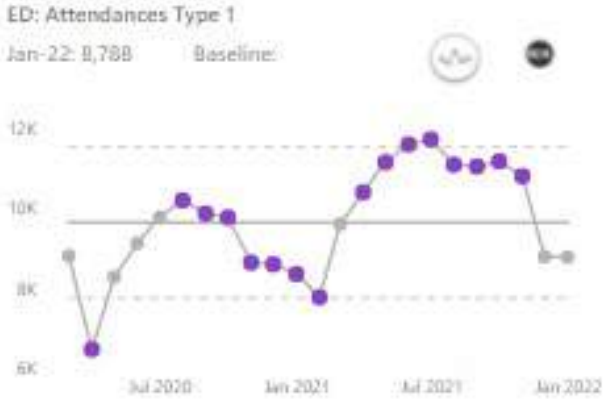

Chart Says	Delivery of the 4 Hour National Standard was not achieved in January 2022. Actual performance was 49.6%
Issues	
Actions	Nurse led streaming and triage at the front door was put back in place on 14 February 2022, as the waits to be seen in the Emergency Care Area were a concern. The NHS Improvement ECIST team recommended 3 opportunities for improvement.
Mitigations	The UTC commenced from the 1st December 2021 in the hope to deliver around 5% improvement. (Currently reporting 1% improvement) A number of Task and Finish groups, QIPs and PDSAs are being established across the Emergency and Urgent Care Pathway that will be monitored either via the Ambulance Handover Steering group or Four hour Delivery Group.

Integrated Performance Report – Responsive

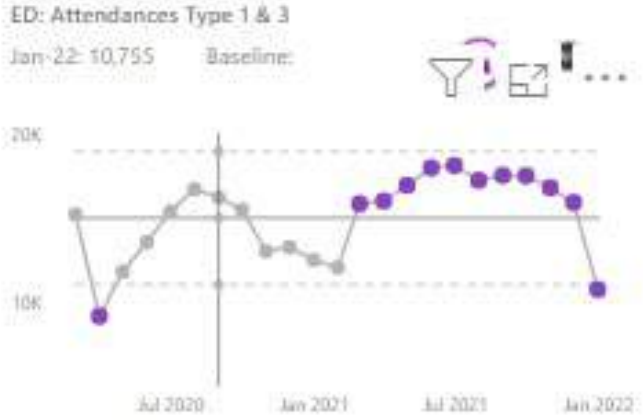

Chart Says	Performance for Type 1 & 3 in January 22 was 58.2%.
Issues	
Actions	
Mitigations	

ED: % of attendees assessed within 30 minutes of arri...

Jan-22: 88.5% Baseline: 91.4%

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ED: % patients waiting over 6 hours in the

Jan-22: 35.3% Baseline: 16.5%

(Blank)

Chart Says
Issues
Actions
Mitigations

ED: Median time between arrival and treatment (min...

Jan-22: 109 Baseline: 65

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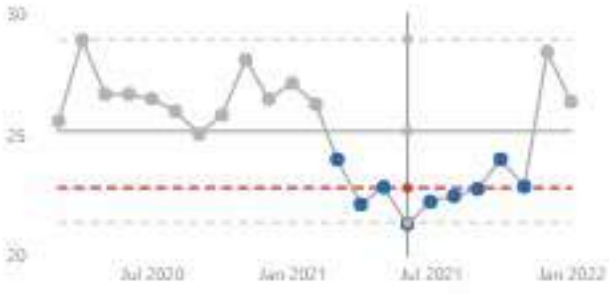
Chart Says
Issues
Actions
Mitigations

ED: Conversion Rate

Jan-22: 26.4% Baseline: 22.8%



ED: 12 hour trolley waits

Jan-22: 4 Target: 0

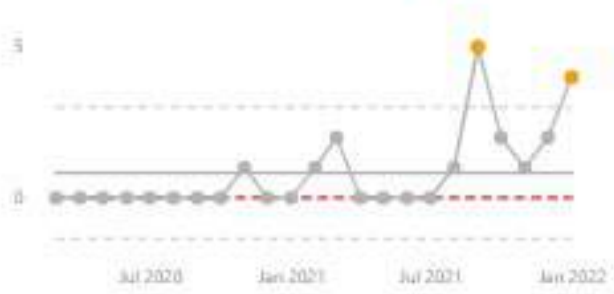


Chart Says	The Trust had 4 x 12 hour trolley waits in January. There were 3 breaches for a hospital bed and 1 mental health breach.
Issues	
Actions	
Mitigations	A rapid review has been undertaken, Duty of Candour was completed along with apologies to the patients for their wait for transfer to the ward or to another provider.

ED: Percentage of patients who Left With

Jan-22: 7.8% Baseline: 2.0%

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Integrated Performance Report – Responsive

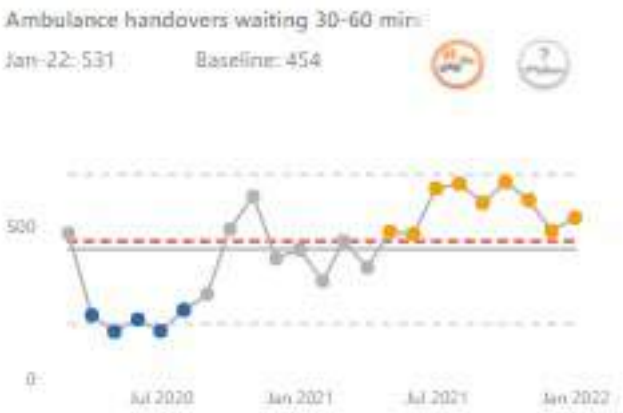

Chart Says	Handover times in January were 29% of handovers within 15-30 minutes
Issues	
Actions	
Mitigations	

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Ambulance handovers waiting <15 minut

Feb-22: 1,214 Baseline: 1,326

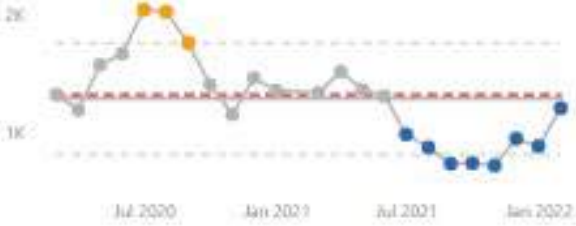


Chart Says	Ambulance delays over 60 minutes was 15.3% in January. This is higher than the previous month.
Issues	The handover times remain a significant problem as a direct result of our ongoing flow issues across the system.
Actions	The Steering Group to oversee the Ambulance improvement plan has met bi weekly from the 16th December 2021 and has representatives from both CCGs, YAS, ECIST and the Trust. A detailed review of the improvement plan is undertaken at each meeting, and metrics have been included to track improvements.
Mitigations	The development of an Urgent Care Co ordination centre had it first workshop on the 6th December 2021 the aim being to create a single point of access (SPA) that will enable Ambulance crews to discuss patients with a senior clinician who can arrange alternatives to conveyance in the community.

% Ambulance handovers waiting 30-60 m

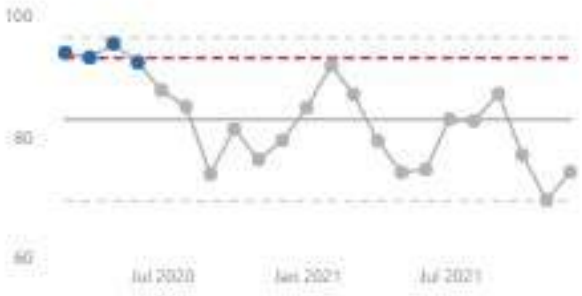
Jan-22: 20.8% Target: 5.0%

% Ambulance handovers waiting >60 mi

Jan-22: 15.3% Target: 5.0%

Cancer 2 week (all cancers)

Dec-21: 74.2% Target: 93.0%



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Cancer 2 week (breast symptoms)

Dec-21: 14.5% Target: 93.0%

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Chart Says	The Trust did not achieve the 2 week wait target in December 2021 with performance at 74.2%, a deteriorating position since September 2021. Following an improvement in September 2021, the 2WW breast symptomatic target significantly deteriorated with a performance of 14.5% in December 2021.
Issues	;
Actions	; A new BI dashboard is under development to establish the accurate numbers that arrive with a FIT result or with a test request only. The MDT Lead Clinician is satisfied that referrals arriving with a FIT request only is acceptable and still allows for effective triage despite the delays in the pathway this causes.
Mitigations	;

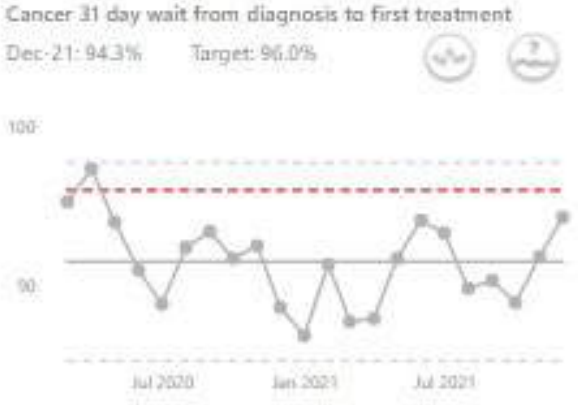

Chart Says	The Trust failed to meet the 31 day primary standard in December, performing at 94.3% however demonstrates a significant improvement and marginally (-1.7%) missing the target.; Performance for January achieved the standard at 100%.; Performance for January achieved the standard at 96.9%.; The Trust failed to meet the 31 day subsequent surgery standard in December, with a 63.5% performance, which was similar to the previous month.
Issues	...
Actions	...
Mitigations	...

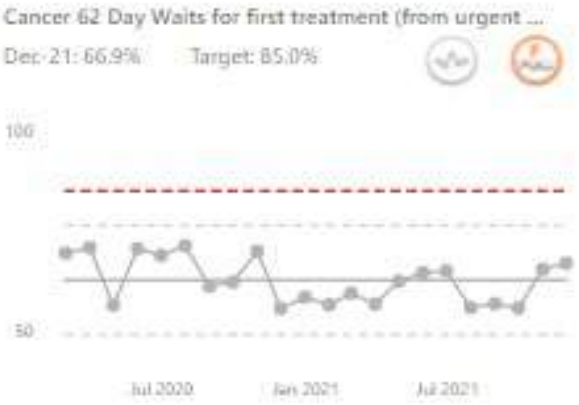

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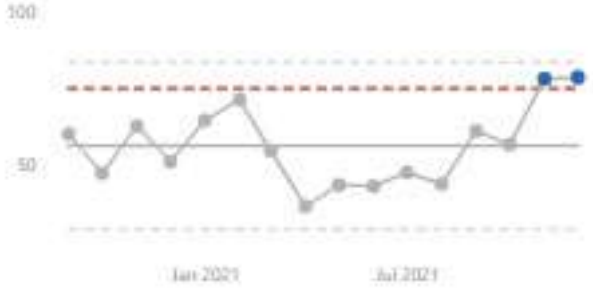
Chart Says	In December 2021, performance against the 62 day Cancer standard was 66.9%, which is a further small improvement on the previous month; The Trust did not achieve the 62 day National Screening standard at 73.9% in December 2021
Issues	Challenges persist across most tumour sites, most of which are in the diagnostic stages of the cancer pathways.; Bowel screening performance continues to face diagnostic constraint challenges (colonoscopy/CTC); timely access hinders achievement of the target.
Actions	;
Mitigations	; Mutual aid and 'other' providers have been explored to help reduce the waits for patients referred for CT Colonoscopy (currently circa 10 weeks) however, to date mutual aid from partners is not available due to their own long waiting times. Other providers of the test continue to be explored.

Cancer 28 Day Wait - Faster Diagnosis Standard

Dec-21: 78.6% Target: 75.0%



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Cancer 104 Day Waits

Dec-21: 53 Target: 0

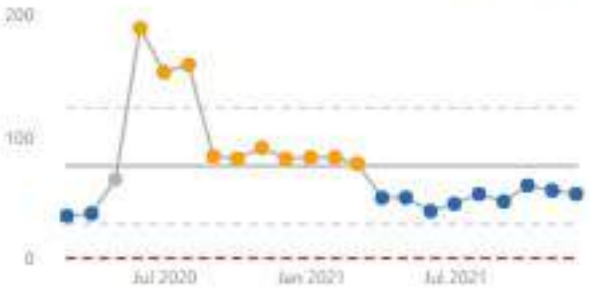

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Chart Says	The Trust failed to meet the Faster Diagnosis Standard (combined) target at 78.6%.
Issues	Bowel Screening at 26.0%, Cervical at 61.5% and Breast at 81.2%. The low percentage for Bowel Screening patients has a significant impact on the overall target.
Actions	
Mitigations	

Integrated Performance Report – Responsive

Chart Says	There were 56 cancelled operations in January 2022 for non clinical reasons; There were 12 patients treated in January 2022 outside of their 28 day rebooking date
Issues	; There were 5 urgent cancelled operations in January 2022 but none cancelled for the second time.
Actions	;
Mitigations	;

Integrated Performance Report – Responsive

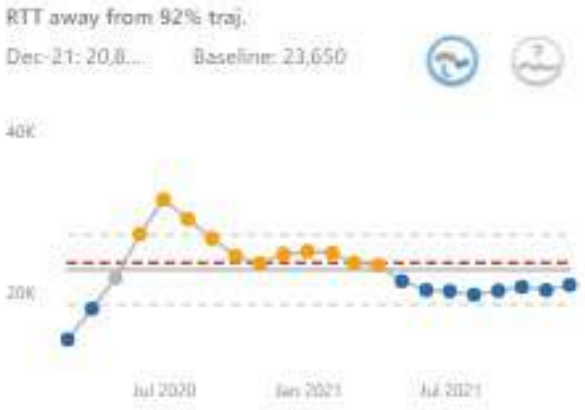

Chart Says	RTT list size for January was above the trajectory at 63,214 (trajectory 60,885)
Issues	
Actions	
Mitigations	

Diagnostics: Patients waiting 6 weeks or more from r...

Jan-22: 37.9% Target: 1.0%

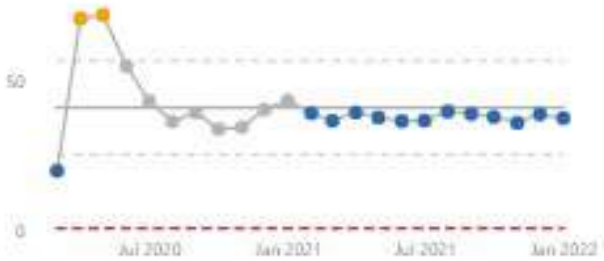

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Chart Says	Diagnostic performance is 37.9% of patients were waiting over 6 weeks which is similar to the previous month
Issues	This equates to 4,542 patients waiting over 6 weeks
Actions	
Mitigations	

Integrated Performance Report – Responsive

Chart Says	Advice and Guidance requests in January 2022 was 2,810
Issues	This is marginally below the H2 plan of 2,825, however, these are predicated on GP requests. The new measure of % of A&G requests to first attendances achieved at 30% against the 12% minimum standard.
Actions	
Mitigations	

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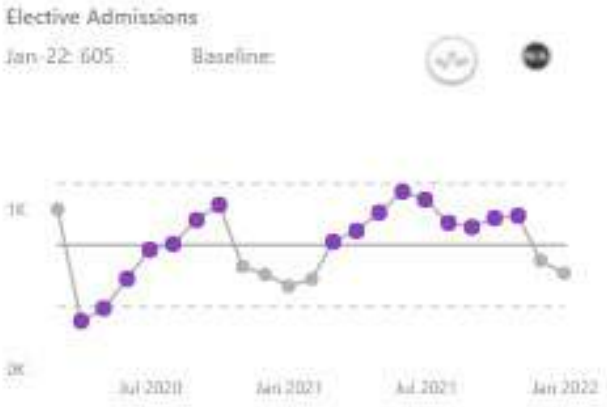
Integrated Performance Report – Responsive

Chart Says	52 week breaches reported is at 5,292 (an increase of 121 on the previous month) and was below the trajectory of 5,526; The 104 week breach reduction target did not achieve the trajectory of 160, reporting 614 at the month end
Issues	The Elective Recovery Group has been paused through the response to Omicron and implementation of the command structure, however will be reinstated form March 2022.; The Trust has set a revised trajectory to deliver a worst case of 612 and best case of 345 at the end of March 2022. The latest Planning Guidance is to have zero by the end of June 2022.
Actions	Further opportunities to insource and outsource capacity are being developed in order to maximise delivery in Q4 to achieve the trajectories and performance requirements; The theatre programme from January to March 2022 will be increased so that 100% of the pre Covid theatre programme will be delivered from 6 March 2022, this will specifically focus capacity for specialities to deliver acute, cancer, P2 and 104 week requirements - this is dependent on an elective surgical bed base and ICU/HDB capacity to support
Mitigations	A separate Elective Recovery Report is provided for the Performance and Finance Committee, which outlines delivery of the plans with exception reports for the Top 12 specialties.; The weekly 104 week performance meeting, chaired by the Deputy COO, continues with a focussed approach to actions at patient level to minimise delays, share best practice in waiting list management and ensure that the over 104 week waits patients is managed to the trajectory by the end of March 2022.

Integrated Performance Report – Responsive

Chart Says	The number of patients waiting over 12 weeks as a Priority 2 at the end of January 2022 was 230 (+54 on previous month).
Issues	Total patients waiting for a P2 procedure was 1,700 (an increase of 464 on the previous mont. Of these, 66 had waited over 4 weeks with performance at 60.8. The Trust has committed to delivering 70% performance by the end of March 2022.
Actions	Full validation is underway on the patients waiting over 12 weeks.
Mitigations	

Integrated Performance Report – Responsive



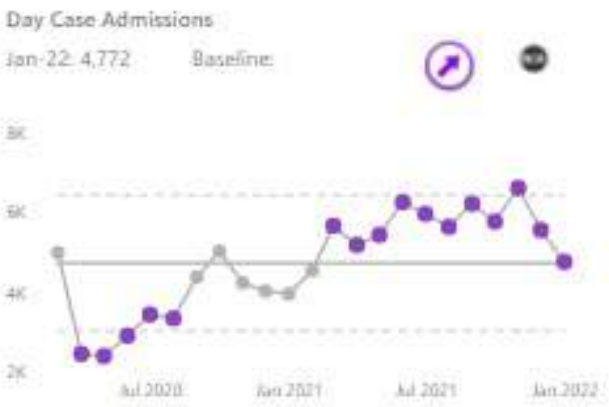


Chart Says

Issues

Actions

Mitigations

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Integrated Performance Report – Responsive

Chart Says

Issues

Actions

Mitigations

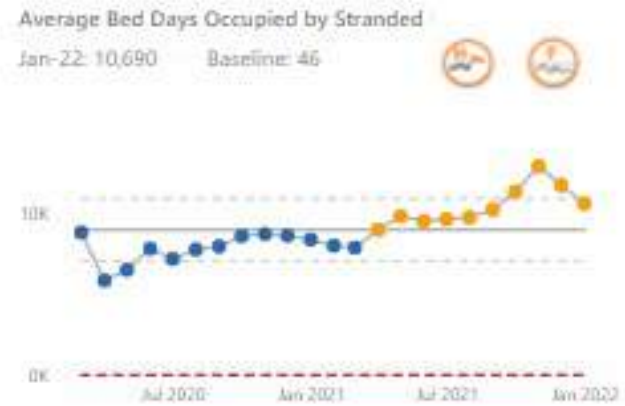

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Chart Says

Issues

Actions

Mitigations

Integrated Performance Report – Responsive

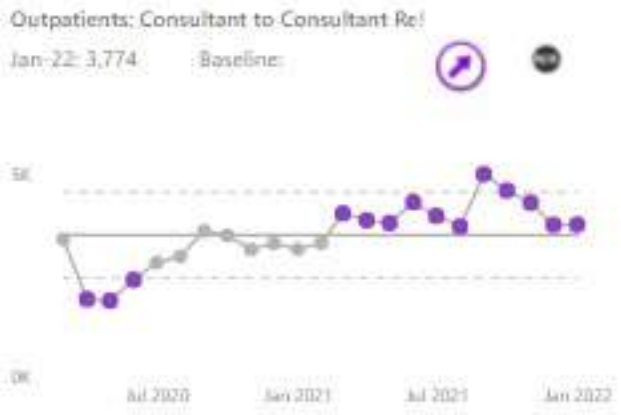

Chart Says

Issues

Actions

Mitigations

Integrated Performance Report – Responsive

Chart Says

Issues

Actions

Mitigations

Integrated Performance Report – Responsive

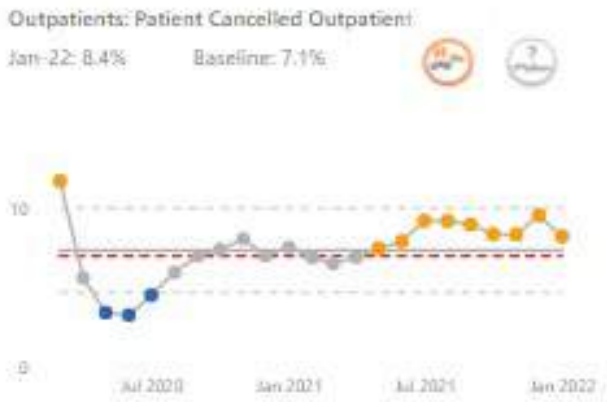

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Chart Says

Issues

Actions

Mitigations

Integrated Performance Report – Responsive

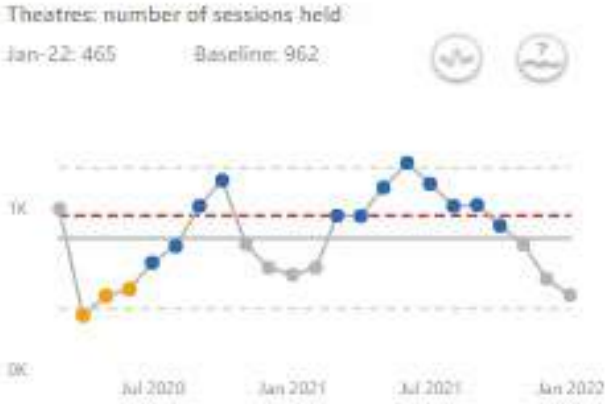

Chart Says

Issues

Actions

Mitigations

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Integrated Performance Report – Workforce

Establishment WTE

Dec-21: 8,259 Baseline: 8,400

Staff in Post WTE

Dec-21: 7,860 Baseline:

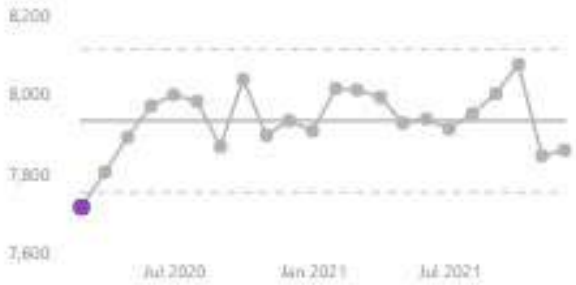


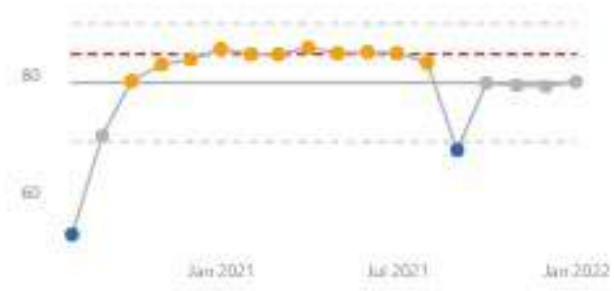
Chart Says	The Trust has 8,076.9 WTE substantive staff.
Issues	
Actions	
Mitigations	In October 2021 the Trust resourced 165.7 WTE temporary staff.

Vacancy Rate %

Dec-21: 4.8% Baseline: 4.6%

% of staff who have a completed Covid 19

Jan-22: 78.8% Target: 83.4%



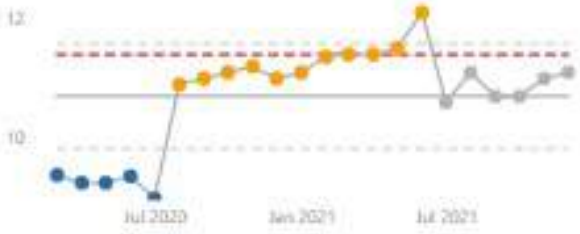
Integrated Performance Report – Workforce

Chart Says	The vacancy rate for the Trust is 371.4 WTE; The vacancy rate for the Trust 4.4%
Issues	This reduces to 205.7 WTE when adjusted for temporary staffing usage.; This reduces to 2.4% when adjusted for temporary staffing usage
Actions	;
Mitigations	;

Integrated Performance Report – Workforce

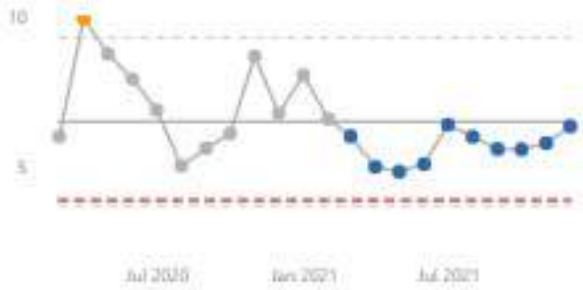
Turnover by Health Group and Staff Group

Dec-21: 11.1% Baseline: 11.4%



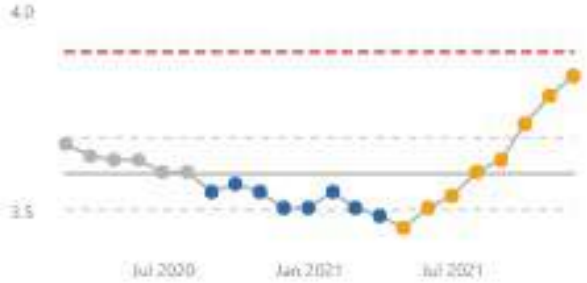
Absence

Dec-21: 6.4% Target: 3.9%



Sickness – Excluding Covid by Health Gro

Dec-21: 3.8% Target: 3.9%



Covid Absence - Positive and Staff Isolati

Dec-21: 2.5% Target: 3.9%

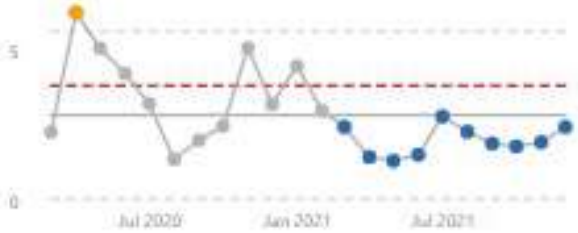


Chart Says	The Trust is currently meeting the sickness target with performance of 3.8%; The Trust is not meeting the target for Turnover.; Covid absence rate was 2.5% during December 2021.
Issues	; The turnover rate has been impacted due to the temporary Covid 19 workforce having left the Trust in the last 12 months. This accounts for 52 WTE of all the Trust leavers within the last 12 months. Excluding these, the Trust turnover would be 9.9%; From August 2021 Covid 19 absence has been decreasing.
Actions	; ;
Mitigations	; ; In the Model Health Hospital the Trust is in Quartile 2 (lowest 50%) for sickness.

Integrated Performance Report – Workforce

Consultant and SAS – Signed off Job Plans %

Dec-21: 65.9% Baseline: 44.2%

Appraisal complete % (AFC)

Dec-21: 71.3% Baseline: 72.5%

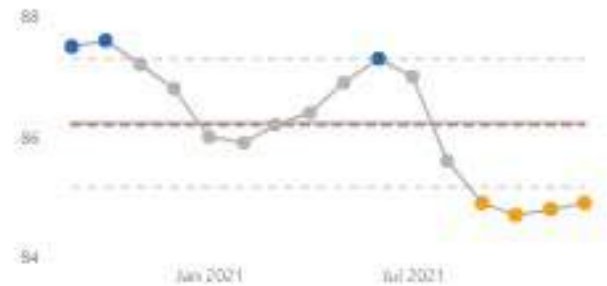
Chart Says	The Trust is 13.4% below the target for AfC staff appraisals; The Trust is 17.8% below the target for Cons/SAS appraisals; The Trust is 5.3% below the Trust target.
Issues	; The Trusts performance in the appraisal targets has been impacted by the Covid-19 pandemic; The Trusts performance in the training target has been impacted by the Covid-19 pandemic.
Actions	; ;
Mitigations	; ;

Appraisal complete % (Consultant)

Dec-21: 82.8% Baseline: 31.7%

Mandatory Training (% completed)

Dec-21: 84.9% Baseline: 86.2%



Integrated Performance Report – Finance

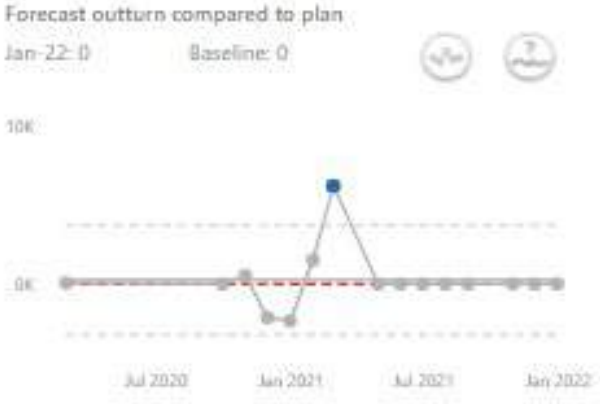
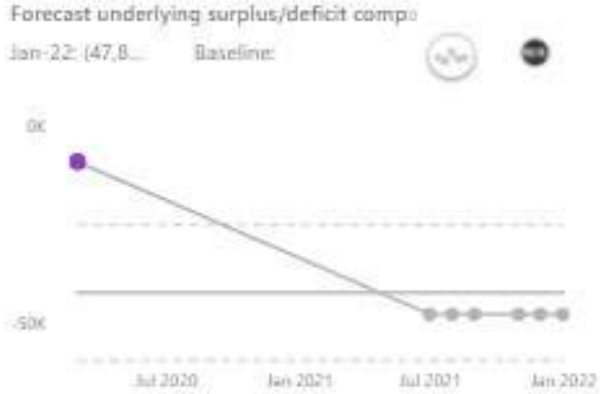


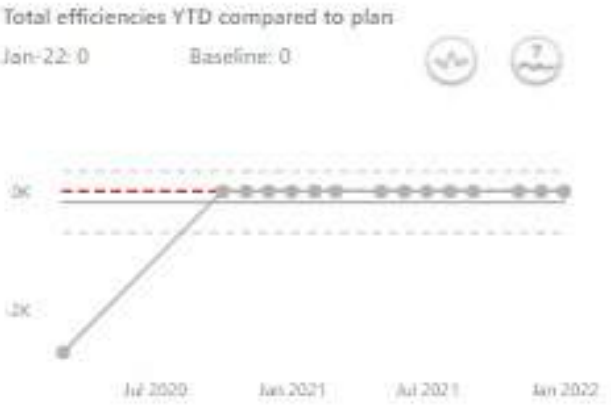
Chart Says

Issues

Actions

Mitigations





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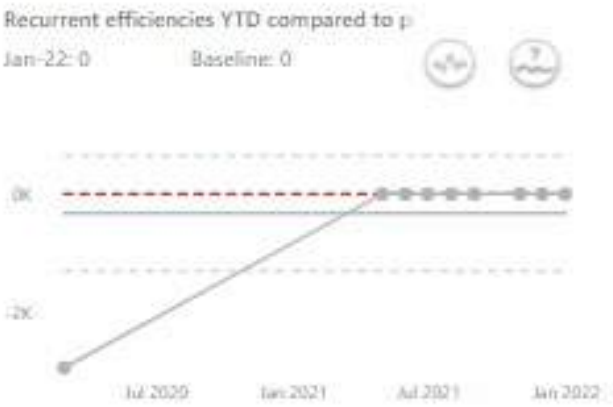

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Chart Says

Issues

Actions

Mitigations

yHull University Teaching Hospitals NHS Trust
Quality Committee
Held on 29 November 2021

Present:	Mr S Hall	Chair
	Dr A Pathak	Non-Executive Director
	Mrs S Rostron	Director of Quality Governance
	Dr M Purva	Chief Medical Officer
	Dr A Green	Lead Clinical Research Therapist
	Mrs R Thompson	Head of Corporate Affairs
	Prof U Macleod	Non Executive Director
	Mrs B Geary	Chief Nurse
	Mr E Quider	Associate Director of Quality
	Mr Sathyapalan	Research and Innovation
	Mrs J Goode	Chief Pharmacist
	Mr P Sedman	Deputy Chief Medical Officer
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Dr Thackray	Associate Medical Director for Cardiology
	Mr A Lockwood	Head of Patient Experience
	Mrs D Lowe	Hull CCG
	Mrs T Craggs	ER CCG
	Ms D Pickering	Head of Patient Safety and Improvement
	Ms J Chambers	Lead Midwifery

No	Item	Action
1	**Apologies** There were no apologies were noted.	
2	**Declarations of interest** There were no declarations received.	
3	**3.1 Minutes of the meeting held on 29 November 2021** The minutes were reviewed by the committee and agreed as an accurate record.	
	3.2 Matters Arising There were no matters arising noted.	
	3.3 Action Tracking List The Committee reviewed the action tracking list; Mr Quider confirmed that the Datix report would be discussed within Development Plan for Lessons Learnt Framework which details the development of dashboards. Mr Hall confirmed the University paper regarding the Trusts COVID response was on the agenda for discussion. Items remaining were scheduled for January's meeting. Mr Hall confirmed the enhanced monitoring regarding service pressure was escalated at Novembers board. Completed items were agreed for removal.	

	3.4 Workplan The work plan is due for review early December, nothing was raised for discussion within the meeting.	
4	**Reports received for Assurance**	
	4.1 Quality Report Mrs Geary shared there had been an increase in SI's in October. There were five within Ophthalmology service in relation to treatment delays and 12 hour DTA trolley breaches. There is a thematic review of these incidents being undertaken. The Trust continues to work through the backlog of SI's and work collaboratively with the CCG's to progress. There are now seven 12 hour DTA trolley breaches SI's in total with the ongoing pressure there maybe future breaches. Mrs Geary took the committee through the quality report discussing; • Incidents • Falls • Pressure Ulcers • Infection, prevention and control • CQC Whistleblowing Mrs Geary shared that the work planned within the community regarding pressure ulcers had not happed but would be discussed further Mrs Lowe in a planned meeting. The Purpose T a new Pressure Ulcer Risk Assessment tool has been rolled out across the Castle Hill site and is scheduled for roll out in April at the HRI site, with teaching currently being undertaken in preparation. Mrs Lowe confirmed that there is a work stream being developed with joint working with HUTH and CHCP to address pressure ulcers, and will be happy to ensure that the terms of reference will capture the necessary work. Mrs Geary shared that there had been increase in COVID 19 in the Trust, both admitted and hospital onset. There were currently the highest number of patients with COVID in this half of the year. Additionally there has been an increase in asymptomatic cases in patients and staff. Mrs Geary shared that following on from the government's announcements regarding the new COVID variant, the Trust has taken the decision to limit visiting and increase social distancing in clinical areas. Revised review history taking on admission will be shared. There will be also be a reduction in face-to-face meetings and staff were able to will be encouraged to work from home. Mrs Geary confirmed this will be operationalised today. Mrs Geary shared that there were two whistleblowing in last month both responses had been submitted to the CQC. Dr Pathak asked why there were the pressures in the system, if it was an increase in patients or was a fatigued workforce. Mrs Geary responded that the pressures were a multifaceted issue; delayed transfers, enormous numbers coming through A&E, sustained increase in trauma patients and the staff are fatigued with an increase in short-term sickness.	

	The Urgent Treatment Centre will be opening 1st December and that should divert patients from A&E. We need a sustained flow out to reduce pressure. Mr Hall requested that we ensure we get the communication right for the public and staff regarding the updates for COVID. Mr Hall shared he was keen to ensure that the right information was being discussed within the committee and we were able to focus on the key areas. Mrs Geary highlighted to the committee that the impact of 83 COVID patients is significant as moving from green to red and flipping wards operationally is a lot of work and being responsive to the needs has a significant impact on the frontline staff. **Resolved;** Mr Hall would like to raise that there is a concern to the committee regarding the significant pressures on front line staff. **4.1.2 Patient Experience** Mrs Geary shared the Trust has around 500 volunteers and we are looking at specific volunteers roles including dining companions and dementia companions. We held a young volunteers meeting in October which had 16 attendees which we hope to develop and expand. Mr Hall asked that we monitor the response on the friends and family survey as there are downwards trends, which are a good indicator of quality. Mr Hall shared that having visited the emergency department, spoke with patients, and staff alongside observing, suggested that in the discharge lounge, patients may benefit from additional human interaction and asked if that was something that could be a volunteer role. Mrs Geary agreed we have looked into an arrangement and Mr Lockwood confirmed that they have been in contact with the discharge lounge and are looking to allocate some volunteer time. **4.1.2 Safeguarding** Mrs Geary shared that we undertook some assurance days in November which safeguarding was invited to present. There were some actions identified following the presentations but overall was a positive position.	
	4.2 National Inpatient Survey Mr Lockwood shared the final report from the national inpatient survey which HUTH received a 44% response rate, the national average was 46% The majority of those responding were of white ethnicity, so we need to reach out to engage other ethnicities. The survey looked a wide range of the patient experience in relation to admission to hospital including environment and staff. A task and finish group has been established and will be looking at the performance and comparing to where we against other Trusts as well as developing an improvement plan. Report is reference only at present but will be looking at where we can focus our work to make improvements. The work will be reported into the patient experience sub-committee.	

	Resolved: Mr Hall confirmed that he had no major concerns and that we have it within our power to make the improvements required.	
	4.3 Quality Strategy Mr Quider shared that the Quality Strategy provides key quality and safety objectives on how our Trust will take forward its vision to deliver Great Care, Great Staff and Great Future, through the implementation of our Trust's QUEST (Quality Effective Safe Trust) towards delivering high quality care for our patients. This strategy builds on our improvements and successes for the past few years to achieve an outstanding CQC overall rating. This Quality Strategy will set out the approach and help shape the direction of improvement in achieving our ambitions for both of our patients and their families, our staff and other stakeholders. The committee was asked to review and endorse prior to Board approval in January 2022. Mr Hall thanked Mr Quider for the succinct presentation to the committee. Mrs Rostron informed the committee that our first cohort of staff QSIR qualified last week, and Mr Quider was one of them. The QSIR training will be fundamental to building the strategy and helps us to apply quality improvement to everything we do. The strategy will be presented at the Board development day in December. Dr Pathak asked if staff would be willing to engage with the staff taking part in the survey, with current pressures. Mr Quider responded that we have had a lot of interest from staff over the last two weeks, and this will empower staff to use quality improvement for patient safety. We will be applying a systematic approach to quality improvement across the health groups, which will be face to face approach whilst managing the pressure. Mrs Rostron confirmed the first year of the strategy focuses on the reset and recovery. Mrs Lowe asked if Learning Disabilities will also be included. Mr Quider responded that yes and as part of the engagement was happy to take any additional suggestions. Mr Hall asked how would learning from patients and staff be captured, as would like to ensure there is a process to capture that. **Resolved:** Mr Hall confirmed that the committee were happy to endorse the strategy.	
	4.4 Cardiology Report Mr Hall shared that a previous committee meeting had discussed the cardiology report and the detailed action plan was submitted to Board but would like the committee to also have sight of the action plan. Dr Thackray, Associate Medical Director - Cardiology was invited to discuss the action plan and the current position within the team.	

	Dr Thackray informed the committee that he was the Associate Medical Director for Cardiology, and that the Royal College review predates his arrival at the Trust therefore was able to provide a fresh perspective. Dr Thackray explained that there was a weekly meeting to review the action plan to keep momentum on the improvements. This group has 6 core members. It was acknowledged that some actions have been easier than others. Dr Thackray shared that the behaviours in the department had noticeably improved and that he was hopeful that the OD work that commenced will help this be sustainable. The Trust is awaiting the outcomes of the junior doctor survey from the college but has received an improvement in the feedback from the middle grade doctors. Dr Thackray reflected that the clinical governance had been problematic in the past but the process had changed entirely. All incidents are now clinically reviewed by two individuals and discussed within 48hours to look at how to manage, including escalating higher in health group where needed. So far there has not been a single episode of unfounded issues, so feel this is working well. There is now a structured monthly Mortality and Morbidity meeting and governance meetings. Mrs Rostron informed the committee the CQC requested information on how we are seeking assurance and that due to the work that has been done by the team it was very easy to respond. Dr Thackray was invited to attend a future CQC engagement meeting to provide the additional assurance. Dr Purva stated that there had been an issue regarding the junior doctors are raising concerns, but they are now able to raise concerns then and there at tackle at the time, rather than formal process which was of course still available. Mr Hall thanked Dr Thackray for the work and asked to visit the department again.	
	4.5 HUTH Covid Response Dr Purva gave the background to the review which was requested by the Chief Executive for the University to review the Trust's response to the pandemic. The University looked at strengths and weaknesses in the response and identified learning for the future. Specific issues related to HUTH that we could control and comparisons not to be made with others but entirely on how it was managed within the Trust. Strengths identified included workforce and the gold command structure. The report made recommendations covering; • Ward management • Harmonisation of Practices between Operational Units • General Management • Strategy and Innovation • Ethos and Policy Dr Purva shared that it was a very useful report and that it did not raise anything we were not aware of.	

	Mr Hall agreed it was very useful and it did not highlight anything previously unaware of as a Committee.	
	4.6 East Riding Safeguarding Report Mrs Geary confirmed that the report was for information only for the committee, which outlines the challenges and opportunities for the next year.	
	4.7 IPC Board Assurance Framework Update Mr Quider informed the committee that the Board had received an update on the on the BAF. The task and finish group continued to meet on a weekly basis and once the action plan has been establish the monitoring of progress would sit with the Strategic Infection Reduction Control Committee. Two risks have been identified for the corporate risk register regarding ventilation and isolation capacity. Mr Hall confirmed the committee would be happy to have an update on progress to maintain assurance, as the situation was not easing.	
5	**Increase the rate of harm-free care each year**	
	5.1 Development Plan for Lessons Learnt Framework Mr Quider shared the proposed development plan for lessons learnt which will create a defined structure for The Lessons Learned Framework in our Trust for the reporting, investigating, learning lessons, implementing and sustaining change as a result of investigation findings and analysis of incidents in order to provide safe, high quality care to our patients and a safe environment for our staff and members of the public. This framework is developed in line with the other enabling strategies and associated policies within our Trust Corporate documents and guidelines This framework is developed in order to generate a systematic approach to the analysis of incidents, accidents, complaints, claims, audit outcomes, mortality review and patient experience, on a collected foundation to provide a risk profile for the organisation and that safety lessons are learnt and shared widely. Improvements in process implementation and consistent outstanding practice will follow because of the effective implementation of lessons learnt (quality recommendations) during investigation, inquiry, reviews and analysis from various sources of validated information Mrs Rostron thanked Mr Quider for a good piece of work and assured the committee that we do currently have processes in place but wanted a consistent approach to ensure everyone is aware of where they can find the information. Dr Green thanked Mr Quider and shared that it looked a useful compilation of information. Dr Green asked if there would be something further to support changing the behaviour for staff that are burnt out, other than an action plan. Mr Quider responded that the achieving behaviour plan is still a draft, which will support how we monitor and how do we support change regarding patient safety, and championing care and how we meet the outstanding care target. Mr Hall asked how we ensure we don't replicate existing work and how we ensure the lessons learnt has been implemented. Mrs Quider responded that there would be a lessons learnt log and an effectiveness log.	

	There should be a way to track the changes and check it has really improved and by linking with the digital delivery, we can reduce any additional documentation being created.	
	5.2 Continuity of Care Mrs Chambers shared that we have been working towards continuity of care model of care with the expectation of a team in place by 2023. The national team visited earlier in the year and the Trust is awaiting the Birth Rate Plus report, once that it is received we will understand the degree of work needed and can develop the recruitment plan and how the workforce can be developed and used differently. Mr Hall asked if we understood what the costs per phase were in regards to the recruitment. Mrs Geary responded that until we receive the Birth Rate Plus report and then we will be able to finalise numbers. We are also looking at other options as the recruitment of midwives will be across the country. We may need to look at international options. Mrs Chambers shared that it has been three years since the last report and there have been significant changes so need that report to understand the deficit. Mr Hall acknowledged that there will be a national pressure for recruitment and asked if we were discussing with the university regarding training. Mrs Chambers responded that we currently aim to employ those that come through university but they won't qualify until September so will need to look at qualified staff. Dr Pathak asked if there was any guidance from NMC. Mrs Geary shared that as a result of the Ockenden report there is focused attention on midwives but there are organisations in a worse position than the Trust. Mrs Chambers advised that midwife teaching programmes have increased and access to the programme expanded.	
6	**Quality Governance**	
	6.1 Enhanced Monitoring/QRP Mrs Rostron shared the standard paper regarding the monthly quality delivery group with commissioners and regulators. The leadership team from the Emergency Department presented at the last meeting around the impact of the current pressures and overcrowding on quality and safety, and what actions were being taken to mitigate this. The information shared was well received with regulators confirming they had received assurance. The Missed Opportunities Audit will be presented at December's meeting and the plan regarding ambulance handovers. Ms Lowe suggested that the quality delivery group using the Quality Risk Profile could look at reducing some of the risk threshold decisions made by the stakeholders, and if the agenda should be refreshed to include anything else. Mrs Rostron responded that for every risk we have provided assurance on the actions taken but this would not necessarily affect the risk rating. Everything that is within the Trust's control is happening, it is the external factors that the Trust cannot mitigate for.	

	Resolved: Mr Hall confirmed assurance that we were managing the risk and recognising the risks and what is controllable and the escalation process of when it becomes unmanageable.	
	6.2 Quality Sub-Committees Terms of References Mrs Rostron shared that the new sub-committee structure was approved in September and the sub-committee structure commenced in October. The terms of references have been submitted to the committee for approval. Mr Hall confirmed that the committee approved the terms of references subject to minor amendments.	
7	**Any Other Business** **Unintended Consequences** Mr Hall is aware of the business of the team but when looking at the terms of reference the uniform comment is that the meeting papers will be with the committee within 3 days of the meeting. Going forward papers should be circulated the Wednesday morning of the preceding week, and if not received within time they will be deferred to the next meeting. Prof Macleod suggested that it may be beneficial to provide guidance to people regarding papers and presenting at committee and boards to ensure the papers and presenting are more agile to ensure people are maximising the attendance and discussions. Mr Hall agreed that we need some consistency across the committees. Mrs Rostron highlighted that whilst agreeing papers should be submitted in a timely fashion, on occasions we need to have the flexibility to have exceptions as would not like important information to be missed due to a late deadline. Mr Hall responded exceptions could be agreed but the message needs to be that it should be an exception.	
8	**Chairman's Summary to the Board** Mr Hall summarised the committee's assurance levels following relevant reports which would feed into the summary report.	
9	**Date and time of the next meeting:** Monday 20th December 2021 – 9am – 11am via Teams	

Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 20 December 2021

Present:	Mr S Hall	Chair
	Mrs S Rostron	Director of Quality Governance
	Dr M Purva	Chief Medical Officer
	Dr A Green	Lead Clinical Research Therapist
	Mrs R Thompson	Head of Corporate Affairs
	Prof U Macleod	Non-Executive Director
	Mr E Quider	Associate Director of Quality
	Mrs J Goode	Chief Pharmacist
	Mr P Sedman	Deputy Chief Medical Officer
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Mrs Greta Johnson	Director of Infection Prevention and Control

No	Item	Action
1	**Apologies** Marie Stern, Ashok Pathak, Beverley Geary	
2	**Declarations of interest** There were no declarations received. Meeting was taken out of agenda order at this point.	
4.1	**Integrated Performance Report** **Infection, Prevent and Control** Mrs Johnson shared that discussions had been held with Dr Purva and Mrs Rostron in regards to an additional paper being presented to Trust Board regarding bed modelling and reduction. Dr Purva acknowledged that the discussion had not been concluded and that further discussion was to be held between Dr Purva and Mrs Geary, was happy to forward the paper to Mrs Geary, Dr Purva and Mrs Rostron. Mrs Johnson provided an overview of Novembers data which covered; • MRSA Bacteraemia • MSSA Bacteraemia • Clostridium Difficile (Clostridioides difficile) • E.coli Bacteraemia • Klebsiella Bacteraemia • Pseudomonas aeruginosa Bacteraemia • Outbreaks / Incidents of Infection • Neonatal Intensive Care Unit (NICU) • COVID-19 Commissioners set no national threshold for MSSA Bacteraemia, although we do not expect to exceed last year's figures and was it is acknowledged that there is room for improvement. The Trust has started to see an increase in infections related to PVC / CVC again, and there is work going on in the background to address this, including changing process, type of lines used and utilising the training provided by the provider. There will be a deep dive into Klebsiella Bacteraemia infections to establish areas of improvement. Some trusts are reporting resistant strains but we have not seen any within the Trust.	

	Meeting has been held with Tech-Care regarding a drain cleaning product they have mitigated concerns and can now re-start production and will commence using the product from 10th January on neo-natal. COVID-19 positive inpatients have increased significantly and there have been ward closures as a result of outbreaks. The Omicron variant is highly transmittable with the incubation period 2-3 days, two vaccines is not as effective with this strain and boosters will be rolled nationwide, which will be a focus for the Trust. Cases are starting to rise in the area and London has declared a major incident. Mr Hall thanked Mrs Johnson for the update and confirmed the Trust is aware of the variant will poses a challenge, and have stepped up the command structure.	
3	**3.1 Minutes of the meeting held on 29 November 2021** The minutes were reviewed by the committee and agreed as an accurate record, following the noted amendment. Page 1, Meeting date in the last meeting showing date as October should be November.	
	3.2 Matters Arising There were no matters arising noted.	
	3.3 Action Tracking List The Committee reviewed the action tracker, there were no actions due for this meeting and items that have been actioned and closed were removed.	
	3.5 Workplan The work plan was reviewed prior to the December committee meeting and updated to reflect the new sub-committee structure.	
4	**Reports received for Assurance**	
4.1	**Integrated Performance Report** Mr Hall shared that some data was removed from the report this month due to the data not being validated with the meeting being forward a week due to the Christmas bank holidays. The Trust declared seven SI's in November; four were related to Emergency Department in relation to delays over 12 hours following decision to admit. This has been a theme in previous months with eight 12 hr DTA breaches reported as serious incidents in 2021/22 and a thematic review is underway. An SI was declared in Ophthalmology in regards to permanent sight loss and there is an expectation there may be further cases as a result of covid protocols. Mrs Rostron shared that the governance team had recently undertaken a series of assurance days in November with services as part of the continuous improvement work against the key components of Safe, Effectiveness, Caring, Responsive and Well-led. The site visits were positive, demonstrating a good level of assurance. Staff were very knowledgeable, professional and welcoming. Patients and parents provided very positive feedback about their experiences. Good documentation was in place, checks were adhered to and there are strong working relationships between the services and the Safeguarding Team. The key improvements to note were in relation to restrictive practices, out of date polices and patient information leaflets, security and ligature risks and incident management.	

	Mr Hall shared that the experience was very positive and were able to identify improvements. For future assurance day's Mr Hall would like to see further NED involvement. Mr Hall confirmed that the committee had reasonable assurance in regards to performance.	
4.1.2	**Patient Experience** Paper was submitted to the committee for information. Mr Hall highlighted the November inpatient results indicate that 98.60% of patients gave the Trust positive feedback and would recommend HUTH to their Friends and Family; this is above the nationally set target of 95%. 1,422 patients who attended the Emergency Department in November 2021 responded to the Friends and Family Test with 70.82% of patients giving positive feedback and 19.06% negative feedback. This is in line with expectations with the current pressures on the department. Since January 2021, our volunteers have contributed an impressive 18,000 hours to the Trust. The majority of volunteers are double vaccinated and have now received their booster vaccine.	
4.1.2	**Safeguarding** The safeguarding report was received by the committee for information.	
4.2	**Board Assurance Framework** Mrs Thompson shared that the BAF for quarter three. The paper provides updates on the actions taken in the previous quarter with a plan for the following quarter. The BAF is supported by the operation and corporate risk register. There are no proposed changes to the risk ratings in quarter three and the Committee was asked to consider the risk ratings and decide if there are any gaps in controls, sources of assurance or further actions to add and if we will meet the target ratings. Mrs Rostron shared that as a committee we could take assurance in regards to BAF 3.2 in Q4 if the Trust is stepped down from the enhanced surveillance. Through enhanced monitoring the Trust has provided assurance and received a positive response due to demonstrating we are mitigating the risks that are within our remit. Prof Macleod stated that with the uncertainly over the coming months it may be premature to reduce the risk rating, the prospect of halting elective again and the effect that will have. Dr Purva agreed that Prof Macleod made a valid point, we are in a slightly better position as our projections are based on elective activity has been stopped so shows an accurate position. We have realistic plans, the specialities have a very good plan and we are better prepared than last time. We will restart elective as soon as possible rather than wait as we have learnt from last time. Mr Hall had recently been on a regional meeting and agreed that simply halting elective cannot continue to be a default option and trusts need to get back to pre-pandemic activity levels quickly.	

4.3	**Enhanced Monitoring / QRP** Mrs Rostron shared with the committee that this was a process that was initiated in May 2021 and through the monthly meetings we have provided significant assurance on each aspect. Mrs Rostron has requested that the January 2022 meeting is proactively stood down rather than cancelling at short notice due to the anticipated operational pressures. The Trust has requested advice on how to exit this enhanced monitoring in view of the positive assurance provided against the risks identified each month. The committee received the presentation shared with NHSI and the CCG's on the 6th December, which provided assurance on P2's, ambulance handover, times and shared the missed opportunities audit. Mr Hall was pleased to hear that the P2 patients had reduced and was concerned about possible patient harm in delayed ambulance handovers and potential harm in the community. Mrs Rostron responded that there had been no reported harm to patients and there were processes in place to ensure patients were monitored whilst in the ambulance. The Trust is unable to report if there is harm in the community as we only report on harm once the patient is transferred to our care. YAS will be reporting on this aspect. Prof Macleod reflected that the primary / secondary divide is broken as a concept and asked if there was thinking about a wider system review. Mrs Rostron confirmed that we are doing what we can within the Trust and that there are working groups to address the wider issues with the other providers and CCG's. Mr Sedman stated there were many system wide problems, including recruitment calibre of workforce. We have recruited a number of GP's that have never worked in the NHS so there is a learning curve. Mrs Rostron confirmed The Missed Opportunities Audit was for the whole system and has agreement on the actions, as do ambulance handovers. Chris Long chairs the A&E delivery group, which has system representatives. Dr Green shared that the HASR workforce review should also be developing new pathways so we can meet patient needs more effectively within our part of the ICS. Mr Hall reflected that emerging from COVID the ICS would need to start thinking very differently and that the new chair was fully invested in their role within that.	
4.4	**Risk Management Strategy** Mrs Thompson shared the draft Risk Management Strategy with the committee and confirmed that it had also been shared with execs, the operational risk and compliance committee, health group governance meetings and the board development day. The risk management strategy sets out to continuously improve the position of the quality of risk registers across the organisation and the inconsistencies in risk ratings and align to the Board Assurance Framework. Mrs Thompson requested endorsement from the committee for approval at the January Board. There will be a half-yearly Risk Management Strategy Indicator report presented to the Operational Risk and Compliance Committee and Quality Committee, including	

	analysis of the high risks alongside the Board Assurance Framework. The Quality Committee will escalate any areas of concern to Trust Board Mrs Thompson confirmed that the Datix system is currently being reviewed and that the Risk Management team would be supporting with the work. Mr Hall confirmed that committee endorsed the strategy.	
4.5	**Continuous Improvement Framework** Mr Quider shared the an update on the proposed Continuous Quality Improvement (CQI) Framework for 2022-2023 before submitting to the Trust Board for approval as part of the Quality Strategy. The Trust now has their first cohort of qualified QSIR Practitioners who will support the context of what we want to achieve in line with the ability and capacity to deliver Quality Improvement once a certified faculty. Once we are accredited, we aim to build a tailored QSIR programme for staff. Prof Macleod was interested to see how it evaluated, medical staff complete some form of quality improvement for their training so it would be nice to link the undergraduates into the strategy. Mrs Rostron confirmed that this will align well and informed the Committee that Dr Purva had now successfully appointed 4 Medical QI Leads to support this work. Dr Green asked the AHP were linked in to include students as they have the vision of how other organisations work and we could develop a structure for capturing that information. Mr Quider confirmed as part of the consultation process he would be happy to have those discussions. Mr Hall thanked Mr Quider for the paper and looked forward to seeing the full report at Board.	
5.1	**Sub-Committees Escalation Reports** **Patient Safety & Clinical Effectiveness Sub-Committee** The escalation report was received for information; there were no items for escalation to the board. **Operational Risk and Compliance Sub-Committee** The escalation report was received for information; there were not items for escalation to the board. Mr Hall requested that in future reports he would like a more detailed report but acknowledged it was the sub-committee's first meeting.	
7	**Any Other Business** **January Meetings** Mrs Rostron shared that a decision at Gold Command had been made to stand down non-essential meetings in January in anticipation of the Omicron variant. All performance and governance meetings at Health Group level would be stood down. Meetings that would continue would be Audit and Board, the weekly Serious Incident Review Group and the Patient Safety Summit.* Mr Hall requested that the Quality Committee go ahead in January with a reduced agenda and no papers.	

	Mrs Rostron shared that the non-clinical quality governance staff would be asked to support the wards and vaccine clinics where possible and the clinical staff would be asked to return to practice for January. Mr Hall agreed to share the information at the NED meeting.	
8	**Chairman's Summary to the Board** Mr Hall summarised the committee's assurance levels following relevant reports which would feed into the summary report.	
9	**Date and time of the next meeting:** Monday 31st January 2022 – 10am – 11am via Teams	

***Post-meeting note. The Acting Chair took the decision to also stand down Trust Board and Audit Committee for January 2022.**

Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 31st January 2022, 10 – 11am
Via MS Teams

Present:	Mr S Hall	Chair
	Mrs R Thompson	Head of Corporate Affairs
	Prof U Macleod	Non-Executive Director
	Mr E Quider	Associate Director of Quality
	Mr P Sedman	Deputy Chief Medical Officer
	Mrs B Geary	Chief Nurse
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Mrs G Johnson	Director of Infection, Prevention and Control

No	Item	Action
1	**Apologies** Mrs Rostron, Dr Purva	
2	**Declarations of interest** There were no declarations received.	
3	**Emerging Issues** Mr Hall shared there is a responsibility to share any issues with the board, and it is important that we ensure quality is maintained, which is why the decision to hold a shortened Quality Committee was agreed with the mandate of no papers being requested. **3.1 Nosocomial infections / 3.2 Other issues relating to Omicron** Mrs Johnson shared a short presentation with the committee relating to COVID19 activity for autumn and winter 2021/22. Which provided information on; • Nosocomial infections figures • Outbreaks within the Trust • Impact of Christmas and New Year on prevalence and incidence of COVID19 on both staff and patients • Capacity and flow issues in relation to surging COVID 19 cases • Patients screening positive being nursed in bays or six bedded areas • Asymptomatic carriage and/or mild symptoms for inpatients, visitors and staff • Movement of patients from other Trusts • Deployment of Redirooms • Lack of clarity/ breakdown in communication resulted in addition exposure • Suboptimal compliance with IPC practice • Increasing numbers of 'no criteria to reside patients' increases risk of nosocomial infections The Trust has experience outbreaks across both sites on a number of wards, however, the number of hospital on-set cases reported have significantly reduced compared to last year despite Omicron being a highly transmittable variant, this illustrates how hard we have tried to minimise transmission and implement IPC. Mr Hall acknowledged this was a significant achievement especially with a highly transmissible variant.	

	Datix has been updated under the infection control tab for the reporting of COVID19 hospital onset cases, which will be monitored by the IPC team. Wards are completing Root Cause Analysis for any individual or clustered hospital onset cases. Alongside COVID19 cases, we still have the other hospital-associated infections being monitored and our CDiff remains under threshold. Staff experienced some difficulties obtaining LFT following the decision for LAMP testing to end in December. The Trust secured testing kits for staff, which were quickly depleted, but NHSE have now secured contracts with Pharmacy chains and Royal Mail to ensure they are available from the Government Website. The Trust have retained a small supply if there are future supply issues. Mrs Geary shared that the Trust held contractual responsibility for the Frenuis Service and the trust have recently recruited a senior matron to provide ongoing support for the service including satellite units to improve IPC compliance. Mr Hall requested a separate discussion regarding Frenuis. Mr Hall asked if we recorded the vaccination status of patients hospitalised. Mrs Johnson confirmed the data was captured throughout the pandemic and its currently a 60/40 split towards the vaccinated although this does differ between specialties where it used to be a 50/50. Mr Hall noted that the lack of communication was highlighted on the University Report and asked if there had been an improvement. Mrs Johnson responded that when there are pressures and decisions to be made, they need to be underpinned by a plan, which has been rectified and they now have the intelligence held by the site team provided by the IPC team for the on-call managers. Out of hours are where the pressures are felt and they are difficult decisions. **3.2 Impact of long stay patients** Mr Hall stated that it is recognised that the longer a patient is in the hospital then greater the risk of hospital acquired infections. It's in our interest for them to be a different environment, and it also impacts on other patients. There is a significant issue at the minute for those that are unable to be discharged, but asked what are the major concerns. Mrs Geary responded that we know when older adults are admitted to hospital they decondition quickly and their care needs become greater than when initially admitted when they may not have had care needs on admission. There is an increased risk of falls or pressure damaged once the patient deconditions. This causes a risk to our ability for P1 A and B patients causing delays in treatment and surgery, as staff are pulled from elective wards to support. Mr Hall asked if the board would have a deep dive on how to review getting back to normal Mrs Geary responded that a deep dive in board development would be a good proposal. Currently the Trust was mitigating the risk by flipping wards and were currently reviewing the care needs of the patients who have high care needs but who are deemed medically fit / no criteria to reside. C9 will have a new standard operating procedure, which will look at an appropriate skill mix of staff and include local authority responsibility and review policies and procedure alongside providing patient and relative information about the ward. The aim is to release registered and medical staff to look after P1 and P2 patients.	

	Humber Gold hold regular meetings, CHCP's CEO was tasked to identify community beds and has identified a potential 200 beds, which would free our wards up and is looking at solutions with the CCG's and developing detailed plans. The Nightingale model was reviewed and discounted as unfeasible. Mrs Geary confirmed she would circulate the SOP following the meeting for information. Mr Hall agreed that we certainly need to think out of the box and put pressure on our partners to support with sustainable solutions. As even supporting different models of care within the Trust, we still need suitable placements for patients to return to the community. Mrs Geary stated that the Head of Patient Safety and Improvement have completed a piece of work regarding patient harm, and there have been no themes identified as of this date. This will also be reviewed with further data analysis on one of the upcoming Executive meetings. Mrs Geary confirmed that the slides would be shared following the meeting. **3.6 Update on medical staffing** Mr Sedman shared that this surge had been handled differently and we anticipated the issues. There were some issues from Health Education England regarding redeployment following the waves, which had impacted on the education of the junior doctors. The workforce group has met daily to support shortfalls and escalate concerns, the meeting has been very effective and is ready to stand down. There has been no requirement for any formal redeployments and the process worked well. There will be further changes with recover phase, where we will look to reprioritise people's workload and innovative ways to cover. **3.4 Quality impact relating to staff shortages** Mrs Geary shared that there had been a big surge in staff absences and that it has gradually reduced daily, and are now lowest in region. We redeploy staff on a daily basis per shift to cover high acuity or high absence and in preparation; we put in a backup rota and also had a shadow rota for on-calls. The backup rota has now been stood down as it has not been needed and the shadow on-call will continue until March. Mr Hall raised concerns over the tired staff within the Trust and if the Trust had a undertaken a review or attention to staff concerns. Mrs Geary responded that staff have always been encouraged to take annual leave and this month staff were offered an option to sell back any leave. We have many wellbeing support spaces and a programme of wellbeing activities. At recent systems meeting best practice was shared and we confirmed we are providing everything that was presented. Mr Sedman agreed there was a supportive environment in the trust but staff fatigue it is a concern locally and nationally. Mr Sedman acknowledged that this was Mr Hall's last quality committee as chair and thanked him for his contributions, which was echoed by all those in attendance. **3.5 Update on vaccination programme / staff numbers** Not discussed	

7	**Any Other Business** **IPC** Mrs Geary shared that NHS Improvement team will be visiting the Trust next month to review the progress we have made since there last visit. Mrs Geary has met with Mr Quider and Mrs Johnson and reviewed the list of actions.	
8	**Chairman's Summary to the Board** Mr Hall shared that it was a positive that the Trust had not reported a significant increase in harm. The committees concerns regarding P1 A&B cancellations and staff working within the wrong environment would be escalated to the board. Mr Hall acknowledged that the wards brought into service for the treatment of COVID was commendable.	
9	**Date and time of the next meeting:** Monday 28th February 2022 – 10am – 11.30am via Teams	

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	**Review of the Hull University Teaching Hospitals (HUTH) Trust's COVID Response in the First and Second Waves: Overview Report**				
Lead Director	Makani Purva, Chief Medical Officer				
Author					
Report previously considered by (date)	The report was previously considered at the Quality Committee in November 2021				

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

Key Recommendations to be considered:
The Trust Board is asked to note that the report has been scrutinised at the Quality Committee in November 2021 and actions and recommendations are being addressed.

Review of the Hull University Teaching Hospitals (HUTH) Trust's COVID Response in the First and Second Waves: Overview Report

Angela Espinosa, Gerald Midgley, Maya Vachkova and Jon Walker

Centre for Systems Studies

Faculty of Business, Law and Politics

University of Hull

Hull, HU6 7RX, UK

November 2021

Acknowledgements

The research team would like to acknowledge the immense level of personal and professional commitment to the NHS and its patients that has been demonstrated by all the staff we have met while conducting this review. Everybody we talked with, without exception, has selflessly gone above and beyond 'normal' duty as part of HUTH's COVID response, and we heard countless stories of people rising to the challenge, again and again. Everyone who participated in our interviews and workshops did so out of a very real desire to improve things for the future, for the benefit of patients and their fellow staff. In this respect, the level of critical and constructive engagement has been extraordinary.

We would like to thank everyone who has given their time to be interviewed, participate in workshops or fill in a survey. The members of our Advisory Group (from HUTH and the University of Hull) and the participants in our workshops deserve particular thanks, as they provided support in a series of out-of-hours meetings. Finally, a special mention is due to Daniel Murphy-Pittock, who was our day-to-day contact point in HUTH, liaising between the team, all the participants and our Advisory Group. His willingness to give us time early on in the review while we were learning about the complexities of the HUTH organisation was particularly noteworthy, as it made all the difference to our ability to keep the review on track and deliver this report in a timely manner.

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Executive summary

In March 2021, the Hull University Teaching Hospitals (HUTH) NHS Trust commissioned the University of Hull to undertake an independent review of their COVID response since the start of the pandemic. Drawing upon data from interviews of 47 staff and patients, 629 survey responses and 5 workshops, strengths and weaknesses of the HUTH COVID response were diagnosed. Also, an organisational analysis evaluated HUTH against a model of good practice that has been widely used over decades to improve the resilience and responsiveness of organisations faced with unpredictable change and pervading uncertainty, and this gave rise to recommendations for improvement. Many of these are focused on what would be useful in the short-term to prepare for a possible third wave of the pandemic in the last quarter of 2021, but some can be held over for medium- or longer-term implementation in preparation for future pandemics and other public health emergencies.

The remit of the review excluded issues outside the influence of HUTH, such as national government policy, but such issues were highlighted for the Trust to raise in evidence to the 2022 national inquiry. No comparison was made between HUTH and other Trusts, and it is undoubtedly the case that many of the issues reported here were experienced very widely elsewhere too. There follows a brief summary of the context, main achievements, issues and recommendations:

Context

Regional Context. Three highly significant factors in the external regional context made a difference to the COVID response. First, excellent collaboration with private health care providers in the area, like Spire and St Hughes. East Riding Community Hospital provided hot beds for elderly patients, which added significant capacity to the system. Second, informal relationships with other public, private and community organisations helped HUTH to successfully deal with the challenge of PPE supply problems early in the pandemic. Third, additional social services provided by partners stopped during both waves, affecting the reintegration of frail older patients back into the community, which had a systemic impact on the capacity to deal with surges of demand.

Internal HUTH Context. Prior to the pandemic, HUTH had a shortage of beds, equipment and staff (it still does), and a serious financial deficit had only just been eliminated, making budgets extremely tight. Nevertheless, the Trust managed to respond to the challenges of the first two waves of the pandemic remarkably well, given these constraints. The Hull Royal Infirmary (HRI) building was, and still is, structurally inappropriate for pandemic conditions, which may have contributed to increased COVID transmission.

Strengths and Issues

Strengths: There was strong camaraderie and mutual support between staff, and good collaborative practice across multi-disciplinary teams. The streamlined, three-tier (Gold, Silver and Bronze) Command Structure was highly effective and timely in shifting the hospitals into emergency mode and managing the crisis periods. Digitalisation of services and communications was a great success. The laboratory team testing samples was strongly endorsed for its efficiency and reliability. The Trust's wellbeing and mental health resources were highly appreciated. Working from home was well supported by the Trust. Both staff testing and the vaccination campaign in Hull were positively evaluated.

Issues: Stopping elective care in the first wave caused a backlog of work and long waiting lists, and this was handled better in the second wave. Nevertheless, in the absence of new resources, it could

take five years to catch up. Anxious, fatigued hospital workers, including some with mental health issues, pose a significant risk of further staff shortages.

Staff-to-staff COVID transmission and hospital-acquired infections happened during both waves, due to the structural issues with HRI; lack of mechanical ventilation; early uncertainty on COVID precautions; and some staff did not read/implement the advice of infection control experts. Two dedicated COVID wards were built, and then further modified on the recommendation of the clinical teams to improve safety, which caused a delay in the space becoming available for full clinical use.

Concerns were expressed, especially early on, that COVID ward staff were not wearing appropriate PPE. Government and other guidance on PPE changed numerous times during the first wave. Although the guidance is now stable, some staff have been left with a continuing mistrust of it.

Preparation for Each Pandemic Wave: A streamlined Command Structure was put in place, based on usual winter planning. Because of its familiarity, it was readily understood and respected by staff. However, the senior team was required by central government to produce elective-treatment recovery plans, and this was a significant focus between the end of wave 1 and the start of wave 2 (August to October 2020). Therefore, the period between the waves was not utilised as well as it could have been for other things, for example to introduce further training on infection control.

Organisational Issues: Extraordinary dedication, collaboration and hard work was demonstrated by a highly professional and effective workforce. Also, the Trust's ethos and values were robust and widespread, and were pivotal in keeping staff committed and motivated to make good decisions. It is therefore safe to conclude that any issues with the HUTH COVID response are *systemic*. This means they stem from how HUTH is managing its work (and how the wider NHS is organized and resourced), rather than being the fault of any individual, which is why comparing HUTH to a model of good organizational practice to deal with turbulent and uncertain environments is useful. It is possible to make improvements in five broad areas:

1. Not all ward staff are fully aware of COVID safety protocols, and individual ward circumstances need to be better accounted for when implementing policy. Some decisions (e.g. on staff redeployments and flipping wards from general use to COVID-19) have multiple impacts, and how to minimise such impacts could be re-examined.
2. Centralised decision-making through the Gold and Silver command structures was mandated by the Level 4 Emergency Protocol, set nationally by NHS England. This centralisation was therefore not open for HUTH to change, and it sometimes resulted in delays in emergency decisions. Also, centralisation affected the oversight, control and communication of critical information for operational decisions affecting patients and ward management, which needed to be more effective and widespread;
3. There is an opportunity for further integrating ongoing clinical and managerial research and innovation efforts to manage COVID within different units in the Trust, to better inform strategic and operational planning;
4. The policies for pandemic management were useful (i.e. the discharge policy; capacity for acuity; infection, prevention and control; patients' pathways; PPE guidelines; FIT testing; and online work), but need to be revisited again based on the key learnings from dealing with the first two pandemic waves. Also, there is no guarantee that clinical criteria will prevail over managerial criteria in emergency situations, which needs to be addressed at the policy level.

Recommendations from the Organisational Analysis

Ward Management:

- Following best practices observed at the ward level, there is a need to self-organise very brief meetings, at the beginning and end of the day, with all the ward's staff and leaders, for three purposes. First, to agree on the tasks for the day and how to tackle them with the available staff. Second, to share updated information coming from the Bronze command structure. Third, to provide feedback to the Bronze command structure on what is needed in the ward. This will ensure that ward staff are kept up to date with adjustments to policies and operational strategies, and will also ensure that Bronze commanders are fully aware of needs and learning 'on the ground'.
- Enhance ward self-governance, e.g., by providing a 'ward dashboard' on a screen, with KPIs specifically relevant to the ward level as well as HUTH more generally. Other examples can be found in the main body of the report.
- Find more effective ways of distributing information to the ward staff, including on clinical criteria for infectious disease control, as many staff say that they don't have time to read emails. The brief ward meetings and 'ward dashboard' mentioned above will be the most important opportunities for information distribution.
- Introduce training for clinical staff on emergency management and decision making, and for non-clinical managers on clinical criteria to deal with infectious disease risks.
- Design a mechanism for transmitting emergency alerts to the Command Structure, so managers are warned of critical issues that they might otherwise miss.
- Identify volunteers on the wards who are passionate about innovation, and give these people time for identifying, evaluating and spreading good ideas for change in working practices (e.g., via monthly meetings) to grow a culture of bottom-up innovation.
- Continue with the excellent work already underway on enhancing staff recruitment and retention, which has put HUTH in a better position with regard to job vacancies than many other trusts. Continuation of this work is necessary, as staff shortages are likely to be the biggest limiting factor impacting on capacity to innovate.

Harmonisation of Practices between Operational Units:

- Develop and widely disseminate a 'COVID-19 Golden Rules' sheet.
- Use a digital screen (or equivalent) in nursing stations, staff rooms and public spaces, providing updated guidelines and critical information.
- Update and provide compulsory COVID-19 training, including to porters and cleaners.
- HUTH has a good relationship with Social Services, and further partnership work on the logistics of patient throughput could be useful to enhance capacity to deal with surges of demand.
- In the medium term, clarify guidelines with each specialist unit (not a 'one size fits all' approach) for online working, to keep and enhance the digital innovations that have worked well, including online consultations with patients.
- The level 4 emergency came with a requirement to conform to nationally-determined structures, policies, protocols and guidelines. Within the constraints of this, however, it is highly desirable for the Trust to foster a culture of 'responsible autonomy' (i.e., people being empowered to take informed local decisions, and also to be accountable for them) at all levels in the organisation. This is core for developing longer-term resilience beyond the pandemic, so will help with preparation for and anticipation of future emergencies.

General Management:

- Enhance the Command Structure with a more decentralised culture and decision-making skills (while preserving accountability) to ensure better inclusion of knowledge of what's happening 'on the ground' (especially on the wards).
- Continue to represent all Health Groups and key management roles on Silver Command.
- Maintain the HR Director's daily bulletins.
- Improve communication between Bronze Command and ward management.
- Ensure that all line managers of ward staff are attentive to and supportive of the physical and mental wellbeing of staff.

Strategy and Innovation:

- Further clarify, focus and develop strategic and innovation roles more effectively supporting the Command Structure, at all levels (from the Trust down to the ward level).
- Develop more proactive and adaptive ways for deciding on emergency plans (i.e. by continuously updating surge plans, PPE supply, records of available staff for redeployment, and protocols for converting wards to COVID status).
- Invite a team of (volunteer) representatives from strategic and innovation roles at the corporate, Health Group and ward levels to support the Command Structure's strategic decision-making (about COVID-19 trends, variants, treatments, trials of affordable management and technological innovations, etc.). The role of this team would also be to contribute to disseminating ongoing innovations; to improve communications between those inside and outside the Trust concerned with innovation; and to enable the existing innovation roles within the Health Groups and COVID-19 wards to operate effectively.

Ethos and Policy:

- Keep Gold Command focused on strategic conversations to agree on high-level policy decisions (rather than lower-level ones being dealt with by Silver and Bronze).
- Establish equal, robust participation in policy making from people representing managerial roles and people representing innovation and strategy roles. Also, ensure these roles interact effectively so that long-term vision and day-to-day practicalities are balanced.
- Enable senior clinicians and managers to discuss how medical and managerial criteria are weighed in emergency situations, and formulate an approach that works for both.
- Undertake future periodic reviews of the Trust's learning in pandemic management.

Overview Report

Introduction

Between March and August 2021, the Hull University Teaching Hospitals (HUTH) NHS Trust commissioned the University of Hull to undertake an independent review of their COVID response since the start of the pandemic. The purposes of the review were:

1. To explore HUTH's response to the COVID-19 pandemic (and previous planning activities), focusing on what is directly under the influence of the Trust; and
2. To provide realistic and practical recommendations pertaining to operations and crisis management, service pressure planning, colleague management, leadership and governance, in order to improve organisational resilience and responsiveness to possible further waves of the current pandemic, as well as future pandemics (and other potential public health emergencies).

This report provides an overview of our findings.

Broadly speaking, the organisation of HUTH's response during the first and second waves of the pandemic was very well led by the Command Structure, which was put in place early in the first wave. It stopped operating when the first wave was over. The Command Structure was reactivated in the second wave, during the Autumn of 2020, and was decommissioned again in May 2021. In this report, we provide a systemic, qualitative analysis of HUTH's organisational performance when dealing with the pandemic. We highlight the main lessons learned and what could be improved. Our recommendations for change are intended to be acted upon to ensure readiness for a new wave of the COVID-19 pandemic (or any other similar public health emergency that might happen in future years).

The relevant context in which HUTH found itself prior to the pandemic was characterised by a shortage of beds, equipment and staff (similar to other NHS Trusts), and a serious financial deficit had only just been eliminated, making budgets extremely tight. Nevertheless, HUTH managed to respond to the challenges of the first two waves of the pandemic remarkably well, given the constraints it was operating under.

The excellent leadership, commitment, solidarity and compassion of the staff, the dedicated technological support, and the agility that the management demonstrated, are all worth commenting on. This agility was particularly notable in relation to quickly redesigning the physical spaces (wards, bed layouts, etc.), reorganising the workforce (e.g., redeployments to COVID-19 wards) and providing support to each other and the patients during the two waves.

Nevertheless, there were lessons learned in each wave concerning issues that could have been dealt with better. Many of these issues have already been identified and acted upon by the Command Structure and those in different support roles who have been working hand in hand with the management to ensure the best possible response to the pandemic. There follows a briefing of the main achievements and problems, the lessons learned, and our recommendations on how, by addressing specific aspects of its current organisation, the Trust may improve its resilience and preparedness for a further wave of COVID-19 or a future pandemic.

Our Approach

To gather the necessary information to undertake our review,

- We undertook 47 interviews with HUTH clinical and administrative employees, as well as patients.[1] The first few interviews were used to test the remit of the review, to make sure that there were no hidden issues that HUTH had been unaware of in writing the remit for us. Once we were satisfied that the remit was sound, the rest of the interviews gathered data on people's experiences of COVID-19 and their understandings of the Trust's response.
- We ran a survey, with 629 responses from clinical and administrative staff.
- We facilitated 5 two-hour workshops with a range of staff with different COVID-facing clinical and managerial roles to undertake an organisational analysis (see the next bullet point) and test the adequacy of our recommendations for improvement.
- We compared the HUTH organisation to a model of good practice that has been widely used over decades to improve the resilience and responsiveness of organisations to turbulent environments where there is constant change and pervading uncertainty – COVID-19 clearly made the environment for HUTH highly turbulent and uncertain, so the model of good practice was very useful in highlighting successes and diagnosing continuing problems that still needed to be addressed. This diagnosis work was contributed to by the HUTH clinical and managerial employees who participated in the 5 workshops (mentioned above) to ensure accuracy, coverage of all the most pressing issues, and the desirability and feasibility of recommendations for change.

All through the project, we were supported by monthly meetings of an Advisory Group, where its members asked for clarifications and suggested improvements to our ongoing work.

National Context

The following are national-level issues that impacted upon the ability of HUTH to respond as well as it might have done to COVID-19. Each of these needs to be a focus for HUTH's evidence for submission to the 2022 national inquiry.

First, the national lockdowns came late in both waves. However, in the first wave, the timing worked well for HUTH, even though it was late for other Trusts, because Hull's first wave started after the rest of the country had already experienced a steep rise in COVID-19 cases. In the second wave, HUTH was still dealing with high COVID numbers when other areas were not, so the lifting of the lockdown was perceived as premature by many HUTH staff. Both of these observations show up limitations of the 'one size fits all' approach to lockdowns stemming from government policy-making to ensure consistency across the whole country. It may be that this is just regional variation that has to be lived with in future pandemics to facilitate a national approach that is easily understood by the public, or it may be preferable to regionalize policy-making – modelling of future pandemic scenarios is required to determine the best approach.

Second, centralised personal protective equipment (PPE) provisions hampered local resilience as people waited for approved PPE. Likewise, the availability of COVID-19 test kits was subject to limitations, which had origins centrally.

Third, government PPE guidance changed frequently (at one point, early in the first wave, up to five times a day), and sometimes conflicting guidance came from different professional bodies. Some staff believed that government guidance was being modified in accordance with the national availability of PPE rather than scientific evidence of good practice.

[1] 15 additional interviews were undertaken in the Breast Care Unit for a separate project, and these were very useful for understanding an area of HUTH that was not primarily COVID-facing (which was important, because COVID decision making has unavoidable impacts on other services), but the data from these interviews was not used in the generation of this report.

Fourth, stopping elective services created a backlog of patient waiting lists. This could be better-managed in future pandemics. Forecasting the course of an emerging pandemic is never certain, even when based on a great deal of evidence from prior pandemics, because new micro-organisms and variants may have different characteristics that take the trajectory of a disease in an unanticipated direction. Nevertheless, a better precaution than the national cessation of elective services is to enable local decision-making (with accountability to government) so hospitals that still have some capacity can continue elective work for longer, thus slowing the growth of waiting lists where possible.

Fifth, GPs were told to limit in-person appointments, and many people simply did not seek healthcare when they needed it.

Finally, English NHS workers may be demotivated to stay in their roles due to the perceived inadequacy of their proposed pay rise and the likelihood that it will take years to catch up with waiting lists, putting further pressures on staff. There is a need for mitigating actions by the government.

Local and Regional External Influences on the Work of the Trust

By and large, the local population kept to the COVID rules when in contact with HUTH services.

The Government released funding for contracts with the private sector. There was excellent collaboration with private health care providers in the area, like Spire and St Hughes. East Riding Community Hospital provided hot beds for elderly patients, which added significant capacity to the system.

During the first wave there were national PPE supply problems, but informal relationships with other public, private and community organisations helped HUTH to successfully deal with this challenge.

Additional social services provided by partners were stopped during the waves. This has to be a priority to address in preparation for a third wave (or future pandemic), as some of these social services are essential for the reintegration of frail older patients back into the community, and support after treatment. Having the capacity to quickly move patients on when they are no longer in need of hospital treatment is vital to retaining the capacity to deal with future large surges of demand on services.

Some patients who did not see their GPs, or who did not go to hospital for appointments, may now be presenting worse malignancies than they would have had if they had promptly accessed healthcare. National estimates suggest that it will most likely take five years for the NHS to 'catch up' with their waiting lists (NHS Providers, 2021). Long waiting lists are often managed on the basis of goodwill at the cost of weekends and annual leaves. Even if these are well paid, this still poses a high risk of burn-outs and staff shortages in the medium term.

As with the national issues discussed earlier, some of the challenges mentioned in this section are not under the influence of HUTH, but they could be raised in the 2022 public inquiry, as they are relevant to national pandemic planning.

Budgetary and Resource Concerns

The Government released COVID funding, and HUTH took advantage of it. The rebalancing of the HUTH budget pre-pandemic was a positive move towards financial stability, but caused a strain on resources. Due to the COVID funding, some roles were subsidised, but there is insecurity about having sufficient human resources into the future.

Physical resources like infrastructure were highlighted as problematic. The Hull Royal Infirmary building is structurally inappropriate for pandemic conditions and, although there were investments in two COVID wards, these needed to be modified on the recommendation of the clinical teams to improve safety. Thus, there was a delay in the space becoming available for full clinical use.

Excellent work has been done to enhance staff recruitment and retention, which has put HUTH is in a better position with regard to job vacancies than many other trusts. Nevertheless, HUTH was understaffed pre-pandemic and still is. While this is a national problem in the NHS, HUTH needs to continue doing what it can to address it locally, continuing to implement it's already-robust policies in this regard.

Internal Influences on the Work of the Trust

There was strong camaraderie and mutual support between staff and good collaboration across teams. Digitalisation of services and communications was a great success. Working from home was well supported by the Trust. The laboratory team was endorsed for its efficiency and reliability. The Trust's various wellbeing and mental health resources (like counselling, online information, courses and meditation apps) were highly appreciated. Staff benefits like the free car parking were welcomed. The free meals were valued by some, but others said they were too basic, with no special dietary requirements catered for, and this caused food waste.

Both staff testing and the vaccination campaign in Hull were positively evaluated. Telephone and online appointments allowed staff to keep in touch with most patients, but some patients still needed to be seen in person or did not have the hardware and/or IT skills to attend video calls (this situation is not under the control of HUTH, and will continue).

Stopping elective care in the first wave caused a backlog of work and long waiting lists, and this was handled better in the second wave. Anxious and fatigued staff and mental health issues pose a significant risk to HUTH of staff burn-outs and further human resource shortages.

Staff-to-staff COVID transmission and nosocomial (hospital-acquired) infections happened during both waves. There were many contributory reasons: estates issues (especially the inappropriate infrastructure at Hull Royal Infirmary and ward design issues); lack of mechanical ventilation; an early lack of certainty on COVID precautions; and some staff on the wards did not read and/or implement the advice of Infection Prevention and Control (IPC) staff.

Concerns were expressed, especially early on, that COVID ward staff were not wearing appropriate PPE: they were given PPE to protect against droplets, rather than aerosol particles. We heard different reports on this. One view was that this happened early in the pandemic because, at that time, nobody knew that COVID could be transmitted by aerosol, and as soon as government guidance changed, HUTH changed its PPE. However, even during the second wave, we were still hearing from staff that they believed they were wearing the wrong PPE. When we followed up on this, a suggestion was made that there is a communication issue, as staff may not all have the same views on where and when it is appropriate to wear different types of PPE.

Preparation for Each Pandemic Wave

A 'Gold/Silver/Bronze' Command Structure was put in place, based on usual winter planning. Because of its familiarity, it was readily understood by all the staff interviewed in the review. Gold Command sets the framework for tactical decision-making, making policy in relation to the overall Trust response, and directing Silver Command to develop and deploy a clinical and operational response within that context. Gold Command ensures that the Silver and Bronze Commands have the resources they need to meet their objectives. It is also responsible for wider system liaison. The Silver Command is supported by a dedicated tactical response unit, and four cross-trust Silver

Command groups lead the tactical response. Silver Command for Clinical Operations is responsible for directing and co-ordinating the overall operational response (e.g., surge plans for the reception, assessment and care of suspected and confirmed COVID-19 patients, including both general and critical inpatient care). Plans for clinically urgent non-COVID activity that must continue are their responsibility too, including the deployment of staff to support these arrangements. The Bronze Command translates these operational plans into actions to be taken on the wards.

The senior team was required by central government to produce elective-treatment recovery plans, and this was a significant focus between the end of the first wave and the start of the second (August to October 2020). As a consequence, the period between the waves was not utilised as well as it could have been: it offered opportunities for training and better preparation for the second wave, which were only partially capitalised upon. The Academy of Medical Science predicted that the second wave would be larger than the first wave, and preparation for the second wave would have been a higher priority than the elective services planning if the latter had not been mandated. Improved communications between the senior team and IPC could be valuable in future pandemics, with an 'emergency channel' of communication set up so managers know, if it is activated, that this requires priority attention. Finally, the recovery phase entails a backlog of training, long waiting lists and a tired workforce.

Organisational Analysis

Given the extraordinarily selfless dedication the research team saw from all HUTH staff during COVID, it is safe to conclude that any issues with the HUTH COVID response are essentially *systemic*. This means they stem from how HUTH is organizing its work (and how the wider NHS is organized and resourced), rather than being the fault of any individual, which is why comparing HUTH to a model of good organizational practice to deal with turbulent and uncertain environments is the best approach to take in this review.

This model of good practice has been widely used over decades to enhance the resilience and responsiveness of organisations so they can survive and thrive in turbulent and uncertain environments. The model suggests that, in an emergency situation like the one experienced during COVID-19, the best approach is one where staff are empowered to make decisions in a timely manner that can be directly responsive to what is happening 'on the ground', but without losing accountability for this decision-making. This is known as 'responsible autonomy'. It allows, at each level of organisation, a fast, adaptive response to the emergency, and ensures capability for learning and adapting in real time. This applies, not only to the organisation of the Trust as a whole, but to the organisation of each one of the Health Groups within it.

According to the criteria in the model, each one of the main units directly involved in the Trust's response to the pandemic should be capable of doing its job properly (which means delivering the health service autonomously, while remaining accountable for performance and quality to the Trust's management) and self-managing its people using the available resources to best advantage. To manage all the health units effectively, the Trust should provide them with effective capabilities and tools for:

a) delivering health services that meet the needs of the population (e.g., treating COVID-19) in a manner that facilitates autonomous, on-the-ground decision making while retaining overall accountability for performance;

b) harmonising health service delivery (i.e. sharing resources, standards, information and knowledge to ensure that each service has what it needs to do its job and works well with others);

c) ensuring appropriate, good quality and synergistic performance of people, physical, financial and technological resources;

d) providing leadership of strategy and innovation; and,

e) enforcing a strong and shared organisational ethos and policy.

If all these organisational capabilities are in place, are high quality and work together, effective self-governance becomes possible – i.e. the organisation becomes capable of responding and adapting rapidly to emergencies, and can re-organise itself as and when required to maintain viability and resilience.

After observing the work of HUTH from this perspective, we were able to reach some broad conclusions as to where there could be room for improvement:

1. Not all ward staff are fully aware of COVID safety protocols, and individual ward circumstances need to be better accounted for when implementing policy;
2. Some decisions (e.g. on staff redeployments, flipping wards from general use to COVID-19) have multiple impacts, for instance on staff safety and morale, and how to minimise such impacts could be re-examined;
3. Centralised decision-making through the Gold and Silver Command structures was mandated by the Level 4 Emergency Protocol, set nationally by NHS England. This centralisation was therefore not open for HUTH to change, but it sometimes resulted in delays in emergency decisions. Also, centralisation affected the oversight, control and communication of critical information for operational decisions affecting patients and ward management, which needed to be more effective and widespread;
4. There is an opportunity for fostering further integration of ongoing clinical and managerial research and innovation efforts to manage COVID within different units in the Trust, to better inform strategic and operational planning; and
5. The policies for pandemic management were useful (i.e. the discharge policy; capacity for acuity; infection, prevention and control; patients' pathways; PPE guidelines; FIT testing; and online work), but need to be revisited again based on the key learnings from dealing with the first two pandemic waves. Also, there is no guarantee that clinical criteria will prevail over managerial criteria in emergency situations, which needs to be addressed at the policy level.

Finally, to improve the Trust's governance capabilities, it needs to more quickly and effectively 'close the learning loop', which means not only adopting new policies and strategies, understanding their results and learning lessons, but also then implementing the required organizational improvements. It is worth adding that, in crisis situations, learning loops are often the first thing to be sacrificed so that people can focus on immediate 'fire-fighting'. This is a significant problem when dealing with a crisis like COVID-19, because of the pervasive uncertainty and the overriding need to learn on the job how to deal with it. The fact that HUTH commissioned this report is evidence that they have a commitment to keeping their learning loops operational. We hope this report will help to focus and reinforce other ongoing internal assessments and provide detailed criteria to establish a self-transformation plan to improve preparedness for a next pandemic wave, or a future pandemic. There follows a brief unpacking of the analysis and recommendations relating to each one of the five broad conclusions about where improvements are possible (mentioned above).

Ward Management

With no exception, we witnessed extraordinary dedication, collaboration and hard work at the ward level from a highly professional and effective workforce. Doctors, allied healthcare workers,

nurses and all the technical and management support roles receiving and treating COVID-19 patients showed remarkably positive attitudes, and were committed over long time-periods to very hard work beyond their formal obligations. Team work was effective and exemplary too. Learning how to 'flip' wards to COVID-19 status, and how to take care of COVID-19 patients, took some time during the first wave and got better over the second wave.

The main risk when there is a significant further wave of COVID-19, vaccines are bypassed by a new variant, or a new pandemic happens, is staff scarcity, staff exhaustion and maintaining staff motivation. As previously stated, excellent recruitment and retention policies are already in place, and should be a continuing focus. Also, there is a need to maintain and continue to develop psychological support (including benefits, private spaces, counselling and other support services, flexible rotas, holidays, feedback and promotions).

There were mistakes in decisions about moving suspected COVID-19 patients, and on flipping beds and wards. Some of them related to a lack of sufficient beds and wards to avoid unnecessary risks; some of them were associated with the need for more staff training, or sometimes the understanding of COVID protocols could have been better (mostly because a minority of frontline staff were too busy to read their emails and absorb frequent updates on the protocols); and some of them related to insufficient autonomy and empowerment of ward staff and management to make urgent decisions, as they needed to wait for the Command Structure's approval for actions that could have been taken at a lower level in order to be fully timely and responsive. Finally, some mistakes were due to inefficiencies in information flows, top down and bottom up from the Command Structure to the wards.

Our main recommendations at this level concern the need to provide more autonomy and empowerment to those managing the wards. More decision making needs to be devolved to lower levels where the complexities of the operations are managed. More effective ways of distributing information to the level where it is required need to be developed to ensure everyone is capable of effectively dealing with the risks involved in managing COVID-19 patients. In particular, there is a need for more distributed knowledge on clinical criteria for infectious disease control, a need for training to be provided to clinical staff on the basic principles for emergency management and decision making; and training for operational, business and general managers on the basic clinical criteria to deal with infectious disease risks.

Following best practices observed at the ward level, there is a need to self-organise very brief meetings, at the beginning and end of the day, with all the ward's staff and leaders, for three purposes. First, to agree on the tasks for the day and how to tackle them with the available staff. Second, to share updated information coming from the Bronze Command structure. Third, to provide feedback to the Bronze Command structure on what is needed in the ward. This will ensure that ward staff are kept up to date with adjustments to policies and operational strategies, and will also ensure that Bronze Commanders are fully aware of needs and learning 'on the ground'. It will also contribute to COVID safety and staff morale at the ward level.

Also, a quick briefing on emergency management principles (taken from the *Commanders training*) could be provided to ward leaders. This will enhance local capabilities in four areas: making effective decisions during an emergency, taking real-time action, managing information, and enhancing accountability for decisions.

A specific mechanism for transmitting *emergency alerts* (e.g. via a dedicated WhatsApp channel just for this purpose), connecting a staff member directly to the relevant part of the Command Structure should also be implemented in the short term, so managers can be warned about critical issues happening on the ground, which they might not otherwise be aware of. This should be used if and when staff became aware of a situation that is threatening to get out of control, and could risk patient or staff safety. Managers can miss important information because they are bombarded

by messages and data, so the idea of an *emergency alert* is to differentiate the most important signals from the rest, so priority attention can be paid to them.

Finally, to strengthen innovation and adaptive capabilities, it is recommended that a volunteer is found to take the role of 'Ward Innovator'. Such a volunteer would be responsible for writing up success/failure stories on wards about patients' management, staff motivation and team work. This person could also involve staff in multidisciplinary, bottom-up dialogues, which can be placed on the agenda of a monthly ward meeting. While the review team recognise that HUTH is severely resource-constrained, enabling bottom-up innovation on the wards is a way to work smarter rather than harder using limited staff time: many new COVID-responsive innovations will have the potential to improve clinical performance, and some may even be life-saving. The relatively modest amount of time that is needed to enhance innovation should be quickly repaid through new developments that improve efficiency, effectiveness and productivity.

Given that staff shortages are the most likely factor to impact the ability to resource ward-level innovation, it is recommended to continue to prioritise implementation of the already-excellent recruitment and retention strategies.

Summary of Recommendations on Ward Management

- Introduce brief, ward-level meetings (where not already in place) at the start and end of the day to encourage COVID safety and raise staff morale.
- Enhance ward self-governance, e.g., by providing a 'ward dashboard' on a screen, with KPIs specifically relevant to the ward level as well as HUTH more generally.
- Find more effective ways of distributing information to the ward staff, including on clinical criteria for infectious disease control, as many staff say that they don't have time to read emails. The brief ward meetings and 'ward dashboard' mentioned above will be the most important opportunities for information distribution.
- Introduce training for clinical staff on emergency management and decision making, and for non-clinical managers on clinical criteria to deal with infectious disease risks.
- Design a mechanism for transmitting emergency alerts to the Command Structure, so managers are warned about critical issues that they might otherwise miss.
- Identify volunteers on the wards who are passionate about innovation, and give these people time for identifying, evaluating and spreading good ideas for change in working practices (e.g., via monthly meetings) to grow a culture of bottom-up innovation.
- Continue with the excellent work already underway on enhancing staff recruitment and retention, which has put HUTH is in a better position with regard to job vacancies than many other trusts. Continuation of this work is necessary, as staff shortages are likely to be the biggest limiting factor impacting on capacity to innovate.

Harmonisation of Practices between Operational Units

The harmonisation of practices is very robust in general. The Trust has the required processes, clarity on roles and responsibilities, standards, quality guidelines, information and communication infrastructure and tools to guarantee smooth operations most of the time.

During the pandemic, HUTH created a more agile decision making and communication Command Structure, which mostly worked well, but could still be improved in certain respects. Our broad recommendation at this level is to continue developing communication and information management tools and training to support more agile decision making and communications in the Command Structure and in the wards.

Possible improvements include complementing existing communication channels like email (which at the height of COVID was accessed by an average of 85% of the staff) with other forms

of briefing. Also, up-to-date information on the management of COVID-19 could be provided to patients and wards through, for example, digital screens (or equivalent) in nursing stations, staff rooms and public spaces. The design of brief 'COVID-19 Golden Rules' and wide dissemination to all staff would be useful, plus updated and compulsory training on COVID-19 best practices for staff, including porters and cleaners.

HUTH has a good relationship with Social Services, and further partnership work on the logistics of patient throughput could be useful to enhance capacity to deal with surges of demand during and beyond pandemics.

It is also very relevant to clarify online working guidelines in the medium term, so good practices in online clinical consultation and remote working can be kept and enhanced post-pandemic. This will require building capabilities (in offering online consultations to patients, and in massively using online tools to improve joint, multidisciplinary responses to emergencies) in collaboration with each specialist unit, so policies are tailored to local clinical need rather than being 'one size fits all'. We also recommend, in the medium to long term, the conscious development of a culture of 'responsible autonomy' (i.e., people being empowered to take informed local decisions, and also to be accountable for them) for staff and patients, including self-awareness, self-care and positive attitudes to others.

Summary of Recommendations on Harmonisation of Practices between Operational Units

- Develop and widely disseminate a 'COVID-19 Golden Rules' sheet.
- Use a digital screen (or equivalent) in nursing stations, staff rooms and public spaces, providing updated guidelines and critical information.
- Update and provide compulsory COVID-19 training, including to porters and cleaners.
- Establish a pandemic planning agreement with social services to enable their additional services to continue during pandemic waves, as these are essential to maintaining the through-put of patients and therefore sufficient capacity to deal with surges of demand.
- In the medium term, clarify guidelines with each specialist unit (not a 'one size fits all' approach) for online working, to keep and enhance the digital innovations that have worked well, including online consultations with patients.
- In the longer term, consciously foster a culture of 'responsible autonomy' (i.e., people being empowered to take informed local decisions, and also to be accountable for them).

General Management

We witnessed many testimonies to a very good and effective Command Structure, with the right approach to emergency planning and management, and excellent information from Business Intelligence and the dashboard. Most people recognised very strong leadership.

In the first wave, the representation of the Health Groups in meetings was too limited, but became better structured (although more complex to manage) in the second wave. While some people preferred the 'leaner' format in the first wave, as their decisions seemed less complex and were taken faster, on balance we suggest that the added complexity of a larger decision-making body is essential to get to grips with. This is because, if participation by those with the requisite knowledge of what is happening 'on the ground' is curtailed, there is a risk of inadequate decisions. This Command Structure needs to be kept 'latent' in the organisation, ready to start working again in case of a new wave.

The main limitations of the Command Structure that we see are:

a) information availability and decision-making being too centralised;

b) some lack of trust in the operational wisdom of staff to know the criteria they need to use to make emergency decisions;

c) difficulties in reaching the ward level with critical information in an effective and timely manner;

d) delays in making decisions in real time when incidents happen; and,

e) difficulty 'closing the learning loop' on operational policies and strategies.

To improve on these points, it is recommended that HUTH should develop a more decentralised culture and decision-making skills.

In particular, we suggest that Silver Command reconfirms representation from all Health Groups and critical management support functions. Keeping a good representation makes the management of meetings and making of decisions more challenging, so we recommend the use of a capable facilitator rather than a traditional meeting chair.

Regarding top down communications, we witnessed appreciation of the Workforce Director's daily bulletins, which should be maintained. However, a more effective communication between Bronze Commanders and ward management needs to be designed and implemented as a priority.

At the ward level, we recommend the development of capabilities for self-management and self-regulation, which can be done by encouraging distributed leadership: i.e. by ensuring wards run brief meetings at the start and end of the day (as discussed earlier); enhancing two-way communication with Bronze Command; providing wards with a daily summary of key information; training key people in emergency decision making; adapting existing KPIs at the ward level; and creating mechanisms for feeding real-time information from the ward into the dashboard.

Finally, we recommend redoubling efforts to ensure that all line managers of ward staff are attentive to the impacts of the pandemic on the physical and mental wellbeing of colleagues.

Summary of Recommendations on General Management:

- Enhance the Command Structure with a more decentralised culture and decision-making skills (while preserving accountability) to ensure better inclusion of knowledge of what's happening 'on the ground' (especially on the wards).
- Continue to represent all Health Groups and key management roles on Silver Command.
- Maintain the HR Director's daily bulletins.
- Improve communication between Bronze Command and ward management.
- Ensure that all line managers of ward staff are attentive to and supportive of the physical and mental wellbeing of staff.

Strategy and Innovation

Centrally, HUTH has the required skills, capabilities and systems to support strategic and tactical planning, but needs more distributed planning and innovation roles. It still has a more reactive than proactive culture for strategy and policy making; fragmented research and practice; and mostly informal collaboration with other Trusts and medical research institutions. It hasn't always effectively and quickly enough 'closed the loops'; i.e. summarised the learning from staff and patients' feedback on lessons from COVID, and adjusted emergency plans and operations accordingly.

We recommend further clarifying, focusing and developing strategic and innovation roles to more effectively support the Command Structure, at all levels (from the Trust down to the ward level).

In particular, develop more proactive and adaptive ways for deciding on emergency plans (i.e. by continuously updating surge plans, PPE supply, records of available staff for redeployment, and protocols for converting wards to COVID status).

Also, we recommend inviting a team of (volunteer) representatives from strategic and innovation roles at the corporate, Health Group and ward levels to support the Command Structure's strategic decision-making (about COVID-19 trends, variants, treatments, trials of affordable management and technological innovations, etc.). The role of this team would also be to contribute to disseminating ongoing innovations; to improve communications between those inside and outside the Trust concerned with innovation; and to enable the existing innovation roles within the Health Groups and COVID-19 wards to operate effectively.

Summary of the Recommendations on Strategy and Innovation:

- Further clarify, focus and develop strategic and innovation roles more effectively supporting the Command Structure, at all levels (from the Trust down to the ward level).
- Develop more proactive and adaptive ways for deciding on emergency plans (i.e. by continuously updating surge plans, PPE supply, records of available staff for redeployment, and protocols for converting wards to COVID status).
- Form a team of representatives from strategic and innovation roles at the corporate, Health Group and ward levels to support the Command Structure's strategic decision-making.

Ethos and Policy

The Gold Command has worked very well in setting up policies, making high-level decisions, communicating requirements from the government, and leading executive deliberations to ensure capacity is achieved to provide the required COVID-19 services.

There were delays in launching the Silver Command in the first wave, but it worked well during the second wave. The main issue we found is that, at times, Gold Command was seen to micro-manage and unnecessarily involve itself in operational details. Our recommendation is to clarify the role of the Gold Command, so that it:

a) focuses on high level policy decisions;

b) facilitates strategic conversations to agree on policy and strategy issues; and

c) guarantees equal and robust participation from both management and strategic innovation roles, ensuring these roles interact to enable a balance between longer-term vision and day-to-day practicalities.

It will be important to design an agenda and run strategic meetings every month, with the equal participation of the roles mentioned in point c (above), to:

a) review the lessons learned from the Trust management of the pandemic;

b) adjust policy and strategy based on lessons learned, and ensure that these policies and strategies are informed by the latest COVID-19 research.

Regarding governance and performance management, we saw good capability for reviewing performance indicators in the Silver Command Structure, excellent use of the information summaries, and very capable executive decision-making. We saw a good relationship with the Board of Directors, and appropriate requests for their support for designing and implementing emergency measures or operational strategies.

A key recommendation is to improve/clarify adaptive capabilities at all levels of organisation (HUTH, Health Groups, wards), and invite representatives to participate in strategic decisions at all levels of the Command Structure.

Also, there is a need to re-balance representation from managers who oversee operational coherence in HUTH (and are therefore ultimately responsible for ensuring that HUTH delivers on its current strategies and policies) and those who have roles in foresight, innovation and information synthesis (whose insights have the potential to *change* strategies and policies). In pursuing this rebalancing, the incentivising and promotion of innovation roles linked to Gold, Silver and Bronze Commands (or the HUTH, Health Groups and ward levels when the Command Structure is not operating) is going to be critical. Organisations have to deal constructively with the tension between those whose roles involve keeping 'business as usual' going, and those whose roles involve *improving* on 'business as usual': if one dominates at the expense of the other, the organisation either fails to learn anything new because change is resisted, or it puts so much energy into change that the core activity of service delivery is compromised. A 'middle path' needs to be negotiated between these two extremes.

Another balancing issue is between managerial and clinical criteria during emergencies. It is fair to say that the majority of managers do not get involved in clinical decision making, and the majority of clinicians would prefer not to have to spend time on planning and budgeting. Nevertheless, several interviewees raised an issue here, saying that the criteria used by these two types of decision maker can and do come into conflict on occasion. A role for senior management could be to convene a dialogue between representatives of both groups to see if there is the possibility of a new policy or approach that would be satisfactory for all parties.

Also, there should be a periodic review of the Trust's performance in the management of the pandemic, which would require the design and/or adjustment of even more meaningful real time KPIs and the participation of clinical and management leaders from each Health Group in future reviews.

Summary of Recommendations on Ethos and Policy:

- Keep Gold Command focused on strategic conversations to agree on high-level policy decisions (rather than lower-level ones being dealt with by Silver and Bronze).
- Establish equal, robust participation in policy making from people representing managerial roles and people representing innovation and strategy roles. Also, ensure these roles interact effectively so that long-term vision and day-to-day practicalities are balanced.
- Enable senior clinicians and managers to discuss how medical and managerial criteria are weighed in emergency situations, and formulate an approach that works for both.
- Undertake future periodic reviews of the Trust's performance in pandemic management.

Conclusion

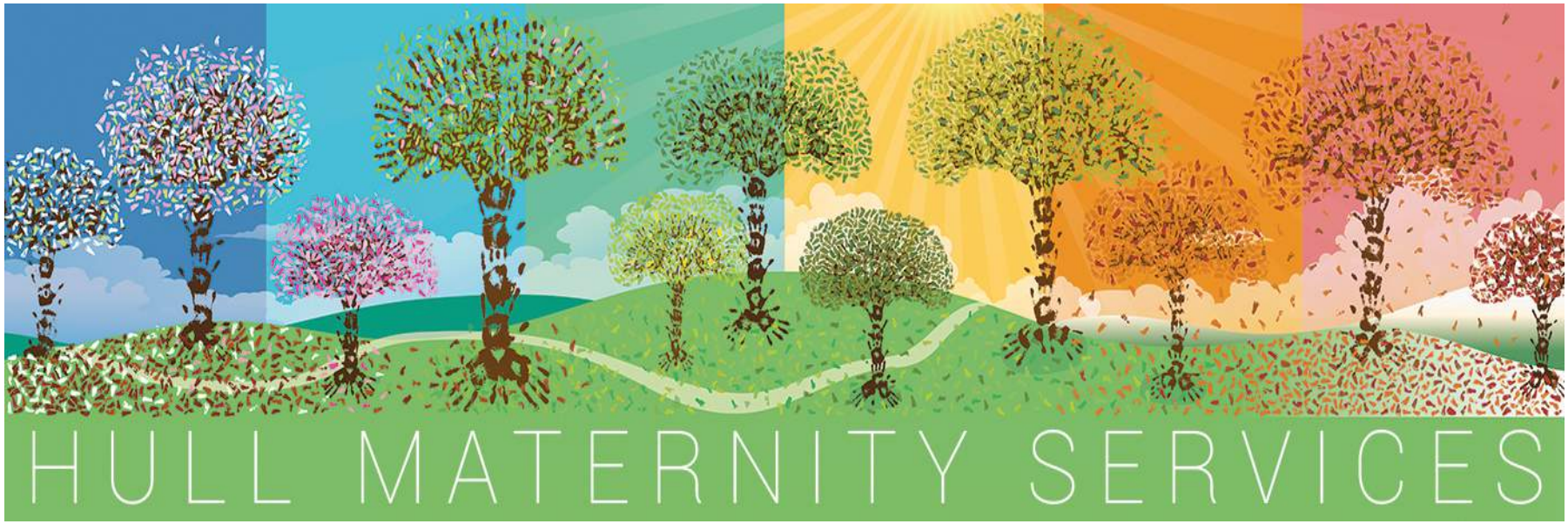
It has been a privilege working with HUTH at a time of crisis to undertake this independent review. Their courage in commissioning it is noteworthy. The research team, with the strong engagement of a range of people in COVID-facing clinical and managerial roles, has developed recommendations (presented above) that are designed to improve the effectiveness of its response in the event of a new wave of COVID-19, another pandemic, or some other public health emergency. We look forward to the next phase of this work as HUTH engages in implementation, building upon past achievements and looking to create a more resilient future.

Reference

NHS Providers (2021). Backlog in some places may take up to 5 year: bold transformative approach needed. 18.04.2021. Available at https://nhsproviders.org/news-blogs/news/recovering-the-nhs-backlog-in-some-places-could-take-up-to-five-years-bold-transformative-approach-needed [Accessed 01/07/2021)

NHS
Hull University Teaching Hospitals
NHS Trust

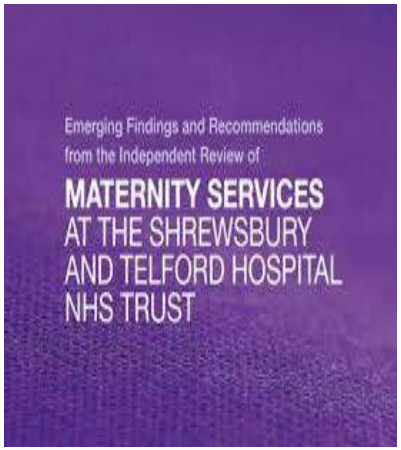
Maternity Services Hull University Teaching Hospital



Ockenden Update February 2022

December 2020 – Ockenden Publication

Hull University Teaching Hospitals NHS Trust



The Ockenden report was published on the 10 December 2020.The report identified a number of important themes which must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement the sharing of emerging findings formed Local Actions for Learning and made early recommendations which were seen as **Immediate and Essential Actions**. The report highlighted 7 Immediate and essential Actions which included:

1. Enhanced Safety
2. Listening to Women and Their Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent

Assurance - HUTH maternity services Journey to date

Hull University Teaching Hospitals NHS Trust

Initial Declaration by chief executive Against the 12 specific and urgent priorities submitted December 2020

Trust to implement all 7 Immediate Essential Actions (IEA)

A Gap analysis has been completed against the maternity service provided by HUTH against the 7 (IEA)

HUTH submitted evidence via the Futures Platform on the 30 June 2021 and received feedback and RAG rating k on the 29 November 2021

HUTH feedback identified 5 red areas and a number of Amber areas, but overall a good stable position

HUTH are compliant or partially compliant with the majority of the 7IEA. Developed fortnightly working group, terms of reference, Ockenden charter and a robust action plan

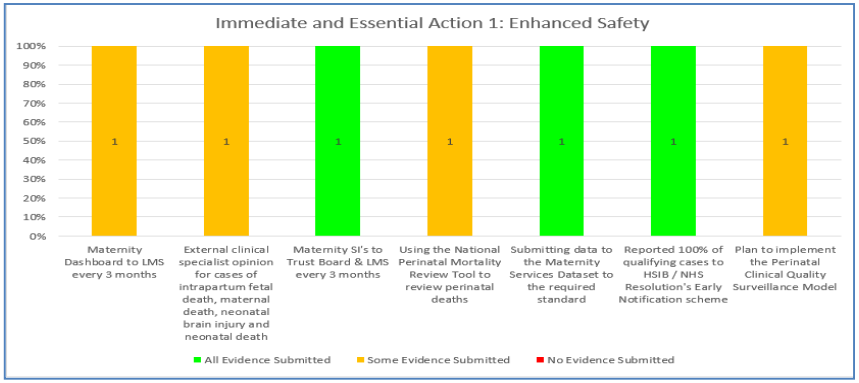
Ongoing work is supported by quality improvements methods, including the use of Quality Service Improvement Redesign (QSIR)

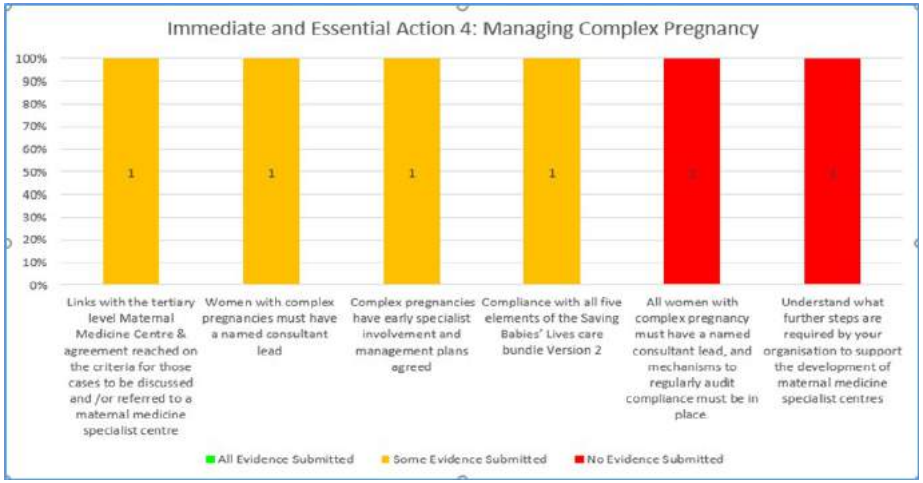
HUTH maternity service an overarching review including.

- Completed the Ockenden assurance Tool
- A current Gap analysis
- Reviewed NICE guidelines
- Reviewed 2018 CQC report/progress
- Review Morecombe Bay report and action plan
- Undertaken Birthrate plus assessment December 2021

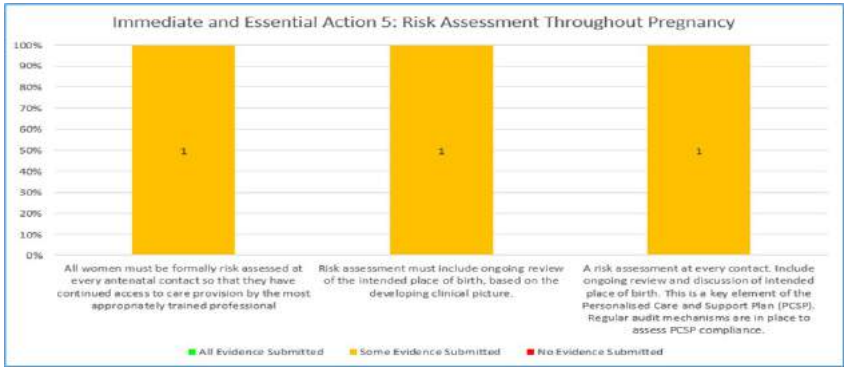
HUTH Ockenden RAG Rating – data submitted on the 30 June 2021

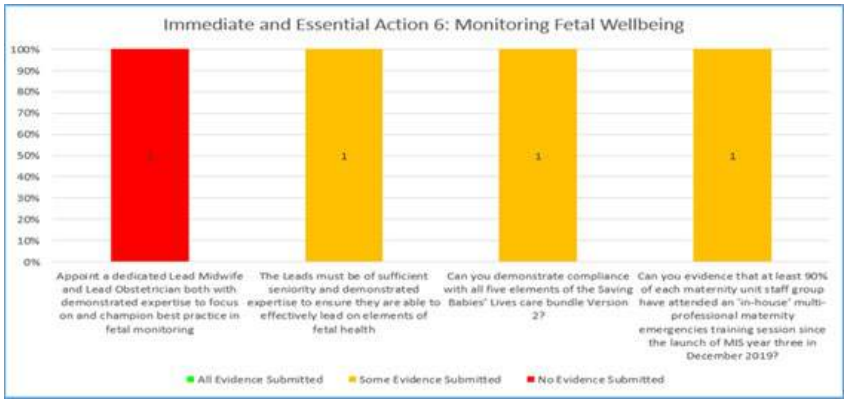
Hull University Teaching Hospitals NHS Trust

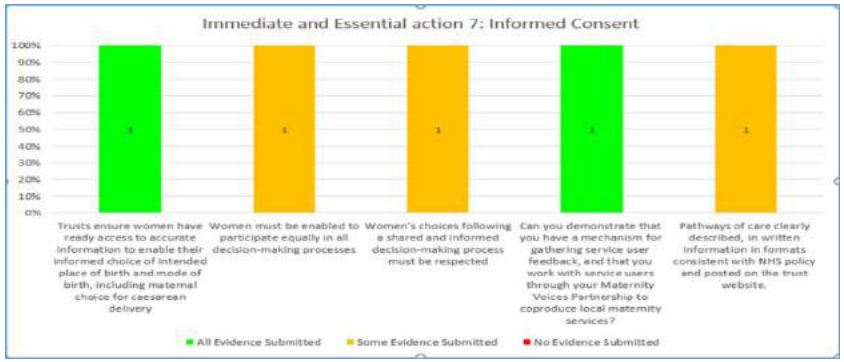


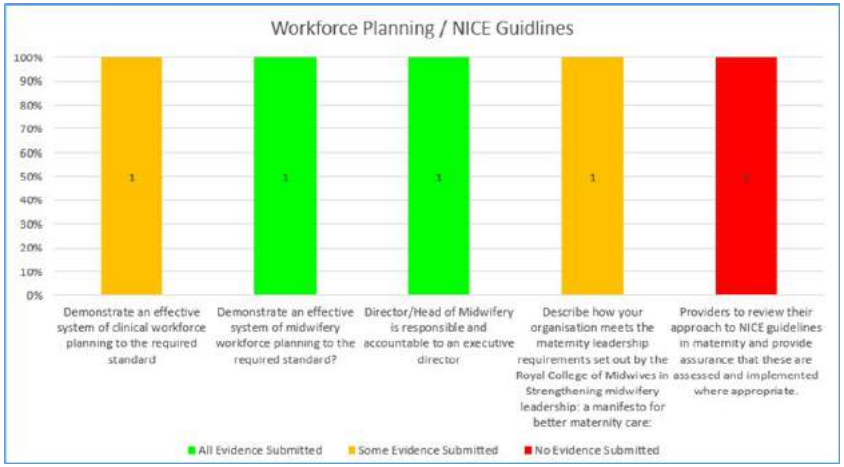


HUTH accepted the findings from the feedback as a true reflection of the evidence submitted to the Futures Platform on the 30 June 2021 and was a captured moment in time.









The maternity service received formal feedback from Tracey Cooper Regional Chief Midwife on Friday the 29 November 2021. Overall the feedback was positive with key areas for improvement identified locally, regionally and nationally. The service has already made improvements against the 7IEA.

The maternity service is working closely with midwifery managers, governance team, Local maternity system and quality team to implement the recommendations for the Ockenden report.

Key achievements (December 2020 – December 2021)

Hull University Teaching Hospitals NHS Trust

- Development of midwife led BCG clinics in line with Public Health England Guidance (guidelines developed, SoP, PGD and implementation of new ways of working)
- £60,000 funding received for 7 CTG monitors for ADU/ANC to support Dawes Redman assessment of Reduced Fetal Movements (RFM)
- £250,000 investment to fully implement SBLV2 (Uterine Artery Doppler scanning and Dedicated preterm birth clinic.
- Successful digital bid so that all maternity systems across the Humber Coast and Vale Local Maternity system (LMS) can move to new LMS wide digital system.
- Agreement and future procurement on centralised CTG monitoring on the labour ward
- Agreement for three more obstetric consultants – with a plan to move towards 24/7 consultant cover for maternity services.
- Implementation of the maternity and neonatal safety huddles on Labour ward twice a day
- A new dedicated preterm birth clinic and pathway of care for women
- HUTH is hosting an exciting LMS wide PNMH project with £600,000 worth of funding from NHS England for those women who have suffered loss/grief
- Successful recruitment of a new Parent Education Lead
- £50,000 funding from NHS England to support a lead Professional Midwifery Advocate (PMA) to provide pastoral support for new starters and existing staff.
- QR codes have been developed to support easy access to guidelines online – another step further to becoming paperless and more digital
- Implemented a level 7 frenulotomy module in collaboration with the University of Hull to ensure a service is provided for women within Humber Coast and Vale LMS. (Identified a Gap in service provision)

Key Priorities/Challenges (1/2)

Hull University Teaching Hospitals NHS Trust

- Meeting the midwifery staffing Gap identified in the 2021 Birthrate plus assessment
- To support, develop, enhance and strengthen a positive culture to ensure maternity services have highly functioning teams. Ongoing work with the Chief Nurse, Director of workforce, Nurse Director and HR colleagues.
- Implementing full all the five elements of the SBLV2 Care Bundle (Business case approved) – sonographers have been appointed and equipment purchased an extra scan room is being refurbished in the old IVF unit.
- Increasing consultant numbers to comply with RCOG curriculum guidance to achieve 24hr consultant cover on site.
- Elective LSCS capacity expansion – due to increase number of complex women
- Achieving year 4 Clinical Negligence Scheme for Trust (CNST) – significant implications for workforce, training, data submission and a more timely reviews of mortality
- Achieving the national ambition for Continuity of Carer (CoC) by 2023 “Put in place the building blocks by March 2022 so that CoC is the default model of care offered to all women by March 2023”
- Following the publication of Ockenden report HUTH has reviewed it services against the 7 Immediate and Essential Actions (IEAs) and specifically the 12 urgent clinical priorities.
    - HUTH in response to Ockenden submitted a bid for Circa £1.8million
    - HUTH received £179K full year effect (0.7WTE obstetrician/0.8WTE midwife)

7 Immediate and Essential Actions – Ongoing work at HUTH

2 Midwives have undertaken baby lifeline investigation training to support LMS wide investigations. 2 further places have been funded for 2022.

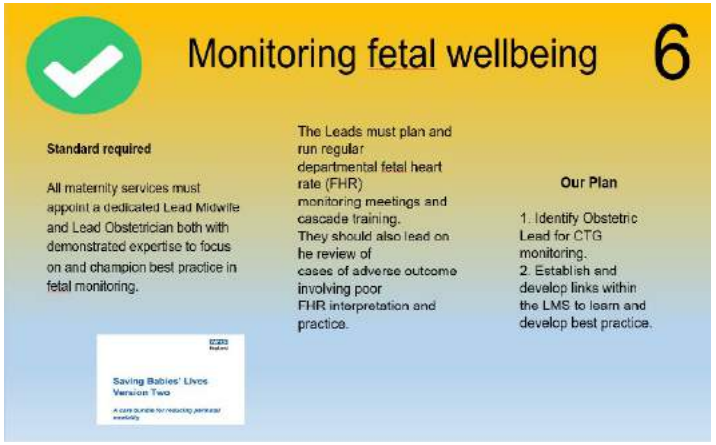
HUTH have two active MVP groups across Hull and the East riding. The maternity service have quarterly meetings with both MVP services. The service continues to receive regular feedback from women who use our service.

All maternity service must ensure that staff who work together train together. Year 4 CNST (Clinical Negligence Schemes for Trust) have set out clear objectives for training. This includes training on Saving Babies Lives Care Bundle, Fetal surveillance in labour, Maternity emergencies and multi-professional training, Personalised care, Care during labour and the immediate postnatal period and Neonatal life support

The Trust supported maternity service with an investment of £250,000. This funding was to support full implement of SBLV2 Care Bundle. HUTH has established a dedicated preterm birth clinic and has ongoing work to undertake Uterine artery Doppler Scanning. National work is ongoing to develop maternal medicine centres for women with complex health needs.

Undertake and record risk assessed at every antenatal contact. Humber Coast and Vale Local Maternity System (LMS) has been working with maternity systems to procured a regional wide digital system. The funding has been secured and this work with be starting in April 2022

HUTH is in the process or reviewing information on the maternity website and information leaflets to ensure information is up to date and correct. This work is in collaboration with MVP chairs and the clinical governance midwife



HUTH has 2 new CTG leads in line with Ockenden recommendations the midwifery Lead is Sue Nelsey and the medical Lead is Dr Yeap. They are both undertaking some fantastic work on improving CTG training compliance and supporting CTG clinical reviews. The LMS has secured funding for HUTH to install central CTG monitoring at a cost of £90,000 this will be coming soon

Ockenden Charter

NHS
Hull University Teaching Hospitals
NHS Trust

Charter Project Name: Maternity Services –Ockenden Work
Organisation/Division: Family & Women's Health Group

Project Sponsor: Julia Harrison-Mizon - Deputy COO
Project Leads: Lorraine Cooper - Head of Midwifery
Project Manager: Nilesh Mehta
Document Version and Date: January 2022 – Approved 18-10-21

Challenge/Benefit Statement:

This project will support the Health Group to deliver the 7 immediate and essential actions detailed below from the Ockenden report, providing a formal centrally located progress tracker and by providing structure and regular meetings to update on progress to-date.

1) Enhanced safety
Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.
2) Listening to women and families
Essential action - Maternity services must ensure that women and their families are listened to with their voices heard.
3) Staff training and working together
Essential action - Staff who work together must train together.
4) Managing complex pregnancy
Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.
5) Risk assessment throughout pregnancy
Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,
6) Monitoring fetal wellbeing
Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
7) Informed consent
Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

High Level Scope:

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones. The Ockenden report has provided an opportunity for parents and families to have their concerns heard, practices to review, lessons learnt and immediate and essential actions and improvements be implemented.

The Ockenden report presents the initial findings on an inquiry into maternity care at Shrewsbury and Telford NHS Trust following a letter from families raising concerns about significant harm and deaths of neonates and mothers. The initial review was of 23 families, this rapidly increased to 1,862 cases between 2000 and 2019. This review addresses 250 cases, the other case reviews are ongoing.

The 1st Ockenden report produced 7 immediate and essential actions which need to be implemented throughout every trust.

The project will seek to use change management and quality improvement methods to identify and address key issues with relevant processes and systems, including the use of The Hull Improvement Approach; The Model for Improvement (Three Key Questions); Plan-Do-Study-Act Cycle; Visual Management and the use of measuring over time specifically Run Charts +/- Statistical Process Control

Key Risks, Dependencies and Barriers:

Risks:

- Risk to patient safety of mother and baby if identified actions are not met.
- Risk to trust reputation and adverse financial impact.
- Risk that mothers and families may not always receive the required support if actions are not implemented
- Risk of poor patient experience if patients feel that they have not been listened to and involved in their care plan.
- Risk that patients may lose confidence in services.
- Risk of an emotional impact on staff when adverse events occur, may impact performance.

Anticipated Resources required:

Admin Support	Weekly Meetings (Agenda & Action Tracker)	
	Monthly Meetings (Agenda, Minutes & Action Tracker)	HIP Admin team – Monthly meeting agenda and action tracker
Programme Manager/Senior Project Manager/Project Manager	Julia Elstob – Programme manager Nilesh Mehta – Project Manager	

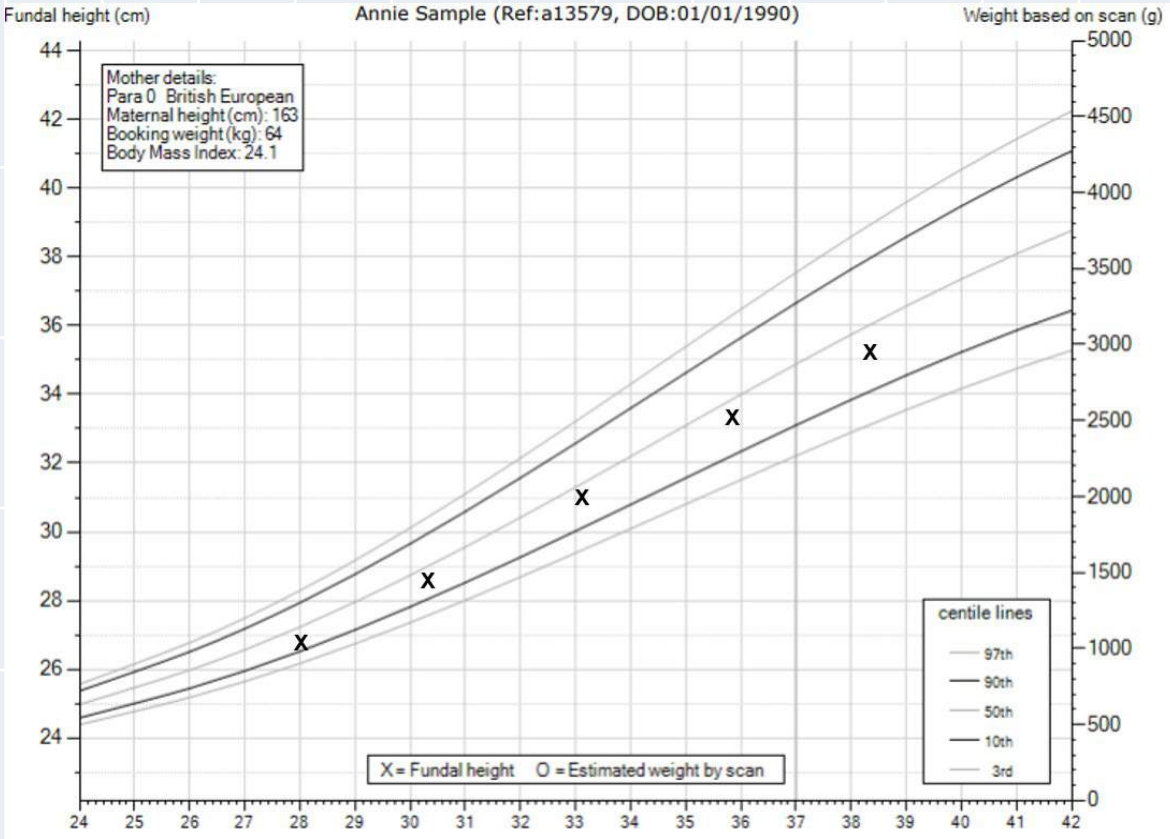
Charter Project Name: Maternity Services –Ockenden Work
Organisation/Division: Family & Women's Health Group

Project Sponsor: Julia Harrison-Mizon - Deputy COO
Project Leads: Lorraine Cooper - Head of Midwifery
Project Manager: Nilesh Mehta
Document Version and Date: January 2022 – Approved 18-10-21

<table>
<tr><td rowspan="2">Dependencies:
All partners/teams are required to engage & work together timely to achieve desired outcomes.
Clear communication and escalation processes required for patient and colleague feedback.
Training capacity within the teams to enable colleagues to confidently understand new processes.
Resource availability and competency assessments to take on roles of responsibility to deliver the required outcomes.
Recruitment and retention of staff.
Environment & system to be able to deliver multi-disciplinary training.
Collaborative working with neighbouring trust networks and CCGS.
Capacity to deliver clinics and care as required.
Sufficient funding.
Barriers:
Insufficient active sponsorship of commitment to the development of the pathway per organisation.
Poor communication and engagement of staff needed to progress actions.
Fear of change/unwillingness to adopt new ways of working could hinder the project.
Ensuring information to patients is accessible in numerous languages & formats</td><td>Data Support</td><td>Benchmarking of key improvement metrics – Tom Wale.
Potential build of new performance dashboard for project KPIs.</td></tr>
<tr><td>Comms Support</td><td>Comms plan/stakeholder analysis to be carried out.
Possible support required with comms/engagement.
Comms will be required to engage with patients and inform of the change and sustainability/feedback plan.</td></tr>
<tr><td>Deliverables: By the end of Jan 2023</td><td colspan="2">Milestones and timescales:</td></tr>
<tr><td>To assist the health group to create and develop a comprehensive stock-take document and action tracker.
To support the health group and drive the delivery of the actions plans based on original submission and review, to deliver the immediate and essential actions, as identified within the Ockenden report by the end of Jan 2022 (specific action plans detailed in action tracker).
To support the health group and drive the delivery of the actions plans based on the second review, expected to be received in the latter part of 2021 and to deliver any further immediate and essential actions, as required and within specified time frames (TBC)</td><td>Project start date:
Stock takes of current actions.
Delivery of actions.
2nd review of Ockenden feedback.</td><td>Date: by the end of Oct 2021
Date: by the end of June 2022
Date: by the end of Jan 2023</td></tr>
<tr><td>In Scope:</td><td colspan="2">Out of Scope:</td></tr>
<tr><td>All elements that fall within the scope of the Immediate and Essential actions, to ensure compliance.</td><td colspan="2">Any work that does not directly impact the immediate and essential actions from the Ockenden report at this time.
Creation of SOPS or clinical documentation
IT transformation or software creation</td></tr>
<tr><td>Project Team:</td><td colspan="2">Project Team Accountable for Delivery to:</td></tr>
<tr><td>Lorraine Cooper – Head of Midwifery
Jayne Gregory – Clinical governance midwife
Julia Chambers – Training and development
Leah Coneyworth – Central governance from SI
Mel Carr – Nurse director
Lisa Pearce – Divisional General Manager
Uma Rajesh– Clinical Lead
Aparna Manou - Clinical lead for neonates
Angela Rymer - Labour ward matron
Sallie Ward – LMNS (sallie.ward1@NHS.NET)
Nilesh Mehta – Quality Lead</td><td colspan="2">Families and Women's Finance and improvement committee
Specific elements will report via
: LMNS (Local Maternity Network System)
: HSIB (Health Safety Investigation Branch)
: Health group monthly governance meetings
: Health group safety champion meetings
: Perinatal Mortality Review Meeting (PMRT)
: Trust board
: Maternity Voices Partnership (MVP)
: Clinical Negligence Scheme for Trusts (CNST)</td></tr>
</table>

Stillbirth Data 2016-21

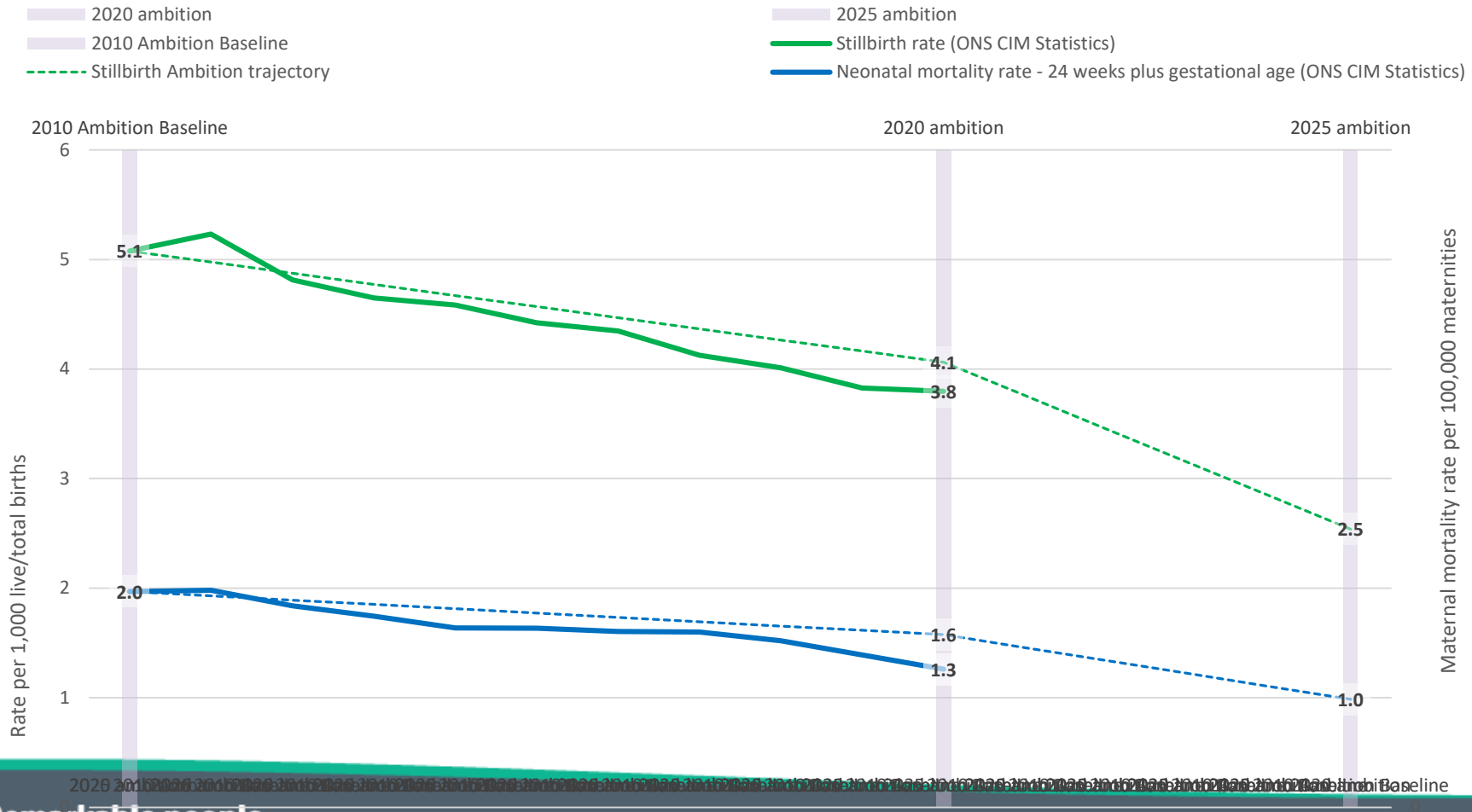
	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total	
Stillbirths 2020/21													14	
Stillbirths 2019/20													20	
Stillbirths 2018/19													16	
Stillbirths 2017/18													17	
Stillbirths 2016/17													27	



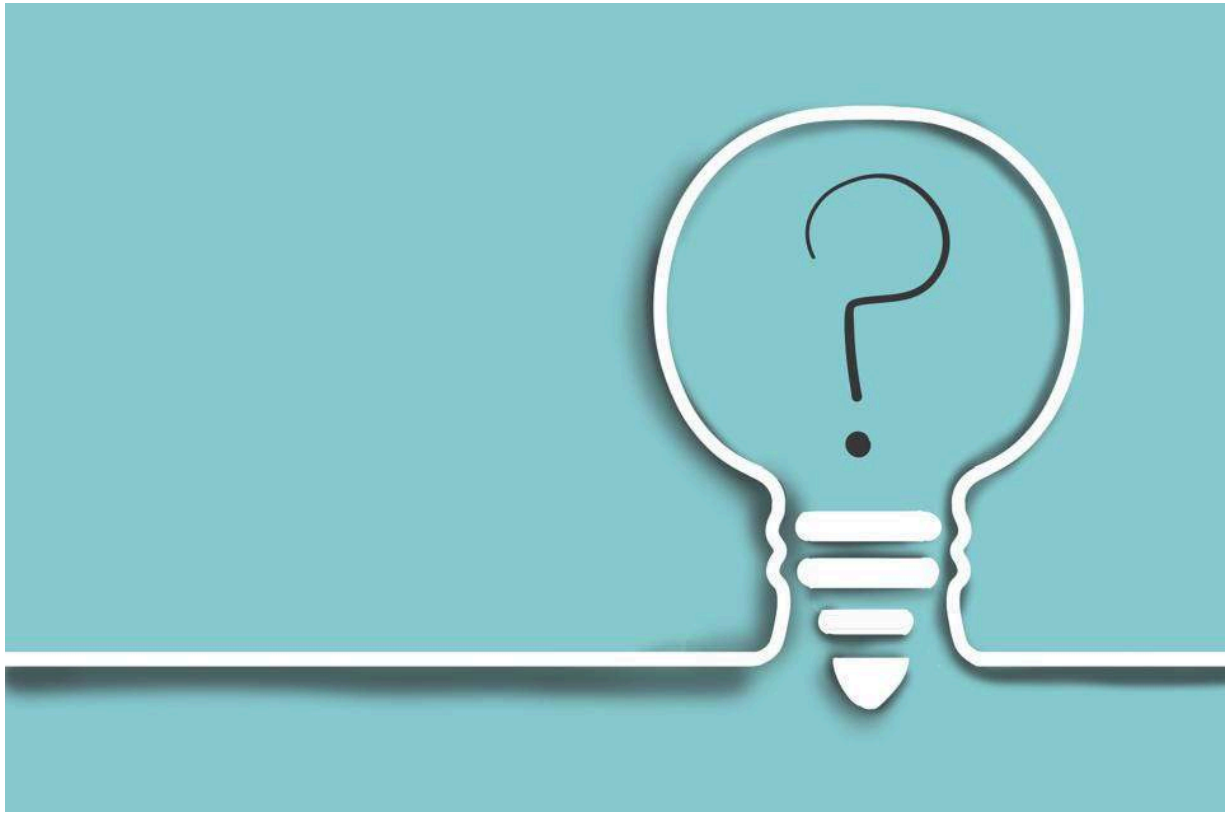
HUTH have nearly halved there stillbirth rates since 2016

ONS Child and Infant Mortality Statistics published on 17th February 2022 include stillbirth and neonatal mortality rates for 2020, which indicate achievement of the associated National Maternity Safety Ambitions:

- The stillbirth rate has reduced by 25.2% from 5.1 per 1000 births in 2010 to 3.8 per 1000 births, equivalent of 752 fewer stillbirths in 2020.
- The neonatal mortality rate has reduced by 36.0% from 2.0 per 1000 live births in 2010 to 1.3 per 1000 live births, equivalent to 412 fewer neonatal deaths in 2020.



Questions



Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8 March 2022
Title	Hull University Teaching Hospital NHS Trust - Ockenden Feedback, update on progress to date.				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee 28/02/2022				

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

Key Recommendations to be considered:

The Committee is requested to:

- Receive the report findings and identified quality improvements for HUTH
- Decide if any further information and/or assurance are required.

MATERNITY SERVICES
Update and progress against Ockenden 7 Immediate and Essential Actions

Executive Summary

1. This paper provides the committee with an overview of the position of this Trust in relation to the recommendations from the 7 Immediate and Essential Actions (IEA) from the Ockenden report published in December 2020.
2. The first requirement was for an initial declaration by the Chief Executive Officer against 12 specific urgent clinical priorities to be submitted to NHSI by December 2020, which was completed.
3. The second requirement is for the Trust to implement the full set of seven Ockenden Immediate and Essential Actions (IEA) and for the Trust Board to have oversight on the progression against the 7IEA.
4. An initial gap analysis has been completed when the actions were first published against the maternity services provided by Hull University teaching Hospital NHS Trust. The analysis of the information was in collaboration with the internal quality improvement team.
5. The organisation submitted its evidence via the Futures Platform on the 30 June 2021 and the Trust received RAG rating feedback on the 29 November 2021. (**appendix 1: HUTH Trust RAG rating**)
   HUTH RAG rating identified 5 Red areas for the organisation which are:
   - Evidence of twice daily consultant ward rounds.
   - Women with complex pregnancies must have a named consultant lead, Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
   - Ongoing work to develop maternal medicine centres (national/regional work).
   - Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. Incident investigations and reviews.
   - Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Audit to demonstrate all guidelines are in date.
6. The organisation is compliant or partially compliant with the majority of the Ockenden 7IEA and has set up a fortnightly working group, developed terms of reference, developed an Ockenden Charter and associated action plan. This project will support the Health Group to deliver the 7 immediate and essential actions detailed below from the Ockenden report, providing a formal centrally located progress tracker and by providing structure and regular meetings to update on progress to-date (**appendix 2: HUTH Ockenden Charter and appendix 4 – Ockenden Action Tracker**).
7. The ongoing project will seek to use change management and quality improvement methods to identify and address key issues with relevant processes and systems, including the use of the Quality Service Improvement Redesign (QSIR).
8. The assurance assessment tool has been reviewed at the Quality Committee, it has also been through the Local Maternity System (LMS) and shared with regional teams.
9. In order to support Board discussion there was a requirement for Trust to complete and take to the Board an assurance assessment tool. As part of that maternity assurance and assessment tool a review of compliance has been completed against the following as an overarching review of maternity service provision.
   - All seven IEAs of the Ockenden Report (Assurance Tool)
   - A current working Gap analysis
   - Review of NICE guidance relating to maternity
   - The last Care Quality Commission (CQC) Report
   - Review of the Morecambe Bay Report and Trust action plan
   - Undertaken a recent Birthrate Plus (BR+) assessment (December 2021)

Conclusion

Maternity services have undertaken a thorough review of the Ockenden report and key recommendations to ensure safety in maternity services. The Trust is complaint or partially complaint with the majority of the recommendations, a working group has been established to support further quality improvement work were required which will be reported internally and to NHSE and NHSI.

Recommendations

The Trust Board is asked to consider whether the assurance mechanism within the Trust are effective and, with the local maternity system (LMS) they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in this organisation.

1. Purpose of the Report

1.1. The purpose of this report is to provide assurance to the Trust Board that the maternity service has received and reviewed Ockenden feedback of evidence that was submitted via the Future NHS Collaborative Platform on the 30 June 2021 and enacted the recommendations and identified quality improvements.

2. Background

2.1. The Ockenden report was written following a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at that Trust.

2.2. The first terms of reference for the review were written in 2017 for a review comprising of 23 families. Since the review commenced more families contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. The terms of reference were amended in November 2019 to encompass over a thousand families.

2.3. Due to the size of the review the second and final independent report is due in 2022. Having performed the first 250 clinical reviews the review team identified emerging themes. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible

3. Ockenden Report

3.1. The Ockenden report was published on the 10 December 2020.The report identified a number of important themes which must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement the sharing of emerging findings formed Local Actions for Learning and made early recommendations which were seen as Immediate and Essential Actions. The report highlighted 7 Immediate and essential Actions which included:

1. Enhanced Safety
2. Listening to Women and Their Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent

3.2. There are seven immediate and essential actions (IEAs) within the Ockenden report comprising 12 specific urgent clinical priorities. An initial gap analysis has been undertaken with the input of the Trust maternity safety champion, Local Maternity System and the executive leads.

3.3. In fulfilment of requirements a declaration against the immediate actions was submitted as required on the 21st December 2020 (**appendix 3: HUTH Initial Declaration**).

3.4. One year on organisations are being asked to review and discuss local findings at Trust Board Level before the end of March 2022. Local reviews should incorporate progress against the 7IEAs and workforce plans outlined in the Ockenden report and the plan to ensure they are working towards full compliance.

4. Enhanced Safety

4.1. The Local Maternity System has supported a number of staff to undertake Baby Lifeline Investigation training to support senior clinicians/midwives to undertake external Serious Incident Investigations (SI). This will enable external clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

4.2. HUTH is fully compliant with the standards for Perinatal Mortality reviews via the MBRRACE UK reporting tool and a quarterly report is submitted to the Trust Board. The Trust in line with national guidance implement the Perinatal Clinical Quality Surveillance Model. The LMS along with clinical leads have established monthly PQSAG meetings to learn from LMS wide incidents. Maternity data and dashboards are shared with the LMS every three months and an over of SIs are discussed and shared quarterly at the LMS delivery Board meetings.

4.3. All maternity SI cases which meet the HSIB reporting criteria have been submitted to HSIB – these are generally reported within 72 hours (there is no standard). We have continued to report all cases to HSIB during the response to the Covid pandemic – with HSIB selecting cases of confirmed diagnosis HIE Grade 2 or above for full investigation.

4.4. Consultants do undertake twice daily ward rounds Monday – Thursday 5-6pm and Friday – Sunday 8-pm, the time difference is due to only having a resident on call consultant on Friday- Sunday. HUTH has support funding for a further three consultant obstetricians so the service can in time work toward 24/7 resident consultant cover.

5. Listening To Women

5.1. Trust safety champions meet bimonthly with Board level champions, Log of attendees and core membership. Safety Champion meetings have a set agenda, ToR that have been reviewed/updated and standard agenda items include maternity and neonatal dashboard data, quarterly reports (PMRT, ATAIN, Growth Assessment, BAPM 7)

5.2. HUTH has identified a Non-Executive Director whose role and responsibilities will be developed and refined in line with issued guidance to support the Board maternity safety champion.

5.3. Currently there are two active Maternity Voices Partnerships (MVP) operating within the Hull and East Riding region. The Hull MVP has been in operation since 2018 and in East Riding since May 2019. Annual events held over the last two years (Hull in 2019 & Goole in 2020) both used the 'whose shoes' tool to engage and listen to women who have used our services. From listening to women, both events identified opportunities for improvements in maternity service; the identified improvements included: Developed a virtual tour showcasing the maternity offer at HUTH using modern virtual reality technology – this was implemented with effect from October 2019. Implemented a monthly carousel event with key stakeholders as "a one stop shop" to enable women to receive important information such as choice of place of birth, feeding choices, immunisation, safe sleeping demonstrations as examples; these events commenced 2018.

6. Staff Training and Working Together

6.1. The maternity services has developed a Training Needs Analysis all staff will receive at the beginning in March 2022 and must be completed no later than the 31 March 2022.

6.2. Mandatory training continues in line with NHS Resolution guidance and the organisation is working towards year four of the Clinical Negligence Schemes for Trust (CNST). The Omnicron variant has placed significant pressure on the training trajectories for 2022-23, some staff training has been cancelled in January due to high absence rates both midwifery and medical.

6.3. HUTH received some Ockenden funding which is being used to support Fetal Wellbeing and CTG training.

7. Managing Complex Pregnancies

7.1. A Yorkshire and Humber working group has been established to support the development of maternal medicine specialist centres. The Implementation Group continues to meet monthly and is supported by the Clinical Pathways Task & Finish Group. The current pathways from the region are being collated and work continues on the following: Epilepsy, Thyroid, Diabetes, Rheumatology and Gastroenterology. The group will agree the prioritisation of the remaining speciality pathways, inviting subject matter experts to review and agree appropriate medical conditions and agree the best outline approach. Local variation will still be possible. The workforce model has gained approval from the three LMS Boards and the NEY Regional MTP Board and commissioning discussions are underway to take this forward. Job descriptions for roles have been sourced from other regions and are currently being worked on by the team to meet the needs of the Maternal Medicine Network. An additional £60k of 21/22 funding to support implementation has now been granted with funds being transferred in the January allocation.

7.2. Women with complex pregnancies must have a named consultant lead, Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.

8. Risk assessment through pregnancy

8.1. Initial risk assessment via the booking in process utilising the HUTH Guideline: 422 – BOOKING APPOINTMENT & SUPPORTING ANTENATAL CARE GUIDELINE. Using this guideline women are categorised on a midwifery led or consultant led care pathway.

8.2. Throughout the maternity journey women who deviate from the initial assessment are reviewed and re-categorised to the pathway accordingly.

8.3. The LMS has secured funding to move to an LMS wide new digital system (Clevermed – Badgernet) this will support the maternity service move towards a paperless system and to capture information more accurately. The system will also support women to have digital access to their records.

9. Monitoring Fetal Wellbeing

9.1. HUTH has an appointed dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The services is required to provide copies of rotas / off duties to demonstrate they are given dedicated time.

9.2. HUTH has implemented the Dawes Redman Criteria for reduced fetal movements the Trust has supported the purchase of 7 CTG monitors for the Antenatal day Unit at a cost of circa £60,000.

9.3. The LMS within the digital bid has secured funding for HUTH to purchase and install central CTG monitoring which will provide an overview to clinicians working on the labour ward.

10. Informed Consent

10.1. HUTH along with MVP chairs needs to review all written and digital information to ensure literature is coproduced. This is the only piece of work that is currently off track due to the COVID-19 pandemic. As part of the

trust's response to the Covid-19 pandemic, supported by the Maternity Transformation Board and local MVPs, the 'Ask The Midwife' messaging service was launched on 30th March 2020. The purpose of this service is three pronged:

- To provide an additional method for women to be able to gain advice from a registered midwife without face to face contact thus providing reassurance.
- To share consistent and accurate messages in relation to changes within the maternity services to a wide audience, especially important due to frequent guidance changes.
- To divert workload away from the clinical environment (either in the form of telephone calls or face to face attendances) so that staff in those environments can concentrate on providing clinical care.

11. Workforce

11.1**.** HUTH in line with national guidance has undertaken a Birthrate plus assessment using three months casemix data for the months of April to June 2021. The Birthrate plus Workforce Planning system provides each maternity service with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. It also provides each service with its own individual ratios of hospital births per whole time equivalent midwife and the number of cases and home births per wte community midwife. This allows each service to apply its own allowances for holiday, sickness and study leave and for time spent in travel by community staff. A 21.6% uplift was applied to cover annual, sickness and study leave has been included in the staffing calculations, and 12.5% travel allowance.

The report identified the percentage of women in Categories IV and V has increased from the 2018 data, and most noticeably in Category V (High category). The Delivery Suite casemix has 74.3% in the 2 highest categories whereas in 2018, it was 66.5% of which 35.8% was in IV and 30.7% in V, an increase of 7.8%. The higher the casemix, the more clinical staffing is required to ensure women receive 1 to 1 care in labour and delivery as a minimum but also to provide additional support as necessary.

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 DS % Casemix	7.9	14.3	3.5	35.4	38.9
	25.7%			74.3%	
2018 DS % Casemix	33.5%			66.5%	
2021 Generic % Casemix	11.8	21.3	3.0	30.5	33.4
(Includes Birth Centre)	36.1%			63.9%	
2018 Generic % Casemix	42.0%			58.0%	

Casemix Table 1

The 2021 Birthrate Plus Report identified Annual Activity based on the FY 2020/2021 total births has fallen to 4814 total birth rate. The 2021 report has identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey. Hull University Teaching Hospitals NHS Trust 2021 Birthrate Plus Report recommends the midwifery budget to be set at 204.80wte Bands 2-8, compared to the funded establishment of 179.65wte resulting in a negative variance of 25.15wte. The service will seek approval from the Family and Women's Triumvirate to proceed with a business case in order to support the increase in the midwifery workforce as identified in the 2021 Birthrate Plus Report.

12. Conclusion

Maternity services have undertaken a thorough review of the Ockenden report and key recommendations to ensure safety in maternity services. The Trust is complaint or partially complaint with the majority of the recommendations, a working group has been established to support further quality improvement work were required which will be reported internally and to NHSE and NHSI. The Trust Board is asked to reflect and to consider on whether the assurance mechanisms within this Trust are effective and, with the local maternity system (LMS) and do they seek further assurance.

Lorraine Cooper Head of Midwifery

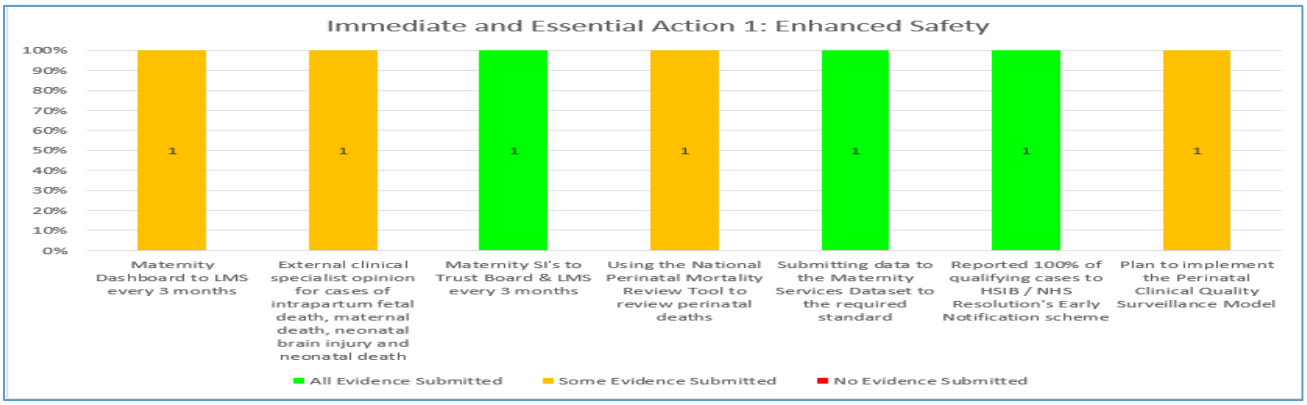
Appendix 1 - HUTH RAG Rating

Methodology and Review of the Evidence
As part of phase 2 of the Ockenden review of maternity services, providers were required to submit their evidence via the Future NHS Collaborative Platform to show that they have enacted the recommendations. This was in the form of documents such as standard operating procedures (SoPs), board minutes, dashboards, patient posters etc.

The team from Midlands & Lancashire CSU (MLCSU) reviewed the evidence provided and determined whether the provider had submitted the evidence (Yes) or not submitted the evidence (No). The evidence was not assessed for quality or clinical appropriateness, rather it was a Yes/No exercise to whether the evidence had been submitted.

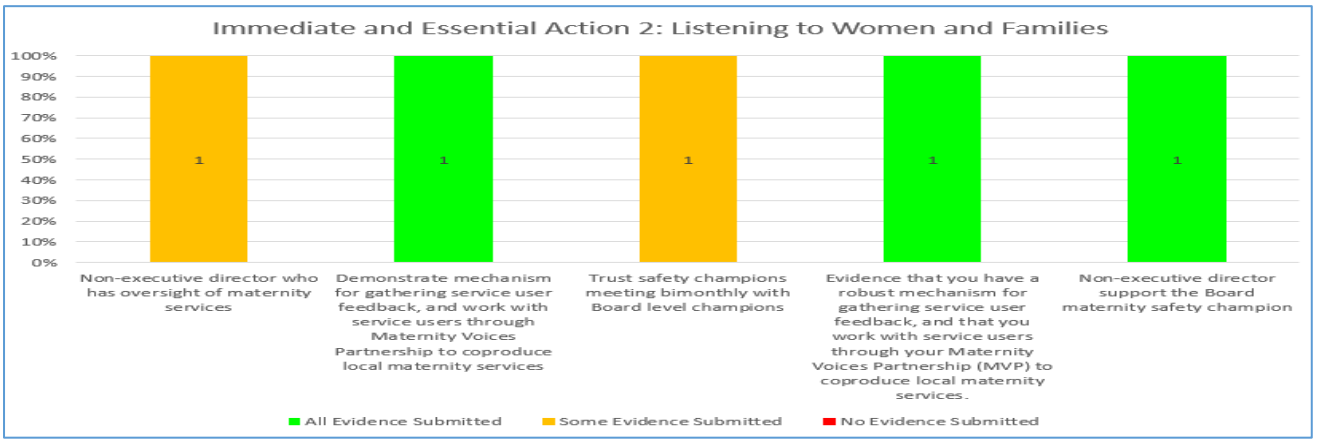
Evidence Marked as 'Yes' files were clearly labelled to which evidence it related to, when looking at the file it matched it's description (i.e. SOPs actually were SOPs). Some evidence applied to several actions (for example MVP involvement). If evidence was given once, 'Yes' was applied to all instances this was required.

Evidence Marked as 'No' they could not see the evidence. In some cases multiple files were uploaded without indication to what evidence they applied to (and therefore could have been missed). In some cases the evidence was not there. Where the evidence content did not match what was needed. For example e-mails or screen shots of clinical systems instead of SOPs.



Actions/Quality Improvements - IEA1 (Enhanced Safety)

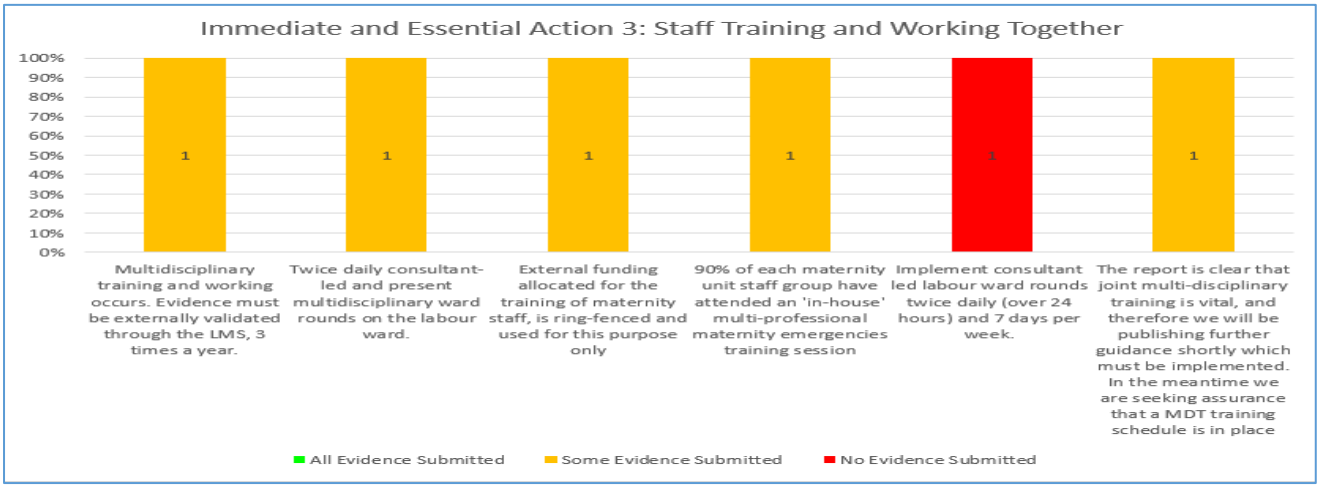
- External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death- Audit to demonstrate this takes place.
- Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
- Plan to implement the Perinatal Clinical Quality Surveillance Model. LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.
- Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.
- Maternity dashboards to be shared with the LMS every 3 months



Actions/Quality Improvements - IEA2 (Listening to Women and Their Families)

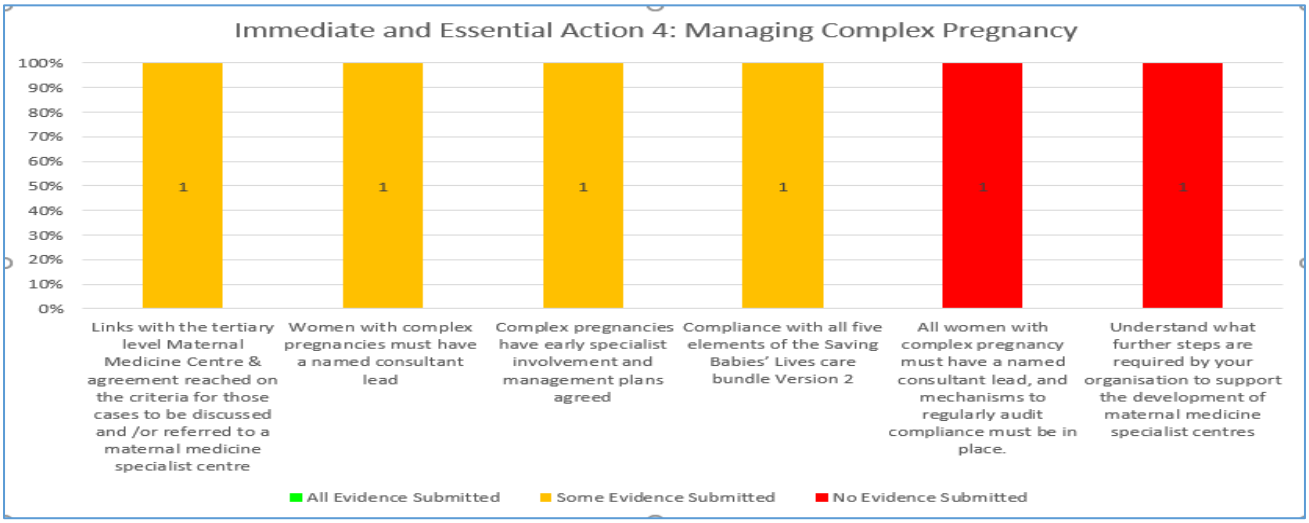
- Evidence of ward to board and board to ward activities e.g. NED walk around and subsequent actions

- Trust safety champions meeting bimonthly with Board level champions, Log of attendees and core membership. SOP that includes role descriptors for all key members who attend by-monthly safety meetings.



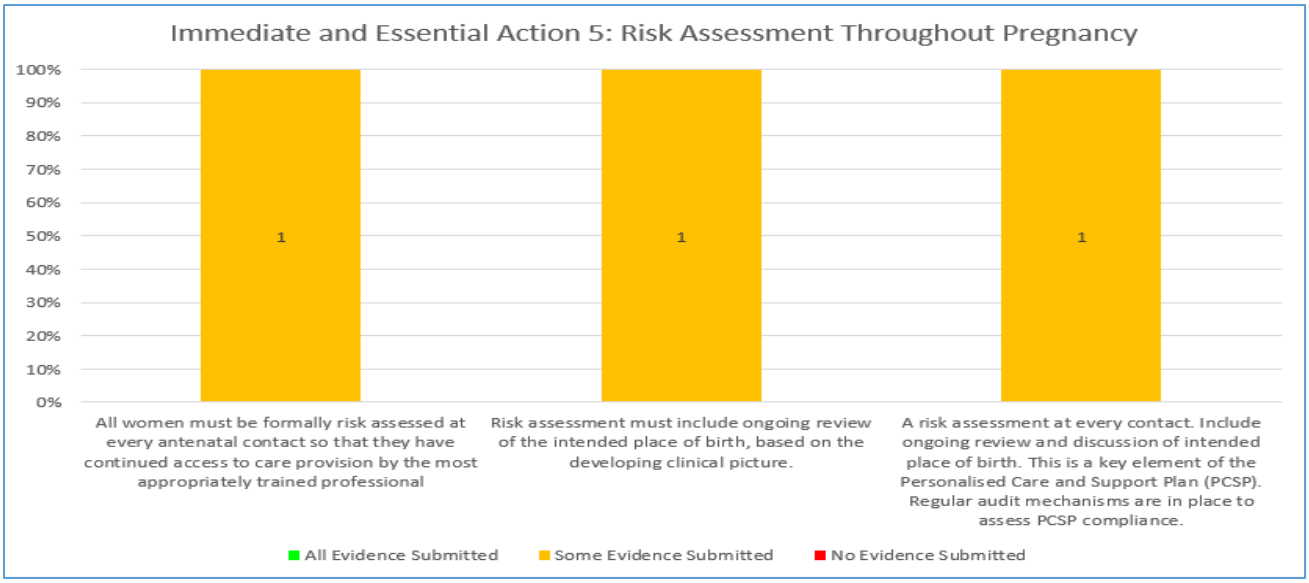
Actions/Quality Improvements – IEA3 (Staff Training and Working Together)

- A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.
- Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)
- External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. Confirmation from Directors of Finance.



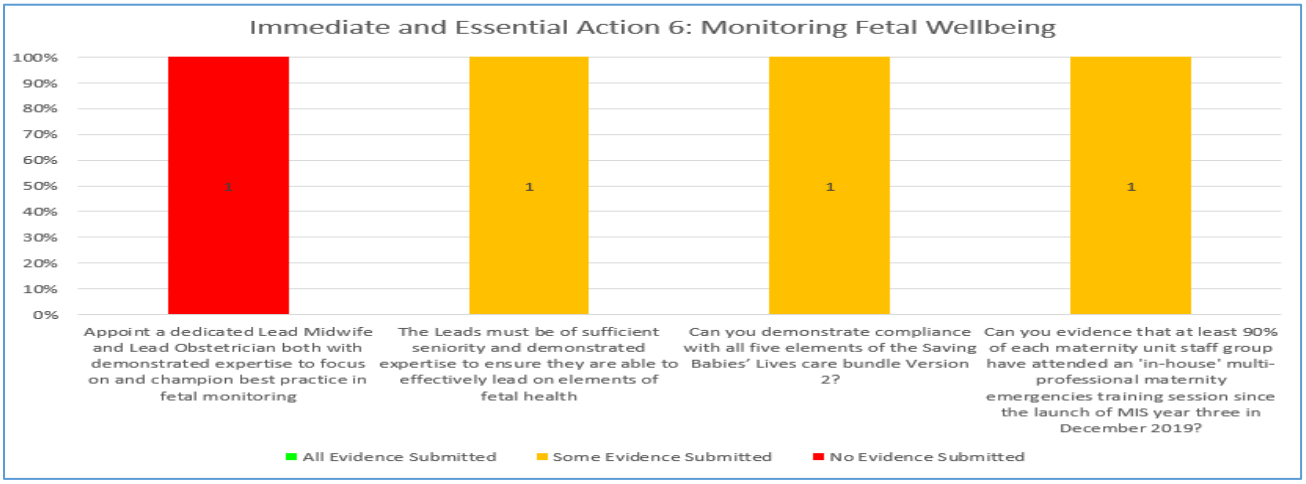
Actions/Quality Improvements – IEA4 (Managing Complex Pregnancy)

- Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians.
- Women with complex pregnancies must have a named consultant lead, Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
- Complex pregnancies have early specialist involvement and management plans agreed, Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.
- SOP that states women with complex pregnancies must have a named consultant lead. Submission of an audit plan to regularly audit compliance.
- Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres. The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.



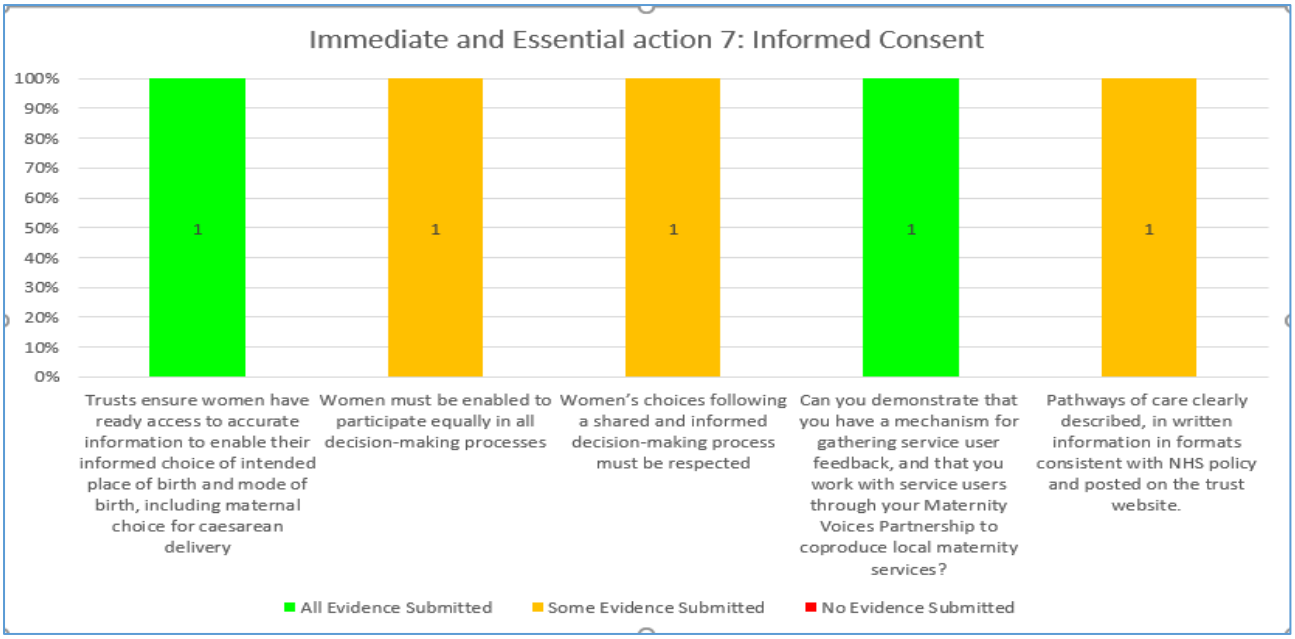
Actions/Quality Improvements – IEA5 (Risk Assessment throughout Pregnancy)

- Review and discussed and documented intended place of birth at every visit.
- SOP that includes review of intended place of birth.
- SOP to describe risk assessment being undertaken at every contact.



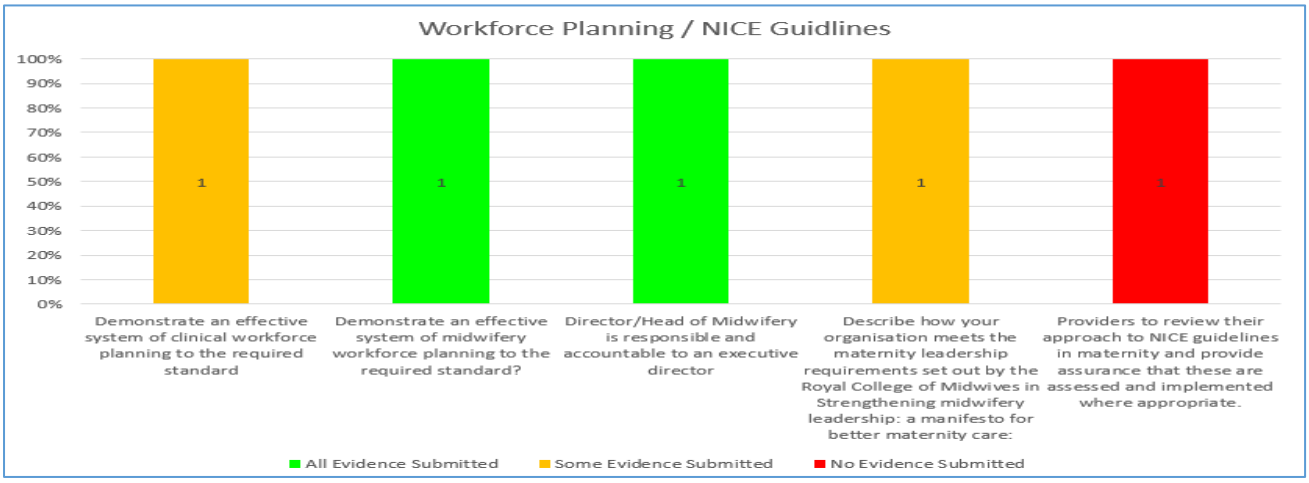
Actions/Quality Improvements – IEA6 (Monitoring Fetal Wellbeing)

- Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. Incident investigations and reviews. Name of dedicated Lead Midwife and Lead Obstetrician.
- Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post.
- Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g. clinical supervision.



Actions/Quality Improvements – IEA7 (Informed Consent)

- Women must be enabled to participate equally in all decision-making processes, an audit of 1% of notes demonstrating compliance. CQC survey and associated action plans.
- An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.
- Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Co-produced action plan to address gaps identified.



Actions/Quality Improvements (Workforce Planning and NICE Guidance)

- Demonstrate an effective system of clinical workforce planning to the required standard, Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan.
- Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Audit to demonstrate all guidelines are in date.

Appendix 2

Charter Project Name: Maternity Services –Ockenden Work
Organisation/Division: Family & Women's Health Group

Project Sponsor: Julia Harrison-Mizon - Deputy COO
Project Leads: Lorraine Cooper - Head of Midwifery
Project Manager: Nilesh Mehta
Document Version and Date: January 2022 – Approved 18-10-21

Challenge/Benefit Statement:	**High Level Scope:**
This project will support the Health Group to deliver the 7 immediate and essential actions detailed below from the Ockenden report, providing a formal centrally located progress tracker and by providing structure and regular meetings to update on progress to-date. **1) Enhanced safety** Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. **2) Listening to women and families** Essential action - Maternity services must ensure that women and their families are listened to with their voices heard. **3) Staff training and working together** Essential action - Staff who work together must train together. **4) Managing complex pregnancy** Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. **5) Risk assessment throughout pregnancy** Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway, **6) Monitoring fetal wellbeing** Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. **7) Informed consent** Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones. The Ockenden report has provided an opportunity for parents and families to have their concerns heard, practices to review, lessons learnt and immediate and essential actions and improvements be implemented. The Ockenden report presents the initial findings on an inquiry into maternity care at Shrewsbury and Telford NHS Trust following a letter from families raising concerns about significant harm and deaths of neonates and mothers. The initial review was of 23 families, this rapidly increased to 1,862 cases between 2000 and 2019. This review addresses 250 cases, the other case reviews are ongoing. The 1st Ockenden report produced 7 immediate and essential actions which need to be implemented throughout every trust. The project will seek to use change management and quality improvement methods to identify and address key issues with relevant processes and systems, including the use of The Hull Improvement Approach; The Model for Improvement (Three Key Questions); Plan-Do-Study-Act Cycle; Visual Management and the use of measuring over time specifically Run Charts +/- Statistical Process Control

Key Risks, Dependencies and Barriers:	**Anticipated Resources required:**		
Risks: • Risk to patient safety of mother and baby if identified actions are not met. • Risk to trust reputation and adverse financial impact. • Risk that mothers and families may not always receive the required support if actions are not implemented • Risk of poor patient experience if patients feel that they have not been listened to and involved in their care plan. • Risk that patients may lose confidence in services. • Risk of an emotional impact on staff when adverse events occur, may impact performance.	**Admin Support**	Weekly Meetings (Agenda & Action Tracker)	
		Monthly Meetings (Agenda, Minutes & Action Tracker)	HIP Admin team – Monthly meeting agenda and action tracker
	Programme Manager/Senior Project Manager/Project Manager	Julia Elstob – Programme manager Nilesh Mehta – Project Manager	

Charter Project Name: Maternity Services –Ockenden Work
Organisation/Division: Family & Women's Health Group

Project Sponsor: Julia Harrison-Mizon - Deputy COO
Project Leads: Lorraine Cooper - Head of Midwifery
Project Manager: Nilesh Mehta
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Dependencies: • All partners/teams are required to engage & work together timely to achieve desired outcomes. • Clear communication and escalation processes required for patient and colleague feedback. • Training capacity within the teams to enable colleagues to confidently understand new processes. • Resource availability and competency assessments to take on roles of responsibility to deliver the required outcomes. • Recruitment and retention of staff. • Environment & system to be able to deliver multi-disciplinary training. • Collaborative working with neighbouring trust networks and CCGS. • Capacity to deliver clinics and care as required. • Sufficient funding. **Barriers:** • Insufficient active sponsorship of commitment to the development of the pathway per organisation. • Poor communication and engagement of staff needed to progress actions. • Fear of change/unwillingness to adopt new ways of working could hinder the project. • Ensuring information to patients is accessible in numerous languages & formats	**Data Support**	• Benchmarking of key improvement metrics – Tom Wale. • Potential build of new performance dashboard for project KPIs.
	Comms Support	• Comms plan/stakeholder analysis to be carried out. • Possible support required with comms/engagement. • Comms will be required to engage with patients and inform of the change and sustainability/feedback plan.

Deliverables: By the end of Jan 2023	**Milestones and timescales:**	
1. To assist the health group to create and develop a comprehensive stock-take document and action tracker. 2. To support the health group and drive the delivery of the actions plans based on original submission and review, to deliver the immediate and essential actions, as identified within the Ockenden report by the end of Jan 2022 (specific action plans detailed in action tracker). 3. To support the health group and drive the delivery of the actions plans based on the second review, expected to be received in the latter part of 2021 and to deliver any further immediate and essential actions, as required and within specified time frames (TBC)	Project start date: 1. Stock takes of current actions. 2. Delivery of actions. 3. 2nd review of Ockenden feedback.	Date: by the end of Oct 2021 Date: by the end of June 2022 Date: by the end of Jan 2023

In Scope:	**Out of Scope:**
All elements that fall within the scope of the Immediate and Essential actions, to ensure compliance.	Any work that does not directly impact the immediate and essential actions from the Ockenden report at this time. Creation of SOPS or clinical documentation IT transformation or software creation

Project Team:	**Project Team Accountable for Delivery to:**
Lorraine Cooper – Head of Midwifery Jayne Gregory – Clinical governance midwife Julia Chambers – Training and development Leah Coneyworth – Central governance from SI Mel Carr – Nurse director Lisa Pearce – Divisional General Manager Uma Rajesh– Clinical Lead Aparna Manou - Clinical lead for neonates Angela Rymer - Labour ward matron Sallie Ward – LMNS (sallie.ward1@NHS.NET) Nilesh Mehta – Quality Lead	Families and Women's Finance and improvement committee Specific elements will report via : LMNS (Local Maternity Network System) : HSIB (Health Safety Investigation Branch) : Health group monthly governance meetings : Health group safety champion meetings : Perinatal Mortality Review Meeting (PMRT) : Trust board : Maternity Voices Partnership (MVP) : Clinical Negligence Scheme for Trusts (CNST)

Appendix 3
To:
Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement &
Chief Executive, NHS Improvement
Cc:
Danielle Lax;
Regional Maternity Transformation Programme Manager (North East & North West)

Dr Tracy Cooper
Chief Midwife for North East & Yorkshire, NHS England (North East & Yorkshire)

21st December 2020

Dear Colleague;
RE: OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION
Thank you for your letter dated 14 December 2020 requesting assurance from Hull University Teaching Hospitals NHS Trust (HUTH) as to the quality and safety of our Maternity Services against the 7 Immediate and Essential Actions (IEAs) of the Ockenden Review; and specifically the 12 urgent clinical priorities.
We have reviewed each of the 12 urgent clinical priorities from the IEAs; our assurance assessment and the supporting details as summarised below:

	Assurance Assessment	**Comments**
1: Enhanced Safety	**Overall; Yes**	
a) Perinatal Clinical Quality Surveillance Model	Yes	HUTH implemented the Perinatal Mortality Tool [PMRT] from April 2018 in line with National Guidance. The completion of the tool is undertaken through an MDT approach and we are currently compliant with all four standards, and this has been the case on a quarterly basis since inception.
b) SIs shared with Boards/LMS/HSIB	Partial	All Serious Incidents declared in maternity services are noted in the Trust Board Quality Report. All draft Serious Incidents are presented at the Trust's Serious Incident Committee (chaired by the Chief Nurse and deputy chair CMO). The reports are scrutinised and approved in this forum; this forum also notes any repeat themes and lessons learnt. From January 2021, all maternity SIs will be minuted as to whether it is a significant SI that requires sharing in full at Trust Board. All Serious Incidents are summarised and circulated across the Trust in the form of global email and discussed at Health Group Governance Meetings. All maternity SI cases which meet the HSIB reporting criteria have been submitted to HSIB – these are generally reported within 72 hours (there is no standard). We have continued to report all cases to HSIB during the response to the Covid pandemic – with HSIB selecting cases of confirmed diagnosis HIE Grade 2 or above for full investigation.

		A process will be developed and implemented with effect from 1 February 2021 which ensures that all maternity SIs are reported to the Trust Board and LMS Board on a monthly basis.
2: Listening to Women and their Families	**Overall; Yes**	
a) Robust service feedback mechanisms	Yes	Currently there are two active Maternity Voices Partnerships (MVP) operating within the Hull and East Riding region. The Hull MVP has been in operation since 2018 and in East Riding since May 2019. Annual events held over the last two years (Hull in 2019 & Goole in 2020) both used the 'whose shoes' tool to engage and listen to women who have used our services. From listening to women, both events identified opportunities for improvements in maternity service; the identified improvements included: • Developed a virtual tour showcasing the maternity offer at HUTH using modern virtual reality technology – this was implemented with effect from October 2019. • Implemented a monthly carousel event with key stakeholders as "a one stop shop" to enable women to receive important information such as choice of place of birth, feeding choices, immunisation, safe sleeping demonstrations as examples; these events commenced 2018. Due to the Covid pandemic these events have been suspended. However, work is underway to develop and publish videos based on the key public health messages with a view to publishing them on an accessible website. We expect this to be finalised by March 2021. All of the *whose shoes* event actions have fed back into the postnatal and choice/personalisation work streams which seek to involve women in co-production of care.
b) Exec/Non-Exec directors in place	Yes	HUTH has identified a Non-Executive Director whose role and responsibilities will be developed and refined in line with issued guidance to support the Board maternity safety champion.
3: Staff training and working together	**Overall; Yes**	
a) Consultant led ward rounds twice daily	Yes	The position for HUTH at 17 December 2020 is that a consultant-led ward is undertaken every morning seven days a week; with the resident consultant undertaking a ward round on Friday, Saturday and Sunday nights. With immediate effect (18 December 2020) we have implemented twice daily ward rounds Mon-Thurs in response to this review which will be provided by the daytime consultant.

		The plan is to change this responsibility to the evening team at the start of their shift once we have consultants resident 24/7 as per the RCOG curriculum paper. HUTH Maternity Services management team has developed a paper/business case identifying the consultant WTE gap in order to provide 24/7 consultant cover which will be progressed through the Trust governance processes.
b) MDT training schedule	Yes	Mandated MDT training is organised/ integrated within a planned programme; this is resourced within job plans and midwife rota tools allocation of Hull maternity service. As part of the response to the Covid pandemic the last full day PROMPT course was completed on the 13/03/2020, after which dates all face to face teaching was cancelled. A reduced face to face PROMPT course was re-commenced on the 18/06/2020. This is a half-day session covering Maternal Resuscitation, Neonatal Resuscitation, Maternal collapse and post-partum haemorrhage (PPH) scenarios. Other theory content is now undertaken as online learning on the K2 programme until the service can reinstate a full day sessions. A number of on-ward emergency simulations were undertaken as part of the planning, revised procedures and testing of systems & processes during the pandemic including PPH, maternal collapse, eclampsia, neonatal resuscitation including an MDT of staff from all areas. Current overall compliance with MDT training is at 80% with a plan to achieve full compliance by May 2021.
c) CNST funding ringfenced for maternity	Yes	HUTH maternity service achieved all 10 maternity safety standards for year two (2019-2020) CNST incentive scheme. The maternity CNST rebate in 2019 was £470K with a further £21K allocated from Trusts who were not compliant. Funding that has been allocated for the training of maternity staff, both pay costs to ensure the safety of the service is maintained and the cost of materials and facilities is ring-fenced within the budgets for the duration of the finance year. The service can also confirm that the first 2 years of the Maternity Incentive Scheme (MIS), has provided a refund allocation to be invested in additional senior medical sessions to support caesarean section capacity and the provision of anaesthetic operating department practitioners to receive enhanced training. Both of these allow the necessary workforce to support the safety and delivery of the maternity service. Additionally capital projects that have facilitated the labour and delivery ward

		and the MLU to deliver an elevated and consistent senior clinical management presence. The balance of the identified investments has been used to support the maternity efficiency programme; all investments are based on a non-recurrent basis due to the nature of the MIS funding allocation.
4: Managing complex pregnancy	**Overall; No**	
a) Named consultant lead/audit	Yes	Every woman risk assessed as a complex pregnancy has a named consultant and the risk assessments are reviewed appropriately.
b) Development of Maternal Medicine Centres	No	Networked maternal medicine services include pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the puerperium. The service specification identifies that the maternity service would require 0.5 WTE Obstetrician (maternal medicine) (this role may be fulfilled in some units by a team of obstetricians; however there is an identified clinical lead for Obstetrics which is separate from the Clinical Director role. WTE Obstetric Physician (this role may be fulfilled in some units by a team of physicians) and 1 WTE Midwife (Band 7). The clinical networks are working with organisation to identify and establish local hubs for maternal medicine. This process is ongoing in line with national work. HUTH are waiting for the outcome of the national work in regards to maternal medicine centres.
5: Risk assessment throughout pregnancy	**Overall; Yes**	
a) Risk assessment recorded at every contact	Yes	Initial risk assessment via the booking in process utilising the HUTH Guideline: *422 – BOOKING APPOINTMENT & SUPPORTING ANTENATAL CARE GUIDELINE*. Using this guideline women are categorised on a midwifery led or consultant led care pathway. Throughout the maternity journey women who deviate from the initial assessment are reviewed and re-categorised to the pathway accordingly. This information is captured and submitted via the MSDS data and reviewed monthly. HUTH are currently undertaking work with Continuity of Care teams on patient activation measures to manage risk, i.e. social prescribing support for high risk diabetic women.
6: Monitoring Fetal Wellbeing	**Overall; Yes**	
a) Second lead identified	Partial	HUTH has implement a 0.40 WTE lead midwife post in line with the Saving Babies Lives Care Bundle Version Two recommendations; the post-holder was appointed February 2020.

		There is currently no lead obstetrician in post however there is an Obstetric Clinical Lead who is responsible for training. There has not been a previous requirement for a specific lead consultant for CTG; in order to implement this, the service would require 0.5 PA per week. The service will develop a proposal for funding consideration through Trust governance processes in January 2021.
7: Informed Consent	**Overall; Yes**	
a) Pathways of care clearly described, on website	Yes	Patient information has been developed and is published on the Trust's maternity website pages - all key elements identified in the Chelsea and Westminster website have been included. A review of HUTH maternity information will be undertaken to share best practice by March 2021. As part of the trust's response to the Covid-19 pandemic, supported by the Maternity Transformation Board and local MVPs, the 'Ask The Midwife' messaging service was launched on 30th March 2020. The purpose of this service is three pronged: - To provide an additional method for women to be able to gain advice from a registered midwife without face to face contact thus providing reassurance - To share consistent and accurate messages in relation to changes within the maternity services to a wide audience, especially important due to frequent guidance changes - To divert workload away from the clinical environment (either in the form of telephone calls or face to face attendances) so that staff in those environments can concentrate on providing clinical care The service is available via the Trust's existing women and children's Facebook page. This is used as a medium to share messages on a large scale and also to answer individual messages privately. To date, 7637 messages have been sent to the service, 173 public posts were made which were shared 3931 times and have received 4474 public comments.

As Chief Executive Officer of Hull University Teaching Hospitals NHS Trust, I am happy to confirm that we are meeting all these standards or have the relevant plans in place for onward work as requested.

This summary and the supporting gap analyses completed have been reviewed myself, the Chief Nurse and the Head of Midwifery.

They were subsequently considered and independently validated by Becky Case, Local Maternity System Programme Lead, and signed off on behalf of the Humber, Coast and Vale Integrated Care System by the SRO Beverley Geary, and Deputy SRO Sarah Smyth on Monday 21st December 2020.

Ockenden Action Tracker

Project Group:
Lorraine Cooper - Head of Midwifery
Jayne Gregory - Clinical Governance Midwife
Julia Chambers - Training and Development
Mel Carr - Nurse Director
Leah Coneyworth - Central Governance
Lisa Pearce - Divisional General Manager
Jayshree Hingorani - Clinical Lead
Sallie Ward - LMNS
Julia Elstob - Programme Manager
Nils Mehta - Project Manager

No.	Immediate and Essential Action	Q. no.	Requirement	Assessment criteria	Minimum Evidence Requirements	Evidence location	Start date	Progress to date	Next steps	Lead (Role)	Lead Name	Due Date	Status
1	**Enhanced Safety Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**	**Q1**	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Confirmation of a Maternity Services Dashboard	SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	Located on LMS website	01/06/2020		n/a	**Data Analysts submit data to LMS/ODM**	**Mike Collins / Natalie Pearson**	**Monthly Monthly/Quarterly Nov 2021 Monthly**	**Complete - June 2021 09/02/21 LC- All data is shared on LMS. PQSAG meeting monthly and data/learning is shared. Data shared by maternity safety champions and LMS delivery board. Action complete.**
				Confirmation this is seen by the LMNS at least Quarterly	Submission of minutes and organogram, that shows how this takes place.	Internal & External organogram re where information is shared held on Y drive	01/06/2020	Internal & External organogram re where information is shared held on Y drive and part of Safety Culture Document	n/a	**Data Analysts submit data to LMS/ODM**	**Mike Collins / Natalie Pearson**	**Monthly/Quarterly**	**Complete**
					Minutes and agendas to identify regular review and use of common data dashboards and the response /	LMS Delivery Board Minutes, Actions & Agenda held on Y drive	over 10 years ago	All progress and actions reviewed at LMS Delivery Board, monthly	All progress and actions reviewed at LMS Delivery Board, monthly	**Clinical Governance Lead**	**Jayne Gregory**	**Monthly**	**Complete**
					Dashboard to be shared as evidence.	Y&H Dashboard sits with Obstetric Delivery Network (ODM) on Y drive F&WHG	Last 2 years	Maternity Services dashboard in existence and now up to date. Yorkshire & Humber Dashboard also in existence Specific Obstetric Dashboard in existence	To ensure this is kept up-to-date and reviewed annually. Next due for review Nov 2021.	**Clinical Governance Lead LMS**	**Jayne Gregory Laurie Palmer**	**Nov 2021**	**Complete**
		Q2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Confirmation of external specialist opinion on reviews	Policy or SOP which is in place for involving external clinical specialists in reviews.	Held on Y drive	Jan-21	New - from Ockenden report. LMS have created an external review process for investigation of SI's and being used/followed.	2 staff undergone Baby LifeLine Investigation bespoke training and undertake reviews as required, internally and externally, as part of wider regional group.	**Clinical Governance Lead Lead Midwife**	**Jayne Gregory Julia Chambers**	**Jan-21**	**Complete 09/02/22 LC - progress made, funded places in LMS for baby lifeline investigation training to undertake investigations across LMS. Training has taken place, and some investigations have started across LMS. Oversight and assurance in complex SIs - need confirmation from LMS. SW- the process is working for external investigations, York and NLAG have completed. York presented an SI for learning, work will continue. There is a meeting with clinical leads for how the actions will be taken forward.**
					Audit to demonstrate this takes place.	Audits with be held with LMS.	Jan-21	Investigations/audits undertaken as required.	LC to chase up progress with Becky Case.	**PMO Lead at LMS**	**Becky Case**	**Jun-22**	**Invite Becky Case to the next meeting. She is preparing paper for LMS.**
		Q3	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Confirmation that SI **GO TO Trust Board** (nab not a sub group of board such as Quality group) Confirmation that a *SUMMARY* of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	Internally - Guidelines within Incidents Policy - held on Pattie.- Central governance policy. Trust Board Agenda, Minutes and Governance Overview section on Y Drive.	Embedded	LMS SOP Submitted to Health group and Obstetric governance, Quality Committee, SI Committee. Trust Board updated Quarterly Chief Nurse/ Nurse Director updates at Operational Quality Committee Trust Board Quarterly Quality Report submitted to Quality Committee and then to Trust Board, monthly/quarterly	Chief Nurse/ Nurse Director updates at Operational Quality Committee Trust Board Quarterly	**Chief Nurse Nurse Director**	**Beverley Geary Mel Carr**	**Quarterly - ongoing**	**Complete**
					Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	Evidence on FWHG Y Drive	Sep 2018	As pre guidance from National Team at NHSE, TOR are in place. Quarterly report to Trust Board demonstrating compliance against National Standards.	Ongoing - CNST Standards have changed and all relevant staff informed. TOR to be reviewed (Nov 2021)and briefing paper prepared for Chief Nurse and sent Sep 2021. Ongoing - quarterly.	**Lead Bereavement Midwife Head of Midwifery**	**Sue Cooper Sue Cooper / Lorraine Cooper**	**Nov-21**	**09/02/22 CNS standards have been changed. LC- sharing SIs across the LMS, there is a standard agenda item on LMS board delivery meeting, including learning from SI's. New standards for CNST perinatal mortality has changed, last quarter report demonstrates HUTH are compliant with standards set out in CMST for PMRT.**
		Q5	Are you submitting data to the Maternity Services Dataset to the required standard?	**Confirmation that Monthly score card completed** (13 mandatory criteria)	• Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	Evidence on FWHG Y Drive Evidence of scorecard, Trust Board papers, Agenda for CNST on Y drive.	2018	We have met standards for Y3 Clinical Negligence Schemes for Trust (CNST)	Standards for Y4 have changed. Contact made with Data Analysts by Head of Midwifery. Sent up-to-date CNST document and spreadsheet of comparison Y3-Y4. Set up fortnightly meeting from end of September until submission June 2022. National Webinar scheduled to attend - 23/09/21 1-2pm and analysts invited. 23.09.21 -Twice monthly held at CNST regarding standards	**Head of Midwifery**	**Lorraine Cooper**	**Jun-22**	**09/02/22 LMS has secured funding for digital system. Procurement in March. A phased approach across 3 Trusts, complete by Summer.**
		Q6	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that **100% of** cases are reported to HSIB & NHS Resolution	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.			We have Quarterly meetings with HSIB. (Health Safety Investigation Branch. Presentation of discussions and ongoing HSIB cases provided. From Jan 2021, also discuss updates form HSIB at monthly Maternity Champion meeting and present to Trust Board and learning from HSIB. During Covid the process of reporting changed from NHS Resolution to HSIB and consequently 4 cases were missed however, on review 1 did not meet the criteria. 3 cases subsequently been reported and rejected from HSIB. Since Ockenden, now linked PMRT & HSIB onto Trust Datix system.	Ongoing	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing**	**Complete**
		Q7	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed off via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	All of FWHG Y drive (Ockenden Folder/CNST Folder)	Jan-21	Undertake monthly report of National Standards set out within the tool. Taken through Obstetric Governance. HG Governance , Quality Committee and Trust Board. Also established monthly meetings across LMS to discuss the tool.	Ongoing	**Lead Midwife**	**Julia Chambers**	**Ongoing**	**Complete**
		Q8	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	Internally - Guidelines within Incidents Policy - held on Pattie.- Central governance policy. Trust Board Agenda, Minutes and Governance Overview section on Y Drive.	Embedded	LMS SOP Submitted to Health group and Obstetric governance, Quality Committee, SI Committee. Trust Board updated Quarterly Chief Nurse/ Nurse Director updates at Operational Quality Committee Trust Board Quarterly Quality Report submitted to Quality Committee and then to Trust Board, monthly/quarterly	Chief Nurse/ Nurse Director updates at Operational Quality Committee Trust Board Quarterly	**Chief Nurse Nurse Director**	**Beverley Geary Mel Carr**	**Quarterly - ongoing**	**Complete**
			Terms of Reference for Safety Champion Meetings		Monthly Maternity Safety Champion meetings.	Held on Y drive	2018	Ongoing	Ongoing	**Chief Nurse**	**Beverley Geary**	**01/08/2021**	**Complete - July 2021**
			Ensure a robust governance process for reporting 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?		• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.			We have Quarterly meetings with HSIB. (Health Safety Investigation Branch. Presentation of discussions and ongoing HSIB cases provided. From Jan 2021, also discuss updates form HSIB at monthly Maternity Champion meeting and present to Trust Board and learning from HSIB. During Covid the process of reporting changed from NHS Resolution to HSIB and consequently 4 cases were missed however, on review 1 did not meet the criteria. 3 cases subsequently been reported and rejected from HSIB. Since Ockenden, now linked PMRT & HSIB onto Trust Datix	Ongoing	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing**	**Complete**

2	**Listening to women & families** **Essential action -** **Maternity services must ensure that women and their families are listened to with their voices heard.**	**Q9**	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	No expectation that this action is met - national guidance awaited		n/a		No expectation that this action is met - National Guidance awaited	No expectation that this action is met - National Guidance awaited			**Ongoing** **09/02/22 LC advised no update, work still ongoing nationally.**
		Q10	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	No expectation that this action is met - national guidance awaited		n/a		No expectation that this action is met - National Guidance awaited	No expectation that this action is met - National Guidance awaited			**Ongoing**
		Q11	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Confirmation of an identified Trust Board Non Exec	• Name of NED and date of appointment • Evidence of ward to board and board to ward activities e.g. NED walk around and subsequent actions • Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed • Evidence of how all voices are represented: • Evidence of link in to MVP; any other mechanisms (Maternity Voices Partnership) • NED JD	Information on Y Drive re role od Non Exec Director (NED) Word documents detailing our NED - Stuart Hall	01-Apr-21	Word documents detailing our NED - Stuart Hall				**Complete**
		Q12	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	• Local PMRT report. • PMRT trust board report. • Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	on Y Drive - Minutes and also in Bulleting following Maternity Safety Champions meetings.	Dec-20	Visit to unit undertaken by NED, Attended PMRT meeting in May 2021 and attends monthly Maternity Safety Champion meetings. Chief Nurse has also undertaken clinical duties within Maternity Unit. - Ward to Board/ Board to Ward.	MVP meetings held Quarterly	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing Quarterly**	**Complete**
		Q13	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	Evidence on Y Drive		TOR for Hull & ER MVP's Agendas ,Minutes & Actions held Surveys undertaken by MVP's Whose Shoes event held - & action tracker - Filmed a home birth and put onto VR headsets, Secured further funding in relation to breastfeeding support, implemented Hello my name is - badges, Met with Bounty to discuss feedback 15 steps to be undertaken by laypeople on MVP, but postposed due to Covid Developed a weekly Birth afterthoughts clinic for women who have had a traumatic experience - run by Professional Midwifery Advocates. Leaflet developed for women re what to expect in 6-8 week post natal check. Introduced some telephone appointments, but feedback form women using this service was not favourable. Developed an online Ask the Midwife Service.	15 steps to be undertaken by laypeople on MVP, but postposed due to Covid currently. Reverted back to F2F 16 week antenatal appointment. Review of Ask the Midwife services, themes, trends and opportunities for improvement. 23.09.21 - JC advised other elements happening in this area (leaflet) etc - to provide further update.	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing**	**Ongoing** **09/02/22 There are two MVPs Hull and East Riding. Quarterly meetings take place. Service user feedback through digital mechanism. 15 steps to be reviewed. Service user engagement event to be reintroduced. Delays due to covid. Feedback/engagement with women ongoing.**
		Q14	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity	• SOP that includes role descriptors for all key members who attend by-monthly safety meetings. • Log of attendees and core membership. • Action log and actions taken. • Minutes of the meeting and minutes of the LMS meeting where this is discussed.	On Y Drive - Evidence of Maternity Safety Champion meetings	2018	Document in place describing roles. TOR, Minutes and Agendas, Actions in place.	Ongoing	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing**	**Complete**
		Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	Evidence on Y Drive		TOR for Hull & ER MVP's Agendas ,Minutes & Actions held Surveys undertaken by MVP's Whose Shoes event held - & action tracker - Filmed a home birth and put onto VR headsets, Secured further funding in relation to breastfeeding support, implemented Hello my name is - badges, Met with Bounty to discuss feedback 15 steps to be undertaken by laypeople on MVP, but postposed due to Covid Developed a weekly Birth afterthoughts clinic for women who have had a traumatic experience - run by Professional Midwifery Advocates. Leaflet developed for omen re what to expect in 6-8 week post natal check. Introduced some telephone appointments, but feedback form women using this service was not favourable. Developed an online Ask the Midwife Service.	15 steps to be undertaken by laypeople on MVP, but postposed due to Covid currently. Reverted back to F2F 16 week antenatal appointment. Review of Ask the Midwife services, themes, trends and opportunities for improvement.	**Head of Midwifery**	**Lorraine Cooper**	**Jun-22**	**Ongoing**
		Q16	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director	• Name of ED and date of appointment • Name of NED and date of appointment • Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors	Information on Y Drive re role of Non Exec Director (NED) Word documents detailing our NED - Stuart Hall	01-Apr-21	Word documents detailing our NED - Stuart Hall Executive Director is Beverley Geary		**Exec Director** **Non Exec Director**	**Beverley Geary** **Stuart Hall**	**2019** **Apr 2021**	**Complete**
			Develop Personal Care, Support plans, and undertake an audit to demonstrate that 5% of records demonstrate a risk assessment and intended place of birth at every visit.			This sits with LMS		New personalised care plan has been developed across the LMS. Just in process of getting printed and published and will be available on LMS website for women to complete.	To implement use and advertise to women via LMS website, Ask the Midwife and social media.	**LMS Midwife**	**Sallie Ward**	**01/01/2022**	**Ongoing** **09/02/22 Personalised care plans on track. 2000 printed copies and electronic version on LMS website. Two videos for staff and patients, due in forthcoming weeks. NM-review in 6 months.**
3	**Staff training and working together** **Essential action - Staff who work together must train together.**	**Q17**	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	All on FWHG Y drive	2018	All in place except TNA. Currently training competency consists of - half day prompt training,(scenario based) MDT, CTG training, MDT (all registered staff) Undertake neonatal resuscitation training	To agree TNA with senior managers and introduce implementation. 23.09.21 - unsure of date for implementation	**Continuity of Care Lead** **Labour Ward Practitioners**	**Claire Spear** **Sue Sallis** **Helen Dent**	**Jan 2022**	**Ongoing**
		Q18	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	**Working together:** Confirmation of **ALL** criteria requested	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	On Pattie and on FWHG Y Drive	Jun-21	Developed SOP for twice daily ward rounds and now in place and CG1 form to audit this.	Completed a Business case for further 5x Consultants - approved in principal and finances currently being worked through.	**Clinical Director**	**Jane Allen**	**Apr-22**	**Ongoing**
		Q19	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc. that is specifically given for training)	Confirmation of ring fenced Maternity training budget	• Evidence that additional external funding has been spent on funding including staff can attend training in work time. • Evidence of funding received and spent. • Confirmation from Directors of Finance • Evidence from Budget statements. • MTP spend reports to LMS	No evidence of this historically.		Plan to record this going forward.	Going forward, this will be recorded via monthly HG Board meetings and evidence held on Y drive, to detail how and where funding is spent. Once next funding received this is to be added to monthly HG F&W Finance and Improvement Committee meeting.	**F&W Finance Lead**	**Peter Grant**	**Jun-22**	**Ongoing** **09/02/22 Received funding in bid for training, will be used for external training. LC- no update on if Trust has achieved year 3 standards. NM to follow up in 6 months.**
		Q20	Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2.	**See section 2**	Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive.		Birth Rate Plus - Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive.	Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive. 23.09.21 - JC advised this is currently underway - data collection.	**Head of Midwifery**	**Lorraine Cooper**	**Nov-21**	**Ongoing**
		Q21	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised	On Y Drive	ongoing	Signing in sheets, met 90% compliance for CNST and documented in Perinatal Quality Surveillance Tool.	Meet Y4 CNST training standards - to be reviewed and monitored at fortnightly meetings and via action tracker. Prior to submission annual challenge meeting to be held with Triumvirate.	**Head of Midwifery**	**Lorraine Cooper**	**Jun-22**	**Ongoing**
		Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	On Pattie and on FWHG Y Drive	Jun-21	Developed SOP for twice daily ward rounds and now in place and CG1 form to audit this.	Completed a Business case for further 5x Consultants - approved in principal and finances currently being worked through.	**Clinical Director**	**Jane Allen**	**Apr-22**	**Ongoing**

		Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	All of FWHG Y drive	2018	All in place except TNA. Currently training competency consists of - half day prompt training,(scenario based) MDT, CTG training, MDT (all registered staff) Undertake neonatal resuscitation training	To agree TNA with senior managers and introduce implementation.	**Continuity of Care Lead**	**Claire Spear**	**Jan 2022**	**Ongoing**
4	**Managing complex pregnancy Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.**	**Q24**	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre	• SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. • Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	SOP available on Pattie Guidance available on Y drive		Pregnancy Risk Guidance in place and SOP developed regarding referral of women with Complex Pregnancies to other units within region - approved at July Governance.	LMS leading work regarding development of Maternal Medicine Centres.	**LMS PMO Lead**	**Becky Case**	**Jul-22**	**Ongoing**
		Q25	Women with complex pregnancies must have a named consultant lead	Named consultant lead for all women identified = Yes	• SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. • Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	All available on Pattie and within evidence folder on Y drive		No SOP but Booking appointment guideline and Pregnancy Risk Guidelines and others. All women with complex pregnancies have a named consultant.	All Guidelines to be reviewed as per documents and signed off at appropriate boards. Audits -still to be undertaken. - Clinical Lead required to register audit	**Clinical Governance Lead Clinical Lead**	**Jayne Gregory Jaishree Hingorani**	**ongoing April 2022**	**Ongoing 09/02/22 UR to catch to speak to Jaishee for progress on CG1 and audit. All audits to be collated. There is a meeting Friday UR to attend, potential to create a wider audit across region, update at next meeting. LC to send UR list of different audits.**
		Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referenced to specialist involvement AND management plans developed	• SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. • Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.			No SOP , but guidelines in place.	Audit of complex pregnancies , early specialist involvement and management plans are developed by clinical team in consultation with the women. Clinical Lead required to register audit	**Clinical Lead**	**Jaishree Hingorani**	**Apr-22**	**Ongoing**
		Q27	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements	• SOP's • Audits for each element. • Guidelines with evidence for each pathway	Pattie Audit and compliance evidence on Y drive		No SOP , but guidelines in place. Previously did not meet all criteria and subsequent Business case and action submitted.	Business case was developed and approved and funding now released - now to implement a dedicated pre-term Birth clinic - weekly (due to start 1/10/21). Also purchased 2x extra scan machines, ordered but not yet received.(September) Due to be in place by end of Oct 2021. Recruited and appointed additional sonographers to support this dedicated service. 23.09.21 - All on track -	**Clinical Director**	**Jane Allen**	**01/06/2022**	**Ongoing 09/02/22 No SOP in place but guidelines in place. Developed and approved funding. Ordered 2 extra machines. Have started a pre term birth clinic, have received machines for sonography/recruited sonographers. Outstanding undertake UAE dopplar scanning. Need to convert IVF room.**
		Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place	• SOP that states women with complex pregnancies must have a named consultant lead. • Submission of an audit plan to regularly audit compliance	All available on Pattie and within evidence folder on Y drive		No SOP but Booking appointment guideline and Pregnancy Risk Guidelines and others. All women with complex pregnancies have a named consultant.	All Guidelines to be reviewed as per documents and signed off at appropriate boards. Audits -still to be undertaken. - Clinical Lead required to register audit	**Clinical Governance Lead Clinical Lead**	**Jayne Gregory Jaishree Hingorani**	**ongoing April 2022**	**Ongoing**
		Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	• The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. • Criteria for referrals to MMC • Agreed pathways	within Y Drive & SOP on Pattie	Jun-21	Developed SOP for referral to Maternal Medicine Centres - approved at July 2021 Obstetric Governance Meeting.		**Clinical Lead**	**Jaishree Hingorani**	**Complete**	**Complete**
5	**Risk assessment through pregnancy Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,**	**Q30**	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact	• SOP that includes definition of antenatal risk assessment as per NICE guidance. • How this is achieved within the organisation. • What is being risk assessed. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	Evidence on Y drive	2019	Booking guidance in place. HUTH have a sticker system to identify risk assessment being undertaken and reviewed. LMS also develop personalised care plans.	Implementation of the personised care plans.	**Head of Midwifery**	**Lorraine Cooper**	**Jan 2022**	**Ongoing**
		Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts	• SOP that includes review of intended place of birth. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. • Out with guidance pathway. • Evidence of referral to birth options clinics	Evidence on Y drive	2019	Booking guidance in place. HUTH have a sticker system to identify risk assessment been undertaken and reviewed. LMS also develop personalised care plans.	Implementation of the personised care plans.	**Head of Midwifery**	**Lorraine Cooper**	**Jan 2022**	**Ongoing**
		Q32	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway	Pattie Audit and compliance evidence on Y drive	1	No SOP , but guidelines in place. Previously did not meet all criteria and subsequent Business case and action submitted.	Business case was developed and approved and funding now released - now to implement a dedicated pre-term Birth clinic - weekly (due to start 1/10/21). Also purchased 2x extra scan machines, ordered but not yet received.(September) Due to be in place by end of Oct 2021. Recruited and appointed additional	**Clinical Director**	**Jane Allen**	**End of Oct 2021**	**09/02/22 JS to check audit and will make sure work is on track.**
		Q33	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place **AND** are they audited	• SOP to describe risk assessment being undertaken at every contact. • What is being risk assessed. • How this is achieved in the organisation. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. • Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	0	2019	Booking guidance in place. HUTH have a sticker system to identify risk assessment being undertaken and reviewed. LMS also develop personalised care plans.	Implementation of the personised care plans.	**Head of Midwifery**	**Lorraine Cooper**	**Jan 2022**	**Ongoing**
6	**Monitoring fetal wellbeing Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	**Q34**	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	BOTH MW and Obstetrician in place	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. • Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews	All on Y Drive	Sep-21	Roles, evidence of duties, audits, training, agenda, actions etc. all on Y drive.	Comply with Y4 CNST Guidance which has changed.	**CTG Fetal Monitoring Lead**	**Sue Nelsey**	**Jun-22**	**Ongoing**
		Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.	JD fulfils **ALL** criteria	• Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post • Improving the practice & raising the profile of fetal wellbeing monitoring • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g. clinical supervision • Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. • Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Evidence on Y drive.	Ongoing	Job Description up-to-date and held on Y drive.	Comply with Y4 CNST Guidance which has changed and monitor progress via fortnightly CNST meetings.	**Head of Midwifery**	**Lorraine Cooper**	**Jun-22**	**Ongoing**
		Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway	Pattie Audit and compliance evidence on Y drive		No SOP , but guidelines in place. Previously did not meet all criteria and subsequent Business case and action submitted.	Business case was developed and approved and funding now released - now to implement a dedicated pre-term Birth clinic - weekly (due to start 1/10/21). Also purchased 2x extra scan machines, ordered but not yet received.(September) Due to be in place by end of Oct 2021. Recruited and appointed additional sonographers to support this dedicated service.	**Clinical Director**	**Jane Allen**	**End of Oct 2021**	**09/02/22 There is a dedicated lead midwife and obstretrician. This meets the criteria in Ockenden. Action complete.**
		Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised	On Y Drive	ongoing	Signing in sheets, met 90% compliance for CNST and documented in Perinatal Quality Surveillance Tool.	Meet Y4 CNST training standards - to be reviewed and monitored at fortnightly meetings and via action tracker. Prior to submission annual challenge meeting to be held with Triumvirate.	**Head of Midwifery**	**Lorraine Cooper**	**Jun-22**	**Ongoing**
		Q38	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	See Q34	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews	All on Y Drive	Sep-21	Roles, evidence of duties, audits, training, agenda, actions etc. all on Y drive. Now appointed Consultant Lead for 1 x PA p/w	Comply with Y4 CNST Guidance which has changed.	**CTG Fetal Monitoring Lead**	**Sue Nelsey**	**Jun-22**	**Ongoing**
7	**Informed consent Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	**Q39**	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	**ALL** place of birth information easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	On Y Drive and Trust Website		Reviewed website and leaflets, asked for MVP chairs re accessibility, navigation, language, information leaflets and apps.	Undertake Gap analysis against Chelsea and Westminster website.	**Head of Midwifery**	**Lorraine Cooper**	**Jan 2022**	**Ongoing**
		Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	**ALL** information is easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	On Y Drive and Trust Website		Reviewed website and leaflets, asked for MVP chairs re accessibility, navigation, language, information leaflets and apps.	Undertake Gap analysis against Chelsea and Westminster website.	**Head of Midwifery**	**Lorraine Cooper**	**Jan 2022**	**Ongoing**
		Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust HAS a method of recording decision making processes that includes women's participation & informed choice	• SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. • An audit of 1% of notes demonstrating compliance. • CQC survey and associated action plans	All on Y Drive		All guidelines and leaflets promote/follow Choice.	Still to undertake audit of 1% notes to demonstrate where choice is recorded. Last CQC inspection was 2018 - actions have been monitored via Obstetric governance, F&W Monthly performance meetings and recent engagement session with CQC (Aug 2021) to review 2018 actions.	**Clinical Lead**	**Jaishree Hingorani**	**Apr-22**	**Ongoing**

		Q42	Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	• SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. • An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. • CQC survey and associated action plans	All on Y Drive		All guidelines and leaflets promote/follow Choice.	Still to undertake audit of 5% notes to demonstrate where pathways differ from recommendations by a clinician. Also to include a selection of women a c section during labour or induction. Last CQC inspection was 2018 - actions have been monitored via Obstetric governance, F&W Monthly performance meetings and recent engagement session with CQC (Aug 2021) to review 2018 actions. Process to be devised to capture when women actively choose a C-section , once induction of labour has commenced.	**Clinical Lead** **Lead Midwife**	**Jaishree Hingorani** **Julia Chambers**	**01/05/2022** **Jun 2022**	**Ongoing**
		Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	Evidence on Y Drive		TOR for Hull & ER MVP's Agendas ,Minutes & Actions held Surveys undertaken by MVP's Whose Shoes event held - & action tracker - Filmed a home birth and put onto VR headsets, Secured further funding in relation to breastfeeding support, implemented Hello my name is - badges, Met with Bounty to discuss feedback 15 steps to be undertaken by laypeople on MVP, but postposed due to Covid Developed a weekly Birth afterthoughts clinic for women who have had a traumatic experience - run by Professional Midwifery Advocates. Leaflet developed for omen re what to expect in 6-8 week post natal check. Introduced some telephone appointments, but feedback form women using this service was not favourable. Developed an online Ask the Midwife Service.	15 steps to be undertaken by laypeople on MVP, but postposed due to Covid currently. Reverted back to F2F 16 week antenatal appointment. Review of Ask the Midwife services, themes, trends and opportunities for improvement.	**Head of Midwifery**	**Lorraine Cooper**	**Ongoing**	**Ongoing**
		Q44	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	All information **ON** trust website	• Gap analysis of website against Chelsea & Westminster conducted by the MVP • Co-produced action plan to address gaps identified • Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc.) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	on Y Drive	Jun-21	Reviewed website and leaflets, asked for MVP user feedback,	Work with MVP to cross reference against Chelsea and Westminster website	**Head of Midwifery**	**Lorraine Cooper**	**01/12/2021**	**09/02/22 Offtrack. Still need to complete gap analysis with MVP chairs. They are reviewed internally website/leaflets. Further work required to see if website information needs to be changed.**
WORKFORCE													
Q45		**Action 4**	Can you demonstrate an effective system of clinical workforce planning to the required standard	Midwifery workforce planning system **in PLACE**	• Most recent BR+ report and board minutes agreeing to fund. • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive.		Birth Rate Plus - Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive.	Last assessment in 2018 and currently undertaking another. Due to be completed Nov 2021. evidence to be saved on Y drive.	**Head of Midwifery**	**Lorraine Cooper**	**Nov-21**	**09/02/22 A meeting has taken place with execs and company for formal feedback. LC has completed paper for triumvirate/6 month staffing report. Papers sent to Trust board in March. Work progressing to develop training needs analysis tool.**
Q46		**Action 5**	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards	• Most recent BR+ report and board minutes agreeing to fund.	Evidence of 6 monthly staffing Board Reports on Y drive.		N/a - No funding requested	undertaking Birth-rate Plus currently. 23.09.21 - New report required - data collection currently underway.	**Head of Midwifery**	**Lorraine Cooper**	**01/11/2021**	**09/02/22 LC to send reports, birth rate plus and 6 month staffing paper. Papers to be signed off by Trust board before circulating to wider teams.**
Q47			Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director	Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	Evidence on Y drive		JD and line of reporting evidence held on Y drive.	n/a	**Nurse Director**	**Mel Carr**	**Complete**	**Complete**
Q48			Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders	**Meets ALL** that apply **Note - Trusts would not lead on actioning all seven steps**	• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care • Action plan where manifesto is not met	Relevance evidence on Y Drive.		Structure explained to NHSE (Via portal) set out structure, specialist Midwive roles, Leadership training and links to local universities.	National Guidance to be followed	**Head of Midwifery**	**Lorraine Cooper**	**01/09/2022**	**Ongoing**
Q49			We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	**ALL** guidance assessed & implemented = Yes (GREEN)	• SOP in place for all guidelines with a demonstrable process for ongoing review. • Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.			SOP for NICE Guidelines and Compliance Review Form - reported to Obstetric Guideline meeting, monthly. All guidelines are version controlled and reviewed periodically as per documents. Clinical Governance Lead monitors these on action tracker.	reviews to be undertaken as /when required and nwe guidelines to be developed in line with National Guidance.	**Clinical Governance Lead**	**Jayne Gregory**	**ongoing**	**Ongoing**

	New actions 09/02/22	
1	NM to update TOR, remove names and add workforce to role item 2, for review and sign off at the next meeting.	NM
2	LC to submit board report and update with progress to date at this meeting.	LC
3	Invite Becky Case to the next meeting.	Admin
4	Q32 JC to check audit and make sure work is on track.	JC
5	Q46 LC to circulate birth rate plus and 6 month staffing report within this group.	LC
6	UR to update the group about creating a wider audit across region after Friday's meeting. LC to send UR a list of the different audits.	UR/LC

7 Ockenden IEAs (including 12 Clinical Priorities):
Trust: Hull University Teaching Hospital NHS Trust
Exec Sign off

	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	**Yes**		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**Yes**		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	**Yes**		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	**Yes**		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	**Yes**		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	**Yes**		
Confirmation that funding allocated for maternity staff training is ringfenced	**Yes**		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place		**Yes**	
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres		**Yes**	
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance		**Yes**	
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	**Yes**		
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	**Yes**		

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 - Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that a multidisciplinary team is completing the national Perinatal Mortality Review Tool (PMRT) to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

2. Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.
NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions, Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will receive a share of any unallocated funds. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on 30 June 2022. Trust submissions will be subject to a range of external verification points including cross checking with MBRRACE-UK data (safety action 1 point a,b,c).

3. Requirements for Safety Action 1;

are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard. **Appendix 1 and 2**

A)

i. Perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust

B) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by

the tool within four months of each death and the report published within six months of each death.

C) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents, should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors, which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

D) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

4. Perinatal Mortality Review Tool (PMRT)

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The PMRT has been designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth
- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report, which should be shared with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

5. Summary

a) i.The requirement to notify perinatal deaths was amended from 2 days to 7 days in January 2022 during the COVID pandemic. From the 8th August until the 31st

December, the Trust was **100%** compliant with the standard. All perinatal deaths were notified to MBRRACE-UK within 7 working days.
ii.In the reporting period there have been 5 stillbirths and 3 neonatal deaths suitable for review. **100%** of all deaths of babies have been started within two months of each death in the Trust during the reporting period. 1 recent death will be commenced this month.

b) In the period from 8th August, 8 cases in the Trust are suitable for review using the PMRT. 3 cases have been completed and the report written and published. 1 cases is complete and the report is being written. 3 cases are under review and the final recent case is to be commenced this month. All case reviews are within the CNST standard time frame. **100%** of the cases completed, were within 4 months.

c) In **100%** of all deaths of babies who were born and died in the Trust Quarter 3 reporting period, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT review.

d) Quarterly reports are submitted as per standard and discussed with the Trust safety champion

6. Recommendations

The Trust Board is requested to:

- Receive (the report outlining the details of the deaths reviewed and the action plans.
- Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that all the required standards have been achieved.
- Decide if any further information and/or assurance are required

Lorraine Cooper

Head of Midwifery January 2022

APPENDIX 1 December 2021 PMRT Update

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review update December 2021									
Outstanding and completed Neonatal cases December 2021									
	MBRRACE ID	Stillbirth/ Neonatal Death	Date of death	PMRT commenced	Target for completion	PMRT Completed	Grading	Report date target	Actions/ Good practice
1	75197	NND 24+3 week Twin	09/05/2021	11/05/2021	09/09/2021				Joint review with York- delayed due to requirement for joint review *(outside of the CNST review period)*
2	77800	NND 24 weeks	14/10/2021	25/10/2021	14/02/2022	22/12/2021	B/A/A	√	Completed- Actions published on action tracker
3	78076	NND 23 weeks	31/10/2021	23/11/2021	28/02/2021				Commenced -joint review with Mid Yorkshire
4	79153	NND 26 weeks	26/12/2021		26/04/2022				To commence joint review with Lincoln
	MBRRACE ID	*Stillbirth/ Neonatal Death*	*Date of death*	*PMRT commenced*	*Target for completion*	*PMRT Completed*	*Grading*		*Actions/ Good practice*
Outstanding and completed Maternity Cases upto December 2021									
1	76761	27+2 week SB	18/08/2021	23/08/2021	18/12/2021	19/11/2021	B/A	√	Actions are with booking unit Aneurin Bevan Health Board
2	77778	30 week SB	15/10/2021	25/10/2021	15/02/2022	21/12/2021	D/A		Escalated for an SI investigation. Writing PMRT report- Actions published on action tracker
3	77982	37 week stillbirth	25/10/2021	29/10/2021	25/02/2022	22/11/2021	B/B	√	Completed- Actions published on action tracker
4	78218	37+1 week stillbirth	05/11/2021	08/11/2021	05/03/2021				In progress- awaiting placental histology

APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION MATERNITYTRACKER DECEMBER 2021

MBRRACE ID	ACTIONS	Lead	Due date	RAG
77982	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Individual feedback to staff involved regarding risk management and case to be shared at Perinatal Mortality meeting	KS/ WM	17/12/21	
	Liaise with new maternal mental health service to implement pre-conceptual mental health counselling	SC	17/12/21	
77778	CTG to be reviewed by leads and discussion with involved staff if concerns highlighted	SN	17/12/21	
	Advise staff via newsletter to use continuous maternal HR monitoring when maternal/fetal tachycardia identified	AB	17/12/21	
	Set a trust standard with frequency of 'fresh eyes' on an antenatal CTG and classifying latent phase CTGs	SN	26/01/22	
	Feedback to staff in newsletter the action if a FFN result is invalid	AB	26/01/22	
	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Liaise with USS regarding DNA process and take to governance meeting	KS	10/01/21	
	Reminder on the monthly newsletter re documentation of observations on the partogram	AB	17/12/21	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
77800	Review guidance and leaflet for Aspirin including when contraindicated	KS	26/01/22	
	Create a pre-term guidance counselling checklist	KS	25/02/22	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
	Reminder on the monthly newsletter re calculating the correct gestation	AB	17/12/21	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

RAG rating

Red – off track and overdue
Amber- off track but recoverable
Green – complete
No colour – not yet commenced

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8 March 2022
Title	**Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool**				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee				

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

Key Recommendations to be considered:

The Committee is requested to:

- Receive the report findings
- Decide if any further information and/or assurance are required.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 - Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool

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A)

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parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents, should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors, which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

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- Decide if any further information and/or assurance are required

Lorraine Cooper

Head of Midwifery January 2022

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Outstanding and completed Maternity Cases upto December 2021									
1	76761	27+2 week SB	18/08/2021	23/08/2021	18/12/2021	19/11/2021	B/A	v	Actions are with booking unit Aneurin Bevan Health Board
2	77778	30 week SB	15/10/2021	25/10/2021	15/02/2022	21/12/2021	D/A		Escalated for an SI investigation. Writing PMRT report- Actions published on action tracker
3	77982	37 week stillbirth	25/10/2021	29/10/2021	25/02/2022	22/11/2021	B/B	v	Completed- Actions published on action tracker
4	78218	37+1 week stillbirth	05/11/2021	08/11/2021	05/03/2021				In progress- awaiting placental histology

APPENDIX 2

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION MATERNITYTRACKER DECEMBER 2021

MBRRACE ID	ACTIONS	Lead	Due date	RAG
77982	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Individual feedback to staff involved regarding risk management and case to be shared at Perinatal Mortality meeting	KS/ WM	17/12/21	
	Liaise with new maternal mental health service to implement pre-conceptual mental health counselling	SC	17/12/21	
77778	CTG to be reviewed by leads and discussion with involved staff if concerns highlighted	SN	17/12/21	
	Advise staff via newsletter to use continuous maternal HR monitoring when maternal/fetal tachycardia identified	AB	17/12/21	
	Set a trust standard with frequency of 'fresh eyes' on an antenatal CTG and classifying latent phase CTGs	SN	26/01/22	
	Feedback to staff in newsletter the action if a FFN result is invalid	AB	26/01/22	
	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Liaise with USS regarding DNA process and take to governance meeting	KS	10/01/21	
	Reminder on the monthly newsletter re documentation of observations on the partogram	AB	17/12/21	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
77800	Review guidance and leaflet for Aspirin including when contraindicated	KS	26/01/22	
	Create a pre-term guidance counselling checklist	KS	25/02/22	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
	Reminder on the monthly newsletter re calculating the correct gestation	AB	17/12/21	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

RAG rating

Red – off track and overdue
Amber- off track but recoverable
Green – complete
No colour – not yet commenced

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	March 2022
Title	Bi Annual Midwifery Staffing Report				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee 28/02/2022				

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

Key Recommendations to be considered:

The Trust Board is requested to:

- Receive the report outlining a sixth month review of maternity staffing
- Decide if any further information and/or assurance are required.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

Background

This report provides a review of the maternity workforce in relation to the quality and safety of care provided. It will incorporate an overview of national maternity transformation, monitoring of maternity workforce, safe staffing reviews, Midwife: Birth ratio, ward review, escalation and reporting. The report will encompass data extracted from June 2021 – November 2021.

1. National Drivers

National Maternity Transformation

Hull University Teaching Hospitals NHS Trust continue to respond to national strategy articulated in 'Better Births' (2016) which sets out clear recommendations for the rollout of Continuity of Carer encompassing all three elements of the maternity pathway. This recommendation is based on a body of evidence that Continuity of Carer is what women want, improves safety and provides significantly better outcomes. This is particularly relevant for outcomes of women at risk of health inequalities and women from a BAME background.

There is strong evidence, along with many national drivers, to support the implementation of Continuity of Carer in maternity services as a service model and choice for women. In addition, NHS England and NHS Improvement are committed to working with regions, systems, providers and partners to implement the actions from the initial Ockenden report published in December 2020.

Transformation objectives remain committed to women receiving continuity of carer as set out in the NHS Long Term Plan. Some potential barriers need tackling at the outset. These include; engaging the midwifery workforce, putting adequate staffing in place, ensuring that the model is based on a team approach with a named obstetrician linked to each team and ensuring training and equipment needs are considered.

Maternity services have been asked to demonstrate a plan, approved by Trust Board by November 2021 that will;

- Put in place the building blocks by March 2022 to ensure that continuity of carer is the default model of care offered to all women by March 2023.
- This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.
- Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds, most deprived areas are placed by on a continuity of carer pathway by March 2022.
- Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.

The Trust Board are requested to review the Maternity Services plan to deliver CoC in conjunction with NHS England 2021/22 priorities and operational planning guidance, implementation guidance. The service request financial investment from the Trust Board to support a phased implementation plan that aims to maintain quality and safety. The detail of the midwifery workforce requirement to deliver CoC is being progressed by the Head of Midwifery, more detailed information will be available following completion of a more up to date Birthrate plus assessment (December 2021).

There are currently four caseloading continuity of carer teams that have been implemented to date:

Team Name	Model	Criteria	Annual Caseload (approx)
Ivy	Caseloading	Geographical HU17	280
Primrose	Caseloading	Geographical HU9	270
Poppy	Caseloading	Geographical YO25 YO42 YO43	250
Bluebell	Caseloading	Geographical HU15 DN14	250

2. Monitoring of Maternity Workforce

HUTH maternity service continues to work in partnership with Hull University to support workforce planning. In the current climate there is an annual intake of students every September that feed into HUTH and NLAG.

The Covid 19 Pandemic has created daily challenges to maintaining safe staffing levels across the service. The available workforce has been reviewed and strategies employed to redeploy staff across the service as required. This has predominantly involved non clinical staff/specialist midwives/managers moving to clinical areas to provide direct care. This has been enacted following individual review of training needs and ensuring that individuals were moved to an area concomitant with their skill set. Adaptations have also been made to patient pathways and where appropriate virtual means of consultations instigated. This has enabled staff working in non-direct patient facing roles to continue to contribute to the provision of safe care particular to support with case conference and strategy safeguarding meetings.

Attendance Rates (June – November 2021)

	June 2021		July 2021		August 2021		September 2021		October 2021		November 2021	
	Attendance %	Sickness %	Attendance %	Sickness %	Attendance %	Sickness %	Attendance %	Sickness %	Attendance %	Sickness %	Attendance %	Sickness %
Community Midwifery	95.74	4.26	93.95	6.05	93.91	6.09	93.88	6.12	93.27	6.73	93.22	6.78
H31 Maple & H33 Rowan Wards	93.97	6.03	92.82	7.18	92.77	7.23	92.45	7.55	92.20	7.80	91.16	8.84
Midwifery Education	92.89	7.11	99.86	0.14	100.00	0.00	100.00	0.00	100.00	0.00	100.00	0.00
Midwifery Led Unit	99.14	0.86	96.46	3.54	96.36	3.64	96.68	3.32	96.73	3.27	96.50	3.50
Obstetric Spec Nurses	96.70	3.30	98.37	1.63	99.28	0.72	99.30	0.70	99.29	0.71	99.18	0.82
Obstetrics Rotational Staff (HMH)	97.09	2.91	51.86	48.14	100.00	0.00	100.00	0.00	100.00	0.00	100.00	0.00
Parental Education	51.21	48.79	97.18	2.82	54.17	45.83	56.88	43.12	59.33	40.67	62.07	37.93
Wch Labour and Delivery (HRI)	97.09	2.91	94.86	5.14	97.24	2.76	97.27	2.73	97.45	2.55	97.59	2.41
Womens and Childrens ANC/ADU HRI	95.16	4.84	94.82	5.18	94.97	5.03	95.05	4.95	95.03	4.97	94.16	5.84
Total	94.80	5.20	93.95	6.05	94.91	5.09	94.96	5.04	94.87	5.13	94.56	5.44

Sickness and absence within maternity services is an ongoing issue, all midwifery managers have initiated the Trust 'Supporting and Managing Attendance Policy CP251' were appropriate and meet regularly with HR managers. The maternity service has acknowledge it has an ageing workforce with some staff having longstanding health issues.

3. Safe Staffing Reviews

In December 2021 all midwifery establishments within the inpatient services were reviewed collaboratively between the senior management team, Assistant Chief Nurse and Nurse Director to understand the workforce requirements needed to effectively manage all clinical areas safely.

Maternity staffing and acuity continue to be reported three times a day in line with HUTH Safe Care reporting mechanisms. The labour ward complete a 4hrly Birth Rate Plus acuity tool and any 'red flags' are reported via the Perinatal Quality Surveillance Tool and the monthly Nurse Directors staffing report. Senior leaders escalate any staffing concerns to the Head of Midwifery or deputy on a daily basis. The Birthrate Plus workforce acuity tool monitors staff versus acuity and is embedded within the maternity services at HUTH. Throughout the audited period to date, there have been 5 reported incidents where 1:1 care in labour was not maintained and coordinators supernumerary status has been challenging to maintain. The most recent report has identified compliance in completing the 4hrly Acuity tool needs to improve across the inpatient clinical areas.

4. Clinical Area Reviews

Quality indicators and staffing continue to be reviewed as part of the weekly managers meeting. This meeting is chaired by the Head of Midwifery or Deputy Matron and facilitates senior oversight of safe staffing levels. Sickness levels are monitored via the senior managers with support from Human Resource department.

5. Birthrate Plus Report 2021

HUTH in line with national guidance has undertaken a Birthrate plus assessment using three months casemix data for the months of April to June 2021. The Birthrate plus Workforce Planning system provides each

maternity service with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. It also provides each service with its own individual ratios of hospital births per whole time equivalent midwife and the number of cases and home births per wte community midwife. This allows each service to apply its own allowances for holiday, sickness and study leave and for time spent in travel by community staff. A 21.6% uplift was applied to cover annual, sickness and study leave has been included in the staffing calculations, and 12.5% travel allowance.

The report identified the percentage of women in Categories IV and V has increased from the 2018 data, and most noticeably in Category V (High category). The Delivery Suite casemix has 74.3% in the 2 highest categories whereas in 2018, it was 66.5% of which 35.8% was in IV and 30.7% in V, an increase of 7.8%. The higher the casemix, the more clinical staffing is required to ensure women receive 1 to 1 care in labour and delivery as a minimum but also to provide additional support as necessary.

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 DS % Casemix	7.9	14.3	3.5	35.4	38.9
	25.7%			74.3%	
2018 DS % Casemix	33.5%			66.5%	
2021 Generic % Casemix	11.8	21.3	3.0	30.5	33.4
(Includes Birth Centre)	36.1%			63.9%	
2018 Generic % Casemix	42.0%			58.0%	

Casemix Table 1

The 2021 Birthrate Plus Report identified Annual Activity based on the FY 2020/2021 total births has fallen to 4814 total birth rate, however women have been identified has having more complex health needs falling into category IV and V and thus requiring an increase in midwifery hours.

The 2021 report has identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey.

6. SUMMARY

Hull University Teaching Hospitals NHS Trust 2021 Birthrate Plus Report recommends the midwifery budget to be set at 204.80wte Bands 3-8, compared to the funded establishment of 179.65wte resulting in a negative variance of 25.15wte. The deficit is subdivided of 13.46wte would be for B3 maternity support worker roles and 11.69wte registered Midwives. The service will seek approval from the Family and Women's Triumvirate to proceed with a business case in order to support the increase in the midwifery workforce as identified in the 2021 Birthrate Plus Report.

7. RECOMMENDATIONS

The Trust Board is requested to:

- Agree that the review of the position of the midwifery staffing report is a true representation of the January 2022 midwifery staffing position
- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery
January 2022

Beverley Geary
Executive Chief Nurse

Trust Board
8 March 2022

Agenda Item		**Meeting**	**Performance and Finance Committee**	**Meeting Date**	**20th December 2021**
Title	Performance Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)					

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

Key Recommendations to be considered:

Urgent and Emergency Care

- Performance against the 4-hour standard was 68% for November 2021
- The 4-hour delivery action plan continues to be further developed.
- The UTC facility at HRI commenced in December 2021.
- Ambulance Handover improvement Steering Group begins 16th December

Cancer (October Performance data)

- The Trust did not achieve the 2-week wait cancer target in the month of October 2021 - delivering 77%, with Gynaecology, Haematology, Lung and Paediatrics achieving the 93% standard.
- Performance against the 62-day Cancer standard was 55.7% for October 2021.
- The Faster Diagnosis Standard achieved in October 2021 at 75.1%.

Diagnostics

- 37.7% of patients on the waiting list for diagnostics have waited over 6 weeks in the month of November 2021, which is an improvement on the October 2021 position (provisional data only).

Referral to Treatment Elective Standards (provisional data only)

- The Trust had 5,616 x 52 week breaches at the end of November 2021, an improvement of 808 on the October 2021 position; the H2 planning trajectory was delivered.
- The Trust had 511 x 104 Week waits at the end of November 2021, which is above the trajectory.
- Total waiting list volume did not achieve the recovery trajectory of 59,592 with 62,682 reported at the month end position.

Performance and Activity Report

November 2021 Performance

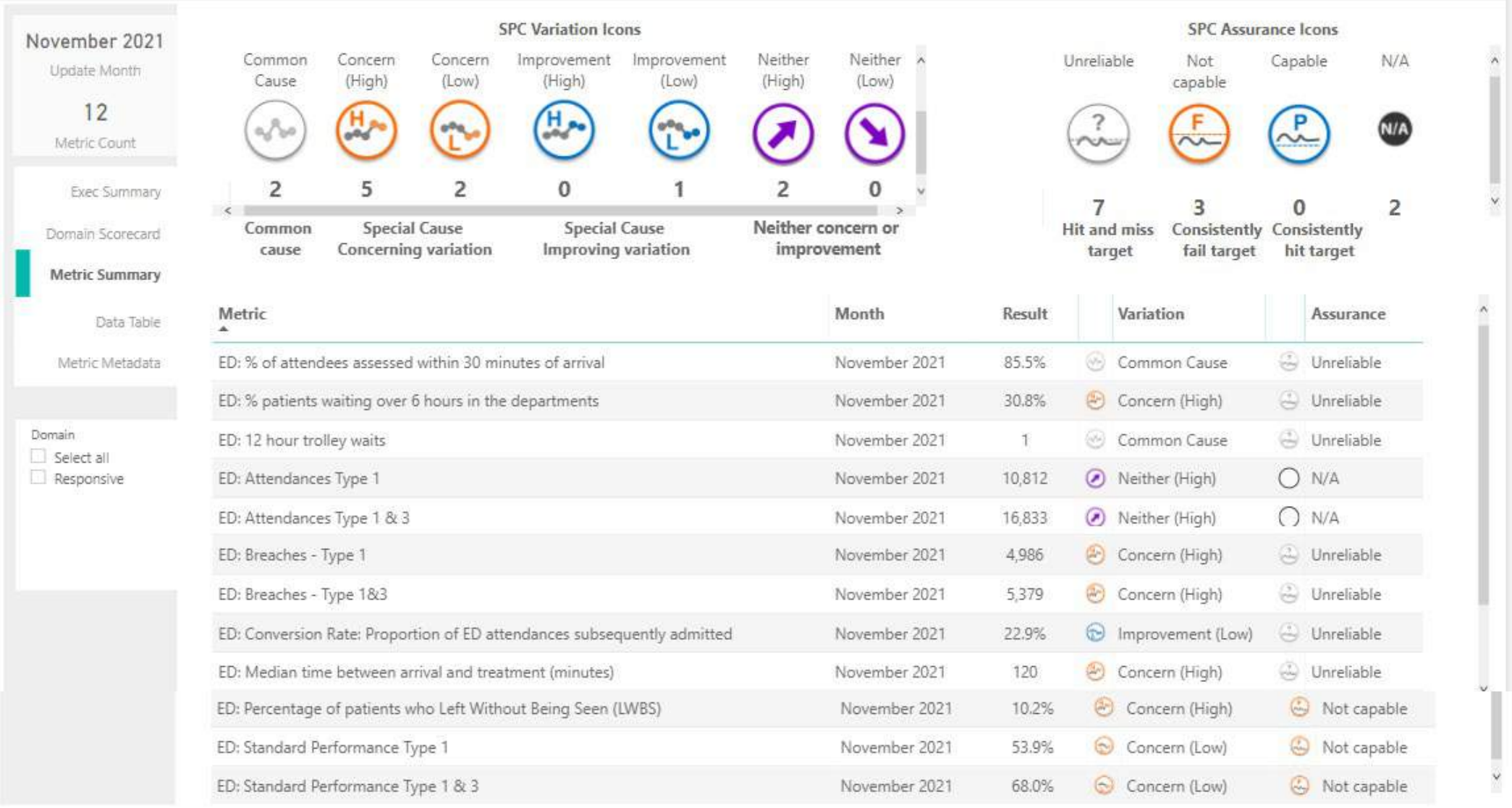
Produced December 2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Contents

1. Operational Performance – Emergency Department



Metric	Month	Result	Variation	Assurance
ED: % of attendees assessed within 30 minutes of arrival	November 2021	85.5%	Common Cause	Unreliable
ED: % patients waiting over 6 hours in the departments	November 2021	30.8%	Concern (High)	Unreliable
ED: 12 hour trolley waits	November 2021	1	Common Cause	Unreliable
ED: Attendances Type 1	November 2021	10,812	Neither (High)	N/A
ED: Attendances Type 1 & 3	November 2021	16,833	Neither (High)	N/A
ED: Breaches - Type 1	November 2021	4,986	Concern (High)	Unreliable
ED: Breaches - Type 1&3	November 2021	5,379	Concern (High)	Unreliable
ED: Conversion Rate: Proportion of ED attendances subsequently admitted	November 2021	22.9%	Improvement (Low)	Unreliable
ED: Median time between arrival and treatment (minutes)	November 2021	120	Concern (High)	Unreliable
ED: Percentage of patients who Left Without Being Seen (LWBS)	November 2021	10.2%	Concern (High)	Not capable
ED: Standard Performance Type 1	November 2021	53.9%	Concern (Low)	Not capable
ED: Standard Performance Type 1 & 3	November 2021	68.0%	Concern (Low)	Not capable

2. Operational Performance – Unplanned Care

November 2021
Update Month
11
Metric Count

Exec Summary
Domain Scorecard
Metric Summary
Data Table
Metric Metadata

Domain
Select all
Effective
Responsive

SPC Variation Icons

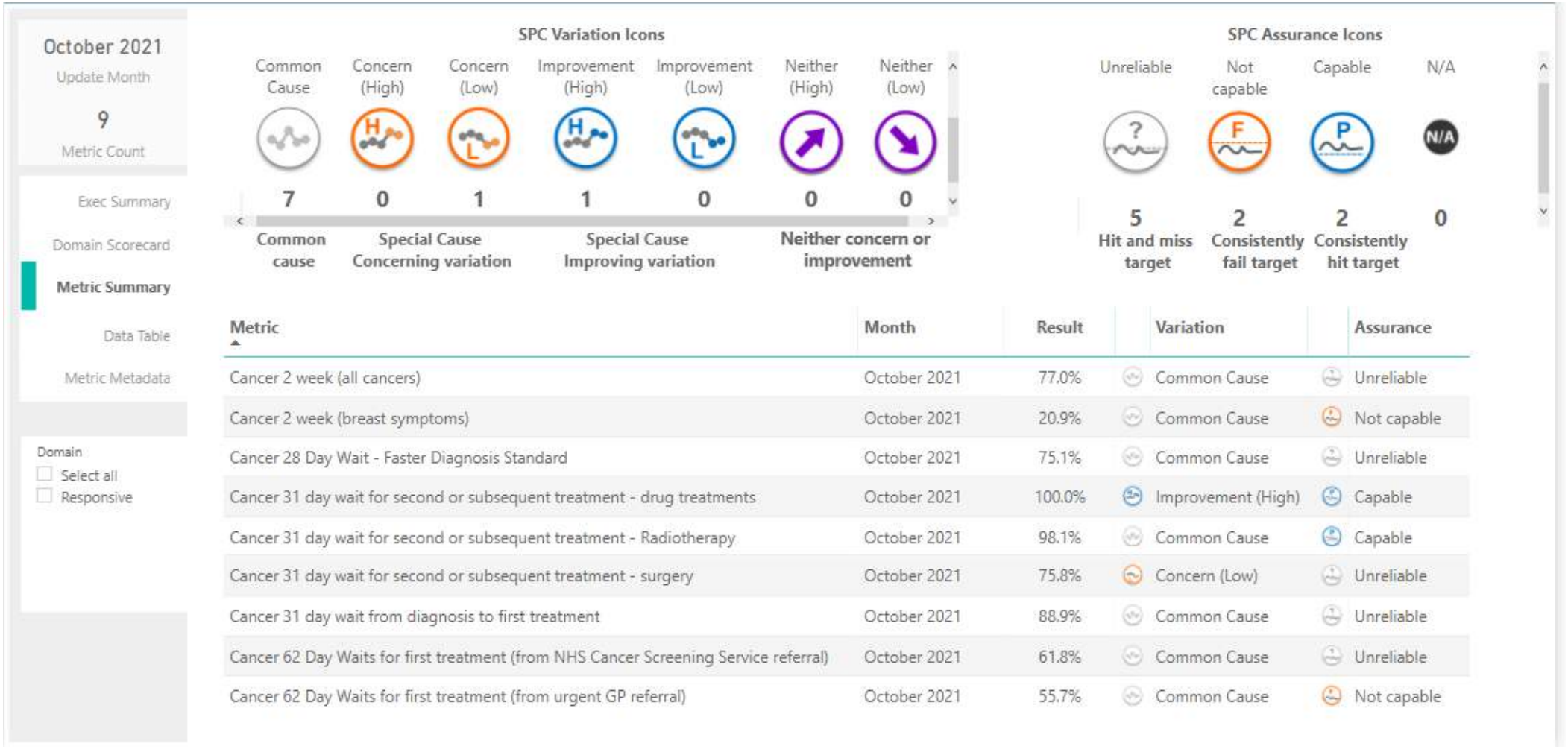
Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
0	9	1	0	1	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
9	2	0	0
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Ambulance handovers waiting >60 minutes	November 2021	439	Concern (High)	Unreliable
Ambulance handovers waiting 15-30 minutes	November 2021	700	Concern (Low)	Unreliable
Ambulance handovers waiting 30-60 minutes	November 2021	561	Concern (High)	Unreliable
Average Bed Days Occupied by Stranded Patients	November 2021	10,018	Concern (High)	Not capable
Average Bed Days Occupied by Super Stranded Patients	November 2021	7,917	Concern (High)	Not capable
Emergency readmissions within 30 days	October 2021	6.2%	Improvement (Low)	Unreliable
Non Elective Admissions	November 2021	5,211	Concern (High)	Unreliable
Patients with a LoS >= 7 Midnights (Elective & Non-Elective)	November 2021	451	Concern (High)	Unreliable
Patients with LOS 0 Days (Elective & Non-Elective)	November 2021	1,308	Concern (High)	Unreliable
Stranded Patients at End of Month 14 days	November 2021	261	Concern (High)	Unreliable
Stranded Patients at End of Month 21 days	November 2021	163	Concern (High)	Unreliable

3. Operational Performance – Cancer



Metric	Month	Result	Variation	Assurance
Cancer 2 week (all cancers)	October 2021	77.0%	Common Cause	Unreliable
Cancer 2 week (breast symptoms)	October 2021	20.9%	Common Cause	Not capable
Cancer 28 Day Wait - Faster Diagnosis Standard	October 2021	75.1%	Common Cause	Unreliable
Cancer 31 day wait for second or subsequent treatment - drug treatments	October 2021	100.0%	Improvement (High)	Capable
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	October 2021	98.1%	Common Cause	Capable
Cancer 31 day wait for second or subsequent treatment - surgery	October 2021	75.8%	Concern (Low)	Unreliable
Cancer 31 day wait from diagnosis to first treatment	October 2021	88.9%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	October 2021	61.8%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from urgent GP referral)	October 2021	55.7%	Common Cause	Not capable

4. Operational Performance – 18 weeks RTT

November 2021
Update Month
13
Metric Count

Exec Summary
Domain Scorecard
Metric Summary
Data Table
Metric Metadata

Domain
Select all
Responsive

SPC Variation Icons

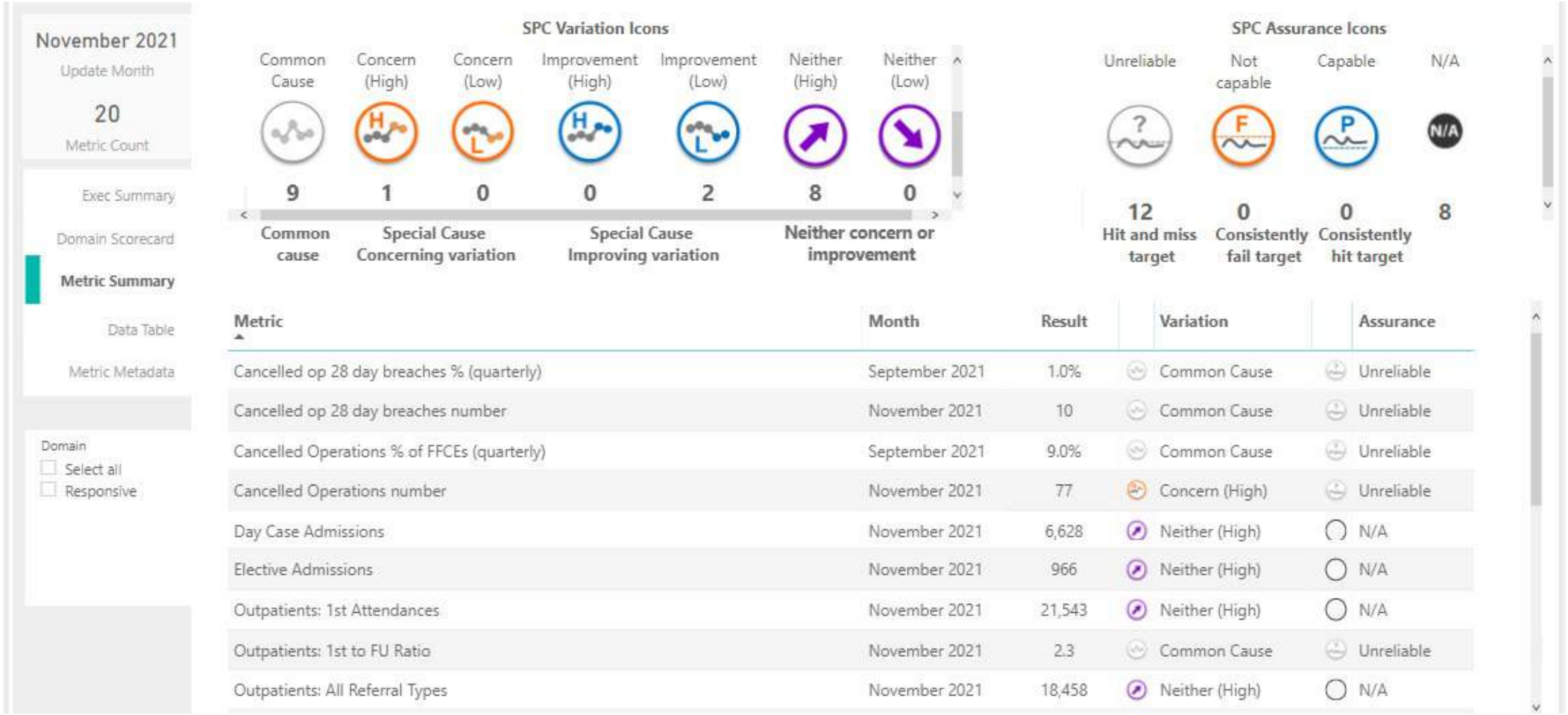
Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
1	6	0	2	4	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

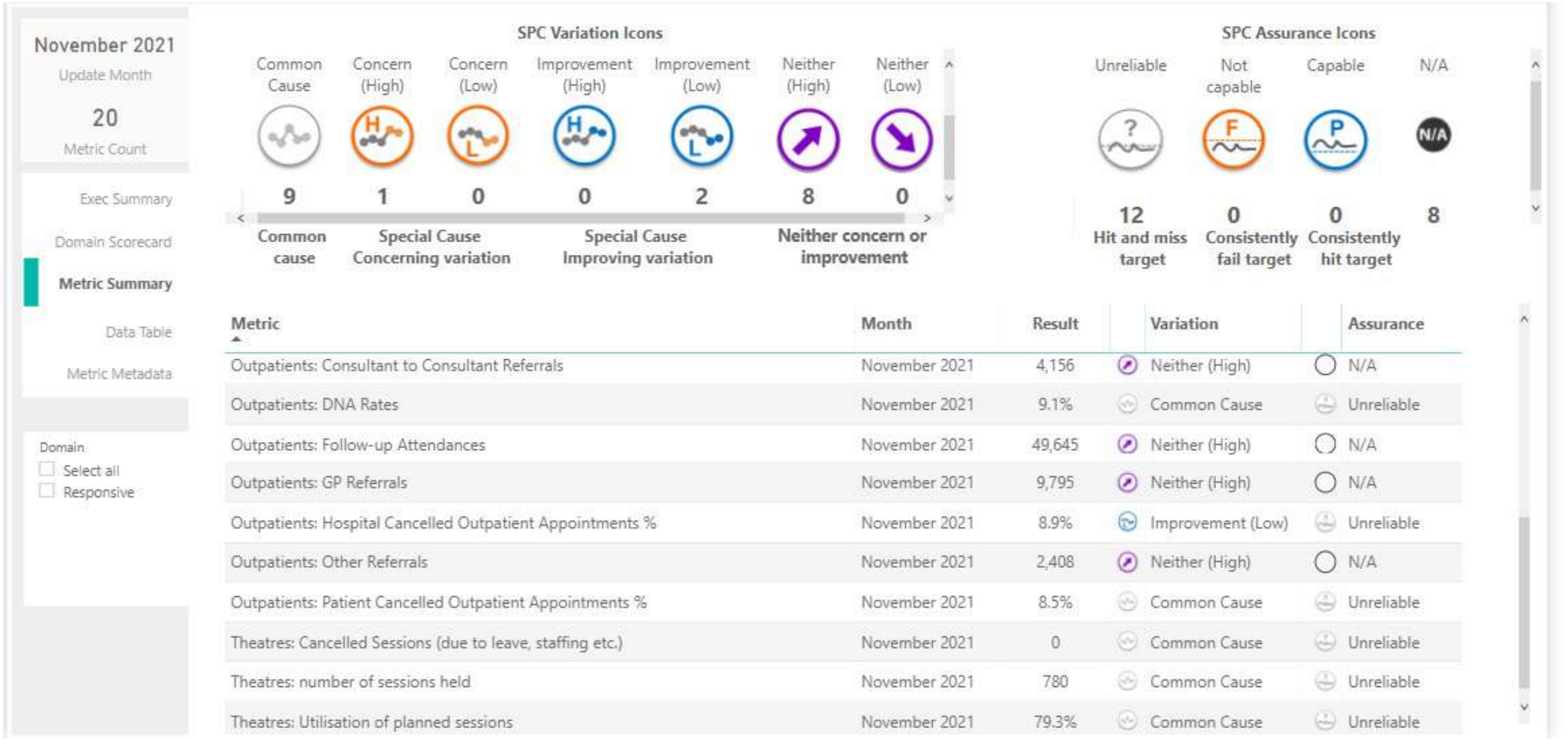
Unreliable	Not capable	Capable	N/A
5	5	3	0
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Advice & Guidance Volume	November 2021	2,608	Improvement (High)	Not capable
Diagnostics: Patients waiting 6 weeks or more from referral to test	November 2021	37.7%	Common Cause	Not capable
e-Referrals Service Rejected Requests and Referrals Returned by RAS	November 2021	14.2%	Concern (High)	Unreliable
Mean Week Waiting Time - Incomplete Pathways	November 2021	13	Improvement (Low)	Unreliable
Number of patients on Admitted Backlog (18+ weeks)	November 2021	13,582	Concern (High)	Capable
Number of patients on Non Admitted Backlog (18+ weeks)	November 2021	49,950	Concern (High)	Unreliable
Number of Priority 2 patients waiting >12 weeks	October 2021	361	Improvement (Low)	Not capable
RTT 104+ Weeks Waiters	November 2021	511	Concern (High)	Not capable
RTT 36+ Week Waiters	November 2021	10,786	Improvement (Low)	Capable
RTT 52+ Week Waiters	November 2021	5,623	Improvement (Low)	Unreliable
RTT Incomplete Pathways % performance	November 2021	59.3%	Improvement (High)	Not capable
RTT Total Waiting List	November 2021	62,682	Concern (High)	Unreliable

5. Operational Performance – Planned Care



Metric	Month	Result	Variation	Assurance
Cancelled op 28 day breaches % (quarterly)	September 2021	1.0%	Common Cause	Unreliable
Cancelled op 28 day breaches number	November 2021	10	Common Cause	Unreliable
Cancelled Operations % of FFCEs (quarterly)	September 2021	9.0%	Common Cause	Unreliable
Cancelled Operations number	November 2021	77	Concern (High)	Unreliable
Day Case Admissions	November 2021	6,628	Neither (High)	N/A
Elective Admissions	November 2021	966	Neither (High)	N/A
Outpatients: 1st Attendances	November 2021	21,543	Neither (High)	N/A
Outpatients: 1st to FU Ratio	November 2021	2.3	Common Cause	Unreliable
Outpatients: All Referral Types	November 2021	18,458	Neither (High)	N/A



Metric	Month	Result	Variation	Assurance
Outpatients: Consultant to Consultant Referrals	November 2021	4,156	Neither (High)	N/A
Outpatients: DNA Rates	November 2021	9.1%	Common Cause	Unreliable
Outpatients: Follow-up Attendances	November 2021	49,645	Neither (High)	N/A
Outpatients: GP Referrals	November 2021	9,795	Neither (High)	N/A
Outpatients: Hospital Cancelled Outpatient Appointments %	November 2021	8.9%	Improvement (Low)	Unreliable
Outpatients: Other Referrals	November 2021	2,408	Neither (High)	N/A
Outpatients: Patient Cancelled Outpatient Appointments %	November 2021	8.5%	Common Cause	Unreliable
Theatres: Cancelled Sessions (due to leave, staffing etc.)	November 2021	0	Common Cause	Unreliable
Theatres: number of sessions held	November 2021	780	Common Cause	Unreliable
Theatres: Utilisation of planned sessions	November 2021	79.3%	Common Cause	Unreliable

6. Emergency Care Standard and Unplanned Care

Operational Context

Delivery of the 4-Hour National Standard in November was not achieved. Actual performance was 53.9% for Type 1 activity and for both Type 1&3 combined 4-Hour performance was 68%, a deterioration of 2% when compared to the October position.

Type 1 ED attendances for the month of November were 10,812.

The Trust had 1 x 12-hour trolley wait on 25th November. A rapid review has been undertaken; duty of candour was completed along with an apology to the patient for their wait for transfer to another provider. This was a Mental Health breach.

Ambulance conveyances in November were 3,095 ambulance arrivals in month or an average of 103 per day.

Handover times in November were 29.5% of handovers within 15 minutes (average handover time was 33 minutes). There were 439 handover delays in November >60 minutes which is an increase on the previous month. The handover times remain a significant problem as a direct result of our ongoing flow issues across the system.

Targeted Actions

The UTC commenced from the 1st December, it was anticipated the service would see between 100-120 patients per day and deliver around a 5% overall improvement, currently the service is seeing between 70 and 90 pts per day and a 1% improvement. It is believed performance will increase as there have been a few days with exceptionally high breach numbers within this short initial period and therefore disproportionately effecting the position. In November 11 days had performance in excess of 70%, whereas 7 of the 1st 11 days were over 70% since the introduction of the UTC.

The Trust Escalation policy is being revised, the latest draft is currently being reviewed by Health Groups for comments. The revision is to ensure that actions taken are in line with the OPEL status and will be consistently enacted across the Trust. This will feed into patient flow meetings currently being trialled, the main change to the meetings is waiting on the IT update expected beginning of January with the standardisation of board rounds.

The development of an Urgent Care Co-ordination centre had it first workshop on the 6th December the aim being to create a SPA that will enable Ambulance crews to discuss patients with a senior clinician who can arrange alternatives to conveyance in the community.

YAS have completed an Upgrade to the EPR that will enable the removal of the administrative process for recording handover time. This is due for release mid January, the data is currently being analysed for expected impact.

The Steering group to oversee the Ambulance Improvement plan is meeting bi-weekly from the 16th December and has representatives from both CCG's, YAS, ECIST and the Trust, the meeting is chaired by the Deputy COO – non elective (HUTH) with the Deputy Chair being the Assistant Director, Acute and Unplanned Care Transformation (ERCCG)

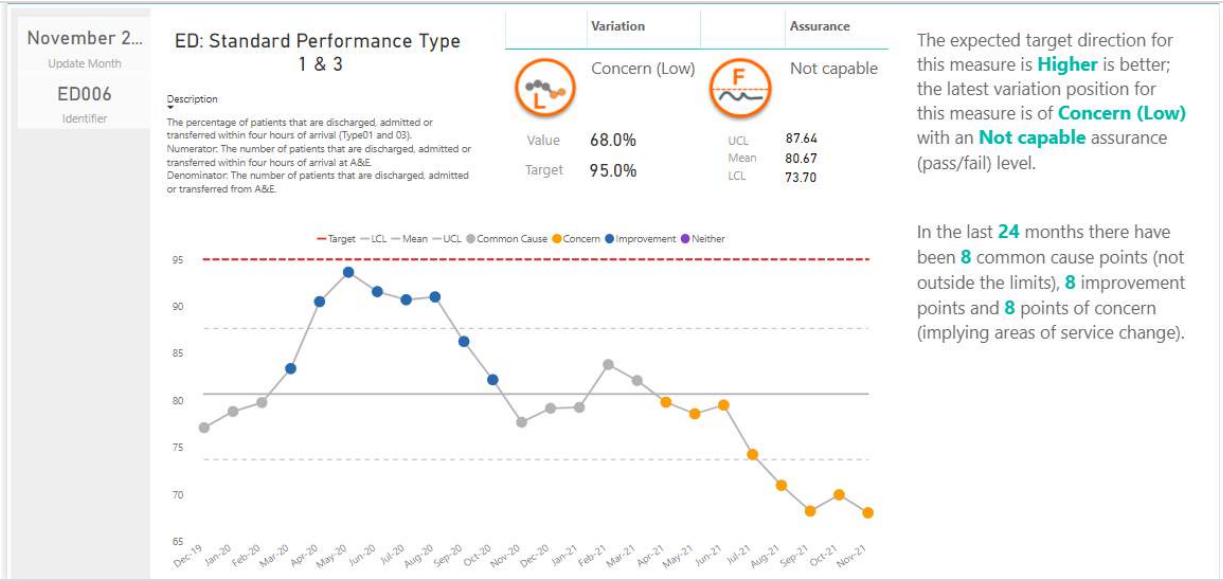
The in-hospital performance dashboard is being updated to include the likely new Emergency Care Standards expected to be confirmed for reporting from 1st April 2022. ED are currently reviewing their delivery in weekly Business meetings. Health Groups have been asked to develop plans for how they will deliver against these and will be monitored through the 4 Hour Deliver Group.

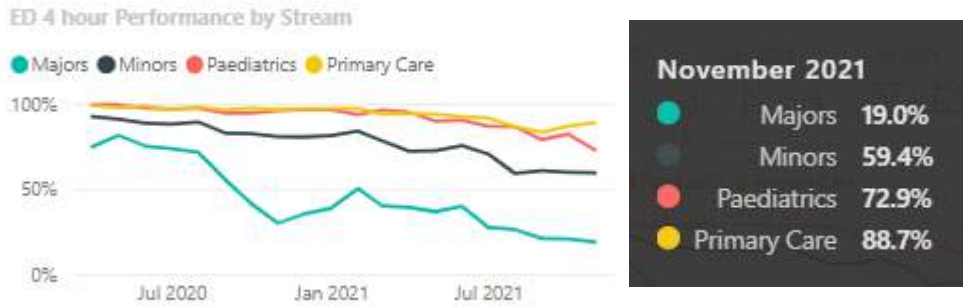
Emergency Care Health group are reviewing processes, triage and staffing model for the ECA area following the introduction of the UTC model to focus on performance improvement within this section of ED.

Outcome

A number of Task and finish groups are being established across the Emergency and Urgent Care Pathway that will be monitored either via the Steering group or 4 hour Delivery Group.

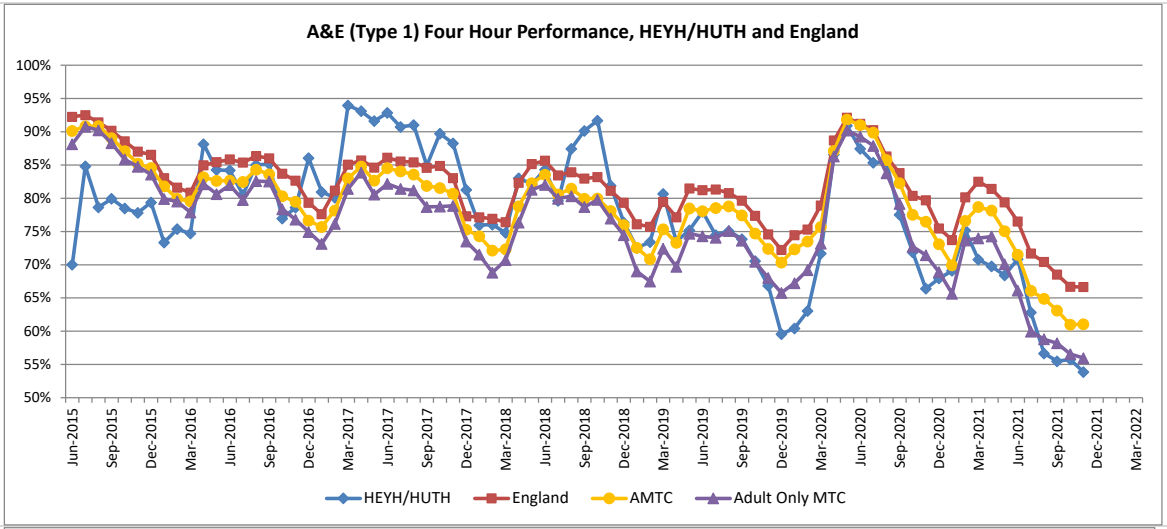
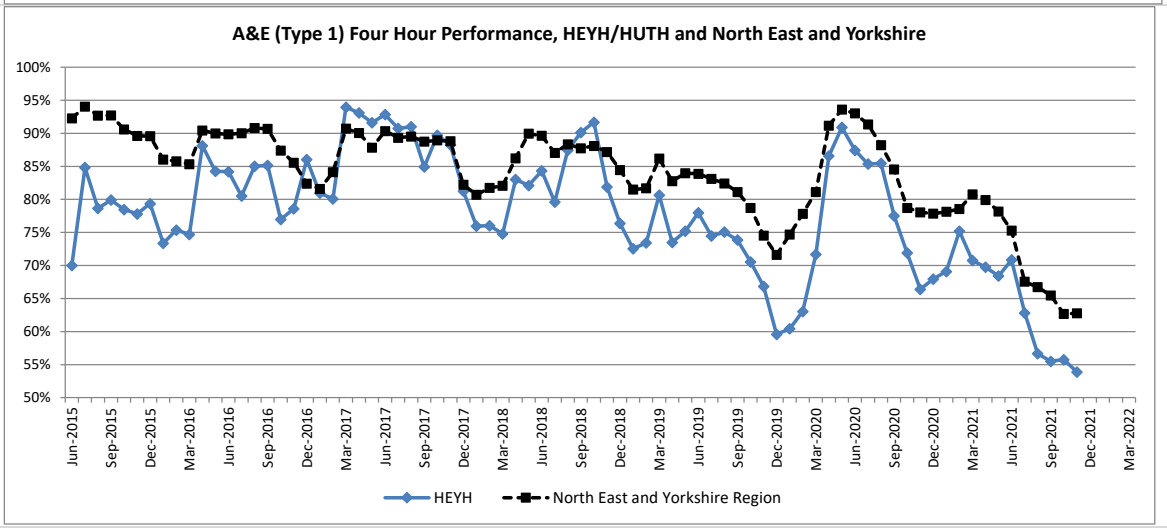
6.1 Emergency Care Standard

Standards	Ensure at least 95% of attendees to Accident & Emergency are admitted, transferred or discharged within 4 hours of arrival
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	The Trust achieved 53.9% in November 2021 for Type 1. Performance for Type 1 & 3 in November 2021 was 68%. • There were 439 handover delays greater than 60 minutes with average handover times at 33 minutes in November 2021. • There was one 12-hour trolley breach • 30.8% of patients spent more than 6 hours in the department The key metrics being monitored by the Trust's 4-hour Delivery Group are • Paediatric performance >95% • Primary care stream performance >95% • Emergency care stream performance >90% • Reduction in 6-hour discharge breaches • Reduction in 8-hour admit breaches
Performance	



Humber ICS Peer Analysis

In November 2021, the Trust ranked 131 out of 133 for Type 1 performance.

National Performance Comparator	
Regional Performance Comparator	

7. Cancer Waiting Times

Operational Context

- The Trust did not achieve the 2WW target in October 2021 with performance at 77.0%; a deteriorating position since September 2021.
- Following an improvement in September 2021, the 2WW breast symptomatic target significantly deteriorated with a performance of 20.9% in October 2021 (Breast Cancer Awareness month).
- In October 2021, performance against the 62-day Cancer standard was 55.7%, which is a further small improvement on the previous month. Challenges persist across most tumour sites, most of which are in the diagnostic stages of the cancer pathways.
- The Trust failed to achieve the 62-day National Screening standard at 61.8% in October 2021 (no significant change since September 2021). Bowel screening performance continues to face diagnostic constraint challenges (colonoscopy/CTC); timely access impedes achievement of the target.
- The Trust failed to meet the 31-day primary standard performing at 88.9%. The services achieving the target are Haematology, Upper GI and Brain (small numbers) whilst others failed to meet 96%.
- The Trust failed to meet the 31-day subsequent surgery standard at 75.5%, which is a deterioration since September 2021.
- The Trust failed to meet the 2WW Screening (combined) target; this was mainly due to Bowel Screening performance.

Targeted Actions

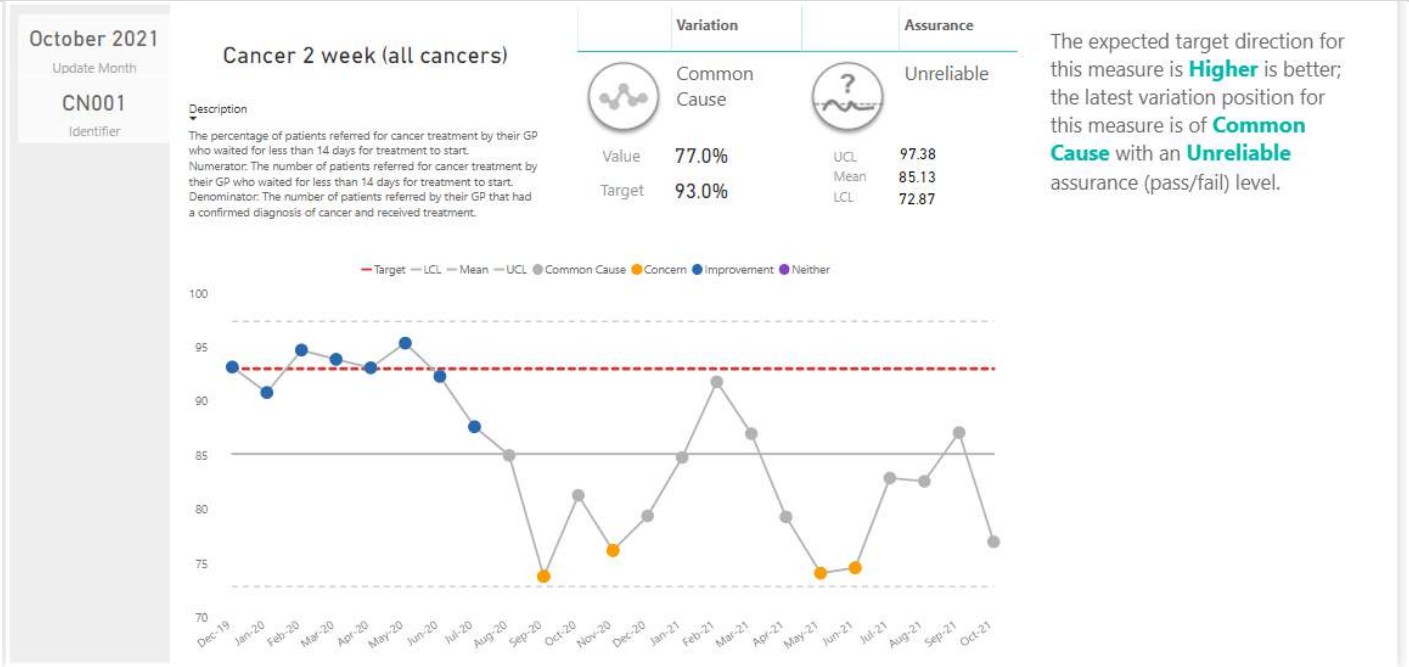
- The cancer transformation programme for improvement is very active and clinical teams are engaging with the process with Task and Finish Groups established in H&N, Lung and Colorectal to progress to implementation of identified improvements and first meetings scheduled for January 2022
- Colorectal – investigating the delays at the beginning of the pathway where triage is being undertaken.
    - GPs referring without FiT test result – means that there is a delay in identifying patients who are appropriate to go straight to test (STT). Further work with local primary care will commence January 2022.
    - Further work has been undertaken in respect of the ongoing (up to) 10-week wait for a CT Colonoscopy. Improved tracking and communication processes are agreed to reduce tracking duplication and progress patients along a 62-day pathway or take action on patients who are persistently non-compliant during the diagnostic stage.

- Breast – the service continues to face capacity issues primarily at the beginning of the pathway. Additional clinic capacity, which would require overtime, has not been forthcoming; work continues to provide as much capacity as possible to accommodate more patient slots.

- Skin – the main constraint is receiving timely histopathology results (specifically diagnostic biopsies). The Trust Cancer Manager is working closely with the Laboratory Manager to ensure that 62 day patient pathway samples are not are outsourced to private laboratories, and for these samples to remain 'in house'.
  The he Laboratory Manager will act as a gatekeeper to ensure that all patients on the skin cancer PTL are allocated to the consultant histopathologist with a request to report as urgent. The current outsourced company arrangements is being reviewed.

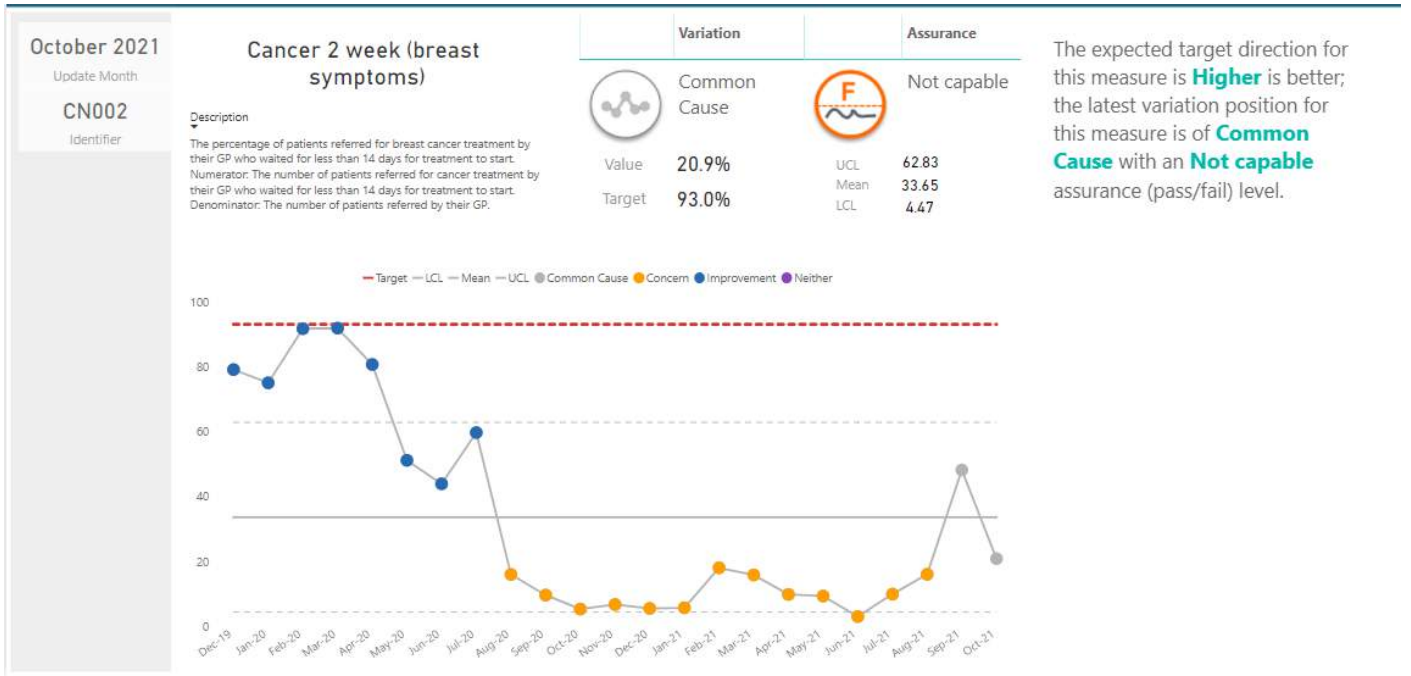
- Joint work across the Humber continues to reduce the number of late referrals sent to HUTH cancer services for treatment.

7.1 2 week wait Referrals

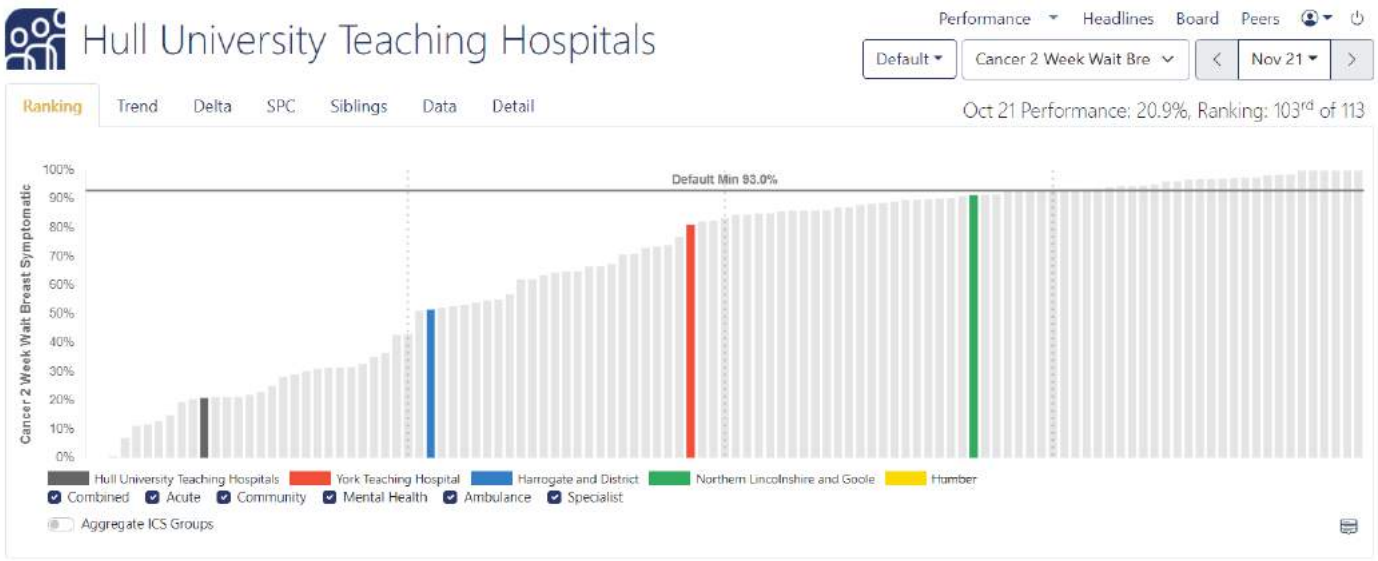
Standards	Ensure at least 93% of GP referrals for suspected cancer seen within 2 weeks of referral.
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	Overall, the Trust delivered 77% performance in October 2021 (a deterioration of 10% on September 2021). • There were 373 breaches of the 2ww standard with the majority in Breast at 192, UGI at 86, Colorectal at 35 and Skin at 32 • 2ww suspected cancer referrals are now back to pre-Covid levels of demand • 2ww Breast Cancer Performance improved to 92.2% in September 2021 but has deteriorated during October 2021 due to staffing levels when combined with Breast Cancer Awareness Month
Performance	

HCV Peer Analysis	Trust cancer 2 week wait when compared to HCV as at October 2021

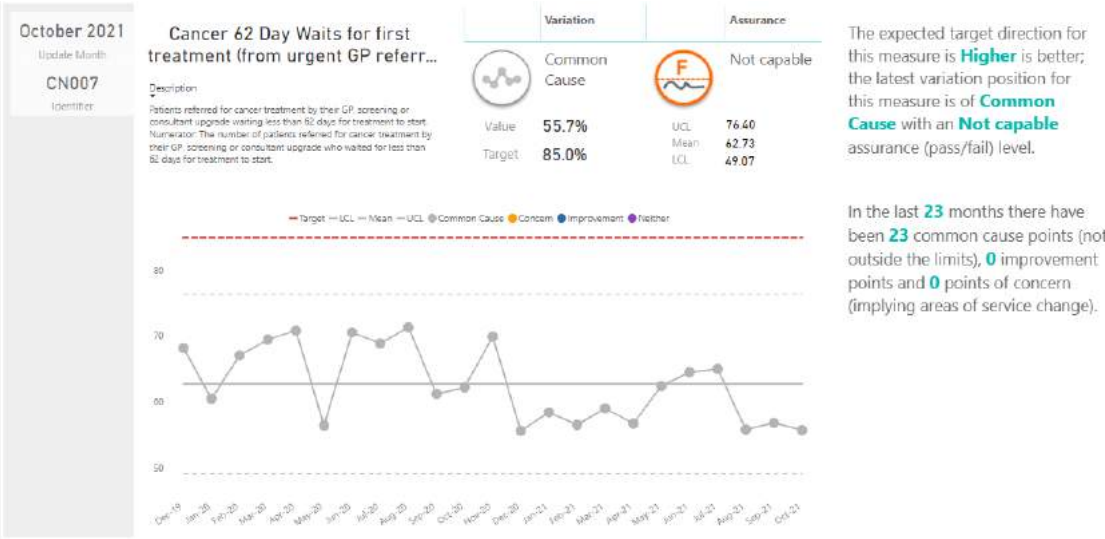
7.2 2 week wait Breast Symptomatic

Standards	Ensure at least 93% of GP referrals for breast symptomatic seen within 2 weeks of referral
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	Overall, the Trust failed to achieve the standard of 93% delivering 20.9% in October 2021 (a deterioration of 27.3% on September 2021) • Of the 163 attendances, 129 patients breached the standard due to consultant staffing shortfalls, radiographer capacity constraints or patient choice • The Trust continues to be significantly lower in performance than all acute Trusts and is ranked 103 of 114.
Performance	

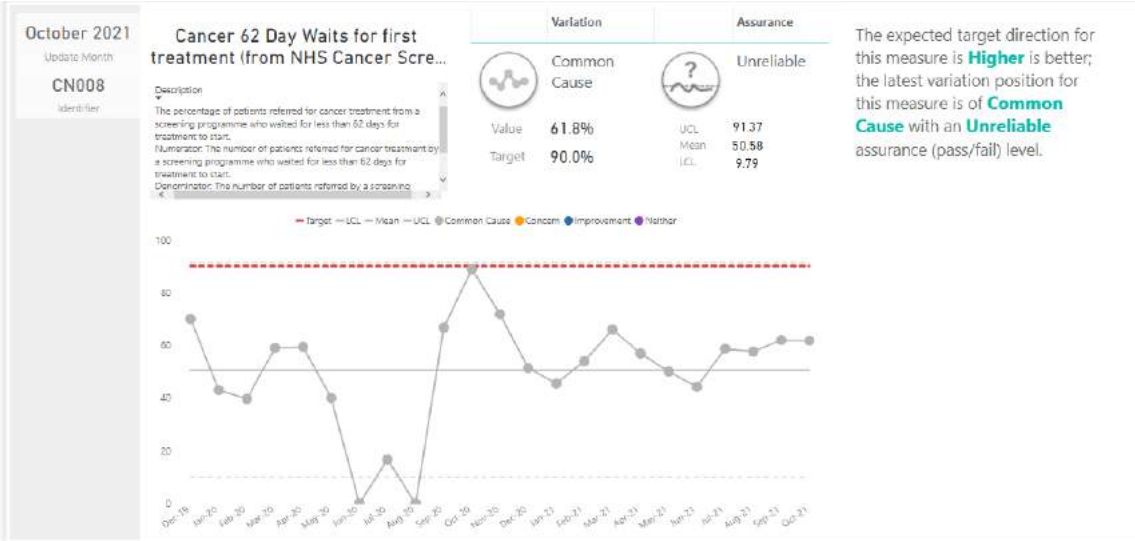
HCV Peer Analysis	Trust 2-week symptomatic Breast Performance compared to HCV as at October 2021.



7.3 62 Day Cancer Waiting Times

Standards	Ensure at least 85% of patients receive first definitive treatment within 62 days of urgent GP or GDP referral
Consequence of under-achievement	Patient experience, clinical outcomes and potential impact on timely access to treatment.
Performance Update:	Overall, the Trust achieved 55.7% performance in October 2021 (a deterioration of 1% on September 2021) • There were 78 accountable breaches (Breast 11.5, Colorectal 12.5, Gynaecology 8, H&N 5, Lung 11.5, UGI 9.5 & Urology 14.5) • Gynaecology is the tumour site with the lowest performance at 27.3% • Waiting list size at the end of October 2021 was 1,218 (a decrease of 119 on the previous month) • 63+ day breaches at the end of October 2021 was 189 against a H1 trajectory of 185 62-day screening performance for October 2021 was 61.8%, broadly similar to the previous month 104 days - At the end of October 2021 there were 56 patients recorded as having waited more than 104 days. The internal trajectory was to have no more than 53.
Performance	**Cancer 62 day Performance – GP referral** 

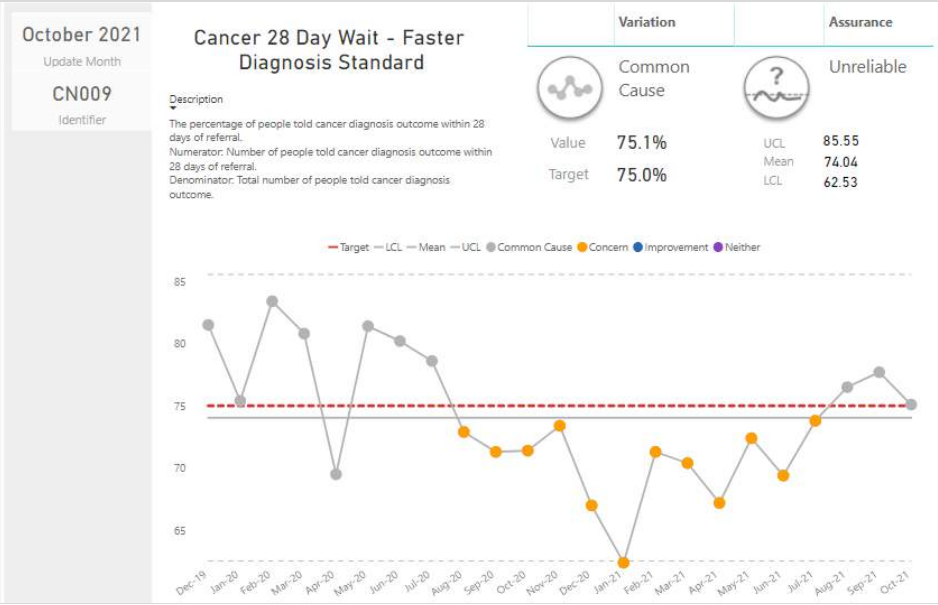
Cancer 62 day Performance – Screening



HCV Peer Analysis

62 day performance against Peer.

7.4 28 Day Faster Diagnosis

Standards	Ensure delivery of 75% of patients that are referred on a cancer pathway receive their diagnosis by day 28
Consequence of under-achievement	Patient experience, clinical outcomes and potential impact on timely access to treatment
Performance Update:	Overall the Trust delivered 75.1% performance in October 2021 a further improvement on the September 2021 position • Colorectal remains the tumour site with the significant problem due to the backlog in Endoscopy procedures at 34.5% • Urology due to capacity constraints for haematuria appointments at 44.8% • Haematology due to late inter-hospital tumour site referrals at 0% (1 patient) • Gynaecology due to failed outpatient Hysteroscopy requiring GA Hysteroscopy capacity and delays in Histology at 73.3%
SpC Analysis	

HCV Peer Analysis	Peer analysis shows that HUTH are performing well in HCV.

8. Planned Care

Operational Context

In November 2021, the Trust RTT provisional performance is 59%, which is broadly similar to the previous month. The provisional waiting list volume was above the H2 plan trajectory at 62,446 (plan 59,592). The final RTT upload is due on 17th December 2021 and validation will continue until that point.

- 52 week breaches reported is provisional at 5,616 (an improvement of 806 on the previous month) and was below the trajectory of 6,240.
- 104 week breach reduction target did not achieve the trajectory of 396, reporting 511 at the month end.
- Provisional Diagnostic performance is 37.7% of patients were waiting over 6 weeks which is a 1% improvement on October 2021. This equates to 4,512 patients waiting over 6 weeks (provisional).
- Outpatient New waiting lists has decreased slightly to 34,000 patients awaiting a first outpatient appointment (RTT applicable only)
- 26,652 patients overdue their follow up >3 months (undated) which is a slight increase on the previous month.
- Non face to face consultations in November 2021 was 19.8% of outpatient attendances which is below the H2 plan requirement of 25%. Further analysis is being undertaken to benchmark against other providers in the region for acute services (without community services), as we are an outlier in HCV.
- Advice and Guidance requests in November 2021 of 2,554 which is below the H2 plan of 2,929, however, these are predicated on GP requests. The new measure of % of A&G requests to first attendances achieved at 26.7% against the 12% minimum standard.
- Patient initiated follow ups (rather than traditional outpatient follow up at a clinically identified time) have been implemented in Cardiology, Dermatology, Neurology, Colorectal Surgery and Orthopaedics. A total of 256 patients were added to PIFU in November 2021 which was below the H2 plan trajectory of 799. The H2 plan requirements are to move 1.5% of all outpatient attendances to a PIFU pathway month; in November the Trust delivered 0.5%.
- There were 77 cancelled operations in November 2021 for non-clinical reasons. . There were 5 urgent cancelled operations in November 2021 but none cancelled for the second time. A further 10 patients were treated in November 2021 outside of their 28 day rebooking date

Targeted Actions

The Elective Recovery Group meet fortnightly and oversee the recovery programme and delivery of the outputs of the Task and Finish Groups; a review of the work programme will be complete by 31 January 2022. A separate Elective Recovery Report is provided for the Performance and Finance Committee, which outlines delivery of the plans with exception reports for the Top 12 specialties.

Elective Recovery Group Task & Finish Group 5 is ensuring that the revised H2 plan requirements improve PIFU and non-F2F consultations with work underway to benchmark the Trust's performance against providers and specialities both regionally and nationally to learn from their experience and delivery, i.e. Sheffield Children's Hospital and their rates of non-face-to-face attendances for paediatrics.

A Deputy Chief Operating Officer (Elective Recovery and Cancer) post has been established to provide additional capacity and oversight into managing the elective recovery and cancer delivery; an internal appointee commenced in post on 1 December 2021

A range of actions are being progressed for 2021/2022 Q4:

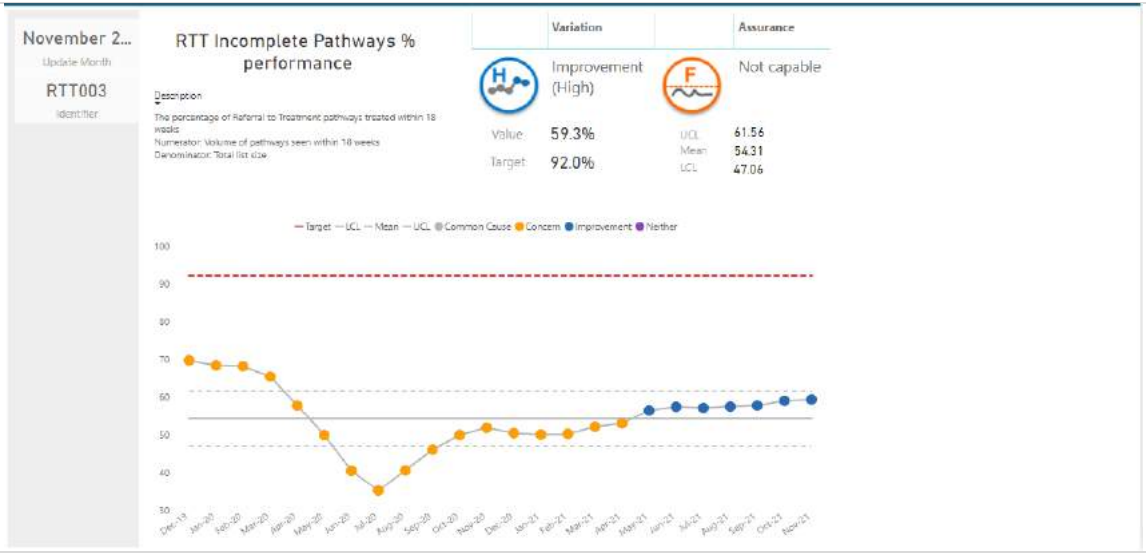
- The theatre programme from January to March 2022 will be increased from that delivered in Q3; specifically focussing capacity for specialities to deliver acute, cancer, P2 and 104 week requirements – this is dependent on an increase in ICU/HOB and surgical beds at CHH being available. Improved ICU capacity at CHH is expected following the opening of the new ICU units at HRI.
- Inter-ICS mutual aide arrangements are being explored to support a swap of capacity and demand between the x4 acute trusts
- Tertiary and specialist inter-provider mutual aide discussions are underway
- Further opportunities to insource and outsource capacity are being developed in order to maximise delivery in Q4 to achieve the trajectories and performance requirements

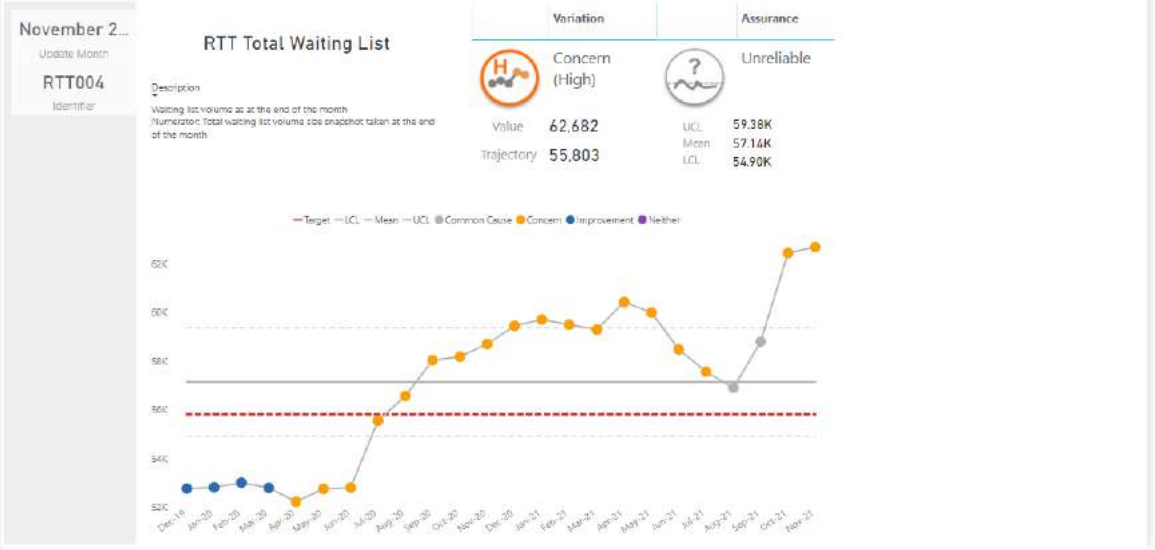
The weekly 104-week performance meeting, chaired by the Deputy COO, continues with a focussed approach to actions at patient level to minimise delays, share best practice in waiting list management and ensure that the over 104 week waits patients is managed to the trajectory by the end of March 2022.

Outcome

Quarterly review meetings with the Health Group triumvirate and Clinical Lead for each of the Top 12 specialties are booked for December 2021 – the purpose of the meetings is to review: H2 plans when compared to H1 plans and/or delivery, areas of risk and mitigating actions, understand if there is further support required.

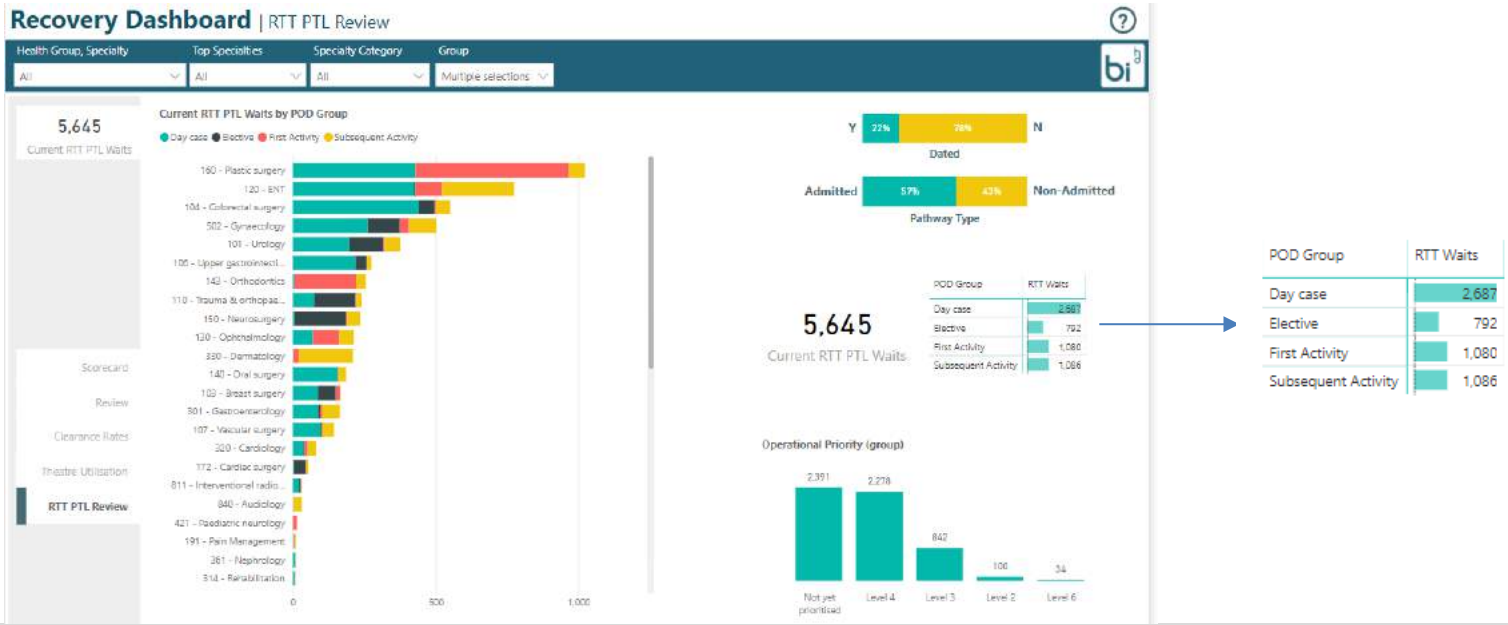
8.1 18 Week Referral to Treatment

Standards	Ensure at least 92% of patients waiting on the incomplete pathways have waited less than 18 weeks Incomplete list size trajectory to be achieved – aim to reduce to 60,618 by end of March 2022
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**Overall the Trust delivered 59% performance in November 2021** • Provisional RTT list size for November was above the trajectory at 62,446 (trajectory 59,592)
Performance	

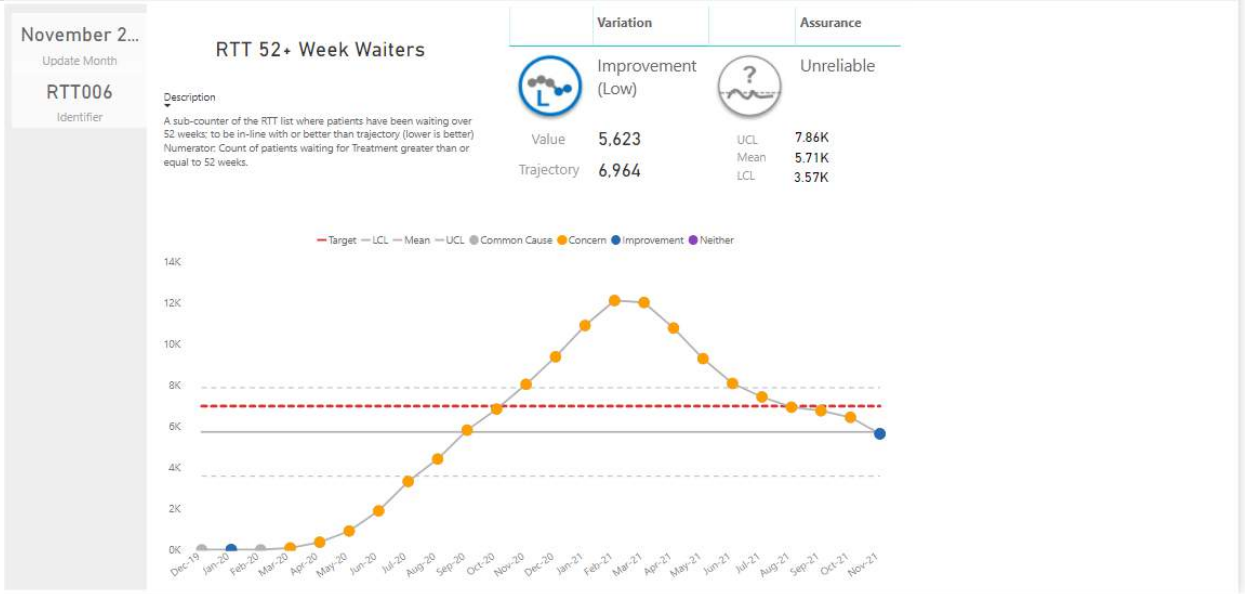
RTT WLV	
Peer Analysis	RTT Incomplete Performance against peer (bars HCV providers) show HUTH ranked at 143 out of 172. 

8.2 52 Week Breaches

Standards	Zero tolerance of 52 week waits
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**Provisional 52 week breaches reported in November is 5,616 (- 806 on October 21) and under trajectory** • 3,190 admitted breaches • 2,426 non-admitted breaches • 18% of the breaches are in Plastic Surgery (1,004) which has reduced by 137 on the previous month. 58% are on a non-admitted pathway – additional capacity being made available from December 2021 • 14% of the remaining breaches are in ENT (807) an improvement of 272 on October 2021.
Performance	The dashboard below shows the 52 week breaches by specialty and Point of Delivery (POD). Note that data below shows the current in-week position.



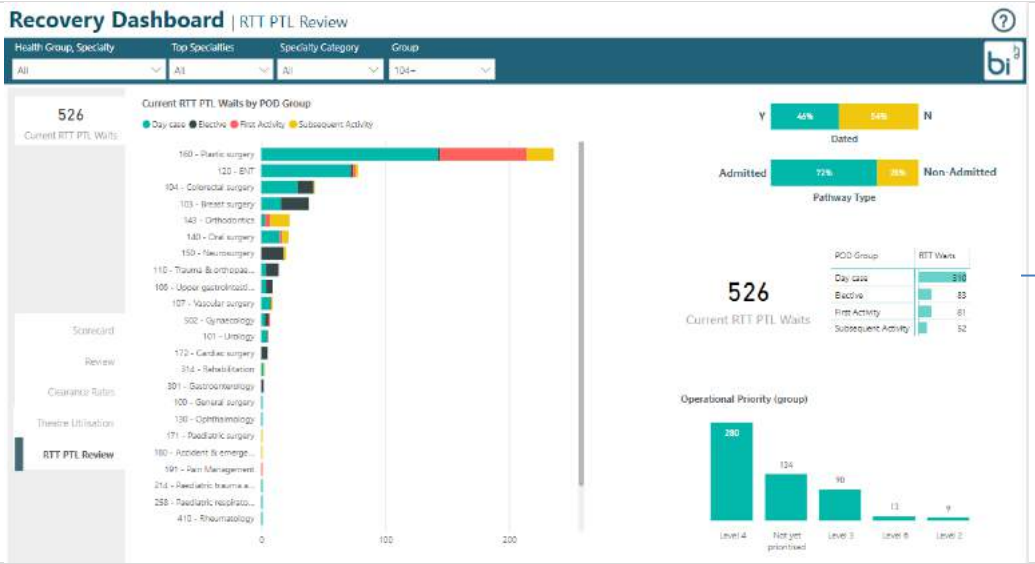
SpC Analysis

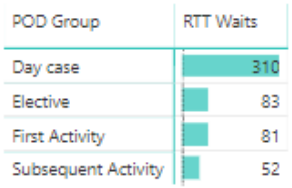


HCV Peer Analysis

8.3 104 Week Breaches

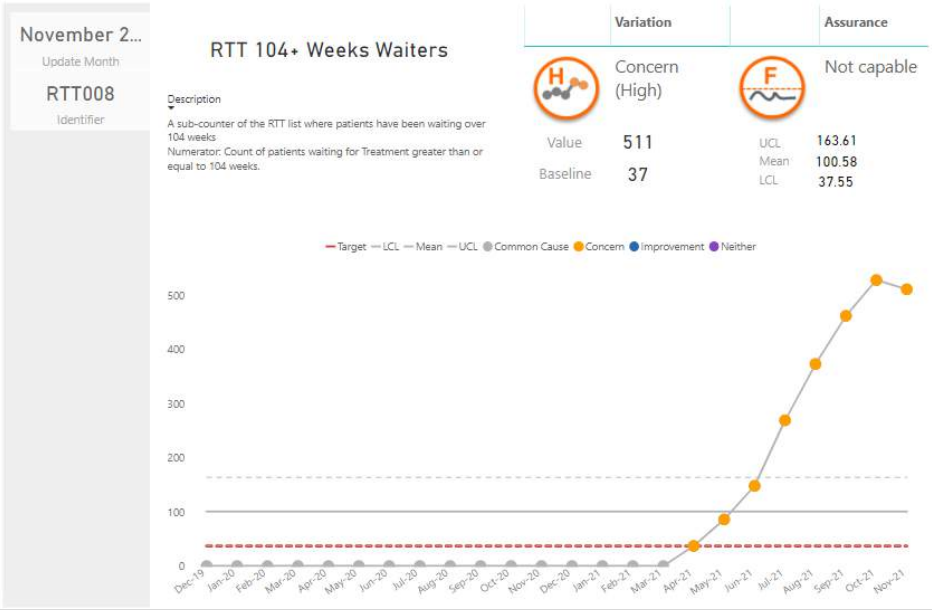
Standards	Zero tolerance of 104 week waits by end of March 2022
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**Provisional 104 week breaches reported at the end of November is 511, a decrease of 17 on the previous month and above the trajectory of 396** • 378 admitted breaches • 133 non-admitted breaches • 45% of the breaches are in Plastic Surgery (231) • 16% of the remaining breaches are in ENT (80) The Trust has the 7th highest number of 104-week breaches nationally and is under significant scrutiny in delivery of zero 104 waits by the end of March 2022. A reduction trajectory has been agreed. All non-admitted patients will have a TCI by the end of December 2021, to be seen by the end of January 2022. Additional Plastic Surgery capacity is being delivered from November 2021 with the commencement of 2 new Plastic Surgeons (one replacement and one additional) which will improve this position. Orthodontics is the highest risk in delivering zero 104-week breaches at the end of March 2022 - a delivery plan has not yet been agreed. Colorectal Surgery, Orthopaedics, Urology and Plastic Surgery are other areas of concern. An ICS wide meeting has been held to look at delivery of zero 104 weeks across HCV and what mutual aid opportunities can be progressed. In addition the Trust is working on a plan to insource and outsource additional work using the independent sector.
Performance	The dashboard below shows the 104 week breaches by specialty and Point of Delivery (POD). Note that data below shows the current in-week position.





POD Group	RTT Waits
Day case	310
Elective	83
First Activity	81
Subsequent Activity	52

SpC Analysis



8.4 Priority 2 Patients

Standards	Reduction in the number of Priority 2 patients waiting longer than 12 weeks
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action. Priority 2 patients should be treated within 4 weeks of decision to treat.
Performance Update:	The number of patients waiting over 12 weeks as a Priority 2 at the end of November 2021 was 176 (+4 on previous month). • Total patients waiting for a P2 procedure was 1,236 (a reduction of 66 on the previous month) • 530 of these had waited over 4 weeks with performance at 57.1% (an increase of 10 on the previous month) The Trust is under scrutiny on the number of patients waiting >12 weeks as a Priority 2 - an additional weekly meeting has been implemented chaired by the Deputy Chief Operating Officer with Divisional General Managers to focus on reduction of this.
Performance	The top 10 specialties by total number of P2 is listed below. Full validation is underway on the patients waiting over 12 weeks.

Count of NHSNo	Priority wait				% Performance
Treatment Function	<4	>4	13+	Grand Total	<4w
Cardiac surgery	20	45	45	110	18.2%
Vascular surgery	18	30	37	85	21.2%
Plastic surgery	70	50	35	155	45.2%
Urology	118	29	15	162	72.8%
Colorectal surgery	43	27	15	85	50.6%
Neurosurgery	32	16	7	55	58.2%
Ophthalmology	50	16	5	71	70.4%
Upper gastrointestinal surgery	24	21	4	49	49.0%
Pain Management	4	18	3	25	16.0%
Oral surgery	16	8	3	27	59.3%

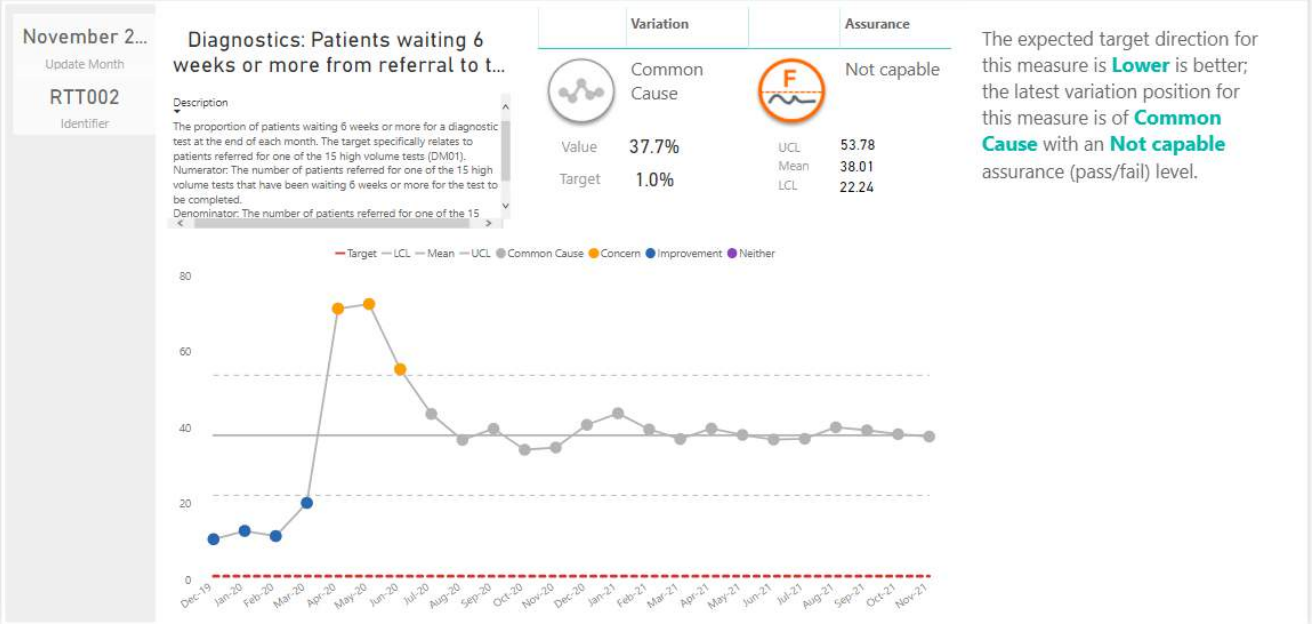
Current constraints:

- Cardiac - access to ICU and/or HOB capacity as we are open to x3 units on HRI ahead of the move to the new building (building handover w/c 06/12/2021 and transfer of patients w/c 13/12/2021).
- Vascular is related to the increased acute demand – we are looking to increase their theatre capacity especially day surgery to support a reduction; the same applies to Urology – both for Q4
- Plastic surgery requires additional theatre capacity now we have the surgeons; again looking to support them with a revised timetable for Q4.
- Colorectal is beds and ICU/HOB capacity as per the above.

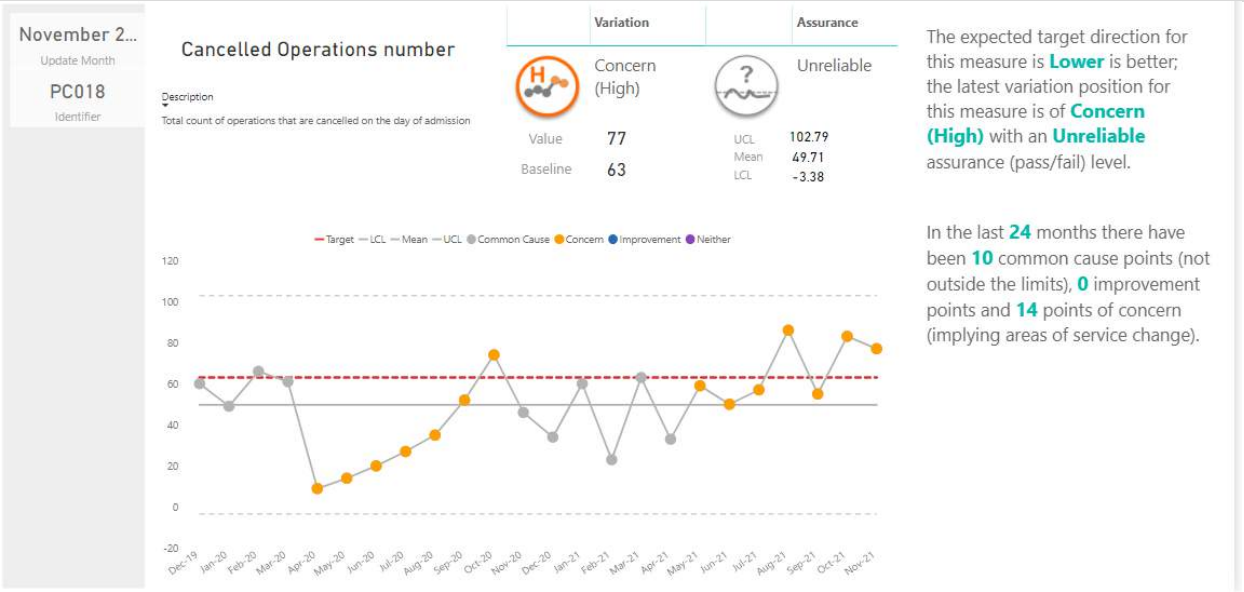
9. Diagnostic 6 week wait (top 15 tests)

Standards	Ensure that less than 1% of patients awaiting diagnostic tests are over 6 weeks.
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**Overall, the Trust achieved 37.7% performance in November 2021 (provisional position), which is 1% improvement on October**. • Total over 6 week waits = 4,512 which is a decrease of 131 on the previous month
Performance	Echocardiography, Colonoscopy and Flexi Sigmoidoscopy have seen a reduction in the 6-week breaches. *Provisional data below*

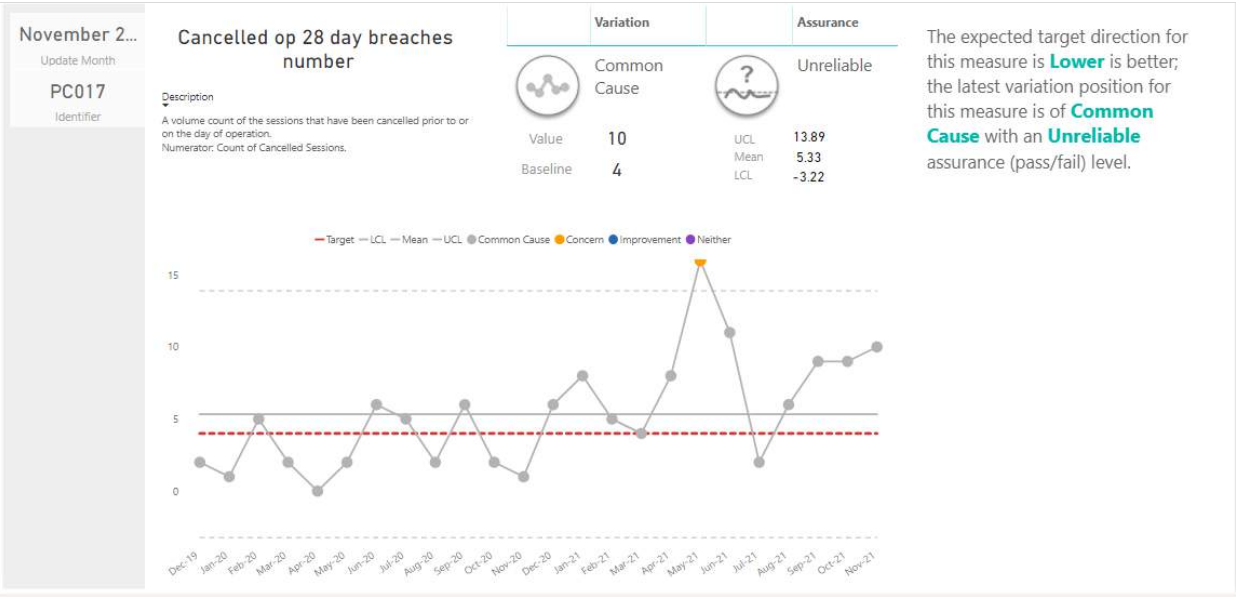
Magnetic Resonance Imaging	71
Computed Tomography	520
Non-obstetric ultrasound	95
Barium Enema	4
Cardiology - echocardiography	977
DEXA Scan	780
Neurophysiology - peripheral neurophysiology	4
Respiratory physiology - sleep studies	1
Urodynamics - pressures & flows	60
Cardiology - electrophysiology (epsip)	0
Colonoscopy	650
Flexi sigmoidoscopy	486
Gastroscopy + ENT	584
Cystoscopy	269
Audiology - Audiology Assessments	11
	4512

SpC Analysis	
HCV Peer Analysis	HCV Peer Analysis for October 2021. 

10. Cancelled Operations

Standards	Ensure no more than 0.8% of operations (as a % of FFCEs) are cancelled for non-clinical reasons on the day of admission. Ensure that any patient affected is re-dated within 28 days of the cancellation
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	Overall, the Trust had 77 patients cancelled for non-clinical reasons in November 2021. • Total number of breaches of the 28-day standard (treated in November 2021) = 10 (Cardiac x1, Neurosurgery x1, Ophthalmology x1, T&O x1, UGI x1, Urology x2, Vascular x3) • There were 5 urgent cancelled operations in November 2021 but none for the second time.
Performance	

Performance – 28 day Breaches



Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.03.22
Title	Finance Report – Month 10				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Deputy Director of Finance				
Report previously considered by (date)					

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

Key Recommendations to be considered:

The Board is asked to note the following:

a) The H2 reported position to date of a £1.0m surplus in line with plan.

b) The forecast delivery of a £1.7m surplus in line with plan

c) The potential £4.4m risk to delivery of the plan, including the £1.5m system risk

d) The review of the underlying position as part of the 2022/23 planning process.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

FINANCIAL UPDATE - MONTH 10 REPORTING

1. Purpose of Paper

To update the Board on the month 10 position and forecast.

2. Background

The Trust delivered its control total target for H1 of a deficit of £1.7m. The Trust has a plan to deliver a surplus of £1.7m in the H2 so that it will be able to report a balanced financial position for the overall 2021/22 year.

3. Month 10

The Trust is reporting that it is has a surplus of £1.0m at month 10 in line with the plan. Appendix 1 shows the breakdown of the variance position. It also shows the forecast variance for H2 and the cumulative variance for the year. Appendix 2 shows the plan and forecast actual for the full year.

For H2 year to date Health Groups and corporate are showing as £0.8m overspent, unchanged from month 9. The movement from Month 8 by Health Group/Corporate area is shown in the table below:

					In-Month
	Month 8	Month 9	Month 10		Change
Health Group	**£000**	**£000**	**£000**		**£000**
Surgery	(8)	46	306		260
Medicine	(29)	19	(37)		(56)
Emergency Care	126	210	415		205
Clinical Support Services	(379)	(517)	(706)		(189)
Pass-Through Drugs	238	110	(244)		(354)
Family & Women's Health	(296)	(492)	(313)		179
Corporate Directors	4	(39)	(59)		(20)
Estates, Facilities & Development	(17)	(141)	(155)		(14)
TOTAL	**(361)**	**(804)**	**(793)**		**11**

In month Surgery and Family & Women's Health Groups recorded underspends due to the low levels of elective activity undertaken, reflecting the continuing high level of Covid19 patients and staff being redeployed to cover high sickness levels. The resultant non-pay savings were above the pressure faced on Junior Doctor staffing and pressures dealing with Paediatric Gastroenterology and Continuity of Carer.

Clinical Support position remains under pressure on consumables due to the increased levels of activity above the 2019/20 baseline in Haematology, Oncology and Direct Access Pathology. There is a shortfall on identification of CRES but the high level of non-recurrent vacancies is offsetting this.

ED is underspending due to high level of junior doctor gaps in the rotas.
Pass through drugs within the block element of the contract overspent by £0.4m in-month, moving the position from an under-spend to an over-spend of £0.2m.

Other areas were close to plan in month.

The Trust spent £0.9m on dealing with Covid19 in month as per the following categories:

`								Total
NHSEI Category	Month 7	Month 8	Month 9	Month 10	H2 Total		H1	Year to Date
	£000	£000	£000	£000	£000		£000	£000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	77	138	199	168	582		1,661	2,243
PPE associated costs	5	5	2	3	15		35	50
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	111	316	40	436	903		172	1,075
Remote management of patients	160	57	75	41	332		702	1,034
Support for stay at home models	4	4	4	4	16		38	54
Segregation of patient pathways	106	215	178	152	650		751	1,401
Decontamination	72	139	119	115	445		775	1,220
Remote working for non-patient activities	0	0	8	1	9		28	37
Total	534	873	625	920	2,952		4,162	7,114

There has been a big increase in month in use of ITU capacity (including respiratory support).

Elective Recovery Income remains slightly above plan at month 10, although this has reduced in month due to the drop in elective activity following the Covid surge..

4. CRES POSITION

To support the Trust position for H2, Health Groups and Corporate areas were set a target of delivering savings of £2.6m. This was approximately 0.8% of the budget.

	H2 CRES Target	Schemes Identified Total	Full Year Effect Total	2022/23 Minimum Target 2.20% Total	2022/23 Still To Find
	£000	£000	£000	£000	£000
Medicine	338	214	63	1,855	1,792
Emergency & Acute Medicine	74	62	69	400	331
Surgery	581	523	1,090	3,108	2,018
Family & Womens Health	340	28	96	1,837	1,741
Clinical Support Services	422	75	163	2,096	1,933
Corporate	299	299	195	1,200	1,005
Estates, Facilities & Development	182	136	176	1,002	826
Other	393	393	0	1,502	1,502
Total	**2,629**	**1,729**	**1,852**	**13,000**	**11,148**

To date £1.7m of savings have been identified with a full year effect of £1.9m. Of the full year effect savings, nearly 60% are from one Health Group, Surgery.

The minimum requirement for savings in 2022/23 will be 2.2% (1.1% full year effect from 2021/22 plus 1.1% for 2022/23). This will be the national requirement with no contribution to support investments that the Trust would wish to make.
If the Trust needs to make further investments for which it cannot source funding, or it faces further cost pressures (for example inflationary pressures), then the savings target will need to be higher.

The table above shows the minimum target for 2022/23 plus how far away Health Groups are from minimum target level.

Health Groups have been tasked to re-establish financial governance arrangements (where not already in place) to support the development of efficiency schemes to meet the minimum targets. Support and monitoring will continue through the Productivity and Efficiency Board.

5. FORECAST OUTTURN

The Trust is reporting that it will deliver its planned position for H2 of a £1.7m surplus.

This contains an element of risk to delivery of the position, including the ICS identifying actions to make £1.5m of savings for the overall system risk that sits within the Trust figures. The Trust risk is estimated at £4.4m. This has reduced from £5.3m at Month 9:

ICS	£1.5m
ERF funding	£0.6m
Health Group Positions	£1.6m (includes £0.9m unidentified CRES)
Reserves Slippage	£0.7m
Total Risk	£4.4m

The ERF risk is the potential non-delivery of the activity that was included in the plan for the last 3 months (including month 10, which is not confirmed).

The Health Group risk is a continuation of the issues experienced in the year to date position plus the current shortfall on CRES schemes.

The plan included a level of slippage on reserves to ensure delivery. As pressures emerge, for example, additional spend required to deal with the growing Covid19 issues this may not allow sufficient flexibility to release this slippage. The potential on reserves is being kept under review along with reviews of the balance sheet to see what possible actions could be taken.

The Trust received additional revenue funding in Month 10 for Digital aspirant (£1.1m), peri-natal mental health (£0.2m), skin pathway (£0.2m) and Bowel Screening (£0.1m).

The underlying position is being reviewed as part of the 2022/23 planning update.

6. Statement of Financial Position (SOFP) and Statement of Cash flow (SOCF)

The SOFP and SOCF for month 10 are reported in appendices 3 and 4.

Capital

The reported capital position at month 10 shows gross capital expenditure of £42.0m against an original plan of £42.0m. The main areas of expenditure relate to the Salix Energy Efficient scheme; Theatre Upgrade; Backlog Maintenance & Compliance and Urgent & Emergency Care.

The planned capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £81.9m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Digital Aspirant (£1.5m) and Day Surgery (£10.0m). The PDC Applications for Theatres and the Gamma Camera have been submitted to the local ICS Finance team for review and approval but due to the Trust's current level of cash balance, it is unlikely that PDC funding will be given. The Trust is however continuing with these schemes and funding through internal cash resources.

In this month's forecast, the Trust has reflected an additional £1.2m of expenditure on equipment and backlog maintenance using additional ICS slippage.

Cash

The Trust's liquidity position remains healthy with a cash balance of £70.3m at the end of January. The forecast cash balance by the end of March 22 is now expected to be £60m and is regularly reviewed to reflect change in timings of capital spend.

To date the Trust has paid 96.4% by volume and 89.3% by value of non-NHS invoices within best practice terms. In January, the figures were 96.6% and 87.4% respectively.

Stocks

Stock levels are at £16.7m, a decrease of £0.3m in month but still £1.7m higher than the year-end figures.

Health Group	Mar 21 £000	Dec 21 £000	Jan 22 £000	Change from March 21 £000
Clinical Support	7,460	7,878	7,988	528
Surgery	4,247	4,461	4,488	241
Medicine	1,026	2,550	2,048	1,022
F & WH	1,174	1,026	1,122	(52)
Other	439	447	448	8
PPE Stock	635	635	635	0
Total	14,982	16,997	16,728	1,747

Stock levels in medicine have increased in the Cardiology area mainly to reflect increased levels of activity in the Cath labs and to mitigate against delays in deliveries of supplies due to leaving the EU and the pandemic.

Debtors

The Trust currently has £3.9m of debt that is over 90 days. This has increased by £0.5m in month. The main debtors being as follows:

Debtors Over 90 Days	December 21	January 22	Change
	£000	£000	£000
City Health Care Partnership	401,979	441,509	39,530
York & Scarborough Teaching Hospitals Nhs Ft	459,765	374,248	-85,516
Northern Lincolnshire And Goole Nhs Ft	214,857	354,904	140,047
Humber Teaching Nhs Foundation Trust	226,503	300,454	73,951
Nhs Hull Ccg	-45,795	148,481	194,276
East Riding Fertility Services Ltd	70,023	102,285	32,262
University Of Hull	109,935	99,793	-10,142
Welsh Health Specialised Services Committee	91,823	91,823	0
Nhs England Yorkshire & Humber Q72	0	85,530	85,530
Fresenius Medical Care Renal Services Ltd	77,505	77,505	0
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
Ge Healthcare	51,962	51,962	0
Abbott Medical Uk	50,000	0	-50,000
Others	1,591,489	1,664,904	73,415
Total	3,370,366	3,863,718	493,351

Work continues with all organisations to reduce outstanding balances. Several invoices have been paid in February for City Healthcare, Northern Lincolnshire, NHS England. Cardiff Trust will pay the Welsh Health Services invoice. The invoice to NHS Hull invoice has been credited and will be re-invoiced at a lower value. Work continues with York Trust to establish a process for monthly blocks with reconciliations to ensure outstanding balances remain at a low level. This may be rolled-out across the ICS.

7. Recommendations

The Board is asked to note the following:

a) The H2 reported position to date of a £1.0m surplus in line with plan.

b) The forecast delivery of a £1.7m surplus in line with plan

c) The potential £4.4m risk to delivery of the plan, including the £1.5m system risk

d) The review of the underlying position as part of the 2022/23 planning process.

Stephen Evans
Deputy Director of Finance
March 2022

APPENDIX 1

Financial Year 2022 Month 10

	M7-12 Budget £000 (H2)	H2 YTD £000	H2 Actual £000	H2 YTD Variance £000	H2 Forecast Variance £000	M1-6 Variance £000	Cumulative Variance £000
Nhs Contract Income	327,492	220,457	220,512	**55**	2,402	281	2,683
Nhs Other Clinical Income	80	53	59	**6**	7	0	7
Education + Training Income	11,009	7,340	7,340	**0**	(173)	0	(173)
Other Income	5,580	5,053	4,991	**(62)**	2,659	(3,162)	(503)
Covid Donated	0	0	0	**0**	0	3,301	3,301
ERF	9,879	5,798	5,889	**91**	0	1,326	1,326
Total Income	**354,041**	**238,701**	**238,791**	**90**	**4,894**	**1,746**	**6,640**
Surgery	(72,069)	(48,517)	(48,211)	**306**	73	(472)	(399)
Medicine	(43,849)	(29,483)	(29,520)	**(37)**	(189)	(458)	(647)
Emergency Care Health Group	(9,401)	(6,274)	(5,859)	**415**	510	439	949
Clinical Support Services	(49,531)	(33,261)	(33,967)	**(706)**	(1,215)	(454)	(1,669)
Pass-Through Drugs	(35,792)	(23,861)	(24,105)	**(244)**	(293)	(675)	(968)
Family + Womens Health	(43,257)	(29,199)	(29,512)	**(313)**	(492)	(441)	(933)
Corporate Directorates	(40,127)	(27,161)	(27,220)	**(59)**	(2)	(8)	(10)
Estates Facilities & Developmt	(23,670)	(15,789)	(15,944)	**(155)**	(128)	9	(119)
Reserves	(10,168)	(7,154)	(6,034)	**1,120**	(617)	759	142
Other Operating Expenditure	(4,139)	(2,704)	(2,629)	**75**	116	82	198
Total Operating Expenditure	**(332,003)**	**(223,403)**	**(223,001)**	**402**	**(2,237)**	**(1,219)**	**(3,456)**
Donated Asset Income	(4,420)	(4,280)	(4,249)	**31**	(2,774)	(527)	(3,301)
EBITDA	**17,618**	**11,018**	**11,541**	**523**	(116)	**0**	(117)
Depreciation	(9,102)	(6,071)	(6,071)	**0**	0	0	0
Interest Payable	(2,956)	(1,983)	(1,983)	**0**	0	0	0
Interest Receivable	0	0	5	**5**	15	0	15
Pdc Dividends	(4,190)	(2,792)	(2,792)	**0**	0	0	0
Profit / Loss On Disposal	0	0	0	**0**	0	(63)	(63)
Transfer by Absorption	0	0	(1,066)	**(1,066)**	(1,066)	0	(1,066)
Total Non Operating Expenditure	**(16,248)**	**(10,846)**	**(11,907)**	**-1,061**	**(1,051)**	**(63)**	**(1,114)**
Impairment	0		0	**0**		0	0
Net Surplus/Deficit	**5,790**	**4,452**	**3,883**	**(569)**	**1,606**	**464**	**2,070**
Donated Asset Adjustment	(4,120)	(3,432)	(3,929)	**(497)**	(2,672)	(527)	(3,199)
Adjusted Financial Performance Surplus/Deficit	**1,670**	**1,020**	**(46)**	**(1,066)**	(1,066)	**(63)**	**(1,129)**
Less Profit/Loss on Disposal (covid) and transfer	**1,670**	**1,020**	**1,020**	**0**	**0**	**0**	**0**

APPENDIX 2

Financial Year 2022 Month 10

	Annual Budget £000	Latest Annual Forecast £000	Forecast Variance £000
Nhs Contract Income	644,100	646,783	2,683
Nhs Other Clinical Income	160	167	7
Education + Training Income	21,383	21,210	(173)
Other Income	16,333	15,830	(503)
Covid Donated	0	3,301	3,301
ERF	17,426	18,752	1,326
Total Income	**699,403**	**710,739**	**6,640**
Surgery	(142,905)	(143,304)	(399)
Medicine	(87,539)	(88,186)	(647)
Emergency Department	(18,504)	(17,555)	949
Clinical Support Services	(103,518)	(105,187)	(1,669)
Pass-Through Drugs	(69,493)	(70,461)	(968)
Family + Womens Health	(87,147)	(88,080)	(933)
Corporate Directorates	(79,491)	(79,501)	(10)
Estates Facilities & Developmt	(47,588)	(47,707)	(119)
Reserves	(9,339)	(9,197)	142
Other Operating Expenditure	(8,207)	(8,009)	198
Total Operating Expenditure	**(653,731)**	**(657,187)**	**(3,456)**
Donated Asset Income	(14,013)	(17,314)	(3,301)
EBITDA	**31,659**	**31,542**	**(117)**
Depreciation	(18,204)	(18,204)	0
Interest Payable	(6,075)	(6,075)	0
Interest Receivable	0	15	15
Pdc Dividends	(7,980)	(7,980)	0
Profit / Loss On Disposal	0	(63)	(63)
Transfer by Absorption	0	(1,066)	(1,066)
Total Non Operating Expenditure	**(32,259)**	**(33,373)**	**(1,114)**
Impairment	0	0	0
Net Surplus/Deficit	**13,413**	**15,483**	**2,070**
Donated Asset Adjustment	(13,413)	(16,612)	(3,199)
Adjusted Financial Performance Surplus/Deficit	(0)	**(1,129)**	(1,129)
Less Profit/Loss on Disposal (covid) and transfer by absorption	**0**	**0**	**0**

APPENDIX 3

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2021 2020/21 £000	Actual 31/06/2021 YTD £000	Actual 31/09/2021 YTD £000	Actual 31/12/2021 YTD £000	Actual 31/01/2022 YTD £000	Movement from 31/03/21 £000
Non-current assets						
Intangible assets	5,980	5,602	6,914	6,514	6,396	416
Property, plant and equipment: on-SoFP IFRIC 12 assets	59,606	59,224	59,605	58,465	58,339	(1,267)
Property, plant and equipment: other	274,732	275,459	288,070	297,505	301,119	26,387
Investment property	100	100	100	100	100	0
Investments in joint ventures and associates						0
Other investments / financial assets	392	392	392	392	392	0
Receivables: due from NHS and DHSC group bodies	1,469	1,469	1,529	1,469	1,469	0
Receivables: due from non-NHS/DHSC group bodies	2,253	2,253	2,193	2,253	2,253	0
Other assets						
Total non-current assets	**344,532**	**344,499**	**358,803**	**366,698**	**370,068**	**25,536**
Current assets						
Inventories	14,982	15,565	16,760	16,997	16,728	1,746
Receivables: due from NHS and DHSC group bodies	8,871	19,978	18,766	7,674	11,494	2,623
Receivables: due from non-NHS/DHSC group bodies	10,298	11,406	11,305	11,331	11,349	1,051
Other investments / financial assets	0	0	0	0	0	0
Other assets	0	0	0	0	0	0
Non-current assets for sale and assets in disposal groups	0	0	0	0	0	0
Cash and cash equivalents: GBS/NLF	58,915	55,170	50,912	74,815	70,339	11,424
Cash and cash equivalents: commercial / in hand / other	12	12	8	18	12	0
Total current assets	**93,078**	**102,131**	**97,751**	**110,835**	**109,922**	**16,844**
Current liabilities						
Trade and other payables: capital	(26,808)	(6,708)	(9,850)	(10,451)	(12,169)	14,639
Trade and other payables: non-capital	(70,087)	(96,971)	(100,160)	(94,363)	(101,381)	(31,294)
Borrowings	(2,917)	(3,035)	(2,946)	(3,032)	(3,103)	(186)
Other financial liabilities	0	0	0	0	0	0
Provisions	(202)	(170)	(137)	(105)	(74)	128
Other liabilities: deferred income including contract liabili	(730)	0	0	(14,061)	(6,357)	(5,627)
Liabilities in disposal groups	0	0	0	0	0	0
Total current liabilities	**(100,744)**	**(106,884)**	**(113,093)**	**(122,012)**	**(123,084)**	**(22,340)**
Total assets less current liabilities	**336,866**	**339,746**	**343,461**	**355,521**	**356,906**	**20,040**
Non-current liabilities						
Trade and other payables	0	0	0	0	0	0
Borrowings	(54,350)	(53,920)	(52,868)	(52,485)	(52,279)	2,071
Other financial liabilities	0					0
Provisions	(5,683)	(5,683)	(5,682)	(5,684)	(5,683)	0
Other liabilities	0	0	0	0	0	0
Total non-current liabilities	**(60,033)**	**(59,603)**	**(58,550)**	**(58,169)**	**(57,962)**	**2,071**
Total assets employed	**276,833**	**280,143**	**284,911**	**297,352**	**298,944**	**22,111**
Financed by						
Taxpayers' equity						
Public dividend capital	292,247	292,247	292,247	302,387	302,387	10,140
Revaluation reserve	21,556	21,556	21,556	21,556	21,556	0
Financial assets at FV through OCI reserve	392	392	392	392	392	0
Other reserves	0	0	0	0	0	0
Merger reserve	0	0	0	0	0	0
Income and expenditure reserve	(37,362)	(34,052)	(29,284)	(26,983)	(25,391)	11,971
Others' equity						
Non-controlling Interest	0	0	0	0	0	0
Charitable fund reserves	0	0	0	0	0	0
Total taxpayers' and others' equity	**276,833**	**280,143**	**284,911**	**297,352**	**298,944**	**22,111**

APPENDIX 4

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2021 2020/21 £000	Actual 31/01/2022 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	1,304	24,796
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**1,304**	**24,796**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	16,506	15,173
Impairments and reversals	15,258	0
Income recognised in respect of capital donations (cash and non-cash)	(2,608)	(14,334)
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	0	
(Increase)/decrease in receivables	20,205	(3,674)
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(382)	(1,746)
Increase/(decrease) in trade and other payables	14,244	31,281
Increase/(decrease) in other liabilities	219	5,564
Increase/(decrease) in provisions	1,026	(128)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows		
Net cash generated from / (used in) operations	**65,772**	**56,932**
Cash flows from investing activities		
Interest received	8	5
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(1,569)	(416)
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(42,225)	(56,062)
Proceeds from sales of property, plant and equipment and investment property	3,069	0
Receipt of cash donations to purchase capital assets	807	11,068
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	**(39,910)**	**(45,405)**
Cash flows from financing activities		
Public dividend capital received	65,464	10,140
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(36,555)	(630)
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(56)
Capital element of PFI, LIFT and other service concession payments	(1,929)	(1,320)
Interest on DHSC loans	(512)	(205)
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(4)
Interest element of PFI, LIFT and other service concession obligations	(5,783)	(4,769)
PDC dividend (paid)/refunded	(6,994)	(3,260)
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	**13,631**	**(104)**
Increase/(decrease) in cash and cash equivalents	**39,493**	**11,423**
Cash and cash equivalents at 1 April - brought forward	19,434	58,927
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**19,434**	**58,927**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**58,927**	**70,350**

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 29 November 2021

Present:	Mr M Robson	Chair
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr P Walker	Deputy Chief Operating Officer
	Mr S Evans	Deputy Director of Finance
	Mrs R Thompson	Head of Corporate Affairs
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)

No	Item
1	**Apologies:** Apologies were received from Mrs Ryabov.
2	**Declarations** There were no declarations made.
3	**Minutes of the meeting held on 25 October 2021** Mr Robson shared he would summarise the committees assurance levels following the keys areas within the meeting to ensure the board summaries reflect the discussions. Minutes of the meetings were reviewed by the committee and agreed as an accurate record.
4	**Action Tracking List** The action tracker was reviewed and updated, all actions have either been completed or scheduled for a later committee.
5	**Workplan 2021/2022** No changes made to the work plan. Mrs Drury shared they would bring a contracting update to January or February's meeting once the changes were understood following the block arrangements stopped. Corporate service benchmarking report was due in the next week. Once published will be brought to a future meeting.
6	**Performance** **6.1 Performance Report Including: National Standards performance** Mr Walker talked the committee through the key areas of the performance report which covered; • Urgent and Emergency Care • Cancer • 18 Weeks Referral to Treatment • Diagnostics

	Mr Walker shared that the data showed our current performance was fluctuating and therefore unable to see consistency. The Urgent Treatment Centre was due to go live on the 1st December, the reporting process was still being refined but the hope was that there would be a quicker turnaround for patients. Mr Walker stated that exit flow still remained an issue for the Trust there was an increase in medically fit patients which impacted our length of stay but the care system was currently saturated. Whilst there was improvement in ambulance handover times it was not currently consistent improvement. Cancer targets in radiotherapy and drugs had seen an improvement. ICU capacity remains a challenge resulting in elective patients being cancelled. We are seeing an improving picture in 104 waits and over 80's. The recent appointment of another deputy chief operating officer will maintain focus on elective recovery delivery. The trajectory is improving but is just under the standards at 87% when the target is 89% Mr Bond raised that the exit flow barrier to progress, is not an issue when we think about paediatrics or minors that's not an issue. Mr Bond asked if we had modelled the impact of the UTC and what the expectations around activity would be. Mr Bond also requested an update on the progress regarding discussion for Humber to have an environment to see patients. Mr Walker responded that the activity had been separated but some details were still being finalised. Mr Bond requested a modelling report which would set out our expectations and enable us to see if the service was value for money. Mr Walker confirmed he would run the final figure and share with Mr Bond outside of the meeting. Mr Walker shared that there have been ongoing discussions with Humber and they have reviewed the proposed site and are keen to use. There are some operational issues needing to be resolved around and costings prepared to bring the site up to specification so whilst discussions are ongoing it is not quick movement. Mr Curry asked if the proposed impact of the UTC would be within the major area of the ED and a reduction in ambulance handover times and trolley waits. In terms of the letter from NHSI how far have we progressed the other issues regarding the areas on the letter. Are there specific actions and timeframes, do we have a plan that will deliver. Mr Walker responded that there would be no direct impact for majors but the aim with providing additional resource is we can keep medical staff in the major and reduce the timescales. In regards to the letter from NHSI we have responded. Yorkshire Ambulance Service have recruited their leaders 24/7 and they will also be part of the site meetings to support. There will also be a new admin process in place by January, which will assist in accurately recording timings.

	Mr Walker shared that community capacity is a concern, and options were being looked into to avoid patients being unnecessarily conveyed and would link with the missed opportunities work. Mr Walker confirmed he was writing to core people to form a steering group to maintain track of all the plans, and would be happy to share the action plans and timings schedule with the committee. Mr Curry thanked Mr Walker for updating the committee on the full range of activity being undertaken which was not within the narrative in the performance report. Mr Walker shared they were progressing Patient Initiated Follow Up, which gave clinical staff the ability to discharge but the patient the opportunity to return quickly if required. Patients would need to have been previously seen to be eligible it was not a self-referral process. Mr Walker updated the committee that East Riding Council were looking at external social care step-down facility which would free up Suite 20 at Castle Hill which could be repurposed for Hull patients with staff to support patient flow. Mr Robson suggested that would give us more control over parts of the system and asked if the new ICU facility would assist in patient flow. Mr Walker confirmed that the new ICU suite would assist in regards to staffing as all staff would be in one area. Mr Bond reflected that the biggest impact ICU will have would be staff morale as the teams are looking forward to moving into the new environment. Mr Bond raised a concern when looking at the residential care business, the worry is that we will fill the beds and it would be a short term gain. There is a potential to create a team to discharge people home, which would work but is in early discussions. **6.2 Elective Recovery Report** Mr Walker shared the key areas of the elective recovery which included; • Activity • Finance • RTT • Cancer • Diagnostics • Outpatient Transformation Mr Walker highlighted that in regards to the virtual wards, some areas are reverting to face to face appointment, which will be reviewed but maybe patient need. In October 2021, the plan for clock stops was 82.3% of 19/20 baseline. The actual clock stops delivered is slightly higher at 83.5%, although lower than the planning requirement of 89% Mr Curry reflected that we were not too far from the target and asked what the confidence was in regards to achieving the target. Mr Bond commented that the report was very helpful, we looked to be doing well over the past few months, and asked if we sustain the progress how long before we are on trajectory. Are we able to make any reliable predictions for the areas of concern.

	Mr Walker responded that the assurance was dependent on the concerns over an increase in COVID infections and the impact on the elective recovery. The medical directors and Mrs Ryabov were meeting to keep the plan on track, and providing a focus on specific specialities. **Resolved:** Mr Robson summarised that the assurance level would remain at amber due to having clear action plans which are progressing but still not yet achieving targets.
7	**Finance** **7.1 Financial Report** Mr Evans took the Committee through the financial report discussing: • Month 7's financial position • Health Groups ongoing pressures • H2 planning • Cash position • Debts • Capital Programme Within the ICS break-even plan, HUTH is required to deliver a surplus of £1.7m. This will enable the Trust to achieve break-even across the full financial year. The profile of the Trust expenditure budgets shows greater expenditure in H2 compared to H1, for example, utilities costs and increment payments, a full understand of the risk will be available in month 8. Mr Curry thanked Mr Evans for the update and clear reporting and asked how concerned are we regarding the longer term implications regarding the underlying deficit position. Mr Bond responded that until we know what the funding will be we are unable to determine if the underlying deficit will be funded or an issue for the Trust. Planning guidance will be available in December until then the figure is a memorandum figure. Mr Evans shared that it would likely be partially funded, which would be a risk for the overall ICS position as that is what we are spending. Mrs Christmas raised at the NED presentation earlier regarding the capital funding there were increasing costs which was a financial burden, increasing the pressures of delivering the capital programme within the financial limits and asked how are we managing the additional costs. Mrs Drury responded that the capital programme is discussed with the Capital Resource Allocation Committee and they have reviewed the schedule and have brought forward some schemes earlier from the priority lists, and deferred some work where there are overspends, providing some flexibility and releasing funds. Mrs Christmas shared the Director of Estates, Facilities and Development was confident the schedule was deliverable. Mrs Drury acknowledged that it will be tight and we are tightening up the process.

	Mr Bond stated that there is a contingency fund within capital budget to support increased costs and that monthly meetings were held with the Director of Estates, Facilities and Development to discuss the position, which Mrs Drury managed the budgets, there was no expected issues with inflation pressures. Mr Bond shared that it was the first time ever the NHS have overspent the capital budget, so want a forecast for next year. There is no projected under or overspend in this area. The Productivity and Efficiency Board has been reinstated and is reviewing opportunities for delivery. The focus will be on developing plans to support the financial plan for 2022/23 but as part of this identification all opportunities will be looked at to bring forward savings into 2021/22. We struggle within 12 months so giving health groups 4 months is a significant challenge. Performance management reviews this week to help understand what the constraints of our productivity and if we can unblock we can unlock elective recovery funding. Mr Bond shared that 10 years ago we would have been really concerned at this point but currently there is still funding around and we expect to meet targets but unable to pin it down. Mr Robson asked what the big risks are within the deficit. Mrs Bond responded that it is money we have committed to but the income changes are the uncertain factor. Will then start to make assessments and hold discussions within the ICS to look at what can be done. Mr Robson asked if smoothing funding was non-recurrent funding. Mr Bond confirmed it was non-recurrent and had already been accounted for. **Resolved:** Mrs Christmas felt that the capital should sit with amber due to the pressures. Mr Bond suggested that there was a significant delivery issue also due to the supply chain. Mr Bond felt that the biggest balance at the moment is the relations within the ICS and the need to cooperate and operates but was confident that it will. Mr Robson confirmed that we would rate the assurance as amber with a note to the areas of concern being capital and the underlying position. **7.2 Digital Pathology – National Pathology Imaging Collaborative (NPIC)** Mrs Drury shared that the process was started last year and was acknowledged would go into this financial year. The collaboration with the National Pathology Imaging Collaborative has secured a grant for £1.7m for the digitisation of Pathology services across Hull and York. The Trust is now in a position to order the digital slide scanners from the national framework and draw down from the grant by the end of March. The committee is asked to approve the orders to enable equipment by end of financial year, one off costs of 72k split with Hull and York offset revenue of capital. Mr Bond shared that strategically this is the correct thing to do, the potential benefits in areas work remotely which with the shortfalls in staffing is not to underestimated. AI development can reduce labour in the longer terms. Mrs Drury shared that as more organisation come on board, those costs should be reduced, NPIC also have the power to drive costs down.

	The approval has come to HUTH as our name on the grant, we will transfer to the Hull York Pathology service once implemented. Mr Robson confirmed that the committee approved the proposal.
8	**Assurance and Governance** **8.1 Capital Resource Allocation Committee** Minutes were available with the papers. Mrs Drury stated that the capital spend is where we need it to be and will do a forecast, and review the forecast in more detail next month.
9	**Any Other Business** **9.1 HEY-14-117 Official Contract Extension** Mr Bond gave an overview of the contract extension. The committee approved the contract. **ACTION: Mr Bond to check the dates are correct within the document.** **9.2 HEY/21/499 Mobile CT Scanner and Trailer** Mr Bond shared that the Mobile CT and MRI scanner were funded through community diagnostics teams, which bid through ICS. As host of the units we can direct what we do with them. There is a problem regarding diagnostics throughout the ICS. Challenges is that there are no staff attached to them, but the team have confidence that we can recruit and staff the units. The committee agreed to approve the contract. **9.3 HEY/21/500 Mobile MRI Scanner and Trailer** Mr Robson confirmed the committee agreed the contract as discussed in 9.2.
10	**Date and time of the next meeting** Monday 20 December 2021, 1.30pm – 4pm via Teams

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 20 December 2021

Present:	Mr M Robson	Chair
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr P Walker	Deputy Chief Operating Officer
	Mr S Evans	Deputy Director of Finance
	Mrs R Thompson	Head of Corporate Affairs
	Mrs A Drury	Deputy Director of Finance
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)

No	Item
1	**Apologies:** Apologies were received from Mrs Ryabov.
2	**Declarations** There were no declarations made.
3	**Minutes of the meeting held on 29 November 2021 and Matters Arising.** Minutes of the meetings were reviewed by the committee and agreed as an accurate record following the following amendments Page 2 – Paragraph 12, Mr Curry asked to confirm that the impact of the UTC would not be within majors, trolley waits, ambulance handovers. Page 6 – Item 9.1 Mr Bond checked the dates and clarified the information via email.
4	**Action Tracking List** The action tracker was reviewed and updated, all actions have either been completed or scheduled for a later committee. Hospital Improvement Team are currently in a period of change for the team and an will provide an update for March 2022.
5	**Workplan 2021/2022** The work plan was reviewed and no changes made to the work plan. 2022/2023 Planning Guidance to be received this week.
6	**Board Assurance Framework** Mrs Thompson shared the quarter three BAF report, it is proposed that BAF Risk 7.1 assurance rating is changed to green as the risk is on track to achieve its target risk rating. The committee was asked to consider if the target risk ratings and assurance ratings are correct, and if the target ratings were going to be met along with considering the proposed risk change to BAF 7.1 to green before it was presented at the Board.

	Mr Bond shared that he believed that the Trust would achieve the end of year financial position and that the Trust would achieve the risk rating and agreed with the green rating. Mrs Christmas challenged if the rating should be moved at this point in the year, with the predicted challenges in quarter three and four. Mr Bond predicted that the staff sickness would increase and elective recovery would reduce and we would be asked to outsource where possible, which may come with income but is not guaranteed. Mr Robson questioned if the committee wanted to endorse the proposed rating change or remain at the current amber rating. Mr Bond responded that the numbers were not currently on track and on that basis suggested the rating was not amended but noted that believed that the organisation would meet the target by the end of the financial year. Mr Robson confirmed that no changes would be made to the BAF. Mrs Christmas asked how the capital budget was. Mr Bond responded that Mrs Drury was the lead regarding capital and that whilst there was always a chase for invoices and ensuring spend it was always achieved. Mrs Thompson asked if BAF 7.2 underlying position remained unchanged. Mr Evans responded that once we have the guidance will be able to look once we received. Mrs Thompson asked if the Trust would meet the Performance target, or in the current position does it need to be reviewed. Mr Bond felt that it would be unlikely we will meet the targets and stated it goes back to the elective recovery and funding / outsourcing and staff absence will be an impact. Mr Curry asked for the narrative to reflect the mitigating actions, the impact and the options for reducing the risk. The committee agreed that BAF 4 was to remain the same.
7	**Performance** **7.1 Performance Report Including: National Standards performance** Mr Walker shared information reported within the Performance and Activity report, which was provided to the committee. The data related to ED and unplanned care has not seen a significant change. Conversation rates have had some improvement and is set to increase with the Urgent Treatment Centre opening. There remains a challenge on delivering the 4 hour national standard but the December data for ambulance handover times has seen an improvement. The UTC commenced from the 1st December, it was anticipated the service would see between 100-120 patients per day and deliver around a 5% overall improvement, currently the service is seeing between 70 and 90 pts per day and a 1% improvement. It is believed performance will increase as there have been a few days with exceptionally high breach numbers within this short initial period and therefore disproportionately effecting the position.

	The Trust Escalation policy is being revised, the latest draft is currently being reviewed by Health Groups for comments. The revision is to ensure that actions taken are in line with the OPEL status and will be consistently enacted across the Trust. This will feed into patient flow meetings currently being trialled, the main change to the meetings is waiting on the IT update expected beginning of January with the standardisation of board rounds. The development of an Urgent Care Co-ordination centre had it first workshop on the 6th December the aim being to create a SPA that will enable Ambulance crews to discuss patients with a senior clinician who can arrange alternatives to conveyance in the community. The Steering group to oversee the Ambulance Improvement plan is meeting bi-weekly from the 16th December and has representatives from both CCG's, YAS, ECIST and the Trust. A number of Task and finish groups are being established across the Emergency and Urgent Care Pathway that will be monitored either via the Steering group or 4 hour Delivery Group. Community discharge is a significant challenge and staffing will be an issue for them and us in the coming months. The Trust has given notice on Suite C20 as currently care delivered by a care home provider but will be managed by the Trust again. Mr Bond acknowledged that Suite C20 was a service we set up three years ago and was a good model at the time but it is no longer working as we need and the Trust is working up a new model and looking to recruit our own workforce to support up to 55 beds. Mr Curry noted that time will tell regarding the impact of the UTC and is interested in patient flow. The initiatives are not easily identifiable within the report and asked what the key ones would be to making an impact, we are aware it is a system but what is within our control. Mr Walker responded sharing the initiatives within our control and confirmed he would include the detail in future reports. Mr Walker shared that the faster diagnostic standard for cancer was achieved but none of the other targets have been achieved for some time. Actions taken to address the diagnostics delays included a pathway analysis to see the delays, identified was that within diagnostic tracking was an issue within pathology as samples sent off site, there is now a gatekeeper in post to keep in-house. Cancer targets remain inconsistent performance and staff are fatigued to keep delivering above normal levels. Colorectal have investigated the delays at the beginning of the pathway where triage is being undertaken and are working with primary care to ensure that a number of tests are performed consistently to support who needs seeing urgently.

	ICU capacity is an issue which is causing a delay to the cancer surgery which is prioritised. Working across ICS the number of patients that are late into the treatment has increased. A Deputy Chief Operating Officer (Elective Recovery and Cancer) post has been established to provide additional capacity and oversight into managing the elective recovery and cancer delivery. A range of actions are being progressed for 2021/2022 Q4. Mr Robson asked if the Trust will have to pause plans. Mr Walker confirmed we are looking to protect what we can and prepare for the wave which is predicted to be hard. Health Groups are looking at robust plans. Mr Bond questioned if the planned work will be stepped down and Mr Walker responded that no not stepped down anything yet, a meeting has been organised to look at order in what we step down. Mr Bond shared that we hope to hit the peak across Christmas which is a quiet period, and it will short-lived enabling us to pick up plans quickly after. Mrs Drury asked if we can expand the plastic independent sector in advance. Mr Walker stated that the independent provider deliver simpler cases but may need to utlise the service differently.
7.2	**Elective Recovery Report** Mr Walker confirmed that most of the details of the report had been covered within 7.1. The Trust did not quite meet the trajectory level and have requested an external validation to look at waiting lists. We are holding the 52 week wait position. The Trust is exploring mutual aid with Newcastle and York providing services. The position was looking positive in November and into the new year. Mr Evans confirmed that the Trust would not receive any additional funding for month eight, as the ICS did not deliver in total. Mr Robson suggested that it focussed the mind to work collaboratively when funding is withheld due to some Trusts don't deliver.
7.3	**Ambulance Handover Plan** Mr Walker provided the committee with the Hull And Eastriding Ambulance Handover Improvement Plan, which had been signed off by the A& E delivery board. There are weekly meetings to track delivery and includes the whole system. The information is being used to predict the demand and how we can respond. Alternatives are used and improvements are seen. The Missed opportunities report feeds into the action plan, calls being validated and the stack provide alternatives. Within the discharge element, the importance to record criteria to reside and almost have a case manager to track and move the patient flow. All services need to be clear and using the same terminology. Use the national framework and engage patients in the process earlier. Mr Robson thanked Mr Walker for the updated and agreed that it sounds like it's a whole system approach.

	Mr Walker confirmed it was early days but some things have started quickly and there is a willingness to work together.
	Resolved: Mr Robson confirmed the previous assurance level as reasonable and felt that following the discussions the committee remained reasonably assured.
8	**Finance** **8.1 Financial Report** Mr Evans took the Committee through the financial report discussing: • Month 8's financial position • Health Groups ongoing pressures • H2 planning • Cash position • Debts • Capital Programme Mr Evans confirmed that we are on plan, there are challenges within clinical support and family and women's health groups which is driven by clinical activity. The Trust also has some agency costs pressures. Surgery and Medicine Health groups remain on plan. The Trust spent £873k on supporting Covid19 in month 8, bringing the cumulative total for H2 to £1.4m. The biggest areas of spend were increasing ITU capacity, segregation of patient pathways and decontamination. Health groups and corporate have been tasked with delivering £2.6m of savings during the H2 period. To date risk adjusted schemes to the value of £1.6m have been identified with a £1m shortfall but they are looking at it. Mrs Christmas asked how the CRES has been identified and Mr Evans confirmed the Productivity and Efficiency Board will continue to review and support Health Groups on identification and delivery of schemes and hopes to produce future plan to be reviewed at the committee. Mr Robson shared that the January committee will be stood down, Mr Evans agreed that he will share a finance report in the absence of the meeting to be circulated. **Resolved:** Mr Robson shared the committee had reasonable assurance at the previous meeting and agreed that it remained as reasonable.
8.2	**Licensing Options Paper** Mr Bond shared the licensing contract was taken on a few months ago but following a significant increase the Trust are looking at alternative options. The paper presented to the committee today was a staging paper to look at where we are at the moment. Current Microsoft licence agreement is becoming increasingly expensive and does not fully use the Microsoft suite of offers linked to the NHS Digital negotiated contract (N365). This paper provides an oversight of the available options being considered from the perspective of work planning, organisational impact and financial planning to enable a decision on future licence arrangements before contract renewal in September 2022.

	The Trust is working with Trustmarque who is the intermediate and it is currently a work in progress. Mr Curry shared he was supportive of the process, have been through similar and there is a benefit to the changes but acknowledged there is some work to do but nothing within the report raised alarms. There will be benefits to a cloud model, we need to look at level of users and what we use and what the alternatives are. Mr Bond confirmed there would be some educational needs to the changes around share point. **ACTION: Mr Bond suggested an update was provided to the committee in May 2022.**
8.3	**NLAG Lorenzo Extension Digital Aspirant Funding** Mrs Drury presented the proposed funding approach for the initial implementation of Lorenzo at North Lincolnshire and Goole NHS FT (NLAG) in conjunction with Hull University Teaching Hospitals NHS Trust (HUTH) as part of the Digital Aspirant Programme. HUTH will host the asset therefore we also place the order, which will incur the maintenance costs but will have a Service Level Agreement in place to ensurre the revenue costs are recharged. Mr Curry made the observation that this will create a bigger dependency and binds the two organisations for sometime, it would be a challenge to unpick. Mr Drury confirmed that it supported the strategic direction. Mr Bond reflected that it was also discussed including York, which is a reasonable ask and would be the strategically right thing to do but currently too big a task. Mr Robson confirmed the committee agreed the contract.
8.4	**HASR Financial Principles and Neurology update** Mrs Drury presented the HASR updated to the committee and the committee was asked to note the financial principles agreed in relation to the HASR interim clinical plan and in particular note the transfer of Neurology outpatient services to form a single Humber service. PAF is asked to note that HUTH's cost base will increase by £59k per month for the existing service, with a further £10.4k increase associated with the appointment of the vacant post. There will be an adjustment to the income flows, mainly from the commissioners on the south bank, to cover the additional costs. Mr Bond confirmed that the financial principals shared between the Trusts in that neither organisation would be any worse off, activity and costs remained aligned to not affect national reporting, there would be no additional funding but the service would be more sustainable. Exception for additional costs for consultant vacancy, HUTH will take on the vacancy and recruitment. Our consultants are covering the vacancy and charging for the costs.

	Mr Bond confirmed NLAG TMB have approved the single service and that it is setting a precedence as the first service we have done this way. Additional services will be pulled together in the same way. Mrs Drury confirmed that Haematology and Oncology are being looked at and hope to be completed by the end of the financial year. Mr Robson asked when we will have a financial model for HASR. Mr Bond said it would be difficult as it is done per speciality dependent of the changes involved. Mr R speaking of CRES we will need to look at in the HASR context and the financial principals and not be restricted. Mr Bond stated it is a very transparent process and is a non-impact position for the Trusts. Including both finance team in month end helps the integration across the organisations. Mr Bond thanks Mrs Drury and Mr Evans for all their hard work on the HASR exercise, it's been a long and hard task to manage across both organisations. Mr Robson confirmed the committee supported the transfer of Neurology outpatient services to form a single Humber service.
8	**Assurance and Governance** **8.1 Capital Resource Allocation Committee** Draft minutes were available with the papers from the 8th December 2021. Mrs Drury reviewed the forecasting. Development of the next three year capital programme and what the priorities will be and what growth there maybe within the ICS. ICS have requested we populate our 3 year capital ambition which we are completing, which also ties in the health group priorities for the next year. The plan will be shared wider before the ICS submission on the 7th January 2022. EMC was made aware that there will be additional costs regarding equipment and will impact on our underlying position. Audit committee have been made aware of performance of PFI in the Queens centre, there are some issues and the legal team have been instructed, a paper will submitted to the audit committee with further details.
9	**Any Other Business** The committee agreed that if needed to be approved in the absence of the committees it would be emailed with the vote button and brought to the meeting retrospectively.
10	**Date and time of the next meeting** Meeting in January has been stood down.

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8.3.22
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

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

Key Recommendations to be considered:
The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

8th March, 2022

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 November, 2021 the Trust had 59 Covid-19 inpatients. As at 3rd March, 2022 the Trust had 126 Covid-19 inpatients, although 52 are now outside of their 14 day isolation period. Whilst the pandemic still poses a real threat to the Trust, staff absence is also a concern, although this has significantly reduced since the end of January, 2022. The Trusts key challenge is the number of 'No Criteria to Reside' patients in a hospital bed which is currently 144 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure. It is inevitable that staff feel tired and exhausted, but they continue to give their best to ensure patients are safe.

3. Key Issues

Staff Absence

The total staff sickness absence for the financial year 2020-21 was 3.51%. The total absence including sickness and Covid-19 for 2020-21 was 7.20%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 83 staff absent due to Covid-19 which is 0.91% of the workforce. Total sickness and Covid-19 absence is currently 5.1%. This is an increase from 3.9% as at the last Board meeting in November.

4. Staff Testing

Symptomatic Testing (PCR)

The Trust continues to operate a drive through testing service for staff and family members as well as partners (OCS, YAS, Humber FT and CHCP). Demand on this service increased significantly during Dec 2021 and Jan 2022 with high numbers of staff tested daily and high levels of positive results. The position improved in February with reduced numbers being tested and positive results falling significantly.

Asymptomatic Testing

The Lamp testing programme in HUTH ceased on the 31st Dec mainly due to the low uptake amongst staff. Any staff wishing to undertake regular asymptomatic testing have been sourcing the Lateral Flow Test (LFT) kits from the Gov.uk website.

Test and Trace

The NHS Test and Trace programme launched on Friday 5th June 2020 and continues today. Over the last 3 months 207 staff in November 317 staff in December and 295 staff in January self-isolated as a result of Test and Trace. The Trust has implemented a risk assessment based upon staff having had their full Covid-19 vaccinations and having a negative PCR test so they can return to work earlier.

Employee Service Centre (ESC)
Buy Bank Annual Leave
This voluntary scheme was part of an initiative to improve staffing levels across the Trust during January and February 2022. Clinical or patient facing staff including Allied Health Professionals, Ward Clerks and Portering staff were able to apply to buy back up to five days annual leave (pro-rata). In total circa 190 staff were paid under this scheme.

5. Staff Vacancies
The Trusts overall vacancy position as at 31st January 2022 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1350.0	1300.2	65.0	0.0	0.0%
Add Prof Scientific and Technical	362.0	332.4	0.5	29.1	8.0%
Administrative and Clerical Staff	1622.5	1568.4	11.9	42.2	2.6%
Allied Health Professionals	498.3	480.8	4.9	12.6	2.5%
Estates and Ancillary	603.9	524.3	1.8	77.9	12.9%
Healthcare Scientists	182.3	154.2	0.0	28.1	15.4%
Medical & Dental - Consultant	502.0	450.7	10.3	41.0	8.2%
Medical & Dental - SAS	66.6	53.3	0.7	12.6	18.9%
Medical & Dental – Trainee Grades	662.6	685.0	18.5	0.0	0.0%
Nursing and Midwifery Registered	2423.0	2335.2	34.7	53.2	2.2%
Trust Total	8273.3	7884.5	148.3	240.5	2.9%

Overall the Trust vacancy position is 2.9%. The Consultant vacancy rate has increased to 8.2%. Whilst our overall vacancy situation remains in a healthy position the Trusts recruitment plans during this financial year have been interrupted, but recruitment and retention remains a key priority.

The vacancy rate for Registered Nursing and Midwifery is currently 2.2% across the organisation.

Interviews have taken place for final year nursing and midwifery students who qualify in September, 2022. The Trust has offered 146 adult nurse students a post and 20 paediatric nurse students predominantly from the University of Hull.

There are currently 44 Registered Nursing Associates (RNA) with a further one who has completed the programme and are awaiting their PIN. Three RNA's have commenced the BSc Nursing Top-up Apprenticeship at the University of Hull in January and are now part of the RNDA programme and there are a further 47 TNA`s in training.

The Trust has trained and employs 13 Registered Nurse Degree Apprentices and has a further 33 in training.

In relation to the Health Care Support Worker Apprentices, there are currently 22 in training, with 14 due to complete the programme in June 2022.

The Trust has successfully recruited 316 international nurses mainly from the Philippines over the last three years with a current a retention rate of 97%.

In response to the recent financial support offered by NHSE/I, the Trust is in the process of recruiting a further 80 international nurses, 60 of these nurses have already arrived in the UK and

have commenced their OSCE training programme with the Trust. A further 20 are due to arrive by the end of March 2022.

Nine HCAs employed by the Trust, who were previously registered nurses in their home country (8 from the Philippines, 1 from India) are currently being supported to become UK Registered Nurses. Of these, 5 have completed their training, with 4 recently receiving their PIN and 1 due to complete their OSCE this month. The remaining 4 continue to progress through their training.

6. Vaccination programme.
The Covid-19 boosters and seasonal flu vaccination programme is jointly managed by Carole Hunter, Head of Occupational Health and Steve Jessop, Chief Nurse Information Officer.

Vaccination hubs at HRI and CHH staffed by a team of vaccinators were set up as reporting and storage requirements and Covid restrictions dictate that it is not feasible for vaccines to be administered in the Dining Rooms or wards or departments by peer vaccinators as in previous years.

Initial courses and booster doses of Covid -19 vaccines are available to all Trust staff. Eighty one per cent of our staff involved in providing patient care had a Covid-19 booster by the end of February.

The seasonal flu vaccine is available to all Trust staff every year and sixty seven per cent of staff received a flu vaccine by the end of February.

It is anticipated that a fourth booster dose of Covid vaccine will be required for healthcare staff in Autumn as well as a seasonal flu vaccine and planning for this has already started.

7. Communications and engagement
2021 National Staff Survey
The Trust has now received its benchmarking report for the National Staff Survey 2021. This remains under embargo until it is published publicly later this month.

We can report however that 44% of staff completed a survey last year which is one of the best response rates we have seen in recent years.

For the first time the report has aligned the key themes to the seven themes in the national People Plan, in addition to Staff Engagement and Morale. Across the NHS, performance against these themes has deteriorated, which was to be expected against the backdrop of managing Covid and regular activity.

Reports have been shared with senior leaders in Health Groups as well as the executive team and a full programme of actions is being developed to address issues raised by staff in the survey. A golden thread of the Trust's approach will be moving from a 'Command and Control' approach which was required during the global pandemic to a return of our normal 'Engage and Involve' management style.

8. Staff Support Arrangements
Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work.

The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for general mental wellbeing support. We also have an in situ Staff Support Clinical Psychologist in ICU. Coaching services are now being accessed via the coaching referral form available on Pattie.

Throughout January and February the psychology, chaplaincy and OD team added in the extra 1:1 capacity provided in previous waves of the pandemic. This also included specific support for those who were needle phobic to support them to access their Covid Vaccines.

In reach into key ward areas has continued from the OD team. A member of the team directly visits the ward staff and their leaders with space to decompress or a safe space to just listen. A number of teams have also been supported with reflective practice and future vision sessions to allow them to reconcile their Covid experiences and look to the future.

The 24/7 staff support hotline will continue to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address. The Quick Guide to Staff Support is available and updated regularly on Pattie to effectively signpost our staff to local and national services.

9. Great Leaders Programmes

As part of the Omicron response, we cancelled all Great Leaders activities throughout January and February 2022. Our new modulised system has ensured that despite the break in learning there has been minimal impact on the schedules of our participants. The process has ensured that there are now minimal delays to participants completing their required learning and is working well. Programmes will fully resume in March. Recruitment is now well underway for new programmes starting in April 2022.

To ensure there are still support networks for leaders in place the bite size Leading with Covid programme is running until the end of March alongside our fortnightly managers decompression spaces.

Great Leaders bite size programme relaunches in April with new courses and some of the popular staples. This programme offers bite size learning on everything from coaching through to managing sickness and absence.

10. Recommendations

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

Officer to contact:
Simon Nearney
Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust
Minutes of the Workforce, Education and Culture Committee
Held on 13 December 2021

Present:	Professor U Macleod	Chair
	Mrs S Rostron	Director of Quality Governance
	Mr J Kastelik	Director of Medical Education
	Mr Nearney	Director of Workforce and OD
	Mrs R Thompson	Head of Corporate Affairs
In attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Mr U Kempanna	Associate Medical Officer
	Professor M Loubani	Guardian of Safe Working

No **Item**

1 Apologies:

Apologies were received from Mrs Geary, Mr Desborough and Dr Pathak.

Professor Macleod confirmed the meeting was not quorate but would still discuss the items but any decisions would need to be deferred to the next committee meeting.

2 Declarations of Interest

Prof Macleod declared that she was the Dean of the Medical School.

3 Minutes of the meeting held 11 October 2021

The minutes of the previous meeting were reviewed and agreed as an accurate record.

3.1 Maters Arising

Professor Macleod requested LGBTQ+ to go on the work plan and that LGBTQ+ representatives from the network would come to talk to this committee in February, 2022.

Undergraduate Placements would be covered on the agenda today.

Professor Macleod requested a brief overview of the current position in the Trust prior to progressing with the agenda.

Dr Purva shared the Trust is now scaling up our vaccine clinics in line with the government request to roll out booster vaccines to all eligible adults. This is impacting on our already stretched resources, the vaccine clinic is staffed with existing staff not additional so frontline staff will be diverted and will result in scaling back elective work, with resources prioritised in key priority areas.

The Trust has seen a reduction in the last few days in COVID+ patients but we anticipate a surge as currently seen in the South East of the UK.
There is still a significant amount of medically fit patients in the hospital equating to four wards and we have two open COVID wards, which will have a significant on patient flow.

Dr Purva shared that we were expecting a high level of infection in the locality but hoped it would be a low mortality rate.

Workforce absence was a concern as there is no slack in the system and is already stretched. The Trust is anticipating the worst winter ever seen if it all plays out as expected.

Mr Nearney shared that there was a national debate currently regarding releasing staff for the vaccine sites and stepping down elective work. The Trust runs the Covid Vaccination programme bank for the ICS.

Dr Purva raised that we needed to include pregnant patients this year into the figures as they were excluded last year.

4 Action Tracker

The action tracker was reviewed and all actions were completed.

5 Board Assurance Framework

Mrs Thompson shared that the BAF for quarter three. The paper provides updates on the actions taken in the previous quarter with a plan for the following quarter. The BAF is supported by the operation and corporate risk register. The are no proposed changes to the risk ratings in quarter three and the Committee was asked to consider the risk ratings and decide:

- If there are any gaps in controls, sources of assurance or further actions to add.
- Consider whether the Workforce risk ratings are on track to deliver

Mrs Thompson asked the committee if the risks for BAF 1 and 2 were on target.

Mr Nearney responded that in regards to the BAF 2 we have made progress in reducing the vacancy rate so are in a good position but acknowledged that there are still pockets of shortages in areas but overall numbers are good. Absence rate is above normal rate. Staff support is in place but the key risk is the increase in self-isolation. Recommendation would be to leave the rating at the current position.

Mr Nearney stated that in regards to the BAF 1 the staff survey which would be available in January would provide a better picture. Recommended that the rating would remain the same and acknowledged it would be a challenge to deliver.

Dr Purva agreed that we are working towards all the actions, despite the challenges and think we will achieve. Medical staffing is in a better place than where we have previously been. EMC capture where the gaps are and how to be more productive. Agreed that the rating should remain at the current level.

Mrs Rostron asked the committee to be clear what will be difference to enable us to achieve the target rating, what we are expecting to see to say we have achieved it as it needs to be clear for audit how achieved it and what is different.

Mr Nearney responded that the staff survey in January which will be presented at February's meeting would be a key indicator and that we are on target to reduce the Trust's overall vacancy position.

Dr Purva stated that there is a specific action plan around medical workforce, which will enable us to show progress and the Associate Chief Medical Officer and the Director of Medical Education can share actions.

6 Workplan

Professor Macleod requested that the committee reviewed the work plan to ensure that everything relevant was on the work plan. Miss Boulton will be reviewing to spread the reports across the year where possible.

ACTION: Miss Boulton to liaise with committee members to alter the workplan.

7 Governance

7.1 People Strategy Progress Report

Mr Nearney shared the report with the committee which covered the following key areas:

- The Trust vacancy level
- Turnover
- Sickness
- Recruitment

Mr Nearney stated that the vacancy rate was in a healthy position, where the gaps are the Trust is redoubling efforts and meeting with HR business partners to support the Health Groups with recruitment plans.

Some work will be undertaken about the number of staff leaving within a year of starting as this needs to be further understood to be able to reduce this number.

Absence levels are above average but we are not alone in this increase. Staff wellbeing programmes are available and HR are supporting managers to support their staff.

Professor Macleod stated that she was reasonably assured by the data but aware that we don't know what's to come. In relation to staff leaving the NHS, asked if we should be thinking creatively to reduce the number of staff that may opt to retire early that may not have considered it pre-pandemic.

Mr Nearney responded that the challenge currently was in getting the time to support that type of planning when the operational pressures are so great. A demoting factor for some will be not being able to see their patients whilst for others it will be a case of being overwhelmed by patients.

The future of NHS Human Resources and Organisational Development which will be discussed later on in the meeting will be seeking to keep the people issues at the heart of the NHS and for the ICS to work differently together.

8 Recruitment and Retention

8.1 Nursing and Midwifery Staffing Report

Mr Nearney shared key points from the paper for the committee on behalf of Mrs Geary.

There are currently three additional wards and ICU beds open.

The nurse vacancy rate will reduce when the 106 new nurses receive their PIN and move from the auxiliary role into the registered role which will also then show a drop in the auxiliary numbers.

Professor Macleod stated that on reviewing the paper there was no cause for concern and that the committee had assurance regarding nurse staffing.

Mr Nearney added that our international nurses retention rate was 97% and that 30 more nurses were on target to get there OSCE at the end of December. Along with the improved access to nursing apprenticeship degrees and the associate nurse roles, the Trust was in a positive position.

8.2 Medical Undergraduate Training
Dr Purva shared the paper with the committee.

It was noted that the activity was more recent than the report date of the 14th June date, which was incorrect.

Dr Purva meets regularly with the new clinical dean, who recently took over the role and has done admirably as there has been considerable disruption within the undergraduate medical education team, with significant changes to staffing.

The key issues have been the expansion of students into year 4 22/23 academic year and the curriculum recovery and how to deliver the placements.

Phase 1 early IPC discussions have enabled us to set boundaries for students on wards and non-clinical areas. Sessions adapted and planned to allow for this. To date, no Phase I face-to-face clinical placement sessions have had to be cancelled.

Phase 2 The key issues to note are gaps in timetables due to difficulties in recruiting Consultant tutors. This is unsurprising given the current pressures on our colleagues due to the ongoing pandemic. Previous planning has mitigated this to a large degree with CTFs back filling the majority of gaps. No immediate solutions but in the near future when recruiting we are looking to build into the business cases that the role includes an academic within the job plan to strengthen the position of us being a teaching hospital.

The key risk is that if the staffing/tutor issues do not resolve we will not be in a position to take an increase in student numbers when expansion reaches year 4 (academic year 22/23).

We are looking at how we can modify current clinic rooms within the HRI HYMS building to create more multipurpose areas on the ground floor. Although this will not solve the issue, it will help to use what space we do have more creatively. Alternative options have also been explored.

Professor Loubani requested that when job planning for new consultants the provision of teaching post-graduate doctors was included in the discussion to provide dedicated support.

Dr Purva responded that it certainly be included. Future recruitment needed to be clear that the full 12 PA's are not all clinical but needed to factor in clinical supervision and academic and are a required part of the role.

Professor Macleod shared her gratitude for the work undertaken and acknowledged the expansion was always going to be challenging. The school are also looking to ensure we are using the placements effectively to prepare the doctors. Previously we have just done more of the same and the pandemic have given an opportunity to review and get the best of what we have.

It was suggested to review questions for consultant's interviews so setting the expectation there is teaching in a teaching hospital from the start.

Professor Macleod confirmed that the committee had assurance regarding the Medical Undergraduate Training.

9 Health and Wellbeing

9.1 Staff Vaccination Progress Report

Mr Nearney shared that the Trust's Flu vaccination position was above national average and that for the Covid booster 81% of staff had received.

Mandatory Covid vaccination for NHS staff was due to be discussed at the Board development discussion tomorrow. There is a choice but the government have made it very clear and it expected to be law on 6th January which will require health staff to have the Covid primary vaccinations.

We have identified a preliminary figure for those staff still requiring the vaccine although we are aware that some staff may have received externally to the Trust. Staff have been asked to provide access to their data held on NIVS by the 17th December, following this date we will be able to drill down into that data and reduce ie. establish who has not had the vaccinations and begin conversations with staff.

Mr Nearney stated that the possibility of redeployment is slim. Some staff have been very clear about not having the vaccine and there is an impact for these staff and some negativity around the teams.

Professor Macleod acknowledged that this would create a lot of extra work for the organisation.

9.2 National Staff Survey

Mr Nearney shared that 3,800 staff completed this year's national staff survey a 40% response rate which is the highest response in 5 years. We will receive a rough cut of the data in January and will bring to the February committee to look at the challenging areas.

In January we will also be running the staff survey for the 4th quarter, which is a national requirement, with 9 set questions.

10 National Committees

10.1 The future of NHS Human Resources and Organisational Development

Mr Nearney shared that the NHSE/I Chief People Officer has launched 'The Future of NHS HR and OD' which sets out a national vision for health and social care staff through 8 people statements and an action plan which articulates what should be addressed at Trust level, ICS system level and nationally. The Director of Workforce and OD will be formulating a Trust plan in response and will bring to the committee in February, and will be happy to add metrics into the People Strategy performance report.

Professor Macleod asked if we were already aware what would be delivered at national and ICS level, as there is competition between local acute Trusts.

Mr Nearney responded that collaboration is important and sharing resources between acute trusts at ICS level.

Dr Purva shared that our ICS was still in its infancy where those in place longer had developed good working relationships, the crisis will accelerate that way of working and FastTrack the changes to enable discussions to be held in regards to patient or staff reallocation to support operational pressure within Trusts.

11 Employee Engagement, Communication And Recognition

11.1 Guardian of Safe Working Report

Professor Loubani shared that the redeployment of junior doctors was managed better in the subsequent waves, in the current climate the same concerns are present but limited number affected currently.

E-rostering roll-out remain poor within only 29% now using the system. Administration staff have now been employed to improve.

Phlebotomy provision within the Trust continues to be an issue for trainees. A business case has been put forward which will be considered in March for approval.

Self-development time (STD) needs to be embedded in all trainee's rotas. Due to staffing levels and work pressures, some departments are finding it difficult to allocate this time to their trainees. This is a contractual requirement therefore we should have 100% of trainees accessing but we are currently reporting 85%

There were a total of 204 exception reports (204 episodes) reported by trainees. The most common reason for submitting an exception report still appears to be related to the volume of work which leads to trainees staying beyond their contracted hours. Other reasons include missed educational and training opportunities. This includes missed self-development time and teaching. As well as staying beyond contracted hours in the interest of patient care and staff shortage. There were 9 fines issued.

Dr Purva confirmed that STD was only a contractual requirement for foundation junior doctors and asked that the report also highlighted what we were doing well with in addition to areas that required improvement. The previous year we didn't report exceptions so it shows the junior doctors now feel able to raise the exceptions.

Professor Macleod asked if we were able to get national or regional figures to provide a comparison.

Mr Kastelik shared that in regards to redeployment, it has been managed very well so far with only small amount of doctors moved and for short periods. This took a lot of organisation from the team working closely with clinical managers. We feel that other Trusts have done something similar without saying its redeployment. There is no current impact on training.

Mr Kastelik confirmed they were aware of issues within elderly medicine and have been in communicated with the dean and a plan is in place for the next rotation.

Mr Nearney stated that Health Education England were raising phlebotomy as an issue and asked if we were confident it will come to fruition following the business case. Dr Purva responded they were confident but would be happy to have additional support for the business case from Professor Macleod.

Professor Macleod stated she would be happy to escalate to the board and would email her support to the Chief Finance Officer.

12 Any Other Business

None raised within the meeting.

Date and time of the next meeting:

Monday 14 February 2022, 10am – 12pm, via Teams

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8th March 2022
Title	Freedom to Speak Up Guardian report – March 2022				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Frances Moverley, Head of Freedom to Speak Up				
Report previously considered by (date)	N/A				

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

Key Recommendations to be considered:

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

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian report – March 2022

1. Purpose of the paper

The National Guardian's Office requires each Freedom to Speak Up Guardian (FTSUG) in the NHS to be able to report directly to their Trust Board. This report provides an update on the concerns raised by staff through the Trust's Freedom to Speak Up Guardian.

This report provides an overview of the themes and learning of the concerns raised during Q3 2021 - 2022 and the activities undertaken by the Trust's FTSUG.

Furthermore, to provide assurance to the Board of the focus on promoting a 'speaking up' culture at the Trust for staff and complying with Key Line of Enquiry 3 as part of the CQC well-led domain.

2. Introduction

Following the Francis Review, all Trusts are required to have a FTSUG in place. This role acts impartially and provides staff with an option to raise concerns in a confidential manner.

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

- Formal Raising Concerns and Whistleblowing Policy
- Anti-fraud service
- Through their line manager
- Through the Bullying and Harassment Policy or through a formal grievance
- Freedom to Speak Up Guardian

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

3. Activities undertaken by the FTSUG during Q3 2021 - 2022

In support of Speaking Up at the Trust, the FTSUG has undertaken the following:

- Promoted National Speak Up month during October 2021. This included:
    - Increased communications across the Trust serving as a reminder about FTSU including news articles, emails and a joint blog supporting Black History Month.
    - The FTSUG, Chair of the BAME Network, Director of Workforce and Director of Quality Governance (Executive Sponsor for FTSU) recorded videos for inclusion on Pattie.
    - Attendance at team meetings including the Chaplaincy Team.
    - Promotion of the Health Education England e-learning modules.
    - Conducted several face to face and virtual drop in sessions, including evening sessions to assist the accessibility of the FTSUG to night workers and clinical staff members.
- Introductory meeting with the Acting Chair of the LGBTQ+ staff network and established regular meetings.
- Introductory meeting with the UNISON branch secretary and local representatives.
- Met with the Volunteers Manager to include Freedom to Speak Up as part of the volunteer's induction and ongoing education.
- Attendance at the HR Business Partner, HR Manager and HR Advisor meeting across all Health Groups to share learning and partnership working.
- Continuing to conduct a gap analysis and review of current speaking up processes and concluding recommendations.
- Joint working with the Well-Being Champion network meeting to promote the FTSU Champion future network.
- Participating in the stakeholder event for the recruitment of the new Chairperson.
- Provided a CQC Assurance presentation to the Director of Quality Governance and Compliance Team.

- Presented at the newly qualified Midwives induction event.
- Invited to attend a 121 with the New Chief Pharmacist.
- Introductory and first 121 with Chris Long, Chief Executive.

4. Freedom to Speak Up Guardian – Trust Contacts during Q3 2021 - 2022

The FTSUG reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting. The data is also required to be reported to the National Guardian Office. The Trust's figures are as follows:

From 1st October 2021 – 31st December 2021 (Q3), the FTSUG has been contacted as follows, in comparison to 1st October 2020 – 31st December 2020 (Q3):

	Number of contacts	
Route of contact	**1st October 2021 – 31st December 2021**	**1st October 2020 – 31st December 2020**
Contacted via anti-bullying Tsar	0	0
Contacted directly by the member of staff	10	6
Requesting advice for a colleague	0	0
Contacted via SALS	0	0
Signposted by manager	0	0
Signposted by Occupational Health	0	0
Signposted by a FTSUG in another Trust	0	0
Signpost by Trust's Guardian of Safe Working Hours	0	0
Signposted by Trade Union contact	1	0
Signposted by Multi-faith team	2	0
Signposted by Staff Support Networks	1	0
In line with the Raising Concerns (whistleblowing) policy	7	0
Other	4	0
Total	**25***	**6**

From 1st October 2021 – 31st December 2021 (Q3), the FTSUG has been contacted as follows (in comparison to 1st October 2020 – 31st December 2020 (Q3):

	Number of contacts	
Type of concern	**1st October 2021 – 31st December 2021**	**1st October 2020 – 31st December 2020**
Concerns about bullying behaviour	5	0
Concerns about HR process involving the member of staff – concerns about fair treatment	1	1
Concern about patient safety	8	0
Concern about worker safety	2	0
Concerns about workload	0	0
Concerns about inappropriate behaviour	2	0
Concerned about role within the Trust	2	1
Concerned about issues directly relating to Covid-19	0	0
Concerns about service delivery	4	2
Concerned about poor working relationships within team	0	1
Unspecified – contacted for general support	1	1
Total	**25***	**6**

	YEAR TO DATE 1st April 2021 to 31st December 2021	TOTAL 1st April 2020 to 31st March 2021
Total number of contacts	43	24

Comments and learning:

- *Please note of the 25 contacts, 11 contacts were for 2 separate cases. The National Guardian Office requires Trusts to count the number of staff members individually.
- There has been a further increase in the number of contacts received (individual contacts from 12 to 25), and standalone cases from 12 to 16.
- The reasons for the concerns varied, the most significant increase was a rise to 8 patient safety concerns.
- There was also an increase in concerns (7) submitted in line with the How to Raise Concerns (whistleblowing) policy. Staff were offered the opportunity to speak with the FTSUG to discuss their concerns.
- The FTSUG was contacted about two concerns in relation to racism – both experienced and witnessed by two staff members. These cases are currently ongoing. The FTSUG is part of the Zero Tolerance to Racism working group and involved in progressing work in this area.
- With consent, an extensive concern was raised and discussed with the Freedom to Speak Up Executive Sponsor, to discuss options to resolve concerns.
- For the next Trust Board reports, the FTSUG will seek to present the data in additional formats, including per staff group.
- The resolution of one concern is detailed below in the case study.

Case study:

During Q3 the FTSUG was contacted by a member of staff regarding an incident that had occurred at the Trust. The FTSUG supported the staff member to speak up and to receive feedback about the action taken in response to the concerns they raised. The situation was successfully resolved, with a positive outcome. The staff member provided the following feedback:

> "I contacted Fran, our Speak up Guardian, when an incident that occurred at work left me not knowing what to do or who to turn to.
>
> Having someone to ask what the 'right thing to do' was made all the difference, as did her unwavering support and knowledge of how to navigate the relevant systems.
>
> I felt seen and understood, and thanks in no small part to Fran, my issue was fully resolved."

5. Planned Activities for the FTSUG Q4 2021 – 2022

The following are planned for Q4:

- Proposal to be drafted and sent to the Executive to propose disbanding the Staff Advice and Liaison (SALs) service due to the low numbers of contacts, and the duplication with the FTSUG role.
- Arrange further drop in sessions (including out of hours) to the build on the positive feedback received from the sessions held during October 2021.
- Invited to present at the Pharmacy Senior Leadership Team meeting and Pharmacy Huddle.
- Attend action plan session as a follow up to the CQC Assurance day.
- Identifying additional support services for Junior Doctors.

- Work with Education and Development to establish if FTSU can be included in the Trust Global Induction.
- Introductory 121 with Sean Lyons, new Chairman.
- FTSUG to undertake training in Trauma Risk Management (TRiM), to support staff with critical incident briefs and signposting to appropriate support avenues.
- The recruitment to Freedom to Speak Up Champions has been delayed due to the operational pressures at the Trust and the suspension of training. The awareness campaign to recruit to the Champion role will now commence.

6. Recommendation

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

Frances Moverley
Head of Freedom to Speak Up
March 2022

Hull University Teaching Hospitals NHS Trust

Trust Board March 2022

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, Intelligence and ESR Systems 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 2021, 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 2022) 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.	

Recommendation:	The Trust Board is requested to note and approve content of this report. Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines (by 30 March 2022).

Hull University Teaching Hospitals NHS Trust

Trust Board – 8th March 2022

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 2021, prior to subsequent 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 2021. 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 2022) 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.

Nationally the Office for National Statistics has noted that their gender pay gap data, including the Annual Survey of Hours and Earnings figures was subject to more uncertainty than normal as there were difficulties measuring data. This is because of the number of employees furloughed under the Coronavirus Job Retention Scheme, fewer lower paid people in the national workforce and temporary factors that have increased the headline growth rate in earnings above the underlying rate.

Locally, at Trust level COVID-19 has impacted on our Gender Pay Gap data. This includes the impact of additional recruitment due to COVID-19 including acting as host employer for staff working for the Humber Coast & Vale Vaccination Hub (casual workers employed on the snapshot date are included in the Trust headcount, and gender pay gap reporting outcomes), and changes to how Clinical Excellence awards were awarded for 2020/21.

4 THE PROPOSED GENDER PAY GAP REPORT FOR 2021

The Trust's overarching Gender Pay Gap Report, the fifth report since the regulations were introduced, is attached for the Boards 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 2022). The detail of the report will also be discussed at the Workforce, Education and Culture Committee in April 2022.

Simon Nearney
Director of Workforce & OD
March 2022

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 2021

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.

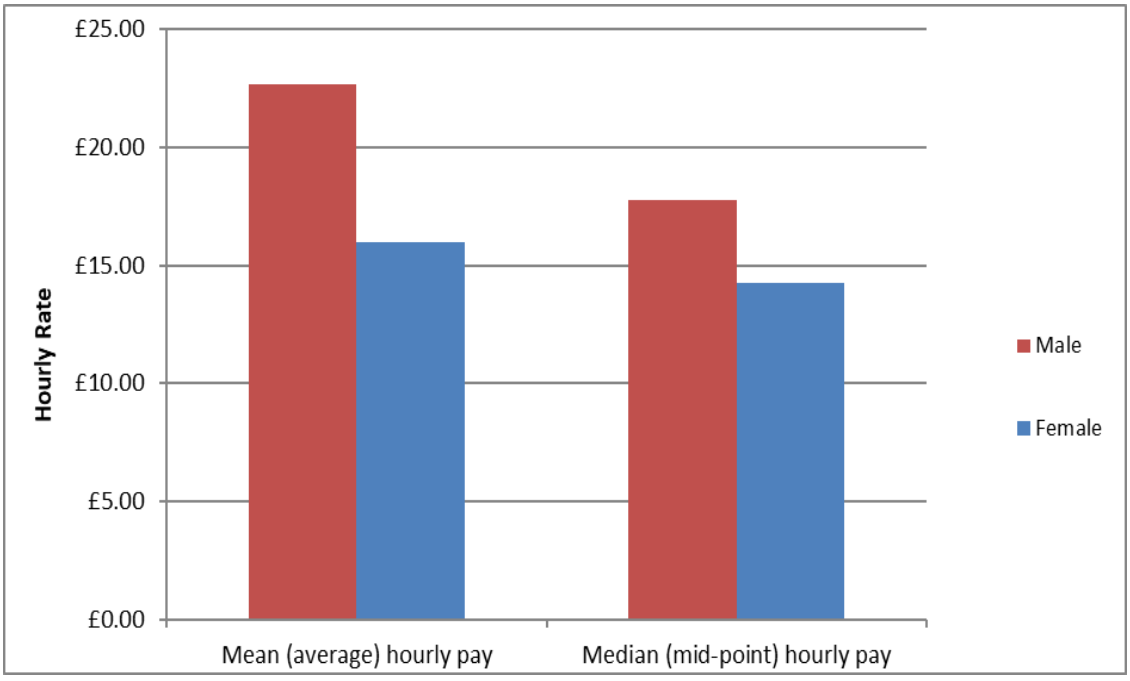
The analysis does not look at whether there are differences in pay for men and women in equivalent posts. Therefore, the results will be affected by differences in the gender composition across the Trust's various professional groups and job grades.

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 2021 is as follows;

3.1 Mean and Median Gender Pay Gap

Gender	Mean (Average) Hourly Pay	Median (Mid-Point) Hourly Pay
Male	£22.67	£17.77
Female	£15.98	£14.24
£s difference	£6.69	£3.53
% difference	29.50% ***(29.5%)***	19.85% ***(19.9%)***



- The mean gender pay gap is 29.50% (i.e. this means that women's average earnings are 29.50% less than men's).
- The median gender pay gap is 19.85% (i.e. this means that women's average median earnings are 19.85% 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 76.08% female and 23.92% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 23.92% of the workforce, there are a disproportionate number of males, 40.16% in the highest paid (upper) quartile, (predominantly medical staff) with 59.84% being female.
- The mean gender pay gap for the whole economy, based on April 2021 data, (according to the Office for National Statistics Annual Survey of Hours and Earnings figures N.B. the ONS noted that their data was subject to more uncertainty than normal as there were difficulties measuring data given the number of employees furloughed under the Coronavirus Job Retention Scheme) is 14.9% while the Trust's mean gender pay gap is 29.50% in favour of males. The median gender pay gap for the whole economy is 15.4%, compared to the Trust average of 19.85%.
- 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 3.68% (a reduction of 0.12% from the 2020 return) or £0.57 (the same as 2020), and the median (mid-point) hourly pay gap is 0.72% (an increase of 0.42% from the 2020 return) or £0.10 (an increase of 0.06p).
- The mean gender pay gap for medical staff is 13.94% (slight increase of 0.06% since 2020 return). The median gender pay gap for medical staff is 15.10% (a reduction of 7.39% from the 2020 return). Nationally the Consultant workforce is predominately male.
- In the current reporting period (2021) the male mean pay (£22.67) falls in the upper quartile, and the female mean pay (£15.98) falls in the upper middle quartile.
- The median pay for males (£17.77) falls in the upper middle pay quartile and female median pay (£14.24) falls in the lower middle quartile.
- The Trust operates a number of salary sacrifice schemes. The overall percentage of staff who pay into salary sacrifice schemes (76.80% female/23.20% male) closely reflects the Trust's Gender split. This headline figure however disguises the 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 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)
2021 Trust Gender split 76.08% female, 23.92% male

Quartile	Male	Female	Total
Lower	54 (19.08%)	229 (80.92%)	283
Lower Middle	74 (17.79%)	342 (82.21%)	416
Upper Middle	68 (16.71%)	339 (83.29%)	407
Upper	142 (40.46%)	209 (59.54%)	351
Total	**338 (23.20%)**	**1119 (76.80%)**	**1457**

In addition, more female staff pay into the salary sacrifice schemes than male staff, as highlighted in table 2 below. Across the schemes 164 staff (125 female/39 male) pay

into more than one schemes. Of these, 151 staff pay into 2 schemes (114 female/37 male), 13 staff pay into three schemes (11 female/2 male).

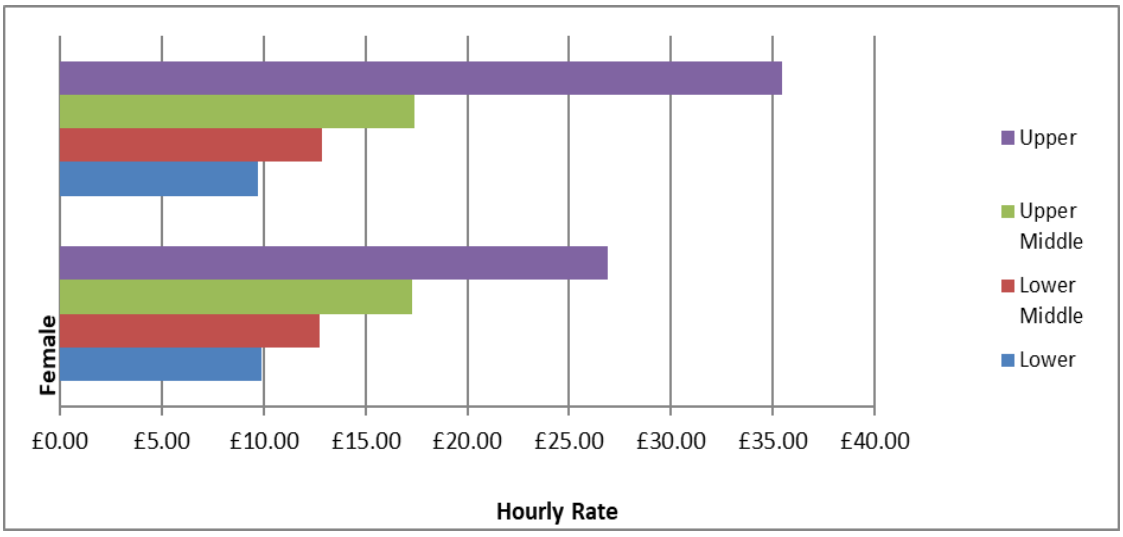
Table 2 – 2021 Data of Salary Sacrifice Schemes by Gender (Childcare, Home Electronics, Lease Car, Cycle)

Schemes: 2021	Number in Scheme		Average Sacrifice per Month		Range	
	Female	Male	Female	Male	Female	Male
Childcare Vouchers	148	52	£107.39	£110.02	£15 – £243	£15 – £243
Home Electronics	800	163	£71.80	£83.96	£3.16 – £294.28	£4.51 – £362.51
Lease Car Scheme	253	116	£421.25	£585.99	£60.40 – £831.10	£116.98 – £1681.64
Cycle Scheme	54	48	£67.47	£129.24	£19.46 – £340.71	£25.29 – £583.33
Total	**1255**	**379**	**£166.98**	**£227.30**	**£3.16 – £831.10**	**£4.51 – £1681.64**

N.B. The table above includes the multiple payments for staff who pay into more than one salary sacrifice scheme.

3.2 Pay Quartiles by Gender

Quartile	Male			Female			Total
	Headcount	% Headcount	Mean (Average) Hourly Pay	Headcount	% Headcount	Mean (Average) Hourly Pay	
Lower	404	17.51%	£9.72	1903	82.49%	£9.90	2307
Lower Middle	437	18.93%	£12.86	1871	81.07%	£12.77	2308
Upper Middle	440	19.06%	£17.39	1868	80.94%	£17.30	2308
Upper	927	40.16%	£35.43	1381	59.84%	£26.92	2308
Total	2208	23.92%	£22.67	7023	76.08%	£15.98	9231



3.2.1 Key Findings

- The table and graph above shows that in the lower quartile female employees are paid more than male employees giving a gender pay gap of -1.82% or -£0.18p. In the lower middle quartile male employees are paid more than female employees giving a gender pay gap of 0.70% or £0.09p. In the upper middle quartile male employees are paid more than female employees giving a gender pay gap of 0.52% or £0.09p (N.B. this is however a shift from the previous return when female employees were paid more than male employees with a gender pay gap of -0.66 or -£0.11p). In the upper quartile the gender pay gap increases to 24.02% or £8.51.
- Based on the Trust's overall gender split (76.08% female and 23.92% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. There a disproportionate number of males, 40.16%, in the upper quartile compared to 59.84% being female. In addition the percentage of males in the upper pay quartile has also risen, from 39.9% in 2020 to 40.16% in 2021, a 0.26% increase. The mean hourly pay gap for the upper quartile has risen from, £7.85 to £8.51, a £0.66 increase on the previous reporting period.
- The Trust has an additional headcount of 150 males and 287 females included within this years return. Where these staff fall in the pay quartiles (as shown in the table below) has also contributed to the Trust's slight increase in the mean and median pay gap data this year.

Additional headcount 20/21 and where they fall in pay quartiles

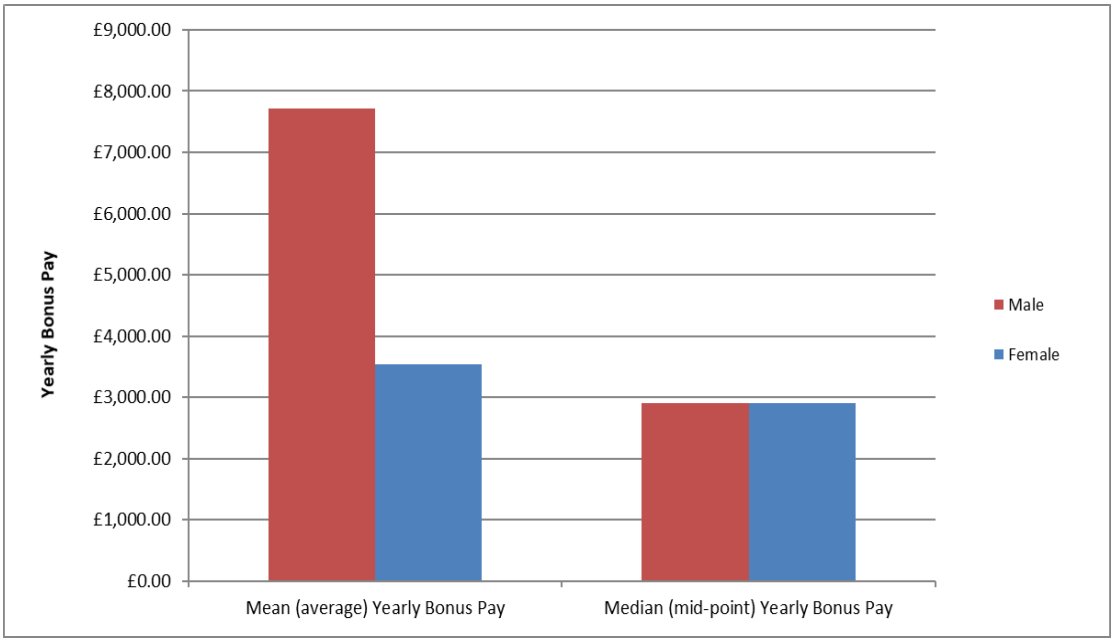
	Males		Females	
	Headcount	%	Headcount	%
Lower	23	15.33%	86	29.97%
Lower Middle	37	24.67%	72	25.09%
Upper Middle	40	26.67%	69	24.04%
Upper	50	33.33%	60	20.91%
Total	150		287	

For males 60% of the additional headcount is within the Upper to Upper Middle quartiles. For females 55% of the additional headcount is within the Lower to Lower Middle quartiles.

- Medical staff account for the majority of the Trust's highest earners. Within the Medical staff group there is a disproportionate gender split (38.02% females and 61.98% male). In the Upper Quartile for Medical staff the headcount split is 35.48% female (0.42% reduction on previous reporting period) and 64.52% male (0.42% increase on previous reporting period).
- The Trust has a split of 58% full time and 42% part time staff. 91.62% of part time staff are female. The majority of part time staff are in the lower quartiles (56.49% are in the lower and lower middle).
- Only 28.86% of staff in the upper quartile are part time, 84.38% of whom are female. This is disproportionate when compared with the Trust wide figure of 42% 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	£7,712.10	£2,898.11
Female	£3,543.91	£2,898.11
£s Difference	£4,168.19	£0
% Difference	54.05% ***(54.1%)***	0% ***(0%)***



3.2.1 Key Findings

- The mean gender bonus gap is 32.82% when long service awards[1] are excluded from the data, rising to 54.05% when they are included in line with national guidance.
- The median gender bonus gap is 0%. This is because the median bonus pay for males and females, both including or excluding long service awards is £2,898.11 (a CEA).
- The improvements in the nationally reported mean and median bonus gap figures (i.e. including long service awards) compared to the previous reporting period (mean bonus gap 70.28%, median bonus gap 99.24%) need to be treated with caution as they are largely due to changes in the allocation of local CEAs in light of the COVID-19 pandemic. Further details on these changes can be found in section 3.5.1.

3.3 Bonus Distribution by Gender including Long Service Awards

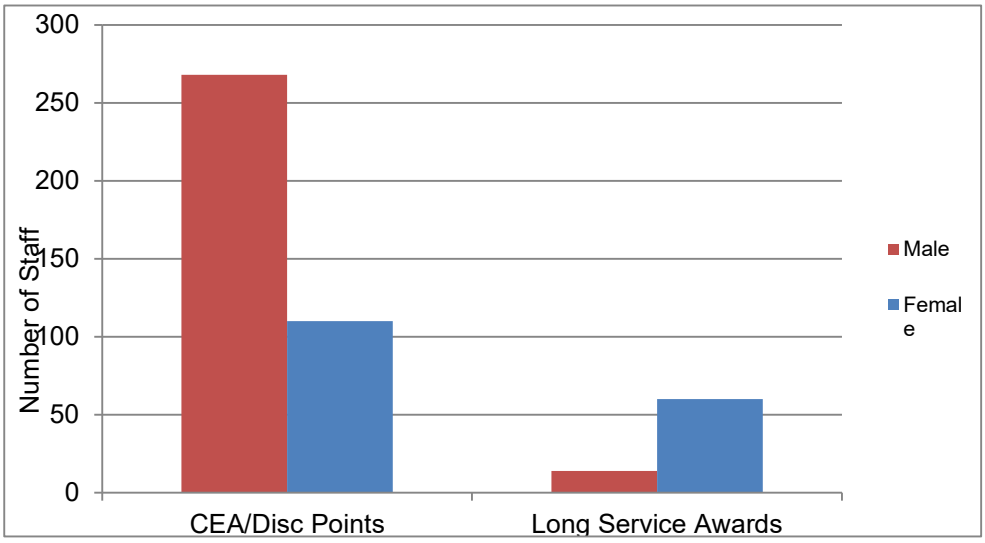
Gender	% Receiving Bonus
Male	12.77% ***(12.8%)***
Female	2.42% ***(2.4%)***

- The proportion of male employees receiving a bonus is 12.14% excluding long service awards (12.77% when included) and the proportion of female employees receiving a bonus is 1.57% excluding long service awards (2.42% when included).

[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.

3.4 Bonus Type by Gender

Bonus Type	Male		Female		Total Headcount
	Headcount	%	Headcount	%	
CEA/Discretionary	268	70.90%	110	29.10%	378
Long Service Awards	14	18.92%	60	81.08%	74
Total	282	62.39%	170	37.61%	452



3.4.1 Key Findings

- This year the Trust has two types of bonus that meet reporting requirements. The first is Long Service Awards, which accounts for 16.37% of payments. The second is Clinical Excellence Awards, which account for 83.63% of payments (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 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.
- The gender split for all bonus pay is 37.61% female and 62.39% male, however as 35.29% of female bonus pay is the £50 long service award and only 4.96% for men, this results negatively on mean bonus pay.
- If long service awards are excluded, the mean bonus pay gap reduces from 54.05% (£4,168.19) to 32.82% (£2,662.69).
- The Trust has a 0% median bonus gap. This is because the median bonus pay for males and females, both including or excluding long service awards, is £2,898.11 (a CEA).
- As at the snapshot date (31 March 2021) the Trust has an overall gender split of 38.02% female and 61.98% male in the Clinical Medical staff group. The Consultant gender split is 27.92% female and 72.08% male.
- The gender split for those receiving a CEA/discretionary payment is 29.10% female and 70.90% male.
- CEA and discretionary points payments range from £418.46 to £59,477.04.

- 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.
- *Existing* (old style) local awards awarded prior to April 2018 will remain consolidated and pensionable and the associated payments will remain protected until at least 31 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.
- The difference in bonus pay is also driven by the payment of higher (accumulated) bonuses under the old pre- April 2018 CEA scheme for Consultant Medical staff where there is a greater proportion of men. Whilst there has been a reduction in the total numbers holding CEAs under this scheme since the last reporting period, from 140 to 133, 76.69% of awards are currently held by male staff compared to 23.31% by female staff.
- In light of the COVID-19 pandemic, new style Local Clinical Excellence Awards (LCEA) did not run for the financial year 20/21. Instead NHS Employers, the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA), the tripartite negotiating group representing senior doctors and their employers, sought and received ministerial acknowledgement of the current exceptional circumstances, and the significant operational pressures that services were under as they responded to the health crisis. An agreement was made to halt the 20/21 LCEA round and related work to enable clinicians and managers to focus on immediate priorities. Following agreement with NHS England, NHS Improvement (NHSE/I) and the Department for Health and Social Care, the award money was distributed equally amongst eligible consultants who chose to opt in to receive a share of this money (N.B. the value of the payment was not, unlike other CEA awards pro-rated for part-time staff). Those consultants who chose to opt in received the payment as a one-off, non-consolidated payment in place of normal LCEA rounds, due to exceptional circumstances. The eligibility criteria remained largely the same as in previous award rounds (with the exception of an in-date appraisal).
- Eligibility for the new CEA/Discretionary points for 2020/21 (28.98% female, 71.02% male) was broadly consistent with the Consultant gender split (27.92% female and 72.08% male).
- 84.9% of CEAs are held by full-time staff. 15.1% of CEAs are held by part-time staff.
- As a greater number of the Trust's female Consultants work flexibly on a part-time basis (12.69% male, 27.21% female) this distorts both the mean and median bonus pay as CEA bonus payments are pro-rated for part-time employees (old style awards and new style awards only, but excluding the 2020/21 local COVID-19 impacted awards). This part-time split is broadly reflected in those with CEAs (10.11% of male CEAs are for part-time Consultants, 27.27% of female CEAs are for part-time Consultants).

4 NATIONAL PICTURE

Moving forwards the Trusts Gender Pay Gap bonus indicators should improve as a result of changes to the national clinical excellence awards scheme and local clinical excellence awards schemes.

The consultation response to reform the national clinical excellence awards scheme was published on 26 January 2022. The reforms aim to broaden access to the scheme, make the application process fairer and more inclusive and ensure the

scheme rewards and incentivises excellence across a broader range of activity and behaviour. Part of the reform includes a name change for the scheme to National Clinical Impact Awards (NCIA's). Although not all the reforms can be enacted immediately, the new scheme and it's operational changes aim to help improve the turnover, diversity and agility of the scheme to reflect the modern NHS workforce, it's needs and priorities, while remaining relevant to the increasingly varied roles senior clinicians undertake. In summary the changes include; increasing the number of available rewards, re-branding the scheme, re-structuring the award levels, refreshing the assessment domains, simplifying the application process, removing pro-rated awards (those working less than full time will no longer have their award payments pro-rated), remove the renewal process, removing the pensionability of awards, simplifying the process for employers.

Local achievement will continue to be recognised by the local awards scheme (LCEA). Work continues with the relevant national bodies leading on the negotiations to develop a new local performance scheme, to recognise the links and interdependencies between national and local schemes, to ensure that local, regional and national impact are recognised and rewarded.

The reforms reflect the changing demography of the medical workforce and take into account wider evidence including recommendations within '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 reforms are also anticipated to help deliver the Long Term Plan in England, alongside the NHS People Plan.

In light of the ongoing effects of the pandemic, Local CEAs will not be run for 2021/22 and, as was the case in 2020/21, the award money will instead be distributed equally amongst eligible consultants.

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 29.50% and median gender pay gap at 19.85% have increased marginally since the previous reporting period, and are above the national averages of 14.9% (mean) and 15.4% (median). Excluding medical and dental staff the Trust figures would be 3.68% and 0.72% respectively.

A number of factors contribute to the Trust's slight increase in the mean and median pay gap data this year.

Firstly, changes to the gender pay gap within the four pay quartiles is evident in this year's data. This includes the impact of where the additional headcount of 437 staff who are included in this year's return fall within the pay quartiles.

Secondly, factors within the upper pay quartile. Within this there remains a disproportionate number of males, 40.16% (a rise of 0.26% from 39.9% in 2020), compared to 59.84% being female. In addition the mean hourly pay gap for the upper quartile has risen since 2020 from, £7.85 to £8.51, a £0.66 increase on the previous reporting period.

Payment into salary sacrifice schemes continues to impact on the Trust's gender pay gap data. Whilst the overall percentage of staff who pay into the schemes closely reflects the Trust gender split this headline figure disguises the impact on mean and median female pay averages, and where females fall in pay quartiles (i.e. they might have otherwise fallen into a higher quartile).

Both the mean and median gender bonus gap have improved, however as noted this improvement needs to be treated with caution as it is largely due to changes in the allocation of local CEAs for 2020/21 in light of the COVID-19 pandemic (as highlighted in section 3.51). The Trust's gender bonus data remains distorted by three main factors; the Trust's Long Service Award scheme, payment of higher (accumulated) bonuses under the old pre-April 2018 CEA scheme for Consultant Medical staff (where there is a greater proportion of men), and the current national requirement (with the exception of the local CEAs for 2020/21) to pro-rata CEA bonus payments for part-time Consultants (the large majority of whom are female).

5.1 <u>What Have We Done to Date?</u>

- Continued to encourage female participation in leadership development programmes.
- Continued review of existing career and talent development opportunities and identification of new opportunities.
- Opportunities to develop interviewing skills have been offered to staff to refresh or upskill their interviewing technique and explore strategies to challenge any unconscious bias.
- Continued support and management of Assessment Centres for several senior roles to ensure robust decision-making and rigour is applied to assessment centre processes.
- 'Civility and Inclusion' and 'Diversity and Inclusion' sessions have been delivered as part of the 'Leading through COVID-19' series of webinars.
- Interviewing Skills Training for applicants offered on an ad-hoc basis or in workshops to provide staff with support in their preparation before interviews.
- The Trust continued to offer a wide variety of apprenticeships at all levels, including degree level. These support both 'grow your own' or external candidates through traditional study and on-the-job learning in addition to providing opportunities to staff who wish to further their qualifications. These include apprenticeships in Nursing, Allied Health Professions, teaching and many other topics.
- Continued the development and extension of new roles including; Consultant Sonographers, Radiographers, reporting Radiographers and Nursing Associates.
- Continued to enshrine career pathways, which clearly map out opportunities for career advancement in a number of areas including Physiotherapy, Radiology, Occupational Therapy, Speech and Language Therapy.

- Further extended roll out of medical workforce roles and medical associate professions, including Advanced Clinical Practitioners, Physicians Associates, Advanced Critical Care Practitioners, Anaesthetic Associates and Surgical Care Practitioners, which provide career development opportunities at a more senior, higher paid level.
- The Trust continued 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. The programme has since been refreshed and the content updated.
- 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.
- The Coaching and Mentoring Network continued to offer opportunities for staff to explore their professional and career development.
- Mentors were trained for a Reverse Mentoring Programme and the training for mentees is to be scheduled.
- Specific retention surveys have been undertaken in areas of high turnover to address any concerns, including equality concerns that may be raised.
- A "Stay and thrive" group, which is part of a national NHSEI network, has been established. The aim of the group is to encourage international nurses (who are predominantly female) to not only stay but to also thrive, and apply for higher banded roles. The group is looking at barriers and how they can overcome these.
- 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 working, or considering working, less than full-time, run in partnership with the BMA remains firmly established. Successes include a comprehensive induction package for doctors returning to training or returning from, for example, family friendly leave. The package incorporates, for example, details of roster changes, what has changed in their medical training, what they need to refresh.
- Medical Staffing have a designated less than full time champion who works with colleagues, who may be changing their part time rota pattern or going part time for the first time, on personalising their rotas.
    - Funding was secured to make an appointment to a Trust Equality, Diversity and Inclusion Lead (Workforce) post in January 2021.

5.2 **<u>Next Steps</u>**

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

- Implementation of actions agreed nationally or locally in light of the 'Mend the Gap, The Independent Review into Gender Pay Gaps in Medicine in England' report published on 15 December 2020.

- The Trust received positive feedback from the 2020 Staff Survey in relation to flexible/home working. Staff value being able to work flexibly and this is an area the Trust is keen to continue and build on.
- Acknowledging that flexible working remains a key enabler to attracting and retaining talent, the Trust was successful in obtaining a place on the NHS 'Flex for the Future' programme. This brand new programme run by NHS England and NHS Improvement to help NHS organisations better embrace flexible working commenced in September 2021. The aim of the programme is to provide NHS organisations with a step-by-step programme to create their own local plan to deliver more flexible working opportunities in all roles, meeting the People Plan commitments. Within the Trust a Flexible Working Change Team has been established to drive this forward. The group's actions include; analysing the organisation's current baseline, examining key areas to address to achieve change in terms of flexible working practices, embedding flexibility within the workforce, supporting managers to have proactive, effective conversations about flexibility in their teams, analysing the range of ways to design jobs flexibly.
- Staff surveys, 1:1 interviews and focus groups focused on 'Talent Management'. This enabled us to understand staff experiences and perspectives in relation to career progression and access to professional development opportunities. Findings will inform a detailed action plan.
- The Equality, Diversity and Inclusion training offer is to be further developed so that staff access a more in-depth and informative session as part of their mandatory required learning. The taught EDI training is being adapted to self-directed E-learning in order to enable more staff to access in-depth information rather than choosing the briefer session.
- The Executive Team and Health Group Directors are participating in an Inclusive Leadership Programme (2021 – 2022).
- Within the Medicine and Emergency Medicine Health Group embed further the Workforce and Finance Committee meetings. These 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.

Locally, at Trust level, the impact of COVID-19 has led to delays in some of the initiatives designed to help reduce the Trust's gender pay gap. Internationally evidence, to date, suggests that COVID-19 will extend the duration to close the gap.

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

The Trust believes, however, that over time, it's commitment to fostering inclusion, fairness and flexibility will be reflected in it's 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.